The Advisory Board Company

Health Care Advisory Board

Health Care 2020

Population Health, Consumerism, and the Future of Health Care Delivery

A Return to the Good Old Days?

Health Care Spending on the Rebound

National Health Expenditures See Biggest Jump Since Pre-Recession

"

Bloomberg Businessweek

"U.S. Health-Care Spending Is on the Rise Again"

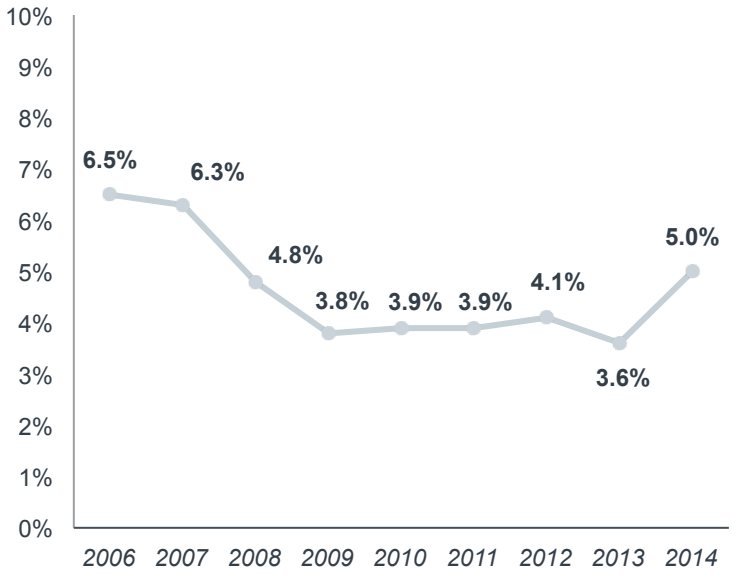
USA TODAY

"Health care spending growth hits 10-year high"

THE WALL STREET JOURNAL.

"Health Spending Is Rising More Sharply Again"

Annual Growth in National Health Expenditures



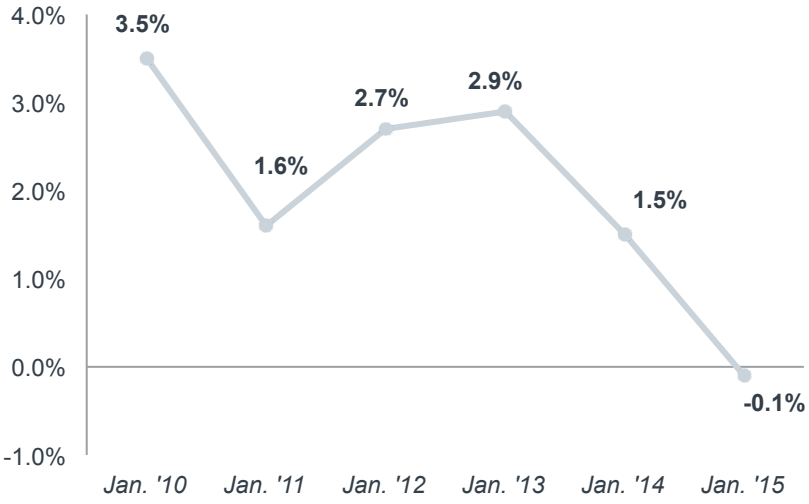
Source: Altarum Institute, Health Sector Trend Report, March 2015, accessed April 2015; Tozzi J, "U.S. Health-Care Spending Is on the Rise Again," Bloomberg Businessweek, February 18, 2015, available at: www.bloomberg.com; Davidson P, "Health care spending growth hits 10-year high," USA Today, April 1, 2014, available at: www.usatoday.com; Altman D, "Health Spending is Rising More Sharply Again," The Wall Street Journal, February 27, 2015, available at: www.blogs.wsj.com; Health Care Advisory Board interviews and analysis.

A Closer Look at the Numbers

Higher Spending Not Exactly a Boon for Hospitals

Hospital Price Growth Down for First Time on Record

Annualized Hospital Price Growth, Jan. 2010-Jan. 2015



2015 Hospital Price Growth Down Across All Payer Classes

(2.9%)
Medicare price growth

(0.1%)
Medicaid price growth

1.6%
Commercial price growth (lowest growth rate since 2002)

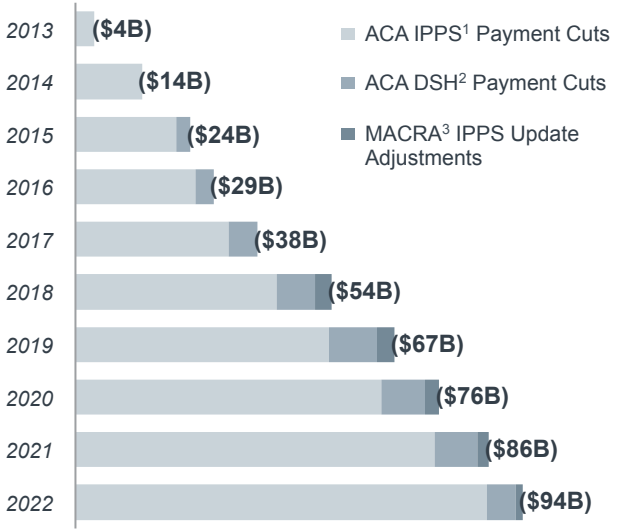
Source: Altarum Institute, Health Sector Economic Indicators: Price Brief, March 2015, March 2014, March 2013, March 2012, available at: www.altarum.org; Health Care Advisory Board interviews and analysis.

No End in Sight

Price Cuts Continue Unabated

Hospitals Bearing the Brunt of Payment Cuts

Reductions to Medicare Fee-for-Service Payments



1) Inpatient Prospective Payment System.
2) Disproportionate Share Hospital.
3) Medicare Access and CHIP Reauthorization Act of 2015.

New Proposals Continue to Emerge

President's FY2016 Budget Proposal Includes Significant Cuts to Providers

$30.8B

Reduction in Medicare bad debt payments

$29.5B

Savings from moving to site-neutral payments

$14.6B

Cuts to teaching hospitals and GME payments

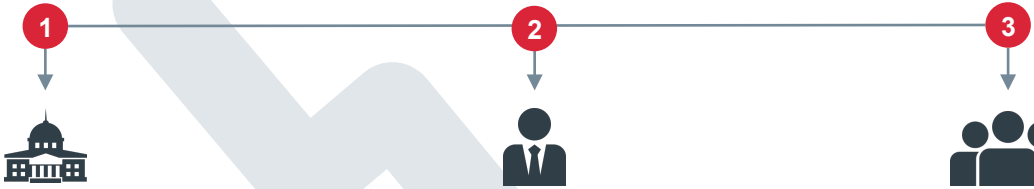
$720M

Cuts to critical access hospitals

Source: CBO, "Letter to the Honorable John Boehner Providing an Estimate for H.R. 6079, The Repeal of Obamacare Act," July 24, 2012; CBO, "Cost Estimate and Supplemental Analyses for H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015; Budget of the United States Government (Proposed) FY 2016; Health Care Advisory Board interviews and analysis.

Market Forces Continue to Threaten Status Quo

All Purchasers Looking to Curb Spending



Government

- Medicare doubling down on risk
- Medicare Advantage poised for reform
- Medicaid experimenting with risk, consumerism

Employers

- Private exchanges increasing pricing pressure
- Self-insured employers focusing on utilization control

Consumers

- Continued premium sensitivity on public exchanges
- Price sensitivity increasing at point of care

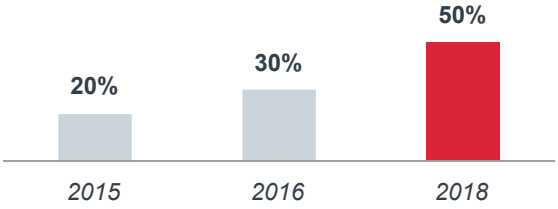
Source: Health Care Advisory Board interviews and analysis.

CMS Lays Down Marker for Value-Based Payment

Historic Payment Targets Demonstrate Commitment to FFS[1] Alternatives

Aggressive Targets for Transition to Risk

Percent of Medicare Payments Tied to Risk Models

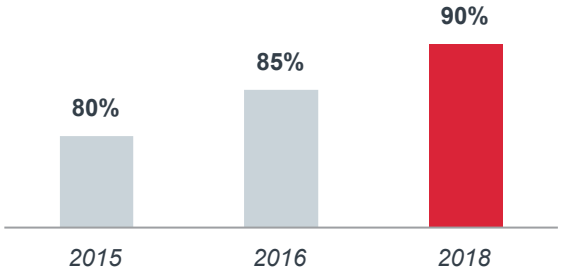


Examples of Qualifying Risk Models

- Medicare Shared Savings Program
- Bundled Payments for Care Improvement Initiative
- Patient-Centered Medical Home

FFS Increasingly Tied to Value

Percent of Medicare Payments Tied to Quality



Examples of Quality/ Value Programs

- Hospital-Acquired Condition Reduction Program
- Hospital Value-Based Purchasing Program
- Hospital Readmissions Reduction Program
- Merit-Based Incentive Payment System

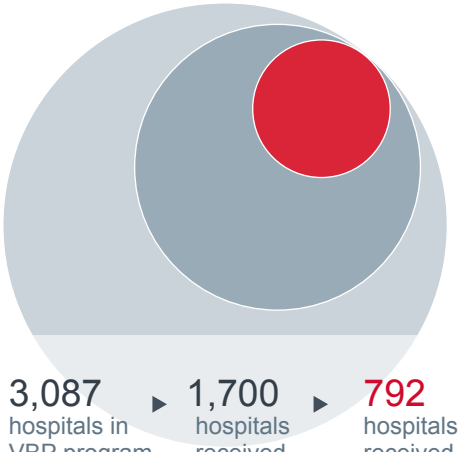
1) Fee-for-Service.

Source: HHS, "Progress Towards Achieving Better Care, Smarter Spending, Healthier People," available at: http://www.hhs.gov/, accessed February 2015; Health Care Advisory Board interviews and analysis.

