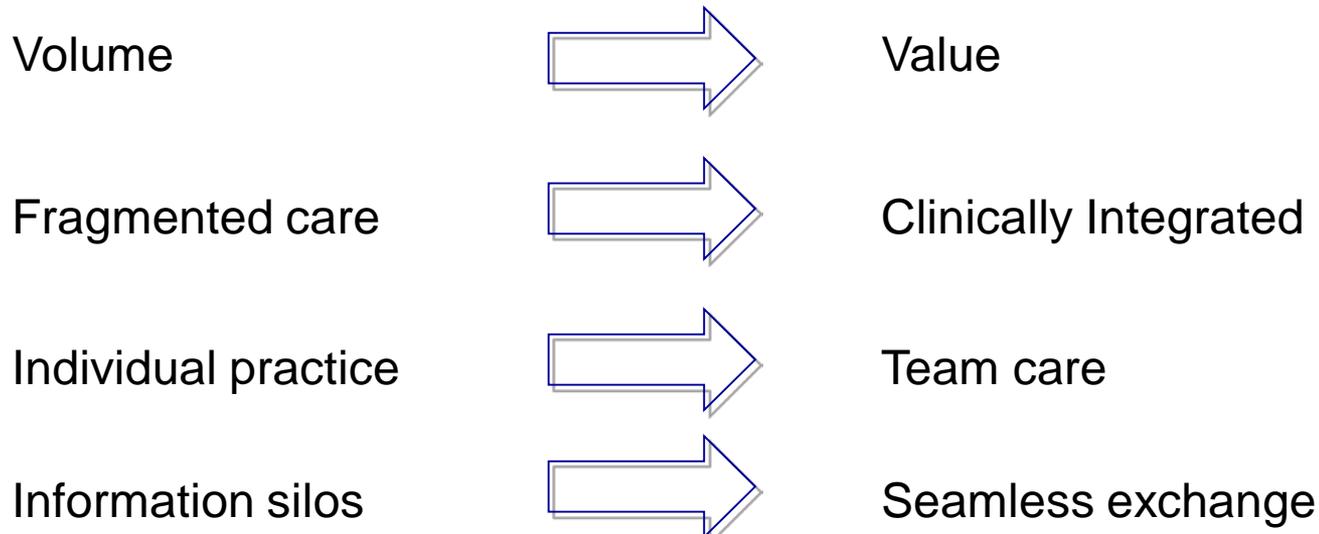


Virginia Healthcare Systems:

**Key Strategies, Cost and
Quality Performance and
Policy Priorities**

Current Context in Healthcare Generally

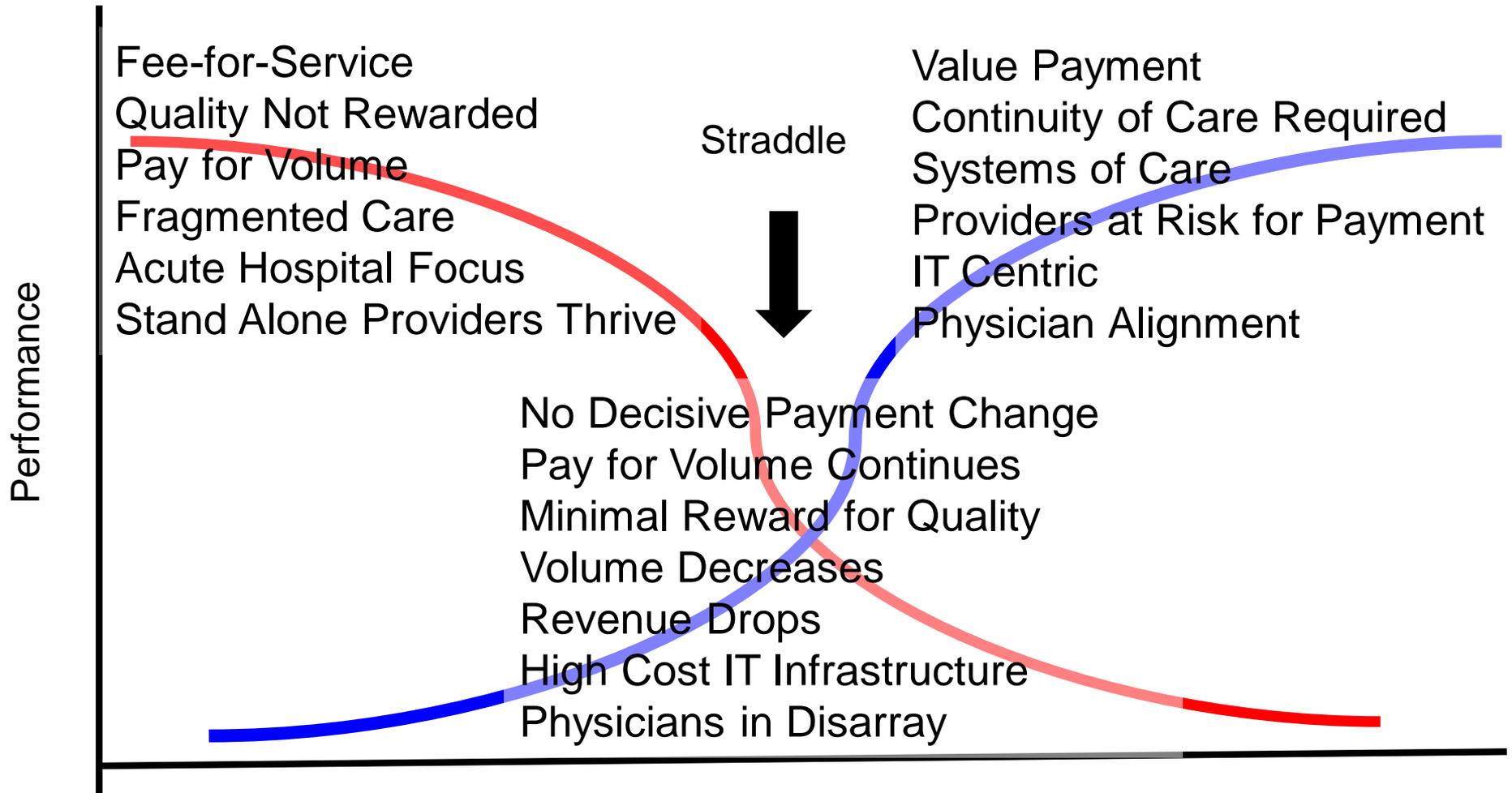
- **Period of remarkable transformation**
- **All parties being required to do business in a very different way**
- **Four main themes of transformation:**



Life During the Transition

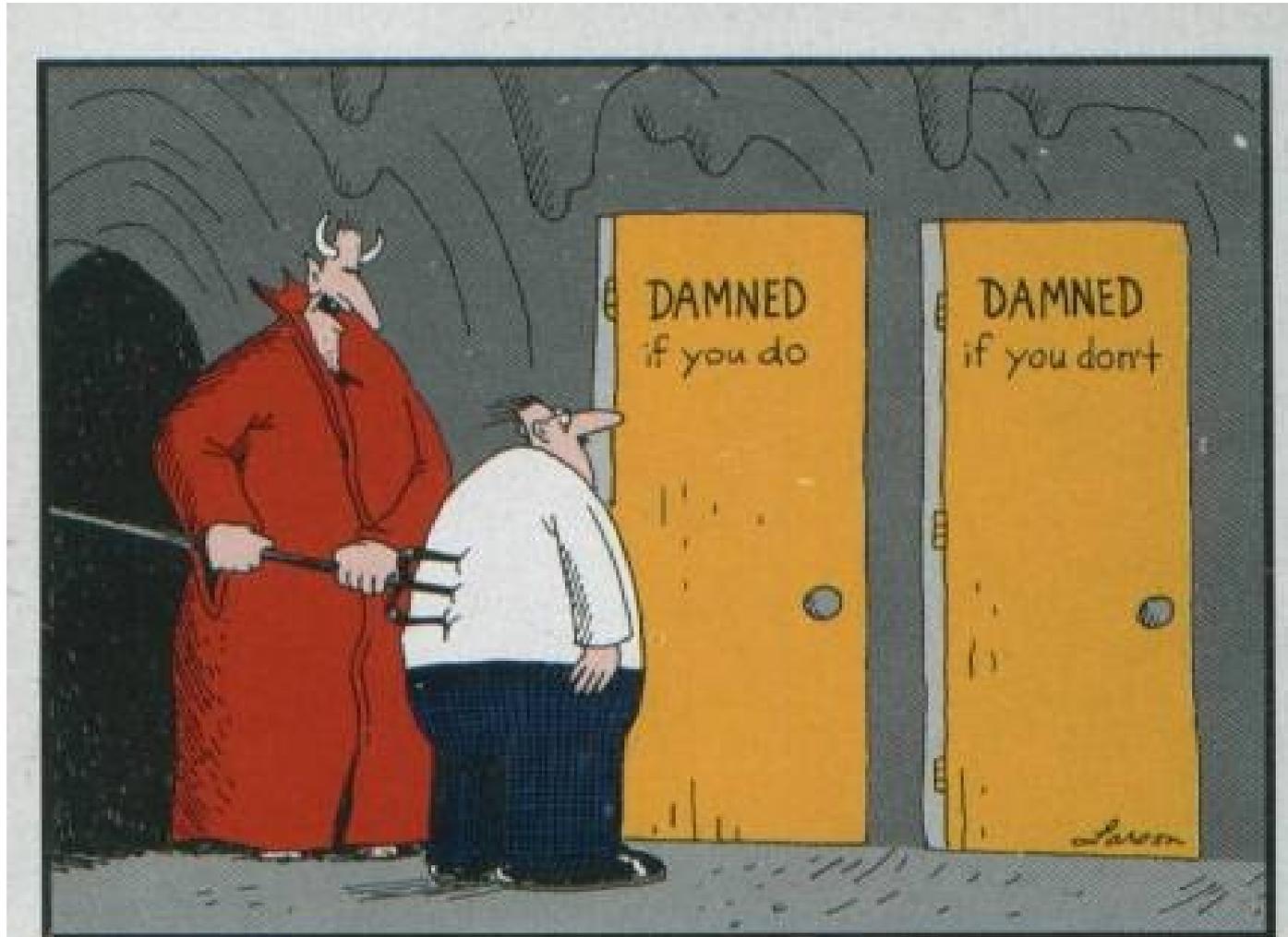
First Curve

Second Curve



Ian Morrison, "The Second Curve: Managing the Velocity of Change"
1996; The Future of the Health Care Marketplace: Life in the Gap, Life
in the Game 2011

