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What's Ahead on the Trail? – The Economic Forecast for Independent Hospitals

The Next Generation of Medicare Risk, High Deductibles, and Physician Integration

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Road Map

1 A New Turning Point for Health Care Reform

2 Reflecting on the First Era of Health Care Reform

3 Adapting Provider Strategy to New Market Realities

Congratulations, Mr. President

Trump Wins in Stunning Upset

Congress and Executive Branch Now in Republican Control

Image: © 2016, Chip Somodevilla/Getty Images

52/100
Senate Republicans

241/435
House Republicans

Source: Health Care Advisory Board interviews and analysis.

Health Care Tops the Day One Agenda

Trump Takes Aim at ACA with Executive Order on First Day in Office

> "To the maximum extent permitted by law, the (Secretary) and the heads of all other executive departments and agencies (agencies) with authorities and responsibilities under the Act shall exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals…"
>
> *Executive Order*
> *Released by the White House, Office of the Press Secretary, January 20, 2017*

Executive Order Does:

- ✔ Signal Trump administration's commitment to ACA repeal
- ✔ Point to potential for future executive action to weaken ACA[1]

Executive Order Does Not:

- ✖ Immediately repeal any elements of the ACA
- ✖ Provide authority to ignore or alter portions of the ACA that are set in law

1) Possible administrative changes include broadening exemptions to and/or reducing enforcement of the individual and employer mandates, reducing essential health benefits requirements, and granting states greater flexibility in administering Medicaid and/or regulating insurance markets.

Source: Office of the Press Secretary, available at whitehouse.gov, accessed January 23, 2017; Health Care Advisory Board interviews and analysis.

The ACA at a Turning Point?

Two Repeal Options on the Table for Congress

Wholesale Immediate Repeal

A full repeal of the ACA through a congressional vote in both the House and the Senate

Piecemeal Change

Changes to specific components of the ACA; most likely through budget reconciliation which only requires a majority vote in Congress

Key Considerations of Each Approach

Potentially requires filibuster-proof majority in Senate

Must contend with Republican governors in states supporting Medicaid expansion

May have to contend with widespread industry pushback

Complicated by entangled ACA policies

Budget reconciliation options limit repeal to tax-related measures

Requires line-item specific transition planning

Source: Health Care Advisory Board interviews and analysis.

An Ambitious Three-Part Agenda

GOP Outlines Three Phases to Health Care Reform

A Three-Pronged Approach to Repeal and Replace the ACA

1 Budget Reconciliation

Process: Requires simple majority in House and Senate

Proposed Target Areas:

- Repeal ACA taxes, employer and individual mandates
- Replace insurance subsidies with refundable tax credits
- Reform Medicaid financing
- Increase contribution limit of health savings accounts
- Allocate funds for state innovations
- Require continuous coverage insurance incentive

2 Administrative Action

Process: Federal agencies issue regulation through rulemaking

Proposed Target Areas:

- Shorten individual market enrollment period and limit special enrollment
- Loosen restrictions on actuarial value of individual market plans
- Enable state flexibility through waiver process
- Approve state Medicaid eligibility changes (e.g. work requirements, premiums)

3 Additional Legislation

Process: Requires simple majority in House, super-majority in Senate

Proposed Target Areas:

- Allow insurance to be sold across state lines
- Expand use of HSAs
- Allow formation of Association Health Plans
- Remove “essential benefits” requirements
- Reform malpractice regulation
- Streamline FDA processes
- Expand flexibility of state use of federal dollars

Source: The White House, “Three-Pronged Approach to Repeal and Replace Obamacare,” March 13, 2017; Health Care Advisory Board interviews and analysis.

House Passes the American Health Care Act

Reconciliation Bill Would Drastically Cut Spending, Reduce Coverage

Legislation in Brief: American Health Care Act

- Reconciliation bill proposed by House Republicans on March 6th that would repeal or modify many elements of the ACA, while leaving others intact
- Following series of amendments, passed by the House on May 5th
- Bill's major goals are to:
  - Repeal ACA's taxes
  - Reform the individual insurance market
  - Remake the Medicaid financing model

Bill Passes House with Razor-Thin Margin

217-213

Final House vote on AHCA; required 216 votes to pass

CBO's[1] Projected Impact of the AHCA

$150B
Decrease in **federal deficit**

24M
Increase in number of **uninsured**

1) Congressional Budget Office projections as of March 13, 2017; does not include MacArthur and Upton amendments.

Source: House Ways and Means Committee, available at: https://waysandmeans.house.gov/american-health-care-act/; House Energy and Commerce Committee, available at: https://energycommerce.house.gov/news-center/press-releases/energy-and-commerce-republicans-release-legislation-repeal-and-replace; Health Care Advisory Board interviews and analysis.

Heavy Focus on Medicaid, Individual Markets

Key Elements of the American Health Care Act

Repeals ACA Taxes

- Beginning in 2017, eliminates ACA taxes on health plans, medications, HSAs, medical devices, tanning services, investment income, etc.
- Delays implementation of the Cadillac Tax until 2026

Reforms Individual Market

- Eliminates individual mandate as of December 31, 2015
- Requires penalties for not maintaining continuous coverage
- In 2020, replaces subsidies with age-based tax credits

Reforms Medicaid Financing

- Freezes expansion, ends enhanced match after 2020
- Reverses DSH cuts[1], provides funding for safety net providers
- Shifts Medicaid to block grant and/or per capita cap in 2020[2]

MacArthur Amendment Boosts State Flexibility on Key Insurance Market Regulations

Health Status Underwriting

States may allow insurers to charge more based on pre-existing conditions[3,4,5]

Age-Ratio Pricing Bands

States may create pricing bands with age-ratios greater or less than the AHCA's 5:1

Essential Health Benefits

States may define the categories and benefits insurers must provide

1) Restores funding in 2018 in non-expansion states and 2020 in expansion states.
2) Block grant option only available for traditional adult and children populations.
3) Only permitted for individuals who fail to maintain continuous coverage.
4) Contingent on state demonstration of plan to provide additional financial assistance for high-risk individuals.
5) Includes funding to help states support high-risk individuals: $1.7B annually from 2018-2026 plus any unappropriated dollars from Patient and State Stability Fund; Upton amendment provides additional $8B.

Source: House Ways and Means Committee, available at: https://waysandmeans.house.gov/american-health-care-act/; House Energy and Commerce Committee, available at: https://energycommerce.house.gov/news-center/press-releases/energy-and-commerce-republicans-release-legislation-repeal-and-replace; Health Care Advisory Board interviews and analysis.

A More Limited Scope Than Previous Proposals

Notable Components of Past Proposals Left Out of Current Bill

Noteworthy Absences from AHCA

Proposed Bill Does Not Target:

Insurance Market Protections

Dependent eligibility until 26

Payment Reform

Center for Medicare & Medicaid Innovation (i.e., no impact on funding)

Medicare Shared Savings Program

MACRA

Medicare

Medicare payment (i.e., no repeal of ACA payment cuts)

Medicare coverage (i.e., no shift to premium support)

Employer Health Benefits

Tax exclusions for employer-sponsored insurance

Drug Spending

Medicare Part D (i.e., no move to Medicare bidding system)

Restrictions on drug importation

Source: Health Care Advisory Board interviews and analysis.

Far From a Done Deal

Senate Likely to Make Significant Changes

Major Roadblocks Remain in Senate

Ensuring Compliance with Reconciliation Rules

Senate parliamentarian must strike any AHCA provisions that she determines do not meet rules of budget reconciliation[1]

Overcoming Thinner Voting Margin

GOP can only afford to lose 2 votes; potentially gives moderates greater influence and ability to dial back coverage losses

Awaiting Pending CBO Score

Senate must extend voting timeline until CBO scores final, amended bill

Senate Promises Longer Timeline, Signals Prospect for Significant Change

"There will be no artificial deadlines in the Senate. We'll move with a sense of urgency but we won't stop until we think we have it right"

Sen. Lamar Alexander (R-Tenn.)

"Any bill that has been posted less than 24 hours, going to be debated three or four hours, not scored? Needs to be viewed with suspicion."

Sen. Lindsay Graham (R-S.C.)

"The bill that passed out of the House is most likely not going to be the bill that is put in front of the president"

Mick Mulvaney, Director, Office of Management and Budget

1) Provisions may only impact spending, revenues, or the federal debt limit.

Source: Everett, B. and Haberkorn, J., "Senate GOP rejects House Obamacare bill," *Politico*, May 4, 2017; Weaver, A. and Ferrichio, S., "House Obamacare repeal bill faces Senate makeover," *Washington Examiner*, May 4, 2017; Bradner, E., "Trump: GOP health care bill 'guarantees' coverage for pre-existing conditions," *CNN*, May 1, 2017; Health Care Advisory Board interviews and analysis.

Regulatory Agenda Taking Center Stage

Administration Has Considerable Leeway to Impact ACA Implementation

Meet the Key Players

HHS Secretary: Tom Price

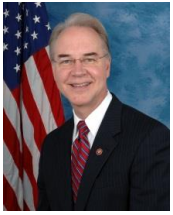

Image: © 2007, District Office of Tom Price

- Six-term Representative from Georgia; retired orthopedic surgeon
- Sponsor of the Empowering Patients First Act
- Confirmed by 52-47 vote

CMS Administrator: Seema Verma

Image: © 2016, Drew Angerer/Getty Images

- National health policy consultant from Indiana
- Helped shape Medicaid expansion in IN, OH, KY, TN
- Confirmed by 55-43 vote

Potential Administrative Actions

- ❑ End cost-sharing reduction payments
- ❑ Delay Cadillac Tax
- ❑ Eliminate, delay, or modify Innovation Center programs (e.g., CJR)
- ❑ Limit special enrollment periods
- ❑ Reduce enforcement of insurance mandates
- ❑ Narrow scope of essential health benefits
- ❑ Allow Medicaid work requirements through 1115 waivers
- ❑ Allow Medicaid premiums, others forms of cost-sharing through 1115 waivers
- ❑ Eliminate contraception requirement

Source: Jackson, D. and Solis, S., "Rep. Tom Price is Trump's pick for Health and Human Services Dept.," *USA Today,* Nov. 29, 2016; "Trump picks Seema Verma to head Centers for Medicare and Medicaid Services," *Politico*, Nov. 29, 2016; Health Care Advisory Board interviews and analysis.

Individual Market Hangs in the Balance

Future of Public Exchanges May Depend on GOP Actions and Inactions

Administration Has a Spectrum of Options for How to Manage Exchanges

Roll Back

- End cost-sharing reduction payments[1]
- Reduce reinsurance payments
- Refuse to settle the risk corridor litigation
- Reduce enforcement of individual mandate[1]
- Eliminate/reduce advertising

Maintain

- Continue to enforce and implement provisions of the ACA related to exchanges (e.g. cost-sharing payments)

Fix

Already Underway[2]:

- Limit special enrollment
- Establish continuous coverage requirement[3]
- Relax actuarial requirements[3]

Other Potential Actions:

- Expand age rating band[4]
- Tweak essential health benefits requirements[4]

1) Would be eliminated by AHCA.
2) Through market stabilization rule finalized on April 13, 2017.
3) Would be enforced by AHCA.
4) Would be implemented by AHCA.

Source: Health Care Advisory Board interviews and analysis.

Medicaid to Remain a Top Priority

Waivers Will Allow Continued Innovation and Experimentation

State Flexibility Through Waivers Likely to Intensify Competing Medicaid Philosophies

Coverage Model

State-Run Entitlement *(Pre-ACA Status Quo)*
Cover low-income/vulnerable as defined on state-by-state basis, so long as certain federal minimum standards are met

Expansive Entitlement *(Democrats' Vision)*
Cover anyone not eligible for Medicare, covered by an employer, and unable to afford individual coverage

Limited Safety Net (*Republicans' Vision)*
Cover truly low-income/vulnerable, provides temporary coverage for unemployed adults (e.g., contingent on work requirements)

Cost Containment Model

Payer-Led Managed Care
Capitate payments to private managed care organizations
e.g., Florida State Medicaid Managed Care

Provider-Led Care Management
Incentivize provider to control utilization, coordinate care
e.g., Oregon's CCOs

Consumer-Driven Health Care
Encourage consumers to be cost-conscious, prioritize high-value care
e.g., Indiana's HIP 2.0

Source: Health Care Advisory Board interviews and analysis.

The Next Era of Health Care Reform

Four Key Principles Guiding GOP Reform Efforts

1 Reduce Federal Entitlement Spending

Focus more aggressively on reducing federal health care spending

2 Devolve Health Policy Control to States

Reduce federal role in health care; provide states more autonomy to make decisions, cut spending

3 Embrace Free Markets and Consumer Choice

Use free-markets to promote private sector competition in payer, provider markets

4 Promote Transparency of Cost and Quality

Mandate greater consumer choice and shopping at the point-of-care and point-of-coverage through improved transparency

Source: Health Care Advisory Board interviews and analysis.

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Hope and Change, Eight Years On

Surely President Obama's Signature Achievement

A Grand Promise for Change

Image: © 2012, Pete Souza

> "The bill I'm signing will set in motion reforms that generations of Americans have fought for and marched for and hungered to see."
>
> *Barack Obama, on the Affordable Care Act, March 23, 2010*

> "This is a big [expletive] deal"
>
> *Joe Biden, on the Affordable Care Act, March 23, 2010*

Source: Solberg S and Pear R, "Obama Signs Health Care Overhaul Bill, With a Flourish," *The New York Times*, March 23, 2010; Health Care Advisory Board interviews and analysis.

