The Coming Retail Revolution

Insurance in Transition, Patients at Risk, and the Redefinition of American Health Care
Health Care Advisory Board

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The Coming Retail Revolution
Insurance in Transition, Patients at Risk, and the Redefinition of American Health Care

Road Map
1. A Crumbling Cross-Subsidy
2. The Coming Retail Revolution
3. Welcome to the Renewals Business
An Industry Built on a House of Cards?

“Cord Cutters” and “Cord Nevers” Giving Up Broad Networks


Paying for More Than You Use

“This is the battle hymn of the cord cutter: You are paying too much for television, and you aren’t watching most of what you’re paying for.” Farhad Manjoo, The New York Times

6.5%
U.S. Households With Internet But No Cable, 2013

18.1%
U.S. Adults Age 18-34 With Netflix or Hulu But No Cable, 2013

Our Existing Business Model

Staying Afloat Through Cross-Subsidization

Traditional Hospital Cross-Subsidy

- Commercial Insurance
  - Above-cost pricing
  - Robust fee-for-service volume growth

- Public Payers
  - Steady price growth
  - Only one component of our total business

149%
Hospital Payment-to-Cost Ratio, Private Payer, 2012

86%
Hospital Payment-to-Cost Ratio, Medicare, 2012

A Strategy Dependent on Well-Worn Channels

Roles of Payers, Providers, Patients Traditionally Stable

Assumptions Underlying Provider Growth Strategy

Entrenched Payer
- Maintain broad provider networks
- Pass excess cost growth on to employers through brokers

Established Provider
- Expect steady public-payer, commercial price growth
- In-network for most plans

Price-Insulated Patient
- Open access to broad provider network
- Seek care with little concern for out-of-pocket payment

Impending Collapse of the Cross Subsidy

Three Trends Threatening the Traditional Provider Business Model

1. Medicare Payment Innovation
   - New risk-based payment models
   - Growth of Medicare Advantage

2. Market-Based Medicaid Reform
   - Growth of Medicaid Managed Care
   - Commercialization through “Private Option”

3. Increased Commercial Market Competition
   - New dynamic individual market
   - New channels for competition in group market
Trend #1: Medicare Payment Innovation

Growing a Wave of Medicare Beneficiaries
Becoming a Bigger Part of Our Core Business

Projected Number of Medicare Beneficiaries

<table>
<thead>
<tr>
<th>Millions of Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
</tr>
<tr>
<td>54.0M</td>
</tr>
<tr>
<td>2015</td>
</tr>
<tr>
<td>55.6M</td>
</tr>
<tr>
<td>2016</td>
</tr>
<tr>
<td>57.3M</td>
</tr>
<tr>
<td>2017</td>
</tr>
<tr>
<td>59.0M</td>
</tr>
<tr>
<td>2018</td>
</tr>
<tr>
<td>60.7M</td>
</tr>
<tr>
<td>2019</td>
</tr>
<tr>
<td>62.5M</td>
</tr>
<tr>
<td>2020</td>
</tr>
<tr>
<td>64.3M</td>
</tr>
</tbody>
</table>

Average Inpatient Case Mix

By Volume

n = 785 Hospitals

<table>
<thead>
<tr>
<th>Year</th>
<th>Self-Pay</th>
<th>Commercial</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>6%</td>
<td>33%</td>
<td>19%</td>
</tr>
<tr>
<td>2022</td>
<td>2%</td>
<td>25%</td>
<td>58%</td>
</tr>
</tbody>
</table>


Medicare Payment Innovation Becoming the Norm

Public-Payer Reimbursement Already a Prime Target

Medicare Payment Cuts Becoming the Norm

ACA’s Medicare Fee-for-Service Payment Cuts

<table>
<thead>
<tr>
<th>Year</th>
<th>Reductions to Annual Payment Rate Increases</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>($4B)</td>
</tr>
<tr>
<td>2014</td>
<td>($14B)</td>
</tr>
<tr>
<td>2015</td>
<td>($21B)</td>
</tr>
<tr>
<td>2016</td>
<td>($25B)</td>
</tr>
<tr>
<td>2017</td>
<td>($32B)</td>
</tr>
<tr>
<td>2018</td>
<td>($42B)</td>
</tr>
<tr>
<td>2019</td>
<td>($53B)</td>
</tr>
<tr>
<td>2020</td>
<td>($64B)</td>
</tr>
<tr>
<td>2021</td>
<td>($75B)</td>
</tr>
<tr>
<td>2022</td>
<td>($86B)</td>
</tr>
</tbody>
</table>

$415B in total fee-for-service cuts, 2013-2022

$260B
Hospital payment rate cuts, 2013-2022

$56B
Reduced Medicare and Medicaid DSH payments, 2013-2022

$151B
Reduced Medicare payments due to sequestration and 2013 budget bill

More Mandatory Risk On the Horizon

**Medicare VBP**1 Program Domain Weights

<table>
<thead>
<tr>
<th></th>
<th>FY 2013</th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Process</td>
<td>70%</td>
<td>45%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
<td>25%</td>
</tr>
<tr>
<td>Outcomes of Care</td>
<td>30%</td>
<td>25%</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>Efficiency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6%

