THE FUTURE OF HEALTHCARE

2018 and Beyond

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Dodging a Boomerang, Not a Bullet

Although there has not (yet) been major legislation to repeal and replace Obamacare, the tax reform of 2017 will have lasting consequences for healthcare.

Paying the Price for Tax Cuts
Placing an Additional Strain on the Budget

Tax Cuts and Jobs Act of 2017

- **$1.46T** Added to Federal deficit, 2018-2027¹
- **$136B** Increase in Federal deficit in 2018¹
- **$25B** Automatic cut to Medicare spending in 2018²
- **13M** Increase in uninsured population by 2027¹

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**“Well, we obviously were unable to completely repeal and replace with a 52-48 Senate. We’ll have to take a look at what that looks like with a 51-49 Senate. But I think we’ll probably move on to other issues.”**

Sen. Mitch McConnell (R-KY)
SENATE MAJORITY LEADER

**“We’re going to have to get back next year at entitlement reform, which is how you tackle the debt and the deficit... [we will] spend more time on the health-care entitlements, because that’s really where the problem lies, fiscally speaking.”**

Rep. Paul Ryan (R-WI)
SPEAKER OF THE HOUSE

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1. Congressional Budget Office estimates
2. Due to triggering of PAYGO rules

Major cuts to the healthcare entitlement programs are nearly inevitable, given the size and projected growth of Medicare and Medicaid.

Where Does the Money Go?
Entitlement Programs Most Likely Targets for Cuts

Federal Budget Expenditures, Actual and Projected
Billions of Dollars


1. Defense and nondefense
2. Unemployment, pensions, veterans, and other Federal assistance
Putting Providers at Risk

Pressure will be greatest on provider payments, which will drive most spending growth

Driving Most of the Spending Growth
Direct and Indirect Payments to Providers

Projected Medicare Expenditures
Billions of Dollars

Source of Spending Growth, 2018-2027
Billions of Dollars

Increase in Medicare Advantage enables greater control over provider cost

1. Includes hospitals, physicians, SNF, home health, outpatient services, and other provider-related expenditures
2. Medicare Advantage
3. Adjustments and recoveries

Pressure will be greatest on provider payments, which will drive most spending growth.

We have a health care system that is unsustainable for our nation’s demographic makeup.

**Demographics is Destiny**

**Aging Beyond the Ability to Support Entitlement Growth**

**Facing an Upside-Down Population Pyramid**

**Number of People 18-64 for Every Person >65**

- **1940**
  - 9.2
- **1980**
  - 5.1
- **2016**
  - 4.1
- **2050**
  - 2.7

- **83.7M**
  - Number of Americans >65 in 2050, twice as many as in 2012
- **19.3 years**
  - Life expectancy at 65 years in 2015, compared to 14.3 years in 1960
- **17.9%**
  - National Health Expenditures as percentage of GDP, 2016 compared to 5.5% in 1960

Still Operating the Delivery System of Yesteryear

Shift from commercially-paid procedures to publicly-funded medical care undermines system economics

“
Our Medicare volumes have gone through the roof. Coming out of 2017 we think Medicare share of revenue will have risen five percent. We didn’t have a hard flu season. The economy is strong. The only explanation is that the tsunami of Baby Boomers is hitting Medicare.”

Chief Strategy Officer
LARGE REGIONAL HEALTH SYSTEM IN THE SOUTHEASTERN U.S.

Delivery System Economics Becoming Unsustainable

2.7%
Mean hospital margin in 2016\(^1\)

Drivers of Declining Margin

- Rising public payer share
- Rising patient acuity
- Declining surgical case mix
- Medicare payment cuts
- Declining commercial price growth

(0.2%)
Mean hospital margin in 2027\(^2\)

1. Operating margin
2. Profit margin, Congressional Budget Office estimate

Looking to Leave Providers “Holding the Bag”

Dominant strategy for contending with rising health spending will be downward pressure on price from all purchasers

Bending the Price (not the Cost) Curve

Handing Off Exposure to Inflation at Each Step

- Federal programs
- States
- Employers
- Insurers
- Individuals

Lower wholesale price
Lower retail price

- Premium support
- Medicare Advantage (MA1)
- Managed care organizations (MCOs2)
- High-deductible plans (HDHPs)
- Defined contribution (DC3)

Provider cost of care

- Labor
- Overhead
- Drugs
- Supplies
- Care model
- Facilities

Purchasers will increasingly use the price lever to lower spending on care, shifting accountability for controlling cost inflation to the most logical owners: providers

- Federal strategy: from mandatory to discretionary spending
  - Medicare to MA1
  - Medicaid block grants to states
- State strategy: Medicaid managed care
- Employer strategy: high-deductibles, eventually defined contribution

Source: Gist Healthcare analysis.
Bipartisan Path to Privatized Medicare Coverage

Implicit federal strategy for more than a decade has been an attempt to shift accountability for managing cost growth to commercial insurers.