Evaluating the ACA Against its Intentions

Major Reform Goals

1 Replace Costly Fee-for-Service Incentive Structures

Chosen Method:
Medicare-led Payment Reform

- FFS cuts
- New payment models
- Intent to catalyze broader commercial market change

2 Improve Health Care Quality

Chosen Method:
Incentives + Transparency

- IT mandates
- Pay-for-Performance programs
- Market-facing transparency

3 Achieve Universal, Affordable Coverage

Chosen Method:
Expansion of Existing System

- Insurance market regulation
- Expanded public coverage
- Market-based exchanges

Obama-era Enabling Legislation

February 17, 2009:
Health Information Technology for Economic and Clinical Health (HITECH) Act

March 23, 2010:
Patient Protection and Affordable Care Act

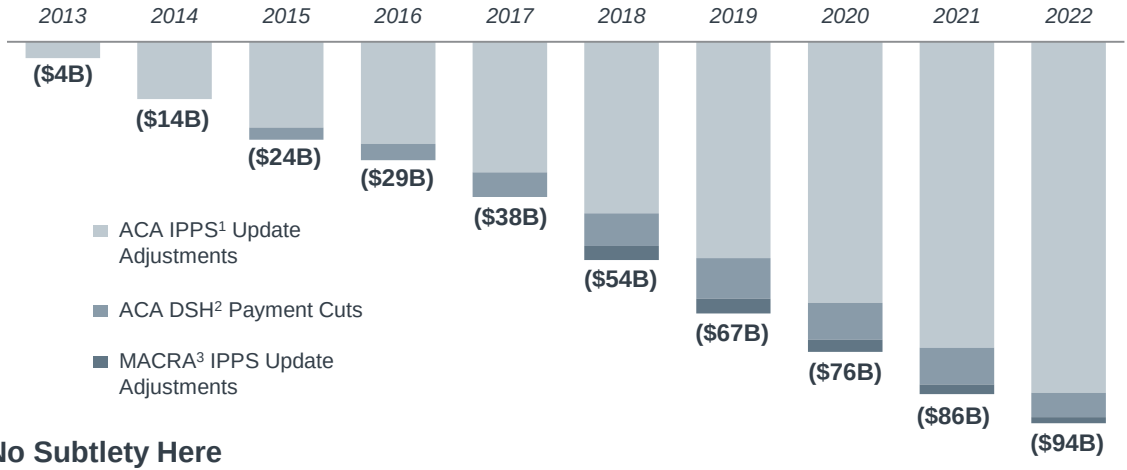
April 16, 2015:
Medicare Access and CHIP Reauthorization Act (MACRA)

Source: Health Care Advisory Board interviews and analysis.

Kicking the Legs Out From Under Fee-for-Service

Policymakers' Intention to Migrate Payment Perfectly Clear

"Productivity" Adjustments and Other Cuts



No Subtlety Here

> "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."

CMS Officials

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

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; 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.

MACRA Rewriting the Rules of Risk

Bipartisan Support at Center of MACRA Rollout

Legislation in Brief: MACRA[1]

- Legislation passed in April 2015 repealing the Sustainable Growth Rate (SGR)
- CMS released final rule in October 2016 stipulating program to be implemented on Jan 1, 2017
- Created two payment tracks:
  - Merit-Based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Model (APM)

Legislation Enjoyed Bipartisan Support

92-8 Senate vote on MACRA

392-37 House vote on MACRA

> "This historic law has been a collaborative effort from the start. We are encouraged by this final rule and CMS's commitment to ongoing collaboration with Congress and the health care community."
>
> Bipartisan Leaders from House Energy and Commerce Committee and Ways and Means Committee

1) Medicare Access and CHIP Reauthorization Act.

Source: CMS, "CY 2016 Physician Fee Schedule Final Rule," Oct 30, 2016, available at: www.federalregister.gov; Health Care Advisory Board interviews and analysis.

A Sweeping Impact Across Providers

Who is Included and Who is Exempt

Included

- Medicare Physician Fee Schedule
- Physicians, PAs[1], NPs[2], Clinical Nurse Specialists, Certified Registered Nurse Anesthetists
- Groups that include any of the above clinicians

Excluded

- Inpatient Prospective Payment System, Outpatient Prospective Payment System (mostly Medicare Part A)
- Clinicians, groups that fall under low volume threshold:
  - $30,000 or less in Medicare charges OR
  - 100 or fewer Medicare patients
- Medicare Part A (i.e., inpatient, outpatient technical hospital payments)

712,000

Estimated number of clinicians affected by MACRA changes in first performance year[3]

> "MACRA is the burning platform for progress in care delivery, just as the ACA was in health care coverage."
>
> *Andy Slavitt, CMS Acting Administrator*

1) Physician Assistant.
2) Nurse Practitioner.
3) CMS estimates between 592,00 and 642,000 clinicians will be required to participate in MIPS in CY 2017, while 70,000 to 120,000 clinicians will participate in APMs in 2017.

Source: Centers for Medicare and Medicaid Services; CMS, "Acting Administrator Slavitt Speech at Datapalooza," May 2016; Health Care Advisory Board interviews and analysis.

Dealing Physicians in on Risk

Greater Payment Updates, Bonuses Depend on Payment Migration

Annual Provider Payment Adjustments

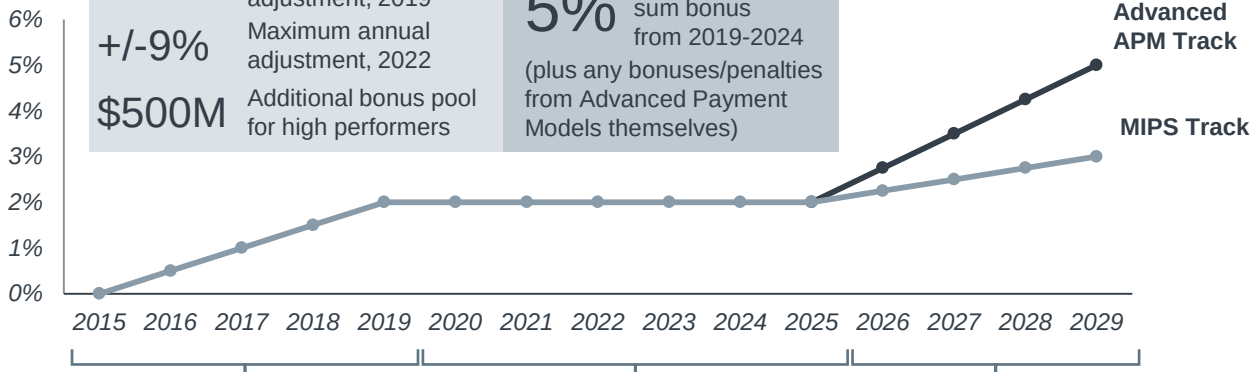
MIPS Bonuses/Penalties

+/-4%	Maximum annual adjustment, 2019
+/-9%	Maximum annual adjustment, 2022
$500M	Additional bonus pool for high performers

APM Bonuses/Penalties

5% Annual lump-sum bonus from 2019-2024

(plus any bonuses/penalties from Advanced Payment Models themselves)



Baseline payment updates[1]:

2015 – 2019:
0.5% annual update (both tracks)

2020 – 2025:
Payment rates frozen (both tracks)

2026 onward:
0.25% annual update (MIPS track)
0.75% annual update (Advanced APM track)

1) Relative to 2015 payment.

Source: The Medicare Access and CHIP Reauthorization Act of 2015; CMS, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, April 25, 2016; Health Care Advisory Board interviews and analysis.

Heavy Bias Toward Downside Risk

Meaningful Provider Exposure Required

APMs

(Affect MIPS payments; do not contribute to Advanced APM track eligibility)

Qualifying Models

Medicare Shared Savings Program Track 1

Bundled Payments for Care Improvement

Medicare Advanced APMs

(Contribute to Advanced APM track eligibility)

Qualifying Models

MSSP Tracks 1+, 2, 3	Comprehensive Primary Care Plus (CPC+)	
Next Generation ACO	Comprehensive ESRD Care Model	
Oncology Care Model Two-Sided Risk	Comprehensive Care for Joint Replacement	Episode Payment Models[1]

Other Advanced APMs

(Contribute to "Other Payer" Advanced APM track eligibility in 2021)

Qualifying Models

Commercial contracts with sufficient downside risk

Medicare Advantage

Requirements for Advanced APM Payment Models:

1. Meet revenue-based standard (average of at least 8% of revenues at-risk for participating APMs) or benchmark-based standard (maximum possible loss must be at least 3% of spending target)
2. EHR use, quality requirements

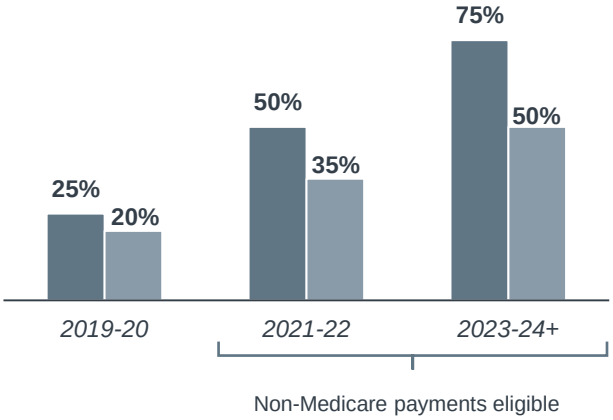
1) Includes the AMI Model, CABG Model, and SHFFT Model, all scheduled to begin on July 1, 2017.

Source: CMS, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, October 14, 2016; Health Care Advisory Board interviews and analysis.

Advanced APM Qualification No Simple Feat

Substantial Share of Payment Must Flow Through Risk-Based Models

Advanced APM Qualification Thresholds



A Long Way to Go

10% - 17%

Physicians currently projected to qualify for Advanced APM track in calendar year 2019

Source: The Medicare Access and CHIP Reauthorization Act of 2015; CMS, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, October 14, 2016; Health Care Advisory Board interviews and analysis.

No Dodging Downside Risk in Many Major Markets

Unavoidable Episodic Price Cuts Expanding in Coming Years

CMS Rapidly Scaling Mandatory Bundled Payment Efforts to New Conditions, Markets

Comprehensive Joint Replacement (CJR)

Covers the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements[1]

$343M
Estimated savings to Medicare over the 5 years of the model

67
Geographic areas (MSAs) selected

Episode Payment Models (EPM)

Includes models for Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG); and Surgical Hip and Femur Fracture Treatment (SHFFT)[2]

$170M
Estimated savings to Medicare over the 5 years of the model

98
Geographic areas (MSAs) selected[3]

Common Characteristics Across Both Bundles

Retrospective Payment

CMS makes FFS payment to providers separately, conducts annual reconciliation process

Comprehensive Episodes

Participating hospitals accountable for all related Part A and B services 90 days post-discharge

Qualifies for APM Track

New HIT requirements in 2018 allow bundles to count toward MACRA APM track

Targets PAC Spend

Aimed at DRGs with a large portion of cost due to variation in PAC utilization

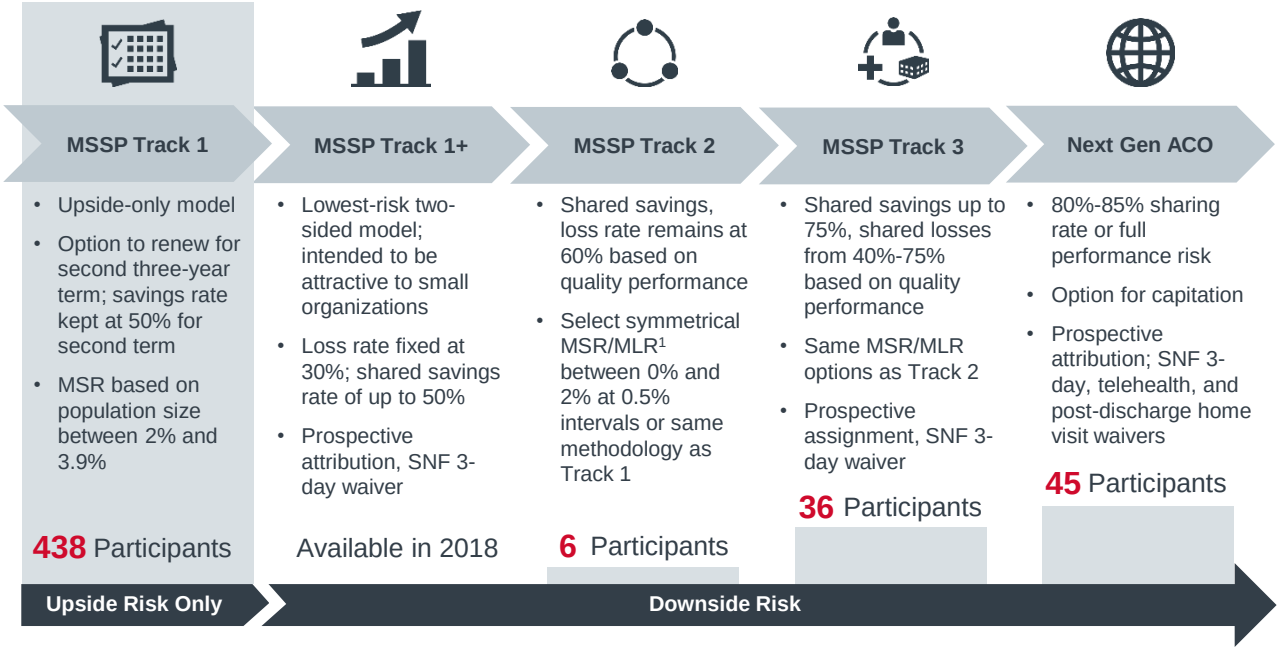
1) MS-DRGs: 469, 470.
2) MS-DRGs: 280-282; 246-251; 231-236; 480-482.
3) Applies to AMI and CABG Models; SHFFT Model to be implemented in 67 CJR markets.

