Healthcare in a Trump World

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June 20, 2017
Poll Question #1

STROUDWATER

Presentation Purpose

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Offer a process for navigating the uncharted health policy waters we're in, and offer strategies for responding to this uncertain period.

Presentation Outline

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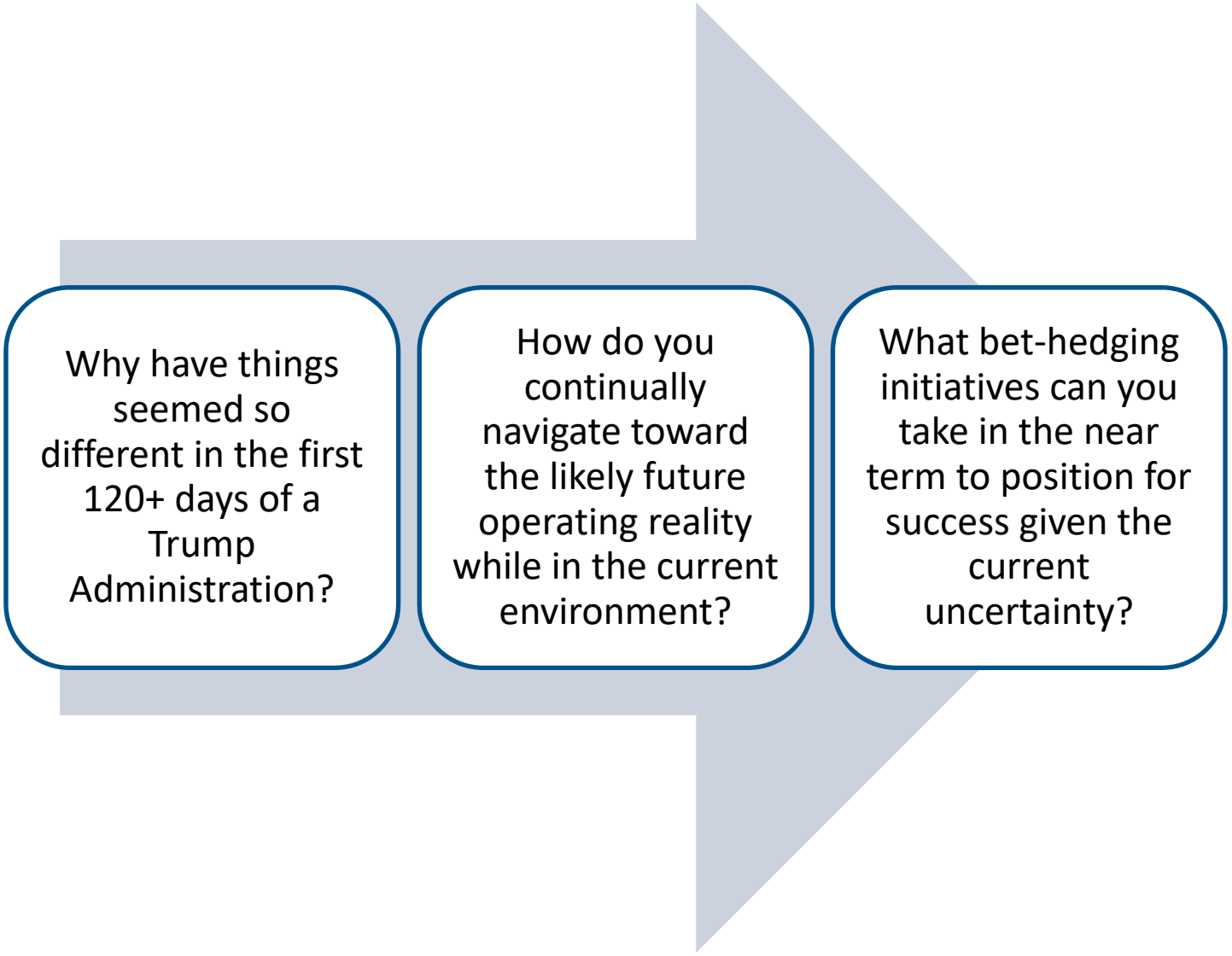

TRUMP: THE FIRST 120 (+) DAYS

End of an 80 Year Progressive Era

FDR Administration: New Deal, 1930s

- "Four Rights" Address: (1) A job and an education (2) Earn enough to buy the necessities (3) Decent housing (4) Medical care and good health

LBJ Administration: Great Society, 1960s, Medicare, Medicaid

Nixon Administration: Early 70's—NHI --- HMO Act

- Policy Theme: Access

End of an 80 Year Progressive Era

Ford Administration: 1974 - Passed legislation initiating CON

- Policy Theme: Supply side cost containment

Carter Administration: 1975 - Shift from universal coverage and NHI to a focus on cost containment

- GDP to healthcare- 8%
- The 10% catastrophe!
- Debt = 35% of GDP
- Policy Theme: Cost containment

End of an 80 Year Progressive Era

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Reagan Administration: "Government is not the solution to our problem; government is the problem" Medicare PPS in 1983

- Policy Theme: Improve Medicare benefits while reducing hospital/physician payments. Forget about NHI

George H. W. Bush Administration: Passage of Stark I prohibiting physicians self-referrals

- Policy Theme: Reduce federal health care spending and fraud and abuse

Clinton Administration: 1993--Hillary Care + HIPPA, Stark II, and CHIP.

- Policy Theme: Expand coverage and create regional delivery systems– control costs with market forces by requiring private insurers to compete

End of an 80 Year Progressive Era

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George W. Bush Administration: Part D Drug coverage, Health Savings Accounts

- Policy Theme: Add benefits because deficits don't matter

Obama Administration: 2,000+ pages of statute + many times this in rules

- Policy Theme: Coverage expansion with innovation and competition to control costs

End of an 80 Year Progressive Era

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Health policy directions have always been discernable

- Improve access (Medicare, Medicaid, CHIP, Part D, ACA)
- Support infrastructure growth (Hill-Burton, NIH, Hi-Tech Act, Cures Act)
- Contain costs by changing incentives (CON Legislation, HMO Act, Hillary Care, Obamacare)
- Improve quality (PROs, Value Based Purchasing, MACRA)

End of an 80 Year Progressive Era

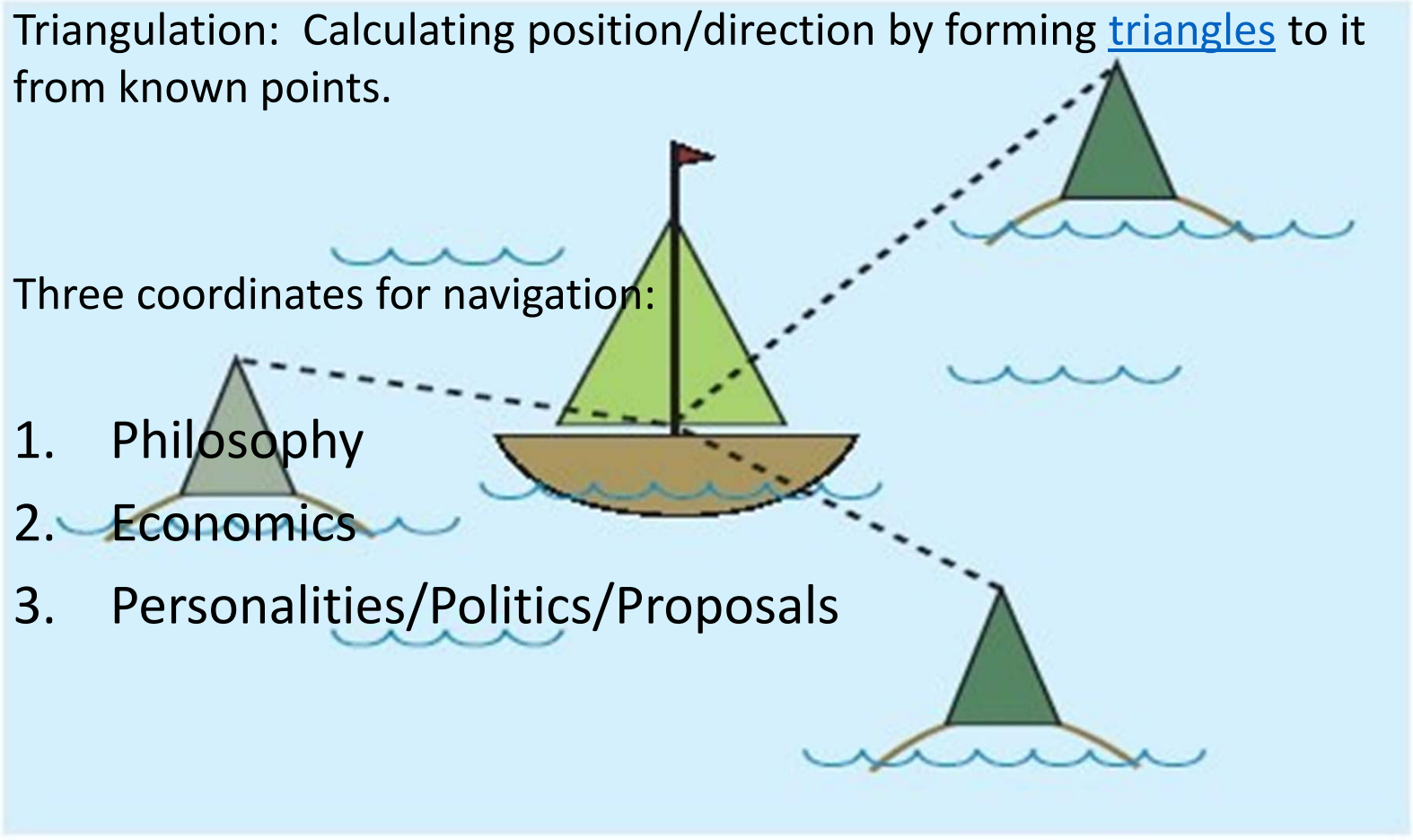
“I never get too attached to one deal or one approach. For starters, I keep a lot of balls in the air because most deals fall out, no matter how promising they seem at first.”

