



**2014 Health Care Investors Conference  
Wednesday, November 19, 2014**

## Agenda

8:30 a.m.–9:00 a.m.	Networking Breakfast and Registration
9:00 a.m.–9:55 a.m.	Provider-Payor Perspectives on Innovation, Consumerism, and Collaboration
9:55 a.m.–10:30 a.m.	Networking Break
10:30 a.m.–11:20 a.m.	Inside the Beltway
11:20 a.m.–12:20 p.m.	Keynote/Lunch
12:20 p.m.–12:30 p.m.	Break
12:30 p.m.–1:20 p.m.	Private Equity Panel
1:20 p.m.–1:35 p.m.	Spotlight Session
1:35 p.m.–2:25 p.m.	The Emerging Market
2:25 p.m.–2:30 p.m.	Closing Remarks

# Provider-Payor Perspectives on Innovation, Consumerism, and Collaboration

## Moderator



Angela Humphreys  
Member, Healthcare  
Bass, Berry & Sims, PLC

## Panelist



Richard Barasch  
Chairman and Chief Executive  
Officer  
Universal American Corp.

## Panelist



Chris Holden  
President, Chief Executive  
Officer and Director  
Amsurg Corp.



## Networking Break

# Inside the Beltway

## Speaker



Sarah Thomas  
Director of Research  
Deloitte Center for Health  
Solutions

# Regulatory Updates



# Political scenarios

# Possible ACA outcomes: SCOTUS results

Suppositions drawn from election forecasting, industry predictions, and research

## Background

- July 2014: two cases ruled differently in the case of federal subsidies issued through the federal exchange; one deemed it unlawful, the other not
- The “unlawful” case ruling was thrown out in appellate court in September 2014; SCOTUS will take up this issue; decision potentially in Spring 2015
- Issue not about the constitutionality of ACA, but rather the legality of regulation implementation as described in the statute
- Until a decision is made, the future of the healthcare coverage of individuals granted subsidies through the federal exchange is in doubt

Judicial	Scenario Outcome	Likelihood of change to ACA	ACA Impact
<b>Supreme Court of the United States (SCOTUS)</b>	<ul style="list-style-type: none"><li>▪ In early November the Supreme Court opted to take the case and Halbig was put on hold</li><li>▪ Could invalidate subsidies for millions of people</li><li>▪ If subsidies not available to purchase coverage, big drop in enrollment in FFM markets, which would create a destabilization in the risk pool</li></ul>	<b>Low</b>  <b>Unlikely, but possible</b>	<b>Negative</b>

# Possible ACA outcomes: 2014 midterm elections

Suppositions drawn from forecasting, industry predictions, and research

Presidential	Senate	House	Scenario Outcome	Likelihood	ACA Impact
<b>President Obama</b> 			<ul style="list-style-type: none"> <li>▪ GOP will attempt ceremonial vote(s) for repeal of the ACA</li> <li>▪ GOP cannot repeal ACA with Pres. Obama in office, but will attempt to dismantle aspects of the law unpopular to their base:                             <ul style="list-style-type: none"> <li>– Tax on medical devices (bipartisan support)</li> <li>– Employer mandate (unlikely to pass)</li> <li>– Individual mandate (even more unlikely to pass)</li> </ul> </li> <li>▪ GOP may use partial repeal as a negotiation tactic in budget or debt limit deliberations</li> </ul>	<b>High</b>	<b>Negative or Neutral</b>

*Senate: 44 Democratic, 2 Independent, 53 Republican, one undetermined as of 11/12/2014; House: 184 Democratic, 244 Republican as of 11/12/2014*

Gubernatorial	Scenario Outcome	Likelihood	ACA Impact
<b>Democratic States – 17</b>	<ul style="list-style-type: none"> <li>▪ Continue to execute ACA implementation; continue or take up Medicaid expansion</li> <li>▪ Possible switching from state marketplaces/exchanges to federal</li> </ul>	<b>High</b>	<b>Positive</b>
<b>Republican States - 31</b>	<ul style="list-style-type: none"> <li>▪ Most continue to reject ACA generally as well as Medicaid expansion. Arkansas 'private option' may be at risk.</li> </ul>	<b>High</b>	<b>Negative or Neutral</b>
<b>Toss-up States - 2</b>	<ul style="list-style-type: none"> <li>▪ Alaska and Vermont still under debate. As of November 12, Bill Walker (other) was winning Alaska, and Peter Shumlin (D) was winning Vermont.</li> </ul>	<b>Med</b>	<b>Neutral or Positive</b>

Source: [What a GOP Senate Would Mean for Healthcare](#), [What Republicans Want to do if They Win the Senate](#), [What Republicans Will Really do to Obamacare if they Win the Senate](#)

# Possible ACA outcomes: 2016 presidential election

Suppositions drawn from election forecasting, industry predictions, and research

Presidential	Senate	House	Scenario Outcome	Likelihood	ACA Impact
<b>Dem Candidate</b> 			<ul style="list-style-type: none"> <li>ACA stays as is or improvements are made</li> </ul>	Med	Positive
			<ul style="list-style-type: none"> <li>Threat to elements of law that are unpopular (employer / individual mandates, subsidies, medical device tax) if not already addressed in previous session</li> <li>If Democrats have Senate majority, any efforts to revoke pieces of ACA likely halted by the Senate</li> </ul>	High	Negative to Neutral
			<ul style="list-style-type: none"> <li>May attempt to repeal pieces of ACA; President likely will veto</li> <li>Dem presidential victory may be interpreted as a mandate to support healthcare reform</li> </ul>	Low	Neutral
<b>GOP Candidate</b> 			<ul style="list-style-type: none"> <li>May dismantle ACA piecemeal; Many aspects of ACA ingrained so challenging to remove the entire law (estimates say 12-15 million more people will be signed up by 2016).</li> <li>GOP may shift focus away from repealing ACA; by 2016, may not be seen as a winning platform</li> </ul>	Med	Negative to Neutral
			<ul style="list-style-type: none"> <li>May dismantle unpopular elements of ACA</li> <li>If Democrats get Senate back, efforts to revoke pieces of ACA will be halted</li> </ul>	High	Negative to Neutral
			<ul style="list-style-type: none"> <li>Potential executive orders passed to remove/change unpopular elements of ACA if public opinion supports without Congressional vote</li> </ul>	Low	Negative to Neutral

10 Democratic, 24 Republican Senate seats up for election

**Legend:** ■ Republican majority ■ Democratic majority ■ Each holding majority in one chamber only or tossup

Source: [What Republicans Want to do if They Win the Senate](#), [House Republican Leaders Finally Admit Obamacare Isn't Going Anywhere](#), [What Republicans Will Really do to Obamacare if they Win the Senate](#), [Clinton Can Win 45 States](#)

# What does the election mean for providers, health plans, and life sciences companies?

## Budget

➤ The '*Continuing Resolution*' that is currently funding the government is set to expire on 12/11/14, before the new Congress is in office, resolution is likely to play out over the next several weeks and months.

## Medicare Physician Payment

➤ Last year, Congress tried to enact major reform to the Medicare payment system, but in the end was unable to find the funding to support the policy changes. As such, *legislation enacted a patch*, through March 2015.

## 21<sup>st</sup> Century Cures

➤ '21<sup>st</sup> Century Cures' focuses on "*accelerating the pace of new cures and treatments.*" With stronger Republican presence in both houses, prospects are more likely for legislation to bring life sciences products to market more quickly.

## Health Insurance Marketplaces

➤ While most states that opted to operate their own marketplaces had Democratic governors, even many Democratic-led states decided not to make the investment into their own marketplaces. The election is unlikely to overcome the *financial and political challenges of standing up a state marketplace for 2016.*

## Medicaid Expansion

➤ After the election results, *additional Medicaid expansion appears unlikely*, except perhaps in Alaska. In Arkansas, a change in the administration could mean that current efforts to expand the program are reversed or reduced.

# Marketplace 2015 Open Enrollment forecast



Areas of  
regulatory uncertainty

# Areas of regulatory uncertainty

**Medicare policy and implementation, “the doc fix”**

**Privacy and security**

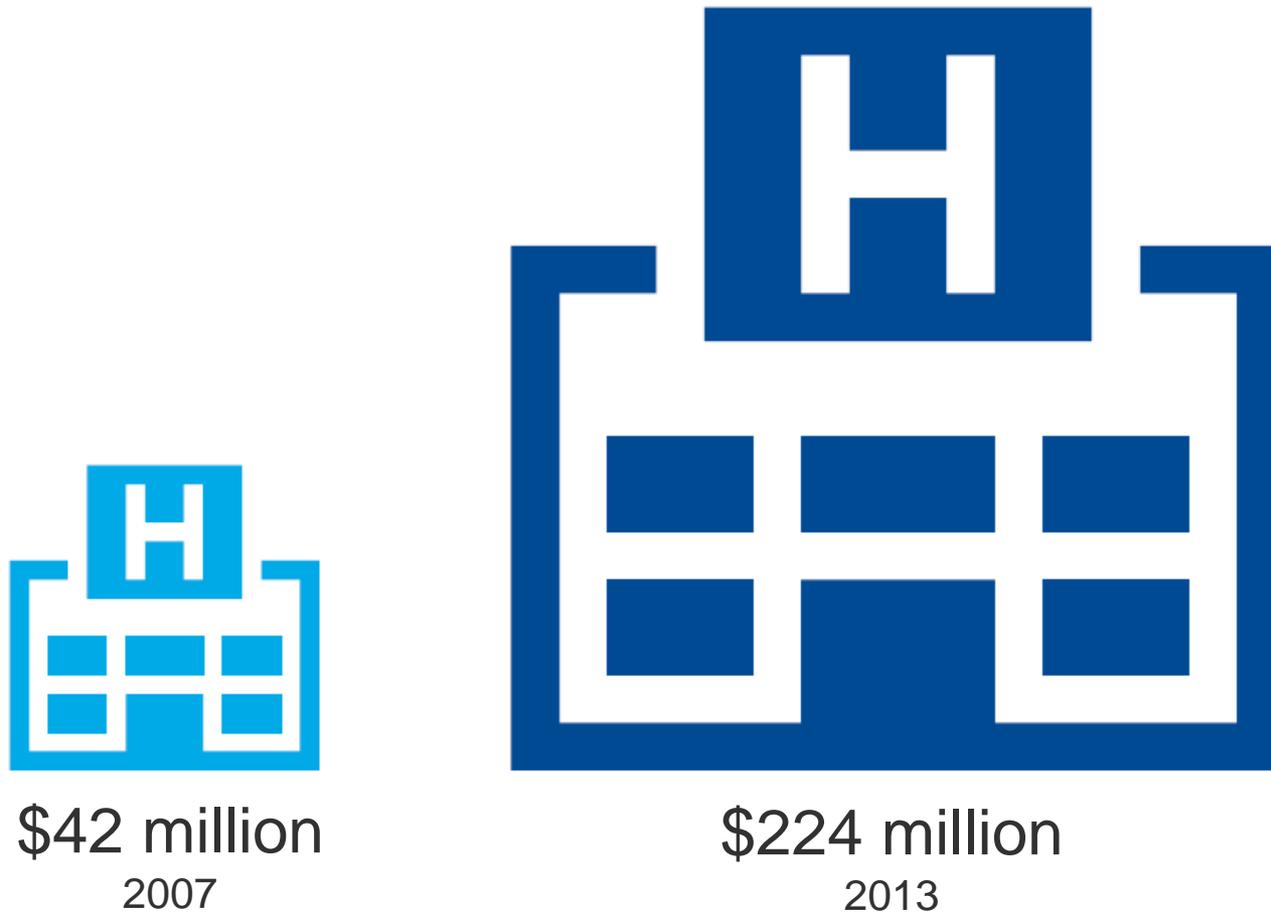
**ICD-10**

**Meaningful Use and interoperability**

**Medicare Advantage and narrow networks**

What are we learning  
about what is going on  
in the health care  
market?

# The great consolidation: Average deal size for hospital acquisitions



Source: Irving Levin Associates, The Hospital Acquisition Report 2014; Deloitte Center for Health Solutions: [“The great consolidation: The potential for rapid consolidation of health systems”](#)

# The health system landscape

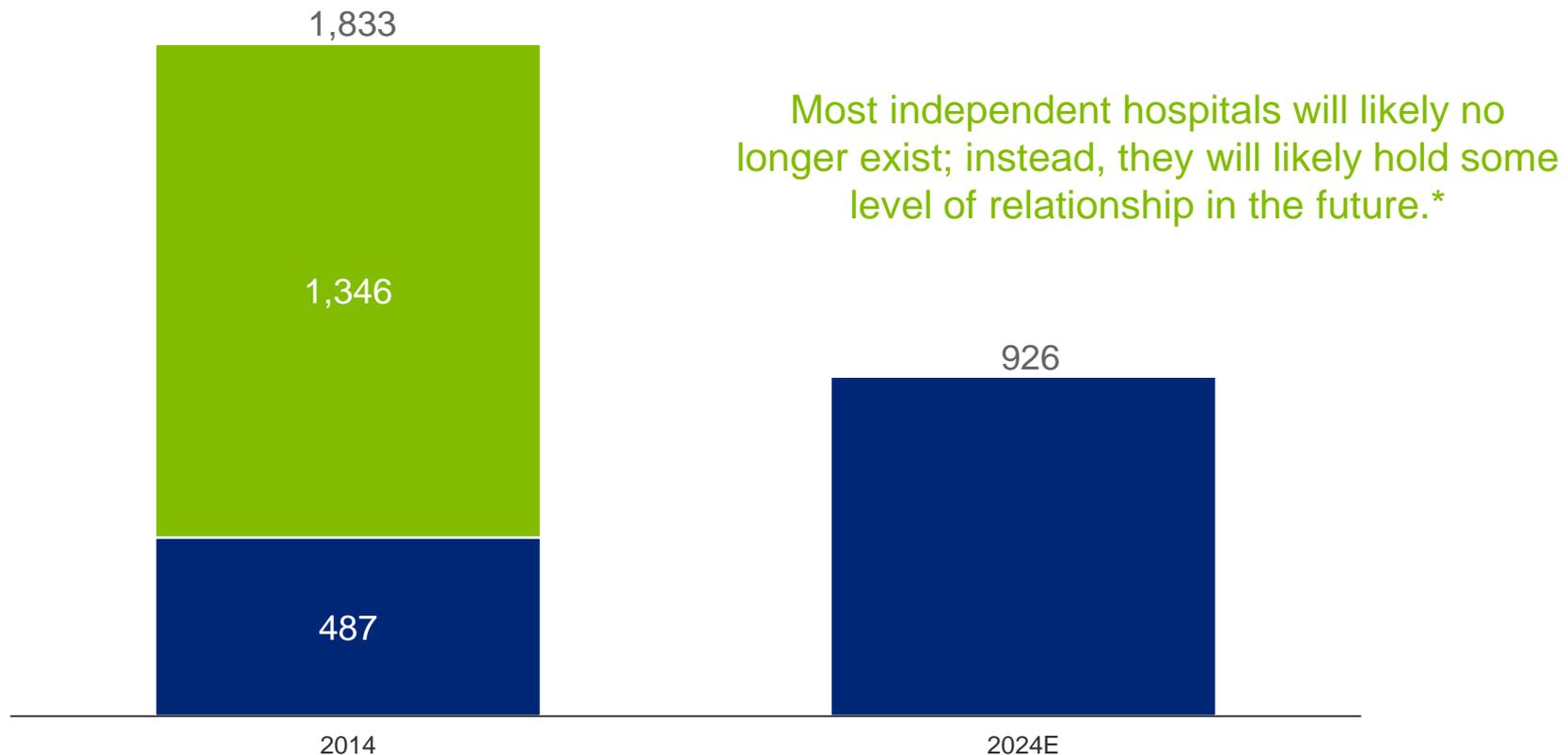
Group	Description	Number of health systems*
Large health systems/national chains	<ul style="list-style-type: none"> <li>• 10+ hospitals</li> <li>• Multi-region or multi-state footprint</li> </ul>	80
Mid-tier health systems	<ul style="list-style-type: none"> <li>• 2-9 hospitals</li> <li>• Local regional/metropolitan area footprint</li> </ul>	273
Academic Medical Centers (AMCs)	<ul style="list-style-type: none"> <li>• Academically affiliated</li> <li>• Independent and multi-hospital systems</li> <li>• Local regional/metropolitan area footprint</li> </ul>	134
Small community health systems	<ul style="list-style-type: none"> <li>• Independent</li> <li>• Located in urban, suburban, and rural markets</li> </ul>	1,346
<b>Total: Non-government health systems</b>		<b>1,833</b>

Source: Deloitte Center for Health Solutions: [“The great consolidation: The potential for rapid consolidation of health systems”](#)

\*Deloitte analysis of “Medicare Cost Report data, 2012”, Centers for Medicare and Medicaid Services.