Mandatory Risk Programs Taking a Toll on Providers

Readmissions, HAC Penalties Outweighing VBP Bonuses

After Accounting for Penalties[1], Few Receive VBP[2] Bonuses



3,087 hospitals in VBP program ▸ 1,700 hospitals received bonus payment ▸ 792 hospitals received net payment increases

Estimated Net Impact of P4P[3] Programs, FY 2015

28%
Hospitals receiving a net bonus or breaking even

50%
Hospitals receiving net penalties between 0% and 1%

6.5%
Hospitals receiving net penalties of 2% or greater

1) Hospital-Acquired Condition Reduction Program, Hospital Readmissions Reduction Program.
2) Value-Based Purchasing.
3) Pay-for-Performance.

Source: Rau J, "1,700 Hospitals Win Quality Bonuses From Medicare, But Most Will Never Collect," Kaiser Health News, January 22, 2015, available at: kaiserhealthnews.org; Health Care Advisory Board interviews and analysis.

SGR Repeal the Latest Push Toward Risk

Both Tracks Impose Greater Risk, Strong Incentives for Alternative Models

PFS[1] Payment Models Beginning in 2019

1

Merit-Based Incentive Payment System (MIPS)

- Consolidates existing P4P programs[2]
- Score based on quality, resource use, clinical improvement, and EHR use
- Adjustments reach -9% / +27% by 2022
- From 2019 through 2024, potential to share in $500M annual bonus pool

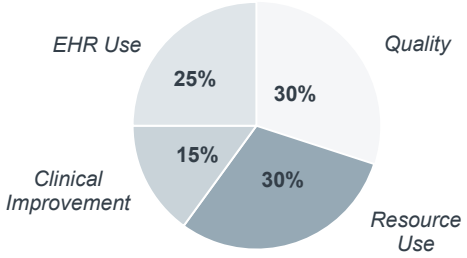
2

Alternative Payment Models (APMs)

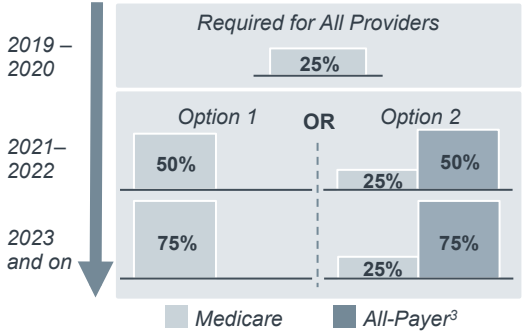
- Provides financial incentives (5% annual bonus in 2019-2024) and exemption from MIPS
- Requires that physicians meet increased targets for revenue at risk
- APMs must involve downside risk and quality measurement

MIPS Performance Category Weights

For 2021



Revenue at Risk Requirements for APMs



1) Physician Fee Schedule.
2) Meaningful Use, Value-Based Modifier, and Physician Quality Reporting System.
3) Includes risk-based contracts with Medicare Advantage plans.

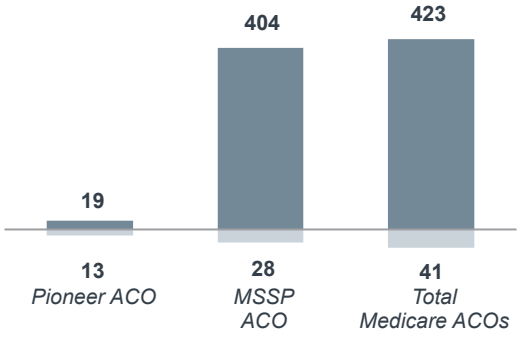
Source: The Medicare Access and CHIP Reauthorization Act of 2015; Health Care Advisory Board interviews and analysis.

MSSP[1] Continues to Grow Despite Mixed Results

89 ACOs Join in 2015, Few Generating Shared Savings in First Year

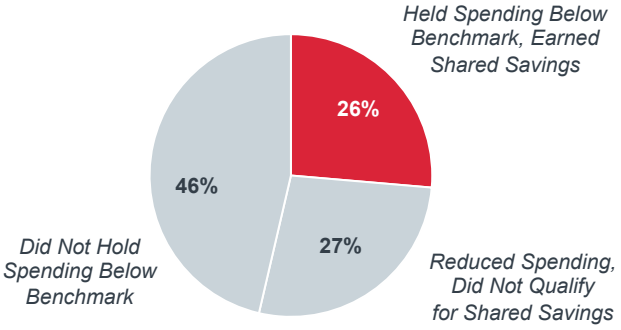
Medicare ACO Program Growth Continues

As of December 2014

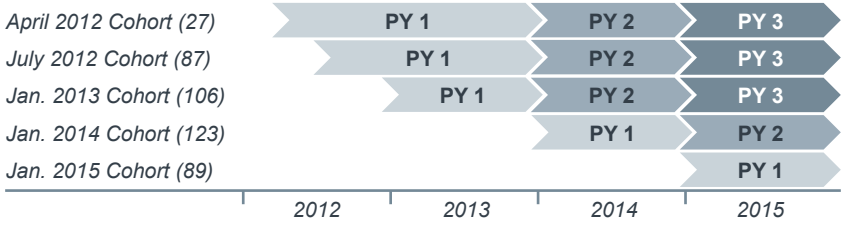


One-Quarter of MSSP ACOs Share in Savings

First Performance Year[2]



Early MSSP Participants Completing Third Performance Year (PY)



1) Medicare Shared Savings Program.
2) For the 2012 and 2013 cohorts; percentages may not add to 100 due to rounding.

Source: Spitalnic P, "Certification of Pioneer Model Savings," CMS, April 10, 2015; available at www.cms.gov; "Shared Savings Program Fast Facts," CMS, April 2015, available at: www.cms.gov; CMS, "Fact Sheets: Medicare ACOs continue to succeed in improving care, lowering cost growth," September 16, 2014, available at www.cms.gov; McClellan M et al., "Changes Needed to Fulfill the Potential of Medicare's ACO Program," Health Affairs Blog, April 8, 2015, available at www.healthaffairs.org/blog; Health Care Advisory Board interviews and analysis.

CMS Charting a Path Toward Greater Risk

Track 3, Pioneer and Next-Gen ACO Filling Out the Continuum

Continuum of Medicare Risk Models

Pay-for-Performance

- Hospital VBP Program
- Hospital Readmissions Reduction Program
- HAC Reduction Program
- Merit-Based Incentive Payment System

Bundled Payments

- Bundled Payments for Care Improvement Initiative (BPCI)

Shared Savings

- MSSP Track 1 (50% sharing)

Shared Risk

- MSSP Track 2 (60% sharing)
- MSSP Track 3 (up to 75% sharing)
- Next-Generation ACO (80-85% sharing)

Full Risk

- Next-Generation ACO (optional full performance risk)
- Medicare Advantage (provider-sponsored)

Increasing Financial Risk

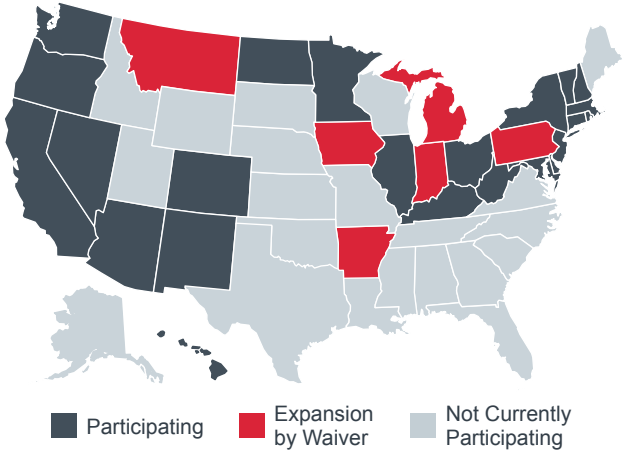
Source: Health Care Advisory Board interviews and analysis.

Future of Medicaid Expansion Less Clear

Benefit of Expansion Clear for Hospitals, But Opposition Remains

29 States and DC Have Approved Expansion[1]

As of April 2015



Medicaid Expansion Positively Impacting Hospital Finances

Medicaid Admissions increased 21% for investor-owned hospitals in expansion states

Self-Pay Admissions decreased by 47% for investor-owned hospitals in expansion states

Uncompensated Care costs reduced by $5 billion in expansion states in 2014

11.7M

Net increase in Medicaid, CHIP[2] enrollment, July-Sept. 2013 to Feb. 2015[3]

27% vs. 8%

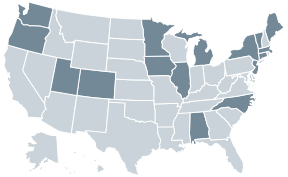
Growth in Medicaid, CHIP enrollment in expansion vs. non-expansion states, July-Sept. 2013 to Feb. 2015

1) Montana's expansion requires federal waiver approval.
2) Children's Health Insurance Program.
3) Excludes CT and ME.

Source: Kaiser Family Foundation, "Current Status of State Medicaid Expansion Decisions," January 27, 2015, available at: www.kff.org; HHS, "Insurance Expansion, Hospital Uncompensated Care, and the Affordable Care Act", March 23, 2015, available at: www.aspe.hhs.gov; PwC Health Research Institute, "The Health System Haves and Have Nots of ACA Expansion", 2014, available at: www.pwc.com; CMS, "Medicaid & CHIP: February 2015 Monthly Applications, Eligibility Determinations and Enrollment Report", May 1, 2015, available at: www.medicaid.gov; Health Care Advisory Board interviews and analysis.

Medicaid Risk-Based Payment Models Expanding

Providers Expanding Care Management Infrastructure to New Populations



17
states have Medicaid ACO programs in place or are pursuing one

Oregon
Coordinated Care Organizations

- 16 organizations accountable for 90% of Medicaid and dual-eligibles
- 21% reduction in ED use, 52% increase in PCMH[1] enrollment since 2012

On track to generate 2% PMPY[2] savings

Colorado
Regional Care Collaborative Organizations

- Seven regional organizations that convene provider networks around PCMHs
- Uses a hybrid of several payment strategies to shift to value

Generated $29-$33M in net savings, 2014

Minnesota
Integrated Health Partnerships

- 15 delivery systems participating in Medicaid ACO program
- Shared savings in year one; shared risk in following years

Generated $10.5M in savings in first year

1) Patient-Centered Medical Home.
2) Per Member Per Year.

Source: Center for Health Care Strategies, "Medicaid Accountable Care Organizations: State Update," March 2015, available at: www.chcs.org; Colorado Department of Health Care Policy & Financing, "Accountable Care Collaborative 2014 Annual Report," available at: www.colorado.gov; Oregon Health Authority, "Oregon's Health System Transformation: 2013 Performance Report," June 24, 2014, available at: www.oregon.gov; Minnesota Department of Human Services, "Integrated Health Partnerships (IHP) Overview," 2015, available at: www.dhs.state.mn.us; Health Care Advisory Board interviews and analysis.

