GETTING *MUCH* CLOSER TO THE COST PRECIPICE

EXECUTIVE SUMMARY

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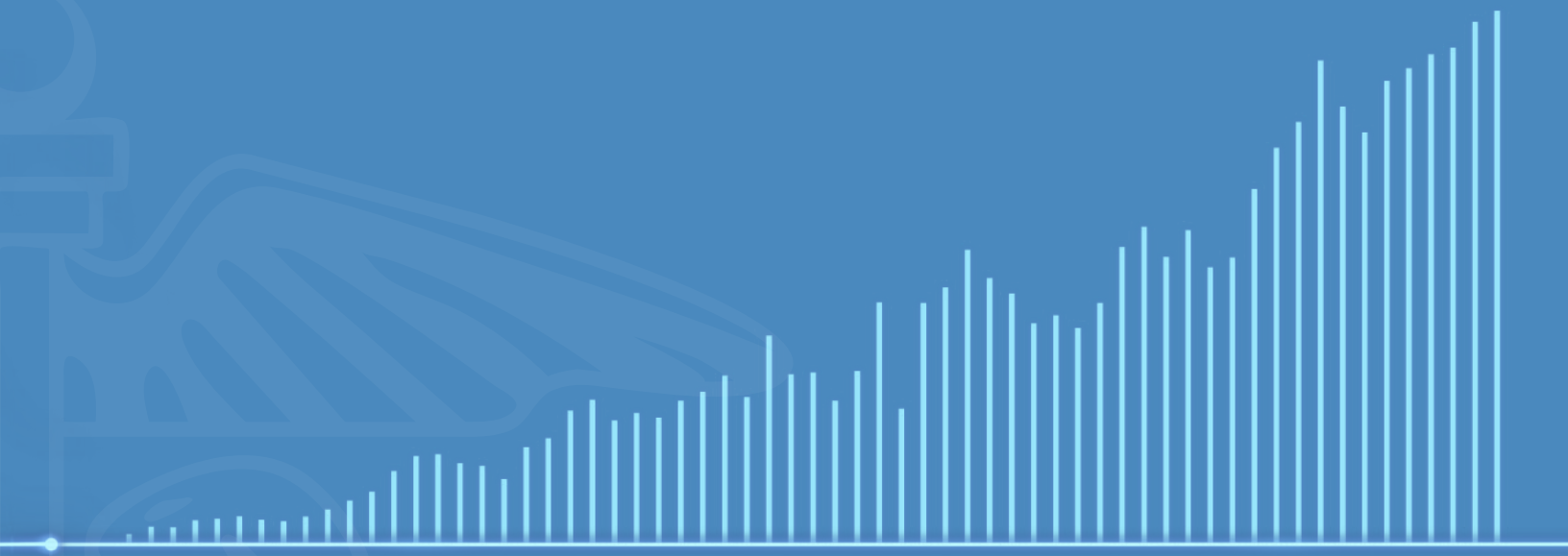


HEALTHCARE: GETTING *MUCH* CLOSER TO THE COST PRECIPICE

U.S. healthcare expenditures have reached crisis proportions, accounting for 17.7 percent of the GDP. Cost estimates from the Congressional Budget Office and the Centers for Medicare & Medicaid significantly understate the likely financial impact of an aging population, not adequately focusing on the five percent of the population accounting for 50 percent of costs. With the cost precipice fast approaching, the U.S. healthcare system is in great need for disruptive transformation.

The Patient Protection and Affordable Care Act (PPACA) is not about transforming the healthcare delivery system. Rather, it is about slowing the rate of Medicare payment increases, selectively reducing Medicare expenditures, exploring new payment models and imposing new taxes. The PPACA increases insurance coverage without adequate consideration of a growing shortage of primary care physicians and a growing need for chronic disease management. Healthcare delivery in the U.S. is mired in reimbursements, with shareholder focus on revenue maximization, and a lack of attention being paid to patient outcomes. With a rapidly aging population increasing demand for services and highlighting system inadequacies, traditional approaches to cost containment, such as provider discounts and cost shifting, will not suffice. There must be a strategic focus on leadership, execution and change management.