- Donald J. Trump, *The Art of the Deal*

- ✓ ACA Repeal
- ✓ Repeal and Replace-GOP Bill 217-213
- ✓ Repeal and Delay
- ✓ Repeal and Revise
- ✓ Keep existing Medicare
- ✓ Privatize Medicare
- ✓ Universal Coverage
- ✓ Individual freedom to not be covered
- ✓ Sharp reductions in the federal budget

Navigating in a Period of Uncertainty

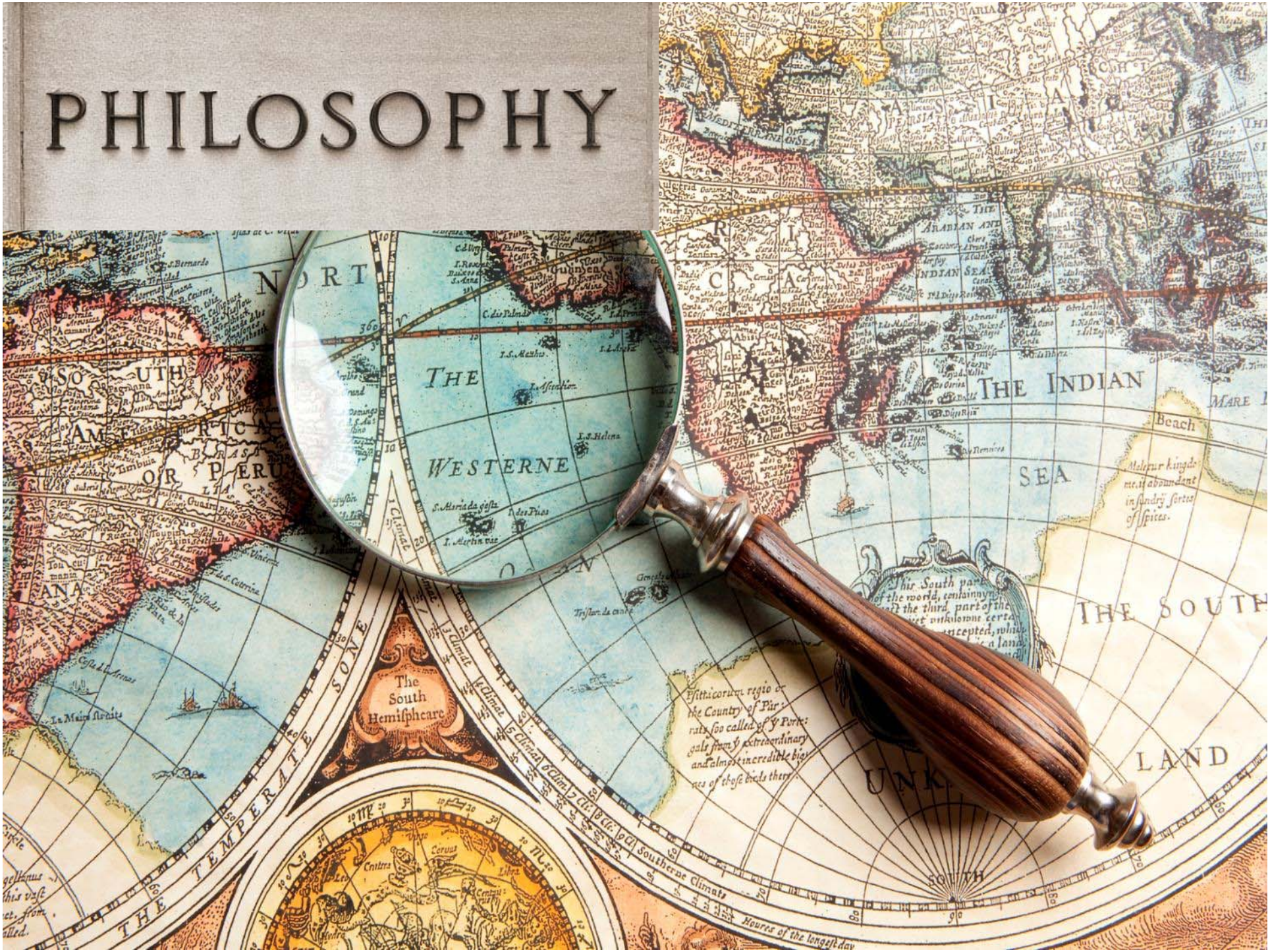
Triangulation: Calculating position/direction by forming triangles to it from known points.



Three coordinates for navigation:

1. Philosophy
2. Economics
3. Personalities/Politics/Proposals

PHILOSOPHY


THE INDIAN
SEA
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LAND
THE
WESTERNE
The South Hemisphere
THE TEMPERATE ZONE
Southerne Climats
Houres of the longest day
SOUTH

Philosophy

Stroudwater

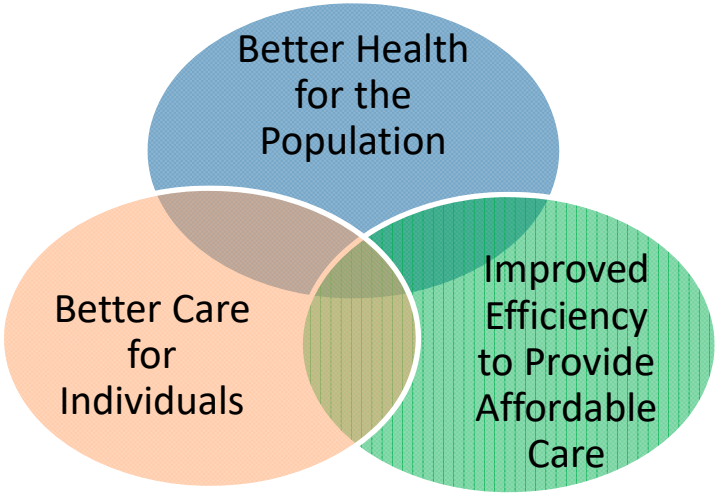
Last 80 years: A philosophical framework rooted in the Progressive Movement's focus on ***social responsibility***

Access (health care and coverage as a right)

Affordability (organize, deliver and pay for care as efficiently as possible)

Quality (high quality as a single standard that does not vary based on individual circumstances)

IHI's TRIPLE AIM



The Trump Administration's Libertarian Philosophy

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Excerpts from the Libertarian Party Statement of Principles

"We, the members of the Libertarian Party**, challenge the cult of the omnipotent state and defend the rights of the individual.**

"We hold that all **individuals have the right to exercise sole dominion over their own lives,** and have the right to live in whatever manner they choose, so long as they do not forcibly interfere with the equal right of others."

