Part II

What Does Health Reform Mean for Providers?

Three Trends That Will Change Everything

1. Growing under-reimbursement for FFS
2. Rising patient out-of-pocket costs
3. Return of individual insurance choice

1. Growing Under-reimbursement for FFS

I Think 5 years From Now…

1. The payer environment will remain essentially the same as now;
2. Most insurance, including employer, individual, Medicare, & Medicaid will be provided by private insurers;

OR,

3. We will be heading toward a single payer system.

PPACA Is Good News, Bad News for Providers on Reimbursement

- Good news: An end (mostly) to uncompensated care
- Bad news: A new era of under-compensated care

Medicaid

- 15 million new covered lives
- Below-cost reimbursement rates
- Short-term benefit
- Long-term pain
- Comprehensively insured
- Greater capacity demands
- Increased provider losses

Medicare FFS

- Mushrooming boomers
- Retiree dumping
- 1997 SGR rules to cut 2012 reimbursements by 29.4%
- Counting on 13th doc-fix? Maybe you shouldn't.
- ACA to cut annual payment updates $196b starting 2012
- ACA to cut DSH payments $18b starting 2014
- ACA's IPAB to cut $15.5b to $24b
- RAC audits to recover $2.1b (5 years)
- More to come
- Congress avoiding necessary restructuring until…?

Result?

Current hospital/doctor revenue model:

- Growing provider losses from Medicaid & Medicare FFS
- CAH preferred reimbursement at risk
- Medicare as the new Medicaid?
- Medicaid race to the bottom?
- Is there salvation in increased cost shifting to private payers?
  - Insurance exchanges
  - Employer-based insurance

Insurance Exchanges

- 17 million new insured starting 2014
- Subsidized private insurance to 400% FPR
- 80/85% MLR requirement
- State *and* federal premium rate review and regulation
- 800-pound adverse selection risk
- Risk that states won't do it right.
- Insurers: Either drive down reimbursements or lose money
- Provider cost-shift opportunity here?

  Highly unlikely

Employer Insurance to the Rescue?

- Historical sponge for cost shifting, but…
- Expanded eligibility mandates
- Grandfathering limits
- New benefit mandates
- Unlimited benefit ceiling
- Employee contribution limits
- Play *and* pay penalty landmines
- Deductible restrictions
- Historical failure to control costs, assure quality
- Largest source of employee complaints
- Largest non-wage expense

A Question for Employers:

If you could:

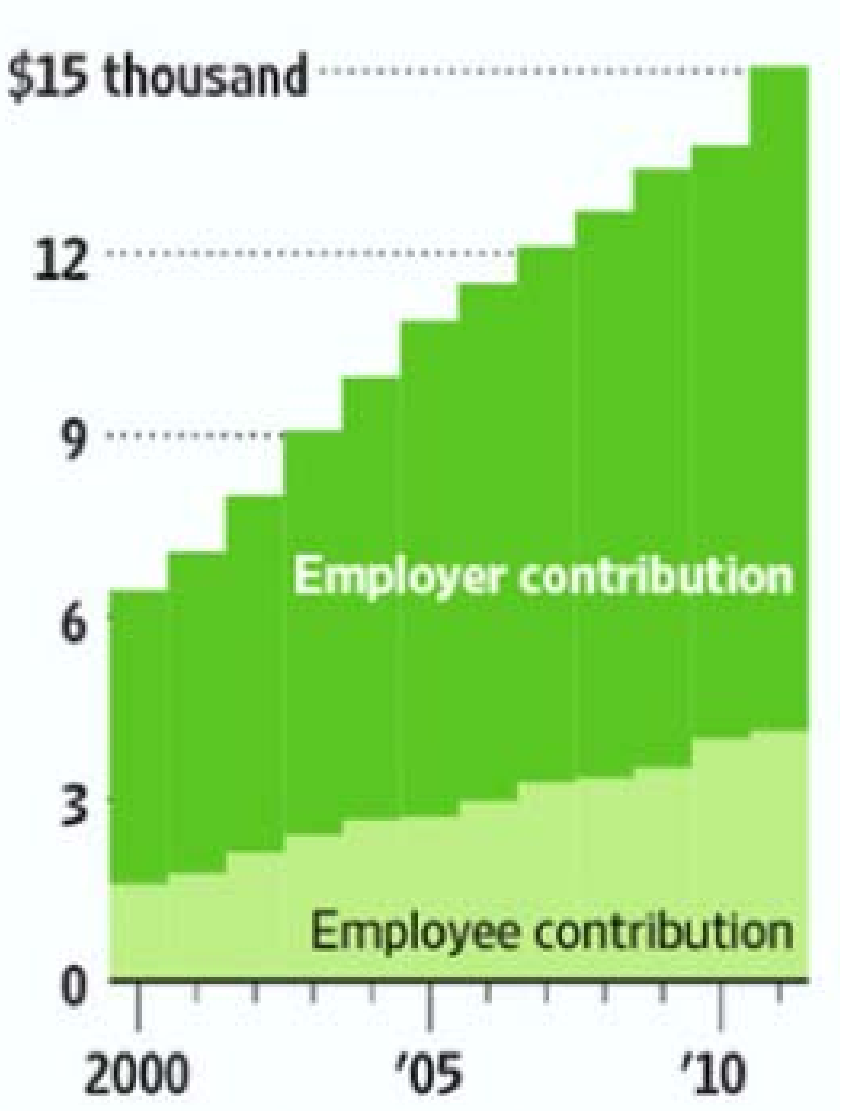
- stop providing employee health benefits
- give employees the money

