The Future of the Healthcare Marketplace: Implications for Retirees

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Outline

- Retirement Security and Health Care
- The Economy and Healthcare coverage
- The Quest for Value
- Health Reform, Policy and Politics
- Delivery System Transformation

The Four Pillars of Retirement Security

- Social Security
  - Will it be there?
- Private pensions and personal savings
  - Defined Benefit to Defined Contribution
  - Will NASDAQ ever be 5,000 again?
- Earnings
  - All the jobs will be in China or India
- Health Insurance Benefits
  - Medicare: Only pays about half of medical costs of elderly
  - Retiree health benefits: Being eroded
  - Supplemental coverage: Getting more expensive
  - Long term care: Cross your fingers……..

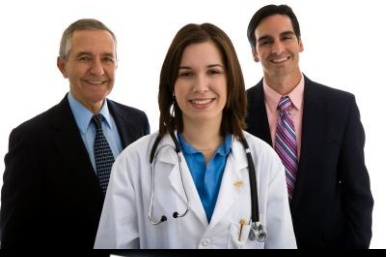
How the Global Economy Worked until Recently in 10 Easy Steps (Part 1)

1. Hard working people in communist countries (e.g. China, Vietnam) made good, cheap products and exported them to America at a profit

2. They saved as much money as they could (like 30% of their income)

3. They loaned their money to US banks and government

How the Global Economy Worked until Recently in 10 Easy Steps (Part 2)



4. Our Banks leveraged the money 30 to 1 and loaned it to Americans to buy big houses we couldn't really afford

5. Many Americans (and a lot of immigrants) were fully employed building these houses; cleaning them; selling mortgages, credit default swaps and title insurance

6. Some Americans worked as nurses, doctors, teachers, waiters or cooks because they weren't any good at real estate or construction

7. The rest of Americans were prison guards or gave Powerpoint presentations to each other

How the Global Economy Worked until Recently in 10 Easy Steps (Part 3)

8. We all had jobs, we all could borrow money to buy stocks and more houses, and there was great demand so the value of the houses and the stocks kept going up and because we all felt rich……

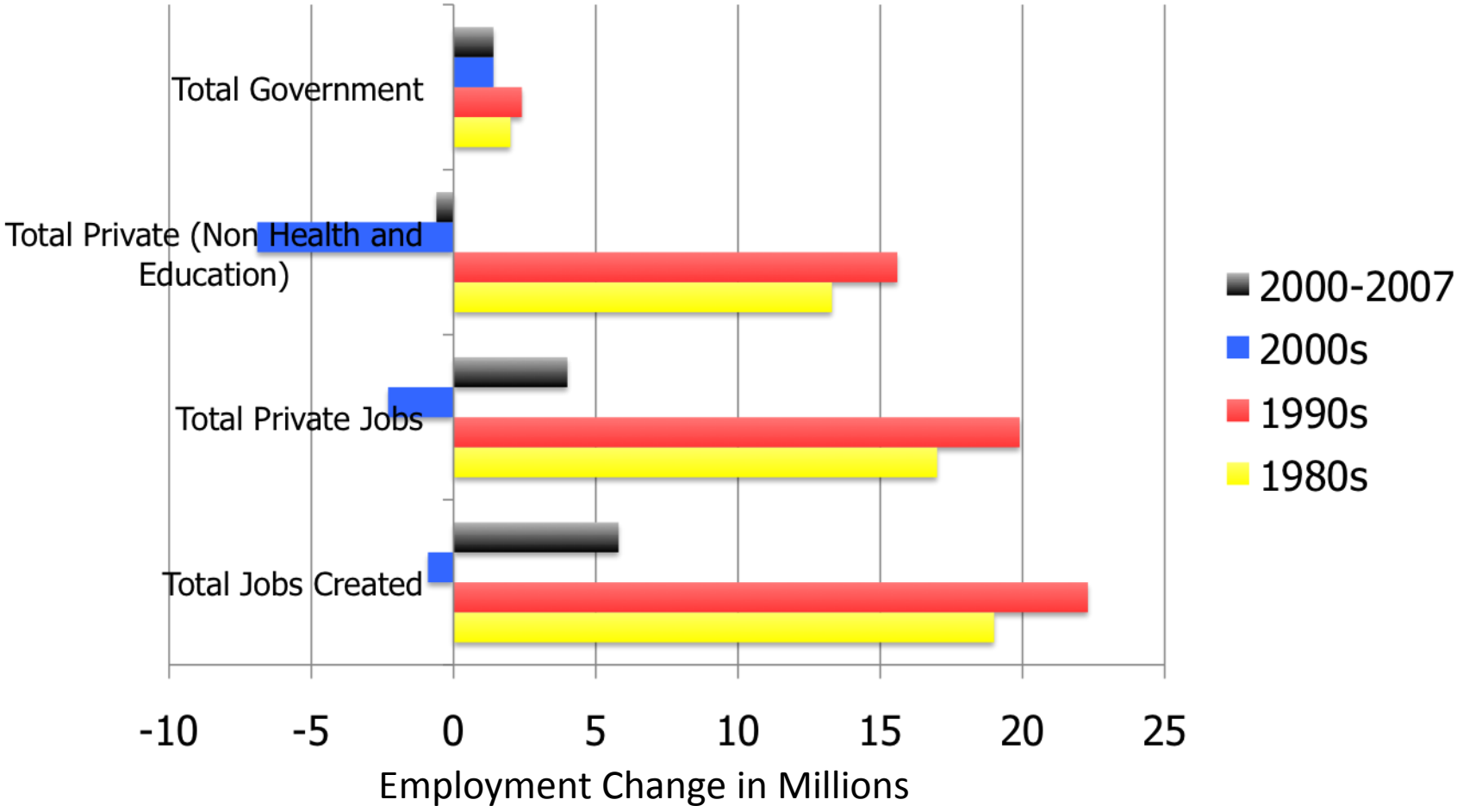
9. We got to borrow even more money so that…..

10. We filled our houses with good, cheap products made by hard working people in communist countries.

The Economy and Healthcare

- The Old Economy is Over
- The Meltdown impacted Healthcare:
  - 7 million people lost employment-based health insurance in 2009 alone
  - 50 million uninsured reached at peak (down to 47 million because of early ACA provisions
  - Cost sharing means volume reduction
  - The credit crunch slowed capital investment
  - Federal and state budgets under huge pressure
  - Yet, employment in healthcare continued to grow by 500,000 from 2009-2011
- The Next Economy more challenging for healthcare as all the math-based jobs move to China and we whack schoolteachers and firefighters

Private Sector has lost Jobs since 2000, even up to peak in 2007 Private Sector (non Healthcare and Education) lost 600,000 jobs from 2000-2007



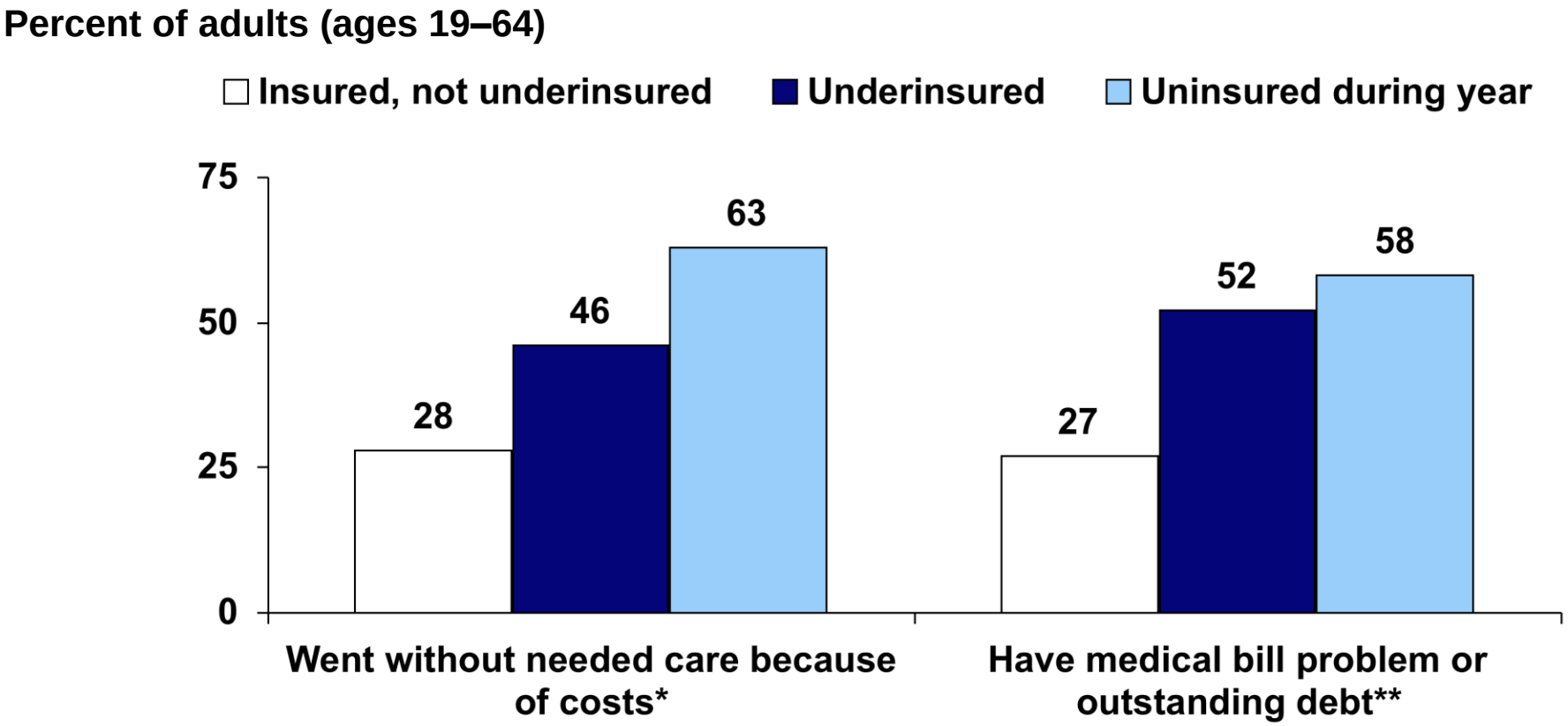
Source: Author calculations from BLS, 2010

Health Insurance Coverage Has Become Worse Since 2001… By How Much?

Base: All Adults Aged 19-64	2001	2005	2010
	%	%	%
Spent 10% or more on premiums	11	14	15
Spent 10% or more on out-of-pocket	21	23	32
Did not visit a doctor because of cost	14	24	26
Did not fill a prescription because of cost	18	25	26
Skipped a test/treatment/follow up because of cost	11	20	25

SOURCE: Commonwealth Fund Health Insurance Survey

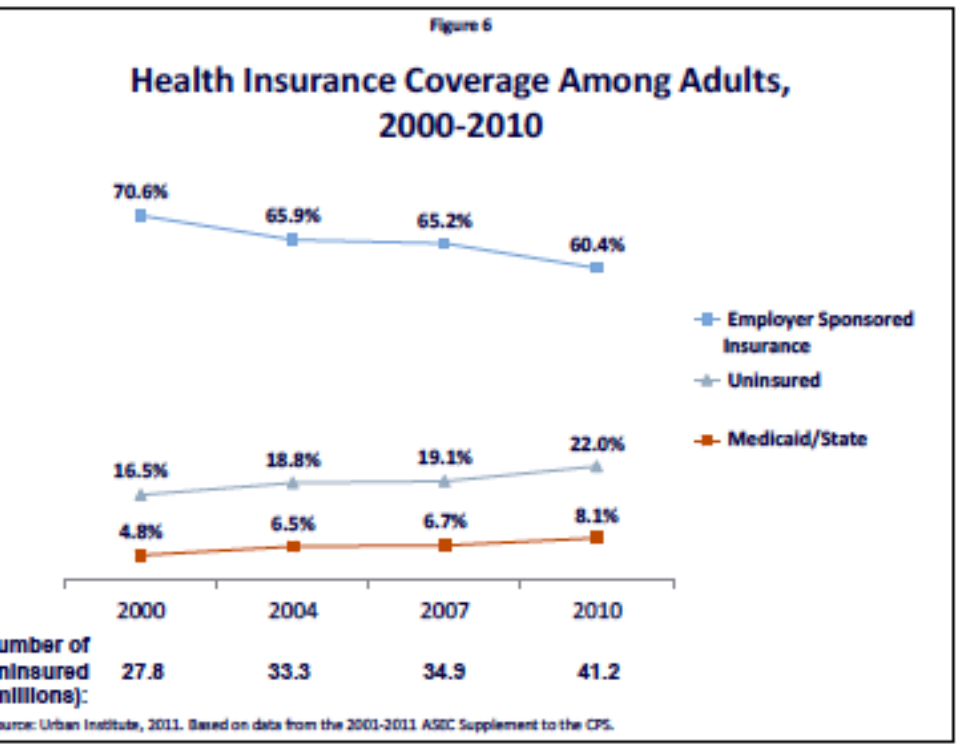
Underinsured and Uninsured Adults at High Risk of Going Without Needed Care and of Financial Stress