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

Medicare Shared Savings a Slow Transition to Risk

Overwhelming Majority of ACO Participants Still in Shallow Water

Continuum of Medicare Risk Models



1) Minimum savings rate/minimum loss rate.

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; Becker's Hospital Review, "River Health ACO drops out of Next Generation program," February 12, 2016; CMS, "Next Generation Accountable Care Organization Model (NGACO Model)," January 11, 2016; CMS, "Open Door Forum: Next Generation ACO Model", March 17, 2015; Becker's Hospital Review, "River Health ACO drops out of Next Generation program," February 12, 2016; Health Care Advisory Board interviews and analysis.

ACO Program Expands Amidst Mixed Results

CMS Bullish Despite Lack of Net Program Savings

CMS Highlights Positive Headlines

Total ACOs which earned savings grew by 4% from 2014 to 2015

Medicare saved $55M more in 2015 than 2014 for total savings of $466M

A Closer Look at ACO Program Generates Concern

Insufficient Savings

CMS owes **$214M** more in 2015 bonus payments than was generated in savings

Select Few Drive Savings

$458M out of 2015's net MSSP savings attributable to just 10 ACOs

Benchmarking Suspect

Providers question accuracy of CMS's benchmarking methodology

Experience Matters

Of ACOs that began in 2012, 42% generated savings above their MSR[1], 5% higher than those that started in 2013, 20% higher than those that began in 2014 or 2015

1) Minimum savings rate.

Source: Centers for Medicare and Medicaid Services; Muhlestein, D et al. "Medicare Accountable Care Organization Results for 2015: the Journey to Better Quality and Lower Costs Continues," *Health Affairs*, Sep. 2016; Health Care Advisory Board interviews and analysis.

CMS Expanding Downside Risk Options

Next Generation ACO Model Provides Higher Rewards, New Waivers

Financial Model

Prospective benchmark using one-year baseline historical spending, trended forward using regional factors

Risk arrangements include 80%-85% sharing rate or full performance risk

Payment mechanisms include traditional FFS (with optional infrastructure payments), population-based payments, or capitation

Engagement Tools

Beneficiary alignment through prospective attribution and voluntary beneficiary alignment

Coordinated care reward up to $50 annually for beneficiaries receiving at least 50% of care from ACO

Benefit enhancements through payment and program waivers for telehealth, home health, and SNF admission

45 Participants in the Next Generation ACO model

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

Medicare Advantage Growth Continues

Potential Advantages of MA over MSSP

Control Over Network, Benefit Design
64% of beneficiaries choose HMO plans, offering improved utilization management, network control, benefits customization

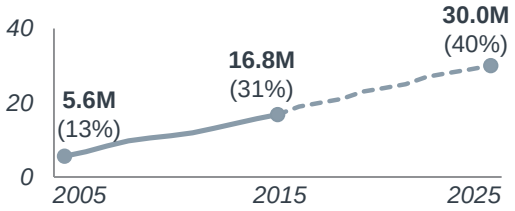
Opportunity to Tailor Risk
Contracts can be structured to include varying levels of provider payment risk, quality incentives

Straightforward Patient Identification
List of enrollees simpler, more immediate than MSSP attribution models

Full Upside Potential
Control of whole premium dollar creates clear incentive for total cost management

MA Enrollment to Nearly Double by 2025

Total Enrollment and Percentage of Total Medicare Population



Provider Sponsorship of Medicare Advantage Plans, 2016

37%
Of existing MA plans[1]

58%
Of new MA plans[1]

1) MA plan refers to a Medicare Advantage Organization, the entity that has contracted with CMS to sell Medicare Advantage products.

Source: Jacobson, G et al., "What's In and What's Out? Medicare Advantage Market Entries and Exits for 2016," *Kaiser Family Foundation*, October 13. 2015; Carpenter, E, "Nearly 60 Percent of New Medicare Advantage Plans Are Sponsored By Healthcare Providers," *Avalere,* January 2016, Health Care Advisory Board interviews and analysis.

M&A on the Rise

Eroding Prices, Demands for Integration Driving Many to Seek Scale

Two Priorities of Transition to Value Drive Toward Consolidation

Erosion of FFS Foundation

- Cuts in provider reimbursement
- Transformational shift of incentive structures
- Reporting, infrastructure burdens

Hospital and Physician Consolidation

Push Toward Integration

- Physician alignment/ care coordination
- IT/operational efficiency

Merger and Acquisition Activity

102
Hospital M&A deals, 2015

$8.7B
Value of hospital M&A transactions, 2015

94,000
Increase in vertically-consolidated[1] physicians, 2007-2013

1) Acquired or employed directly by hospitals or health systems.

Source: PricewaterhouseCooper, "Analysis and trends in US health services activity 2015 and 2016 outlook," February 2016, available at: www.pwc.com; Becker's Hospital Review, "6 forecasts for healthcare M&A in 2016," February 24, 2016, available at: www.beckershospitalreview.com; GAO, "Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform," December 18, 2015, available at: http://www.gao.gov/products/GAO-16-189; Health Care Advisory Board interviews and analysis.

Regulators Challenging Recent Consolidation

But FTC's Assertiveness Under New Administration Uncertain

FTC Delivering on Earlier Threats

FEDERAL TRADE COMMISSION
PROTECTING AMERICA'S CONSUMERS

Recent Mergers Challenged

- Advocate and NorthShore
- Penn State Hershey and PinnacleHealth

Cited Concerns

- Higher prices
- Fewer incentives to boost quality, serve consumers

Source: Schencker L, "FTC challenges Northshore, Advocate mega-merger in Illinois," December 18, 2015; Schorsch K, "FTC expert warns of $45 million cost increase at Advocate-NorthShore hearing," *Modern Healthcare*, April 14, 2016, Schencker L, "FTC moves to block Penn State Hershey merger with PinnacleHealth," December 8, 2015; Federal Trade Commission, "FTC Challenges Proposed Merger of Two West Virginia Hospitals," November 6, 2015, available at: www.ftc.gov; https://www.ftc.gov/news-events/press-releases/2015/11/ftc-challenges-proposed-merger-two-west-virginia-hospitals; Health Care Advisory Board interviews and analysis.

Replacing Fee-for-Service: A Stalled Transition

1

Replace Costly Fee-for-Service Incentive Structures

Chosen Method:
Medicare-led Payment Reform

- FFS Cuts
- New payment models
- Intent to catalyze broader commercial market change

Overall Grade:

MACRA:

- Large, limited-time incentive to adopt downside risk models
- Wide range of potential impact in complex MIPS track

Grade: ?

Bundled Payments

- Noticeable cost savings to Medicare
- Significant provider interest
- Limited scalability without further mandates

Grade: B

ACO Programs

- Very little cost savings in aggregate so far
- Constant battle to retain participants while also accelerating migration to downside risk
- Unattractiveness of ACO programs driving many to Medicare Advantage

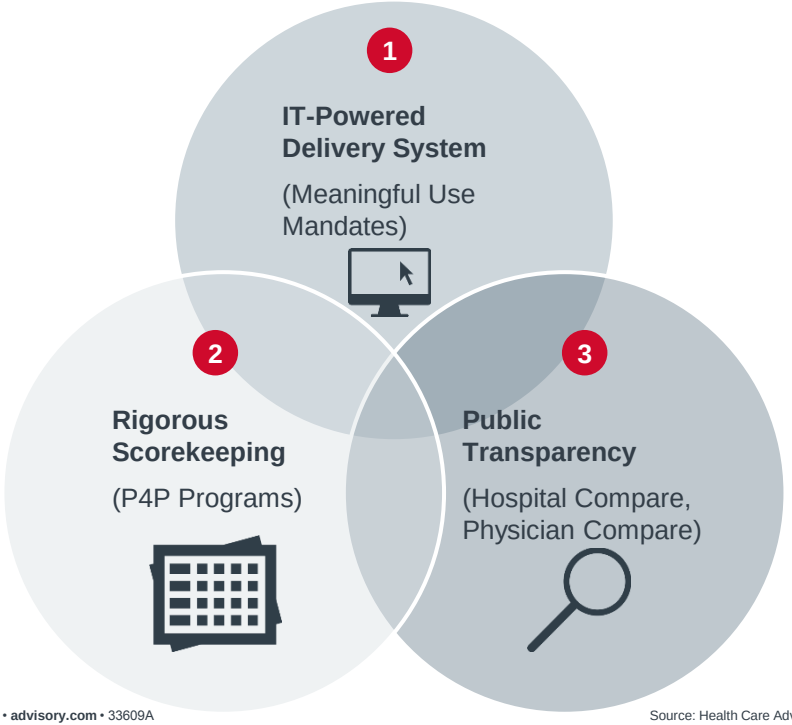
Grade: C-

Source: Health Care Advisory Board interviews and analysis.

Metrics and Transparency Drive Quality Approach

Emphasis on Collection, Reporting of Performance Data

Information-Focused Approach to Quality Improvement



Source: Health Care Advisory Board interviews and analysis.

Laying the Groundwork for Performance Management

Today's Focus on Connectivity; Quality Impact Still Over the Horizon

> "Over the past five years, we've more than doubled the adoption of electronic health records for physicians. So that means they can track what's going on better and make fewer mistakes."
>
> *Barack Obama, 2013*

Current State

Stage I (2011-2014): Data Capture, Sharing

- Basic EHR functionality
- Connect to public health
- Privacy and security protections

Stage II (2014-2017): Advanced Clinical Processes

- Care coordination
- Patient engagement
- Data-driven quality improvement

Stage III (2018-Onward): Improved Outcomes

- Data improves delivery, outcomes
- Enhanced access, care continuity
- Evidence-based medicine, team-based care/case management
- Patient-centered care coordination
- Engaged, self-managed patients
- Disease registries, population health management

Source: Health Care IT Advisor, "Meaningful Use 'Crash Course,'" 2016, available at: www.advisory.com; Health Care Advisory Board interviews and analysis.

Multiple Initiatives to Measure and Incent Quality

Rapid Proliferation of Metrics

Hospital Readmissions Reduction Program

- Reimbursement penalty based on excessive 30-day readmission rates
- 1%-3% hospital inpatient Medicare payments at risk

Hospital Value-Based Purchasing Program

- Pay-for-performance based on success against variety of value measures
- Only 792 hospitals out of 3,087 received bonuses in 2015

Hospital-Acquired Conditions Program

- Reimbursement penalty targeted hospitals with higher rates of HACs
- 25% of hospitals mandated to face penalty

Other CMS Programs

Source: CMS, "CMS Measures Inventory," accessed December 8, 2016, available at: www.cms.gov; Health Care Advisory Board interviews and analysis.

Having a Measurable Impact on Quality

CMS Estimates of ACA's Impact on Quality

2010-2014

2.1M Fewer hospital-acquired conditions

$20B Health care cost reductions

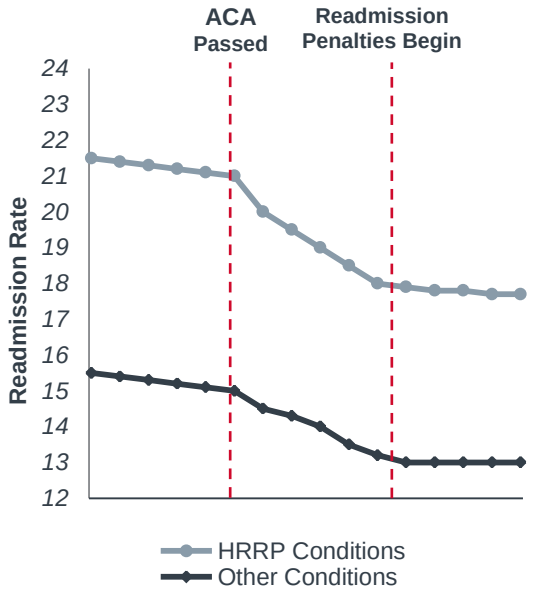
87K Patient lives saved

"These results represent real people who did not die or suffer infections or harm in the hospital."

Patrick Conway, MD
Chief Medical Officer, CMS

Hospital Readmissions

HRRP[1] and all-causes, 2010-2014



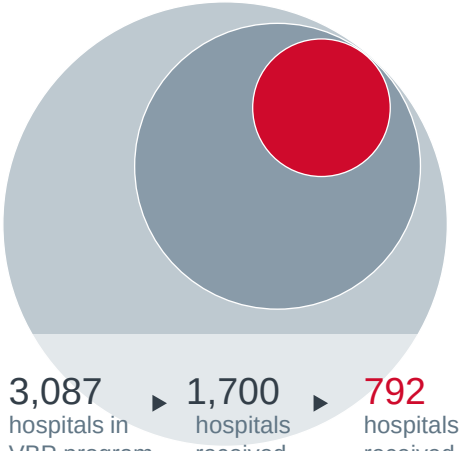
1) Hospital Readmissions Reduction Program; focuses on heart attack, heart failure, pneumonia, COPD, and elective hip r knee replacement.

