Back to the Future!

The health care system was never broken, it was built this way!

Those who cannot remember the past are condemned to repeat it!

If you always do what you've always done, you will always get what you've always got.
No insurance coverage

Health insurance as we know it today is non-existent. Some companies, especially those tied to dangerous trades, offer accident and sickness settlements for those hurt on the job and forced to miss work for a long period. Voluntary fraternal organization and "mutual protection societies" also offer limited coverage for injured and ill members.
1911
Montgomery Ward pioneers group insurance

Retailer Montgomery Ward enters into a contract with a third-party insurer, the London Guarantee and Accident Company of New York, to provide benefits to employees who miss work. It’s the nation’s first group health insurance plan. In the same year, Great Britain passes its National Insurance Act.
1912

Starts and stops

Former President Teddy Roosevelt, now of the Progressive party, campaigns on “social insurance” issues. In the same year, the American Association for Labor Legislation publishes a draft bill that would provide health coverage for all, modeled on similar plans in Europe. The plan dies with WWI.
1929
Baylor's plan forms foundation of Blue Cross

Prepaid insurance coverage starts at the Baylor University Hospital in Dallas, Texas, when some 1,500 school teachers were covered for 21 days of semi-private room and board and hospital extras in any one year. It’s the predecessor to our modern Blue Cross.
1939
California makes it statewide

The first state-wide Blue Shield plan — which pays physicians, as opposed to hospitals — was developed, called the California Physician Service.
1942
Health insurance becomes tied to employment

Congress passes the Wage Stabilization Act, meant to keep employee earnings in check during WWII. Stagnant wages cause companies and unions to offer more generous health benefits. Subsequent court rulings find that benefits arranged by an employer are not subject to wage and income taxes. The effect is that health insurance is now directly tied to your job.
1965
Medicare and Medicaid become law

The Social Security Act of 1935 is amended to include a federal program called Medicare, which provides health insurance to people age 65 and older. Medicaid, which is administered by the states and offers health coverage to certain low-income and disabled populations, also becomes law.
1974
Hopes dashed for national health care plan

President Richard M. Nixon resigns. With his resignation, any hopes nationalized health plan — a compromise between the Nixon plan and a plan offered by Sen. Edward Kennedy — are extinguished, despite concerns over fast-rising health care costs.
1993
Health Security Act is DOA

President Bill Clinton introduces the Health Security Act, a package whose main goal was universal care for all Americans. The package is opposed by insurers, Republicans, and even lots of Democrats, and is declared dead by Senate leaders the following year.
2010
Affordable Care Act arrives

President Barack Obama’s Affordable Care Act is signed into law. It includes caps on health insurer profit margins, prohibitions on health plans that exclude enrollees based on preexisting health conditions, and a major expansion of the Medicaid program.
The Future of Employer Sponsored Health Care
- The Physician Provider Perspective -

Charlie Stiernberg, MD, MBA
Chief Executive Officer, Houston Regional Accountable Care Organization, LLC
Chief Operating Officer, Hillcroft Medical Clinic
Sugar Land, Tx
### Texas Physician Distribution - 2015

<table>
<thead>
<tr>
<th>Texas</th>
<th>Primary Care</th>
<th>Specialists</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>27,859</td>
<td>30,322</td>
<td>58,181</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation
The Traditional Physician Business Model

The “Classic” Fee for Service Model
Today’s Physician Business Model

- Movement Away from FFS
- Towards “Value Based Payment System”
What is a “Value Based” Payment System

• Payment is on quality rather than volume

• Must measure and report quality

• Focus on Preventive Medicine
Shifting to the “Value Based” World

By 2016, 30 percent of all Medicare provider payments will be in alternative payment models. The goal is 50% by 2018.

-- HHS Secretary Burwell
**Accountable Care Organizations**

1) What is an ACO? – Depends on who you ask

2) Coined term in 2006

3) Started by CMS

4) Clinically Integrated Networks (CIN’s)

5) Two basic types: federal and commercial
Accountable Care Organizations

# Estimated ACO Covered Lives
In millions

1/11  1/12  1/13  1/14  1/15  1/16  1/17  1/18  1/19  1/20

2.6  5.6  14.6  19.2  23.5  28  40  50  60  72
Who Can form an ACO?

Federal Govt

Hospitals and Hospital Systems

Business Entrepreneurs

Doctors
Concept of Shared Savings

Who shares what and why?

