OSU | MEDICINE

2020 Health Care Industry:

Outlook and Environmental Review

Payment reform

- ACA
- Medicare for All and policy proposals
- Shift to value-based care

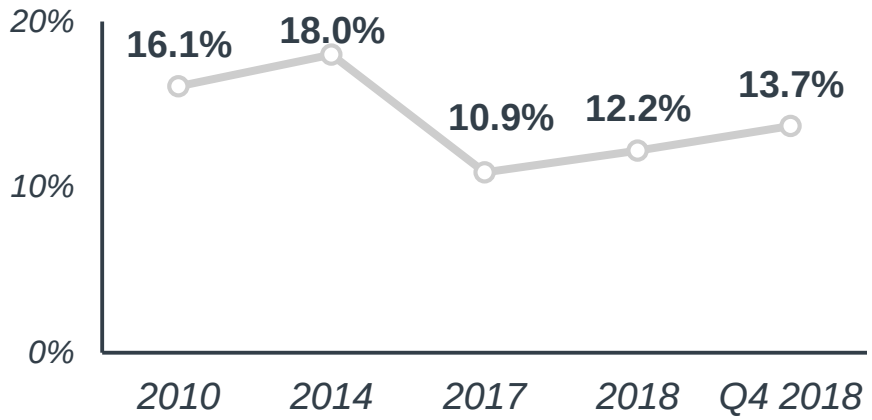
Declining insurance coverage sparking concern

If upheld, challenge to ACA would eliminate coverage gains

ACA didn't deliver universal coverage

2M CBO estimate of additional uninsured individuals in 2019 compared to 2017

Percentage of Americans who report they are uninsured (ages 18+)



Ongoing legal challenges compounding uncertainty

Texas vs. United States

Background

Challenges constitutionality of individual mandate without associated penalty

What's at stake

Argues that without mandate, constitutionality of the ACA in its entirety should be struck down

Current status

District Court → **Fifth Circuit** → Appeals court → **Supreme Court**

Source: "Federal subsidies for health insurance coverage for people under age 65: 2019 to 2029," Congressional Budget Office, May 2019; Witters D, "U.S. Uninsured Rate Rises to Four-Year High," Gallup, January 23, 2019.

Unaffordability is the biggest reform catalyst of all

Consumers and policymakers grapple with unsustainable cost trajectory

Consumer unaffordability

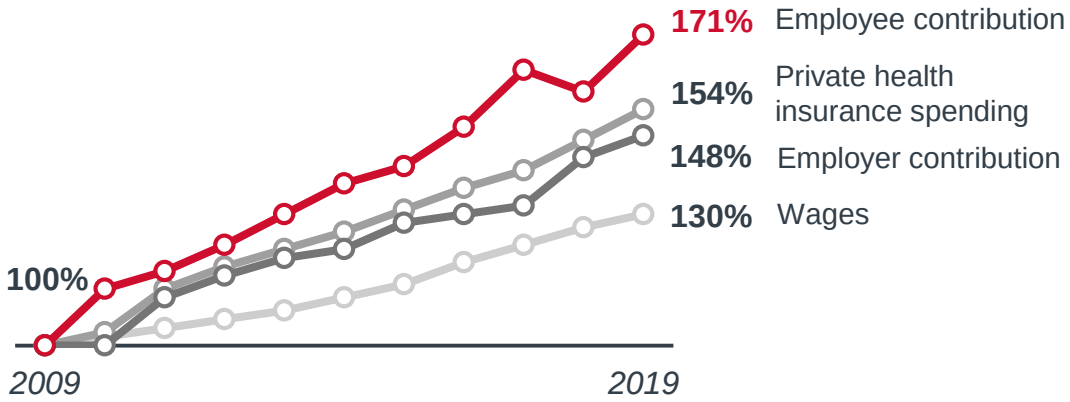
$20,000 Average **total cost of employer-provided coverage** for a family in 2019

Government unaffordability

2026 Estimated date by which Medicare's **trust fund will be depleted**, 3 years earlier than previously expected

Health economic indicators

Cumulative increase; Indexed to 100% in 2009



Expiration of ACA rate adjustment in 2019 means higher rate increases—and worsened budgetary problems for CMS

+3.1% Finalized **payment rate update for IPPS[1] in FY 2020**

Source: "Wage Growth Tracker," Federal Reserve Bank of Atlanta, May 9, 2019; Kamal R and Sawyer B, "How much is health spending expected to grow?" Kaiser Family Foundation, March 12, 2019; Kaiser Family Foundation, Employer Health Benefits Survey, 2009-2019; Girod C, et al., "2018 Milliman Medical Index," Milliman, May 2018; "2019 annual report of the boards of trustees of the federal hospital insurance and federal supplementary medical insurance trust funds," Medicare Board of Trustees, April 22, 2019.

1. Inpatient Prospective Payment System.

Medicare for All would entail large reimbursement shift

A clear threat to the cross-subsidy

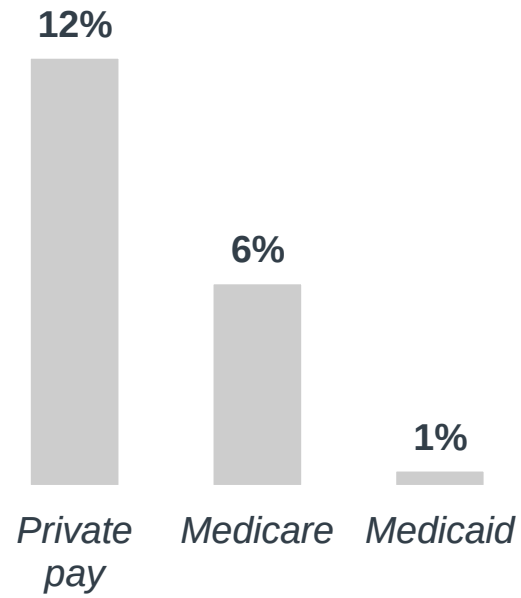
Employers shoulder an outsized share of health care costs

241%

Percentage that private health insurance pays hospitals compared to Medicare, on average

Cumulative hospital price growth by payer segment

June 2014–February 2019



Initial Medicare for All projections paint bleak picture for hospital finances

JAMA

15.9%

Projected **net decline in hospital revenue** under Medicare for All

Navigant

22%

Projected **decline in net margin at model health system** under Medicare for All

Source: White C and Whaley C, "Prices paid to hospitals by private health plans are high relative to Medicare and vary widely," RAND, 2019; "Health sector economic indicators: Price brief," Altarum, March 15, 2019; Schulman K, "The implications of 'Medicare for All' for US hospitals," JAMA, April 4, 2019; Goldsmith J, et al., "Medicare expansion: A preliminary analysis of hospital financial impacts," Navigant, 2019.

Considerable variability in current reform proposals

Comparing plans to expand public coverage

	Medicare for All	Medicare public option	Medicare buy-in at 50	
Proposed approach	Would transition all U.S. residents to a national health insurance plan. *Legislation has been introduced in the Senate.*	Would offer a public health plan tied to Medicare fee schedule as an option on the public exchanges. *Legislation has not been introduced in Congress.*	Would offer Medicare Parts A and B and/or Medicare Advantage as options on the exchanges for those aged 50-64. *Legislation has been introduced in the Senate.*	
Disruptive potential	Very high	High	Medium	
Current supporters	Bernie Sanders, Kamala Harris, Elizabeth Warren, Cory Booker, Kirsten Gillibrand	Joe Biden, Pete Buttigieg, Amy Klobuchar, Michael Bennet	Debbie Stabenow, Tammy Baldwin, Cory Booker, Amy Klobuchar, Kamala Harris	

Source: United States, Congress, Senate, "Medicare for All of 2019"; United States, Congress, Senate, "Medicare at 50 Act of 2019"; United States, Congress, House, "State Public Option Act of 2019."

States testing a range of spending caps

Non-comprehensive overview of 2019 proposals and announcements

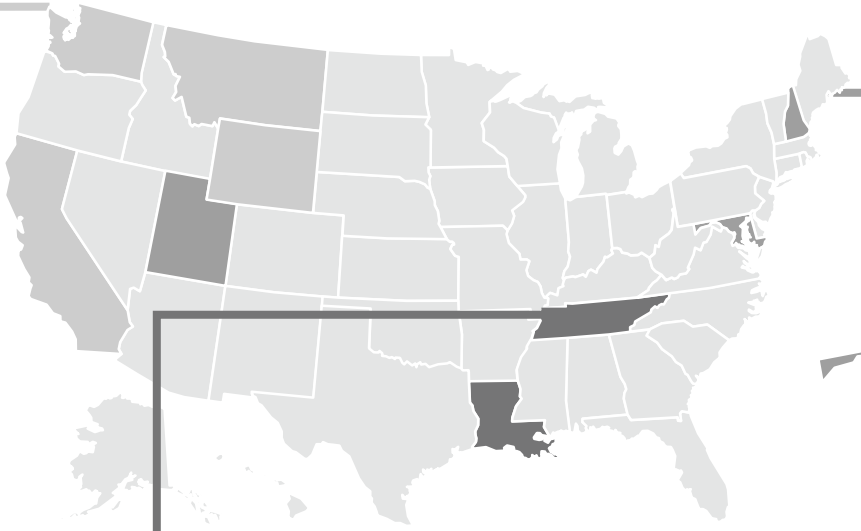
Price cap

WA: Legislature passes **"public option"** proposal for the exchanges; caps rates at 160% or Medicare

MT: Announces $13.6M savings from **indexing rates to Medicare** for state health plan

WY: Requesting waiver to reimburse for all air ambulance services in the state at **Medicaid rates**

CA: Sets payment for **surprise out-of-network bills** at greater of 125% of Medicare's rate or the average in-network rate in the region



Per capita cap

NH: **All-payer ACO model** limits expenditure growth to 3.5%; sole SIM[1] model to slow increase in spending

MD: Expands **all-payer global budget program** to outpatient services, setting a per capita limit on total cost of care

UT: Received waiver for partial **Medicaid expansion** with annual spending caps

Global spending cap

TN: Approved legislation for state to submit **Medicaid block grant** proposal to CMS

LA: **"Netflix model" caps spending** for Hepatitis C drugs

1. State innovation model.

Health Care Advisory Board interviews and analysis.

Bipartisan support for regulating drug prices

But disagreement over *how* to regulate

Range of price controls under consideration garner bipartisan support across Senate, House and Administration

Empower HHS Secretary with broad authority to **negotiate prescription drug prices**, both for Medicare and for the private market

Require **inflationary clawbacks** through which manufacturers would have to pay a rebate if drug prices increase above the rate of inflation

Restructure Part D benefits to **cap beneficiary out-of-pocket costs** and realign financial incentives within the benefit structure

Stakeholder implications

Providers

Lower reimbursement for administered drugs

Drug manufacturers

Greater competition and pricing pressure

Health plans

Greater financial exposure for pharmaceutical costs

Source: United States, Congress, House, "Lower Prescription Drug Costs Now Act of 2019"; United States, Congress, Senate "Lower Health Care Costs Act of 2019."

Surprise bills a focal point in the affordability debate

Aggressive industry pushback invites additional scrutiny

May 2018 - April 2019

Media coverage drives support for government solution

- Reporter begins year-long investigation into hospital billing
- Media collects thousands of bills, publishes dozens of stories on the prevalence and impact of surprise billing

April 2019 - July 2019

Bipartisan agreement: Surprise bills must go

- House holds first-ever hearing on surprise medical bills
- President Trump calls on Congress to enact legislative solution
- Senate and House introduce surprise billing legislation

August 2019

Divisions widen amid pushback and lobbying

- $30+ million spent on ads to kill surprise billing legislation over Congress' August recess
- Divisions among lawmakers widen over optimal solution

September 2019

House refocuses, shines spotlight on lobbying efforts

- House launches investigation into private equity's role in lobbying against legislative fix
- House proposes negotiated rulemaking process to resolve differences on surprise bills

Source: Kliff S, "Hospitals kept ER fees secret. We uncovered them," Vox, February 27, 2018; Roubein R, "Health groups backed dark money campaign to sink 'surprise' billing fix," POLITICO, September 13, 2019.

A renewed push to mandate transparency

Administration's actions on health care transparency in 2019

Finalized regulations

CMS builds app-based out-of-pocket cost calculator for Medicare procedures and drugs and procedure price lookup tool

Hospitals must post list prices online as of January 1, 2019

Drug makers required to disclose list prices in TV ads for prescription drugs[1]

Impending regulations

June 24, 2019: Executive Order on Improving Price and Quality Transparency

Directs federal agencies to create regulations requiring hospitals and insurers to disclose prices and provide pre-service bills

November 15, 2019: Final Hospital Outpatient Prospective Payment Rule

CMS finalizes rules requiring hospitals to publish payer-specific negotiated charges for all items and services effective January 1, 2021

"We are fundamentally changing the nature of the health care marketplace… prices will come down by numbers that you won't even believe."

—President Donald Trump

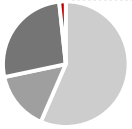
1. Struck down by a federal judge on July 8, 2019; HHS currently working with Department of Justice to determine next steps.

Source: Florko N, "Drug makers will have to include prices in TV ads as soon as this summer," Statnews, May 8, 2019; Executive Order 13877 on Improving Price and Quality Transparency in American Healthcare to Put Patients First, June 24, 2019; Remarks by President Trump at Signing of Executive Order 13877, White House.