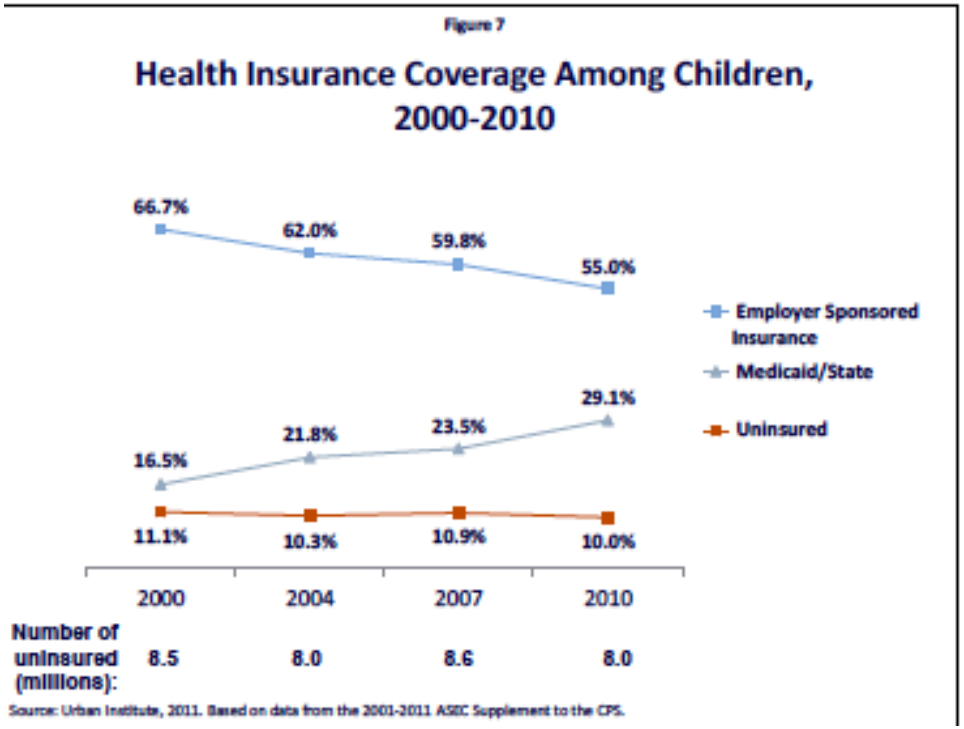


* Did not fill prescription; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor; or did not get needed specialist care because of costs. ** Had problems paying medical bills; changed way of life to pay medical bills; or contacted by a collection agency for inability to pay medical bills or medical debt.

Source: C. Schoen, M. Doty, R. Robertson, S. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent," *Health Affairs,* Sept. 2011. Data: 2003 and 2010 Commonwealth Fund Biennial Health Insurance Surveys.

Employer Sponsored Coverage Down Medicaid Up





Source: KFF, December 2011

December 2011

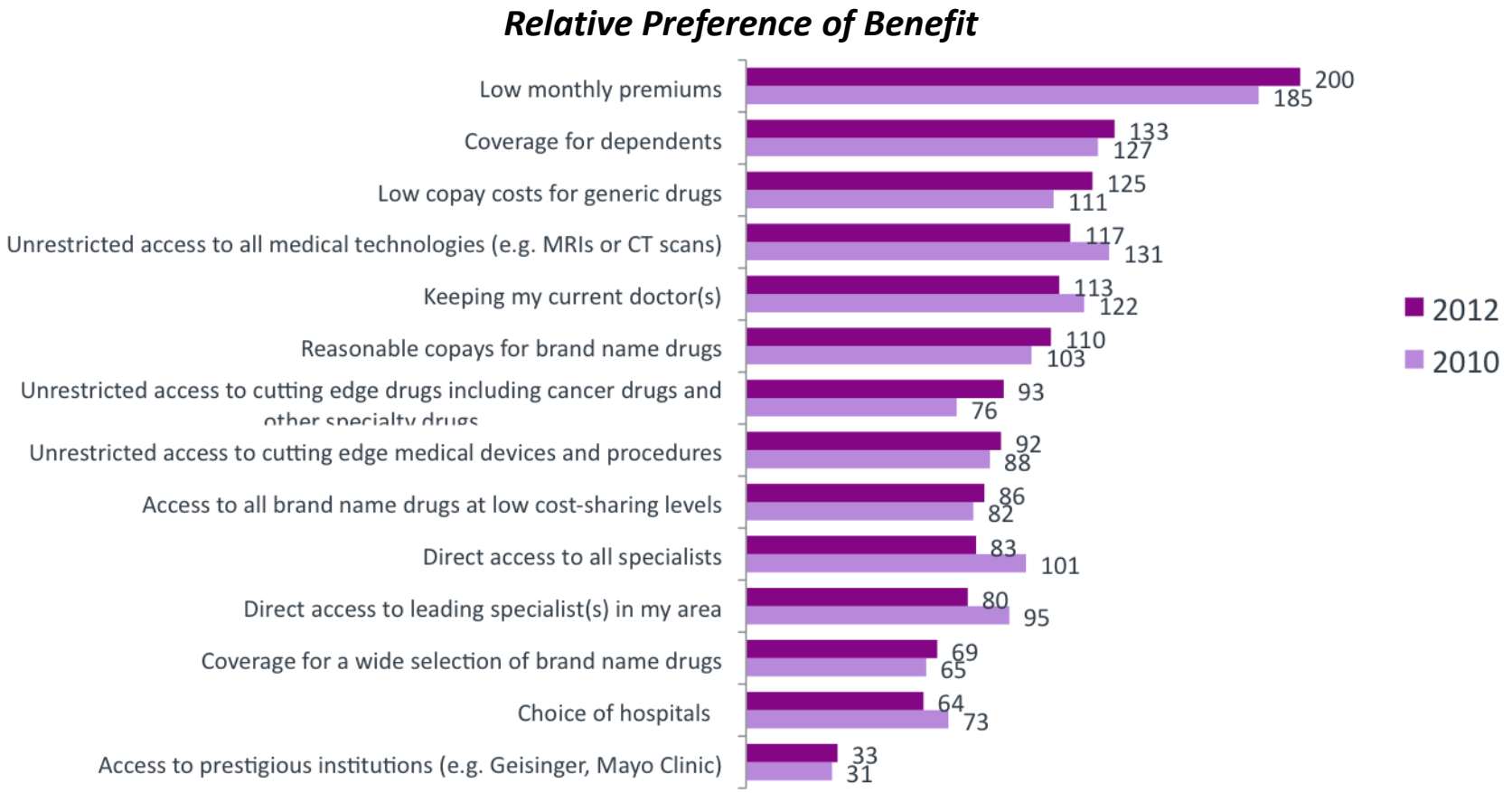
Changes in Health Insurance Coverage in the Great Recession, 2007-2010

John Holahan and Vicki Chen

The Urban Institute

mmary

The Narrow Network Threat: Consumers want low premiums and are willing to trade off narrow networks to get them



Base: All US Adults Less than 65

SOURCE: Strategic Health Perspectives 2012 Consumer Survey

Respondents were given a maximum difference trade off exercise in which they were forced to choose the most preferred and least preferred plan feature.

Consumers continue to be receptive to skinny networks, with demand jumping as you move from $100 to $200 monthly increase

Consumer Response to Premium Increases

	If monthly premium increases by $100…		If monthly premium increases by $200…	
	2010	2012	2010	2012
Pay the premium increase and keep the plan that you have	40%	35%	16%	15%
Switch to a **high deductible** health plan	21%	24%	32%	36%
Switch to a **closed network** health plan	39%	40%	52%	49%

Base: All US Adults

SOURCE: Strategic Health Perspectives 2012 Consumer Survey

Purchasers reassessing their role

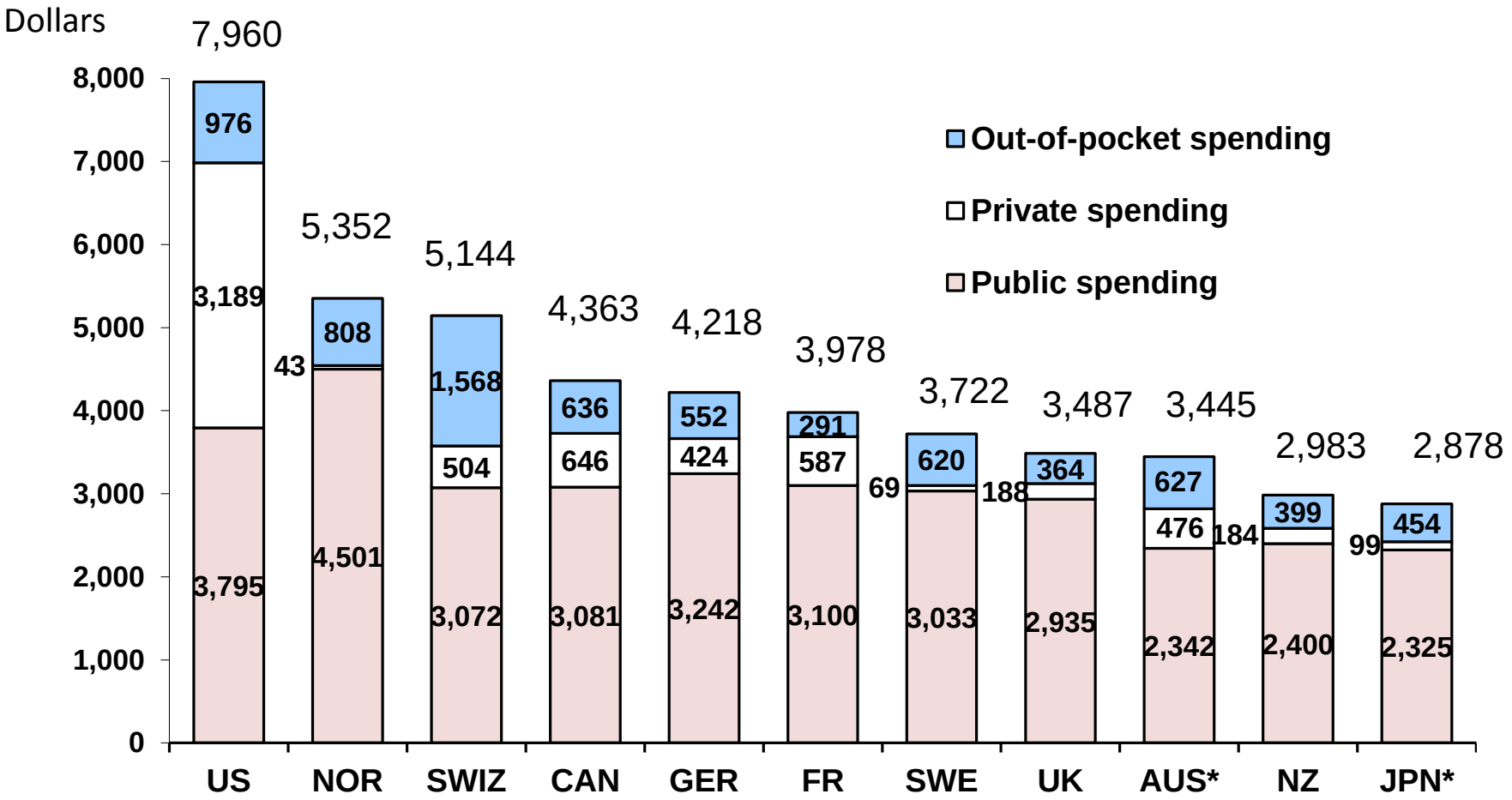
- Growing interest in direct contracting with providers and ‘accountable’ systems
- Early consideration of the role of Exchanges and possible ‘exit’ from employer-sponsored benefits
- Pushing greater responsibility onto employees to encourage them to shop based on cost, quality (movement toward defined contribution strategy, more limited plan offering, consumer shopping tools).
- Placing greater faith in infrastructure to support continuous improvement (Health IT)

Source: Personal Communication, PBGH, 2012

Defining Value of Health Services

$$\text{Value} = \frac{(\text{Access}+\text{Quality}+\text{Security})}{\text{Cost}}$$

