Advisory Board | Health Care Advisory Board

State of the Union 2017

Health System Strategy in the Post-ACA Era

Health Care Now Squarely in the Hands of the GOP

Congress, Executive, and Majority of States Now in Republican Control

33/50
Republican Governors

32/50
Republican-Led Legislatures

Image: © 2017, United States Department of State

52/100
Senate Republicans

241/435
House Republicans

Majority of Americans Hold GOP Responsible for Health Care

64% Of individuals who believe "President Trump and Republicans in Congress are now in control of the government and they are responsible for any problems with the ACA going forward[1]"

1) Survey conducted a telephone sample of 1,171 adults age 18+ living in the US.

Source: Kirzinger, A. et al., "Kaiser Health Tracking Poll - Late April 2017: The Future of the ACA and Health Care & the Budget," *KFF*, April 26, 2017; Health Care Advisory Board interviews and analysis.

The Next Era of Health Care Reform

Four Key Principles Guiding GOP Reform Efforts

1 Reduce Federal Entitlement Spending

Focus more aggressively on reducing federal health care spending

2 Devolve Health Policy Control to States

Reduce federal role in health care; provide states more autonomy to make decisions, cut spending

3 Embrace Free Markets and Consumer Choice

Use free-markets to promote private sector competition in payer, provider markets

4 Promote Transparency of Cost and Quality

Mandate greater consumer choice and shopping at the point-of-care and point-of-coverage through improved transparency

Source: Health Care Advisory Board interviews and analysis.

Officials Poised to Implement GOP Agenda

Administration Has Considerable Leeway to Alter Current Reform Efforts

Meet the Key Players

HHS Secretary: Tom Price

Image: © 2007, District Office of Tom Price

- Six-term Representative from Georgia; retired orthopedic surgeon
- Sponsor of the Empowering Patients First Act
- Confirmed by 52-47 vote

CMS Administrator: Seema Verma

Image: © 2017, CMS

- National health policy consultant from Indiana
- Helped shape Medicaid expansion in IN, OH, KY, TN
- Confirmed by 55-43 vote

Potential Administrative Actions

- ❑ End cost-sharing reduction payments
- ❑ Delay Cadillac Tax
- ❑ Eliminate, delay, or modify Innovation Center programs (e.g., CJR)
- ❑ Reduce enforcement of insurance mandates
- ❑ Narrow scope of essential health benefits
- ❑ Allow Medicaid eligibility, cost-sharing reform through 1115 waivers

ACA Leaves Enormous Amount to the Secretary's Discretion

1442

Times the ACA says 'the secretary shall' or 'the secretary may'

Source: Jackson, D. and Solis, S., "Rep. Tom Price is Trump's pick for Health and Human Services Dept.," *USA Today,* Nov. 29, 2016; "Trump picks Seema Verma to head Centers for Medicare and Medicaid Services," *Politico*, Nov. 29, 2016; Eilperin, J. and DeBonis, M., "Trump administration still plans to undo parts of the ACA, Tom Price testifies," *The Washington Post*, March 29, 2017; Health Care Advisory Board interviews and analysis.

An Ambitious Three-Part Agenda

GOP Unveils Three Phases to Health Care Reform

A Three-Staged Approach to Repeal and Replace the ACA

1 Budget Reconciliation

Process: Requires simple majority in House and Senate

Proposed Target Areas:

- Repeal ACA taxes, employer and individual mandates
- Replace insurance subsidies with refundable tax credits
- Reform Medicaid financing
- Increase contribution limit of health savings accounts
- Allocate funds for state innovations
- Require continuous coverage insurance incentive

2 Administrative Action

Process: Federal agencies issue regulation through rulemaking

Proposed Target Areas:

- Shorten individual market enrollment period and limit special enrollment
- Loosen restrictions on actuarial value of individual market plans
- Enable state flexibility through waiver process
- Approve state Medicaid eligibility changes (e.g. work requirements, premiums)

3 Additional Legislation

Process: Requires simple majority in House, super-majority in Senate

Proposed Target Areas:

- Allow insurance to be sold across state lines
- Expand use of HSAs
- Allow formation of Association Health Plans
- Reform malpractice regulation
- Streamline FDA processes
- Expand flexibility of state use of federal dollars

Source: The White House, "Three-Pronged Approach to Repeal and Replace Obamacare," March 13, 2017; Health Care Advisory Board interviews and analysis.

House Passes the American Health Care Act

Reconciliation Bill Would Drastically Cut Spending, Reduce Coverage

Legislation in Brief: American Health Care Act

- Reconciliation bill proposed by House Republicans on March 6th that would repeal or modify many elements of the ACA, while leaving others intact
- Following several amendments, passed by the House on May 5th
- Bill's major goals are to:
  - Repeal ACA's taxes
  - Reform the individual insurance market
  - Remake the Medicaid financing model

Bill Passes House with Razor-Thin Margin

217-213

Final House vote on AHCA; required 216 votes to pass

CBO's Projected Impact of the AHCA[1]

$150B
Decrease in **federal deficit**

24M
Increase in number of **uninsured**

1) Congressional Budget Office projections as of March 13, 2017; does not include MacArthur amendment or Upton amendment.

Source: House Ways and Means Committee, available at: https://waysandmeans.house.gov/american-health-care-act/; House Energy and Commerce Committee, available at: https://energycommerce.house.gov/news-center/press-releases/energy-and-commerce-republicans-release-legislation-repeal-and-replace; Health Care Advisory Board interviews and analysis.

Far From a Done Deal

Senate Likely to Make Significant Changes to Bill

Major Roadblocks Remain in Senate

Ensuring Compliance with Reconciliation Rules

Senate parliamentarian must strike any AHCA provisions that she determines do not meet rules of budget reconciliation[1]

Overcoming Slimmer Voting Margin

GOP can only afford to lose 2 votes; potentially gives moderates greater influence and ability to dial back coverage losses

Awaiting Pending CBO Score

Senate must extend voting timeline until CBO scores final, amended bill

Senate Promises Longer Timeline, Signals Prospect for Significant Change

"There will be no artificial deadlines in the Senate. We'll move with a sense of urgency but we won't stop until we think we have it right"

Sen. Lamar Alexander (R-Tenn.)

"Any bill that has been posted less than 24 hours, going to be debated three or four hours, not scored? Needs to be viewed with suspicion."

Sen. Lindsay Graham (R-S.C)

"The bill that passed out of the House is most likely not going to be the bill that is put in front of the president"

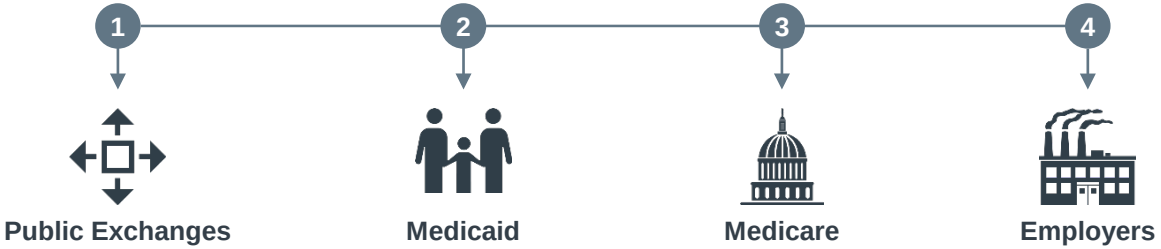
Mick Mulvaney, Director, Office of Management and Budget

1) Provisions may only impact spending, revenues, or the federal debt limit.