Continued transition to risk-based alternative payment

Though pace of transition highly variable across payer segments

Progression to alternative payment methodology

	Traditional fee-for-service	Pay-for-performance	Shared savings and bundles	Population-based payments[1]
 **Medicare Advantage**	48.0%	2.5%	39.2%	10.3%
 **Original Medicare**	10.5%	51.2%	33.8%	4.5%
 **Medicaid**	67.8%	7.2%	20.8%	4.2%
 **Commercial**	56.5%	15.2%	26.6%	1.7%
All-payer	**41.0%**	**25.4%**	**29.8%**	**3.8%**

1. Prospective PMPM payments, global budgets or full/percent of premium payments, and integrated delivery systems.

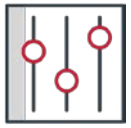
Source: "Progress of alternative payment models," HCP LAN, 2018.

CMS continues its multi-front advance toward value

Administration actions on value-based payment in 2019

Decrease regulatory barriers to value-based care

- Allow MA plans and Medicaid MCOs to use government funds to cover non-medical services
- Expand reimbursement for telehealth services
- Allow ambulance care teams greater flexibility (ET3)[1]
- Investigate reforms to Stark law to enable care coordination



Refine alternative payment model options

- Revamp ACO program to accelerate transition to downside risk
- Establish shared risk/reward program for Part D plans
- Create Direct Contracting (DC) and Primary Care First (PCF) models for primary care providers and risk-bearing entities

Mandate participation

- Propose mandatory Radiation Oncology bundled payment model (RO) for radiotherapy treatment of 17 common cancer types
- Propose mandatory End-Stage Renal Disease Treatment Choices payment model (ETC) for End-Stage Renal Disease (ESRD) treatment facilities and clinicians who manage beneficiaries with ESRD

1. Emergency triage, treat, and transport.

Source: Porter S, "Verma: CMS developing more mandatory payment models," April 26, 2019.

CMS trying to accelerate transition to downside and support physician-led ACOs

Program overhaul seeks to accelerate shift to downside risk, boost physician-led ACO participation

Accelerate transition to downside risk

Amount of time spent in upside-only reduced **from six to two years**

Encourage participation of physician-led ACOs

Low-revenue ACOs may stay in upside-only for an additional year, are subject to lower maximum losses

2018 ACO results reaffirm: Risk-bearing and physician-led ACOs achieve greatest savings

	ACO type	Generated total savings	Generated total losses
	**Upside-only**	64%	36%
	**Downside**	**78%**	22%
	**High revenue**	58%	42%
	**Low revenue**	**77%**	23%

$739M In total net savings in 2018

1. Medicare Shared Savings Program.
2. Previous Track 1 participants must begin participation at Level B; previous participants in risk-based models (e.g., Tracks 2 or 3) may not participate in BASIC track.

Source: CMS, "Final Rule Creates Pathways to Success for the Medicare Shared Savings Program," December 21, 2018.

New pilots “foster independence, reward outcomes”

“Primary Cares” models downplay importance of size and access to capital

Initial ACO eligibility requirements favored hospitals

Required scale

- Have enough physicians to manage a minimum of **5,000 Medicare FFS beneficiaries**
- Must be in same TIN[1] and participating TINs must be clinically integrated

Required capital reserves

- Must be able to cover expense of population health investments a year or more before savings distributed
- Must invest in IT integration to meet quality reporting requirements and enable data mining

Direct Contracting and Primary Care First models encourage smaller, non-hospital partners

Welcomes smaller practices

- Primary Care First requires only **125 beneficiaries** to participate
- Voluntary alignment may help attract more beneficiaries to meet minimum Direct Contracting model requirement

Eases capital requirements

- Earlier performance reconciliation and payout
- Enhanced data sharing may reduce need to invest in EHR integration

Offers salary enhancement

CMS officials estimate that a PCP making **$200K today could make $300K** under the model

1. Tax identification number.

Source: “Direct Contracting,” CMS Newsroom, April 22, 2019; “Primary Care First: Foster independence, reward outcomes,” CMS Newsroom, April 29, 2019.

Both public and private payers looking to physicians

CMS creating tailored value-based care programs for physicians

Refining existing ACO program

MSSP overhaul includes distinction between high- and low revenue ACOs to create lower-risk participation option for physician groups

Creating new "Primary Cares" models

- Primary Care First track targeted to individual physician practices
- Direct Contracting track targeted to large medical groups and risk-bearing entities

Private payers creating closer relationships with physicians

Employers promoting independent PCPs

PepsiCo Inc. waives premiums for employees that use an independent physician in Dallas-Fort Worth

Health plans offer path to value

- **BCBS of Massachusetts** and Atrius announce seven-year deal that pays a prospective, capitated amount for 130K commercial PPO members
- **CareFirst PCMH** model offers practice support without downside financial risk

Health plans building hospital-less IDNs

- **OptumCare[1]:** 17 networks across 13 states
- **Humana:** 233 owned, joint-ventured, and alliance clinics across 30 markets

1. Advisory Board is a subsidiary of Optum. All Advisory Board research, expert perspectives, and recommendations remain independent.

Source: Schnurman M, "Why PepsiCo is paying D-FW employees to go to the doctor's office," The Dallas Morning News, December 2, 2018; "Atrius Health, Blue Cross Blue Shield of Massachusetts announce deeper collaboration to transform health care experience," BCBS of MA Newsroom, February 7, 2019; "CareFirst PCMH Program Background, History and Results (2011-2016)," CareFirst BlueCross BlueShield, Q2 2017; Japsen B, "Humana to expand senior care clinic network to new markets," Forbes, March 19, 201.

Purchaser behavior

- Risk shifting
- Medicaid and Medicare
- Employers

The era of risk-shifting has yielded decidedly mixed results

Private payers **shifted risk to consumers**

PRIMARY GOALS	STATUS TODAY
Off-load greater financial responsibility to patients	Cumulative out-of-pocket spending increased by 12.2% from 2013 to 2017[1]
Incentivize consumers to seek high-value care	Workers with deductibles are more likely to delay care; deductibles reduce use by 13.8%[2]
Encourage competition between providers on basis of price	Little evidence of shopping beyond imaging; only 14.4% of HDHP[3] enrollees shop based on price

Public payers **shifted risk to providers**

PRIMARY GOALS	STATUS TODAY
Elevate delivery of high-quality care	MedPAC calls for overhaul of Medicare quality payment programs in March 2019
Eliminate incentives encouraging delivery of unnecessary care	38% of Medicare payments tied to APMs[4] as of 2018, compared to goal of 50%
Reduce government spending on health care	Medicare spending growth accelerated to 5.9% in 2018

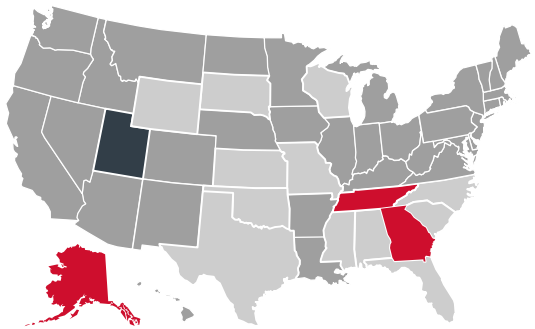
1. Employer-sponsored insurance.
2. For those with a deductible greater than $1,000.
3. Defined as deductible amount greater than $1,350.
4. Alternative payment models.

Source: "2017 health care cost and utilization report," HCCI, February 2019; Brot-Goldberg Z, et al., "What does a deductible do? The impact of cost-sharing on health care prices, quantities, and spending dynamics," NBER, October 2015; Kullgren J et al., "A survey of Americans with high-deductible health plans identifies opportunities to enhance consumer behaviors," HealthAffairs, March 2019; "Medicare payment policy: 2019 report to the congress" MedPAC, March 2019; "National Health Expenditure Projections 2018-2027," CMS, February 2019; "HHS not adhering to Obama admin's 2018 value-based payment goals," *Daily Briefing*, February 21, 2018; "Progress of alternative payment models," HCP LAN, 2018.

Block grants for Medicaid back on table

Funding caps could limit enrollment and reimbursement prospects

Medicaid program status



- Expanded Medicaid
- Have not expanded Medicaid
- Per capita cap
- Block grant debated by state officials[1]

Tennessee proposes alternative Medicaid financing structure

Draft proposal submitted to CMS on October 1 and is currently under review

Block grant amount calculated based on projected costs and serves as the floor for federal funding, inflated annually

Per capita adjustments to block grant amount account for enrollment increases that may occur in future years

Shared savings mechanism by which savings to the federal government are shared equitably with the state

Open questions

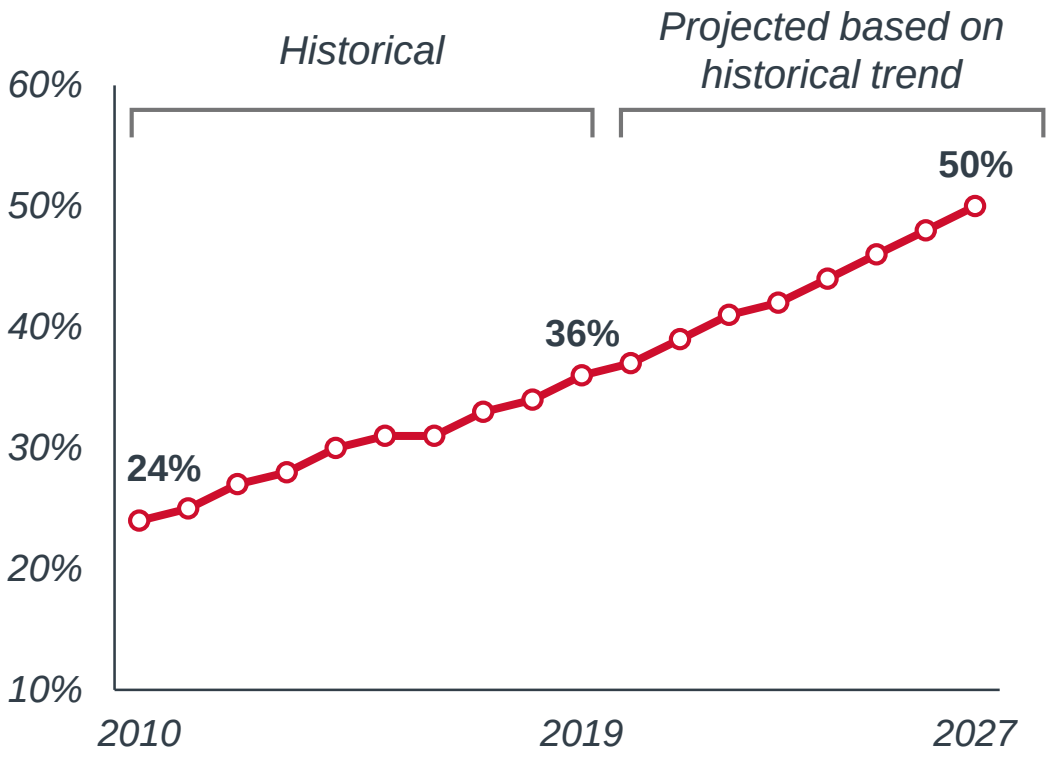
- Does CMS have the authority to approve block grants under current law?
- If block grants are approved, how will enrollment, Medicaid financing, and provider rates be affected over time?
- Will other states use flexibility granted by CMS to reshape Medicaid payment structure?

1. Georgia and Tennessee have not expanded Medicaid; Alaska has expanded Medicaid.
2. The Trump administration has rejected Utah's request for partial expansion as of July 2019.
3. Federal poverty level; estimated 40K fewer people covered compared to full expansion.

Source: "Status of state Medicaid expansion decisions," Kaiser Family Foundation, May 13, 2019.

Medicare Advantage continues rapid growth

Medicare Advantage penetration, historical and projected



Trump Administration reaffirms bet on MA

Executive Order on Medicare calls for:

- Innovative MA benefit structures and plan designs
- Payment models that give beneficiaries rebates for seeking high-value care
- Streamlined approval process for telehealth technologies to accelerate adoption

Health plans doubling down on MA growth in 2020

- UnitedHealthcare[1] will sell coverage in 100 new counties
- Humana will expand to 29 new counties
- Cigna will expand to 37 new counties
- CVS Health's Aetna will expand MA sales to 264 new counties

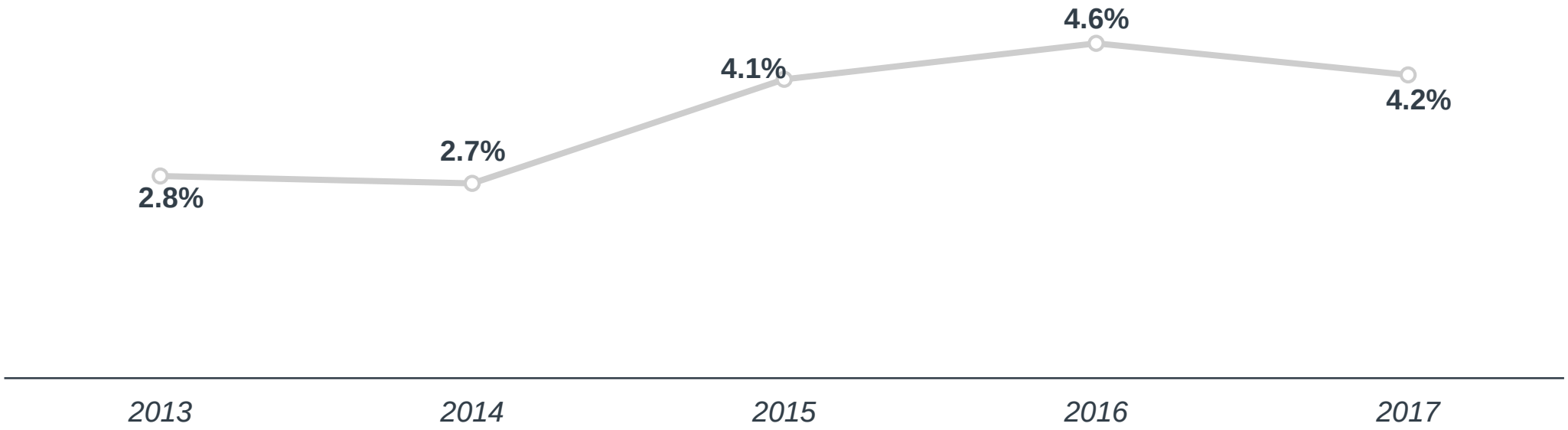
1. Advisory Board is a subsidiary of UnitedHealth Group. All Advisory Board research, expert perspectives, and recommendations remain independent.