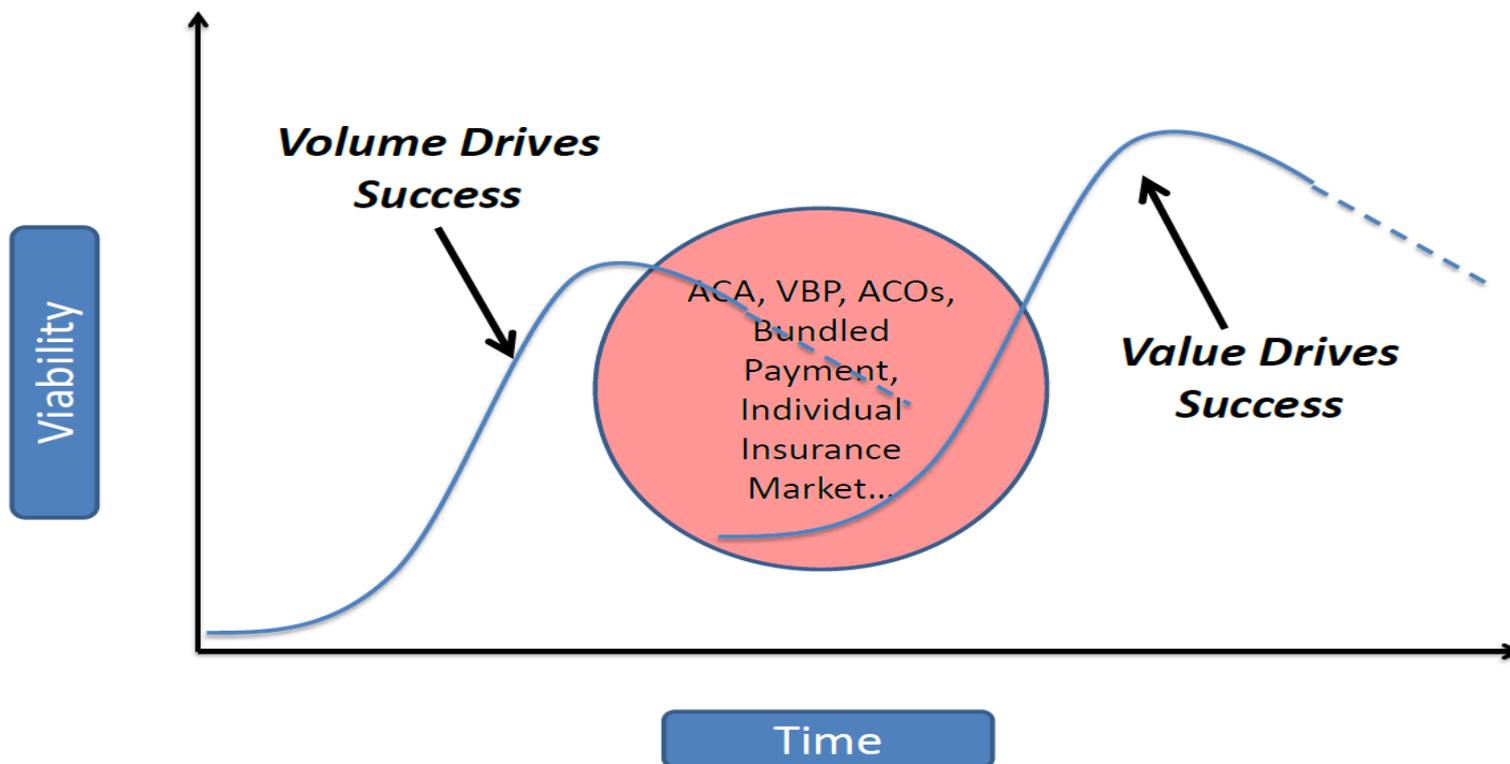
The Prevailing Mood in the C-suite



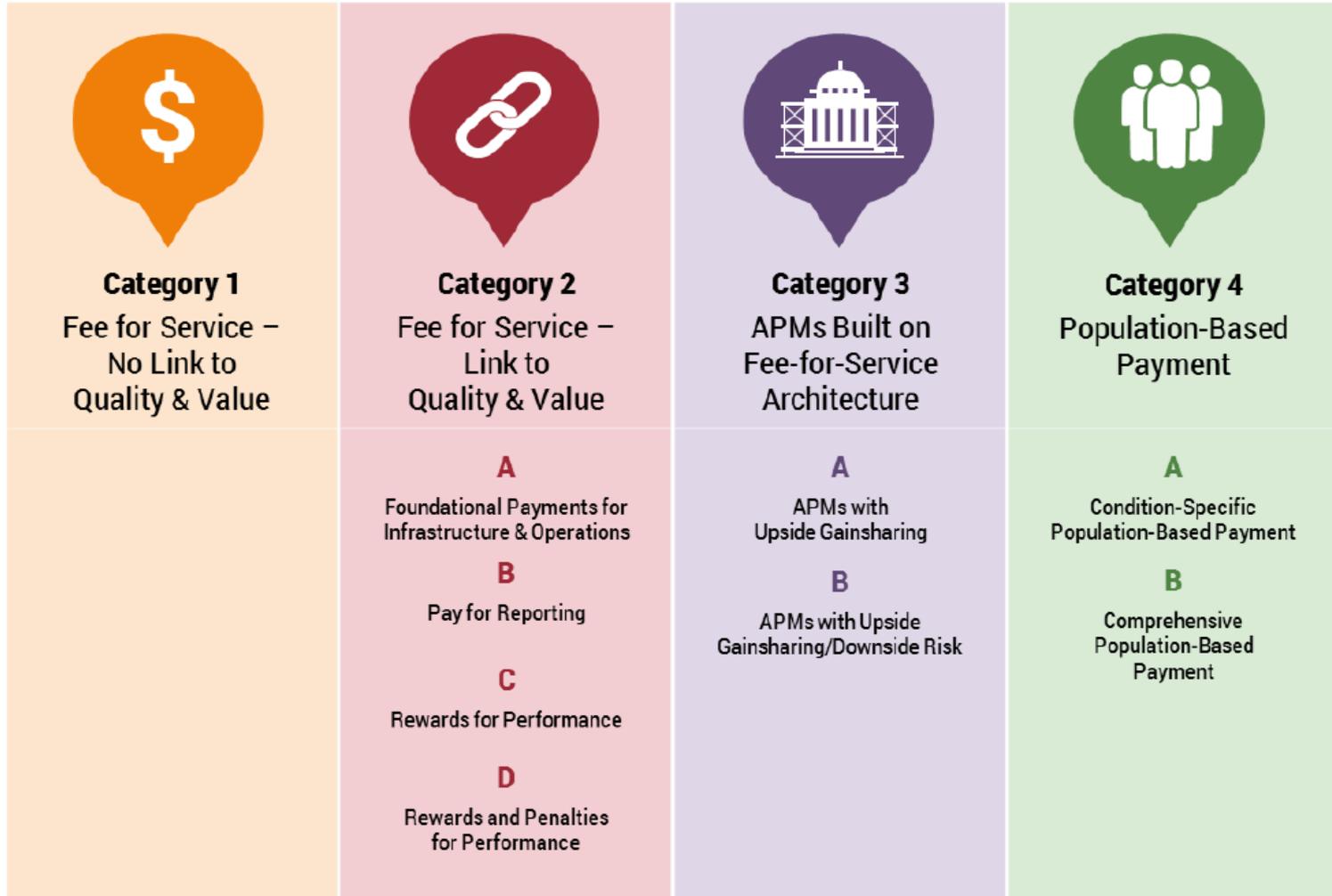
“C’mon, c’mon — it’s either one or the other.”

Key Strategic Question for Health Systems

When to make the leap?

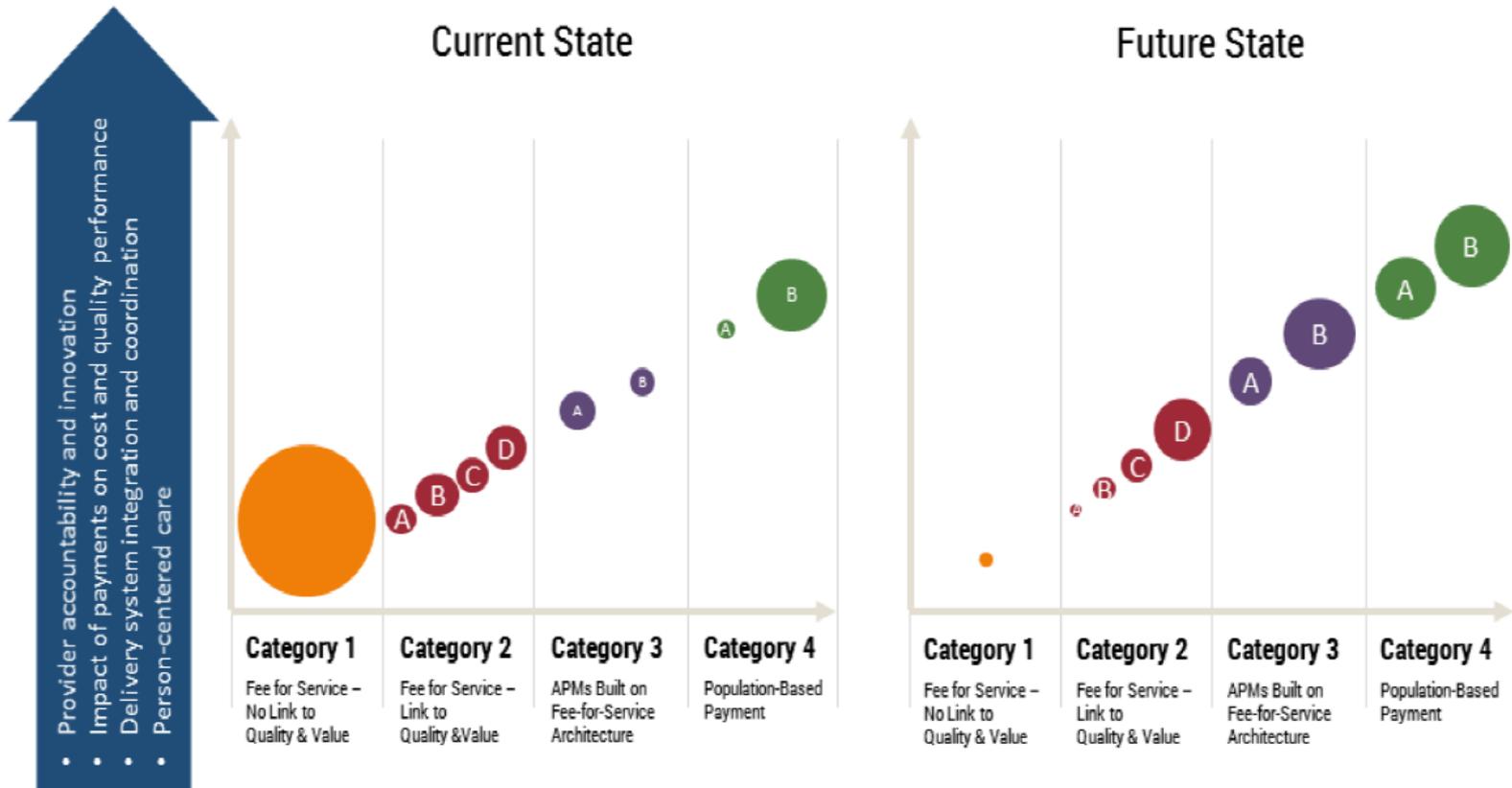


What does Payment Reform mean?



Source: Melinda Hancock VHHA Payment Reform Summit, Alternative Payment Model Framework and Progress Tracking Workgroup, "Alternative Payment Model (APM) Framework", HCP-LAN. 12 Jan 2016. Web. 31 Jan 2016.

Where are we today and where are we going?



Source: Melinda Hancock, VHHA Payment Reform Summit presentation.

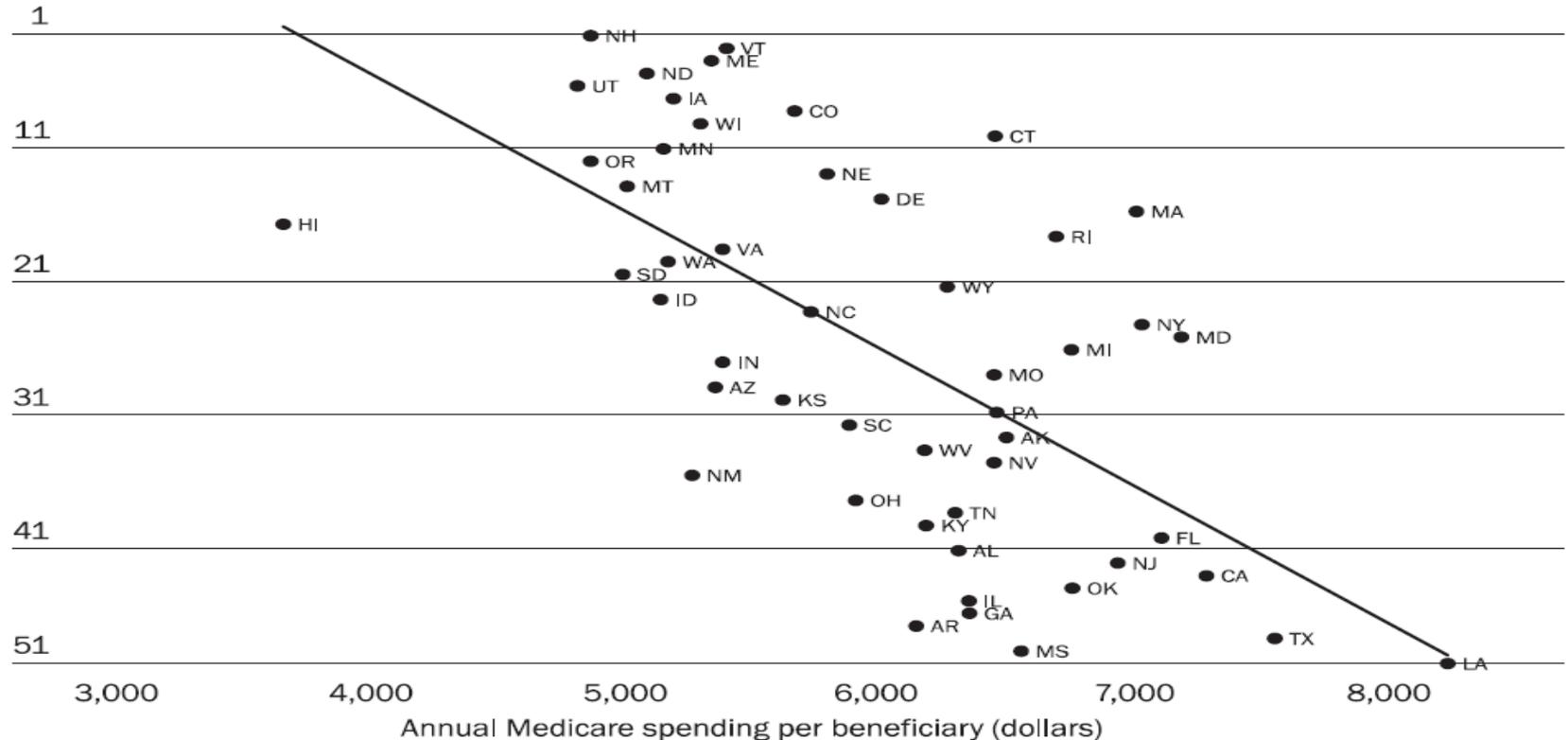
Triple Aim Goals

- **Better care for patients**
 - Our primary responsibility (all providers)
 - Committed to achieving top-tier performance
- **Better health for populations**
 - Shared responsibility, public and private
 - Patient/employee engagement, support and incentives critical
 - Major driver of productivity and cost
- **Lower trajectory on total health care costs**
 - Delivery system and payment reform essential
 - Everyone will need to do business differently

Quality and Cost Related

Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001

Overall quality ranking



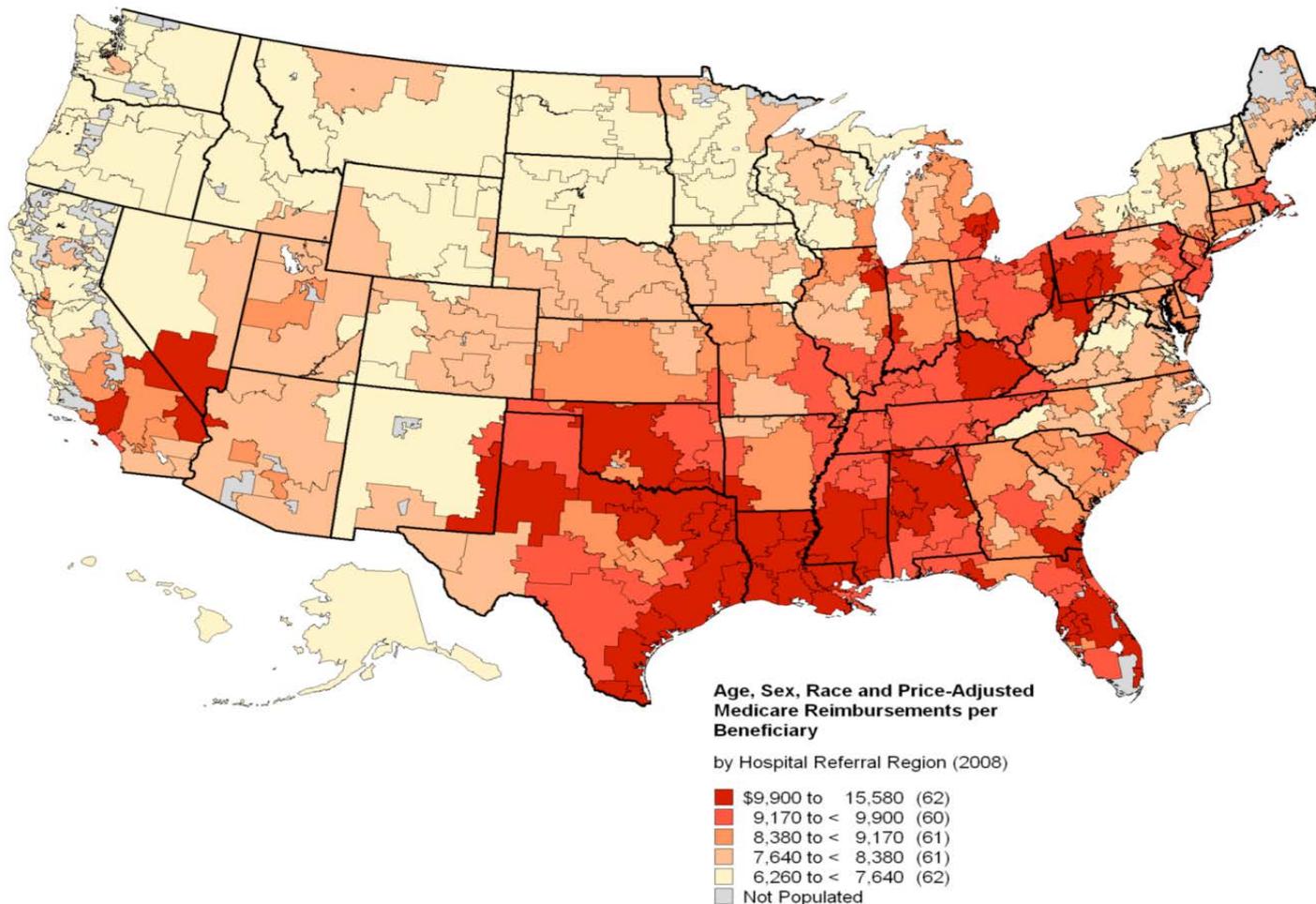
SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.

