The Road Ahead: Impacts of Healthcare Reform in the Coming Decade

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Context: U.S. health system is fragmented, expensive, complex, labor intense, capital intense, and highly regulated

Compound annual growth rate (CAGR) +7% per year, 17.9% of the U.S. gross domestic product (GDP), 7.8%* of household discretionary spending, 23% of federal budget

*2011 median income; includes health insurance, medical services, drugs, medical supplies as defined by Bureau of Labor Statistics, Consumer Expenditure 2011
Context: the Affordable Care Act (ACA) and related laws

- 2010 Patient Protection and Affordable Care Act
- New Clinical Coding Standards (ICD-10)
- Children’s Health Insurance Program Reauthorization Act (CHIPRA)
- Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security
- CORE Standards Development
- Health and Education Reconciliation Act of 2010
- State-based reforms
- American Recovery and Reinvestment Act (ARRA)
- Consolidated Omnibus Budget Reconciliation Act (COBRA) Expansion
- Health Information Technology for Economic and Clinical Health (HITECH)

Source: Patient Protection and Affordable Care Act (P.L. 111-148)
Context: system discontent

**HEALTH SYSTEM REPORT CARD**

- % of respondents giving a grade of “A” or “B”
  - Consumers: 34%
  - Physicians: 35%
  - Employers: 35%

- % of respondents giving a grade of “C” or below
  - Consumers: 63%
  - Physicians: 65%
  - Employers: 65%

The new normal: two major changes—financing, delivery

**Delivery system changes**
- Increased linkage between performance (outcomes, costs) and payments/incentives
- Increased integration of physicians, hospitals and long term care providers
- Increased access to health services by under-served populations
- Increased alignment of coverage with evidence

**Insurance system changes**
- Elimination of pre-existing condition, lifetime and annual limits for insurance plans
- Required coverage of preventive health services without co-payments
- Creation of health insurance exchanges in each state to facilitate access to affordable insurance and manage subsidized purchases by individuals and employers
- Federal-state regulation of insurance plan coverage, premiums, and medical expenditures

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**Consumerism**
- Engaged, accountable
  - Preventive health, individual insurance, PHR

**Primary Care 2.0**
- The front door and “home”
  - Home monitoring, retail medicine, LTC, medical homes, retail medicine, medical homes, health coaching

**Comparative Effectiveness**
- What works best, at what cost?
  - Personalized medicine, bundled payments, provider adherence/performance-based payments liability reforms

**Health Information Technology**
- Information driven health: cost, quality, safety
  - Electronic medical records, health information exchanges, fraud detection, administrative simplification, clinical data warehousing, ICD-10

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The Anticipated “New Normal” Delivery System

Source: Congressional Budget Office, 2012
Looking ahead: ACA implementation in the decade of economic recovery

**Budget Control Act, HITECH, Sustainable Growth Rate (SGR) Fix**

**2010-2013**
- Insurance compliance: medical loss ratio (MLR), premiums, coverage
- Coordination: state-federal governments, agencies
- Rules, guidelines, task forces, agencies
- Excise taxes—insurance, medical devices, drug companies
- Patient Centered Outcomes Research Institute (PCORI)

**2014-2016**
- Individual mandate
- Health insurance exchanges
- Employer pay or play
- Independent Payment Advisory Board (IPAB)
- Accountable care organizations (ACOs)
- Value-based purchasing
- Episode-based payments
- Medical home
- Self referral limits
- Transparency (Physician Quality Reporting Initiative [PQRI], etc.)

**2017+**
- Comparative effectiveness
- Delivery system re-alignment
- Value not volume
- Convergence: public health & delivery system
- Retail insurance market
- Consumerism

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**Rules, Regulations, & New Funding**

**Mandates, Pilots, & Exchanges**

**“New Normal”**

**ICD-10, Electronic medical records, Comparative effectiveness implementation**

*Source: Patient Protection and Affordable Care Act (P.L. 111-148)*
2013 will be a pivot year:

Clarity
…the ACA is the law; its implementation should require every stakeholder’s attention.

Compliance
…the rules are complex, forthcoming, and massive. Proceed with caution.

Health care transformation

Costs
…radical cost reduction across the system may be necessary to survival requiring new ways of managing people, processes, and technologies.

Consolidation
…many are going big or getting out.

Consumers
…how they define value, act as purchasers and voters, and behave as users will set the stage for the new normal. They’re neither patient nor patients, they are consumers.
Center for Health Solutions recent publications

**Health reform memos**
On a weekly basis, DCHS publishes the Monday Memo: Health Reform Update, which highlights news from the previous week on various health care reform efforts and implications for stakeholders. Subscribe to the Memo at [www.deloitte.com/us/healthmemos/subscribe](http://www.deloitte.com/us/healthmemos/subscribe)

**Breaking constraints: Can incentives change consumer health choices?**
Innovative incentive programs may well help individuals overcome the inertia that limits engagement in wellness programs, disrupting the trade-offs people make when pursuing health care goals. The issue brief explores factors driving employer interest in incentivizing participation in worksite wellness programs. [http://dupress.com/articles/breaking-constraints/](http://dupress.com/articles/breaking-constraints/)

**2013 Survey of U.S. Physicians: Perspectives about health care reform and the future of the medical profession**
This report presents key findings on physician perspectives about health care reform and the future of the medical profession. Based on the results of the survey, most U.S. physicians are concerned about the future of the profession and consider many changes in the market to be a threat. [www.deloitte.com/us/2013physiciansurvey](http://www.deloitte.com/us/2013physiciansurvey)

**Health System Chief Information Officers: Juggling responsibilities, managing expectations, building the future**
Chief Information Officers (CIOs) in traditional, acute health care systems face enormous challenges as they race to prepare their organizations to make the transition to an information-driven health system—the “new normal.” The Deloitte Center for Health Solutions interviewed CIOs in 12 major health care systems to assess their opinions about and preparedness for the challenges ahead. Their responses are presented in this report. [www.deloitte.com/us/2013CIOstudy](http://www.deloitte.com/us/2013CIOstudy)

