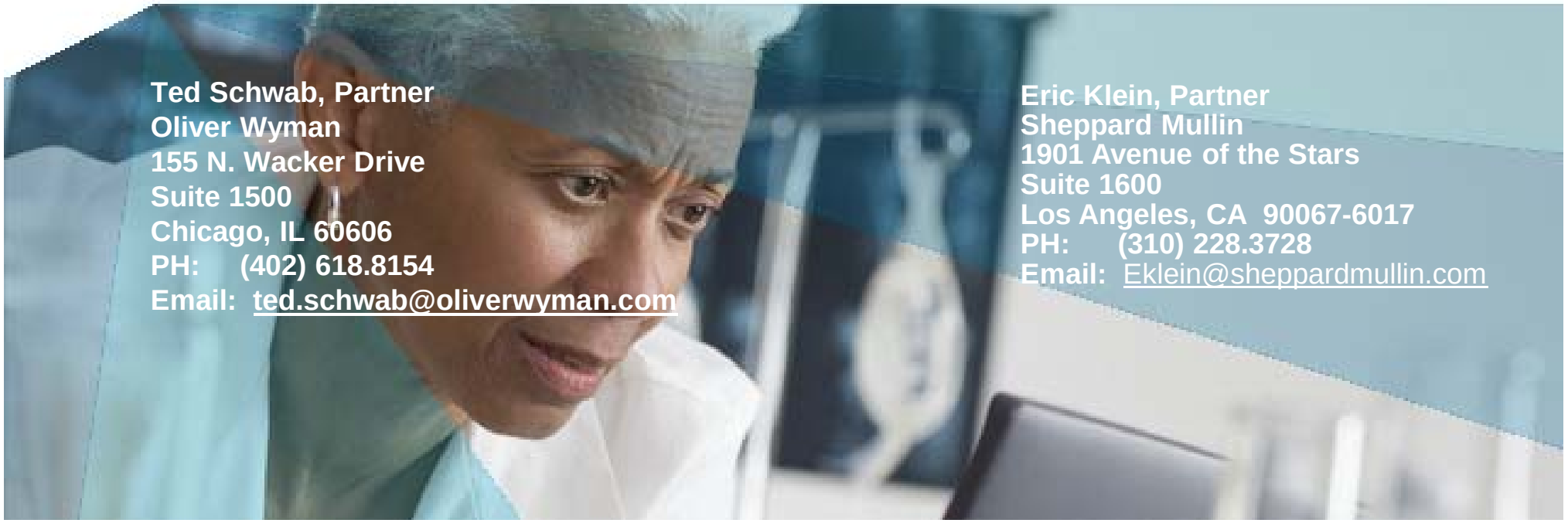
Volume to Value: A presentation to HASC

May 24, 2012



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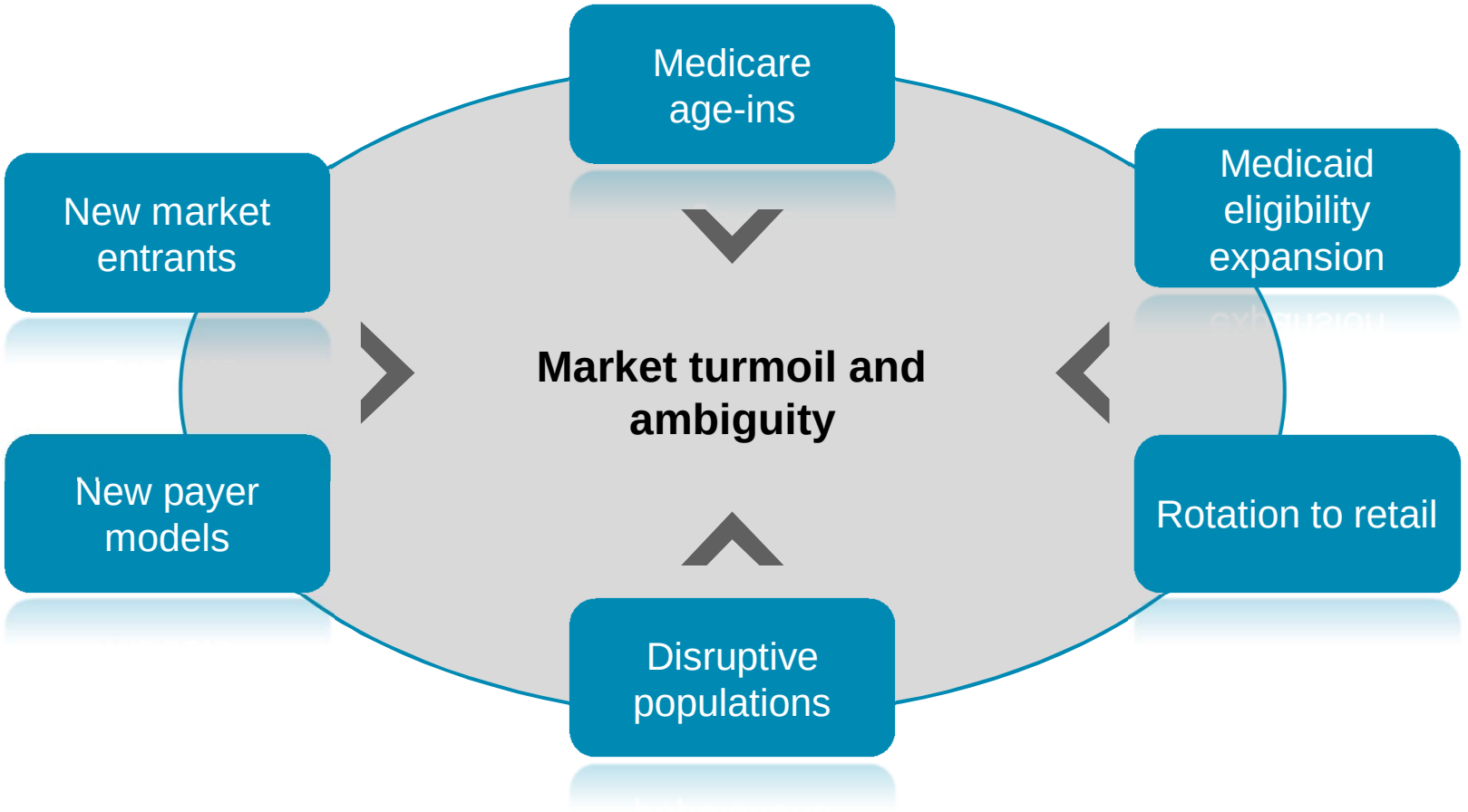
Convergence of disruptive forces will continue to drive change, volatility, and opportunity in the markets

