LOOKING FORWARD:
THE FUTURE OF MEDICAID AND THE HEALTHCARE SYSTEM

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BASIC RULES FOR FUTURISTS

• Always make forecasts about things that are far off
• Make so many forecasts that one of them has to be right
• Never give people a number and a year in the same sentence
• Whatever you do, don’t talk about elections the day of an election
• Elections Matter
• American Healthcare: Progress and Promise
• Looking Forward:
  – The Future of the HealthCare System
  – The Future of Medicaid
• Leading Change
ELECTIONS MATTER
BREXIT OR BLOWOUT?
SCOTLAND, NORTHERN IRELAND AND LONDON VOTED TO REMAIN

<table>
<thead>
<tr>
<th>Region</th>
<th>Remain</th>
<th>Leave</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>62.0%</td>
<td>38.0%</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>55.8%</td>
<td>44.2%</td>
</tr>
<tr>
<td>North West</td>
<td>46.3%</td>
<td>53.7%</td>
</tr>
<tr>
<td>North East</td>
<td>42.0%</td>
<td>58.0%</td>
</tr>
<tr>
<td>Yorkshire &amp; the Humber</td>
<td>42.3%</td>
<td>57.7%</td>
</tr>
<tr>
<td>Wales</td>
<td>47.5%</td>
<td>52.5%</td>
</tr>
<tr>
<td>East Midlands</td>
<td>41.2%</td>
<td>58.8%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>40.7%</td>
<td>59.3%</td>
</tr>
<tr>
<td>South West</td>
<td>47.4%</td>
<td>52.6%</td>
</tr>
<tr>
<td>East of England</td>
<td>43.5%</td>
<td>56.5%</td>
</tr>
<tr>
<td>South East</td>
<td>48.2%</td>
<td>51.8%</td>
</tr>
<tr>
<td>London</td>
<td>59.9%</td>
<td>40.1%</td>
</tr>
</tbody>
</table>
SCOTLAND, NORTHERN IRELAND AND LONDON VOTED TO REMAIN:
NEWS TO DONALD TRUMP
OLDER, LESS WELL EDUCATED AND NATIONALISTIC VOTERS MORE LIKELY TO BREXIT

How different age groups voted

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Leave</th>
<th>50%</th>
<th>Remain</th>
</tr>
</thead>
<tbody>
<tr>
<td>18–24</td>
<td>27%</td>
<td></td>
<td>73%</td>
</tr>
<tr>
<td>25–34</td>
<td>38%</td>
<td></td>
<td>62%</td>
</tr>
<tr>
<td>35–44</td>
<td>48%</td>
<td></td>
<td>52%</td>
</tr>
<tr>
<td>45–54</td>
<td>56%</td>
<td></td>
<td>44%</td>
</tr>
<tr>
<td>55–64</td>
<td>57%</td>
<td></td>
<td>43%</td>
</tr>
<tr>
<td>65+</td>
<td>60%</td>
<td></td>
<td>40%</td>
</tr>
</tbody>
</table>

Of the 30 areas with the...

- most elderly people, 27 voted Leave
- fewest graduates, 28 voted Leave
- most people identifying as English, all 30 voted Leave

Source: Lord Ashcroft Polls

Source: Census 2011
THE PARTISAN DIVIDE ON HEALTHCARE

Figure 3: Voters' Evaluations of How Well the ACA is Working

Source: Harvard/Politico October 2016
VIEW ON ACA ARE BASED ON VIEWS ON GOVERNMENT ROLE IN IMPROVING HEALTHCARE SYSTEM

Source: Harvard/Politico October 2016
WHAT SHOULD HAPPEN TO ACA?

Source: Harvard/Politico October 2016
REALITIES OF A POLARIZED AMERICA – 2016 AND 2018

• **Major changes** in health policy only occur when one party holds the Presidency and both Houses of Congress

• **Some major changes** occur when one party holds the Presidency and one House of Congress

• **Only small incremental changes** occur otherwise – with the exception of a few non-polarized issues.
CHANGES IN ACA WITH DEMOCRAT WIN

- More funds for subsidies for all
- Subsidies to reduce high-deductible plans
- Efforts to expand coverage to some uncovered groups
- More funds for prevention
- Some intervention in pharma pricing policies
- Reduction or elimination of “Cadillac insurance tax”
- Debates but no action on ‘Medicare for all’ / Single-Payer – but state “public options” likely
- Maybe, more states expand Medicaid
MAJOR CHANGES IN ACA WITH REPUBLICAN WIN

