The Coming Era of Radical Network Value Management

The 2019 health plan strategic landscape
From the invisible hand to the iron fist

Double-edged growth opportunities

A new era of referral management

Specialized management of specialty drugs

Enabling a community services network
Happy Deductible Relief Day

Extreme cost sharing makes members self-fund half the year

“Deductible Relief Day,” annually

Day of the year when average health spending for large group members exceeds the average deductible in that year

States facing their own tradeoffs

State Medicaid spending catching up to public education

**Largest state spending categories**

*Direct state spending as a percent of state’s total direct expenditures*

- **Elementary & secondary education**: 21%
- **Direct public welfare (mostly Medicaid)**: 13.4%

<table>
<thead>
<tr>
<th>Year</th>
<th>Elementary &amp; secondary education</th>
<th>Direct public welfare</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>21%</td>
<td>13.4%</td>
</tr>
<tr>
<td>2004</td>
<td>21%</td>
<td>13.4%</td>
</tr>
<tr>
<td>2008</td>
<td>17.8%</td>
<td>13.4%</td>
</tr>
<tr>
<td>2012</td>
<td>17.8%</td>
<td>13.4%</td>
</tr>
<tr>
<td>2016</td>
<td>18.2%</td>
<td>13.4%</td>
</tr>
</tbody>
</table>

Purchasers increasingly going around plans

Tolerance for spending growth wearing thin

Highlights from state and purchaser initiatives to directly modify rates

**Complement to plan**

- **Consumer protections**
  - California *sets payment for surprise OON*¹ bills at 125% of Medicare’s rate or average regional in-network rate

- **Rate standardization**
  - Montana State Benefit Plan indexes rates to 230% of Medicare rates

**Substitute for plan?**

- **Direct negotiation**
  - Peak Health Alliance negotiated rates directly with providers, then sought coverage bids from plans

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¹ Out of network.

Medicare for All a sign of frustration for many

Presidential candidates endorsing Medicare for All, 2016

Presidential candidates supporting some version of “Medicare for All,” 2020

Others running on health care as a central issue

Public support for Medicare for All

56%
Survey respondents who favor a national health plan in which all Americans would get their insurance from a single government health plan

…if it would do the following

- Guarantee insurance as a right: 71%
- Eliminate premiums and out-of-pocket costs: 67%
- Eliminate private health insurance: 37%
- Require most Americans to pay more in taxes: 37%

Unaffordability is driving radical cost-reduction initiatives by frustrated public and private purchasers

Today’s unaffordable care sparks dramatic political action. While federal legislation remains tenuous, market frustration is already leading to increasingly extreme spend reduction initiatives.
1. From the invisible hand to the iron fist
2. Double-edged growth opportunities
3. A new era of referral management
4. Specialized management of specialty drugs
5. Enabling a community services network
Growth available, but to what end?

Key market outlooks for major purchasers

- **MEDICARE ADVANTAGE**
  - Medicare Advantage enrollment projected to rise to 40% by 2025

- **STATES**
  - Individual market stabilizing
  - Medicaid expansion continues

- **EMPLOYERS**
  - Strong economy demands competitive benefits

Increasing growth opportunities...

- Medicare Advantage enrollment projected to rise to 40% by 2025
- Individual market stabilizing
- Medicaid expansion continues
- Strong economy demands competitive benefits

...but diminishing plan flexibility over cost control methods

- Revenue increasingly tied to quality as service scope grows
- Eligibility restrictions and diverse products threaten to shift case mix
- Private insurance pays hospitals 241% of Medicare prices on average

Medicare Advantage

Medicare’s “Benjamin Button” decade winding down

An “old-old” boomer generation will strain future economics

Share of Medicare enrollment

<table>
<thead>
<tr>
<th>Year</th>
<th>Ages 65-74 years</th>
<th>Ages 85+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td></td>
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<tr>
<td>2025</td>
<td></td>
<td></td>
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<tr>
<td>2030</td>
<td></td>
<td></td>
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<tr>
<td>2035</td>
<td></td>
<td></td>
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<tr>
<td>2040</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2045</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hospitalizations per 1,000 enrollees

<table>
<thead>
<tr>
<th>Year</th>
<th>“Young-old” (65-74)</th>
<th>“Old-old” (85+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2021</td>
<td>114</td>
<td>286</td>
</tr>
</tbody>
</table>

Surgical portion of MS-DRG volumes

<table>
<thead>
<tr>
<th>“Young-old” (65-74)</th>
<th>“Old-old” (85+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.1%</td>
<td>15.8%</td>
</tr>
</tbody>
</table>

Most plans slow to embrace newly allowed benefits

But continued scope expansion may raise competitive bar

Supplemental benefits offered in MA products, 2019

Percent of plans offering benefit type [among plans offering any supplemental benefits]

n=2047 plan products with supplemental benefits

- Over-the-counter drug benefit: 36% (2018) vs. 42% (2019)
- Meals: 19% (2018) vs. 42% (2019)
- NEMT\(^1\): 28% (2018) vs. 39% (2019)
- Home safety devices: 2% (2018) vs. 5% (2019)
- Nicotine replacement therapy: 13% (2018) vs. 47% (2019)
- Caregiver support: 3% (2018) vs. 13% (2019)
- In-home support: 2% (2018) vs. 3% (2019)
- Social worker phone line: 2% (2018) vs. 3% (2019)
- Home-based palliative care: 1% (2018) vs. 3% (2019)


\(^1\) Non-emergent medical transportation.
A good time for the Medicaid business?

