

Bringing Healthcare Reform into Focus Part 1

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Topics for Today... Part 1

- Healthcare Reform – Past, Present and Expectations
- The Details as of Now
- Impacts of Healthcare Reform
 - Reimbursement
 - Payment Reform
 - Collaboration
 - Health Insurance
- What do you do next? (A Lead into Part 2)



The Market – What's on the minds of leading CEOs, Boards and Owners?

Critical Issues Facing ALL Our Clients...

- The effects of a new economy and capital planning
 - Affecting Access to capital
 - Addressing the issue of Negative inflation (shrinking margins)
- Impacts of health care reform and the new payment landscape
 - As an Employer
 - As a Provider
 - ◇ Negative Payment Pressures
 - ◇ Federal and State Budgets
 - ◇ Accountable Care Organizations
 - ◇ Episodic, Bundled or Global Payment
- New Forms of Relationships
- Technology – new applications and reliance



In the short term...

... not much has changed.

Home Care

- Industry profits driven by Medicare – overall margins continued to be very strong during 2009 through 2011
- Favorable policy environment – “RAC” audit threat is looming, but initial activity is relatively low
- M&A activity hit plateau – values high but relatively stable. Will this be changing? Has it changed in Missouri?
- Compliance remains a high priority
- Health care payment reform and reimbursement stability is greatest concern

Home Care Reimbursement Updates

- PPS Refinements have driven increased profits for intermittent home health
- MedPac recommendations – Rate freeze or decline for home health agencies
- Increased scrutiny of fraud due to error rate increases in filed claims
- State budget issues causing concern

Hospice Trends...

- Healthcare Reform Bill
 - Estimated \$7.8 billion in cuts to the Medicare hospice benefit (\$6.8 billion estimated by NHPCO)
 - Payment rate reduction
 - ◇ Market Basket Reduction
 - ◇ Productivity Adjustment of approximately 1%
 - Update cost report
 - More qualitative information
- MedPac
 - Projected 2010 Aggregate Medicare Margin
 - Recommended Payment Update

The Past, Present and Expectations.....

... things get more unsettled.

Why Reform?

"Health care in America is badly organized, highly inconsistent, internally dysfunctional, sometimes brilliant, almost always compassionate, close to data free, amazingly unaccountable in key areas, too often wasteful, too often dangerous, and extremely expensive. Care costs more in America than it does anywhere else in the world—by every measure. Care costs more per person, more by the unit, more by the dose, more by the disease, and more in the aggregate. We spend far more than anyone else in the world on care, and we are alone among the industrialized countries in not covering all of our people. We need to do a lot better."

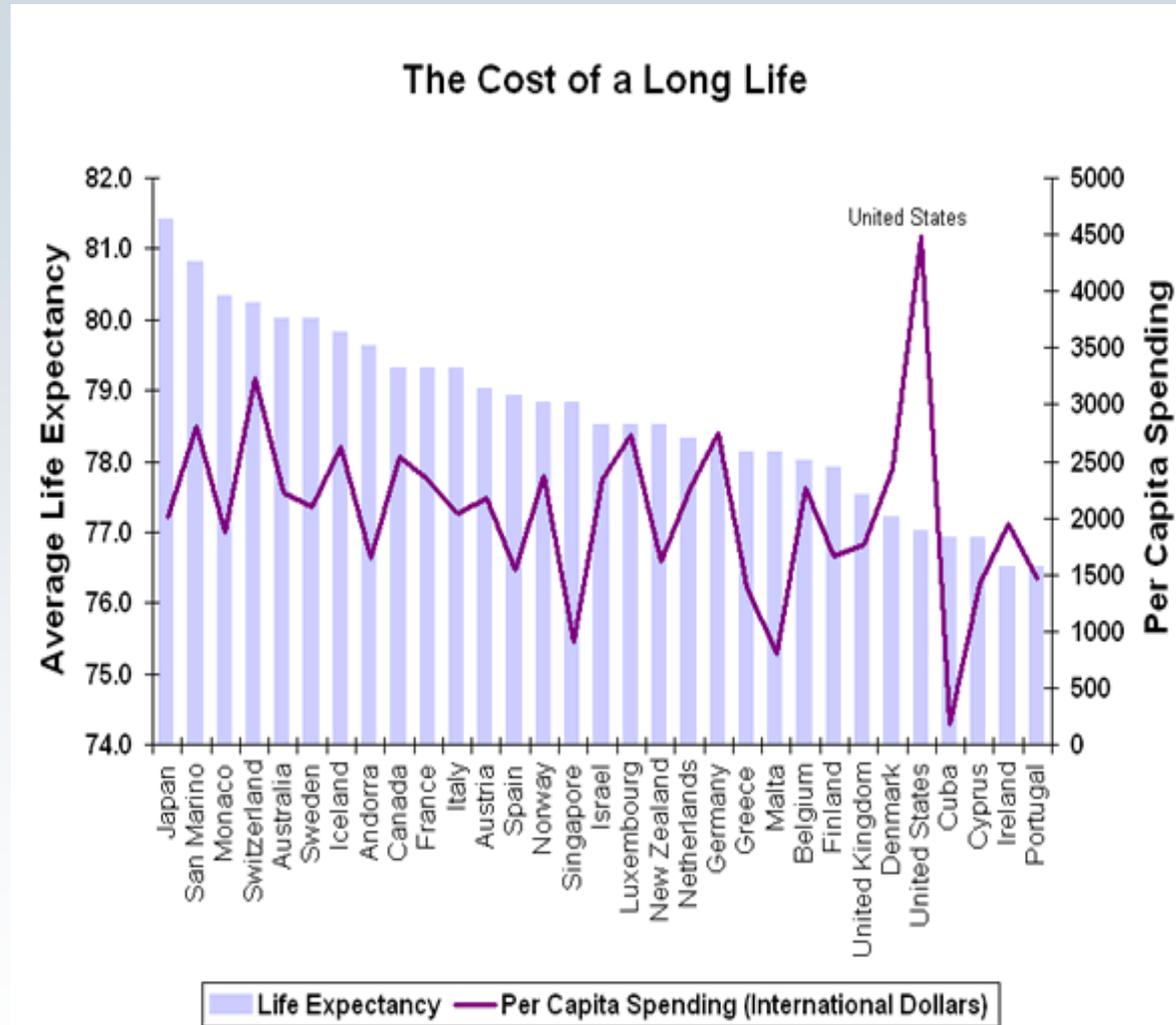
George Halverson, Health Care Will Not Reform Itself.