Can Employers share in these Savings?

FOOTNOTE: About 70% of MSSP’s generating shared savings were physician-led.
Where can We Find Savings

Top 10 HCG PMPM Opportunities for Medicare, 2011

<table>
<thead>
<tr>
<th>Service</th>
<th>Savings (PMPM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Medical</td>
<td>$63.18</td>
</tr>
<tr>
<td>Inpatient Surgery</td>
<td>$56.97</td>
</tr>
<tr>
<td>SNF</td>
<td>$32.26</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$20.60</td>
</tr>
<tr>
<td>Non-hospital DME, Supplies</td>
<td>$12.69</td>
</tr>
<tr>
<td>Physician Office/Home Visits</td>
<td>$12.07</td>
</tr>
<tr>
<td>Physician Hospital Visits</td>
<td>$7.36</td>
</tr>
<tr>
<td>Physician, Outpatient Surgery</td>
<td>$7.24</td>
</tr>
<tr>
<td>Home Health</td>
<td>$6.87</td>
</tr>
</tbody>
</table>

Source: Millman / Advisory Board
A Case Study

- **Established 2015**
- **Built by Independent Physicians**
- **Wholly Owned / Managed by IP’s**
Texas Medical Association & Practice Edge

- Bring Physicians together in CIN’s
- Offer Added Value Services/Products
Houston Business Coalition on Health

Dr. Paul Hodgins
Chief Medical Officer
Agenda

• Health services in oil and gas
• Areas of focus
• Improving access to care
• Onsite clinics – strategy and outcomes
ConocoPhillips Health Services

ConocoPhillips
- Exploration and Production
- 18,100 employees
- 27 countries

Health Needs
- Emergency/Primary Care
- Occupational Health
- Absence Management
- EAP
- Wellness

Health Services Organization
- ~60 employees/40 contractors
- Report to VP HR (corporate)
- Report to HR or HSE or operations (business units)

Corporate staff (10)
- Businesses (90)
- U.S. (20)
- Non-U.S. (80)
Health Focus

• Reducing employee health risks
• Improving employee health and productivity

Approach

• Target risks based on health claims and biometric results
• Align health/wellness and benefit programs
  • Biometrics, wellness challenges, Incentives for healthy behaviors
  • Nutrition Boot Camp, weight loss programs
• Align wellness with safety programs
  • Focus on fatigue, stress and distraction
• Encourage preventive care and facilitate access to care
Benefits Focus

- Increase participation in HDHP
- Outcome based wellness incentives
- Evaluate price transparency tools
- Assess reference based pricing
- Revise contributions for pharmacy
- Evaluate STD/LTD design change
- Evaluate ACOs
- Evaluate health care exchanges for pre-65 retirees and active employees
Overall Prevalence Analysis

- Pre-Hyptertension: 46.90%
- Overweight: 39.78%
- Obese: 29.88%
- Pre-Hyperlipidemia: 24.62%
- Pre-Diabetes: 17.99%
- Hyptertension: 13.09%
- Hyperlipidemia: 6.96%
- Diabetes: 3.93%
Facilitating Access to Care

• Onsite Clinics – primary care and dental
• Telemedicine for remote sites with clinics – North Sea/Alaska/other
• Teladoc for phone consultations
• Telephone/videoconferencing for EAP/psychiatry
Considerations Regarding On-site Clinics

• Primary care/urgent care
  • Goals? – benefits/wellness
  • Encouraging appropriate screenings
  • Avoiding over-utilization
  • Population needed ~3000
  • Quality of provider
  • Reputation of the vendor
  • Acceptance by employees/contractors
  • Security issues/access
Primary Care and Dental Clinic Utilization

- Objective: Provide convenient quality on-site health care and eliminate productivity loss due to driving/waiting

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Primary Care</th>
<th>Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opened</td>
<td>April 2013</td>
<td>September 2014</td>
</tr>
<tr>
<td>Average patients per day</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td>Average waiting time</td>
<td>5-10 mins</td>
<td>5 mins</td>
</tr>
<tr>
<td>Patient Satisfied/very satisfied</td>
<td>6%/94%</td>
<td>4%/96%</td>
</tr>
<tr>
<td>Vendor business goals met</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Quality measures met</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