• Major structural changes to ACA – changed name
• End of mandates – individual/corporate
• Elimination or reduction of “Cadillac insurance tax”
• Establishing state pre-existing condition pools
• Less federal subsidies for uninsured and Medicaid
• More state discretion for Medicaid spending
• Less insurance regulation
AMERICAN HEALTHCARE: PROGRESS AND PROMISE

- **Coverage Expansion**
  - Obamacare: Exchanges and Managed Medicaid

- **Payment Reform**
  - ACOs, MACRA, Medicare Advantage, Managed Medicaid, Bundles and value based payment in private sector

- **Volume to Value**
  - Payment reform in concert with shift to Population Health, Providers at Risk

- **Consolidation and Integration**
  - Plans, health systems and physicians merging and partnering more and more

- **Delivery Shift to Ambulatory Environment**
  - Outpatient, alternate site and retail

- **IT Infrastructure**
  - Ubiquitous EHRs, Telehealth, Big Data, and Consumer facing apps

- **Enhancing the Consumer (and Provider) Experience**
  - High Deductible health care is a blunt instrument
  - High bar of service in a world of Apple, OpenTable, and Uber
BIG DROP IN UNINSURED UNDER OBAMACARE

Percentage Uninsured in the U.S., by Quarter
Do you have health insurance coverage? Among adults aged 18 and older

SOURCE: GALLUP-HEALTHWAYS WELL-BEING INDEX
Figure Legend:
Decline in Adult Uninsured Rate From 2013 to 2015 vs 2013 Uninsured Rate by StateData are derived from the Gallup-Healthways Well-Being Index as reported by Witters and reflect uninsured rates for individuals 18 years or older. Dashed lines reflect the result of an ordinary least squares regression relating the change in the uninsured rate from 2013 to 2015 to the level of the uninsured rate in 2013, run separately for each group of states. The 29 states in which expanded coverage took effect before the end of 2015 were categorized as Medicaid expansion states, and the remaining 21 states were categorized as Medicaid nonexpansion states.
LOOKING FORWARD AT AMERICAN HEALTHCARE

10 Big Stories for 2016 and Beyond
• Serving Shallow-Pocketed Consumers
• Consolidation: Good or Bad?
• Employers: Stay or Go?
• Provider Prices for Private Insurance
• Specialty Pharmaceuticals
• Making Volume to Value Real
• Population Health
• Physician Discontent
• Innovation at Scale
• Massive Medicaid
SERVING SHALLOW-POCKETED CONSUMERS
CUMULATIVE INCREASES IN HEALTH INSURANCE PREMIUMS, WORKERS’ CONTRIBUTIONS TO PREMIUMS, INFLATION, AND WORKERS’ EARNINGS, 1999-2016

AVERAGE ANNUAL WORKER AND EMPLOYER CONTRIBUTIONS TO PREMIUMS AND TOTAL PREMIUMS FOR FAMILY COVERAGE, 1999-2016

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

PERCENTAGE OF COVERED WORKERS ENROLLED IN A PLAN WITH A GENERAL ANNUAL DEDUCTIBLE OF $1,000 OR MORE FOR SINGLE COVERAGE, BY FIRM SIZE, 2006-2015

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

NOTE: These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

CUMULATIVE INCREASES IN HEALTH INSURANCE PREMIUMS, WORKERS’ CONTRIBUTIONS TO PREMIUMS, INFLATION, AND WORKERS’ EARNINGS, 1999-2015

INSURED ADULTS WITH LOWER INCOMES WERE MORE LIKELY TO REPORT THEY HAD DELAYED OR AVOIDED GETTING CARE BECAUSE OF THEIR COPAYMENTS OR COINSURANCE

Percent responding “yes”

<table>
<thead>
<tr>
<th>Condition</th>
<th>&lt;200% FPL</th>
<th>200% FPL or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had a medical problem, but did not go to a doctor or clinic</td>
<td>30</td>
<td>10</td>
</tr>
<tr>
<td>Did not fill a prescription</td>
<td>28</td>
<td>10</td>
</tr>
<tr>
<td>Skipped a medical test, treatment, or follow-up recommended by a doctor</td>
<td>28</td>
<td>12</td>
</tr>
<tr>
<td>Did not see a specialist when you or your doctor thought you needed to see one</td>
<td>24</td>
<td>10</td>
</tr>
<tr>
<td>At least one cost-related access problem</td>
<td>46</td>
<td>21</td>
</tr>
</tbody>
</table>

Insured adults ages 19–64 who pay a copayment or coinsurance

Note: FPL refers to federal poverty level.
DOES SATISFACTION MATTER? COMPARED TO WHAT?