Forces Driving Reform...

- Growing Uninsured Population
- Exponential Growth in Expenditures
- Looming Medicare Insolvency
- Cost to Quality Comparisons

Why Reform?

- Reform is a must!
 - Cost is too high
 - Quality is too low
- The United States spends more than any other country on health care, but historically ***has not*** received a return on it's investment when compared to other countries.



* Sources: UC Atlas of Global Inequality: Health Care Spending <http://ucatlans.ucsc.edu/spend.php>

What Happened?

Two Years Ago Already

- In March 2010, Congress passed and the President signed health reform in:
 - The Patient Protection and Affordable Care Act
 - The Health Care and Education Affordability Reconciliation Act of 2010.
 - ◇ Increases access to health coverage (32 million)
 - ◇ Aims to reduce costs via payment reductions and focus on wellness and prevention
 - ◇ Seeks to reward “value-based” care delivery
- Impact of the Act:
 - Cost: \$940 Billion over 10 years
 - Coverage: + 32 Million by 2019



Patient Protection & Affordable Care Act

Includes...

While details are not yet clear as to what is included in the PPAC Act or how the implementation and administrative rules will be written, **key provisions** are as follows:

Cost Cutting	Market basket update adjustments for productivity reduce reimbursement
Delivery System Reforms	Implements VBP, reduced payments for high volumes of hospital-acquired conditions and readmissions, and pilot programs to test bundled payments ACOs and medical homes
Independent Payment Advisory Board	Creates MedPac-like commission that has Medicare rate setting authority (starts 2015); Not applicable to hospitals until 2019.
Medicaid	Expands Medicaid to 133% (2014) of FPL and uses revised definition of income.
Tax Exempt Status	Includes four new criteria hospitals must satisfy to retain not-for-profit status.
Mandates	<u>Individuals</u> : must purchase insurance or pay penalty. <u>Businesses</u> : must provide insurance (if more than 50 employees) or pay penalty if any of their employees receive federal premium or cost-sharing subsidies.

Home Health Care Reform – Patient Protection and Affordable Care Act

- Medicare Home Health Payment Reductions
 - \$37.9 billion (2011 – 2019)
- Medicare Home Health Payment Adjustments
 - 3% rural add-ons for episodes and visits ending on or after April 1, 2010 and before January 1, 2016
 - Beginning in 2011, cap total outliers at 2.5%; impose individual agency outlier cap of 10%
 - Reduce market basket update by 1 percentage point in 2011, 2012 and 2013
 - Rebasing in 2014 phasing in through 2017; rebasing adjustment limited to no more than 3.5% reduction per year
- Physician Interaction
 - Physicians will now be required to have face-to-face encounter with a patient prior to certifying them for home health services or durable medical equipment. - fraud & abuse issue

Policy Emphasis on Home and Community Based Services

Creates new and expanded home and community-based options for seniors and individuals with disabilities:

- Offers states a new State Medicaid Option for HCBS attendant care services, **Community First Choice**, for individuals with disabilities. (Oct. 1, 2011)
- Removes barriers to home and community-based services (Health Reform Sec. 2402). Changes the Spousal Impoverishment rules.
- *Creates the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services by October 1, 2015.*
- An additional option for states includes **Medicaid Home & Community Based Services State Plan Option**. This option allows states to expand Home & Community Based Services in addition to those who offer waiver services
- Expands the **Aging & Disability Resource Centers** and funding available
- Develops **Independence at Home Demonstration and Community Based Care Transitions** programs to coordinate care across sites of service.

Is Health Reform Here to Stay?