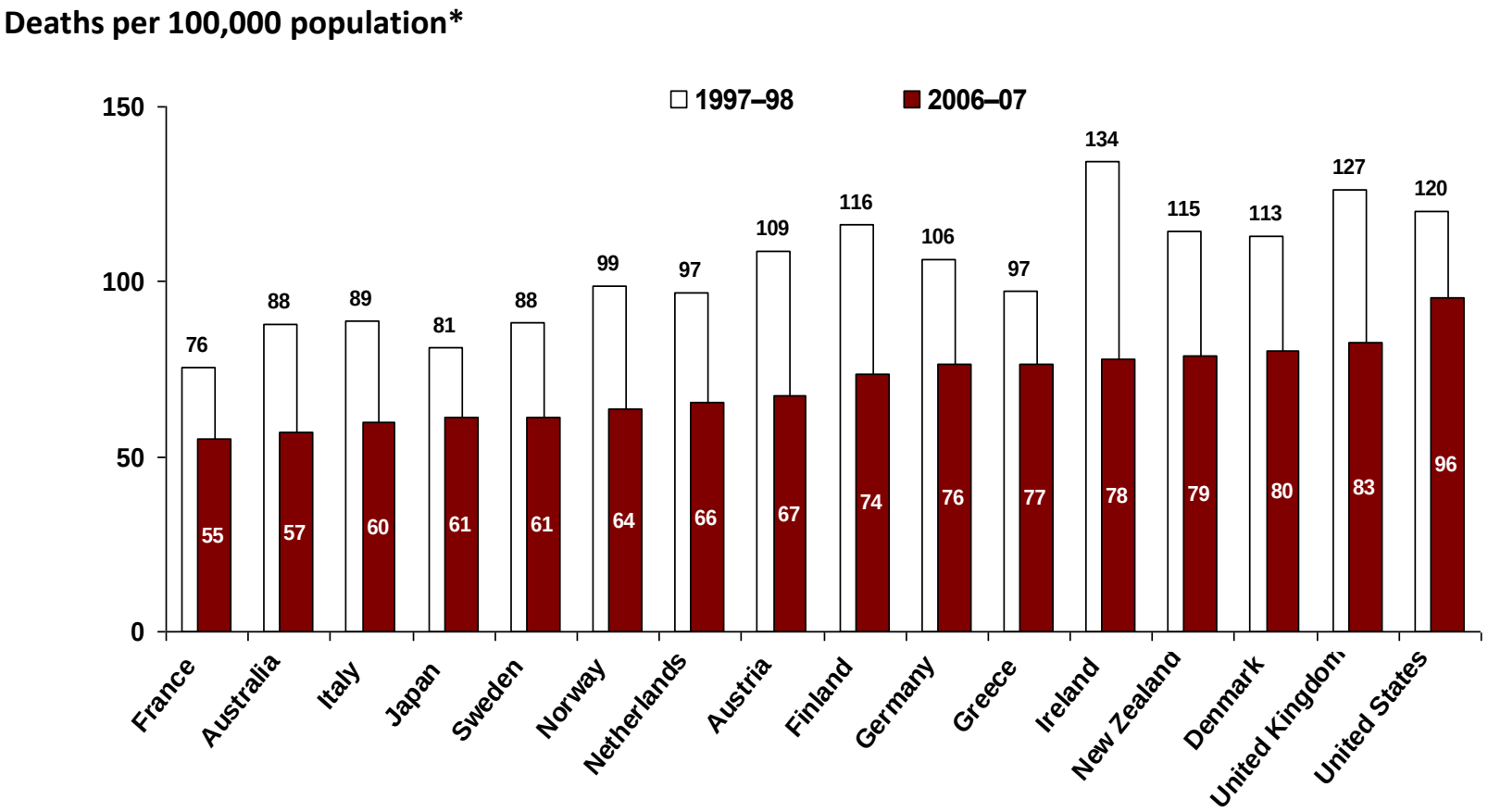
Health Care Spending per Capita by Source of Funding, 2009
Adjusted for Differences in Cost of Living



* 2008.

Source: OECD Health Data 2011 (June 2011).

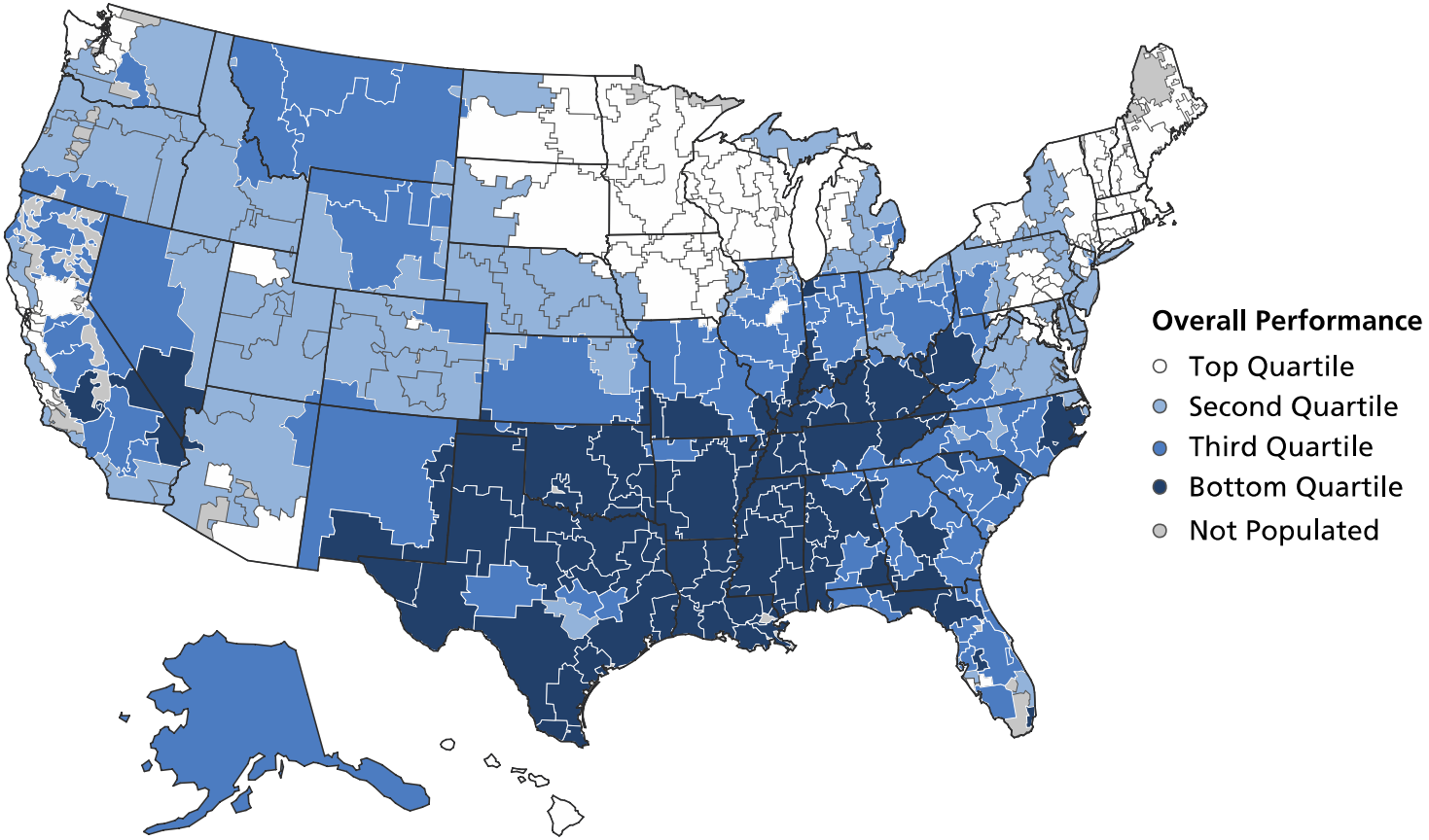
U.S. Lags Other Countries: Mortality Amenable to Health Care



* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections. Analysis of World Health Organization mortality files and CDC mortality data for U.S.

Source: Adapted from E. Nolte and M. McKee, "Variations in Amenable Mortality—Trends in 16 High-Income Nations," *Health Policy,* published online Sept. 12, 2011.

Overall Health System Performance



Source: Commonwealth Fund Scorecard on Local Health System Performance, 2012.

HEALTHCARE REFORM

Obamacare

Medicare

3 Long Term Futures

WE "BEND THE CURVE"

Reimbursement Reform Works

OR

OUT-OF-POCKET COSTS INCREASE DRAMATICALLY

Red meat (not just skin) in the game

OR

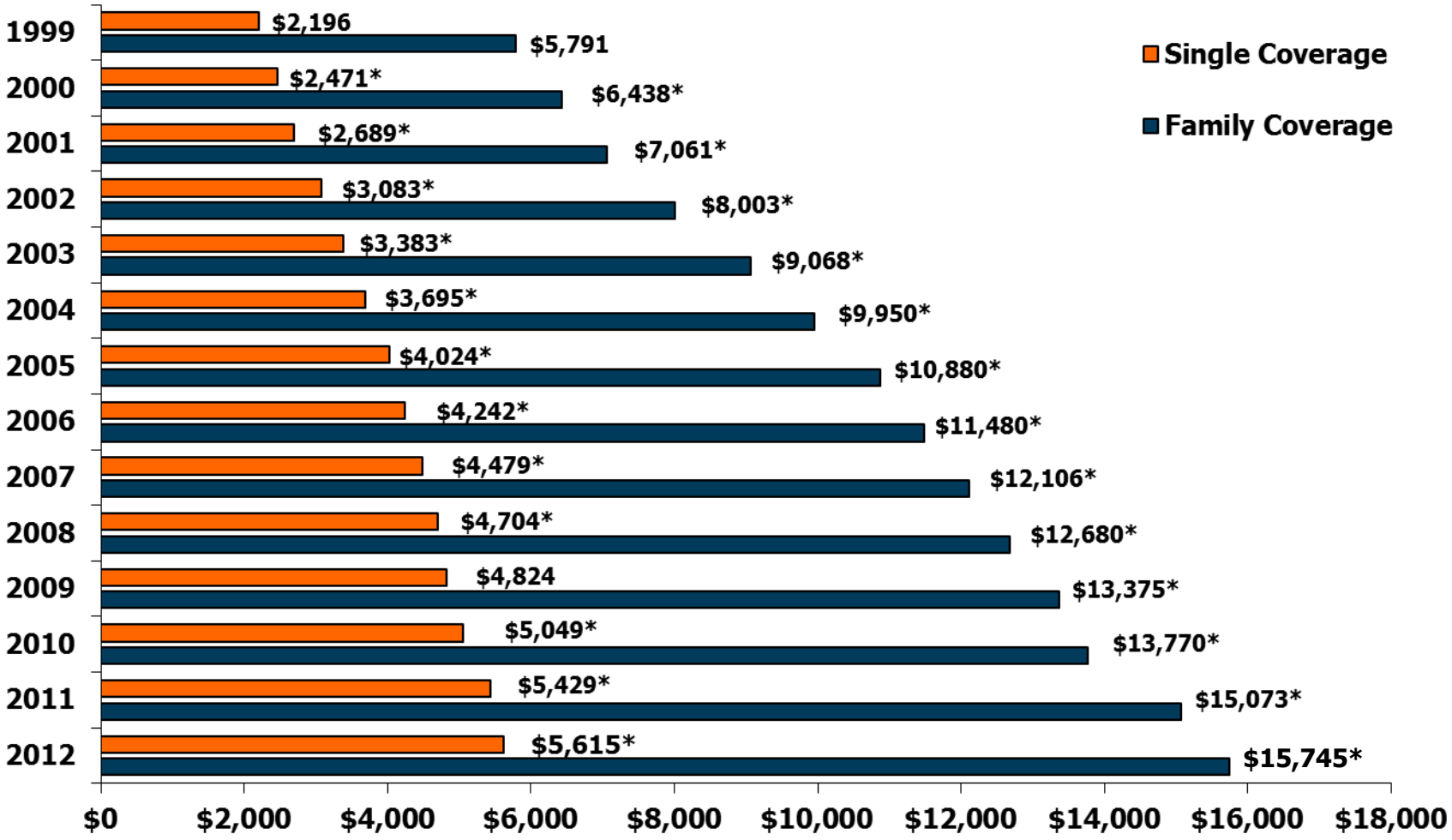
BRUTAL PRICE CONTROLS

"Medicaid prices for all"

Healthcare Reform: The Basic Problem

- The Average family cannot afford the Average Premium
- There are not enough Rich People to go around (The 98/2 Problem)
- It's the Delivery System Stupid!
- We don't want less than what we have now, we want more
- Nobody wants to take a pay cut or to be denied even ineffective care