Source: Everett, B. and Haberkorn, J., "Senate GOP rejects House Obamacare bill," *Politico*, May 4, 2017; Weaver, A. and Ferrichio, S., "House Obamacare repeal bill faces Senate makeover," *Washington Examiner*, May 4, 2017; Bradner, E., "Trump: GOP health care bill 'guarantees' coverage for pre-existing conditions," *CNN*, May 1, 2017; Health Care Advisory Board interviews and analysis.

Reform Poised to Touch Every Purchaser Segment

Next Era of Reform Will Impact Every Sector of Insurance Market



Source: Health Care Advisory Board interviews and analysis.

Individual Market at a Crossroads

While Some Participants Falter, Others Renewing Commitment

Certain Insurers and States Struggling

Aetna

No longer selling exchange plans in 2018; expects to lose $200M on exchange business

Humana

Plans to withdraw from exchanges in 2018; stands to lose $45M in 2017

Iowa

Two major carriers weighing departure; would leave 15,600 without insurance

25%

Increase in counties with only one insurer in 2017

But Market Showing Signs of Stabilization

> Looking forward, we expect insurers, on average, to get close to break-even margins in this segment in 2017…If the market continues unaffected…we expect 2018…to be one of gradual improvement with more insurers reporting positive (albeit low single-digit) margins."
>
> *Standard and Poor's analysis of 32 BCBS insurers with exchange plans*

"Insurer Centene Commits to Shaky ACA Exchanges for 2018"

"Centene Corp.'s exchange enrollment has swelled 74% since last year, up to nearly 1.2 million people"

Source: Castellucci, M., "Iowa likely to have no insurers selling on exchanges for 2018," *Modern Healthcare*, May 4, 2017; Cancryn, A. "Humana becomes first major insurer to quit Obamacare exchanges," *Politico*, Feb. 14, 2017; Cox, C. et al. "2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces," *KFF*, Oct. 24, 2016; S&P "The US ACA Individual Market Showed Progress in 2016, But Still Needs Time to Mature," April 7, 2017; Murphy, T. "Insurer Centene Commits to Shaky ACA Exchanges for 2018," *ABC News*, April 25, 2017; Livingston, S., "Aetna bails on ACA exchanges," *Modern Healthcare*, May 10, 2017; Health Care Advisory Board interviews and analysis.

Future of the Exchanges Hangs in the Balance

Depends Heavily on GOP's Actions and Inactions

Administration Has a Spectrum of Options for How to Manage Exchanges

Roll Back

- End cost-sharing reduction payments[1]
- Reduce reinsurance payments
- Refuse to settle the risk corridor litigation
- Reduce enforcement of individual mandate[1]
- Eliminate/reduce advertising
- End Heathcare.gov enrollment for small businesses

Maintain

- Continue to enforce and implement provisions of the ACA related to exchanges (e.g. cost-sharing payments)

Fix

Already Underway[2]:

- Limit special enrollment
- Establish continuous coverage requirement[3]
- Relax actuarial requirements[3]

Other Potential Actions:

- Expand age rating band[4]
- Tweak essential health benefits requirements[4]

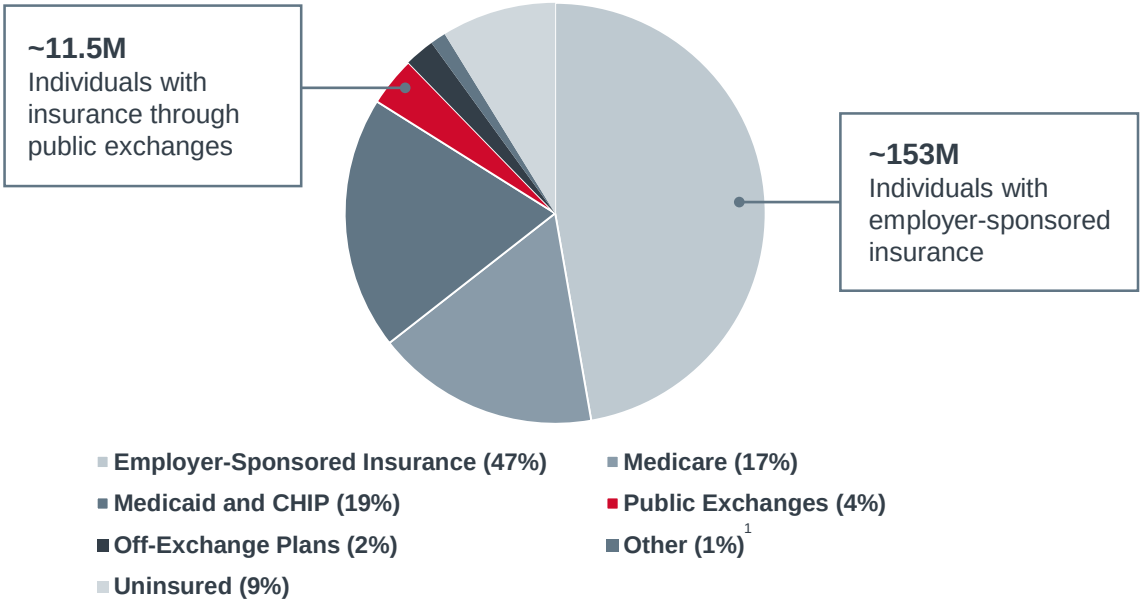
1) Would be eliminated by AHCA.
2) Through market stabilization rule finalized on April 13, 2017.
3) Would be enforced by AHCA.
4) Would be implemented by AHCA.

Source: Health Care Advisory Board interviews and analysis.

For Providers, a Relatively Limited Impact

Despite Political Significance, Exchanges Only a Small Segment of Market

Approximate Coverage of US Population by Payer Sector
As of March 2016



1) Student, IHS, CH+.

Source: Gaba, C., "Healthcare Coverage Breakout for the Entire U.S. Population in 1 Chart," *ACASinups.net*, March 28, 2016, available at: http://acasignups.net/16/04/18/show-your-work-healthcare-coverage-breakout-entire-us-population-1-chart; Health Care Advisory Board interviews and analysis.

AHCA Would Fundamentally Alter Individual Market

Repeals

Insurance Premium Subsidies

Eliminates ACA tax credits based on income and tied to the growth of the regional silver plan premiums

Insurance Mandate

Eliminates penalty on individuals and employers for not gaining or not offering insurance coverage

Alters

Age-Rating Ratio

Allows age-based premium differential for individual plans to increase from 3:1 to 5:1

Capabilities of Health Savings Accounts

Increases annual tax free contribution limit and reduces taxes on withdrawals

State Insurance Market Authority

Offers states three new waivers to change essential health benefits or community rating[1]

Establishes

"Patient and State Stability" Fund

Grants flexible federal funding for states to support insurance markets (e.g. by creating high-risk pool or assisting with out-of-pocket costs)

Continuous Coverage Incentive

Requires insurers to penalize individuals who have had a two-month coverage gap in previous 12 months with a 30% premium surcharge

Individual, Refundable Tax Credits

Provides tax credits for purchasing insurance to those not offered employer-sponsored plans; credits are based on age and income and tied to CPI-U growth

1) Community rating waivers apply to individual, exchange markets; essential health benefits apply more broadly.