- **Congressional Repeal of Health Reform**
 - House passed, Senate said, “No”
 - Death by a thousand cuts or repeals of pieces of reform
 - ◇ Repeals as of April 2011: 1099s, Free choice vouchers
- **The Courts - Litigation Challenges to Reform**
 - Three district courts upheld, two courts say unconstitutional
 - Appellate court action:
 - ◇ 4th Circuit: Threw out both cases
 - ◇ 6th and DC circuit: Upheld law
 - ◇ 11th Circuit: Mandate unconstitutional but rest of law stands
 - Supreme Court: **See next slide on update**
- **Administrative Agencies' Action**
 - Issuing rules and guidance on both employer and provider initiatives

Supreme Court Action

- Hearings on the constitutionality of health reform held March 26-28
- Ruling anticipated in June 2012
- Issues under review
 - Individual mandate
 - Anti-Injunction
 - Medicaid Expansion
 - Constitutionality of the whole law

Reform Summary Timeline

- *High risk insurance pools established.*
- *Small business tax credits for offering employee health insurance established*
- *Insurers can no longer deny coverage to children for pre-existing conditions.*

2010

- *New group and individual plans required to cover preventive services at 100%.*
- *Dependents coverage expanded to age 26.*
- *Annual review of insurance premium increases effective.*
- *Grandfathered plan notification requirements.*

- *Increased penalty on non-medical distributions from HSAs.*
- *Insurance administrative simplification begins.*
- *Medical loss ratios become effective for small group and individual plans.*

2011

- *New simple cafeteria plans available to small businesses*
- *Workplace wellness program grants available for small employers*
- *Annual fees assessed on pharmaceutical companies.*
- *Application of non-discrimination regulations to fully-insured plans.*
- *OTCs no longer reimbursable under various health spending accounts*

- *Employers to disclose health insurance benefits on W-2s.*
- *CLASS Act: National voluntary LTC insurance program established.*

2012

- *Health plans to pay per participant fee to pay for Comparative Effectiveness Research.*

Reform Summary Timeline *(cont'd)*

- *Large employers disclose health insurance benefits on W-2s*
- *Health insurers required to begin following administrative simplification regulations.*
- *Limits placed on flexible spending accounts.*
- *New 3.8% Medicare Tax for Unearned Income .*

2013

- *Medicare Earned Income Tax Increases to 2.35% for higher income earners.*
- *Employer tax deduction for Part D subsidies eliminated.*
- *Insurance Exchange open enrollment begins*

- *State insurance exchanges operational.*
- *Individual penalties imposed for failure to obtain health insurance coverage.*
- *Insurance industry pays fees based on market share.*
- *Insurers prohibited from restricting coverage and imposing benefit limits.*

2014

- *Employer "shared responsibility" penalties imposed.*
- *Small employers to begin reporting health benefits on W2s.*
- *Large employers to begin auto-enrolling FT employees into health insurance plan.*
- *Insurers must guarantee issue and renew plans*

- *Large employers may be able to offer Exchange plan as employer-sponsored coverage (2017)*
- *Excise tax imposed on "Cadillac" health plans (2018)*

2015 - 2018

2012 : W-2 Disclosure of Health Coverage Cost

- IRS delayed W-2 disclosure employer-provided health benefits costs for 2011 [IRC Sec. 6051(a)]
 - Includes medical insurance, dental and vision plans(unless separate plans), and self-insured arrangements
 - No reporting for employee salary-reduction FSAs or employer HSA or Archer MSA funding
 - Include family coverage amount, if applicable
- Reporting begins for most employers for 2012 expenses

2012: W-2 Disclosure of Health Coverage Cost

- W-2 reporting of health care costs applies to W-2s issued for 2012 benefits.
- **Small Employers –fewer than 250 W-2s in 2011**
 - Disclosure is optional for 2012 and until further guidance is issued, at least until January 2014.

Additional Resources

- **Interim implementation guidance:** IRS Notices 2011-28: <http://www.irs.gov/pub/irs-drop/n-11-28.pdf>
- **2011 W-2 form:** <http://www.irs.gov/pub/irs-pdf/fw2.pdf>

Pending Implementation: Fully-insured plans can no longer discriminate

- Expands the nondiscrimination rules to cover fully-insured group health plans (IRS Code Section 105(h), which already applies to self-insured)
 - Also includes HRAs or stand-alone Medical Reimbursement Plans (MRPs)
 - Affects non-grandfathered plans for plan years beginning on or after 9/23/10
- **Penalties**
 - An employer who sponsors a discriminatory insured group health plan will be subject to an excise tax liability of **\$100 per day per employee affected with a maximum penalty of \$500,000**
- As of 12/27/2010, compliance has been **delayed** until guidance/ rules issued
- Additional comment period on proposed guidance closed 3/11/11
 - See IRS Notice 2011-1

Health Plan Fees/Taxes

Comparative Effectiveness Research Plan Fee (2012)

- Effective for plan years ending after 9-30-2012, health insurance and self-insured plans must pay a per participant fee
 - If self-insured, employer pays fee.
- Fee
 - Year 1: \$1/participant
 - Year 2: \$2/participant
 - 2014: Inflation adjusted rate
 - 9/30/2019: Phased out

IRS Notice 2011-35: Proposed guidance, seeking comment

Cadillac Plan Tax (2018)

- 40% excise tax assessed on health insurer or plan administrator offering “high-cost” health coverage
 - “High cost” = annual premium > \$10,200 single coverage or \$27,500 family coverage

2013: Contribution Limits on Flexible Spending Accounts

- Places an annual limit on employee's FSA contributions to \$2,500.
 - Current law imposes no limit.
 - The limit will be indexed for inflation beginning in 2013.
- This contribution limit does not impact Dependent Care FSAs. Contributions to Dependent Care FSAs will continue to be subject to a \$5,000 per year limit.

