Population Health & Care Coordination Colloquium
March 13th – 15th Philadelphia
The Cost of Healthcare: A 360 Stakeholder View

Prepared by Michael J Taylor
Senior Vice President, Health and Benefits
Aon Hewitt
What I will cover

- Recent Healthcare Cost Headlines
- Basic Data
- A 360 Stakeholder View
- The Impact of Reform
- Overall Cost Reduction Ideas
- Final Thoughts
Recent Healthcare Cost Headlines

Wall Street Journal 1/7/2013
Health Cost Pause Nears End and Americans Boost Spending on Doctors, Tests as More Regain Job-Based Insurance

PBS News Hour 1/7/2013
Health Care Spending Increases but Rate Slows with Recession and Economy

The Washington Post 1/7/2013
The $2.7 trillion question: Are Health Care Costs Really Slowing?

Modern Healthcare 1/7/2013
In 2011, U.S. healthcare spending growth stayed at slowest rate in 52 years

NY Times 2/11/2013
Slower Growth of Health Costs Eases Budget Deficit
Basic Data
Widespread Recognition That Health Care is the Central Feature of Budget Deficits

Source: Congressional Budget Office.
State Budgets are an Equal Mess

MASSACHUSETTS STATE BUDGET, FY2001 VS. FY2011

STATE SPENDING (BILLIONS OF DOLLARS)

<table>
<thead>
<tr>
<th>Category</th>
<th>FY2001</th>
<th>FY2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Coverage</td>
<td>$5.1 B</td>
<td>$4.0 B</td>
</tr>
<tr>
<td>(State Employees/GIC; Medicaid/Health Reform)</td>
<td>(+59%)</td>
<td>(-20%)</td>
</tr>
<tr>
<td>Public Health</td>
<td>-38%</td>
<td>-38%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>-33%</td>
<td>-33%</td>
</tr>
<tr>
<td>Education</td>
<td>-15%</td>
<td>-15%</td>
</tr>
<tr>
<td>Infrastructure/Housing</td>
<td>-23%</td>
<td>-23%</td>
</tr>
<tr>
<td>Human Services</td>
<td>-13%</td>
<td>-13%</td>
</tr>
<tr>
<td>Local Aid</td>
<td>-50%</td>
<td>-50%</td>
</tr>
<tr>
<td>Public Safety</td>
<td>-11%</td>
<td>-11%</td>
</tr>
</tbody>
</table>

Source: Massachusetts Budget and Policy Center [Budget Browser](#)
Basic healthcare component cost increases by the numbers for commercial payors

- Inpatient surgical admission average facility price was $29,858 and grew 8.5% in 2011
- Average outpatient surgery visit in 2011 was $3,673 and grew at 9.7% in 2011
- Emergency room average facility price was $1,381 and grew at 5.4% in 2011
- Average price of a radiology facility service in 2011 was $471 and grew at 5.6% in 2011
- Brand name average prescription price was $268 and grew at 17.7% in 2011
- Average inpatient facility unit prices was $12,482 and grew at 5.9% in 2011
- Average professional procedure unit prices was $58 and grew at 3.7% in 2011
- Average outpatient visit unit prices was $134 and grew at 9.6% in 2011

Most increases between 5 – 10%

Source: Healthcare Cost Institute 2012
Basic healthcare component cost increases by the numbers as measured by CMMS in the NHE 2011 report

- Overall growth in NHE in 2011 was 3.9% reaching $2.7 Trillion
- Hospital growth (inpatient and outpatient) was 4.3%
- Physician services growth was 3.6%
- Clinical services (Lab and radiology) growth was 7.1%
- Growth rates were lower for NHE than commercial and included the non price factors. Significant impact of Medicare and Medicaid
- While medical price increases moderated, there was an uptick in non price factors such as use and intensity of healthcare goods and services.

**Most increases 3 – 5%**

Source: CMMS, Office of Actuary, National Health Statistics Group 2012
Aggregate Total Hospital Margins, (1) Operating Margins, (2) and Patient Margins, (3) 1991–2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Margin</th>
<th>Operating Margin</th>
<th>Patient Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>91</td>
<td>-6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92</td>
<td>-4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>93</td>
<td>-2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>4%</td>
<td></td>
<td></td>
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<tr>
<td>97</td>
<td>6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>-2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>00</td>
<td>2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>01</td>
<td>4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>6%</td>
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<td></td>
</tr>
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<td>05</td>
<td>4%</td>
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<tr>
<td>07</td>
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<tr>
<td>08</td>
<td>-2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09</td>
<td>-4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>-6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>-4%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2011, for community hospitals.