General Impression of Health Insurance
(Top-2 Box %)

| Satisfaction with your insurance benefits | 77% 79% 84% 81% 79% 77% |
| Satisfaction with out of pocket costs for prescription medications | 62% 66% 72% 66% 67% 66% |
| Satisfaction with out of pocket costs for health care services | 58% 59% 66% 62% 61% 61% |

However...

| Insurance plan meets my/my family’s needs very/extremely well | 69% 66% 55% 56% |

Only 47% of Exchange based plan holders feel their plan meets needs very or extremely well, 54% of Medicaid, 61% of Medicare and 56% of those with commercial plans.

Prepared for: Strategic Health Perspectives
Source: Q600: How satisfied or dissatisfied are you with each of the following?: Q185: Thinking now about all the different components of your health insurance plan, how well does your plan meet your/your family’s health needs?

Significance tested at 95%
CONSUMERS EMOTIONS TOWARDS HEALTHCARE THEY RECEIVE

Not much change Nationally but Californians are significantly more positive in 2016

Some change towards the positive, but 1 in 4 consumers remains powerless

Consumer Emotions Towards Healthcare They Receive

California 2016 in Red

Base: All US Adults (2014 n=2501, 2015 n=5037, 2016 n=30052)
Source: Q90 How would you describe your feelings about the health care you receive today, including how much you pay for it and the benefits you receive? Please select all that apply.
COST MATTERS BECAUSE CONSUMERS PAY MORE OF THE INCREASE...THIS MAKES THEM FEEL MORE POWERLESS

- Received a balance bill for care they thought was covered
  - California 21%
  - 28%
  - 20% Resigned/Given up, 21% Powerless, 10% Depressed, 18% Angry

- Received a bill for hospital services "not in network" even though the hospital was in network
  - California 6%
  - 8% TOTAL

  - California 13%
  - 13% EXCHANGE
  - 14% Resigned/Given up, 21% Powerless, 25% Depressed, 11% Angry
WHO IS BORDERLINE?

They are NOT on public insurance!

- 40% Have Employer based insurance
- 7% Have Medicaid
- 20% Are uninsured

Overall medical care is major financial burden

- 32% Had 1+ ER visits last year
- 42% Had 3+ doctor visits last year
- 51% Received a balance bill for care they thought was covered

Extremely concerned about ability to pay bills insurance doesn’t cover

- 48% Gen Pop
- 21% Empowered
- 15% Hopeful
- 15% Relieved
- 15% Accepting
- 15% Neutral
- 14% Resigned/ Given up
- 14% Powerless
- 12% Depressed
- 17% Angry

They are NOT on public insurance!
LOW OUT OF POCKET COST REMAINS CRITICAL IN PICKING INSURANCE

Consumers concerned with premiums, deductibles and copays...reasonable cost sharing for hospital services and retail clinic coverage are surging.

### Relative Importance of Benefit

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Above Average</th>
<th>Average*</th>
<th>Below Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low monthly premiums</td>
<td>205</td>
<td>155</td>
<td>76</td>
</tr>
<tr>
<td>Has a low deductible</td>
<td>181</td>
<td>149</td>
<td>66</td>
</tr>
<tr>
<td>Low copay for doctor visits</td>
<td>161</td>
<td>132</td>
<td>59</td>
</tr>
<tr>
<td>Access to all medical imaging at reasonable cost-sharing/co-pay</td>
<td>149</td>
<td></td>
<td>48</td>
</tr>
<tr>
<td>Reasonable cost sharing, or copay levels for hospitalization</td>
<td>143</td>
<td></td>
<td>47</td>
</tr>
<tr>
<td>Direct access to all specialists (no referral needed)</td>
<td>111</td>
<td>90</td>
<td>38</td>
</tr>
<tr>
<td>Includes an extensive network of doctors</td>
<td></td>
<td>101</td>
<td>66</td>
</tr>
<tr>
<td>Access to leading hospitals in my area</td>
<td></td>
<td>94</td>
<td>60</td>
</tr>
<tr>
<td>Coverage for dependents</td>
<td></td>
<td>93</td>
<td>59</td>
</tr>
<tr>
<td>Coverage for medical care at retail clinics or urgent care centers</td>
<td></td>
<td>87</td>
<td>48</td>
</tr>
<tr>
<td>Low copay for generic drugs</td>
<td></td>
<td>90</td>
<td>47</td>
</tr>
<tr>
<td>Access to cutting edge medical devices and medications</td>
<td></td>
<td>88</td>
<td>38</td>
</tr>
<tr>
<td>Access to brand name drugs at reasonable cost-sharing, or co-pay,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>levels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides me with cash incentives or rewards for healthy behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage for a wide selection of brand name drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes an extensive network of hospitals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage for over-the-counter medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to specialty hospitals (i.e. children’s hospitals)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The insurance brand is a name I know and trust</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Average is 100, and the scores represent importance relative to that average.