Source: Commins J, "HACs Plummet 17%, Save $20B Under Obamacare," *HealthLeaders Media*, December 2, 2015; Boccuti C. and Casillas, G., "Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program," *The Kaiser Family Foundation*, Sep. 30, 2016; Health Care Advisory Board interviews and analysis.

Creating Winners and Losers

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.

MIPS Rewriting Rules for Physician Quality, Payment

MIPS Score Components

1

Quality (Replaces PQRS, VBPM):

- Over 200 measures to choose from, 80% of which are tailored to specialists
- Providers only required to report 6 measures

2

Cost:

- Continuation of two measures from VBPM: Total per capita costs for all attributed beneficiaries and MSPB
- Adds episode-based measures for specialists
- Seeks to include Part D costs
- No reporting requirement

3

Improvement Activities:

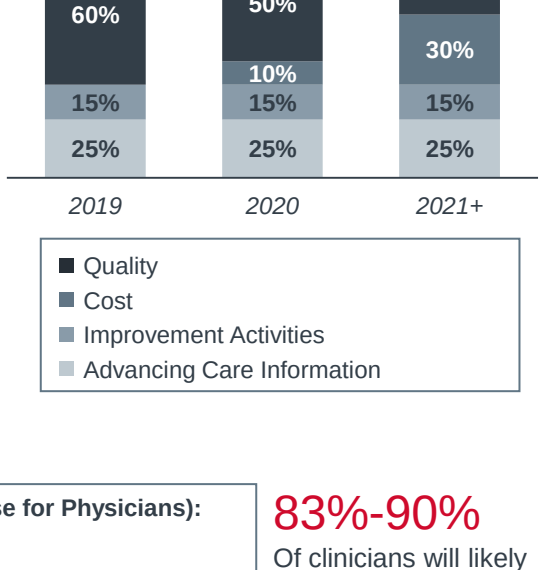
- Over 90 activities to choose from; some activities weighted higher than others
- Clinicians in non-eligible APMs and NCQA Patient-Centered Medical Homes receive favorable scoring

4

Advancing Care Information (Replaces Meaningful Use for Physicians):

- Applies to all clinicians[1]
- Clinicians given opportunity to report as group or individual
- No longer requires all-or-nothing EHR measurement; requires reporting of 5 measures

Weights of MIPS Score Components



83%-90%

Of clinicians will likely fall into MIPS track in CY 2017

1) Physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such clinicians.

Source CMS, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, October 14, 2016; Health Care Advisory Board interviews and analysis.

Allowing Clinicians to Ease into MIPS

CMS Setting Up 2017 as a Transition Year With "Pick Your Pace" Options

2017 MIPS Reporting Structure

1. Clinicians report all MIPS-required data for at least 90 days and are eligible to receive the full bonus
2. Clinicians report more than one measure for at least 90 days and are eligible to receive a smaller bonus[1]
3. Clinicians report any data for any period of time and receive no positive or negative adjustment in payment

Physician Leaders Praise CMS Reporting Flexibility

"[These] actions help **give physicians a fair shot** in the first year of MACRA implementation. This is the flexibility that physicians were seeking all along."

Dr. Andrew Gurman, President of the AMA

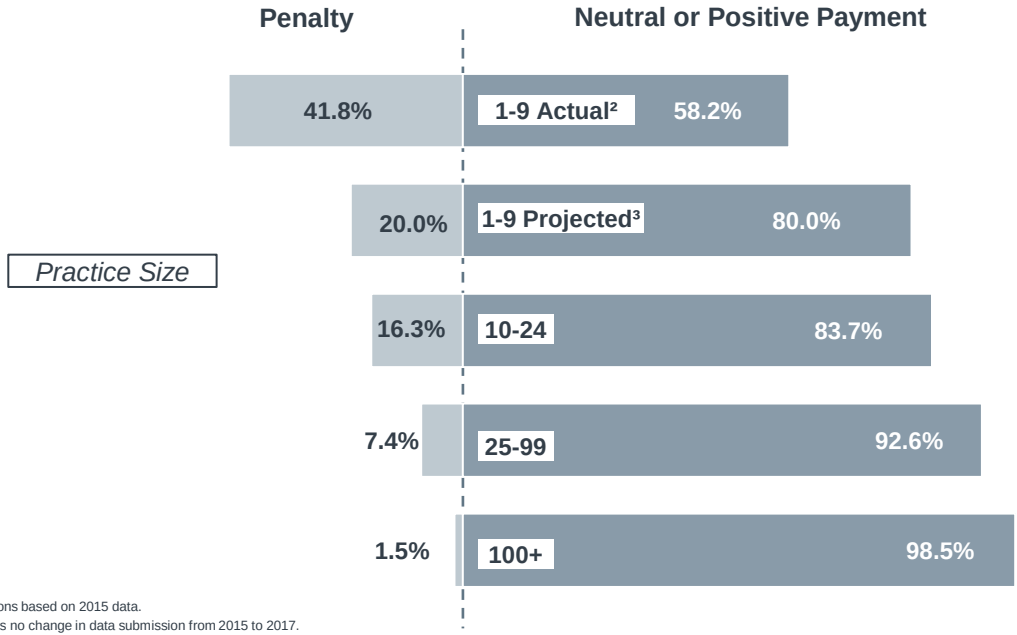
1) Clinicians must report one quality measure, more than one improvement activity, or more than the required IT measures to receive a smaller bonus.

Source: Centers for Medicare and Medicaid Services; Dickson, V, "CMS will give providers flexibility on MACRA requirements," *Modern Healthcare,* September 2016; Health Care Advisory Board interviews and analysis.

Larger Practices Expected to Fare Better

Reporting Flexibility, Data Submission Experience Helps Smaller Groups

Percentage of Eligible Clinicians Projected to Receive MIPS Penalties, Bonuses[1]



1) Projections based on 2015 data.
2) Assumes no change in data submission from 2015 to 2017.
3) Assumes 80% of groups with 1 to 9 clinicians will submit data in 2017.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," October 2016; Health Care Advisory Board interviews and analysis.

Creating a Land Grab for Physicians?

MACRA Potentially Accelerating End of Independent Physician Practice

Clinicians Already Seek Hospital Employment

86%

Increase in hospital ownership of physician practices from 2012-2015

50%

Increase in physicians employed by hospitals from 2012-2015

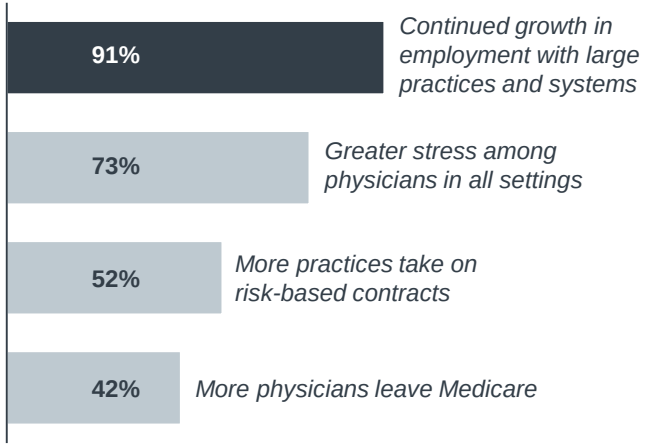
38%

Of U.S. physicians are employed by a hospital or health system

MACRA Potentially Accelerating Current Trend

Modern Healthcare CEO Survey
n = 106

Due to the Requirements of MACRA, over the next few years we are likely to see:



Source: Whitman, E, "CEO Power Panel: Are your physicians ready for reform?" *Modern Healthcare*, September 2016, : Castellucci, M, "Hospital ownership of medical practices grows by 86% in three years," *Modern Healthcare*, September 2016; Health Care Advisory Board interviews and analysis.

Scant Efforts Toward Meaningful Transparency

Compare Websites Not Hitting the Mark

Establishment of *Compare* Websites

1998: Nursing Home Compare

2005: Home Health Compare

2005: Hospital Compare

2010: Physician Compare

Difficult to Use…

> "Historically, the *Compare* websites have conveyed few conceptual clues to help orient lay users to the sites' overall purpose and content."
>
> *L&M Policy Research and Mathematica Policy Research*

…And Little Used

Hospital, Physician Compare users

10M Annually

Healthgrades users

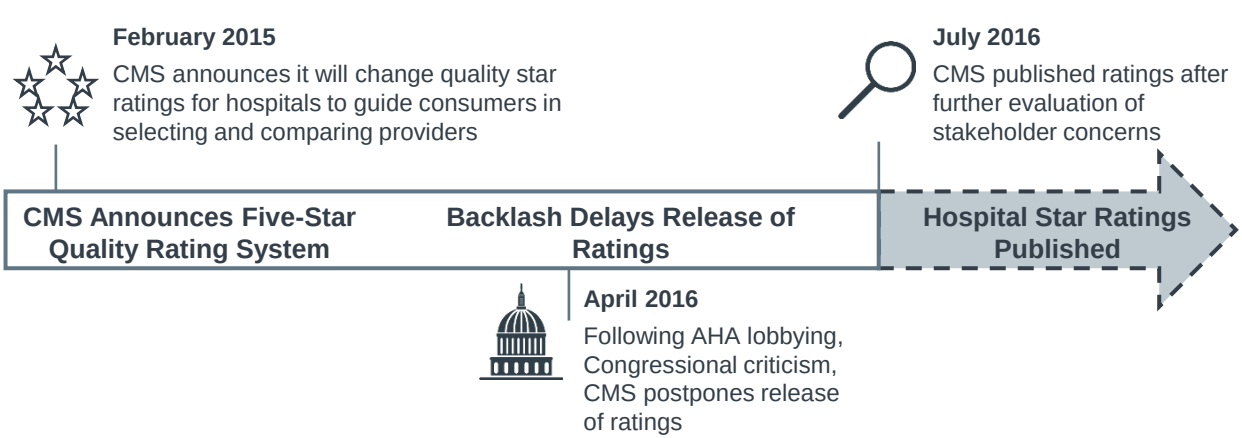
8.9M Monthly

Source: Findlay SD "Consumers' Interest in Provider Ratings Grows, and Improved Report Cards and Other Steps Could Accelerate their Use," *Health Affairs* 35 no. 4 (2016): 688-696; L&M Policy Research and Mathematica Policy Research, *Quality Reporting on Medicare's Compare Websites: Lessons Learned from Consumer Research, 2001-2014*. December 2015: Health Care Advisory Board interviews and analysis.

Concerns about Oversimplification Add Up

CMS Finally Publishes Hospital Quality Star Ratings

Hospital Concerns Previously Delayed Long-Awaited Release



Key Complaints From Detractors

Confusing Methods

AHA was unable to come up with the same conclusions as CMS using the same raw data

Demographic Data Unaccounted For

Unique challenges for hospitals caring for low-income or comorbid populations not acknowledged in star ratings

Source: American Health Care Association, "Five Star: What You Need to Know," February 2015, available at: www.ahcancal.org; Rice S, "CMS Delays New Hospital Quality Ratings Amid Pressure from Congress, Industry," *Modern Healthcare*, April 20, 2016, available at: modernhealthcare.com; "No hospital quality stars today: Why CMS just delayed the new ratings," Advisory Board Daily Briefing, April 21, 2016, available at: www.advisory.com; Health Care Advisory Board interviews and analysis.

Improving Health Care Quality: Mixed and Complex

2

Improve Health Care Quality

Chosen Method:
Incentives + Transparency

- IT mandates
- Pay-for-Performance programs
- Market-facing transparency

Overall Grade:

IT Infrastructure and Interoperability

Grade: B-

- EHR implementation proceeding; likely much more aggressively than without intervention
- Costs crowding out other investment

Pay-for-Performance Programs

Grade: B+/C-

- Providers responded quickly to readmission, HAC incentives
- Infrastructure in place to scale up financial consequence if needed
- Overengineered metrics proving burdensome

Market-Facing Transparency

Grade: C

- Government-run transparency platforms of limited use, infrequently used

Source: Health Care Advisory Board interviews and analysis.

Expanding Coverage by Reforming Existing System

Correcting for the Deficiencies of the Market

Insurer Regulations

- Essential health benefits
- Guaranteed issue
- Dependent coverage to age 26
- Community rating

Medicaid expansion

- Intended to apply to all adults under 138% of federal poverty level
- Supreme Court decision gave states option not to expand

Employer mandate

Intended to prevent dumping into new safety nets

Individual mandate

Intended to preserve quality of risk pools

Exchange subsidies

- Commercial insurance sold on consumer-facing marketplaces
- Subsidies for those between 100%-400% of federal poverty line

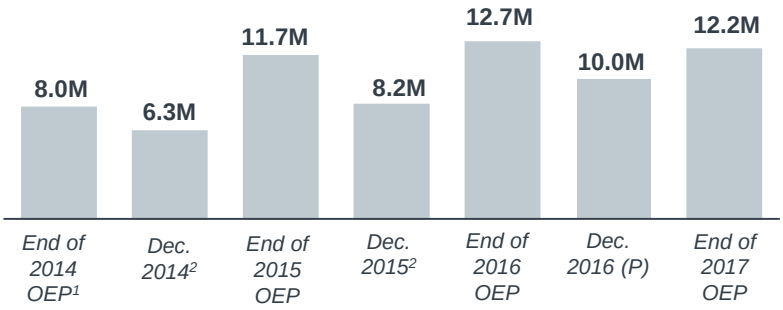
Source: Health Care Advisory Board interviews and analysis.