Excerpts from the Libertarian Party Statement of Principles

"**All political parties (other than our own) grant to government the right to regulate the lives of individuals and seize their labor without consent.**

"People should not be forced to sacrifice their lives and property for the benefit of others. They should be left free by government to **deal with one another as free traders.** The only economic system compatible with the protection of individual rights is the free market."

LIBERTARIAN
Minimum Government Maximum Freedom

The Trump Administration's Libertarian Philosophy

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Health Care Section of the Libertarian Party's 2016 Platform

"We favor a free-market health care system. We recognize the **freedom of individuals to determine the level of health insurance** they want (if any), the **level of health care** they want, the care **providers they want**, the **medicines and treatments** they use, and **end-of-life decisions**.

"People should be free to purchase health insurance across state lines."

LIBERTARIAN
Minimum Government Maximum Freedom

Turning Philosophy to Policy

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Heritage Foundation:

PHI (Private Health Insurance)

- Repeal the employer tax exclusion and replace it with a universal tax deduction or tax credit for health expenses
- Replace the current tax treatment of health benefits with tax relief that is revenue-neutral/ budget-neutral
- Devolve the regulation of health insurance back to the states, except that:
  - Individuals who receive **and keep** coverage cannot be denied coverage due to pre-existing conditions
  - Individuals who wait until they are sick to enroll in coverage are penalized

LIBERTARIAN
Minimum Government Maximum Freedom

Turning Philosophy to Policy: Heritage Foundation

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✓ **Medicare**

- Spent $692 billion in 2016 covering 58M (81M in 2030).
  - Biggest entitlement: will generate an unfunded liability of $32T to $43T over next 30 years
- Transition the entire Medicare program from defined-benefit system to defined-contribution system (premium support or vouchers), giving consumers choice
- Get rid of 15% cap on payer administrative costs

✓ **Medicaid:**

- 70 million Americans enrolled. Combined federal/ state spend = $554 billion
- Eliminate enhanced funding for the new expansion population
- Allow those currently enrolled in Medicaid—specifically the non-disabled, non-elderly—to opt out of Medicaid and purchase coverage of their choice using existing Medicaid dollars

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Minimum Government Maximum Freedom

Turning Philosophy to Policy

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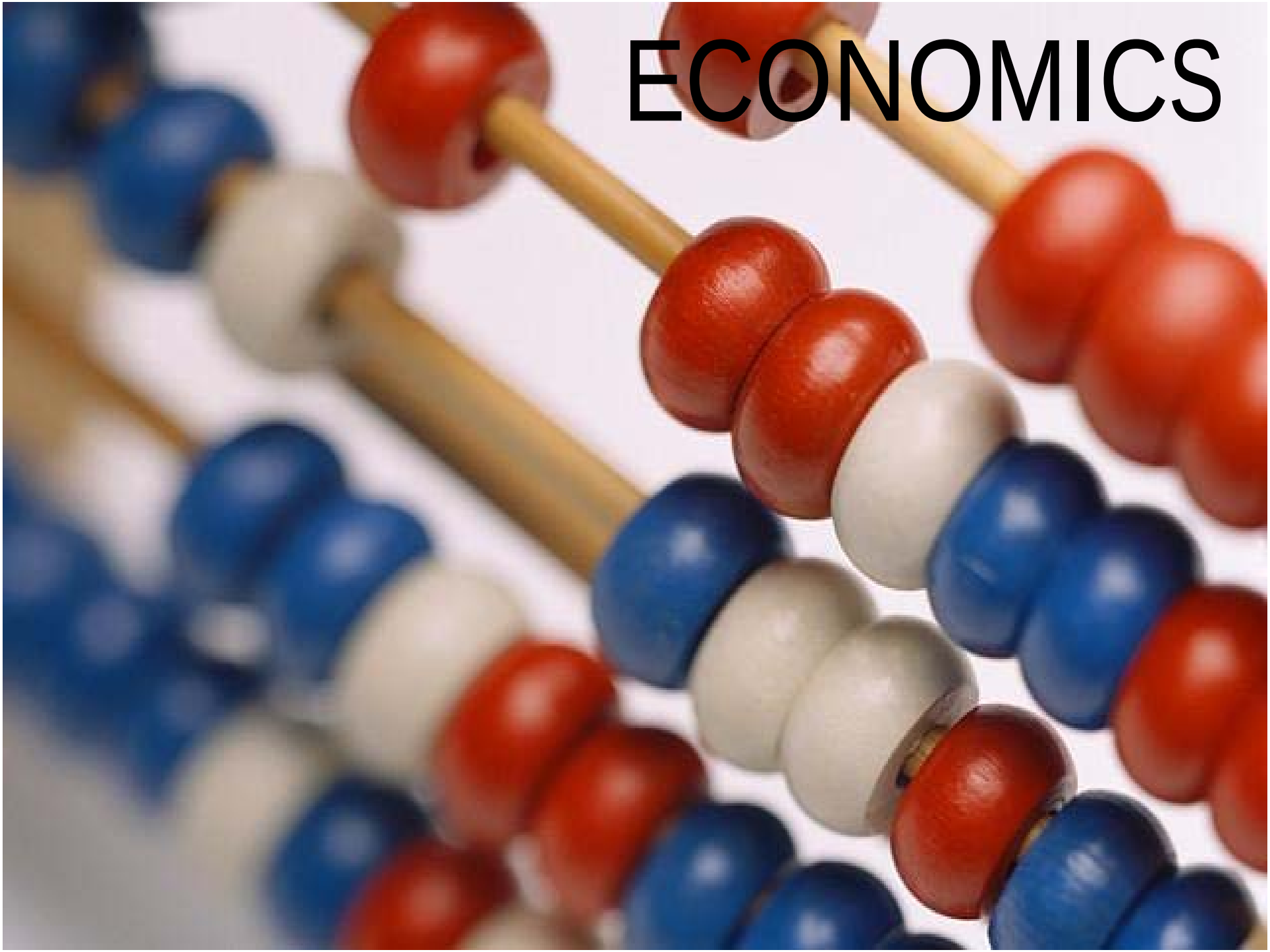
Turning Philosophy to Policy: The Big Shifts		
Social responsibility	Shifts to	Personal responsibility
Taxes to support social programs	Shifts to	Tax cuts (credits/deductions)
Govt. policies/rules to shape services	Shifts to	Dismantle the governments' administrative rules
Govt. as healthcare payer	Shifts to	Individual as payer armed with tax credits


ECONOMICS

Economics

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Debt

Household = $14.2T

Federal = $20.0T

Business = $12.8T

State/Local = $3.0T

Total = $50.0T

2.6 x GDP

$166k per taxpayer

Source: "The United States of Insolvency," Time, James Grant, p.31; USDebtClock.org

Economics

Consumers: Broke

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Underinsurance Rates Among Adults Who Were Insured All Year
by Source of Coverage at the Time of Survey

Percent adults insured all year ages 19–64 who were underinsured*	2003	2005	2010	2012	2014
Total	12%	13%	22%	23%	23%
Insurance source at time of survey**					
Employer-provided coverage	10%	12%	17%	20%	20%
Individual coverage^	17%	19%	37%	45%	37%
Medicaid	22%	16%	32%	31%	22%
Medicare (under age 65, disabled)	39%	24%	45%	32%	42%
Firm size (*Base: Full- or part-time workers with coverage through their own employer*)					
<100 employees	12%	14%	17%	25%	27%
100 employees or more	8%	11%	16%	16%	14%

* Underinsured defined as insured all year but experienced one of the following: out-of-pocket expenses equaled 10% or more of income; out-of-pocket expenses equaled 5% or more of income if low income (<200% of poverty); or deductibles equaled 5% or more of income.
** Adults with coverage through another source are not shown here. Respondents may have had another type of coverage at some point during the year, but had coverage for the entire previous 12 months. ^ For 2014, includes those who get their individual coverage through the marketplace and outside of the marketplace.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005,2010, 2012, and 2014).