Medicare revenue at risk from mandatory pay-for-performance programs2, FY 2017

More Providers Taking the Hint

**ACO Presence Steadily Extending Nationwide**

<table>
<thead>
<tr>
<th>Total Number of Operating ACOs</th>
<th>January 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 MSSP Cohorts</td>
<td>23</td>
</tr>
<tr>
<td>2013 MSSP Cohort</td>
<td>114</td>
</tr>
<tr>
<td>2014 MSSP Cohort</td>
<td>106</td>
</tr>
<tr>
<td>Private Sector ACOs</td>
<td>240</td>
</tr>
<tr>
<td>Total</td>
<td>606</td>
</tr>
</tbody>
</table>

52%

Portion of US population living in a primary care service area with an ACO

14%

Portion of US population treated by an ACO

5.3M

Medicare FFS beneficiaries treated by an ACO

---

1. Value-Based Purchasing
2. Includes Value-Based Purchasing Program, Hospital Readmissions Reduction Program, and Hospital Acquired Conditions Program.
3. Request for information.


Physician-Led ACOs More Likely to Generate Savings

First-Year Spending Reduction By MSSP¹ ACOs

- 2012 Cohort
- Earned Shared Savings (25%)
- Reduced Spending But Did Not Earn Shared Savings (22%)
- Did Not Reduce Spending (53%)

Percent of MSSP ACOs that Earned Shared Savings by Sponsorship

- 2012 Cohort
- Physician-Led: 29%
- Hospital-Led: 20%

$126M
Shared savings earned by 2012 MSSP ACOs in first year

$147M
Total cost savings by Pioneer ACOs in first year

¹) Medicare Shared Savings Program

Medicare Advantage Growth Unlikely to Abate

Precipitating an Individualization of the Medicare Market

2013 Projections vs. 2010 Projections

- Projected Number of Medicare Advantage Enrollees
- Millions of Enrollees
- 29.5% of Medicare beneficiaries
- 19.0M enrollees
- 10.4M enrollees
- 8.2M enrollees

(1.9%)
Initial proposed 2015 MA¹ payment rate cut

0.4%
Final announced 2015 MA payment rate increase

¹) Medicare Advantage

Trend #2: Market-Based Medicaid Reform

Medicaid Expansion Finds Its Footing

"Red Carpet Effect" Driving Enrollment in Non-Expansion States

State Participation in Medicaid Expansion

March 2014

4.8M
Increase in Medicaid and CHIP enrollment, October 2013 to March 2014

(2.4%) Average decline in projected 10-year hospital margin in states not expanding Medicaid

2.8% Average Medicaid enrollment increase across non-expansion states

Budget Pressures Creating Impetus for Reform

Pushing Risk to Providers and Payers

Three Non-Traditional Models of Medicaid Reform

Full Medicaid Managed Care
E.g., Florida’s Statewide Medicaid Managed Care Program

Provider-Led Care Management
E.g., Oregon’s “Coordinated Care Organizations”

Exchange-Based Privatization
E.g., Arkansas’ “Private Option”

Expansion of Traditional Medicaid

Growing Interest in “Arkansas Model”

Shifting Medicaid Beneficiaries to the Public Exchanges

Arkansas “Private Option” Medicaid Expansion Process

1) Federal poverty line.

Growing Interest in “Arkansas Model”

Shifting Medicaid Beneficiaries to the Public Exchanges

Arkansas “Private Option” Medicaid Expansion Process

1) Federal poverty line.

How Long Can Employer-Sponsored Coverage Last?

“Cadillac Tax” Forcing Pay or Play Decision

Spectrum of Options for Controlling Health Benefits Expense

1) Federal poverty line.

How Long Can Employer-Sponsored Coverage Last?

“Cadillac Tax” Forcing Pay or Play Decision

Spectrum of Options for Controlling Health Benefits Expense

1) Federal poverty line.
Bumpy Rollout Did Not Hurt Future Projections

Public Exchange Enrollment in Qualified Health Plans

<table>
<thead>
<tr>
<th></th>
<th>October to December</th>
<th>January to February</th>
<th>March</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-2014</td>
<td>7.0M (Original CBO Projection)</td>
<td>2.1M</td>
<td>3.8M</td>
<td>8.0M</td>
</tr>
<tr>
<td>2013-2014</td>
<td>2.2M</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Renewed Interest for 2015

“We had a very modest footprint in 2014. We do have a bias to increase that participation in 2015. […] The size of the overall market is positive.”

Gail Boudreaux, EVP UnitedHealth Group

States expecting to see more insurers on their public exchange in 2015

10+

Individuals Gravitating Toward Leaner Plans

Metal Tiers of Plans Chosen on Public Exchanges

<table>
<thead>
<tr>
<th></th>
<th>All Enrollees</th>
<th>Enrollees Without Premium Subsidies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>65%</td>
<td>Gold 5% Platinum 2% Catastrophic 9%</td>
</tr>
<tr>
<td>Silver</td>
<td>20%</td>
<td>Platinum 2% Gold 5% Platinum 12%</td>
</tr>
<tr>
<td>Gold</td>
<td>9%</td>
<td>Silver 25% Bronze 33% Silver 10%</td>
</tr>
</tbody>
</table>

Average Monthly Premiums By Metal Tier

27-Year-Old Before Financial Assistance

<table>
<thead>
<tr>
<th></th>
<th>Catastrophic</th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premiums</td>
<td>$129</td>
<td>$163</td>
<td>$203</td>
<td>$240</td>
</tr>
</tbody>
</table>