2014: Auto-enrollment for Large Employers

- Employers with 200+ FT employees will be required to auto-enroll employees into their employer-sponsored health plan
 - Employees can opt out
- Originally, effective January 1, 2011, implementation is delayed until U.S. Dept. of Labor issues rules expected prior to 2014 – (may not happen by 2014 based on discussions ongoing currently)
 - Definition of full-time employee
 - Clarity around which plan to enroll employee into if multiple plans offered
 - Specifics on opt-out notification

2014: Individual Mandate

- **Individual mandate to obtain health coverage:** Beginning in 2014, most individuals must obtain a minimum-level of health insurance coverage or pay a penalty
- **Minimum essential coverage includes:**
 - Medicare, Medicaid, TRICARE
 - Insurance purchased through an Exchange, on the individual market
 - Employer-sponsored coverage that is affordable & provides minimum value
 - Grandfathered plans (group plan in effect on 3/23/2010)
- **Penalties for failure to obtain coverage:**
 - In 2014: greater of \$95 or 1.0% of income
 - In 2015: greater of \$325 or 2.0% of income
 - In 2016: greater of \$695 or 2.5% of income
 - Penalty is capped at three times the per person amount for a family
 - Assessed penalty for dependents is half the individual rate

Hardship exemption
Premium cost for
lowest cost plan > 8%
of Household Income

2014: Government assistance to help some individuals obtain coverage

- **Medicaid expansion:** Expands eligibility to individuals and families up to 133 % of the federal poverty level (FPL)
 - If cost effective, states can opt to subsidize employer-sponsored premiums for this group
- **Premium and cost share assistance:**
 - Individuals and families with household income of 100 - 400 % FPL may be eligible for sliding-scale assistance in the form of:
 - ◇ Tax credits to help pay premiums; and
 - ◇ Out-of-pocket reductions to help with cost sharing (e.g., co-payments and co-insurance)

133% FPL
Individual =
\$14,484
Family of 4 =
\$29,726

400% FPL:
Individual=
\$43,560
Family of 4=
\$89,400

2014: State Health Insurance Exchanges

What is an exchange?

A marketplace for individuals and small businesses to shop for insurance.

- Offer a choice of health plans
- Standardize health plan options
- Allow consumers to compare plans based upon price
- Intended to provide a more competitive market
- Provides consumers with a neutral party to assist with plan enrollment, information and eligibility determination for any subsidies

Who can participate?

- **In 2014, small employers** can offer an Exchange plan as their employer health plan
- **Individuals:** Includes self-employed or unemployed individuals (2014)
- In 2017, states can allow **large employers** to participate
- Each state must establish a health insurance **exchange**
- HHS Secretary to establish the rules around exchanges

<https://exchange.wisconsin.gov/>

2014: Exchange Plans

Types of exchange plans to be offered by insurers

- **Bronze** = 60% actuarial value (lower fixed cost premium but higher risk for actual claims)
- **Silver** = 70% actuarial value
- **Gold** = 80% actuarial value
- **Platinum** = 90% actuarial value (higher fixed cost premium but lower risk for actual claims)
- **Catastrophic plan**
 - ◇ Only available to individuals **less than 30 yrs old**, or those exempted from the individual mandate due to unaffordability or hardship. (The “Invincible’s”)
 - ◇ Plan must cover:
 - “minimum essential benefits”
 - a minimum of **three primary care visits per year**
- All exchange “metal” plans **must** cover essential health benefits, limit cost-sharing and have a specified actuarial value

2014: Potential Large Employer Penalties

Law does NOT require employers to offer health insurance

- Beginning in 2014, employers with 50+ FTEs must pay a “shared responsibility” penalty if any FT employee receives Exchange subsidies
 - Different penalties whether or not employer offers affordable, “**minimum essential coverage**” to employees
 - **Minimum essential coverage** = Plan with 60% actuarial value
 - **Affordable** = Employee premium cost < 9.5% of household income

FTE = FT employees
+ FT equivalents

FT employee =
works avg. 30 or
more hours per
week

FT equivalents =
Hours worked in a
month by all PT
employees divided
by 120

Employer “shared responsibility” penalty

Penalty only assessed if a FT employee receives Exchange subsidies.

- **No or Inadequate Insurance Penalty**
 - \$2000 x each full-time worker (after first 30 workers)
- **Unaffordable Employer Coverage Penalty**
 - At least, \$3000 x # of full-time employees who receive exchange subsidies
 - Maximum penalty = \$2000 x each full-time employee (except for first 30 full-time workers) penalty
 - No penalty for Medicaid eligible employees

Employees are not eligible for Exchange subsidies if their employer coverage is deemed “affordable”

“**Affordable**” means the employee premium contribution under the employer plan is **less than** 9.5% of their household income

Key Provisions of Aug. 12 Proposed Rules

- **Affordability for Employee:** If employee's premium cost for self-only coverage is less than 9.5% of their W-2 wages for the employer, the health insurance is considered affordable even if they have a family and take family coverage
 - It appears that if coverage is affordable for employee but not their family, the employer will not pay a penalty.
 - Employer's not subject to penalty if employee receives tax credit but later employer-sponsored insurance is determined to be affordable.
 - **Affordability for related individuals:** For premium tax credits eligibility = cost of self-only coverage related to household income; for the individual mandate penalty = family coverage premiums in proportion to household income.
- **Must file tax return:** All individuals receiving an advanced premium assistance tax credit must file an income tax return, regardless if they are otherwise required to file.