And your employees could:

- buy their own health insurance
- with equal or better benefits
- for equal or lower premiums,

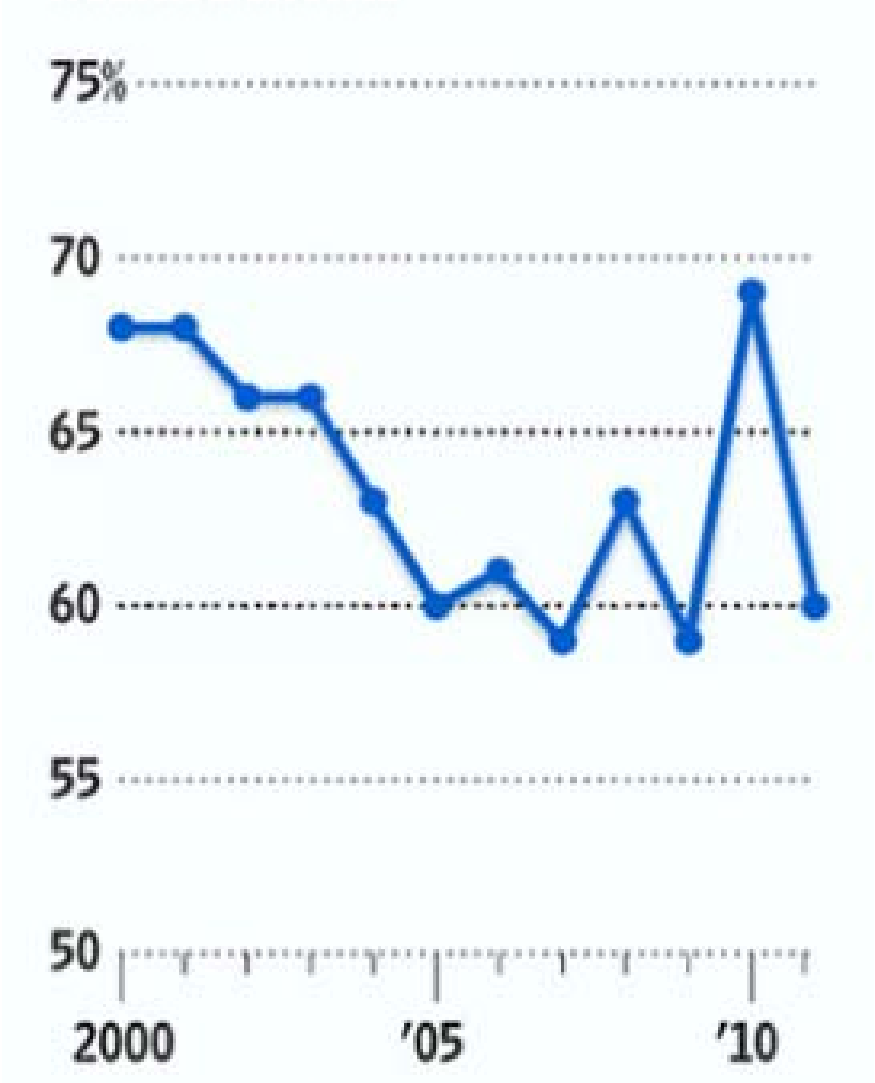
Would you do that?

Average Annual Premiums for Family Coverage



Source: Kaiser Family Foundation; Health Research & Educational Trust, as referenced by Anna Wilde Mathews in the Wall Street Journal, September 28, 2011, *Employers' Health-Care Premiums Jump 9%*

Percentage of Firms Offering Health Benefits



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Would you do that?

1. Yes
2. No

The Hyde Poll of 250 CEOs

98% of CEOs have answered either

- Yes
- Hell, yes!

2%: Is this a trick question?

Insurance Exchanges will provide that option.

What Will Employers Do?