Source: KFF, "Compare Proposals to Replace The Affordable Care Act," April 26, 2017, available at: http://kff.org/interactive/proposals-to-replace-the-affordable-care-act/; Health Care Advisory Board interviews and analysis.

MacArthur Amendment Gives States More Flexibility

AHCA Waivers Offer States Control Over Three Distinct Market Regulations

1

Health Status Underwriting

States may give insurers the right to charge consumers more based on pre-existing conditions instead of exercising the AHCA's continuous coverage penalty

2

Age-Ratio Pricing Bands

States may create pricing bands with age-ratios either greater or less than the AHCA's 5:1

3

Essential Health Benefits

States can define the categories and specific benefits insurers must provide; lifetime, annual limits and out-of-pocket limits only apply to EHBs

Waiver Imposes Additional Requirement

States must demonstrate a plan to provide financial assistance for high-risk individuals, create a reinsurance program, or join the federal, invisible high-risk pool

Source: Jost, T. "The MacArthur Amendment Language, Race In The Federal Exchange, And Risk Adjustment Coefficients," *Health Affairs*, April 25, 2017; Health Care Advisory Board interviews and analysis.

AHCA Bets on High Risk Pools to Limit Coverage Gaps

Current Estimates Suggest Proposed Funding is Likely Insufficient

Federal Invisible High Risk Pools

- Provides $1.7B annually from 2018-2026 plus any unappropriated dollars from the AHCA's Patient and State Stability Fund; Upton amendment provides additional $1.6B annually from 2018-2023
- Operates through prospective determination; CMS would define eligibility based on a list of high-cost medical conditions; insurers could also voluntarily qualify individuals
- Insurers would cede some portion of the premiums of these individuals
- CMS would establish a dollar threshold on an individual's claims above which it would pay insurers a certain percentage

Predictions of Program Solvency Inhibited by Unanswered Policy Questions

1. *What portion of premiums will insurers cede?*
2. *Above what dollar threshold will CMS cover beneficiary expenses?*
3. *Would CMS pay Medicare or commercial rates?*
4. *Would the program have waiting lists, maximum annual coverage limits, or lifetime limits?*
5. *What responsibility do states have to contribute?*
6. *Which conditions would automatically qualify individuals for enrollment?*

$1.6B to $20B

Currently estimated potential annual budget shortfall[1]

1) Based on a Milliman actuarial model and a Center for American Progress analysis.

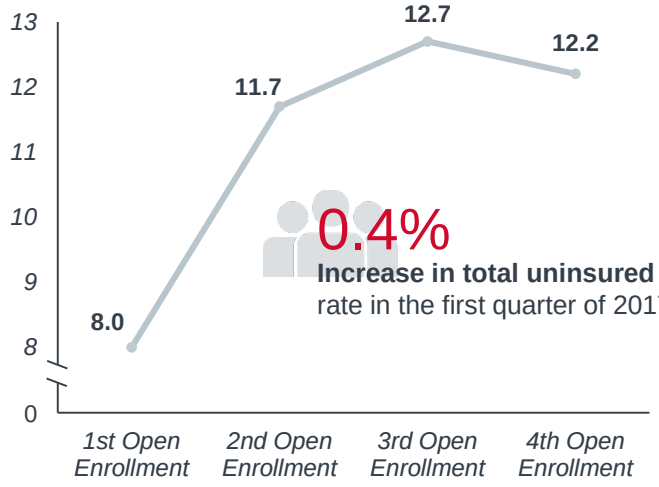
Source: Gee, E., "House Health Care Plan Is Not Enough to Keep High-Risk Pools Afloat," *Center for American Progress*, May 2, 2017; Jost, T., "House GOP Moves To Add 'Invisible Risk Sharing Program' To AHCA; Other ACA Developments," *Health Affairs Blog*, April 6, 2017; Archambault, J. et al., "Correcting Misconceptions About Invisible Risk-Sharing," *Health Affairs Blog*, April 25, 2017; Hall, M. and Bagley, N., "Making sense of 'invisible risk sharing,'" *Brookings*, April 12, 2017; Ely, K. et al., "The Federal Invisible High Risk Pool," *Milliman*, April 17, 2017; Jacobs, C., "What You Need To Know About 'Invisible High Risk Pools' The GOP Is Considering," *The Federalist*, April 10, 2017; Health Care Advisory Board interviews and analysis.

New Administration Already Impacting Enrollment

Coverage on Public Exchanges Dips Following Change in Administration

Exchange Enrollment Numbers Fall for First Time

Enrollees in ACA Marketplaces
In Millions



0.4%
Increase in total uninsured rate in the first quarter of 2017

Administration's Decision to Pull Advertising Hurt Enrollment Down Homestretch

"Just 367,260 people signed up for coverage in the final two weeks of [2017] enrollment on the federal exchange…compared to more than 700,000 plan selections in the last week of 2016 enrollment."

CNBC News

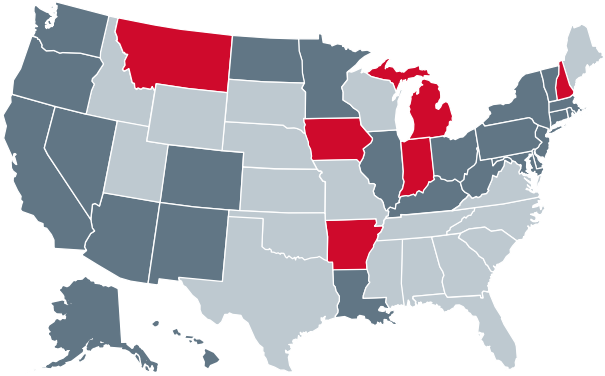
Source: Rudowitz, R., "Medicaid Enrollment & Spending Growth: FY 2016 & 2017," *KFF*, Oct. 13, 2016; Levitt, L., et al., "Assessing ACA Marketplace Enrollment," *KFF*, March 4, 2016; CMS, "Health Insurance Marketplaces 2017 Open Enrollment Period Final Enrollment Report; Nov. 1, 2016-Jan. 31, 2017," March 15, 2017; Mangan, D., "Obamacare enrollment drops in face of Trump repeal effort: More than 9 million people signed up on federal exchange," *CNBC*, Feb. 3, 2017; Mangan, D., "'Sabotage:' Trump administration reportedly kills Obamacare ads for HealthCare.gov with less than week to go in open enrollment," *CNBC*, Jan. 26, 2017 Health Care Advisory Board interviews and analysis.

Changes to Medicaid Would Have Larger Impact

AHCA Would End Enhanced Federal Funding for Expansion in 2020[1]

31 States and DC Have Approved Expansion[2]

As of March 2017



But Few Have Means to Sustain Programs Without Federal Support

$73B Federal funding provided to the states for Medicaid expansion in 2016

14M Fewer people would be enrolled in Medicaid by 2026 under AHCA[3]

8 States would automatically eliminate expansion in 2020 if federal contribution drops below 90%[4]

"It's almost beyond imagination that Pennsylvania's Medicaid expansion could survive the reduction in enhanced federal funding."