- Different models some have health plan design implications
- Implementation costs low for insurance based clinic
- Impact: Quality care for employees, productivity gains, competitive healthcare costs
UnitedHealthGroup at a glance

Our United Culture

Integrity • Compassion • Relationship • Innovation • Performance

Health Benefits

Employers
Seniors
Individuals
Veterans
Medicaid Recipients
Active Military

Health Services

Care Delivery
Financial Solutions
Research
Health Analytics
Consumer Guidance
IT Solutions
Pharmacy
Population Management
Exchanges

Helping people live healthier lives
Dedicated to making the health system work better for everyone

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"If you aren’t focused on addressing the total cost of care, you’re missing the boat." – Dr. Robbins, CEO Texas Medical Center

OUR FOCUS: TOTAL COST OF CARE

Unit Costs
(Discounts)

Number of Units
(Population Health Management)

Total Cost of Ownership

Contracted Discounts
Pay for Performance
Risk Share

Evidence-Based Care
Member Engagement
Clinical Programs
WE ARE TRANSFORMING HOW WE PAY FOR HEALTH CARE AND HOW HEALTH CARE IS DELIVERED

We are paying for value through outcome-based payment models that reward care providers for improvements in quality and cost-efficiency.

We are helping to transform the delivery system to be more accountable for cost, quality and experience outcomes, helping make health care more affordable.

We are aligning incentives across employers, consumers and care providers to achieve the Triple Aim of better health, better care and lower costs.
OUR MODULAR SET OF VALUE-BASED PAYMENT MODELS ARE DEPLOYED ACROSS THE CONTINUUM. WE ARE ABLE TO ALIGN OUR VALUE-BASED PAYMENT MODELS WITH A CARE PROVIDER’S RISK READINESS.
OUR FOCUS: TOTAL COST OF CARE

“If you aren’t focused on addressing the total cost of care, you’re missing the boat.” – Dr. Robbins, CEO Texas Medical Center

Unit Costs (Discounts)  Number of Units (Population Health Management)  Total Cost of Ownership
Why INDIVIDUAL HEALTH OWNERSHIP is important

The current health care situation in the U.S. is unsustainable. Driving sustained reduction in costs = increasing Individual Health Ownership.

114% Increase in family coverage costs since 2000

52% Estimated U.S. population expected to have diabetes/pre-diabetes by 2020

41% Consumer health care decisions that are less than optimal

50% Patients who leave their doctor’s appointment not knowing what they were told or what they are supposed to do

100,000 Number of deaths every year linked to poor health literacy

50% Medications not taken as prescribed

50-75% Costs driven by lifestyle decisions

25-30% Employer health care costs due to avoidable diseases

The time to act is now. But what does this mean for you and where do you start?


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### UnitedHealth Tier 1 Providers

**Incentives to use Tier 1 Providers, where chronic care starts**

#### Premier Plan Tiering

<table>
<thead>
<tr>
<th>Office Visit</th>
<th>All Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care physician</td>
<td>$25</td>
</tr>
<tr>
<td>co-payment</td>
<td></td>
</tr>
<tr>
<td>Tier 1 Specialty office</td>
<td>$25</td>
</tr>
<tr>
<td>visit co-payment</td>
<td></td>
</tr>
<tr>
<td>All Other Specialty office</td>
<td>$40</td>
</tr>
<tr>
<td>visit co-payment</td>
<td></td>
</tr>
</tbody>
</table>

#### Advanced Plan Tiering

<table>
<thead>
<tr>
<th>Office Visit</th>
<th>Tier 1 physicians</th>
<th>All other physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP office visit co-payment</td>
<td>$25</td>
<td>$40</td>
</tr>
<tr>
<td>Specialty office visit</td>
<td>$40</td>
<td>$60</td>
</tr>
<tr>
<td>co-payment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Fees /</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### UnitedHealth Premium Designated Tier 1 doctors...

- 38% of Primary Care Physicians (79,000 docs)
- 31% of specialists (37,000 docs)
- 27 specialties influence 80% of costs
- Avoids Emergent Care issue inherent with narrow network approaches

**Results:**

- Spend 25% lower for members with 75% of eligible spend at premium physician
- Members engaged with Premium Providers more than 70% of the time show:
  - 13-24% **reduction** in the episodic cost of care
  - 18% **lower** total costs
  - 4.4 points **lower** readmission rate
  - 27% **lower** ER utilization
  - 59% **lower** complications
  - 64% **lower** procedure re-do’s
  - 20% **lower** surgery costs
CLINICAL ENGAGEMENT
Health matters | Clinical integration

We monitor 100% of the population looking for opportunities to help employees improve their health and get more value for every health care dollar.