# Projected consolidation: Number of health systems

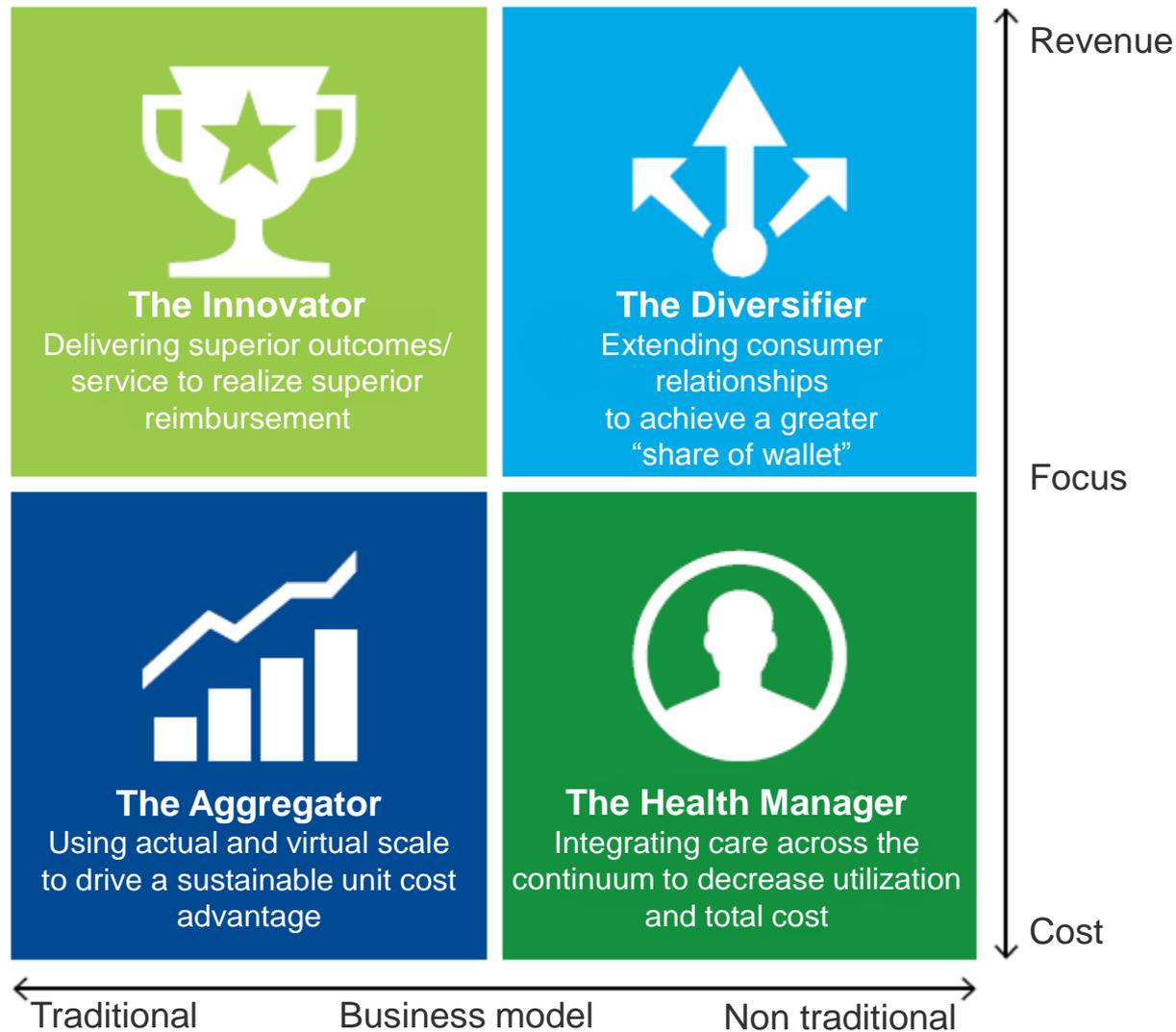
Deloitte's analysis – using three independent approaches where results converged – estimates that likely only 50 percent of today's unique health systems are expected to remain.



\*Note: Consolidation may include acquisitions, affiliations, partnerships, or collaborations.

Source: Deloitte Center for Health Solutions: "[The great consolidation: The potential for rapid consolidation of health systems](#)"

# Possible positioning for consolidation



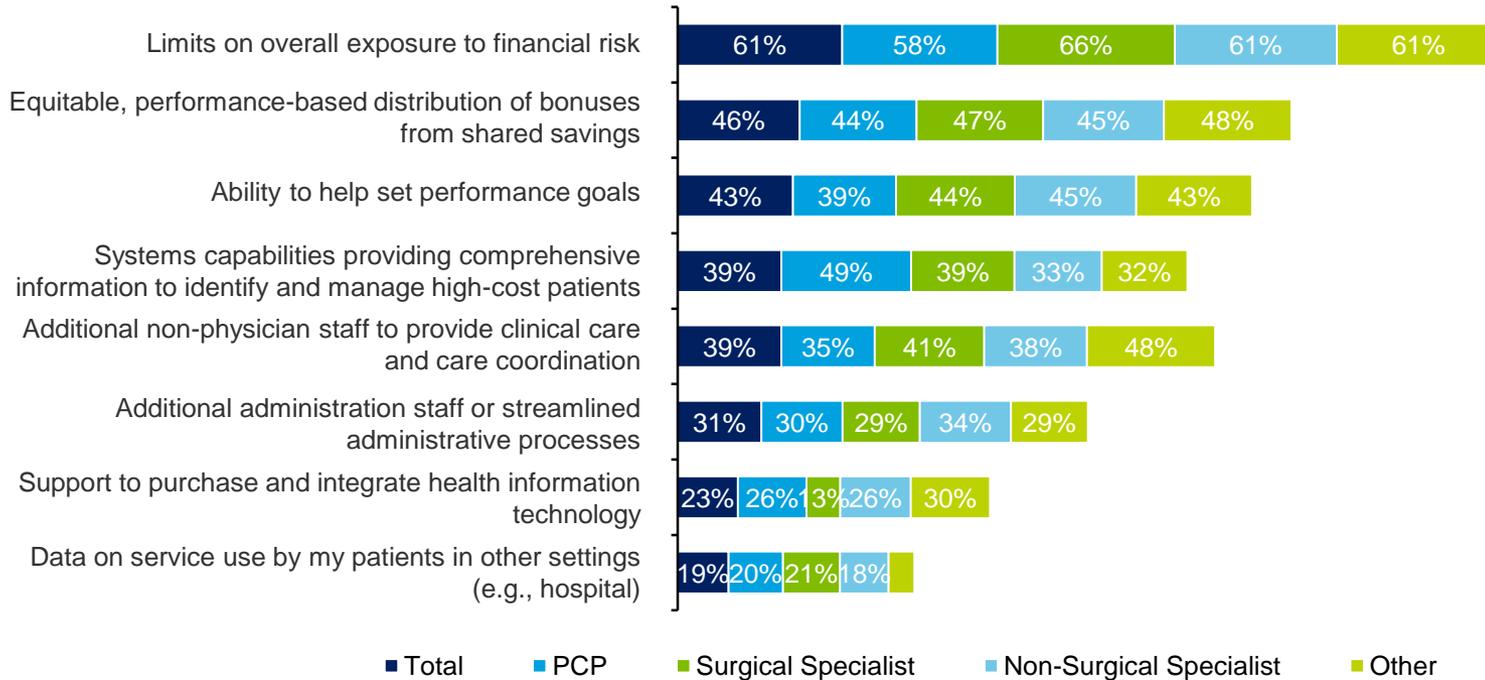
Source: Deloitte Center for Health Solutions: "[The great consolidation: The potential for rapid consolidation of health systems](#)"

# Results of the Deloitte 2014 Survey of U.S. Physicians

# Physicians report financial protection and support staff are important factors to consider when entering into value-based payment models

Q720. Which of the following factors are most important when constructing a risk-based compensation arrangement? Please select the three most important factors from the list below.

## Percentage selecting following factors by physician type

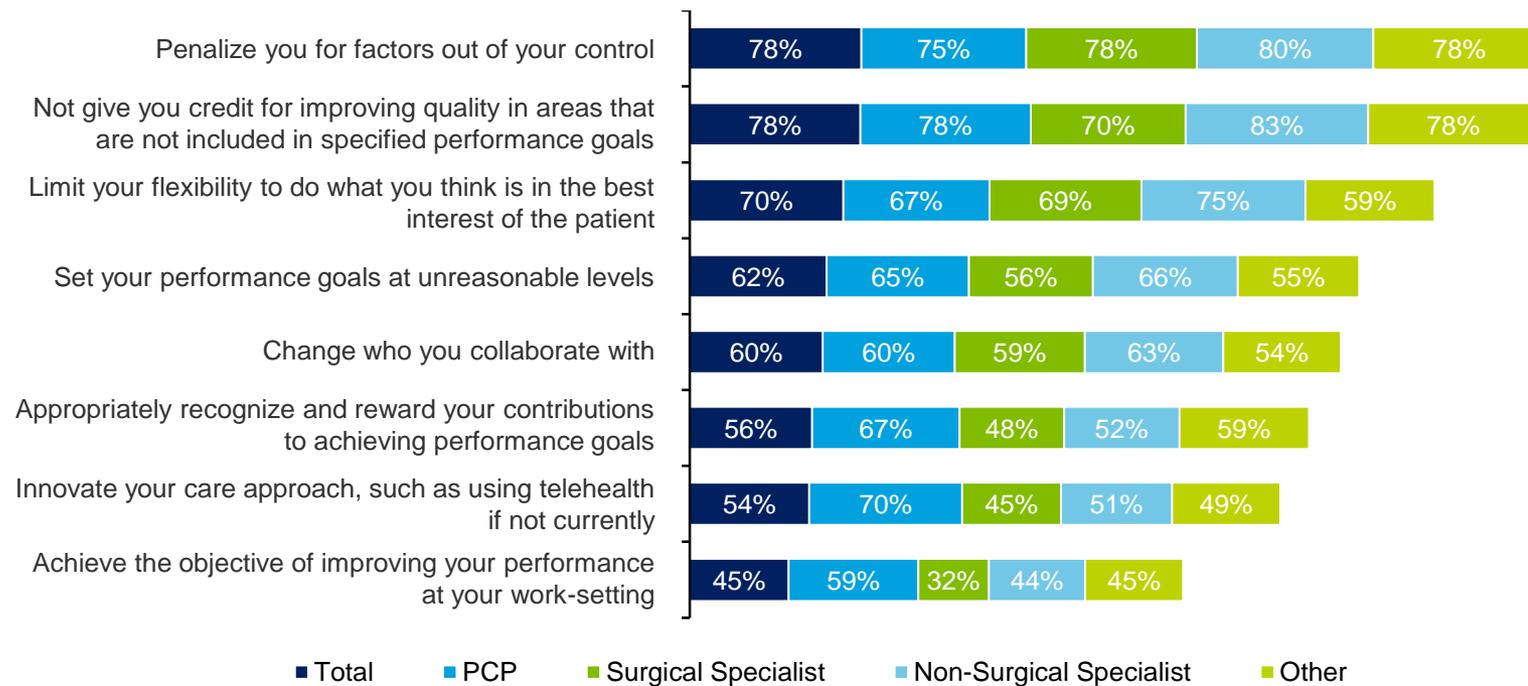


Responses of 10% or less not labeled  
Data are weighted

# Physicians report value-based payment models may penalize them for factors out of their control or not give credit them for quality improvements achieved outside of performance goals

Q725. Please indicate how much you agree or disagree that risk-based compensation arrangements will...

## Percentage responding “strongly agree” or “agree” by physician type



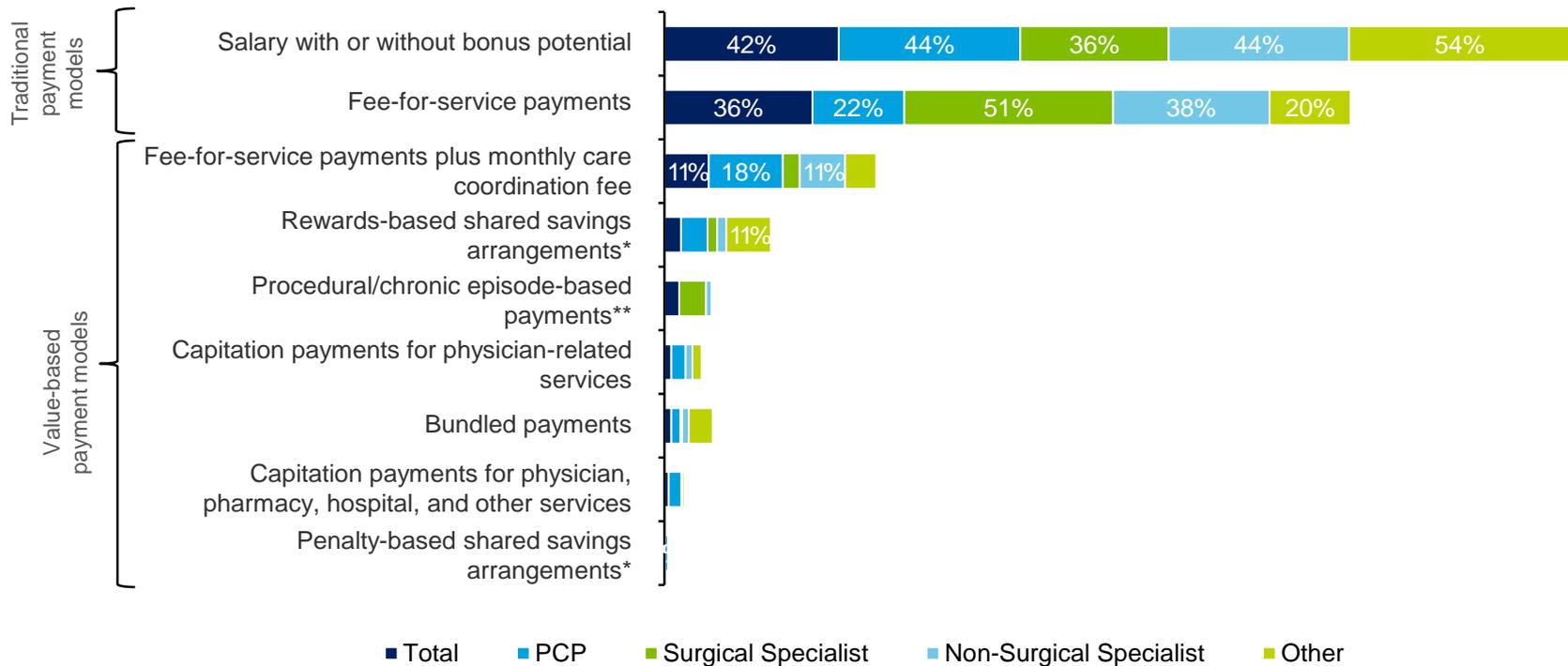
Data are weighted

Source: Deloitte Center for Health Solutions: 2014 Survey of U.S. Physicians

# Physicians report preference toward traditional payment models versus value-based payment models

Q715. From the list below, please rank in order of importance, the top three compensation arrangements you would most prefer.

