PNC BANK

Patients Take the Wheel:
The Impact of Healthcare Consumerism on Companies

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Operator: Ladies and gentlemen, once again it is my pleasure to welcome you to today's PNC Advisory Series webinar. Before we get started with today, let me quickly point out some of the ways that you will be able to participate.

Today's presentation utilizes a dynamic console that allows you to adjust and resize any of the windows that are available to you on your screen, and you can simply move those windows around by clicking the top title bar of those screens, or you can resize them by clicking on the lower right side to move those and resize those to your preference.

We, of course, encourage you to get the most out of today's presentation by asking any and all questions that you may have. And you can easily do that by looking into the Q&A window on the bottom left portion of your console, type your questions into the very bottom field of that Q&A window, and then hit the Submit button. We'll take as many questions as we have time for at the conclusion of today's presentation.

Lastly, if you're having any technical issues, we would encourage you to submit your technical issue through that Q&A window, and we'll be more than happy to help resolve any issues you might be experiencing.

And with that, let's go ahead and begin today's PNC Advisory Series event. It's my pleasure to turn today's call over to our moderator for today, and that is Jean Hippert, Senior Managing Director of PNC Healthcare. Jean, with that, I'll turn it over to you.

Jean Hippert: Okay, thanks a lot, Aaron. Appreciate it. And good afternoon, everyone, and welcome to our PNC Advisory Series webinar, "What to Expect as Employees Become Healthcare Consumers." Thanks so much for joining us today. As Aaron mentioned, I'm Jean Hippert. I'm the Senior Managing Director for PNC Healthcare, and I will function as your moderator.

Before we get started, I just wanted to highlight PNC's ongoing commitment to providing market insights, new ideas, and best practices like you're about to hear. Our commitment is reflected in the types of conversations our bankers are having with companies like yours every day. It's also reflected in our PNC Ideas Thought Leadership Series, which features a monthly e-newsletter, live webinars, and a dedicated website at PNC.com/ideas, and we do hope you'll visit. From brief videos, articles, and economic reports to financial market commentary and webinar replays, we continue to choose topics and formulate our ideas based on the input we get from you.

So with that in mind, at the end of today's session, please provide the feedback we need to keep focusing on the right information for you and your company.

PNC

Okay, let's get started with our event today. We're excited to have two great presenters with us, Greg Jelinek and James Gandolfo — or, as we like to call him, Jim. Greg and Jim are going to discuss how companies are facing an environment of constant change in healthcare, from HIPAA in the 1990s to the passage more recently of the Affordable Care Act. There's also, as we understand it, a paradigm shift in patient attitudes and behaviors with respect to healthcare consumption.

PNC Healthcare Group commissioned Shapiro+Raj to explore these changes and understand their impact on providers, payers, and employers. And we're going to cover that information and the findings out of that study, including some of the following concepts: how patients are beginning to take the wheel as consumers; trends in consumerism and the influence, particularly of Millennials, on healthcare consumption and delivery; and implications for your company as you face these new realities.

We're going to facilitate a question-and-answer session at the end of the presentation, but you, as Aaron mentioned, can submit questions any time throughout the presentation using the questions widget found in the lower portion of your screen.

So let me briefly introduce our presenters. First, Greg Jelinek. Greg is the Executive Vice President and National Sales Director of Treasury Management for the PNC Healthcare Group. Greg has joined the company in about 1986. He took his current position last year. Previous to his current role, he led the asset management strategy to grow wealth and institutional investment business for the PNC Corporate and Institutional Bank. Greg also served as Market Manager for the Commercial Banking Team in northern Ohio and Chief Credit Officer for the Wealth Management business. He's also held positions as head of business banking, head of the dealer finance unit, and various leadership positions in our Corporate Banking Group, Investment Real Estate, Credit and Retail Banking.

Greg served on the Board of the Metro Health Foundation and got a lot of great healthcare experience in that capacity. And he was also on the Advisory Committee for the Baldwin Wallace Center for Innovation and Growth. He also formerly served as a Board member of the Western Reserve Historical Society and on that Executive Committee and was Chair of the Hale Farm Advisory Committee.

Greg graduated from the University of Dayton in 1985 with a bachelor's degree in finance and earned his master's degree from Cleveland State University and currently is living in Columbus, Ohio.

Jim Gandolfo, our other presenter, is Senior Vice President in PNC Treasury Management and is the healthcare lead for our Treasury Solutions Group. He is responsible for the health savings account development and distribution. And previous to being with PNC, Jim was with PNC Global Investment Servicing, where he was responsible for the HSA administration solution there. His experience also includes a long tenure with Wilmington Brokerage Services Company, a registered broker-dealer, where he was President and CEO.

Jim graduated from Radford University in Virginia and holds a Bachelor of Science in political science and history. He's licensed by FINRA, including Series 6, 7, 24, and 63, and he's Chairman — very importantly for this discussion today — of the American Banker Association's

HSA Council and a member of the Board of Directors of the HSA Coalition. He's been recognized widely throughout the industry for his work with public policy. And Jim joins us from Wilmington, Delaware.