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Two Paths to “Discretionary” Medicare
Encouraging the Growth of Private Coverage

**Medicare Advantage**

- 19M Enrollees in 2017, 33% of all Medicare beneficiaries
- 10.3% Annual growth rate, 2004-2017
- 66% Beneficiaries in plan offered by “big five” carriers

**Medicare**

- Incentive redesign
- Premium support

**Strategic High Ground**

- Integrated payer-provider MA networks
- Buy physician practices
- Launch health plan
- Provider-led ACOs
- Physician incentive: MACRA
- Hospital incentive: Productivity adjustment

**Payer-led networks**

- Beneficiaries use vouchers to purchase on exchange
- Plans compete on premium

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1. UnitedHealthcare, Aetna, Humana, Cigna, Blue Cross Blue Shield
2. Accountable care organizations
3. Medicare Access and CHIP Reauthorization Act
4. Medicare Advantage

Federal programs have not provided sufficient incentives to move most providers to full risk, while motivated systems have been frozen by market barriers to entry.

1. 2018 enrollment: Track 1+, 55 participants; Track 2, 8 participants; Track 3, 38 participants
2. Medicare Advantage
3. Provider-sponsored plans
4. MACRA APM-eligible


19% of MA² members, 6% of Medicare beneficiaries in PSPs³
“A Better Way” Aims to Create a Medicare Marketplace

Potential impact for...

...Federal government:
- Five-year savings of $184-419B
- Ability to control inflation via tax credit

...beneficiaries:
- Greater exposure to cost, creating incentive to shop on price, self-ration
- Likely emergence of market segments, ability to “buy up” to Medicare FFS
- “Consumer choice” in context of government entitlement

...providers:
- Downward price pressure as payers control premium via network design
- Increasingly price-sensitive patients in the Medicare population

Relying on the Imperative to Balance the State’s Budget

Offloading Inflation Exposure to States...

Per-Capita Caps

Fixed federal spend per beneficiary, with set annual growth rate

Block Grants

Annual grant based on benchmark year spend independent of enrollment growth; allows states flexibility to change eligibility

$772-834B

CBO¹ estimate of Medicaid savings in House and Senate bills brought to floor in 2017²

...Creates Urgent State Budget Pressure

1. Work with existing fee-for-service system

2. Direct provider rate cuts

3. Expand use of Medicaid managed care

4. Lower provider rates from Medicaid MCOs³

5. Encourage provider-led Medicaid ACOs

6. Providers assume direct risk for cost growth

7. Use waivers to change benefits and eligibility

8. Increased bad debt from rising uninsured

Federal attempts to block grant Medicaid spending will create increased urgency for states to budget spending and limit enrollment (where possible)


1. Congressional Budget Office
2. American Health Care Act and Better Care Reconciliation Act
3. Managed care organizations
Employers are poised to shift to defined contribution, and are preparing the way with HSAs¹ and HDHPs².


¹. Health savings accounts
². High-deductible health plans
³. PPO plan as representative
⁴. Single coverage, deductible > $2000

Shifting the (Growing) Cost of Coverage

Employees Spending Over Ten Percent of Income on Insurance Alone

Annual Cost of Insurance

<table>
<thead>
<tr>
<th>Year</th>
<th>Employee Contribution</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$4,824</td>
<td>$13,375</td>
</tr>
<tr>
<td>2011</td>
<td>$5,429</td>
<td>$15,073</td>
</tr>
<tr>
<td>2013</td>
<td>$5,884</td>
<td>$16,351</td>
</tr>
<tr>
<td>2015</td>
<td>$6,251</td>
<td>$17,545</td>
</tr>
<tr>
<td>2017</td>
<td>$6,690</td>
<td>$18,764</td>
</tr>
</tbody>
</table>

Average Employee Deductible

2009: $2,503
2011: $1,505
2013: $1,700
2015: $1,900
2017: $2,000

Percent in HDHPs

2009: 17%
2011: 23%
2013: 29%
2015: 36%
2017: 40%

Aided by HDHPs, adoption of defined contribution plans is accelerating, and will mirror the shift in retirement benefits.