Average Annual Premiums for Single and Family Coverage, 1999-2012

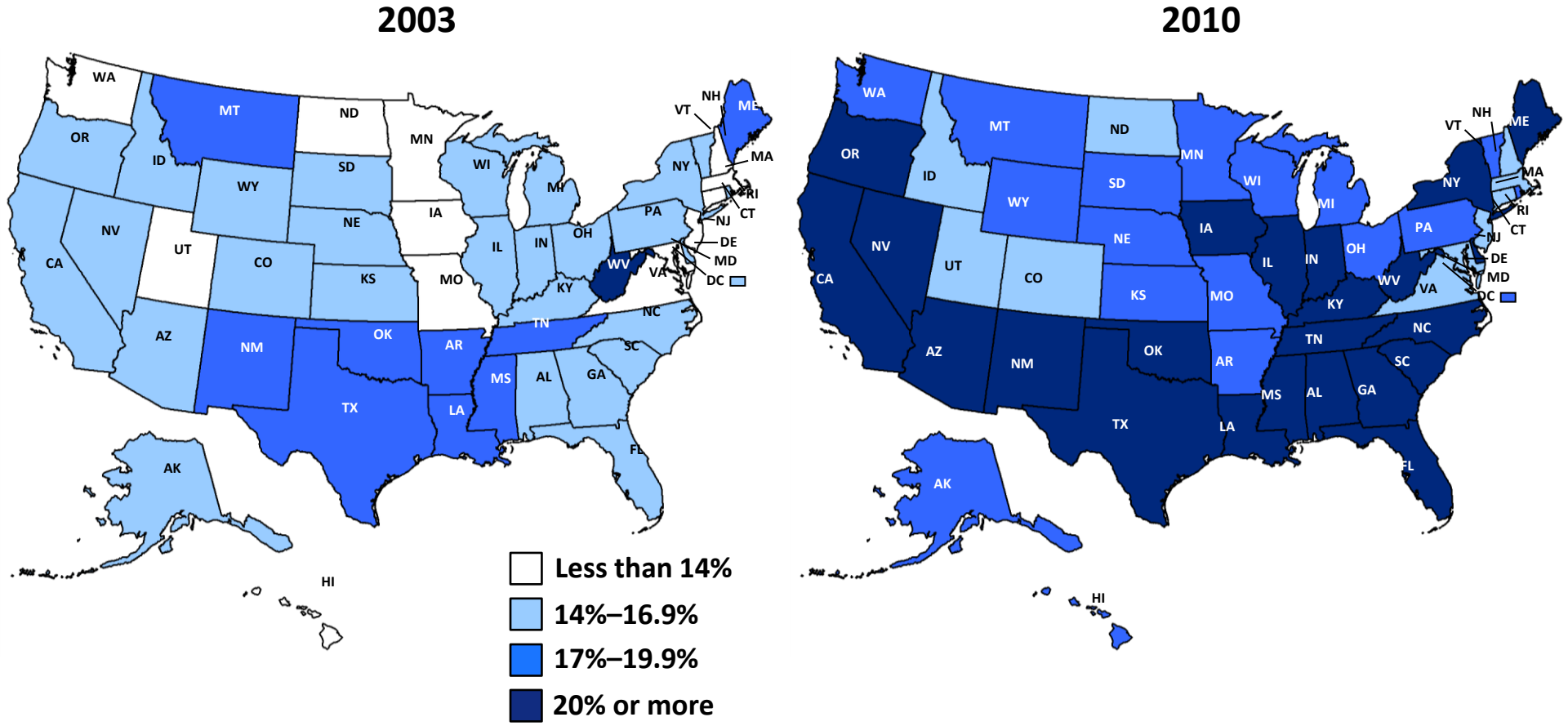


* Estimate is statistically different from estimate for the previous year shown (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012.

Employer Premiums as Percentage of Median Household Income for Under-65 Population, 2003 and 2010

62 percent of under-65 population live where premiums are 20 percent or more of income

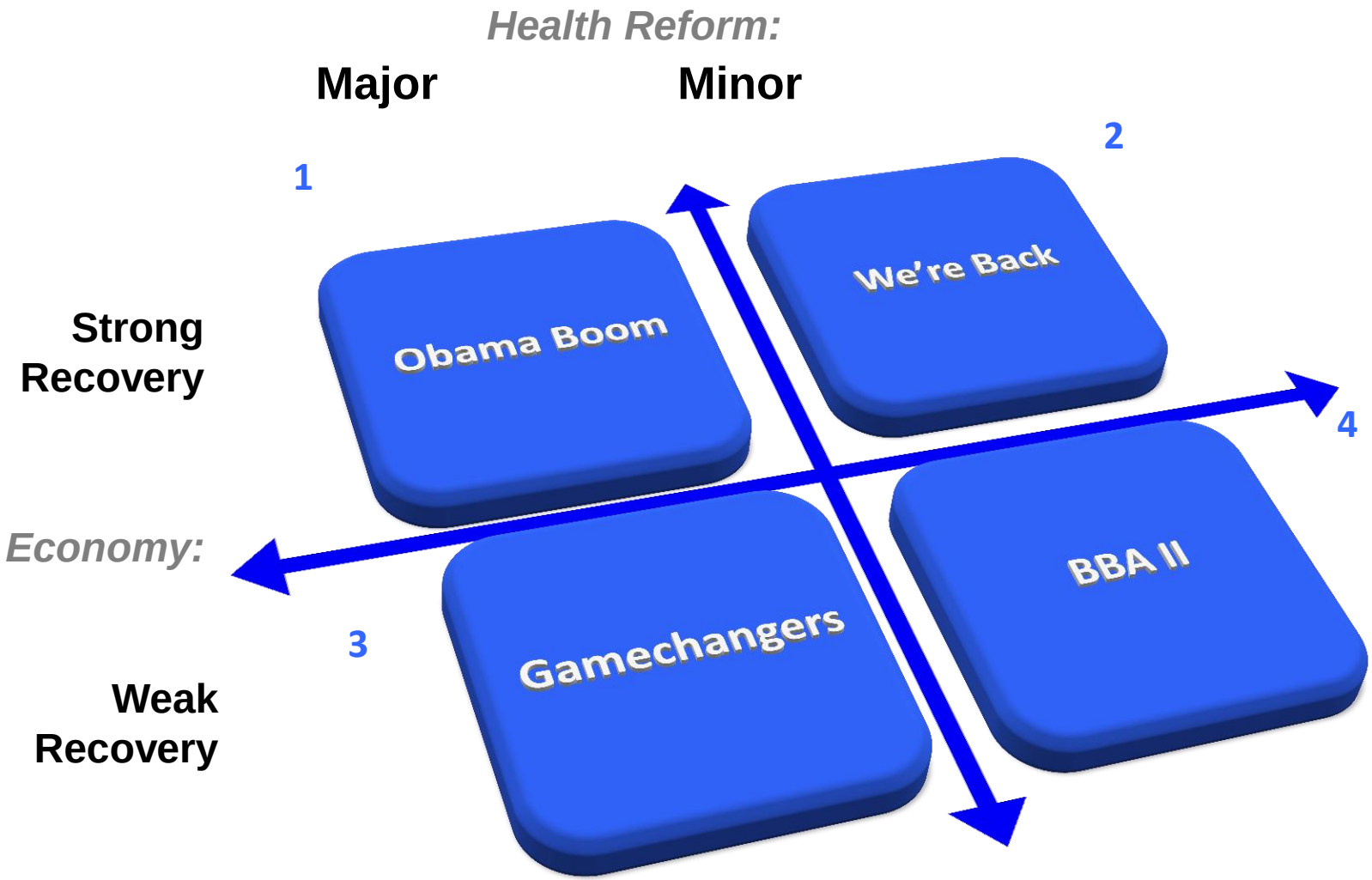


Sources: 2003 and 2010 Medical Expenditure Panel Survey–Insurance Component (for total average premiums for employer-based health insurance plans, weighted by single and family household distribution); 2003–04 and 2009–10 Current Population Surveys (for median household incomes for under-65 population).

Obama Care: The Simple Version

- Coverage Expansion to 32 million people in 2014
  - 16 million through Medicaid Expansion
  - 16 million through subsidized health insurance exchanges
- Regulation of health insurance practices
  - Guaranteed issuance
  - Individual Mandate
- Paid for by supplementary Medicare Tax on $250K+ earners and “voluntary” taxes on healthcare stakeholders
- Promising pilots and processes for reimbursement reform
  - Patient Centered Medical Homes
  - Accountable Care Organizations
  - Innovation Center at CMS

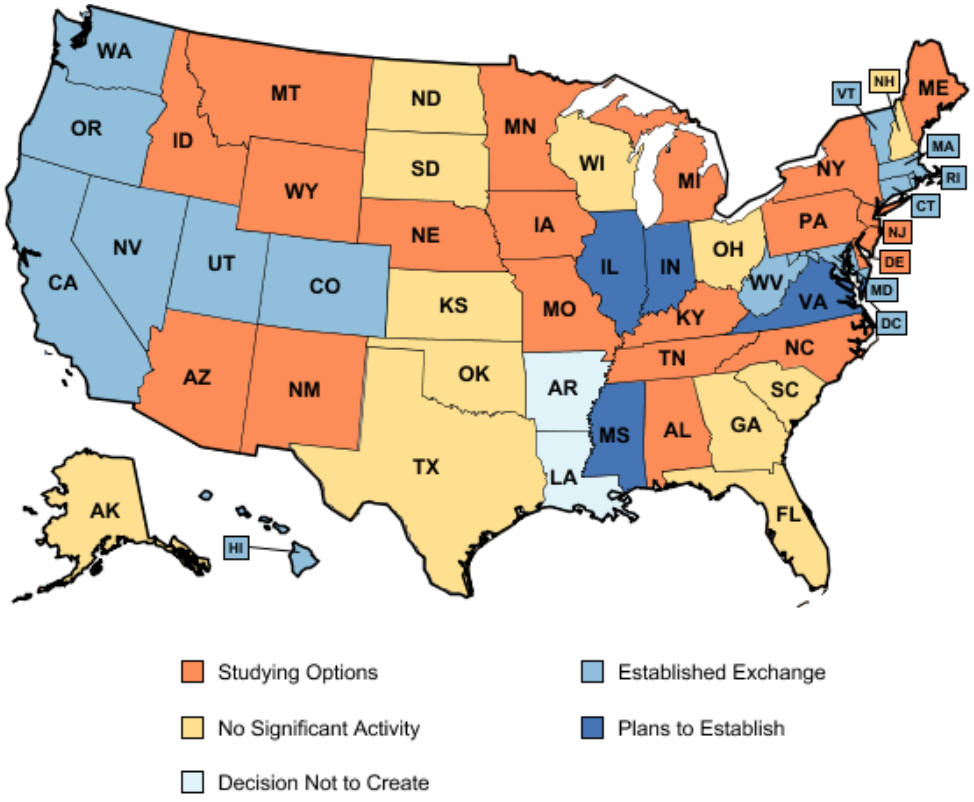
Four Scenarios for US Healthcare
2010-2015



The Supremes

- Roberts emerges as adult in the room
- It's not a tax ….but it is
- Medicaid ruling opens door for more state variation
- Many conservative states will wait until after the election
- They will be behind on exchanges and coverage expansion
- They may continue to refuse to accept 10c dollars to cover the poor
- The federal tanks will not come in
- Two more hurdles for PPACA: the Election and the Budget Crisis of 2013

Health Insurance Exchange Update



State Action Toward Creating Health Insurance Exchanges, as of March 1, 2012: Status of State Action

statehealthfacts.org
Your source for state health data

14 states have established exchanges

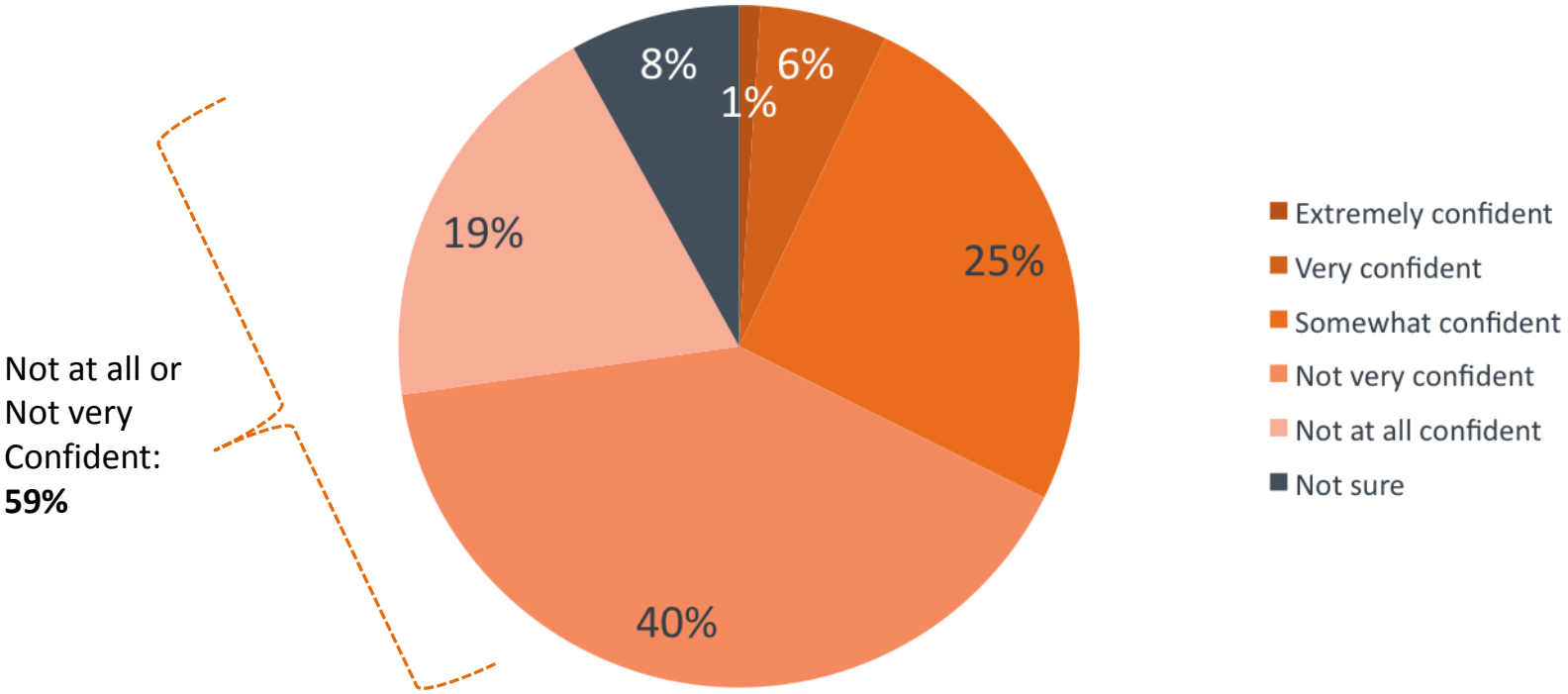
4 more have plans to establish exchanges

28 states have accepted planning Funds

49 states took the $1 million

The majority of Employers are not confident HIEs will be a viable alternative to employer coverage

Confidence in Health Insurance Exchanges
As a Viable Alternative to Employer Sponsored Coverage
Base: All Employer Health Benefit Decision Makers (n=360)



SOURCE: Strategic Health Perspectives 2011 Employer Execs Survey, Harris Interactive

Care or Car: even after subsidy: payments are high, wouldn't you rather have the car?