And with that, I'm going to turn it over to Greg, and Greg, you can begin our discussion today. Thank you.

Greg Jelinek: All right, thank you, Jean. It's great to be here with everyone this afternoon. I'm really excited to share some of the findings that we have out of our study with Shapiro+Raj. But before I get started on that, though, I thought I'd give a little bit of a brief background on PNC and our healthcare business.

PNC is the seventh-largest U.S. bank as measured by deposits and assets. And as you can see on this slide, our retail footprint is shown in orange. In addition, we have many other offices across the country, in Canada, the U.K., and China to support our corporate and national businesses. PNC Healthcare is one of those national businesses, in addition to our corporate finance business, real estate, industries, capital markets, investment banking, equipment finance, asset-based lending, and our mortgage business. We are fortunate to have a strong financial performance as well as a strong capital position.

A little bit about our healthcare business. We do have over 25 years of focus on healthcare. We support over 1,900 clients on a national basis, and we currently have more than $12 billion in capital committed in terms of credit commitments in healthcare. We do take a leadership position in industry standards, integration with health systems, HIPAA privacy and compliance, and we have a full suite of core treasury management products as well as revenue cycle solutions.

You can see here from some of our revenue cycle metrics that we process a very significant volume of transactions and payments. And to give you a sense of scale of our healthcare business, approximately one-third of our lockbox transactions going through eight of our domestic lockbox sites in 2014 were healthcare related.

In terms of the scope of our healthcare business, we have a very broad focus. We do focus on providers and payers primarily, but we also focus on physician practice groups, lab and ambulatory care, in addition to alternative care institutions, such as home healthcare, rehabilitation, and skilled nursing. We also do quite a bit of business with group purchasing organizations that are focused on healthcare.

So with that, I thought it would be helpful to give you a little bit of that background. It would set the stage for the rest of our presentation. I will present the Shapiro study at a very high level on the consumerism trends in healthcare, and then I'll transition to Jim to give a little deeper dive on the healthcare industry, healthcare accounts, and the impact on employers.

But you may be asking at this point, "Why did a bank like PNC undertake this work?" And it really started and was elevated as one of the most important topics by our Healthcare Advisory Board. We do have an advisory board that is made up of treasurers, CFOs, and chief revenue cycle officers in our clients on a national basis, so we currently have, I believe, 22 board members. And they elevated this as one of the most important topics that they're facing today in the industry.

And also, based on our experience in meeting with many healthcare executives across the country, this is an ongoing upcoming issue that always comes up in terms of the C-level suite, and they are very engaged around this issue and how these changes are happening and how they will impact their business.

We also strive to be a thought leader, and we undertook this work really to support our clients with information and to help them navigate the changing landscape of healthcare, in addition to informing our own direction in terms of our investment in new capabilities to handle what they need, not to mention the fact that PNC has approximately 54,000 employees. And as a company, this information is very important to us and informative in terms of where we need to go with our own healthcare for our own employees.

Of the study that I'll go into today, I'm going to take it at a very high level for our purposes today, and I'll really try to hit on some of the key highlights and findings from the study. But before I do that, I'd like to set a little bit of the background in terms of how the study was conducted and what took place.

So as we mentioned, we did undertake with Shapiro+Raj to explore the shift toward patient-centered care and what it really means to the future of healthcare. And these are some of the questions that we asked as we were getting into this study and that we wanted to answer with the study.

And the study was really conducted in three different stages. Stage 1 was interviews with key opinion leaders. And those really involved in-depth interviews with hospital executives around the country to identify trends, challenges, and innovations in patient-centered care.

Stage 2 was really exploratory research with consumers. And that was staged with 12 focus groups with consumers in four U.S. markets. So the markets that we did the focus groups in were Philadelphia, Nashville, Los Angeles, and Miami. And in those focus groups, they really represented six different consumer segments: the uninsured, chronic conditions, Millennials, Medicare patients, high-income patients, and families with children.

And then Stage 3 of the study was really to validate and quantify what we found in the focus groups. And that really consisted of a large-scale national survey of over 5,000 U.S. adults. And that survey was conducted online. It was supplemented by about 300 telephone calls, really to capture the older adult population. And it was sized to permit analysis by the key consumer segments that I mentioned earlier. The sample that we used was representative of the U.S. population based on gender, age, ethnicity, and geography.

So at a very high level, some of the key findings of the study were really interesting. First of all, Millennials are now the largest group, and they will shape the road ahead in American healthcare. Compared to other groups, Millennials seek change throughout the healthcare system. A couple of examples of that: one, they embrace retail and acute care clinics; they take the most responsibility for their own healthcare through lifestyle; they spend more time researching online, finding providers and getting others' opinions on those providers; and they really will force much more change compared to Boomers and seniors.