Expansion States Experimenting with Benefit Design

States Using Waiver Flexibility to Redesign Benefits, Influence Behavior

Medicaid Waivers Encourage Healthy Behavior, Personal Responsibility

Demonstration Proposals Approved by CMS

Demonstration Proposals Rejected by CMS

- ✖ Work requirements as condition of eligibility
- ✖ Mandated premiums for beneficiaries below 100% FPL[2]
- ✖ Cost sharing exceeding amounts permitted under federal law

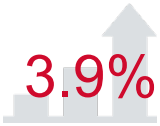
1) Qualified Health Plans.
2) Federal Poverty Level.

Source: Kaiser Family Foundation, "The ACA and Recent Section 1115 Medicaid Demonstration Waivers," November 24, 2014, available at: www.kff.org; Modern Healthcare, "CMS Gives Arkansas, Iowa More Leeway in Medicaid Expansion Waivers," available at: www.modernhealthcare.com, accessed January 5, 2015; Health Care Advisory Board interviews and analysis.

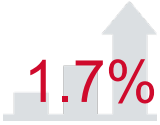
Employer Health Cost Growth Slowing, but Enough?

"Cadillac" Tax Motivating Quicker Action

Good News and Bad News



3.9% Predicted growth in per-employee health benefit cost, 2015 (second lowest since 1997)



1.7% Annual consumer inflation, October 2014

Refresher: The "Cadillac" Tax

- 40% excise tax assessed on amount of employee health benefit exceeding $10,200 for individuals, $27,500 for families
- Intended to encourage cost-effective benefits, offset ACA implementation cost
- Threshold adjustments tied to consumer inflation, not health care inflation
- If employers make no changes to current benefit plans:

31% of all employers could incur tax in 2018

51% of all employers could incur tax in 2022

Source: Mercer, "Survey Predicts Health Benefit Cost Increases Will Edge Up in 2015," September 11, 2014, available at: www.mercer.com; Hancock J, "Employer Health Costs Rise 4 Percent, Lowest Increase Since 1997," Kaiser Health News, November 14, 2012, available at: www.kaiserhealthnews.com; Mercer, "Modest Health Benefit Cost Growth Continues as Consumerism Kicks into High Gear," November 19, 2014, available at: www.mercer.com; Health Care Advisory Board interviews and analysis.

Not Converging on a Single Strategy

Spectrum of Options for Controlling Health Benefits Expense

Manage Proactively

- Offer and encourage uptake in care management, disease management, preventive care
- May involve direct partnerships with ACOs

Shift to Private Exchange

- Outsource administrative burden to third party
- Facilitate shift to defined contribution
- Encourage employee uptake of HDHPs[1]

Drop Coverage

- Shift employees to public exchange
- Trade Cadillac tax for employer mandate penalty

1) High Deductible Health Plan.

Source: Health Care Advisory Board interviews and analysis.

Activist Employers Investing in a Range of Tools

Four Primary Models for Controlling Employee Utilization

Manage Costs at Point of Network Assembly

"The One-Stop Shop"

ACO networks:
Employer contracts with single delivery system based on promise of reduced cost trend

Manage Costs at Point of Referral, Point of Care

"The Accountable Physician"

Enhanced primary care:
Employees directed to PCPs with proven ability to reduce utilization, refer responsibly

"The Neutral Third Party"

Personal health navigators:
Guide employees through all health care related decisions, refer to high-value providers

"The Second Opinion"

Specialty carve-out networks:
Employees evaluated against appropriateness of care criteria, sent to centers of excellence

Source: Health Care Advisory Board interviews and analysis.

Early Adopters of ACO Models Expanding Efforts

Intel Extends Connected Care Model

Established in New Mexico, 2013

PRESBYTERIAN Healthcare Services

Established in Oregon, 2014

KAISER PERMANENTE®

PROVIDENCE Health & Services

Key Components of Connected Care Oregon

- Premium incentives to choose narrow network; both Kaiser and Providence networks set at $0 premium
- Members assigned to PCMH
- FFS payments tied to performance against cost, quality goals

Case in Brief: Intel Corporation

- Large, multinational employer headquartered in Santa Clara, California
- In 2013, entered into narrow-network contract with Presbyterian Healthcare Services, an 8-hospital system in New Mexico, for employees at Rio Rancho plant
- In 2014, implemented similar model in Oregon with Kaiser Permanente and Providence Health & Services

Source: Hayes E, "Intel Shares Details on Its New Providence and Kaiser Health Plans," Portland Business Journal, October 24, 2014, available at: www.bizjournals.com/portland/blog; Health Care Advisory Board interviews and analysis.

Market Dynamics Slowing Broader Adoption

Direct-to-Employer ACO Arrangements Remain Rare

Carrier, Broker Resistance

- Little desire to disrupt stability of ESI[1] marketplace
- Hesitant to narrow networks for fear of jeopardizing provider relationships necessary for broad product offerings
- Resistance from national employers to compete directly with regional ACOs
- Fear that employer partners will bypass completely and partner directly with providers instead

Market Immaturity

- Hesitance by employers to disrupt employee benefits without concrete proof of efficacy of ACO model
- Lack of mature “plug and play” solutions means employers must invest significant time, energy into implementing ACO model
- More interest from employers in models requiring incremental changes, rather than broad disruption to benefits

1) Employer-Sponsored Insurance.

Source: Health Care Advisory Board interviews and analysis.

Employers Moving Away From the Traditional HMO

Looking to Combine Network Advantages with Consumer Accountability

Employers Looking to Narrower Networks, But Not Interested in the Traditional Model

77%

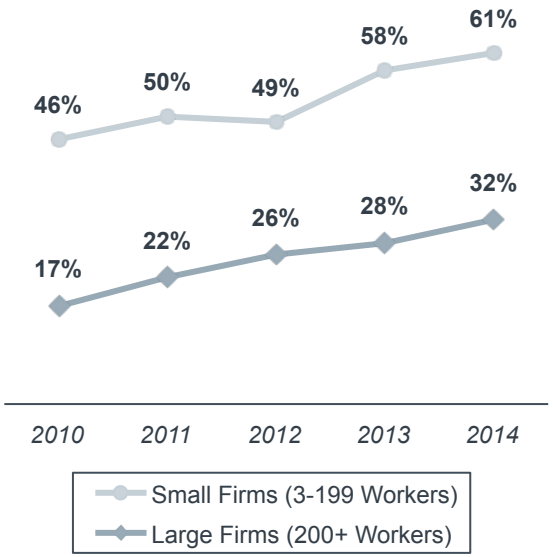
Small employers who would select a high-performance network with >10% cost reduction

36%

Large employers who have eliminated or plan to eliminate all HMO plan options by 2015

> We'd love to eliminate our HMO options. Not because we're opposed to narrower networks, but because HMOs isolate individuals from the true cost of health care."
>
> *Direct of Benefits, Large National Employer*

Percent of Covered Workers Enrolled in a Plan with a $1,000+ Deductible



Source: Bernardo J, "High Performance Networks Entice Health Plan Sponsors," Society for Human Resource Management, August 18, 2014, available at: www.shrm.org; Kaiser Family Foundation/Health Research & Educational Trust, "Employer Health Benefits 2014 Annual Survey," September 2014, available at: www.kff.org; Health Care Advisory Board interviews and analysis.

Consumerism Comes to the HMO

Combining Population Health with Greater Consumer Accountability

Kaiser Offering Deductible HMO Products Through Three Channels

Direct to Employer

Responding to direct employer demand for plan options that integrate with high-deductible benefit design

Public Exchanges

Most Silver and Bronze Kaiser offerings on public exchanges included deductibles

Private Exchanges

Kaiser offered on several multi-carrier private exchange platforms; must meet exchange plan requirements, including HDHP design

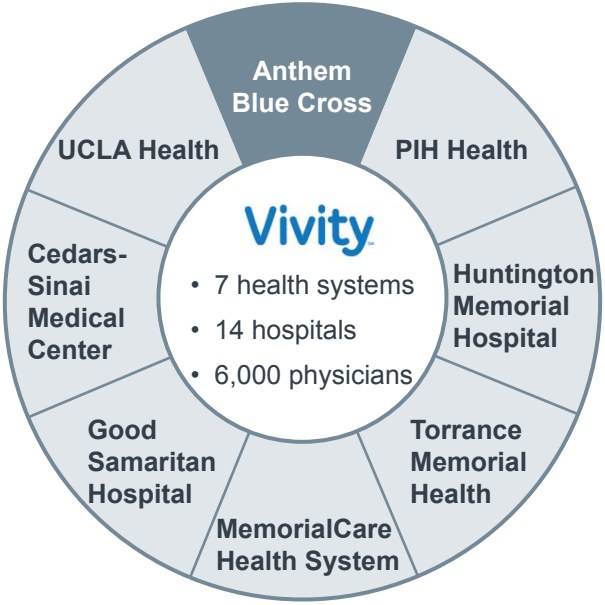
Case in Brief: Kaiser Permanente

- Not-for-profit health plan headquartered in Oakland, CA
- Includes Kaiser Foundation hospitals and subsidiaries, Kaiser Health Plan, and The Permanente Medical Groups
- Serves over 9 million members nationwide
- Historically offered traditional HMO products with no deductibles, limited cost sharing through copays

Source: Kaiser Permanente, "Our Deductible Plans," available at: www.info.kaiserpermanente.org, accessed May 8, 2015; Kaiser Permanente, "Silver 1500/45 Summary of Benefits and Coverage," available at: www.coveredca.com/small-business, accessed May 8, 2015; Kaiser Family Foundation, "Examining Private Exchanges in the Employer-Sponsored Insurance Market," September 2014, available at: www.kff.org; Health Care Advisory Board interviews and analysis.

Stakeholders Beginning to Recognize Opportunity

Insurer Coordinates with Seven Systems to Offer Market-Wide Solution



"What we are recognizing is that **the most effective delivery model is an integrated delivery model**. We can reduce waste, improve quality of care, provide people access to the top facilities in the nation, frankly, and do that in an integrated way."

