The Advisory Board Company | Health Care Advisory Board

Health Care 2020

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

Prepared for Cassling

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Health Care Advisory Board

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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"

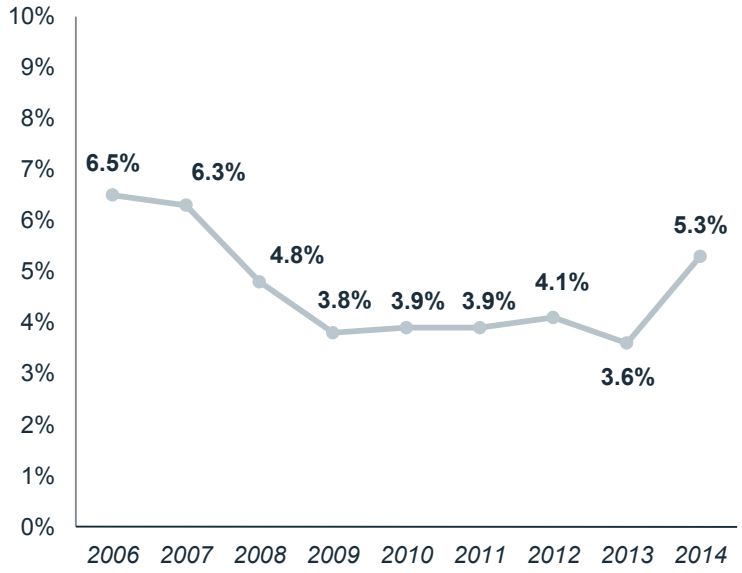
USA TODAY

"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



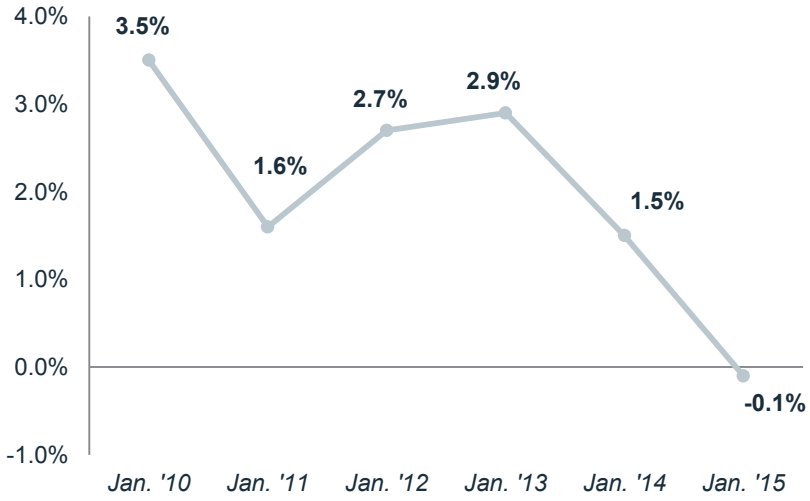
Source: Altarum Institute, Health Sector Trend Report, March 2015, accessed April 2015; Tozzi J, "U.S. Health-Care Spending Is on the Rise Again," Bloomberg Businessweek, February 18, 2015, available at: www.bloomberg.com; Davidson P, "Health care spending growth hits 10-year high," USA Today, April 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; CMS, "CMS Releases 2014 National Health Expenditures," December 2, 2015, available at: www.cms.gov; 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)

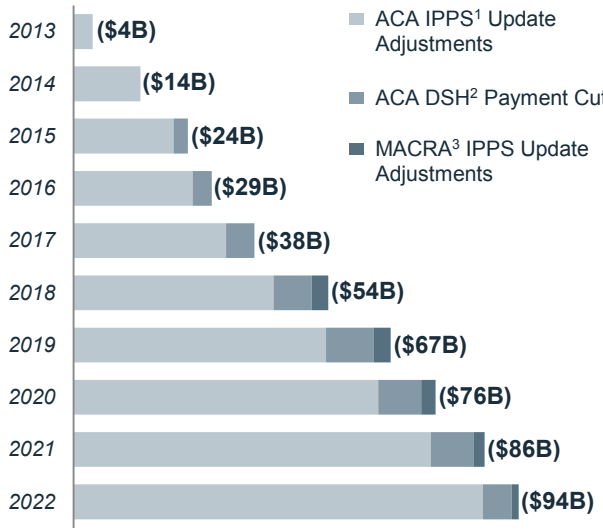
Source: Altarum Institute, Health Sector Economic Indicators: Price Brief, March 2015, March 2014, March 2013, March 2012, available at: www.altarum.org; Health Care Advisory Board interviews and analysis.

No End in Sight

Price Cuts Continue Unabated

Hospitals Bearing the Brunt of Payment Cuts

Reductions to Medicare Fee-for-Service Payments



Site-Neutral Payment Taking Effect

Bipartisan Budget Act of 2015

- Eliminates pricing advantage for new hospital-owned outpatient sites
- Scheduled to go into effect on January 1, 2017
- Excludes sites receiving provider-based rates prior to the law's enactment on November 2, 2015
- Upcoming rulemaking process will establish details of site-neutral payment policy

$29.5B Potential savings from fully moving to site-neutral payments

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

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; The Daily Briefing, "How to Understand Last Week's Big Budget Deal," November 2, 2015; Budget of the United States Government (Proposed) FY 2016; Health Care Advisory Board interviews and analysis.

No Shortage of Health Reform Ideas

2016 Presidential Election Off and Running

Senator Bernie Sanders

- Implement single-payer health care system
- Empower Medicare to negotiate drug prices
- Allow states flexibility in designing health care programs

Secretary Hillary Clinton

- Lower out-of-pocket expenses, especially for prescription drugs
- Guarantee transparency and avoid surprise bills
- Fight back against premium hikes and scrutinize mergers
- Promote value-based care

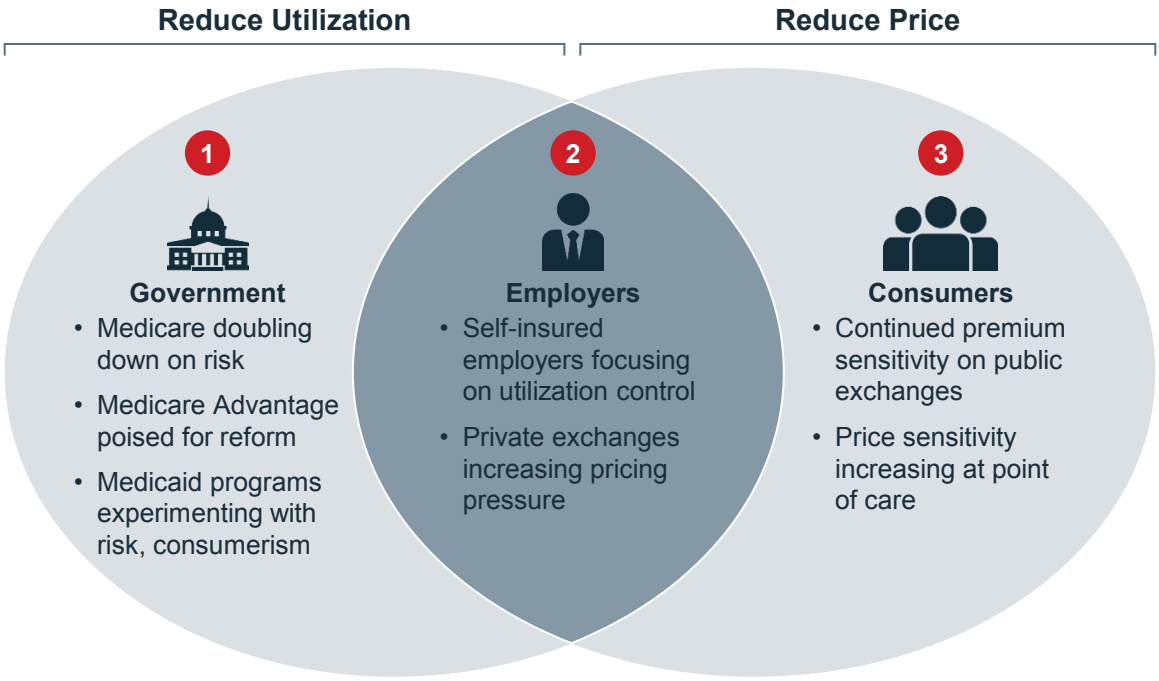
Republican Field

- Increase consumer choice
- Reduce government intervention
- Allow health insurance plans to be sold across state lines