Andy Carter, CEO
Hospital and Health System Association of Pennsylvania

1) States retain enhanced rate for continuously covered beneficiaries, but due to significant churn in Medicaid population, total population turnover is expected within two years.
2) Montana's expansion requires federal waiver approval.
3) According to CBO projections, March 13, 2017.
4) Required by laws in Arkansas, Arizona, Illinois, Indiana, Michigan, New Hampshire, New Mexico, and Washington.

Source: Meyer, H., "If GOP repeal bill becomes law, most states likely to end their Medicaid expansion," *Modern Healthcare*, May 4, 2017; Kaiser Family Foundation, "Current Status of State Medicaid Expansion Decisions," January 27, 2015, www.kff.org; Fausset R and Goodnough A, "Louisiana's New Governor Signs an Order to Expand Medicaid," *New York Times*, January 12, 2016; Pradhan R, "Medicaid expansion fight rages on after Obamacare repeal fails," POLITICO, March 28. 2017; Advisory Board interviews and analysis.

States Already Straining to Cover Medicaid Budgets

Even Without AHCA's Cuts, Federal Funding Set to Phase Down

Medicaid Budget Pressure to Increase in Years Ahead

Some States Already Facing Difficult Decisions

"Medicaid could make up close to half of Louisiana's state budget"
"'We can't control our costs. We're growing out of control,' said state Rep. John Schroder, R-Covington"

"Oregon lawmakers consider ending Medicaid expansion to shore up budget"
"Ending Medicaid expansion, which has led to 350,000 people gaining coverage, would save the state $256 million over the next two years."

31
States face revenue shortfalls as of Jan. 2017

1) AHCA would repeal DSH payment cuts.
2) Beginning in 2020, AHCA would repeal enhanced federal matching rate for expansion population.

Source: Mitchell, A., "Medicaid's Federal Medical Assistance Percentage (FMAP)," *Congressional Research Service*, Feb. 9, 2016; Health Payer Intelligence, "OR May Cut ACA Medicaid Expansion Funds to Favor State Budget," April 24, 2017; Maness, R. "Thirty-One States Face Revenue Shortfalls for the 2017 Fiscal Year," *Multi-State*, Jan. 3, 2017; O' Donoghue, J., "Medicaid could make up close to half of Louisiana's state budget," *nola.com*, April 5, 2017; Mitchell, A., "Medicaid Disproportionate Share Hospital Payments," *Congressional Research Service*, June 17, 2016; Health Care Advisory Board interviews and analysis.

Medicaid Financing Coming to the Forefront

Bill Would Also Fundamentally Transform Financing Model

Beginning in 2020, AHCA Would Replaced Unlimited Federal Match With Two Alternatives

Per Capita Caps

- Default financing option
- Fixed federal contribution per enrollee
- States responsible for all costs over payment cap

Block Grants

- Optional financing alternative
- Single, lump sum provided regardless of enrollment
- Removes match rate, provides flexibility to states in appropriating funds

1) Non-elderly, non-disabled, non-expansion adults.

Source: American Health Care Act, H.R. 1628, 115th Congress, 2017, available at: www.congress.gov/bill/115th-congress/house-bill/1628; Health Care Advisory Board interviews and analysis.

Both Models Use Same Basic Formula

AHCA's Proposed Formula for Calculating Federal Funding Medicaid

Federal Funding = (2016 Expenditures) x (Growth Rate)

Two Major Implications

1

Locks States in at Past Spending Levels

- High-spending states will receive more generous funding indefinitely
- Low-spending states may have healthier populations, be more accustomed to less generous benefits

2

Size of Funding Shortfall (or Gain) Hinges on Spending Growth

- States expecting high levels of spending growth will be worse off
- A small number of states expecting extremely low levels of spending growth could see increase in federal funding

Source: American Health Care Act, H.R. 1628, 115th Congress, 2017, available at: www.congress.gov/bill/115th-congress/house-bill/1628; Health Care Advisory Board interviews and analysis.

Per-Capita Caps the Default Option

Accounts for Fluctuations in Enrollment, Offers Higher Growth Rates

Key Elements of Model

Retains matching structure; funding formula sets a cap on amount of federal match

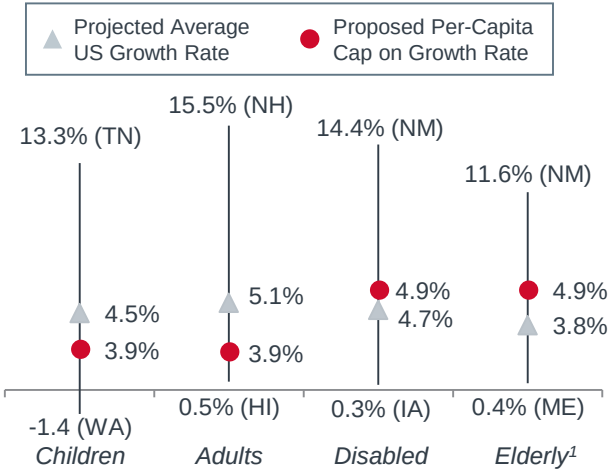
Funding calculated **per-enrollee** and adjusts based on enrollment

Funding calculated separately for **each enrollment category**

Funding for elderly and disabled would grow by **CPI-M+1,** versus **CPI-M** for children and adults

Past, Projected Growth Exceed Proposed Cap

Projected Growth Rates (FY2016-2025) Relative to Historical Range in Annual State Per-Enrollee Spending Growth (FY2000-2011)



1) Excludes Prescription Medication.

Source: HHS, "2016 Actuarial Report on the Financial Outlook for Medicaid," Sep. 2016, available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf; US Inflation Calculator, "Consumer Price Index Data from 1913 to 2017," available at: www.usinflationcalculator.com/inflation/consumer-price-index-and-annual-percent-changes-from-1913-to-2008/; American Health Care Act, H.R. 1628, 115th Congress, 2017, available at: www.congress.gov/bill/115th-congress/house-bill/1628; KFF, "Data Note: Variation in Per Enrollee Medicaid Spending Across States," Feb. 23, 2017; Health Care Advisory Board interviews and analysis.

Block Grant Option Offers Even More Flexibility

Allows States to Tweak Eligibility in Exchange for Lower Growth Rate

Key Elements of Model

- Alternative funding mechanism for **adult and children enrollment categories only**
- **Eliminates matching structure,** state receive lump sum funding and keep any surpluses
- State would be obligated to cover pregnant women and children, but have discretion to **scale back eligibility among able-bodied, working-age adults**

States Would Have Seen Even More Substantive Cuts Under Proposed Block Grant Growth Rates

Projected Medicaid Spending Growth, FY2016-2025

Overall annual growth in spending per-category	
Adults	6.2%
Children	5.5%
Proposed per-capita growth rates	
CPI-M +1%	4.9%
CPI-M	3.9%
Proposed block grant growth rate	
CPI-U	2.5%

1) Excludes Prescription Medication

Source: HHS, "2016 Actuarial Report on the Financial Outlook for Medicaid," Sep. 2016, available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf; US Inflation Calculator, "Consumer Price Index Data from 1913 to 2017," available at: www.usinflationcalculator.com/inflation/consumer-price-index-and-annual-percent-changes-from-1913-to-2008/; American Health Care Act, H.R. 1628, 115th Congress, 2017, available at: www.congress.gov/bill/115th-congress/house-bill/1628; KFF, "Data Note: Variation in Per Enrollee Medicaid Spending Across States," Feb. 23, 2017; Health Care Advisory Board interviews and analysis.