Premium after subsidy for Family of Four by Percentage of FPL

FPL Level*	Premium After Subsidy	Monthly	Auto Equivalent Lease Payment
150% ($33,525)	$1,505	$123	Chevy Aveo
200% ($44,700)	$2,778	$232	Chevy Malibu
250% ($55,875)	$4,438	$370	Infiniti G37
300% ($67,050)	$6,483	$540	Cadillac SRX
350% ($78,225)	$7,563	$630	Lexus GS
400% ($89,400)	$8,636	$720	X5 BMW

Loaded!!!!!!

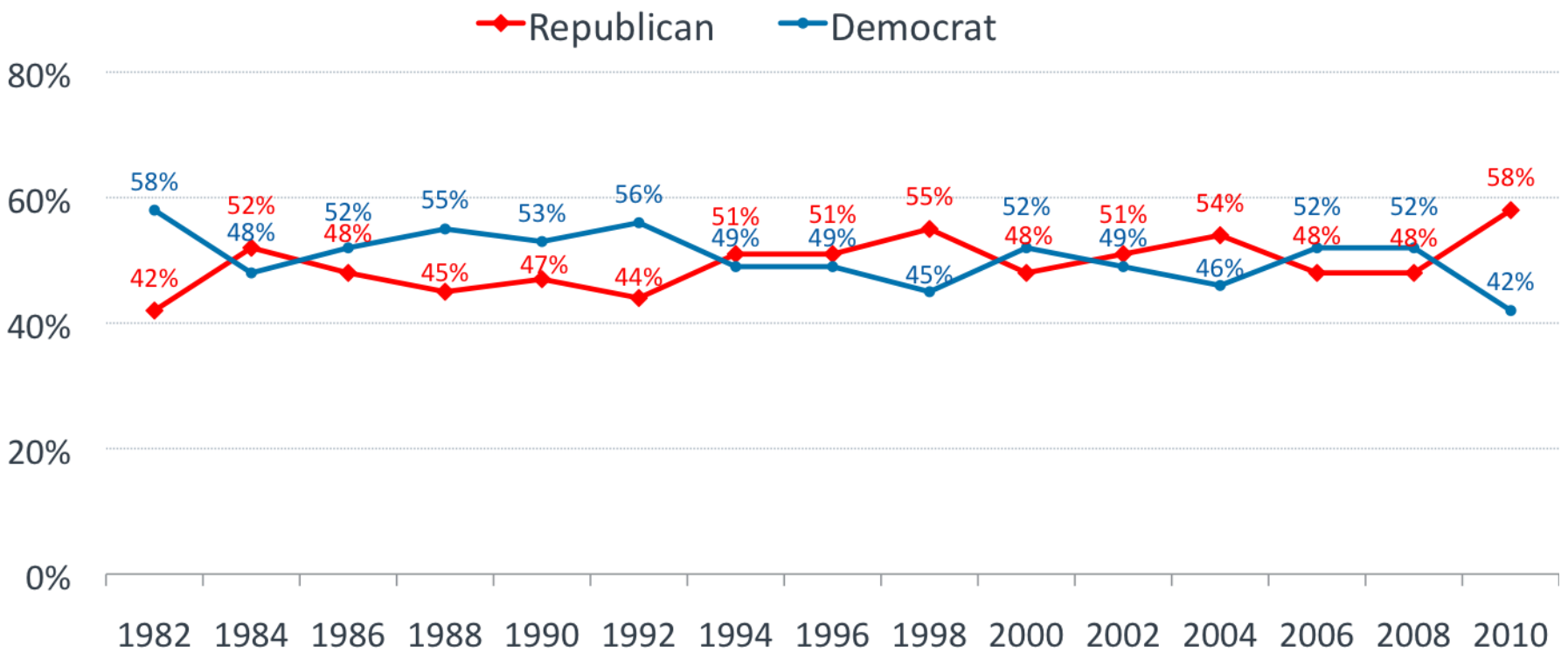
SOURCE: KFF.org, AOL Autotrader, *Federal Register Vol. 76, No. 13, January 20, 2011, pp. 3637–3638.*

* Federal Poverty Level for 48 contiguous states and the District of Columbia

Health Insurance Exchange Forecasts

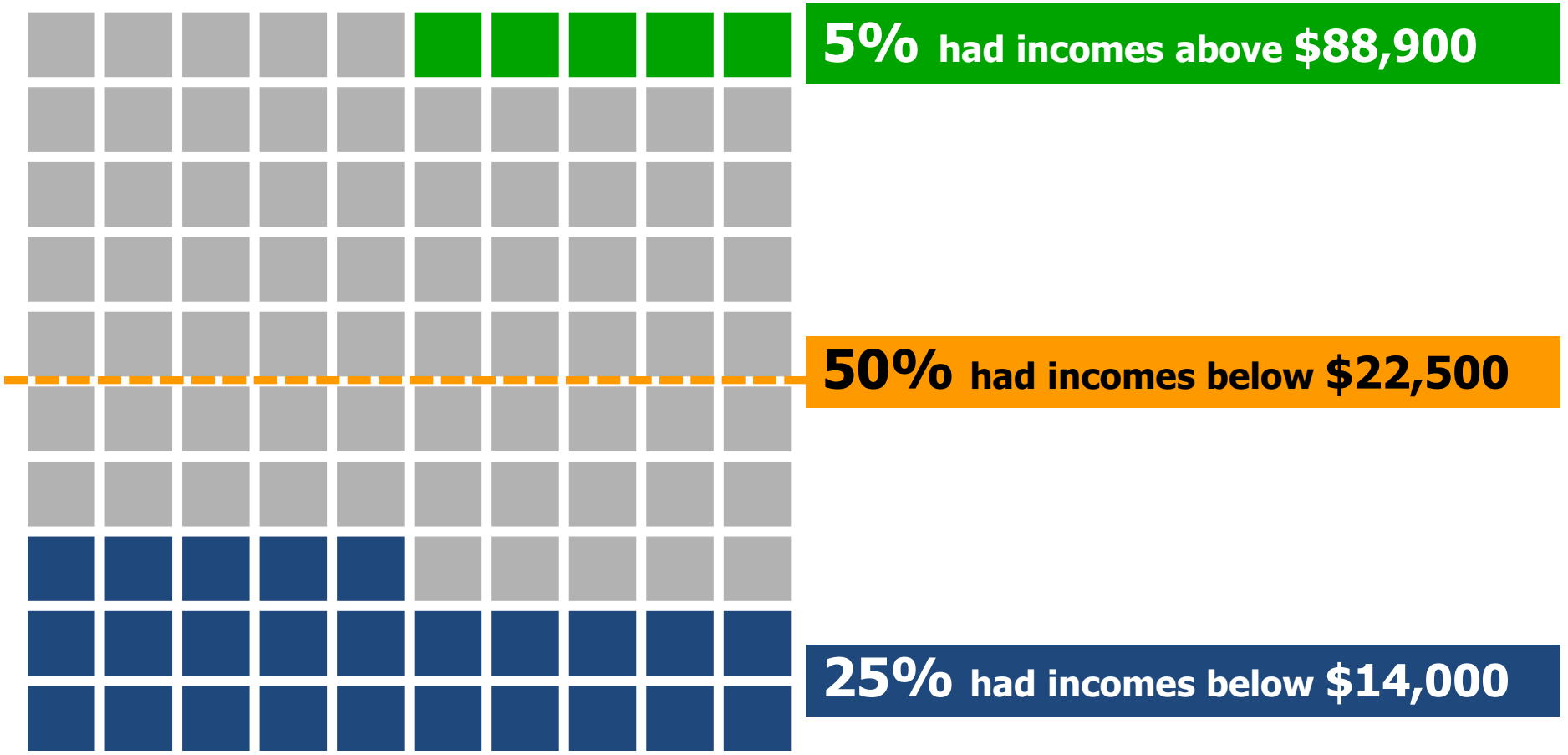
- Don’t substitute error for uncertainty…it all depends on politics, policy and execution, at both federal and state level
- Likely to be a high degree of variation across the country
- May create a lot of disruption, shift to retail, and risk shifts
- No matter what likely to have high deductible plans and skinny networks
- Employers see Private Exchanges and Public Exchanges as part of their strategy to exit or move to defined contribution

Vote Choice in U.S. House Elections, 1982-2010: Voters 60 and Older



SOURCE: New York Times, Portrait of the Electorate, November 6, 2010

Distribution of Medicare Beneficiaries by Income Level, 2012



NOTE: Total household income for couples is split equally between husbands and wives to estimate income for married beneficiaries.
SOURCE: Urban Institute analysis of DYNASIM for the Kaiser Family Foundation, "Income-Relating Medicare Part B and Part D Premiums Under Current Law and Recent Proposals: What are the Implications for Beneficiaries?" February 2012.

How does Medicare fit into the public's priorities for reducing the deficit?
(Summary of multiple polls)

Most favored approaches to deficit reduction (50%+ support)

- Reduce foreign aid
- Reduce overseas military commitments
- Raises taxes - $250,000+ incomes
- Limit tax deductions large corporations
- Reduce federal spending on community projects

Middle range support for proposals for deficit reduction (35-49%)

- Limit mortgage tax deductions
- Reduce defense spending
- Repeal new health care law
- Cut spending on Medicaid benefits
- Cut funding for low income programs

Least favored approaches to deficit reduction (less than 34%)

- Eliminate mortgage, charitable, employer health insurance, state/local tax deductions
- Raises taxes for everyone
- Cut future Medicare benefits
- Cut future Social Security benefits

SOURCE: Blendon, R. J., & Benson, J. M. (September-October, 2011). Partisan conflicts among the public on the economy and budget deficit in 2011. Challenge, 54, 5. National Journal/United Technologies Deficit Reduction Poll, September 15-18, 2011.

For the public, what are the most and least popular choices for reducing Medicare spending? *(Summary of multiple polls*)

Most favored approaches to lowering Medicare spending

- Higher income people pay higher Medicare premiums
- Limits on malpractice awards
- Limit future Medicare payments to hospitals, and nursing homes
- Paying pharmaceutical companies less for prescription drugs for Medicare patients
- Not pay for treatments that work as well as less costly ones

Middle range support for lowering Medicare spending

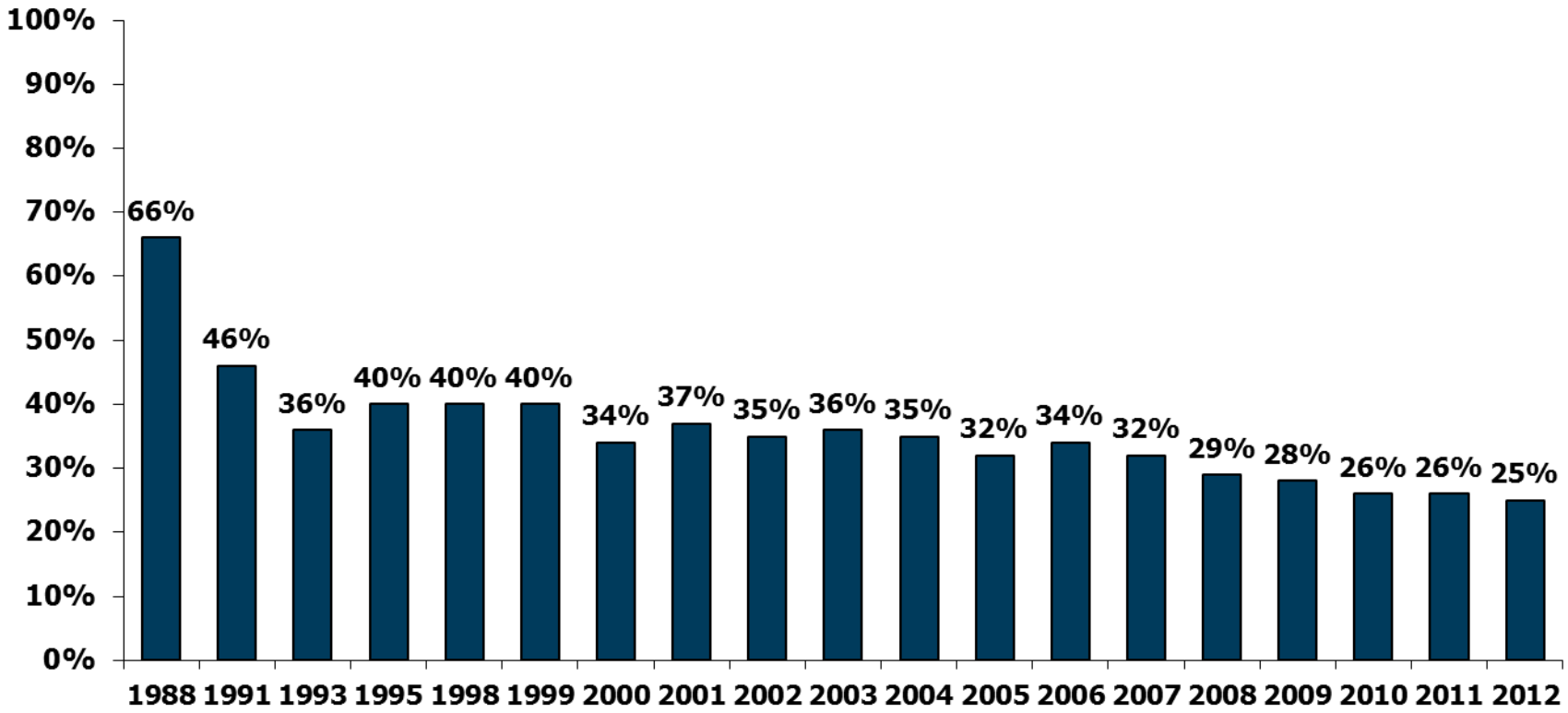
- Reducing doctors' fees for seeing Medicare patients
- Raise the age of eligibility from 65 to 67
- Giving premium supports or credits in future for new retirees to purchase private insurance
- Not pay for high cost treatments that are not worth the benefits
- Raise Medicare payroll taxes – employee/employer