(1) Total Hospital Margin is calculated as the difference between total net revenue and total expenses divided by total net revenue.

(2) Operating Margin is calculated as the difference between operating revenue and total expenses divided by operating revenue.

(3) Patient Margin is calculated as the difference between net patient revenue and total expenses divided by net patient revenue.
Physician Compensation in 2011

- Overall physician compensation increased 2.8%
  - Primary care was up 4%
  - Surgery was up 3.4%
  - Other specialties were up 2.8%

- Highest increases
  - Medical oncologists and hematologists were up 7.13%
  - Nephrologists were up 6.99%

- Highest Decreases
  - Endocrinology was down 4.98%
  - Radiology was down 1.39%

- Others of note
  - Hospitalists were up 3.14%
  - Nurse Practitioners and Physician’s Assistants were up 9%

Source: MGMA 2011 Physician Compensation Annual Survey
# Average Annual Premiums for Employer-Based Coverage, 1999–2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Single Coverage</th>
<th>Family Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>$2,196*</td>
<td>$5,791</td>
</tr>
<tr>
<td>2000</td>
<td>$2,471*</td>
<td>$6,436*</td>
</tr>
<tr>
<td>2001</td>
<td>$2,669*</td>
<td>$7,081*</td>
</tr>
<tr>
<td>2002</td>
<td>$3,063*</td>
<td>$8,003*</td>
</tr>
<tr>
<td>2003</td>
<td>$3,363*</td>
<td>$9,068*</td>
</tr>
<tr>
<td>2004</td>
<td>$3,695*</td>
<td>$9,950*</td>
</tr>
<tr>
<td>2005</td>
<td>$4,024*</td>
<td>$10,880*</td>
</tr>
<tr>
<td>2006</td>
<td>$4,242*</td>
<td>$11,460*</td>
</tr>
<tr>
<td>2007</td>
<td>$4,479*</td>
<td>$12,106*</td>
</tr>
<tr>
<td>2008</td>
<td>$4,704*</td>
<td>$12,660*</td>
</tr>
<tr>
<td>2009</td>
<td>$4,824</td>
<td>$13,375*</td>
</tr>
<tr>
<td>2010</td>
<td>$5,049*</td>
<td>$13,770*</td>
</tr>
<tr>
<td>2011</td>
<td>$5,429*</td>
<td>$15,073*</td>
</tr>
<tr>
<td>2012</td>
<td>$5,615*</td>
<td>$15,745*</td>
</tr>
</tbody>
</table>

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

Affordability Gap Widens

Cumulative Active Employee Health Care Costs vs. Wage Increases

Cumulative health care costs have grown more than four times faster than workers’ earnings over the last decade, leading health benefits to become a much larger portion of employees’ total rewards.


Source: 2011 Towers Watson/NBGH Employer Survey on Purchasing Value in Health Care

Active Workers’ Health Insurance Premiums | Workers’ Earnings
However, Approximately 1/3 of Medical Spending is Unnecessary

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor care delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unnecessary services</td>
<td>$192 billion</td>
<td>7%</td>
</tr>
<tr>
<td>Failures of care delivery</td>
<td>$128 billion</td>
<td>5%</td>
</tr>
<tr>
<td>Failures of care coordination</td>
<td>$35 billion</td>
<td>1%</td>
</tr>
<tr>
<td>Excessive prices</td>
<td>$248 billion</td>
<td>9%</td>
</tr>
<tr>
<td>Administrative costs</td>
<td>$131 billion</td>
<td>5%</td>
</tr>
<tr>
<td>Fraud and abuse</td>
<td>$177 billion</td>
<td>7%</td>
</tr>
<tr>
<td>Total (per year)</td>
<td>$910 billion</td>
<td>34%</td>
</tr>
</tbody>
</table>

Source: Berwick and Hackbarth, JAMA, 2012.
And we spend almost twice as much as the next developed country

Health Expenditures Per Capita (US$ PPP)

Health Expenditures (% of GDP)

<table>
<thead>
<tr>
<th>Country</th>
<th>Per Capita Expenditure</th>
<th>% of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>$8,233</td>
<td>17.6%</td>
</tr>
<tr>
<td>Switzerland</td>
<td>$5,270</td>
<td>11.4%</td>
</tr>
<tr>
<td>Netherlands</td>
<td>$5,056</td>
<td>12.0%</td>
</tr>
<tr>
<td>Denmark</td>
<td>$4,464</td>
<td>11.1%</td>
</tr>
<tr>
<td>Canada</td>
<td>$4,445</td>
<td>11.4%</td>
</tr>
<tr>
<td>Germany</td>
<td>$4,338</td>
<td>11.6%</td>
</tr>
<tr>
<td>France</td>
<td>$3,974</td>
<td>11.6%</td>
</tr>
<tr>
<td>Sweden</td>
<td>$3,750</td>
<td>9.6%</td>
</tr>
<tr>
<td>U.K.</td>
<td>$3,433</td>
<td>9.6%</td>
</tr>
<tr>
<td>OECD Average</td>
<td>$3,268</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