Finding number 2, really, at a high level, was the far-reaching societal changes are really affecting healthcare. So advances in technology, demographic shifts, and consumer and retail trends are having a very big impact on some of the changes in healthcare.

Just as a point of reference, in August of 2014, the global population was estimated to be about 7.2 billion people, of which 3 billion were active Internet users, 3.6 billion were active mobile users, and about 2 billion were active social media users. This is really clearly driving demand for more digital access to healthcare and health information. So a clear message: really, the patients are seeking to leverage the skills and experience that they have in other sectors as they interact with the healthcare sector; especially, they're digital-savvy. Each generation is also becoming more and more proactive with their healthcare.

As we look at the healthcare journey, it's a little bit of a bumpy road. So as we look at all of the different points of connection in terms of healthcare along that journey, satisfaction with healthcare is really a bumpy road with a lot of variation. As you can see here, some of the highest-ranked areas as they go through that journey are satisfaction with care in general and the discharge process. Some of the lowest-ranked points of contact were the length of wait once the patient arrives for treatment and the actual out-of-pocket cost and communication about those costs. The study really found this to be true, especially with respect to understanding the planning for patient responsibility of cost upfront. We'll talk a lot more about this as we get a little further into the discussion today.

So in general, the study found that consumers have some concerns and lack of confidence in the future of healthcare. Patients of all age groups expressed confidence in the availability of good doctors in the future. However, they were much less confident in their ability to rely on Medicare and to afford medical costs in general.

Millennials expressed the greatest concern about their ability to afford care for their children in the future. And younger consumers were more willing to modify their health behavior for both better service and better price for both themselves and their children.

Some interesting statistics here that I thought were worth noting: 43% of Millennials are willing to go out of network for a better doctor compared to only 32% of Boomers and 35% of seniors; 46% of Millennials said that they would also switch the primary care provider if they could find care at a lower price, compared to only 21% of Boomers and 10% of seniors; and 56% of Millennials said that they would usually wait a few days before seeking medical care for a child, versus only 44% for Boomers. So Millennials are much more willing to change what I would consider traditional healthcare behavior.

In the study, we then kind of turned the table a little bit and we asked, "What is the number-one issue facing healthcare today?" As you can see from this chart, billing problems and healthcare costs constituted the most acute pain points for consumers by a pretty large margin. 79% felt that medical care was too expensive. 77% agreed that healthcare costs are unpredictable. And significantly, 54% of Millennials and 53% of Gen Xers said that they would delay or avoid getting treatment because of cost compared to 37% of Boomers and 18% of seniors.

At the same time, in the focus groups that we conducted, many commented that they felt the quality of time spent with their provider had declined and that the doctors spent more time entering information into the medical record than interacting with the patient. So kind of a bad dynamic in terms of very expensive cost and less value that they're receiving in their own perception of healthcare.

So then we asked the respondents to rank the usefulness of some potential concepts to help them manage their healthcare on a nine-point scale. As you can see, the major categories here that broke out included billing and cost help, online tools, easy answers and educational resources, easier check-in, a personal touch with a human advisor, and physician access.

While consumers were most interested in solutions that addressed billing and cost, seniors were most interested in easier check-in and easier answers and educational resources. They also wanted to retain the personal touch. In addition, in terms of the highest-ranked initiatives, discounts for the patient portion of the bill ranked the highest, followed by patient financing, a cost estimator, consolidated statements for the episode of care, and the prompt-pay discount. So a lot of focus on cost there and how that patient really handles that expense.

Patient portals and online scheduling were also seen as very valuable, as well as easier check-in and more automation in the scheduling process. So patients are really adapting to the new healthcare realities.

A couple of other examples here: 34% of Millennials and 28% of Gen Xers visited a retail healthcare clinic in the last year, so they're definitely looking at alternative care solutions, and that compares to 17% of Boomers and 15% of seniors. And all of the age cohorts reported using a patient portal in the last year, and 93% said that that patient portal was very or somewhat useful. And they all really liked the idea of electronic medical records and were in favor of those, expressed relatively few concerns about privacy or data breaches, which is interesting to me, coming from a bank where this is something we're very, very focused on.

But as we dug a little bit deeper to really understand some of the strong feelings about billing and cost and managing the financial obligations, we found that 40% of those interviewed had experienced some problems with provider billing in the last year. 19% had received an unexpected bill, and 10% had received multiple bills for the same procedure or visit. So in general, they were unable to really understand their bills or to understand or were unable to get an estimate upfront. That really speaks to the need for a cost estimator that's accurate and a consolidated bill, which is something we see coming out very often.

So unlike many other large consumer transactions, upfront estimates in healthcare are still an exception. Only one in three consumers who had inpatient or outpatient treatment at a hospital in the past year received an upfront estimate for that treatment. Millennials and Gen Xers are demanding this much more and are much more likely to both ask and receive estimates upfront than older patients. Unfortunately, based on the study, at this time they feel like upfront estimates are only accurate about half of the time. So we have work to do as an industry to get this right. And interestingly, some of the new competitors in the industry, like retail clinics, do a far better job than most other healthcare providers in terms of communicating with patients about their out-of-pocket costs and doing that upfront.