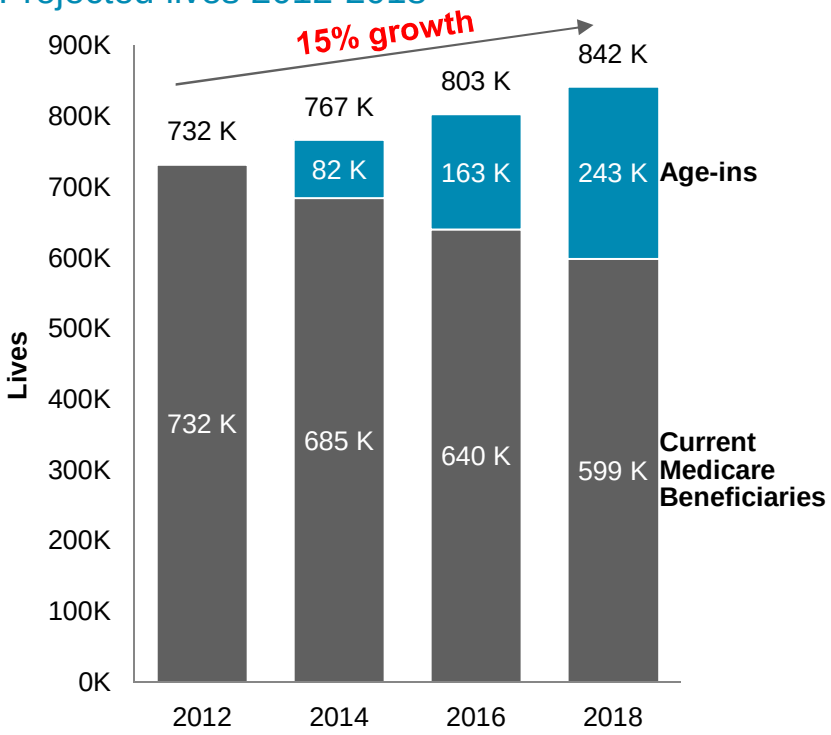


This volatile environment creates opportunities for productization of delivery assets, clinical transformation, market realignment, and new partnering models

The Medicare market will be driven by new age-ins, rapid growth of Medicare Advantage and CMS movement to risk

Medicare expansion

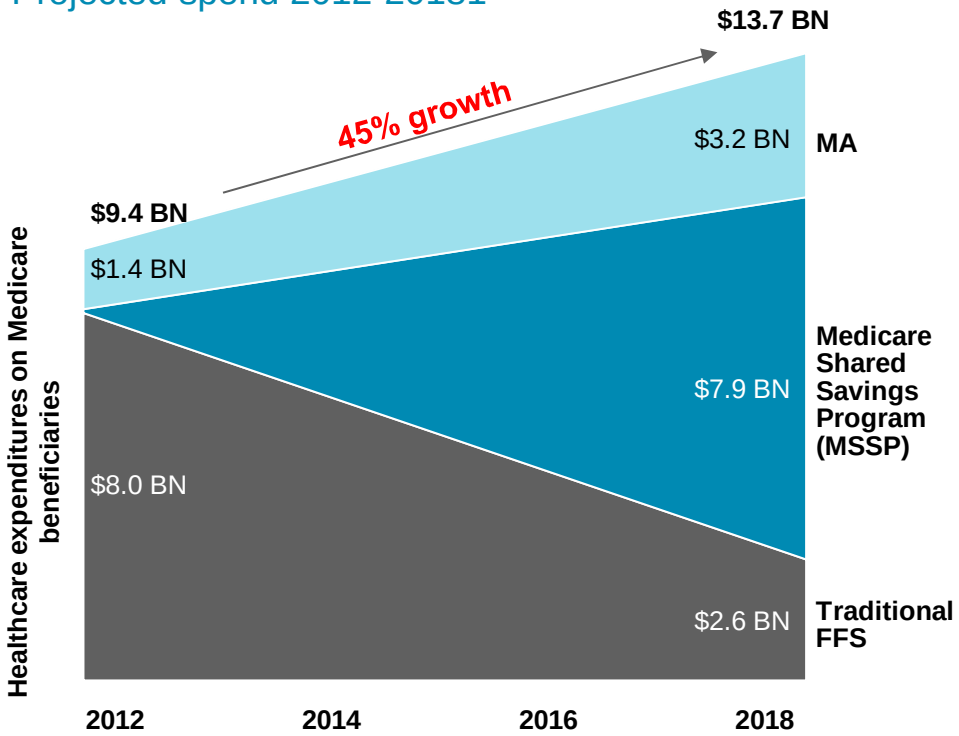
Projected lives 2012-2018



These sample markets will see an additional 110 K Medicare members as Baby Boomers age into Medicare