Medicaid buy-in and public option plans also gaining traction nationwide

Revived ACA expansion activity

- **Virginia**
- **Maine**
- **Idaho**
- **Nebraska**
- **Utah**

Several states considering Medicaid buy-in or public option legislation

- **Virginia** and **Maine** expanded Medicaid in 2019
- **Idaho, Nebraska, and Utah** voters approved expansion in 2018
- **North Carolina** actively debating expansion pathways

State Map:
- Passed buy-in/public option legislation
- Considering buy-in/public option legislation
- Passed study legislation
- Considering study legislation
- Considering both

Source:

1) Maine and Idaho do not have managed care programs.
### Case mix may shift with Medicaid enrollment threats

#### Policy activities affecting Medicaid enrollment

<table>
<thead>
<tr>
<th>Eligibility restriction</th>
<th>Enrollment deterrence</th>
<th>Limits on spending?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Federal district court rulings</strong></td>
<td><strong>Trump administration issues immigration rule</strong></td>
<td><strong>Tennessee’s pending block grant proposal</strong></td>
</tr>
<tr>
<td>D.D.C.¹ rules to set aside work requirements in Arkansas, Kentucky, and New Hampshire</td>
<td>Use of Medicaid, SNAP,² and Section 8 housing assistance can prevent visa approval</td>
<td>• Lump sum payment given to state with fixed baseline</td>
</tr>
<tr>
<td><strong>CMS offers waiver support</strong></td>
<td></td>
<td>• Funding rises with inflation and annual projected spend, rather than enrollment</td>
</tr>
<tr>
<td><strong>Further waiver progress still likely</strong></td>
<td></td>
<td>• Any savings shared with federal government</td>
</tr>
<tr>
<td>1 implemented</td>
<td></td>
<td>• Exempts state from service coverage, enrollment, quality, and access requirements</td>
</tr>
<tr>
<td>5 approved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 pending</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.1M projected possible coverage losses  
13.5M enrollees estimated to be or live with noncitizens  
1M TennCare enrollees likely to be affected

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¹ United States District Court for the District of Columbia.  
² Supplemental Nutrition Assistance Program.

Profitable outlook comes at a steep price

Carriers find stability amid enrollment declines

Individual marketplace exchange enrollment, participation, and financing, 2014-2019

<table>
<thead>
<tr>
<th>Year</th>
<th>Total enrollment (millions)</th>
<th>Average annual deductible¹</th>
<th>Average annual premium¹</th>
<th>Average annual gross margin¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>8.0M</td>
<td>$3,276</td>
<td>$2,425</td>
<td>$67</td>
</tr>
<tr>
<td>2015</td>
<td>11.7M</td>
<td>$3,312</td>
<td>$2,563</td>
<td>($65)</td>
</tr>
<tr>
<td>2016</td>
<td>12.7M</td>
<td>$3,588</td>
<td>$3,064</td>
<td>$173</td>
</tr>
<tr>
<td>2017</td>
<td>12.2M</td>
<td>$4,308</td>
<td>$3,609</td>
<td>$834</td>
</tr>
<tr>
<td>2018</td>
<td>11.8M</td>
<td>$5,772</td>
<td>$4,034</td>
<td>$1,447</td>
</tr>
<tr>
<td>2019</td>
<td>11.4M</td>
<td>$5,724</td>
<td>$4,375</td>
<td>$4,034</td>
</tr>
</tbody>
</table>

Total enrollment (millions):
- 2014: 8.0M
- 2015: 11.7M
- 2016: 12.7M
- 2017: 12.2M
- 2018: 11.8M
- 2019: 11.4M

Average annual deductible¹:
- 2014: $3,276
- 2015: $3,312
- 2016: $3,588
- 2017: $4,308
- 2018: $5,772
- 2019: $5,724

Average annual premium¹:
- 2014: $2,425
- 2015: $2,563
- 2016: $3,064
- 2017: $3,609
- 2018: $4,034
- 2019: $4,375

Average annual gross margin¹:
- 2014: $67
- 2015: ($65)
- 2016: $173
- 2017: $834
- 2018: $1,447
- 2019: $4,034


1) Silver benchmark plan, combined medical and prescription.