Pam Kehaly
Anthem Blue Cross

Source: California Healthline, "Anthem, Seven California Health Systems Team Up To Form HMO", September 17, 2014, available at: www.californiahealthline.org; Commins J, "Anthem Blue Cross, 7 CA Health Systems Create New Challenger, Business Model," HealthLeaders Media, September 18, 2014; Health Care Advisory Board interviews and analysis.

Not Everyone Buying Into the Value of Systemness

Innovators Looking to Unbundle the Delivery System

> Quality doesn't happen at the system level. Quality happens at the individual physician level. **If I steer my employees to a single delivery system, the one thing I can be certain of is that the quality of care that they'll receive will be variable**."

Direct of Benefits, Large National Employer

Pushing for Two Levels of Unbundling

Physician Level

- Aggregate level facility or procedural data not a guarantee of individual physician performance
- Innovators looking to identify high-performing clinicians and ensure steerage to those individuals

Procedure Level

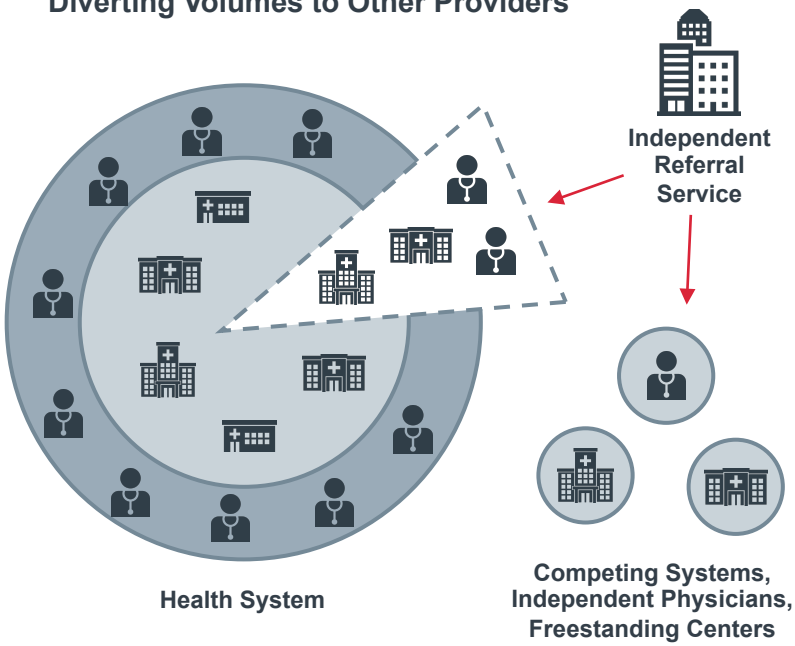
- Single health system may not be high-quality across all clinical areas
- Innovators cherry-picking facilities based on quality and cost efficiency with specific procedures (e.g. heart surgery)

Source: Health Care Advisory Board interviews and analysis.

Outside Parties Directing Referrals to High Performers

Creating De-Facto Narrow Networks at the Point of Referral

Narrowing Referral Options Within Systems, Diverting Volumes to Other Providers



Implications for Providers

- Variation in quality among providers and facilities leads to cherry-picking of system components
- Reduced volumes result from patients bypassing the system (e.g., for treatment at COE[1])
- Care management efforts hindered by patients seeking care out of network
- Decreased volume to lower performers complicates quality improvement efforts

1) Center of Excellence.

Source: Health Care Advisory Board interviews and analysis.

Incentivizing PCPs to Make Smart Referrals

Shifting Risk onto the Primary Care Physician

Case in Brief: Iora Health

- Progressive medical group based in Cambridge, Massachusetts with 12 clinics throughout the U.S.
- Refers selectively to high-quality, cost-effective specialty partners

> "In our initial arrangements, we were creating a lot of value, but not always sharing in it. Now, with broader shared risk, the incentives are more aligned."
>
> *Zander Packard, COO, Iora Health*

Identifying High-Value Referral Partners

1 

Eliminating High Spenders

Use payer claims data to eliminate physicians who are drumming up volumes

2 

Finding a Cultural Fit

Identify most collaborative partners (e.g. those willing to commit to curbside consults)

Giving PCPs Control of the Budget

From Primary Care Capitation to Global Risk

Under original model, Iora receives PMPM fee for primary care services

New contracts with insurers include shared risk based on total cost

Source: Iora, available at: www.iora.com, accessed April 17, 2015; Health Care Advisory Board interviews and analysis.

Concierge Navigators Influencing Referral Patterns

Compass Delivers Savings to Employers Through Premier Providers

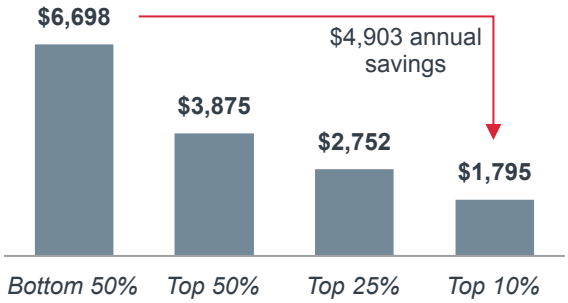
Premier Providers Chosen for High-Quality, Cost-Effective Care

Compass reviews medical claims data, conducts interviews to identify top performers

Providers must:

- Maintain updated medical practices
- Demonstrate compassion and concern for patients
- Deliver care that reduces excessive visits and spending

High-Quality Physicians Reduce Employees' Average Annual Health Care Spending



Case in Brief: Compass Professional Health Services

- Health navigation and transparency company based in Dallas, Texas
- Markets a health activation platform to employers that provides cost and quality data, promotes wellness and prevention, and engages employees in care pathways using Compass Premier Providers
- Clients include Southwest Airlines, Dillard's, Michaels, and The Container Store

Source: Compass, available at: http://www.compassphs.com/solutions/pathways/, accessed April 30, 2015; Health Care Advisory Board interviews and analysis.

Steering Employees to High-Performing Facilities

Centers of Excellence Help Employers Reduce Procedural Spend

BridgeHealth Offers Three Tiers of Service Targeting Surgery Spend

Scope of Services

SURGERY PATH

- Web portal that helps guide employees when making surgery treatment decision
- Offers shared decision-making and transparency tools

HIGH PERFORMANCE NETWORK

- Care coordinators direct employees to hospitals in top quartile of quality ranking system
- Offers case rates 15-40% below typical PPO payments

SURGERY BENEFIT MANAGEMENT

Combines Surgery Path and High Performance Network offerings to maximize impact, increase employee decision support options

Case in Brief: BridgeHealth Medical

- Health care company based in Denver, CO; helps employers manage surgery spend
- Identifies high-performing hospitals and surgical teams for key procedures and negotiates preset case rates
- Uses care coordinators to guide employees through process of selecting facility for procedure, scheduling, and follow up

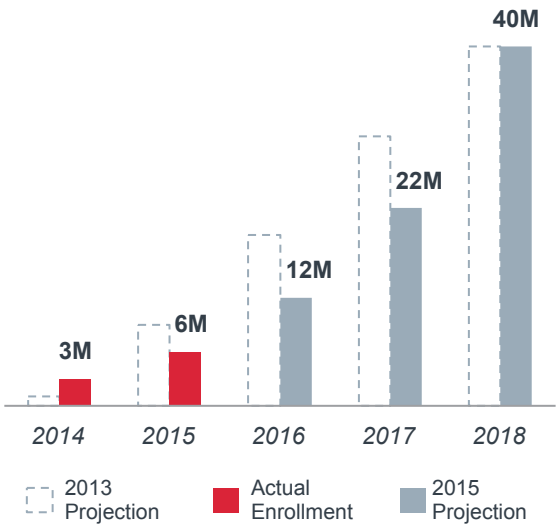
Source: BridgeHealth Medical, "Products," available at: www.bridgehealthmedical.com/products, accessed May 8, 2015; Health Care Advisory Board interviews and analysis.

Other Employers Taking a More Hands-Off Approach

Private Exchange Enrollment Continues to Grow

Private Exchange Enrollment Doubles in 2015, But Lags Behind Initial Projections

Projected Private Exchange Enrollment Among Pre-65 Employees and Dependents



Analysts Remain Bullish on Long-Run Growth Prospects

More Big Names Making the Jump

starwood Hotels and Resorts

Time Inc.

Newer Market Entrants Hitting Their Stride

50% Enrollment growth for Towers Watson's exchange solutions, 2015

(800k→1.2M)

500% Enrollment growth for Mercer's exchange solutions, 2015

(220k→1M)

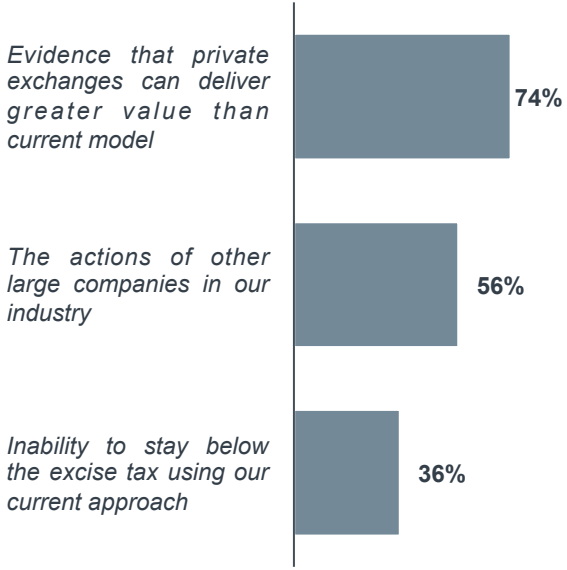
Source: Accenture, "Private Health Insurance Exchange Enrollment Doubled from 2014 to 2015," April 7, 2015, available at: www.accenture.com; Towers Watson, "Enrollment in Health Benefits Through Towers Watson's Exchange Solutions Expected to Reach About 1.2 Million in 2015," March 19, 2015, available at: www.towerswatson.com; Mercer, "Mercer Marketplace-the flexible private exchange-posts individual participant and client gains," October 13, 2014, available at: www.mercer.com; Health Care Advisory Board interviews and analysis.

Many Still in Wait-and-See Mode

Long-Run Impact Depends on Results, Broader Uptake Across Industries

Employers Waiting to See Results, Watching Industry Peers

Top Three Factors That Would Cause Employers to Consider a Private Exchange



> "For us, the decision to move to the private exchange model was independent of the ACA. We had pulled all of the levers available to us as a self-insured employer—there was nowhere left to go from a cost-savings perspective. At the end of the day, the private exchange was a way to achieve more predictable cost savings."