Medicare market spend by channels

Projected spend 2012-20181



Reimbursement will shift dramatically over the next 6 years as MA expands and Traditional FFS is replaced by value driven Shared Savings payments

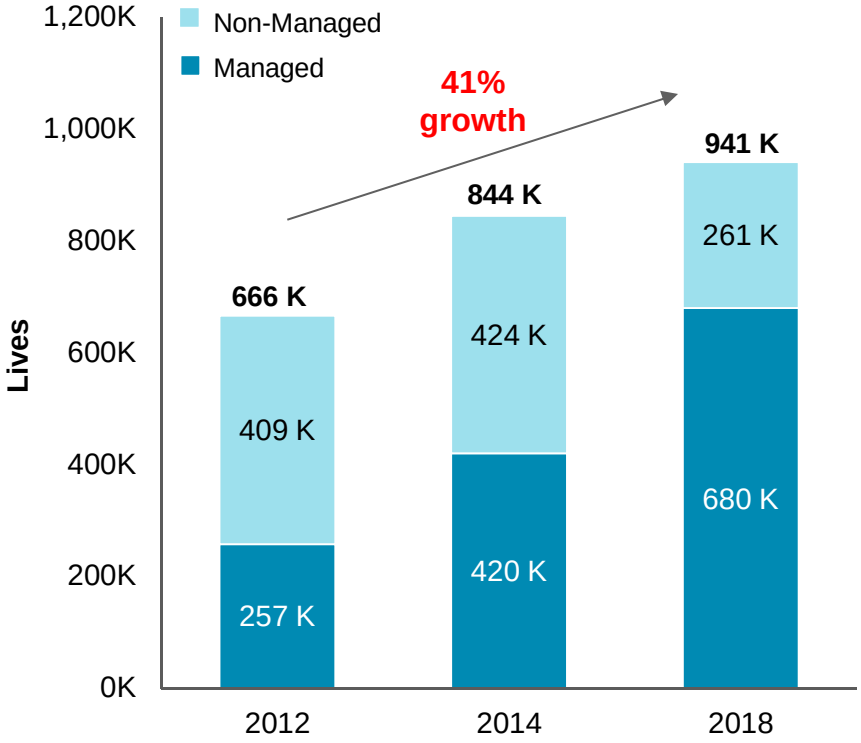
Source: OW analysis, Claritas, CDC Mortality Rates, CMS National Expenditure data

1. Total spend increase driven by growth in lives and growth in per-person expenditures. MA and Medicare FFS expenditures assumed to increase at 4% annually.

Medicaid will see explosive growth over the next six years as ACA expands eligibility requirements and states re-engage around Medicaid managed care

2012-2018 Medicaid expansion

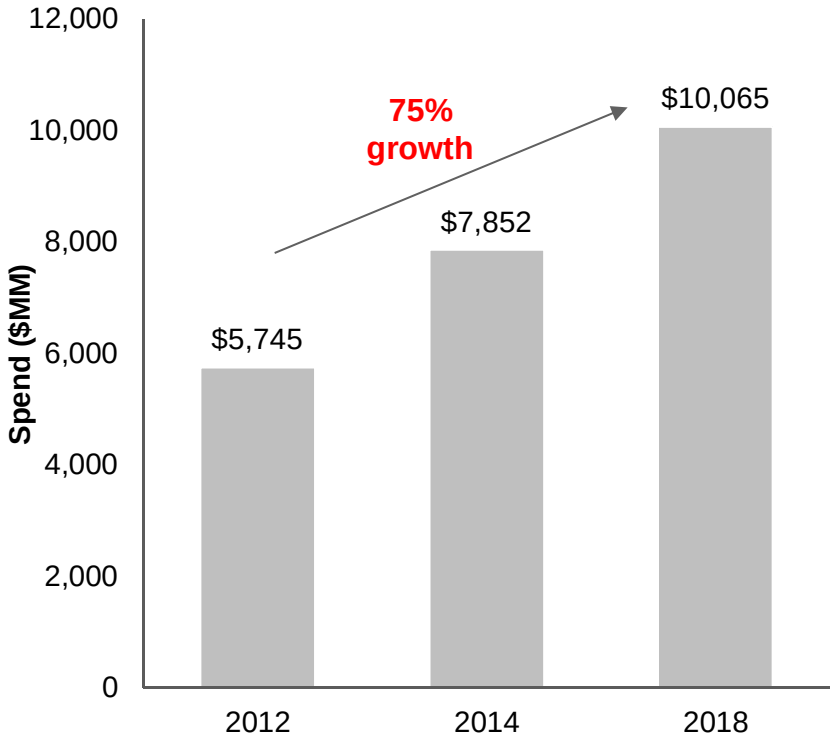
Projected for these sample markets



Managed Medicaid penetration is expected to increase from 40% today to over 70% in 2018 as states push to find ways to control costs