I thought this quote was interesting on here, where it really gets to the concept of the patient's desire to pay but not having visibility or enough communication around that. What they really want to avoid, they really don't want any surprises. And that quote is, "It's one of the only things in the world where it could cost you zero dollars or thousands of dollars, and you have no way of knowing until you walk out the door." That's kind of interesting, and it really speaks to that concern I think that patients have around visibility of their costs upfront.

So now I thought I'd shift a little bit to go to some of the bigger trends that we saw through the study. And over the last 20 years, there's really been a dramatic shift in the control from the primary care physician to the patient. Historically, the primary care physician really directed the care and either handled the issue themselves or they referred the patient out to a specialist to continue the care. Patients of all age groups are now utilizing their digital savvy as they seek and experience care. And over time, more control is shifting to the patient.

Millennials and Gen Xers do more in this regard. However, tech-savvy seniors also behave in very similar ways to Millennials. There are just fewer of them, so it's not as noticeable. We also found that Millennials and Gen Xers tend to rely on friends for recommendations regarding providers and care, but they're also interested in reliable reviews for providers online as well.

And then there's this concept of self-triage, which is really taking place, and it's happening as patients research, consult, and self-refer to many providers and ultimately make decisions on which providers they will go to.

Millennials are really demanding a much more consumer-centric model. As we look at proactive behaviors like those listed here, each younger generation is more and more proactive in terms of these behaviors. Some of the statistics that we got out of the study, Millennials who exhibited some proactive behavior in the last year, 70% of Millennials exhibited some proactive behavior, followed by 66% of Gen Xers, 52% of Boomers, and 46% of seniors, so the younger generations are much more proactive in their healthcare.

Millennials are really driving the future, and the road ahead will likely be much more competitive. So what do I mean by more competitive? Well, consumers, like I mentioned, are self-triaging among many different providers. The expanding role of retail and acute care clinics is becoming more and more apparent. Emergency rooms are going to be relegated to true emergencies, and more competitors are competing for outpatient care.

Healthcare will also be more transparent, so more demand for cost transparency and patient access to records, online price comparison charts for common procedures, expanded use of online reviews for healthcare providers and expanded patient portals — all of this will make healthcare much more transparent.

And then more digital. Consumers are demanding everything digital. I mentioned expanded patient portals. We will also be seeing more and more online registration and scheduling, online pricing information, and live-person options with the explosion of telehealth, where you can actually get on your iPhone, talk directly to a doctor kind of face-to-face electronically through a telehealth live phone option, and get diagnosed over the phone. So it's really becoming much more digital.

And then more responsive. The consumer-centric model, the consumers really are going to demand that they are placed first when it comes to price, service, and change. And it means that they're going to want to access that customer service through multiple channels, so online, via the phone, via 24/7 call centers. So very much a changing dynamic in the healthcare model.

So what we really found is patients really are taking the wheel. The big question is, is the industry ready? Based on our experience, the answer is not yet, but many companies are making progress, and health executives are very engaged. They realize that progress needs to be made to address the following challenges:

(1) Improving the patient conversation, so from the front-end check-in to the back-end billing and collection.

(2) Improved management of information, responsiveness to the patient's desire for more information. One, as healthcare moves from a system of being paid based on volume to being paid based on outcomes, information will be much more important and much more critical. And two, the patients are asking for and demanding much more information on their own healthcare and their own health information.

(3) The patient experience overall is becoming more and more important as patients have options and are shopping for their healthcare; and

(4) The competitive model really needs to be addressed in terms of how each of these healthcare institutions is going to deal with the change that's taking place and deal with the more active role of the healthcare consumer.

So from an employer's perspective, these are important issues as well, as the expectations of employees are changing. And at PNC, as I mentioned before, we share those challenges as well, with our large employee base, which is obviously very important to us.

So from a PNC Healthcare perspective, our strategy is really to build solutions that address the full patient-centric revenue cycle. And really, what we are doing is we are creating a patient-centered approach. It's not an easy task, but it is an evolution. Our focus is really to provide solutions for our healthcare clients that manage their payments, information, and processing requirements as well as to give their patients access to scheduling, making payments, and managing their family's healthcare activities. And if we can bring those together, that's really where we see the win that we can deliver in terms of solutions for our clients. We continually evaluate the evolving market requirements, the changing healthcare preferences, and other industry best practices as we look to really refine our strategy.

So in a nutshell, that is what we're doing to focus on some of these changes. And at this time, I'm going to transition to Jim, who's going to dive a little bit deeper into some of the industry changes and how they are affecting your businesses. Jim?

Jim Gandolfo: Great, thank you for that excellent background. And good afternoon, all. Thanks for, again, having us here. It was a great segue into what I describe when I go around the country and talk about these issues with individuals and businesses and employers, specifically as sort of a tough news, good news, and then storm clouds perhaps on the horizon, wherein we always have to be vigilant.