Synchronize diverse data points to monitor population needs
- Claims data
- Pharmacy data (OptumRx)
- Lab data
- Health Assessment results
- Biometric data
- Network and quality and efficiency rated physician utilization
- On Site Wellness Coordinator and/or Service Representative

Total population monitoring
- Holistic member view for proactive identification
- Outreach and health management

Persistent consumer engagement
- Care provider engagement

Staying Healthy Wellness & Prevention
- Getting Healthy Care Management
- Living with a Chronic Condition
Advocate4Me
Enhanced Customer Service Model

Targeted Employers: National Accounts - all new business and all existing customers (migrations until mid-2015)

We take our understanding of their family’s situation and history...

And connect them to the Advocate suited to support them.

CREATING A RELATIONSHIP BETWEEN FAMILIES’ AND ADVOCATES

Member identification

Natural Language Routing (phone only)

Robust data & insights

Demographics

Claims data

Life and health stage

Preference data

Behavior analytics

ADVOCATE

Nurse Advocate

- Clinical license (LPN or RN)
- Experienced at providing:
  - health education
  - decision support
  - other clinical education
  - pharmacy

Health Advocate

- Claims and wellness expert
- Experienced at:
  - program enrollment
  - detailed benefits/claims support
  - preventive care education
  - basic health education

Benefits Advocate

- Customer service expert
- Experienced at:
  - member tools
  - preventive care education
  - provider verification and appointment scheduling
  - program enrollment

EXPERTISE

Significant Health Issues

(Chronic, complex, multiple, etc.)

Complex Claim Issues

(Recent frequent user, out-of-network use, etc.)

Infrequent Health Issues

(Good health, mainly routine/preventive)

*Family or household refers to employees and their covered family members. Family-based discussions subject to appropriate authorization.
Advocate4Me
Reasons to believe

97% overall satisfaction
Over 95% of consumers have high level of trust in information received from Advocate
Nearly 40% less transfers when seeking support
Over 99% of the time follow-up with consumers is delivered within committed timeframe

Over 24% of all Treatment Decision Support cases are acquired via Advocate referral
Nearly 30% of all wellness cases are acquired via Advocate referral
Over 15% of all clinical program enrollments are coming from the Advocate referral process†

Advocate4Me goals:
employee productivity, engagement, trust and satisfaction in UnitedHealthcare and preventive screenings and visits
calls to human resources, gaps in care, emergency room utilization, repeat calls for same inquiry and medical and pharmaceutical costs

Source: UnitedHealth Group Advocate4Me Operations Scorecard, January – September 13, 2014, approximately 1.5 members. Trust score and transfer data is through July 31, 2014.
* Trust = Question as asked in the United Experience Survey - Rate the trust you have in the answer you received. † Of those consumers with access to Advocate4Me

Patent Pending

2014 Genesys Customer Innovation Award

Frost & Sullivan 2014 Best Practices Award

Operational performance
Satisfaction
Engagement
Health care outcomes

11

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### Plan Benefits
#### Core Plan Design
- **CDHP <25%**
  - Mainly PPO or POS type designs

- **CDHP 25-50%**
  - More HSA enrollment

- **CDHP 50%+**
  - HSA or dynamic account

- **CDHP 75%+**
  - HSA or dynamic account

#### Cost-Share and Funding (Reform Metallic Plans)
- **>90% actuarial value**
  - Gold/Platinum

- **90-80% actuarial value**
  - Silver/Gold

- **<80% with rewards integration**
  - Silver level designs

- **<70% with rewards integration**
  - Silver and Bronze

### Better Decisions
#### Network Design
- Broad network
- Limited OON cost share

#### Quality and Transparency
- myuhc network directory
- Basic messaging

#### CLINICAL RESOURCES/Rx, SPECIALTY INTEGRATION
- Initial deployment of programs
- Variability evaluation

#### REWARDS/WELLNESS STRATEGY
- Limited to none (e.g. health assessment reward <$200)
- Challenges/Health site

#### PERSONALIZED EXPERIENCE (Communications, Devices, Resources)
- Myuhc.com <30% overall
- Enrollment support / communications only