Source: Huffington Post, "Hillary Clinton's Plan for Lowering Out-of-Pocket Health Care Costs," 2015; MSNBC, "Hillary Clinton talks health care policy in Iowa," March 15, 2015; NBC News, "Carson Talks Obamacare," March 14, 2014; Ballotpedia, "Presidential Elections," 2015; MSNBC, "Repeal and replace with something terrific," July 30, 2015; Health Care Advisory Board interviews and analysis.

Beyond Politics, Formidable Pressures Abound

All Purchasers Looking to Curb Spending



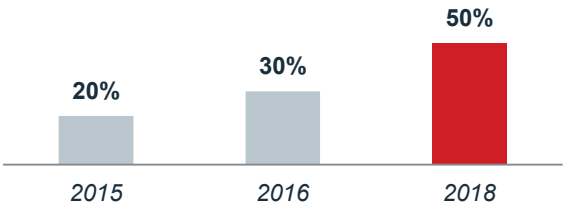
Source: Health Care Advisory Board interviews and analysis.

CMS Lays Down Marker for Value-Based Payment

Explicit Targets Hint at Forceful Measures Ahead

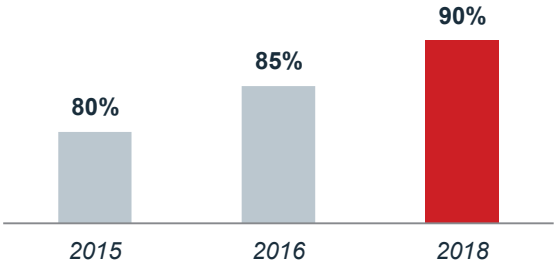
Aggressive Targets for Transition to Risk

Percent of Medicare Payments Tied to Risk Models



FFS[1] Increasingly Tied to Value

Percent of Medicare Payments Tied to Quality



> "Providers should compare ACO earnings not with what they could earn in today's fee-for-service payment environment but with what they could expect to earn in the future if they didn't participate in such alternative payment models."
>
> *Senior CMS Officials*

1) Fee-for-Service.

Source: HHS, "Progress Towards Achieving Better Care, Smarter Spending, Healthier People," available at: http://www.hhs.gov, accessed February 2015; Pham H, et al., "Medicare's Vision for Delivery-System Reform – The Role of ACOs," *New England Journal of Medicine*, September 10, 2015; Health Care Advisory Board interviews and analysis.

SGR Replacement 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

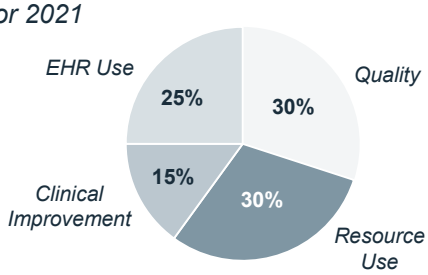
2

Alternative Payment Models (APMs)

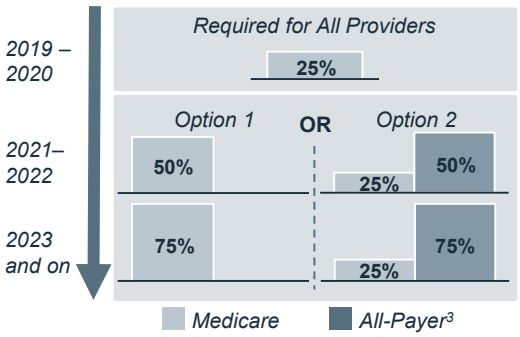
- Provides financial incentives (5% annual bonus in 2019-2024) and exemption from MIPS
- Requires that physicians meet increased targets for revenue at risk
- APMs must involve downside risk and quality measurement

MIPS Performance Category Weights

For 2021



Revenue at Risk Requirements for APMs



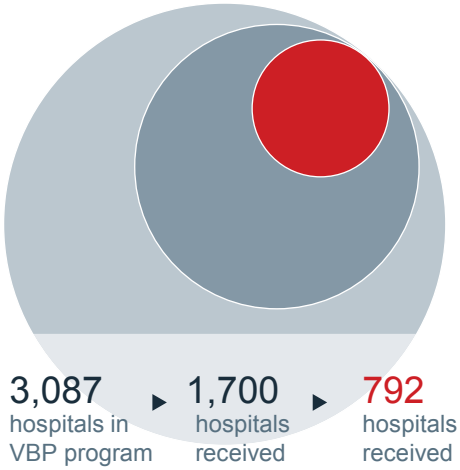
1) Physician Fee Schedule.
2) Meaningful Use, Value-Based Modifier, and Physician Quality Reporting System.
3) Includes risk-based contracts with Medicare Advantage plans.

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

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.

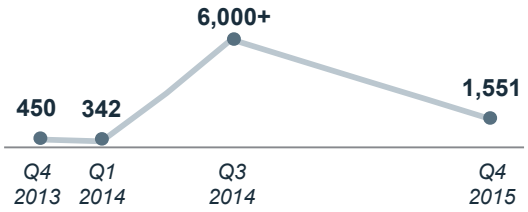
Source: Rau J, "1,700 Hospitals Win Quality Bonuses From Medicare, But Most Will Never Collect," Kaiser Health News, January 22, 2015, available at: kaiserhealthnews.org; Health Care Advisory Board interviews and analysis.

Bundled Payments Taking Hold

Early Results from Medicare's Bundling Programs Encouraging

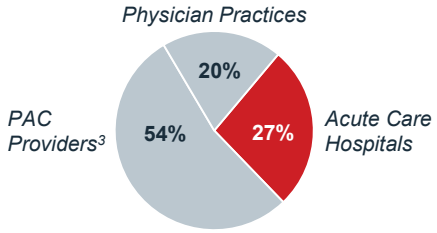
Total Number of BPCI[1] Participants

As of October 2015



Types of Organizations Participating in BPCI

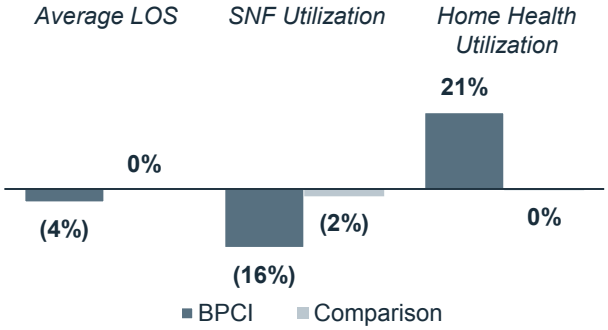
Episode Initiators as of October 2015[2]



Model 2 Results

BPCI Participants' Performance Relative to Comparison Group

$3,724
Average savings per episode for orthopedic cases excluding spine[4]



1) Bundled Payments for Care Improvement Initiative.
2) Percentages may not add to 100 due to rounding.
3) Includes SNFs, HHA, Inpatient Rehabilitation Facilities, and Long-term Acute Care Hospitals.
4) Based on difference-in-differences analysis of 335 BPCI episodes and 10,926 control episodes.