Networks Narrowing on the Public Exchanges

Payers Responding to Anticipated Premium Sensitivity

Average Percent of PPO Network Specialists Included in Exchange Plan Networks

Anthem BlueCross BlueShield, 2014

<table>
<thead>
<tr>
<th>OB/GYNs</th>
<th>Orthopedists</th>
<th>Oncologists</th>
<th>Cardiologists</th>
</tr>
</thead>
<tbody>
<tr>
<td>62%</td>
<td>59%</td>
<td>59%</td>
<td>48%</td>
</tr>
</tbody>
</table>

100% PPO Network Breadth

Degree of Hospital Exclusion Across Public Exchange Plans

20 Urban Markets, December 2013

- Broad: 32%
- Narrow: 38%
- Ultra-Narrow: 30%

Excludes 30% of 20 largest hospitals
Excludes 70% of 20 largest hospitals

26% Median premium reduction directly attributable to network narrowing


Growing List of Private Exchange Operators

Each Looking for Best Set of Network Offerings

Confirmed Private Exchange Enrollment

Number of Lives, 2014

- Buck Consultants: 400K
- Aon Hewitt: 600K
- Mercer: 200K
- Towers Watson: 640K
- Confirmed Private Exchange Enrollment: 3.0M

Newest Benefit Consultants to Launch Private Exchanges

- September 2013: National Financial Advisors
- December 2013: AIA Benefits Resource Group
- February 2014: BSwift Inc.
- April 2014: First Niagara Benefits Consulting
- October 2013: The Partners Group

Projected private exchange enrollment, 2018

- 40M


Projected private exchange enrollment, May 2014

- 140+

Private exchange operators, May 2014
Employees Not Regretting Early Choices

Migration of Plan Levels Generally Downward

Changes in Enrollee's Selection of Plans

Aon Active Health Exchange, 2013-2014

- 26% "Bought Down"
- 32% Same Value
- 42% "Bought Up"

2013 (Year 1) 2014 (Year 2)


A Burgeoning Retail Market

Disrupting Traditional Channels of Coverage

Projected Size of the Potential Retail Market

2018

Public Exchange

*Private Option* Medicaid Expansion

Private Exchange

Medicare Exchange

Total Retail Market

- 25M
- 5M
- 40M
- 17M
- 87M

1) Based on number of lives falling into the "Medicaid expansion gap" in non-expansion states.
2) Based on the number of Medicare Advantage enrollees.

Path #2: Hands-On Management

Self-Funding Spreading to Smaller Employers

Spurred By Upcoming Regulatory Changes

Percent of Firms Whose Brokers Had Discussed the Possibility of Self-Insurance

\[ n = 604 \text{ Small Firms} \]

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>74%</td>
<td>26%</td>
</tr>
</tbody>
</table>

ACA Requirements Avoided By Self-Funding

- Modified Community Rating
- Essential Health Benefits
- Guaranteed Issue and Renewability
- Medical Loss Ratio Requirements

**Hands-On Network Management a New Possibility**

Custom Network Builders Offering Local Solutions

IHS¹ “Custom Provider Network” Solution

- Self-funded employer submits list of physicians, hospitals, and ancillary care
- IHS negotiates cost-effective provider agreements using Medicare-based pricing
- IHS continually evaluates network providers to “ensure competitive price contracts”

“Working with the TPA and employer, we replace the ‘one size fits all’ network with a cost-effective customized network created around the needs of your business and your employees.”

Innovative Healthcare Services

**Case in Brief: Innovative Healthcare Services**

- Private company based in Arnold, Maryland that markets software solutions for PPOs, TPAs, providers, and payers
- Provides “Custom Provider Network” solution for self-funded employers to limit the network to selected list of hospitals, physicians, and ancillary care

Source: Innovative Healthcare Services, Inc., Arnold, MD; Health Care Advisory Board interviews and analysis.

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Custom Networks Becoming Widely Available

Exporting Walmart’s Centers of Excellence Program

Two New Employer Coalition Partnerships Forged in 2013

Employers Health Coalition (Canton, Ohio)
- 300+ employer members with employees in all 50 states
- 3M covered lives

Pacific Business Group on Health (San Francisco, California)
- 60 large employer members with employees in all 50 states
- 10M covered lives

“It would be prohibitive for a small employer, with only one or two employees needing surgery a year. When you spread the administrative costs over a number of employers, it becomes more attractive.”

Bruce Sherman
Medical Director, Employers Health Coalition

Case in Brief: Health Design Plus

- Third-party administrator based in Hudson, Ohio that creates Centers of Excellence (COE) programs for self-funded employers
- In 2013, partnered with Employers Health Coalition in Ohio and Pacific Business Group on Health to make COE program available to employer members

Some Providers Leading Network Assembly

Key Components of Partnership

Narrowing of Health Plan Options
Intel reducing number of health plan options from 8 to 4; two remaining plans are narrow networks of PHS1 providers

Shared Accountability
Upside and downside risk for health care spending compared to projected target

Customized Care Offerings
Addition of depression screening into customary provider workflow

Infrastructure for Care Management
Conversion of Intel’s on-site clinic into full service patient-centered medical home

5,400 Covered lives in contract
$8-10M Projected savings through contract, 2013-2017