NOTE: For quality ranking, smaller values equal higher quality.

Q: How does Virginia healthcare value rank?

A: Defining value a challenge, but promising evidence on costs

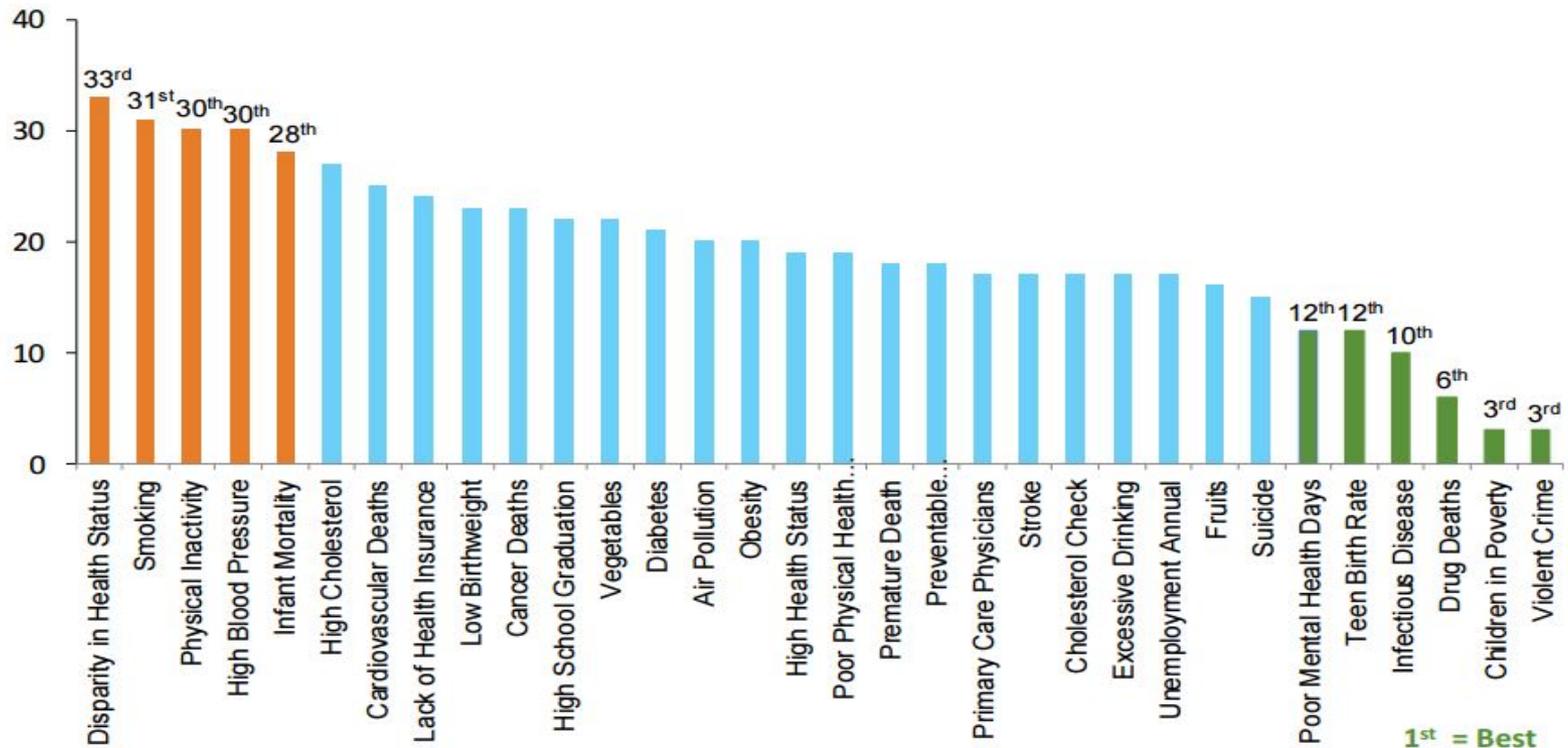
Map 1. Price-adjusted Medicare expenditures per beneficiary by hospital referral region (2008)



How does Virginia Rank on Health?

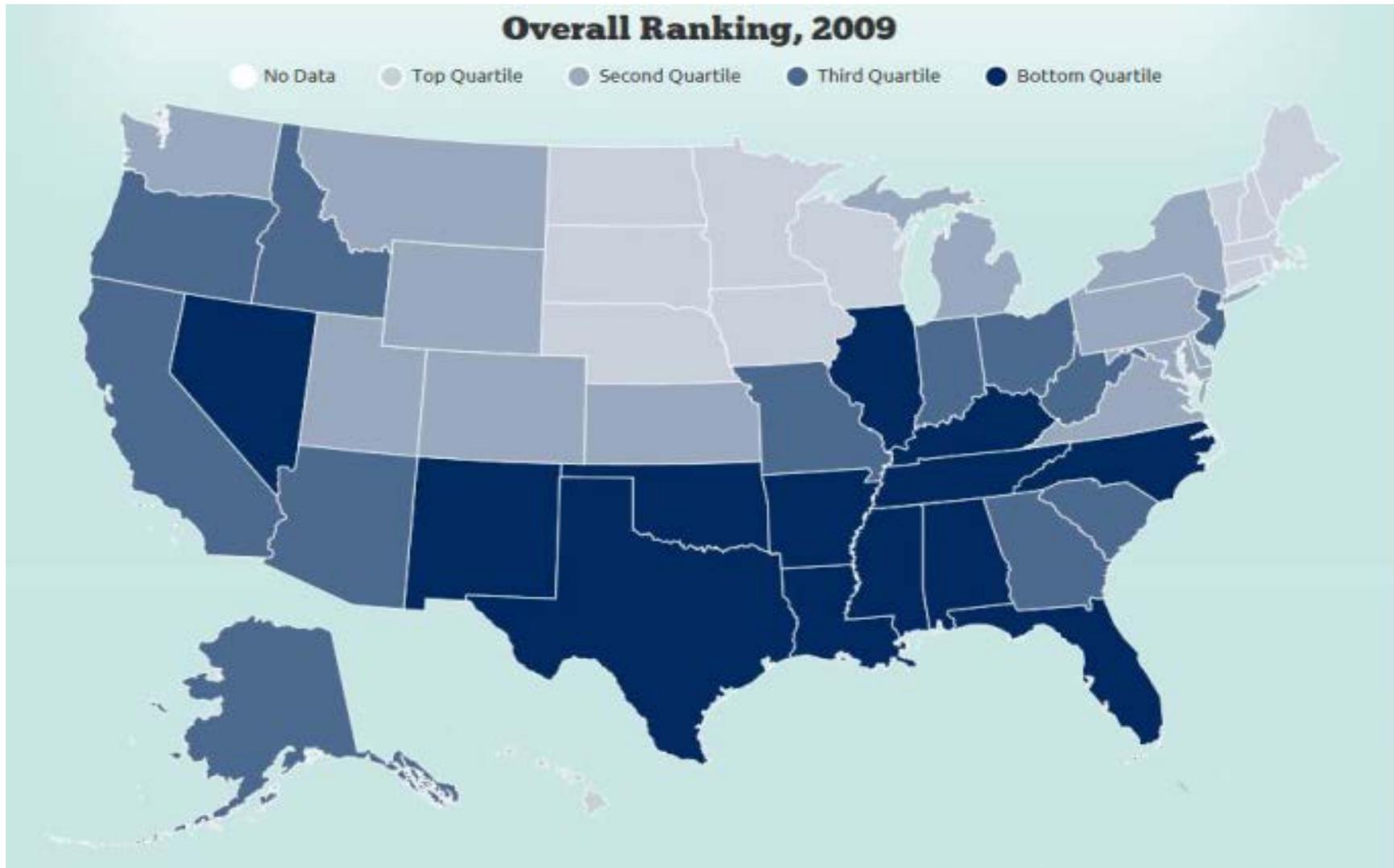
Virginia Compared to Other States, 2014

Overall Ranking = 21st



Source: American Health Rankings by United Health Foundation, Released 12/10/15

Health System Ranking Among States



Source: Commonwealth Fund – health system ranking includes measures relating to access, prevention & treatment, avoidable hospital use and costs, and healthy lives

The Patient Protection and Affordable Care Act (ACA)

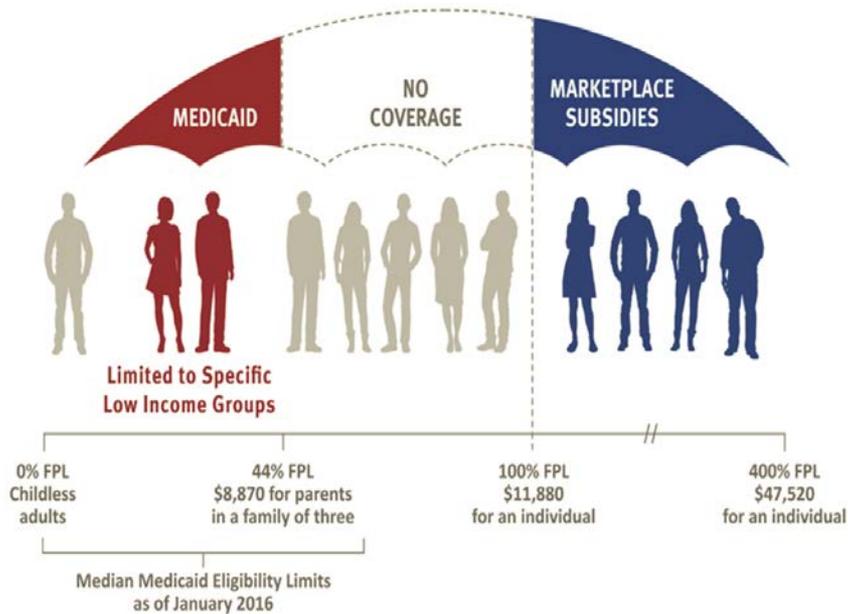
Key Provisions of the ACA

- **Employer and Individual Mandates**
 - Tax penalties for non-compliance
- **New limits on HSAs and employer contributions to a flexible spending account (FSA) limited to \$2,500 per year**
- **Premium Assistance Tax Credits to assist individuals with purchasing insurance**
 - Individuals with incomes between 100% FPL and 400% FPL
 - Age and income adjusted
- **Cost-sharing subsidies**
 - Individuals with incomes between 100% and 250% FPL
 - Paid to insurers to reduce premiums and out-of-pocket costs for eligible individuals
- **Medicaid Expansion – non-elderly adults with income up to 138% FPL**

Key Provisions of the ACA

- **Created new state-based and a federal insurance exchange**
- **Imposed numerous new requirements on insurance companies and plans**
 - Guaranteed issue
 - Rating variation limited to four factors: age (3:1), geography, family composition, tobacco use
 - Prohibition on pre-existing conditions exclusions
 - Prohibition on lifetime and annual limits
 - Dependent coverage up to age 26
 - Limits on annual cost sharing: \$7,150 for individuals and \$14,300 for families, indexed to inflation
 - Mandated four cost sharing levels: bronze (60% AV), silver (70% AV), gold (80% AV) and platinum (90% AV)
 - All plans must cover 10 essential health benefits

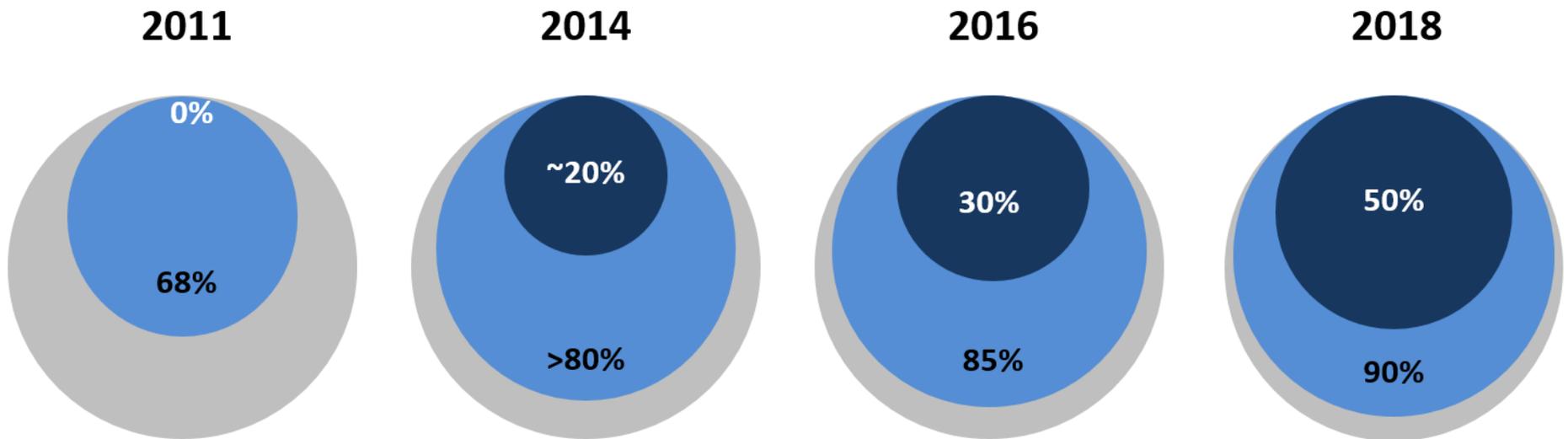
Key Provisions of the ACA – Medicaid



- Expanded Medicaid to all non-elderly adults with incomes up to 138% FPL
- Provided states with 100% federal funding for the expansion population phased down to 90%
- States initially required to expand their Medicaid program, but the Supreme Court rendered it optional