**BASE:** ALL QUALIFIED RESPONDENTS (2015 n=5037)

Q65: Respondents were given a maximum difference trade off exercise in which they were forced to choose the most preferred and least preferred plan feature. *Average is 100, and the scores represent importance relative to that average.
OUT OF POCKET COST CONCERNS ARE BIPARTISAN

Partisan Differences in Health Care Priorities

If we could greatly improve one of these, which ONE would you choose?

- Reducing the out-of-pocket cost of healthcare to the consumer
  - Gen Pop: 43%
  - Republican: 47%
  - Independent: 43%
  - Democrat: 39%

- Improving the quality of care
  - Gen Pop: 19%
  - Republican: 19%
  - Independent: 20%
  - Democrat: 18%

- Reducing the cost of health care to the government (and the taxpayer)
  - Gen Pop: 19%
  - Republican: 24%
  - Independent: 21%
  - Democrat: 15%

- Reducing the number of people with inadequate or no health insurance
  - Gen Pop: 19%
  - Republican: 10%
  - Independent: 16%
  - Democrat: 28%

Prepared for: Strategic Health Perspectives
Base: All US Adults (n=10011 split sample), Party Affiliations (Republican n=2666, Democrat n=3328, Independent n=2826)
Source: Q60 If we could greatly improve one of these, which ONE would you choose?
CONSOLIDATION: GOOD OR BAD?
HEALTH PLAN CONSOLIDATION CONTINUES

Aetna buys Humana for $37 billion making a $115 billion run rate company

Anthem closes on Cigna in $54 billion makes a $117 billion run rate company

New Rivals for $154 billion UnitedHealth Group

Other:
- Centene buys Health Net for $6.3 billion
The **Massive Consolidation continues toward 100-200 Large Regional Systems**

- Doctors running to hospitals
- Hospitals consolidating regionally
- Role of private equity and for profits in consolidation
- Focus on “Essentiality” may run into Attorney Generals and Anti-Trust concerns
- The rich get richer: significant returns to scale and to integration
- Doctors discretion in selection of specific technologies and clinical protocols will be increasingly constrained by large motivated health systems that employ them
EMPLOYERS: STAY OR GO?
EMPLOYERS ARE SEEING A PROLONGED RESPITE FROM DOUBLE-DIGIT PREMIUM INCREASES, BUT THESE ARE STILL RUNNING AT TWO TIMES CPI

FEWER EMPLOYERS ARE LOOKING FOR AN EXIT; CONTINUE TO FEEL RESPONSIBILITY FOR EMPLOYEE HEALTH NEEDS

Company’s Position on Employer-Sponsored Healthcare: Providing Benefits
(Top-2 Box % - Describes Completely/Very Well)

- It is our responsibility to ensure our employees' health needs are met
- My company is actively exploring ways to get out of providing health insurance to our employees
- Employer-based health insurance will soon become a thing of the past
- My company feels it is worth it to pay the penalty associated with not providing employee health benefits rather than providing health benefits to our employees.*

* Asked only of Employers with 50 or more employees.
Base: All Employer Health Benefit Decision Makers (n=340)
Q800: Please indicate your level of agreement with the following statements. Do you strongly agree, somewhat agree, somewhat disagree or strongly disagree?
PERCENTAGE OF ALL WORKERS COVERED BY THEIR EMPLOYERS’ HEALTH BENEFITS, IN FIRMS BOTH OFFERING AND NOT OFFERING HEALTH BENEFITS, BY FIRM SIZE, 1999-2016

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

PROVIDER PRICES FOR PRIVATE INSURANCE
MEDICARE SPENDING VERSUS PRIVATE SPENDING: A DIFFERENT STORY

Source: cited in NY Times, December, 15th, 2015
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
AGGREGATE HOSPITAL PAYMENT-TO-COST RATIOS FOR PRIVATE PAYERS, MEDICARE AND MEDICAID, 1994 – 2014

Source: Analysis of American Hospital Association Annual Survey data, 2014, for community hospitals.