Percentage responding most preferred (rated "1") by physician type



\*Rewards - and Penalty-based shared savings arrangements are based on quality/cost outcomes

\*\*Option only presented to specialists

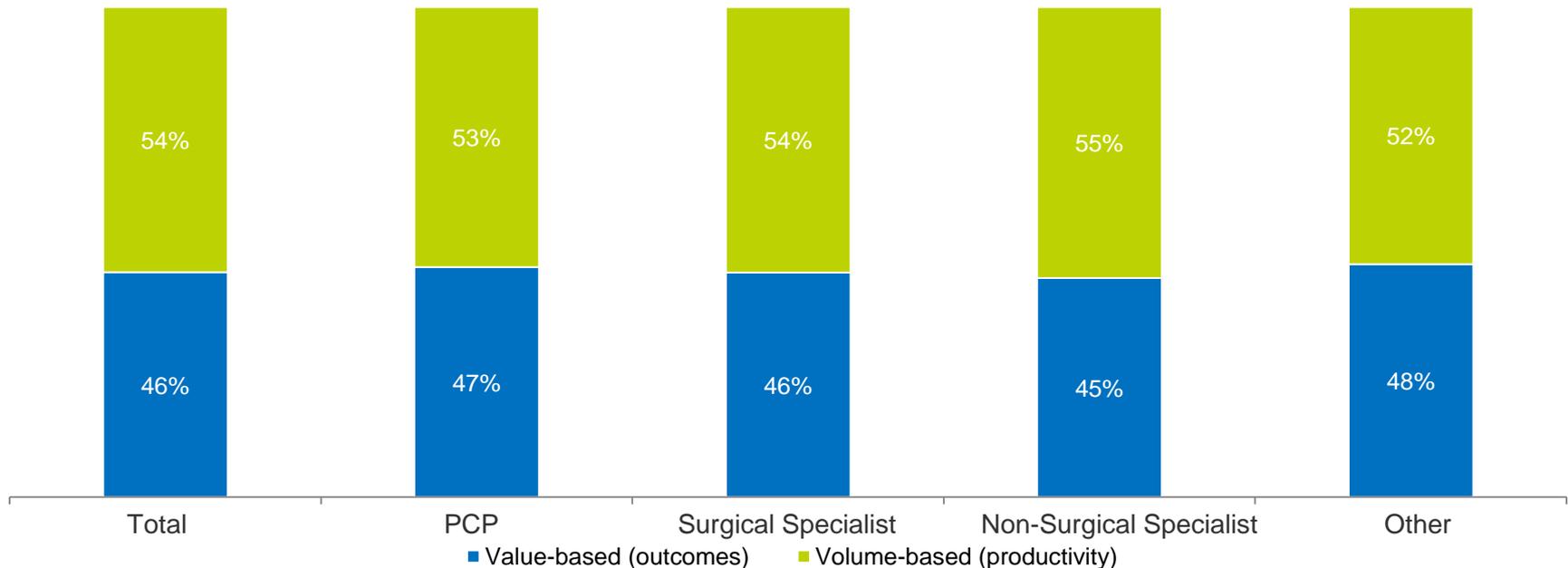
Responses of 10% or less not labeled  
Data are weighted

Source: Deloitte Center for Health Solutions: 2014 Survey of U.S. Physicians

# Physicians report that value-based payment models in 10 years will comprise nearly half of their total compensation

Q730. Based on your understanding of how medicine is changing, what do you anticipate the physician compensation mix will be 10 years from now?

## Physician compensation mix\* by physician type



\*Mean, including zero

Source: Deloitte Center for Health Solutions: 2014 Survey of U.S. Physicians

Responses of 10% or less not labeled  
Data are weighted

Rising out-of-pocket  
health care costs

# Total health care expenditure: NHEA + non-NHEA

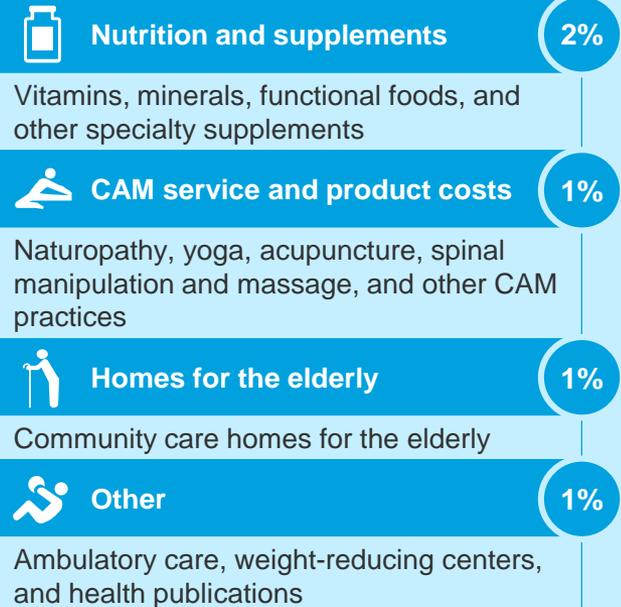
## 81% NHEA

Health care spending in the United States reported by the National Health Expenditure Accounts (NHEA)



## 4% Other non-NHEA spending

Spending (excluding supervisory care) that is not conventionally reported in the NHEA



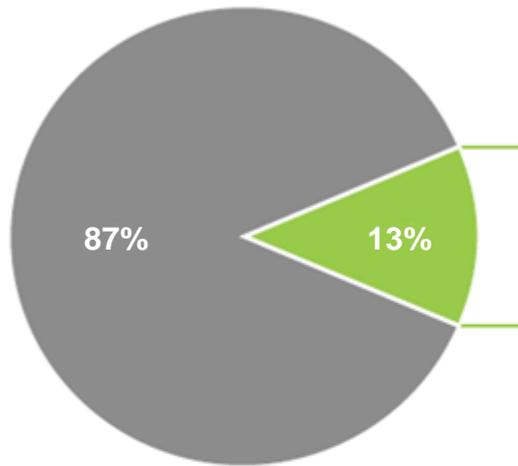
## 15% Supervisory care

Deloitte's estimate of the imputed value of unpaid care at home provided by a family member or friend to someone with limited capacity to self care

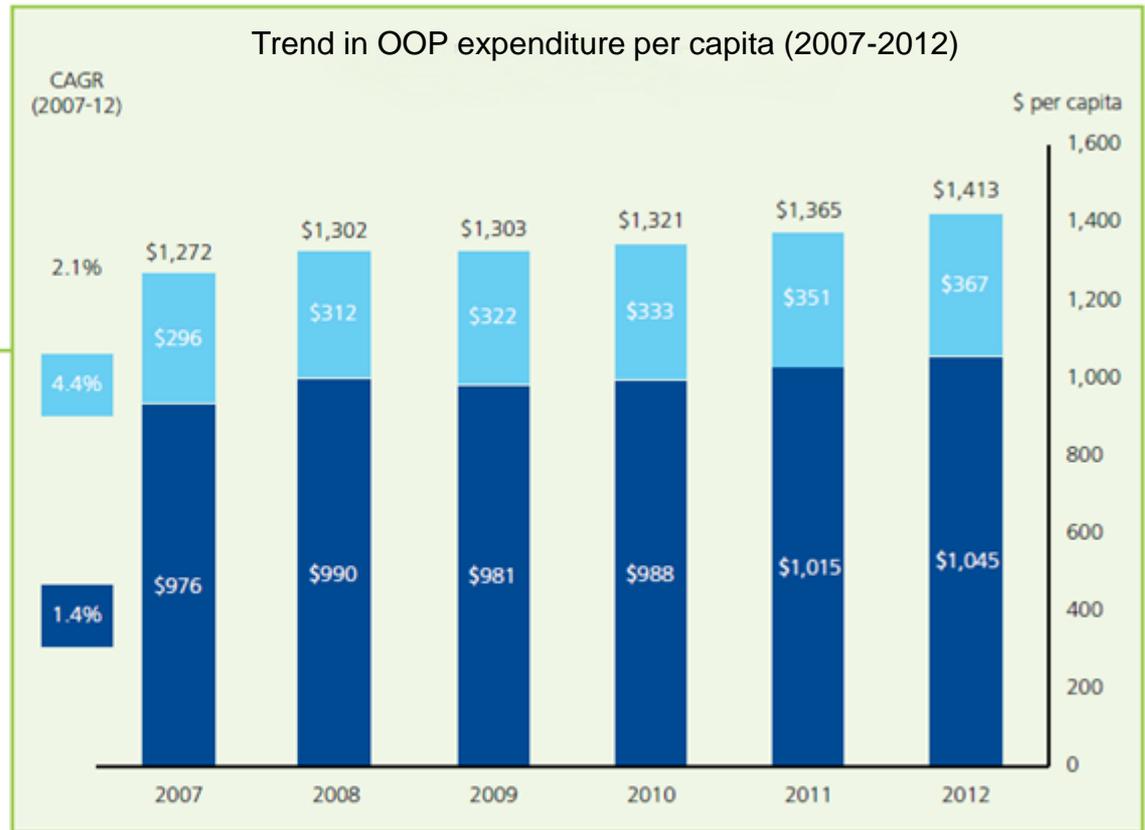
Note: Numbers are rounded.

# NHEA data shows rising OOP expenditures; amounts are higher when hidden costs are included

OOP expenditure makes up 13 percent of total health care spending



2012 total health care spending = \$3,466 billion



■ Non-OOP spending ■ OOP spending

■ NHEA OOP per capita ■ Non-NHEA OOP per capita

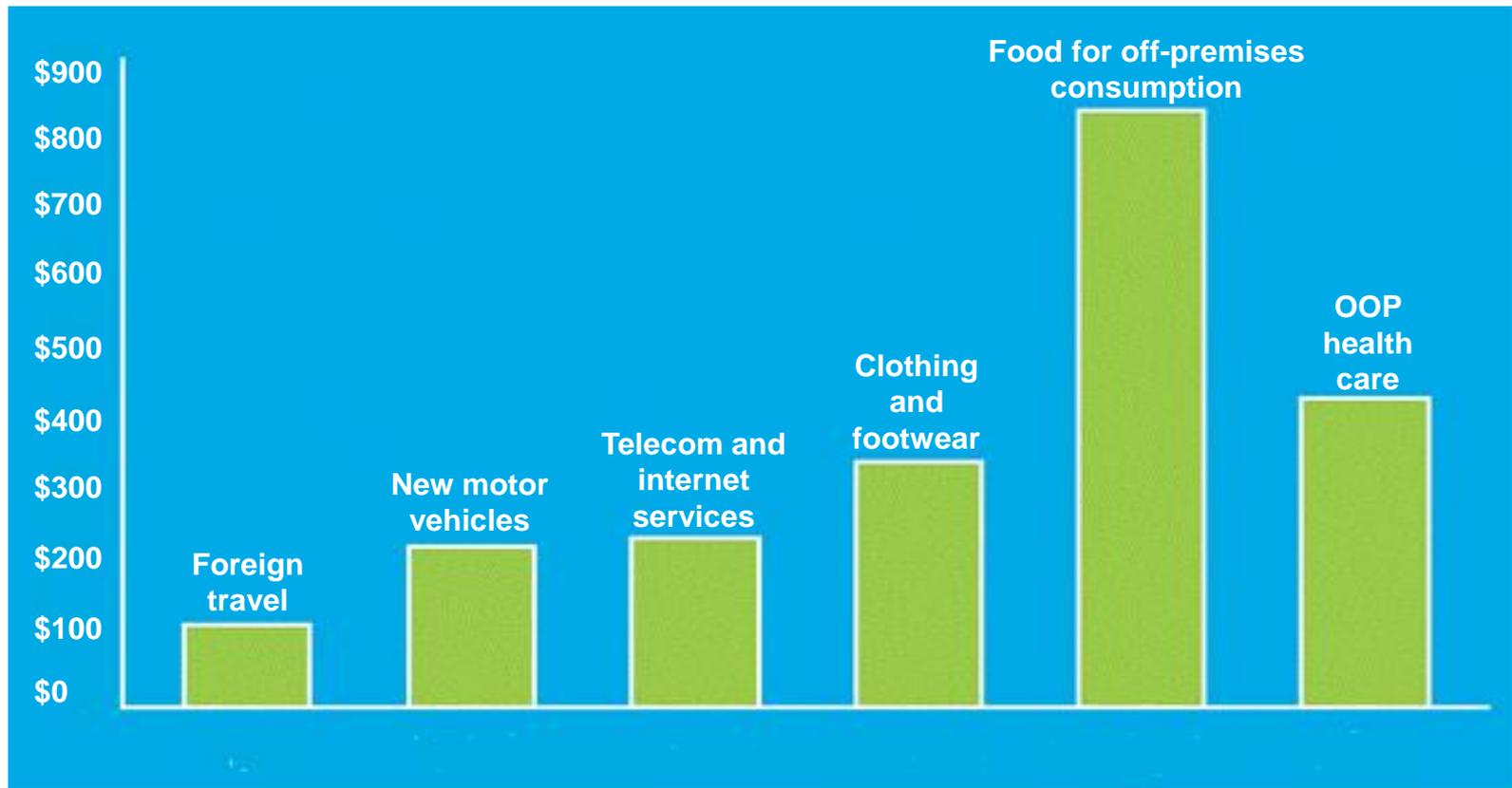
Note: Numbers are rounded.

Since completion of this study, NHEA has published health care expenditure forecasts for 2013-23 along with minor revisions in the historical data.

Source: Deloitte Hidden Costs Analysis, 2014.

# OOP spending relative to other household expenses: Another perspective

Aggregate spending on selected categories, U.S. \$ billions, 2012



Source: Bureau of Economic Analysis and Deloitte calculations

# Contact information

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# Keynote

## Speaker



R. Lawrence Van Horn  
Associate Professor of  
Management (Economics)  
Executive Director of Health  
Affairs  
Vanderbilt University

# The Mathematical Challenge Facing the US Health Care Industry

R. Lawrence Van Horn, Ph.D, MPH, MBA  
Executive Director for Health Affairs  
Associate Professor of Economics and Management  
Associate Professor of Health Policy  
Associate Professor of Law



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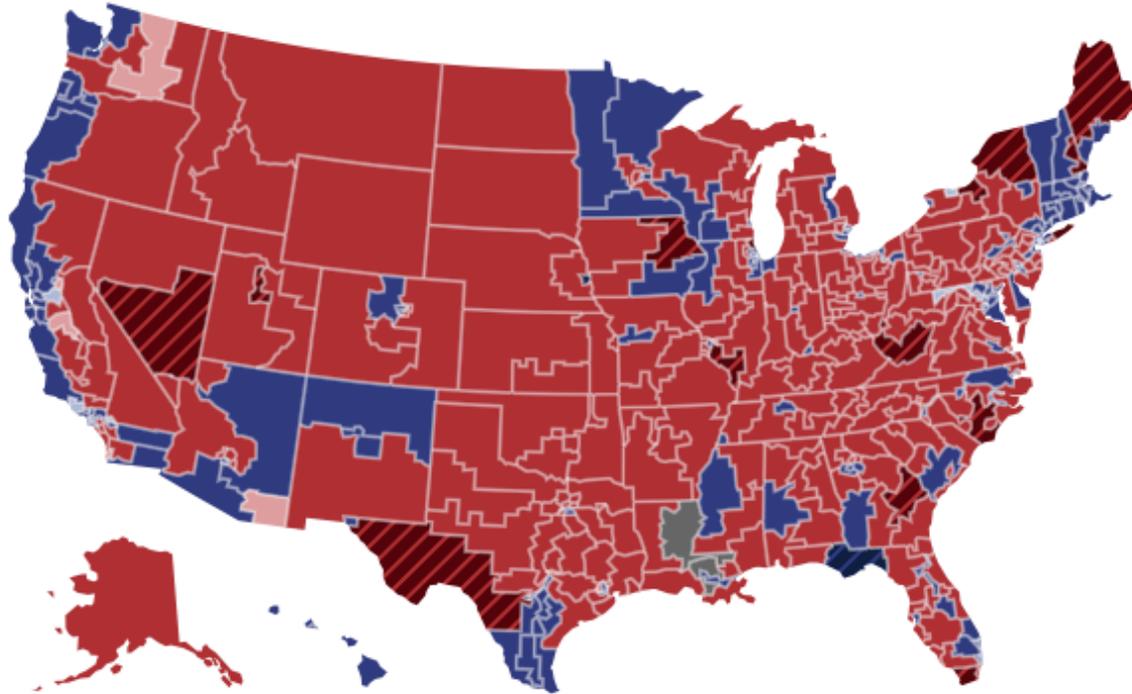
# Roadmap

- The macro math challenge facing our country
- Trend has slowed – are we good?
- A step back – How did we get here?
- More health care does not equal more health.