Public Exchange Enrollment Falling Short of Targets

Group Market Longevity Limiting New Growth

Exchange Enrollment

2014-2016



Smaller and Sicker Than Expected

25M Original CBO Projection for public exchange enrollment

28% Proportion of total public exchange population made up of **"young invincibles"**[3]

Employers Not Dropping Coverage

"Concerns about employer-sponsored health insurance evaporating after the implementation of health reform have not materialized…as of now, **the law has had little to no effect on employer-sponsored insurance.**"

Kathy Hempstead
Robert Wood Johnson Foundation

1) Open Enrollment Period.
2) Drop-off due to individuals not paying premiums or voluntarily dropping coverage.
3) Enrollees aged 18-34.

Source: HHS, "Health Insurance Marketplace Open Enrollment Snapshot – Week 13," Feb. 2016; HHS, "Health Insurance Marketplace Open Enrollment Snapshot – Week 7," Dec. 2015; HHS, "Health Insurance Marketplace 2015 Open Enrollment Period: December Enrollment Report," Dec. 2014; HHS, "Health Insurance Marketplace 2015 Open Enrollment Period: March Enrollment Report," Mar. 2015; HHS, "Open Enrollment Week 13: February 7, 2015 – February 15, 2015; HHS, "Open Enrollment Week 14: February 16, 2015 – February 22, 2015; CBO, January 2015 Baseline: Insurance Coverage Provisions for the Affordable Care Act; Washington Times, "Obamacare Official: 7.3 Million Americans Are Still Enrolled and Paid Up," Sept. 2014; Kaiser Family Foundation, "Total Marketplace Enrollment and Financial Assistance," Jun. 2015; Pradhan R, "White House Lowballs Obamacare Target in an Election Year," *Politico*, Oct. 2015; KFF, "Survey of Non-Group Health Insurance Enrollees, Wave 3", May 2016; KFF, "Marketplace Plan Selections by Age," Feb. 2016, available at: http://kff.org/health-reform/state-indicator/marketplace-plan-selections-by-age/?currentTimeframe=0; Health Care Advisory Board interviews and analysis.

Increasingly Unstable Public Exchanges?

Established Carriers Scaling Back, Co-ops Faltering

Some Insurers Reconsidering Participation

aetna 11 State exchanges Aetna is departing in 2017

Humana. 8 State exchanges Humana is departing in 2017

> "We cannot broadly serve [the exchange market] on an effective and sustained basis."
>
> *Stephen J. Hemsley*
> *CEO of UnitedHealth Group*

Startup Ventures Largely Failing

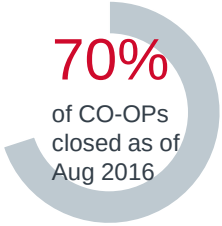
Notable CO-OP failures:

Kentucky Health Cooperative

Louisiana Health Cooperative

nhc nevada health co-op

Health Republic Insurance of New York



> "To date, more than half a million Americans have lost coverage thanks to the failure of these co-ops."
>
> *Adrian Smith*
> *The Wall Street Journal*

Difficulties Facing Exchange Plans

- Adverse selection
- Inaccurate risk adjustment
- Risk corridor underpayment
- Abuse of special enrollment period

Source: Smith A "ObamaCare's Cascading Co-op Failures" *The Wall Street Journal*, Nov. 2015; Blase B et al. "The Affordable Care Act in 2014: Significant Insurer Losses Despite Substantial Subsidies" Mercatus Center, George Mason University; Sachdev A, "Blue Cross Parent Lost $1.5 Billion on Individual Health Plans Last Year" *Chicago Tribune*, Mar. 2016; Commonwealth Fund, "Why Are Many CO-OPs Failing? How New Nonprofit Health Plans Have Responded to Market Competition," Dec. 2015; The Hill, "Frustration mounts over ObamaCare co-op failures," Aug. 2016; Health Care Advisory Board interviews and analysis.

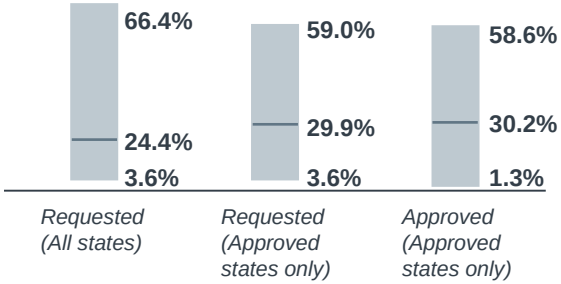
Rate Increases and Reduced Competition

Subsidy Growth Likely to Stress Federal Budget

2017 Individual Marketplace Premium Increases

Minimum, Average, Maximum

As of August 30, 2016



Subsidy Growth Tracks Premium Spikes

"More than **eight in 10 marketplace enrollees won't be directly** affected by increases in [2017] premiums because they receive a government subsidy that will insulate them."

Kaiser Health News

!

36% Of exchange regions will have only one participating insurer in 2017

5 State exchanges with only one participating insurer

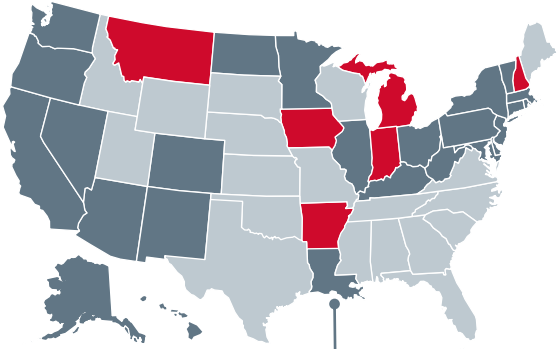
Source: Tracer, Z, "UnitedHealth to quit 22 U.S.-organized state health markets," *Chicago Tribune,* April, 2016; Tracer, Z, "Aetna to Quit Most Obamacare Markets, Joining Major Insurers," *Bloomberg,* Aug. 2016; Castellucci, M, "One-third of ACA exchanges will lack competition in 2017," *Modern Healthcare*, Aug. 2016; Herman, B, "Humana dumps ACA plans as feds blast its Aetna deal," *Modern Healthcare*, Jul. 2016; Gaba C, "Avg. Indy Mkt Rate Hikes: 24.1% Requested (all states); 29.6% Requested (11 states); 30.0% APPROVED (11 states)," Aug. 2016; Health Care Advisory Board interviews and analysis.

Medicaid Expansion Stagnating

Opposition Remains Strong in Many States

31 States and DC Have Approved Expansion[1]

As of October 2016



Louisiana

Only state to expand Medicaid in 2016

Participating | Expansion by Waiver | Not Currently Participating

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

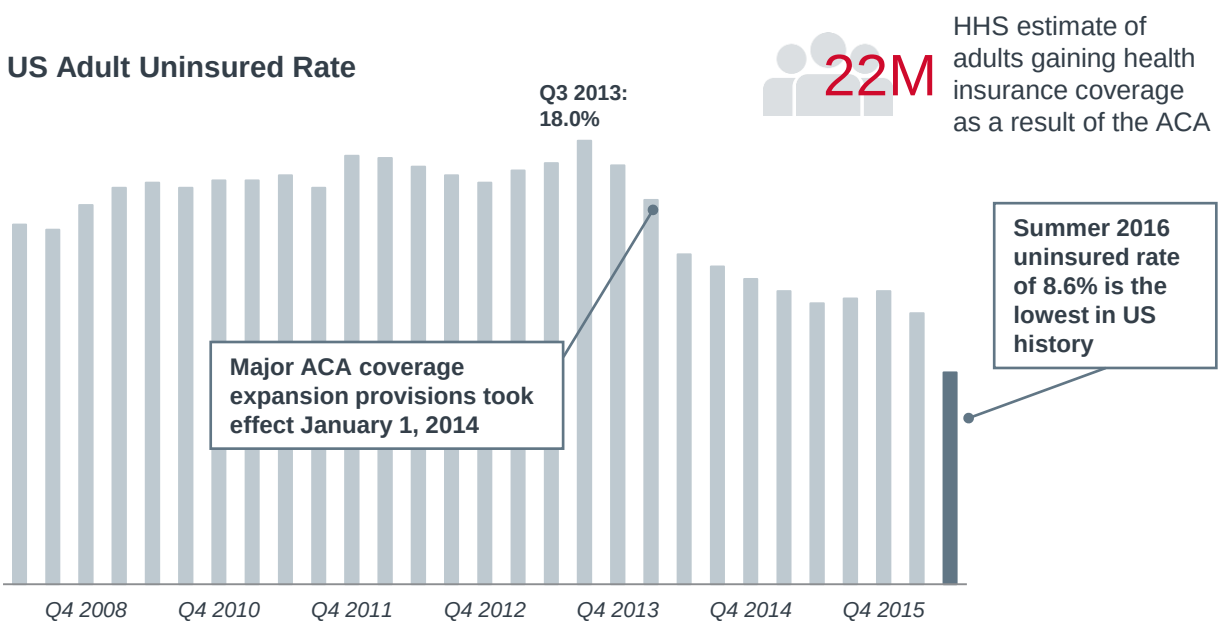
Uncompensated care costs reduced by $5 billion in expansion states in 2014

1) Montana's expansion requires federal waiver approval.

Source: Kaiser Family Foundation, "Current Status of State Medicaid Expansion Decisions," January 27, 2015, 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, www.aspe.hhs.gov; PwC Health Research Institute, "The Health System Haves and Have Nots of ACA Expansion", 2014, www.pwc.com; CMS, "Medicaid & CHIP: February 2016 Monthly Applications, Eligibility Determinations and Enrollment Report", April 29, 2016, www.medicaid.gov; Health Care Advisory Board interviews and analysis.

Coverage Expansion Impact Unmistakable

"Universal Coverage" Still a Distant Goal, but Millions More Now Covered



Source: Gallup, "U.S. Uninsured Rate at 11.0%, Lowest in Eight-Year Trend," April 7, 2016, available at: www.gallup.com/poll/190484/uninsured-rate-lowest-eight-year-trend.aspx; Gallup, "U.S. Uninsured Rate 11.9% in Fourth Quarter of 2015," January 7, 2016, available at: www.gallup.com/poll/188045/uninsured-rate-fourth-quarter-2015.aspx; Health Care Advisory Board interviews and analysis.

Universal, Affordable Coverage: Clear Progress

3

Achieve Universal, Affordable Coverage

Chosen Method:
Expansion of Existing System

- Insurance market regulation
- Expanded public coverage
- Market-based exchanges

Overall Grade:

Insurance Regulation — **Grade:** A-

- Guaranteed issue, other provisions fundamentally reshaped coverage access
- Political fights persist; mandates weak

Insurance Exchanges — **Grade:** B+

- Enrollment stable
- Premium growth reasonable; "death spiral" largely avoided
- Market-driven value dynamic accelerating

Medicaid Expansion — **Grade:** B

- 31 states + DC have expanded coverage
- 19 states not yet expanding
- 16 million more Medicaid/CHIP enrollees, largely in expansion states
- Waivers offer flexibility to some state models

Source: Health Care Advisory Board interviews and analysis.

Final Grade: Incomplete

Progress Toward Obama Administration's Goals Only Part of the Picture

1	2	3
Replace Costly Fee-for-Service Incentive Structures	Improve Health Care Quality	Achieve Universal, Affordable Coverage
		
C-	B	A-

Unfinished Business:

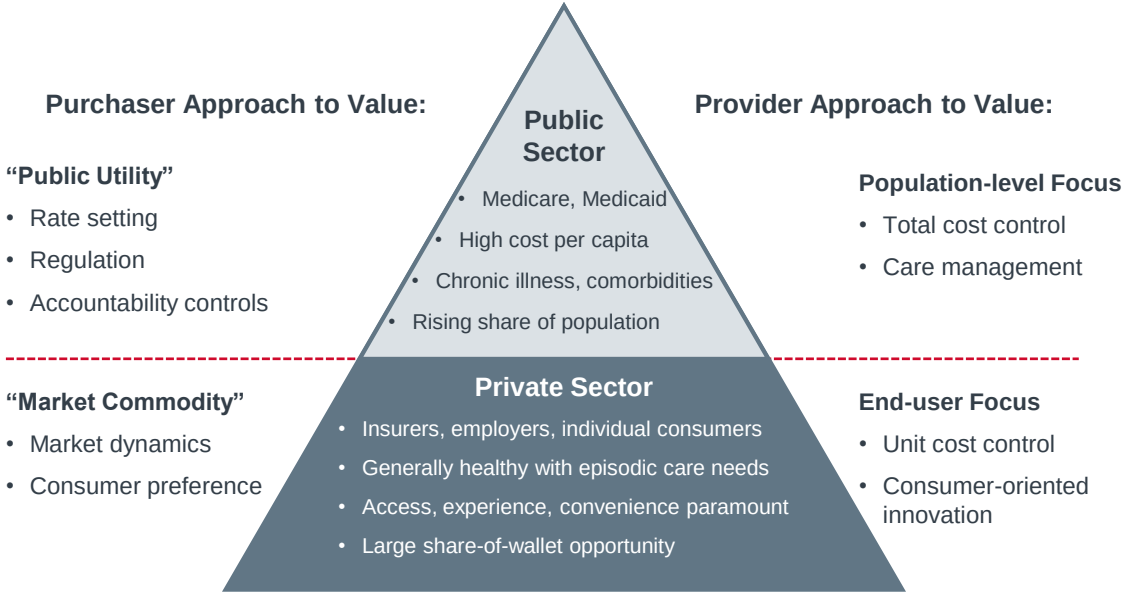
Reengineer health care delivery system, not just payment system, to generate greater value

Catalyze private market reform, not just entitlement program reform

Source: Health Care Advisory Board interviews and analysis.