Tom Sondergeld,
Senior Director of Health & Wellness,
Walgreens

Source: Towers Watson/National Business Group on Health, "Employer Survey on Purchasing Value in Health Care," 2014, available at: www.towerswatson.com; Health Care Advisory Board interviews and analysis.

Exchanges Delivering on First-Order Savings

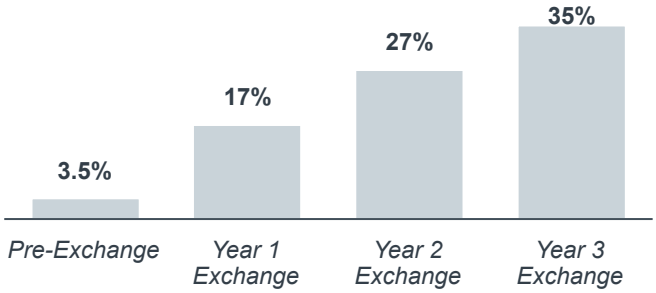
Facilitating Shift to Defined Contribution, Encouraging HDHP Uptake

Sears Exchange Model

- Fully-insured
- Defined contribution
- Multi-carrier

Three Years In, Sears Continues to See Migration to HDHPs Grow Year-Over-Year

Percentage of Sears Employees Selecting HDHP Option



Case in Brief: Sears Holdings Corporation

- Retail chain headquartered in Hoffman Estates, Illinois
- One of earliest large employers to adopt private exchange model; implemented Aon Active Health Exchange in 2013
- Has held defined contribution steady over the last few years; future adjustments based on premium growth and business performance

Source: Health Care Advisory Board interviews and analysis.

Future Success Hinges on Ability to Control Trend

Exchanges Must Innovate on Network Design, Population Health Tools

Controlling Cost Trend Crucial for Both Fully-Insured, Self-Insured Models

Fully-Insured

- Long-term sustainability depends on ability to keep premium growth low
- Carriers rely on low costs to keep premiums low

Self-Funded

- Long-term sustainability depends on ability to keep employers' variable costs low (i.e. claims)
- Dependent upon reduced unit prices, reduced utilization, or a combination of both

Strategies to Control Cost Trend

1 

Reduce Per-Unit Spending

Control price growth; encourage consumers to use lower-cost options

2 

Reduce Utilization

Through care management, disease management, utilization management services. These could be provided by:

- Carriers
- Exchange operators
- Providers

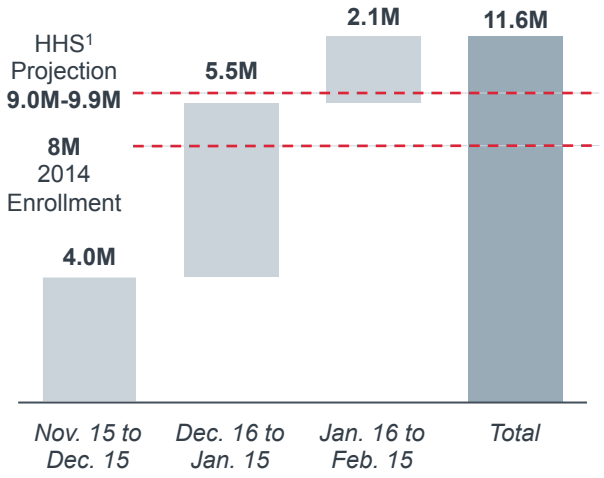
Source: Health Care Advisory Board interviews and analysis.

Consumers Continue to Flock to Public Exchanges

Second Round of Enrollment Hitting Targets

Second Open Enrollment Period Yields Nearly 12 Million Enrollees

Total 2015 Plan Selections in the Marketplaces



Federal Exchanges Driving Most Enrollment

8.8M
Enrollment on federally facilitated exchanges, 2015

2.8M
Enrollment on state run exchanges, 2015

Demographics Largely Unchanged

28%
2015 enrollees aged 18-34 (compared to 28% in 2014)

1) Health and Human Services.

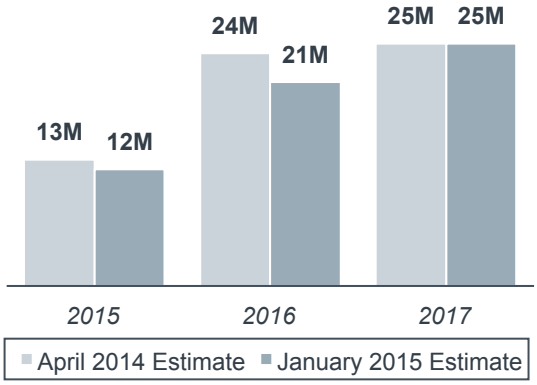
Source: HHS, "Health Insurance Marketplace 2015 Open Enrollment Period: December Enrollment Report," Dec. 30, 2014; HHS, "Health Insurance Marketplace 2015 Open Enrollment Period: January Enrollment Report," Jan. 27, 2015; HHS, "Open Enrollment Week 13: February 7, 2015 – February 15, 2015, available at: http://www.hhs.gov/healthcare/facts/blog; HHS, "Open Enrollment Week 14: February 16, 2015 – February 22, 2015, available at: www.hhs.gov/healthcare/facts/blog; HHS, "Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report," March 10, 2015; CBO, January 2015 Baseline: Insurance Coverage Provisions for the Affordable Care Act, available at: www.cbo.gov; Washington Times, "Obamacare Official: 7.3 Million Americans Are Still Enrolled and Paid Up," Sept. 18, 2014; available at: http://www.washingtontimes.com; Health Care Advisory Board interviews and analysis.

Long-Run Enrollment Projections Holding Steady

Eventual Size of Exchange Marketplace Depends on Impact of Penalties

CBO[1] Projects Slower Ramp-Up, but Holds Long-Term Projections Steady

Projected Enrollment in Public Exchanges



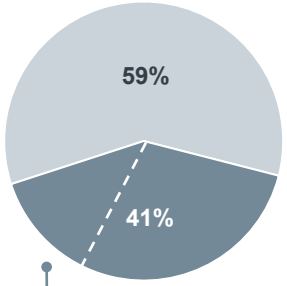
Cited Drivers of Enrollment Growth

1 Increased outreach efforts

2 Greater awareness of individual mandate

Some Skeptical of Motivational Power of Individual Mandate

Awareness of Penalty Among Uninsured



Uninsured who are aware of penalty and choosing to remain uninsured

Uninsured who were unaware of penalty prior to survey

Once informed of the penalty, only 30% of previously unaware stated that they would change their mind and enroll (equivalent to 12% of all currently uninsured)

1) Congressional Budget Office.

Source: CBO, The Budget and Economic Outlook: 2015 to 2025, Updated Estimates of the Insurance Provisions of the Affordable Care Act, January 2015, available at: www.cbo.gov; CBO, April 2014 Baseline: Insurance Coverage Provisions of the Affordable Care Act, available at: www.cbo.gov; Avalere Health, "Individual Mandate Penalty May Be Too Low to Attract Middle-Income Individuals to Enroll in Exchanges," April 24, 2015, available at: www.avalere.com; McKinsey & Co., 2015 OEP: Insight into Consumer Behavior, March 11, 2015, available at: www.healthcare.mckinsey.com; Health Care Advisory Board interviews and analysis.

In Year Two, Premium Adjustments Abound

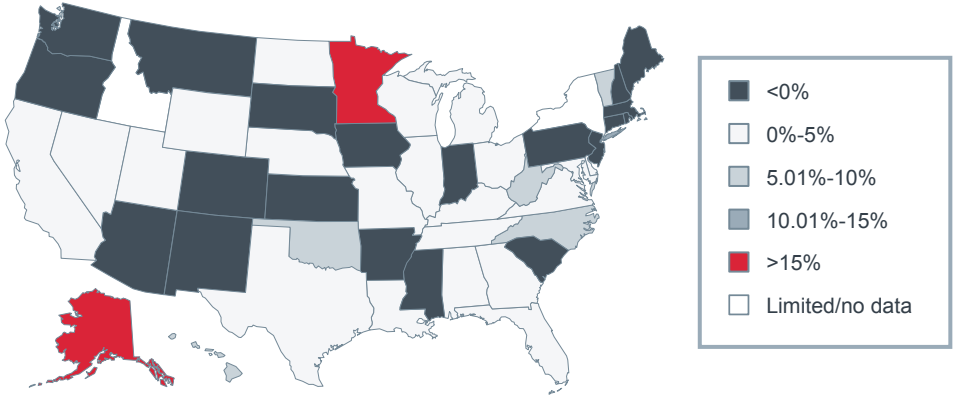
Competitive Marketplace Driving Premium Changes

Average Premium Increases Modest, but High Market-by-Market Variability

Statewide Average Premium Changes for Benchmark Silver Plans, 2014 to 2015[1]

0%

Average premium increase nationally



Takeaways

Competition Increased
Number of carriers increased by 19%; number of products increased by 27%

New Entrants Priced Competitively
Over half of new price leaders were either recent or new entrants

1) For 40-year-old, non-smoker.

Source: The Commonwealth Fund, "Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums," accessed May 1, 2015, available at: www.commonwealthfund.org; Health Care Advisory Board interviews and analysis.

Exchanges a More Fluid Marketplace Than Expected

Avoiding Premium Increases the Primary Motivation for Shoppers

Switching Rates Higher Than Expected

12%

Average annual switching among active employees with FEHBP[1] coverage

29%

Returning federal exchange enrollees changing plans in 2015

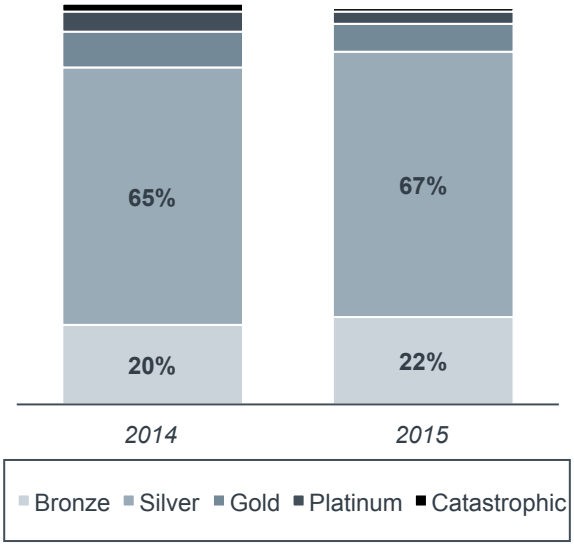
Premium Increases the Primary Motivator

55%

Switchers who cited rise in monthly premiums as among top three reasons for switching

Most Continue to Select Silver, Bronze Plans

Plan Selections on Healthcare.gov, 2014-2015



1) Federal Employee Health Benefits Plan.

