Healthcare Spending in the United States

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Empower Results®

Agenda/Topics

1. Introduction

2. State of Health Care in the U.S.
   - Healthcare Spending
   - Current Problems (and global comparisons)

3. Why is Health Care So Expensive?

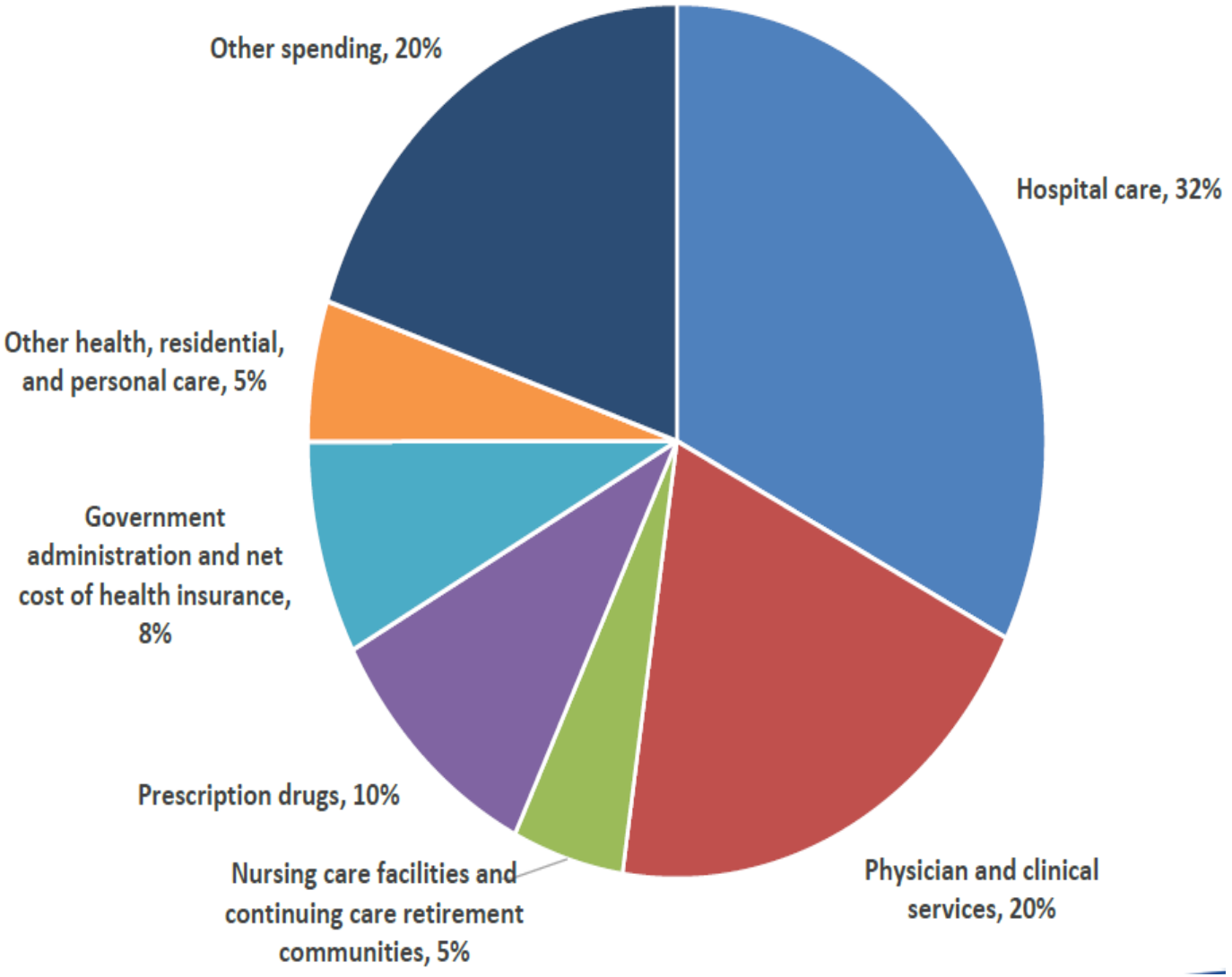
4. Who is to Blame?

5. Efforts to Solve the Problem
   - What's happening already
   - Other thoughts/Next steps?

6. Some Good Signs – spending growth on downswing

State of Health Care in the U.S.

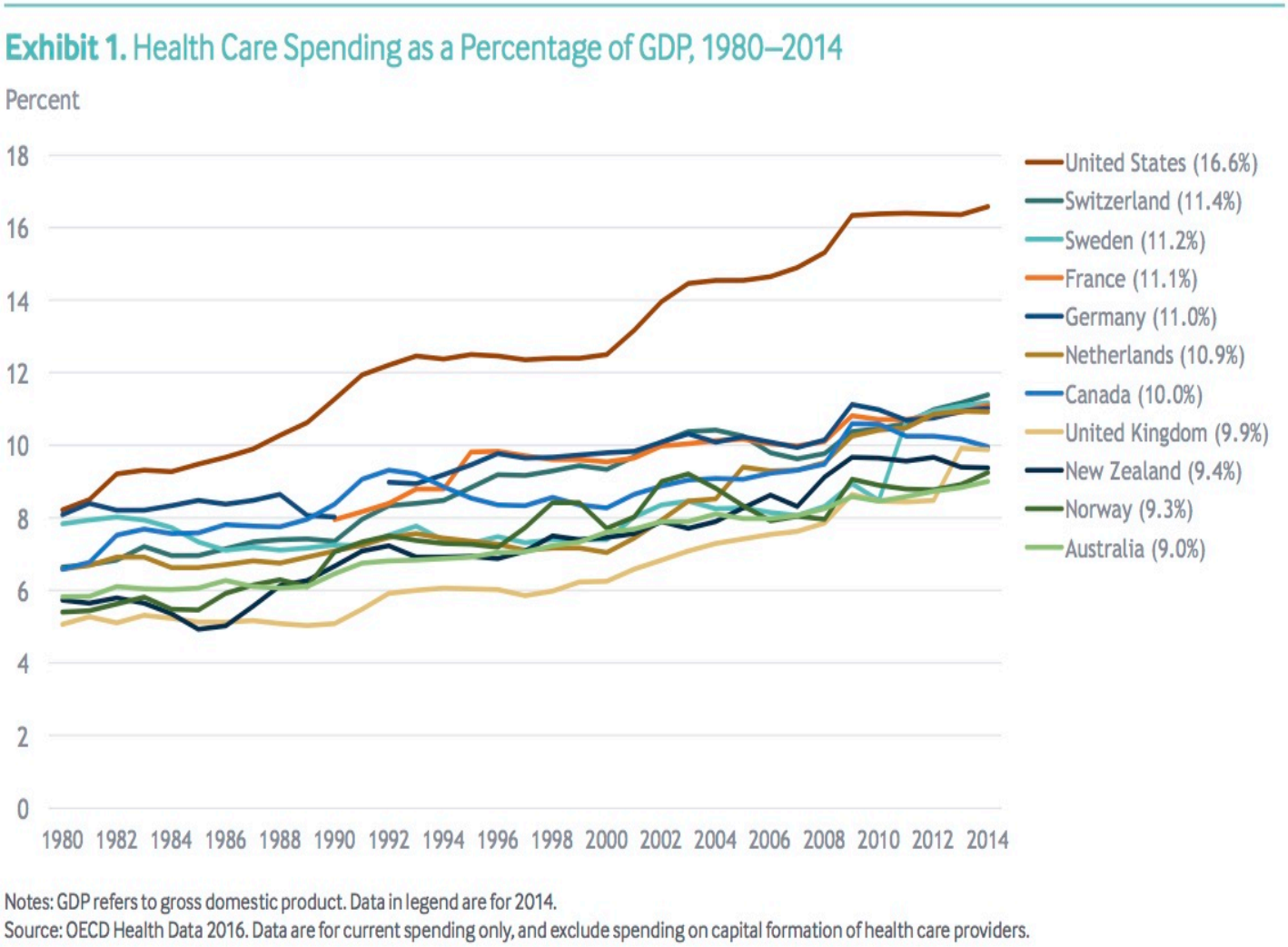
Health Care Spending: Where did it go?