So in the next few minutes, I'll try to cover for you how we got where we are and what consumer-driven healthcare really means and focus in on those accounts, and then talk about the trends, the effects on employers and employees, and then the potential regulatory challenges for consumer-driven healthcare in the future and how, as an industry and a group with insight to the industry, we are addressing them as effectively as is possible.

So first, a little bit about how we've gotten here. Well, this won't be any shocking news to anybody, but according to the Organization of Economic Cooperation and Development, which is most of the large economically developed countries in the world, when surveyed, the United

States spends more than 2.5 times on each patient than the average for all countries through the world that are part of this organization, and yet our healthcare outcomes are not 2.5 times better when compared to the rest of the world.

And so when we talk about the problem and how we got there, you always have to, I think, take into account where the funding has come from and how that's affecting change and the dialogue that has been healthcare reform throughout this country for many years, since the 1960s.

So this chart evidences the growth in expense. And if you go back and check me, you'll see that $1.00 in 1980 is worth about $3.00 today. And so when you take a look at this chart, you'll see the costs and where they've risen, all the way through to the end of 2013/beginning of 2014, the most recent data.

And in 1980, out-of-pocket expenses for an individual were $58.00, public funding represented about $108.00 per participant per medical patient, and then insurance paid about $89.00. And if you just take three times that, or 3X that, you would expect that those numbers should be something along the order of about $174 for out-of-pocket, $324 for public funds, and $267 for insurance payers.

But the reality is much different. At the end of 2013/beginning of 2014, out-of-pocket expenses were 2X that, $339.000; $1,453, 5X for public funds, so a growing number of dollars from the public sector; and as well, insurance, 5X to $1,126 per participant. So a much different picture than you might expect under normal circumstances and normal inflationary purposes.

This next slide shows the rise of insurance premiums for large company and small company, small being the lighter of the two colors and the large being the darker of the two colors. And this is just since 1999, so this is only in a 15-year period, relatively. And what you see here is that the cost of an average premium for a family policy, for a large corporation back in 1999 was $5,845, and for a small, $5,683. And you compare that to the end of 2014, where those numbers were $17,000 and $15,000, so just more than tripling, almost, of the cost of insurance over that period of time. And that has had a dramatic effect on wages and on companies in general. And so there's a real human effect here.

This chart will show you the relative closeness and alignment between inflation and workers' wages. But when you look at the cost of premiums over that period of time, you can see, even where there's a dip, it still outstretches what we're paying to our workers nationally. And what that effect is, then, is less productivity in companies, more challenging times.

To share an anecdotal situation, I visited with a large corporation, what we would consider a large corporation, who had an 8% growth rate last year, year over year, which is a relatively good rate of return. But the problem for them was that the cost of insurance went up 16% over that same period of time. So it's making it more difficult to stay competitive throughout the United States.

So here comes some of the good news that we have an opportunity to embrace and, as a country, have developed over time. So this conversation about the rising cost of healthcare has been going on since the 1960s. So a bit about how we got here now. And the timeline that you see depicts that growth and evolution.

Back in the 1970s, the cafeteria 125 plan is introduced. And Thomas Wood, who was the then Chairman of Hewitt & Associates, is generally credited with coming up with the concept. And the IRS introduces the cafeteria 125 salary reduction plan in 1978, November of 1978. And that allowed individuals to set aside pre-tax dollars, so $100 in those days, the tax rate was 50%. And so for a company to cover what it would cost them to give to an individual, $100 to cover expenses, would cost them $200 in those days to just equal that buying power.

And so this concept that you could set aside dollars in a pre-tax basis, save the company FICA and FUTA taxes, and as well give your employees an opportunity to set aside dollars to carry expenses that were over and above deductibles, which were rising even in those days, was a new concept embraced in the cafeteria 125. And out of it comes a defined benefit plan called the FSA, the Flexible Spending Account.

In the 1980s and the 1990s, that was extended, and growth of those vehicles included the first health reimbursement arrangements, and importantly to our industry today, the Treasury Demonstration Project called the Archer Medical Savings Accounts. And then those two types of accounts, the three that I've described, the big difference between the first two — the FSA and the HRA — is in the FSA, the contribution is made by the employer and the employee, and the HRA is all by the employer. But in any case, those dollars revert to the employer should that employee leave in advance.

In the MSA, it was the first time an account that was truly a savings account was created, and those dollars were very portable. You took them with you. But the Treasury Demonstration Project was limited to 50 employees or less. And so it needed expansion, and that happened at the end of 2003 in December with the passage of the Medicare/Medicaid Prescription Drug Modernization Act, and that's generally known as the act that created Part D for Medicare.

And part of that was the HSA legislation, which tied a savings account to a high-deductible health plan and gave Americans the opportunity to set aside dollars that they would take and would be portable from one employer to another, or even well into retirement. And so that's the first piece of what we now consider the full cycle of consumer-driven healthcare, where you start to engage employees in ownership and then through that process, create a relationship between cost and benefit.