Source: Press et al., "Medicare's New Bundled Payments: Design, Strategy, and Evolutions," JAMA, December 17, 2015; CMS, "Bundled Payments for Care Improvement (BPCI) Initiative: General Information," October 13, 2015; The Lewin Group, "CMS Bundled Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report," January 2015; Health Care Advisory Board interviews and analysis.

From Voluntary to Mandatory Bundled Payments

CMMI Program Will Require Orthopedic Bundling in 67 Select Markets

The Comprehensive Care for Joint Replacement (CJR) Model

Key Program Features

Focus on joints

Average expenditure varies from $16,500 to $33,000 by geography

Comprehensive episode

Includes all related Part A and Part B services for 90 days post-discharge

Mandatory in 67 markets

Includes IPPS[1] hospitals only; excludes hospitals participating in BPCI[2] Model 1 or Phase 2 of BPCI Models 2 or 4 for LEJR[3]

Retrospective bundle

CMS make FFS pay to each provider separately, conduct annual reconciliation process

Program Timeline

November 2015

Final details announced, including hospital participant list and revised quality methodology

April 1, 2016

First performance year begins; no episode discount for first year

2017-2020

Downside risk incorporated; up to 3% episode discount, depending on hospitals' quality performance scores

$343M

ESTIMATED SAVINGS TO MEDICARE OVER THE 5 YEARS OF THE MODEL

1) Inpatient Prospective Payment Systems.
2) Bundled Payments for Care Improvement Initiative.
3) Lower extremity joint replacements.

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.

CMS Announces New Medicare ACO Participants

Providers Selecting from a Range of ACO Contracting Options

Pioneer ACO Model

- Advanced path that allows providers to form ACOs that serve Medicare fee-for-service beneficiaries
- Offers greater financial risk and reward, as well as more flexibility, than the MSSP's Tracks 1 and 2
- Features of the Pioneer ACO Model were included in the Medicare Shared Savings Program's new Track 3

9 Participants

Medicare Shared Savings Program

- Enables providers to form ACOs that serve Medicare fee-for-service beneficiaries
- Establishes financial accountability for the quality, cost of care for an attributed population of at least 5,000 Medicare beneficiaries
- Offers three tracks with different levels of financial risk, bonus opportunity, and flexibility in program design

434 Participants

Next Generation ACO Model

- Gives advanced population health managers higher levels of risk and reward than the MSSP and the Pioneer ACO Model
- Offers two shared or full risk arrangements with shared savings/loss rates between 80% and 100%
- Contains three different payment models for 2016, with capitation becoming a fourth option in 2017

20 Participants

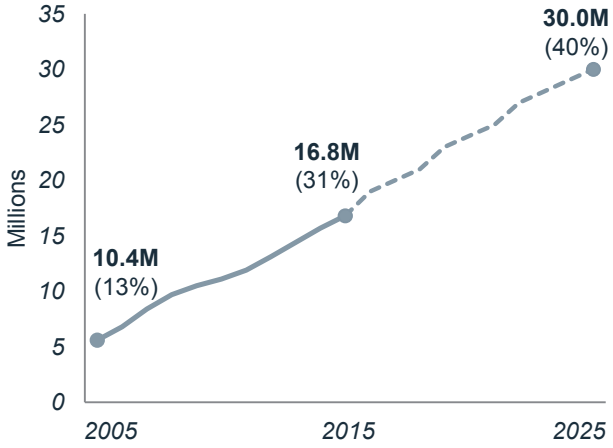
Source: CMS, "New Hospitals and Health Care Providers Join Successful, Cutting-Edge Federal Initiative that Cuts Costs and Puts Patients at the Center of Their Care," January 11, 2016, available at: www.cms.gov; Becker's Hospital Review, "River Health ACO drops out of Next Generation program," February 12, 2016, available at: www.beckershospitalreview.com; Health Care Advisory Board interviews and analysis.

Medicare Advantage Continues to Grow

Penetration Varies by Geography

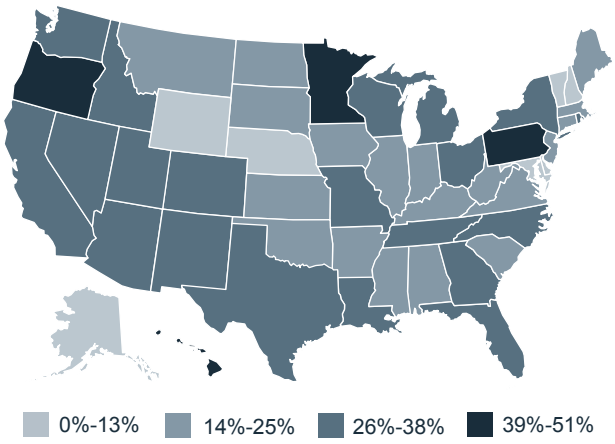
MA Enrollment to Nearly Double by 2025

Total Enrollment and Percentage of Total Medicare Population



MA Penetration Varies by State

Total MA Enrollment as a Percent of Total Medicare Population



22% of newly eligible beneficiaries chose MA in 2011

39 states currently have provider-led plans in their markets

69% of provider-led plans offer MA coverage options

Source: KFF, Medicare Advantage 2015 Spotlight: Enrollment Market Update," June 30, 2015; KFF, "Medicare Advantage Fact Sheet," May 1, 2014, available at: www.kff.org; CBO, "March 2015 Medicare Baseline," March 9, 2015, available at: www.cbo.gov; KFF, "Medicare Advantage Enrollees as a Percent of Total Medicare Population," 2014, available at: www.kff.org; Mark Farrah & Associates, "Medicare Advantage Tops 17 Million Members", March 27, 2015, available at: www.markfarrah.com; Jacobson G et al., "At Least Half of New Medicare Advantage Enrollees Had Switched from Traditional Medicare During 2006-11," Health Affairs, January 2015, available at www.healthaffairs.org; McKinsey & Co., "Provider-Led Health Plans: The Next Frontier—Or the 1990s All Over Again?", January 2015, available at: healthcare.mckinsey.com; Health Care Advisory Board interviews and analysis.

Provider Interest Fueling MA Growth

Ability to Customize Contracts, Maintain Narrow Network Key Differentiators

Attractive Elements of MA Contracts

Greater Control Over the Network
64% if beneficiaries choose HMO plans, offering improved utilization management and network control

Fewer Patient Identification Issues
Providers can target patients who are enrolled in the plan with lower levels of churn than in MSSP

Greater Opportunity to Tailor Risk
Carrier contracts can be structured to include varying levels of provider payment risk and quality incentives

Customized Cost Target Development
Providers can determine the cost target as part of negotiations with the plan, perhaps using the MLR

White Paper: Why a Successful Population Health Strategy Must Include Medicare Advantage

Highlights attractive elements of MA and offers strategies to incorporate it into population health strategy

70% of new MA plans approved since 2008 are provider-sponsored

18% of MA enrollees chose a provider-sponsored MA plan in 2014 (about 2.8M enrollees)

91% of MA plans receiving 5-stars in 2013 were provider-sponsored

Source: Gutman J, "Tide of Rising Provider MA-Plan Sponsorship is Likely to Continue," AIS Health, February 19, 2015, available at: www.aishealth.com; Kaiser Family Foundation, "Medicare Advantage Fact Sheet," May 1, 2014, available at: www.kff.org; Health Care Advisory Board interviews and analysis.

