Health Care Industry Trends 2015

Ready-to-Use Presentation Slides
1. Payment Reform
2. Provider Market
3. Purchaser Behavior
4. Provider Selection Trends
Payment Reform

- Overview of Accountable Payment Models
- Update on Value Based Purchasing Program
- Update on Bundled Payments
- Update on Accountable Care Organizations
Overview of Accountable Payment Models

<table>
<thead>
<tr>
<th>Key Attributes</th>
<th>Value-Based Purchasing</th>
<th>Bundled Payments</th>
<th>Accountable Care Organizations (ACOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Pay-for-performance program differentially rewards or punishes hospitals (and likely ASCs and physicians in coming years) based on performance against predefined process and outcomes performance measures</td>
<td>Purchaser disburses single payment to cover certain combination of hospital, physician, post-acute, or other services performed during an inpatient stay or across an episode of care; providers propose discounts, can gain share on any money saved</td>
<td>Network of providers collectively accountable for the total cost and quality of care for a population of patients; ACOs are reimbursed through total cost payment structures, such as the shared savings model or capitation</td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td>Create material link between reimbursement and clinical quality, patient satisfaction scores</td>
<td>Incent multiple types of providers to coordinate care, reduce expenses associated with care episodes</td>
<td>Reward providers for reducing total cost of care for patients through prevention, disease management, coordination</td>
</tr>
<tr>
<td><strong>Advisory Board Assessment</strong></td>
<td>Withhold-earn back model will put significant dollars at risk for all providers, force immediate focus on quality and experience metrics</td>
<td>Increases accountability for cost and quality within episodes of care without removing FFS volume incentive; new lever for financial alignment between independent specialists and hospitals</td>
<td>Long-range goal of CMS to migrate to risk contracting; will spark industry-wide investment in primary care infrastructure to establish narrower networks</td>
</tr>
<tr>
<td><strong>Role of CMMI</strong></td>
<td>Dedicating $500M to Partnership for Patients, targeting hospital-acquired infections, readmissions</td>
<td>Accepting providers’ proposals to test four different bundled payment models, including one without inpatient care</td>
<td>Accepting providers’ proposals to test various payment systems, including both shared savings and partial capitation</td>
</tr>
</tbody>
</table>

1) Center for Medicare and Medicaid Innovation.

Source: Marketing and Planning Leadership Council interviews and analysis.
UPDATE ON VALUE BASED PURCHASING PROGRAM

CMS ADDS EFFICIENCY METRIC TO VBP PROGRAM

INITIALLY WEIGHTED AT 20%, REDUCING CLINICAL PROCESS WEIGHT

MEDICARE VBP\(^1\) PROGRAM DOMAIN WEIGHTS

<table>
<thead>
<tr>
<th>Domain</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>40%</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>30%</td>
<td>25%</td>
<td>10%</td>
<td>5%</td>
</tr>
</tbody>
</table>

1) Value-Based Purchasing.

Over 6000 Providers Participating in BPCI¹

BPCI¹ Participation by State

August 2014

1) Bundled Payments for Care Improvement.

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.
Number of ACOs Continues to Grow

Update on Accountable Care Organizations

As of April 2014.

Total Number of Operating ACOs

Total: 626

- Pioneer ACO Model: 23
- MSSP Cohort: 306
- Private Sector ACOs: 210
- Private & Public ACOs without announced contracts: 74
- ACOs without announced contracts: 13

Widening Reach of ACOs

- Portion of U.S. population living in a primary care service area with an ACO: 67%
- Portion of U.S. population treated by an ACO: 17%
- Medicare FFS beneficiaries treated by an ACO: 5.3M

Where the Medicare ACOs Are

23 Pioneer and 343 Shared Savings Program ACOs

April 2014

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.
Early Adopters Beginning to Reap Results

Physician-Led ACOs More Likely to Generate Savings

First-Year Spending Reduction By MSSP\(^1\) ACOs

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

Percent of MSSP ACOs that Earned Shared Savings by Sponsorship

- \(29\%\) Physician-Led
- \(20\%\) Hospital-Led

\(\text{2012 Cohort}\)

- \(\$126M\) 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.
Some Pioneers Dropping Out of the Program

Performance, Persistence Closely Correlated

### Pioneer ACO Performance

**Gross Savings as Percentage of Benchmark**

<table>
<thead>
<tr>
<th>First-year performance</th>
<th>Second-year performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Dropped out after second year; second-year performance not reported</td>
<td></td>
</tr>
</tbody>
</table>