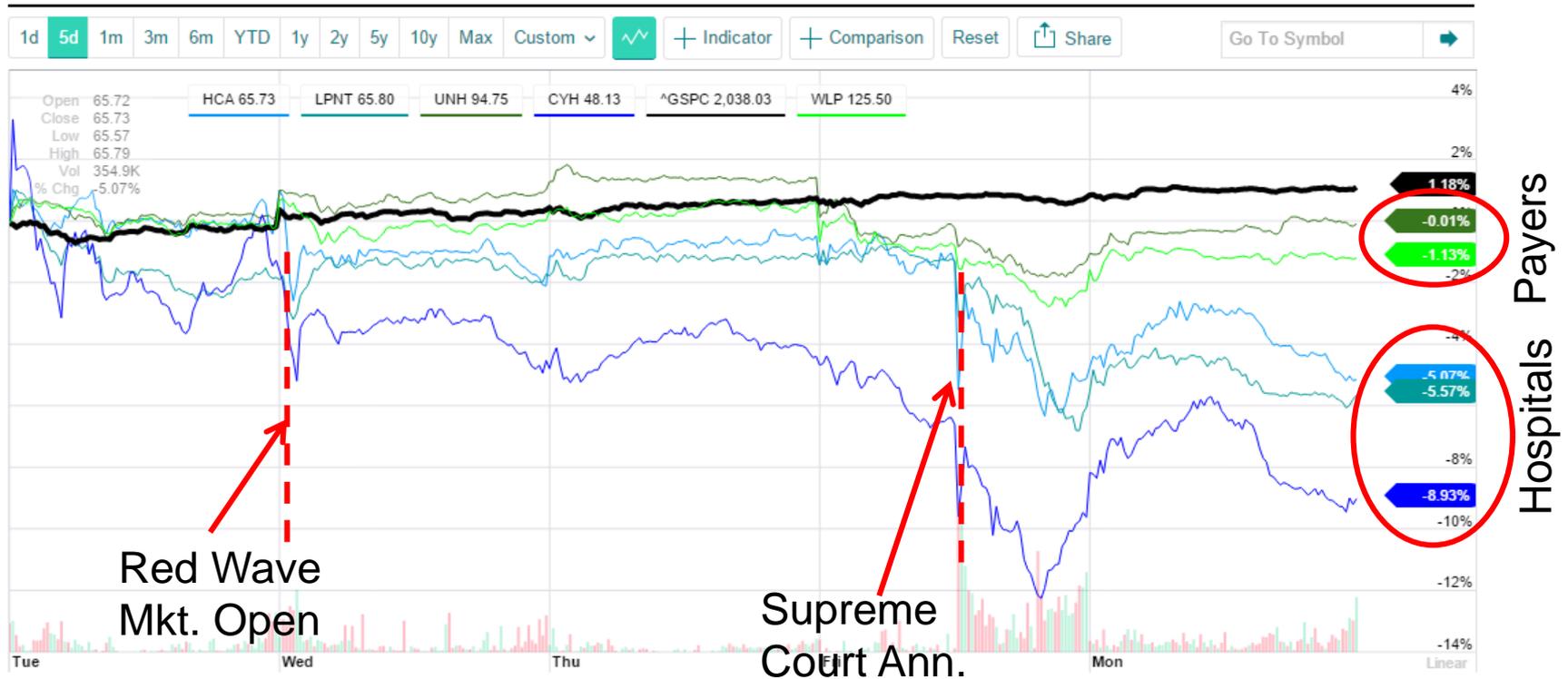
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# Red America



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# Market Reaction to a big election week



# ECONOMIC PICTURE



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# The financial picture of the Jones Family (husband / wife and 2 kids)

- Income \$28,220
  - Expenses \$35,520
    - » Shortfall \$7,300
  - Credit Card Balance \$175,400
- But wait there is more .....**
- Needed for Retirement \$540,000



# The financial picture of the Jones Family (husband / wife and 2 kids)

- Income \$28,220
- Expenses \$35,520
  - » Shortfall \$7,300
- Credit Card Balance \$175,400
- Needed for Retirement \$540,000

But wait there is more .....

Now multiply by \$100 million and you have our Federal Budget.



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# The Current Sad State of Affairs



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# US Debt Clock.org

State Debt Clocks

World Debt Clocks

Debt Clock Time Machine

### US NATIONAL DEBT

**\$17,758,397,419,212**

DEBT PER CITIZEN  
**\$55,671**

DEBT PER TAXPAYER  
**\$152,155**

US FEDERAL SPENDING **↑100%**

**\$3,533,078,494,505**

US FEDERAL BUDGET DEFICIT

**\$549,869,160,657**

US FEDERAL TAX REVENUE **↑51%**

**\$2,983,209,318,677**

INCOME TAX

**\$1,382,066,418,426**

PAYROLL TAX

**\$1,033,085,538,883**

CORPORATE TAX

**\$351,077,488,164**

STATE REVENUE

**\$1,587,352,493,709**

STATE DEBT

**\$1,187,739,247,694**

LOCAL REVENUE

**\$1,098,386,521,711**

LOCAL DEBT

**\$1,890,117,439,837**

US GROSS DOMESTIC PRODUCT **↑74%**

**\$16,813,488,934,774**

TOTAL FEDERAL/STATE/LOCAL SPENDING

**\$6,176,294,394,673**

GROSS DEBT TO GDP RATIO

**105.6147484%**

REVENUE TO GDP RATIO

**33.7166821%**

SPENDING TO GDP RATIO

**36.7339828%**

US POPULATION

**318,993,566**

US WORK FORCE 2014

**146,550,120**

US INCOME TAXPAYERS

**116,713,085**

US WORK FORCE 2000\*

**153,854,190**

MEDIAN INCOME 2014

**\$28,490**

NOT IN LABOR FORCE 2014

**92,414,180**

MEDIAN INCOME 2000\*

**\$28,665**

NOT IN LABOR FORCE 2000\*

**78,495,041**

PRIVATE SECTOR JOBS

**115,796,475**

STATE/LOCAL EMPLOYEES

**19,741,349**

SELF-EMPLOYED

**8,421,386**

FEDERAL EMPLOYEES

**4,375,497**

OFFICIAL UNEMPLOYED

**9,474,068**

FULL-TIME WORKERS

**118,808,603**

ACTUAL UNEMPLOYED

**18,544,764**

PART-TIME WORKERS

**27,731,881**

US RETIREES

**47,826,269**

MEDICARE ENROLLEES

**54,552,919**

DISABLED (SSI)

**10,935,698**

MEDICAID RECIPIENTS

**33,748,951**

LIVING IN POVERTY

**47,330,870**

FOOD STAMP RECIPIENTS

**46,192,644**

WITHOUT INSURANCE

**46,865,058**

TOTAL RECEIVING BENEFITS

**157,240,952**

### Largest Budget Items

MEDICARE/MEDICAID

**\$911,061,386,728**

SOCIAL SECURITY

**\$845,037,234,573**

DEFENSE/WAR

**\$606,006,038,040**

INCOME SECURITY

**\$316,287,106,403**

NET INTEREST ON DEBT

**\$235,014,088,756**

FEDERAL PENSIONS

**\$243,010,063,397**

US TOTAL INTEREST PAID

**\$2,526,014,216,137**

INTEREST PER CITIZEN

**\$7,919**

US TOTAL DEBT **↑123%**

**\$59,456,877,561,874**

TOTAL DEBT PER CITIZEN

**\$186,389**

TOTAL DEBT PER FAMILY

**\$730,321**

SAVINGS PER FAMILY

**\$8,647**

TOTAL PERSONAL DEBT **↑101%**

**\$16,649,628,090,874**

MORTGAGE DEBT

**\$13,358,519,639,641**

STUDENT LOAN DEBT

**\$1,299,222,848,371**

CREDIT CARD DEBT

**\$890,991,831,107**

PERSONAL DEBT PER CIT.

**\$52,194**

### Money Creation

MONETARY BASE 2014 **↑588%**

**\$4,131,272,666,967**

M2 MONEY SUPPLY 2014 **↑133%**

**\$11,424,084,153,936**

TREASURY SECURITIES 2014 **↑290%**

**\$934,026,827,622**

CURRENCY AND CREDIT DERIVATIVES 2014 **↑710%**

**\$751,026,639,913,855**

MONETARY BASE 2000

**\$599,815,767,346**

M2 MONEY SUPPLY 2000

**\$4,873,825,666,172**

TREASURY SECURITIES 2000

**\$238,690,250,995**

CURRENCY AND CREDIT DERIVATIVES 2000

**\$92,571,881,218,324**

### Trade Numbers

US DEBT HELD BY FOREIGN COUNTRIES

**\$5,965,526,547,599**

US TRADE DEFICIT

**\$707,199,144,068**

US TRADE DEFICIT • CHINA

**\$328,102,429,993**

US IMPORTED OIL

**\$350,547,200,844**

IMPORTED OIL • OPEC

**\$128,927,704,848**

SMALL BUSINESS ASSETS

**\$9,232,096,621,791**

CORPORATION ASSETS

**\$20,039,818,391,516**

HOUSEHOLD ASSETS

**\$82,919,772,371,506**

TOTAL NATIONAL ASSETS

**\$112,191,687,384,592**

ASSETS PER CITIZEN

**\$351,705**

SOCIAL SECURITY LIABILITY

**\$15,380,778,916,950**

PRESCRIPTION DRUG LIABILITY

**\$20,557,209,990,778**

MEDICARE LIABILITY

**\$80,389,380,968,397**

US UNFUNDED LIABILITIES

**\$116,327,369,877,050**

LIABILITY PER TAXPAYER

**\$996,695**



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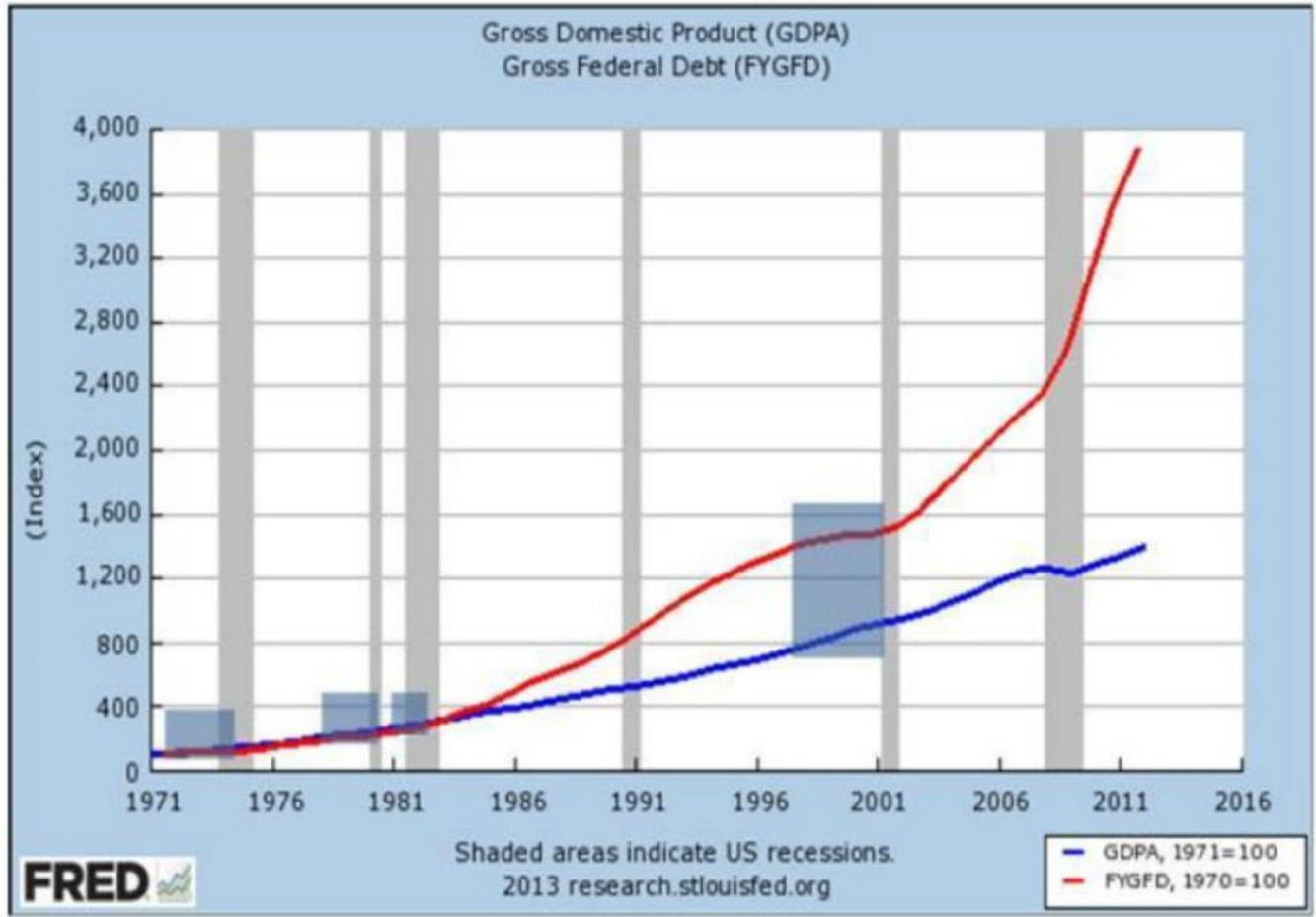
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# MERCY

TEACH EVERY CHILD YOU MEET THE IMPORTANCE OF FORGIVENESS.  
IT'S OUR ONLY HOPE OF SURVIVING THEIR WRATH ONCE THEY REALIZE  
JUST HOW BADLY WE'VE SCREWED THINGS UP FOR THEM.

Date	GDP Growth Rate	GFD Growth Rate	Delta
1971-01-01			
1972-01-01	10%	7%	3%
1973-01-01	12%	7%	5%
1974-01-01	8%	4%	5%
1975-01-01	9%	12%	-3%
1976-01-01	11%	16%	-5%
1977-01-01	11%	12%	-1%
1978-01-01	13%	10%	3%
1979-01-01	12%	7%	5%
1980-01-01	9%	10%	-1%
1981-01-01	12%	9%	3%
1982-01-01	4%	14%	-10%
1983-01-01	9%	21%	-12%
1984-01-01	11%	14%	-3%
1985-01-01	7%	16%	-9%
1986-01-01	6%	17%	-11%
1987-01-01	6%	11%	-4%
1988-01-01	8%	11%	-3%
1989-01-01	7%	10%	-3%
1990-01-01	6%	12%	-6%
1991-01-01	3%	12%	-9%
1992-01-01	6%	11%	-5%
1993-01-01	5%	9%	-4%
1994-01-01	6%	7%	0%
1995-01-01	5%	6%	-1%
1996-01-01	6%	5%	0%
1997-01-01	6%	4%	3%
1998-01-01	6%	2%	4%
1999-01-01	6%	2%	4%
2000-01-01	6%	0%	6%
2001-01-01	3%	3%	1%
2002-01-01	3%	7%	-4%
2003-01-01	5%	9%	-4%
2004-01-01	6%	9%	-2%
2005-01-01	6%	7%	-1%
2006-01-01	6%	7%	-1%
2007-01-01	5%	6%	-1%
2008-01-01	2%	12%	-10%
2009-01-01	-2%	19%	-21%
2010-01-01	4%	14%	-10%
2011-01-01	4%	9%	-5%
2012-01-01	4%		



**We are now supposed to believe that during the biggest credit crunch of the last century, the economy is going to start growing FASTER than debt & reduce this spread...**



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# Problem with Interest

- Current debt is 37% higher than pre-crisis average.
- When the economy recovers and the government debt rolls over, that additional debt is going to increase government net interest payments by about 1.85 percent of GDP
- How much is 1.85% of GDP



# 1.85% of GDP is a LOT! (approx. \$325B)

- Equivalent to spending this year on all military personnel (uniformed + civilian) + all science, space, and technology research + all spending on the environment, conservation, national parks, and natural resources + all spending on highways, airports, bridges, and all other transportation infrastructure.