2012-2018 Medicaid expenditure

Projected for theses sample markets[1]

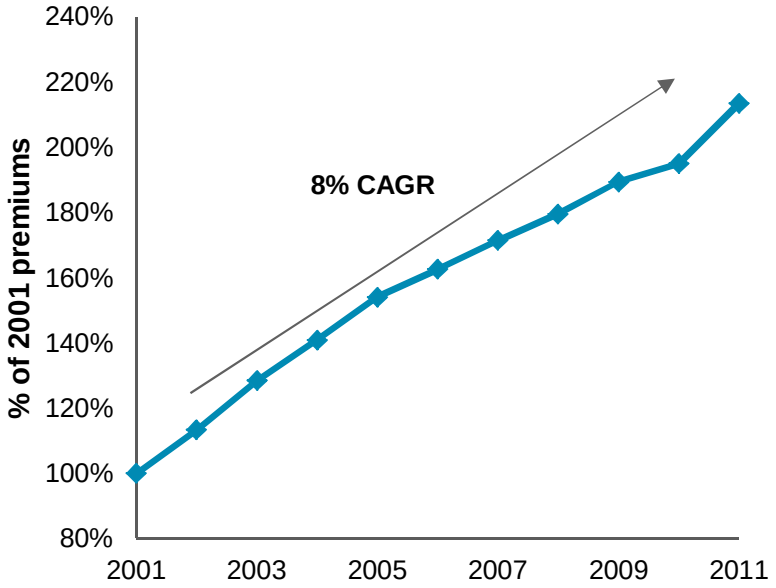


States will be hard pressed to sustain even modest rate increases; meaning that this population's profitability will likely decline even as its utilization increases

1. 2018 spend figures are pre-transformation

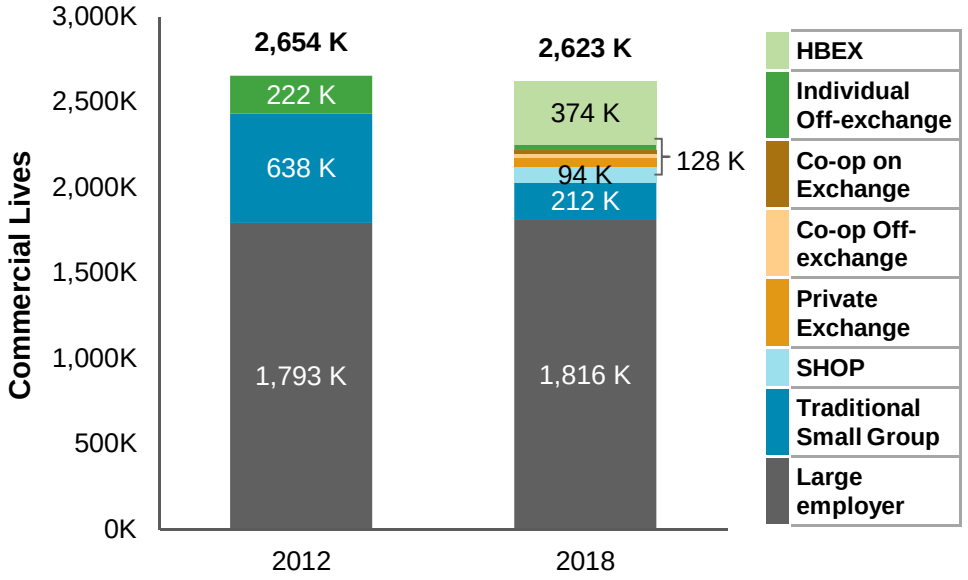
The Commercial market is rapidly rotating to a retail environment as consumers grow increasingly price sensitive and new retail channels intensify insurer competition

Commercial premiums for employer-sponsored family plans
National, 2001-2011



Over two-thirds of employers believe health insurance trends are unsustainable[1] and many are alleviating costs by buying-down and shifting costs to members

Commercial market lives by insurance channel
projected for the six markets 2012-2018



Commercial profitability will be financially strained as the take up of new retail channels beginning in 2014 heightens downward pressure on costs of insurance coverage

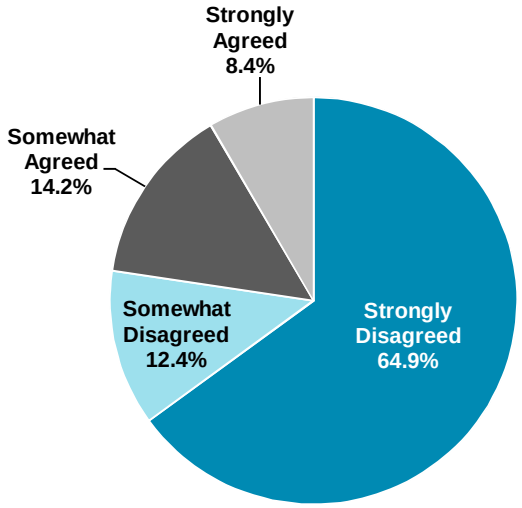
1. Oliver Wyman 2012 Employer Survey

The “tipping point”: We see large employers undecided about whether to continue to provide health benefits and more talk around direct contracting (especially with primary care).

While most employers indicate that they are unlikely to drop healthcare benefits due to reform…

Survey Findings

Our organization would be better of if we dropped employee health care coverage and simply paid the fine:



“No one’s going to make a big move to drop benefits unless they see an industry leader, a big company, make a move.”