Underinsured
- Out-of-pocket expenses 10% of income
- < 200% of FPL or deductibles >5% of income

Source: http://www.commonwealthfund.org/publications/issue-briefs/2015/may/problem-of-underinsurance

The COMMONWEALTH FUND

Economics

Consumers: Broke

- 47% of U.S. workers can't come up with $400 for an emergency
- 71% concerned about covering everyday expenses
- Median net worth down 85.3% from 1983 to 2013 (2013 = $54,000)
- Fragile with a credit card life raft
- LA free clinic: 10,000 patients showed up, a majority *with* health insurance
- Out-of-pocket liabilities in 2015 = $360B

Source: Federal Reserve Board

Economics

Consumers: Broke

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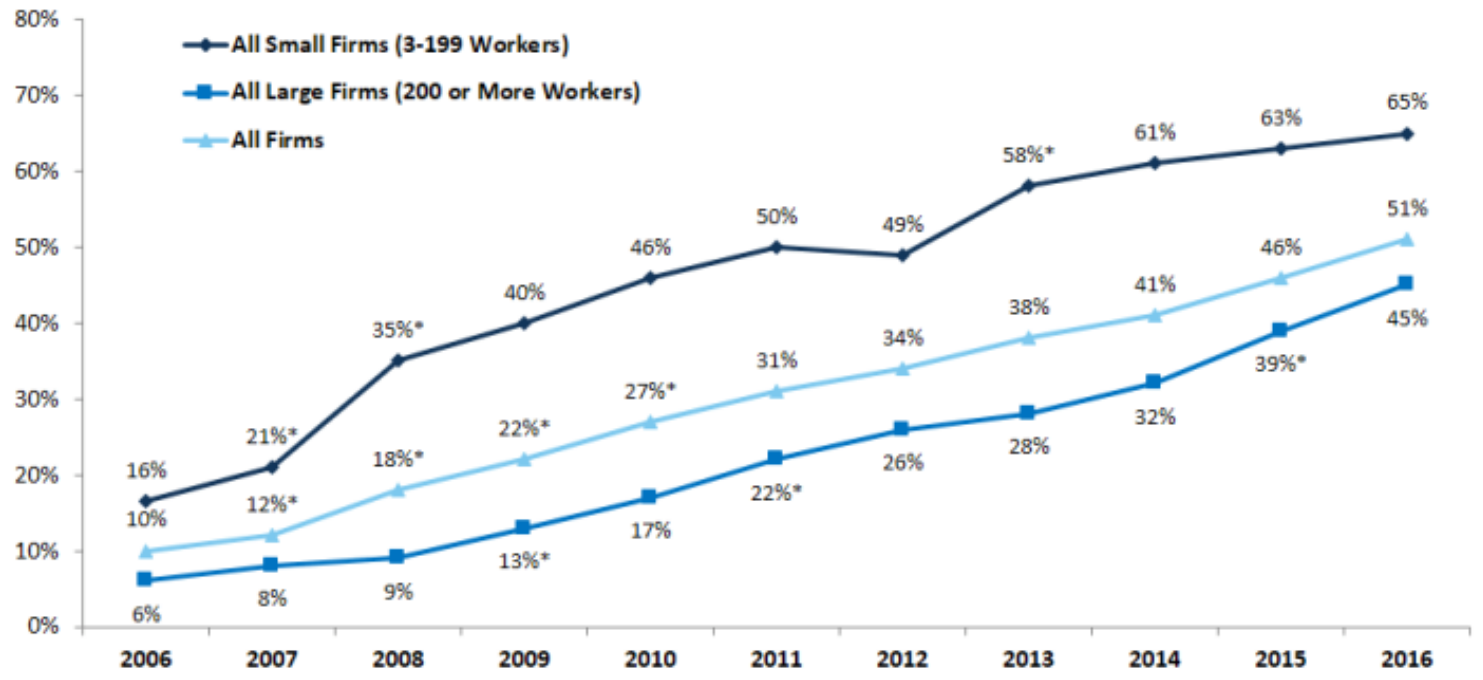
Exhibit F:

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, By Firm Size, 2006-2016



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

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

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2016.

THE HENRY J. KAISER FAMILY FOUNDATION

Economics

Economics: The Big Shifts		
Significant levels of benefit coverage	Shifts to	High deductibles
Modest focus on pre-tax HSAs	Shifts to	HSAs as a major source of funding
Reasonable level of individual liquidity	Shifts to	Very limited individual liquidity
Room for more Federal leveraging	Shifts to	Federal deficit about to exceed GDP

Poll Question #2

PERSONALITIES, PROPOSALS, AND THE POLITICS OF HEALTHCARE REFORM

Personalities: Drivers of Health Policy Reform

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A Fractured Republican Party. *There is no clear, ideological center to the fractured Republican congressional caucus.*

- **Tea Party/Freedom Caucus wing**, rooted in a libertarian-leaning, "disruptive" conservatism
- **Establishment Republican wing**, still oriented on conservative-oriented policy reform but less ambitious in anticipated outcomes

Orbits of Influence. Personalities at various orbits of influence and proximity to the President that ultimately shape ideological direction of any healthcare reform bill.

Politics: Make America Vote Trump Again

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The Battle Plan:

1. Reconciliation repeals Obamacare taxes, spending and mandates [Requires Senate simple majority]
2. HHS deregulates the marketplace through administrative action to eliminate rules and letters of guidance
3. Pass legislation for new initiatives like inter-state insurance sales, etc. [Requires 60 Senate votes to overcome filibuster]

A Likely Point of Policy Stability: MACRA

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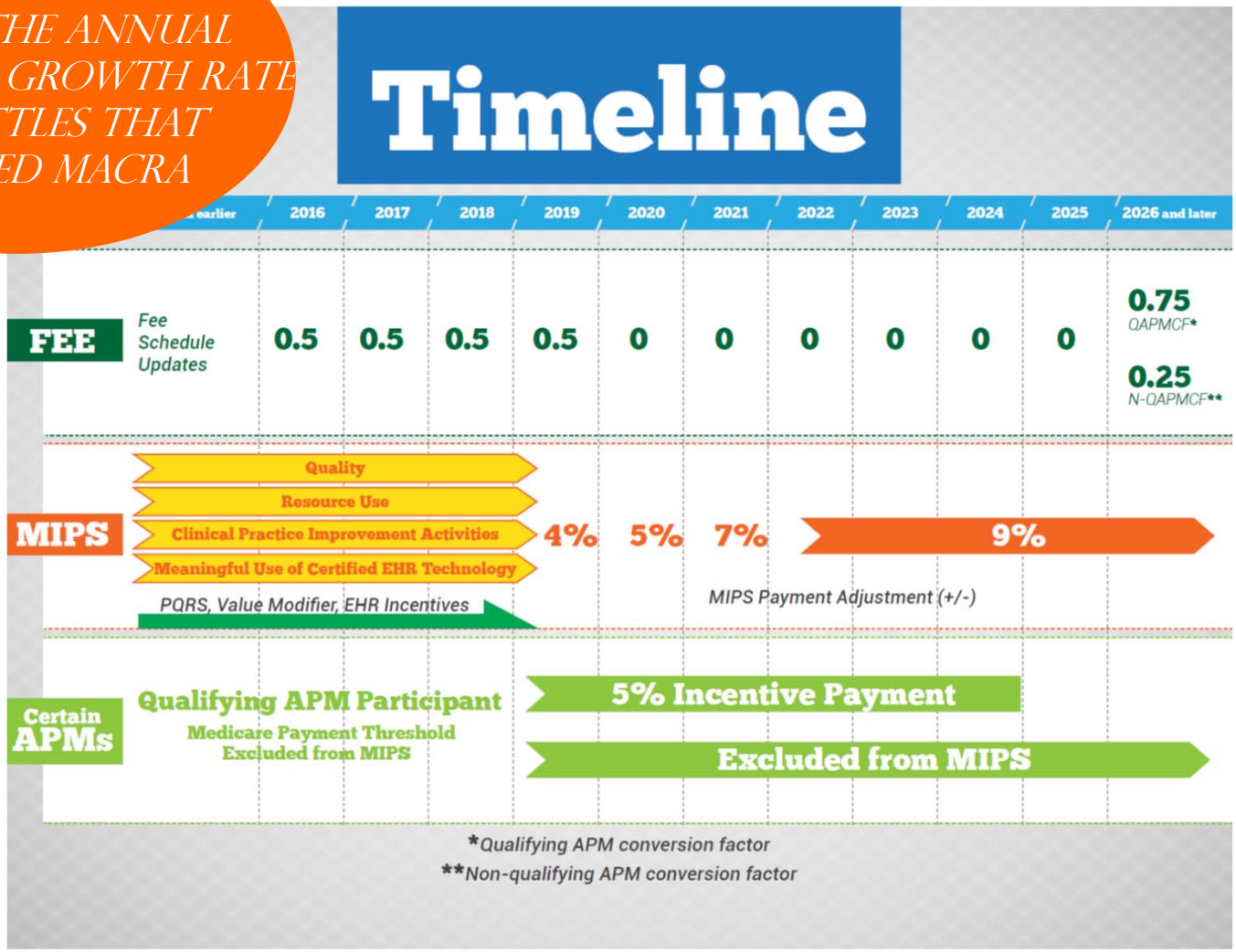
NO APPETITE FOR GOING BACK TO THE ANNUAL SUSTAINABLE GROWTH RATE (SGR) BATTLES THAT PRECEDED MACRA