*2011 data: Switzerland, $5,489 (11.5% GDP); Canada, $4,608 (11.2% GDP)

Source: OECD Health Data, released June 28, 2012
A 360 Stakeholder View
Multiple Stakeholders and Influencers

Health Care in 2017

- Exchange and Individual Solutions
- Rapid Consolidation
- System Overload
- Broad Adoption
- More Strategic Options
- New Normal
- Expanded Coverage
- Employers
- Government Programs
- Insureds
- Exchanges
- Providers
- Health Plans
- Technology

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Everyone Agrees: Delivery System Reform is Key

Healthy person → Continued health → Chronic illness

Chronic illness → Successful management

Successful management → Acute episode

Acute episode
- Primary care physicians
- Specialist physicians
- Pharmacy
- Labs

Acute episode → Post-acute care

Post-acute care
- Post-acute providers
- Primary care physicians
- Specialist physicians
- Pharmacy
- Labs
As well as Payment Reform—Transition Out of Fee-for-Service Payment
Key Issues facing Providers in 2013

- Increased margin pressure
  - Payment rate decreases from Medicare and Medicaid
  - Lingering unemployment leading to more uninsured/bad debt
  - Increased consumerism making people more conscious of costs

- Transition from fee for service to outcome based reimbursement
  - Physician Quality Reporting Initiative expanded by ACA with incentives then penalties

- Participate in new delivery systems like ACO and PCMH

- Consider employment by hospitals or larger physician organizations

- Create stronger brand and consumer relationships with existing and new patients

- Utilize more technology for connectivity and practice efficiency
Key Issues for consumers in 2013

- Understanding the impact of Healthcare Reform and the introduction of exchanges
- Increased payroll contributions and requirements for benefit coverage
- Lower subsidies for dependents
- Increased accountability and responsibility for their healthcare both within Consumer Driven Health Plans and in more traditional coverages like PPO
- Understanding the new delivery system structures like ACO, PCM and multiple tiered network options with differing combinations of providers
- Navigating the barrage of health information, mobile apps and social media that is targeting the individual consumer.
  - Not just the health plan
- Difficulty in accessing the right providers when needed
  - Doctor shortage plus the influx of 30 M newly insured
Impact of Reform
ACA Basics

Expanded Health Insurance Coverage

- Health Insurance Exchanges with Reformed Rules
- Federal Subsidies to Buy Health Insurance In Exchanges
- Optional State Expansion of Medicaid
- Employer Mandate

Individual Mandate to buy Health insurance

Paying for Expanded Coverage

- Medicare/Medicaid Payment Changes
- ACA Penalties and Fees on Employer
- Increased Medicare Taxes on High-Income Individuals
- 2.3% tax on Advanced Medical Devices
- Taxation of High-Cost Employer Health Care Coverage

“Tax” on Individuals without health insurance
Bending the Cost Curve is Still a Challenge

ACA addressed access to health insurance
Not the cost of health insurance

<table>
<thead>
<tr>
<th>Year</th>
<th>% Increase in Total Plan Premium Cost</th>
<th>Average Cost per Employee</th>
<th>Average Employee Premium Contribution</th>
<th>Average Employee OOP Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 (projected)</td>
<td>6.3%</td>
<td>$11,188</td>
<td>$2,385</td>
<td>$2,429</td>
</tr>
<tr>
<td>2012</td>
<td>4.9%</td>
<td>$10,522</td>
<td>$2,204</td>
<td>$2,200</td>
</tr>
<tr>
<td>2011</td>
<td>8.5%</td>
<td>$10,034</td>
<td>$2,090</td>
<td>$2,072</td>
</tr>
<tr>
<td>2010</td>
<td>6.2%</td>
<td>$9,246</td>
<td>$1,927</td>
<td>$1,761</td>
</tr>
<tr>
<td>2009</td>
<td>5.0%</td>
<td>$8,703</td>
<td>$1,797</td>
<td>$1,580</td>
</tr>
<tr>
<td>2008</td>
<td>5.3%</td>
<td>$8,290</td>
<td>$1,691</td>
<td>$1,508</td>
</tr>
<tr>
<td>2007</td>
<td>5.3%</td>
<td>$7,874</td>
<td>$1,567</td>
<td>$1,364</td>
</tr>
</tbody>
</table>