Moving From Volume to Value

- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)

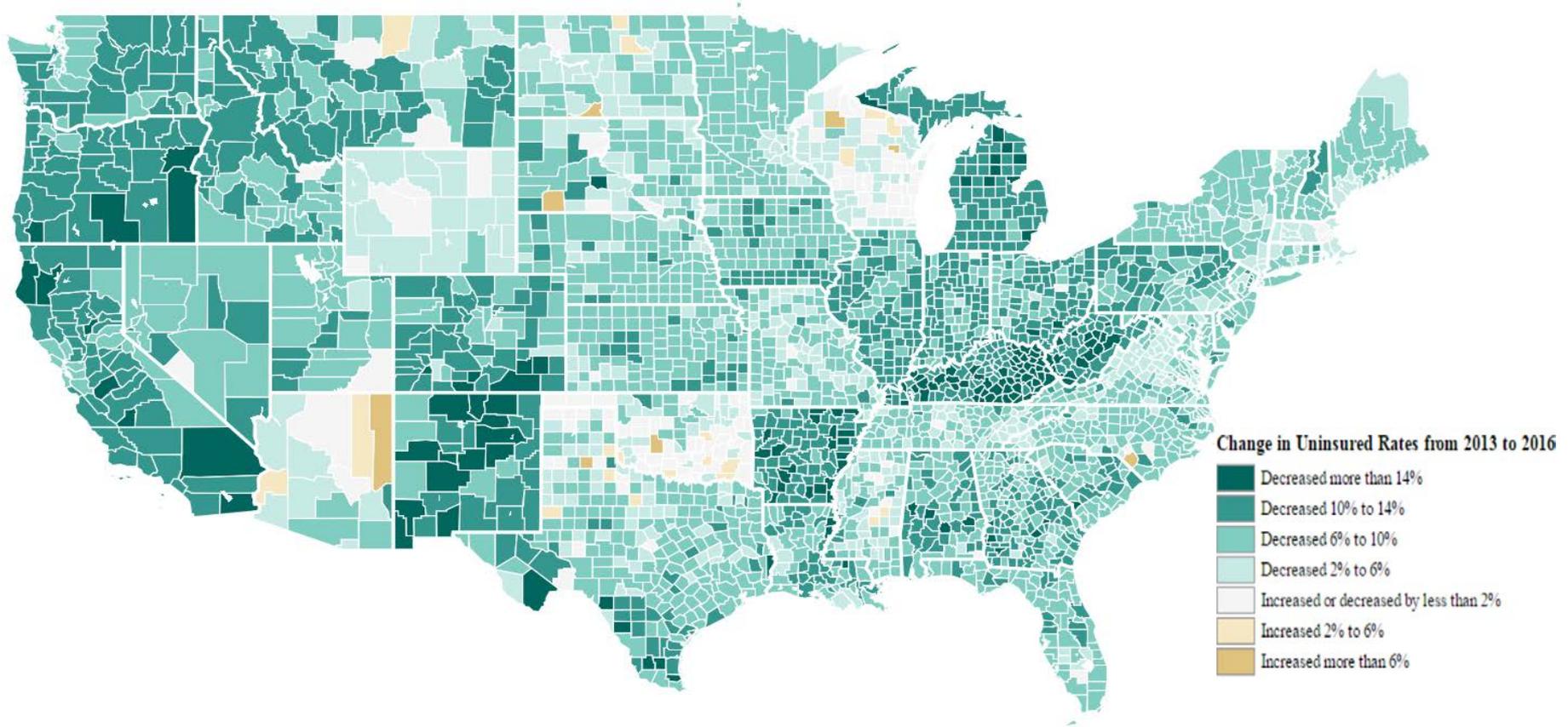


Historical Performance
(Pre-Announcement)

Goals

The ACA's Mixed Results

Decline in Uninsured Rate



What gains have occurred in Virginia are predominantly in the individual marketplace; 410,726 Virginians signed up for coverage during 2017 open enrollment.

Individual Marketplace

During the 2017 open enrollment period, 410,726 Virginians signed up for coverage through the individual marketplace

Location	Age <18	Age 18-34	Age 35-44	Age 45-54	Age 55-64	Age 65 and Over	Total Individuals Who Have Selected a Marketplace Plan
Virginia	47,652	118,337	64,785	79,674	95,551	4,727	410,726

Location	Bronze Plan	Silver Plan	Gold Plan	Platinum Plan	Catastrophic Plan	Total Individuals Who Have Selected a Marketplace Plan
Virginia	86,878	303,804	11,976	828	7,240	410,726

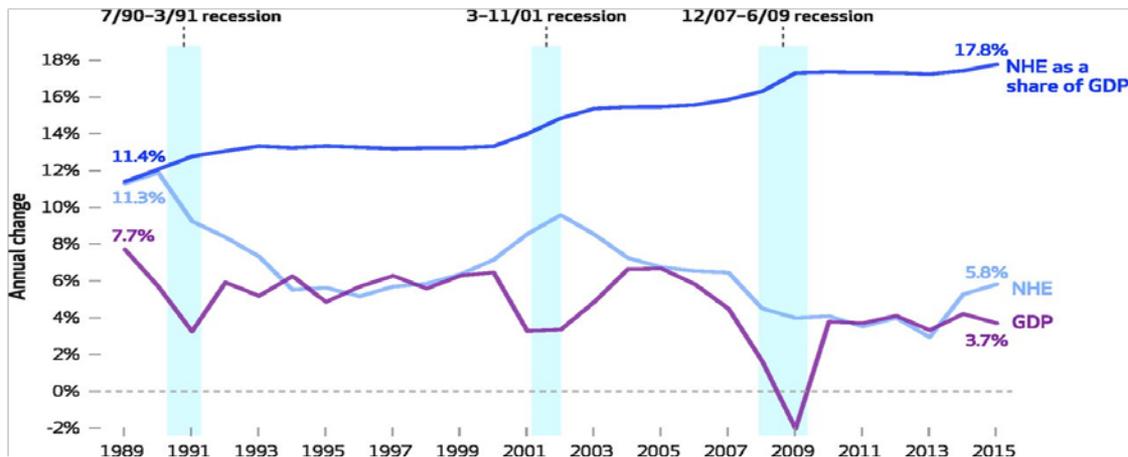
Location	100% - 150% FPL	>150% - 200% FPL	>200% - 250% FPL	>250% - 300% FPL	>300% - 400% FPL	Unknown/Other FPL	Total Individuals Who Have Selected a Marketplace Plan on Healthcare.gov
Virginia	143,760	81,881	59,505	32,419	32,238	60,923	410,726

Recent Progress on Healthcare Costs

But Individual Insurance Premiums Spiking in Some States

- Large employer and group premiums increased on average 3% in 2016*
- Overall health care expenditures have moderated significantly over last six years, although further progress depends on further coverage gains and continued innovation in payment and delivery reform

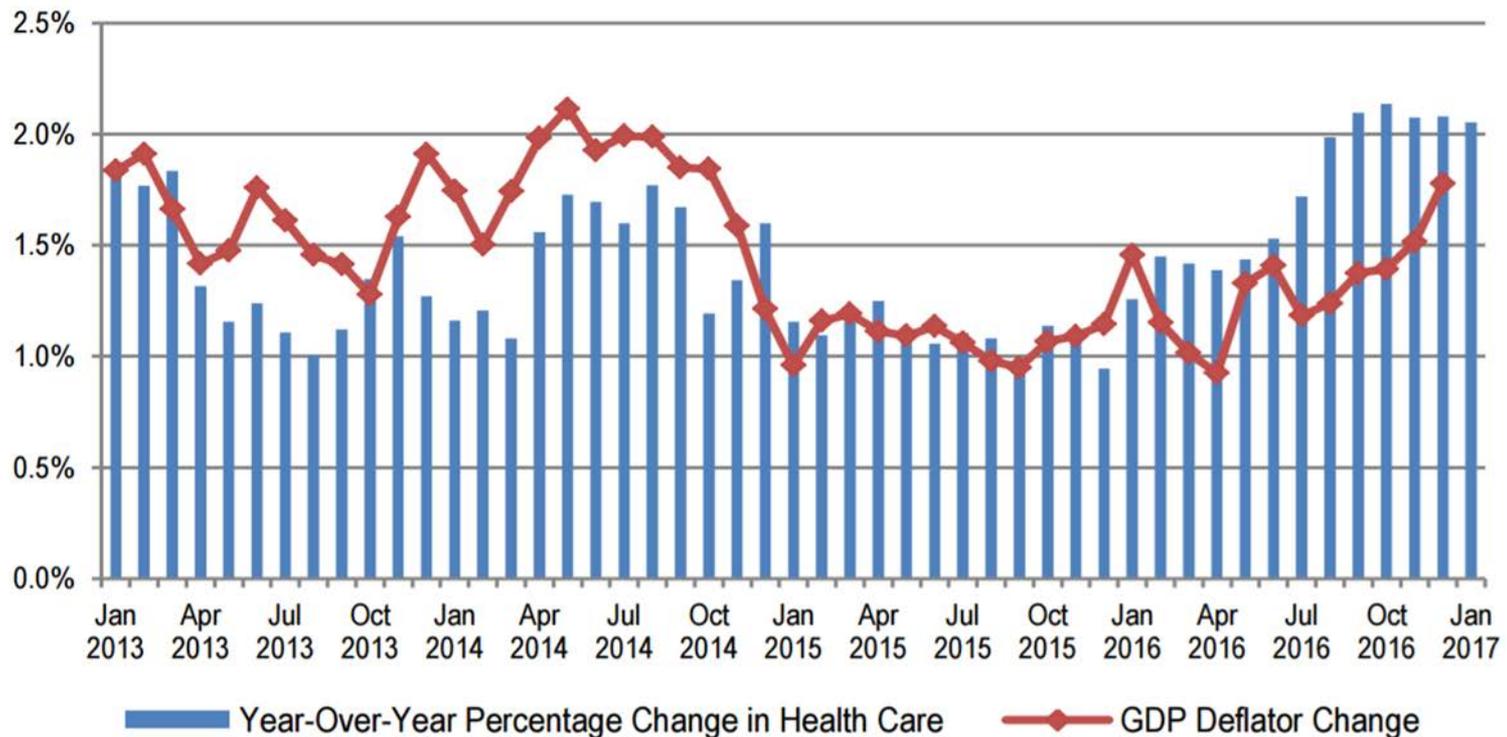
Growth in national health expenditures (NHE) and gross domestic product (GDP), and NHE as a share of GDP, 1989–2015.



- Declining plan choices and premium jumps in some exchange/individual insurance markets due to adverse risk selection, not overall healthcare costs

Healthcare Spending in the United States

Exhibit 1. Year-over-Year Growth Rates in HCPI and GDPD



Source: Altarum analysis of monthly BLS data.

Note: This exhibit compares monthly prices with the same month from the previous year.

Change in Prices for Health Care Elements

Exhibit 4. Annualized Percentage Change in Prices for the Major Components of National Health Expenditures

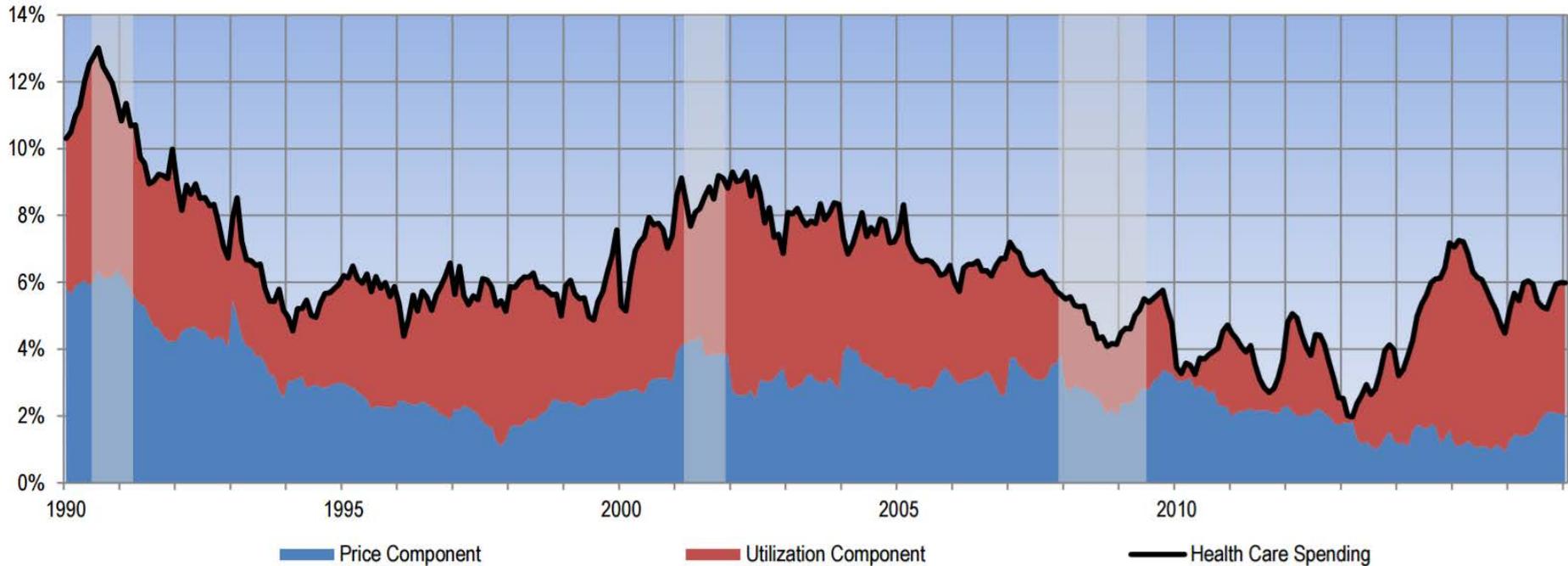
	Ending January 2015	Ending January 2016	Ending January 2017
HCPI	1.2%	1.3%	2.1%
Hospital care	0.5%	1.0%	1.5%
Physician and clinical services	-1.0%	0.1%	0.5%
Prescription drugs	5.6%	3.0%	6.1%
Nursing home care	2.1%	2.1%	2.8%
Dental services	2.2%	2.7%	2.1%
Home health care	1.7%	2.0%	0.4%
Other professional services	1.1%	0.5%	2.7%
Other personal health care	2.0%	2.8%	2.6%
Other nondurable medical products	-1.1%	-0.7%	0.1%
Durable medical equipment	0.2%	0.6%	0.4%

Source: Altarum analysis of monthly BLS data.