Source: "Medicare Advantage premiums continue to decline while plan choices and benefits increase in 2019," CMS, September 28, 2018; Jacobson G, "A dozen facts about Medicare Advantage," Kaiser Family Foundation, November 13, 2018.

Employer health spending continues to grow

Employer health care spending continues to rise

Percent change in annual spending per person, relative to previous year

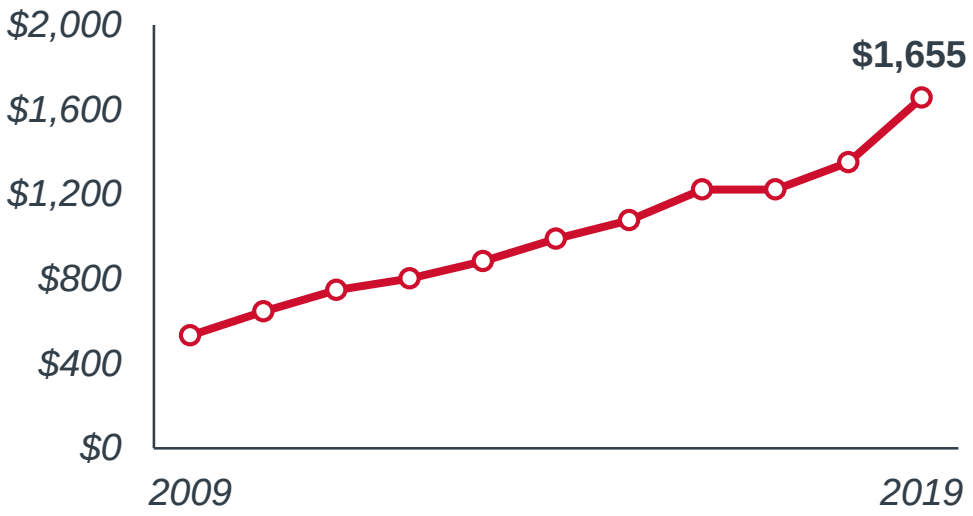


Source: HCCI, "2017 Health Care Cost and Utilization Report," February 2019.

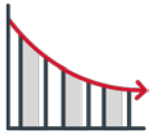
Employers recognize HDHP shortfalls

Off-loading more costs to patients

Average annual deductible for single coverage

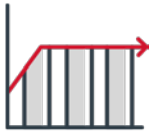


Two major shortfalls of HDHPs



“Too blunt”

HDHPs lead to delays in care and reductions in utilization for all services below the deductible, including preventive care.



“Too limited”

HDHPs do not encourage price shopping for services above the deductible, including many high-cost, “shoppable” services.

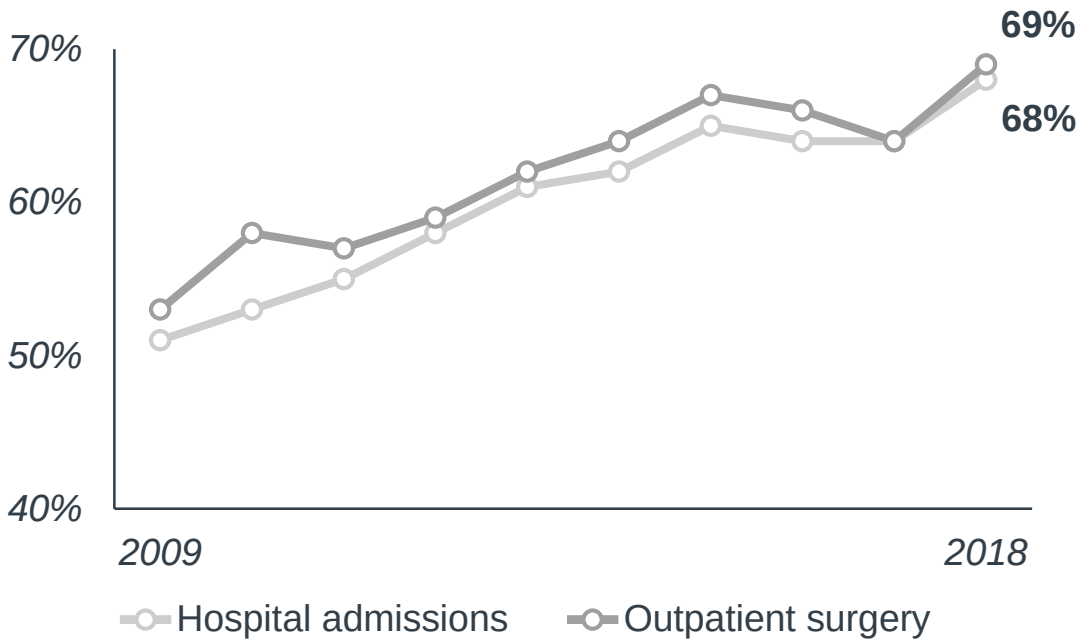
Source: “2019 annual survey: Employer health benefits,” Kaiser Family Foundation, 2018.

Coinsurance a partial—but still limited—solution

Despite increases in plans with coinsurance, few services are "shoppable"

In theory, rise in coinsurance provides incentive to shop beyond deductible

Percentage of workers in a plan with hospital and outpatient coinsurance



In practice, out-of-pocket max still limits incentive to shop

Price threshold where consumer hits out-of-pocket max

Plan type[1]	Price threshold
1 Generous plan • Deductible: $800 • OOP max: $2,000	<$7,000
2 Average plan • Deductible: $1,600 • OOP max: $3,872	**<$13,500**
3 Skimpy plan • Deductible: $3,200 • OOP max: $6,000	<$18,000

1. Assumes coinsurance sharing rate of 19%.

Source: "2018 annual survey: Employer health benefits," Kaiser Family Foundation, 2018.

Health Care Advisory Board interviews and analysis.

Targeting cost exposure at the provider level

Walmart evolves and expands financial incentives to ensure COE use

2013

Offers **zero cost-sharing** for use of a center of excellence (COE) for heart, hip and knee, and spinal procedures

2017

Raises employee cost-sharing to 50% for use of non-COE locations for spine surgery

2019

Mandates use of a COE location for spine surgery; raises cost-sharing for use of non-certified imaging centers

2020

Curates network of high-quality physicians across eight specialties to steer employees in select markets

CASE EXAMPLE

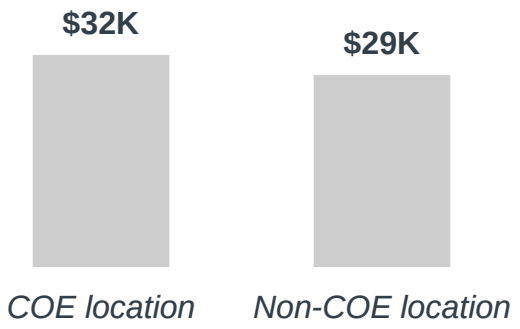
Walmart

Retail corporation with 1.5M employees • Bentonville, Arkansas

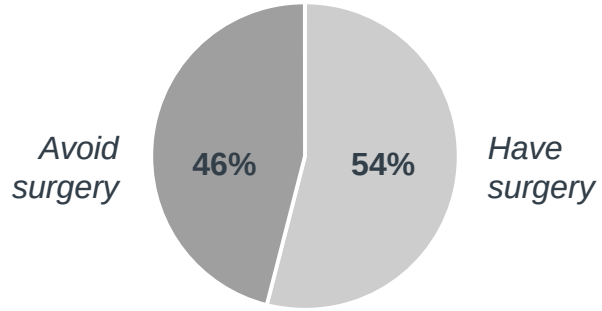
- Starting in 2019, employees must use a COE location for spine surgery or else pay the full cost at a non-COE location; selected 800 preferred imaging centers to improve diagnostic accuracy and reduce unnecessary procedures
- Since the program's inception, Walmart has expanded the number of COE locations to 15 health systems and expanded the number of surgical episodes it covers under the program

Savings come from surgery avoidance

Walmart payments



Employee surgeries



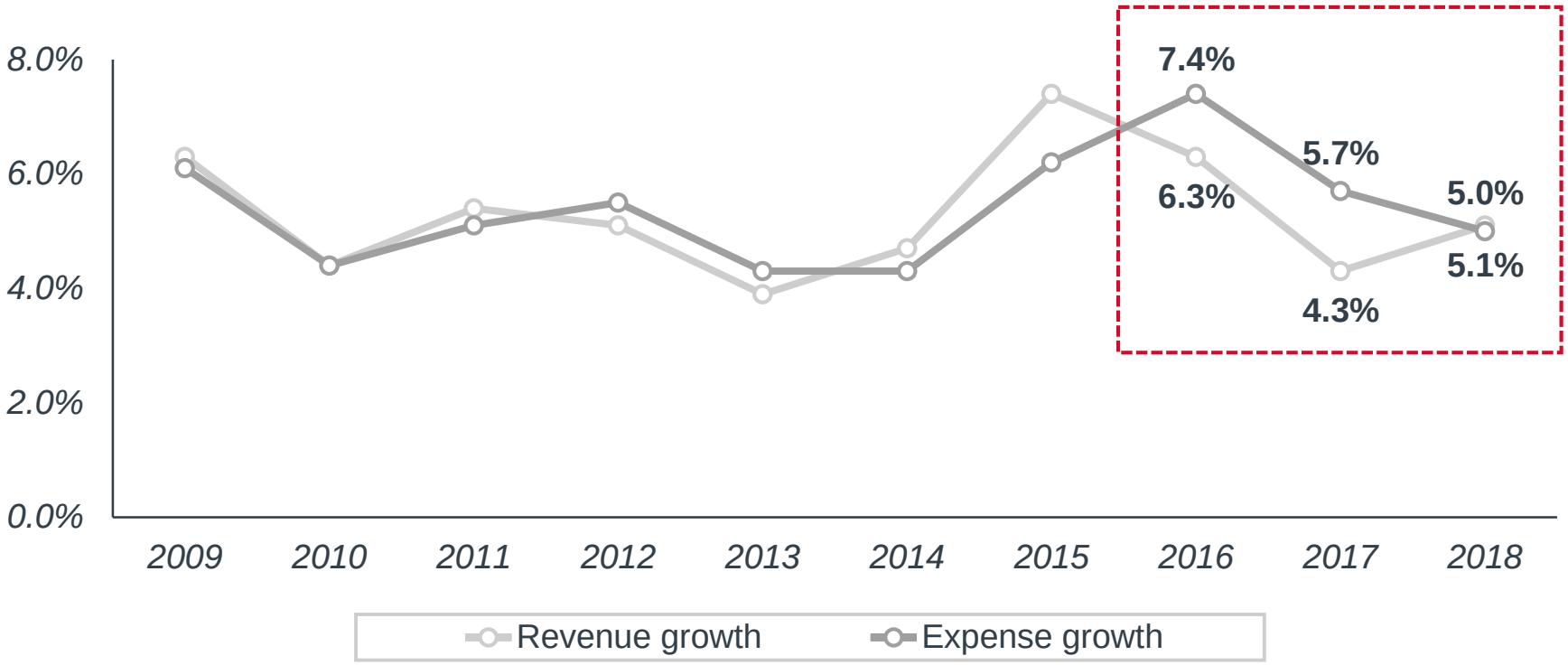
Source: Evans M, "Walmart, other employers get choosier about workers' doctors," The Wall Street Journal, April 4, 2019; Galewitz P, "Walmart charts new course by steering workers to high-quality imaging centers," Kaiser Health News, May 15, 2019.

Provider market

- Hospital performance
- Mergers and acquisitions
- Outpatient shift
- Ambulatory networks
- Provider shortage and wait times
- Care delivery disruptors and AI

Despite progress on cost control, hospital margins remain slim

Median revenue and expense growth rates for nonprofit hospitals



DATA SPOTLIGHT

1.7%

Median operating margin among nonprofit hospitals in 2018

Source: Moody's Investors Service, "Preliminary Medians – Profitability Holds Steady as Revenues and Expenses Converge," April 25, 2019; Moody's Investors Service, "Revenue Growth and Cash Flow Margins Hit All-Time Lows in 2013 US Not-for-Profit Hospital Medians," August 2014.