Least favored approaches

- Cut spending on Medicare benefits
- All seniors pay higher Medicare premiums
- Requiring seniors to pay a larger share of Medicare costs out of their own pockets

Blendon, R. J., & Benson, J. M. (July 28, 2011). The public's views about Medicare and the budget deficit. *New England Journal of Medicine, 365,* 4. Kaiser Family Foundation/Harvard School of Public Health Public's Health Care Agenda for the 112th Congress Poll, January 4-14, 2011.Harvard School of Public Health/Alliance for Aging Research Comparative Effectiveness-Patient Access Poll, December, 2011. Kaiser Family Foundation, Health Tracking Poll, February 2012. Strategic Health Perspectives 2012 Survey of Consumers, Harris Interactive poll March 2012.

Among All Large Firms (200 or More Workers) Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, 1988-2012

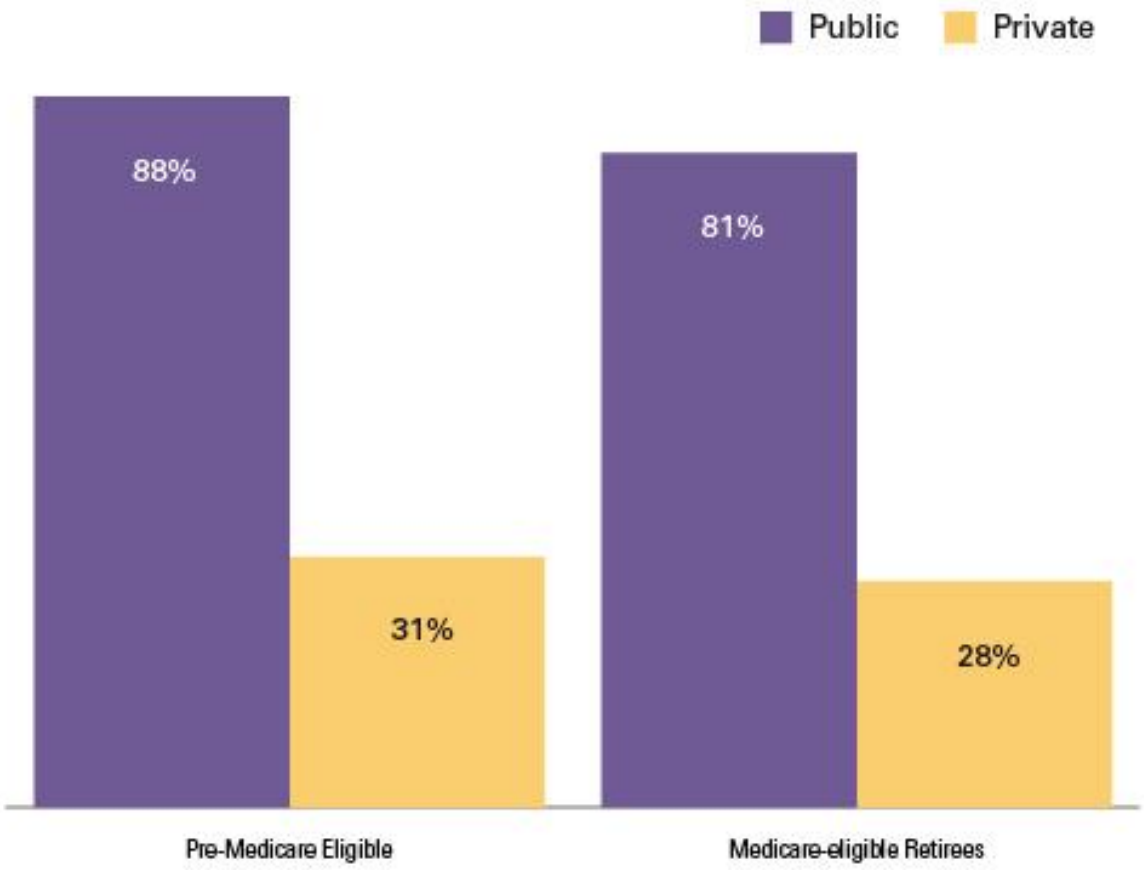


Note: Tests found no statistical difference from estimate for the previous year shown ($p<.05$). No statistical tests are conducted for years prior to 1999.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012; KPMG Survey of Employer-Sponsored Health Benefits, 1991, 1993, 1995, 1998; The Health Insurance Association of America (HIAA), 1988.

Employers Offering Retiree Coverage,
Public vs. Private Sector, 2005

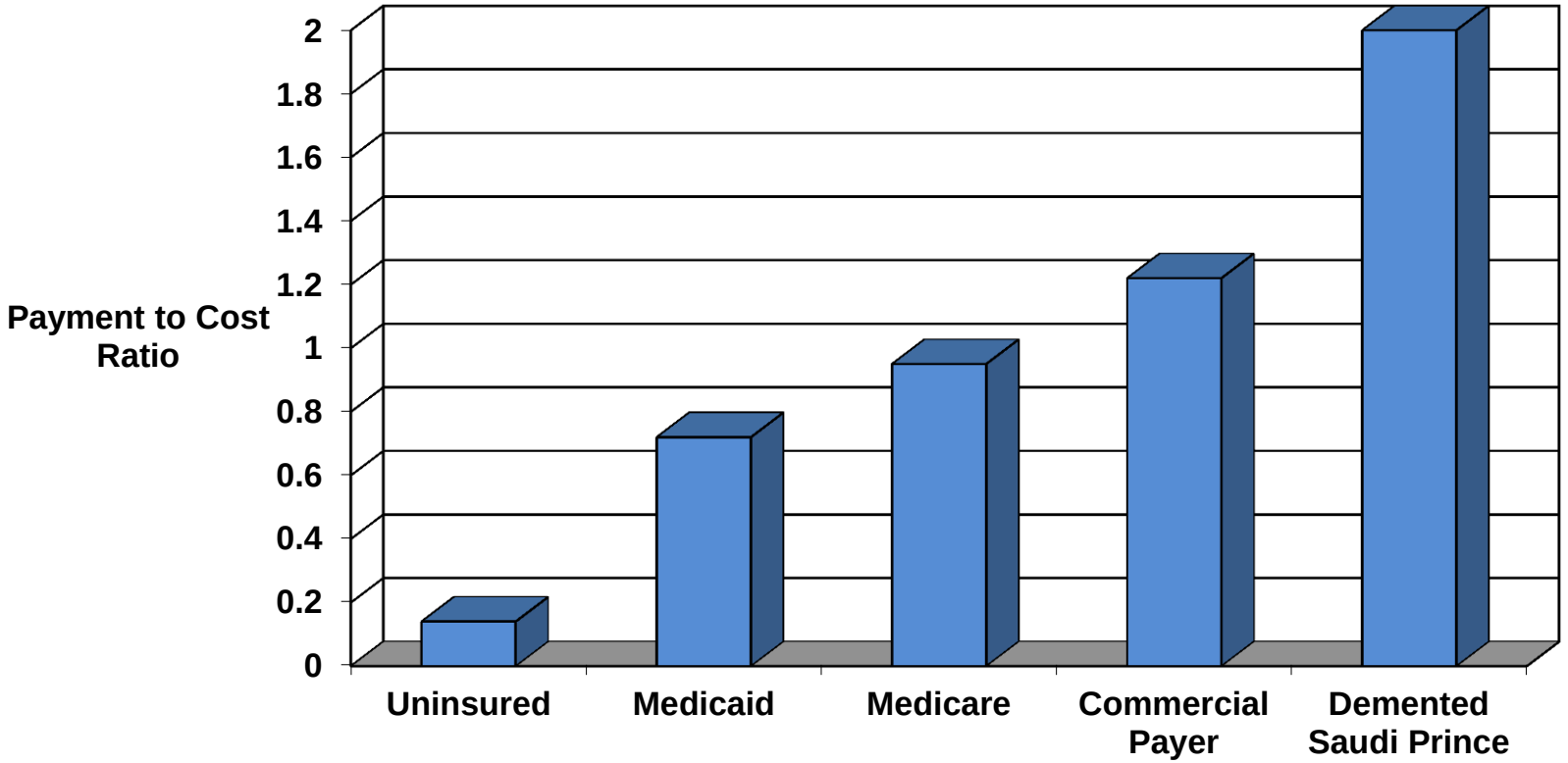
Percentage Offering to...



Source: Mercer National Survey of Employer-Sponsored Health Plans, 2005.

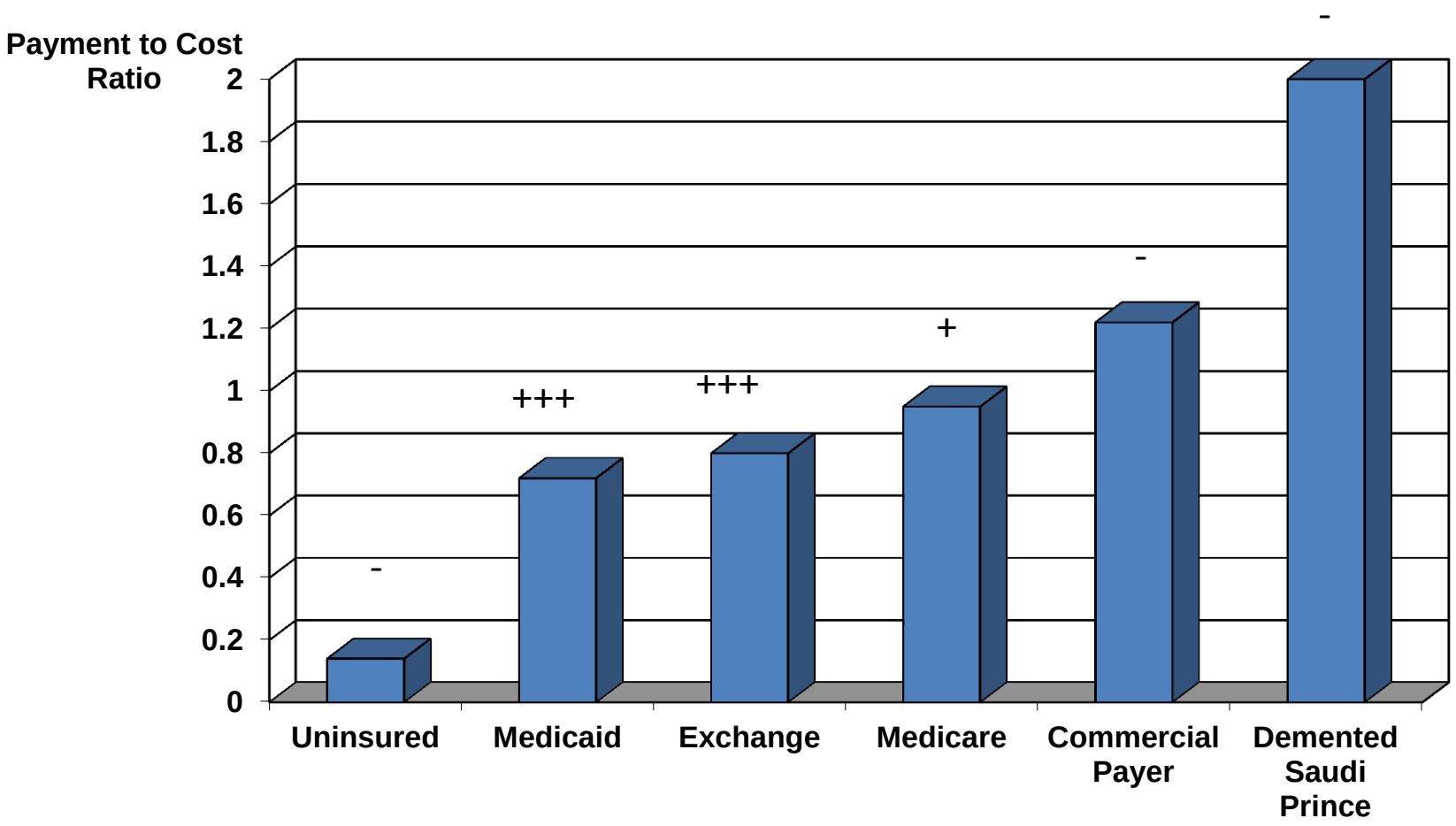
In California, the public sector offers retirees medical coverage at almost three times the rate in the private sector, whether or not they are eligible for Medicare.