**Employers In the Middle of a Decade-Long Transition**

Growing Adoption of Defined Contribution

<table>
<thead>
<tr>
<th>Year</th>
<th>Implemented (%)</th>
<th>Considering (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>11</td>
<td>25</td>
</tr>
<tr>
<td>2017</td>
<td>12</td>
<td>36</td>
</tr>
</tbody>
</table>


"We’ve been evaluating private exchanges for three years, and I anticipate we’ll make the move next year. Most importantly, our employees are ready. If we went there from a zero-deductible PPO, we’d have a revolt. But high deductibles provide a cushion. Now it’s a good thing to get to choose your own $3000-deductible plan.”

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1. High-deductible health plans
Awakening a Sleeping Giant: The American Consumer

As individuals face greater direct exposure to the cost of healthcare, they begin to behave as they do in the rest of the consumer economy.

Decision Path of the Motivated Health Care Consumer

Delay or Forgo Care?

First year after HDHP$^1$ rollout:

- **42%** Reduction in all spend under deductible
- **18%** Decline in physician office visits
- **20%** Lower drug spend
- **10%** Decline in preventive care, even when fully covered

Conflict with population health strategies

Shop on Price?

Patients shopping for care:

- **48%** Attempt to find price
- **53%** Report saving money after price comparison
- **70%** Believe higher price not associated with better quality

Share lost to low-cost non-hospital providers

Fail to Pay?

When facing bills for care:

- **44%** Cannot produce $2000 in 30 days$^2$
- **1 in 3** Kansas City residents with medical debt in collections
- **62%** Personal bankruptcies due to medical debt

Rising bad debt and uncompensated care

Sparking a Scramble for Higher Ground

As the potential for major healthcare realignment grows, a new wave of merger activity in healthcare has begun.

1. Urgent care centers
2. Long term care hospitals

**The Physician Angle**
- Optum acquires DaVita Medical Group for $4.9B
- Doubles size of Optum’s owned physician enterprise to ≈60K
- Largely MA-driven model sees 1.7M patients/year in 300 clinics, 35 UCCs¹ and six surgery centers

**The Post-acute Angle**
- Humana to acquire Kindred for $738.2M
- Co-investing with private equity firms; will initially own 40% of Kindred
- Largest home health and hospice operator in US; operates 77 LTCHs² and 19 rehab hospitals

**The Pharmacy Angle**
- CVS to acquire Aetna for $67.5B
- Largest drugstore chain in US; third largest commercial insurer
- Will combine retail clinics, pharmacy and other health services into new care management centers

**Case in point: Cross-sector M&A activity**

Bringing “Everyday Low Prices” to Our Industry

Walmart’s sheer scale puts it in a position to disrupt every segment of healthcare, with its relentless focus on lowering price for consumers.

Talk About Awakening a Sleeping Giant
Largest Retailer (and Employer) Poised to Create the “Copper Plan”

- In preliminary talks to acquire Humana
- Operates 4,700 stores in the US
- Already offers co-branded Medicare Part D plan with Humana
- Piloting $4/$40 primary care clinics in 19 locations

Introducing the Marginal Revolution

In the marketplace for care, consumers don’t care what your costs are.

“The difficulties of economics are mainly the difficulties of conceiving clearly and fully the conditions of utility.”

William Stanley Jevons
THE THEORY OF POLITICAL ECONOMY, 1871

Orienting Around Consumer Value in Healthcare

The rise of activated consumers will drive a shift to a business-to-consumer model in healthcare, with choice driven by value to the end user.

Consumerism is About Value-Based Choice
What is Value, and Why Don’t Consumers Receive It?

To make any selection, customers use two basic criteria, benefits and price... Value equals benefits minus price. Customers select the product or service they believe is the superior value compared to competing alternatives.”

M. Lanning and E. Michaels
MCKINSEY & COMPANY, 1988

Legacy Model Limits Ability to Choose

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Convenience</td>
<td>• Wholesale</td>
</tr>
<tr>
<td>• Service quality</td>
<td>• Retail</td>
</tr>
<tr>
<td>• Clinical quality</td>
<td></td>
</tr>
<tr>
<td>• Ease of use</td>
<td></td>
</tr>
<tr>
<td>• Relationship</td>
<td></td>
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</tbody>
</table>

Limits range of benefits
Limits range of prices

In a defined-contribution, consumer-driven world, competition is based on value creation at the point of coverage and the point of care.