<u>Hospital Care (1/3 spend):</u>

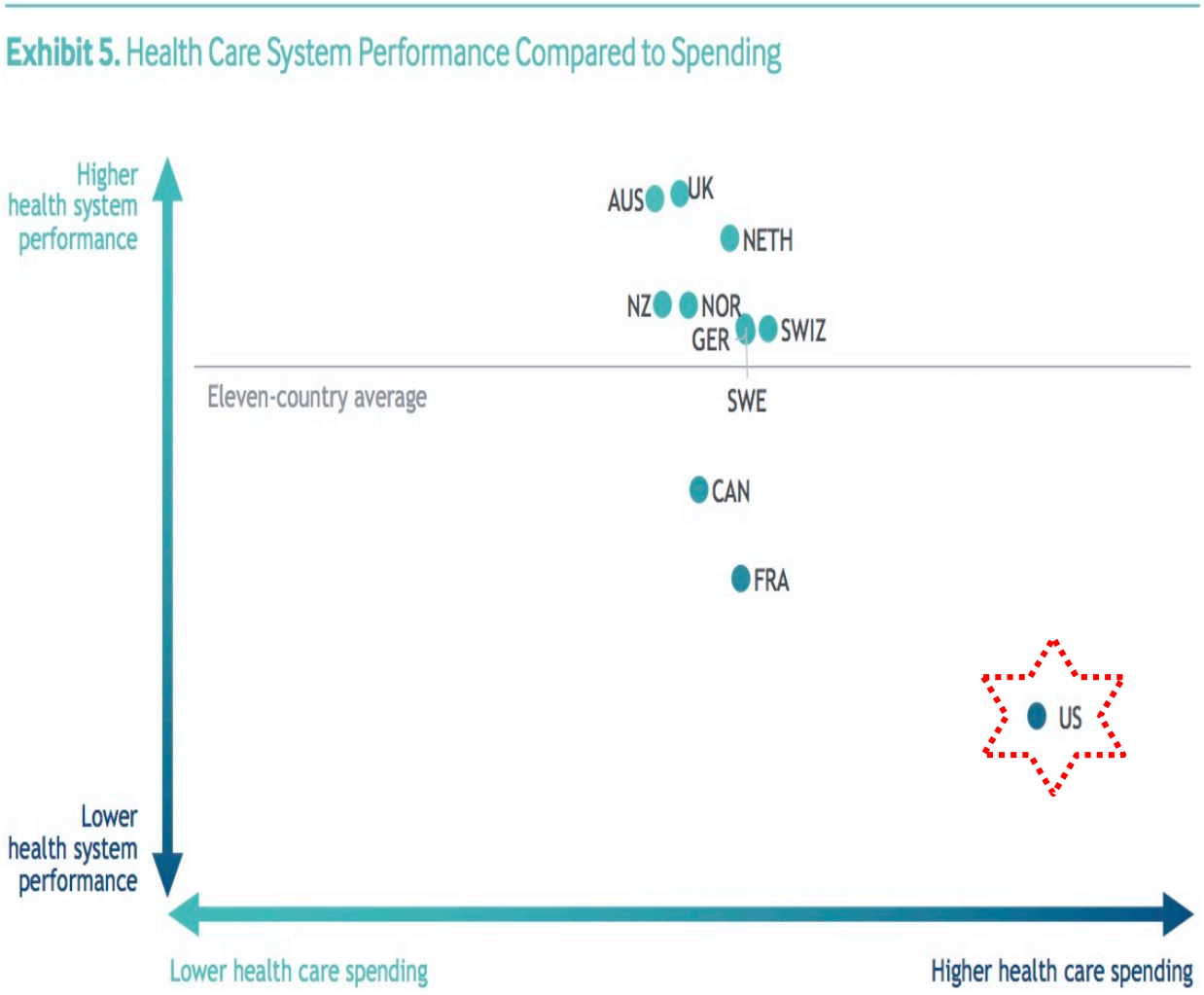
- Pricing is a mystery
- The more dominant a hospital is in its region, the higher the prices it can force insurance companies to pay
- Hospital consolidations rising → likely going to be a bigger problem