Age-based case mix shift to exacerbate margin pressure

"Young-old" (65-74)

113.95	Hospitalizations per 1,000 enrollees
34.1%	Surgical portion of MS-DRG volumes[1]

	Highest volume inpatient conditions, 2017
1	Major hip and knee joint replacement
2	Septicemia
3	Heart failure
4	COPD
5	Pulmonary edema & respiratory failure

"Old" (75-84)

189.84	Hospitalizations per 1,000 enrollees
25.9%	Surgical portion of MS-DRG volumes[1]

	Highest volume inpatient conditions, 2017
1	Septicemia
2	Major hip and knee joint replacement
3	Heart failure
4	COPD
5	Pulmonary edema & respiratory failure

"Old-old" (85+)

285.97	Hospitalizations per 1,000 enrollees
15.8%	Surgical portion of MS-DRG volumes[1]

	Highest volume inpatient conditions, 2017
1	Septicemia
2	Heart failure
3	Kidney & urinary tract infection
4	Major hip and knee joint replacement
5	Simple pneumonia

DATA SPOTLIGHT

Inpatient per-case Medicare FFS contribution margin
2017

$4,103
Medical cases

$8,675
Surgical cases

Source: CMS Standard Analytical Files (SAF), January 1 – December 31, 2017; PwC, "Medical cost trend: Behind the numbers 2020," June 2019; HFMA, Leavitt Partners, and McManis Consulting, "What is Driving Total Cost of Care?" 2018.

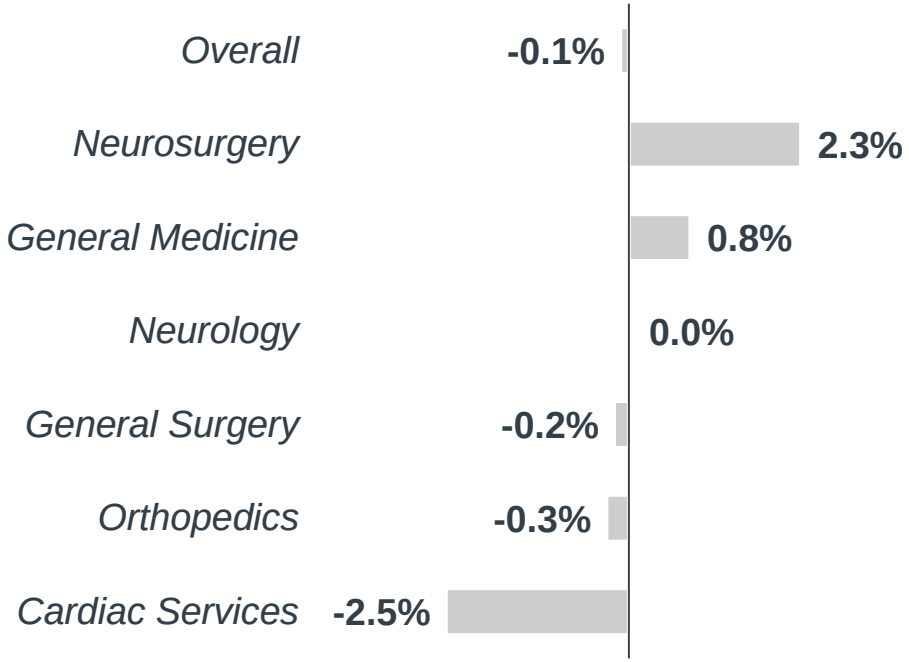
1. Excludes MS-DRGs with fewer than 11 cases.

Hospital-based volume projections remain modest

Inpatient and hospital-based outpatient volume projections

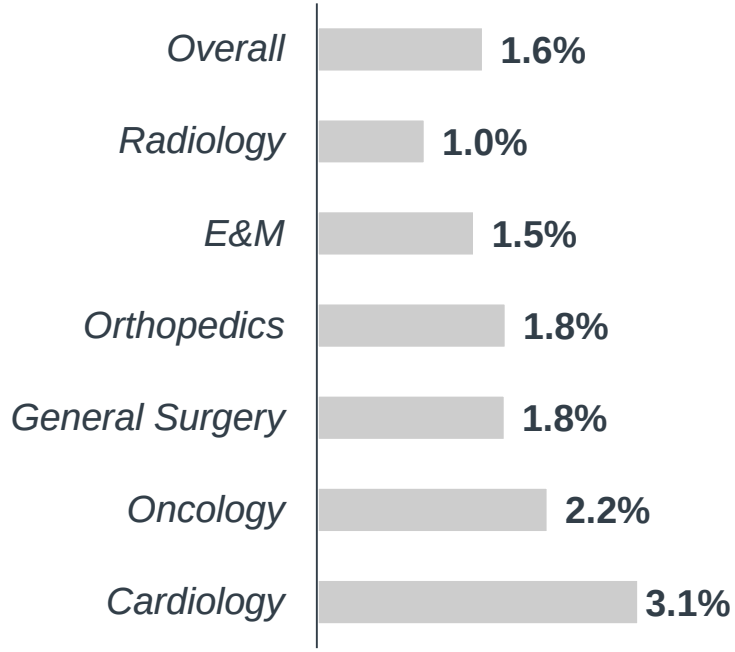
Inpatient volume, CAGR[1]

2018-2023



Hospital-based outpatient volume, CAGR

2018-2023



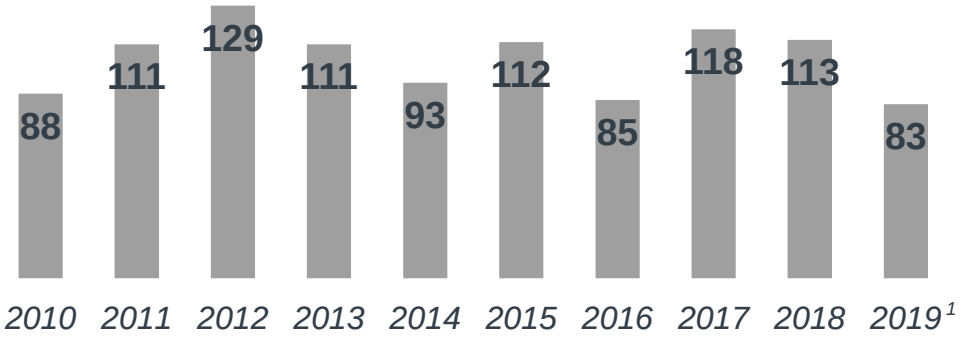
1. Compound Annual Growth Rate

Source: Advisory Board Market Scenario Planner.

M&A activity continues at a steady clip

Hospital M&A activity

Total deal volume



DATA SPOTLIGHT

Community hospitals part of a health system

3,231 in 2018

3,494 in 2019

1. Estimated, based off data available in December 2019.

Hospital, physician integration correlated with increased price

Hospital prices increase with reduced competition

$2,000

Per-admission price differential between markets with one hospital and markets with four or more hospitals

Hospital prices increase with reduced competition

12% Average price increase by primary care physicians

34% Average price increase by specialists (e.g. cardiologists)

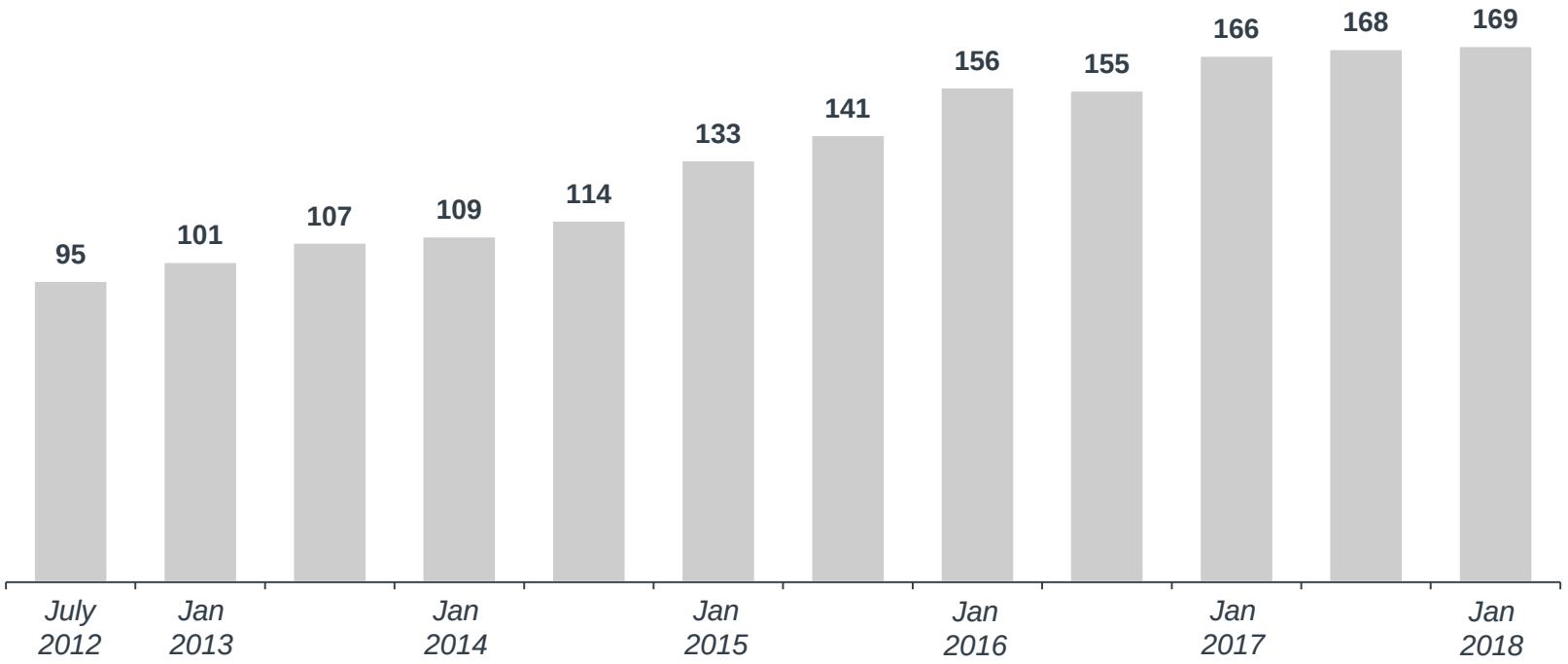
Source: Ponder & Co, "Announced Hospital M&A Activity Report Q1-4 2018," January 2019; Ponder & Co, "Announced Hospital M&A Activity Report Q1-3 2019," October 2019; Kaufmann Hall, "2017 in Review: The Year M&A Shook the Healthcare Landscape," January 2018; Evans, M., "Data suggest hospital consolidation drives higher prices for privately insured," Modern Healthcare, Dec. 15, 2015; AHIP, "Data Brief: Impact of Hospital Consolidation on Health Insurance Premiums," June 2015; Neprash, H. et al., "Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices," JAMA Internal Medicine, Dec. 2015; Kaufmann Hall, Hospital Merger and Acquisition Activity Continues Upward Momentum, According to Kaufman Hall Analysis; American Hospital Association, "2018 Edition, AHA Hospital Statistics."

Physician employment by systems continues

28,000+ physicians transitioned to hospital employment since July 2015

Employment of physicians

Number of hospital-employed physicians, in thousands



DATA SPOTLIGHT

Between July 2016 and January 2018

8,000

Independent physician practices acquired by hospitals

6%

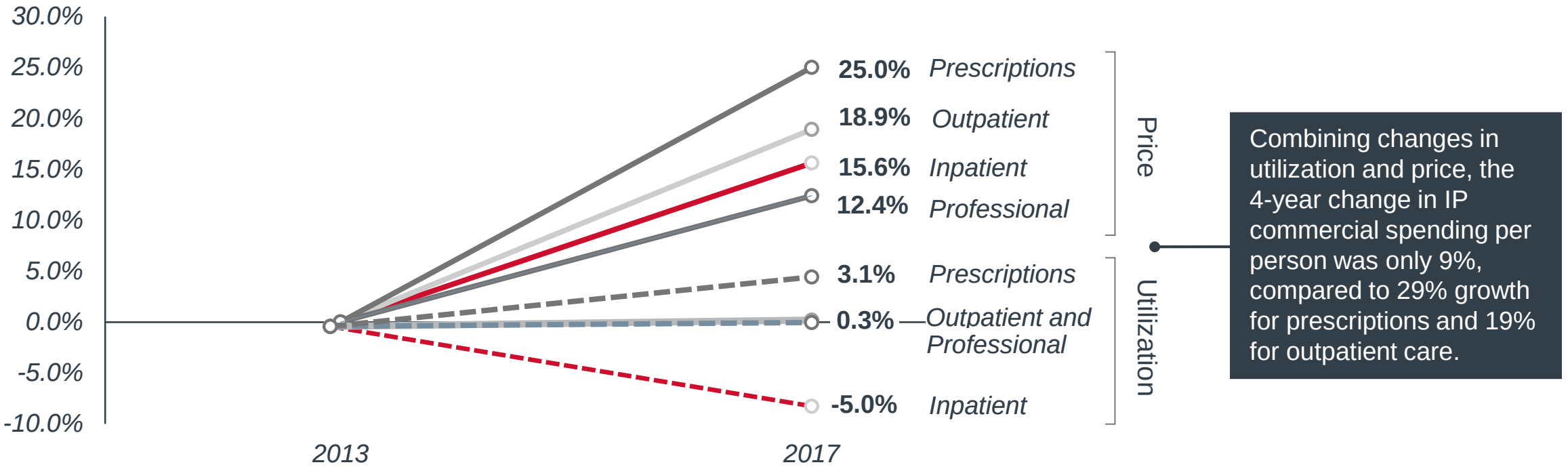
Increase in percentage of hospital-employed physicians

Source: Avelere Health and Physicians Advocacy Institute, "Updated Physician Practice Acquisition Study," February 2019.

Commercial spending also shifting outpatient

Commercial spending growth driven by changes in price and utilization

Cumulative percent change in price, utilization



Combining changes in utilization and price, the 4-year change in IP commercial spending per person was only 9%, compared to 29% growth for prescriptions and 19% for outpatient care.