**Unlocking the value in health plan M&A: Sometimes the deals don’t deliver**
The number of M&A transactions among commercial health plans is increasing, fueled by legislative, economic, and strategic drivers that are prompting some plans to consider consolidating as a way to improve economies of scale and remain competitive. Yet health plan executives contemplating mergers and acquisitions should take note: Deloitte’s analysis of 44 transactions between 2006 and 2012 points to a startling conclusion: Fewer than half led to sustained improvements in comparative market value three years after the deal closed. [www.deloitte.com/us/2013planconsolidation](http://www.deloitte.com/us/2013planconsolidation)

**mHealth in an mWorld: How mobile technology is transforming health care**
The report examines factors driving the adoption of mHealth, ways in which it could reshape the health care value-chain, and barriers to realizing potential benefits. DCHS finds that mobile apps only scratch the surface of possibilities offered by mHealth. Improvement opportunities exist along the value chain, from engaging patients to maximizing provider productivity to controlling costs. [www.deloitte.com/us/mobileandtechnology](http://www.deloitte.com/us/mobileandtechnology)
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Monday memo

Health reform update

This week’s headlines:

- My take
- Implementation update
  - IRS releases final rule on excise tanning tax: fitness facilities not assessed tax
  - Chairman and vice-chairman appointed to the Long-Term Care Commission
  - Report: MA enrollment increases
  - CMS issues proposed rule on HIX, SHOP, premium stabilization, and consumer protections
- Legislative update
  - MedPAC recommends changes in Medicare payment policies
  - FDA concerns about food safety
  - CO-OP loan program gets attention from House committee; 5 of 24 considered at risk of non-performance
  - Senators urge vote on compounding pharmacy bill
  - Congress asks CMS to delay the Competitive Bidding Program for DMEPOS
  - FDA issues cybersecurity warnings for medical devices
  - Lawmakers call for an integrated EHR for Defense and Veterans Affairs by October 2016
  - Senators question HHS on HIX navigators
  - Medical, dental, nursing schools warned against hepatitis B discrimination
- State update
  - Small-business exchanges not attracting plans
  - State round-up: Medicaid
  - State round-up: HIX
  - State round-up
- Industry news
  - Supreme Court: genes cannot be patented
  - MGMA study: docs not prepared for ICD-10
  - Physician compensation up in 2012; gap between specialist and primary care income significant
  - Hospital ownership status linked to performance
- Research snapshots
- Quotable
- Fact file
- Subscribe to the Health Care Reform Memo
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My take
From Paul Keckley, Executive Director, Deloitte Center for Health Solutions

The idea that doctors, hospitals, and health professionals should be compensated on the basis of performance and outcomes makes sense. Health insurers and employers are keen to replace fee-for-service (FFS) with incentives for better results at lower costs, and consumers want to compare results. The tricky part is how to do it.

In the Affordable Care Act (ACA), risk sharing arrangements between Medicare and "clinically integrated" teams of doctors, nurses, allied health professionals, hospitals, and post-acute providers are encouraged: episode-based payments, avoidable readmission penalties, patient-centered medical homes, limitations on physician ownership of standalone acute hospitals, and the Medicare Shared Savings Program (accountable care organizations, ACOs) are key elements in the ACA’s intentional replacement of Medicare incentives from volume to value. Likewise, in many states, governors are looking to risk sharing arrangements for their Medicaid programs, and are especially interested in solutions for their dual eligible populations. And in the commercial population, large employers and private health plans have accelerated efforts to shift risk to doctors and hospitals, and most of the larger health insurance companies are seeking to partner with providers by providing infrastructure and operational expertise. Case in point: as of March 2013, there were almost 450 ACO efforts underway. For instance, there are 220 in the Medicare Shared Savings Programs and over 160 ACOs that involve risk sharing with private health insurers or large employers.

The fervor about risk sharing and accountable care is not new: we’ve been there before. In wave one, circa the 1990’s, providers organized as Independent Practitioner Associations (IPAs) and Physician-Hospital Organizations (PHOs) for the same purpose. Some were successful, especially when risk sharing between health insurers and the providers was balanced, and some failed. “Managed care” became a prominent theme in policy circles as discounted FFS arrangements with open panels of providers were replaced in some markets by prospective payments in closed systems. But in wave two, “accountable care” will be different for four reasons:

1. Economic realities: simply stated, employers, insurers, and the government on behalf of Medicaid and Medicare face a slowdown in the rate of spending for health care services. There will be fewer dollars for sharing, and each party will be hyper-defensive about protecting their piece of the pie. The traditional riffs between plans and providers will intensify because dollars to be shared will become scarce, and the need for revenue growth off-setting margin erosion will propel industry consolidation. The total health care spend in this country has exceeded our annual gross domestic product (GDP) growth by 2.5% annually for 35 years; looking ahead, most like the independent Bipartisan Policy Center anticipate the gap will close to 1% or less.

2. The regulatory framework: the ACA is an unprecedented backdrop for payers, imposing significant restrictions on how employers and insurers provide benefits to employees a la medical loss ratio requirements, essential health benefits, affordability and shared responsibility, and so on. As insurers and employers entertain risk sharing arrangements with providers, they’re not relieved of the ACA’s requirements. Likewise, for doctors, hospitals, post-acute and ancillary providers, the new normal imposes huge changes in how care is diagnosed, treated, and results reported—all leveraged by big investments in clinical information systems to coordinate care, capture outcomes, and measure results. The ACA, in tandem with likely slower growth in annual spending, mean wave two risk sharing will be more risky!
3. **Big data about quality and costs:** the tools of the trade in risk sharing are more advanced in wave two, as is the data required to prove results and demonstrate value. In wave one, risk sharing via capitation and other payment models relied almost exclusively on claims-based data to assess risk and allocate savings bonuses. The methods were crude, and clinical efficacy and effectiveness on a severity-adjusted basis were widely variable and haphazard. In wave two, savings are shared based on adherence to well-documented, evidence-based algorithms and patient data obtained across multiple clinical settings achieving the lowest cost. In wave one, the clinical data was held in disparate clinical settings, and the financial data by health plans. Now the two are one: data about quality and costs that’s shared and searchable is controlled by the risk-sharing entity itself. For example, in the Medicare Shared Savings Program, an ACO must score at least 90% on various performance benchmarks to get the maximum bonus points for up to 33 measures, while also demonstrating the entire clinical team’s adherence to evidence-based practices in diagnosing and treating patient populations.