### Cost Share
- Target messaging
- Cost transparency emphasis

### Quality and Transparency
- Tiered cost sharing (Premium, place of service)
- Centers of Excellence (COE) incentives

### Future
- Narrow and/or gatekeeper market enrollment options
- Micro Network designs: ACOs, PCMHs, other
- Gatekeeper designs (embedded or plan option)
- Onsite clinics or other network augmentation (virtual/tele)

### Rewards/Wellness Strategy
- Activity based rewards
- $300-$1000
- Screening and coaching
- Or <50% engagement

### Personalized Experience
- Consumerism 101
- Limited member support: tools and resources

### CLINICAL RESOURCES/Rx, SPECIALTY INTEGRATION
- Optimize fit to risk profile of the population
- Performance norm or better
- Medical Necessity

### Population Health
- Total population management
- Value-based designs
- Seamless integration

### REWARDS/WELLNESS STRATEGY
- Outcomes-based and compliance
- Active vs. non-active impact
- >50% engagement

### Personalized Experience
- Personalization through tools / devices
- Ongoing reinforcement
- Concierge models
- Segmentation

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HBCH – Local Health System Strategies

Shawn Griffin, MD
Chief Quality and Informatics Officer, MHMD
October 8, 2015
Major Trends

• Houston Price Pressures Increasing
• Health Systems Expanding Into Growing Markets
• Payer, System, and Group Consolidation Changing Existing Relationships
• Accountable Care Organizations Growing, but Not All Systems Buying In
• Primary Care Affiliations Expanding
## Traditional Healthcare – A Flawed Model

### How the industry has functioned

- Physicians, hospitals, and insurers working in silos
- Lack of data sharing across the functions that touch the patient
- Billboard Medicine - Management of a single occurrence, not the population
- Patient engaged after becoming sick
- Inadequate transparency and access to data
- Lack of population management tools and comprehensive data
- Misaligned incentives between providers and insurers
- Disease and care management only an insurer function
- Little focus on systemic improvement

### How it will have to function

- Willingness to depart from old models and change roles of key players
- New technologies enable data flows to all providers wherever the patient presents
- Focus on population health, prevention, and the patient outside the health care setting
- Proactive patient engagement
- Transparent sharing of data among providers and between providers and insurer
- Population management tools employed and informed by data to give 360° view
- Aligned incentives reward providers and hospitals for improved quality and cost
- Providers and insurer collaborate on disease & care management to maximize impact
- Investment in continuous improvement
Accountable Care = Healthier Population

Doesn’t that sound simple?

Evidence-based Utilization
A Very Basic Premise

MHMD ↔ MHHS

Physicians

Hospitals
Who you contract with “commoditizes” other parts.
How will we get there?

- Education
- Cultural Change
- Aligned Incentives
- Organizational Structure
- Commitment to Evidence Based Medicine
- Information
We Started Many Years Ago…

5 Key Strategic Inflection Points

- Clinical Programs Committees (CPCs) (2000)
- Clinical Integration (2005)
- The Physician Compact (2008)
- The Patient-Centered Medical Home (PCMH)(2011)
- The Accountable Care Organization (ACO) and Single Signature (2012)
Organization Timeline
Authority of the CPCs

Delegation from the health system

- **Protocols** (creating and measuring EBM practices and order set templates)
- **Performance** (setting and monitoring progress against established quality standards and protocols)
- **Products** (drives the standardization of vendors, formularies, supply chain decisions)
- **Payment** (Pay for performance goals, co-management agreements, ACO project metrics, PCMH elements)
- **Projects** (ED to ED transfer policy, CT scanning in pediatric head trauma, standardized order sets in Observation units, service line, credentialing and privileging standards)
- **Program Rationalization** (Consolidation and concentration of clinical service delivery – i.e. open heart and joint programs)
Iatrogenic Pneumothorax

MH Southeast Hospital

Southeast Adult Iatrogenic Pneumothorax
Do No Harm
Rate/1000 Discharges for Secondary Diagnosis

Ultrasound Mandatory

514 CPC Recommendations in 2014

20 Months
Zero Iatrogenic Pneumothorax

Mean = 0.56
Mean = 0.00

Generated: 9/15/2011 11:57:49 AM
Source file date: 9/13/2011

produced by System Quality and Patient Safety
Participating physicians must participate
• Selecting quality measures
• Reporting performance
• Determining performance targets (setting realistic goals)
• Participate in committee work, performance feedback, and quality improvement activities
• Time, effort and IT infrastructure all required