Notes: This exhibit compares a given month's prices with those of the same month from the previous year.

Healthcare Spending is Increasing Due to Utilization

Exhibit 6. Personal Health Care Spending Growth by Price and Utilization Components

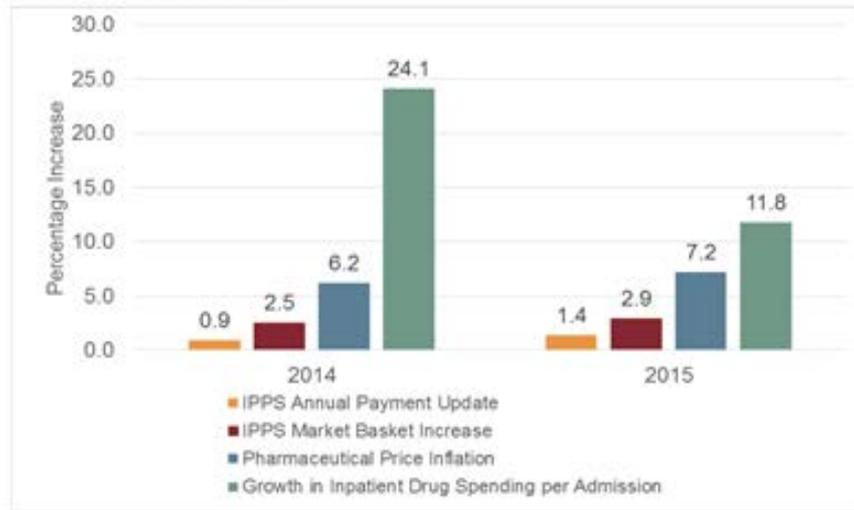


Source: Altarum calculations from Health Sector Economic Indicators data.

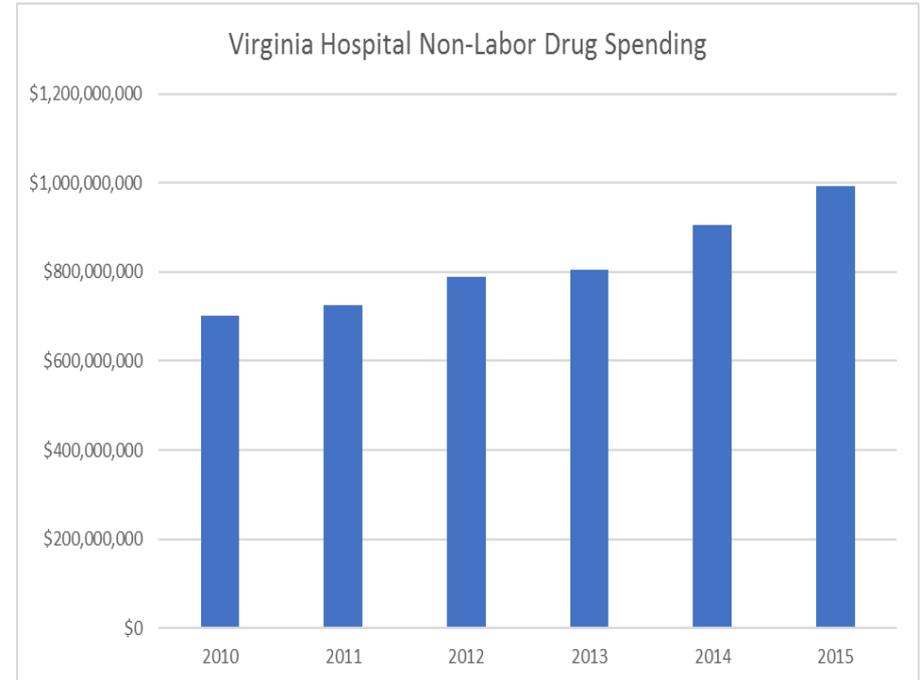
Note: Lightly shaded bars denote recession periods.

Drug Costs

Figure 3. Growth in Inpatient Drug Spending Has Far Outpaced Payer Reimbursement and Pharmaceutical Price Inflation

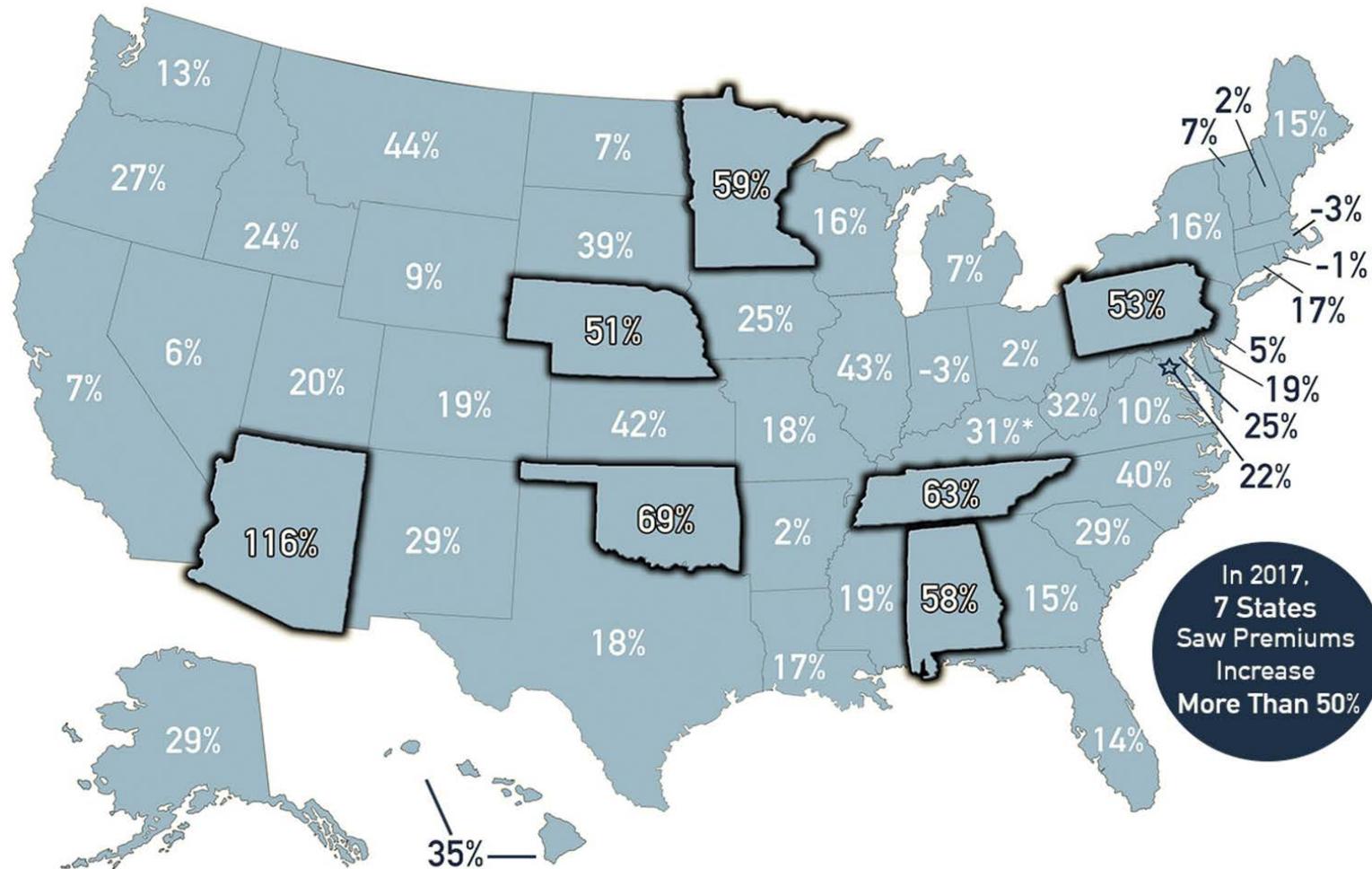


Source: CMS, Bureau of Labor Statistics, National Health Expenditure Data, AHA-FAH Drug Survey



Virginia hospitals have seen a more than 41% increase in spending on drugs in the past 6 years.

Individual Market Premiums



*As high as 31 according to the Kentucky Department of Insurance.

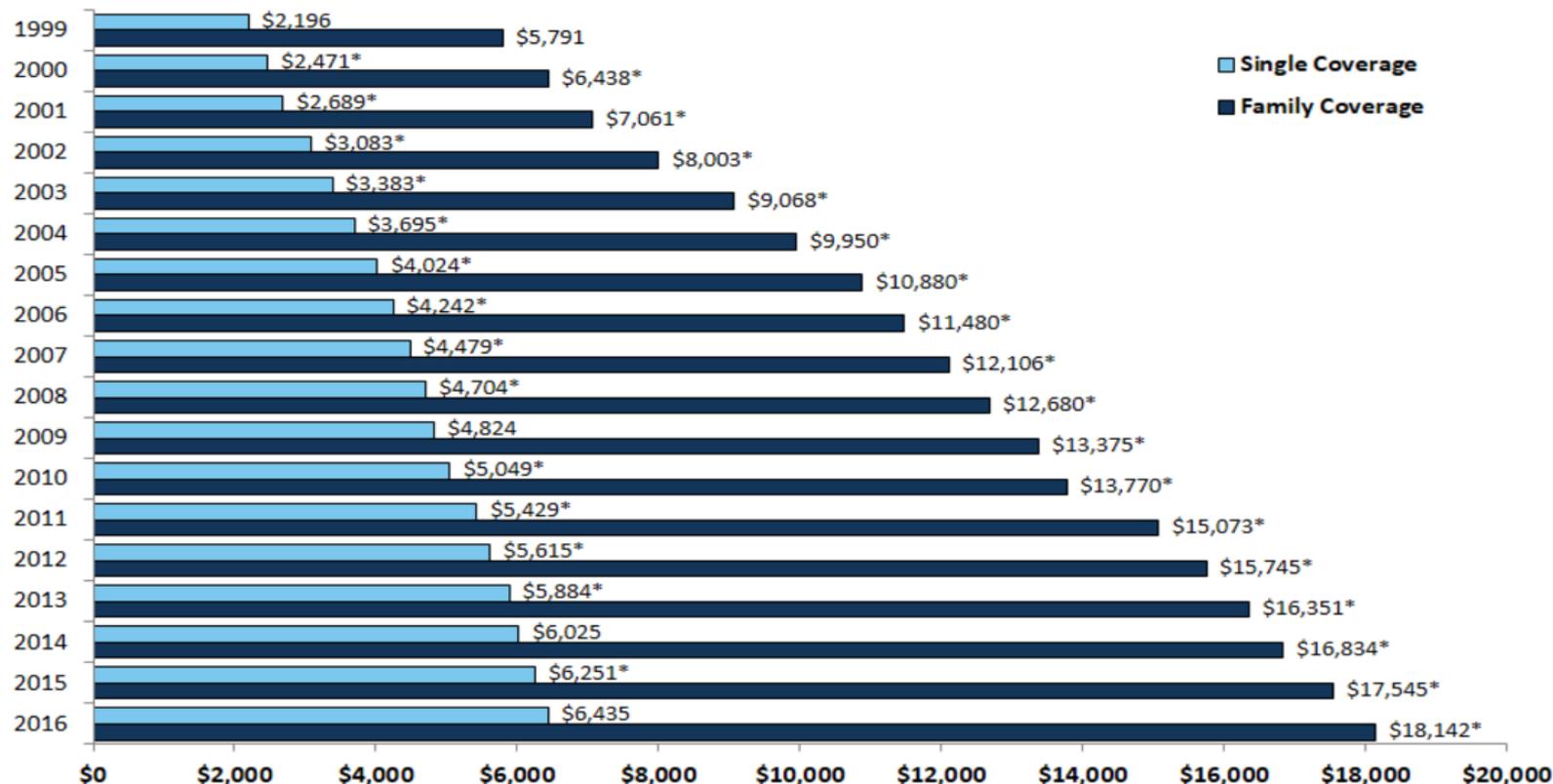
Source: Department of Health and Human Services;

Herron, J. (2017). Here's How Much Obamacare Premiums Are Rising in All 50 States. The Fiscal Times.