Key Future Anticipated Regulations

- Anticipated to provide employer **safe harbor** from penalty assessment if they meet certain requirements.
- Employer large group plans will not be required to cover all of the essential benefits or 10 categories of benefits.
- May provide some transition relief with respect to meeting the “minimum value” requirement for plans. (Potential for a phase in to the 60% requirement (Bronze Medal) rather than hard cut on 1/1/14)



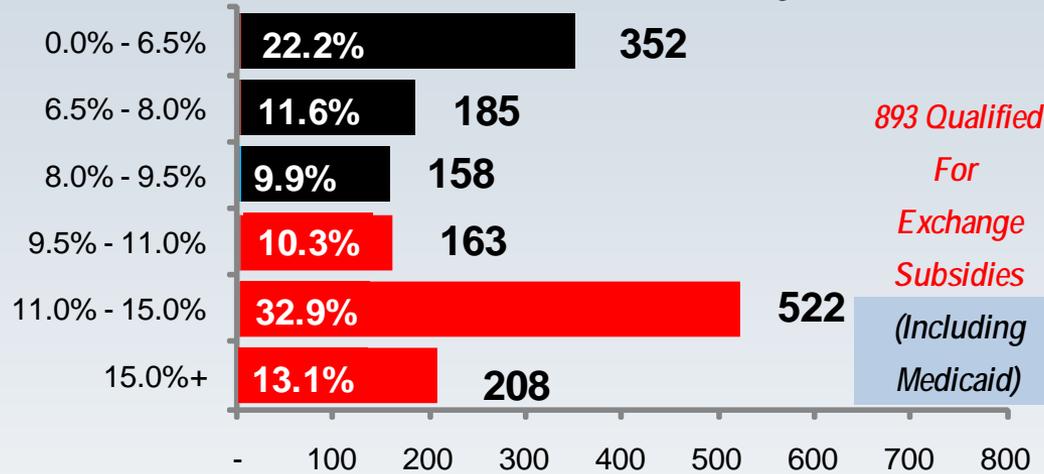
CLIFTONLARSONALLEN
HEALTH INSURANCE &
PENALTY (HIP) CALCULATOR

Employer Health Insurance & Penalty (HIP) Costs

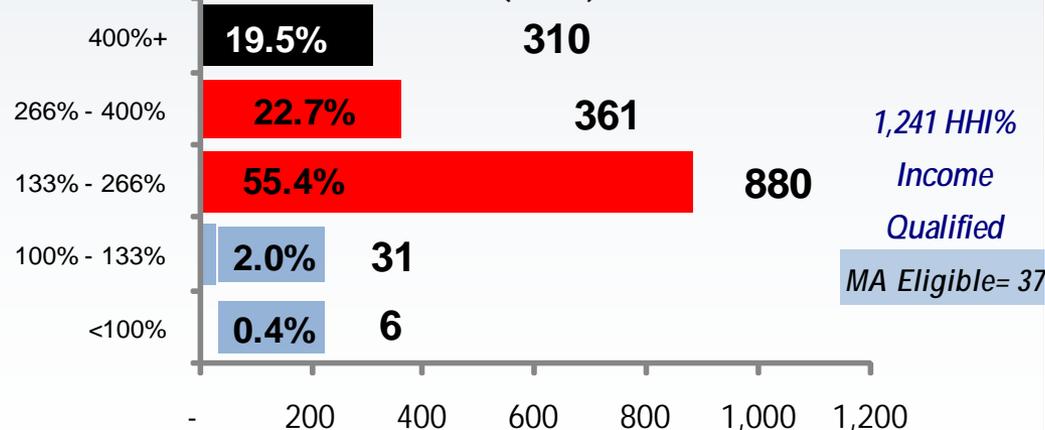
				HEALTH REFORM SUBSIDIES IMPACT ON HEALTH COSTS			
		Sample Organization		Today's	2014 Offer	2014 Drop/	
		(\$000s)		Cost	Coverage	Don't Offer	
Full-Time Employees	1,588	<i>(711 Insured / 877 Waived)</i>					
Total Staffed	2,639	<i>(104 PT Insured/947 PT No ESI)</i>					
2014 PPACA FTEs	2,204						
HEALTH REFORM KEY DRIVERS							
Today's Single Coverage Employer Premium Cost							
Average Single Employer Cost	\$	6,840					
Employer Contribution %		77%					
Medicaid Eligible Employees							
Total FT Medicaid Enrollees		37					
Employer Estimated Cost Savings	\$	292	<i>(\$000s)</i>				
Employer Unaffordable Coverage Penalty							
Subsidy Eligible Full-Time Employees		856					
Subsidy (\$3,000)	\$	3					
Estimated Subsidy Penalty	\$	2,568	<i>(\$000s)</i>				
% Total Full-Time Employees		53.9%					
Employer No ESI Insurance Penalty							
Total Full-Time Employees		1,588					
Less: 30 Employees		(30)					
Adjusted Full-Time Employees		1,558					
No Insurance Penalty (\$2,000)	\$	2					
Estimated Subsidy Penalty	\$	3,116	<i>(\$000s)</i>				
2014 Pre Reform Projected HC Costs	\$	7,220	<i>(\$000s)</i>				
Estimated Net Savings	\$	4,104	<i>(\$000s)</i>				
				Baseline Premium Cost	\$ 5,575	\$ 5,575	\$ 5,575
				2012-2014 Premium Increase (9.0% / Yr)	-	1,645	1,645
				Pre-Reform Projected Premium Cost	5,575	7,220	7,220
				Tax Adjusted Premium Costs	3,624	4,693	4,693
				PLUS: Additional Reform Impact			
				Previously Waived FT Employees	-	7,733	-
				Change in Employer contribution	-	-	-
				Penalty: Subsidy Eligibles & ESI	-	2,568	-
				Health Reform Increased Cost	-	10,301	-
				LESS: Previous Premium Liabilities			
				Medicaid Employee ESI	-	(292)	-
				Subsidy Eligible FT Employees ESI	-	(7,582)	-
				Health Reform Decreased Cost	-	(7,874)	-
				No Minimal Essential Coverage			
				Less: 2014 Inflation Adjusted HC Cost	-	-	(7,220)
				Plus: Subsidy Eligible Penalty	-	-	3,116
				Health Reform No ESI Cost	-	-	(4,104)
				Post Reform HC Costs	\$ 5,575	\$ 9,647	3,116
				HC Cost Change to 2014 Projected		\$ 2,427	\$ (4,104)
				% HC Cost Change to 2014 Projected		34%	-57%
				Tax Adjusted HC Costs	\$ 3,624	\$ 7,169	3,116