– Midwest Business Group on Health , April 2010

Source: Crain Communications survey of employers with 25,000+ employees

…several employers are actively considering changing coverage for selected employee groups

OPINION | MAY 21, 2010

Goodbye, Employer-Sponsored Insurance

Companies are discovering that it's cheaper to pay fines to the government than to cover workers.

3M to give some retirees vouchers for health care

'Reimbursement
By John Welbes
jwelbes@pioneerpr
Updated: 10/05/201

3M Co. will stop offer
starting in 2013 and

The Maplewood-bas
health care reform le
such a move, expert

"If you're going to do
University of Wiscon

But it's too early for a
compare to corporat

3M said Monday that
Reimbursement Arra

HEALTH INDUSTRY | SEPTEMBER 30, 2010

McDonald's May Drop Health Plan

Article | Video | NEW Market Quotes | Comments (389)

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By JANET ADAMY

McDonald's Corp. has warned federal regulators that it could drop its health insurance plan for nearly 30,000 hourly restaurant workers unless regulators waive a new requirement of the U.S. health overhaul.

The move is one of the clearest indications that new rules may disrupt workers' health plans as the law ripples through the real world.

Trade groups representing restaurants and retailers say low-wage employers might halt their coverage if the government doesn't loosen a requirement for "mini-med" plans, which offer limited benefits to some 1.4

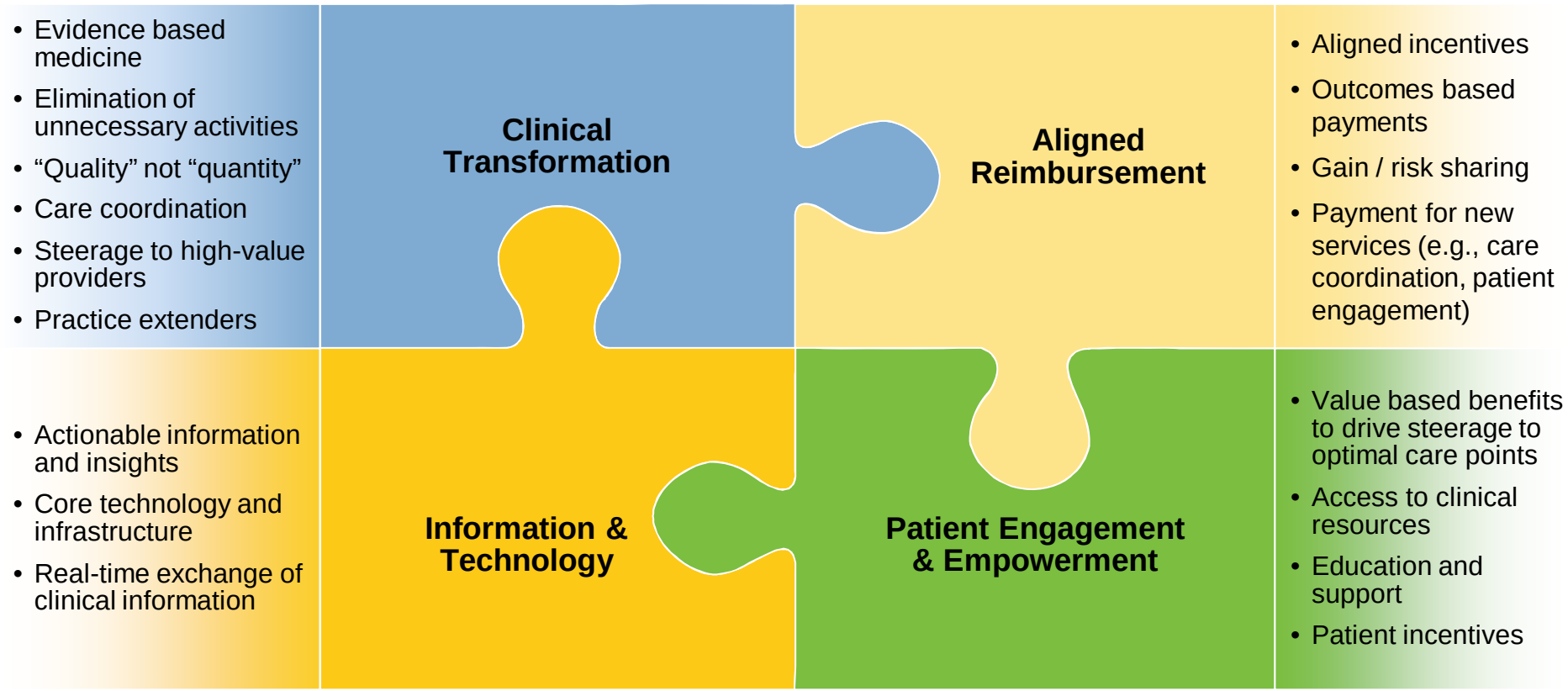
“If I could get out of buying health insurance for my employees, I would do it tomorrow. And every CEOI know would do the same thing.”