Some other notable items in the timeline is Massachusetts creates the statewide health reform, and that included an HSA option on an exchange. Indiana created the Patient Power Account. And those were two efforts to actually engage individuals in savings. And, of course, in the Massachusetts instance, it becomes pretty much the basis for what we consider today healthcare reform, the ACA, Affordable Care Act, Patient Protection and Affordable Care Act, or Obamacare — however you want to refer to it.

Some other notables. Obviously, the Patient Protection and Affordable Care Act was passed in 2010. And now, in 2012, HSA plans are embraced as one type of bronze plan in the exchanges.

And so to give you an idea of the scope of these accounts, Flexible Spending Accounts are, again, funded by the employer or by the employee, and they are defined benefit plans. They are actually an insurance plan, and there is a use-it-or-lose-it rule, except for $500 rollover, which just passed last year by the Treasury, which enables you to carry over $500 into the future. All of your expenses are adjudicated, meaning that they all have to be certified by a TPA to make sure

that they are acceptable medical expenses. There is some expense to that. So that's the Flexible Spending Account — very popular throughout the United States.

Health Reimbursement Arrangements have been around since the 1980s. They evolved and became part of the Code, the IRC Code, in 2002. And the HRA is employer-funded only. The unused funds remain with the employer, and the benefit of the HRA to the employer is that the HRA allows the employer to structure a defined benefit plan which may limit the providers that the individual may see. It could be a premium reimbursement below or above the deductible, and so on down the line. So it can be an actual insurance plan created and scoped by the actual individual companies.

And then finally, the HSA, and they're funded by the employer or the employee in any combination, and the funds always belong to the account holder. And then, just as a side note, HSAs can only be used with an FSA or an HRA so long as those two types of plans are limited to either dental or vision.

So this next slide then gives you some of the parameters of the HSA. And again, these are special tax-free trusts and custodial accounts, and they're generally in combination — well, they have to be, by law — with a high-deductible health plan as defined by the IRS. And that really means that there is the opportunity for an actuary to understand what the exposure is for the insurance company.

And so putting the deductible in front of the actual covered expenses allows that insurance actuary to sell that and/or price that policy at a lower price, so that you get a lower premium and the ability to create a savings and ecosystem of healthcare consumerism by attaching ownership of the dollars and the contributions by the employer to the employee as well. So this slide might be interesting to you for the purposes of seeing what the actual contribution levels are.

And now what are the trends? What's happening around the country? So first we'll share with you some of the findings from the Healthcare Trends Institute. These are just selected findings. And this slide just gives you a background of who was surveyed. And so you can see that it was all around the United States and that the vast majority that were surveyed were the companies between 101 and 1,000. And there's a pretty good showing of companies that are less than that, but a good selection from around the United States.

And so as an idea, then, of what they found in these trends, just to highlight this, the Healthcare Trends Institute found that employee health benefits were offered by 91.3% of employers throughout the United States. So the idea that employers would drop insurance under healthcare reform, at least so far, has not come to fruition.

In addition to that, PPOs are still the most popular plan, but now 30.8% of employers that were surveyed offer a high-deductible health plan, too, and that's a great amount of an increase since their introduction back in 2004. And of those companies, 39%, a majority, offer just one plan. So you can measure yourself against these results. The majority of respondents, over 58%, said that health benefits remain extremely important to the growth and welfare of their company.

And then an interesting fact now is that in light of the ACA and consumer-driven healthcare, more are thinking about wellness and prevention than ever before throughout the United States. And there is a great deal of increasing cost, some cost shifting from the employer to the employee, and then, again, about half are concerned about the Cadillac tax.

Now, to define the Cadillac tax very briefly, the Cadillac tax is the high-value insurance tax that's part of the ACA, and it has two different levels. It basically says that if you pay for an insurance policy under today's guidelines — and that's all they are; they're not finalized yet — of $10,200 for an individual or $27,500 for a family, then every dollar over that amount would be taxed at a 40% excise rate. And so the growth of consumer-driven healthcare has been tied to the advent of the Cadillac tax, in our opinion.

Some other trends that might be interesting to you. I won't go through them all, but one that I will point out again is that nearly 51% of those companies that were surveyed, again, are starting to initiate wellness plans inside of their overall offering.

So what are the trends? What's happening with employees as they go about this? Well, to tie back into what Greg was talking about, with Millennials, this study found evidence that those that owned consumer-driven healthcare and those that are in a high-deductible health plan — so those that have the account and/or don't have the account but are covered by a high-deductible health plan — are much more likely than those in traditional plans to exhibit a number of cost-conscious behaviors. They checked where the plan would cover care, they asked about a generic drug, they talked to their doctors about treatment and whether they were covered or not, they developed a budget to manage healthcare expenses, they checked the price of the service before they got the care, and they used the online tracking systems that Greg had mentioned as well.