CMS Charting a Path Toward Greater Risk

CJR, Track 3, and Next Gen ACO Filling Out the Continuum

Continuum of Medicare Risk Models

Pay-for-Performance	Bundled Payments	Shared Savings	Shared Risk	Full Risk
• Hospital VBP Program • Hospital Readmissions Reduction Program • HAC Reduction Program • Merit-Based Incentive Payment System	• Bundled Payments for Care Improvement Initiative (BPCI) • Comprehensive Care for Joint Replacement (CJR) Model	• MSSP Track 1 (50% sharing)	• MSSP Track 2 (60% sharing) • MSSP Track 3 (up to 75% sharing) • Next Generation ACO Model (80-85% shared savings option)	• Next Generation ACO Model (full risk option) • Medicare Advantage (provider-sponsored)

Increasing Financial Risk

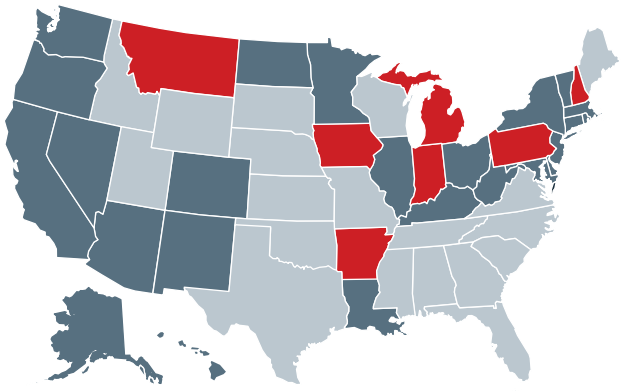
Source: Health Care Advisory Board interviews and analysis.

Future of Medicaid Expansion Less Clear

Benefit of Expansion Clear for Hospitals, But Opposition Remains

31 States and DC Have Approved Expansion[1]

As of January 2016



11.7M

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

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

27% vs. 8%

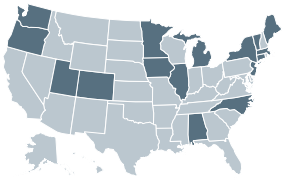
Growth in Medicaid, CHIP enrollment in expansion vs. non-expansion states, July-Sept. 2013 to Feb. 2015

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; Fausset R and Goodnough A, "Louisiana's New Governor Signs an Order to Expand Medicaid," *New York Times*, January 12, 2016; 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 Frequently Turning to Risk, Too

Providers Expanding Care Management Infrastructure to New Populations



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

Oregon Coordinated Care Organizations	**Colorado** Regional Care Collaborative Organizations	**Minnesota** Integrated Health Partnerships
• 16 organizations accountable for 90% of Medicaid and dual-eligibles • 22% reduction in per-capita ED use rate, 56% increase in medical home enrollment since 2011	• Seven regional organizations that convene provider networks around PCMHs • Uses a hybrid of several payment strategies to shift to value	• 15 delivery systems participating in Medicaid ACO program • Shared savings in year one; shared risk in following years
↓	↓	↓
On track to generate 2% PMPY[1] savings	Generated $29M-$33M in net savings, 2014	Generated $61.5M in savings, 2014

1) 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: 2014 Performance Report," June 24, 2015, available at: www.oregon.gov; Minnesota Department of Human Services, "Integrated Health Partnerships: Partnerships save $76 million in Medicaid costs," 2015, available at: www.dhs.state.mn.us; Health Care Advisory Board interviews and analysis.

Employer Health Cost Growth Slowing, but Enough?

Pressure Mounting, Even if "Cadillac" Tax Delayed

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

Outlook for Employer-Sponsored Coverage Less Clear

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

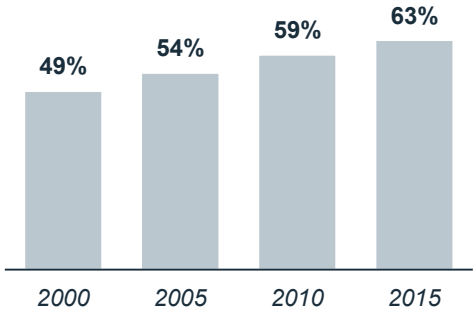
1) High Deductible Health Plan.

Source: Health Care Advisory Board interviews and analysis.

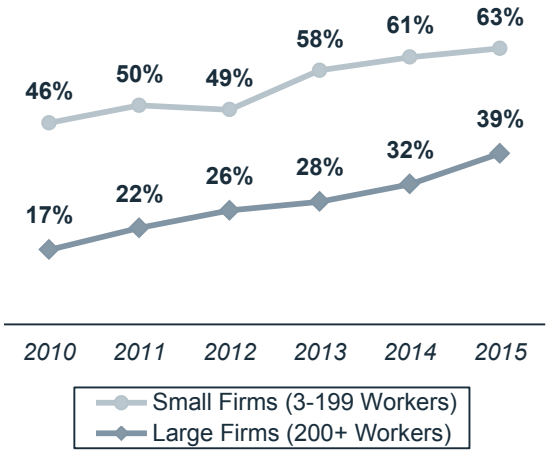
Employers Bearing the Risk

But Looking to Increase Consumer Accountability

Percentage of Covered Workers in Self-Funded Plans



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



26% of small employers'[1] brokers have discussed the possibility of self-insurance with them

1) 3 to 50 FTEs.

Source: Gabel JR et al., "Small Employer Perspectives On The Affordable Care Act's Premiums, SHOP Exchanges, And Self-Insurance," *Health Affairs*, 32(11): 2032-39; Kaiser Family Foundation/Health Research & Educational Trust, "Employer Health Benefits 2015 Annual Survey," September 2015, available at: www.kff.org; 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

Established in Oregon, 2014

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

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

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

Health Plans Gaining Even More Concentration

57% Average market share of largest insurer per state, 2013

43% Estimated percentage of insured Americans that would be covered by the "Big 3" plans post-mergers[2]

1) Employer-Sponsored Insurance.
2) Anthem/Cigna, UnitedHealth Group, and Aetna/Humana.

Source: Kaiser Family Foundation, "Individual Insurance Market Competition," 2013; Smith J and Medalia C, "Health Insurance Coverage in the United States: 2014," U.S. Department of Commerce's Economics and Statistics Administration, September 2015, available at: www.census.gov; AIS, "Health Plan Facts, Trends and Data: 2015-2016," 2015; 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."