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## Where Federal, State and Local Tax Dollars Go

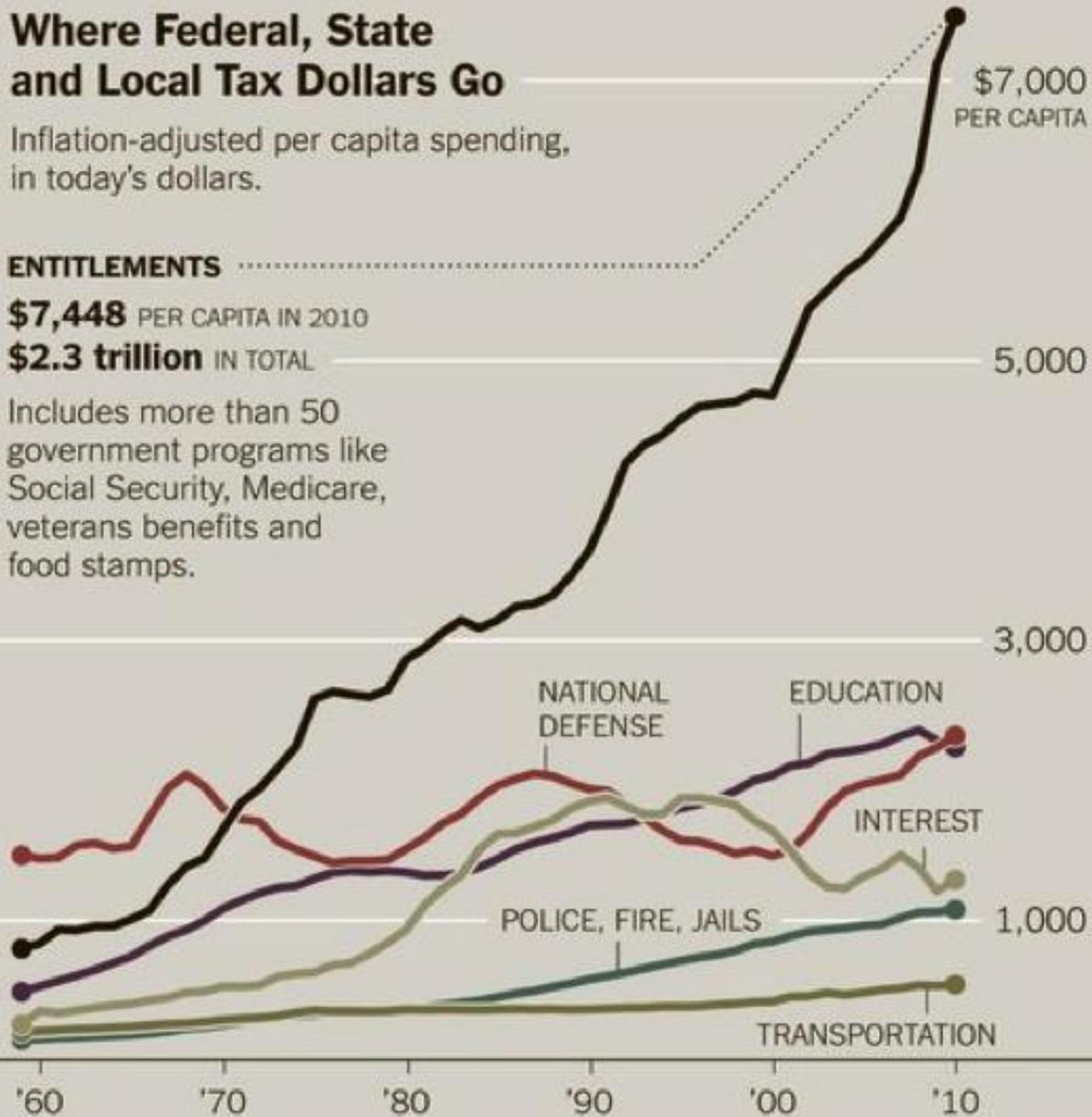
Inflation-adjusted per capita spending, in today's dollars.

### ENTITLEMENTS

**\$7,448** PER CAPITA IN 2010

**\$2.3 trillion** IN TOTAL

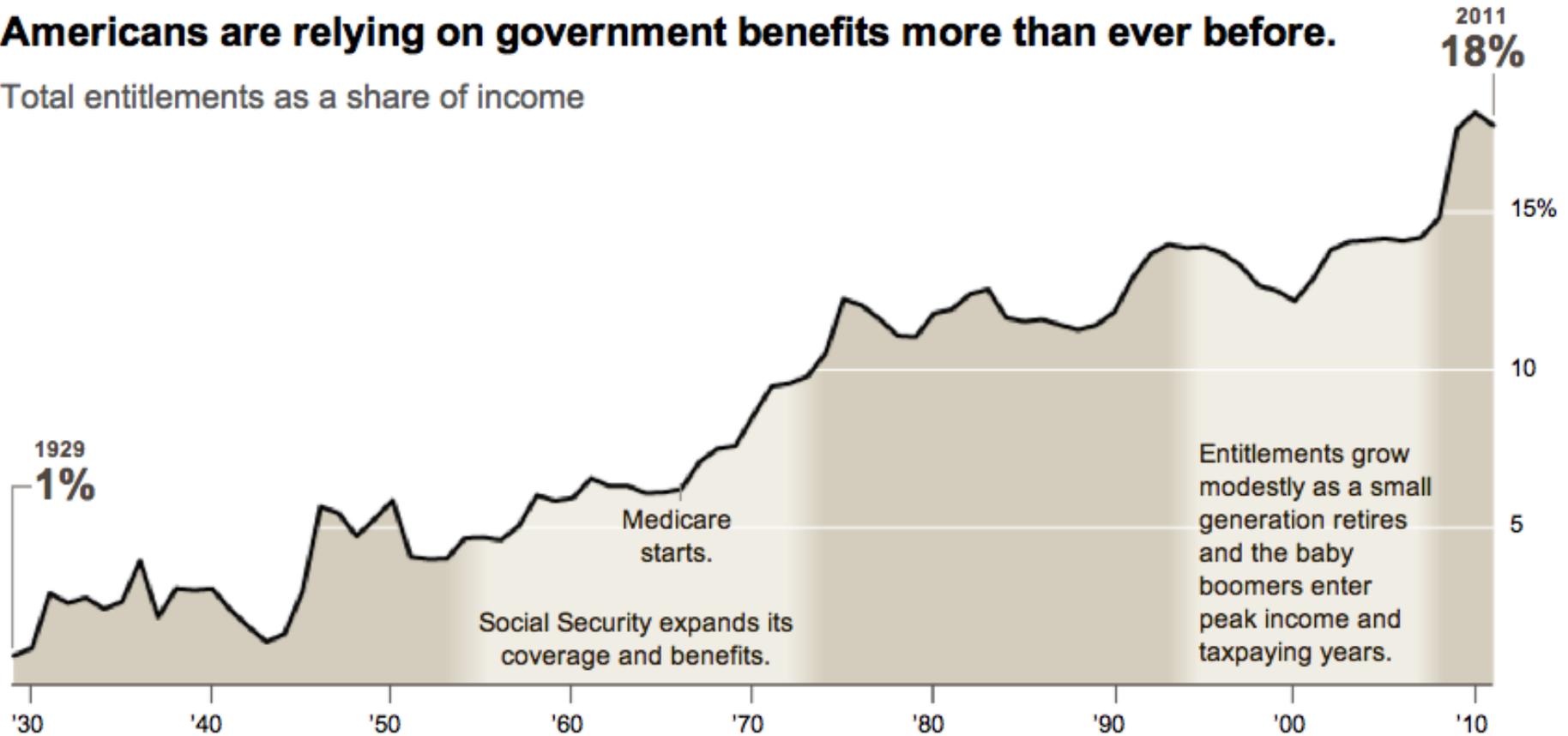
Includes more than 50 government programs like Social Security, Medicare, veterans benefits and food stamps.



Source: New York Times January 2012

# Americans are relying on government benefits more than ever before.

Total entitlements as a share of income



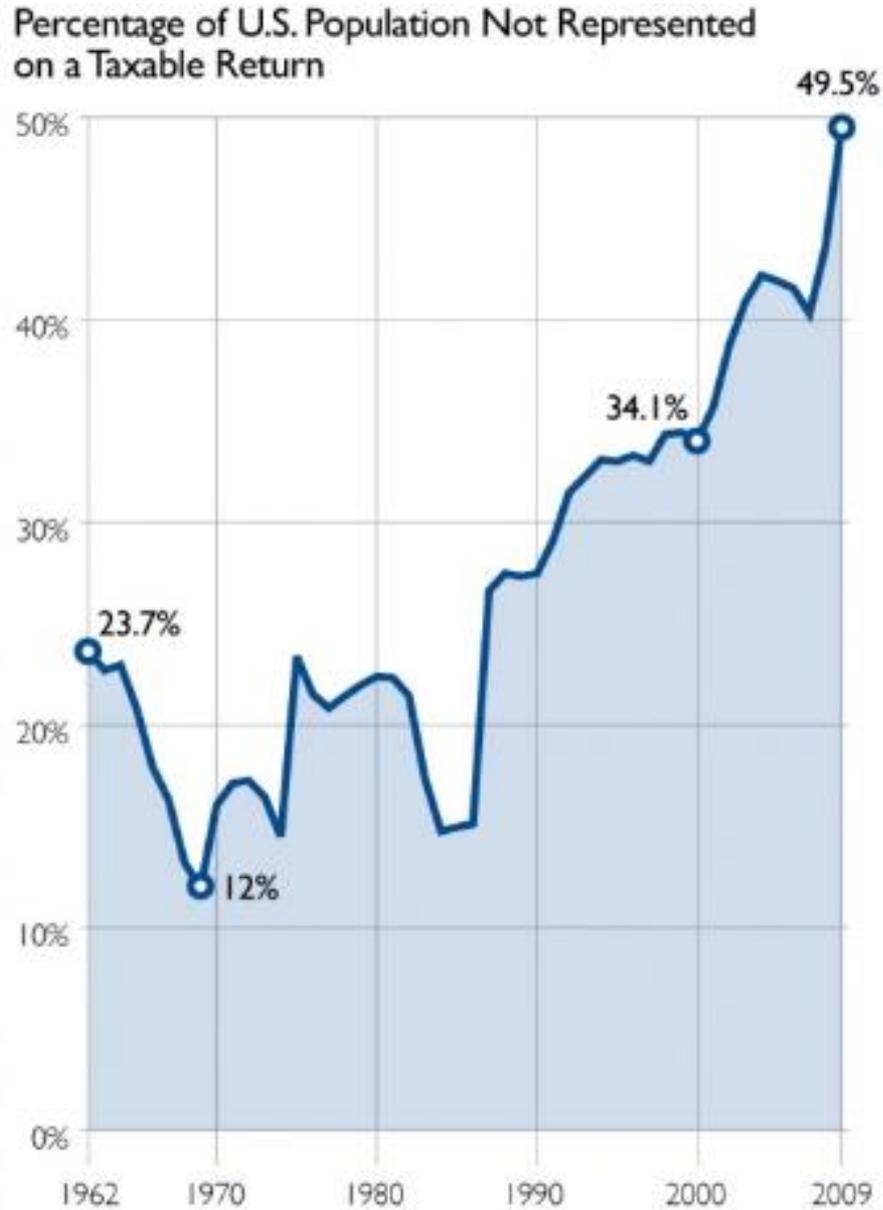
Source: New York Times January 2012



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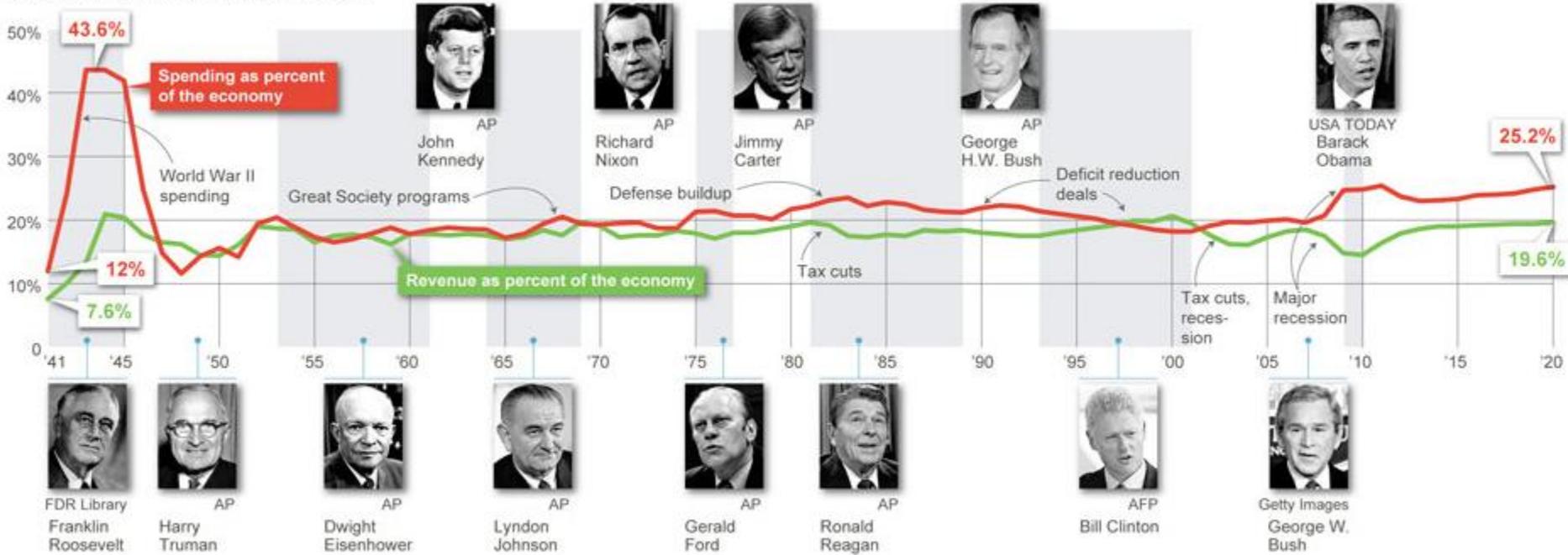
Owen Graduate School of Management

# Nearly Half of All Americans Don't Pay Income Taxes



# Deficits forever

The federal government has spent more than it has raised every year since 1970, except for a four-year period at the end of the Clinton administration. Projections show this year's record gap will narrow as the economy improves, but it won't be closed.