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Unsubsidized ACA consumers turn to STHPs

May contribute to marketplace enrollment mix shift

**eHealth**\(^1\) consumer enrollment in STHPs\(^2\) and unsubsidized ACA plans

*Percentage of enrollees by plan type*

n=38,090 in Q4 2017, n=39,130 in Q4 2018

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Q4 2017</th>
<th>Q4 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsubsidized ACA plans</td>
<td>47%</td>
<td>53%</td>
</tr>
<tr>
<td>STHPs</td>
<td>53%</td>
<td>47%</td>
</tr>
</tbody>
</table>

eHealth consumers **not fully comparable** to Marketplace population

**Coming soon?**

**EXPANDED HRAS**\(^3\)

Employers can offer employees HRA funds to purchase individual market coverage in January 2020

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1) eHealth is a private exchange whose consumers may be wealthier than the average U.S. population.
2) Short term health plan.
3) Health reimbursement arrangements.

Labor competition dampens product pain tolerance

Employers ease benefit restrictions and add low-cost options

Changes in 2019 employer offerings (from 2018)
Percentage point change in proportion of firms with health benefit feature

SERVICES
Covered retail clinics¹
Offered onsite clinic
Covered telemedicine¹

NETWORK
Tiered or high-performance network¹
Eliminated hospitals from network²
Narrow network option²

Unemployment rate
September

9.8%

Lowest rate since 1969

3.5%


1) For firm’s product with largest enrollment.
2) For any product offered by firm.


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A clear cross-subsidy threat reaching its limits

Employers shoulder an outsized share of total health care costs

Average relative hospital reimbursement

<table>
<thead>
<tr>
<th>Payer Segment</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private pay</td>
<td>241%</td>
</tr>
<tr>
<td>Medicare</td>
<td>100%</td>
</tr>
</tbody>
</table>

Cumulative hospital price growth by payer segment (2014–2019)

<table>
<thead>
<tr>
<th>Payer Segment</th>
<th>2014-2019 Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private pay</td>
<td>12.4%</td>
</tr>
<tr>
<td>Medicare</td>
<td>5.9%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

Employees increasingly unable to bear their growing burden

27 percentage point difference in employee and employer growth of health spending contribution, 2009-2017

Percentage of disposable income saved on average by US families¹

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage Saved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960s-1970s</td>
<td>10%</td>
</tr>
<tr>
<td>2015</td>
<td>6%</td>
</tr>
<tr>
<td>2018</td>
<td>3%</td>
</tr>
</tbody>
</table>


¹ Based on US Federal Reserve data.
New growth and diversification opportunities come with rising competition, limited revenue, and challenging case mix shifts.

Current business line trends offer new possibilities for health plan differentiation, but growing scope and competition will make resource efficiency the chief lever for securing growth. Simultaneously, demographic changes, eligibility policy changes, and new product options will likely shift segments of healthy members.
Will bigger be better?

Market share growth primarily accruing to large plans

Market share, by type of plan

<table>
<thead>
<tr>
<th></th>
<th>Medicare Advantage</th>
<th>Medicaid Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered lives</td>
<td>15,368,914</td>
<td>47,741,697</td>
</tr>
<tr>
<td>2015</td>
<td>19,547,561</td>
<td>52,462,136</td>
</tr>
<tr>
<td>2019</td>
<td>28%</td>
<td>52%</td>
</tr>
<tr>
<td></td>
<td>23%</td>
<td>44%</td>
</tr>
<tr>
<td></td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>57%</td>
<td>38%</td>
</tr>
<tr>
<td></td>
<td>65%</td>
<td>46%</td>
</tr>
</tbody>
</table>

Will bigger be better?

Market share growth primarily accruing to large plans

Centene + WellCare: A looming new giant?

Combined size

18M
Members nationwide, becoming 4th largest insurer

$97B
Estimated revenue

COMPETITIVE IMPACT IN QUESTION

AHA
“Threatens to reduce competition…”

CENTENE
“Comparable size… would enhance competition.”


1) Includes Anthem, Centene, Molina, United, and WellCare for the Medicaid managed care market and Aetna, Anthem, Humana, Kaiser, and United for the Medicare Advantage market. LA Care becomes the 5th largest Medicaid plan when Centene and WellCare are combined.
A rising surge of medical spend

U.S. health care spending per capita, indexed to 2010

1) Actual and projected.

Calling Bruce Willis...
From the invisible hand to the iron fist

Double-edged growth opportunities

A new era of referral management

Specialized management of specialty drugs

Enabling a community services network
A rising surge of medical spend

U.S. health care spending per capita, indexed to 2010

1) Actual and projected.

No two physicians are the same

Wide variety exists in network performance

Risk-adjusted physician cost for back surgery

All non-outlier episodes of joint degeneration of the back with surgery for one commercial payer in the Southeast

n=123 physicians for 1278 surgeries

Average episodic cost (thousands of dollars)

Min: $2.6
Median: $16
Max: $165

Source: Optum Advisory Services-Symmetry Advanced Analytics; Health Plan Advisory Council research and analysis.