Those who do not participate even after remediation, must be removed!
MHMD Compact

MHMD PHYSICIAN COMPACT

PHYSICIANS AGREE TO:

- Practice evidence-based medicine
- Uphold regulatory, quality and safety goals
- Report quality data
- Meet Clinical Integration criteria
- Attend meetings and feedback sessions
- Receive MHMD information
- Accept decisions of physician committees
- Be flexible and professional
- Collaborate with colleagues and hospitals
- Share ideas

MHMD AGREES TO:

- Be loyal to physicians
- Negotiate well to align incentives
- Include physicians in work decisions
- Provide clear and timely information
- Offer vital services and education
- Seek feedback from physicians
- Maintain confidentiality
- Communicate with physicians
- Host informative meetings
- Create leadership training
BUT WHAT WAS MISSING? WHAT ABOUT OUTPATIENT?
Primary Care Network
>350 Adult & Pedi Physicians

North Region
60 APCPs
Region Leader – Dr. Ken Davis

West Region
70 APCPs
Region Leaders – Dr. Ankur Doshi & Dr. David Reininger

Southwest Region
76 APCPs
Region Leader – Dr. John Vanderzyl

Northeast Region
27 APCPs
Region Leader – Dr. Tejas Mehta

Northwest Region
56 APCPs
Region Leader – Dr. Kevin Giglio

Southeast Region
48 APCPs
Region Leaders – Dr. Maqsood Javed & Dr. Adnan Rafiq
Putting Inpatient and Outpatient performance together when caring for whole populations…

WHAT DID WE LEARN ABOUT OUR PERFORMANCE AS A COST & QUALITY PROVIDER?
Favorable Performance Metric Trends

<table>
<thead>
<tr>
<th>Metric</th>
<th>Memorial Hermann</th>
<th>Houston market</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Days/ 1000</td>
<td>208</td>
<td>236</td>
<td>13% better</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>3.5</td>
<td>3.9</td>
<td>11% better</td>
</tr>
<tr>
<td>Re-admission rates</td>
<td>5.1%</td>
<td>6.0%</td>
<td>18% better</td>
</tr>
<tr>
<td>ER visits / 1000</td>
<td>164</td>
<td>180</td>
<td>8% better</td>
</tr>
</tbody>
</table>

Aetna Commercial Data
Memorial Hermann is more efficient than the market.
Along Came Health Reform

*by any other Name....*

- Accountable Care Organizations
- Affordable Care Act / Obamacare
- Population Health
- Clinical Integration
- Patient Centered Medical Homes
- And the ability to apply to become a Medicare ACO participant
What Does an ACO Mean?

- Allowed for collaborative **aligned incentives** programs between hospital and physicians
- Relaxed **fraud and abuse restrictions**
- Provided for safe harbors
- Provided exclusive **single signature** capabilities
AND THE PAYERS RESPONDED TO OUR MODEL
Covered Lives (2015)

- BCBS (90,000)*
- United (45,000)*
- Aetna Whole Health (ACO) (26,000)
- Aetna Commercial (85,000)
- Aetna Medicare Advantage (5,800)
- United Medicare Advantage (8,800)
- CMS MSSP (ACO) (45,000+)
- Humana Medicare Advantage (5,000)
- Humana Commercial (18,700)
- Health Solutions Commercial (45,000+)

*estimated.

370,000+ Covered Lives
Evolution of Partnerships

Payers
- aetna
- Humana
- CMS
- UnitedHealthcare
- Cigna

Health Plans

MHMD

Physicians

MHHS

Memorial Hermann Healthcare System

Hospitals
DID IT WORK?