Director 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

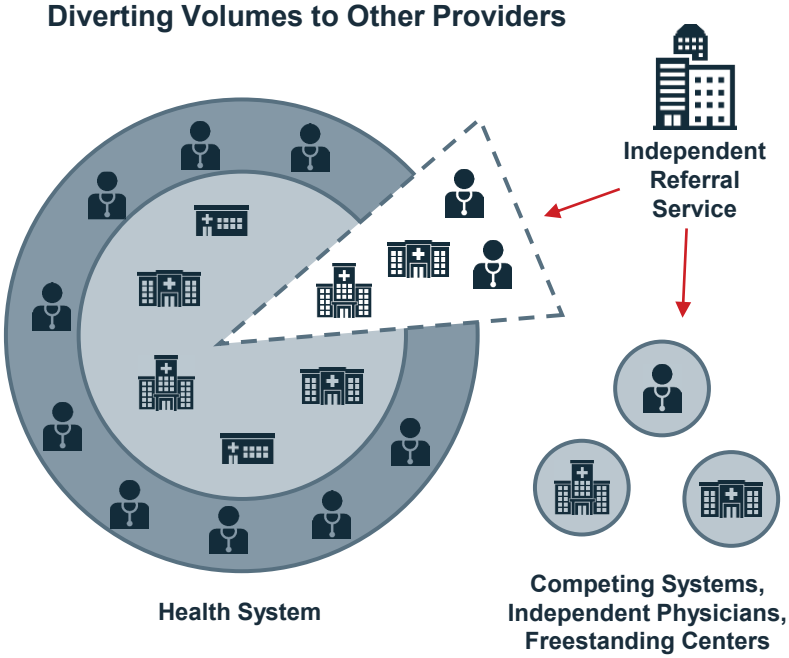
- Single health system may not be high-quality across all clinical areas
- Innovators cherry-picking facilities based on quality and cost efficiency with specific procedures (e.g. heart surgery)

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.

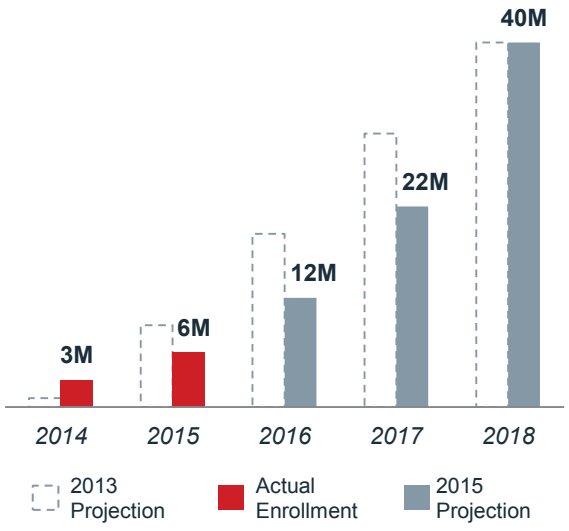
Source: Health Care Advisory Board interviews and analysis.

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% *(800k→1.2M)* Enrollment growth for Towers Watson's exchange solutions, 2015

500% *(220k→1M)* Enrollment growth for Mercer's exchange solutions, 2015

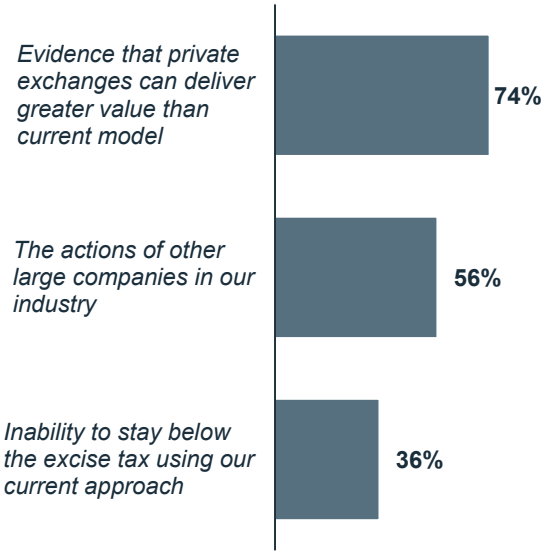
Source: Accenture, "Private Health Insurance Exchange Enrollment Doubled from 2014 to 2015," April 7, 2015, available at: www.accenture.com; Towers Watson, "Enrollment in Health Benefits Through Towers Watson's Exchange Solutions Expected to Reach About 1.2 Million in 2015," March 19, 2015, available 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

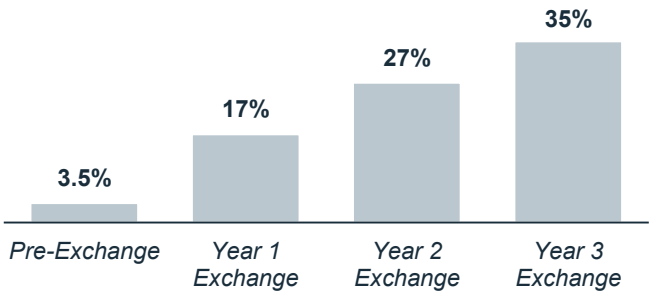
Facilitating Shift to Defined Contribution, Encouraging HDHP Uptake

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

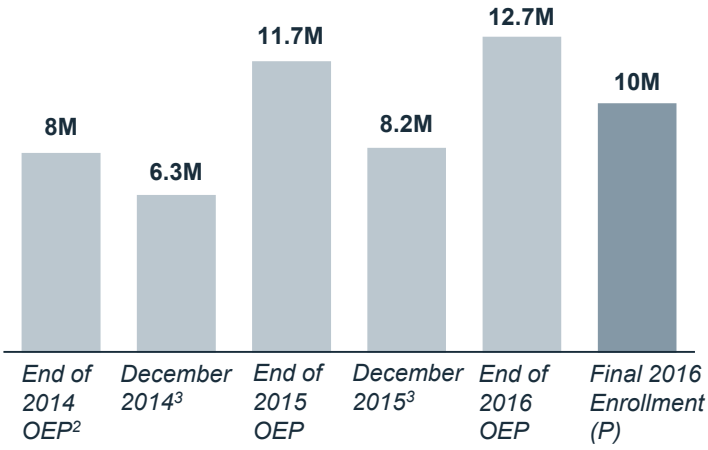
Source: Health Care Advisory Board interviews and analysis.

Public Exchange Safety Net Still Developing

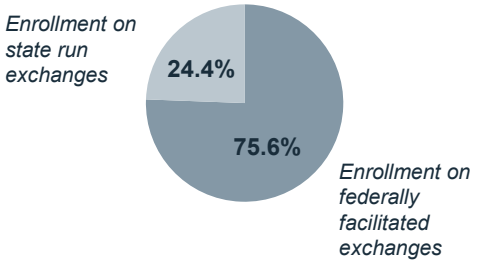
Third Round of Open Enrollment Complete

Exchange Enrollment Results and Projections

Plan Selections in the Marketplaces, 2014-2016



Federal Exchanges Driving Enrollment, 2016



Similar Enrollment of "Young Invincibles"

2.7M

2016 federal exchange enrollees aged 18-34 (compared to 2.5M in 2015)

1) Health and Human Services.
2) Open Enrollment Period.
3) Drop-off due to individuals not paying premiums or voluntarily dropping coverage.