Source: PwC, "Medical cost trend: Behind the numbers 2020," June 2019..

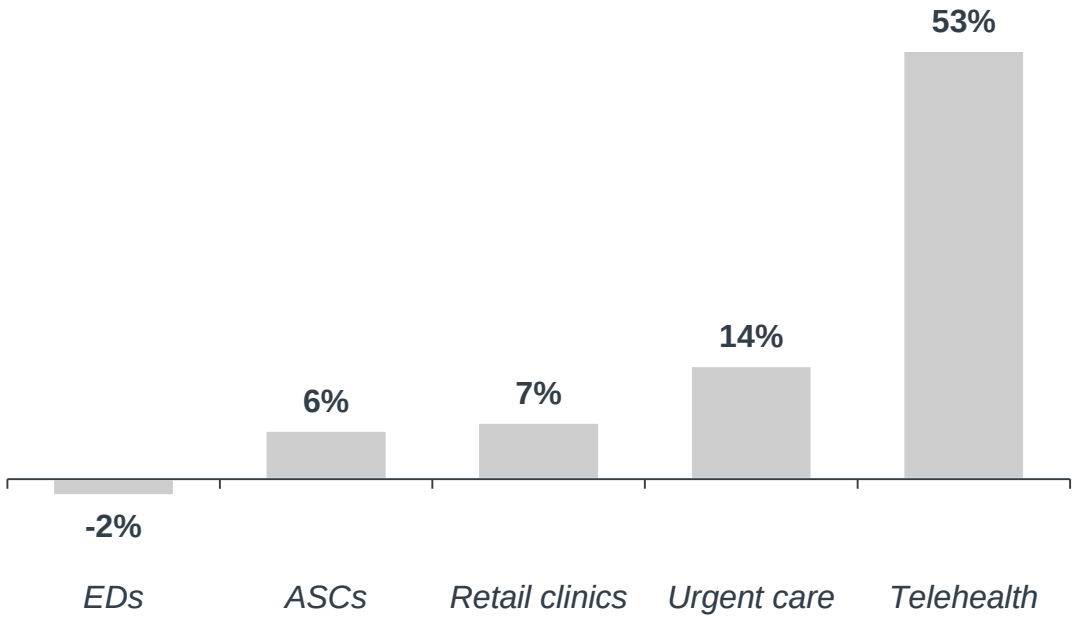
Market Innovation Center interviews and analysis.

Ambulatory sites experiencing swelling volumes

Providers competing to draw patients upstream

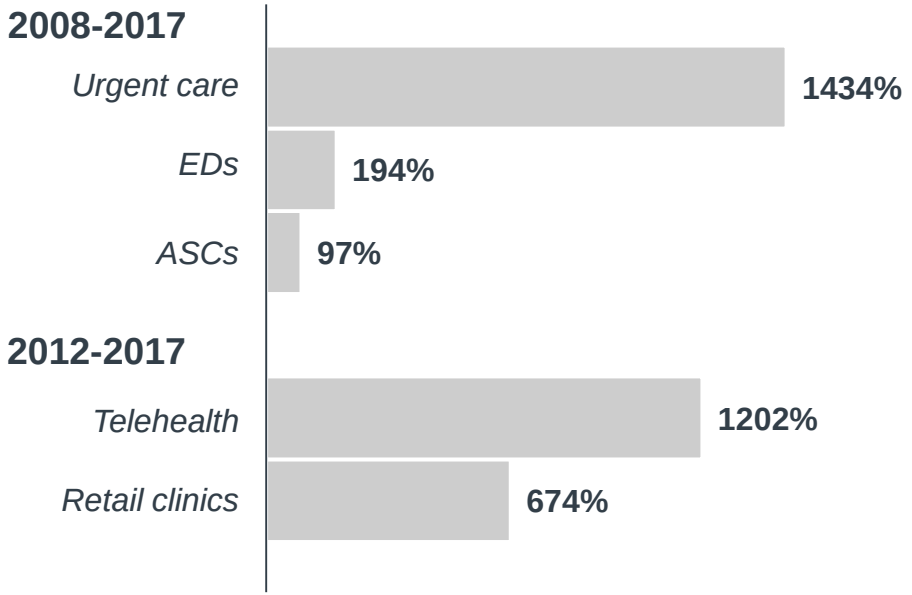
One-year change in ambulatory utilization

% change in claims lines (2016-2017)



Multi-year change in ambulatory utilization

% change in claims lines



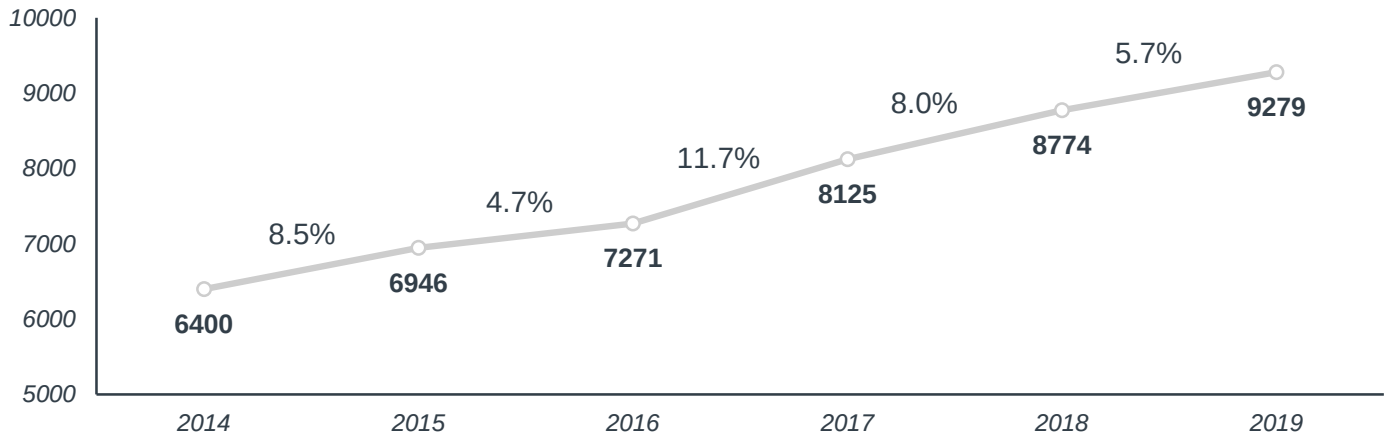
Source: FAIR Health, "FH Healthcare Indicators and FH Medical Price Index 2019," April 2019.

Urgent care centers continue to see steady growth

Providing notable percent of primary care and outpatient physician visits

Year-over-year growth in urgent care centers

Number of operating urgent care centers



Operator	Concentra	MedExpress Urgent Care	NextCare Urgent Care	Doctors Express Urgent Care
Operational Urgent Care Centers[1]	496	250+	144	227

DATA SPOTLIGHT

23% Percent of primary care visits handled at an urgent care center in 2018

13% Percent of outpatient physician visits handled at an urgent care center in 2018

112M Estimated national volume of patient visits per year at urgent care centers

1. As of January 2020.
2. Includes other brands under the same ownership as of January 2020.

Source: UCAoA, "Urgent Care Industry Whitepaper," November 2019; Concentra, "Locations;" US Health Works, "Find a Medical Center;" AFC Urgent Care, "Locations," MedExpress, "About," NextCare, "Locations."

Telehealth utilization continues to grow

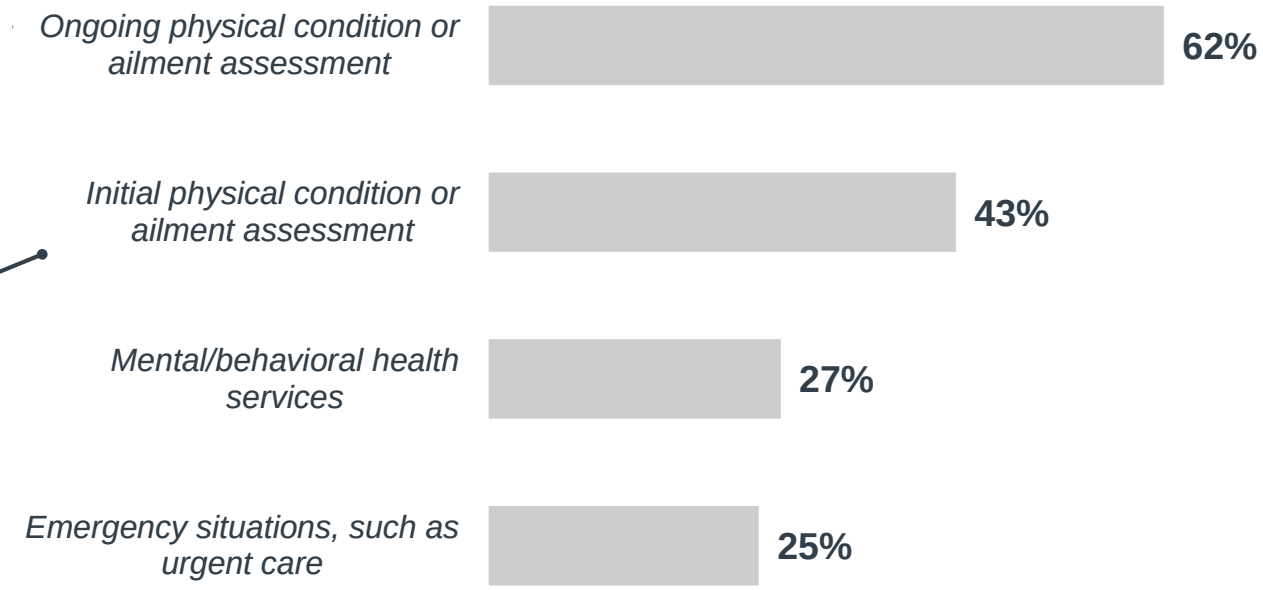
Especially among those with employer coverage and ongoing care needs

1202%

increase in telehealth utilization 2012-2017

Overall, **49%** of consumers with employer coverage are willing to use telehealth in place of an in-person visit for physical, mental, and emergency health services.

Willingness of consumers with employer coverage to use telehealth in place of in-person services



Source: FAIR Health, "FH Healthcare Indicators and FH Medical Price Index 2019," April 2019; PwC, "Medical cost trend: Behind the numbers 2020," June 2019.

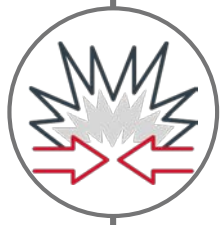
At current course, insufficient PCP supply to meet demands

Rising stakeholder demands

Consumers want on-demand access to care

Physicians want a lower burden of work

Wholesale purchasers want to control spending



Limited primary care supply

DATA SPOTLIGHT

14K

Number of primary care physicians currently needed to meet demand of designated physician shortage areas

21K-55K

Number of primary care physicians the US will be short from projected demands in 2032

49%

Percentage of physicians self-classifying as burnt out in 2019—a 6% increase from 2015

Source: "2019 Update, The Complexities of Physician Supply and Demand, Projections from 2017 to 2031," Associate of American Medical Colleges, April, 2019.

A tale of two realities in ambulatory care

Consumers experience both unprecedented access options and longer wait times

On one hand, more access points than ever…

LOCATIONS

Retail clinics located near areas where consumers live, work, and recreate

HOURS

Urgent care clinics open nights and weekends

VIRTUAL OPTIONS

Video visits available through concierge groups

44% Growth in urgent care centers between 2013 and 2018

445% Growth in retail clinics between 2006 and 2014

On the other, wait times long and getting longer

24 Average days to new patient physician appointment in 15 large metro markets in 2017

30% Increase in average wait time for a physician appointment in 15 large metro markets since 2014

33% Higher wait times for mid-sized markets than large metro markets

57% Of c-suite executives ranked “improving ambulatory access” as their top area of interest in 2019

Source: Merritt Hawkins, “2017 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates,” 2017; Burns J, “The Urgent Care Surge,” *Managed Care*, April 30, 2019; Accenture, “US Retail Healthcare Clinics to Surge by 2017,” https://www.accenture.com/t20160413t223640__w__/us-en/_acnmedia/accenture/conversion-assets/dotcom/documents/global/pdf/industries_18/accenture-chart-retail-health-clinics-double-by-2017.pdf.

Wait times high across specialties and geographies

Average time to appointment in U.S. by specialty

Dermatology

32.3 days

Family medicine

29.3 days

Ob/Gyn

24.4 days

Cardiology

21.1 days

Orthopedic surgery

11.4 days

This wait time for family medicine represents a **37% increase** from the 2015 average of **18.5 days**

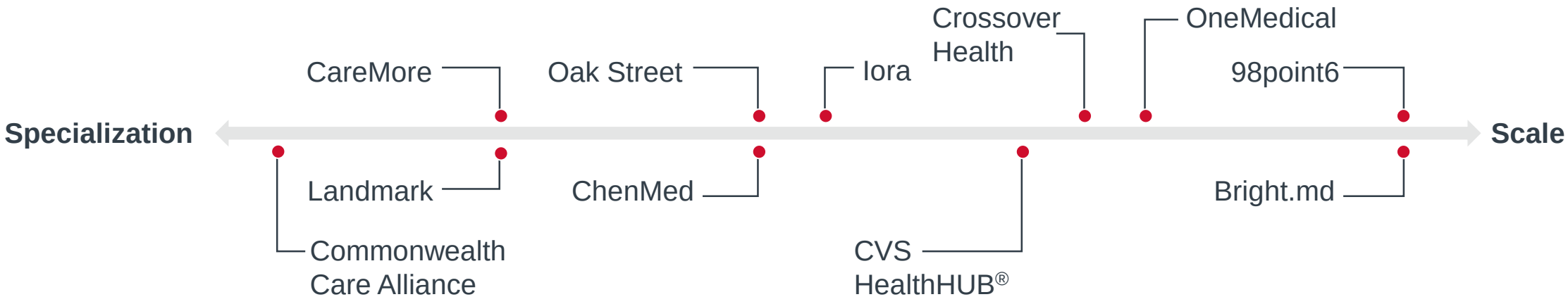
Average family medicine time to appointment by select city

Large metro areas		Mid-sized metro areas	
Boston, MA	*Minneapolis, MN*	*Albany, NY*	*Billings, MT*
109 days	8 days	122 days	7 days

Source: Merritt Hawkins, "2017 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates," 2017.