4. **Transparency:** in wave one, deals between payers and providers were treated as business transactions with limited visibility and seemingly low levels of interest to the public. And results—outcomes, satisfaction, and savings—were closely guarded secrets. What’s new is the public’s appetite for transparency—how deals are structured between payers and providers, who profits and by how much, and how their personal health information is used. And the era of social media means uncontrollable sharing of information among consumers about the performance of these risk-sharing relationships, and how their interests are served.

In wave two of accountable care, delicate questions are being asked: Who owns the clinical and financial data? How should bonuses be shared between payers and providers, or with patients? How and when can information be shared with the public? What's the right timeframe for calculating savings based on outcomes—weeks, months, or years for certain populations? And who will pay for the cost of operating the risk-bearing infrastructure?

For doctors and hospitals, an overarching strategic question exists: does a risk sharing relationship with “Plan A” put it at risk in contracting with other local plans? And if risk-sharing is the future, what level of investment is necessary to build the new set of core competencies required, or is a business partner necessary?

For health insurance plans, seeking risk sharing business partnerships with providers poses unique challenges in wave two: how to choose the right partnership, and demonstrate value commensurate with the services provided while navigating the historic sensitivities about trust are ominous challenges.

For employers, risk sharing involving direct contracting requires caution and careful due diligence: a provider organization’s “accountable care” might not deliver better care at lower costs unless carefully structured around clinical and financial goals. Knowing how an accountable care organization diagnoses and manages medical problems for specific patient (employee) populations is as important as understanding the costs associated with these activities.

And for consumers, if providers are at risk for results, adherence to recommended treatments is key. Accountable care relationships must feature tools for self-monitoring and cost-benefit analysis to facilitate shared decision-making with the clinical care team.

The results of wave two of “accountable care” will start rolling in next year. The flurry of activity about the health insurance exchanges (HIX) might subdue attention to the news of savings achieved or missed, but over time, wave two accountable care is likely to be as significant if not more than any feature in health reform.
P.S. In today's Fact File, see updated data about the ACO Medicare Shared Savings Program.


Implementation update

IRS releases final rule on excise tanning tax: fitness facilities not assessed tax

Last week, the Internal Revenue Service (IRS) released final guidance on the indoor tanning excise tax per Section 10907 of the ACA. The rules: consumers who use certain indoor tanning services through a gym in which they pay a monthly membership fee are exempt from the excise tax. Reasoning: “requiring a qualified physical fitness facility to allocate its customers’ monthly membership fees among tanning and non-tanning services under such an arrangement would be burdensome and difficult to administer.”

Note: the membership fee is not subject to the indoor tanning services tax if the facility meets the definition of a “qualified physical fitness facility.” A “qualified physical fitness facility” is a facility (i) in which the predominant business or activity is providing facilities, equipment, and services to its members for purposes of exercise and physical fitness, (ii) indoor tanning services is not a substantial part of its business and, (iii) it does not offer tanning services to the public for a fee or offer different pricing options to its members based on indoor tanning services.
Chairman and vice-chairman appointed to the Long-Term Care Commission
The 15 member Long-Term Care Commission established after the Community Living Assistance Services and Supports (CLASS) Act was repealed has elected a chairman and vice chairman. The Commission will convene for the first time on June 27, 2013.

Background: the Commission was established in January 2013 as an advisory board to Congress. The Commission will develop “a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the availability of long-term services and supports for individuals in need of such services and supports, including elderly individuals, individuals with substantial cognitive or functional limitations, other individuals who require assistance to perform activities of daily living, and individuals desiring to plan for future long-term care needs.”

Report: MA enrollment increases
The Kaiser Family Foundation and Mathematica Policy Research group reported that in March 2013, 14.4 million beneficiaries enrolled in Medicare Advantage (MA) plans, a 10% increase from the previous year. Despite payment changes enacted under the ACA, enrollment in MA plans increased 30% since 2010: 28% of Medicare beneficiaries are currently enrolled in Part C plans.

Background: Section 1102 of the ACA reduced MA benchmarks relative to current levels. Benchmarks will vary from 95% of Medicare spending in high-cost areas to 115% of Medicare spending in low-cost areas, with benchmarks increased in all areas for high-quality plans. Changes will be phased in over three, five, or seven years, depending on the level of payment reductions. ACA Section 3202 prohibited MA plans from charging beneficiaries cost sharing for covered services greater than what is charged under the traditional FFS program. The Congressional Budget Office (CBO) projected in 2010 that the ACA would result in $200 billion in cuts to the MA program.

CMS issues proposed rule on HIX, SHOP, premium stabilization, and consumer protections
Late Friday afternoon, the Centers for Medicare and Medicaid Services (CMS) released a 253-page proposed rule on program integrity, safeguarding federal funds, and ensuring consumer protections on several insurance market reforms enacted by the ACA. The U.S. Department of Health and Human Services (HHS) will accept comments on the rule until July 20, 2013. Highlights:

Oversight of premium stabilization programs (reinsurance, risk corridors, and risk adjustment):
- Restrict the use of reinsurance funds for administrative expenses, and unused funds must be carried over to the next program year.
- Establish accounting requirements for state-operated reinsurance and risk adjustment programs, requirements for states to keep records for a minimum of ten years, and submit to HHS and make public reports on operation for independent external audits for these programs.

Qualified health plans (QHPs) on HIXs:
- Require QHP issuers to accept a variety of payment formats including paper checks, cashier’s checks, money orders, and reloadable pre-paid debit cards to accommodate individuals without a bank account.
• QHP issuers who directly enroll consumers in a HIX using their own web site must clearly distinguish between QHPs for which the consumer is eligible and non-QHPs that the issuer may offer.

• HHS may review the premiums charged to qualified individuals by issuers of QHPs in the federally-facilitated exchange (FFE) through compliance reviews.

• QHP issuers may enroll a consumer who comes directly to them to be enrolled in a HIX so long as the QHP issuer follows the enrollment process for qualified individuals.

• Agents and brokers assisting or enrolling consumers in the individual market of an FFE must establish policies and procedures implementing privacy and security standards and train their employees.