Employee Exchange Subsidy Eligibility Factors

Health Insurance Affordability



Household Income (HHI) % Above FPL



Exchange Subsidy Eligibility =

Affordability

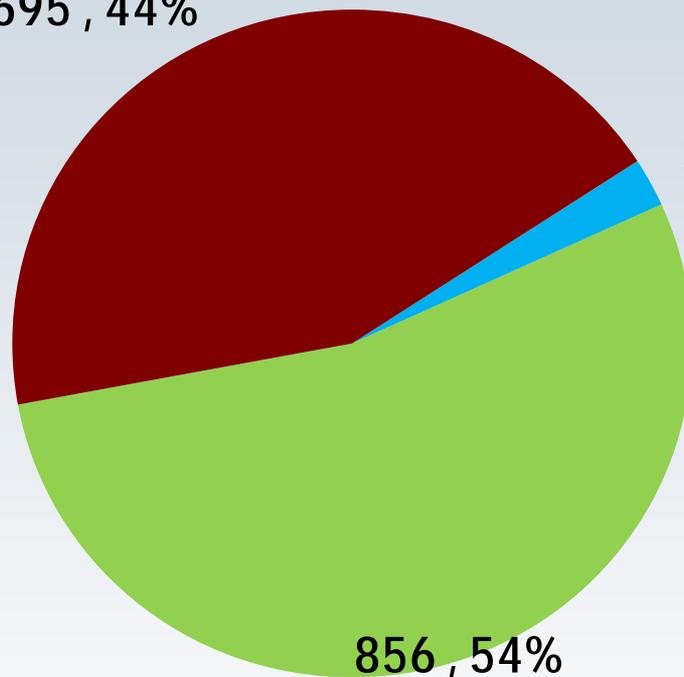
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133-400% of FPL

In 2014, employer pays penalty when a FT employee is eligible for Exchange Subsidy.

2014 Coverage Breakdown

Post Reform ESI 695, 44%
FT Employee
Insurance Mix



- Medicaid Eligible
- Subsidy Eligible
- ESI Coverage

We estimate 56% of your full-time employees will be eligible for either Exchange subsidies or Medicaid, and that 44% will enroll in the ESI.

Average Premium Cost Per Employee Perspective

Resources

- For updated guidance, proposed rules and other information about PPACA implementation issues:
<http://www.irs.gov/newsroom/article/0,,id=220809,00.html>
- Proposed rule on the Health Insurance Premium Tax Credit:
<http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf>

Health Insurance and Penalty (HIP) Calculator

HEALTH CARE REFORM

HOW MUCH MORE WILL HEALTH REFORM COST MY BUSINESS?

Find Out

2011 **2012** **2013** **2014**

www.larsonallen.com/HIP

The New Normal... for Many Americans

1. Declining wages
2. Housing issues
3. Unemployment
4. Lower or flat productivity
5. Increased focus on cost-cutting
6. Increased family care

Each of these issues will have a significant impact on the legal services field.

The New Normal Operating Environment – Decline in Wealth

The Implications:

1. Wealth of 65+ will be lower than current cohort
 - May choose to work in retirement
 - May choose to live with children rather than other alternatives
 - May delay moves to senior communities
2. Older adults will increasingly have employer sponsored health insurance
 - Reimbursement may be lower than Medicare
 - Coverage benefits may be different
3. Reportedly, increasing numbers of older adults are moving in with adult children to preserve assets & support children
 - Increased use of emergency room, physician offices, home & community services and other venues as frail elders need services
4. Adult children, who have also experienced declines in wealth, are assisting parents make aging services choices with new lens
5. Financially stressed adult children may increasingly look to parents for assistance impacting the elder's financial strength

The New Normal Operating Environment – Housing Prices

The Implications:

1. Housing stock of foreclosed or short sales is expected to increase number of houses on the market in 2010 by 40%
 - It is estimated that it will take about 4 to 6 years to balance demand with supply
 - Older adults will not be able to sell their homes or the sale will take longer
 - The rebound in home prices for homes will be longer than originally estimated
2. HUD has proposed expanding service options and case management at HUD properties to reduce the transfers to SNF and Medicaid expenses
3. Greater numbers of elders will reside in the community and seek in-home services reducing the short term demand for independent and possibly, assisted living further