Case in Brief: Intel Corporation

- Large, multinational employer headquartered in Santa Clara, California
- Entered into narrow-network contract with Presbyterian Healthcare Services, an 8-hospital system in New Mexico, for employees at Rio Rancho plant

Winning Share at Two Points of Sale

Multiple Opportunities To Appeal to Decision-Makers

Decision Processes Involved in Provider Choice

Network Assembly
- Being chosen by payers, employers, exchange operators, custom network builders, and accountable physician entities to be offered as a network option

Network Selection
- Being chosen by individuals during enrollment

Care Decision
- Being chosen by patients at the point of care

1 Secure Enrolled Lives
2 Win Share of Volumes

Capturing New Channels of Growth

Key Decision-Makers in Traditional and New Growth Channels

Secure Enrolled Lives
- Entrenched Payer
- Established Provider

Win Share of Volumes
- Relationship-Based Referring Physician
- Cost-Conscious Referring Physician
- Price-Sensitive Consumer

Traditional Growth Channels
- Custom Network Builder
- Activated Employer
- Vulnerable Payer
- Exchange Operator
- Accountable Physician Entity
- Individual Insurance Shopper

New Growth Channels
No Longer Insulated From Market Forces

Catalyzing a Shift in Network Demands

**Characteristics of a Traditional vs. Retail Market**

<table>
<thead>
<tr>
<th>Traditional Market</th>
<th>Retail Market</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passive employer, price-insulated employee</td>
<td>Activist employer, price-sensitive individual</td>
</tr>
<tr>
<td>Growing number of buyers</td>
<td></td>
</tr>
<tr>
<td>Broad, open networks</td>
<td>Narrow, custom networks</td>
</tr>
<tr>
<td>Proliferation of product options</td>
<td></td>
</tr>
<tr>
<td>Increased transparency</td>
<td>Clear plan comparison on exchange platforms</td>
</tr>
<tr>
<td>Disruptive for employers to change benefit options</td>
<td>Easy for individuals to switch plans annually</td>
</tr>
<tr>
<td>Constant employee premium contribution, low deductibles</td>
<td>Variable individual premium contribution, high deductibles</td>
</tr>
<tr>
<td>Greater consumer cost exposure</td>
<td></td>
</tr>
</tbody>
</table>

Redefining “Value” in Health Care

Delivering Desirable Network Attributes at Low Cost

**Four Imperatives for Health Systems**

- **Low Unit Price**: Radically restructure to accept low unit prices
- **Total Cost Control**: Develop population health model to control cost trend
- **Geographic Reach and Clinical Scope**: Meet minimum network adequacy demands
- **Clinical and Service Quality**: Differentiate to consumers, network assemblers

<table>
<thead>
<tr>
<th>Low Cost</th>
<th>Desirable Network Attributes</th>
</tr>
</thead>
</table>
Redefining “Value” in Health Care

Delivering Desirable Network Attributes at Low Cost

<table>
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<tr>
<th>Four Imperatives for Health Systems</th>
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<tr>
<td>Low Unit Price</td>
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<tr>
<td>Radically restructure to accept low unit prices</td>
</tr>
<tr>
<td>Geographic Reach and Clinical Scope</td>
</tr>
<tr>
<td>Meet minimum network adequacy demands</td>
</tr>
</tbody>
</table>

Low Cost  Desirable Network Attributes

Source: Health Care Advisory Board interviews and analysis.
Low Premiums Shaping More than Network Selection
Care Choices, Network Assembly Dynamics Driven by Premium Pressure

Effects of New Premium Sensitivity

Premium Sensitivity at Point of Coverage

Price Sensitivity at Point of Care

Total Cost Scrutiny in Network Assembly

“Our price is now given by the market. Our business is changing from cost-based pricing to price-based costing.”
Health Plan Executive

Patient Cost-Sharing Continues to Accelerate
Particularly Severe for Out-of-Network Care

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

Single Coverage

Average In- and Out-of-Network Deductibles for Group Plans

n = 1,100 employers

**Cost-Shifting Exacerbated By Exchange Markets**

**Individuals Selecting “Ultra”-High Deductible Plans**

### Annual Deductibles of Individual Plans Offered For ESI and Public Exchanges

<table>
<thead>
<tr>
<th>Deductible Range</th>
<th>ESI</th>
<th>Public Exchanges</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000-$1,999</td>
<td>$1,135</td>
<td>$2,500</td>
</tr>
<tr>
<td>$1,000-$1,999</td>
<td>$2,500</td>
<td>$6,250</td>
</tr>
<tr>
<td>$500-$999</td>
<td>$39%</td>
<td>$30%</td>
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<tr>
<td>&lt; $500</td>
<td>$11%</td>
<td>$13%</td>
</tr>
<tr>
<td>$5,000+</td>
<td>$3%</td>
<td>$5%</td>
</tr>
<tr>
<td>$1,000-$1,999</td>
<td>$13%</td>
<td>$11%</td>
</tr>
<tr>
<td>$2,000-$2,999</td>
<td>$11%</td>
<td>$3%</td>
</tr>
<tr>
<td>$3,000-$5,999</td>
<td>$5%</td>
<td>-</td>
</tr>
<tr>
<td>$6,000+</td>
<td>-</td>
<td>-</td>
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<td>$6,000+</td>
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<tr>
<td>$6,000+</td>
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<tr>
<td>$6,000+</td>
<td>-</td>
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</tr>
</tbody>
</table>