The following fact-based analysis, which contains nearly 200 identified references, is a must-read for every concerned U.S. citizen. Alvarez & Marsal's Healthcare Industry Group analyzed the $2.6 trillion healthcare sector to better understand the potential impact of the PPACA. This analysis takes a convergent view across the healthcare industry spectrum, incorporating multiple vantage points; from clinical medicine to hospital system C-suites and employers; from the finance community to public policy leaders.

We invite you to take a seat at the table in this important debate.

Guy Sansone
Managing Director

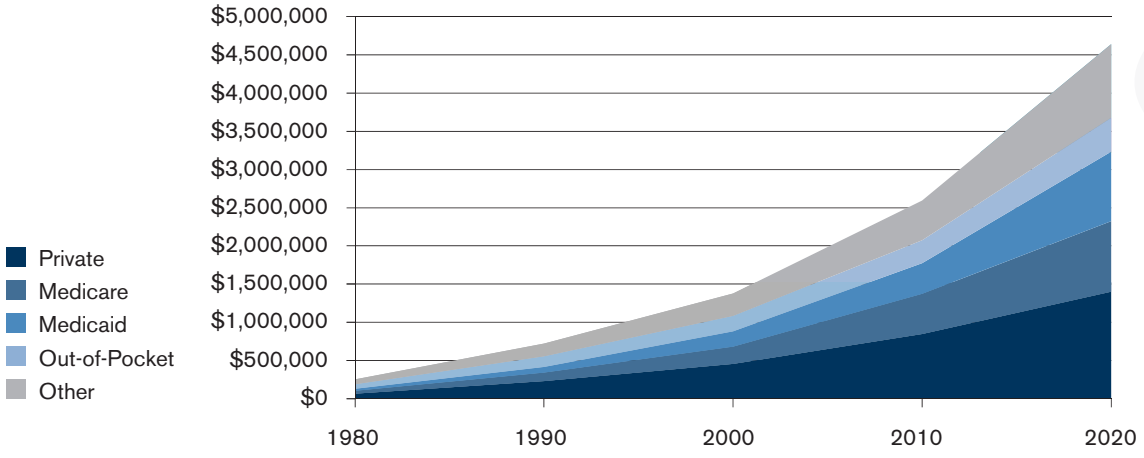
HEALTHCARE: APPROACHING THE COST PRECIPICE

Alvarez & Marsal (A&M) undertook an analysis of the $2.6 trillion healthcare sector to better understand the potential impact of the Patient Protection and Affordable Care Act (PPACA) and its ability to increase access while slowing the rate of underlying spending growth. Our differentiated, fact-based analysis incorporates multiple vantage points, from that of clinical medicine to hospital CEOs, corporate executives, financial analysts, and public policy experts. The full report contains nearly 200 identified references, and considers the practicum of execution.

Irrespective of PPACA intentions, the U.S. healthcare system is broken; disruptive transformation is required.

U.S. healthcare expenditures have already reached crisis proportion, accounting for 17.7% of the GDP. National health expenditures increased from $1.4 trillion to $2.6 trillion in 2000-2010, and are forecast to reach $4.6 trillion in 2020.[1] Average out-of-pocket household expenditures for healthcare, as a percentage of income, have now reached double digits. Combined Federal outlays for Medicare and Medicaid are the single largest Federal government expenditure, exceeding Social Security. Public debt, a figure excluding Treasury issuances, is at 72.5% and remains highly susceptible to rising interest rates and continued deficit spending.[2]