**Gross Savings as Percentage of Benchmark**

- **Dropped out after first year**
- **Dropped out after second year**


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Provider Market

- Volume Performance
- Mergers and Acquisitions
- Partnerships and Affiliations
- Imaging Centers
- Ambulatory Surgery Centers
- Primary Care Network
Modest Growth Anticipated for the Near Term

Inpatient and Hospital Based Outpatient Volume Projections

<table>
<thead>
<tr>
<th>Inpatient Volume, CAGR¹</th>
<th>Hospital-Based Outpatient Volume, CAGR¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-2018</td>
<td>2013-2018</td>
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</tbody>
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<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>Neurosurgery</th>
<th>General Medicine</th>
<th>Orthopedics</th>
<th>General Surgery</th>
<th>Neurology</th>
<th>Cardiac Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>0.4%</td>
<td>2.6%</td>
<td>1.3%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>0.5%</td>
<td>(2.3%)</td>
</tr>
<tr>
<td>Neurosurgery</td>
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<tr>
<td>General Medicine</td>
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<td>Orthopedics</td>
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<tr>
<td>Neurology</td>
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<tr>
<td>Cardiac Services</td>
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<thead>
<tr>
<th></th>
<th>Overall</th>
<th>Oncology</th>
<th>Radiology</th>
<th>Cardiology</th>
<th>E&amp;M</th>
<th>General Surgery</th>
<th>Orthopedics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>1.5%</td>
<td>3.1%</td>
<td>1.8%</td>
<td>1.6%</td>
<td>1.2%</td>
<td>1.0%</td>
<td>0.8%</td>
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<tr>
<td>Oncology</td>
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<td>Radiology</td>
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<td>General Surgery</td>
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<td>Orthopedics</td>
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</table>

¹) Compound Annual Growth Rate

Source: Advisory Board Inpatient and Outpatient Market Estimators; Advisory Board research and analysis.
Volumes Continuing to Shift Outpatient

Medicare Volume Growth

Cumulative Percent Change

2006

2012

(12.6%)

28.5%

All Payer Volume Growth Projections

2013-2018

Cardiac Services

(11%)

11%

Vascular Services

(3%)

16%

Orthopedics

5.0%

15%

Neurosurgery

14.0%

17%

Outpatient Services per FFS Part B Beneficiary

Inpatient Discharges per FFS Part A Beneficiary

1) Outpatient services represent entire market regardless of site of service (includes hospital-based settings, ASCs, other freestanding providers and physician offices)

Volume Performance

Medicare to Become Majority of Volume by 2022

Projected Number of Medicare Beneficiaries

Millions of Beneficiaries

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2016</th>
<th>2018</th>
<th>2020</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>54.0</td>
<td>55.6</td>
<td>57.3</td>
<td>59.0</td>
<td>60.7</td>
</tr>
</tbody>
</table>

Average Inpatient Case Mix By Volume

n = 785 Hospitals

- 2012
  - Self-Pay: 33%
  - Medicaid: 19%
  - Commercial: 42%
  - Medicare: 6%

- 2022
  - Self-Pay: 25%
  - Medicaid: 15%
  - Commercial: 58%
  - Medicare: 2%

Mergers and Acquisitions Continue to Rise

Hospital Mergers and Acquisitions

<table>
<thead>
<tr>
<th>Year</th>
<th>Mergers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>65</td>
</tr>
<tr>
<td>2011</td>
<td>89</td>
</tr>
<tr>
<td>2012</td>
<td>95</td>
</tr>
<tr>
<td>2013</td>
<td>98</td>
</tr>
</tbody>
</table>

Number of Hospitals Part of a Health System 2000-2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>2542</td>
</tr>
<tr>
<td>2003</td>
<td>2626</td>
</tr>
<tr>
<td>2006</td>
<td>2775</td>
</tr>
<tr>
<td>2009</td>
<td>2921</td>
</tr>
<tr>
<td>2012</td>
<td>3100</td>
</tr>
</tbody>
</table>