– Fortune 100 CEO, August 2009

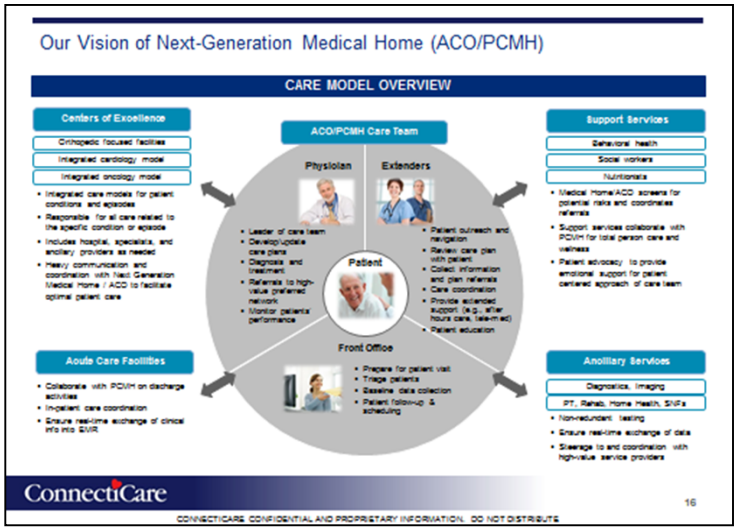
Value based health care has four critical components

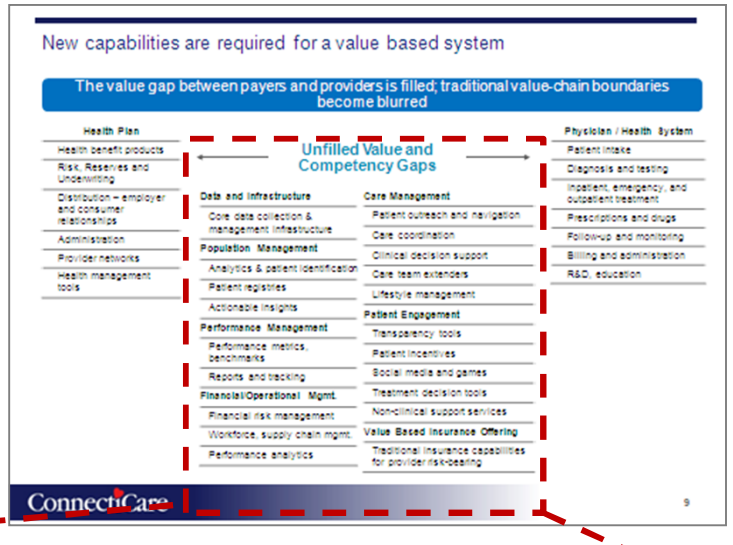
Traditional partnerships focus on just "payment contracts" without enabling fundamental delivery transformation; we are looking to partner on all four fronts

Components of Value Based Health Care



To enable care model transformation and “fill the gap”, capabilities in six categories are required





Value Based Enablement Solutions

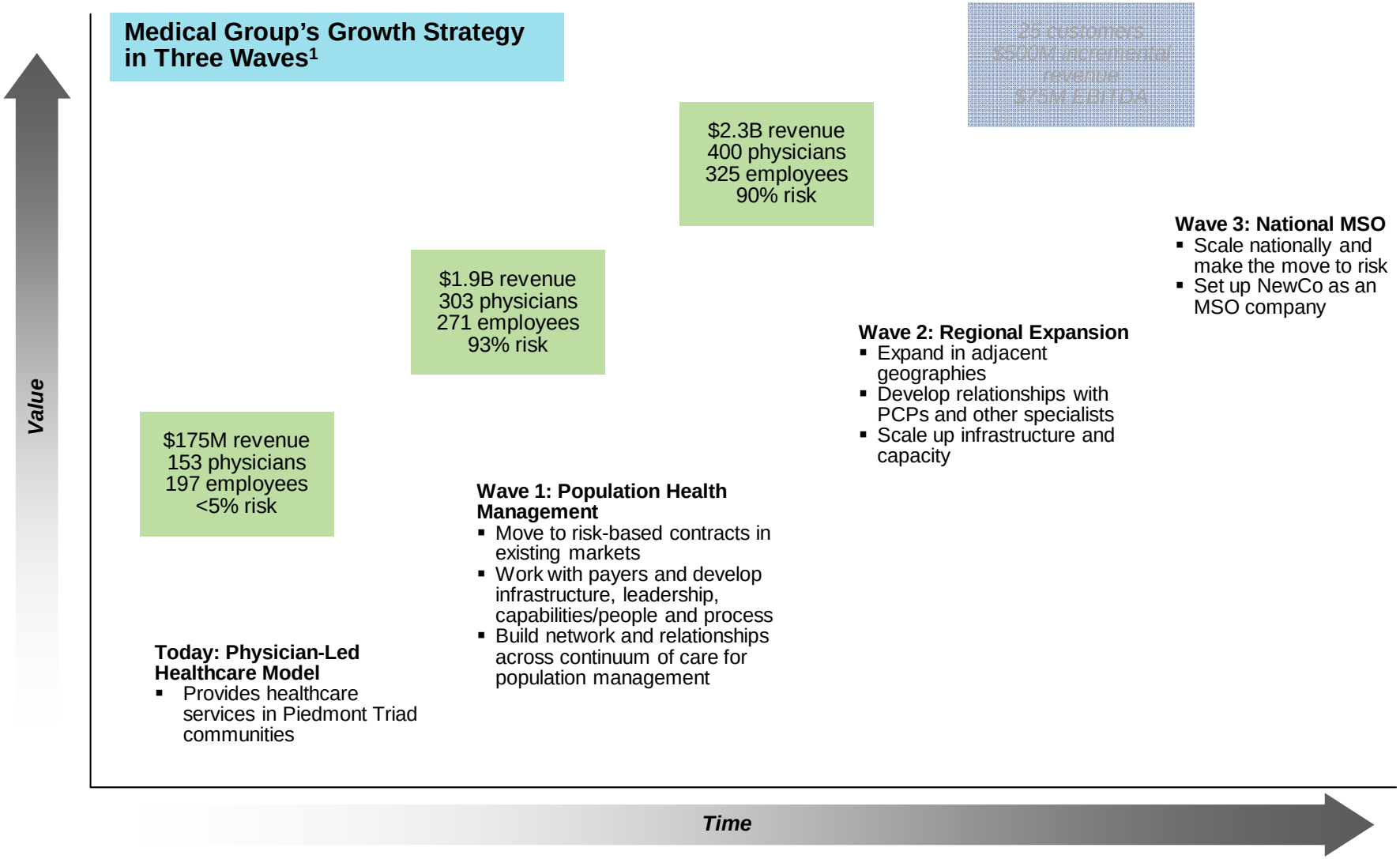
1. **Clinical Analytics & Population Management**
2. **Care Management**
3. **Patient Engagement Tools and Services**
4. **Performance Management**
5. **Financial & Operational Management**
6. **Insurance and Risk Management Solutions**