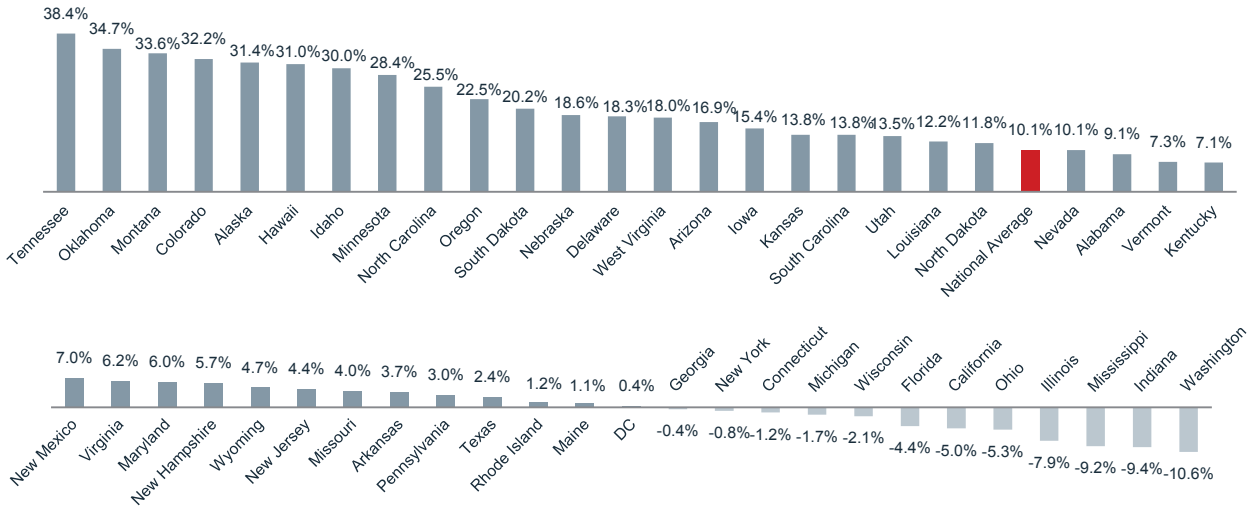
Source: HHS, "Health Insurance Marketplace Open Enrollment Snapshot – Week 13," February 4, 2016; HHS, "Health Insurance Marketplace Open Enrollment Snapshot – Week 7," December 22, 2015; HHS, "Health Insurance Marketplace 2015 Open Enrollment Period: December Enrollment Report," Dec. 30, 2014; HHS, "Health Insurance Marketplace 2015 Open Enrollment Period: March Enrollment Report," March 10, 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; 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; Kaiser Family Foundation, "Total Marketplace Enrollment and Financial Assistance," June 30, 2015; Pradhan R, "White House Lowballs Obamacare Target in an Election Year," Politico, October 15, 2015; Health Care Advisory Board interviews and analysis.

In Year Three, Premium Adjustments Abound

Competitive Marketplace Driving Premium Changes

Percentage Changes in Benchmark Silver Plan Premiums

2015 – 2016[1]



1) Data based on premium changes from major cities within each state where complete rates were available for all insurers; no data were available for Massachusetts.

Source: Kaiser Family Foundation, "Analysis of 2016 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," October 27, 2015; Health Care Advisory Board interviews and analysis.

As Experience Grows, Insurers' Strategies Evolving

Major Players Debating How—and If—to Compete

UnitedHealth Group Potentially Exiting Public Exchanges

UnitedHealth Group®

- Covers 550K exchange beneficiaries in 34 markets
- Lowered Q4 2015 earnings projections by $425M, citing exchange product performance

> "The Company is evaluating the viability of the insurance exchange product segment and will determine during the first half of 2016 to what extent it can continue to serve the public exchange markets in 2017."

For Some, Doubts Creeping In…

"Blue Cross Blue Shield Texas Dropping Individual PPO Plan"

"More Than Half of ACA Co-ops Now Out of Insurance Marketplaces"

"Feds Short Insurers $2.5 Billion on Exchange Plan Losses"

…But Others Sensing Opportunity

"Number of Obamacare Insurers to Rise by 25% in 2015"

1) Consumer Operated and Oriented Plan.

Source: UnitedHealth Group, "UnitedHealth Group Provides 2015 Earnings Update, Initial 2016 View," November 19, 2015; Goldstein A, "More Than Half of ACA Co-ops Now Out of Insurance Marketplaces," *Washington Post*, November 3, 2015, available at: www.washingtonpost.com; Herman B, "Feds Short Insurers $2.5 Billion on Exchange Plan Losses," *Modern Healthcare*, October 1, 2015, available at: www.modernhealthcare.com; Mangan D, "Number of Obamacare Insurers to Rise by 25% in 2015," CNBC, September 23, 2014, available at: www.cnbc.com; Health Care Advisory Board interviews and analysis.

Exchanges a More Fluid Marketplace Than Expected

Shoppers' Primary Motivation: Avoid Premium Increases

Switching Rates Higher Than Expected

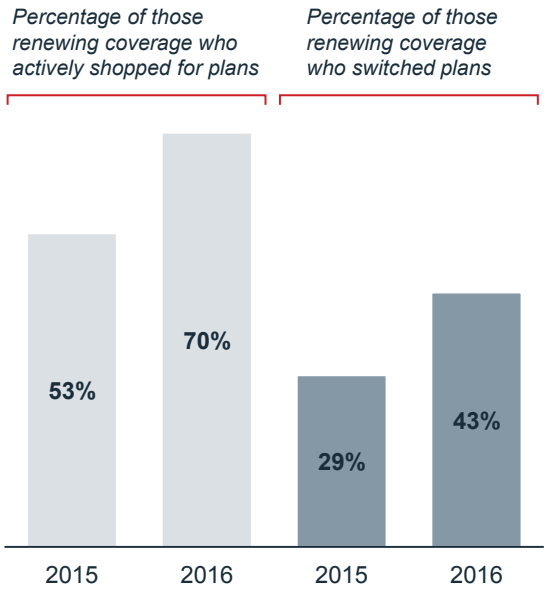
12%
Average annual switching among active employees with FEHBP[1] coverage

43%
Returning federal exchange enrollees changing plans in 2016

Premium Increases the Primary Motivator

55%
Switchers who cited rise in monthly premiums as among top three reasons for switching

Active Health Plan Shopping on the Rise



1) Federal Employee Health Benefits Plan.

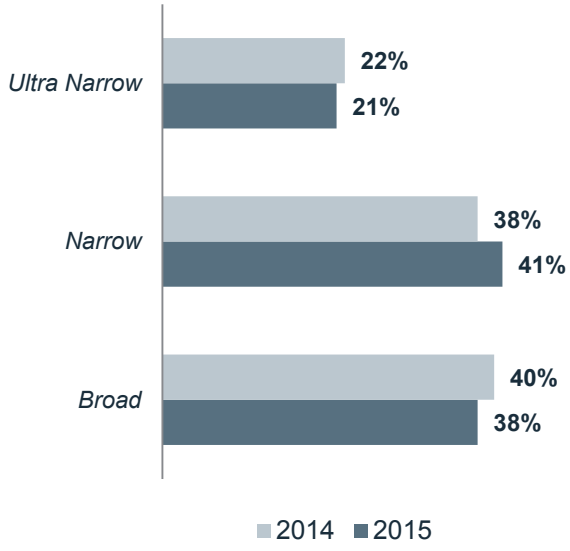
Source: HHS, "Health Insurance Marketplace Open Enrollment Snapshot – Week 13," February 4, 2016;The Advisory Board Company Daily Briefing, "More than 1 Million ACA Enrollees Changed Their Health Plans This Year," March 2, 2015, available at: www.advisory.com; McKinsey & Co., 2015 OEP: Insight into Consumer 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.

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



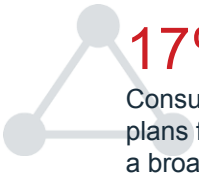
Narrow Network Premium Advantages Increasing Over Time

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.