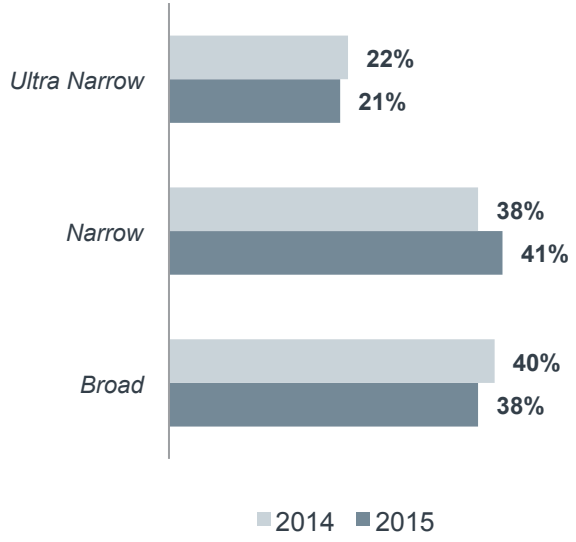
Source: The Advisory Board Company Daily Briefing, "More than 1 Million ACA Enrollees Changed Their Health Plans This Year," March 2, 2015, available at: www.advisory.com; McKinsey & Co., 2015 OEP: Insight into Consumer Behavior, March 2015, available at: www.healthcare.mckinsey.com; HHS, Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report, March 10, 2015, available at: www.aspe.hhs.gov; Health Care Advisory Board interviews and analysis.

Despite Predictions, Networks Remain Narrow

Insurers Betting Consumers Will Continue to Trade Choice for Price

Narrow Network Plan Designs Continue to Dominate Exchange Marketplace

Network Breadth in Largest City of Each State



Narrow Network Premium Advantages Increasing Over Time

Median PMPM Difference For Products From the Same Payer and Product Type

11-17%
Narrow network premium advantage in 2014

15-23%
Narrow network premium advantage in 2015

Few Buying-Up to Broad Networks

17%
Consumers with narrow-network plans for year one that switched to a broad-network plan in year two

Source: McKinsey & Co., "Hospital Networks: Evolution of the Configurations on the 2015 Exchanges," April 2015, available at: www.healthcare.mckinsey.com; Health Care Advisory Board interviews and analysis.

Trading Low Premiums for High Deductibles

Average Public Exchange Deductibles by Tier, 2015

Bronze:

$5,181	$5,081
2015	*2014*

Silver:

$2,927	$2,898
2015	*2014*

Gold:

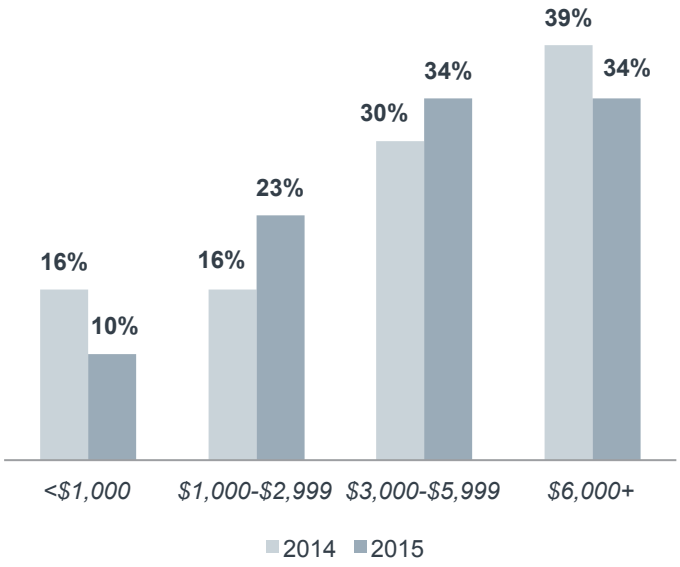
$1,198	$1,277
2015	*2014*

Platinum:

$243	$347
2015	*2014*

2015 Enrollees Favor Higher Deductibles

Annual Deductibles as Percentage of All Individual Plans Selected on eHealth Platform, 2014-2015



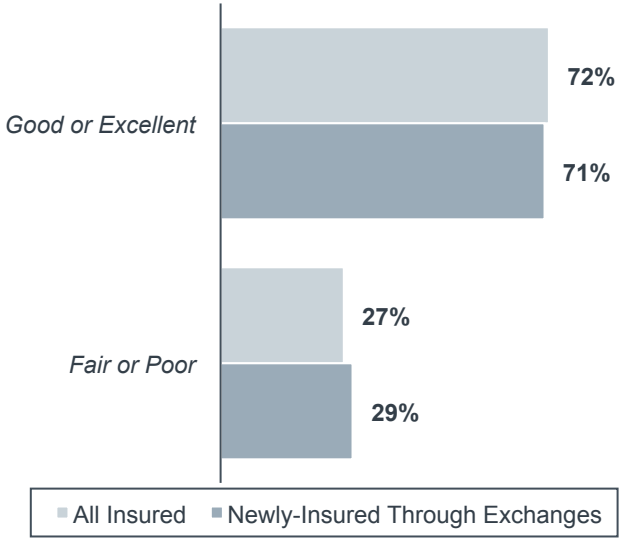
Source: eHealth, "Health Insurance Price Index Report for the 2015 Open Enrollment Period," March 2015, available at: www.news.ehealthinsurance.com; HealthPocket.com, "2015 Obamacare Deductibles Remain High but Don't Grow Beyond 2014 Levels," November 20, 2014, available at: www.healthpocket.com; Health Care Advisory Board interviews and analysis.

Majority Satisfied with Coverage

So Far, Backlash Against Narrow Networks, HDHPs Not Widespread

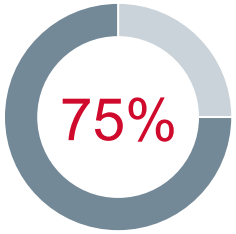
Exchange Enrollees Generally as Happy as Others with Health Coverage…

Ratings of Healthcare Coverage Quality, 2014

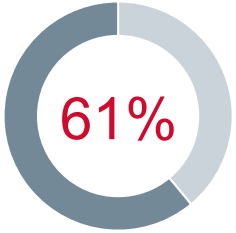


…And Particularly Satisfied with the Cost of Their Coverage

Ratings of Healthcare Coverage Cost, 2014



Newly insured satisfied with cost of health care



Satisfaction rate among all insured individuals

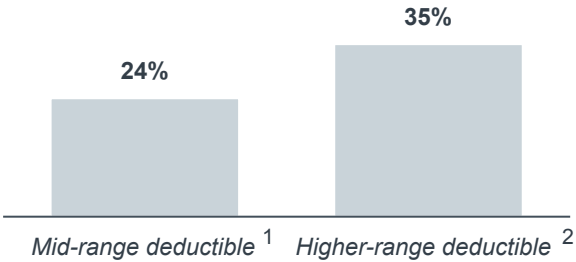
Source: Gallup, "Newly Insured Through Exchanges Give Coverage Good Marks," November 14, 2014, available at: www.gallup.com; Health Care Advisory Board interviews and analysis.

Higher Deductibles Driving Increased Price Sensitivity

Consumers Increasingly Soliciting Pricing Information

Many Americans Lack Cash Flow to Cover Potential OOP Costs

Households Without Enough Liquid Assets to Pay Deductibles



"A surprising percentage of people with private insurance…simply do not have the resources to pay their deductibles."

Drew Altman, President, Kaiser Family Foundation

More Consumers Attempting to Find Pricing Information

Consumers who have tried to find out how much they would have to pay before getting care

Those with **deductibles of $500 to $3,000** who have solicited pricing information

Those with **deductibles higher than $3,000** who have solicited pricing information

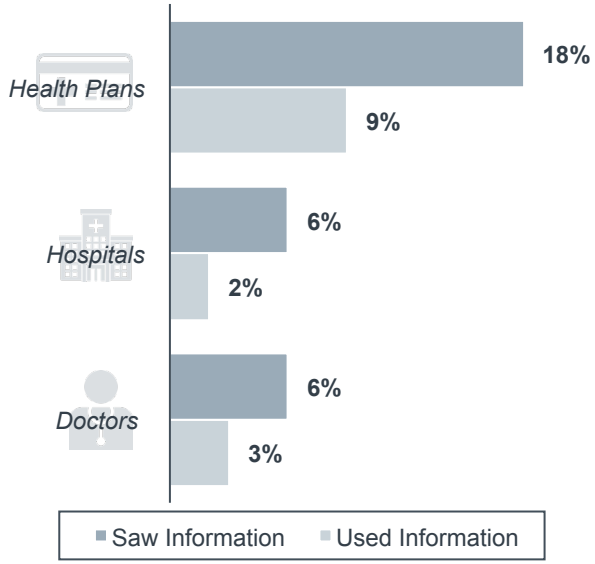
1) $1,200 Single; $2,400 Family
2) $2,500 Single; $5,000 Family

Source: Altman D, "Health-Care Deductibles Climbing Out of Reach," Wall Street Journal, March 11, 2015, available at: www.blogs.wsj.com; Health Care Advisory Board interviews and analysis.