Health Care Spending as a Percentage of GDP



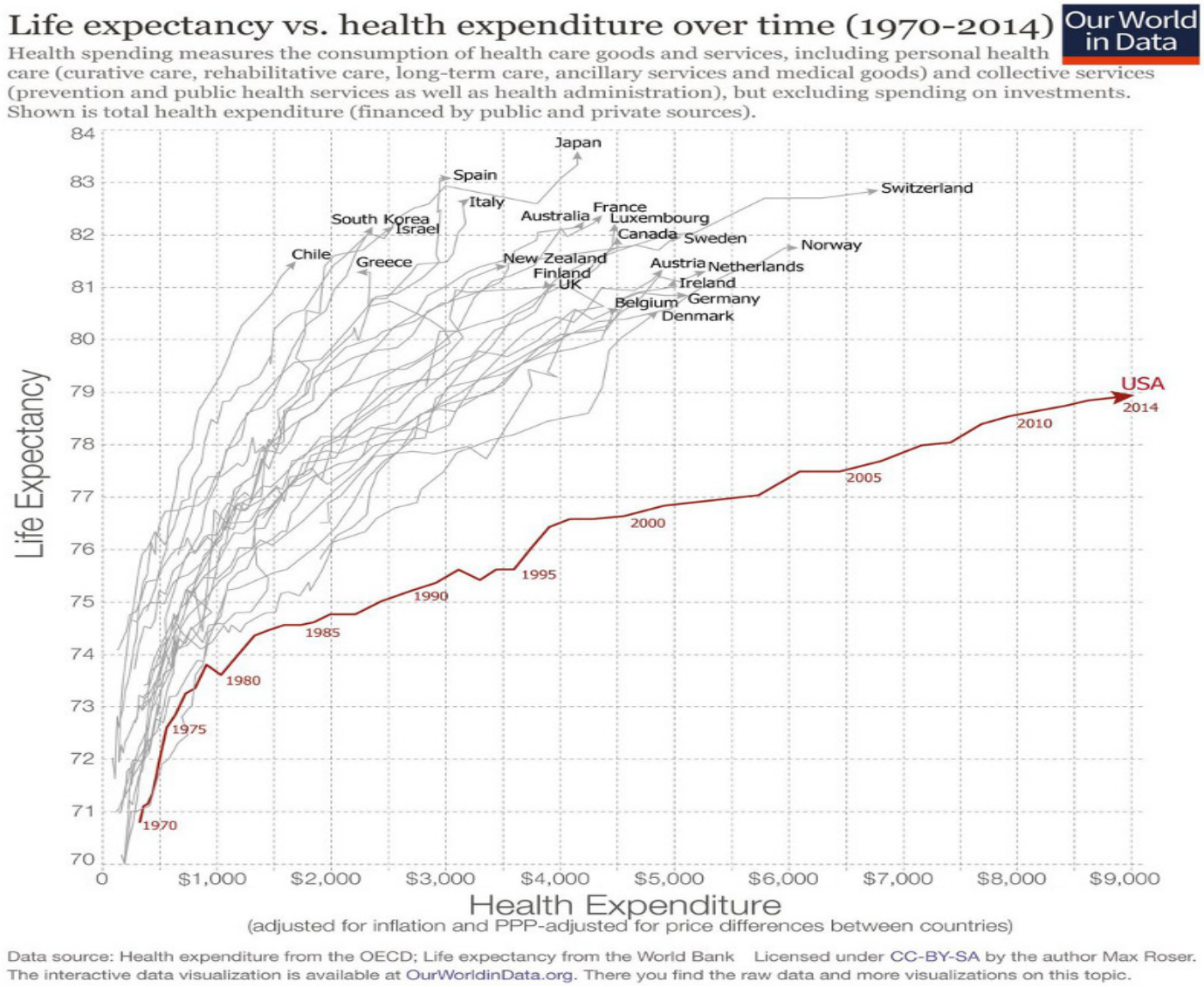
Notes: GDP refers to gross domestic product. Data in legend are for 2014.
Source: OECD Health Data 2016. Data are for current spending only, and exclude spending on capital formation of health care providers.

Are we getting our money's worth → No!



- Wide regional variation in spending even after demographic adjustments
- Resource use is sensitive to supply:
  - More beds, more IP hospitalizations
  - More doctors, more visits
- More aggressive treatment doesn't equal better outcomes

Per Capita Health Spend vs. Life Expectancy (USD Adj.)



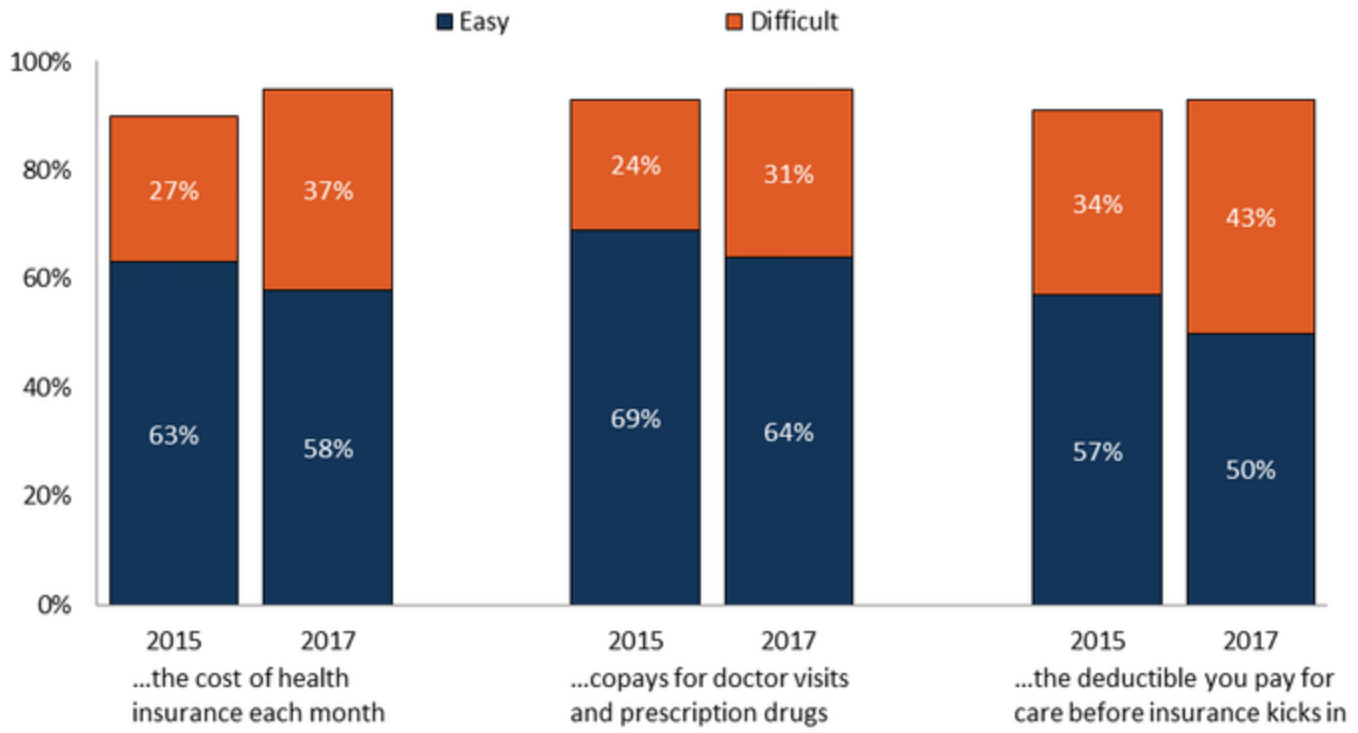
- USA has lower life expectancy (79yrs) than the average by approx. 3yrs
- If the United States had Canada's system, it would save $1.7 trillion dollars → as much as last year's after-tax profits of all U.S. corporations combined