The New Normal Operating Environment – High Unemployment

Implications:

1. Staffing shortages will continue to ease and projected estimates of staff shortages may be overstated
 - Potential worker shift to urban areas may create shortages in rural areas
2. Quality issues may develop due to stressed and tired staff taking on second jobs
3. Coordination of schedules, particularly in nursing and service level employees will be complex
4. Salary and benefit pressures have declined in some markets
5. Employees returning to jobs may have fewer benefits and fewer pay differentials, i.e., level of bonuses for selected shifts, weekend pay, etc.
6. Unemployment levels may level off at above 6% long term as fewer new jobs are created



The New Normal Operating Environment – Flat Pricing Growth

Implications:

1. Net income will result from improved efficiencies, expansions and other revenue sources
 - Economic downturn has impacted productivity & morale and requires special attention
 - A renewed interest in technology may occur to reduce costs & improve productivity
2. Increasing pressures to substitute levels of care may occur
 - Potential health care reform changes to H&CBS funding & eligibility could expand services
3. Future reimbursement changes will require performance data
 - Current metrics for performance data is inadequate
 - Understanding episode of care patterns will be critical
 - New payer strategies will be required
4. Negotiated rates will be most successful if discrete cost accounting occurs

New Normal Operating Environment – Caregiver Focus

Implications:

1. Providers will find new ways to engage informal caregivers
 - Informal caregivers will be expected to participate in care planning and some care tasks
 - Caregivers will look to providers for a broader array of supports that are affordable and that reduce challenges & stresses
2. Health care reform proposals include resources and programs to lengthen the time informal caregivers provide services in the community
3. Caregivers may look to organizations that have assisted them when they need to find a more intensive care for their family member
4. The growth in numbers of elders without caregivers will challenge the H&CBS system and other aging providers
5. Some programs will be developed to support caregivers w/o financial eligibility requirements



Decreasing Role of Family Pushes up Demand for all Services

Percentage of Family Caregiving:



National Ratios:

Year	Caregiver Ratio	Elderly Dependency Ratio
1988		4.75
1995	7.51	
2001		4.61
2010	6.78	2.76
2030	4.34	

The Caregiver Ratio is a comparison of the number of elders 85 + to women aged 45 to 64. The Elderly Dependency Ratio is the number of elders 65+ compared to workers aged 20 to 64. The lower the ratio the fewer the number of caregivers or workers.

Source: National Caregivers Association & US Census Population Projections by Age & Sex

New Relationship Focus will Position for Success

Health care is local and relies on strong relationships. Today's relationships focus on:

- Physician/patient
- Skilled Care/family/resident
- Home care/informal caregiver/physician/client
- Skilled care/hospital social worker
- Payer/provider
- Others

Future health care relationships will include greater reliance on:

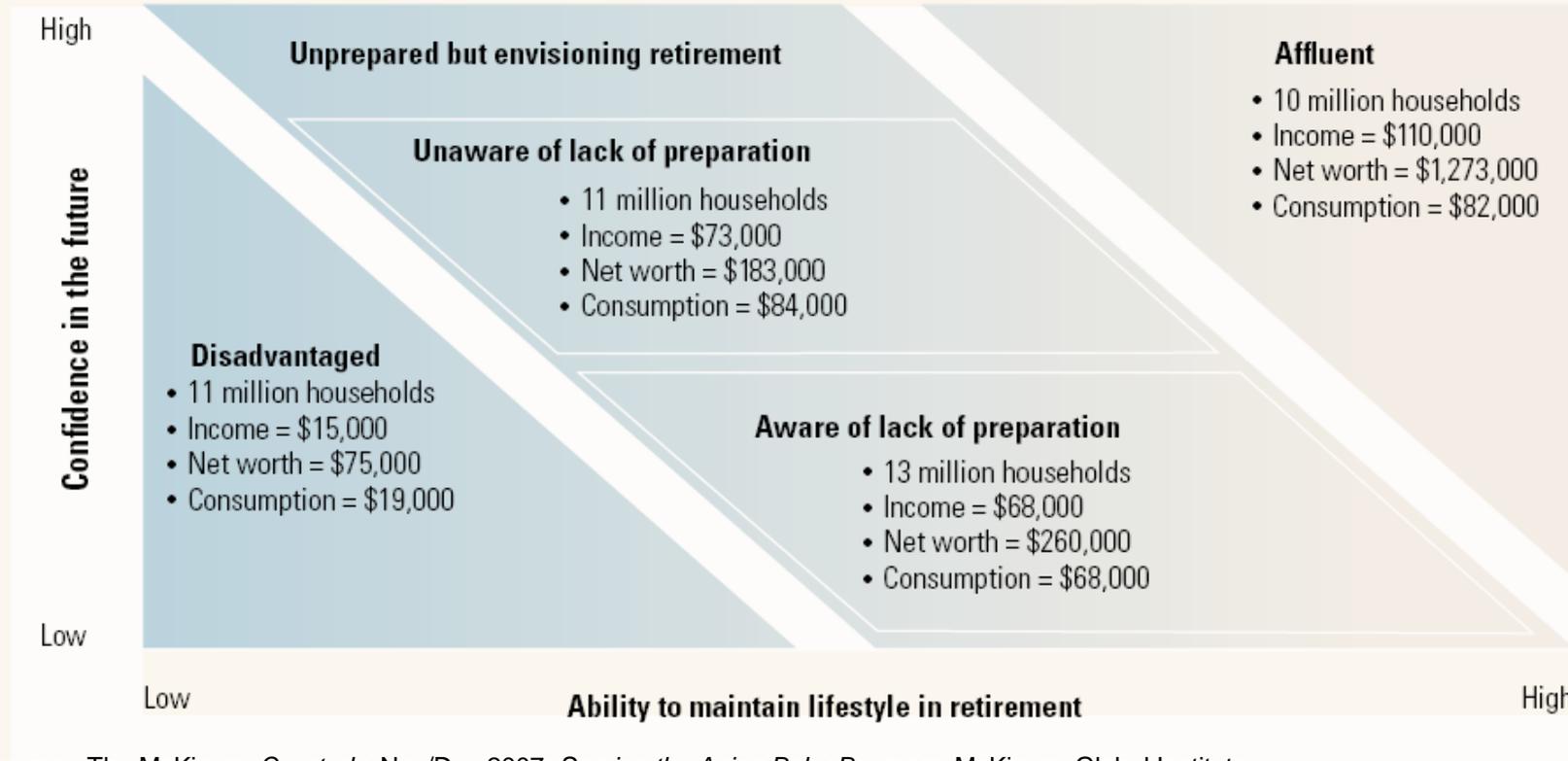
- Physicians/Accountable Health Organizations as the payer
- Independent care managers
- Strategic partnering with other provider organizations which start with CEO/Board relationships
- Greater reliance on volunteer/informal caregiver relationships