M&A Plans for the Next 12 Months

- No M&A Activity: 12%
- Planned: 88%


1) September 2013.
New Partnerships Aim at Integration Without M&A

Partnerships and Affiliations On the Rise

- Large academic medical center signs preliminary partnership agreement with six rival hospitals to better compete with bigger systems
- Allina and HealthPartners affiliate to create a “testing lab” for accountable care
- Medium-sized academic medical center partners with smaller rival to fill cath lab service deficiencies
- New Hanover Regional Medical Center, Wilmington Health, BCBSNC agree to accountable care alliance
- Large medical center agrees to sell CON-approved open-heart surgery suite to competitor
- Baylor, CHI form community hospital joint venture to explore joint affiliation options

Growth Goals for Partnerships

- Ambulatory footprint
- Access to new regions
- New clinical program
- Brand equity

## Partnerships and Affiliations

### Five Major Types of Provider Partnership

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Merger or Acquisition</strong></td>
<td>Formal purchase of one organization’s assets by another, or the combination of two organizations’ assets into a single entity</td>
</tr>
<tr>
<td><strong>Clinically-Integrated Hospital Network</strong></td>
<td>Collection of hospitals contracting jointly in order to support improved coordination, outcomes; modeled after physician CI networks</td>
</tr>
<tr>
<td><strong>Accountable Care Organization</strong></td>
<td>Independent entity, owned by one or several independent organizations, that accepts risk-based contracts and distributes shared savings</td>
</tr>
<tr>
<td><strong>Regional Collaborative</strong></td>
<td>Flexible umbrella structure, often encompassing many independent organizations of similar geography, that may serve as foundation for further integration</td>
</tr>
<tr>
<td><strong>Clinical Affiliation</strong></td>
<td>Typically bilateral agreement to cooperate around a particular initiative or service line; may involve local or national partners</td>
</tr>
</tbody>
</table>
Imaging Center Market Dips After Years of Growth

First Decline Since 2009

Total Number of Imaging Centers in the U.S.

2005-2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Centers</th>
<th>Net Percent Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>6,241</td>
<td>5.60%</td>
</tr>
<tr>
<td>2008</td>
<td>6,455</td>
<td>3.40%</td>
</tr>
<tr>
<td>2009</td>
<td>6,150</td>
<td>-4.70%</td>
</tr>
<tr>
<td>2010</td>
<td>6,311</td>
<td>2.60%</td>
</tr>
<tr>
<td>2011</td>
<td>6,383</td>
<td>1.10%</td>
</tr>
<tr>
<td>2012</td>
<td>10,074</td>
<td>10.80%</td>
</tr>
<tr>
<td>2013</td>
<td>6,816</td>
<td>-3.60%</td>
</tr>
</tbody>
</table>

ASC Growth at All-Time Low

Total Number of Medicare-Certified ASCs

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Number</th>
<th>Net Percent Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>4,798</td>
<td>5.9%</td>
</tr>
<tr>
<td>2008</td>
<td>5,001</td>
<td>4.2%</td>
</tr>
<tr>
<td>2009</td>
<td>5,111</td>
<td>2.2%</td>
</tr>
<tr>
<td>2010</td>
<td>5,203</td>
<td>1.8%</td>
</tr>
<tr>
<td>2011</td>
<td>5,291</td>
<td>1.7%</td>
</tr>
<tr>
<td>2012</td>
<td>5,357</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

A Growing Network of Immediate Access Choices

Markets Responding to Unmet Needs

Consumer-Oriented Service Delivery Sites Filling the Gap

Driving Provider Questions:

- Should we partner to establish **retail clinics**?
- Should we build or expand our **urgent care** footprint?
- Is **virtual care** something that we should provide?
- When should we enter into **partnerships** to meet patient demands?

Source: Mehrota A et al, “Visits To Retail Clinics Grew Fourfold From 2007 To 2009, Although Their Share Of Overall Outpatient Visits Remains Low,” Health Affairs, August 2012; Health Care Advisory Board interviews and analysis.
Major Opportunity to Shift Primary Care Volumes

Redistributing Non-emergent Care to Appropriate Lowest-Acuity Sites

Visits At Risk of Shifting to Other Sites of Care

- **Annual Visits to PCPs**: 573M
- **Visits Eligible for NP-Led Care**: 103M (18% of PCP visits could be handled by NPs at convenient care sites)
- **Annual ED Visits**: 132M
- **Non-urgent ED Visits Shifted to Other Care Sites**: 47M (Non-urgent ED visits could be treated at urgent care, retail or primary care)

Retail Clinics Expected to Continue Growing

Estimated Total Number of Retail Clinics in the US 2000-2015

Growth trajectory depends on preferred payer relations, PCP capacity, and health system partnerships

Retailer

Operational Retail Clinics¹

minuteclinic  900+

Walgreens healthcare clinic  400+

The Little Clinic  135

Walmart  14

TARGET  75+

¹ As of Oct. 2014.