Not a Rosy Picture

Regardless of Model, Spending Cuts Would Impact Hospitals

ACA Boost to Medicaid Funding Positively Impacted Hospital Finances

Largest, investor-owned hospital systems see clear financial impact in 2014

Medicaid admissions increased an average of 21% in expansion states

Self-pay admissions decreased by 47% in expansion states

Uncompensated care costs reduced by $5 billion in expansion states

Potential State Reactions to Funding Reductions

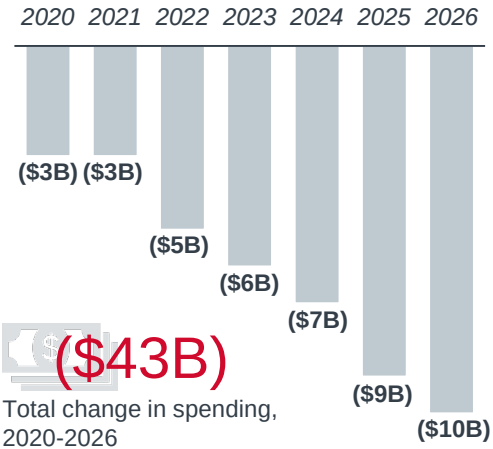
Options		*Provider Impact*
Pull back on eligibility	→	Spike in uninsured rate, uncompensated care
Cut enrollee benefits	→	Fewer reimbursed services; potentially sicker population
Cut or freeze payment rates	→	Lower reimbursement levels
Reform provider payment	→	Opportunity to transform delivery model, mitigate reimbursement losses

Source: Health Care Advisory Board interviews and analysis.

AHCA Cuts Hit Pediatrics Across the Country

Federal Funds Reduced Regardless of Region or Financing Model

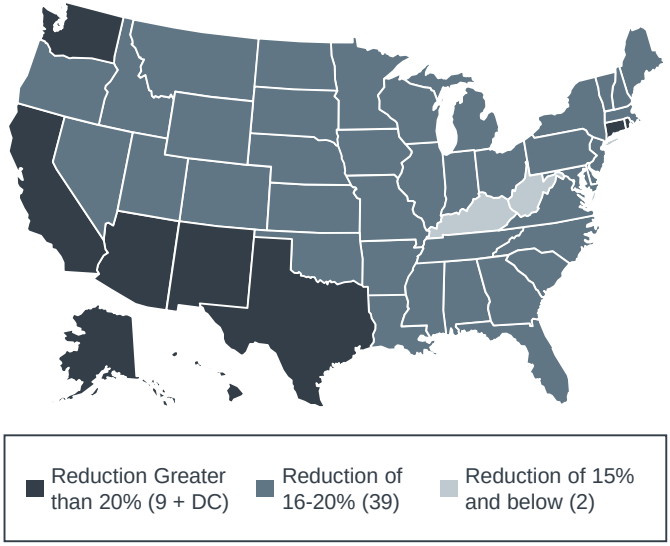
Change in Federal Medicaid Spending for Traditional Children Under AHCA, 2020-2026



($43B)

Total change in spending, 2020-2026

Percent Reduction in 2026 Federal Medicaid Spending for Children Under AHCA Block Grant By State



Avalere Health, "The Impact of Medicaid Capped Funding on Children," May 18, 2017; Health Care Advisory Board interviews and analysis.

Waivers Offer Funding and Enable Experimentation

States Using Waivers to Drive Three Major Types of Medicaid Reform

1 Payer-Led Managed Care

- Section 1932 and 1915 waivers, some 1115
- Implemented in 39 states
- Controls state spending by shifting beneficiaries to managed care with per-capita spending limits and/or home-based care alternatives

2 Consumer-Driven Insurance Design

- Section 1115 waivers
- Implemented in 7 states
- Allows states to change Medicaid coverage and eligibility options, often implementing more conservative features (e.g. cost-sharing requirements)

3 Provider-Focused Delivery Reform

- Section 1115 waivers, notably DSRIP[1] waivers
- Implemented in 16 states
- States receive federal dollars upfront; commit to delivery and/or payment reform that will save federal government in long-term

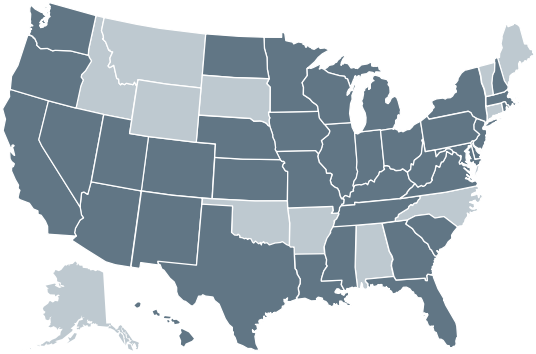
1) Delivery System Reform Incentive Payment.

Source: Health Care Advisory Board interviews and analysis.

Medicaid Managed Care Reaching Its Limits

39 States and DC Have At Least One Medicaid Managed Care Organization

As of September 2016



MCOs[1] No MCOs[1]

58% Increase in MCO enrollment in 19 expansion states, Dec. 2013-Sep. 2016

Implications of Medicaid Managed Care for Providers

Continued **payment rate cuts**

Increased **opportunity for health plans**, including PSHPs[2]

> [The number of Medicaid beneficiaries covered by insurers] is staggering. It's nearly a quarter of the population, [but] the easy growth is over."

Ari Gottlieb, Director Health Industries Payer Strategy, PwC Advisory

1) Capitated Medicaid managed care organizations.
2) Provider Sponsored Health Plans.

Source: KFF, "Total Medicaid MCOs," Sep. 2016, available at: http://kff.org/medicaid/state-indicator/total-medicaid-mcos/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; Demko, P. "Insurance industry profits booming under Obamacare," *Politico*, May 1, 2017; Health Care Advisory Board interviews and analysis.

Indiana Tests Medicaid Coverage Reform

Injecting Consumer-Driven Principles Into Medicaid Market

Case in Brief: Healthy Indiana Plan

- Section 1115 Medicaid expansion waiver modifying traditional program elements implemented in 2015
- Includes enrollee premiums, co-pays, incentives for preventive services, 2 plan tiers, and penalties for non-payment
- Providers reimbursed at Medicare rates to encourage provider Medicaid acceptance
- 73% of eligible Medicaid beneficiaries participated in 2015, the first year

HIP[1] Attempts to Encourage Three Behaviors:

1

Taking Personal Responsibility

- Requires monthly contributions to "POWER" health savings account; failure to pay results in reduced benefits
- No retroactive coverage

2

Using Preventative Services

- Free preventative services
- POWER account balances roll over if beneficiaries access these services
- Higher copays for use of ED in a non-emergency situation

3

Staying on Employer-Sponsored Coverage

- HIP Link program offers Medicaid-eligible individuals with employer-sponsored insurance a state-funded POWER account with $4,000 to cover out-of-pocket expenses

1) Healthy Indiana Plan

Source: Harper, J., "With the Healthy Indiana Plan up for renewal, is the Medicaid expansion experiment working?" *MedCity News*, Feb. 28, 2017; "State Waivers List," www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html; Health Care Advisory Board interviews and analysis.