1) See next slide for additional data notes.
Data notes

- Data retrieved from Optum\(^1\) symmetry tool
- Sample represents all completed non-outlier episodes for a commercial population from one payer in the Southeast
- Actual cost for episodes calculated per provider and expected cost based on the average across all providers; costs are a function of both cost and utilization, and include both medical benefit drugs and Rx coverage
- Expected costs are calculated by the average cost per surgery across providers for a specific surgery and severity
- Episode Treatment Groups (ETG) unit of analysis used to adjust by episode of care, by severity level, and by treatment type
  - Base ETG (e.g., Diabetes) + the ETG severity (which is impacted mainly by comorbidities) + the treatment type (non-surgical versus surgical)
- Some of the providers may have capitation for a portion of the office visits. This would effectively reduce the allowed amount of their episodes. These data are mainly surgical ETGs, so the impact would be minimal.
“Insurance premiums use the savings from the most efficient providers to subsidize the least efficient providers.”

Kyle Rolfing
Co-founder and President, Bright Health

Provider cost variation represents an insurance subsidy driving wasteful spending—and innovators are taking aim to avoid this.

Insurance has long been a mechanism for subsidizing the high-cost care of sicker patients with the premiums of healthy patients using little care. As health care costs rise and expand across populations, the variation of provider costs has become a conspicuous source of wasteful spending. New innovators in network management are taking aim at the cross-subsidization occurring across providers, rather than member segments.
The new network management revolution

Two paths for radically activist network management

1. **Empower efficient physicians**

2. **Target exclusive providers**

Source: Health Plan Advisory Council research and analysis.
Rapid growth of high-touch primary care continues

Plans eagerly coaxing innovator groups into local markets

Growth of select primary care organizations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Locations</th>
<th>Decrease in Hospitalizations</th>
<th>Decrease in ER Visits</th>
<th>Decrease in Hospitalizations</th>
<th>Decrease in ER Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iora Health</td>
<td>24</td>
<td>40%</td>
<td>46%</td>
<td>40%</td>
<td>46%</td>
</tr>
<tr>
<td>Oak Street Health</td>
<td>40</td>
<td>44%</td>
<td></td>
<td>44%</td>
<td></td>
</tr>
<tr>
<td>ChenMed</td>
<td>50+</td>
<td></td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vera Whole Health</td>
<td>17</td>
<td>25%</td>
<td></td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Cityblock</td>
<td>$65M</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Sample plans recruiting new partners to local markets

<table>
<thead>
<tr>
<th>Plan</th>
<th>Recruiting Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBSNC</td>
<td></td>
</tr>
<tr>
<td>Aetna</td>
<td></td>
</tr>
<tr>
<td>Humana</td>
<td></td>
</tr>
<tr>
<td>BlueKC</td>
<td></td>
</tr>
<tr>
<td>Empire</td>
<td></td>
</tr>
</tbody>
</table>

Choose specialists who prioritize primary care

Vera Whole Health’s care center referral process

- Member managed in extended primary care visits
- PCP can consult with high-quality specialists
- Member referred to a specialist who will return member to PCP

Success of Vera Whole Health

- 5 Care centers launched with BCBSKC and Providence Health Plan, Jan 2019
- 85% Member care delivered at Vera Care Clinics
- 10-25% Cost savings for self-funded employers
- 14-46% Increase in cancer screenings in first 6 months

1) For employers launched with Vera in 2018.
Bet on advanced primary care and data-driven referrals

Invest in high-quality providers and guide members to use them

**Centivo’s network structure**

**‘Centivo Select’**
- Identify, reward, and support high-value primary care practices
  - PMPM\(^1\) for **care coordination and access**
  - Actionable incentives for **appropriate referrals**
  - Referral recommendations **personalized for different patient demographics**

**Full Network**
- Rent broad network from traditional health plan
- Complement employer’s existing plan
- Use reference-based pricing

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10-20%
Less expensive than a comparable plan, estimate

92%
Percentage of members who have chosen a PCP through Centivo’s app or concierge

$34M
Series A funding

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\(^1\) Per member per month.

Connection to a specialized expert

Propose virtual specialty consult to PCPs, emphasizing patient interest

CareFirst’s Expert Consult Program

**Member concern**
Member with multiple PCP and specialist visits voices concern to plan’s PCMH care manager

**Physician approval**
Care manager determines with PCP if an expert consult is indicated and appropriate

**Third party consult**
Care manager arranges a consult with Teladoc® then shares results with member, PCP, and specialist

**Member-indicated opportunities**
- “I don’t really understand my diagnosis”
- “I have to decide whether to have this surgery or not”
- “My doctors are recommending different treatments”
- “My side effects are interfering with my life”

**Value propositions for physicians**
- Your patient requested a virtual consult
- The treatment decision is ultimately up to you
- Virtual consults will be from peer-voted physicians
- We’ll take care of the logistics and share all data

Source: Program Description and Guidelines for CareFirst PCMH and TCCI, CareFirst, 2017, https://member.carefirst.com/carefirst-resources/pdf/pcmh-program-description-guidelines.pdf; CareFirst BlueCross BlueShield, Baltimore, MD; Health Plan Advisory Council interviews and analysis.