### Cost-Shifting Exacerbated By Exchange Markets

**Annual Deductibles of Individual Plans Selected on eHealth**

- **October 2013 – March 2014**
- **$6,000+**
- **$5,000-6,999**
- **$2,000-2,999**
- **$1,000-1,999**
- **< $500**

**Kicking the Can Down The Road?**

**HDHP Enrollees Have Greater Motivation to Price Shop**

### Consumers Paying More Out-of-Pocket

- **Fall within HDHP deductible**
- **Fall within PPO deductible**

### MRI Price Variation Across Washington, DC

- **$2,183**
- **$730**
- **$411**
- **$900**
- **$1,269**

- **Price-sensitive shoppers will be acutely aware of price variation**
- **MRI prices range from $400 to $2,183**

---

1. Employer-sponsored insurance.
2. Silver plans, medical deductible only.

---

**ESI Public Exchanges**

<table>
<thead>
<tr>
<th>Deductible Range</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000-$1,999</td>
<td>$1,135</td>
<td>$2,500</td>
</tr>
<tr>
<td>$1,000-$1,999</td>
<td>$2,500</td>
<td>$6,250</td>
</tr>
<tr>
<td>$500-$999</td>
<td>$39%</td>
<td>$30%</td>
</tr>
<tr>
<td>&lt; $500</td>
<td>$11%</td>
<td>$13%</td>
</tr>
<tr>
<td>$5,000+</td>
<td>$3%</td>
<td>$5%</td>
</tr>
<tr>
<td>$1,000-$1,999</td>
<td>$13%</td>
<td>$11%</td>
</tr>
<tr>
<td>$2,000-$2,999</td>
<td>$11%</td>
<td>$3%</td>
</tr>
<tr>
<td>$3,000-$5,999</td>
<td>$5%</td>
<td>-</td>
</tr>
<tr>
<td>$6,000+</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

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Betting Big on Price Transparency

Castlight Seeing Tremendous Revenue, Investment Growth

Largest Price Variation Nationally for Lower Back MRI

Widest price variation in US within 170 miles

$2,635

$676

Castlight Reported and Forecast Revenue

Annual Revenue, 2011-2014

Forecast

$40-41M

$1.9M $4.0M $13.0M $8.4M

2011 2012 2013 2014

29 clients implemented in Q1

Case in Brief: Castlight Health

• Health IT company based in San Francisco, California that presents provider cost and quality data to employees

• Completed IPO on March 14, 2014; beat initial share price valuation and first quarter revenue estimates, saw 149% increase in share price on IPO opening day

Beyond Everyday Low Prices

Walmart Quietly Enters Full Primary Care

Walmart Care Clinic Model

Walmart associate or customer visits Care Clinic

Care Clinic staffed by two NPs from QuadMed, an employer onsite clinic provider

NP provides primary care services, refers to external specialists and hospitals

The Largest “Activated Employer” Yet

“As the largest private employer in the U.S., we are committed to finding ways to drive down health care costs for our 1.3 million U.S. associates and the 140 million customers who shop our stores each week.”

Labeed Diab

President of Health and Wellness, Wal-Mart

Visit fee for Walmart associates

$4

Visit fee for Walmart customers

$40
Broadening Our Concept of Cost Advantage

Network Assemblers Looking at More Than Unit Price

Two Provider Strategies to Appeal to Network Assemblers on Cost

<table>
<thead>
<tr>
<th>Low Unit Price</th>
<th>Total Cost Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Price Cut</td>
<td>$</td>
</tr>
<tr>
<td>Improve efficiency to offer lower fee schedule</td>
<td>Trend Control</td>
</tr>
<tr>
<td>Implement care management to control cost growth trend</td>
<td></td>
</tr>
</tbody>
</table>

Degree of Cost Control

---

Creating Cost-Conscious PCPs

CareFirst PCMH Total Cost Incentive Model

<table>
<thead>
<tr>
<th>Risk-adjusted PMPM¹ Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMPM Cost Target</td>
</tr>
<tr>
<td>Actual PMPM Cost</td>
</tr>
</tbody>
</table>

“Virtual panel” of 10-15 PCPs

Baseline | Year 1 | Year 2

---

Case in Brief: CareFirst BlueCross BlueShield

- Not-for-profit health services company serving 3.4 million members in Maryland, D.C., and northern Virginia
- In 2011, launched PCMH program providing opportunities for virtual panels of 10-15 PCPs to earn bonuses based on quality and total cost metrics
- Provides PCPs with color-coded rankings of specialists based on risk-adjusted PMPM costs

- Percent of eligible PCPs participating in PCMH program
- Average pay increase for PCPs receiving bonuses

1. Per member per month

---

Steering Care to Most Efficient Specialists

Total Cost Transparency Key to Referral Changes

Specialists Color-Coded By Total Cost

- PCP Virtual Panels
- Employed Specialist A (Red)
- Employed Specialist B (Yellow)
- Independent Specialist C (Green)
- Hospital A
- Hospital B

Difference in risk-adjusted PMPM cost between top- and bottom-quartile PCPs: 27%

Percent of panels earning bonuses, 2012: 66%

Savings from PCMH program, 2012: $98M

“We’re seeing that [the data] changes the patterns. Now there’s a general hubbub among the panels to see what their choices are, and what it costs them.”