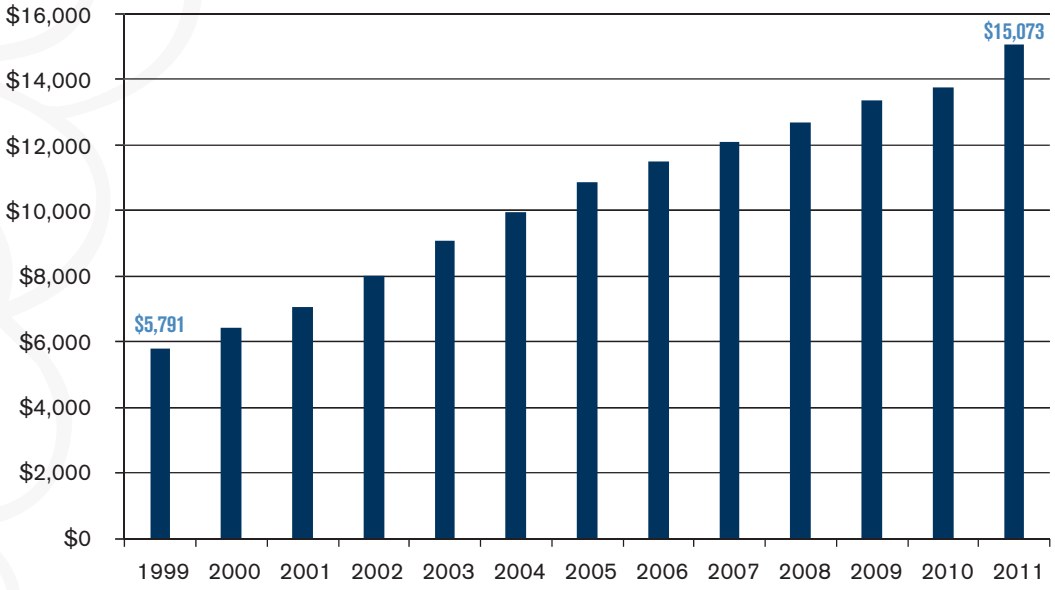
FIGURE 1: NATIONAL HEALTH EXPENDITURES 1980 - 2020



Source: Centers for Medicare and Medicaid Services, Office of the Actuary

The average family (of four) coverage premium of $15,073 has increased 160% in only twelve years. Employers currently pay $10,944, whereas family contributions, the amount of money paid by an employee for insurance coverage, has reached $4,129. Employee co-payments, deductibles and other out-of-pocket expenses add an additional $2,007.[3] Total employee household healthcare expenditures of $6,136 represent 12.3% of the median annual income.

FIGURE 2: AVERAGE FAMILY COVERAGE PREMIUMS



Source: Kaiser Family Foundation (KFF) and Health Research and Educational Trust (HRET)

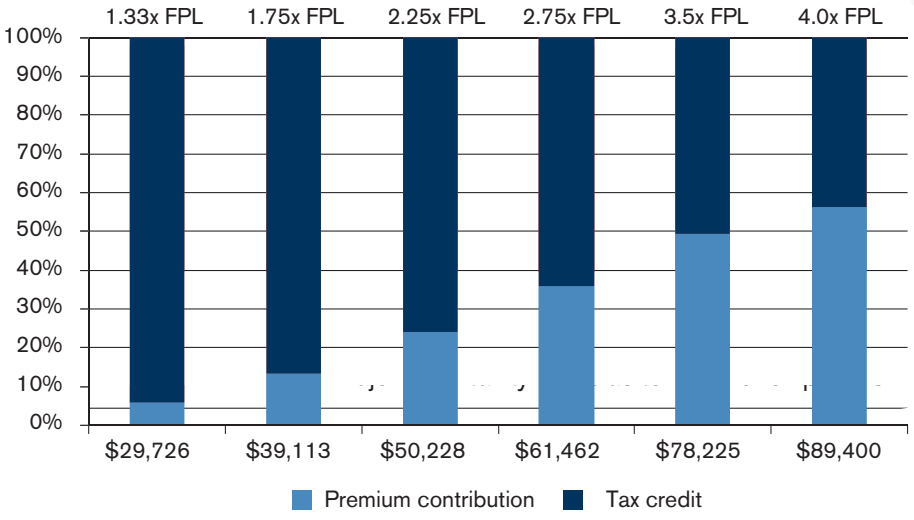
Healthcare is mired in following reimbursement dollars and not patient outcomes. We need to get beyond the fragmentation of care delivery to focus on the needs of patients as people, with physical, mental and social needs.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: ACCESS, SPENDING AND SUBSIDIES