Integrity of HIX and Small Business Health Options Program (SHOP) marketplaces:

• Plans sold outside of HIXs will be subject to the risk corridors program only if the plan is the same as the plan offered by that issuer on the HIX.

• States may operate a state-based SHOP while its individual market HIX is an FFE operated by HHS. A state-operated SHOP would be required to cover the same geographic areas as the FFE.

• Nondiscrimination requirements applicable to state-based exchanges (SBE) also apply to FFES.

Consumer protections for enrollment assistance:

• Limits a web broker’s obligation to disclose and display the QHP information to information provided by the HIX or directly by the issuer.

• Requires web-brokers’ internet web sites in an FFE to prominently display language notifying consumers that: it is not an FFE web site; the web-broker’s site might not display all QHP data available on the FFE site; the broker has entered into an agreement with HHS, and the web-broker agrees to comply with HHS standards.

Establishment of standards for HHS-approved enrollee satisfaction survey vendors:

• HHS will approve and oversee enrollee satisfaction survey vendors that will administer enrollee satisfaction surveys on behalf of QHP issuers.

• Only HHS-approved enrollee satisfaction survey vendors could administer the survey on behalf of QHP issuer.

• In future rulemaking, the enrollee satisfaction survey will be modeled on the CAHPS® Health Plan survey.

Legislative update

MedPAC recommends changes in Medicare payment policies

Friday, the Medicare Payment Advisory Commission (MedPAC) released its June 2013 Report to the Congress: Medicare and the Health Care Delivery System. The report included three major recommendations:

Redesigning the Medicare benefit: the Commission recommends use of competitively determined plan contributions (CPC), wherein Medicare beneficiaries would receive care through either a private plan or traditional FFS, with premiums varying depending on the coverage option they chose. “How much the federal government pays for a beneficiary’s care would be determined through a competitive process comparing the costs of available options for coverage.” Per the Commission, the key issues to be resolved if the CPC is
pursued: how benefits could be standardized for comparability, how to calculate the Medicare contribution, the role of FFS, and the structure of subsidies for low-income beneficiaries.

Reducing Medicare payment differences across sites of care: what Medicare pays for services varies by where the service is delivered: for example, Medicare pays 141% more for a level II echocardiogram done in a hospital outpatient department than if done in a physician's office. “The Commission previously recommended reducing the rate Medicare pays for basic office visits from the payment rate in the outpatient setting to the physician office rate. Using similar criteria, this report identifies additional services that may be eligible for equalizing or narrowing payment differences across settings.”

Bundling post-acute care services: “each year, one-quarter of Medicare beneficiaries receive care following a hospitalization from a post-acute care provider, such as a skilled nursing facility, home health agency, or inpatient rehabilitation facility.” But use varies widely for reasons not related to a person’s health status. “Under traditional Medicare, the program pays widely varying rates for different settings and—characteristic of FFS—pays based on the volume of care provided, without regard to quality or resource use.” MedPAC is considering possibility of bundling services as a way to encourage providers to coordinate and furnish needed care more efficiently. “In this report, the Commission explores the implications for quality and program spending for different design features of the bundles, such as the services included, the length of time covered by the bundle, and the method of payment.”

Reducing hospital readmissions: “in 2008, the Commission recommended a hospital readmissions reduction program to improve patient experience and reduce Medicare spending.” It was included in the ACA and was implemented in 2012. “In this report, the Commission suggests further refinements to improve incentives for hospitals and generate program savings through reduced readmissions rather than higher penalties.”

Payments for hospice services: “the Medicare hospice benefit is an important option for end-of-life care. At the same time, the Commission has identified several problems in the way Medicare pays for hospices that lead to inappropriate use of the benefit. The report presents information on the prevalence of long-stay patients and the use of hospice services among nursing home patients—both of which may inform policy development in the hospice payment system in the future. It also presents further evidence to support the Commission’s March 2009 recommendations to revise the hospice payment system.”

Improving care for dual-eligible beneficiaries: “beneficiaries eligible for both Medicare and Medicaid—many of whom have complex medical and social needs—often have trouble accessing services and receive little care coordination, resulting in poorer health outcomes and higher spending relative to other beneficiaries. In the report, MedPAC notes that federally qualified health centers and community health centers should be used to coordinate care for dual-eligible beneficiaries because they provide primary care, behavioral health services, and care management services, often at the same clinic site.”

Background: MedPAC is an independent federal body established by the Balanced Budget Act of 1997 to advise the Congress on issues affecting the administration of the Medicare program.

**FDA concerns about food safety**

Thursday, the House Appropriations Committee approved the fiscal year (FY) 2014 Agriculture U.S. Food and Drug Administration (FDA) spending bill, expressing concern about delays in food safety rulemaking, nutrition labeling requirements for restaurants, lack of FDA guidance on seafood safety, dietary supplements, and labeling requirements for abuse-deterrent painkillers. The committee also recommended the agency change user fee calculations to account for sequestration.

*Background: due to automatic budget cuts (the Budget Control Act of 2011, “Sequestration”), $85 million in FDA user fees collected from pharmaceutical companies is currently in the U.S. Department of Treasury and may not be used. For the FDA to access the user fees, cuts would have to be made elsewhere in the agency’s budget to keep it under caps set by the Budget Control Act.*

**CO-OP loan program gets attention from House committee; 5 of 24 considered at risk of non-performance**

Darrell Issa (R-CA), Chairman of the House Oversight Committee, sent a letter to HHS Secretary Sebelius citing concerns about the ACA Consumer Operated and Oriented Plan (CO-OP) loan program citing a $33 million loan to the Vermont CO-OP. The CO-OP subsequently failed to meet the state’s insurance standards and was denied a health insurance license. The committee review of applications and external reports concluded that 5 of the 24 health co-ops that received $2 billion in loans are in jeopardy due to financial or regulatory issues.