Affordability Trends

Figure 2

More Insured Americans Now Report Difficulty Affording Health Care

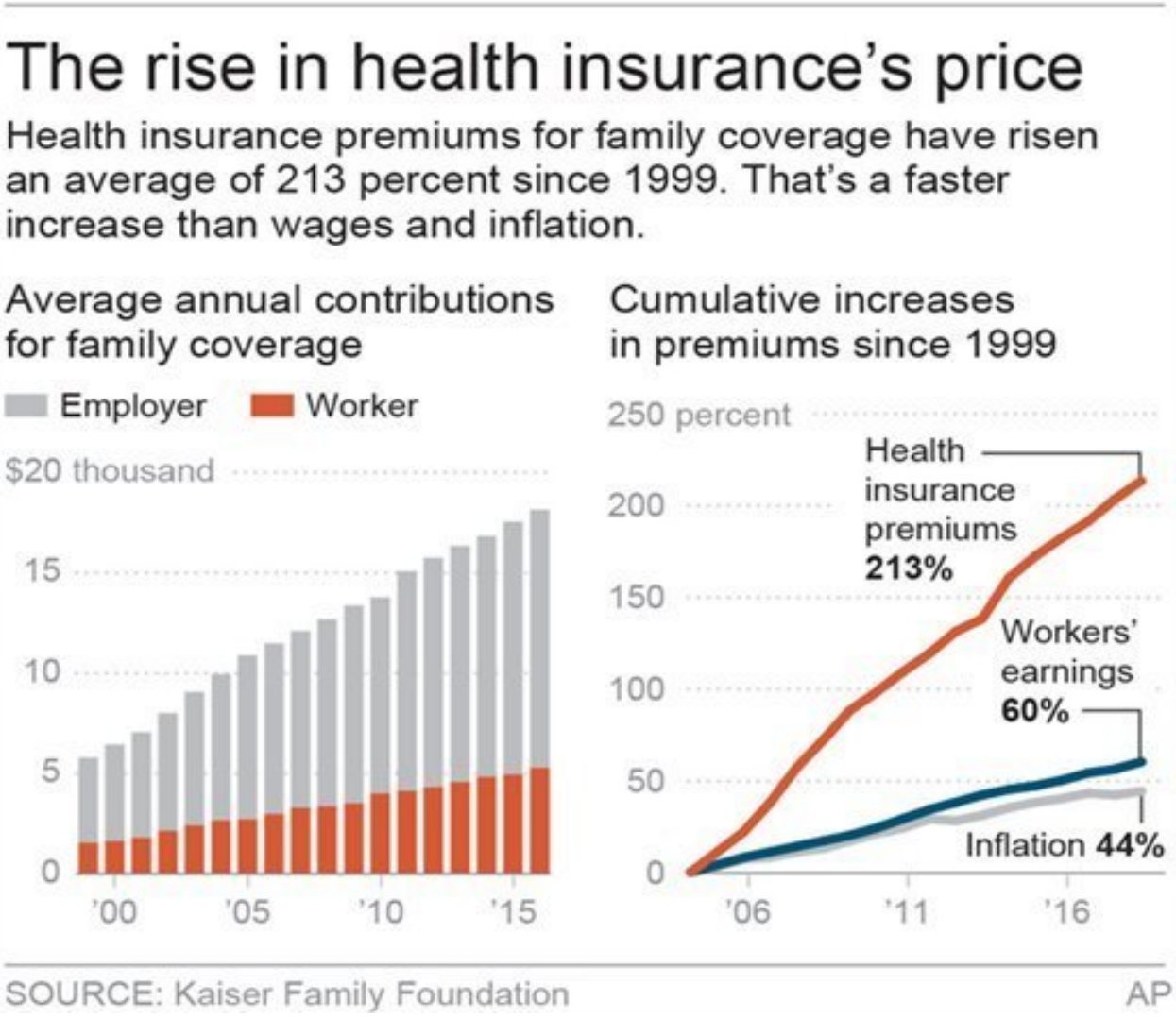
AMONG THE INSURED: In general, how easy or difficult is it for you to afford to pay…



NOTE: Don't have to pay (Vol.) and Don't know/Refused responses not shown.
SOURCE: Kaiser Family Foundation Health Tracking Polls