Providers Expanding the Applications of Virtual Care

From Administrative Transactions to Real-Time Care Delivery

Virtual Care Platform Function

- **Automate Administrative Functions**
  - View medical records
  - Schedule in-person appointments
  - Refill existing prescriptions
  - Pay bill

- **Streamline Clinical Transactions**
  - Prescribe new medications
  - Receive lab results
  - Deliver online education, shared decision-making tools

- **Virtualize Care Delivery**
  - Asynchronous, message-based visits
  - Live, video-based visits

**A Fast-Emerging Market Segment**

- **Estimated revenue from virtual visits in 2018, up from $100M in 2013**:
  - $13.7B

- **Projected increase in households using virtual care between 2013-2018**:
  - 220%

Purchaser Behavior

- Commercial Payers
- Employers
- Medicare
- Coverage Expansion
Anticipated Provider Reimbursement Rates for Exchange Plans

- **Catholic Health Initiatives**: Modest discounts from commercial rates
- **Tenet Healthcare**: Up to 10% below commercial rates
- **Millern Medical Center**: 20% below commercial rates
- **Meyers Health**: 10% above Medicare rates
- **WellPoint Inc.**: Between Medicare and Medicaid rates
- **Meriwether Hospital**: 5% below commercial rates

Employer Shifting Risk by Increasing Cost-Sharing

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*

<table>
<thead>
<tr>
<th>Year</th>
<th>Small Firms (3-199 Workers)</th>
<th>Large Firms (200+ Workers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>40%</td>
<td>13%</td>
</tr>
<tr>
<td>2010</td>
<td>46%</td>
<td>17%</td>
</tr>
<tr>
<td>2011</td>
<td>50%</td>
<td>22%</td>
</tr>
<tr>
<td>2012</td>
<td>49%</td>
<td>26%</td>
</tr>
<tr>
<td>2013</td>
<td>58%</td>
<td>28%</td>
</tr>
</tbody>
</table>

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

*n = 1,100 employers*

<table>
<thead>
<tr>
<th>Year</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$680</td>
<td>$1,000</td>
</tr>
<tr>
<td>2010</td>
<td>$760</td>
<td>$1,380</td>
</tr>
<tr>
<td>2011</td>
<td>$1,010</td>
<td>$1,750</td>
</tr>
<tr>
<td>2012</td>
<td>$940</td>
<td>$1,570</td>
</tr>
<tr>
<td>2013</td>
<td>$1,230</td>
<td>$2,110</td>
</tr>
</tbody>
</table>

Public HIX Participants Choosing High Deductibles

Annual Deductibles of Individual Plans Selected on eHealth

October 2013 – March 2014

- 30% of plans had $3,000-$5,999 deductibles
- 5% had $2,000-$2,999 deductibles
- 13% had $1,000-$1,999 deductibles
- 3% had $500-$999 deductibles
- 11% had $1,000-$1,999 deductibles
- 3% had < $500 deductibles
- 39% had $6,000+ deductibles

Public Exchange Plans Mainly Narrow Network

Payers Responding to Anticipated Premium Sensitivity

Majority of Public Exchange Plans Exclude >30% of Largest Hospitals

20 Urban Markets, December 2013

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

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

Traditional Employer Coverage Eroding

Will Employers Maintain Coverage, and How?

Spectrum of Options for Controlling Health Benefits Expense

“Abdication”

Drop Coverage

Pros:
- Escape from cycle of rising premium costs

Cons:
- Employer mandate penalty
- Labor market disadvantage

“Activation”

Convert to Self-Funding

Pros:
- Close control over network design
- Exemption from minimum benefits requirements

Cons:
- Greater financial risk
- Network assembly challenging

Shift to Private Exchange

Pros:
- Responsiveness to employee preference
- Predictable, defined contributions

Cons:
- Disruption to benefit design
- Risk employees may underinsure

Source: Health Care Advisory Board interviews and analysis.
Employers’ Alternatives to Providing Coverage