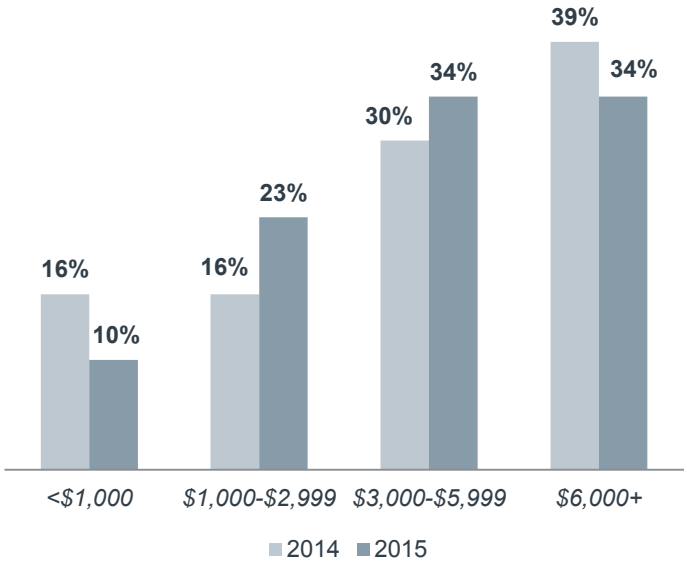
Trading Low Premiums for High Deductibles

Average Public Exchange Deductibles by Tier, 2016

	2016	2015
Bronze:	$5,731	$5,181
Silver:	$3,117	$2,927
Gold:	$1,165	$1,198
Platinum:	$233	$243

2015 Enrollees Favor Higher Deductibles

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



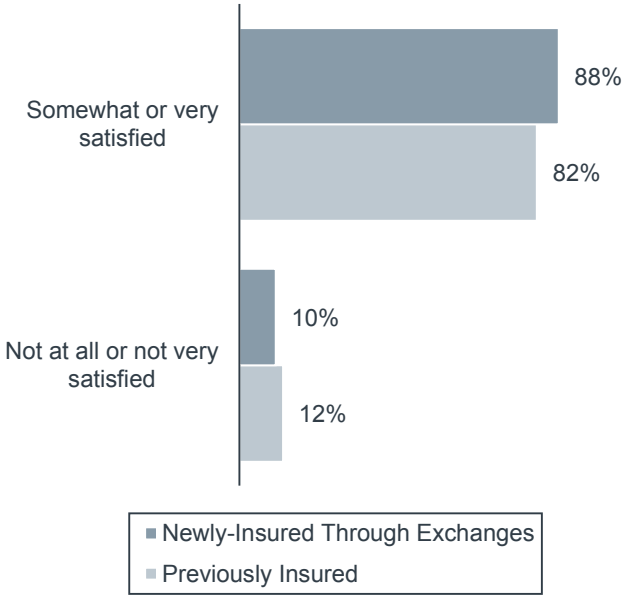
Source: HealthPocket.com, "2016 Affordable Care Act Market Brings Higher Average Premiums for Unsubsidized," November 11, 2015, available at: www.healthpocket.com; eHealth, "Health Insurance Price Index Report for the 2015 Open Enrollment Period," March 2015, available at: www.news.ehealthinsurance.com; 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

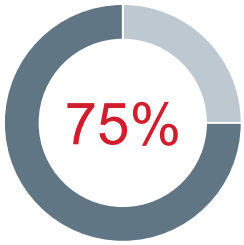
Exchange Enrollees Generally as Happy as Others with Health Coverage…

Ratings of Health Care Coverage Quality, 2015

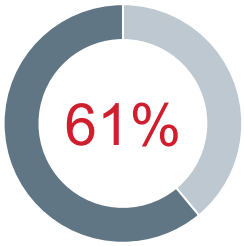


…And Particularly Satisfied with the Cost of Their Coverage

Ratings of Health Care Coverage Cost, 2014



Percentage of newly insured individuals satisfied with cost of health care



Percentage of all insured individuals satisfied with cost of health care

Source: Commonwealth Fund, "Americans' Experiences with Marketplace and Medicaid Coverage: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March-May 2015," June 2015, available at: www.commonwealthfund.org; 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

Consumer Responses Generally Dangerous for Provider Economics

1 Forgo Care?

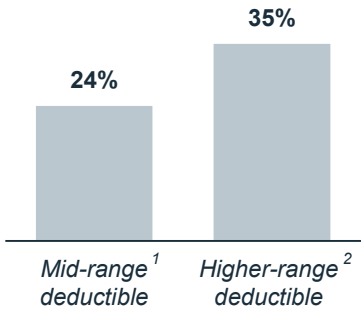
Spending Reductions Following Implementation of High-Deductible Health Plans

25% Reduction in physician office spending

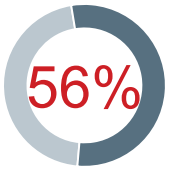
18% Reduction in ED spending

2 Fail to Pay?

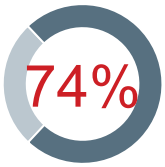
Households Without Enough Liquid Assets to Pay Deductibles



3 Shop Carefully?



Consumers searching for price information before getting care



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

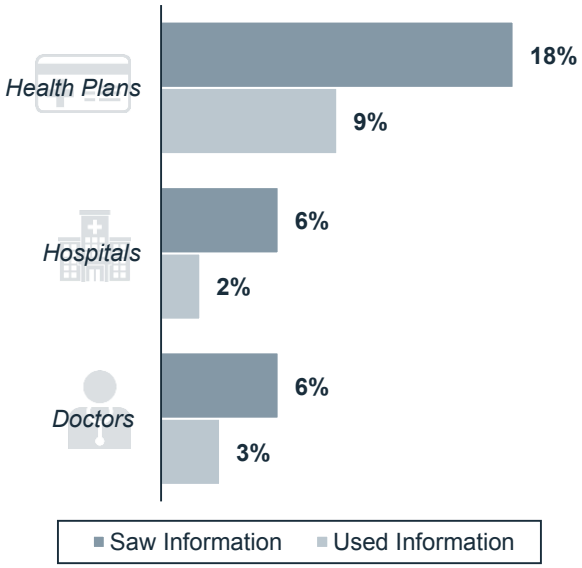
1) $1,200 Single; $2,400 Family.
2) $2,500 Single; $5,000 Family.

Source: Brot-Goldberg Z et al., "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics," The National Bureau of Economic Research, October 2015, available at: http://www.nber.org; 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

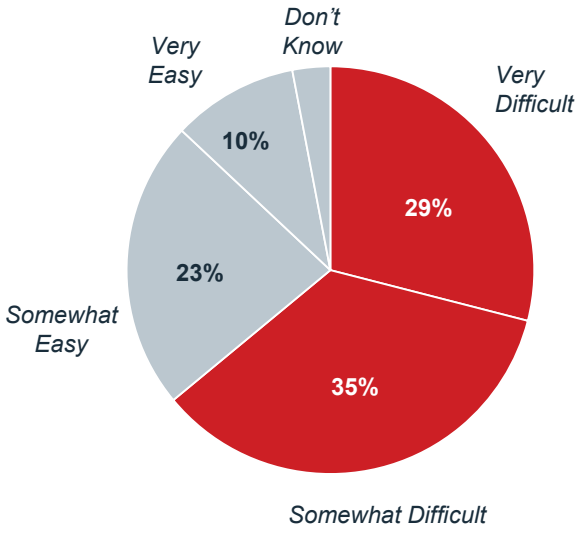
Few Consumers Have Actually Seen or Used Price Information

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

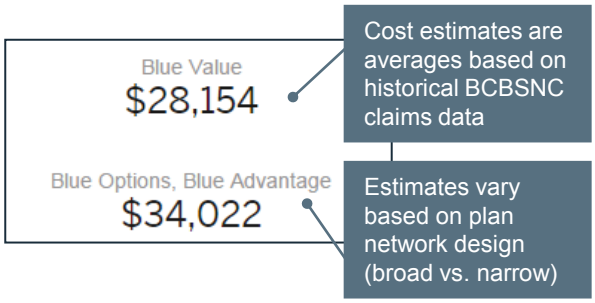


Source: Kaiser Family Foundation, "Kaiser Health Tracking Poll: April 2015," April 21, 2015, available at: www.kff.org; Health Care Advisory Board interviews and analysis.