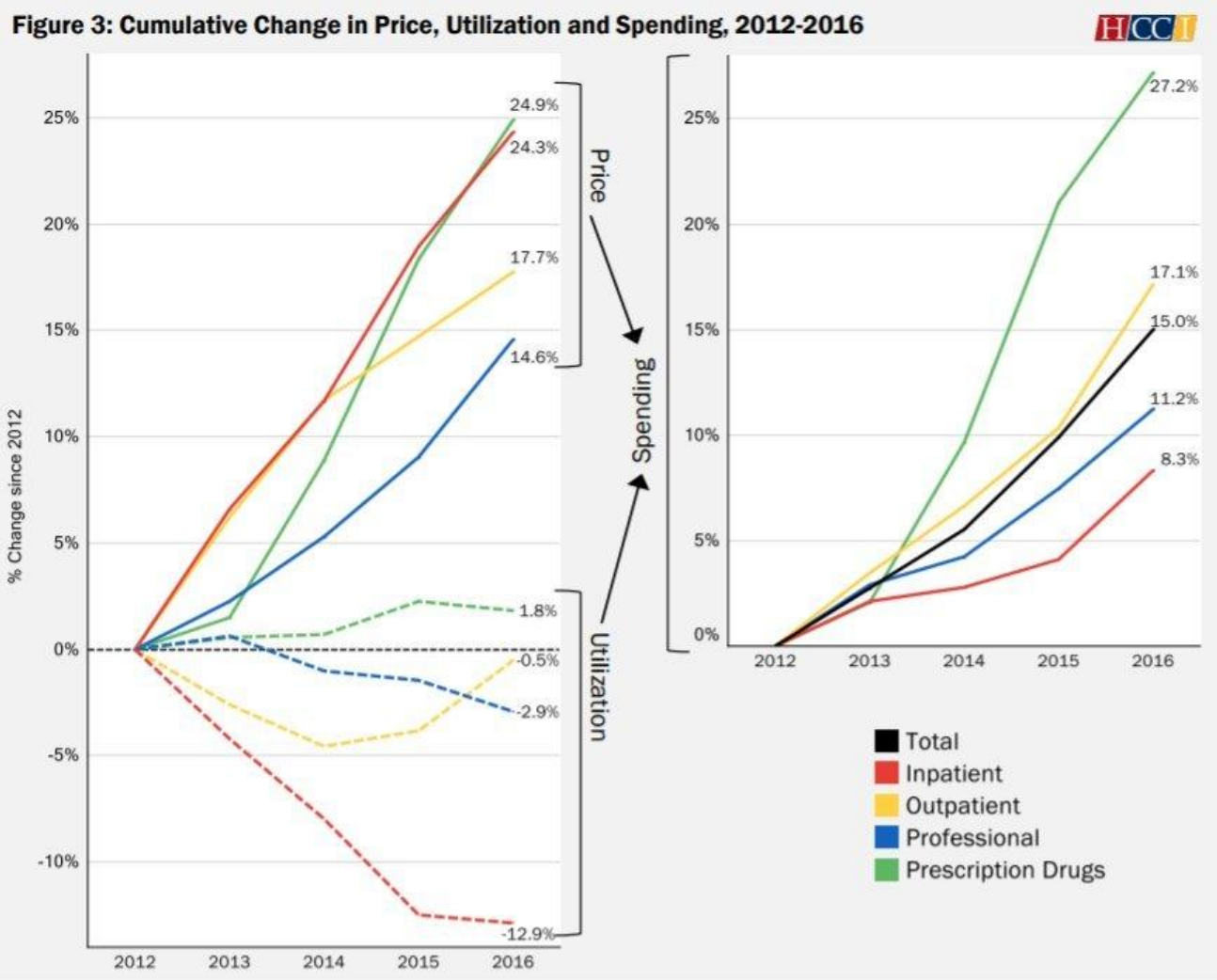
THE HENRY J. KAISER FAMILY FOUNDATION

Rise in Premiums vs. Earnings



Why is Health Care So Expensive?

“It’s the Prices, Stupid”



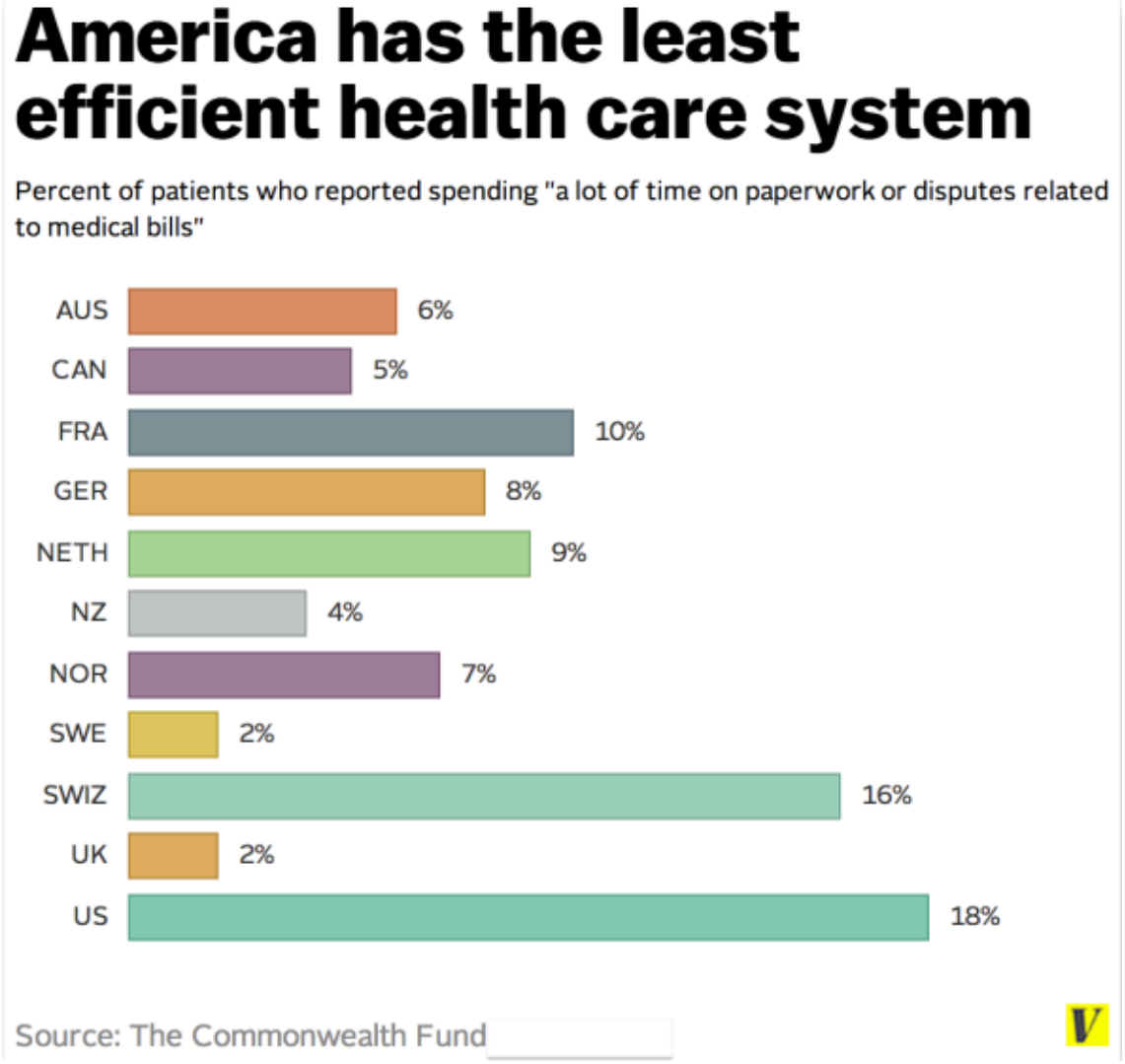
Utilization vs. similar nations, USA has:

- Lower rates of physician visits & days spent in the hospital
- Similar Primary Care versus specialist

Prices vs. similar nations, USA has:

- Coronary bypass surgery $75K vs. $16K
- Pharmaceutical per capita 2-3X
- Average general physician salary at $220K vs. a range of $85-150K