(1) Includes Medicaid Disproportionate Share payments.

(2) Includes Medicare Disproportionate Share payments.
SPECIALTY PHARMACEUTICALS
END OF “PATENT CLIFF” AND EXPLOSION IN SPECIALTY SPENDING PUTS RX INDUSTRY IN THE SPOTLIGHT
HEP-C? TAKE A THREE MONTH LUXURY VACATION TO EGYPT AND GET YOUR EMPLOYER TO PAY FOR IT

The cost of a 12 week course of Sovaldi is $84,000 in the US, $900 in Egypt.

84 days at the Nile Ritz Carlton at $250 per night = $21,000
84 Days meal allowance at $100 per day = $8,400
Business Class Airfare from SFO = $2,800

TOTAL $32,200

Savings to Your Employer $51,800

Options
Bring your spouse/partner Add $11,200
10 day Luxury Nile Spa Cruise for Two Add $11,120

TOTAL $54,520

Savings to Your Employer $29,480
MAJORITY CONTINUE TO SUPPORT PRICE CONTROLS

While most still feel the need for price controls for pharma and hospitals, physician price control significantly dropped this year

Level of Support for Price Controls

(Top 2 Box: Strongly/Somewhat Support)

Price controls or caps on pharmaceutical/medical device manufacturers: 72%

Price controls or caps on hospitals: 67%

Price controls or caps on physician payment: 60%

Change from 2015:

- Price controls or caps on pharmaceutical/medical device manufacturers: +0
- Price controls or caps on hospitals: -1
- Price controls or caps on physician payment: -10
MAKING VOLUME TO VALUE REAL
RISK BEARING STRATEGIES VARY CONSIDERABLY

Hospitals committing to clinical integration for contracting w/ payers but full risk only for the few

Base: All Hospital-Based Execs (2016: n=205; 2015: n=200; 2014: n=202)

Q980: Which of the following best describes your hospital’s/hospital system’s “risk bearing” strategy?
THE TENSION

**Bundles**
- More is still better
- Encourages improvement
- Not everything is easily bundled
- “Screw me on the bundle, and I’ll screw you on the rest”

**Population Health/Risk/Accountable Care**
- Frequency
- Appropriateness
- Determinants of Healthcare
- The Mutual Disrespect Problem
- Social Work not Medical Care
WHAT POPULATION LEVEL ANALYTICS REVEAL

• The 5/50 Problem
  – 5% account for 50% of spending
  – 1% account for 20%
  – Bottom 50% account for about 2%

• Segmentation of populations

• What you will find...
  – HONDAS
  – Behavioral Health
  – End of Life Care
  – Cancer
  – Frail elderly
  – Social Work not Medical Care
  – Specialty Pharmaceuticals
THE TRUCK, THE REFRIGERATOR AND THE BUS
POPULATION HEALTH MANAGEMENT

- Segment high-risk populations
- Harness advanced analytics
- Use patient registries and medical homes
- “No outcome, no income”
- Go upstream
- Eat your own cooking
- Focus on the whole population
- Meet people in their lives
- Emphasize wellness and prevention
- Think outside the box
- Leverage Technology
- Partner, partner, partner
HEALTH AND SOCIAL CARE SPENDING AS A PERCENTAGE OF GDP

Notes: GDP refers to gross domestic product.
EXPECTED AGE AT DEATH VS. HOUSEHOLD INCOME PERCENTILE FOR MEN AT AGE 40

Top 1%: 87.3 Years

Bottom 1%: 72.7 Years
RACE-ADJUSTED EXPECTED AGE AT DEATH VS. HOUSEHOLD INCOME FOR MEN IN SELECTED MAJOR CITIES

Expected Age at Death for 40 Year Olds in Years

Household Income Ventile

- New York City
- San Francisco
- Dallas
- Detroit

$30k
$60k
$101k
$683k

70 75 80 85 90
MASSIVE MEDICAID
### MASSIVE MEDICAID

<table>
<thead>
<tr>
<th></th>
<th>Country</th>
<th>Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Germany</td>
<td>81,083,600</td>
</tr>
<tr>
<td>17</td>
<td>Iran</td>
<td>78,317,300</td>
</tr>
<tr>
<td>18</td>
<td>Turkey</td>
<td>77,695,904</td>
</tr>
<tr>
<td>19</td>
<td>Democratic Republic of the Congo</td>
<td>71,246,000</td>
</tr>
<tr>
<td>20</td>
<td>France [Note 4]</td>
<td>66,121,000</td>
</tr>
<tr>
<td>21</td>
<td>Thailand</td>
<td>65,104,000</td>
</tr>
<tr>
<td>22</td>
<td>United Kingdom</td>
<td>64,800,000</td>
</tr>
<tr>
<td>23</td>
<td>Italy</td>
<td>60,788,845</td>
</tr>
</tbody>
</table>