Source: Aon Hewitt
### ACA created exchanges

#### Defined Contribution Subsidy
- **Health Care Credit**

#### Insured Plan Offerings for Participants
- **Medical**
  - Standardized Plans: Bronze, Bronze Plus, Silver, Gold, Platinum
  - Competing Carriers: Cigna, United, BCBS, Kaiser, HealthNet
- **Dental**
  - Standardized Plans: Bronze, Silver, Gold, Platinum
  - Competing Carriers: United, Delta, MetLife
- **Vision**
  - Standardized Plans: Bronze, Silver, Gold
  - Competing Carriers: MetLife, United, VSP

#### Exchange Background Mechanics with Carriers
- **21 Rating Bands**
  - Heartland: WI, IN, KY, WV
  - Midwest: ND, SD, MN, IA
  - Mid-Atlantic: SC, VA, MD, DE
  - New England: CT, RI, MA, NH, VT, ME
  - Northeast: PA, NJ
  - Pacific Northwest: ID, MT, WY, AK
  - Plains: CO, NE, KS, MO
  - South: MS, AL, TN, GA
  - South Central: AR, LA
  - Southwest: NV, UT
  - AZ, FL, IL, MI, OH, NC, NM, OK
  - NY, Northern CA, Southern CA, TX, WA, OR

#### Risk Adjustment
But CBO’s Latest Projections Show Cost of Exchange Subsidies Rising

CBO’s annual projections of average Exchange subsidy per subsidized enrollee in 2014

Source: Congressional Budget Office February 2013
It is about employee migration

Status Quo (No Migration)
- 9,731 under 250% FPL
- 4,815 over 250% FPL

Status Quo (With Migration)
- 9,731 under 250% FPL
- 4,815 over 250% FPL

Exit
- 9,731 under 250% FPL
- 4,815 over 250% FPL

Employer Plan
- $49,612,000
- Cost Sharing
- Premium

PPACA Costs
- $54,945,000
- Cost Sharing
- Premium

Premium Cost Sharing
- $36,918,000
- $38,439,000
- $56,363,000

Fed Subsidies
- $46,885,000

Employer Costs
Employee Costs
Federal Subsidies

400 EEs in Employer Plan
400 EEs in Medicaid
400 EEs with no coverage

400 EEs in State Exchanges

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Will exchanges save money?

Cost Drivers

- Risk charges
- Profit charges
- Premium taxes
- Mandated benefits
- Commissions

Cost Reducers

- Competition
- Risk adjustment
- Best-in-class networks/provider discounts
- Pricing approach
- Standardized designs
- Reduced admin/consulting costs

2012 RFP Summary

<table>
<thead>
<tr>
<th>2013 Projected Self-Insured Gross Cost</th>
<th>2013 Corporate Exchange Gross Cost</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,837,000,000</td>
<td>$2,804,000,000</td>
<td>-1.2%</td>
</tr>
</tbody>
</table>
The ACA’s Added Fees, Taxes, and Costs to Pay For Expanded Access, Possible Medicare Revenue Shifting to Employer Plans

<table>
<thead>
<tr>
<th>Item</th>
<th>Estimate ($ Billion/10 Yrs)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Cadillac” Tax</td>
<td>$32 - 111</td>
</tr>
<tr>
<td>ER Mandate/Free Rider Assessment</td>
<td>$56 - 106</td>
</tr>
<tr>
<td>Health Industry Surtax</td>
<td>$87 - 165</td>
</tr>
<tr>
<td>State Reinsurance Plan Tax</td>
<td>$25</td>
</tr>
<tr>
<td>Medicare Surtax on High Income Earners</td>
<td>$210 - 318</td>
</tr>
<tr>
<td>Health Account Changes</td>
<td>$19 - 24</td>
</tr>
<tr>
<td>Tax on Retiree Drug Subsidy</td>
<td>$5</td>
</tr>
<tr>
<td>Comparative Effectiveness Fee</td>
<td>$2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$436 - 756</strong></td>
</tr>
<tr>
<td><strong>Medicare Spending Growth Cuts</strong></td>
<td><strong>$500 - 716</strong></td>
</tr>
</tbody>
</table>


Sources: Congressional Budge Office, Letter to House Speaker Boehner (R-OH) on the Repeal of Obamacare Act, July 24, 2012
Congressional Budget Office, 2010; US Congress, Joint Committee on Taxation, 2010