And that effect has also been shown in the way that the informed decisions are being made. And again, back to Greg's point out of the Millennials, if you look at this chart, and I'll show you in the next slide or two who owns these policies, nearly half are owned by individuals that are less than 40 years old. And so, again, this chart will give you an idea of how those groups are really working to make decisions. And those that are in a consumer-driven healthcare policy and have the account, or those that are covered by a high-deductible health plan are much more informed, and they're making their own decisions. So just something I will point out to you.

If you take a look at the results of this piece of the survey, you'll see that those two individuals, the ones that are covered by a high-deductible health plan and the ones that are in consumer-driven healthcare, went to their website, they went to an outside website for information, they went to the HR department's conversations about healthcare — in fact, then, are much more engaged than the traditional owner of the PPO.

This chart just illustrates where we've come since 2004. And what's not shown here is that in the end of 2004, we had roughly about $469 million in savings throughout the United States in HSA accounts. And today, that number is $25.2 billion projected for 2015. We started out with about a like number of accounts in 2004, and today, that number is going to eclipse 15.5 million by the end of 2015.

Two more notable statistics for you: most of the growth in high-deductible health plans and consumer-driven health plans has been in the large group market in 2014. And then, very important, again tying back into what Greg was talking about with the Millennials, 48% are under the age of 40, so that's who owns them. So now that's the good news about engagement, about how cost and benefit are being drawn together.

And now I'll touch on some of the elements that might continue to require our vigilance. And so there's really two potential challenges for consumer-driven healthcare, and this now is the opinions of the American Bankers Association HSA Council, of which we are a member. I am obviously the Chairman, so I don't disagree, but they are not necessarily PNC's opinions.

So there are two potential challenges for consumer-driven healthcare. One is the Cadillac tax itself. And the inclusion of the employer and employee contribution to the HSA, which is proposed by the guidance that's been released by the IRS, under current review, and the comment period has just ended. That contribution by the employer and the employee may well count towards the cost of the policy and therefore be calculated into the Cadillac tax, which is coming up in 2018.

The second is the reintroduced so-called fiduciary rule by the Department of Labor. And that fiduciary rule swept up HSA, because HSA was based on the regulation that created the IRA.

So first, the potential effects of the Cadillac tax. One is if it's included in the calculation, then it will be included in how much the policy actually costs. And so what could happen is that employers may curtail their contributions, employees may be barred from making contributions, and employers that offer HSA-compatible insurance policies may not endorse an integrated platform solution. They may take people out into the field for their solution and let them solve it themselves.

The American Bankers Association HSA Council has issued an advisory letter to the IRS, and we pointed out, really, a couple of notable points as to why the HSA should be excluded from the Cadillac tax, and here they are. They're not insurance policies, and ownership means something. The individual can make a contribution to these accounts, and that is not an employer contribution. It can come from the outside; how would you make a differentiation? So we pointed that out.

But most importantly, the Council also pointed out that the behavior of the HSA owner counts. Account contributions tend to increase as employees age and prepare for retirement, and those that have a chronic condition are more likely to make contributions because they need those dollars. And so the behavior that we're trying to encourage, the ability to deliver employees to Medicare with dollars in their pockets, may be under threat from the inclusion to the Cadillac tax.

And in terms of the Department of Labor's so-called fiduciary rule, potentially makes HSA subjected to ERISA, potentially, could make employers then subjected to ERISA, and potentially subject platform providers, such as banks and broker-dealers, to become ERISA covered as well. And while we have no issue with the good effect of regulation on conflict of interest, the potential consequences could be: it may discourage employers from offering HSAs as an integrated solution with the platform; it may consider or cause consolidation in the industry; it may cause platform providers to drop the investment options; and it may cause costs to rise.

And so, as a result of that, the Council has suggested through an advisory letter to the Department of Labor that HSAs are distinguishable from IRAs and other retirement accounts. Because of how they're used, they're really a spending account. We point out that 86% of every dollar that's in an HSA is in an FDIC-insured option. That's the bank account, and that's much different than a security and not at all appropriate for regulation in this regard. And then in three, HSAs, if they are not excluded, then we've asked that the platform providers may be

exempted. And then if that doesn't have effect and doesn't come to good offices, then we propose that the rule, that the HSA custodian and trustees do not provide investment advice and therefore should not be subjected to ERISA, based on a referral to a brokerage firm for a selected group of mutual funds.

So those elements are in the marketplace today. There are always challenges to any great movement. I hope I've given you some idea of how we got to where we are, some hope for the future, and things that we are very diligently watching.

And so, Jean, at this point I will turn it back over to you.

Jean Hippert: Thanks, Jim. That was a lot of excellent information. Hopefully, everybody tracked with it. I did want to let you know that we have a couple of questions we've already received. I think we may be able to get to them, and perhaps even a couple more. I'd just encourage you again, if you're interested in posing a question, use the question Q&A widget at the bottom of your screen, and hopefully, that will help you type in a question. And we'll take a look at our first one in a moment.