*Background: CO-OPs were originally proposed as an alternative to a public option or single payer system as part of the health reform debate in 2009. ACA Section 1322 offers low-interest loans to nonprofit, consumer-governed health insurance plans (i.e., CO-OPs) for start-up and operational costs. In the ACA, $6 billion was set aside as a loan program to assist states in setting up and operating a not-for-profit, community-governed exchange in each state—later reduced to $3.4 billion and then H.R. 8 (the fiscal cliff deal) cut $2.3 billion from the program.*

**Senators urge vote on compounding pharmacy bill**

In response to a second outbreak linked to compounded pharmaceuticals, U.S. Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Tom Harkin (D-IA) and ranking member Lamar Alexander (R-TN) are urging leaders to bring their legislation on the oversight of compounding pharmacies to the Senate floor in July. On June 7, 2013 FDA announced that it had found bacterial and fungal growth in samples from two separate unopened batches a compounded drug produced by Main Street Family Pharmacy in Tennessee. The pharmacy voluntarily recalled all compounded products on May 28, 2013 after FDA received seven reports of skin abscesses, including one that originated from fungus.

*Background: the Pharmaceutical Compounding Quality and Accountability Act (S. 959), introduced in May, would allow the FDA to regulate certain compounding drug manufacturers, which is currently outside the of the FDA’s authority. The HELP committee approved the bill by voice vote and also voted to combine it with the Senate’s track-and-trace legislation. The Drug Supply Chain Security Act (S. 957) would establish a system that would eventually be able to trace drug distribution to the “unit level”—individual bottle of pills or vial of drug dispensed.*
Congress asks CMS to delay the Competitive Bidding Program for DMEPOS
Last week, over 200 members of Congress sent a letter to CMS Administrator Marilyn Tavenner requesting that CMS delay the start of the Competitive Bidding Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) through the end of 2013. The issue: lawmakers believe that contracts have been awarded to suppliers that are ineligible and that “any mishandling of the bidding process will impact Medicare’s ability to serve its beneficiaries in the respective bidding areas.”

FDA issues cybersecurity warnings for medical devices
Thursday, FDA released draft guidance on cybersecurity issues for medical device manufacturers to consider, recommending manufacturers submit detailed plans about cyber-attacks prevention when submitting applications for premarket FDA approval. Comments must be submitted guidance by September 12, 2013 to be considered for the final version of the guidance.

Lawmakers call for an integrated EHR for Defense and Veterans Affairs by October 2016
Last week, Representatives Buck McKeon (R-CA) and Adam Smith (D-WA) introduced an amendment to the National Defense Authorization Act for Fiscal Year 2014 to require the establishment of an integrated electronic health record (EHR) for the U.S. Department of Defense and U.S. Department of Veterans Affairs by October 2016. Last year, the departments decided to pursue their own EHR systems, which McKeon and Smith claim “jeopardizes the stated goal of providing a patient centered health care system that delivers excellent quality, access, satisfaction, and value, consistently across Departments.”

Senators question HHS on HIX navigators
On June 7, 33 House Republicans backed by the National Association of Professional Insurance Agents sent a letter to HHS Secretary Kathleen Sebelius asking for a detailed explanation to questions regarding consumer protections and transparency for families enrolling in HIXs with the help of Navigators. The lawmakers expressed concern that under the proposed rule issued by CMS for the Navigator Program, Navigators are not required to be licensed or insured against accidental mistakes or omissions as insurance agents or brokers and may not receive formal on-going training. Therefore, according to the letter, Navigators would be unable to provide the public with appropriate service. For more information on the HIX navigators proposed rule, see the April 8, 2013 Monday Memo.

Medical, dental, nursing schools warned against hepatitis B discrimination
The Departments of Justice, Education, and Health and Human Services sent a joint letter Friday to all U.S. medical schools, dental schools, nursing schools, and other health-related schools expressing concern that some may be making enrollment decisions based on an incorrect understanding of the hepatitis B virus, resulting in discrimination. The letter cites a March 2013 settlement between a medical school and a school of osteopathic medicine. The Justice Department resolved allegations that the schools violated the Americans with Disabilities Act by excluding previously-accepted applicants with hepatitis B from their programs.
Background: 800,000 to 1.4 million people in the U.S. have hepatitis B; Asians, Native Hawaiians, and Pacific Islanders are 4.5% of the U.S. population, but are 50% of the persons with hepatitis B in the U.S.

State update

Small-business exchanges not attracting plans

Most of the attention on HIXs has been about individual market offerings but some are taking notice of health plans’ lack of participation to date in the SHOP market through the exchanges:

“Obamacare’s new insurance marketplaces for small businesses, which have already stumbled before getting out of the gate, are facing another pressing question just months before millions can sign up for benefits: What happens if insurers don’t show up to sell? Early looks at insurance offerings on the Obamacare exchanges show that insurers aren’t exactly signing up in droves to sell on the new Small Business Health Option Program exchanges. In some states, just one insurer has signed up for the SHOP exchange, which are supposed to foster competition and make it easier for small businesses to purchase coverage. The SHOP exchanges exist alongside the exchanges for individuals, which have gotten more attention in preparation for the health law’s rollout.”—Jason Millman, Politico, “Small-business exchanges draw few insurers,” June 13, 2013

State round-up: Medicaid

To date, 27 states and D.C. have said they will or are in support of expanding their Medicaid programs; 20 states have indicated they are unlikely to expand their programs in 2014:

<table>
<thead>
<tr>
<th>Announced expansion or Governor in support of expansion</th>
<th>Not participating or highly unlikely to participate</th>
<th>Undecided or undeclared</th>
</tr>
</thead>
<tbody>
<tr>
<td>AR, AZ, CA, CO, CT, DE, DC, HI, IA, IL, KY, MD, MA, MI, MN, MO, ND, NH, NM, NY, NJ, NV, OR, OH, RI, VT, WA, WV</td>
<td>AL, AK, FL, GA, ID, IN, LA, ME, MS, MT, NE, NC, OK, PA, SC, SD, TN, TX, VA, WI</td>
<td>KS, WY, UT</td>
</tr>
</tbody>
</table>

- Democratic governor  ■ Republican governor  ■ Independent governor

Sources: NASHP, PoliticoPro, Kaiser Family Foundation. Updated May 27, 2013

- Last week, the Arizona House passed a state budget that includes Medicaid expansion following a Senate passage in May. There are currently 1.3 million Arizonans enrolled in Medicaid, and expansion will likely add 300,000 enrollees.