Source: National Business Group on Health, 2012 Executive Series
Reform supports Accountable Care Organizations and Patient Centered Medical Homes

- Healthy person
- Continued health
  - Chronic illness
    - Primary care physicians
    - Specialist physicians
    - Pharmacy
    - Labs
  - Successful management
    - Acute episode
      - Hospitals
      - Specialist physicians
      - Pharmacy
      - Labs
    - Post-acute care
      - Post-acute providers
      - Primary care physicians
      - Specialist physicians
      - Pharmacy
Savings from Accountable Care Organizations and Patient Centered Medical Homes

- Designed to impact the coordination of conditions that make up 80% of chronic care costs
  - 8 lifestyle behaviors that impact 15 conditions that impact 80% of chronic costs

- Initial results both from Medicare and commercial ACO are encouraging but not definitive
  - Savings around 1 – 2% annually
  - Medicare cost savings estimated to be $800 Million with initial MSSP program

- Similar results from early PCMH
  - Savings around 1 – 2%
Overall Cost Reduction Ideas
Rand Study on Reducing Costs
Rand Policy Recommendations

- **Foster efficient and accountable providers**
  - Focus on value rather than volume
  - Eliminate waste and inappropriate care
  - Identify and apply the best available evidence
  - Enhance patient safety
  - Strengthen primary care

- **Engage and empower consumers**
  - Give consumers “skin in the game”
  - Provide understandable and actionable information

- **Promote population health**
  - Support prevention
  - Promote health at local level
  - Recognize the role of family and community in promoting health

- **Facilitate high value innovation**
  - Enhance the efficiency of federally sponsored research
  - Expand use of HIT
  - Use State’s Experience to Assess Innovative Health Policies
The Workforce of the Future will be different…

From Boomers through Millennials, the “face” of the workforce is shifting; by 2020, it will be more:

- Global
- Tech Savvy
- Diverse
- Virtual
- Adaptable
- Willing to be Challenged

By 2020, half the workforce will be Millennial, with the other half Boomer and Gen X: different needs, different work styles, different expectations
…Leading us to a “New Normal”

<table>
<thead>
<tr>
<th>Buy Local</th>
<th>Keep It Simple</th>
<th>Make It Relevant</th>
<th>Data-Driven, Evidence Informed</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ ACOs</td>
<td>▪ Fewer choices</td>
<td>▪ Individual health improvement plans</td>
<td>▪ Focus on risks and behaviors</td>
</tr>
<tr>
<td>▪ Medical homes</td>
<td>▪ Reduced barriers to care</td>
<td>▪ Targeted communication and decision support</td>
<td>▪ Results-based incentives</td>
</tr>
<tr>
<td>▪ Health centers</td>
<td>▪ Concentrate on 2 to 3 priorities</td>
<td></td>
<td>▪ Drive for intrinsic behavior change</td>
</tr>
</tbody>
</table>

Data-Driven, Evidence Informed

- Focus on risks and behaviors
- Results-based incentives
- Drive for intrinsic behavior change
Employers must, with equal focus, address the declining health of their employees and families and exert pressure on health plans and providers to change how we direct people to, and how we pay for, health care services.
Medical Spending in Massachusetts With and Without Reform ($ Billion)

- **Current**
  - 2012: $68
  - 2014: $76
  - 2016: $80
  - 2018: $93
  - 2020: $106
  - 2022: $114
  - 2024: $144

- **With reform**
  - 2012: $68
  - 2014: $76
  - 2016: $80
  - 2018: $93
  - 2020: $106
  - 2022: $114
  - 2024: $144
How Long Does it Take to Save One-Third?

<table>
<thead>
<tr>
<th>Overall impact</th>
<th>1–2 years</th>
<th>3–5 years</th>
<th>5–10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in site of care</td>
<td>Change in site of care</td>
<td>Prevention; Pat. engagement</td>
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<tr>
<td>Process redesign</td>
<td>Administrative savings</td>
<td>Preventing errors; Patient engagement</td>
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<td>Changes within institutions</td>
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The Bottom Line on Healthcare Costs

- Reducing costs is extremely difficult
  - Just because the early results are equivocal, we should continue to innovate across the entire delivery system, the continuum of care and the consumer segments
  - There is no new money, likely to be reallocation to support this reduction.
  - Focus and phasing of effort will be required,

- The time is now
  - Changes to the delivery system are happening at the right time and at the right scale to have impact
  - While health GDP percentage has not changed in 2011, it is unlikely to remain flat. There are other pressing problems that could use that percentage of GDP

- Every stakeholder must participate actively, no single one can influence this complex ecosystem

- Jump in now
Thank You and Questions

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