Sources: White House Office of Management and Budget; Congressional Budget Office

By Julie Snider, USA TODAY

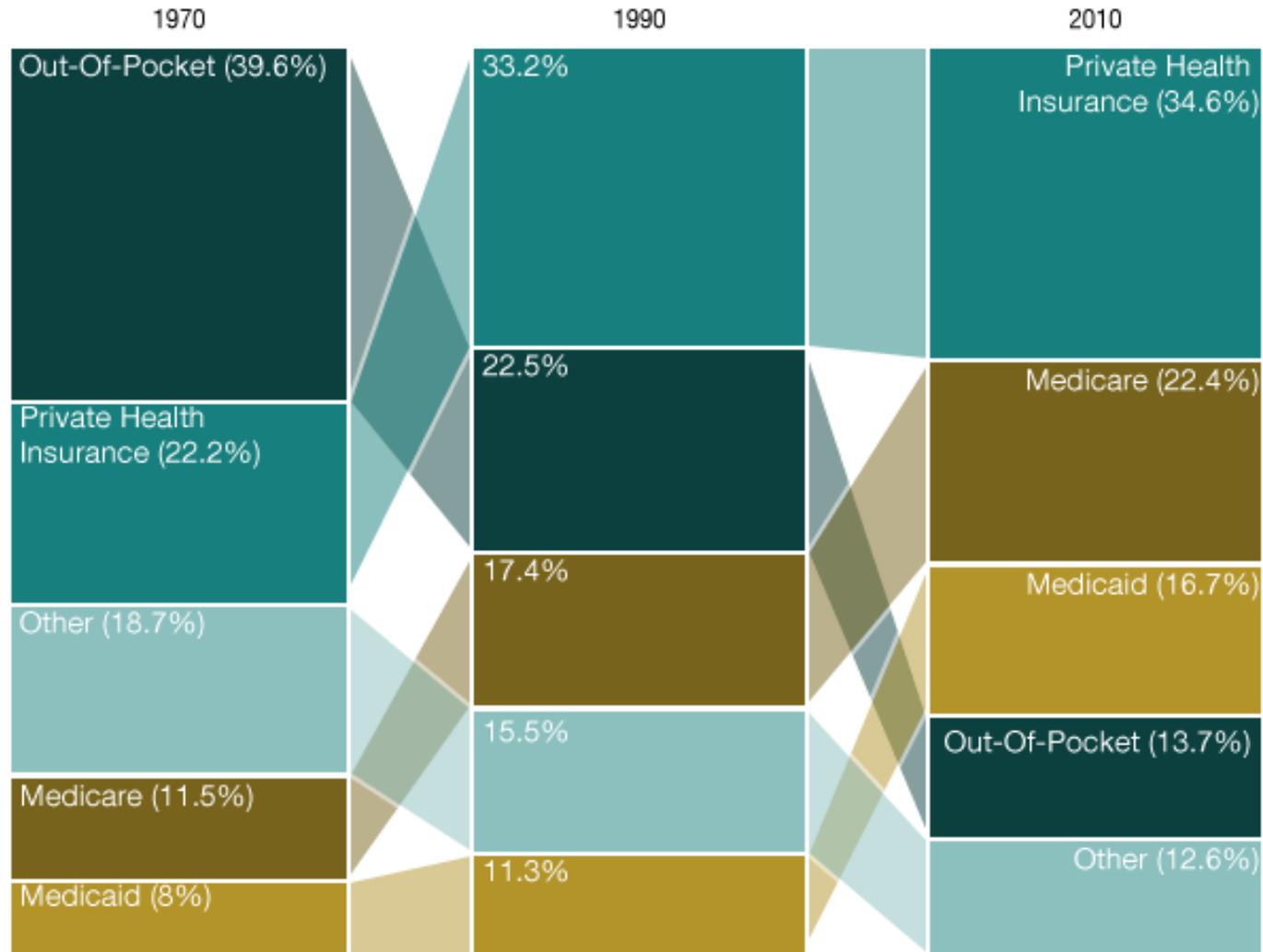
## The 20% impossibility proposition

*You can't get more than 20% of GDP through current tax system*



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# Health Care: Where The Money Comes From



# Will the Slowdown in Health Care Costs Last?

By Katherine Peralta | Sept. 26, 2014 | 12:01 a.m. EDT

Promising news that the rise in health costs has slowed is making Washington rethink its budget assumptions.

This is promising news for those who point to spending in the category as a major culprit for runaway budget deficits. Though experts debate the cause of the slowdown -- could it be improved efficiency within the medical industry, the after-effects of the economic downturn or simply that younger Medicare enrollees are healthier than prior generations? -- the trend has provided some overall relief to the federal budget.

Sep 10, 2014  
News Release

## Employer-Sponsored Family Health Premiums Rise 3 Percent in 2014

*Average Annual Family Premiums Stand at \$16,834, With Workers Contributing \$4,823*

*Workers Now Face Deductibles Averaging \$1,217, Up 47 Percent Since 2009*



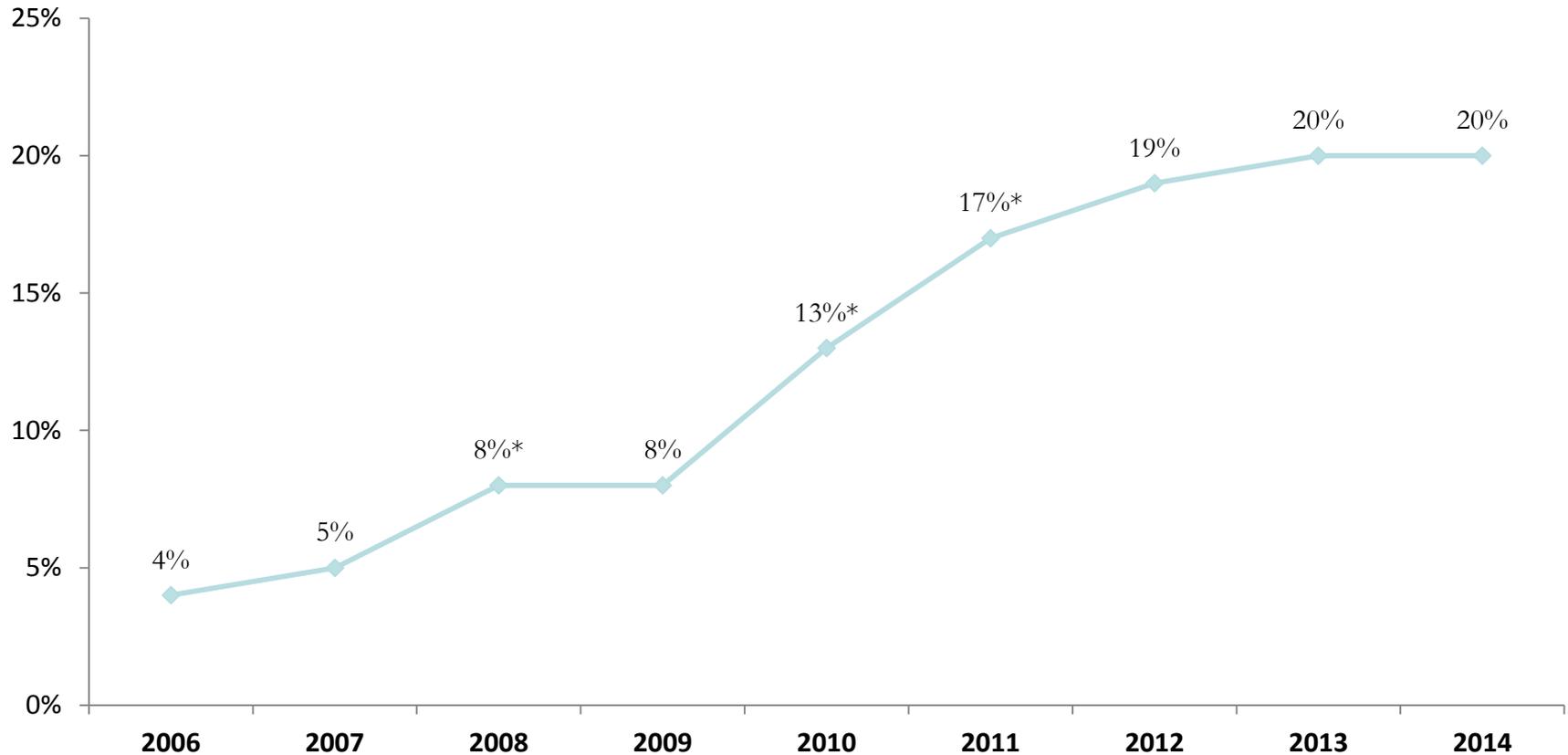
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# Larry's Opinion

- The action is coming from changes in the demand side of the market.
  - Changes in patient cost sharing.
  - Higher deductibles
- Not clear that we will ever “rebound” when economy recovers (if it does)



# Percentage of Covered Workers Enrolled in Either a HDHP/HRA or HSA-Qualified HDHP, 2006-2014



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

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2014.



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# Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of \$2,000 or More for Single Coverage, By Firm Size, 2006-2014



\* 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, 2006-2014.



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# Americans are so broke that .....

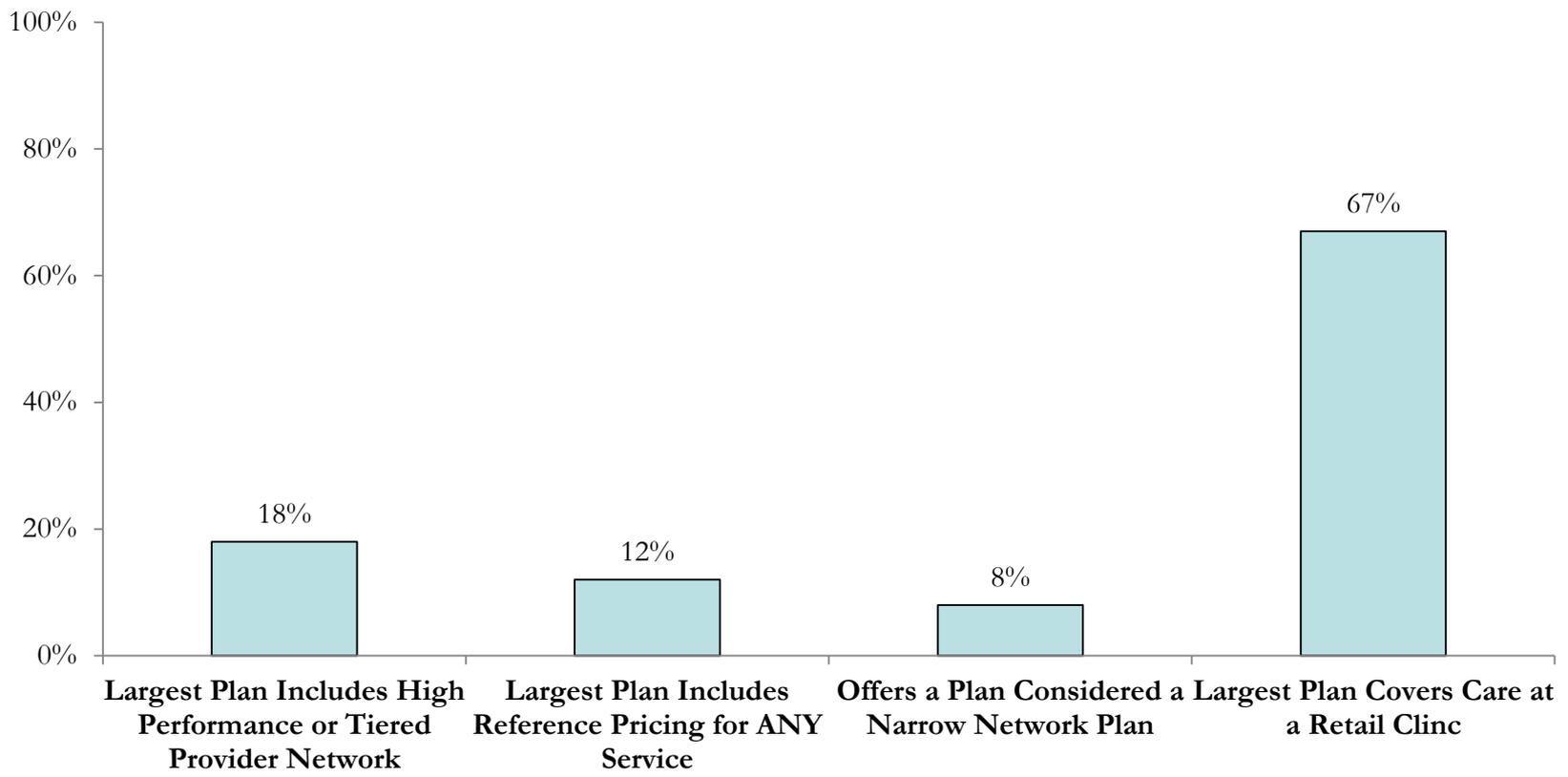
- Americans are so broke that about a third of them have debt collectors on their heels.
- Americans are so broke that 52 percent of them cannot even afford the homes that they are living in right now.
- Americans are so broke that they are running up record levels of debt. Overall, U.S. households are 11.68 trillion dollars in debt right now.
- Americans are so broke that 76 percent of all Americans are living paycheck to paycheck.



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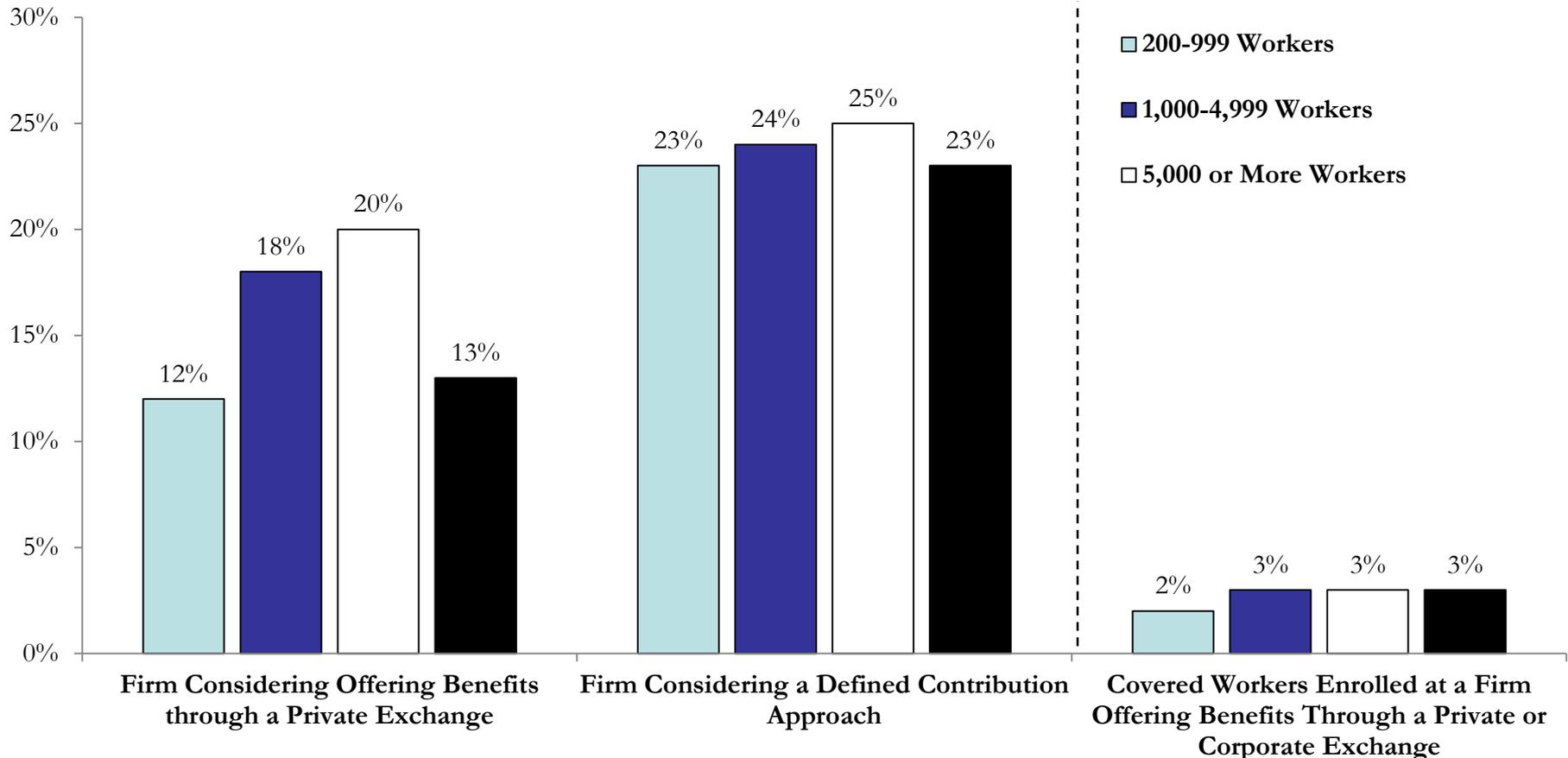
# Among Large (200 or More Employees), Offering Firms, Percentage of Firms whose Largest Plan has Various Features, 2014



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014.



# Percentage of Firms Considering Offering Benefits Through a Private Exchange and the Percentage of Covered Workers Currently in a Private Exchange, by Firm Size, 2014



NOTES: 2% of large firms did not know if they were considering a private exchange and 3% did not know if they were considering a defined contribution approach. A private exchange is one created by a consulting company, not by either a federal or state government. Private exchanges allow employees to choose from several health benefit options offered on the exchange.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014.



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-AND-





## The Disconnect



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# The biggest problem - Cultural

- We feel comfortable consuming healthcare and miraculously having “insurance” [other people’s money] pay for it.
- Medicare and Medicaid funds must come from other taxpaying Americans
- We don’t value much of what we consume in excess of the cost.
  - Consider the well child visit.
- We don’t feel comfortable making cost part of the conversation around tradeoffs.
  - If we increase quality cost will magically drop.