New business models for primary care emerging

Competitors choosing between specialization and scale



High-touch management
Coordinate care for complex chronic care patients

Care model

Convenient access
Provide low-cost access for generally healthy patients

Control total costs
Destroy demand for hospitalizations, ED visits, and specialty care referrals to profit from risk contracts

Business model

Enhance efficiency
Improve productivity of clinical workforce to profit from primary care itself

Health plans dial up primary care investments in 2019

UnitedHealth Group/Optum[1]

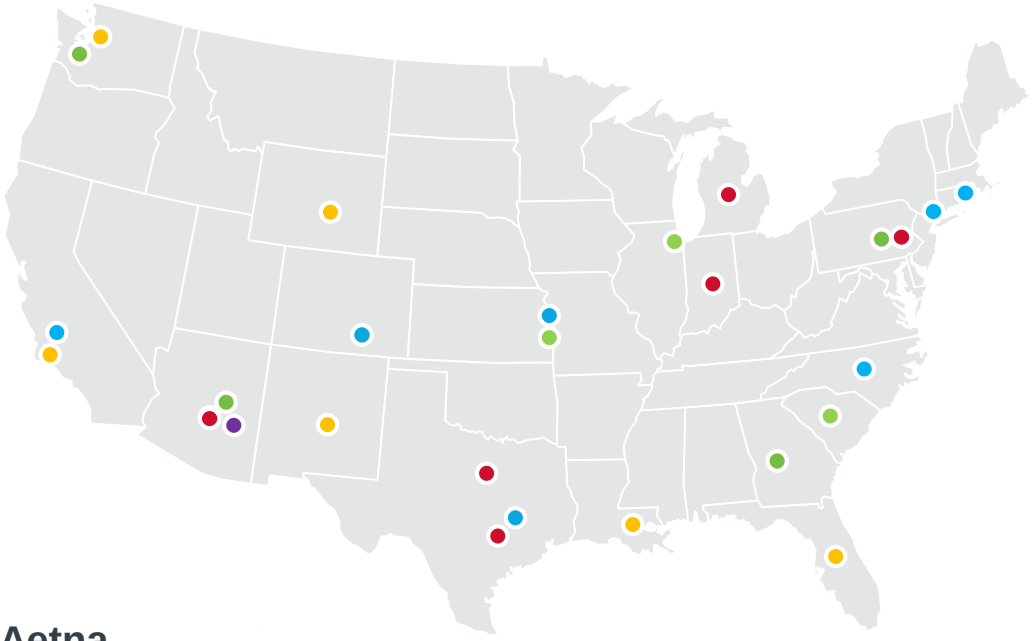
Scaling value-based physician network

- Acquires **Peoples Health** in LA
- Acquires **DaVita Medical Group** practices in CA, CO, FL, NM, WA
- Acquires **Polyclinic** in WA

Humana

Doubling down on senior focus

- Partners with **Walgreens** to open 2 centers in MO, 1 in SC
- Partners with **Iora Health** to open 10 clinics across WA, AZ, GA
- Partners with **ChenMed** in PA
- Partners with **Oak Street Health** in IL
- Partners with **Doctor on Demand** to launch virtual primary care plan



Aetna

Establishing infrastructure for high-tech retail model

- **CVS** opens 3 HealthHUBs®, plans to expand to 1,500 by 2021
- Partners with **98point6** to offer virtual care to Banner-Aetna members
- Partners to offer IN and MI members access to **Oak Street Health**

Cigna

Experimenting with polychronic model

- Partners with **CareMore Health** in AZ

Blue Cross Blue Shield

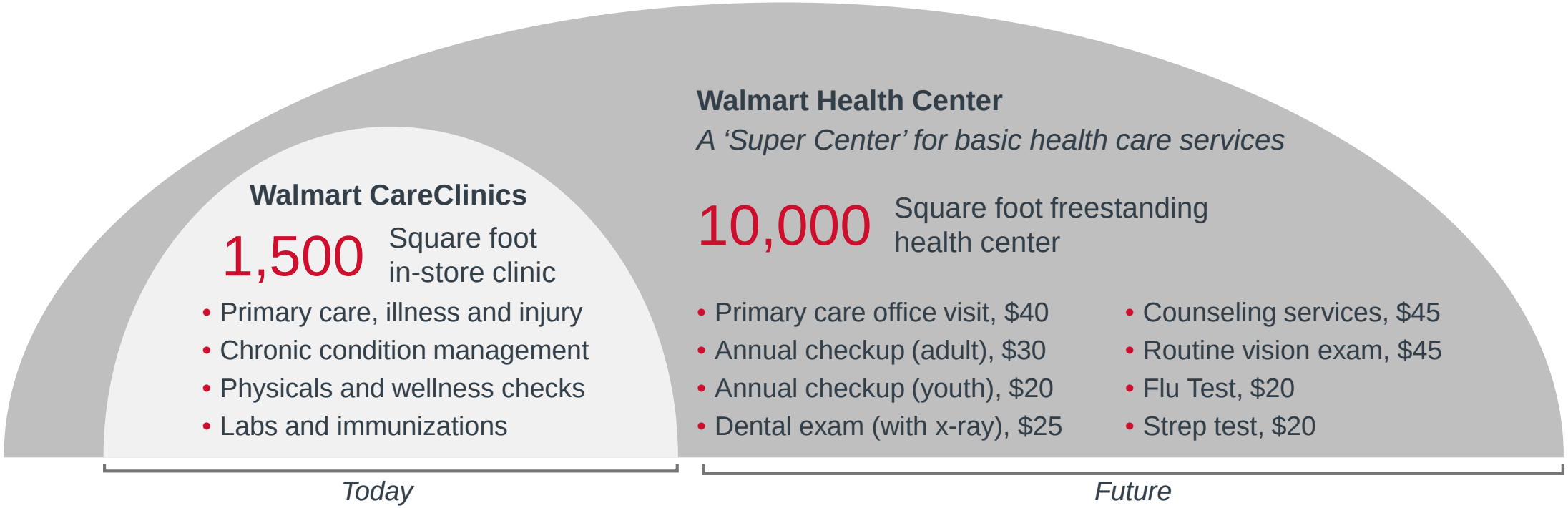
Preserving physician autonomy

- Partners with **Aledade** in CA
- Partners with **CareMore Health, Cityblock Health, Iora Health** in NC
- Partners with **Sanitas** to open 10 clinics in TX
- Partners with **Vera Whole Health** to open 3 clinics in MO
- Partners with **Oak Street Health** to open 3 clinics in RI
- Partners with **Cityblock Health** to open clinic in NY

1. Advisory Board is a subsidiary of UnitedHealth Group. All Advisory Board research, expert perspectives, and recommendations remain independent.

Retail clinics 2.0: Dedicated space, expanded services

Walmart advances multi-front health strategy, including employee education



Building a workforce to support future health services growth

1.5M Walmart associates eligible for education benefit program

$1 Per day for employees to earn health care degrees and career diplomas

Source: Slovenski S, "Introducing the Walmart Health Center," Walmart, September 13, 2019; "Summarized pricing list for Dallas, GA," Walmart Health.

CVS HealthHUBs® seek to create a new front door to care

20%

Of CVS stores are dedicated to health services

1,500

HealthHUB® locations planned by 2021

ED avoidance and downstream navigation	Connect members to screening services, smart devices, and disease management apps	Drive down total costs
Chronic disease management	Offer low-cost alternative to ED; direct members to lower-priced downstream care sites	
Member engagement in wellness	Provide on-site dietitians and group activities (e.g., yoga classes, weight management, smoking cessation)	
Cross-sell products	Adjust cost-sharing to promote use of HealthHUB ® services, including pharmacy	Leverage benefit design
Growth of MA membership	Non-Aetna members who use the HealthHUBs® can be converted to Aetna's MA plan	Grow membership

Source: "CVS Health testing new HealthHUB store format," CVSHealth, February 13, 2019; LaVito A, "CVS to open 1,500 HealthHUB stores over next two years," CNBC, June 4, 2019

Amazon moves into care delivery with virtual employee clinic

Virtual clinic aims to improve access, decrease cost for Seattle employees

“Amazon Care” combines virtual and in-person care

Virtual access to services

Care chat

In-app text chat connects patients with a nurse in minutes

Video care

In-app video visits with a doctor or NP for diagnoses, treatment or referrals

On-demand access to in-person care

Mobile care

Nurses dispatched to patients’ home or office for in-person exams, testing or treatment

Care courier

Prescription delivery to patients home or office within hours

Potential drivers fueling Amazon’s care delivery strategy

- **R&D lab**
  Opportunity to test new health care products in an internal research and development lab
- **Market opportunity**
  Avenue to expand into new business such as population health management and health care IT
- **Decrease costs**
  Mechanism to control rising health care costs within its own employee population

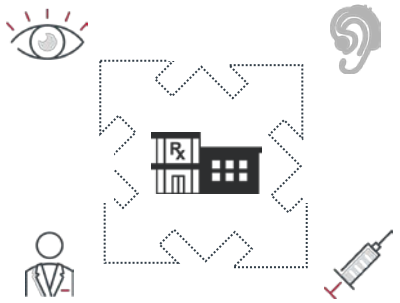
Source: Farr C, “Amazon launches Amazon Care, a virtual medical clinic for employees,” CNBC, September 24, 2019.

Walgreens exploring new opportunities in care

Walgreens tests new integrated care services and supply chain initiatives

Evolving delivery model through partnerships

- Connected health platform integrating telehealth stations, digital health tools, and mHealth services through partnership with Microsoft
- Telehealth consults in select markets through partnership with NewYork-Presbyterian
- Co-located Walgreens retail health clinics with MedExpress urgent care centers in six states in partnerships with UnitedHealth Group
- Senior-focused clinics launched in Kansas City and expanded to South Carolina in partnership with Humana



Expanding services in select stores

- Optical care and optometry services
- Hearing screenings through Starkey partnership
- Digital marketplace that allows users to search for providers and schedule appointments in select markets
- Lab services through LabCorp partnership at select sites
- Walgreens health guides for care navigation

Source: LaVito, A, "Walgreens and CVS are Redesigning their Drugstores to Focus More on Health. Here's How They Compare," *CNBC*, February 18, 2019; Johnsen, M, "Walgreens Launches Pilot Program in Gainesville, Fla. Stores," *DSN*, April 21, 2018; "Humana and Walgreens to Open Additional In-Store Partners in Primary Care Centers," *Walgreens Press* Releases, July 30, 2019; Wicklund, E, "Walgreens, Microsoft, Announce mHealth, Telehealth Partnership," mHealth Intelligence, January 15, 2019.

Provider selection

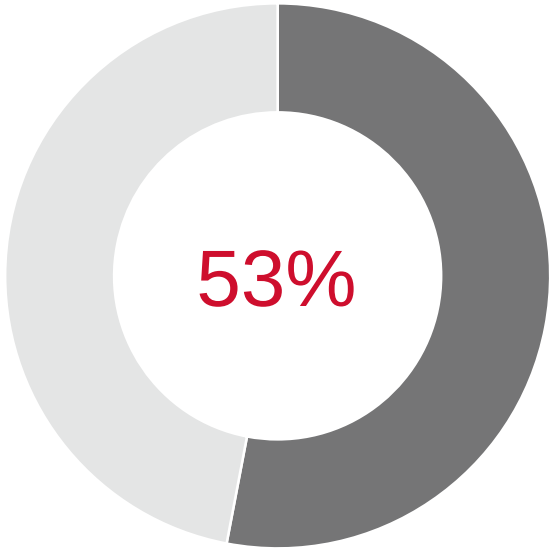
- Physician referrals
- Payer influence
- Consumerism
- Patient loyalty
- New consumer preference data

Large opportunity in enhancing physician loyalty

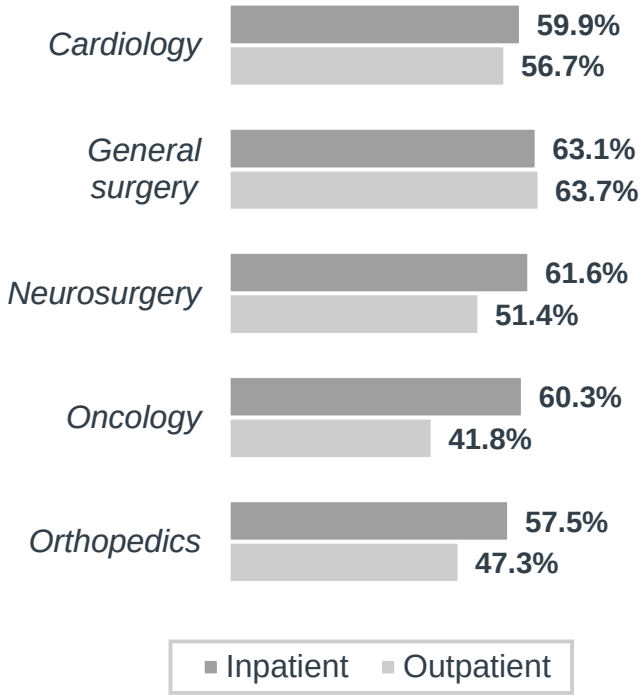
PCP referral integrity

Advisory Board CMA members (n=284)