Retrieved from <http://www.thefiscaltimes.com/2016/11/01/Here-s-How-Much-Obamacare-Premiums-Are-Rising-All-50-States>

Employer-Sponsored Insurance Premiums

Average Annual Premiums for Single and Family Coverage, 1999-2016



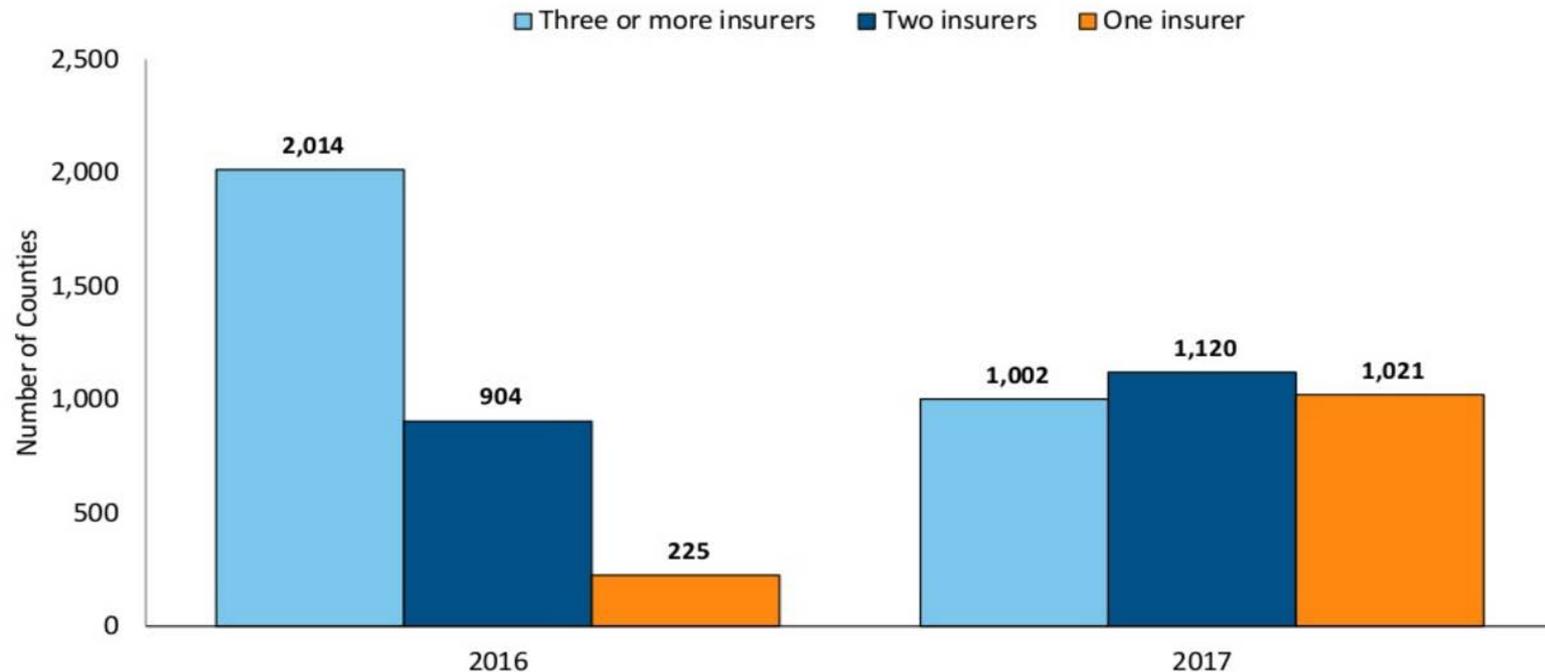
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2016.



Insurer Availability in Exchanges

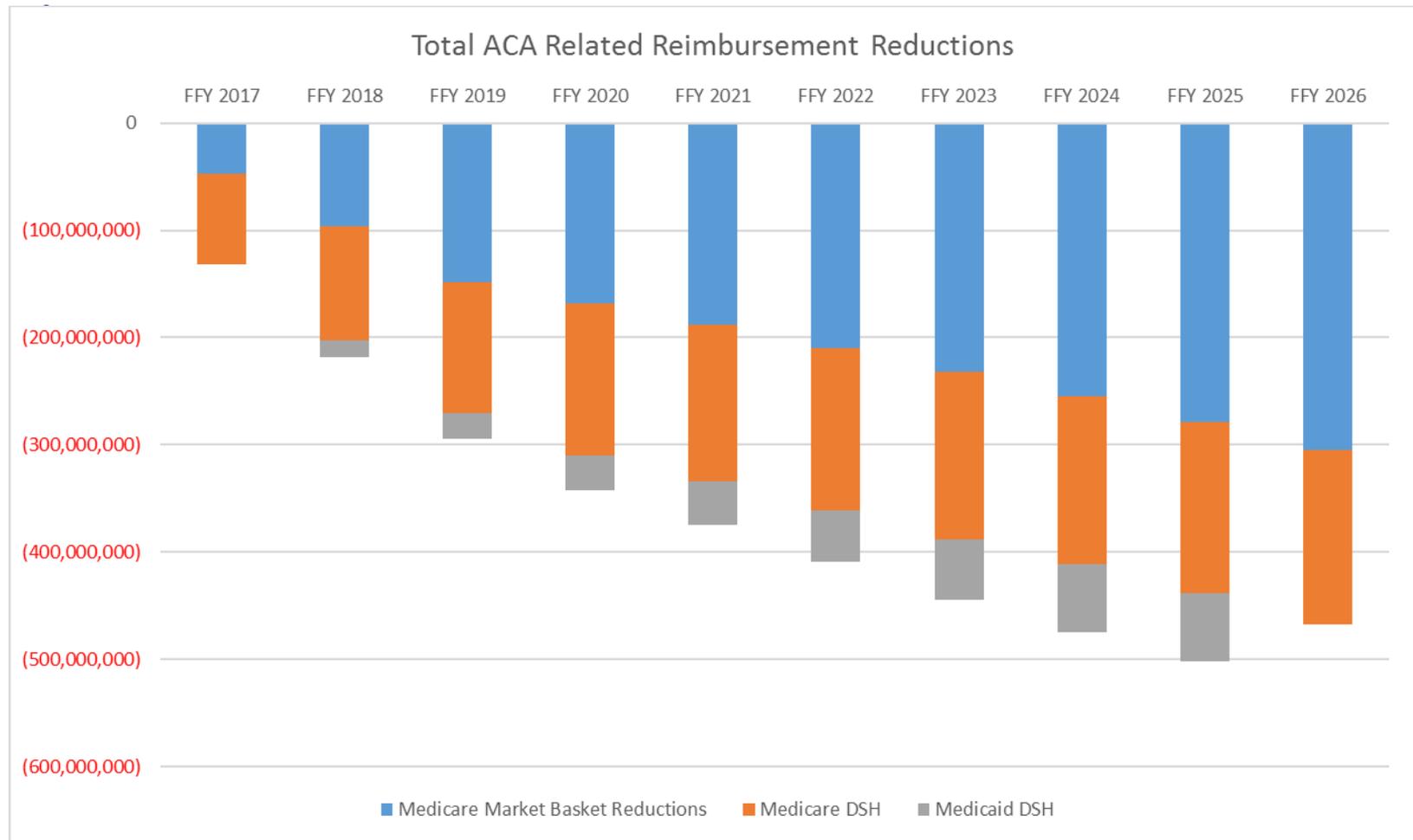
1,021 counties have only one exchange insurer in 2017 compared to 225 counties in 2016



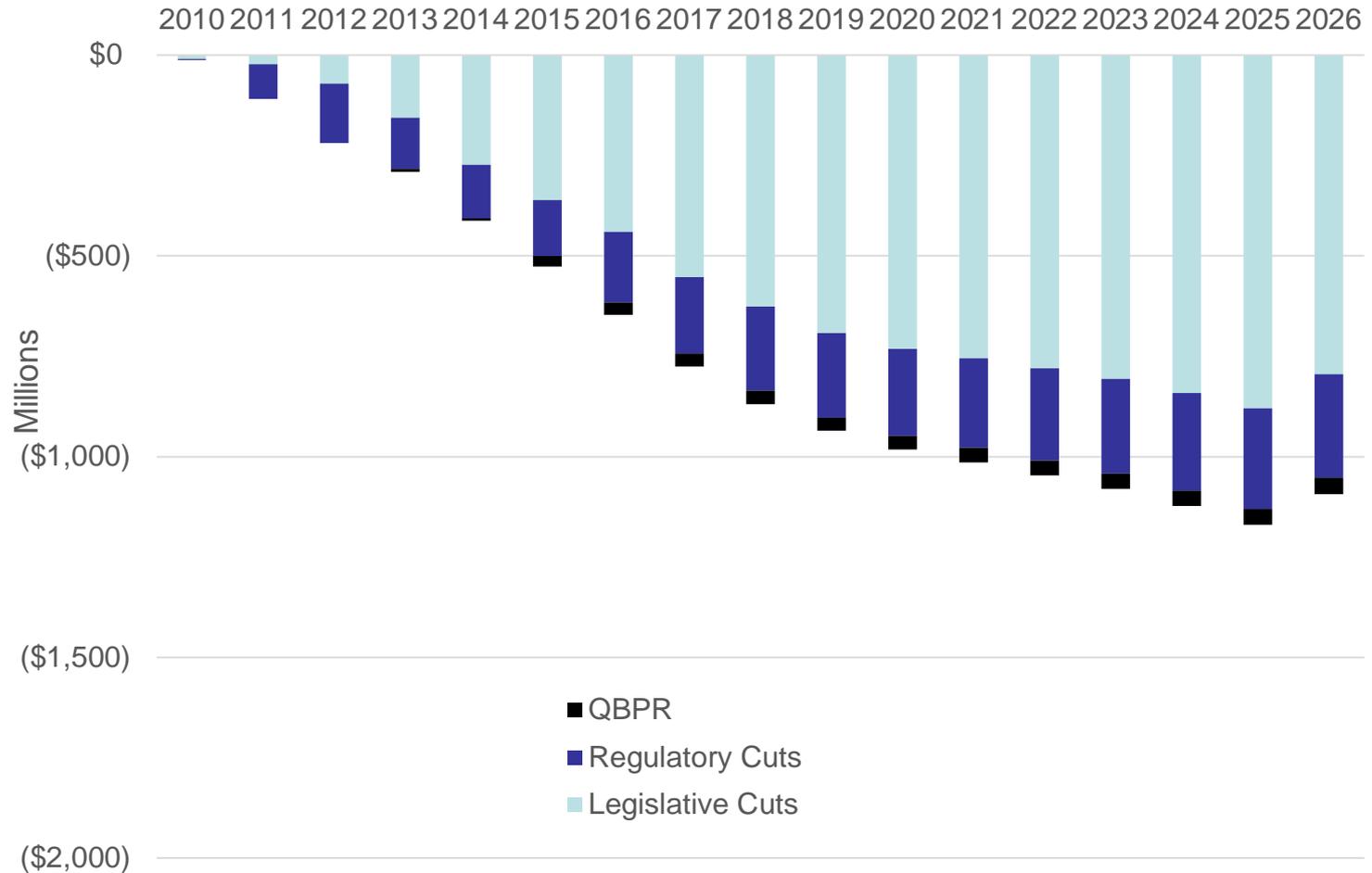
Source: Kaiser Family Foundation analysis of data from the 2017 QHP Landscape file released by healthcare.gov on October 24, 2016. Note: For states that do not use healthcare.gov in 2017, insurer participation is estimated based on information gathered from state exchange websites, insurer press releases, and media reports as of August 26, 2016. Enrollment is based on 2016 signups.