The PPACA increases health insurance coverage and ensures that people with pre-existing conditions will not be denied coverage. Insurance companies are banned from dropping coverage of ill patients and those meeting lifetime caps. Children under the age of 26 can remain on their parent's insurance policy. As a result, the number of uninsured in the U.S. is forecast to decline from 48.5 million in 2010 to 25.9 million in 2020, representing 15.6% and 7.7% of the population respectively.[4] Increased coverage will exacerbate the growing primary care shortage, forecast to reach 45,400 physicians in 2020.[5]

States will be required to raise Medicaid eligibility from 100% to 133% of the Federal Poverty Limit (FPL). Federal tax credits will be provided to Americans earning 133% to 400% of the FPL (individual: $14,400-$43,300; family of four: $29,300-$88,200). Assuming an average health insurance premium of $15,100 for a family of four results in a range of individual premium contributions based on income from $900-$7,400. Conversely, the tax subsidy ranges from $14,200 for those with a household income of 1.33x the FPL ($29,700) to $7,600 for those with the maximum income eligible for a tax subsidy at 4.0x the FPL ($89,400). Health insurance tax credits represent another unaffordable program.

FIGURE 3: PAYMENT MIX FOR SUBSIDIZED INSURANCE RECIPIENTS



Source: Congressional Research Service, Kaiser Family Foundation. 2011 Federal Poverty Limit (FPL) for a family of four = $22,350; Premium cost = $15,073.

A major uncertainty exists as to whether employers currently offering health insurance to their employees will drop coverage, due to the favorable economics, more specifically paying $2000 instead of $10,000-$12,000 in insurance premiums. This uncertainty applies especially to the 5.9 million smaller firms employing 60 million Americans, an average of 10.2 employees per firm.

Medicare and Medicaid expenditures are projected to nearly double from $926 billion in 2010 to $1,830 billion in 2020, reflecting a 7.0% compound annual rate of growth. The comparable rate of growth between 2000 and 2010 was 8.1%.[6] Slowing expenditure growth is forecast despite an increase in the number of non-elderly with health insurance by 32 million in 2016 and a rapidly aging Baby Boomer and elderly population.[7]

Cost containment initiatives are limited and they focus on permanent reductions in the Medicare fee-for-service (market basket adjustment) payment rates ($196 billion between FY10-19) and lowering Medicare Advantage rates based on average bids submitted in each market ($135 billion). Minor savings of $500 million to $3 billion per annum are forecast for (a) hospitals receiving disproportionate Medicare payments for serving low income patients, (b) modifications to the part B premiums for high income recipients, (c) creating an independent Payment Advisory Board, and (d) applying penalties to hospitals for excessive hospital re-admissions and hospital acquired conditions.[8]

Pilot initiatives, including episodes of care payment and Accountable Care Organizations, are voluntary and thus unlikely to generate significant savings. Efforts to mandate new payment models or transform care delivery are limited.

Revenue provisions, also known as taxes and fees, raise $391.7 billion in 2010-2019, $146.9 billion from firms and $244.8 billion from individuals.[9]

In late March, the Supreme Court heard oral arguments on the constitutionality of the individual mandate. Other issues to be addressed include (a) whether the individual mandate can actually be decided today or in 2015, when the first individual penalty is assessed, (b) whether the entire PPACA or specific portions are unconstitutional, and (c) whether the Federal government can mandate additional Medicaid coverage to states.[10]

Irrespective of the Supreme Court outcome, healthcare costs will continue to rise.