Source: https://qpp.cms.gov/

The Republican Plan: American Healthcare Act (March 6, 2017)

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COMMITTEE PRINT

Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act

TITLE I—ENERGY AND COMMERCE

Subtitle A—Patient Access to Public Health Programs

SEC. 101. THE PREVENTION AND PUBLIC HEALTH FUND.

AHCA – Innovation Grants

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High Risk Pools

- Preliminary budget number $138B over 10 years
- Flexible, but used to:
  - Revive a high-risk pool that has gone dormant since the ACA's passage
  - Lower the premiums for the standard risk pool

The reality: Per Kaiser Family Foundation and its "more conservative estimates," $25B needed each year to fund high-risk pools, or $250B over 10 years.

$122B shortfall

ACA "Repeal and Replace" Timeline

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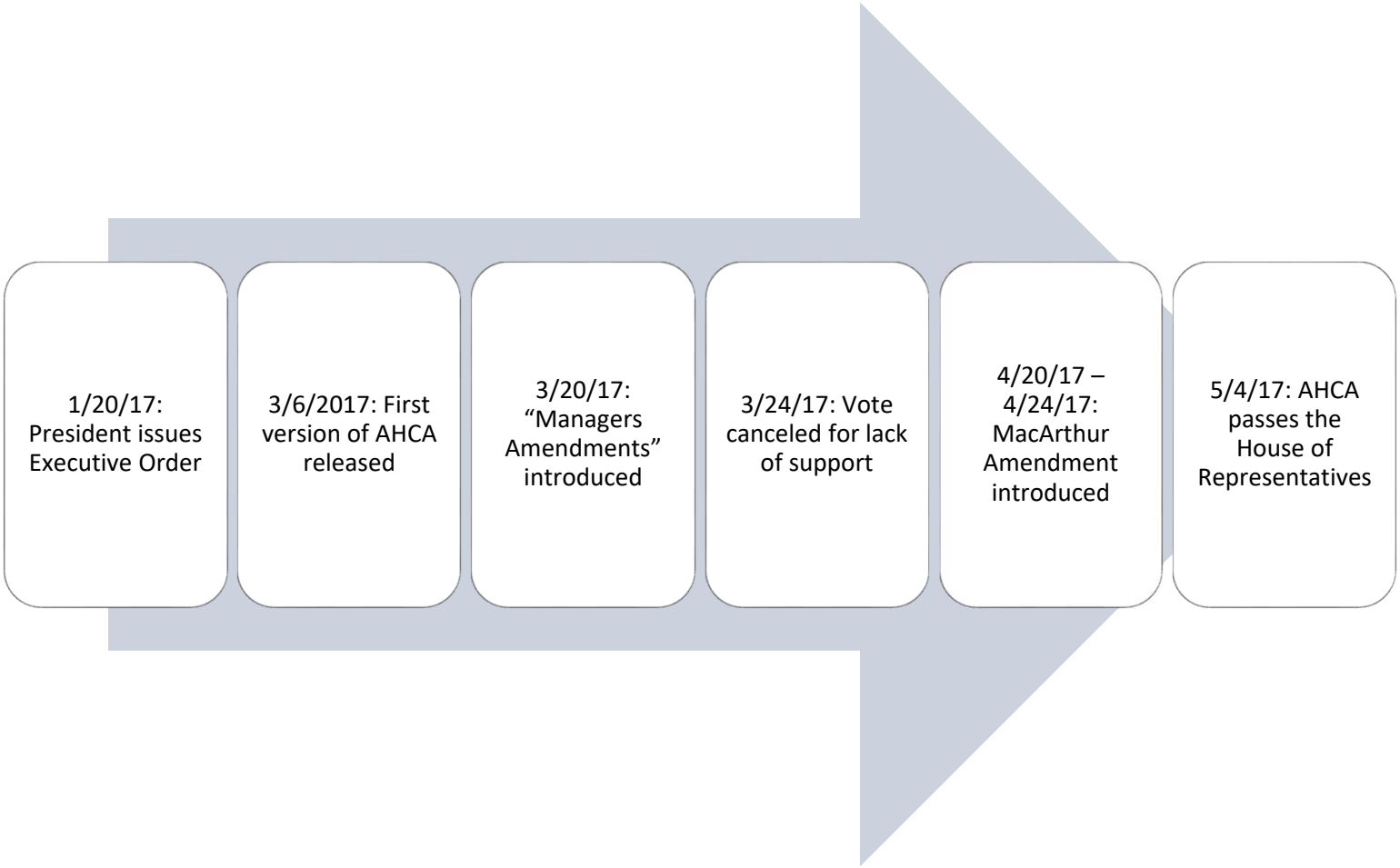

The AHCA versus the ACA

	ACA	AHCA (proposed)
Medicaid	• The federal government and states share the cost of insuring the poor • The federal government is almost entirely funding Medicaid expansion in the states that have chosen to do so	• Move to a "block grant" structure in 2019 • Funding for Medicaid expansion would be eliminated by 2020
Insurance Costs	• People using healthcare marketplaces and making less than $48,000 a year receive subsidies to help them buy insurance • The amount of the subsidy is tied to a person's income and to the cost of insurance in the person's area • The subsidies are automatically applied to the consumers' monthly insurance bills rather than having to wait for a rebate	• People would receive refundable tax credits, which would phase out at incomes of $75,000 per year; credits of $2,000 - $4,000 per year • Credit would be tied to a person's age, not income • The credit would offset the cost of annual insurance premium in the individual market • Permitted annual contributions to HSA increased to $6,550 (individual) and $13,100 (family)

Source: Los Angeles Times, *A side-by-side comparison of Obamacare and the GOP's replacement plan*, Noam N. Levy and Kyle Kim, 3/8/17 updated 5/24/17 http://www.latimes.com/projects/la-na-pol-obamacare-repeal/

The AHCA versus the ACA

	ACA	AHCA (proposed)
Insurance Mandate	• A person is required to purchase health insurance or pay a tax penalty	• No tax penalty, but a 30% premium surcharge for those who let insurance lapse for two months
Guaranteed Coverage	• Americans are able to get health insurance even if they're sick • Insurers are barred from charging sick consumers more for coverage • Insurers cannot impose annual or lifetime limits on coverage • Insurers must offer a basic set of benefits, including mental health, prescription drugs and maternity care • Insurers cannot charge older consumers more than three times more than younger consumers	• States can scale back benefits that insurers must cover, arguably in place to provide consumer protection • States would also be able to opt-out of the minimal essential benefits • Insurers would have greater flexibility to structure premiums based on the insured's risk profile E.g. Insurers would be able to charge older consumers five times more than younger consumers, a reversion to pre-ACA standards for health plans

Source: Los Angeles Times, *A side-by-side comparison of Obamacare and the GOP's replacement plan*, Noam N. Levy and Kyle Kim, 3/8/17 updated 5/24/17 http://www.latimes.com/projects/la-na-pol-obamacare-repeal/