Pricing Tools Currently Falling Short

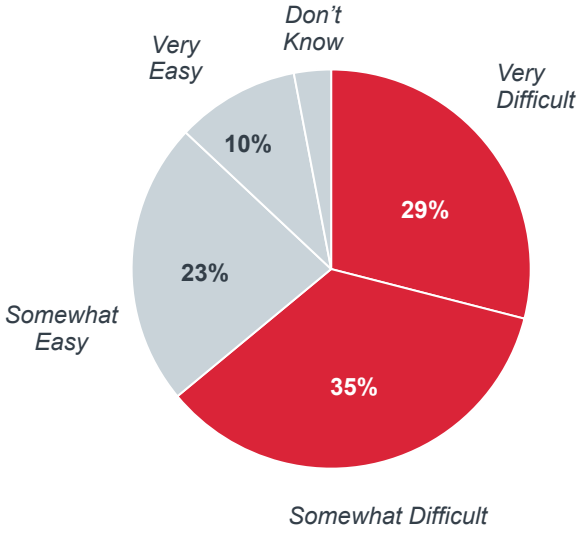
Few Consumers Have Actually Seen or Used Price Information

Percentage of Consumers Who Have Seen or Used Price Information in Past 12 Months



Majority Report Difficulty Finding Cost Information

Consumer Assessment of Difficulty Locating Pricing Information for Doctors and Hospitals

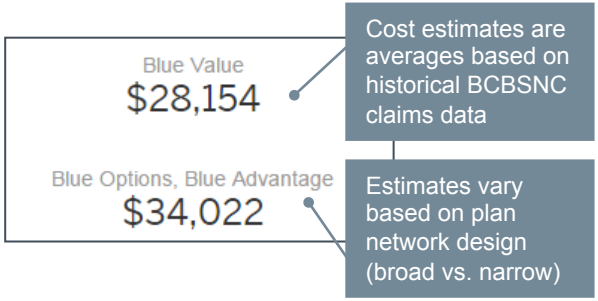


Source: Kaiser Family Foundation, "Kaiser Health Tracking Poll: April 2015," April 21, 2015, available at: www.kff.org; Health Care Advisory Board interviews and analysis.

Transparency Goes Mainstream

Tools Increasing in Accessibility, Sophistication

Surprise Release Makes Pricing Information Available to General Public



Payers Pooling Pricing Information to Create More Accurate Datasets

Case in Brief: BCBS North Carolina

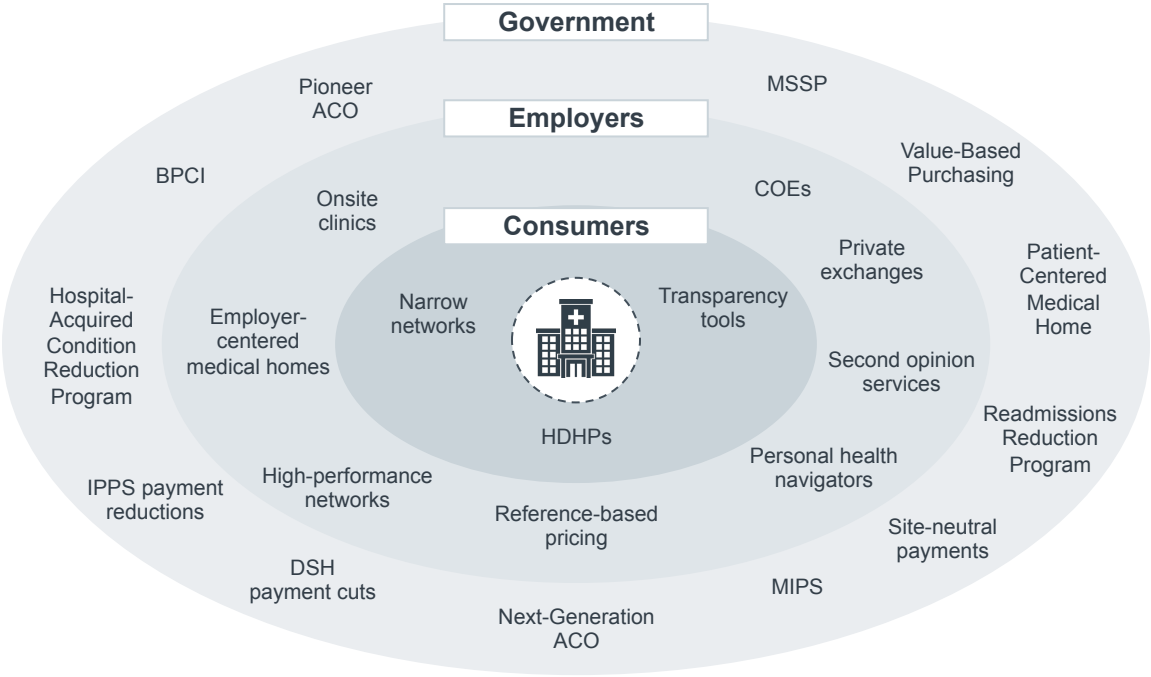
- Not-for-profit health insurance company based in Chapel Hill, North Carolina
- In January 2015, released new pricing transparency tool to general public

Case in Brief: Guroo

- Price transparency tool powered by the Health Care Cost Institute
- Aggregates three billion insurance claims from over 40 million Americans

Source: Munro D, "Could This Pricing Tool For Consumers Disrupt Healthcare?" Forbes, January 15, 2015, available at: www.forbes.com; Guroo, available at www.guroo.com, accessed May 1, 2015; Health Care Advisory Board interviews and analysis.

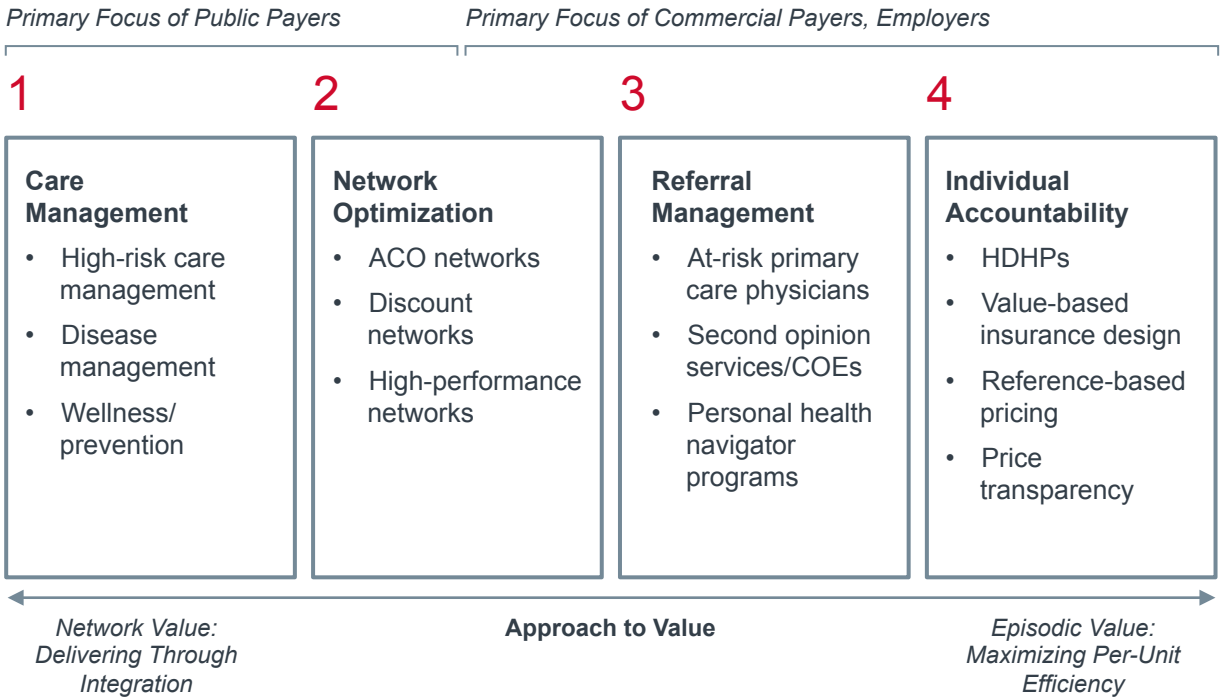
Facing a Dizzying Array of Cost Control Efforts



Source: Health Care Advisory Board interviews and analysis.

Purchasers Pulling Four Distinct Cost-Saving Levers

Goal is Clear, but Methods Vary



Source: Health Care Advisory Board interviews and analysis.

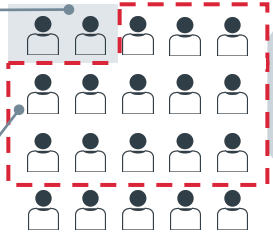
Scale Lives Under Management to Maximize ROI

Providers Must Move Beyond Initial Populations of Focus

Patients currently covered by population health pilots

Number of lives required under risk-based contracts to meaningfully change practice patterns

Typical Patient Population



Necessary Elements for Achieving an ROI on Care Management

1. Number of lives under management is sufficient to offset investment costs
2. Purchasers beyond Medicare recognize value of population health capabilities
3. Provider able to reduce unnecessary utilization, streamline cost structure

Expanding ACO Networks to Lower Acuity Populations

Public Payers → *Commercial Payers, Individuals*

- Traditional Medicare beneficiaries
- Medicaid managed care beneficiaries
- Dual-eligible beneficiaries

→

- Medicare Advantage enrollees

→

- Large group commercial members
- Large non-provider employers
- Individual enrollees

Source: Health Care Advisory Board interviews and analysis.

Embrace High-Performance Networks

Push Toward Narrower Networks a Potential Advantage for Providers

The Old World Mindset

Narrow Networks:

Impede volume growth

Network exclusion reduces potential for profitable volume; inclusion prioritized over exclusivity

Require detrimental payment cuts

Payers require trade-off on price that providers are unwilling to make due to negative impact on revenue

Resist narrow networks, lobby for "Any Willing Provider" laws

The Value-Based Mindset

Narrow Networks:

Drive growth in covered lives

Narrow networks funnel enrollees to a smaller number of network providers, increasing attributed lives

Improve network integrity

Narrow networks encourage patients to remain in network, enhancing coordination and care management efforts

Lead network optimization efforts, drive narrow network development

Source: Health Care Advisory Board interviews and analysis.

Win Preference at the Point of Network Assembly

Providers Must Demonstrate Network-Level Value

Baseline Requirements

Cost

- Low unit prices relative to competitors
- Willingness to further reduce prices in return for steerage
- Investment in infrastructure that signals ability to control cost trend

Access

- Geographic coverage that aligns with purchaser of interest
- Ability to meet convenience demands of consumers (after-hours, weekend access; virtual care; etc.)

Elements of an Attractive Network

Clinical Quality

- Better outcomes than competitors
- Adherence to evidence-based clinical practices

Service Experience

- High patient satisfaction ratings
- Strong brand reputation

Differentiators

Source: Health Care Advisory Board interviews and analysis.