ACA Hospital Reimbursement Cuts

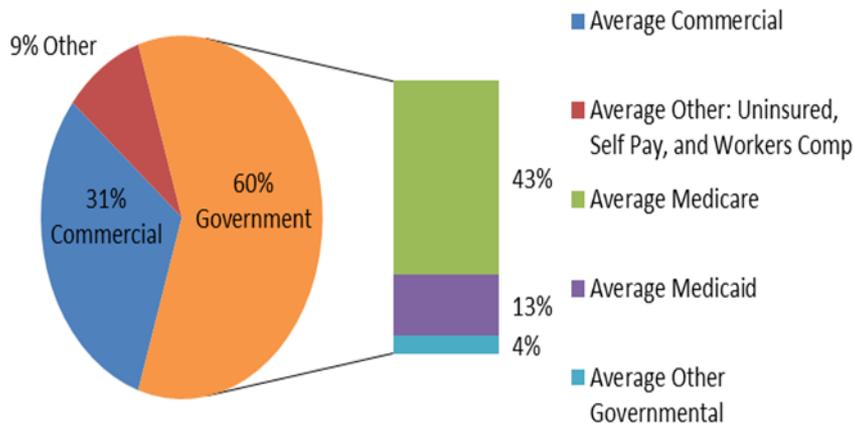


Total Federal Reimbursement Cuts

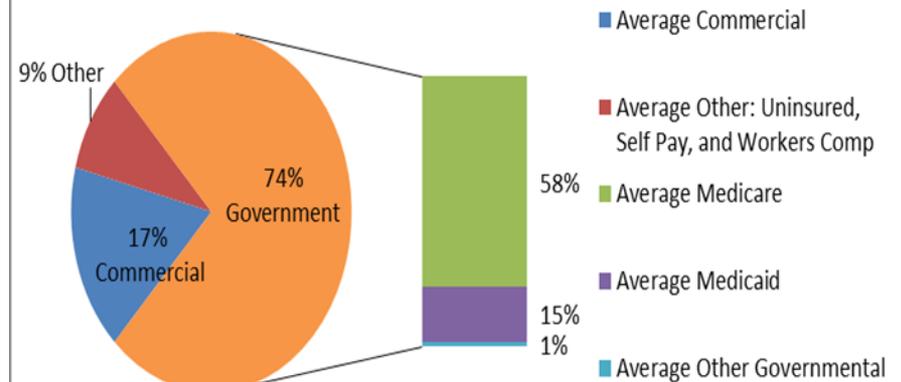


Patient Payer Mix

Urban Hospital Payer Mix by Admissions



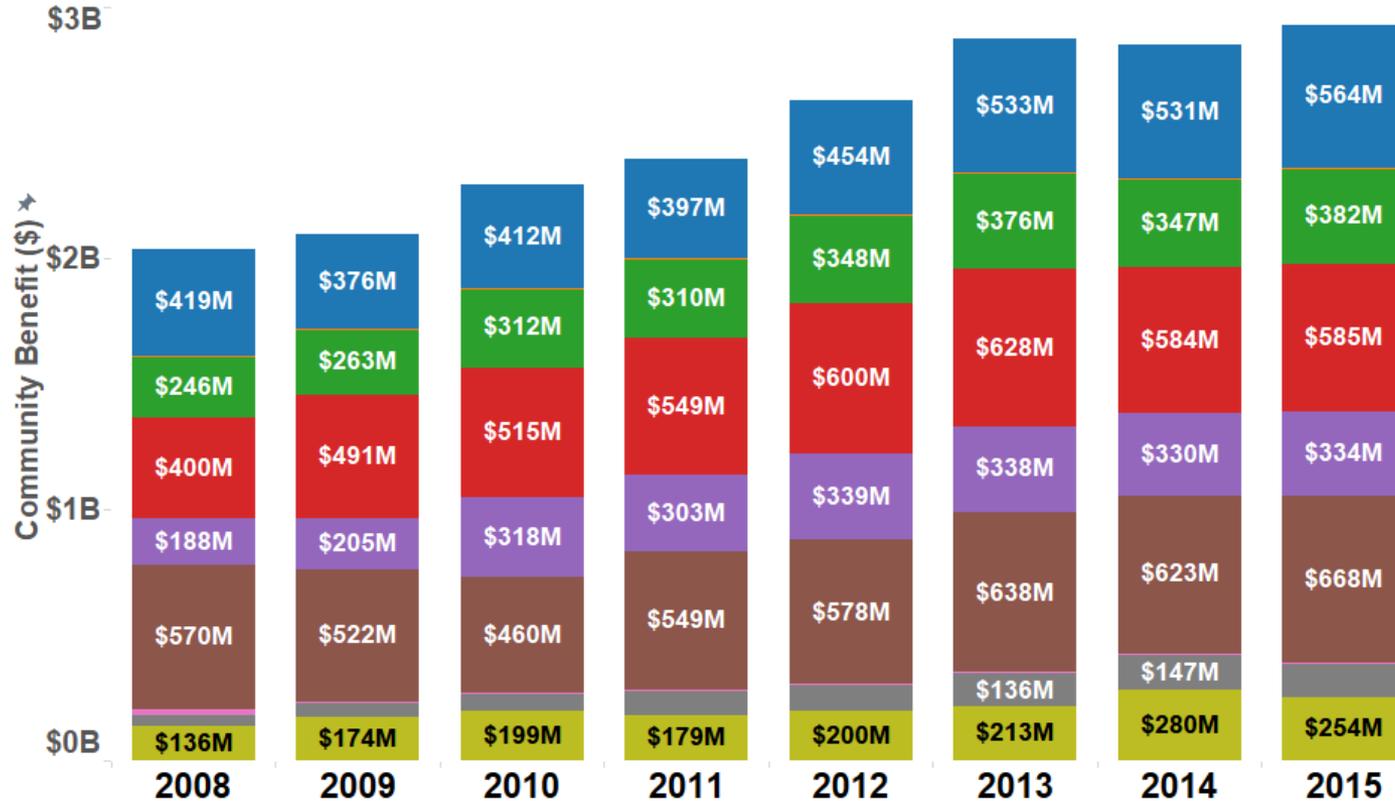
Rural Hospital Payer Mix by Admissions



A significant majority of all inpatient admissions involve the uninsured, or Medicare and Medicaid enrollees.

Significant Growth in Bad Debt and Medicare Shortfalls

Virginia Hospital Community Benefit (2008-2015)



Measure

- Bad Debt Expense
- Community Building
- Community Programs and Services
- Financial Assistance/Charity Care
- Medicaid Shortfall
- Medicare Shortfall
- Other Means-Tested Government Pr..
- Subsidized Health Services
- Taxes Paid

The 115th Congress

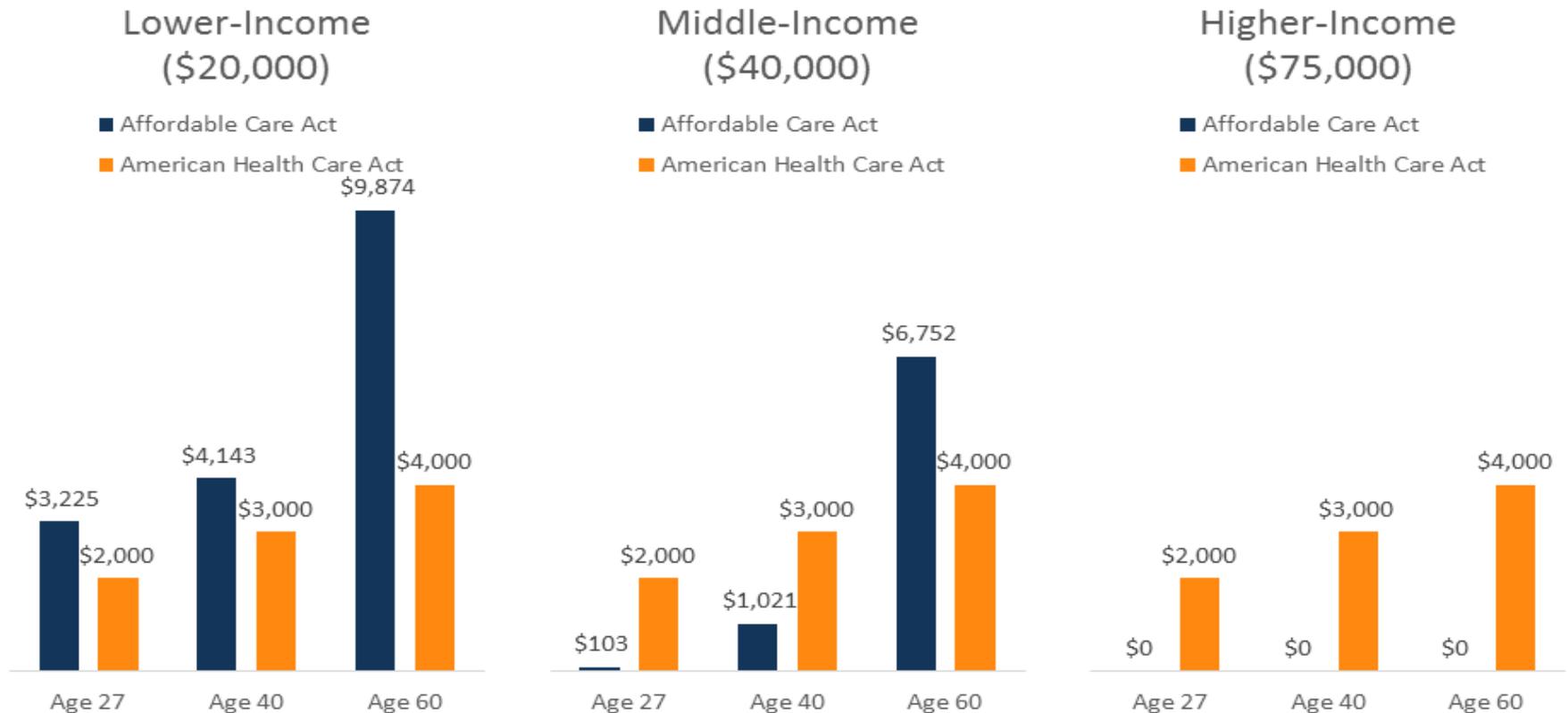
American Health Care Act

- Because reconciliation must deal with federal spending, most of the insurance market requirements imposed by ACA remain
- Essentially eliminates the employer and individual mandates by zeroing out the penalties beginning in taxable year 2016
- Authorizes insurers to charge a 30% premium penalty for individuals who lacked insurance for longer than 63 days in the preceding 12 month period
- Repeals the ACA's Premium Assistance Tax Credits and implements new age-adjusted, advanceable, and refundable tax credits
 - Credits are phased out above \$75,000/\$150,000 but are not means tested
 - Range from \$2,000 for individuals under 30 to \$4,000 for individuals 60 and older
 - Capped at \$14,000 maximum credit for families
- Continues Medicaid expansion through 2019, but phases out enhanced federal funding thereafter

American Health Care Act

Figure 1

How House Republicans' health reform plan might shift average health insurance tax credits, based on income and age, in 2020



Source: Kaiser Family Foundation analysis. Note: Data for Affordable Care Act represent the average tax credit available across all counties in the United States, at a given age.

American Health Care Act

- **Converts Medicaid program funding to a per capita allotment or block grant**
- **Provides \$100 billion for the Patient and State Stability fund to help lower the costs of insurance for high-risk individuals**
- **Provides \$10 billion for non-expansion states for safety net provider funding**
- **Eliminates ACA limitations on HSAs and increases the maximum annual contribution limit**
- **Eliminates ACA-related taxes and fees including, among others:**
 - Limitations on the business expense deduction for prescription drug costs
 - The increased threshold for deducting medical expenses
 - The medical device tax, the tanning tax, and the net investment tax
 - The fee on certain brand name pharmaceuticals
 - The fee on health insurers

American Health Care Act

- **The Budget Committee recommend several changes to the proposed legislation, including:**
 - Giving states the option to choose a pure block grant
 - Enhancing the value of the tax credits for elderly and low-income populations
 - Authorizing states to impose work requirements on able-bodied adults
- **The Manager's Amendment proposed several substantive and a number of technical amendments to the legislation, including:**
 - The changes recommended by the Budget Committee
 - Prohibiting additional states from expanding and capping enrollment in 2017
 - Eliminating the ACA's taxes and fees in 2017 instead of 2018
- **Prior to the Easter Recess, the Budget Committee approved an amendment to the legislation creating a new \$15 billion Federal Invisible High Risk Pool**
- **MacArthur Amendment – enables states to seek waivers from three insurance market requirements**
 - Age rating
 - Essential Health Benefits
 - Factoring in health status in setting premiums, provided a state participates in the PSSF or has its own high-risk pool
- **Upton amendment added another \$8 million to address high-cost individuals**

Republican Replacement Proposals

Four Key Principles Likely to Guide GOP Reform Efforts

1 Reduce Federal Entitlement Spending

More assertive focus on reduction in 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

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

4 Promote Transparency of Cost and Quality

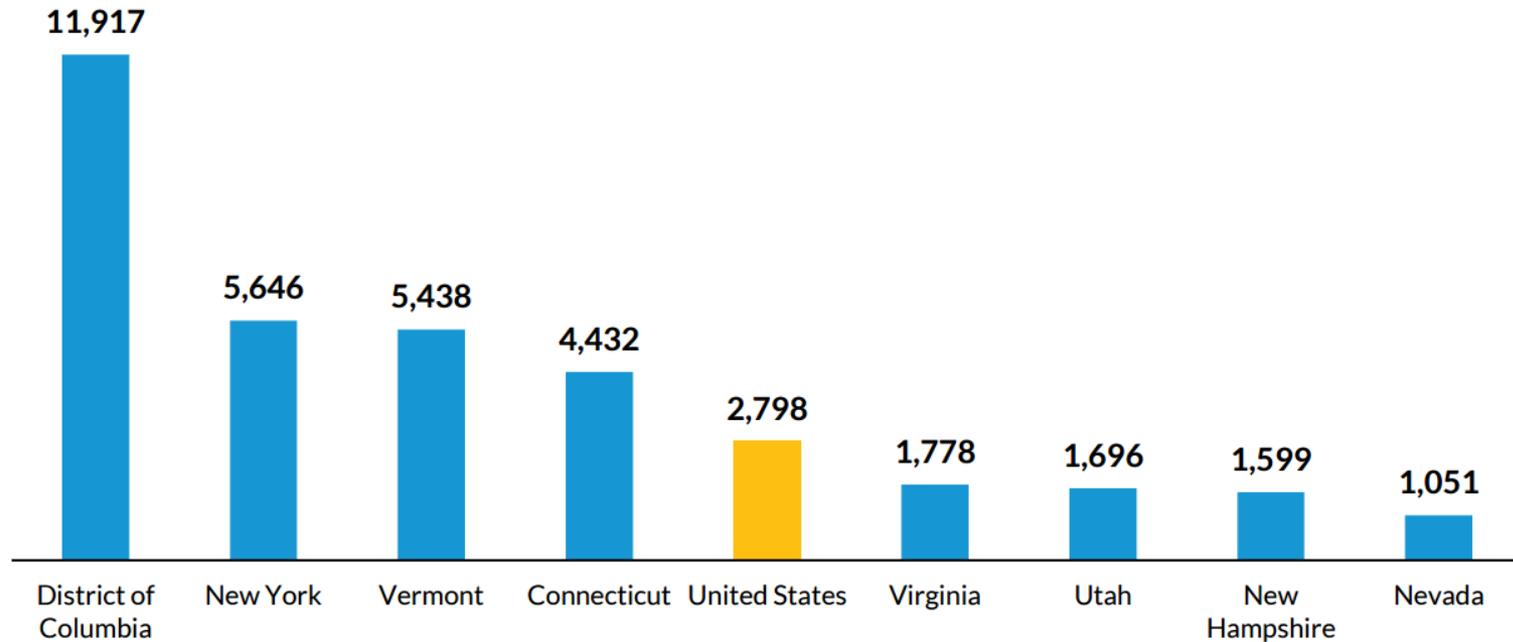
Mandate greater consumer choice and shopping at the point-of-care and point-of-coverage through improved transparency

Medicaid Block Grants

Estimates from the Urban Institute show that Virginia will be on the losing end of Medicaid per capita or block grant proposals.