Several Strategies to Avoid ACA Mandate Penalties…

1. Cut jobs to remain under 50 FTEs
2. Convert full-time employees to part-time status
3. Hire all new employees at part-time status
4. Split into smaller companies with fewer than 50 FTEs

…Though Some May Consider Penalty a More Economical Option

$2,000
Penalty per employee for failing to provide qualifying health coverage

Average Cost of 2014 Employer-Sponsored Insurance

- Single: $5,884
- Family: $16,351


1) Full-time equivalents.
Huge Growth Forecast for Private Exchanges

Low-Wage Employers Most Active Today, but Skilled Industries in the Wings

Potential Growth Path for Private Exchange Enrollment

Prominent Employers Using Private Exchanges

For Active Employees:  
Walgreens  petco  SEARS  Olive Garden

For Retirees:  
(Medicare Advantage, Medigap plans)

172  Private exchange operators as of October 2014

Source: Accenture, “Are You Ready? Private Health Insurance Exchanges are Looming;” privatehealthexchange.com; Health Care Advisory Board interviews and analysis.
Self-Funding Strategies Steadily Gaining Ground

Percentage of Covered Workers in Self-Funded Plans

<table>
<thead>
<tr>
<th>Year</th>
<th>49%</th>
<th>54%</th>
<th>59%</th>
<th>61%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td></td>
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<td></td>
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<tr>
<td>2005</td>
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<tr>
<td>2010</td>
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<tr>
<td>2014</td>
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ACA Benefits Standards Avoidable Through Self-Funding

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

Medicare FFS Payment Cuts Continue

**ACA’s Medicare Fee-for-Service Payment Cuts**

*Reductions to Annual Payment Rate Increases*

<table>
<thead>
<tr>
<th>Year</th>
<th>Payment Cuts</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>($25B)</td>
</tr>
<tr>
<td>2018</td>
<td>($32B)</td>
</tr>
<tr>
<td>2019</td>
<td>($42B)</td>
</tr>
<tr>
<td>2020</td>
<td>($53B)</td>
</tr>
<tr>
<td>2021</td>
<td>($64B)</td>
</tr>
<tr>
<td>2022</td>
<td>($75B)</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

1) Includes hospital, skilled nursing facility, hospice, and home health services; excludes physician services; annual reductions rounded.

2) Disproportionate Share Hospital.

Majority of States Expanding Medicaid

State Participation in Medicaid Expansion

September 2014

Public Exchange Enrollment Exceeds 8 Million

Bumpy Rollout Did Not Dampen Projections

Projected and Actual Enrollment in Qualified Health Plans

2014-2019

Unchanged despite flawed rollout

Individuals Gravitating Toward Leaner Plans

Metal Tiers of Plans Chosen on Public Exchanges

*October 2013 to April 2014*

- **All Enrollees**
  - Silver: 65%
  - Bronze: 20%
  - Gold: 9%
  - Platinum: 5%
  - Catastrophic: 2%

- **Enrollees Without Premium Subsidies**
  - Silver: 25%
  - Gold: 21%
  - Platinum: 10%
  - Bronze: 12%
  - Catastrophic: 33%

Second Round of Open Enrollment Will Reveal True Dynamics

Trends to Watch:

1 Enrollment
   • Are the technical glitches really fixed?
   • Will higher individual mandate penalties change anyone’s mind?
   • Will the young and healthy turn out in force?

2 Choice and Mobility
   • How will automatic reenrollment affect consumer behavior?
   • Will last year’s bargain hunters regret choosing high deductibles and narrow networks?
   • Can plans that raise premiums maintain market share?

3 Market Reaction
   • How aggressively will providers court the newly insured?
   • Will employers dump workers onto the exchanges?
Provider Selection Trends

- Independent Physicians
- Patients
Referral Choice Criteria Different for PCPs, Specialists

Emerging and Traditional Differentiators for Physicians

The Extended Service Line Referral Pathway

PCP → Medical Specialist → Proceduralist → Hospital

Sources of Influence:
- Consumer Interventions
- Value-Based Incentives
- Steerage Mechanisms

Traditional Differentiators
- Top-notch specialty capabilities and technology
- Superior specialist access
- Operations focused on specialist efficiency

Emerging Differentiators
- Comprehensive care continuum
- Highest value of care
- Superior patient access and experience

Source: Service Line Strategy Advisor interviews and analysis.
Referrals Hinge on Accessibility and Communication