Data Collection, Sorting and Storage, Connectivity, and Analytics Infrastructure

Commercial payers are driving the market to adopt value based delivery systems

Managed care company	Key value-based initiatives
Wellmark BlueCross BlueShield	Wellmark has already rolled out its PCMH and value based reimbursement schemes. It is now embarking on a gain-sharing ACO partnership for its commercial book of business
WellPoint	WellPoint is aggressively moving towards transforming care delivery as it rolls out PCMH and Medical home initiatives nationally. WellPoint's recent acquisition of CareMore affirms their investment in the growing aging population and the MA business.
Arkansas BlueCross BlueShield	AR BCBS has shown a strong interest in organizing and advancing primary care, including shared investments in primary care practices. It is actively developing clinical care models and working in parallel with the state to launch Medicaid bundled payments.
UnitedHealth Group	United is pursuing CIN infrastructure relationships through its subsidiary Optum (e.g. Steward Health System), is purchasing delivery system assets through its ACS division (e.g. Monarch), and is partnering on all books of business for clinical risk
aetna	Aetna has launched its CIN infrastructure initiative, is actively partnering with delivery systems (e.g. Carillion), and is contemplating a PCMH support business. It is actively engaged in more than two dozen "ACO" arrangements
Coventry Health and Life Insurance Company	Coventry has developed its "High Performance Network" initiative and is building co-branded "ACO" narrow network products in more than 20 markets
HUMANA	Humana has purchased provider assets (e.g. Concentra) and has a market based, flexible approach to sharing risk. In some markets providers are harvesting over 150% of traditional Medicare in its MA shared risk arrangements.

Medical group's growth strategy will occur in three waves



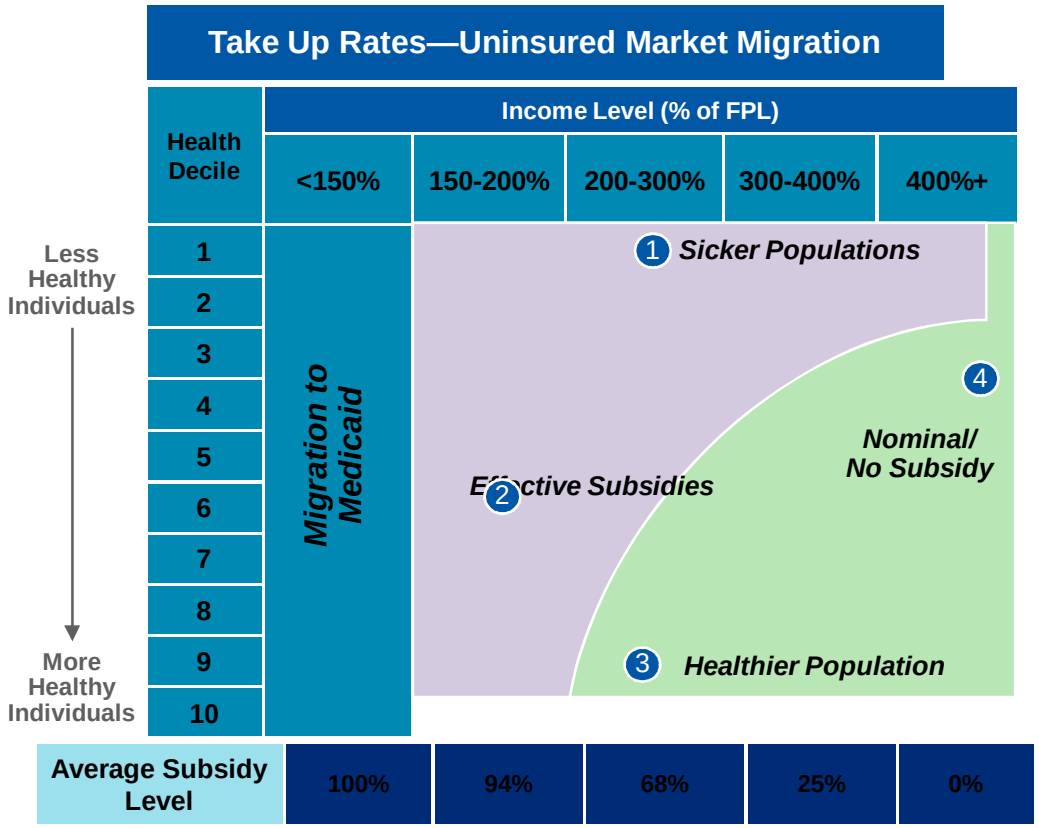
1 Physician and employee counts are cumulative over time for each wave; employee counts include corporate and administrative staff