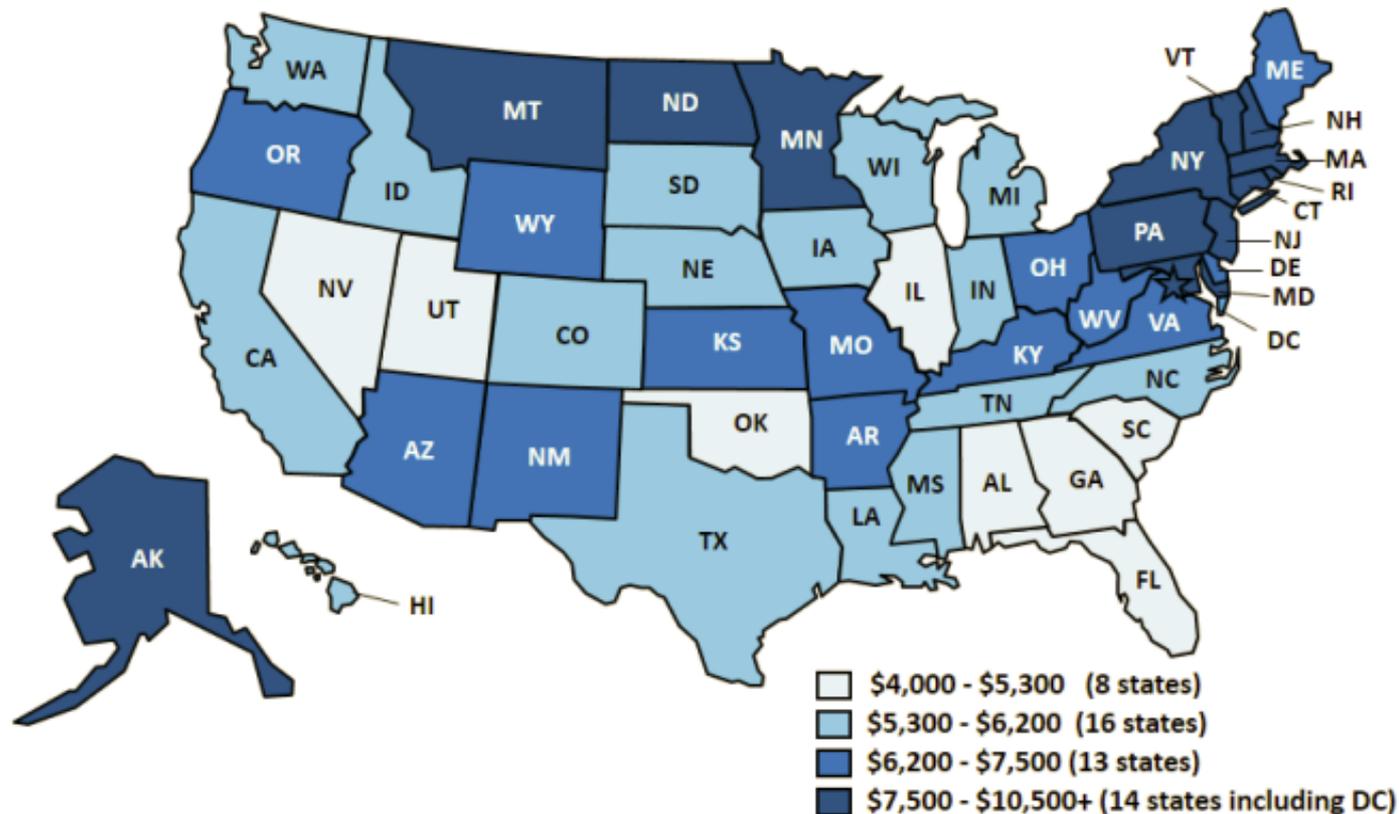
Estimated Federal Block Grant Spending per Low-Income Person, 2017

Dollars



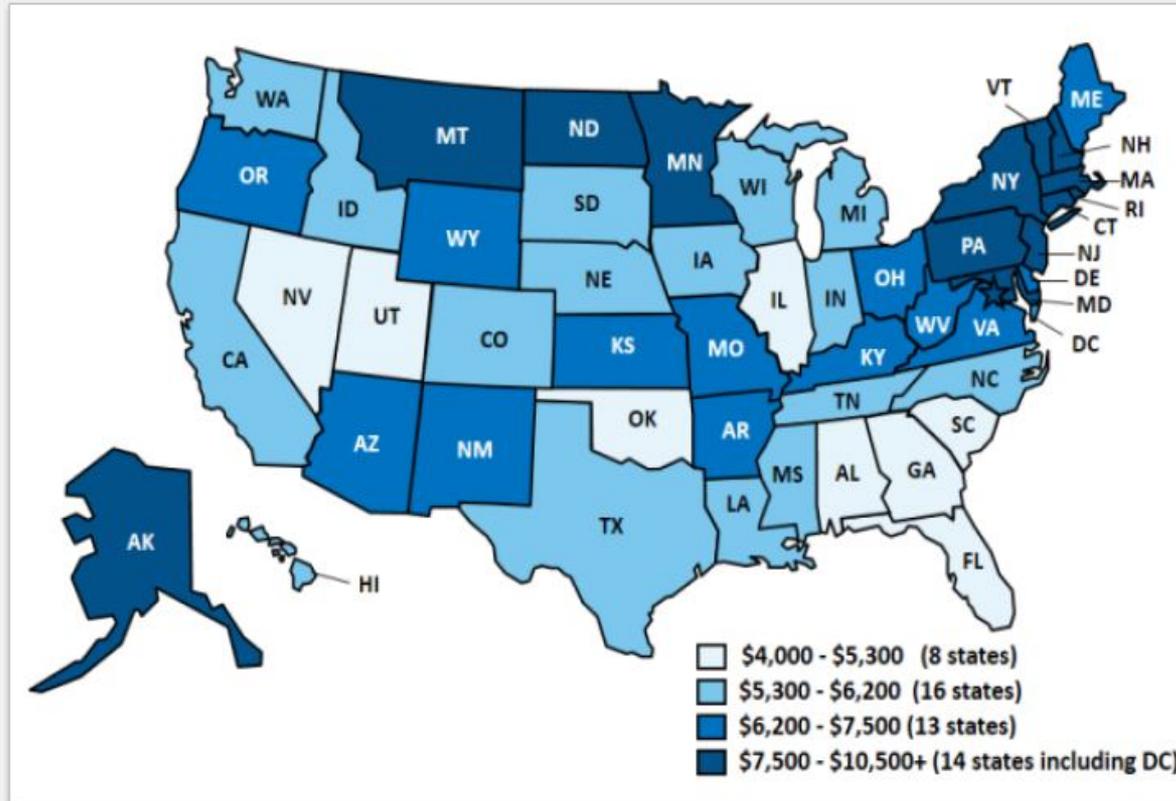
Medicaid Spending Differences

Total Spending per full Medicaid Enrollee FY2011



Medicaid Spending per Recipient

Spending Per Full Medicaid Enrollee, FY 2011

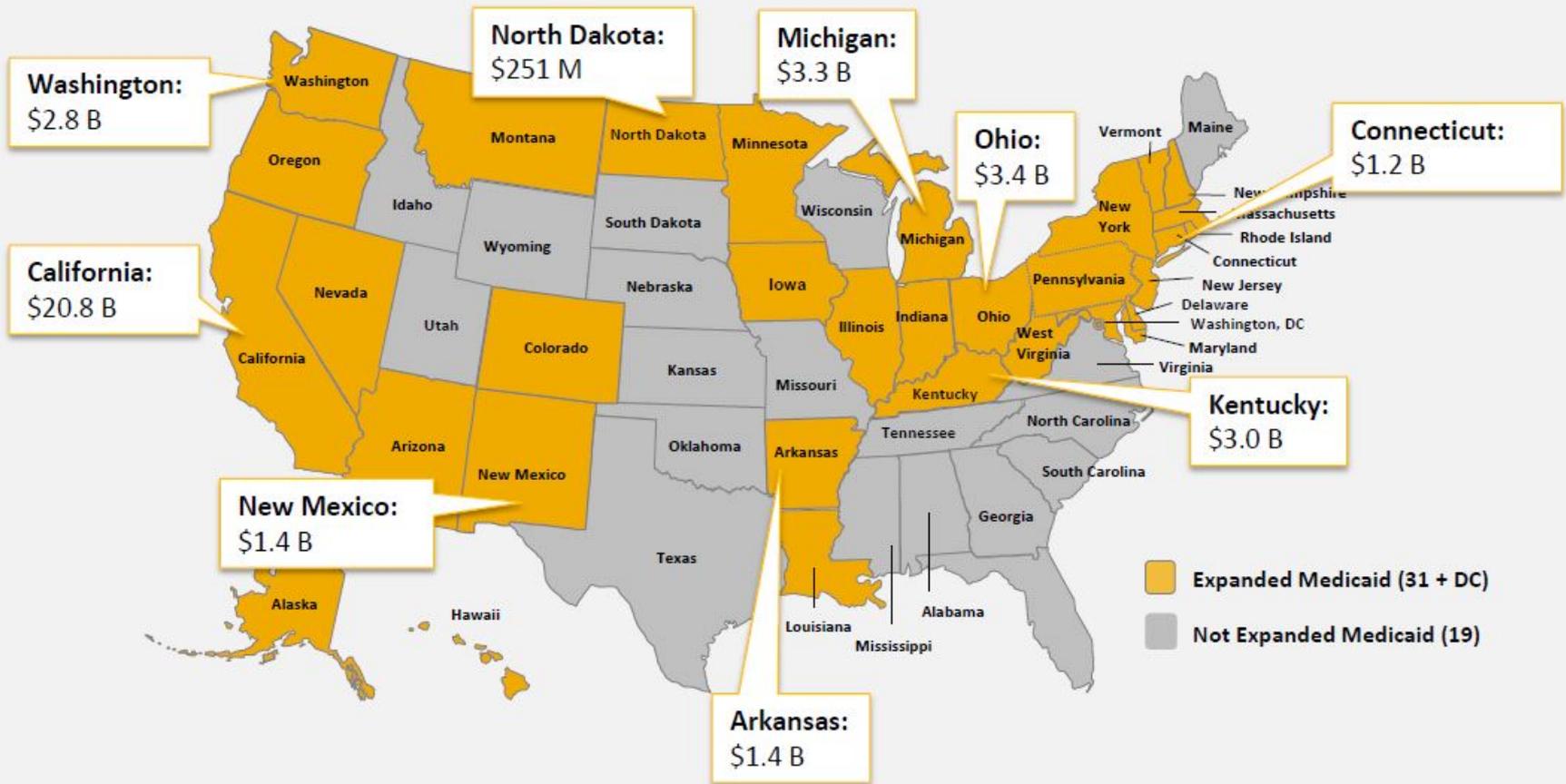


Source: Rudowitz, R., Garfield, R., and Young, K., "Overview of Medicaid Per Capita Cap Proposals," Kaiser Family Foundation, June 2016. Available at: <http://kff.org/report-section/overview-of-medicaid-per-capita-cap-proposals-issue-brief/>

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Medicaid Variation with Expansion

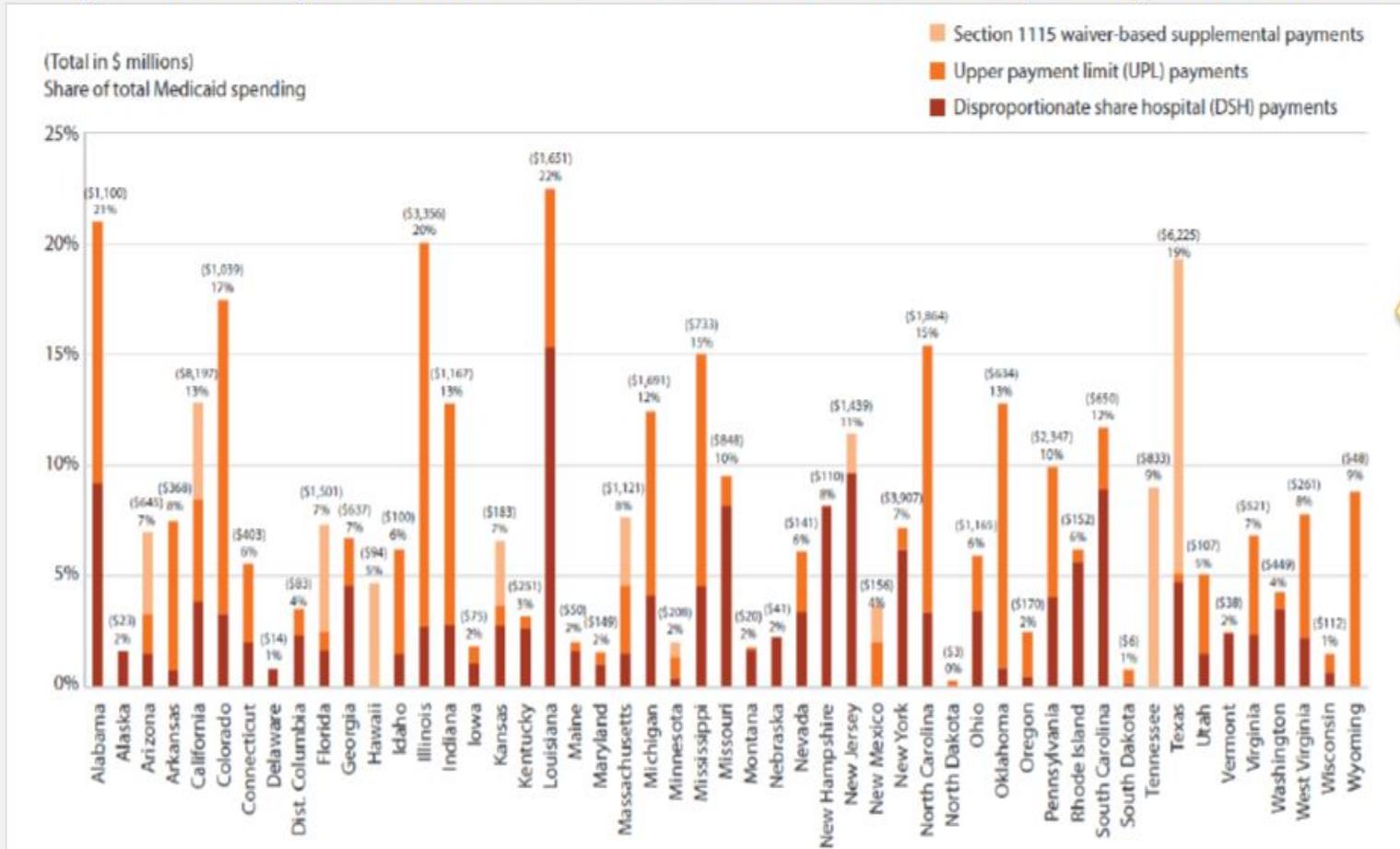
Examples of federal funds for new adult group



Note: Federal funding does not reflect enhanced funding provided by the ACA to states that expanded before the ACA ("early expansion states"). Total federal funding for all expansion adult enrollees (not just those that are newly eligible) from January 2014 - June 2015 was \$78.8 billion.

State Use of Medicaid Creative Financing

Supplemental Payments Per State as a Share of Total Medicaid Spending, Federal FY 2014



The **Patient CARE Act** would include supplemental payments in the cap.

A Better Way excludes DSH and GME from the cap and is silent about other supplemental payments

Moving Forward

- **Consideration of the AHCA now moves to the Senate**
- **No consideration until CBO score is available**
- **Substantial amendments/changes expected**
- **July/August before Senate takes final vote on new/modified bill, and then if bill passes it returns to the House**
- **Key Issues to track:**
 - Medicaid expansion, treatment of state differences in eligibility and funding
 - Medicaid financial restructuring – per capita caps and/or block grants
 - Income adjustments to premium subsidies
 - Pre-existing conditions and essential benefits
- **STAY ENGAGED!**

Republican Replacement Proposals

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Usage of 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

Constants Among the Chaos

- **Pressure to lower overall costs intensifies, but we know too that better quality leads to lower costs**
- **Incentives to coordinate care and manage risk will continue to expand**
- **Technological change can help, but better data and better connectivity absolutely essential**
- **Partnerships and leadership on underlying causes of illness and disparities key**