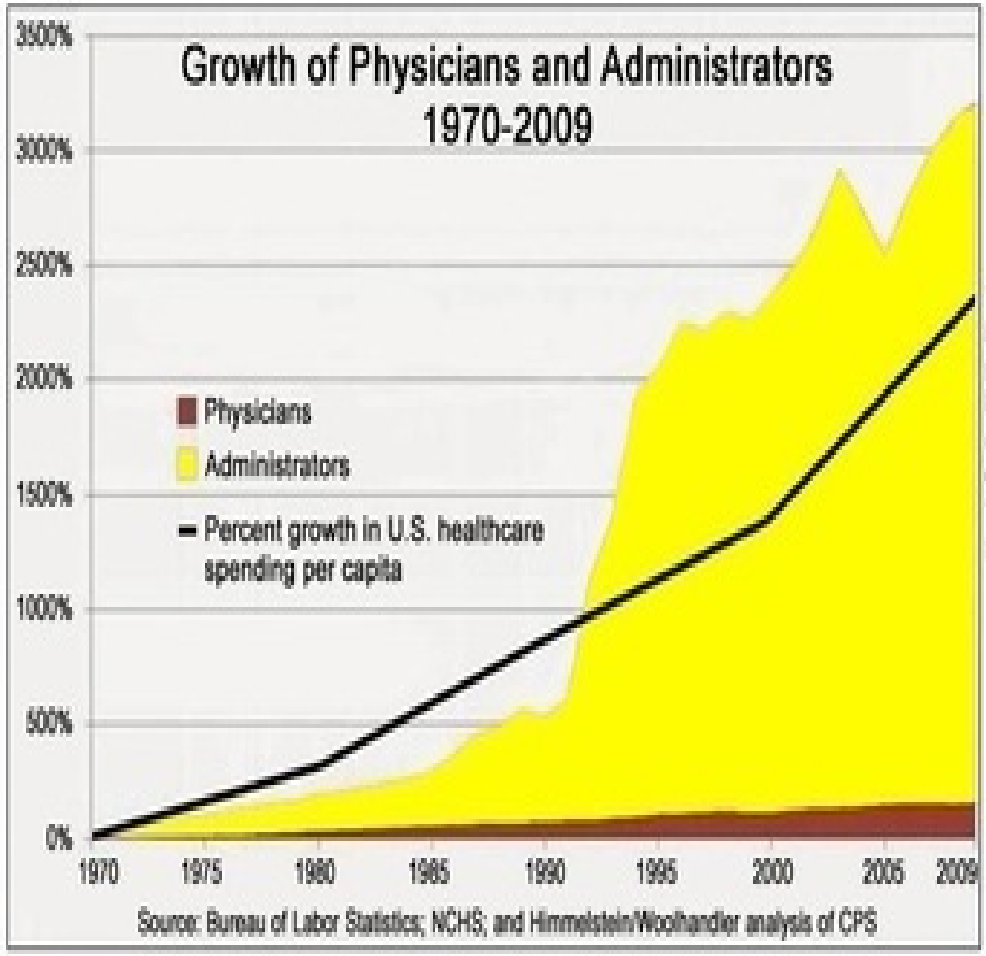
Health Care Inefficiency



- A 2014 Commonwealth Fund report ranked the US last among industrialized nations who reported spending a lot of time on paperwork or disputes related to their medical bills (over $31 Billion a year)

- Asymmetric Information
  - Services first, cost later
  - No price transparency

Claim Administration



* 2300% increase in U.S. healthcare spending per capita between 1970-2009 (Source: Health Care Costs: A Primer, The Henry J. Kaiser Family Foundation)

Growth of Administrators through the years:

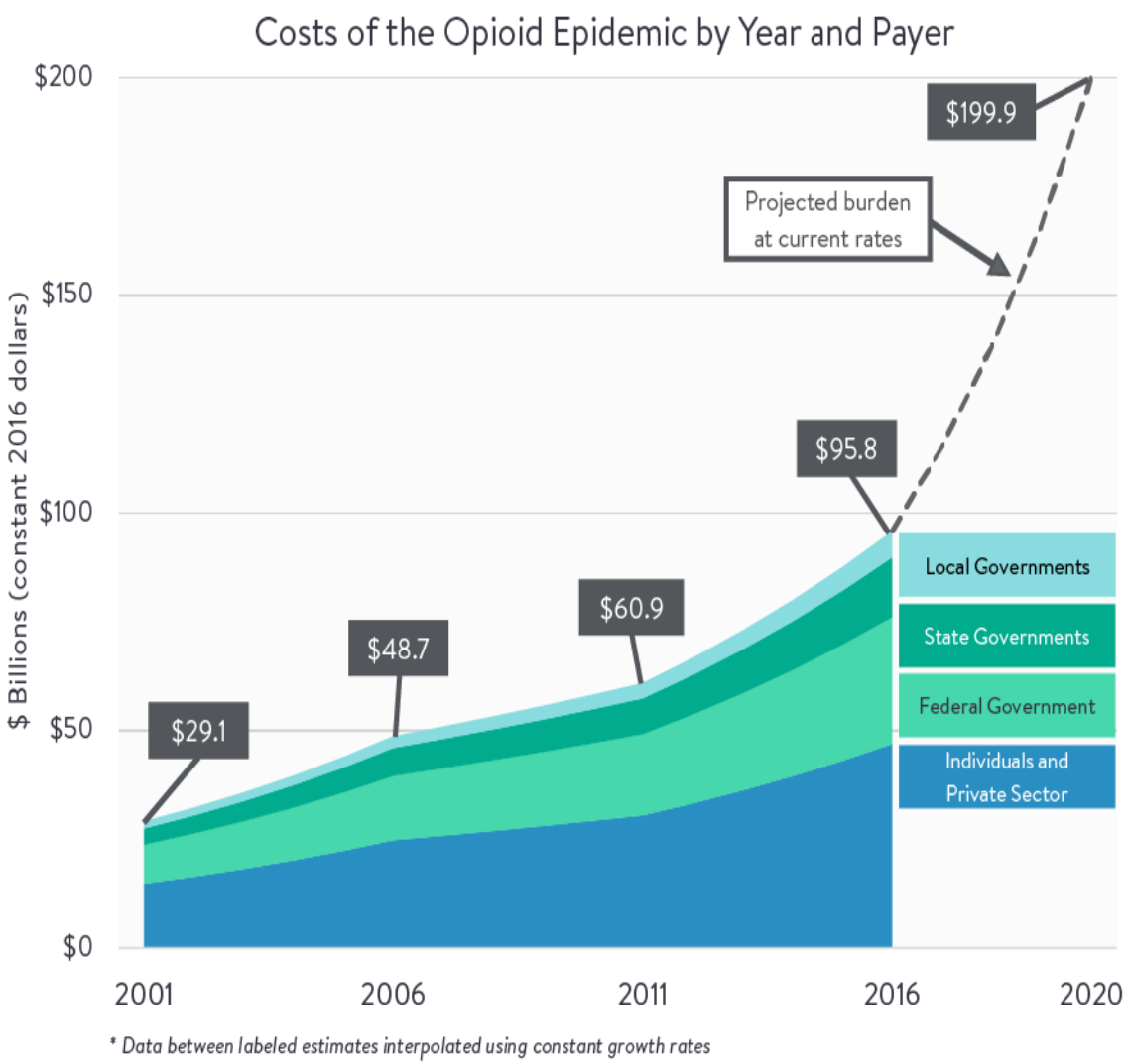
- Plan administration in the USA makes up 8% of costs vs. 1-3% abroad
- Growth of administrators outpaced the US spending growth

Claim denials:

The private insurance industry has greatly increased overall health care costs and waste by hiring countless administrators to maximize profits by denying care:

- A study found California's 7 largest insurers collectively denied over 45.7 million claims
- Another study found that few denied claims were challenged but when they were, over 50% were reversed

Costly Opioid Crisis



- USA makes up 5% of the world's population and consumes 80% of world's opioid drugs
- In the USA, an est. 54M people age 12+ have used prescription drugs for nonmedical reasons in their lifetime
- Examples:
  - State of WV: from 2007 to 2012, drug firms poured a total of 780 million painkillers into the state — which has a total population of about 1.8 million
  - Town of Kermit (pop. 392): a single pharmacy received 9 million hydrocodone pills over two years from out-of-state drug companies