The AHCA versus the ACA

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	ACA	AHCA (proposed)
Insurance Marketplaces	• The Obamacare marketplaces enable people who don't get health benefits at work to compare plans • All plans on the marketplaces must offer a basic set of benefits, such as hospital care, mental health services and prescription drugs	• It is unclear how the marketplaces would work because insurers might potentially offer health plans that do not offer the same set of benefits
Women's Health	• Insurance companies cannot charge women more than men for the same health plan • Insurers are required to provide a basic set of benefits including maternity care, pediatric care and contraceptives • Planned Parenthood receives federal funding for family planning and other medical services used by Medicaid recipients. Abortion cannot be funded with federal dollars.	• Insurance companies would still be banned from charging women more • States could seek waivers to allow insurers to drop some basic benefits, such as maternity care and contraceptives • Medicaid would no longer have to offer these benefits, which would impact low-income women • Medicaid would be barred from providing funding for any health clinics that provide abortion services, including Planned Parenthood
Taxes	• Insurance companies and medical device makers, which benefit from new customers under the law, pay more taxes • Taxpayers with incomes over $250,000 are also taxed more	• Medical device makers, insurance companies and wealthy Americans would all receive a tax cut as these taxes are eliminated • The tax cuts total about $663 billion over the next decade

Source: Los Angeles Times, *A side-by-side comparison of Obamacare and the GOP's replacement plan*, Noam N. Levy and Kyle Kim, 3/8/17 updated 5/24/17
http://www.latimes.com/projects/la-na-pol-obamacare-repeal/

American Health Care Act: Manager's Amendments 3/20/17

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GOP changes primarily designed to win over more conservative members and those concerned about CBO projections that the bill will make insurance less affordable for those 50-64

- **Tax Sunset**. End most of the ACA's taxes at the end of this year, one year earlier than original bill
- **End Medicaid Expansion**. Bar any new states from expanding Medicaid to low-income adults and receiving enhanced federal funding for that population
- **Work Requirement**. Establish a work requirement for Medicaid enrollee adults who aren't disabled, elderly or pregnant
- **Medicaid Funding Reform**. State option to receive federal Medicaid funding in the form of fixed block grants (not based on number of enrollees), or in the form of per capita allocations
- **Cost Inflation**. Increase the growth rate of capped federal payments to the states for elderly and disabled beneficiaries by the medical component of the consumer price index plus one percentage point; the growth rate for other beneficiary groups would be the medical component of CPI, which lags behind actual per-capita Medicaid spending by 0.7 percentage points, according to the CBO
- **Cadillac Tax**. Delay implementation of the ACA's excise tax on high-value employer health plans for an additional year, from 2025 to 2026

Modern Healthcare 3/20/17 *GOP leaders amend ACA repeal bill, mostly to the right* by Harris Meyer

The MacArthur Amendment 4-13-17

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- House Republican leadership pulled AHCA from a scheduled floor vote due to lack of support in March
- Afterwards, Tom MacArthur (R-NJ), co-Chair of the House Republican Tuesday Group (moderate faction) and Mark Meadows (R-NC) of the Freedom Caucus began meeting to develop a compromise package
  - **Reinstate Essential Health Benefits** at the federal standard (allow for state waivers for benefits including emergency services, maternity care, and mental health/substance abuse services)
  - **Maintain** the following provisions of the AHCA:
    - ✓ Prohibition on: Denying coverage due to preexisting conditions
    - ✓ Guaranteed: Issue of coverage to all applicants, coverage renewal, coverage for dependents up to 26
    - ✓ Community Rating Rules: No underwriting based on gender, health status (unless eligible for high risk pool), or age (except 5:1 age related ratio)
  - **Conventional Wisdom:** The more that the bill changed to get through the House, the less chance it has of surviving the Senate

Source: MacArthur Amendment to the American Health Care Act 4/13/17 via POLITICO
http://www.politico.com/f/?id=0000015b-8ab0-df96-a9db-dff115c30001

Updated CBO Report 5/24/17

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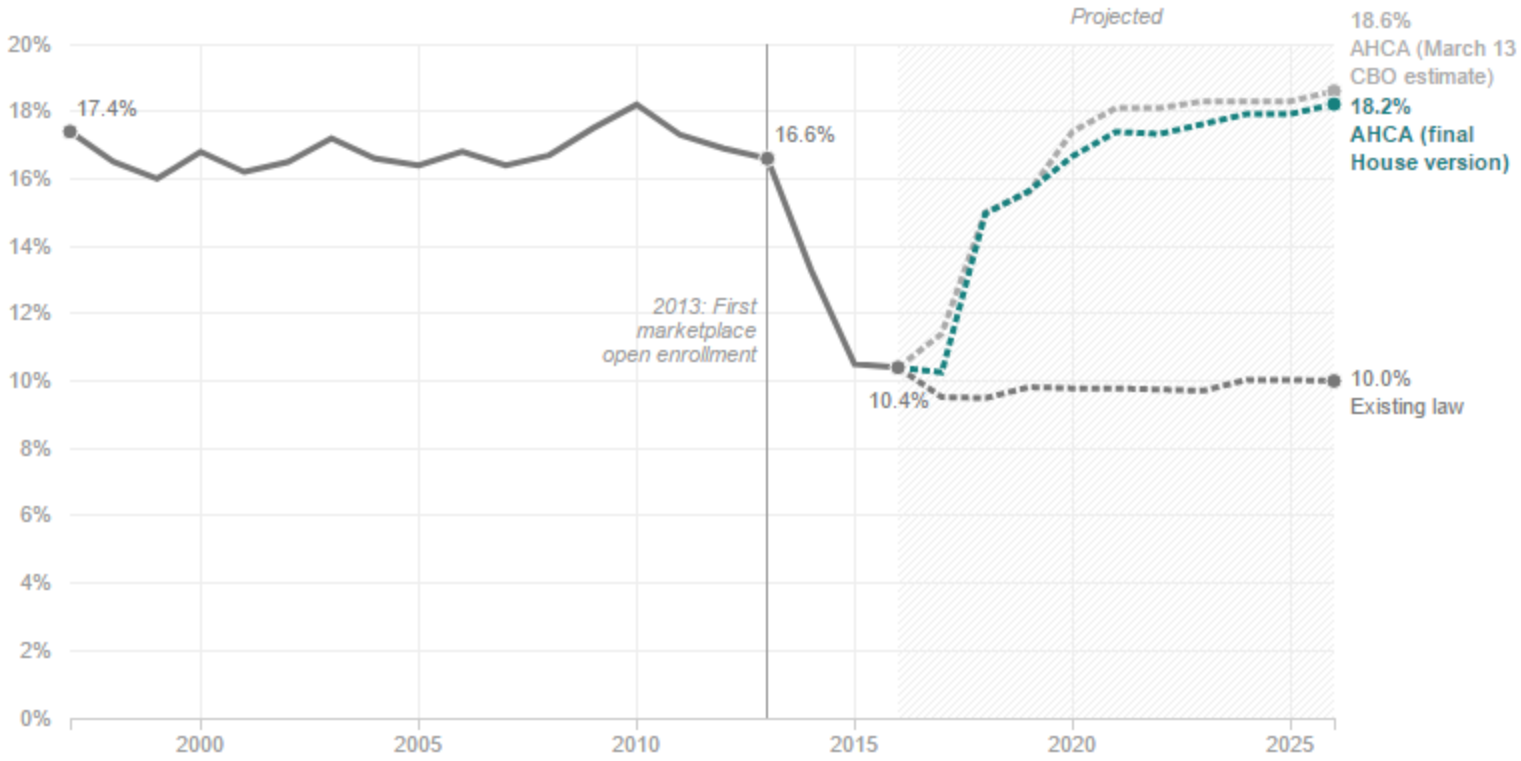
Share Of Uninsured U.S. Residents Would Rise Under GOP Plan

Estimated share of U.S. residents under age 65 who are uninsured



Source: National Health Interview Survey, Congressional Budget Office (March 13, May 24)

Credit: Alyson Hurt/NPR

Source: NPR.org http://www.npr.org/2017/05/24/529902300/cbo-republicans-ahca-would-leave-23-million-more-uninsured

Updated CBO Report 5/24/17

Revised AHCA will leave 23 million more people uninsured in 2026 than if the ACA were to remain in place

More than half of that increase in the uninsured — 14 million — would come from reduced Medicaid enrollment