- Mississippi lawmakers must resolve disputes about the state’s Medicaid program and the issue of its expansion by July 1st—the date it must be reauthorized. A supermajority is needed to reauthorize Medicaid, but Democrats say they will refuse to vote on reauthorization until Medicaid expansion is decided. Governor Phil Bryant (R) may reauthorize Medicaid through an Executive Order in absence of a legislative decision. Mississippi’s Medicaid currently covers 700,000 people, and expansion would add an additional 300,000 enrollees.

- The Michigan House passed a bill last Thursday to expand its Medicaid program, limiting the length of time the 470,000 newly eligible beneficiaries can remain on Medicaid. After four years on the program, enrollees will decide either to remain on the program by paying more out of pocket, or to buy exchange coverage with
federal subsidy assistance. The proposal will head to the state GOP-controlled Senate this week, and Republican Governor Rick Snyder hopes to see the bill before the Legislature’s summer break. Federal approval from HHS is required for this bill to become law.

- **Florida’s** Medicaid overhaul waiver was officially approved by the federal government last Friday. The state will require Medicaid beneficiaries to enroll in HMOs or other managed care organizations (MCOs). MCOs will have a mandatory medical loss ratio of 85%, meaning they will have to spend 85% of revenues on patient care. Florida lawmakers passed the Medicaid-managed care enrollment mandate in 2011, and in February 2013, CMS promised to grant this proposal.

State round-up: HIX

Seventeen states—12 led by Democratic governors, four led by Republicans, and one Independent—and the Democratic mayor of D.C. have announced plans to operate SBEs. Seven states—five led by Democratic governors and two led by Republicans—will participate in state-partnership exchanges (PE). The remaining 26 states will default to a FFE.

<table>
<thead>
<tr>
<th>State-based exchange</th>
<th>State-partnership exchange</th>
<th>Federally-facilitated exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA, CO, CT, DC, HI, ID**, KY, MA, MD, MN, NM**, NV, NY, OR, RI, UT*, VT, WA</td>
<td>AR, DE, IA, IL, NH, MI, WV</td>
<td>AK, AL, AZ, FL, GA, IN, LA, KS, ME, MO, MS, MT, NC, ND, NE, NJ, OH, OK, PA, SC, SD, TN, TX, VA, WI, WY</td>
</tr>
</tbody>
</table>

*Democratic governor ■ Republican governor ■ Independent governor

**Individual market will be a FFE; SHOP will be a state-based. **Feds will help run the individual market in 2014.

(Source: HHS)

- The **New Hampshire** Senate rejected a $5.3 million federal grant for ACA consumer education on Wednesday, June 12 by a 13-11 vote. The state insurance department was awarded the grant in April, pending legislative approval. Opponents believe it is the federal government’s responsibility to provide consumer assistance for the PE.

- Last Tuesday, **Colorado** named the 58 organizations it has selected to form the state’s “assistance network” to help residents enroll for health coverage via the state’s HIX. Eleven of the 74 applicants received funding.

- In **Minnesota**, health insurance prices on the SBE, MNsure, will not be revealed until MNsure opens October 1. Although carriers have already filed their proposals, state law requires confidentiality of premium costs in order to promote competition among insurers.

- Current debate over two bills in the **California** legislature regarding the hiring of 20,000 health reform workers may delay the launch of the SBE. The bills require background checks and fingerprints for health reform workers and would ban hiring individuals with felony records. Covered California board members believe implementation of its SBE cannot move forward until these bills are decided. Supporters believe these laws will help protect privacy and avoid fraud and abuse of patients’ confidential information. Opposition stems from the bills’ violations of equal opportunity employment rights and support.
### Number of Carriers per State: Individual Exchange vs. SHOP

<table>
<thead>
<tr>
<th>State</th>
<th>Individual Exchange</th>
<th>SHOP</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Maryland</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Colorado</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Arkansas</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Connecticut</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Nebraska</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Montana</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>North Carolina</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Maine</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Rhode Island</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Vermont</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

* Unless otherwise noted, data represent number of applicants based on QHP or rate filing submissions, and are subject to changes and final approval by federal or state regulators. For unlisted states, filing deadlines have not passed or data was unreleased.

* MN, NE figures are total I + SG combined, split unclear or not public

* AK, NE figures are as of 6/7/2013 and may change, deadlines have not passed

**Additional Comments:**
- CA had 32 applicants, 13 of which were selected, pending rate approval
- WA had one applicant on its SHOP, and may delay SHOP altogether

**Per White House Memo, 5/30/13:**
- Three out of four states with FFEs will see at least one new insurer
- One in four insurance company applicants are new to the individual market
- Two out of three new entrants are looking at states currently dominated by one insurer
- Fifteen plans per carrier on average

*Source: Deloitte analysis of publically available information as of June 7, 2013*
State round-up

- The California legislature is expected to agree to Governor Jerry Brown’s (D) $96.2 billion budget which includes a 10% provider cut to Medi-Cal.

- New York’s legislature is debating a bill that would require one nurse for every two intensive care patients and one nurse for every four regular medical and surgical units. The New York State Nurses Association supports the bill while New York hospitals oppose it claiming it would cost $3 billion annually and reduce services and emergency room diversion. A study conducted in the *Journal of American Medical Association* found that death rates within 30 days after admission to a hospital rose 7% for each additional patient assigned to a nurse.

Industry news

**Supreme Court: genes cannot be patented**

Last Thursday, the U.S. Supreme Court ruled that synthetic DNA is patent eligible but "genes and the information they encode are not" in a unanimous ruling in the case Association for Molecular Pathology v. Myriad Genetics. The decision invalidated patents on breast cancer susceptibility genes, but upheld patents on synthetic DNA. "[T]his case does not involve patents on new applications of knowledge about the BRCA1 and BRCA2 genes," the decision says. It further cites an earlier lower court decision that says as the first party with knowledge of the DNA sequences, "Myriad was in an excellent position to claim applications of that knowledge. Many of its unchallenged claims are limited to such applications."

(Source: U.S. Supreme Court, Association for Molecular Pathology v. Myriad Genetics, June 2013)

**Background:** the Association for Molecular Pathology originally brought the case that centers on two genes, Breast Cancer Susceptibility Genes 1 and 2 (BRCA1 and BRCA2), that are used by Myriad Genetics, Inc. for diagnostic purposes.