I also, while we're answering our questions, want to make sure that our participants have access to the link to the survey. And again, just really encourage you to please respond to our survey so we can continue to deliver the kind of information that's useful to your business.

Jim, I think I'm going to put this first one in your court, because I think you may have answered it a little bit, but just want to be sure that our questioner got the full content. And that is, the question is, "I've heard that the participant contributions to an employer-sponsored HSA plan would count toward the threshold of the Cadillac tax. Can you comment on it?" Anything additional to the Cadillac tax comments that you just made, Jim, that you'd like to add?

Jim Gandolfo: Yes. Just very quickly, Jean, it's a great question, and that's as proposed, but we're not sure where that's going to come out. We might have a ruling on that later. But again, it's not hard and fast yet. It's still in advisory.

Jean Hippert: So stay tuned, I guess, is the answer, huh?

Jim Gandolfo: Right.

Jean Hippert: Okay. Greg, I'm going to ask this next question of you. The question is, "What are our clients doing to address the number-one issue of patients, which is the cost of care? It's broadly known that there's 30% waste in the current system — non-value-added tests, bloated administrative costs, et cetera." And I think a joinder to that is the U.S. is spending 2.5 times on average but still scores the lowest of the OECD countries on many measures. Our questioner says, "This is a value-destroying proposition," and suspects that the issue may be worse than providers want to or even can admit. And the question is, "What are we doing to help our clients address that particular issue?" — the patient cost of care.

Greg Jelinek: Yes, well, that's a big question, and I can maybe scratch the surface on it. But I equate the healthcare system to kind of how banking was 20 years ago. What we're seeing is a lot of consolidation going on in the healthcare providers and the payers. We're seeing consolidation of back office and creation of what I would call centers of excellence around the full revenue cycle and processing and operations. And we help out a lot there in terms of some of our solutions that we have. We really try to automate, become electronic, take the paper out of the system, help the providers really deal with exceptions rather than every claim process or whatever. So I think there's a lot of work being done there.

They're also consolidating their patient accounting systems, as many of them have multiple patient accounting systems. It's kind of like banking with their core systems. You know, there's a lot of consolidation going on there.

And then there's also the rationalization of the fixed infrastructure. There's just an overcapacity of beds in the system, and there's a lot of fixed cost. And I think, as we see modernization and upgrading of these health facilities, they're actually getting closer to where the patients are, with satellite offices and that kind of thing. It really requires a big rationalization of the whole fixed infrastructure in healthcare. So a lot of big things going on there.

And then when you look at the care, it's really more about alignment of care and making sure that there's good electronic medical records, there's good communication and sharing of information. So you're seeing a lot of our clients are acquiring, for example, physician practices, and they're bringing the specialists in-house so that they have a better alignment of their care and can really manage that much more effectively and efficiently, as they're now being required over time to get paid based on outcomes rather than volume. You know, that really puts a lot more risk in the system for them to provide the right kind of care in the right way and do it in an efficient manner. Because if they don't, they're not going to get paid for their services. So I think there's some built-in things that are going to really cause a lot of change to happen in the system.

So I know I'm probably only scratching the surface, but those are kind of some of the things that we're seeing.

Jean Hippert: Thanks, Greg. I totally agree with what you're saying. I mean, as Jim pointed out earlier, and you did, we are an employer also. We have a lot of employees. And so part of our concern also is to figure out ways that we can encourage wellness and access to some of the programs that we help our folks utilize to manage their own care and be a little bit healthier, perhaps. But I agree with you — a lot going on in terms of electronification of transactions and working to help people sort of improve their processes around very basic things. So thanks for that answer.

And with that, we really are at the top of the hour. I want to be very respectful of our audience's time and sum up as follows. It's certainly interesting for all of us and, hopefully, you as well, to really contemplate the fact that consumers want a healthcare experience that's similar to their experience in other areas of the U.S. economy. That, of course, is very easy to see in the behavior of Millennials.

But we think as that behavior develops, it's an indication that the consumer behaviors are really solidifying. And we think it's a great opportunity for employers, payers, and providers all to capitalize on securing the loyalty of this Millennial generation. As they get older, as they have

families, the extent to which you begin to answer some of the needs that have been articulated in the research findings at the beginning of this call are going to help you capitalize on keeping them as your patients or your employees for a longer period of time.

We're excited about it. We're anxious to help our clients achieve in that area, and we hope what we've provided to you today is thought-provoking. I definitely want to thank both Jim and Greg for a great presentation. Both of you had good insight and perspective. And thank all of our audience for attending.

There will be a PDF of today's presentation as well as a CTP certification credit and a Trending Topic article about innovation in healthcare. Those are going to be available for you to download from the green Resource List file folder widget that you can find, again, down in the lower center portion of your screen. So a PDF of the presentation, CTP certification credit, and then the Trending Topic article. I hope you'll take advantage of those.

And again, one more encouragement to please access the short survey on your screen since your feedback is very important to us.

And that concludes our presentation today. Thank you again very much for joining us.