1) Patient-centered medical home.
Secondary consults drive primary savings

External guidance on elective procedures reduces unnecessary costs

How CareFirst chooses procedures for expert consults

<table>
<thead>
<tr>
<th>Elective</th>
<th>Variable</th>
<th>Expensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedures such as orthopedic surgeries and benign uterine conditions</td>
<td>Specialties that can be impacted such as oncology, gastroenterology, neurology, rheumatology, and orthopedics</td>
<td>Cases are expected to exceed $75K in annual spending</td>
</tr>
</tbody>
</table>

Expert Consult Program Results

<table>
<thead>
<tr>
<th>$7K</th>
<th>4 of 5</th>
<th>95%</th>
<th>92%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average reduction in medical cost per case</td>
<td>Providers adopt the expert consult report findings</td>
<td>Of members would recommend this program to family or friends</td>
<td>Of cases result in recommended treatment change</td>
</tr>
</tbody>
</table>

Source: Program Description and Guidelines for CareFirst PCMH and TCCI, CareFirst, 2017, https://member.carefirst.com/carefirst-resources/pdf/pcmh-program-description-guidelines.pdf; CareFirst BlueCross BlueShield, Baltimore, MD; Health Plan Advisory Council interviews and analysis.

1) Level 2 consults are done for elective and variable procedures. Level 1 (most intense) consults are done for elective, variable, and expensive procedures.
Support primary care risk taking

Aledade provides non-ownership path for independent PCPs

BCBSNC¹ partners with Aledade on Blue Premier ACO pathway

Key support resources from BCBSNC and Aledade

- Technology & data analytics
- Capital for practice transformation
- Enhanced fee schedule
- Operational, regulatory advice
- Scale for ACO risk pooling
- Multi-year glide path to downside risk


¹) Blue Cross Blue Shield of North Carolina.
Partnerships with primary care providers will hinge on the ability to refer members to high-value specialty care

These empowered providers—with enhanced incentives and broader resources—are simultaneously managing comprehensive care and challenging the dominance of high cost specialists and systems. Where target populations align, plans should capitalize on these providers through clearly defined partnerships.
The new network management revolution

Two paths for radically activist network management

1. Empower efficient physicians

2. Target exclusive providers

Source: Health Plan Advisory Council research and analysis.
Transition to exclusive COE network

Walmart evolves financial incentives to ensure COE use

Timeline of Walmart’s COE\(^1\) program

- **2013**: Offers zero cost-sharing for use of a COE location for heart, hip, knee replacement, 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.

Savings come from surgery avoidance

- **Employee surgeries**: 46% have surgery, 54% avoid surgery.
- **Walmart payments**: $32K for COE location, $29K for non-COE location.


\(^1\) Center of excellence.
Pick the best surgeons for new employer contract

Employers contracting with systems for the best physicians’ capacity

Six best Mount Sinai surgeons chosen for COE\(^1\) program with 32BJ\(^2\)

Health system contracts with local union, 32BJ

Surgeons follow standardized care pathway, deliver $12,000 savings per case to employer

System selects six highest-quality surgeons

In the past, we were always reliant on surgeons to bring cases to the system. Now, the system is also bringing cases to the physicians.

Niyum Gandhi, Chief Population Health Officer, Mount Sinai

10% $\rightarrow$ 60%

Shift in market share for lower-extremity joint replacements

Source: Health Care Advisory Board research and analysis.
Chart the future one surgeon at a time

Delivering on employers’ demands for the best of the best

Carrum Health’s selective provider contracting process

Find most efficient facilities and surgeons in a market using:

1. Recommendations for surgery appropriateness from high-quality specialist advisors
2. Public quality and claims data
3. Confidential data provided by system or group

Statistics on Carrum Health’s surgeons¹

- 57% Fewer complications
- 45% Fewer readmissions
- 25% Avoided surgeries

¹ Compared to the national average.

Source: Carrum Health, San Francisco, CA; Health Plan Advisory Council research and analysis.
Highlight the impact of PCP referrals on patient out-of-pocket costs

BCBSLA’s¹ ancillary service cost one-pager²

Highlight effects on patient out-of-pocket costs to encourage physician use

Start with ancillary services because PCPs often lack insight into cost differences

Keep the focus on the cost difference rather than specific numbers

Impacts from one-pager

23%
Decrease in radiology services going to outpatient facilities

28%
Decrease in labs going to the more expensive facilities

Source: Blue Cross and Blue Shield of Louisiana, Baton Rouge, LA; Health Plan Advisory Council interviews and analysis.

1) All providers have been pseudonymed.
2) Blue Cross and Blue Shield of Louisiana.

Helping Your Patients Get High-Quality, Low-Cost Services

Blue Cross and Blue Shield of Louisiana values the care you provide to our shared customers (your patients, our members) through our partnership in the Quality Blue program.

We know that many times, patients rely on their doctors to help them find high-quality, low-cost providers when they need to be referred for services outside of office visits.

We are sharing the information below on Lafayette-area providers of common services for your consideration when referring your patients. In general, patients pay less for services at a stand-alone diagnostic center rather than one within a hospital. You can see the differences in costs for the same procedures at various locations below. Cost differences are based on our claims data.