Employed PCP overall loyalty



Employed PCP loyalty by specialty



Optimized loyalty scenario

Scenario: Raise in-network PCP referral integrity from 53% to 80%

Practical Maximum Referral Loyalty	80%
Downstream Care Delivery Revenue	$80.7M
Total Increase in System Revenue	7.1%

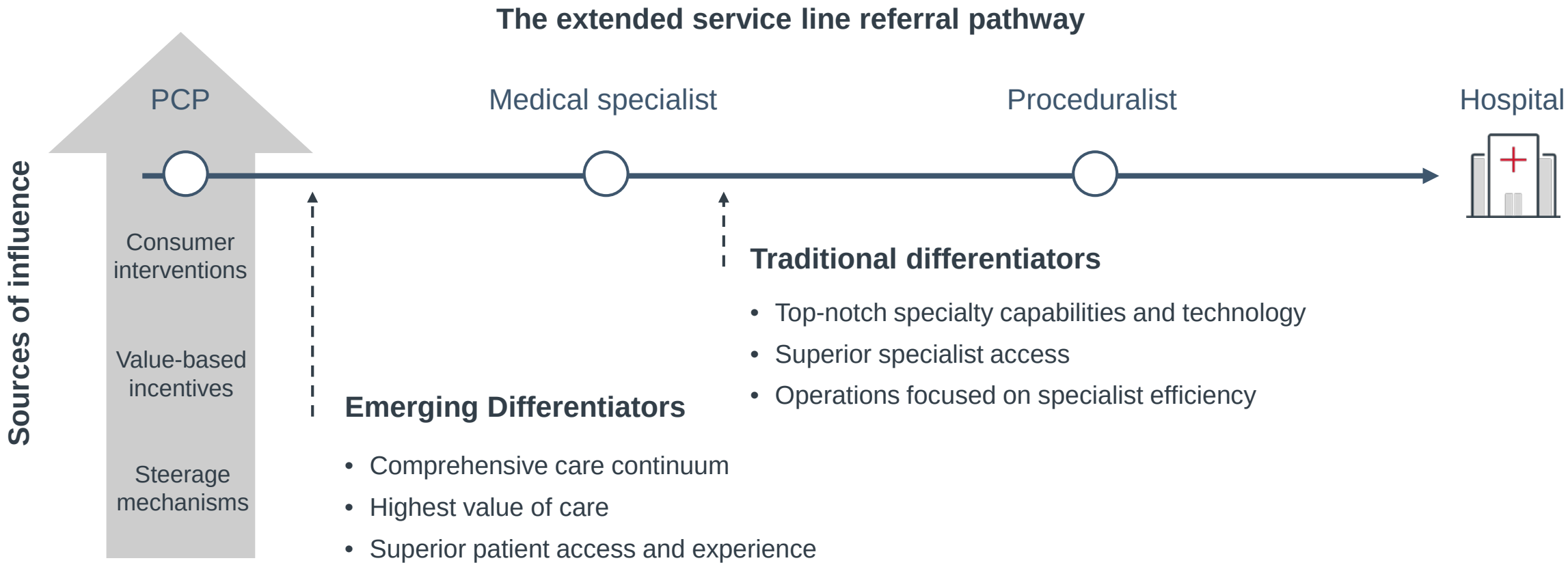
Major Assumptions of Scenario:

- Sample health system has baseline revenue of $1.1B; 54% of PCP referrals are in-network
- 34% of specialist visits are from self-referrals
- Hospital occupancy can fill by 20%
- Convenient care referral integrity does not increase

Source: Advisory Board Crimson Market Advantage.

Referral choice criteria different for PCPs, specialists

Emerging and traditional differentiators for physicians



Employers applying the COE[1] concept to primary care

PepsiCo steering employees to high-value PCPs

PepsiCo's Dallas-Fort Worth market challenges

60% Of patients have never seen a PCP

39% Increase in overall health care costs in 2018

31% Increase in emergency department costs in 2018

6% Higher rate of inpatient admissions than other markets

Primary care partner network

Comprised of three physicians groups[2] for primary care and Blues Distinction providers for specialty care

Physicians measured against performance metrics and patient satisfaction

Clinics offer evening and weekend appointments, and next-day access guarantee for sick patients

Revised benefit structure

- If patients choose a PCP within PepsiCo's partner network, PepsiCo will cover the patient's insurance premiums for the year, a $650 value
- If patients visit the PCP before April 1, they will receive a $100 bonus payment
- Patients have a $500 dollar in-network deductible and $4,000 out-of-pocket limit with no coverage for non-network providers[3]

1. Centers of excellence.
2. Catalyst Health Network, Genesis Physicians Group, North Texas Clinically Integrated Network.
3. PepsiCo PPO Core Plus Select Plan, effective 01/01/2019.

Source: Why PepsiCo is paying D-FW employees to go to the doctor's office," The Dallas Morning News, December 2, 2018.

Health care is hardly a functional consumer market

Revisiting the prerequisites for shopping - and their absence in health care

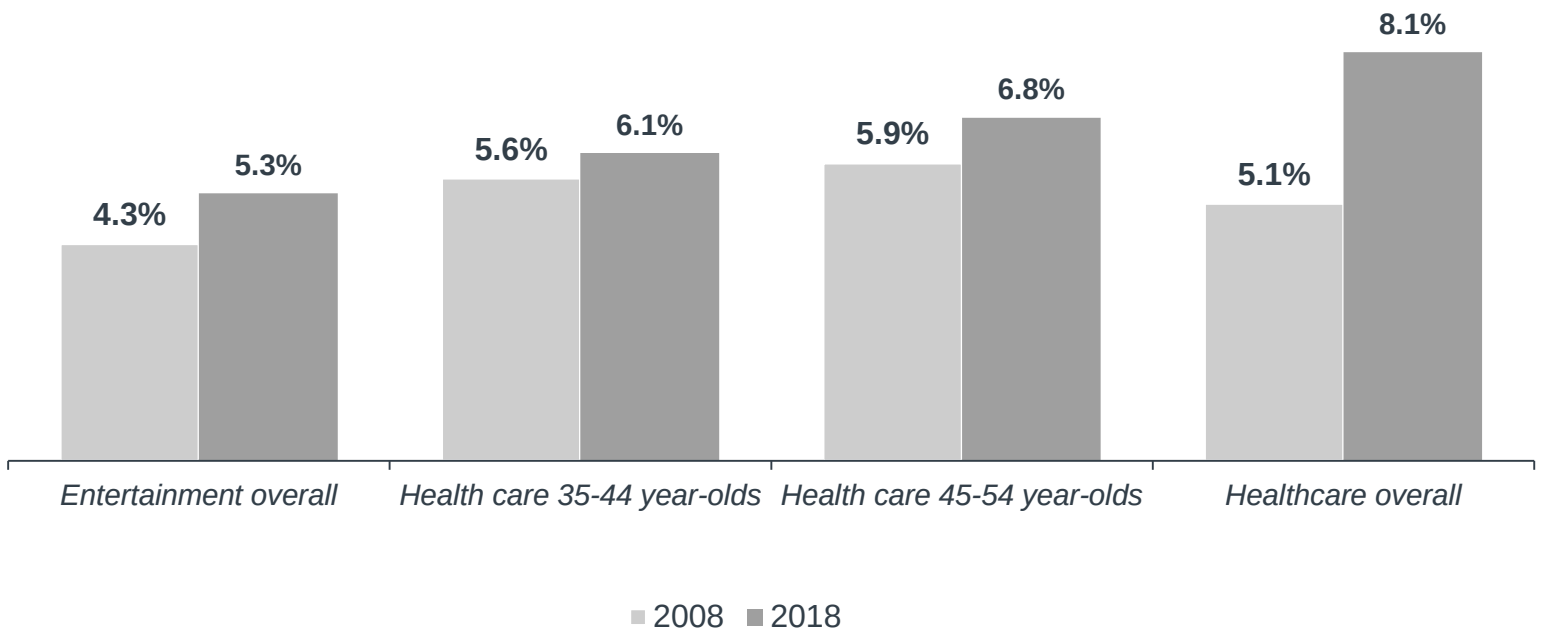
Necessary conditions for shopping

Necessary condition	*Description*	*Current state in health care*
Choice	Meaningful variation in price and/or quality	✓ Significant variation between new and existing players
Transparency	Ability to compare between different options that are available	✗ Reviews increasingly accessible, but price comparisons remain elusive
Financial responsibility	Consumer has financial stake in purchasing process	✗ Incentive to shop limited to services under deductible; coinsurance impact limited

More of consumers' wallets going to health

Health care spend as % of total household spending

2008 vs. 2018



Households now spend nearly 3% more on health care than entertainment overall.

8.0%

growth in health insurance spending alone in 2017

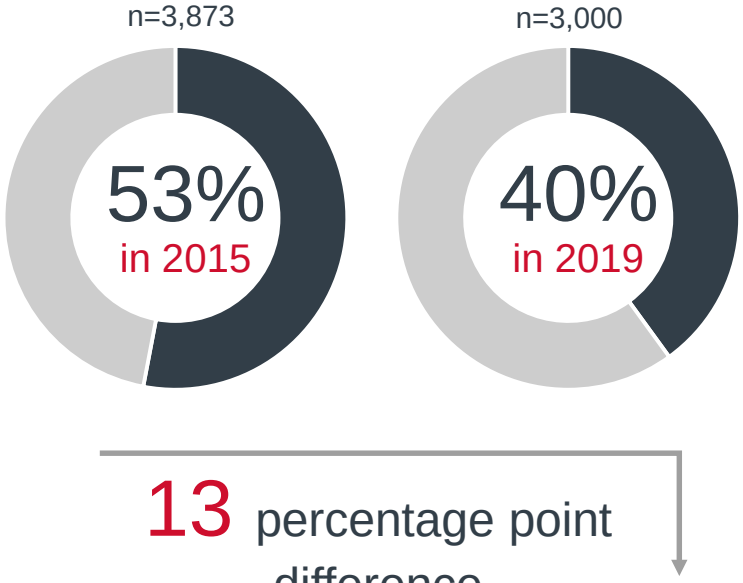
Source: Bureau of Labor Statistics, "Consumer Expenditure Survey 2018," September 2019.

Most patients are not loyal to a PCP

And many are willing to consider alternative access points for primary care

Change in percent of consumers highly loyal to a PCP

How likely are you to **stay** with your primary care physician over the next 12 months?

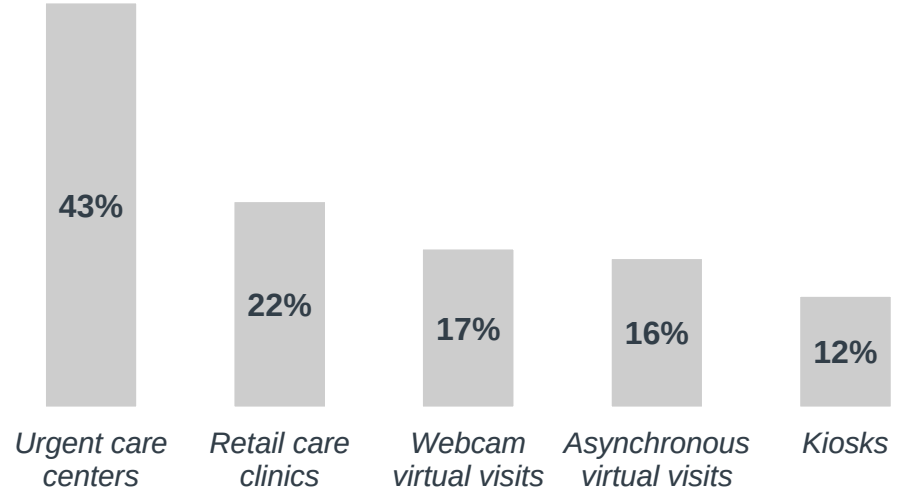


13 percentage point difference

High willingness to consider alternative care options

How willing are you to **probably or definitely** consider using alternative primary care options?