National hospital – centric system creates managed care subsidiary to offer products in six major markets

Revenue Source	Program	Description	2018 Base Revenue Moved to Risk	2018 Incremental Delivery Revenue	2018 Incremental Operating Income[2]
Medicare	Medicare Shared Savings Program	Participation in Medicare Shared Savings to manage an attributed FFS population	$1,170M – $1,430M	$90M - $110M	$65M - $80M
	MA Product	System -led narrow network products that secures MA market share by 2018	$350M - $450M	$60M - $75M	$60M - $70M[1]
	Contract for MA Risk	Contracting with private payers for population risk on MA members	$250M - $350M	$25M - $30M	$20M - $25M
Commercial	Individual Product	System -led narrow network products primarily offered on public exchanges	$500M - $600M	$30M - $40M	$25M - $30M[1]
	Small Group Product			$50M - $60M	$40M - $50M[1]
	Contract for Commercial Risk	Contracting with private payers for population risk on Commercial members	$900M – $1,100M	$90M - $115M	$45M - $50M
Medicaid	Medicaid Product	System -led narrow network product that secures portion of the Managed Medicaid market	$150M - $200M	$90M - $110M	$20M - $30M[1]
	Contracts for Managed Medicaid Risk	Contracting with private payers for population risk on Managed Medicaid members	$250M - $350M	$140M - $170M	$15M - $25M
Total			**$3,500M - $4,500M**	**$580M - $710M**	**$290M - $360M**

1) Operating income for licensed insurance products includes insurance profit margin
2) Operating income shown is prior to distributions to provider network partners and incentive payments to physicians

Large California Health System obtains Knox-Keene and building health plan for 2014



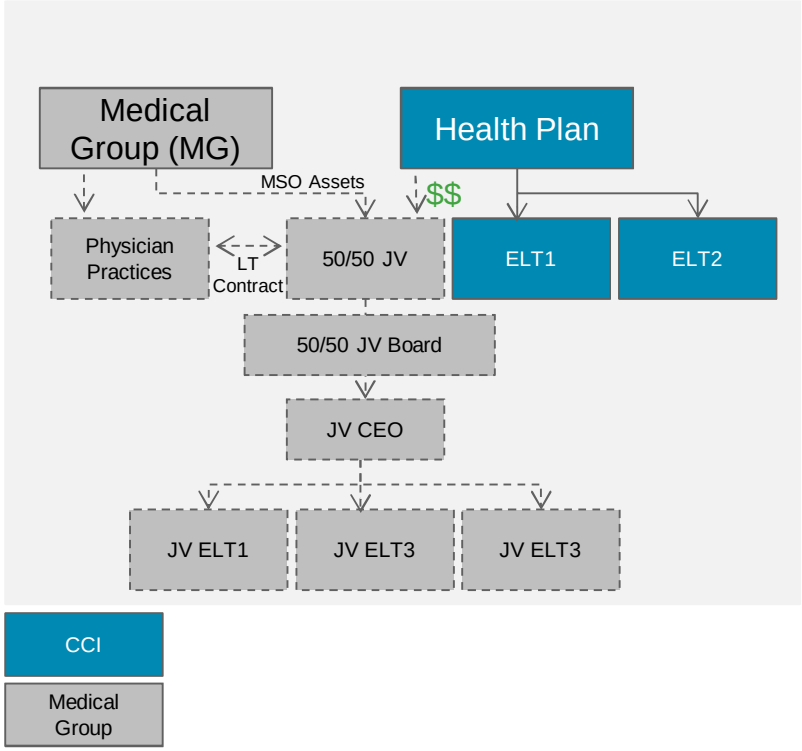
Impact of Subsidies Varies by Segment

1. **Sicker Population—**individuals with expected claims in excess of premiums are most likely to comply with mandates and subsidies (85-95% compliance)
2. **Effective Subsidies—**cover the majority of the premium expense for low income (<200% FPL), removing the affordability barrier (65-85% compliance)
3. **Healthier Population—**healthier, higher income individuals don't see the value in premiums and are reluctant to comply (33-50% compliance)
4. **Nominal/No Subsidy—**higher income population ineligible for subsidies are less likely to comply (20-50% compliance)

In addition, compliance with mandates/subsidies will be impacted by premium increases: take up rates are diminished with higher costs, particularity among healthier populations.

Large Health Plan and medical group create 50/50 JV MSO to manage risk and build narrow network products; all clinical operations remain independent

Deal Overview



Reasoning	•	Both parties want to build new core business
Investment Structure	•	Health Plan invests cash into Newco while partner invests technology contracts and capabiliites, but no cash
Organizational Structure	•	JV is a free standing organization with its own governance.
Decision Making	•	JV executives report to the JV Board of Directors
Technology	•	Limited integration with Health Plan
Financial Characteristics	•	Newco designed for replication and scale.
Leadership	•	Employment contracts for existing management staff that transfer to Newco
Integration	•	Limited
Replication	•	IPAs, networks

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