But, Everyone is to Blame (Misaligned Incentives)

Everyone is to Blame: Patients

- Motivated to spend as little as possible out of pocket (Adverse Selection)

- Conditioned to expect healthcare to be inexpensive or free, because the majority of their expenses are covered by a third-party payer (a commercial health insurance company or the government)

- May not value healthcare as a service in which they are willing to invest their own money upfront
    - Little incentive to actively participate in reducing costs
    - May be reluctant, for example, to make a dietary change to reduce cholesterol levels when a once-daily pill can achieve the same results

- Employers and health insurers push patients toward high-deductible health plans that require them to pay more for their care upfront
    - Plans reduce spending in the short-term, but may discourage patients from seeking necessary care, leading to costly complications down the road
    - A survey indicated patients are increasingly fearful that they will not be able to afford necessary care as medical costs continue to grow

Everyone is to Blame: Pharma

Drug Manufacturers

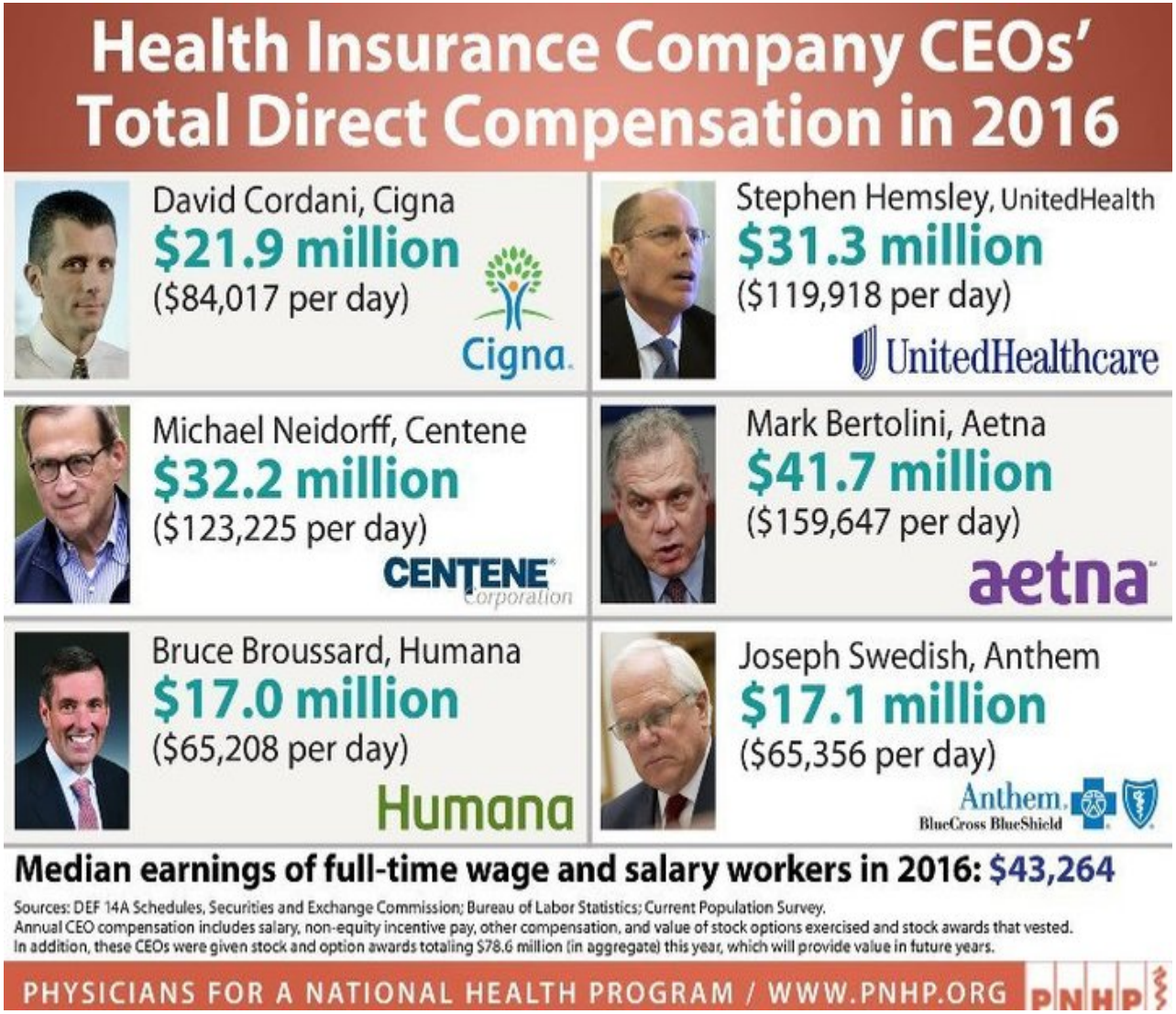
Charge a higher price for their drugs so as to:

- Account for payer coverage gaps (e.g., donut hole), formulary placement and restrictions, and the rebates and discounts required in the distribution and reimbursement channel
- Recoup their substantial investment in research and development, as well as marketing and other expenditures needed to bring the drug to market and achieve uptake among physicians and patients

Pharmacy Benefit Manager (PBM) Spread Pricing

- Difference in what the PMB bills employers and what they reimburse the pharmacies
- Far greater variations with generic than with brand name drugs because the discounts for generics are based off ingredient costs while brand names are based off average wholesale cost
- *Bloomberg* reported that based upon an analysis of 90 drugs in 2017, Medicaid paid pharmacy benefit managers $1.3 billion in excess costs out of the $4.2 billion total spend

Everyone is to Blame: Health Insurers/Payers



- Payers motivation is to collect more in premium dollars than they spend on healthcare services for their members
- Limited by legislation due to profit ceilings, but not insulated with flooring on losses

Everyone is to Blame: Providers

- In a fee-for-service model, providers are incentivized to provide more services, but not necessarily higher-quality care. Financial pressures may exist to:
  - Repay substantial student loans
  - High costs of malpractice insurance

- Similar to pharmaceutical manufacturers, providers must also negotiate for reimbursement with public and private payers:
  - In geographic markets where an insurer is a dominant player, physicians may have little choice but to accept the reimbursement offered by the insurer or risk going out of business because of a diminished volume of patients.

- Physicians must also follow the protocols put in place by payers that are designed to improve the quality and consistency of care provided to a population of patients. These may:
  - Limit physicians' autonomy
  - Have adverse financial impacts

Everyone is to Blame: The Government

- The government has a slightly different motivation from other healthcare stakeholders, because it does not earn profit, but it seeks to save money where possible while providing access to care for America's most vulnerable populations.