# A 45 YEAR PERSPECTIVE



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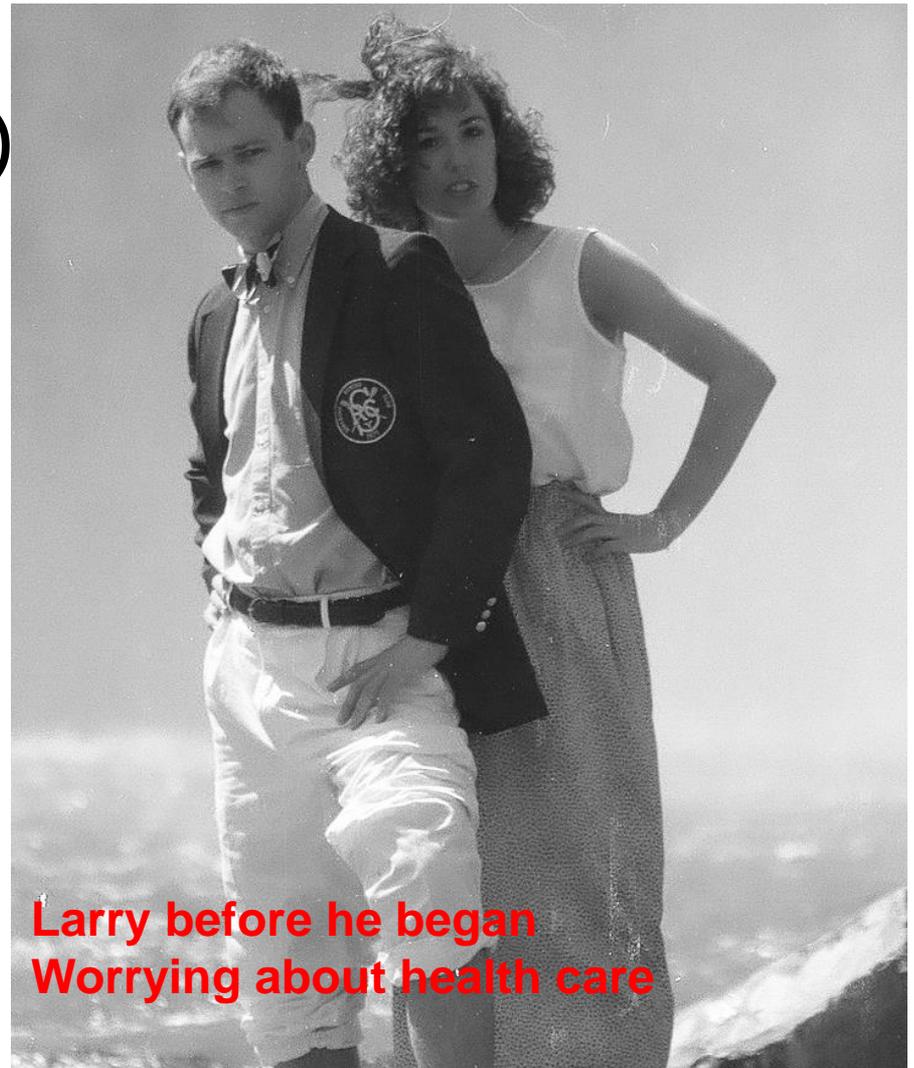
# A 45 years ago.....(the good ol' days) Economic Tension existed.

1. When I was a kid my parents paid for my visits to the pediatrician out of pocket.
2. We had major medical which reimbursed my parents for 80% of the cost of hospital care.
3. Elderly lived with their families.
4. As a population we were thinner.
5. People took few prescription drugs.



# 25 Years Ago ( the great undoing)

1. Growing health care cost inflation
2. Growth of HMOs ruined price sensitivity
  1. Comprehensive health benefit
  2. Low cost sharing – copays
3. Acknowledgement that health care costs were a problem for individuals and companies.



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# Today

- I spend less out of pocket to take my kids to the pediatrician than my parents did 40 years ago.
- My grandma lives in a nursing home a state responsibility rather than my family.
- I am a balding middle aged fat man with a BMI of 30.
  - I take 6 prescription drugs a day.
  - I struggle to make good decisions



These are a few of my favorite things.....

### Things I like

- Mayonnaise ( on everything)
- Beer
- Red-meat
- Carbohydrates
- Cholesterol
- Afternoon naps
- Electric golf carts

### Things I don't

- Green leafy things
- Sweating
- Physical exertion
- Moderation
- Belts
- Personal Trainers
- My treadmill



# But my employer wants me to be healthy.

health.plus@vanderbilt.edu  
**Go for the Gold** Incomplete-Last Chance 10/29/2013  
Time is running out. You still have steps to complete.

health.plus@vanderbilt.edu  
**Go for the Gold** Incomplete-Deadline Nears 10/15/2013  
There are still steps you need to complete. Do it today-only

health.plus@vanderbilt.edu  
**Go for the Gold** Incomplete 8/21/2013  
You have not yet completed your annual Health Risk

health.plus@vanderbilt.edu  
Go for the Gold Incomplete Thu 4:07 AM  
You have not yet completed your annual **Health** Risk

health.plus@vanderbilt.edu  
Go for the Gold Incomplete-Don't miss out! Wed 9/17  
There are still steps you need to complete. Do it today!

Below is your **Go for the Gold** status as of 12 Noon, October 28, 2013.

- [Health Risk Assessment](#): NOT COMPLETE
- [Wellness Actions Log](#) : NOT COMPLETE
- [Game Plan for Your Health](#): NOT COMPLETE

Once you have completed your step(s), log in to the [Health & Wellness Information Portal](#) to see your latest **Go for the Gold** status.

A wellness credit of up to \$240 per year is available to faculty and staff paying for Vanderbilt Health Plan benefits in 2014.



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# Today - sadly

- I engage in health care transactions daily which are value destroying.
- I have little ownership over my health.



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# How Joe Q Public thinks about medical care

- Physicians were the smartest people in the class and they make scientifically determined treatment decisions in my best interests.
- Hospitals are safe places where coordinated care.
- Medical care will solve my problems.

Point: There is a disconnect between what providers define as value and what patients define as value



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## Hospital Errors are the Third Leading Cause of Death in U.S., and New Hospital Safety Scores Show Improvements Are Too Slow

- **Washington, D.C., October 23, 2013** – New research estimates up to [440,000 Americans](#) are dying annually from preventable hospital errors. This **puts medical errors as the third leading cause of death** in the United States, underscoring the need for patients to protect themselves and their families from harm.

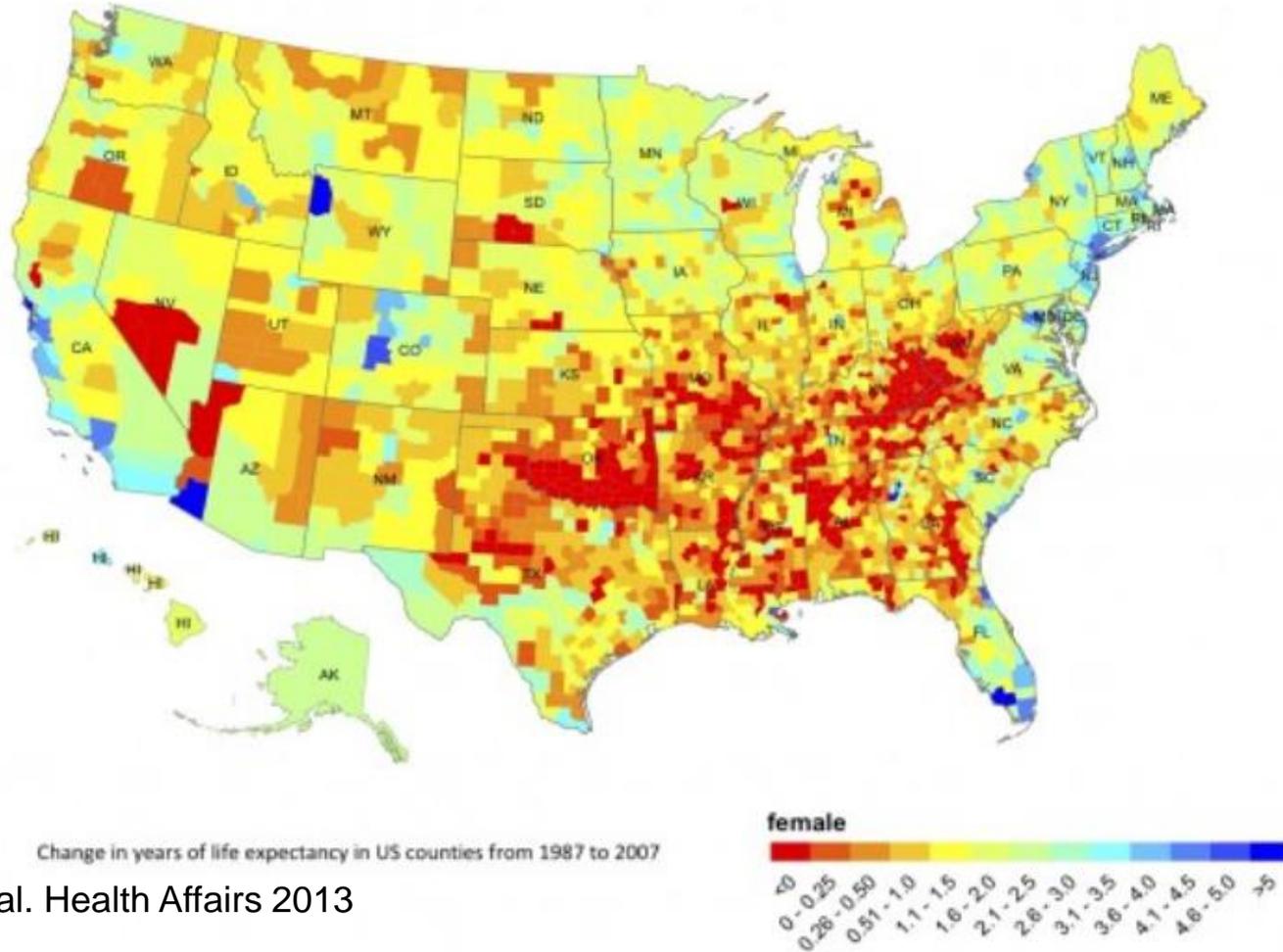
**JOURNAL OF  
PATIENT SAFETY**

September 2013 - Volume 9 - Issue 3 - p 122–128  
doi: 10.1097/PTS.0b013e3182948a69  
Review Article



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# Life expectancy of women is declining in 43% of US counties



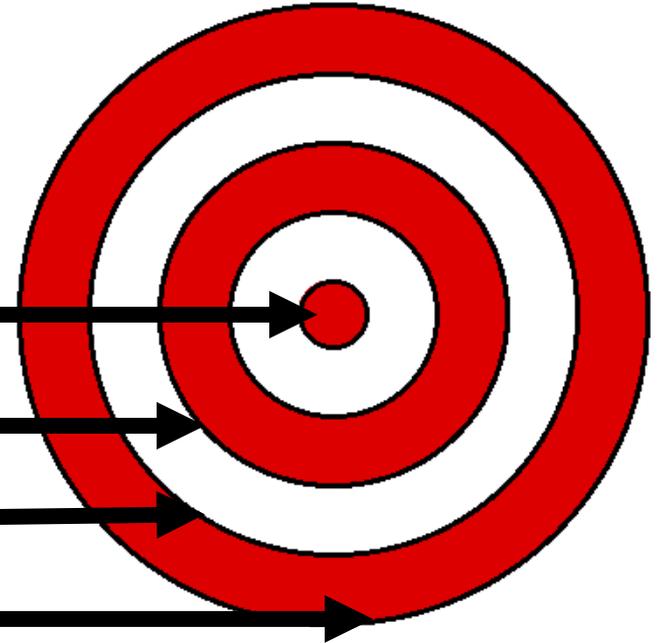
Kindig et al. Health Affairs 2013



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# What determines health?

- 40% behavior
- 30% genetics
- 15% social conditions
- 10% remedial health care
- 5% environment



Steven A. Schroeder, M.D., *We Can Do Better – Improving the Health of the American People*, *New England Journal of Medicine*, 357:12, p. 1221, Sept. 20, 2007.



# Debt Stress

- Higher debt-to-asset ratio was associated with higher perceived stress and depression, worse self-reported general health and higher diastolic blood pressure.
- Those with higher debt were found to have a 1.3 percent increase (relative to the mean) in diastolic blood pressure -- which is clinically significant.
  - A two-point increase in diastolic blood pressure, for example, is associated with a 17 percent higher risk of hypertension and a 15 percent higher risk of stroke.
- The researchers found that individuals with high compared to low debt reported higher levels of perceived stress (representing an 11.7 percent increase relative to the mean) and higher depressive symptoms (a 13.2 percent increase relative to the mean).

<http://www.northwestern.edu/newscenter/stories/2013/08/high-debt-could-be-hazardous-to-your-health.html>



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# Mental Health Matters

Extreme loneliness worse for health than obesity and can lead to an early grave, scientists say



Between 20 and 40 per cent of older adults feel lonely

- Increases risk of early death by 14% which is as bad as being overweight and almost as bad as poverty in undermining a person's long-term wellbeing
- A study of more than 2,000 Americans aged over 50 who were followed-up over six-years found that the degree to which they felt lonely could be linked to their overall risk of death due to ill health at the end of this period.



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# Perceived neighbourhood social cohesion and myocardial infarction

Eric S Kim,<sup>1</sup> Armani M Hawes,<sup>1</sup> Jacqui Smith<sup>1,2</sup>

## Your Neighbors Might Kill You

Living next to mean people may give you a heart attack, study finds.

- —"I really feel part of this area."
  - —"If [I] were in trouble, there are lots of people in this area who would help."
  - —"Most people in this area can be trusted."
  - —"Most people in this area are friendly."
- 
- 4 years later, 148 of the 5,276 people had heart attacks
  - each point increase in perceived neighborhood social cohesion reduced the risk of heart attack by 17 percent.
  - those who agreed the most with the statements had a 67 percent decrease in heart-attack risk
  - The difference is "approximately comparable to the reduced heart-attack risk of a smoker versus a non-smoker,"



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# Takeaways

- Our country is broke, Medicare is a Ponzi scheme and we have mortgaged our children's future – this is immoral
- You don't increase health of a population by encouraging more health care consumption
- The past is the future.
- More attention to how we live our lives day in day out has the greatest potential to improve health.