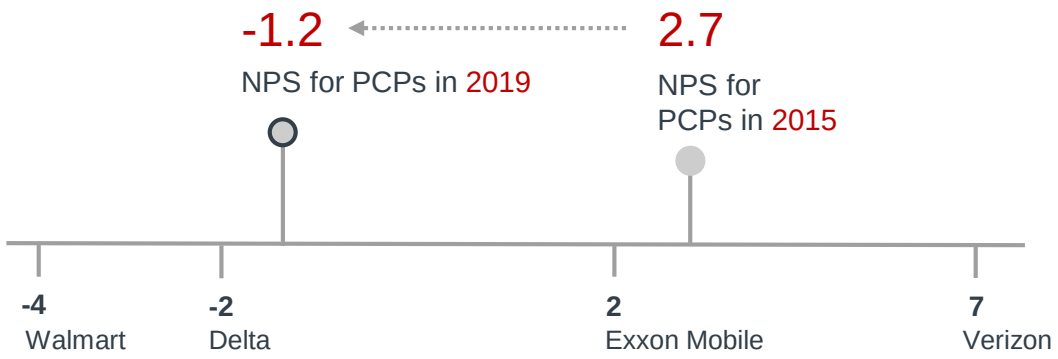
2019 data; n=3,000



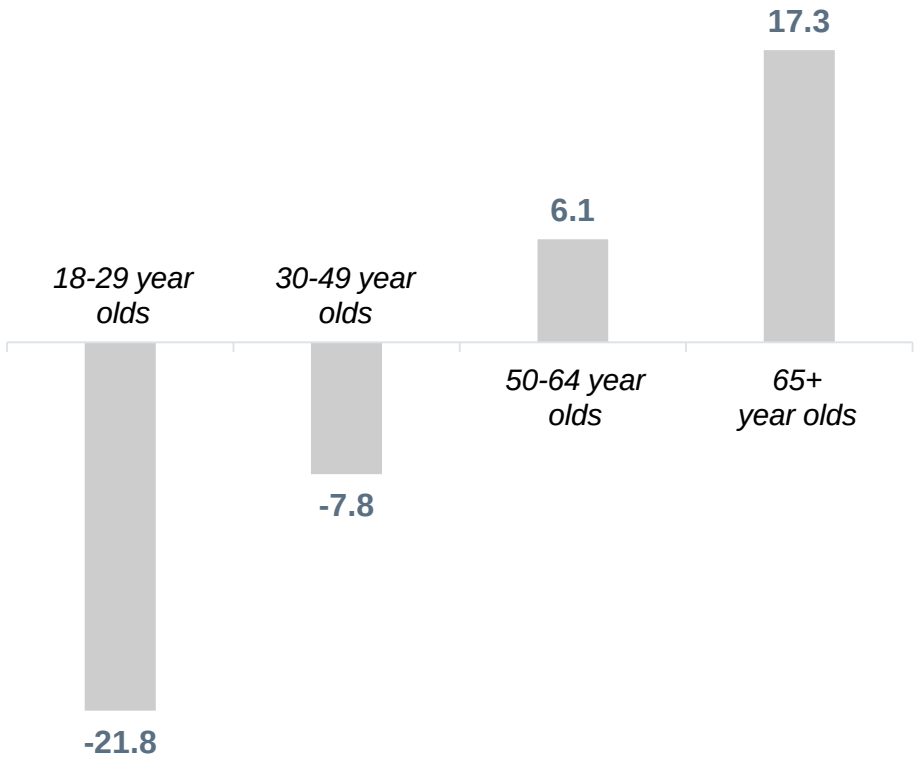
Source: Market Innovation Center, "Primary Care Physician Consumer Loyalty Survey," 2019.

Patients, especially younger ones, lacking in loyalty to PCPs

Shifts in PCP Loyalty, 2015 versus 2019



2019 Net Promoter Score by age



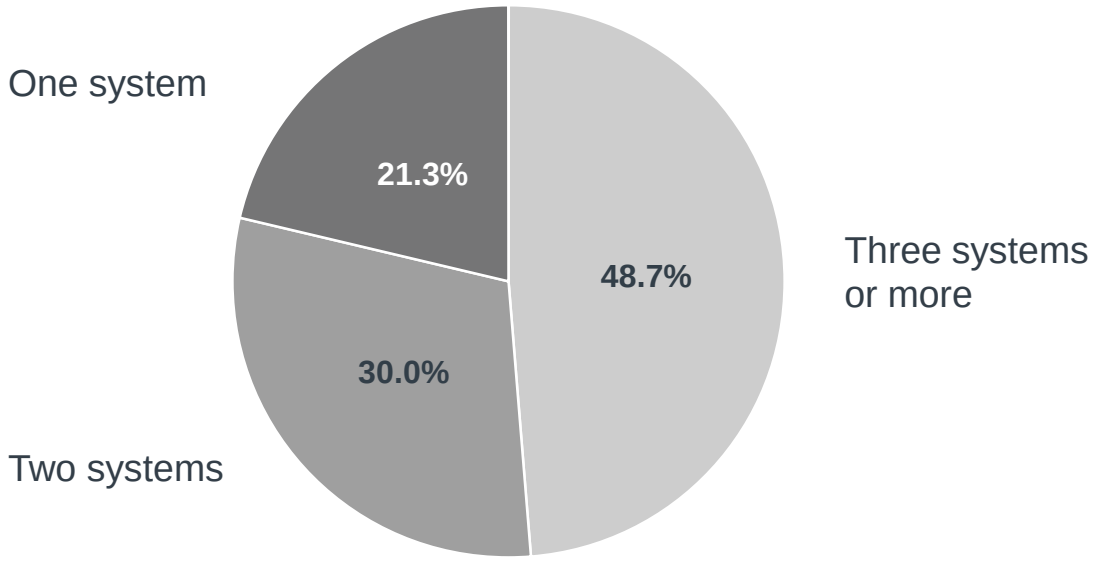
Source: "What Drives Consumer Loyalty to a PCP?" Advisory Board, 2015; "Net Promoter Score benchmarks for Fortune 500 Companies," Customer Guru (2019).

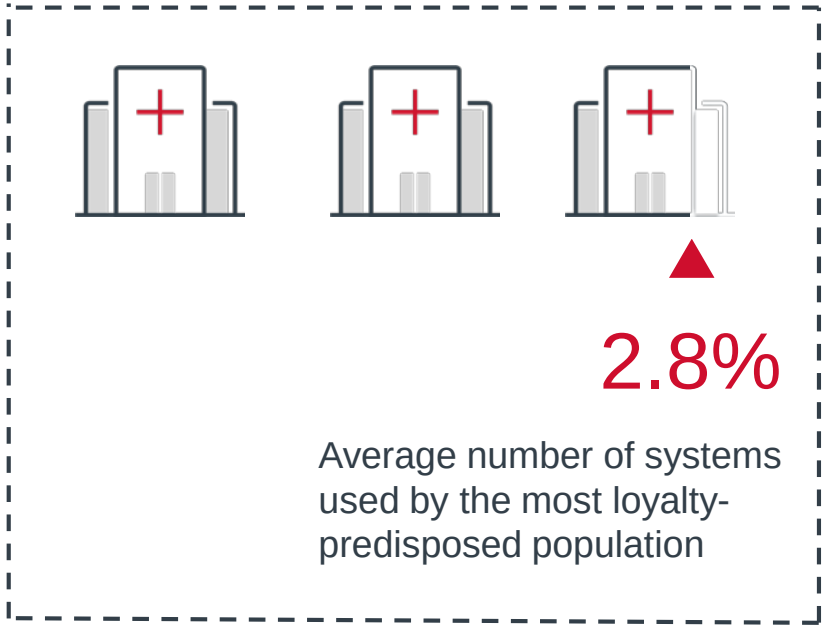
Nearly 80% of consumers use multiple systems

Average Medicare patient visits more than two systems in five years

Percentage of consumers using:

Across five years





Top ten primary care clinic attributes, 2014 vs 2019

Top ten attributes, 2014

1. I can walk in without an appointment, and I'm guaranteed to be seen within 30 minutes
2. Lab tests and x-rays done on site
3. The provider is in-network for my insurer
4. The visit will be free
5. The clinic is open 24/7
6. I can get an appointment for later today
7. The provider helps me plan ways to stay healthy in the future
8. Each time I visit the clinic, the same provider will treat me
9. Prescriptions filled on site
10. The clinic is located near my home

Top ten attributes, 2019

1. I can walk in without an appointment, and I'm guaranteed to be seen within 30 minutes
2. I can walk in without an appointment, and I'm guaranteed to be seen within an hour
3. Lab tests and x-rays done on site
4. I can get an appointment for later today
5. I will be treated by a doctor instead of an NP or PA
6. The clinic is open 24/7
7. The clinic is open on weekends
8. The clinic staff will coordinate any follow-up care
9. The provider helps me plan ways to stay healthy in the future
10. It will take me 10 minutes or less to travel to the clinic

Source: Market Innovation Center, "Primary Care Consumer Choice Survey," 2019.

In primary care, immediate access even more important

Comparison	2014 (n = 3,873)	2019 (n = 1,501)
"I can walk in without an appointment and be guaranteed to be seen within 30 minutes"	**#1**; utility score was **2.3x** more important than the average attribute	**#1**; utility score was **5x** more important than the average attribute
Number of the top seven attributes related to on-demand access	**3**	**5**
The seven on-demand attributes we tested garnered…	**19.3%** of respondents' utility scores	**45.3%** of respondents' utility scores
"The clinic is open 24/7"	**#5**	**#6**
"I can get an appointment for later today"	**#6**	**#4**
"I can walk in without an appointment and will be seen within one hour"	**#39**	**#2**

In 2019, this ranked #1 for respondents choosing a new PCP clinic

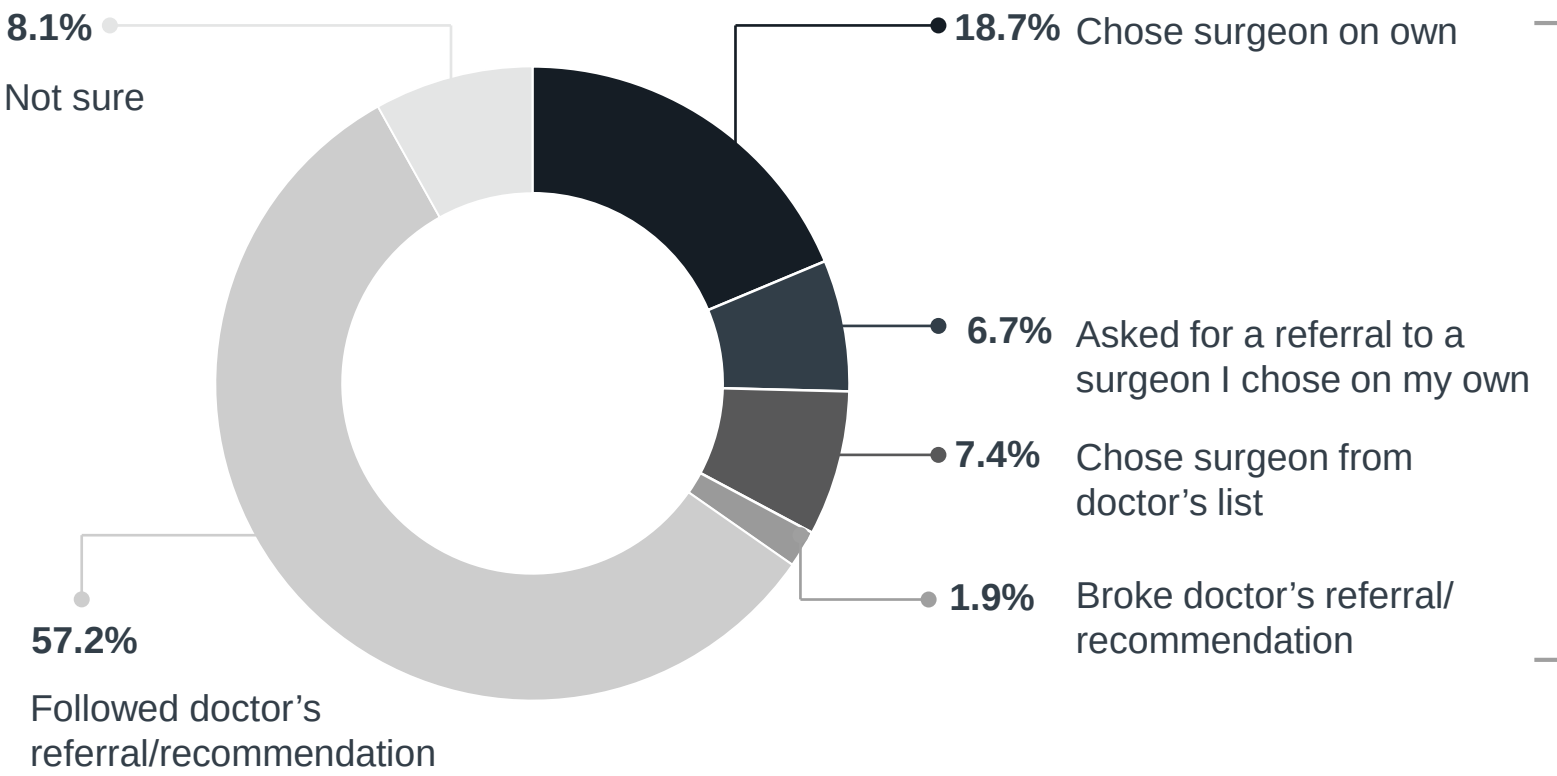
In 2019, this ranked #2 for respondents choosing a new PCP clinic

Source: Market Innovation Center, "Primary Care Consumer Choice Survey," 2014 and 2019..

One third of consumers shop for orthopedic care

How did you choose an orthopedic surgeon?

(n=855)



DATA SPOTLIGHT

35%

Of our 855 survey respondents who had a prior orthopedic surgery played an active role in choosing their surgeon

Source: Market Innovation Center, "Orthopedic Care Consumer Loyalty Survey," 2018.

Market Innovation Center interviews and analysis.

7 Quick Summary Points

1. Lingering financial and economic effects of COVID-19 on our industry and society remain unclear, but, assuredly difficult. This, combined with historically low oil prices is providing a compounding negative outlook.
2. Continued growth in retail and telehealth services and healthcare delivery options. It is real and here to stay.
3. Direct Primary Care Model progress though infancy.
4. More consumers with higher deductibles will seek transparency, competitive pricing, and convenient access to services.
5. Medicare Advantage plans continue strong growth. Congruently, Washington politics continue pursuit of growing governments role in purchasing.
6. We are in unchartered waters, yet leaders must take decisive action to ensure their organizations are resilient.
7. Four distinct scenarios emerge based on current trends and critical uncertainties.