**Reaction:** "Today’s decision offers urgently-needed certainty for research-driven companies that rely on cDNA patents for investment in innovation…but it is a troubling departure that could hamper other types of biotech research...The United States is now the only developed country to take such a restrictive view of patent eligibility, signaling an unjustified indifference towards our global economic and scientific leadership in the life sciences."—Jim Greenwood, President, Biotechnology Industry Organization

MGMA study: docs not prepared for ICD-10

A Medical Group Management Association (MGMA) survey of 1,200 medical groups (55,000 physicians) found only 4.8% of practices reported that they have made significant progress when rating their overall readiness for ICD-10 implementation. Other findings:

- 52.5% indicated they had not heard from their practice management system vendor regarding when software changes would be available to the practice.

- 11.9% reported that external testing with their clearinghouse has started or is complete vs. 59.7% that had have not heard from their clearinghouse regarding a testing date.

- Nearly 60% are “slightly” or “not at all confident” that their major health plans will be ready to meet the October 1, 2014 compliance date.
• 89% are concerned or very concerned about the expected changes to clinical documentation.

• For practices that must cover the costs themselves, “the average cost for a 10-physician practice to upgrade or replace their practice management system and EHR software to accommodate ICD-10 is $201,690.”


Background: CMS has mandated the ICD-10 diagnosis code set for use by physician practices, other providers, clearinghouses and health plans by October 1, 2014. There is five times the number of codes in ICD-10 than are in ICD-9 and incorporate a different structure.

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Physician compensation up in 2012; gap between specialist and primary care income significant

• 3% of primary-care physicians' and 2% of specialists compensation was tied to quality metrics

• Median compensation for specialists was 180% higher than for physicians primary-care ($388,199 vs. $216,462)


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Hospital ownership status linked to performance

Per the Truven Analytics data:

• **Average length of stay (ALOS):** ALOS was 4.94 days at not-for-profit, faith-based hospitals vs. 5.08 days at investor-owned facilities and 5.17 days at government-owned hospitals.

• **Patient satisfaction:** for faith-based per the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey was 261.2 vs. of 253.1 for investor-owned and 258.4 for government hospitals.

• **Core measures:** investor-owned scored an average of 97.3% on core measures vs. faith-based hospitals (96.5%); other not-for-profits (96.2%); and government hospitals (95%)

• **Case mix and wage-adjusted inpatient expense per discharge:** $5,811 investor-owned vs. $6,170 average for faith-based hospitals and $6,633 for government-owned facilities.

Source: Foster, Zrull, & Chenoweth, “Hospital Performance Differences by Ownership,” Truven Analytics, June 2013

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Research snapshots

Study: consumer directed health plans get mixed results

Abstract: “Consumer-directed health plans (CDHPs) are designed to make employees more cost- and health-conscious by exposing them more directly to the costs of their care, which should lower demand for care and, in turn, control premium growth. These features have made consumer-directed plans increasingly attractive to employers. We explored effects of consumer-directed health plans on health care and preventive care use, using data from two large employers—one that adopted a CDHP in 2007 and another with no CDHP. Our study had mixed results relative to expectations. After four years under the CDHP, there were 0.26 fewer physician office visits per enrollee per year and 0.85 fewer prescriptions filled, but there were 0.018 more emergency department visits. Also, the likelihood of receiving recommended cancer screenings was lower under the CDHP after one year and, even after recovering somewhat, still lower than baseline at the study’s conclusion. If CDHPs succeed in getting people to make more cost-sensitive decisions, plan sponsors will have to design plans to incentivize primary care and prevention and educate members about what the plan covers.”

Source: Paul Fronstin, Martín J. Sepúlveda, and Christopher Roebuck, “Consumer-Directed Health Plans Reduce The Long-Term Use Of Outpatient Physician Visits And Prescription Drugs,” Health Affairs, June 2013

Quotable

“Washington has been stuck for ages in tired, circular Medicare debates about increasing premiums on the wealthy and raising the age of eligibility. Those are important issues. They do not, however, reform the healthcare delivery system for the sickest seniors. This ought to be a priority for the days ahead...Our objective should be to make the adverse selection issue disappear, by creating specific consumer protections for seniors in plans that specialize in senior chronic care, while fully retaining the current protections against discrimination for all other seniors under current law.”—Senator Ron Wyden (D-OR), incoming Chairman, Senate Finance Committee, June 13, 2013, speech at the National Accountable Care Summit in Washington

“Annual events can serve as a snapshot of an industry, providing an opportunity to reflect on changes year over year. The sessions of the 9th annual Government Health IT meeting, held last week in Washington, DC, reflected the slow, yet steady, progress the health care industry on several fronts. First, the conversation has shifted from the need to adopt electronic health records to the productive use of the data held within. In addition, physicians are no longer seen as the sole consumers of information, with consumer engagement and transparency emerging as a central theme. More importantly, the spotlight is now on harnessing analytics to measure outcomes and manage the health of populations, and the transition from “volume to value” lurches forward.”—Harry Greenspun, M.D., Senior Advisor, Health Care Transformation and Technology, Deloitte Center for Health Solutions

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### Fact file

- **Characteristics of the 220 ACOs within the Medicare Shared Savings Program (ACA Section 3022)**

<table>
<thead>
<tr>
<th>Population density</th>
<th>Number of ACOs</th>
<th>Percent of total ACOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (85-100% in metro areas)</td>
<td>161</td>
<td>73%</td>
</tr>
<tr>
<td>Low (0-40% in metro areas)</td>
<td>16</td>
<td>7%</td>
</tr>
<tr>
<td>Mixed (40-85% in metro areas)</td>
<td>43</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>220</td>
<td>--</td>
</tr>
</tbody>
</table>

**Payment characteristics**

<table>
<thead>
<tr>
<th>Payment characteristic</th>
<th>Number of ACOs</th>
<th>Percent of total ACOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Track 1 (one-sided)</td>
<td>215</td>
<td>98%</td>
</tr>
<tr>
<td>Track 2 (two-sided)</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Advance Payment (CMMI Initiative)</td>
<td>36</td>
<td>16%</td>
</tr>
<tr>
<td>Interim Payment</td>
<td>17</td>
<td>8%</td>
</tr>
<tr>
<td>Total</td>
<td>220</td>
<td>--</td>
</tr>
</tbody>
</table>