- Many will stop providing insurance
- Avoid or pay the government penalties
- Give the money (or exchange voucher) to employees
- Let them buy exchange insurance

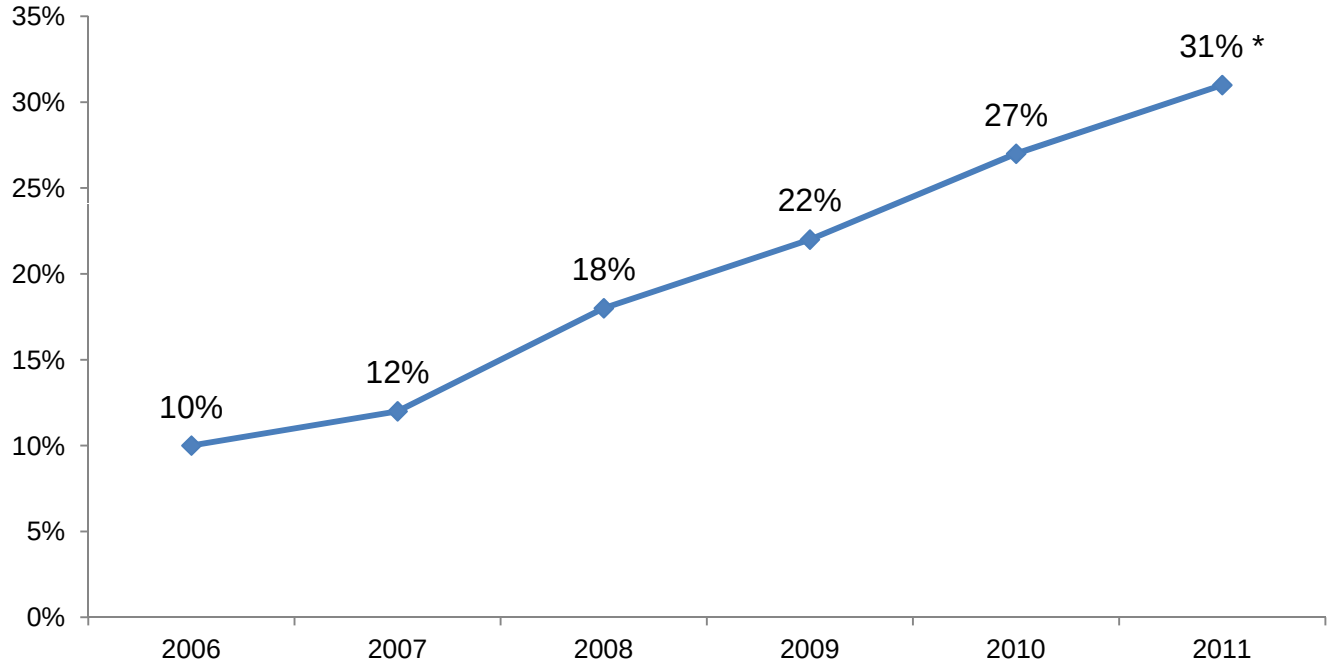
Who will providers cost-shift to now?

2. Rising Patient Out-Of-Pocket Costs

For your organization, are you:

1. Increasing write-offs?
2. Turning over to collection?
3. Increasing pre-admission counseling, financing plans, discounted prepay?
4. Adopting retail pricing?
5. Refusing non-emergent care?
6. Not having a problem?

Percentage of Workers With Deductible of $1,000 or More



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2010.; Single Coverage; and The Wall Street Journal.

2. As High Deductibles Become Standard:

- Health insurance less relevant for most people
- Growing provider collection problems
- Increased patient information demands
  - Price
  - Quality
  - i.e. VALUE (Quality/Price)
- Current provider revenue models and charge structures won't cut it

3. Return of Individual Insurance Choice

- Individual insurance exchanges
  - 2014: Individuals and small employers
  - 2017 (or earlier): All employers
- Medicare Advantage
- Medicaid managed care
- First opportunity since HMOs in the '80s to create local health plans focused on high-value medical providers

Conclusions:

- Consumers increasingly in control of *all* their health care dollars
  - Out of pocket medical care
  - Individual health insurance purchasing
- Providers increasingly stressed to succeed financially (witness growing integration, consolidation, & failures)
- High-value providers that can monetize patient value with value-based revenue models will be in best position to survive and thrive
- Not as difficult as it may sound
- Ok, it's difficult, but far from impossible.

Takeaway for Providers

Change or Die
Or Retire Soon

How Do You Plan to Change?

1. Go horizontal (acquire or be acquired)
2. Go vertical (doctor/hospital integration)
3. Optimize FFS revenue cycle
4. Adopt value-based revenue model
5. Stay the course
6. I'm a consultant/vendor

Next Up: One Big Trend-ACOs