# Private Equity Panel

## Moderator



Phil Pfrang  
Partner  
Deloitte & Touche LLP

## Panelist



Michael Dal Bello  
Investment Partner  
Pritzker Group Private Capital

## Panelist



Benjamin Edmands  
Managing Partner and  
Co-Founder  
Consonance Capital Partners

## Panelist



Joseph Ibrahim  
Managing Director  
Spindletop Capital

# Deloitte M&A Trends Survey

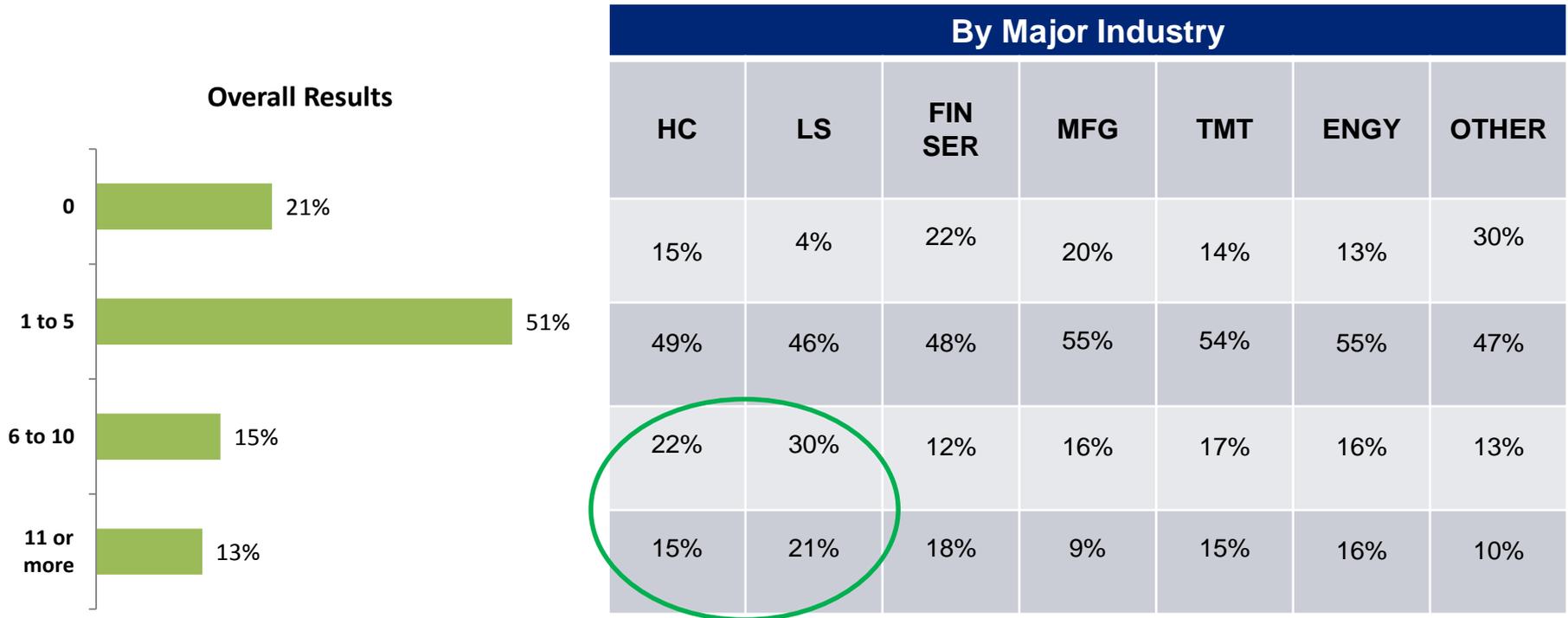
*“Several important factors have converged to create an ideal environment for corporate combinations.”*

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- ***From March 17 to April 21, 2014, a Deloitte survey conducted by OnResearch, a market research firm, polled 2,182 executives at U.S. companies and 318 executives at private equity firms to gauge their expectations, experiences, and plans for mergers and acquisitions in the coming one to two years.***
  - ***Of the 2,500 corporate and private equity respondents, 84 percent of corporate executives anticipate a sustained, if not accelerated, pace of M&A activity in the next 24 months.***
  - ***Similarly, the vast majority of private equity executives (89 percent) are expecting average to high deal activity going forward.***
  - ***We have highlighted significant trends identified by both corporate strategic and private equity firms as it relates to the Life Sciences and Healthcare industry sectors.***
-

# On average, how many M&A transactions does your company actively pursue in a typical year?

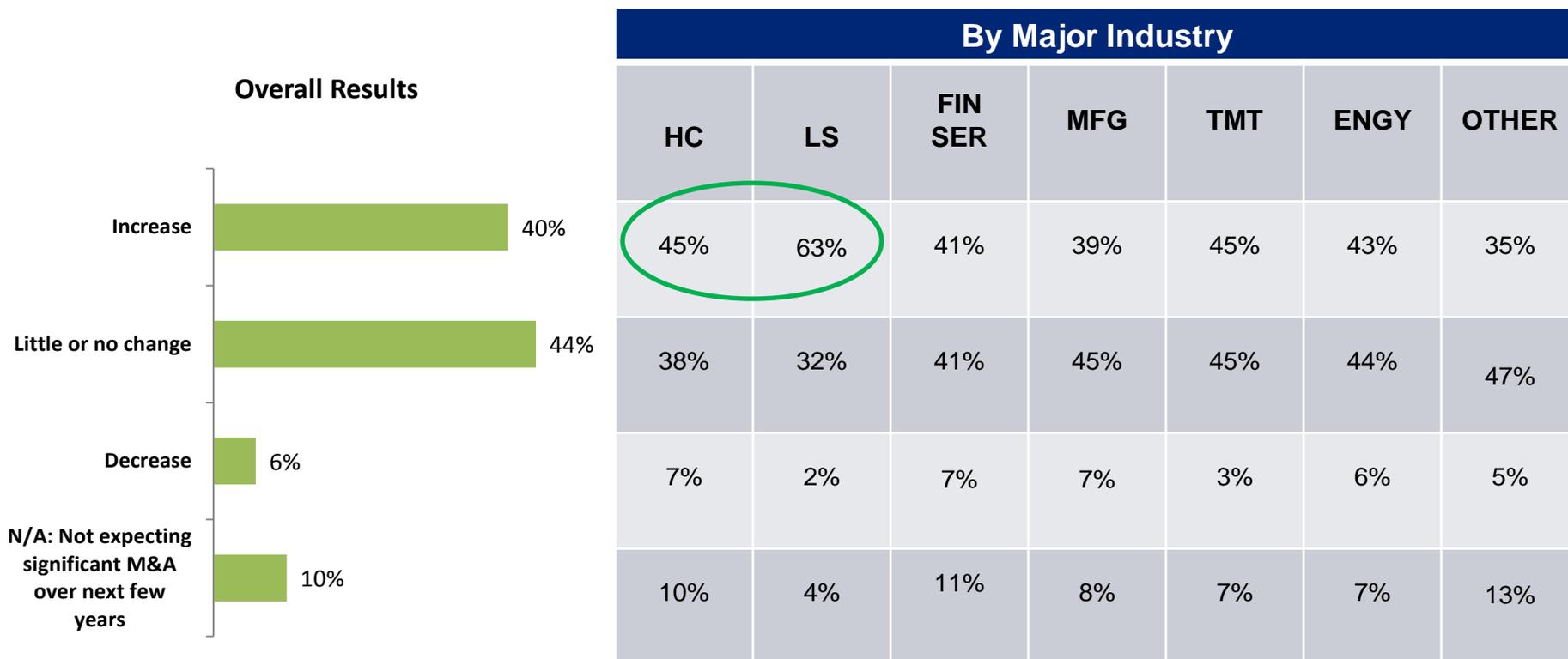
- HC/LS is more likely than most other industries to pursue a higher number of transactions.
- LS appears to be driving this, more so than HC.



Financial Services includes: Asset Management, Banking Securities, Insurance, Real Estate, other FS. Manufacturing includes: Aerospace & Defense, Automotive, Consumer Products, Process/Industrial products, other Manufacturing. TMT includes: Media & Entertainment, Technology, and Telecom. Energy includes: Oil & Gas, and other Energy.

# Do you expect the average number of deals that your company actively pursues to increase or decrease over the next two years?

- HC/LS is more likely than most to expect an increase in the number of deals their company pursues over the next 2 years. This is again driven by LS.



Financial Services includes: Asset Management, Banking Securities, Insurance, Real Estate, other FS. Manufacturing includes: Aerospace & Defense, Automotive, Consumer Products, Process/Industrial products, other Manufacturing. TMT includes: Media & Entertainment, Technology, and Telecom. Energy includes: Oil & Gas, and other Energy.

# Spotlight Session

## Speaker



Laurie McGraw  
President and CEO  
Shareable Ink

ShareableInk®

IMMEDIATE. EFFORTLESS. ACTIONABLE.



Laurie McGraw, President and CEO  
November 2014

# HEADLINE NEWS

**FierceEMR**

ER docs spend more time looking at EHRs than interacting with patients

**THE WALL STREET JOURNAL.**

AMA Urges Overhaul of Electronic Medical Records



**Healthcare IT News**

Missed Ebola diagnosis leads to debate on EHR usability



 **HIStalk**

Rob Lamberts, MD: useless “computer vomit” now required

**ShareableInk**  
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# MARKET ASSESSMENT

- We have been preparing for the post-EHR market, which has now arrived...
- Billions spent on EHR
- Created new problems...
  - Physicians are exhausted and unhappy using systems with poor usability
  - Concerns around patient focus/safety
  - Productivity negatively impacted (workaround Scribes)
- Users and Administrators saying they don't believe EHR vendors will "get it" and are incapable of solving the problem
- Creates opportunity for high value, disruptive physician-centric approach to **clinical data capture...**
- That is the founding principle of **Shareable Ink**

# ABOUT SHAREABLE INK

- Company poised for the post-EHR Market
  - ✓ Products launched, proven, and ready to sell
  - ✓ 150+ Live client sites across the U.S.
  - ✓ Developed sales and channel capabilities
- **One scalable** technology platform for simplified clinical documentation that addresses multiple underserved, lucrative markets
  - ✓ Anesthesia (established market share)
  - ✓ Ambulatory Surgery Centers
  - ✓ Patient Intake
  - ✓ *Emergency Departments*
- Industry leading partnerships
  - ✓ Surgical Notes
  - ✓ HCA
  - ✓ Allscripts
- Commercial management team in place

RECOGNITION



# DIFFERENT BY DESIGN

## THE TRADITIONAL APPROACH



VS.

## SHAREABLE INK APPROACH



ShareableInk®  
IMMEDIATE. EFFORTLESS. ACTIONABLE.

Our **Mission** is to

**Amplify What Works in Healthcare**

by enabling

**Simplified Clinical Documentation**

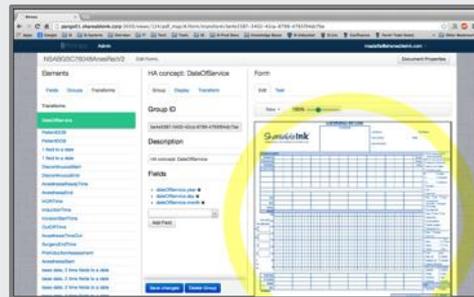
that is

**Immediate, Effortless, and Actionable**

# CLOUD BASED ENTERPRISE PLATFORM



**Client Templates**



**Mimeo**



**Mobility Tools**



**Insights**

One high performing, highly scalable platform

Three patents pending

Multiple products and markets served

# WHO USES SHAREABLE INK?

## Physician Groups



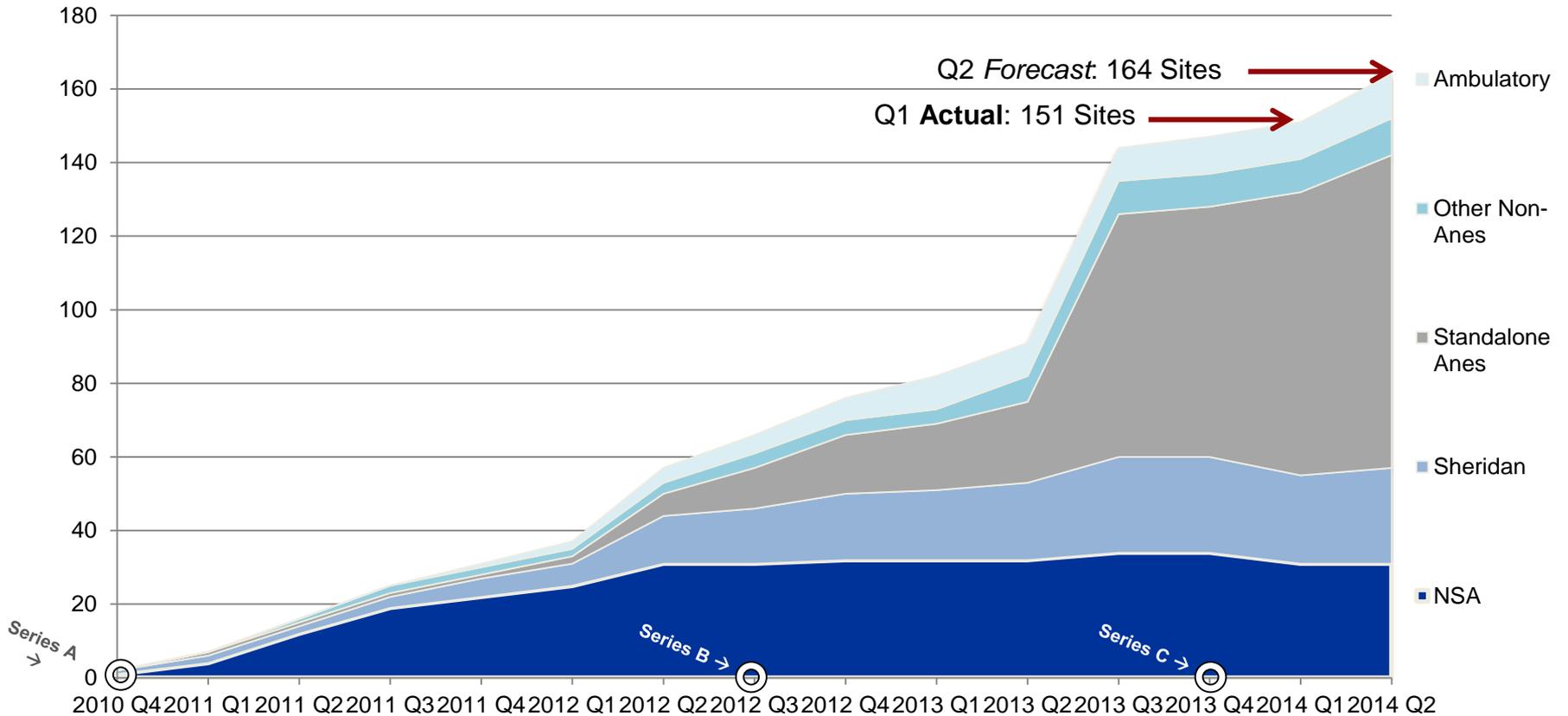
## Hospitals



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# MARKET VALIDATION OF UNIQUE APPROACH

## Live Sites Over Time



# YOUR WORKFLOW POWERED BY THE CLOUD

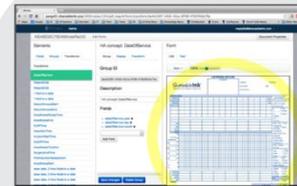
Where Shareable Ink Works

## Solutions For:

- Anesthesia
- Ambulatory Surgery Centers
- Physician Engagement:  
Point of Care Workflows
- Patient Engagement:  
Waiting Room/Portal  
Workflows
- Quality Capture Programs
  - Meaningful Use
  - Perioperative Care



Your Templates



Mimeo



Mobility Tools



Insights

# INITIAL CAPTURE MARKETS (>\$1.5B)

## Simplified Clinical Documentation Solutions For

Markets	Anesthesia	ASC	Patient Intake	Emergency Department
Providers/ Sites/Visits	80,000 Providers	6000 Sites	1.2 Billion Visits	130 Million Visits
Greenfield	67%	80%	80%	90%
Addressable	53,600	4,800	960 million	130 million
Market Size	> \$300 million	> \$125 million	\$1B	> \$250 million
Buyers	Anesthesia Provider Groups; Hospitals	ASC; ASC Companies	Physician Practices	Hospitals; Outsourced Provider Groups
Market Needs	Patient Safety; Quality Data; Productivity; Preparing for Reimbursement Changes	Productivity; Cost Data Quality Data	Patient Satisfaction; Front office cost reduction	High Volume; Patient Safety Productivity; Reimbursement Changes

# SUMMARY

- The Post EHR Market is Here
- New Disruptive Solutions are needed to solve Clinical Documentation Capture
- Shareable Ink Can Help

# THANK YOU

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IMMEDIATE. EFFORTLESS. ACTIONABLE.

# The Emerging Market

## Moderator



Michael Burcham  
President and CEO, Nashville  
Entrepreneur Center  
SVP, Galen Partners

## Panelist



John Donahue  
Chairman and CEO  
axial healthcare

## Panelist



Daniel Hightower  
CEO and Co-Founder  
Clariture

## Panelist



Baxter Webb  
CEO  
MEDarchon



## Closing Remarks

## **About Bass, Berry & Sims PLC**

As one of the largest Healthcare practices in the U.S., Bass, Berry & Sims PLC has a depth of healthcare expertise that ranges from operational and regulatory compliance to government investigations, litigation, and complex corporate transactions. We work closely with venture capital, mezzanine capital and private equity funds, as well as numerous venture and private equity-backed companies — from start-ups to one of the largest private equity-backed companies in the world, HCA. From our offices in Washington, D.C. and Nashville — the capital of for-profit healthcare — we also provide an uncommon blend of healthcare transactional, regulatory and operational counsel. We have earned a reputation for delivering the sophistication and experience demanded by private equity firms from a lower cost platform. For more information, visit [www.bassberry.com](http://www.bassberry.com).

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