First-Year Results for Healthy Indiana Plan are Mixed

Challenges with Cost, Complexity Somewhat Offset by Coverage Expansion

First-Year Results

60% Of enrollees **were previously uninsured** or became eligible for the program due to a change in income

75% Of members that remained in the program for a year **accessed preventative care**

46K Applicants earning above the FPL[1] **were never enrolled** because they didn't make their first payment[2], Feb. 2015-Nov. 2016

13K Beneficiaries were **disenrolled after failing to pay**, Feb. 2015-Nov. 2016

Key Takeaways

Program Impact

- Significantly expanded number of individuals with coverage
- Not yet clear if POWER accounts truly encourage enrollees to shop for the highest value providers and services

Provider Response

- Employed navigators to assist eligible resident with enrollment

Future Plans

- In February 2017, officials filed to extend the waiver through 2021, with the addition of voluntary job-related services

1) Federal poverty level.
2) Either because they had not heard of a POWER account or because they could not afford the payment.

Source: Pradhan, R., "Indiana Medicaid expansion blocks out thousands, report finds," *Politico*, May 2, 2017; Harper, J., "With the Healthy Indiana Plan up for renewal, is the Medicaid expansion experiment working?" *MedCity News*, Feb. 28, 2017; The Lewin Group, Inc., "Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report." July 2016, available at: www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf; Health Care Advisory Board interviews and analysis.

Following in Indiana's Footsteps

New Proposals Even More Expansive than HIP

Key Components of Select State Medicaid Waiver Requests Further Embrace Conservative Aims

			Amending current Medicaid expansion			*Not expanding Medicaid*	
		Indiana[1]	Arizona[2]	Ohio	Kentucky	Maine	Wisconsin
Eligibility and Enrollment	Coverage conditional on first premium payment	✗	✓	✗	✗	✓	✗
	Waives retroactive eligibility	✓	✗	✗	✗	✓	✗
	Work requirements	✗	✓	✓	✓	✓	✓
	Substance abuse screening and testing	✗	✗	✗	✗	✗	✓
	Time limit on coverage	✗	✓	✗	✗	✗	✓
Cost Sharing	Coverage or select benefits conditional on continued premium payments	✓	✓	✓	✓	✓	✓
	Healthy behavior incentives	✓	✓	✓	✓	✓	✓
Benefits	Waive non-emergency medical transportation	✓	✗	✗	✓	✓	✗

1) Waiver already approved by CMS.
2) Already has approval for premiums, healthy behavior incentives.

Source: Musumeci, M. et al. "Proposed Medicaid Section 115 Waivers in Maine and Wisconsin," *KFF*, May 10, 2017; Musumeci, M. et al., "Key Themes in Section 1115 Medicaid Expansion Waivers," *KFF*, Mar. 14, 2017; Wisconsin DHS, "Section 1115 Demonstration Waiver-BadgerCare Reform," April 25, 2017, available at: www.dhs.wisconsin.gov/badgercareplus/waivers-cla.htm; Arkansas Governor, "Governor Hutchinson to Seek Changes to Arkansas Works Waiver, Legislation Needed," March 3, 2017, available at: http://governor.arkansas.gov/press-releases/detail/governor-hutchinson-to-seek-changes-to-arkansas-works-waiver-legislation-ne; Dickson, V., "Maine joins the throng seeking Medicaid work requirements," *Modern Healthcare*, April 26, 2017; Health Care Advisory Board interviews and analysis.

Work Requirements Poised to Become Reality

New Administration Signals Willingness to Allow Controversial Requirements

Work Requirements in Brief

General Mechanics:

Require "able-bodied" adults between ages of 19-64 to work, care for a someone ill or disabled, or participate in an approved job search or training program to maintain Medicaid coverage

Prevalence (March 2017):

7 States have submitted 1115 waivers that include work requirements (AZ, KY, OH, ME, WI, FL, AR)

3 Have voluntary work programs (IN, MT, NH)

Scope of Impact Dependent on Whom Qualifies for Exemption

~22M	Adults, 58% of Medicaid beneficiaries nationwide that qualify as "able-bodied"
~11M	"Able-bodied" adults who report that they are already working
~5M	Of "able-bodied" adults have potentially disqualifying "serious health conditions"
~6-11M	People potentially impacted nationwide

> **Work requirements are important.** They're something that is restorative to people's self-worth ... We believe it's important for folks to have a job, that they contribute not just to society but they contribute to their own ... well-being."
>
> *Tom Price, HHS Secretary*

Source: Weixel, N., "Push for Medicaid work requirements draws fire," *The Hill*, Mar. 21, 2017; Musumeci, M., "Medicaid and Work Requirements," *KFF*, Mar. 23, 2017; Altman, D., "Don't expect Medicaid work requirements to make a big difference," April 3, 2017; Ku, L and Brantley, E., "Medicaid Work Requirements: Who's at Risk?" *Health Affairs*, April 12, 2017; Health Care Advisory Board interviews and analysis.

Payment Reform an Increasingly Popular Strategy

State Demonstrations Fall Along Traditional Value-Based Spectrum





Pay-for-Reporting

- **New Jersey** Funds private hospital projects focused on one of eight conditions
- **New York** Offers provider coalitions incentive payments for delivery reform

PCMHs[1]

- **Arkansas** Offers PMPM[2] payments and shared savings potential if cost and quality thresholds are met
- **Colorado** Distributes PMPM payments to cover enhanced services (e.g. care coordination)

Bundled Payments

- **Arkansas and Tennessee** Accountable physicians rewarded or penalized based on quality and cost performance

Population-Based, ACOs

- **Alabama** Regional Care Organizations
- **Oregon** Coordinated Care Organizations
- **Vermont** Accountable Care Organizations

Total Cost of Care

- **Maryland** Global budget caps for hospital services

Upside Risk Only → **Potential for Downside Risk**

1) Patient Centered Medical Homes.
2) Per-Member Per-Month.

Source: Health Care Advisory Board interviews and analysis..

Offers Most Opportunity for Providers

Delivery Waivers Offer Alternative to Cuts to Coverage and Reimbursement

Items to Watch For

- Will more comprehensive cost, savings, and quality data from existing demonstrations be forthcoming?
- How will the Trump administration assess new and renewal waiver proposals?
- Will more commercial payers get involved in these demonstrations?
- Will CMMI create a third round of State Innovation Models (SIM) grants?

Provider Considerations

- Take advantage of money available from current demonstrations to fund new initiatives or ongoing projects
- Leverage model parameters to enhance value-based care capabilities; align incentives across distinct Medicaid, uninsured enrollment groups; and prepare for population health under MACRA
- Proactively engage with state officials to participate in shaping and improving program structure

1) The Medicare Access and CHIP Reauthorization Act of 2015.

Source: Health Care Advisory Board interviews and analysis..

Employer Health Spending Continues to Grow

AHCA Delays Cadillac Tax, Holds Back on Any New Caps on Employer Spend

"Cadillac Tax" Delayed

- 40% excise tax assessed on employee health benefit spend exceeding $10,200 for individuals, $27,500 for families
- Originally proposed in ACA to begin in 2020; effective date postponed in AHCA[1] to 2025

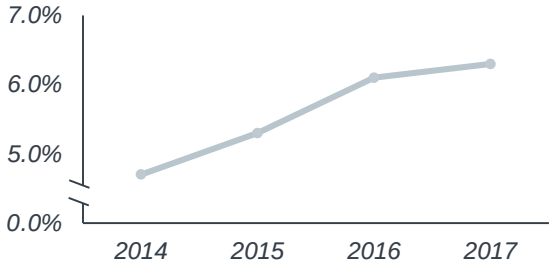
Cap on Tax Exclusions Dropped

- Limit on existing tax exclusions for employer contributions to health plans
- Model proposed in "A Better Way;" absent from the AHCA and contemporary GOP alternatives

Even Without Regulatory Pressure, Employers Still Have a Cost Problem

~47% US population covered by employer-sponsored insurance

Average Annual Growth Rate Among Private Business's Health Expenditures
FY 2014-2017



1) American Health Care Act.
2) Projection from Willis Towers Watson Employer Survey.