**Imperative to Provide Value at Both Levels**

*To Earn Consumer Choice, Costs Must Enable Competitive Price*

- Provider excluded from network because price too high relative to benefits
- Provider not selected because price too high relative to benefits
- Network not selected because premium too high relative to benefits
- Network not selected because price too high relative to benefits

Source: Gist Healthcare analysis.
**True Cost Reduction Easier Said Than Done**

Providers have been challenged to reduce cost by meaningful amounts for reasons that are inherent to the model of care and payment.

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## Difficult for Providers to Address Drivers of Cost

*Finding Challenges Every Step of the Way*

<table>
<thead>
<tr>
<th>Cost reduction lever</th>
<th>Examples</th>
<th>Obstacles to deployment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduce input prices</strong></td>
<td>• Provider compensation</td>
<td>• Dependence on referrals</td>
</tr>
<tr>
<td></td>
<td>• Supply costs</td>
<td>• Limitations of GPO(^1) model</td>
</tr>
<tr>
<td></td>
<td>• Drug and technology costs</td>
<td></td>
</tr>
<tr>
<td><strong>Shift mix of inputs used</strong></td>
<td>• Top-of-license labor</td>
<td>• Guild protectionanism</td>
</tr>
<tr>
<td></td>
<td>• Standardized PPIs(^2)</td>
<td>• Fear of alienating physicians</td>
</tr>
<tr>
<td></td>
<td>• Formularies for drugs</td>
<td></td>
</tr>
<tr>
<td><strong>Capture scale efficiencies</strong></td>
<td>• Consolidate back office</td>
<td>• Legacy organizational silos</td>
</tr>
<tr>
<td></td>
<td>• Increase purchasing power</td>
<td>• Fear of alienating physicians</td>
</tr>
<tr>
<td></td>
<td>• Rationalize service delivery</td>
<td></td>
</tr>
<tr>
<td><strong>Reduce waste and variation</strong></td>
<td>• Standardize operations</td>
<td>• Lack of reliable data</td>
</tr>
<tr>
<td></td>
<td>• Standardize clinical care</td>
<td>• Fear of alienating physicians</td>
</tr>
<tr>
<td><strong>Lower unnecessary utilization</strong></td>
<td>• Coordinate care delivery</td>
<td>• Counter to FFS(^3) incentives</td>
</tr>
<tr>
<td></td>
<td>• Shift to lower-cost settings</td>
<td>• Resistance to “rationing”</td>
</tr>
<tr>
<td></td>
<td>• Eliminate unnecessary care</td>
<td></td>
</tr>
<tr>
<td><strong>Reduce price to purchaser</strong></td>
<td>• Lower charge-master rates</td>
<td>• Fragile financial model</td>
</tr>
<tr>
<td></td>
<td>• Lower retail prices</td>
<td></td>
</tr>
</tbody>
</table>

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\(^1\) Group purchasing organization  
\(^2\) Physician preference items  
\(^3\) Fee for service

Source: Gist Healthcare analysis.
Admitting a Home Truth: We Follow the Money

The largest impediment to serious efforts to lower the cost of care is the way that providers are paid.

In Need of a Longer Accountability Horizon
Enabling Providers to Address Larger Drivers of Cost

- Event-based incentives
  - FFS
  - Case rates
  - Bundles
- Time-based incentives
  - Partial cap
  - Full cap

Incentive to reduce
- Unit cost of care
- Total cost of care

Cost reduction levers
- Inputs
- Efficiency
- Reliability
- Mode
- Utilization

Source: Gist Healthcare analysis.

1. Fee for service
2. Episodic bundles, which could vary by scope and length
3. Partial capitation
4. Full capitation
Successful health systems will begin with the end in mind, asking how value will be created, and working backwards to service and facility choices.