**ACO reported composition**

<table>
<thead>
<tr>
<th>Network Type</th>
<th>Number of ACOs</th>
<th>Percent of total ACOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Networks of individual practices</td>
<td>121</td>
<td>55%</td>
</tr>
<tr>
<td>Group practices</td>
<td>90</td>
<td>41%</td>
</tr>
<tr>
<td>Hospital/professional partnerships</td>
<td>66</td>
<td>30%</td>
</tr>
<tr>
<td>Hospital employing ACO professionals</td>
<td>44</td>
<td>20%</td>
</tr>
<tr>
<td>Federally qualified health center</td>
<td>15</td>
<td>7%</td>
</tr>
<tr>
<td>Rural health clinic</td>
<td>11</td>
<td>5%</td>
</tr>
<tr>
<td>Critical access hospital</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>220</td>
<td>--</td>
</tr>
</tbody>
</table>

*Multiple responses may apply to an ACO.


- **ACOs and assigned beneficiaries regional data**

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of ACOs</th>
<th>Number of assigned beneficiaries</th>
<th>Percent Medicare population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Boston (CT, ME, MA, NH, RI, VT)</td>
<td>28</td>
<td>371,631</td>
<td>14.6%</td>
</tr>
<tr>
<td>2: New York (NJ, NY, PR, VI)</td>
<td>29</td>
<td>398,881</td>
<td>7.6%</td>
</tr>
<tr>
<td>3: Philadelphia (DE, DC, MD, PA, VA, WV)</td>
<td>21</td>
<td>188,475</td>
<td>3.7%</td>
</tr>
<tr>
<td>4: Atlanta (AL, FL, GA, KY, MS, NC, SC, TN)</td>
<td>68</td>
<td>657,599</td>
<td>6.2%</td>
</tr>
<tr>
<td>5: Chicago (IL, IN, MI, MN, OH, WI)</td>
<td>39</td>
<td>674,402</td>
<td>7.9%</td>
</tr>
<tr>
<td>6: Dallas (AR, LA, NM, OK, TX)</td>
<td>21</td>
<td>204,186</td>
<td>3.7%</td>
</tr>
<tr>
<td>7: Kansas City (IA, KS, MO, NE)</td>
<td>11</td>
<td>187,442</td>
<td>8.0%</td>
</tr>
<tr>
<td>8: Denver (CO, MT, ND, SD, UT,)</td>
<td>4</td>
<td>31,766</td>
<td>2.1%</td>
</tr>
<tr>
<td></td>
<td>Minimum</td>
<td>Median</td>
<td>Maximum</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------</td>
<td>--------</td>
<td>---------</td>
</tr>
<tr>
<td>End-stage Renal disease (ESRD)</td>
<td>0.3%</td>
<td>1.0%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Disabled</td>
<td>8.5%</td>
<td>16.5%</td>
<td>49.3%</td>
</tr>
<tr>
<td>Aged dual eligible</td>
<td>0.3%</td>
<td>5.0%</td>
<td>76.8%</td>
</tr>
<tr>
<td>Aged non-dual eligible</td>
<td>12.9%</td>
<td>76.5%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Male</td>
<td>35.1%</td>
<td>41.8%</td>
<td>48.2%</td>
</tr>
<tr>
<td>Female</td>
<td>51.8%</td>
<td>58.2%</td>
<td>64.9%</td>
</tr>
<tr>
<td>Age less than 65</td>
<td>8.9%</td>
<td>17.2%</td>
<td>51.0%</td>
</tr>
<tr>
<td>Age 65-74</td>
<td>26.9%</td>
<td>40.4%</td>
<td>52.4%</td>
</tr>
<tr>
<td>Age 75-84</td>
<td>13.0%</td>
<td>28.4%</td>
<td>37.7%</td>
</tr>
<tr>
<td>Age 85+</td>
<td>4.1%</td>
<td>12.9%</td>
<td>24.1%</td>
</tr>
</tbody>
</table>

**ACO performance data**

**Demographics**

<table>
<thead>
<tr>
<th>Demographic Category</th>
<th>Minimum</th>
<th>Median</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>End-stage Renal disease (ESRD)</td>
<td>0.96</td>
<td>1.08</td>
<td>1.24</td>
</tr>
<tr>
<td>Disabled</td>
<td>0.78</td>
<td>1.11</td>
<td>1.62</td>
</tr>
<tr>
<td>Aged dual eligible</td>
<td>1.08</td>
<td>1.53</td>
<td>1.98</td>
</tr>
<tr>
<td>Aged non-dual eligible</td>
<td>0.77</td>
<td>1.05</td>
<td>1.46</td>
</tr>
</tbody>
</table>

**ACO risk profile (average risk scores by demographic category)**

<table>
<thead>
<tr>
<th>Benchmark (historical per capita annual expenditures)</th>
<th>Minimum</th>
<th>Median</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benchmark 2012 starts (2011 dollars and risk)</td>
<td>7,256</td>
<td>9,785</td>
<td>17,236</td>
</tr>
<tr>
<td>Benchmark 2013 starts (2012 dollars and risk)</td>
<td>4,981</td>
<td>10,030</td>
<td>20,522</td>
</tr>
</tbody>
</table>

*An ACO may be in multiple regions.
<table>
<thead>
<tr>
<th>Utilization (per thousand assigned beneficiaries unless otherwise noted)</th>
<th>Values for individual ACOs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Minimum</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>226</td>
</tr>
<tr>
<td>Emergency department visits</td>
<td>287</td>
</tr>
<tr>
<td>Emergency department visits with hospitalization</td>
<td>34</td>
</tr>
<tr>
<td>CT events</td>
<td>243</td>
</tr>
<tr>
<td>MRI events</td>
<td>86</td>
</tr>
<tr>
<td>Ambulance events</td>
<td>229</td>
</tr>
<tr>
<td>Primary care service visits total (per assigned beneficiary)</td>
<td>6.6</td>
</tr>
<tr>
<td>ACO primary care service visits (per assigned beneficiary)</td>
<td>3.4</td>
</tr>
<tr>
<td>Percent primary care charges in ACO</td>
<td>46.6%</td>
</tr>
</tbody>
</table>


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