Serving Two Masters

Public, Private Markets Demanding Different Value in Different Ways



Source: Health Care Advisory Board interviews and analysis.

The ACA Did Not Disrupt the Zero-Sum Status Quo

Risk-Shifting Logic Has Further Entrenched Traditional Players

Risk Shifting in Health Care, 2016

"Zero sum competition involves the pursuit of greater bargaining power rather than efforts to provide better care. Health plans, hospital groups, and physician groups have consolidated primarily to gain more clout and to cut better deals with suppliers and customers. But the quality and efficiency gains from consolidation are quite modest."

Michael Porter, 2004

Source: Michael Porter and Elizabeth Teisberg, "Redefining Competition in Health Care." *Harvard Business Review,* 2004 82(6):64-76, accessible at https://hbr.org/2004/06/redefining-competition-in-health-care; Health Care Advisory Board interviews and analysis.

Moving from Zero-Sum to Positive-Sum Competition

Value-Seeking Agents Catalyzing New Market

Employers

Consumers

> "Competition at the wrong level has been exacerbated by the pursuit of the wrong objective: reducing cost…**The right goal is to improve value** (quality of health outcomes per dollar expended)."
>
> *Michael Porter, 2004*

Source: Michael Porter and Elizabeth Teisberg, "Redefining Competition in Health Care." *Harvard Business Review*, 2004 82(6):64-76, accessible at https://hbr.org/2004/06/redefining-competition-in-health-care; Health Care Advisory Board interviews and analysis

Employers Reaching the Limits of Their Tolerance

Scale, Data Assets, Provider-Side Expertise All Command Attention

HEALTH TRANSFORMATION ALLIANCE

Founding Members

- American Express
- American Water
- BNSF
- Brunswick Corporation
- Caterpillar, Inc.
- Coca-Cola
- DuPont
- HCA
- Hartford Financial Services Group
- IBM
- Ingersoll Rand
- International Paper
- Lincoln Financial
- Macy's
- Marriott
- NextEra Energy
- Pitney Bowes
- Shell
- Verizon
- Weyerhaeuser

4M Covered lives

$14B Annual health spending

HTA's Announced Goals

- Greater marketplace efficiencies
- Learning from data
- Educating employees
- Breaking bad habits

April 15, 2016:
"Health Transformation Alliance Announces Appointment of Dr. Glenn Steele as Vice Chairman"
"Former Geisinger CEO Brings Decades of Experience in Health Care Innovation and Influence to HTA"

Source: Health Transformation Alliance, available at: http://www.htahealth.com/; "Health Transformation Alliance Announces Appointment of Dr. Glenn Steele as Vice Chairman," Health Transformation Alliance Press Release, April 15, 2016, "Leading US Companies Announce Plan to Transform the Corporate Health Care System," Health Transformation Alliance Press Release, February 5, 2016; Health Care Advisory Board interviews and analysis.

Sentinel Efforts to Circumvent Traditional Approach

Boeing Signs Value-Based Direct Contracts in Two New Markets

2015: Direct Contract with Major Systems Near Seattle Headquarters

Provider partners:

PROVIDENCE Health & Services

UW Medicine

2016: Expansion to Other Major Boeing Locations

St. Louis

Charleston

Enhanced Benefits Attract Employees

- Free primary care
- Free generic drugs
- Reduced premiums

Case in Brief: The Boeing Company

- Over 148,750 US employees
- Issued highly-prescriptive RFP for risk-bearing health system partners in Seattle region
- Early success prompts expansion to other markets

Source: Health Care Advisory Board interviews and analysis.

Some Employers Steering for Specific Procedures

United Airlines Expands Bundle Offerings to Orthopedics

Case in Brief: United Airlines

- 82,000 employees; headquarters in Chicago, Illinois
- Recently launched bundled payment contract with Rush University Medical Center for hip and knee replacements, and spinal fusion surgeries
- Bundled payment contract also in place with Cleveland Clinic for cardiac surgery

Quality Is Top Concern

"The entire motivation for us is the quality of the care…. We don't want cost to be a barrier for our employees."

Anthony Scattone, VP of Benefits
United Airlines

Key Program Features

- Financial incentive for participating employees (waiving of copays and coinsurance)
- Physicians review medical record, determine eligibility
- Comprehensive travel planning for patient and caregiver
- Flat bundle price paid to Rush
- Rush at financial risk for complications, such as infections or implant failures

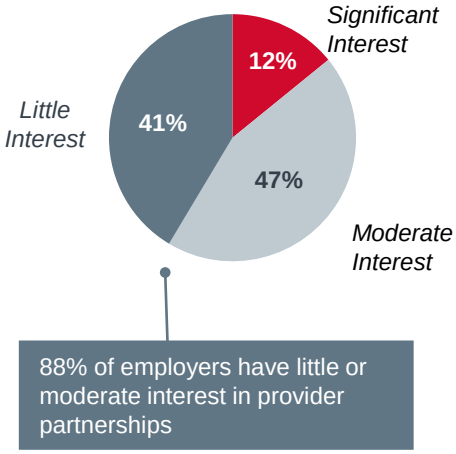
Source: Sachdev A., "United Offers Employees Cheaper Hip, Knee Replacements if They Travel to Chicago's Rush," *Chicago Tribune*, May 6, 2016, http://www.chicagotribune.com/business/ct-rush-united-cheaper-surgery-0508-biz-20160506-story.html; Health Care Advisory Board interviews and analysis.

Significant Barriers Slowing Wider Adoption

Basic Practical, ROI Questions Are Still Unanswered

Employer Interest in Direct Contracting with Providers

n=106



Largest Barriers to Partnering with or Purchasing Services Directly from Providers

Percentage of Surveyed Employers Ranking Barrier in Top 3

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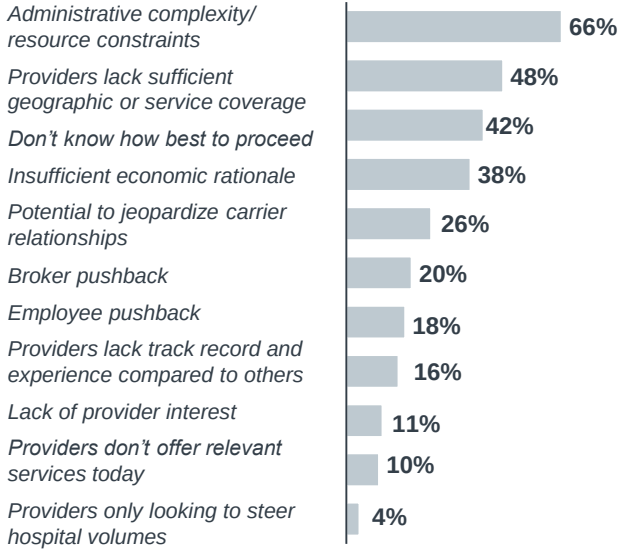


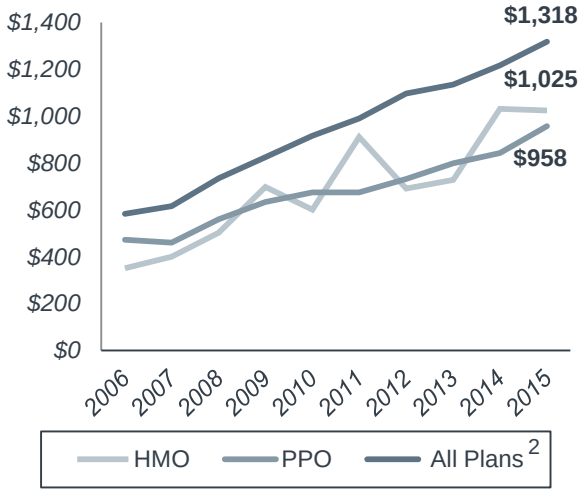
Source: CEB Survey of Employers on Future Health Benefits Changes 2015; Health Care Advisory Board interviews and analysis.

Onboarding Risk, then Offloading to Employees

Employers Increasingly Turning to High-Deductible Plans

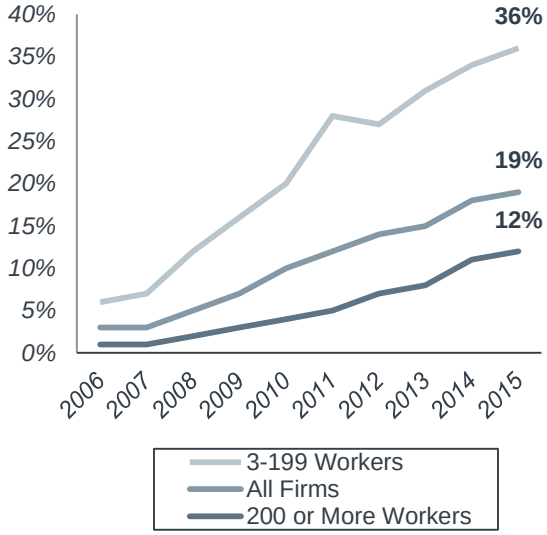
ESI Average Deductible for Single Coverage[1]

By Plan Type, 2006-2015



Percentage of Covered Workers with Annual Deductible of $2,000 or More[3]

By Firm Size, 2006-2015



1) Among covered workers with a general annual health plan deductible.
2) Includes HDHP/SO.
3) For single coverage.

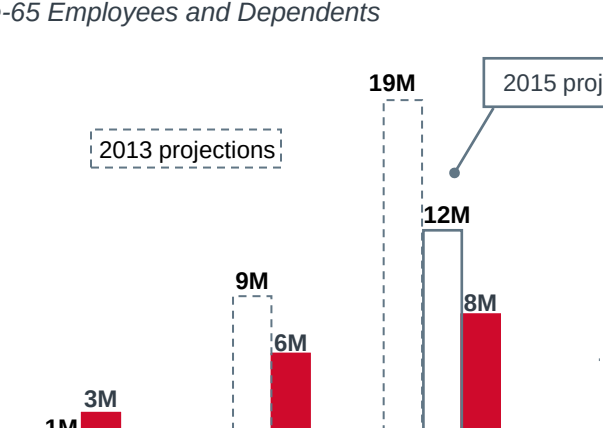
Source: Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits 2015 Annual Survey"; Health Care Advisory Board interviews and analysis.

Defined Contribution the Next Major Shift?

Private Exchange Enrollment Continues to Grow

Private Exchange Enrollment Still Grows in 2016, But Lags Behind Initial Projections

Projected Private Exchange Enrollment Among Pre-65 Employees and Dependents



40-60% Employees on private exchanges who select a high-deductible health plan option

Newer Market Entrants Hitting Their Stride

50% *(800k→1.2M)* Enrollment growth for Towers Watson's exchange solutions, 2014-2015

500% *(220k→1M)* Enrollment growth for Mercer's exchange solutions, 2014-2015

Source: Accenture, "Eight Million U.S. Employees Enrolled in Private Health Insurance Exchanges for 2016 Benefits, According to Accenture" January 20, 2016; 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; "Private Insurance Exchanges: What You Need to Know" Health Care Advisory Board 2015; Health Care Advisory Board interviews and analysis.

The Implications of a Consumer Market

Financial Exposure	Shift of health care cost exposure to end consumer expands
Radical Transparency	Proliferation of third-party transparency vendors continues
Consumer-Oriented Marketplaces	New online marketplaces connecting consumers directly to out-of-market providers
Non-Hospital Innovators	New market entrants providing attractive alternatives at low prices

Following the Dollars

$3.9B Venture capital funding for digital health, first six months of 2016

> "Patient/consumer experience remains a dominant market in the first half of the year [2016], leading significantly in both funding amount and deal amount."

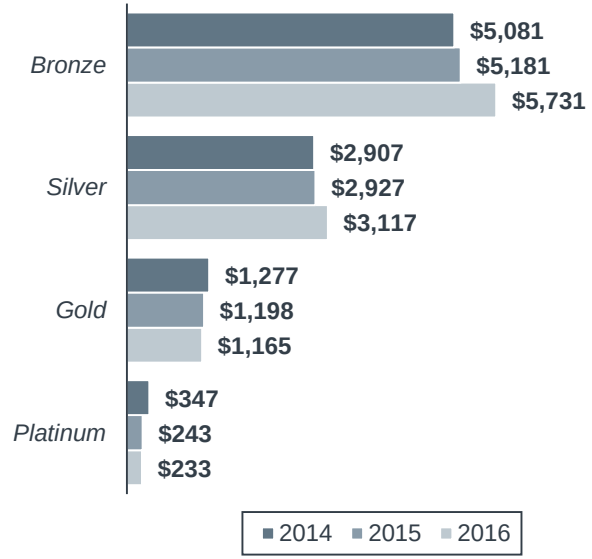
StartUp Health Insights 2016 Midyear Report

Source: StartUp Health Insights, available at: www.startuphealth.com/#1; Health Care Advisory Board interviews and analysis.