Medicaid would face $834 billion in cuts

*"IN PARTICULAR, OUT-OF-POCKET SPENDING ON **MATERNITY CARE** AND **MENTAL HEALTH** AND **SUBSTANCE ABUSE** SERVICES COULD INCREASE BY THOUSANDS OF DOLLARS IN A GIVEN YEAR FOR THE NONGROUP ENROLLEES WHO WOULD USE THOSE SERVICES," – CBO REPORT*

Source: NPR.org http://www.npr.org/2017/05/24/529902300/cbo-republicans-ahca-would-leave-23-million-more-uninsured

6/6/17: ACA Repeal Senate Vote Is Imminent, Despite Uncertainty

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- The Washington Post (6/6) reports top Senate GOP lawmakers "**are aiming to conclude their perilous and divisive effort to rewrite the nation's health-care laws as soon as late this month,** giving themselves only weeks to resolve substantial disagreements and raising the possibility that their push will collapse."
- The AP (6/6) reports that "even as senators headed toward a make-or-break vote before the Fourth of July, **deep uncertainty remained about whether the emerging legislation would command enough support to pass."**
  - As a result, senators "spent time discussing a fallback plan that would involve a stopgap measure to stabilize insurance markets."
- According to Politico (6/6), GOP senators **"can lose only two votes and still repeal and replace the law via a fast-track process that sidesteps Democratic filibusters."**

Source: AHLA Health and Life Sciences Law Daily 6/7/17

CMS Actuary: Estimated Financial Effects of the AHCA

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Over fiscal years 2017-2026, selected provisions of the AHCA are anticipated to **reduce Federal expenditures by over $328 billion primarily because of lower Medicaid spending.**

In 2018, the **number of uninsured is estimated to be about 4 million higher** under the AHCA than under current law, mainly due to the impact of repealing the individual mandate. By 2026**, the number of uninsured is estimated to be roughly 13 million higher under the AHCA,** mostly as a result of

- Declines in eligibility for Medicaid
- The impact of the repeal of the individual mandate
- Net reduction to the subsidies available for the purchase of individual insurance

In 2026, Medicaid enrollment is estimated to be 8m lower under the AHCA than under current law due to the combination of two factors: (i) a decline of 6 million in enrollment for newly eligible adults under current law and (ii) a decline of 2 million in enrollment for all other Medicaid enrollees attributable to more frequent eligibility redeterminations, the repeal of retroactive eligibility, and optional State work requirements for adults.

When this effect is combined with the implementation of per capita allotments as specified under the AHCA, overall Medicaid spending is estimated to be $105 billion, or nearly 11 percent, lower under the AHCA than under current law in 2026.

Source: CMS Office of the Actuary Memorandum 6/13/17 “Estimated Financial Effect of the “American Health Care Act of 2017”

ACA vs. AHCA: National Health Expenditures

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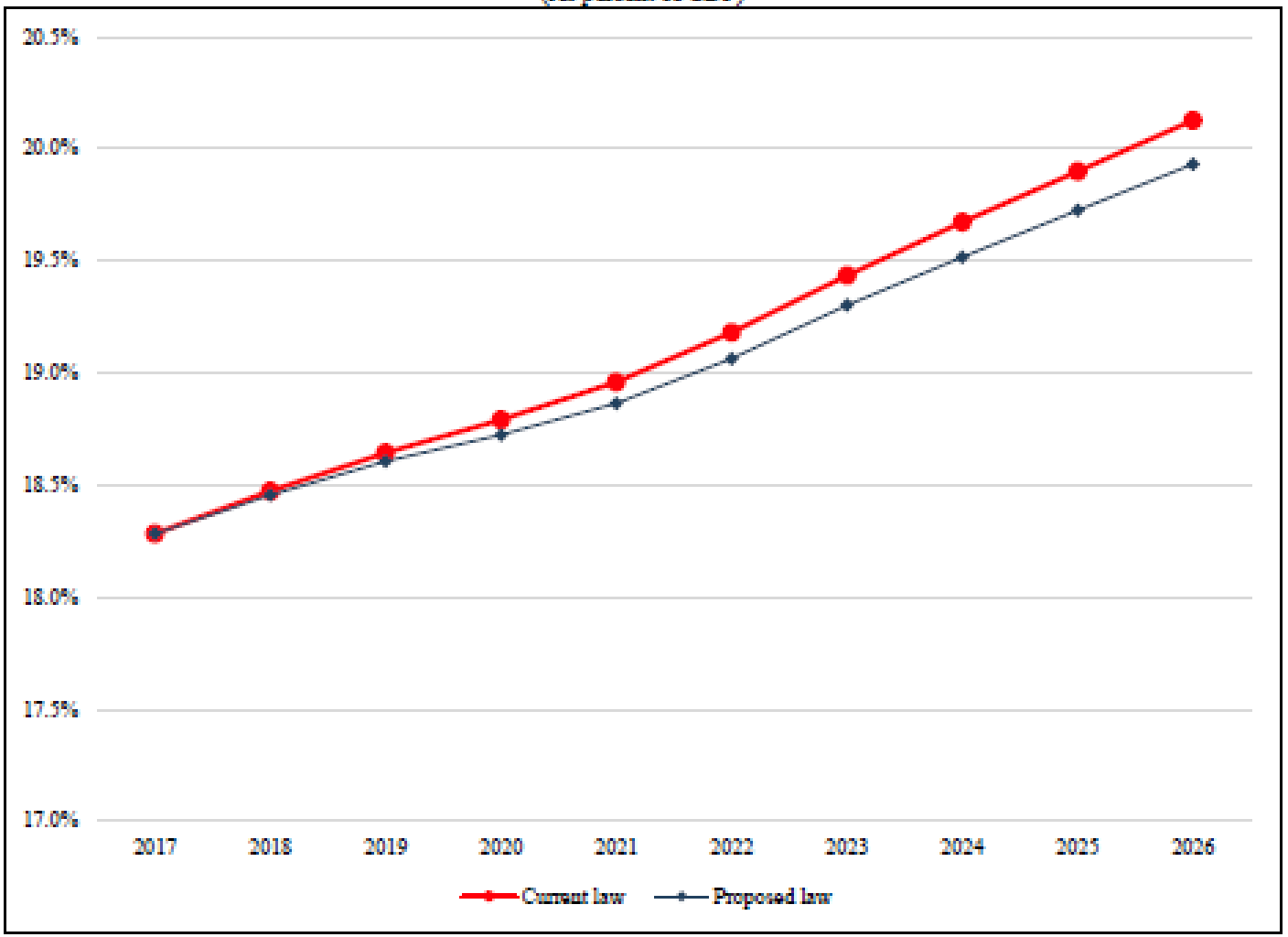
Exhibit 9—Estimated Effect of the American Health Care Act of 2017 on National Health Expenditures
(As percent of GDP)



Source: CMS Office of the Actuary Memorandum 6/13/17 "Estimated Financial Effect of the "American Health Care Act of 2017"

If Legislative Efforts Are Abandoned…

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- Look for a hard pivot to healthcare reform a la the administrative state (i.e., regulatory rule making and waiver processes through HHS and CMS).
- President Trump's Inauguration Day Executive Order on healthcare, while largely symbolic, provides executive branch agencies with the basis for promulgating rules and regulations that relax/erode various aspects of the ACA.
  - E.g.: State waiver applications for Medicaid (section 1115) and private health insurance markets (section 1334)
  - Per Secretary Price and Administrator Verma, goal is to encourage more "consumer-directed healthcare" and "increase consumer choice."
    - Greater reliance on HSAs as features of Medicaid and private health insurance plans
    - State flexibility in insurance plan coverage requirements
- Take-away: Less federal financial exposure for healthcare spending.

  Who picks up the tab?