**Top Four Factors When Choosing a Specialist**

Rated as Moderate or Major Importance

\[ n = 553 \]

<table>
<thead>
<tr>
<th>Factor</th>
<th>Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Skill</td>
<td>100%</td>
</tr>
<tr>
<td>Appointment Timeliness</td>
<td>96%</td>
</tr>
<tr>
<td>Quality of Communication</td>
<td>95%</td>
</tr>
<tr>
<td>Patient Experience with Specialist</td>
<td>94%</td>
</tr>
</tbody>
</table>

**PCPs’ Referral Decision Factors Compared to Specialists**

1.5x

PCPs 1.5 times more likely to refer based on physician communication than specialists

2x

PCPs two times more likely to refer based on timely availability of appointments than specialists

---

1) Top four factors (out of 17 options) rated by PCPs as either a moderate or major factor in their specialty referral decision

Market Forces Turning Patients into Consumers

Catalyzing a Shift in Network Demands

Characteristics of a Traditional vs. Retail Market

**Traditional Market**
- Passive employer, price-insulated employee
- Broad, open networks
- No platform for apples-to-apples plan comparison
- Disruptive for employers to change benefit options
- Constant employee premium contribution, low deductibles

1. **Growing number of buyers**

2. **Proliferation of product options**

3. **Increased transparency**

4. **Reduced switching costs**

5. **Greater consumer cost exposure**

**Retail Market**
- Activist employer, price-sensitive individual
- Narrow, custom networks
- Clear plan comparison on exchange platforms
- Easy for individuals to switch plans annually
- Variable individual premium contribution, high deductibles

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

Patient Experience Vital For Securing Purchaser Choice Year Over Year

Network Selection and Ongoing Experience

- 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

Day 1
Day 365

Care Decision

Patient Experience

Care Decision

Care Decision

Care Decision

Care Decision

Care Decision

Source: Health Care Advisory Board interviews and analysis.
Consumers’ Top 10 Primary Care Clinic Attributes

Prioritizing Convenience and Affordability

### Average Utilities for Top Ten Preferred Primary Care Clinic Attributes

*n=3,873*

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Utility</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can walk in without an appointment, and I’m guaranteed to be seen within 30 minutes</td>
<td>4.11</td>
</tr>
<tr>
<td>If I need lab tests or x-rays, I can get them done at the clinic instead of going to another location</td>
<td>3.98</td>
</tr>
<tr>
<td>The provider is in-network for my insurer</td>
<td>3.95</td>
</tr>
<tr>
<td>The visit will be free</td>
<td>3.94</td>
</tr>
<tr>
<td>The clinic is open 24 hours a day, 7 days a week</td>
<td>3.91</td>
</tr>
<tr>
<td>I can get an appointment for later today</td>
<td>3.70</td>
</tr>
<tr>
<td>The provider explains possible causes of my illness and helps me plan ways to stay healthy in the future</td>
<td>3.04</td>
</tr>
<tr>
<td>Each time I visit the clinic, the same provider will treat me</td>
<td>3.01</td>
</tr>
<tr>
<td>If I need a prescription, I can get it filled at the clinic instead of going to another location</td>
<td>3.00</td>
</tr>
<tr>
<td>The clinic is located near my home</td>
<td>3.00</td>
</tr>
</tbody>
</table>

Patient Preferences for Online Care Growing

Survey Finds Email Visits Preferred to Clinic Near Errands or Work

Preference for Location of Services

- Clinic located near work
- Clinic located near errands
- Emailing provider with symptoms
- Clinic located near the home

Increasing Consumer Preference

1) Based on proportions of respondents interested in telehealth.

Young, Wealthy, Busy—Strongest Potential Telehealth Targets

- 54% Of 18-29 yrs olds
- 49% Of those making >$71K per year
- 53% Of those working >35 hours per week

Consumers Seeking Accurate Estimates

Patients

Primary Care Consumer Survey Results

55th Rank, out of 56 attributes, of “not knowing how much the visit would cost until receiving the bill”

Compared to Not Knowing How Much the Visit Costs Until Receiving the Bill:

- Would rather pay $100 out of pocket: 38%
- Would rather pay $50 out of pocket: 74%
- Would rather drive 20 minutes to the clinic: 76%
- Would rather have to go to another clinic for lab tests, x-rays, or pharmacy: 92%

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