**Asset-Driven Approach**
- Appropriate combination of settings
- Asset model

**Value-Driven Approach**
- Appropriate bundle of services
- Service model

**Business model**
- Consumer

**Value model**
- Successful fulfillment of need

**Whom do we serve?**
- Government payers
- Private payers
- Self-pay patients
- Referral sources

**How do we create value?**
- Successful reimbursement of event

**What do we deliver?**
- Procedures
- Intensive care
- Emergency care
- Acute care
- Nursing care
- Diagnostics
- Preventative care

**Where do we deliver?**
- Hospital
- ED
- ASC
- FQHC
- Clinic
- SNF
- Hospice
- Phone
- ICU
- FED/MH
- UCC
- MOB
- Retail
- LTAC
- Home
- Online

Source: Gist Healthcare analysis.
Today’s System Built for Single Servings
Often Too Fragmented, Costly for Consumers

Event Health

- Today’s dominant model, driven by FFS
- Multiple, disconnected interactions with health system across time
- Fragmented care
- Suited for single, acute consumer needs

Consumers with ongoing needs forced to access and pay on event basis

Current approach organizes and delivers services on a one-off, fragmented basis, which falls short of how consumers experience care needs.
Choosing Our Value Model for the New Market

Most incumbent health systems are still in the “event” business, but must shift over time to embrace multiple identities, based on their own competitive advantages.

Building Toward Membership Health
Future Model Requires Embracing Multiple Roles

Source: Gist Healthcare analysis.
Raising the Bar on Consumer Value Delivery

Successful health systems must be able to deliver benefits to consumers in excess of price paid, at every level of interaction.

Adding Value Beyond Baseline Expectations
Providers Must Deliver at Multiple Levels

Consumer Value Equals Benefits Minus Price

- **Member Health**
  - Customized
  - Branded
  - Information-powered
  - Lasting

- **Episode Health**
  - Coordinated
  - Curated
  - Connected

- **Event Health**
  - Access options that are:
    - Convenient
    - Appropriate
  - Timely
  - Efficient
  - Access options that are:
  - Events that are:
    - Curated
    - Coordinated
    - Connected

At all levels:
- Timely
- Convenient
- Efficient
- Effective
- Consistent
- Safe
- Transparent
- Easy to understand
- Empowering
- Humane
- Appropriate

Source: Gist Healthcare analysis.
While the CHRONIC Care Act opened telemedicine access to millions, Medicare lags behind many commercial payers in adoption and payment.

**CHRONIC Care Act Expands Telemedicine Access**

**Coverage Extended Beyond Next-Gen ACO Patients**

Number of Medicare Beneficiaries

<table>
<thead>
<tr>
<th>Millions</th>
<th>FFS</th>
<th>Track 1</th>
<th>Tracks 2&amp;3</th>
<th>NextGen</th>
<th>MA</th>
</tr>
</thead>
<tbody>
<tr>
<td>28.5</td>
<td></td>
<td>7.8</td>
<td>1.2</td>
<td>1.5</td>
<td></td>
</tr>
</tbody>
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Estimated 21.7M beneficiaries now covered for telemedicine

Ensuring a High-Value Clinical Production Model

Labor Model
Who will deliver care?

- Apply top-of-capability labor across all events
- Look for technology substitutions
- Align provider governance and incentives with value

Delivery Model
How will care be delivered?

- Eliminate wasteful or unneeded care
- Shift to appropriate level of care
- Standardize needed services
- Hardwire improvement and innovation

Asset Model
Where will care be delivered?

- Determine lowest cost site of service
- Deliver care at the right level of acuity and access
- Use virtual care delivery whenever appropriate

Core Challenge
Can we displace doctors as the object of strategy?

Core Challenge
Can we move beyond an initiative-driven approach to improvement?

Core Challenge
Can we stop treating assets as profit centers?
Organizing Around Value Delivered

Leading health systems creating organizational structures, business units around consumer needs and value rather than assets or geography

“One Intermountain” Creates Two Clinical Enterprises
Organized Around Business Model Over Assets

Community Care Group
Keeping people well through prevention and primary care
- Primary care
- Homecare
- Senior Services
- Chronic disease management
- Minor injury care

Specialty Care Group
Providing episodic care needed to treat a serious illness or injury
- Specialty care
- Hospital inpatient care

Value Provided

Services Delivered

Enterprise Value
Deliver consistent, excellent care, and experience while maximizing operational efficiency and agility

“We hope ... regardless of where you are in the system, for any given condition, you get the same safety, quality, access, approach, consistency, as you would anywhere else.”

Marc Harrison, MD
CEO, INTERMOUNTAIN HEALTHCARE

Case in point: Intermountain Healthcare


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