Providers with fewer $ are recommended as the most cost-effective for referrals.

Outpatient Radiology Services
- Spruce Radiology
- Maple Imaging
- Willow Imaging
- Magnolia Surgery Hospital
- Banyan General Hospital
- Oak General Medical Center
- Hemlock Children’s Hospital
- Walnut Medical Center

Mammogram/ Breast Radiology Screening
- Pine Breast Center
- Maple Imaging
- Willow Imaging
- Magnolia Surgery Hospital
- Hemlock Children’s Hospital
- Walnut Medical Center

Endoscopy/ Colonoscopy/ GI Screening
- Sycomore Surgery
- Acorn Endoscopy Center
- Hemlock Surgicare

Lab Services
- Cherry Lab Company
- Popular Labs
- Chestnut Physician Office
- Magnolia Surgery Hospital
- Banyan General Hospital
- Oak General Medical Center
- Hemlock Children’s Hospital
- Walnut Medical Center

Source: Blue Cross and Blue Shield of Louisiana, Baton Rouge, LA; Health Plan Advisory Council interviews and analysis.
Informing referral priorities, not just decisions

Use clinician-tested reports to probe PCPs’ own priorities

Mochi Health Plan’s¹ specialist data report excerpt²

<table>
<thead>
<tr>
<th>NPI Name</th>
<th>NPI</th>
<th>Specialty</th>
<th>Attributed CoP</th>
<th>Attributed Episodes</th>
<th>Volume Rating</th>
<th>Total Cost Rating</th>
<th>Utilization Rating</th>
<th>Unit Cost Rating</th>
<th>Episode Count</th>
<th>Volume Rating</th>
<th>Utilization Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider A</td>
<td></td>
<td>Cardiology</td>
<td>$137,346.00</td>
<td>8</td>
<td>Higher than Expected</td>
<td>Higher than Expected</td>
<td>Same as Expected</td>
<td>140</td>
<td>18</td>
<td>Low Vol</td>
<td>Higher than Expected</td>
</tr>
<tr>
<td>Provider B</td>
<td></td>
<td>Cardiology</td>
<td>$91,292.00</td>
<td>4</td>
<td>Higher than Expected</td>
<td>Higher than Expected</td>
<td>Lower than Expected</td>
<td>176</td>
<td>36</td>
<td>Avg Vol</td>
<td>Lower than Expected</td>
</tr>
<tr>
<td>Provider C</td>
<td></td>
<td>Cardiology</td>
<td>$25,657.00</td>
<td>10</td>
<td>Lower than Expected</td>
<td>Higher than Expected</td>
<td>Higher than Expected</td>
<td>400</td>
<td>77</td>
<td>High Vol</td>
<td>Higher than Expected</td>
</tr>
<tr>
<td>Provider D</td>
<td></td>
<td>Cardiology</td>
<td>$75,331.00</td>
<td>5</td>
<td>Lower than Expected</td>
<td>Lower than Expected</td>
<td>Higher than Expected</td>
<td>154</td>
<td>12</td>
<td>Low Vol</td>
<td>Higher than Expected</td>
</tr>
<tr>
<td>Provider E</td>
<td></td>
<td>Cardiology</td>
<td>$57,775.00</td>
<td>13</td>
<td>Lower than Expected</td>
<td>Lower than Expected</td>
<td>Same as Expected</td>
<td>151</td>
<td>33</td>
<td>Avg Vol</td>
<td>Lower than Expected</td>
</tr>
<tr>
<td>Provider F</td>
<td></td>
<td>Cardiology</td>
<td>$142,254.00</td>
<td>27</td>
<td>Lower than Expected</td>
<td>Lower than Expected</td>
<td>Same as Expected</td>
<td>119</td>
<td>41</td>
<td>Avg Vol</td>
<td>Same as Expected</td>
</tr>
<tr>
<td>Provider G</td>
<td></td>
<td>Cardiology</td>
<td>$47,843.00</td>
<td>21</td>
<td>Lower than Expected</td>
<td>Lower than Expected</td>
<td>Same as Expected</td>
<td>199</td>
<td>18</td>
<td>Low Vol</td>
<td>Lower than Expected</td>
</tr>
<tr>
<td>Provider H</td>
<td></td>
<td>Cardiology</td>
<td>$45,645.00</td>
<td>4</td>
<td>Lower than Expected</td>
<td>Lower than Expected</td>
<td>Lower than Expected</td>
<td>451</td>
<td>72</td>
<td>Avg Vol</td>
<td>Lower than Expected</td>
</tr>
</tbody>
</table>

Consultative referral guidance implementation process

**Opportunity Assessment:** Consultant presents data on opportunity for improved care quality and spend to PCP

**Custom Prioritization:** Consultants prompt PCPs to share and understand their priorities

**Granular Action Plan:** Consultants walk through tangible steps for change with clinicians and staff

Sample probing questions asked by consultants

- Can the low cost specialists handle the capacity?
- Is the location convenient for the patient?
- What communication do you want from the specialist?