ARE WE MANAGING COST & IMPROVING QUALITY?
PARTNERING WITH EMPLOYERS
Clinical Economics Improved

Efficiency Metrics

- Impactable Admits /1,000
- Impactable Medical Admits /1,000
- Impactable Surgical Admits /1,000
- Impactable Medical Bed Days /1,000
- Impactable Surgical Bed Days /1,000
- High-Tech Radiology Visits /1,000
- CT Scans and MRIs /1,000

ACO Network, YOY performance
Clinical Quality Improved

- Asthma: Use of appropriate medications
- Breast cancer screening
- Cervical cancer screening
- Colorectal cancer screening
- Diabetes: Lipid profile
- Diabetes: Hemoglobin A1c testing

Aetna National Average vs. 2014 MHMD Performance
Better Cost and Quality for Employers

Global Engineering and Construction Co. supporting Energy, O&G industry

### Efficiency Results

<table>
<thead>
<tr>
<th></th>
<th>TARGET</th>
<th>RESULT</th>
<th>DELTA</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Impactable” Medical Admissions/1,000</td>
<td>55.0</td>
<td>16.7</td>
<td>69.6%</td>
</tr>
<tr>
<td>Potentially Avoidable ER Visits/1,000</td>
<td>95.4</td>
<td>65.7</td>
<td>31.1%</td>
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<tr>
<td>High Tech Radiology Visits/1,000</td>
<td>170.3</td>
<td>149.0</td>
<td>12.5%</td>
</tr>
<tr>
<td>CT Scans and MRIs/1,000</td>
<td>66.3</td>
<td>60.5</td>
<td>8.7%</td>
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</table>
BEST IN THE COUNTRY MSSP PERFORMANCE
<table>
<thead>
<tr>
<th>MSSP ACO</th>
<th>State</th>
<th>Total Savings</th>
<th>ACO Share</th>
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</thead>
<tbody>
<tr>
<td>Memorial Hermann Accountable Care Organization</td>
<td>TX</td>
<td>$57.83 M</td>
<td>$28.34 M</td>
</tr>
<tr>
<td>Palm Beach Accountable Care Organization, LLC</td>
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<td>$39.57 M</td>
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<tr>
<td>Catholic Medical Partners-Accountable Care IPA, Inc.</td>
<td>NY</td>
<td>$27.92 M</td>
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<tr>
<td>Southeast Michigan Accountable Care, Inc.</td>
<td>MI</td>
<td>$24.68 M</td>
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<td>RGV ACO Health Providers, LLC</td>
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<td>$20.24 M</td>
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<td>ProHEALTH Accountable Care Medical Group, PLLC</td>
<td>NY</td>
<td>$21.91 M</td>
<td>$10.74 M</td>
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<tr>
<td>Triad Healthcare Network, LLC</td>
<td>NC</td>
<td>$21.51 M</td>
<td>$10.54 M</td>
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<tr>
<td>WellStar Health Network, LLC</td>
<td>GA</td>
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<tr>
<td>Accountable Care Coalition of Texas, Inc.</td>
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<td>$19.10 M</td>
<td>$9.36 M</td>
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## MSSP Performance Year 2 (12mo)

<table>
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<th>MSSP ACO</th>
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<th>Total Savings</th>
<th>ACO Share</th>
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<td>Memorial Hermann Accountable Care Organization</td>
<td>TX</td>
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<td>Palm Beach Accountable Care Organization, LLC</td>
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<td>Physician Organization of Michigan ACO</td>
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<td>Oakwood ACO, LLC</td>
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<tr>
<td>Millennium ACO</td>
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<td>$17.49M</td>
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<td>ProHEALTH Accountable Care Medical Group, PLLC</td>
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<td>Allcare Options, LLC</td>
<td>FL</td>
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<tr>
<td>Qualuable Medical Professionals, LLC</td>
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<tr>
<td>Accountable Care Coalition of Texas, Inc.</td>
<td>TX</td>
<td>$16.04M</td>
<td>$6.34M</td>
</tr>
</tbody>
</table>
What Employers Need to Do

- Expect Consolidation in Healthcare Market
- Recognize that Primary Care Relationship is Key to Health for Employees.
- Push For Greater Transparency with Payers and Conversations Directly with Providers.
- “Own” Wellness and Target Benefit Design to Reinforce Goals.
- Align Incentives for Employees, Payer, and Providers
Presentation Outline

- Texas market trends: Brief overview of
  - HMO enrollment and inpatient hospital utilization
  - Financial results and outlook for HMOs and hospital systems
- What strategies are providers and health plans pursuing? What are the implications for employer purchasers?
- Changes in the geography of local markets
- Changes in payment and risk arrangements
Texas HMO Enrollment, 1994-2014
Health Plan Trends

- Growth and competition in individual market
- Large and medium employers move to self-funded plans
- Medicaid managed care grows, including low-income and dual eligibles
- Medicaid expansion would provide huge business opportunity for HMOs, significant benefit to low-income families, providers and employers
Impact of Proposed Health Plan Mergers in Texas

- Analysis of market power by line of business and geography.
  - Example of Medicare Advantage plans in Houston-Woodlands-Sugar Land area. About one-third of 510,000 seniors are in MA plans. Combined Aetna and Humana would have 40,000, about the same as SelectCare. UnitedHealthcare is 3rd with about 31,000 seniors.