Setting the Context - The Changing Customer

Portrait of a generation

Average annual financial data per household in 2006,¹ by segment of US baby boom generation (born from 1946 to 1964)

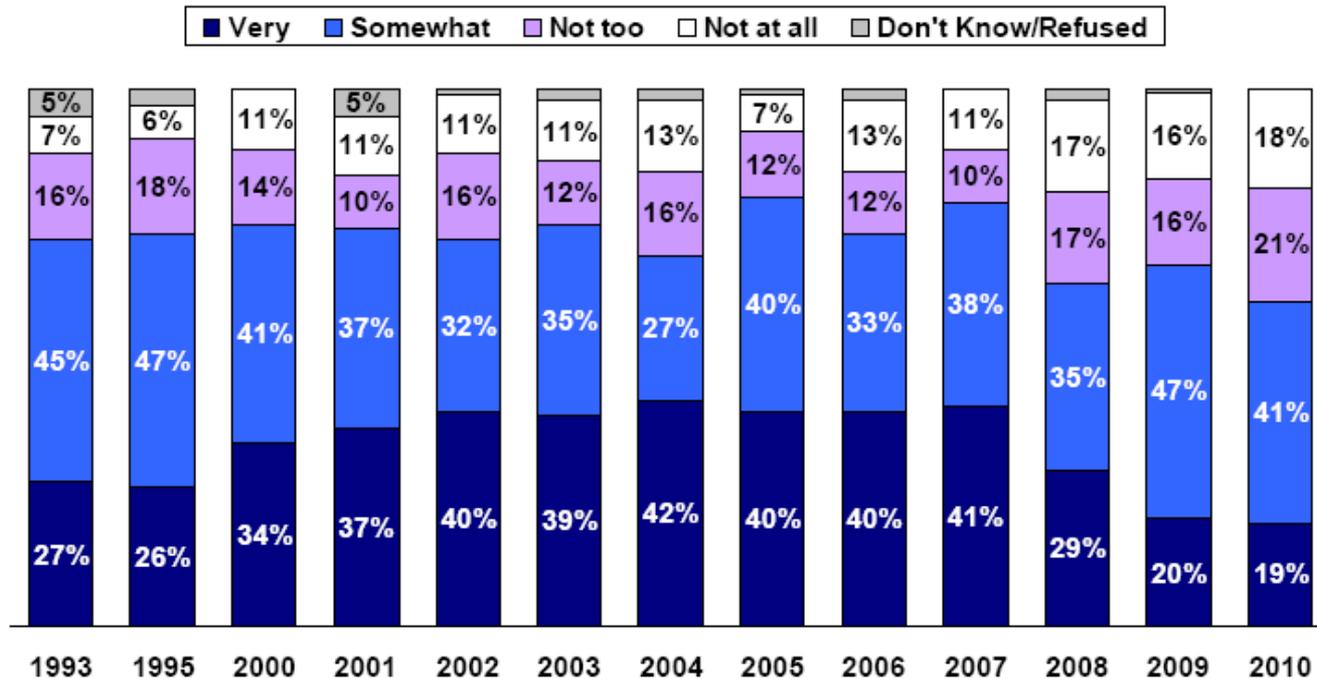
In 2015 60% of all consumption by boomers will come from those who are unprepared for but envision retirement.



Source: The McKinsey Quarterly, Nov/Dec 2007; *Serving the Aging Baby Boomers*; McKinsey Global Institute

Economic Position of Elders Continues to Evolve

Figure 2
Retiree Confidence in Having Enough Money to Live Comfortably Throughout Their Retirement Years



Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 1993–2010 Retirement Confidence Surveys.

Source: Released March, 2010 and accessed via the web from EBRI.com

What does all this mean? Come see Part 2

...and what do we do about it?

Questions

Thank you

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