- In 2015, for the first time government-sponsored programs surpassed the private industry; these programs now represent the majority of healthcare spending in the United States.
    - Medicare covers approximately 57 million elderly and disabled people, whereas Medicaid and the Children's Health Insurance Program serve as a safety net for more than 70 million children and low-income adults
    - Medicaid is the largest single payer for maternity care, childbirth, mental health services, and long-term care in the United States.

Efforts to Solve Problem

Obamacare

- Created Insurance Exchanges with subsidies for the poor → access to care increased and uninsured halved from 46M to 23M in 2016
  - Initial increase in average premiums
  - Market expected to stabilize and premiums normalize

- To combat adverse selection:
  - Risk Adjustment, Risk Corridor, Reinsurance
  - Individual Mandate: requirement to buy insurance or pay penalty

- Delivery Systems reform:
  - Hospital: EMR; Incentives to reduce readmissions & infections
  - FFS to Bundled Payments
  - Telehealth: distribution of health-related services and information via electronic information and telecommunication technologies
    - Improves access and lowers cost
  - ACOs:
    - Group of doctors/hospitals/other committed to give coordinated care
    - Bonus payment for costs coming below target

Millennial Mindset

"Disintermediation": opportunities to get what we want directly from the source and eliminate the middle-man (think Amazon, Netflix, eBay)

Hospitals

Needed for emergency care, intensive care and complex acute care

- But imaging, lab, urgent care, etc. can all be provided elsewhere with the same quality, greater convenience and at lower prices

Drug companies & PBMs

Jacks up the price of prescription drugs before it gets to the consumer

- Figure out how to link patients and drug manufacturers directly

Insurance companies

Sit between health care providers and patients, with no incentive to improve health care and a poor performance at controlling costs

- The push toward bundled payments, reference pricing and employer self-insurance could eliminate a big chunk of what they do
- New Startups: Oscar, Collective Health, Doctor on Demand

Physicians

Patients could skip the annual physical, monitor their own medical condition on a smart phone, see a doctor when necessary at a retail clinic, and use telemedicine when a physical appointment is inconvenient

Recent Consolidation & Mergers

- Amazon, Berkshire & JP Morgan Chase partner on healthcare (~1M employees)
  - Hired Harvard surgeon and journalist as CEO
  - Taking aim at middlemen citing high administrative costs, etc.
  - Focus on wasteful spending, reduction & customer satisfaction
  - Not intended to generate a profit, but rather find innovative ways to fix the healthcare system → and make available to other companies
  - Raised questions about the future role of employers in the U.S. health care system, as workers increasingly move between jobs or work in many smaller roles that don't provide insurance in the gig economy

- CVS & Aetna Merger
  - Large retail pharmacy network (& PBM) & large Insurer
  - 80% of the U.S. public is located within five miles of CVS's nearly 10,000 stores
  - "Tent Without Walls": Like Apple's genius bar, walk in and get personalized care

- UnitedHealth Group has a PBM unit, Optum, which other health insurers have sought to emulate as it has become increasingly profitable

- Anthem announced plans to ditch PBM Express Scripts Holding and launch its own PBM in 2020. Anthem expects the move will save it more than $4 billion a year

Regulatory Strategies

- **CMS's Billed Charges publication rule (effective January 2019)**
  - Pricing transparency regulation that requires hospitals to make available a list of their current standard charges via the Internet in a machine readable format and to update this information at least annually, or more often as appropriate
  - The impetus for this additional guidance is two-fold—President Trump's desire for greater price transparency and public outcry over large patient healthcare liability (often due to out-of-network services).

    Critics point out that these charges aren't very meaningful since few providers get paid based upon billed charges (but rather contracted rates with the carrier) and that the charges listed in a hospital's chargemaster are arbitrary and not comparable

    - Effective discount reporting is meaningless

    - Carrier guarantees & shared savings are based off fictitious billing charges

- **HHS wants full disclosure of the retail list price of a 30-day supply included within the ad itself, on every advertisement**

  The New York Times reports that experts feel this would be misleading to consumers since they don't pay the list cost

Regulatory Strategies (contd.)

- Drug Patent Protection Reform
  - Patents were originally intended to encourage innovators and maximize the greater good
  - Today, distorted by the political system, intense lobbying and large campaign contributions. The resulting prices are to the detriment of the consumers
  - Drug companies are not investing in R&D proportional to the profits earned from the drugs they bring to market
    - They either buy the rights to drugs developed by others and raise the prices many times over (as with Sovaldi) or to obtain a medication already in existence and, using monopolistic control, raise the price as much as 500% or more (as with the EpiPen)
  - As a consequence, the patent protection process now primarily serves the drug companies, most often not on behalf of the American people, but, rather, at their expense

- Convert Medicaid to a Block Grant
  - Reward states that achieve better health outcomes and lower-cost
  - Give the federal government budget predictability
  - States would also have stronger incentives to develop ways to save money

- Reform the Malpractice Tort System (medical liability insurance premiums)
  - Capping awards and limiting attorneys' fees

Employer Strategies

- Many employers are cutting out insurers completely and contracting directly with providers and/or creating near-site or on-site health clinics for primary care
  - Walmart's Center of Excellence network for spinal surgeries
  - NBGH states 11% of employers have interest in this (vs. 3% last year)

- Reference-Based Pricing
  - For example, 200% of Medicare

- Engagement of their own employees
  - Telemedicine to reduce ER costs and improve mental health
    - Employers need to do better educating employees on how to access care
    - Although the stigma surrounding mental health is lessening, accessing quality, affordable mental health care is an issue which can be impacted with telemedicine
  - Make the most out of wellness with condition management
    - General wellness programs are great for employee morale, but limited wellness resources should be directed towards conditions that can be impacted, such as metabolic syndrome (cluster of conditions)
  - Cost transparency tools are getting better
    - Sophisticated data analysis tools that can identify actionable items
      - E.g., Morgan Stanley CMO hiring

Good Signs

Good Signs/Results

Trend slowdown in 2016

- Medicare (20% of Health Care Spend)
  - Spending grew by 3.6% in 2016, which was lower than growth in the previous two years (4.8% growth in 2015 & 4.9% in 2014)
  - Slower growth due to slower growth in spending for both the Medicare fee-for-service (2.2% in 2015 to 1.8% in 2016) and Medicare Advantage (11.1% in 2015 to 7.4% in 2016) portions of Medicare

- Medicaid (17% of Health Care Spend)
  - Spending grew by 3.9% in 2016, which was lower than growth in the previous two years (11.5% in 2014 and 9.5% in 2015).

- Private Health Insurance (34% of Health Care Spend)
  - Spending grew by 5.1% in 2016, which was lower than the 6.9% growth in 2015.

Obamacare results

- Uninsured population slashed in half
- Made health insurance more comprehensive (EHB)
- Example ➔ In 2017, Highmark saved $260M in avoidable costs due to value-based initiatives: 11% fewer ER ($40M) & 16% fewer IP admissions ($220M)