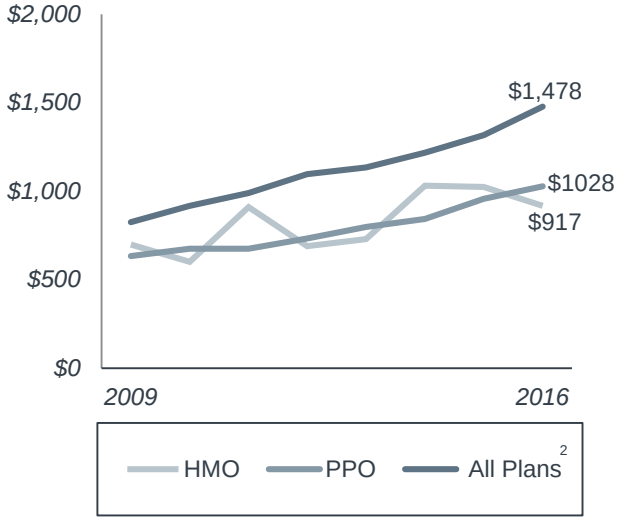
Source: Gaba, C., "Healthcare Coverage Breakout for the Entire U.S. Population in 1 Chart," *ACASinups.net*, March 28, 2016, available at: http://acasignups.net/16/04/18/show-your-work-healthcare-coverage-breakout-entire-us-population-1-chart; US Bureau of Labor Statistics, "Employee Tenure Summary," September 2016 ; Berman, R., "Why Some Conservatives Are Unhappy About Obamacare Cuts," *The Atlantic*, Dec. 17, 2015; Health Care Advisory Board interviews and analysis.

Cost-Shifting Continues to be the Dominant Strategy

Migration to High Deductible Health Plans Well Underway

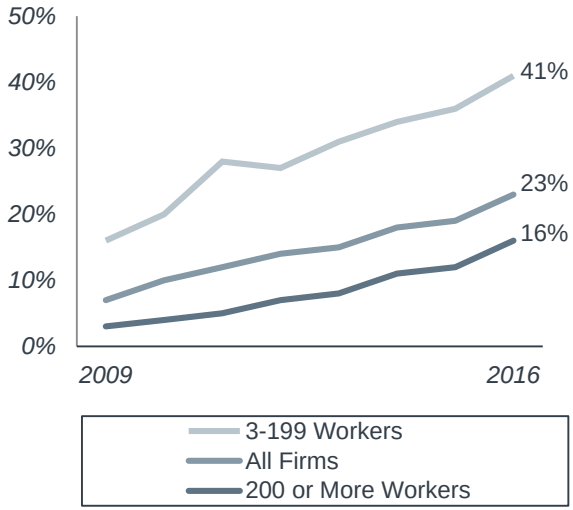
ESI Average Deductible for Single Coverage[1]

By Plan Type, 2009-2015



Percentage of Covered Workers with Annual Deductible of $2,000 or More[3]

By Firm Size, 2009-2016



1) Among covered workers with a general annual health plan deductible.
2) Includes HDHP/SO.
3) For single coverage.

Source: KFF, "2016 Employer Health Benefits Survey," available at: http://kff.org/health-costs/report/2016-employer-health-benefits-survey/; Health Care Advisory Board interviews and analysis.

Defined Contribution the Employer End Game?

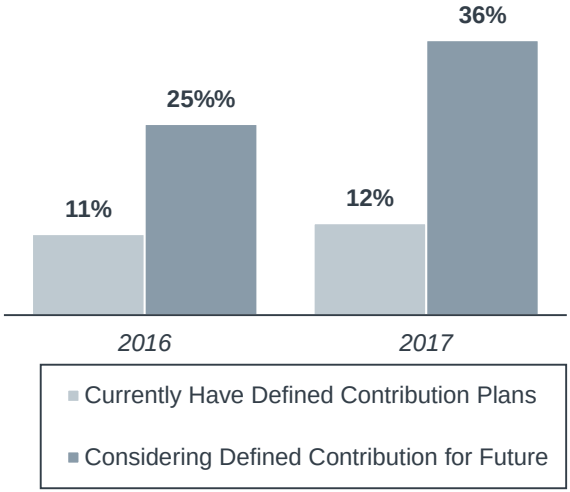
Increasing Employer Awareness Not Yet Manifesting in Wider Adoption

Concept in Brief: Defined Contribution

- Provide employees a fixed amount to buy health insurance of their choice
- May curate plan options through a private exchange or allow employees to purchase coverage through public exchanges, individual insurance market

Employers Report Growing Familiarity, Interest in Defined Contribution

Employer Responses to 2016,2017 Health Care Trends Institute's Benefits Survey



Source: Health Care Trends Institute, "2017 Healthcare Benefits Trends," 2017, available at:: http://www.healthcaretrendsinstitute.org/wp-content/uploads/2017/02/2017-Healthcare-Benefits-Trends.pdf; Health Care Trends Institute, "2016 Healthcare Benefits Trends," 2016, available at: http://www.healthcaretrendsinstitute.org/wp-content/uploads/2016/02/HTI_SurveyReport_2016HealthcareBenefitsTrends.pdf; Health Care Advisory Board interviews and analysis.

Growth Driven by HSA-Qualified Plans

Employers Pushing for True Cost Exposure

Concept in Brief: Health Savings Accounts

- Medical savings accounts in which contributions, interest, and withdrawals for qualified expenses[1] are tax-free
- After retirement, funds can used for non-medical expenses, but would be subject to income tax
- Owned by an individual, portable, and anyone may contribute to them
- To open an HSA, an individual must have a qualified HDHP[3] and cannot be a dependent/enrolled in Medicare
- Accounts have no upward limit, but annual contributions are capped[2]

HSAs Have Mixed Track Record Thus Far

Data as of 2015

Consumers Increasingly Contributing to HSAs

45%

Of HSAs received an individual contribution

$3,623

Average account balance for owners age 65 and over

But Not Yet Using Accounts to Full Potential

43%

Of people with HSA qualifying plans had not opened an HSA

3%

Of HSAs had invested assets

1) Most medical expenses and some insurance premiums (COBRA, long-term care, non-Medigap Medicare); excludes non-prescription drugs, supplements, cosmetic surgery, concierge fees.
2) $3,400 for individuals and $6,750 for families; individuals over 55 may contribute an additional $1,000.
3) Minimum deductible of $1,300 for individuals and $2,600 for families AND a max OOP limit of $6,550 for individuals and $13,100 for families.

Source: Anderson, T., "Health savings accounts are the big winner as Republicans hash out an Obamacare replacement," *CNN*, May 8, 2017; KFF, "2016 Employer Health Benefits Survey," available at: http://kff.org/health-costs/report/2016-employer-health-benefits-survey/; Health Care Advisory Board interviews and analysis.