- Would be unusual to successfully object to merger based on commercial enrollment.
Hospital Systems Prosper, But Face Risks

- System consolidation and growth results in better payment terms, higher profitability and often higher costs to employers – “must have hospitals” -- which, in turn, finances enormous construction programs

- How much capacity is needed? New stage of system building - adding hospitals to extend geographic reach and specialty centers to compete with entrepreneurs and to cement ties with star physicians
Houston Hospital Profitability

Average 2013 margin of 11.1%
Is Inpatient Care in Decline?

Inpatient Days in Houston Area
Three Provider Strategies

Seeking to build stronger brands

- Consolidation
- Strategic partnerships
- Expansion through new facilities, new convenient care locations
1. Provider Consolidation/ System Expansion

- National and local deals have impact in local markets: examples of Tenet/Vanguard, Catholic Health Initiatives/St. Luke, Community Health Systems/HMA
- Hospitals added or expanded in places like The Woodlands, Sugar Land and Katy, also at the Texas Medical Center
- Employing more physicians, both primary care and specialty
2. Strategic Affiliations

- National networks for Mayo Clinic and Cleveland Clinic
- M. D. Anderson Centers in New Jersey (Cooper University), New Mexico (Presbyterian Kaseman) and Arizona (Banner Health)
- Marketing theme: “Get ______ quality medicine close to home”
3. New Convenient Care Sites

- Growth of retail clinics, urgent cares and freestanding emergency rooms
- CVS Minute Clinics in 62 Texas cities, affiliations with UT Medical Branch and San Antonio, Texas Health in north; 20 RiteAid RediClinics in Houston area Memorial Hermann – note location strategies
- Urgent cares by Tenet (MedPost), Optum
- Freestanding ERs (5 Memorial Hermann, 25 First Choice)
Changing Geography of ‘Local Markets

Systems developing statewide presence/brand

- HCA
- University of Texas
- Baylor Scott and White
- Tenet
- Community Health Systems
- New alliance of UT Southwestern and Texas Health
Changing Payment From Volume to Value

- Most payment still tied to discounted fee-for-service – rewarding volume
- CMS goal: 50% of Medicare payments based on quality by 2018
- UnitedHealthcare goal: increase payments tied to value to $65 billion in 2018
- Even so – what % of provider payments are actually tied to performance now? Can a tipping point be reached?
Providers Taking Risk

- Significant history for provider groups in Houston, especially for Medicare
- Capitation declines here—less than 14% of HMO provider payments in 2013
- Provider sponsored health plans – new generation emerges nationally and here
- ACO arrangements for Medicare and commercial plans – limited risk-sharing, population health focus. Outlook for future?
ACOs, Shared Savings and Payment Reform

- Goal: replace a quest for volume with a quest for value – Medicare and commercial plans
- Two Pioneer ACOs drop out: Seton and Plus! North Texas ACO
- Memorial Hermann ACO - $28.3 million in shared savings for 2013, $22.7 million in 2014. Other local ACOs that earned shared savings: Accountable Care Coalition of TX, Physicians ACO
Transparency in Pricing and Quality

- Health plan online calculators and provider evaluation programs
- Websites from Medicare, state agencies and provider associations with ratings and measures of quality for both health plans and hospitals
- Yelp comes to physician ratings
Provider Strategies: Implications for Employers

- Research: Provider consolidation often accompanied by price increases to insurers and purchasers
- Providers respond to health plan consolidation by seeking to work directly with employers: wellness programs, population health initiatives, narrow network plans for self-funded employer groups
Summing Up: Opportunities and Risks

- Changes in geography of local markets for providers
- Consolidation continues and affiliations are increasingly important
- Health plans and provider systems each take turns to expand their market reach and power – how will they relate to employer purchasers?
- Convenient care sites gaining wider acceptance
For Additional Information

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