Secure Consumers at Enrollment, Re-Enrollment

Getting Ahead of Common Concerns with Narrow Networks

Three Keys to a Consumer-Friendly Narrow Network

Key at Point of Enrollment

Key at Point of Re-Enrollment

? *"What's in this for me?"*

Pricing

- Consumer generally require 10-15% premium advantage
- Self-funded employers may be willing to cover 100% of premium costs

? *"How do I know who's actually in-network?"*

Predictability

- Work with payer to provide up-to-date provider directories
- When possible, use unified branding to simplify patient navigation
- ED Ensure flexibility around out-of-network ED usage

? *"Will it be harder for me to get an appointment?"*

Ease of Use

- Ensure system has capacity to take on increased volume
- Set aggressive targets for same-, next-day appointments
- Expand networks of convenient access points

Source: Health Care Advisory Board interviews and analysis.

Maintain Network Integrity Through Benefit Design

Point-of-Care Cost Differential Must Incent Consumers to Stay In Network

Benefit Design Must Keep Lives in Network at the Point of Care

Co-Insurance/Copay

Strategies to consider:

- $0 copays for in-network office visits, preventive care
- Co-insurance differential of 20 to 30 percentage points

Deductible

Strategies to consider:

- Separate in-network and out-of-network deductibles
- Out-of-network deductible at least double in-network deductible

"Initially, we didn't go far enough with benefit design to really keep people in our network. Moving forward, we'll be requiring more commitment from our partners. What we're saying to the payers is: **if you're going to ask for a true, preferred discount, then you need to deliver a true, preferred network**."

Chief Marketing Officer,
Large Health System in the West

Source: Health Care Advisory Board interviews and analysis.

Understand the Decision Matrix

Increasing Scrutiny on Procedure-, Physician-Level Performance

Innovators Using Wide Range of Criteria to Identify Top Performers

Personal Health Navigators

ACCOLADE COMPASS Healthcare Redefined.

Primary Care Organizations

iorahealth PALADINA HEALTH

2nd Opinion/COE Programs

GRAND ROUNDS BridgeHealth MEDICAL

Cost
- Historical cost
- Referral patterns
- Where procedures are performed
- Willingness to accept set price

Access
- After-hours availability
- Telehealth capabilities

Quality
- Complication, mortality rates
- Readmission rates
- Patient functional status

Patient Experience
- Patient satisfaction scores
- Communication skills
- Seamless integration with other providers (e.g., sharing reports)

Appropriateness of Care
- Correct diagnosis
- Appropriate intervention

Physician Experience
- Volume of procedures
- Board certification
- Research experience
- Fellowships

Primary Data Sources: *Claims* | *Medicare data* | *Public tools, databases, rankings* | *Interviews*

Source: Health Care Advisory Board interviews and analysis.

Turn Price Sensitivity to Your Advantage

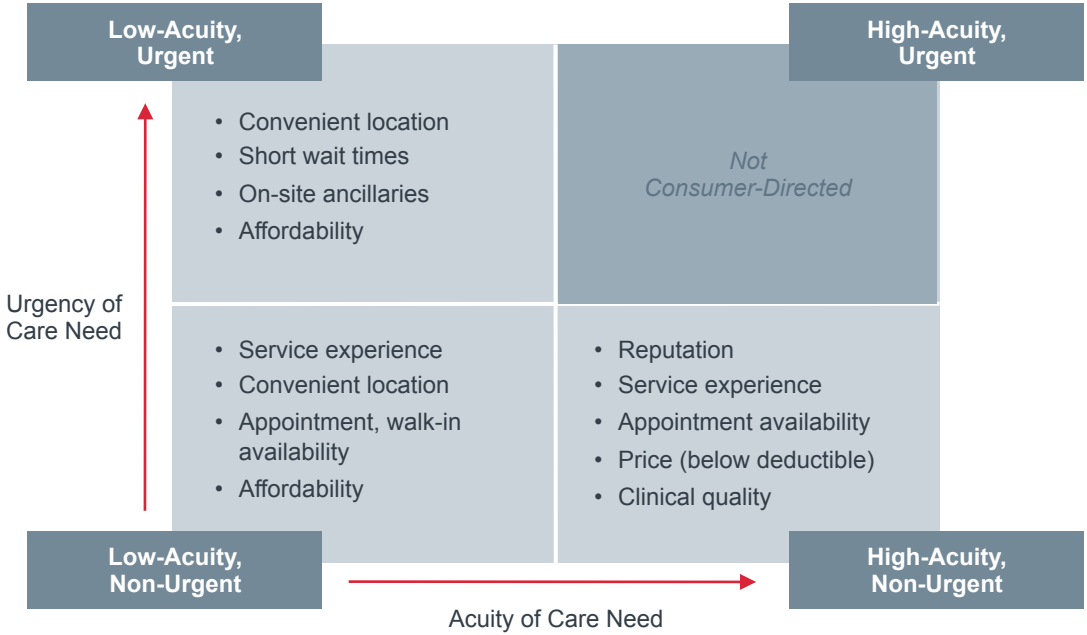
From Threat…	…To Competitive Advantage
Price-sensitive patients seek lower-cost options	Target price reductions to points of greatest sensitivity
Price sensitivity commoditizes health care services	Empower patients to make trade-offs between price, non-price differentiators
Patients delay or forego necessary care	Exert influence over benefit design to rightsize utilization

Source: Health Care Advisory Board interviews and analysis.

Make the Conversation About More Than Price

Activated Consumers Make Trade-Offs Between Price, Service, Quality

Consumer Preferences Vary by Acuity, Urgency of Care



Source: Health Care Advisory Board interviews and analysis.

Thriving in a World of Cost Containment

Keys For Turning Cost-Control Efforts to Your Advantage

Care Management

1. Scale number of covered lives under risk-based contracts
2. Increase degree of risk assumed in contracts

Network Optimization

3. Gain strategic pricing flexibility to ensure in-network status
4. Demonstrate network-level value on access, quality, and experience

Referral Management

5. Reinforce consumer loyalty with navigation support
6. Ensure best-in-class performance for easily-splintered services

Individual Accountability

7. Tailor product design to consumer preferences
8. Align pricing with population health efforts

Source: Health Care Advisory Board interviews and analysis.

Market Coalescing Around Two Broad Approaches

Purchasers Pulling Us in Two (Potentially Opposite) Directions

Network Value: Delivering Through Integration

Episodic Value: Maximizing Per-Unit Efficiency

1 Shifting risk to the delivery system

- Provider network held accountable for total cost of care
- Care coordination put in hands of delivery system
- Network may be formally narrowed around delivery system at the point of network assembly

2 Unbundling the health system

- Consumers held accountable for financial implications of care decisions
- Care coordination outsourced to a third party
- Purchasers refer to high-performing physicians, rather than high-performing systems

Source: Health Care Advisory Board interviews and analysis.

Medicare's Risk Goal Provides Clarity for Providers

Integrated Care Delivery the Way Forward for the Nation's Largest Payer

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Better Care, Smarter Spending, Healthier People: Improving Our Health Care Delivery System

The Affordable Care Act offers many tools to improve the way providers are paid to reward quality and value instead of quantity, to strengthen care delivery by **better integrating and coordinating care for patients**, and to make information more readily available to consumers and providers. Doing so will improve the **coordination and integration of health care**, engage patients more deeply in decision-making and improve the health of patients – with a priority on prevention and wellness. It is our role and responsibility to lead this change, and we will lead.

Source: HHS, "Better, Smarter, Healthier: In Historic Announcement, HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value," January 26, 2015, available at: www.hhs.gov; Health Care Advisory Board interviews and analysis.

Proving Value of Integration Elsewhere No Easy Lift

System Value Largely an Unmet Promise Today

Many Skeptical of Providers' Ability to Deliver on Promise of Integration

Lack of historical evidence on meaningful strides toward integration

Belief that health systems have largely focused on expansion without spending time on necessary post-deal integration

Past experience suggests consolidation actually produces negative value

Heavily consolidated markets have experienced price increases without meaningful quality, experience improvements

"The FTC recognizes that more coordinated and integrated care can help transform health care delivery and payment toward a risk-based financially and clinically integrated system that will improve and reward patient outcomes. But we determined, and the courts agreed, that these goals [can] be achieved by aligning incentives in other ways, rather than allowing an acquisition[1] that would **substantially lessen competition and create a risk of significantly higher prices**."

Edith Ramirez,
Chairwoman, Federal Trade Commission

1) Reference to St. Luke's Health System's acquisition of Salzer Medical Group in Nampa, Idaho.

Source: Federal Trade Commission, "February 24, 2015 Workshop Transcript: Examining Healthcare Competition," February 24, 2015, available at: www.ftc.gov; Health Care Advisory Board interviews and analysis.

Our Leadership Challenge

Delivering on the Promise of Systemness

Core Competencies of a True System

Cost Efficiency

- Scale-enabled lean cost structure
- Rationalized footprint
- Rightsized services portfolio

Trend Control

- Care managers, navigators have system-wide perspective
- Cross-continuum assets are leveraged to send patient to appropriate care site

Integration

- Interconnected care infrastructure that enables patient flow
- Single IT infrastructure with seamless transfer of information

Standardization

- Uniform care processes to produce consistent clinical outcomes
- Ability to communicate best practices across a system

Source: Health Care Advisory Board interviews and analysis.

Patients the Greatest Beneficiaries of True Systemness

System Competency	Patient Benefit	System Benefit
Cost Efficiency	**Affordability** Cost efficiency may be translated into market-facing unit price advantages	Consumer Loyalty
Trend Control	**Quality** Reflective of an ability to effectively manage utilization	
Integration	**Coordination** Interconnectivity creates seamless, stress-free experience	
Standardization	**Predictability** Standardized outcomes, with a consistent experience, at a predictable price point	

Source: Health Care Advisory Board interviews and analysis.

Health Care 2020

Questions Guiding Future Strategy

1. How do we adapt our growth strategy to respond to diverging approaches within the marketplace? Which strategies that serve us well under the government's push toward risk will also help us defend our value proposition in the commercial marketplace?

2. What is the true, unique advantage of a health system? Where are our biggest opportunities to use our scale and assets to deliver tangible value to purchasers?

3. How prepared are we to pursue those opportunities and where are we falling short today? Do we have the right leadership and governance structures in place to enable meaningful change?

4. How do we transition from a service-centric organization to a consumer-centric organization? What opportunities do we have to "productize" system value and sell directly to the end consumer?

5. How do we use our advantages not just to gain preference but to reinforce productive consumer behavior and engage our patients as true partners—encouraging financial responsibility, health-conscious behavior, and, ultimately, system loyalty?

Source: Health Care Advisory Board interviews and analysis.

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