Payment to Cost Ratio (Illustrative)



Source: Morrison Estimates, in other words a good guess

Payment to Cost Ratio (Illustrative)



Source: Morrison Estimates, in other words a good guess

Commercially Insured and Medicare Spending per Enrollee, Relative to U.S. Median Spending for Each Population

Commercial Spending

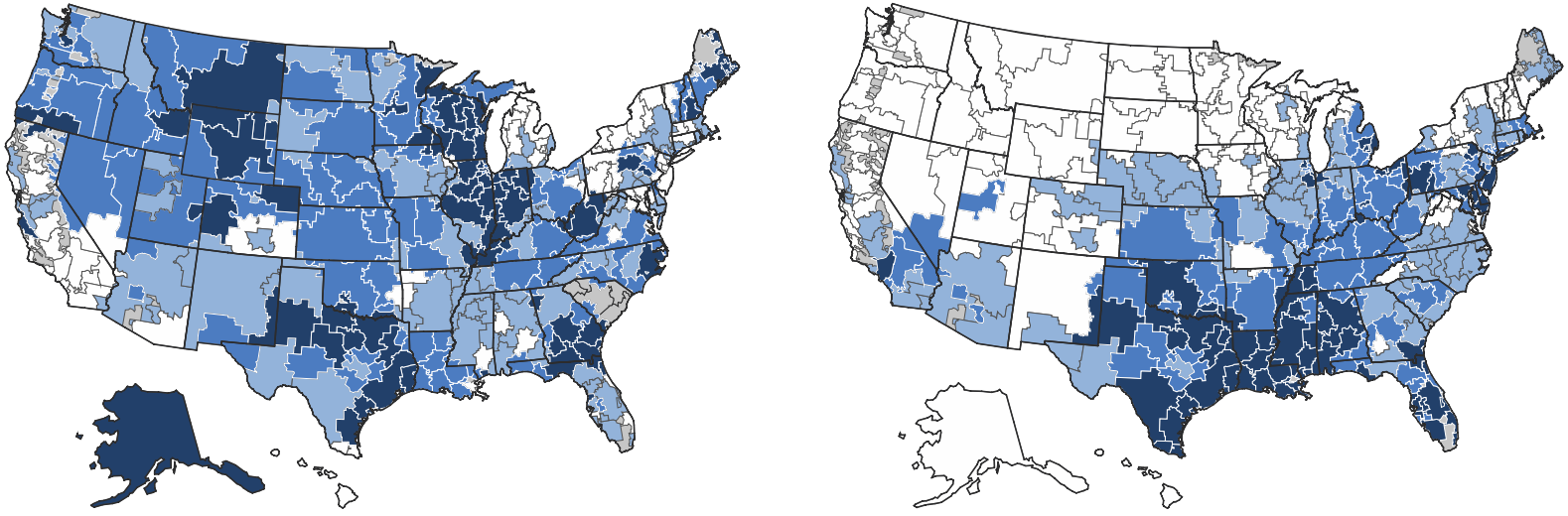
Expressed as ratio to median commercial spending

- 0.61–0.89 (71 HRRs)
- 0.90–0.99 (79)
- 1.00–1.09 (80)
- 1.10–1.53 (71)
- Not Populated or Missing Data (5)

Medicare Spending

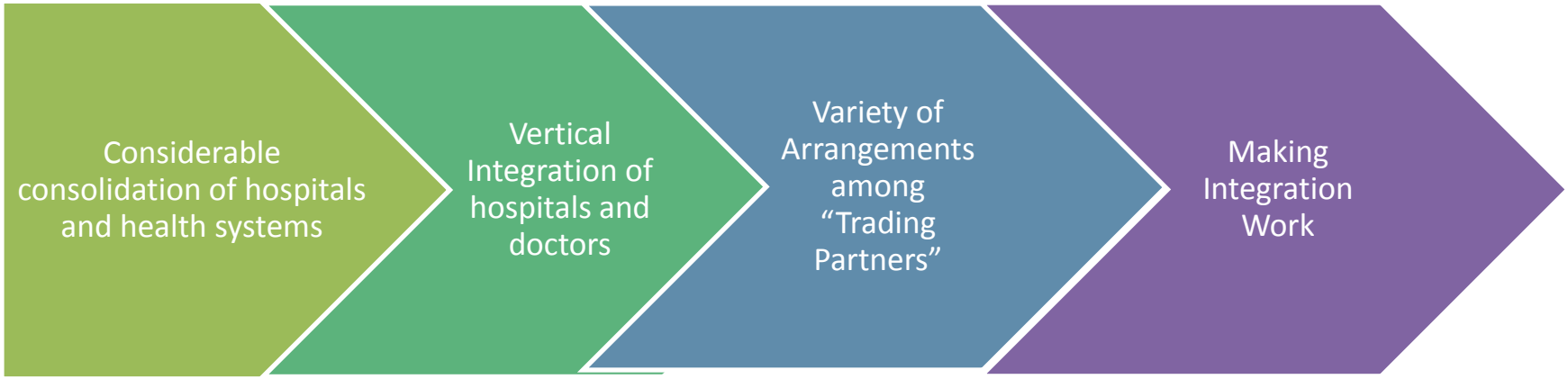
Expressed as ratio to median Medicare spending

- 0.63–0.89 (81 HRRs)
- 0.90–0.99 (72)
- 1.00–1.09 (75)
- 1.10–2.00 (78)
- Not Populated



HRR = hospital referral region.
Data: Commercial – 2009 Thomson Reuters MarketScan Database, analysis by M.Chernew, Harvard Medical School. Medicare – 2008 Medicare claims as reported by IOM.
Note: Ratio values lower than 1.0 indicate lower than median spending, ratio values higher than 1.0 indicate higher than median spending. Median spending is determined separately for the commercially insured (ages 18–64) and Medicare populations (age 65 and older).

Delivery System is Integrating Rapidly



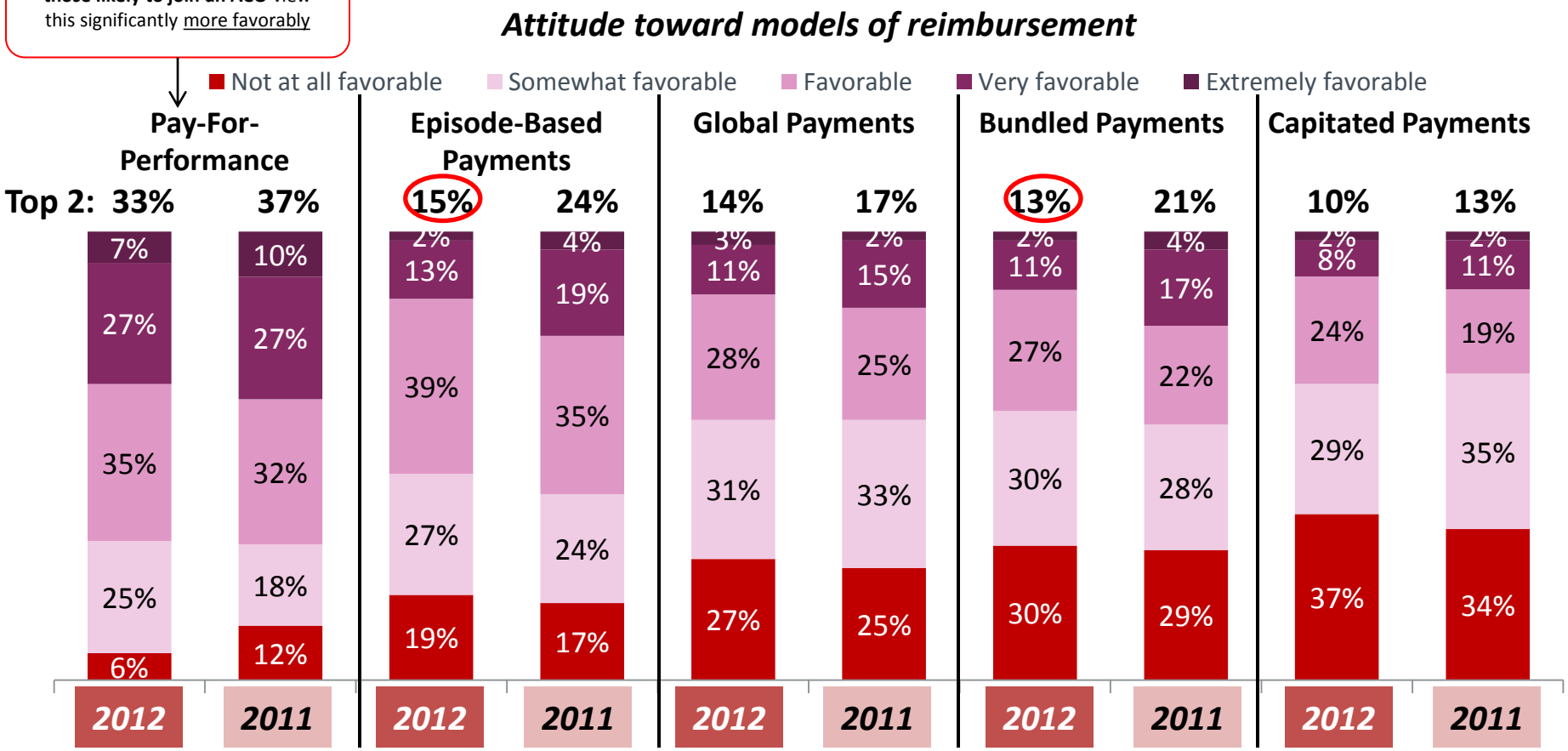
Delivery System is Integrating Rapidly

Considerable consolidation of hospitals and health systems

- Anticipation of moving from pay for volume to pay for value
- Desire for scale
- Availability of financing: Cash, profitability and private equity
- “Best Year Ever”
- Uncertainty of health reform
- More mega deals to come
- “Everyone is talking to everyone”
- Are Leaders too far ahead of followers?

Only a minority of hospitals are very/extremely enthusiastic about different models of reimbursement

Current ACO participants and **those likely to join an ACO** view this significantly more favorably



Base: All Hospital Execs (2012: n=250; 2011: n=253)

- *Significantly lower than 2011*

Q800: *There are a number of different proposals being discussed for changing the way providers, including physicians and hospitals, are reimbursed. How favorable or unfavorable would your hospital be toward each of the following models of reimbursement?*

SOURCE: Harris Interactive, Strategic Health Perspectives 2011/2012 Hospital Exec Surveys