¹) Pseudonym.
²) National Provider Identifier (NPI) has been covered in this excerpt.

Source: Health Plan Advisory Council interviews and analysis.
Contracting norms leave little room for granularity

Capability will only become harder to build as systems merge

Limitations of network contracting

- Pick-and-choose service inclusion
- Reimbursement rate variation
- Preferential steerage to clinicians

HEALTHCARE FINANCE
January 28, 2019

Healthcare mergers and acquisitions had record year in 2018, up 14.4 percent

Radical steerage to the most efficient clinicians for specific services will become the norm across specialty and procedural care

Though narrow networks are not a new idea, they are often frustrating to consumers and impossible for plans with already thin networks. However, purchasers are now seeking to construct even narrower networks themselves, at the physician and service level. As demands for network design become more granular, new entrants will offer a-la-carte network construction and health plans will have to ensure network operations keep pace with emerging industry results.
Not enough high performers to go around?

Network activists will secure efficient providers first

Risk-adjusted physician cost for back surgery

All non-outlier episodes of joint degeneration of the back with surgery for one commercial payer in the Southeast

n=123 physicians for 1278 surgeries

The scramble for desirable physicians

TRAINING

Kaiser and Geisinger jump into the medical school business

OWNERSHIP

OptumCare\(^1\) seeks population health-minded practices

PARTNERSHIPS

BCBSMA\(^2\) and Atrius Health enter 7-year global risk contract

---

1) Advisory Board is a subsidiary of Optum. All Advisory Board research, expert perspectives, and recommendations remain independent.
2) Blue Cross Blue Shield of Massachusetts.

Source: Optum Advisory Services-Symmetry Advanced Analytics; “Kaiser Permanente School of Medicine to open summer 2020”, Permanente Medicine, Feb 2019; “Geisinger Commonwealth School of Medicine MD Class of 2018 celebrates successful Match Day”, Geisinger, Mar 2018; “Atrius Health, BCBSMA announce deeper collaboration to transform health care experience”, BCBSMA, Feb 2019; Health Plan Advisory Council research and analysis.
As the industry competes for high-performing providers, plans must weigh major investments in recruiting, funding, and even training

Though beyond a plan’s traditional competency, plans will not be able to completely rely on the existing supply of providers and venture funding for new primary care models. Increasing competition for a limited supply of physicians is prompting more drastic measures to guarantee network participation—direct training, acquisition, and business partnerships. Plans will need to actively invest in securing the high-performing providers their network requires.
From the invisible hand to the iron fist

Double-edged growth opportunities

A new era of referral management

Specialized management of specialty drugs

Enabling a community services network
A rising surge of medical spend

U.S. health care spending per capita, indexed to 2010\textsuperscript{1}

1) Actual and projected.

Drug savings in plane sight

Utah health plan for state employees starts pharmacy tourism to Tijuana

Utah Public Employees Health Plan (PEHP)’s pharmacy tourism program

*The Salt Lake Tribune*
October 28, 2018

To fight high drug prices, Utah will pay for public employees to go fill prescriptions in Mexico

- Plane tickets to San Diego
- Transportation to Tijuana
- $500 cash for patients who need specific MS, cancer, or autoimmune drugs

“Why wouldn’t we pay $300 [in transportation costs] to go to San Diego, drive across to Mexico and save the system tens of thousands of dollars? If it can be done safely, we should be all over that.”

Rep. Norman Thurston, R-Provo

Bringing out the sledgehammer for pharmacy prices?

But track record on policy follow-through causes skepticism

Range of price controls under debate

- **Index and/or cap reimbursement** to rates paid by international governments (U.S. pays 80% more for drugs on average\(^1\))
- Give the federal government the authority to **negotiate**—or centrally set—the **prices** of drugs
- Allow states, wholesalers, and pharmacies to **import drugs from other countries**, notably Canada
- Modify patent laws and FDA approval processes to **limit exclusivity periods** and promote generic entry

Implementation outlook?

- **July 11, 2019**
  “Trump Administration Drops Plan to Curb Drug Rebates”

- **July 8, 2019**
  “Trump Rule Requiring Drug Prices in TV Ads Blocked”

- **July 24, 2019**
  “Senate Will Not Vote On Drug-Pricing Bills Before August Recess”

\(^1\) Compared to 16 other developed economies for 27 Part B drugs included in CMS’s analysis.