Chet Burrell
President & CEO
CareFirst BlueCross BlueShield

Discerning When Not to Operate

The Value of a Second Opinion

Percentage of referred patients who do not undergo surgery: 30-50%

Large Employers and Hospitals Participating in Centers of Excellence Programs

October 2013

- Walmart
  In 2013, expanded Centers of Excellence program to cover cardiac, spine, and hip/knee replacement surgery

- Pepsi Co.
  In 2011, offered employees free cardiac and complex joint replacement surgery at Johns Hopkins Medicine

- Lowe’s
  In 2010, offered employees free heart surgery at Cleveland Clinic

Making the Case for Care Management Capabilities

Assuring Employers of Ability to Manage Future Costs

Four Ways to Demonstrate Care Management Capabilities

- **Investment in Data Analytics**
  Shows capability to assess patient risk and pinpoint interventions

- **Clinical and Claims Data Integration**
  Illustrates advantage over traditional health plan

- **Demand for Out-of-Network Claims Data**
  Shows commitment to continuously manage care for attributed population

- **Telehealth Platforms and Programs**
  Demonstrates ability to keep low-acuity cases in most appropriate care site

> “In our market, there is plenty of talk about ‘accountable care’, but we are differentiating with the organizational commitment and the infrastructure investment to sustain a new economic model.”
> 
> **Chief Marketing Officer**
> **Large Health System in the West**

Promising Total Cost Savings to Employers

**Savings Guaranteed Off Of Projected Costs**

Baseline spending projected using three years' historical spending

Employer Health Spending

Guaranteed Savings

Time

**Two Separate Products with Different Payer Partners**

1. **Aetna Whole Health**
   (Aetna)

2. **Blue Priority**
   (Anthem Blue Cross and Blue Shield)

**Roundy’s Supermarkets, Inc.**
was first large employer client

**10%**
Average savings guaranteed to employers over three years

**Case in Brief: Aurora Health Care**

- 15-hospital, not-for-profit health system based in Milwaukee, Wisconsin
- Announced separate narrow network products with Aetna and Anthem Blue Cross and Blue Shield that offer employers guaranteed savings over three years

Source: Health Care Advisory Board interviews and analysis.
Redefining “Value” in Health Care
Delivering Desirable Network Attributes at Low Cost

Four Imperatives for Health Systems

- **Low Unit Price**
  Radically restructure to accept low unit prices

- **Total Cost Control**
  Develop population health model to control cost trend

- **Geographic Reach and Clinical Scope**
  Meet minimum network adequacy demands

- **Clinical and Service Quality**
  Differentiate to consumers, network assemblers

Low Cost
Desirable Network Attributes

Some States Creating Prescriptive Network Adequacy Requirements

**Washington State Network Adequacy Requirements**
- **Urgent Care**
  - Access to urgent appointments without prior authorization within 48 hours
- **Primary Care**
  - Ratio of PCP within insurer’s service area meets or exceeds average ratio for Washington State
  - 80% of enrollees within 30 miles of a “sufficient number” of PCPs in an urban area (60 miles for rural area)
  - Access to appointment within 10 business days of request
- **Specialty Care**
  - Access to appointment within 15 business days of referral

**State Activity on Regulating Provider Networks**

- **Washington State**
  Passed aggressive network adequacy rules for on- and off-exchange plans; take effect in 2015
- **Nevada**
  Legislators authorized insurance commissioner to regulate provider networks
- **New Hampshire**
  Insurance commissioner held meeting to discuss ways to strengthen network adequacy rules

Combining Geographies to Match Purchaser Footprint

Addressing Individual Limits in Geographic Reach

Partnering to Expand Geographic Reach

Cincinnati-based employers have employees living on both sides of river

Neither Organization Able to Offer Adequate Geographic Coverage Alone

Network in Brief: Healthcare Solutions Network

- Joint venture collaboration between Cincinnati, Ohio-based TriHealth and Edgewood, Kentucky-based St. Elizabeth Healthcare
- Offers health insurers access to a unified, high-quality, low-cost network that covers the entire Tristate region
- Both organizations offering the network to their current employees and dependents

St. Elizabeth Healthcare

Ohio

Kentucky

TriHealth

Full Care Continuum Important for Payer Partners

Four Reasons PinnacleHealth System Selected for Risk-Based Product

- Favorable Pricing Structure
- Comprehensive Clinical Scope
- Broad Provider Geographic Footprint
- 6-12 Months’ Experience Under Performance Incentives

Sample Clinical Services

- Primary Care
- Pediatric Care
- Imaging
- Cardiovascular Care
- Orthopedics
- Physical Therapy and Rehab
- Inpatient Care

Case in Brief: CareConnect Point of Service

- Accountable care narrow network plan for mid-sized employers, created around PinnacleHealth System and offered by Capital BlueCross in central Pennsylvania
- Network is open for specialty and inpatient care but narrowed to PinnacleHealth System’s PCPs for primary care
- Will be expanded to individual market in 2015
Which Would You Choose?

Broad Geographic Reach…

Network in Brief: Crescent Health¹
• National hospital provider with hospital campuses across the country
• Despite broad geography, limited clinical depth at local level

…or Deep Clinical Scope?