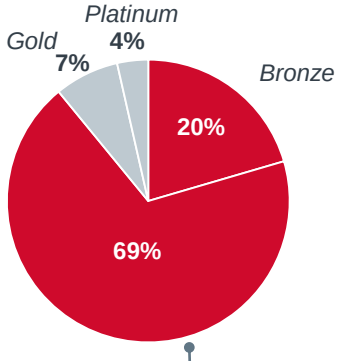
Many Apparently Willing to Bear Point-of-Care Costs

Consumers Electing to Bear Very High Cost Exposure

Average Deductible for Exchange-Sold Health Plans
2014-2016



Exchange Enrollment, by Metal Tier
2015



Nearly 90% of exchange enrollees are in bronze or silver plans

Source: 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.

Consumers Proving to Be Savvy Coverage Shoppers

Purchase Decisions Driven Largely by Price

Switching Rates Higher Than Expected

12%

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

43%

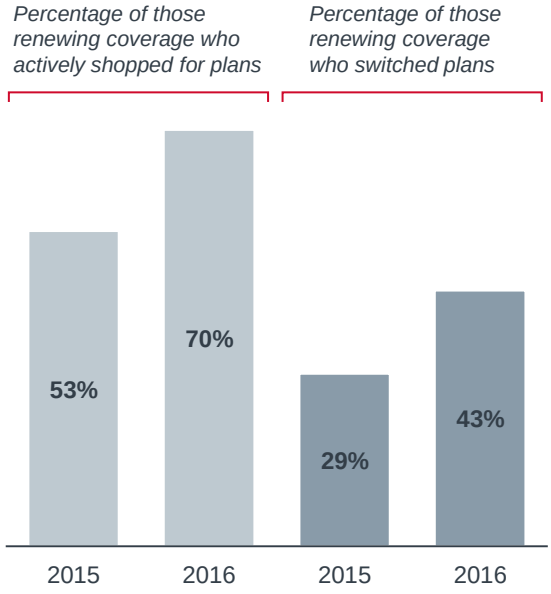
Returning federal exchange enrollees changing plans in 2016

Premium Increases the Primary Motivator

55%

Switchers who cited rise in monthly premiums 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.

Higher Deductibles Driving Increased Price Sensitivity

Consumer Responses Generally Dangerous for Provider Economics

1 Forgo Care?

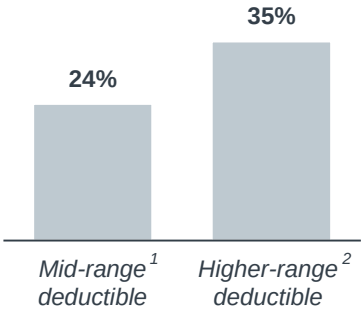
Spending Reductions Following Implementation of High-Deductible Health Plans

25% ↓
Reduction in physician office spending

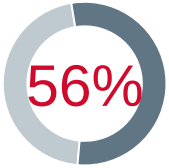
18% ↓
Reduction in ED spending

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.

Living Under a Microscope

Consumers Have Access to More Information than Ever Before

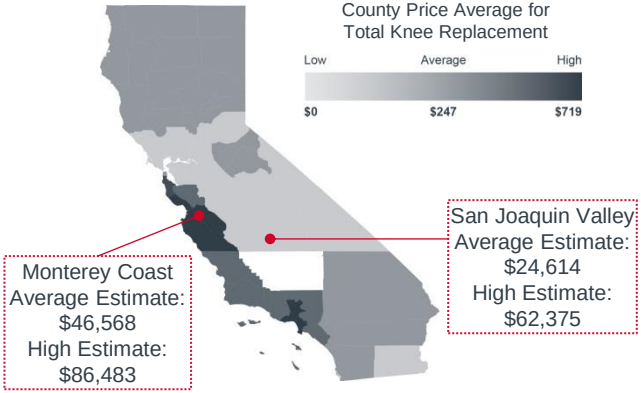
Transparency Comes to California

September 21, 2015

Attention Shoppers: New Calif. Website Details Costs, Quality of Medical Procedures

Where You Live Matters

What you pay may differ based on where you live



Sample Transparency Sites

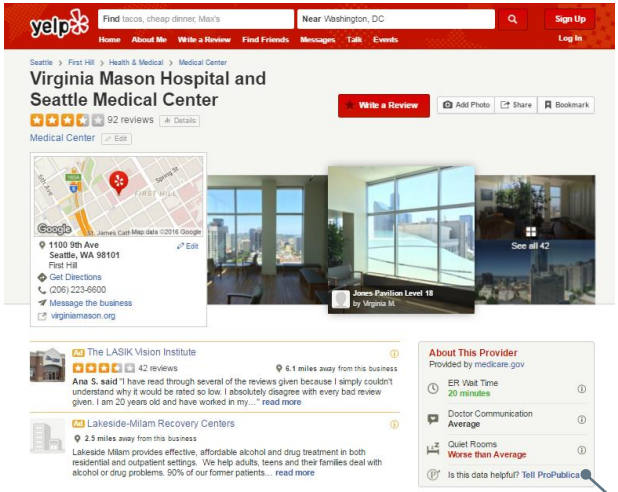
Healthcare Bluebook
CASTLIGHT HEALTH
vitals
guroo
HEALTHGRADES THE HEALTHCARE QUALITY EXPERTS
ZocDoc
g+
Angie's list
yelp
pokitdok

All logos are registered trademarks.

Source: Ostrov BF, "Attention Shippers: New Calif. Website Details Costs, Quality of Medical Procedures," *Kaiser Health News,* available at: http://khn.org/news/attention-shoppers-new-calif-website-details-costs-quality-of-medical-procedures; Health Care Advisory Board interviews and analysis.

Turning to Unlikely (and Uncomfortable) Sources

Crowdsourced Reviews Getting More Reliable



"Now the millions of consumers who use Yelp… will have even more information at their fingertips when they are in the midst of the most critical life decisions, like which hospital to choose for a sick child or which nursing home will provide the best care for aging parents."

Jeremy Stoppelman, CEO
Yelp

Acclaimed news source partners with review website with more than 85 million monthly users

Incorporates Medicare data on more than 25 thousand facilities, including 4,600 hospitals

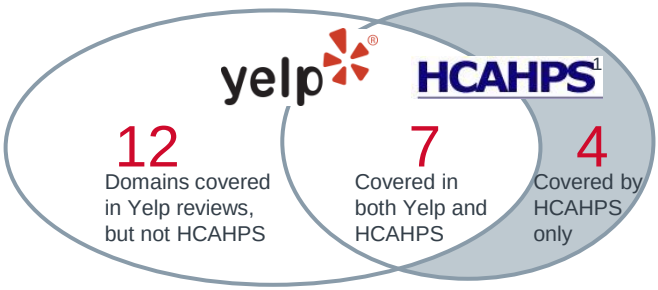
ProPublica compiles and provides Yelp with Hospital Compare metrics on ER wait time, doctor communication and room noise levels

Source: "Yelp's Consumer Protection Initiative: ProPublica Partnership Brings Medical Info to Yelp" Yelp, Official Blog, August 5, 2015; https://www.yelpblog.com/2015/08/yelps-consumer-protection-initiative-propublica-partnership-brings-medical-info-to-yelp; Health Care Advisory Board interviews and analysis.

Just What Consumers Are Looking For

Yelp Reviews Capture Surprisingly Detailed Picture of Consumer Experience

Topic Domains Addressed by Yelp, HCAHPS



Study in Brief: Yelp Reviews Of Hospital Care Can Supplement And Inform Traditional Surveys Of The Patient Experience Of Care

- Published in Health Affairs, April 2016
- Analysis of 16,862 hospital Yelp reviews, HCAHPS scores for 1,352 hospitals
- Moderate correlation found between Yelp, HCAHPS scores

Topics Covered in Yelp Reviews Without Clear HCAHPS Analogue

- Cost of hospital visit
- Insurance and billing
- Ancillary testing
- Facilities
- Amenities
- Scheduling
- Compassion of staff
- Family member care
- Quality of nursing
- Quality of staff
- Quality of technical aspects of care
- Specific type of medical care

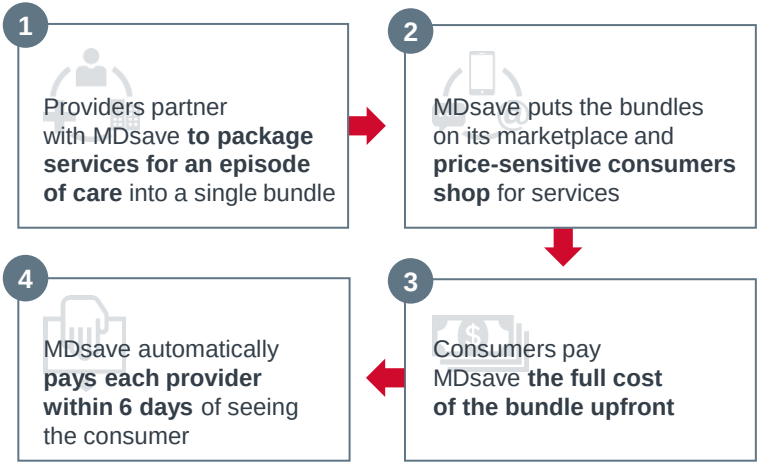
1) Hospital Consumer Assessment of healthcare Providers and Systems..

Source: Ranard B et al.; "Yelp Reviews Of Hospital Care Can Supplement And Inform Traditional Surveys Of The Patient Experience Of Care," *Health Affairs*, April 2016; Health Care Advisory Board interviews and analysis.

Shopping for Care from the Comfort of Your Couch

Consumer-Oriented Marketplace Connects Consumers to Solutions

MDsave's Marketplace Model



Case in Brief: MDsave

Online health care episodic bundle marketplace based in Nashville, TN and San Francisco, CA

A Compelling Value Proposition

40-50%
Average consumer savings per episode of care

4,000
MDsave bundles sold in July, 2016; currently growing 10-15% per month

140
Markets in which MDsave operates (26 states)

Source: MDsave, www.mdsave.com; Health Care Advisory Board interviews and analysis.

Online Marketplaces Flourishing

New Exchanges Enabling Consumers to Shop for Range of Services

Consumer-Oriented Marketplaces Span a Variety of Health Care Needs

honor

Honor

Connects **home health** professionals with seniors in need of care

Funded by **$20M** in venture capital investment

amwell

Amwell

Offers on-demand **telemedicine** via video or phone to serve needs including urgent care, therapy, and chronic care management

Reported **100%** total growth in visits in 2015

ZENDYHEALTH

ZendyHealth

Allows consumers to shop based on their own preferred price for **bundled procedural episodes**

80% of consumer proposed prices are accepted within two days

MediBid

MediBid

Brings patients options for **high-end surgeries** through an online marketplace in which they can bid for care

Typically offers a **50%** average discount over insurance-negotiated prices

Source: Honor, www.joinhonor.com; Amwell, https://amwell.com; ZendyHealth, https://zendyhealth.com; MediBid, www.medibid.com; Health Care Advisory Board interviews and analysis.

Innovations Crowding Onto the Field

Disruptive Services and Tech for Consumer Use (Existing and In Development)

Inexpensive, rapid care at a 'provider' site

- **SmartChoice MRI**
- **Right Care**
- **PediaQ**
- **Mend**
- **OrthoNow**

Retail Clinics

- **Walgreens**
- **CVS Health**
- **Wal-Mart**

Physician hailing

- **Pager.com**
- **Heal**
- **Dispatch Health**
- **MedZed** (pediatric house calls)

Remote diagnosis and link to clinicians

- **Opternative**: iPhone eye exam, e-mail RX
- **Google contact lens**: glucose monitoring
- **EpiWatch**: predicts seizures
- **MoleMapper:** cancerous mole screening
- Iphone-directed walk tests, cognition, fine motor skill, tremor evaluations

Patient apps for condition self-management

- **Iodine's** Start app: Tracks depression symptoms and drug efficacy
- **OneDrop**: diabetes tracker
- **ACC's** Statin intolerance self-checker

25%

Consumers used a retail clinic in 2015— up from 15% in 2013

Source: Oliver Wyman, "The New Front Door to Health Care Is Here," 2016, available at http://www.oliverwyman.com; Health Care Advisory Board interviews and analysis.

Not Your Father's Urgent Care

Consumer Demands are the Center of the Zoom+ Universe

Illness visits start at $145, specialty at $200 for self-pay patients

Most clinics open until midnight on weekdays, more limited hours on weekends

Scheduling, e-visits, bill pay can all be accomplished via mobile app

Case in Brief: Zoom+

- Private network of consumer-oriented clinics based in Hillsboro, Oregon; founded in 2006 as Zoomcare
- Low prices, evening and weekend hours, and co-located services appeal directly to consumers
- Currently offering primary, specialty, and urgent care services at more than 25 locations; multiple tiers of coverage through Zoom+ Performance Health Insurance

Establishing a Loyal Base

250K

Annual Zoom users, 2014 (before rebrand, expansion)

Source: Portland Business Journal, "ZoomCare inks investment deal with Endeavour Capital," July 8, 2014; Chase D, "I've Seen the Future of Health Care. I Like What I See,' *Forbes*, November 23, 2015, available at: http://www.forbes.com/sites/davechase/2015/11/23/ive-seen-the-future-of-american-healthcare-i-like-what-i-see/#6567e0135178; Health Care Advisory Board interviews and analysis.