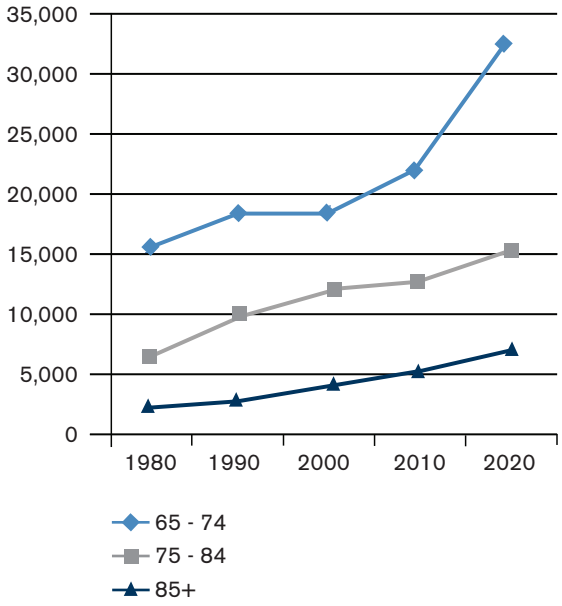
The realities of system dysfunction, combined with continued fee for service reimbursement, will be compounded by increased coverage for millions of Americans. This will only harken the inevitable day of reckoning.

U.S. CARE DELIVERY: INEFFICIENT AND INEFFECTIVE

Healthcare delivery within the U.S. is excessively complex, inefficient and ineffective. A rapidly aging population will increase demand for services and highlight system inadequacies.