Network in Brief: Silica Healthcare¹
• 6-hospital system in the Midwest with employed physician network
• Care sites concentrated in roughly half of single metropolitan area

Geographic and Clinical Demands Intertwined

National and Hyper-Local Competition Reshaping Notions of Sufficiency

Purchasers’ Geographic Preferences for Clinical Services

Balancing an Increasing Demand for Convenience with an Increasing Willingness to Travel

Potential Differentiators

• Alternative access points (e.g. retail, urgent care)
• E-visits, remote monitoring
• Home health

• Disease management, care navigation
• Digestive health
• Women’s midlife
• Sports medicine
• Midwifery

• Transplants
• Neurosurgery
• Complex cardiac (e.g. TAVR)¹
• Clinical trials

Core Services

• Primary care
• Pediatrics
• Imaging
• Ambulatory surgery
• Radiation therapy
• Medical oncology

• Emergency
• Dialysis
• Rehab
• Stroke
• Cardiology
• OB/Gyn

• Routine orthopedics
• SNF
• Pediatric specialty
• Oncology

• Cardiac surgery
• Technology-intensive procedures

¹) Transcatheter Aortic Valve Replacement

Source: Health Care Advisory Board interviews and analysis.
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  - Differentiate to consumers, network assemblers

Low Cost

Desirable Network Attributes

“Quality” Means Different Things for Different People

Quality Demands of Network Assemblers and Individuals

- **Network Assemblers**
  - Facility-level clinical process, outcome measures

- **Individuals**
  - Network-level quality, access, service ratings
  - Actual ease of access, care experience

Network Selection  Care Decision
Custom Network Builders Scrutinizing Performance

Steering Care Toward High-Quality Providers

Imagine Health Provider Evaluation Process

Step 1: Evaluation of Clinical Performance Data
- National Top Quartile Clinical Performance

Step 2: RFP Evaluation of Additional Factors
- Per capita cost of care
- Efficiency of care utilization
- Care experience programs

Case in Brief: Imagine Health

- Company based in Cottonwood Heights, Utah that builds custom, high-performance provider networks for self-funded employers
- Selects participating provider systems using clinical performance data and an RFP process
- Steers volumes to in-network providers through benefit design and employee education

High Performance Yields Market Share Gains

New Platform for Provider Competition

Cost Savings, Quality Gains
- $1,200-2,000 per-employee-per-year savings through price discounts
- 11% reduction in utilization-associated cost per episode
- 26% average improvement in clinical performance measures

Market Share Gains
- Two-fold increase in volumes for in-network providers in first year; three-fold increase by second year
- 20-40% average absolute market share shift for inpatient, outpatient, and physician care

"If [carriers] were to aggressively form a narrow network and actually move volume from one large hospital system to another, they would risk their broad panel products and relationships."
Allison Robbins, CEO, Imagine Health

Product Improvement

Market Reward
- 50% average reduction in out-of-pocket payment
- Referral protocols for onsite clinics
- Robust communication effort for employees
Winning Contracts By Meeting Access Demands

“Winning access is not enough anymore. It has to be as good as the competition,” says one large payer. “We need providers to meet our access requirements, but we also need them to deliver a positive patient experience.”

Providers Must Also Deliver on Ease of Access

1) Pseudonym.

Case in Brief: Providence-Swedish Health Alliance

- Alliance between Providence Health Systems, Swedish Health Services in Seattle, WA
- Awarded contract to serve as Boeing’s narrow ACO network option
- Access paramount in Boeing’s RFP

Access Requirements in Boeing’s RFP

- Same-day PCP appointment for acute conditions
- 3-day PCP appointment for any condition
- 10-day specialist appointment
- Extended hours of operations
- Extended urgent care hours
- Centralized 1-800 number at ACO level with care navigators for triage and advocacy
- Member website
- Phone apps

“A purchaser’s decision is primarily based on the financial offer and the network geography and comprehensiveness – access is critical. But we can’t lose sight of the patient experience. Health care consumers need to see a positive change in how they are able to access healthcare.”

Chris Gorey, Chief Marketing Officer
Providence Health Systems

Paying to Bolster Primary Care Access

“Concierge-Lite” Practice Becomes Employer Offering

One Medical Group Care Model

- Same-day appointment booking online through One Medical mobile app
- Physician email consultations for minor illnesses, ongoing health management
- Coordination of tests, treatments, specialist referrals, hospitalizations
- Telehealth service through Google Hangouts

Employer Subscribers
Adobe, Doximity, Fitbit, NBCUniversal, On Deck Capital, Percolate, Quanticast, Sequoia Benefits, Uber, Wanelo

50% Growth in membership, 2013
40+ Companies subscribing to enterprise offering

Case in Brief: One Medical Group

- 90-physician network practicing in San Francisco, New York, Boston, Chicago, Los Angeles, and Washington, DC
- $149 to $199 annual membership allows access to same-day appointments, email consultations, and online electronic medical records
- Recently debuted enterprise offering for employers to offer as a perk

Online Access Becoming the New Baseline

An Expected Part of the Patient Experience

Portal Features Demanded By Consumers

<table>
<thead>
<tr>
<th>Feature</th>
<th>Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Medical Records</td>
<td>82%</td>
</tr>
<tr>
<td>Online Appointment Booking</td>
<td>77%</td>
</tr>
<tr>
<td>Prescription Refill Requests</td>
<td>76%</td>
</tr>
<tr>
<td>Receiving E-Mail/Text Reminders</td>
<td>74%</td>
</tr>
</tbody>
</table>