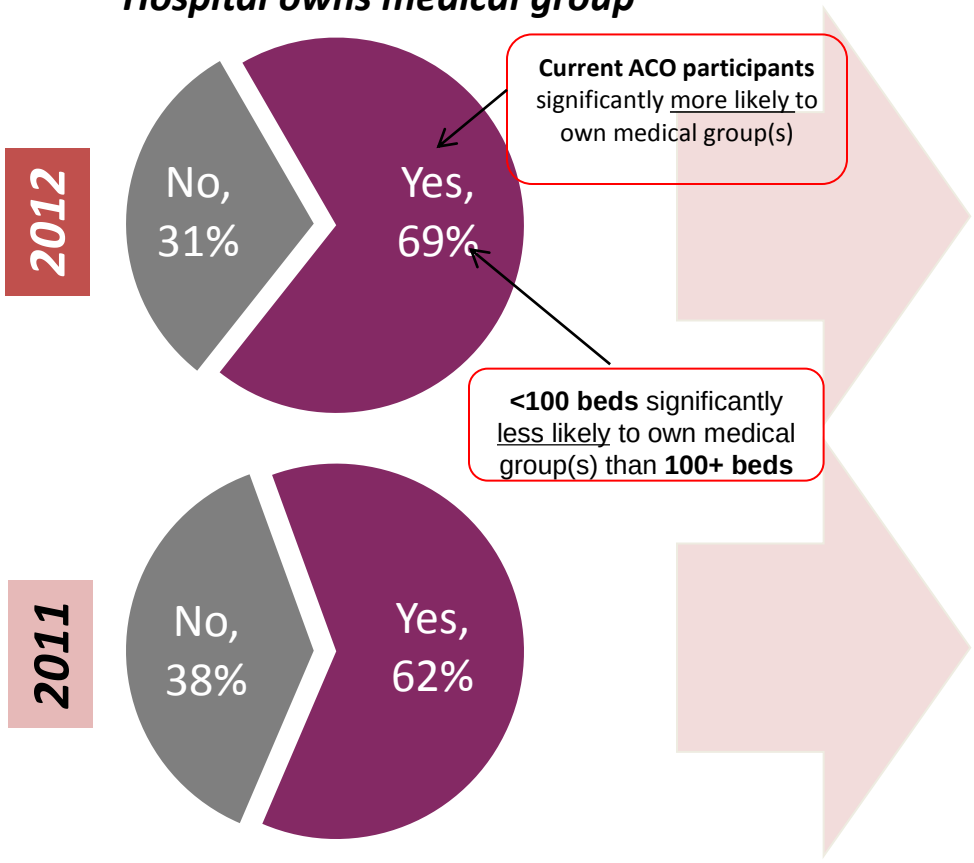
Delivery System is Integrating Rapidly

Vertical Integration of hospitals and doctors

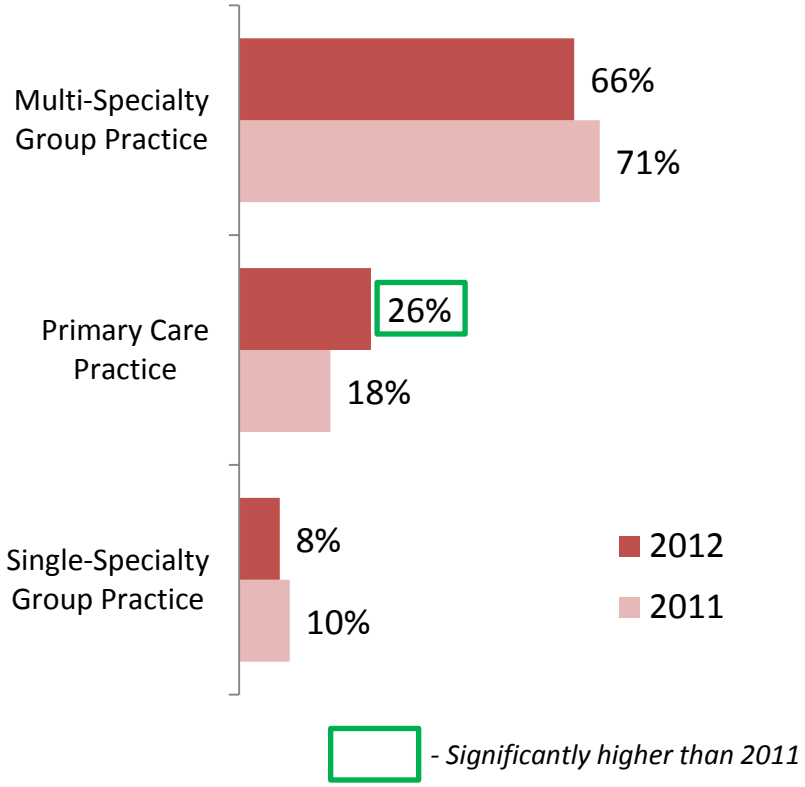
- Doctors and hospitals running to meet each other
- Provider Based Reimbursement meets SGR uncertainty
- Medical groups earning high valuations
- “It’s like the 1990s all over again”
- But, “Nobody told the specialists…..”
- Significant variation in attitudes among physicians
  - Believers
  - Adapters
  - Resisters

Two-thirds of Hospitals already own one or more medical group(s)

Hospital owns medical group



Type of medical group



Base: All Hospital Execs (2012: n=250; 2011: n=253)
Q900: *Does your hospital own one or more medical groups?*
Base: Has a medical group (2012: n=172; 2011: n= 157)
Q920: *Is your medical group…?*

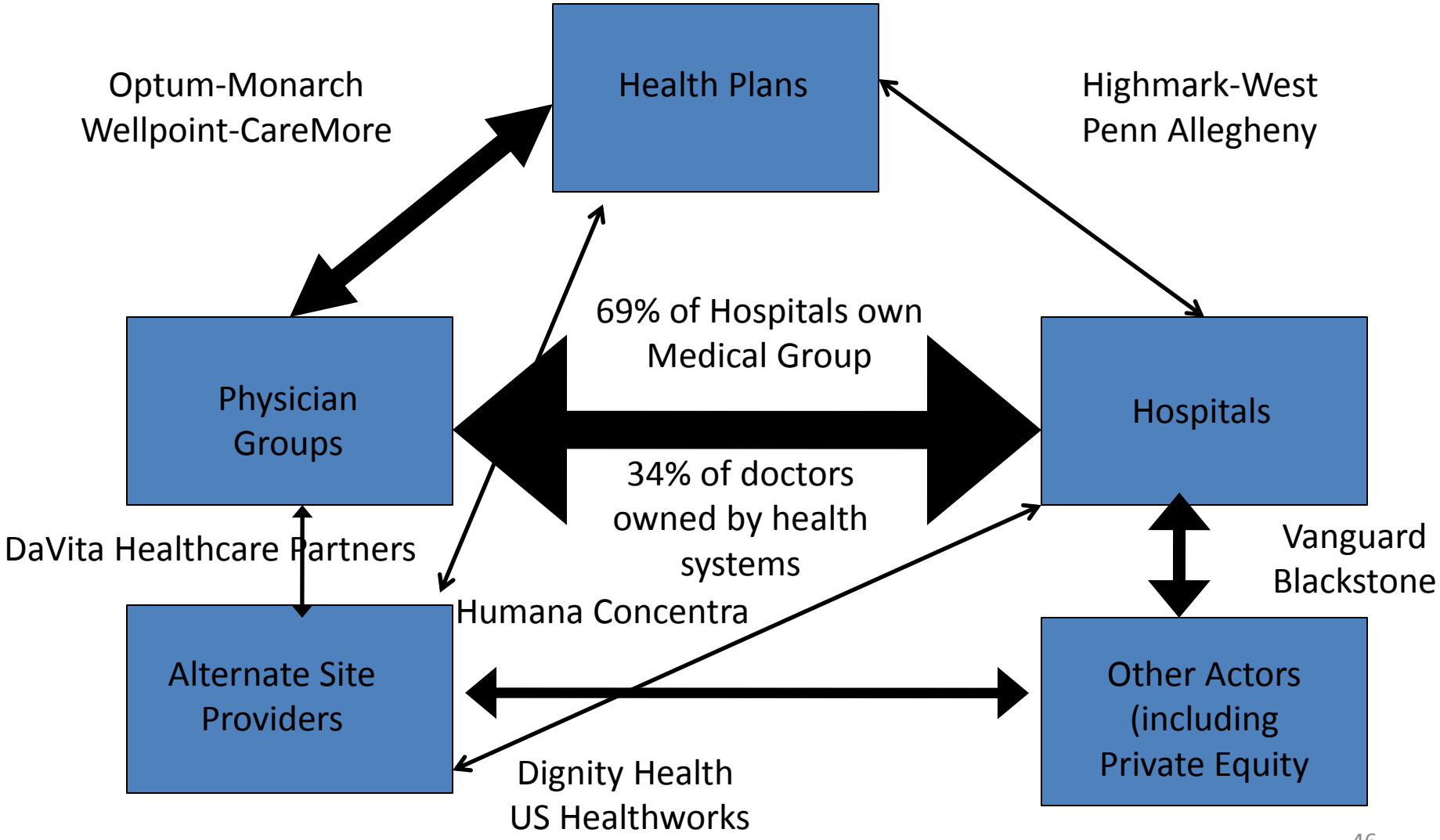
SOURCE: Strategic Health Perspectives 2011/2012 Hospital Exec Surveys

Delivery System is Integrating Rapidly

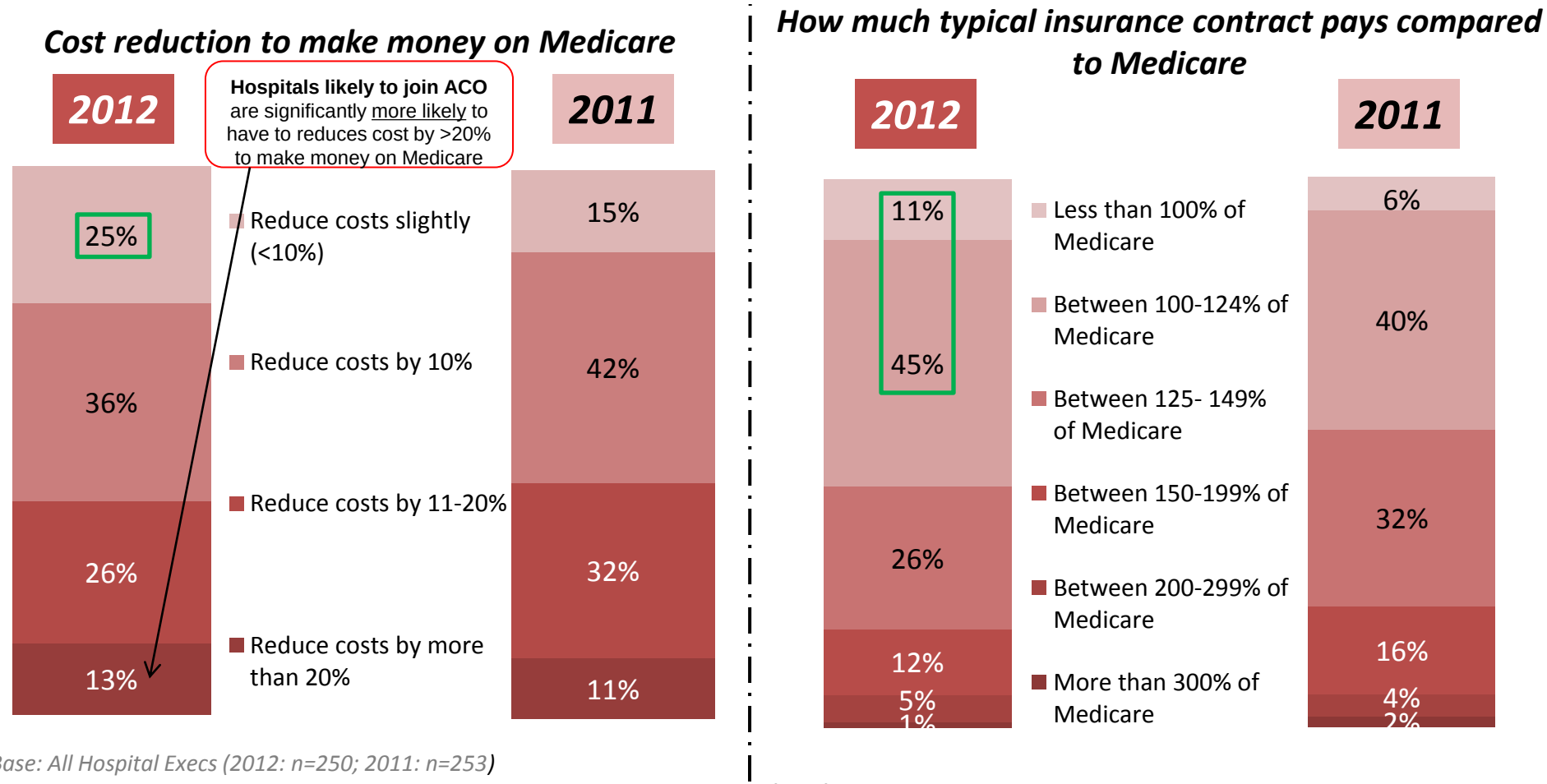
Variety of Arrangements among "Trading Partners"

- Hospitals acquiring medical groups e.g. 69% hospitals own medical groups, a third of doctors now in hospital owned groups
- Health plans partnering/acquiring medical groups e.g. Optum Monarch
- Health plans acquiring health systems (rare) e.g. Highmark
- Alternate site actors partnering with medical groups e.g. DaVita Healthcare Partners

Trading Partners coming together in new ways



Half of Hospital Execs feel they would need to reduce costs between 10 and 20% in order to make money on Medicare



Base: All Hospital Execs (2012: n=250; 2011: n=253)

Q1110: *In order to be able to make money on Medicare, please indicate which of the following your hospital will have to do.*

Q1116: *Thinking of your typical health insurance contract, such as a PPO, what do commercial payers pay you relative to Medicare?*

- Significantly higher than 2011

SOURCE: Strategic Health Perspectives 2011/2012 Hospital Exec Surveys

Hospitals Must Flip the Switch: When the Time is Right

- Integrate for Accountable Care
  - Financial risk for the care of patients
  - Integrated medical staffs dedicated to high performance
  - Performance measurement and management across the continuum of care
  - Integrated HIT solutions
  - Business model to sustain it all
- Make it Cheaper
- Make it Better
- Focus on Outcomes
- Innovate on the Side
- Flip the Switch

The Work

- Centrality of Clinical Integration
- Health IT as platform not panacea
- Learning to live on Medicare
- Managing Business Model Migration
- Building a culture of Quality and Accountability
  - "We have the anatomy of an Accountable Care Organization but none of the physiology"

Summary

- Economy creating wealth not jobs, impacts politics and demand for healthcare
- Health Reform course will be decided by 2012 election, the jobs situation will play a part, as will turnout and the views of elderly voters
- If Republicans prevail they will attempt to roll back provisions of PPACA at federal and state level
- No matter what, there will be huge pressure on the healthcare delivery system to improve performance
  - Pressure from Households who can't afford it
  - Pressure from Government who can't afford it
  - Pressure from Business who can't afford it
- Health system leaders can make a difference and meet any future by improving performance and developing a culture of accountability
- The work of healthcare transformation is our most pressing national issue if we are to have a sustainable economy and still serve our seniors

Closing Advice

- Don’t get sick
- Don’t get poor
- Don’t retire