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

aetna
ASSURANT
guroo
UnitedHealthcare
Humana

Case in Brief: BCBS North Carolina

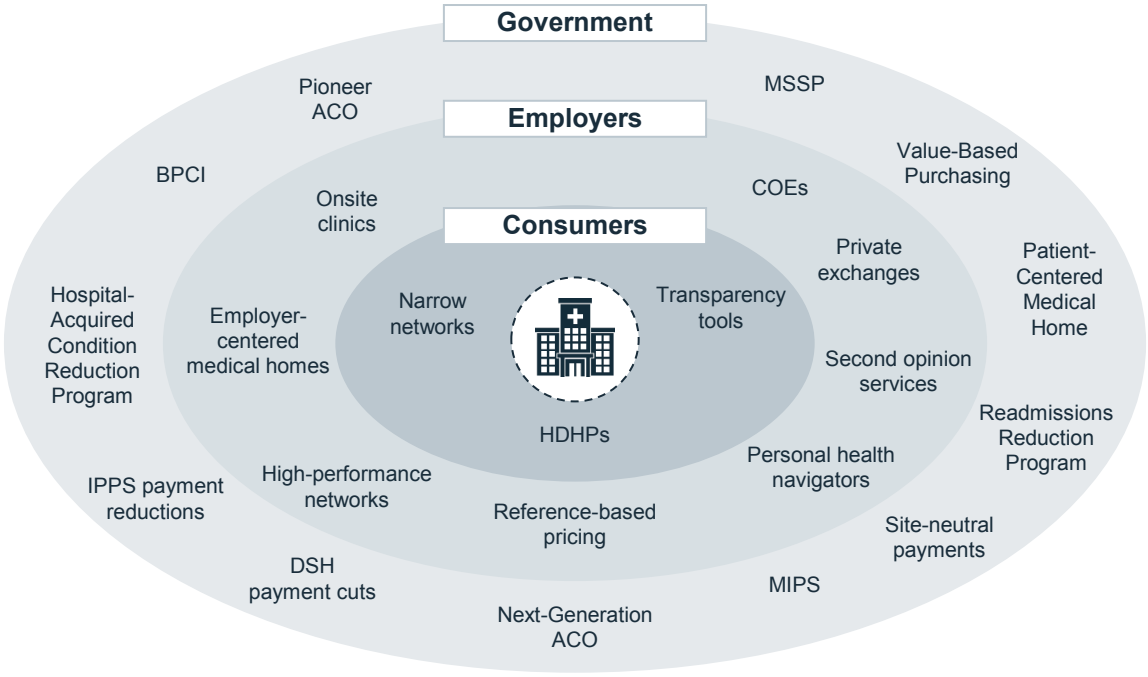
- Not-for-profit health insurance company based in Chapel Hill, North Carolina
- In January 2015, released new pricing transparency tool to general public

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.

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 Betting on Wholesale Value

- Purchasers prefer integrated, comprehensive solutions
- Health systems win market share at organizational level through narrow networks, tiering
- Providers bear much of risk for total cost of care

2 Unbundling the Health System

- Purchasers prefer best-in-class point solutions; care coordination possibly outsourced to third parties
- Health systems win market share at service line or patient level
- Purchasers continue to bear risk for total cost of care

Source: Health Care Advisory Board interviews and analysis.

Resolving the Tension

Health Systems Must Respond to Both Integration and Unbundling

Health System Strategy 2020

Integrate the Delivery System

Providers cannot ignore the demands of their largest payer; hospitals and health systems must pursue integration to prepare for the inevitability of Medicare risk

Convert Integration into Competitive Advantage

Providers cannot forfeit lucrative commercial business; hospitals and health systems must derive benefits from integration to deliver the value that employers and consumers demand

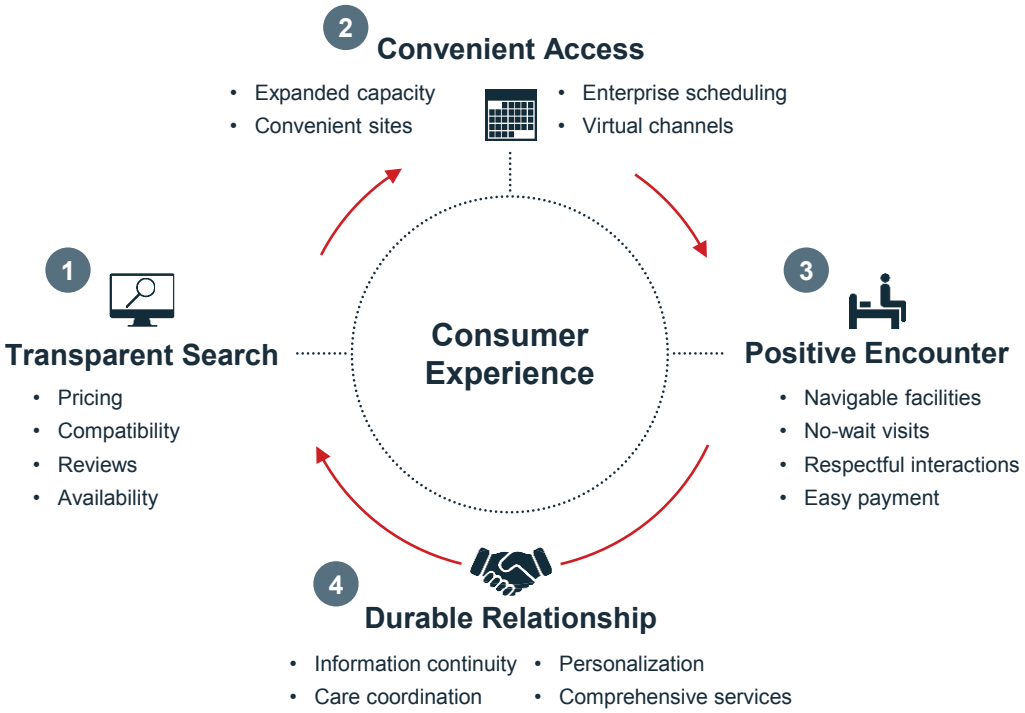
Key Implications for Leaders

1. Embrace operating company model to unlock the potential value of integration
2. Accelerate transition to risk to capture ROI on care management
3. Reduce cost structure to enable pricing flexibility
4. Improve episode efficiency to compete for unbundled volumes
5. Deliver exceptional consumer experience to build durable patient relationships

Source: Health Care Advisory Board interviews and analysis.

Harness Experience to Secure Patient Loyalty

Aspiring Toward Durable, Enduring Relationships



Source: Health Care Advisory Board interviews and analysis.

Proving Our Value

Providers Must Demonstrate Affordability and Desirability

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.

The Advisory Board Company | Health Care Advisory Board

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