Growing A Health System From A Very Different Seed

Zoom+ Services

Zoom+Super for "near-emergency" needs, open 20 hours a day

Pediatric primary, specialty, and wellness care

On-Site pharmacy, labs, and imaging

Specialty care, including cardiology, dermatology, orthopedics, and ENT

Zoom+Performance "Olympic-level" coaching, neuro-agility, body composition analysis

Wellness coaching including food and movement-as-medicine

Expansion Plan

1

Adds

Specialist Services

- Employs common specialists
- Partners with local health systems for others

2

Incorporates

Insurance Plan

First sold on Oregon exchange in 2015

3

Expands to new

Markets

- Expanding into California
- New clinics opening in Portland, Boise, Seattle

Source: Portland Business Journal, "ZoomCare inks investment deal with Endeavour Capital," July 8, 2014; Chase D, "I've Seen the Future of Health Care. I Like What I See,' *Forbes*, November 23, 2015, available at: http://www.forbes.com/sites/davechase/2015/11/23/ive-seen-the-future-of-american-healthcare-i-like-what-i-see/#6567e0135178; Health Care Advisory Board interviews and analysis.

Road Map

1 A New Turning Point for Health Care Reform

2 Reflecting on the First Era of Health Care Reform

3 Adapting Provider Strategy to New Market Realities

Path Forward Not Dependent on Politics

No-Regrets Priorities for Next Era of Health Care Reform

Accessibility

- **Multi-channel navigation platform**, including search, price estimation, and triage/scheduling helps streamline transactions
- Development of **diverse network of access points** (e.g. urgent care, retail, enhanced access to specialty care, primary care) to meet varied consumer access demands

Reliability

- **Organization-wide commitment** and investment in service delivery and quality improvement drives broad engagement in delivering superior outcomes
- **High-reliability approach** to both service delivery and clinical quality ensures baseline of performance

Affordability

- Willingness to **partner with lower-cost providers** offers patients affordable options, helps prevent markets from becoming overbuilt
- When markets are already overbuilt, commitment to **scale back excess capacity** ensures affordability in the long-term

Source: Health Care Advisory Board interviews and analysis.

Adapting Provider Strategy to New Market Realities

Four Key Steps to Succeed In the Next Era of Health Care Reform

1

Radically Reduce Cost Structure

Reduce cost structure to enable pricing flexibility

2

Establish a Sustainable Medicare Risk Strategy

Carefully pace transition to Medicare risk to capture returns from care management

3

Build a Consumer Loyalty Platform

Prioritize consumer loyalty strategy to build durable patient relationships

4

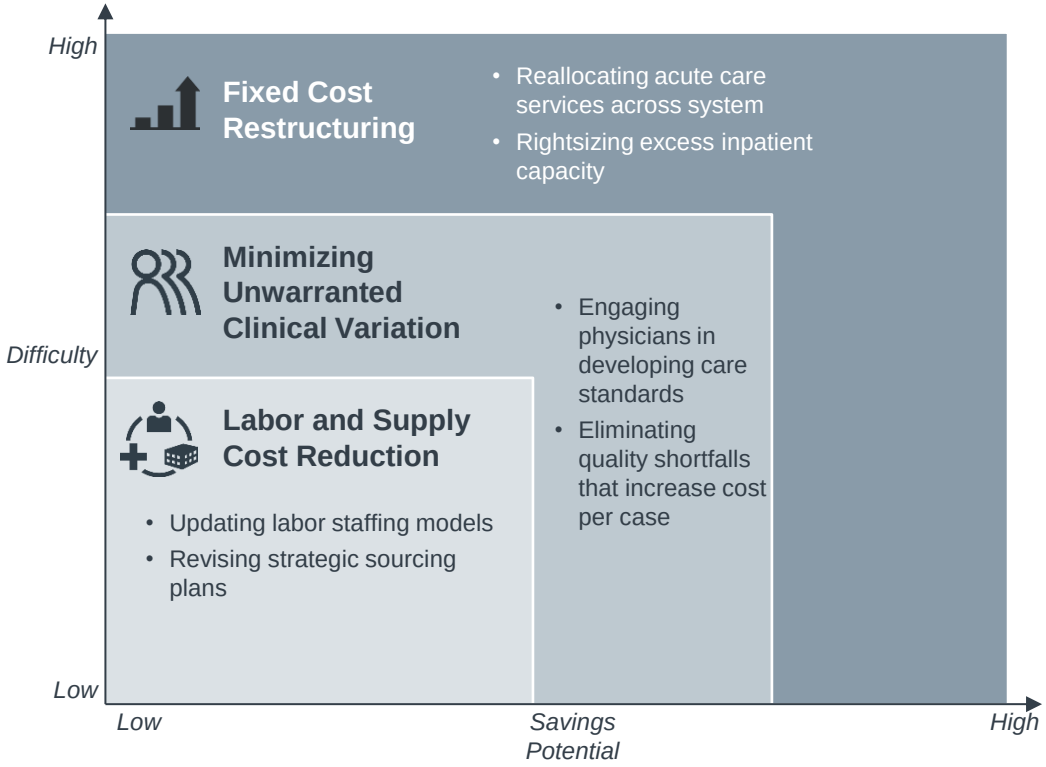
Elevate Physician Network Performance

Restructure physician network to meet twin mandates of population health and consumerism

Source: Health Care Advisory Board interviews and analysis.

Manage Costs to Weather Pricing Pressure

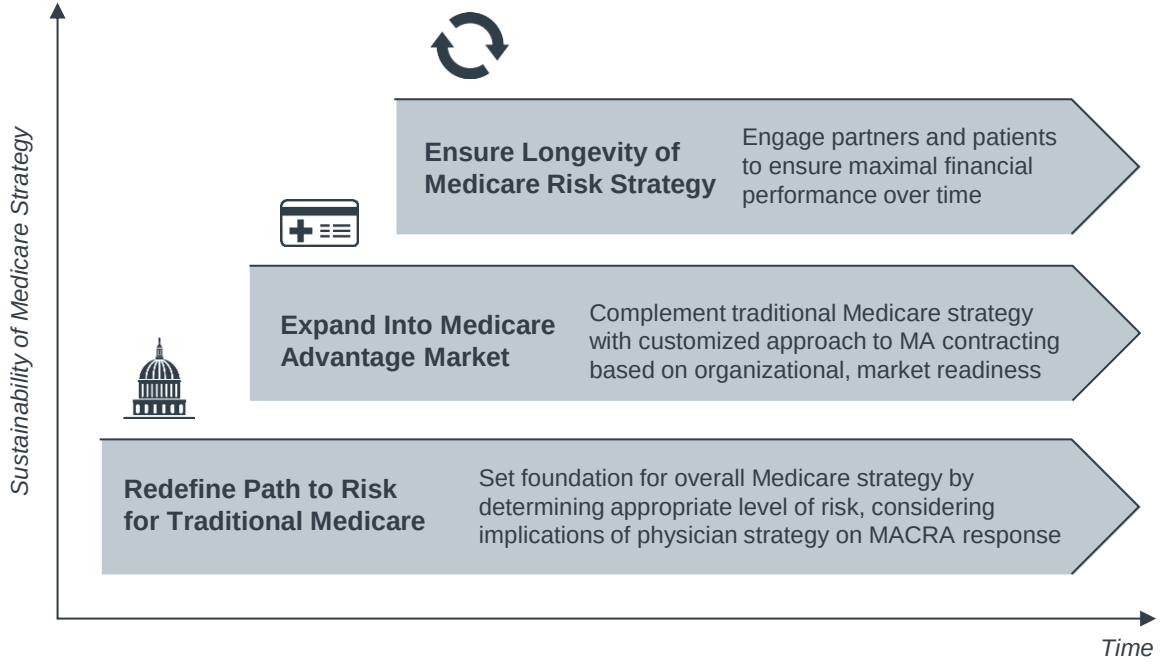
Prepare to Live Under a Budget



Source: Health Care Advisory Board interviews and analysis.

Define an Intentional Medicare Risk Strategy

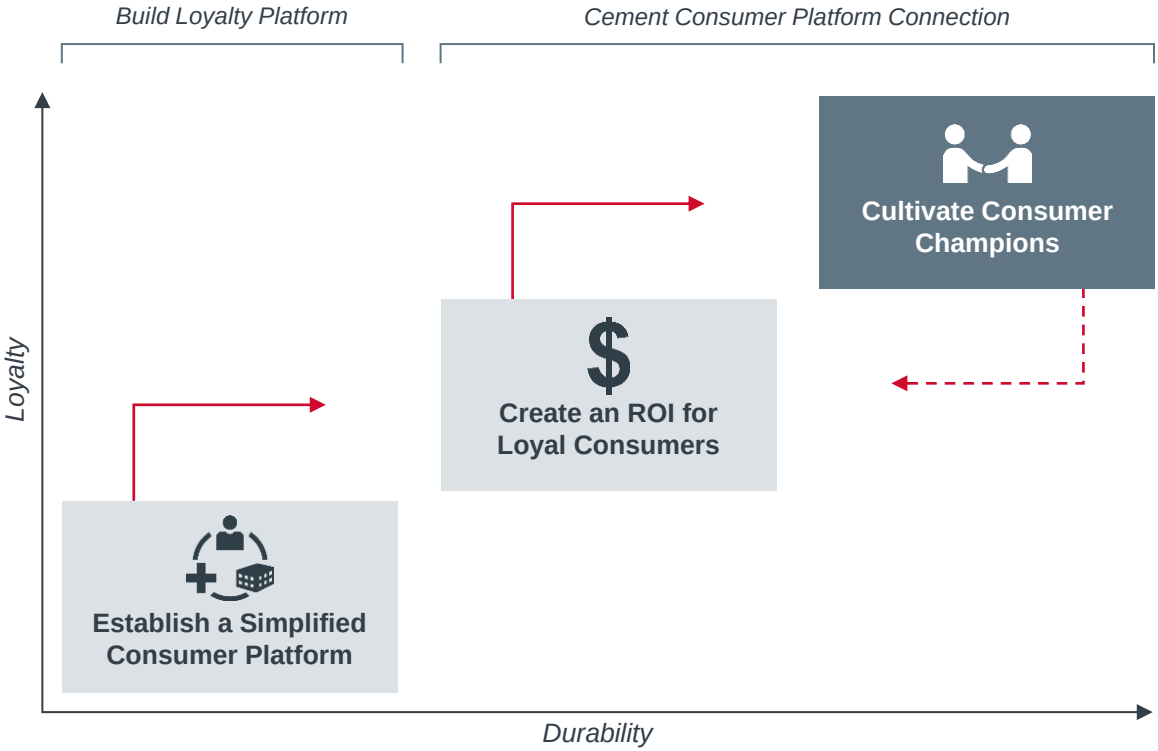
Three Steps to Establishing a Sustainable Medicare Risk Strategy



Source: Health Care Advisory Board interviews and analysis.

Develop a Consumer Relationship Platform

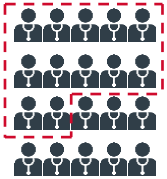
Establishing Durable Loyalty to the Health System Enterprise



Source: Health Care Advisory Board interviews and analysis.

Build the High-Performing Physician Network

Incumbent on Health System to Curate, Direct, and Support Partners



1 Redefine Network Purpose for System

- Delineate network role in advancing system priorities
- Take segmented approach to strategy rollout

2 Curate a High-Performing Network

- Design network with long-term needs in mind
- Select partners according to new value drivers

3 Support Physicians in Meeting New Mandates

- Build supports and incentives to enable high performance
- Reinstate policies that promote sustainable practice

Source: Health Care Advisory Board interviews and analysis.

Don’t Overlook the Advantages of Incumbency

Harness Health System Strengths to Navigate Next Era of Health Reform

Incumbent Advantages

1 

Financial Scale

2 

Comprehensive Clinical Scope

3 

Robust Information Assets

4 

Established Provider and Patient Relationships

Imperatives for Hospitals and Health Systems

Prioritize no-regrets, scalable investments; use pricing leverage strategically

Assemble and coordinate diverse services into differentiated, consumer-oriented solutions

Augment clinical data with broader market analytics, consumer-level insight to create unparalleled information advantage

Convert patient-physician relationships and loose brand affinities to durable consumer loyalty

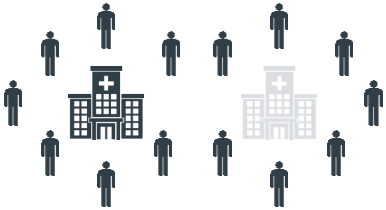
Source: Health Care Advisory Board interviews and analysis.

Viewing Our Strategy Through a New Lens

Competitor-centric Strategy

Strategic Benchmark: **Closest competitor's performance**
Financial Metric: **Share of existing market**
Executive Focus: **Stewardship of community asset**

Customer-centric Strategy



Strategic Benchmark: **Maximum consumer value**
Financial Metric: **Share of wallet, lifetime loyalty**
Executive Focus: **Ongoing drive for improvement**

> [I have a] passion to figure out customer-focused strategies as opposed to, say, competitor-focused strategies. If you're competitor-focused, you tend to slack off when your benchmarks say that you're the best. But if your focus is on customers, you keep improving.

Jeff Bezos
CEO, Amazon

Source: Kirby, J and Stewart, T, "The Institutional Yes," Harvard Business Review, October 2007; Health Care Advisory Board interviews and analysis.

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