Personalities/Proposals/Politics

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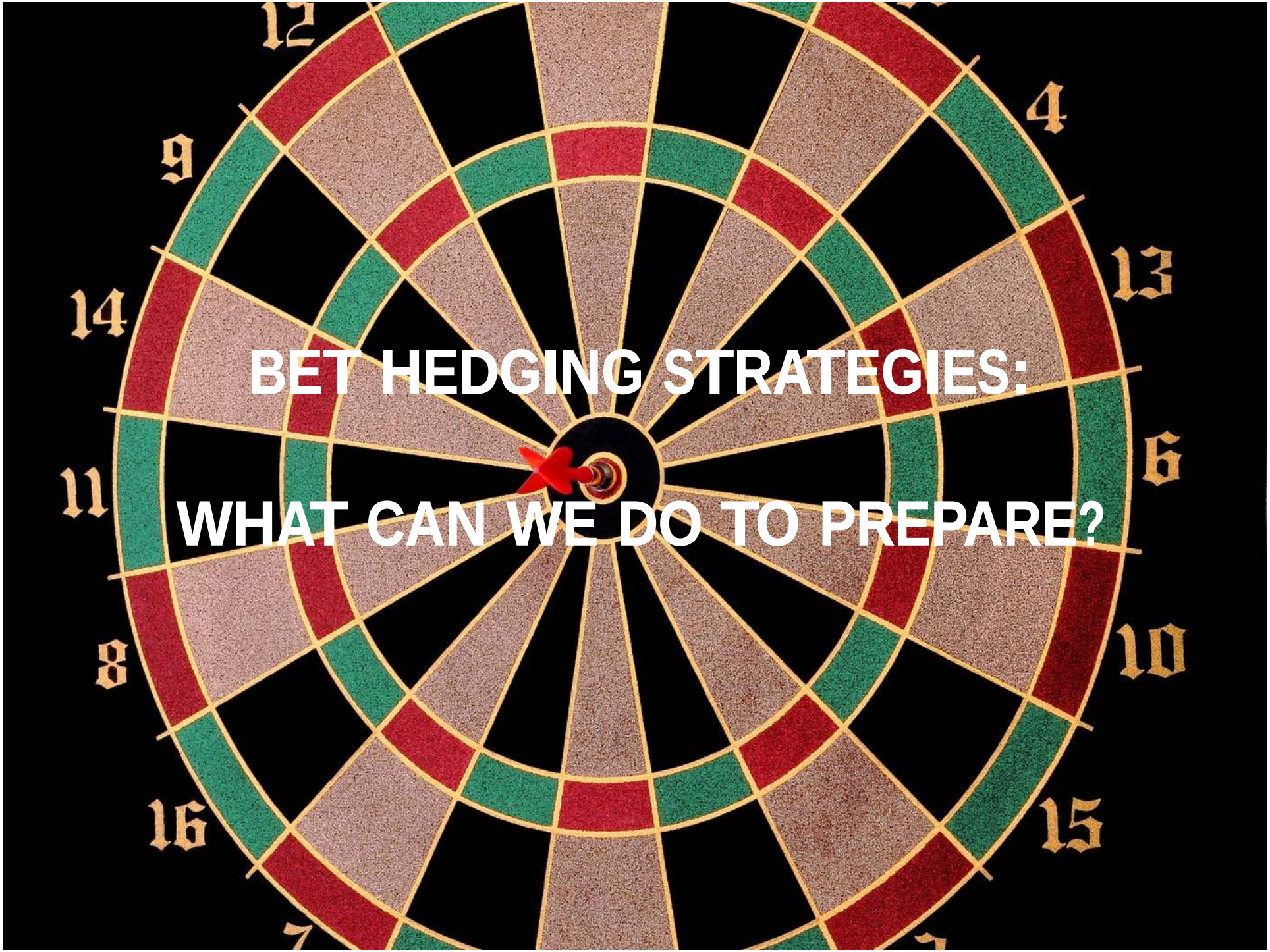
Personalities/Proposals/Politics: The Big Shifts		
Personalities embrace progressive philosophies	Shifts to	Personalities are variously committed to libertarian values
Coherent policy agendas by each party	Shifts to	Major disagreements in each party and big commitment is to the art of the deal (*i.e.*, getting something done)
Generally passive electorate	Shifts to	Increasingly activist electorate
Developing policy directions via legislation	Shifts to	Developing policy directions via budget appropriations, executive orders, and regulatory process

Poll Question #3


BET HEDGING STRATEGIES:
WHAT CAN WE DO TO PREPARE?

Bet Hedging Strategies for Smart Operators

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1. People with growing personal financial exposure are going to shop hard. Pricing and the consumer experience is going to matter – a lot. Act on this.
    - More of our clients are reviewing their charge masters and pricing strategies, particularly for key community-based competitive services where there is meaningful price/service competition.
    - Customer experience counts (particularly with millennials). Begins with the first phone call and goes right through the billing/collection process.
        - This can move market share!
        - Make a formal effort to shift from a provider perspective to patient perspective of your service experience
        - Distributed care delivery
        - White labeling Amwell for 24/7 on-demand care primary care availability

Bet Hedging Strategies for Smart Operators

STROUDWATER

2. Payer mix will move at the margins:
    - More Medicaid share if 1115 Waiver is implemented in non-Medicaid expansion states
    - More self-pay as subsidized Exchange coverage is switched to $2,000 - $4,000 tax credits
    - More medical indigent population as Exchange subsidies disappear
    - In the longer run, potential reductions in Medicare benefits if Ryan priority to move to vouchers or premium support (i.e., defined contribution) is enacted
    - Begin to develop strategies by payer category (Medicaid, Medicare, Indigent, Commercial) that address the different market/competitive realities of each

Bet Hedging Strategies for Smart Operators

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3. Get really good at point-of-service collections. This form of payment will grow in parallel with high deductibles, HSAs, and reductions in coverage.
    - Every professional service registration and discharge process needs to have a scripted approach to dealing with these collection opportunities.

Bet Hedging Strategies for Smart Operators

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4. Get lean! Make a commitment to get to benchmark performance in terms of cost and operations. This period could eventually create the same kind of margin pressure that off-shoring of manufacturing did for many businesses in the past two decades.
    - In applying Accelerated Operations Improvement tools with clients, we have yet to find an enterprise where there is not 2% - 3% minimum potential for increasing operating margin.
    - Determining where the operational performance improvement opportunities are during a period characterized by strong margins and liquidity is a tough but useful discipline.

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5. Take a full-court press approach to reducing losses related to your employed physicians/providers.
    - The average hospital loss per employed provider nationally is $190k. Some of our clients are losing more than the hospital's margin on their practices.
        - Our experience is no "magic bullet" techniques. Multivariate review of everything from "top of license" service delivery to revenue cycle.
    - Get out in front of MACRA–it's not going away, and will make a meaningful difference in revenue over the next few years.

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6. Consider strategies ranging from direct contracting with employers to creating opportunities to contract with payers using upside risk and managing full risk when you have the population management skills.
    - The single biggest new margin opportunity is managing care (and the Medical Loss Ratio) so that budgeted payments exceed the cost of delivering care to defined populations.
    - Use your own enrolled employee population (already a full-risk line of business if self-funded) to learn how to manage care (and risk—e.g., stop-loss and epidemic supplements) so these learnings can be applied elsewhere.

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7. Engage in ongoing capital structure planning. Consider whether your real estate portfolio makes sense. Ask whether you should consider taxable bonds as a leverage option that provides more flexibility regarding investment positioning.
    - If you enjoy a strong balance sheet, you have the ability to think and act strategically in support of organizational mission. This flexibility can erode quickly during times of unprecedented and unpredictable change such as the current moment…
    - If you have a weak balance sheet, reconsider whether certain assets are core vs. non-core to overall organizational mission.

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8. Generate routine what-if financial projections that provide a sensitivity analysis of the impact of various scenarios. Share with the Board.
   - The scale of the range estimate impact of various federal and state health policy initiatives is unprecedented. Conduct scenario financial planning to understand the impact of various possibilities.
   - This enables leadership to consider options in a concrete way vs. succumbing to hoping for the best or fearing the worst.

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9. While short-run environmental impacts are foggy, the long run is actually more predictable.
   - Federal budget deficits make it almost inevitable that Medicare and Medicaid will both end up defined contribution programs (i.e., budget limited funds per capita) vs. the open-ended federal liabilities that they are now.
   - Technology is going to increasingly become a resource for leveraging every aspect of healthcare. From Artificial Intelligence to robots to big data, it will be a key source of accreting new levels of value. Take an organized approach to knowing what is working.
   - Continuing to push for quality and safety will provide financial, market, and mission based returns. Success will reside at the confluence of value based payment, reputation, recruitment/retention, and mission.
   - Learning to effectively manage population-based risk will end up an enterprise skill that can be monetized in the long run.

Poll Question #4

Thank you

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