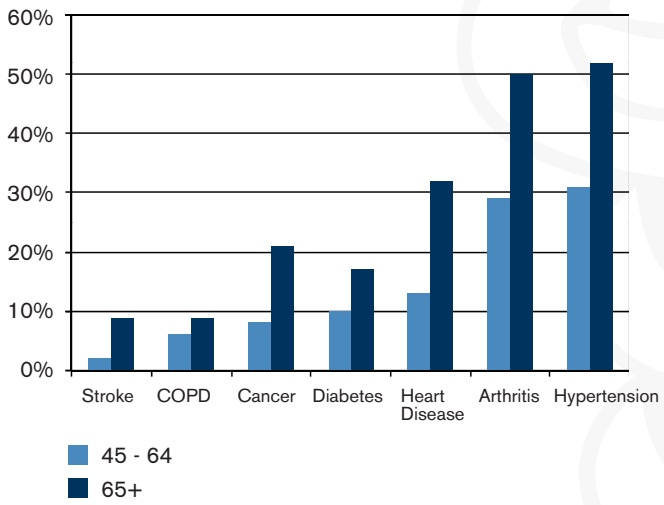
FIGURE 4: AGING AND DISEASE

AGING DEMOGRAPHICS



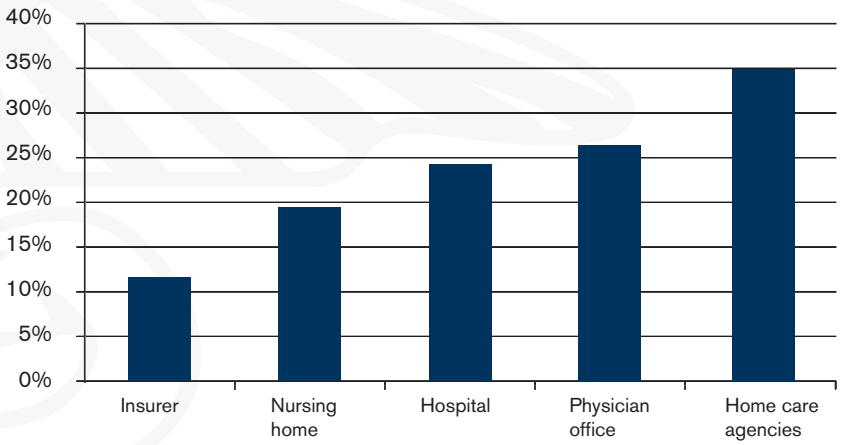
Source: U.S. Census Bureau

RISING PREVALENCE OF DISEASE



Care delivery is constructed to treat acute events in newly diagnosed patients or treat exacerbations in patients with an underlying chronic condition; 84% of all healthcare costs occur in patients with chronic conditions.[11] Primary and secondary prevention, key elements of chronic care management, are not rewarded. Site and specialist transitions are poorly coordinated. Fee for service reimbursement encourages utilization. Misaligned stakeholders utilize lobbying effectively to influence public policy and regulation. Oligopolistic price competition and a lack of price transparency sustain high prices. Excessive fraud and abuse, malpractice premiums and awards raise costs. Annual price increases by commercial insurers, Medicare and Medicaid are based on embedded inefficiencies.

FIGURE 5: COSTS OF HEALTH ADMINISTRATION



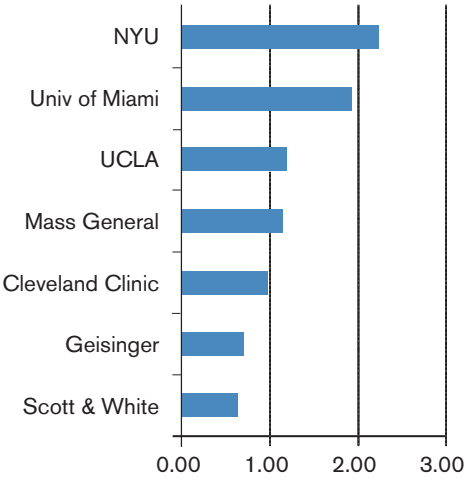
Source: Woolhandler S, et al. Costs of Health Care Administration in the U.S. and Canada. NEJM 349 (8); p768-775. August 21, 2003

The U.S. healthcare delivery system is ineffective. Focus is not provided to the five percent of the population accounting for nearly 50 percent of healthcare costs. Primary care physicians, the linchpin of chronic disease management, remain underpaid, overworked and in short supply. Patients are people, not diseases or conditions carved up by specialists or insurance companies with limited care coordination, collaboration or continuity.

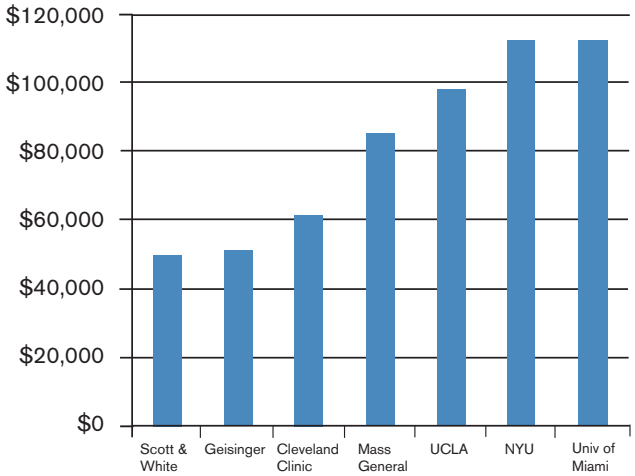
Treatment adherence, resource utilization and lifestyle decisions are being affected by under-diagnosed and untreated mood and anxiety disorders. Significant geographic and local variation in care delivery exists. End-of-life care received by dying patients is often inconsistent with their wishes. And, the lack of personal accountability affects the ability to make lifestyle changes and influence self-management.