GOP Planning to Expand HSAs

AHCA Would Encourage Use of HSA "Backpack"

Increased Contribution Limit

Raises annual limit on HSA contributions to match out-of-pocket limit; allows both spouses to make catch-up contributions to one account

Expanded Spending Flexibility

Lifts ACA restriction on spending HSA funds on over-the-counter medications; allows retrospective payments within 60 days

Decreased Tax Penalties

Lowers the penalty for using HSA funds to pay for non-qualifying medical expenses to 10%; eliminates penalty for those over 65[1]

1) Must still pay income tax on non-medical expenses.

Source: American Health Care Act, H.R. 1628, 115th Congress, 2017, available at: www.congress.gov/bill/115th-congress/house-bill/1628; Health Care Advisory Board interviews and analysis.

Cost Shifting Reaching Its Limits?

Employers Increasingly Looking to Supplement Cost-Shifting Strategies

Cost Shifting Causing Consumers to Forgo Care, Increasing Bad Debt…

Spending Reductions Following Implementation of HDHPs

25%
Reduction in physician office spending

18%
Reduction in ED spending

Increasing Bad Debt as Consumers Face Growing Financial Exposure

61%
Of those reporting difficulty paying medical bills used up all or most of their savings, 2016

20%
Increase in bad debt among Minnesota Hospital Association Members, 2014-2016

…But Not Incentivizing Shopping

> "[We found] that spending reductions are entirely due to outright reductions in quantity. We found no evidence of consumers learning to price shop after two years in [a HDHP]"
>
> *The National Bureau of Economic Research*

> "Consumers want to make better choices. They want to save money. They just want someone else to do the work and show them how"
>
> *Jim Winkler, Global Chief Innovation Officer, Aon*

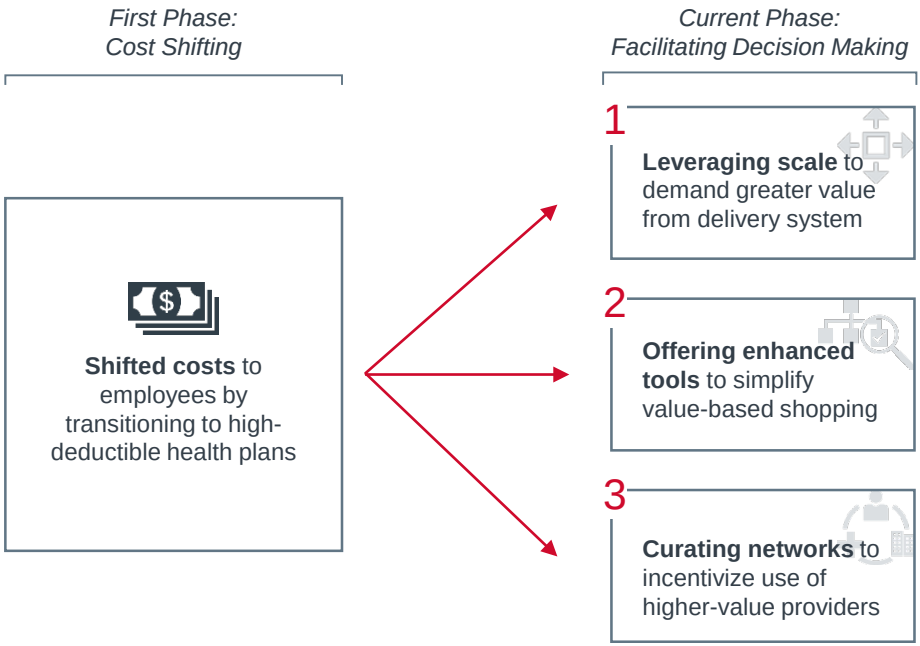
1) $1,200 Single; $2,400 Family.
2) $2,500 Single; $5,000 Family.

Source: Brot-Goldberg Z et al., "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics," The National Bureau of Economic Research, October 2015, available at: http://www.nber.org; Altman D, "Health-Care Deductibles Climbing Out of Reach," *Wall Street Journal*, March 11, 2015, available at: www.blogs.wsj.com; KFF, "2016 Employer Health Benefits Survey," available at: http://kff.org/health-costs/report/2016-employer-health-benefits-survey/; Health Care Advisory Board interviews and analysis.

New Tools Aim to Facilitate Consumer Shopping

Helping Employees Make High-Value Choices

Employers Entering a New Era of Benefit Design



1) High-Deductible Health Plans.

Source: Health Care Advisory Board interviews and analysis.

Payers Pulling Pricing Levers to Curb Spending

Every Segment of the Purchaser Market Seeking to Control Spending

1

Public Exchanges

- Decreasing subsidies
- Increasing premiums

2

Medicaid

- Decreasing federal funding
- Tightening restrictions on benefits and eligibility
- Reducing reimbursement
- Reforming provider payment models

3

Medicare

- Reforming provider payment models
- Cutting reimbursement
- Shifting to narrower MA networks

4

Employers

- Shifting costs
- Narrowing networks
- Developing new consumer shopping tools

Key Themes Across Payers

- Price Cuts
- Consumerism
- Network Curation
- Cost-Shifting
- Payment Reform
- Slimmer Coverage

Source: Health Care Advisory Board interviews and analysis.

An Industry in Flux

Market-Based Approach Taking Hold in Health care

Source: Health Care Advisory Board interviews and analysis.

Not an Unfamiliar Story

Market Forces, Regulatory Changes Have Driven Rapid Transformation in Other Sectors

Industry	Transformative Forces	Industry Evolution
AIRLINES 	• 1978 Airline Deregulation Act • Influx of low-cost carriers drives price competition	*Market Share Among Four Largest Domestic Carriers* 1977: 56% → 2000: 61% → Present: 87%
BANKS 	• Deregulation in 80s decreases barriers to geographic expansion, expands scope of allowable services • Development of ATM technology	*Number of Commercial Banks in the US* 1984: 14,400 → 2000: 8,458 → Present: 5,031
TELECOM 	• Rapid advancement of technology (e.g. smartphone) in 2000s rewards those with massive capital resources • Demand for national infrastructure, coverage rewards geographic scale	*Market Share Among Four Largest US Wireless Carriers* 2003: 63% → 2009: 90% → Present: 98%

https://fred.stlouisfed.org/series/USNUM;
https://venturebeat.com/2013/07/08/iphone-carrier-consolidation/

Value to Consumers Paramount

Consolidation and Scale Deliver End-User Value in Other Industries

- **Lower prices**: After adjusting for inflation, airline prices have declined by 50% since 1978
- **Improved access**: In 1965, only 20% of Americans had ever been on a plane; in 2000, the average American flew twice

- **Improved access:** Number of bank branches grew from 53,000 in 1980 to 71,000 by the end of 1998; digital banking now on the rise
- **Broader scope:** Wider range of products and services (e.g. more types of accounts, personal finance)

- **Lower prices**: Cost of wireless voice service per minute has declined by more than 30% since 1993
- **Improved access**: National, wireless networks ubiquitous, enabling long-distance calls

Imperatives for Health Systems

Reduce Prices
Reduce both unit cost and total cost of care

Improve Access
Make care more convenient, with focus on virtual realm

Broaden Scope
Offer wider range of services