Case in Brief: Kaiser Permanente Northern California
- Nation’s largest not-for-profit health plan based in Oakland, California; serves 9 million members nationwide and 3.3 million in Northern California
- Began offering online health services in 1996; fully deployed KP.org patient portal in 2007

KP.org Portal Key Features
- Communicate with physician
- Assign proxy access
- View medical record
- Fill prescriptions
- Schedule appointments
- View lab results

Access Really Matters During Care Decision

Common Top Priority for Primary Care

Top Ten Consumer Preferences by Category

6 OF TOP 10 FEATURES ON ACCESS, CONVENIENCE

Sample Access Attributes
- I can walk in without an appointment, and I’m guaranteed to be seen within 30 minutes
- The clinic is open 24 hours a day, 7 days a week
- The clinic is located near my home

Survey-in-Brief: Primary Care Consumer Choice
- Almost 4,000-consumer, nationwide conjoint survey of preferred attributes of primary care clinics when seeking care for the flu
- Conjoint methodology forces respondents to prioritize preferences, make trade-offs across 56 attributes (18 sub-categories, 5 categories)
## Promising On-Demand Access at Network Selection

### Marketing “A New Kind of Insurance”

**Advertising Free “Televisits” To Potential Enrollees**

- **Talk with our doctors for free**

  Promises response time of less than one hour

- **7 min**
  - Average “televisit” response time

- **$40**
  - Fee paid to physician for each “televisit”

- **10.6K**
  - Public exchange enrollees as of March 2014

### Case in Brief: Oscar

- **Startup insurance company based in New York, New York that sells plans on New York’s public exchange**
- **Offers free “televisits”, free generic drugs, and a limited number of free PCP visits per year**

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## Winning Market Share in a Retail World

### Arena of Competition Expanding Beyond Care Decision

<table>
<thead>
<tr>
<th>Network Assembler</th>
<th>Individual Consumer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost</strong></td>
<td></td>
</tr>
<tr>
<td>Low total per-member cost</td>
<td>Low premium</td>
</tr>
<tr>
<td>Promise of total cost savings</td>
<td>Low employee contribution</td>
</tr>
<tr>
<td><strong>Reach and Scope</strong></td>
<td></td>
</tr>
<tr>
<td>Broad geographic footprint</td>
<td>Inclusion of preferred physicians</td>
</tr>
<tr>
<td>Comprehensive clinical scope</td>
<td>Proximity to access points</td>
</tr>
<tr>
<td><strong>Clinical and Service Quality</strong></td>
<td></td>
</tr>
<tr>
<td>High clinical process, outcomes performance</td>
<td>Great care experience</td>
</tr>
<tr>
<td>Adherence to evidence-based care</td>
<td>On-demand access options</td>
</tr>
<tr>
<td>On-demand access options</td>
<td>Prompt appointment times</td>
</tr>
<tr>
<td>Centralized navigation services</td>
<td>Extended hours</td>
</tr>
<tr>
<td>Prompt appointment times</td>
<td></td>
</tr>
<tr>
<td>Extended hours</td>
<td></td>
</tr>
</tbody>
</table>

### Threshold / Differentiating Factors

- **Expanding Arena of Competition**
Low Total Cost A Difficult Balance to Strike

Long-Term Trend Control Requires Short-Term Investments

The Tension Between Unit Price and Total Cost

**The Bottom Line**

“If you can’t deliver lower cost, you’re out of the running.”

Patrick Carter, MD
Medical Director for Care Coordination and Quality Improvement, Kelsey-Seybold Clinic

**Short-Term Investments**
- IT infrastructure
- Care management staff
- Care coordination programs
- New access points

**Long-Term Payoff**
- Cost trend control
- Improved health outcomes
- Improved patient satisfaction

Higher Immediate Unit Prices
Lower Future Total Cost

Source: Health Care Advisory Board interviews and analysis
Welcome to the Renewals Business

New Imperative to Secure Purchaser Choice Year Over Year

- Annual network selection in fluid insurance market implies consistent reevaluation of network performance
- Clinical interactions represent repeated opportunities to reinforce patient preference through superior experience

The Missing Link for Population Health?

Retail, Population Health Strategies Converge

- Winning at Point of Network Selection
  - Successful Population Health Management
  - Lower Total Cost
  - Lower Premium
  - Network Selection

- Experience
- Engagement
Competing in a Retail Market

Forces Shaping Provider Strategy in the New Health Care Economy

Questions Guiding Future Strategy

1. How can our growth strategies adapt as individual choice of provider networks and care sites becomes increasingly important? How do we need to shift our focus as the arena of competition expands beyond the point of care to network selection and network assembly?

2. How is our brand and service portfolio viewed by network assemblers, purchasers, and consumers? In what ways does our current identity support our growth strategy—and where is it in conflict?

3. What key assets, skills, and competencies are currently missing from our care delivery system? How will we fill these gaps—build, buy, or partner? Which services that we offer today could undermine our future system goals?

4. How can we “productize” and differentiate our care delivery system in the eyes of network assemblers and individual consumers? How will we communicate our cost, quality, and service advantages?

5. Are we prepared for the end of price-extractive growth strategies? How will we reorient our leaders, clinical partners, and capital plan to support a value-based growth ambition?