- **US Medicaid** Population edges out *France and the Congo* for top 19 spot in total population with 72,650,000 enrollees
- **US Medicaid spending** edges out *Argentina* for top 25 economies at $540 billion
- **US Medicaid** is bigger than Wal-Mart by $50 + billion
MASSIVE MEDICAID

• Churning in Medicaid eligibles and exchange population
• Who will take these enrollees and what will be the financial impact on providers that do take them?
• Medicaid covers kids, mums, expansion populations, supports the dual eligible and is the default LTC policy for the middle class
• Can we design financially sustainable delivery models for Medicaid?
Medicaid is dominant for low income and children
- Medicaid population has significant churn of approximately 25%
- Exchange Population has 40% churn due mainly to changing life circumstances
- Get to 65 and you are “home free on Medicare” ....at least for now
- Republicans may move age of Medicare eligibility up
- Democrats may move age of eligibility (or buy in) down

Transitions in Coverage Type are the Norm for Most Consumers Over Time (US population by insurance coverage type)

FPL = federal poverty level.
Note: Each dot represents 50,000 people. Medicaid figures exclude dual eligibles, who are counted in the Medicare category in MPACT. Medicaid enrollees above 138% FPL include children on CHIP, pregnant women, higher income parents in some states, and blind and disabled beneficiaries.

Source: McKinsey Center for US Health System Reform’s MPACT7.5 model with data from the 2014 American Community Survey
NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society
INNOVATION AT SCALE
THE SCOUT BADGE PROBLEM

- Patient Centered Medical Home
- Readmission Reduction Program
- Quantified Self App
- Care Bundles
- Remote Patient Monitoring
- E-Consults
- Accountable Care Organization
- Telehealth Initiative
- Patient Portal
- Diabetes Disease Registry

But how many? And what is the denominator?
LOOKING TO 2020

- Pressure on public payment sources will continue
- Private Payers will not tolerate costs shift willingly
- Exchanges, Medicare Advantage, Managed Medicaid and Consumer Engagement among employers makes market more retail
- Long run three payer segments: Managed Medicaid, HDHP (Exchange and Employer) and Medicare Advantage/ACO increase pressure to deliver value
- Care Redesign for higher performance
  - Migrating Business model to Risk
  - Care coordination and management across the continuum of care
  - Alignment of all physicians, nurses and caregivers with this process
  - Consumer facing innovation in delivery and tele-health
  - Innovation at Scale
- Governance and leadership to sustain it all
THREE FUTURES FOR AMERICAN HEALTHCARE

• **Berwickian Nirvana**: Large integrated delivery systems successfully innovate and transform care to meet the Triple Aim spurred by major payment reform by public and private payers

• **Darwinian Consumerism**: Federal subsidies and support are cut and healthcare adapts to a world of high deductibles and economic rationing

• **Dumb Price Controls**: Democratic majority administration regulates budgets and prices locking in massive regional and institutional inequities and unjustified clinical variation
THREE FUTURES FOR MEDICAID

• **Berwickian Nirvana:**
  – Innovate in partnership with Managed Care Organizations and pursue Population Health Initiatives with like minded providers who want to bear risk
  – Combine all social spending in targeted, focused initiatives to raise the well being of communities suffering multiple deprivation from lack of economic opportunity, poverty, criminal justice failures, housing and transportation inadequacies

• **Darwinian Consumerism:** If Federal subsidies are cut either:
  – Bring back Disproportionate Share
  – Institute “Fair Share” which mandates that providers (including physicians) take their fair share of uninsured and Medicaid

• **Dumb Price Controls:** Focus on managing quality, appropriateness and outcome in a world of administered prices
LEADING CHANGE

• Maintain and expand coverage
• Fix the financial gotchas for vulnerable patients
• Reduce churn by extending eligibility for a calendar year
• Consolidate and integrate for value not economic power
• Innovate at scale
• Improve the patient and provider experience
• Harness the new science
• Lead don’t follow to the future