FIGURE 6: LOCAL VARIATION IN CARE AND COST

HOSPITAL CARE INTENSITY (HCI) INDEX (NATIONAL AVERAGE = 1.0)



TOTAL MEDICARE REIMBURSEMENT FOR THE LAST TWO YEARS OF LIFE



Source: The Dartmouth Atlas of Health, 2003-07. The Hospital Care Intensity (HCI) index "is based on two variables: the number of days patients spent in the hospital and the number of physician encounters (visits) they experienced as inpatients. Total Medicare reimbursement based on population of beneficiaries with one of nine chronic conditions."

OPPORTUNITIES FOR MARKET LEADERSHIP

The future of healthcare requires strategic and enterprise-wide approaches to cost containment. Rationing will not be necessary if operational and process-of-care efficiencies are focused on major cost drivers. Traditional approaches, such as provider discounts and cost shifting, will not suffice. Strategic focus needs to be combined with the execution capabilities found within entrepreneurial organizations. Benchmark performers already exist and are readily identifiable; the need for pilot studies and related deliberations is over. Change management is essential for organizations and systems embedded with inefficiencies. A multi-year effort is required.

The provision of healthcare services remains, with exception, a small scale "cottage industry." Consolidation would generate economies of scale.

Performance improvement has traditionally focused on financial metrics: revenue cycle, budgeting and financial planning, capital expenditures, labor productivity, supply chain, risk management and third-party contracting and reimbursement. Patient access, throughput and level of care, combined with work flow analytics and re-design, have also entered the vernacular. Zero-based budgeting will help to identify embedded inefficiencies.

Clinical process redesign, incorporating evidence-based care and patient safety factors are essential. The PPACA pilots episodes-of-care payment models, but not the full continuum of care associated with chronic disease management. Primary and secondary prevention activities need to be adequately reimbursed. The latter is critical to avoiding episodes-of-care and reducing their severity, should they occur. Unnecessary emergency department and hospital visits require elimination. Concepts incorporated into the medical home, such as continuity of care services (coordination, collaboration and transition management), team-based care, case management and timely access to providers, need to be widely adopted. Patients need to be treated for all their co-morbid medical and behavioral issues holistically and not carved into specialty or provider segments. The productivity enhancing and engagement potential of emerging information technology, communications and mobile phones must be integrated into care delivery.

Consumer engagement impacts lifestyle and treatment adherence, major determinants of health outcomes. Medicine remains transactional and not based on relationships. Physicians and other providers must engage in a shared decision making process. Technology supported self-care, inclusive of telehealth, the Internet, and social media, are potential scalable and impactful solutions for rising healthcare costs.

Efficient and effective healthcare delivery are clearly possible.

> **"You can never solve a problem with the same kind of thinking that created the problem in the first place."**
>
> ALBERT EINSTEIN

AUTHOR'S BIOGRAPHY

David Gruber MD, MBA is Director of Research with Alvarez & Marsal's (A&M) Healthcare Industry Group.

Dr. Gruber brings nearly 30 years of healthcare experience as a corporate executive, Wall Street analyst and physician focused on strategy, technology, innovation and new ventures. Since 2009, he completed a wide variety of consulting assignments while supporting three different IT start-ups. Until December 2008, he was VP, Corporate Development and New Ventures with Johnson & Johnson Consumer Group of Companies.

Between 1995-2004, Dr. Gruber worked on Wall Street as a top-ten rated medical supplies and devices analyst at Lehman Brothers, Piper Jaffray and Sanford Bernstein. He was the lead analyst for the initial public offering of Intuitive Surgical and Given Imaging and an investment in Therasense. Prior to entering Wall Street, Dr. Gruber was Vice President, Planning & Business Development, for the $1.6 billion Healthcare Group at Bristol-Myers Squibb.

Dr. Gruber is a magna cum laude graduate of a six-year BS-MD program, having received his bachelor's degree from CCNY and his medical degree from the Mt. Sinai School of Medicine. He also has an MBA from Columbia University, and was a Kellogg Foundation National Fellow. Dr. Gruber is currently a Senior Fellow, Healthcare Innovation and Technology Lab (HITLAB) at Columbia Presbyterian.

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