Specialty quickly becoming the norm

Traditional drug spending no longer guaranteed to offset total growth

Per capita drugs spending and growth\(^1\)

*Real 2018 dollars, net of rebates*

<table>
<thead>
<tr>
<th>Year</th>
<th>Specialty Drug Spending</th>
<th>Traditional Drug Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$1,000 (\times $262)</td>
<td>$738 (\times $738)</td>
</tr>
<tr>
<td>2010</td>
<td>$1,006 (\times $279)</td>
<td>$727 (\times $727)</td>
</tr>
<tr>
<td>2011</td>
<td>$988 (\times $289)</td>
<td>$699 (\times $699)</td>
</tr>
<tr>
<td>2012</td>
<td>$931 (\times $300)</td>
<td>$631 (\times $631)</td>
</tr>
<tr>
<td>2013</td>
<td>$922 (\times $318)</td>
<td>$603 (\times $603)</td>
</tr>
<tr>
<td>2014</td>
<td>$981 (\times $385)</td>
<td>$595 (\times $595)</td>
</tr>
<tr>
<td>2015</td>
<td>$1,043 (\times $438)</td>
<td>$605 (\times $605)</td>
</tr>
<tr>
<td>2016</td>
<td>$1,064 (\times $471)</td>
<td>$592 (\times $592)</td>
</tr>
<tr>
<td>2017</td>
<td>$1,034 (\times $489)</td>
<td>$546 (\times $546)</td>
</tr>
<tr>
<td>2018</td>
<td>$1,044 (\times $517)</td>
<td>$527 (\times $527)</td>
</tr>
</tbody>
</table>

\(^1\) Pricing at the manufacturer level.

Unpacking the future of drug costs

Major challenges driving future drug spending

- **90%** of prescriptions dispensed are generic, up from 75% in 2009
- **97%** of the time, generics used when available
- **28%** reduction in absolute drug spending attributed to rebates, 2018
- **34 of 59** FDA novel drug approvals in 2018 were for rare diseases

**Generics saturation**

**Pipeline portfolio**

**Persistent rebates**

**Provider economics**

- **Revenue** potential via buy & bill drugs, specialty pharmacy
- **Cost** management potential through care coordination

Today’s value framework falls short

Plans will need to evolve a ‘rubric’ for accommodating broader evidence

Major drivers of value, by frequency of use

Today’s standard coverage framework

Growing interest in TCOC models that consider cost-reduction as driver of value, but definitions and practical applications are convoluted

Ad-hoc use in coverage determination

REGULATORY REQUIREMENTS

TOTAL COST OF CARE

HOLISTIC CHARACTERISTICS

Safety

Clinical benefit

Cost to deliver

Cost to access

Avoidable cost

Member experience

Social benefit

• Unit costs
• Site of care
• Medical administration

• Out-of-pocket cost
• Care, utilization management

• Hospitalizations
• ED, urgent care visits

• Adverse reactions
• Prior auth, step therapy
• Ease of use

• Premiums
• QALYs1
• Herd immunity

“We’re far down the road in discussions about value-based contracts with some drug and device manufacturers, but we haven’t transacted any. How are we going to define ‘value’? I think we have a fundamental disagreement on what value is.”

CMO, large provider-sponsored health plan

Source: Advisory Board research and analysis.

1) Quality-adjusted life years.
No drug financing panacea

Traditional and emerging specialty drug cost management strategies for health plans

TARGET USERS

Large population

Niche segment

Coverage restriction

Pharmacist-guided utilization

Large-scale reinsurance

Comprehensive appropriate use protocols

Initial expenditure

Ongoing adherence

KEY COST DRIVER

Source: Health Plan Advisory Council interviews and analysis.
The population tipping point?

Plans must weigh new subscription models against poor alternatives

The Hepatitis C drug price shock

<table>
<thead>
<tr>
<th>New treatments launch</th>
<th>2013</th>
<th>Sovaldi</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
<td>Olysio</td>
</tr>
<tr>
<td></td>
<td>2014</td>
<td>Harvoni</td>
</tr>
</tbody>
</table>

Massive cost impact

$35k-100k for full course of treatment

13% increase in total drug spending, 2013-14

COMMON COST MANAGEMENT APPROACHES

Benefit Design Restrictions

99% of plans created a new specialty tier for HCV agents\(^1\)

95% of plans applied an average 32% coinsurance for HCV agents\(^1\)

36% of members prescribed HCV agents were denied coverage

PLANS

STATES

Louisiana Medicaid + Gilead
Unlimited access to a generic version of Epclusa for 5 years for 10K Medicaid beneficiaries

Washington Health Care Authority + AbbVie
Unlimited access to hepatitis C treatment for all state benefits members (including Medicaid and state employees)


\(^1\) Data from formularies of Medicare Advantage Prescription Drug Plans (n=1,635) in 2015.
Costs for rare drugs often passed to consumers

Plan approaches seek to broaden reinsurance

“The $6 Million Drug Claim”

*The Patterson Family*

3 members using *Strensiq*

$2M annual per-person charge for Strensiq (compared to $285K expected)

35¢ per hour per worker contribution to family’s Strensiq prescriptions at union offering coverage

Union put drug payment on hold; considered raising premiums for the first time in eight years

Pharma: the payer of last resort?

$116M
Pharma company donations to patient advocacy groups, 2015¹

$63M
Pharma company lobbying activities, 2015¹

Plan-PBMs add new reinsurance “protection” programs

**Cigna** launches Embarc Benefit Protection℠ program to offer select gene therapy coverage for additional PMPM payment

**CVS** adding new gene therapy stop-loss protection offering for self-insured **Aetna** clients

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¹ Data from IRS filings of 14 large pharmaceutical companies.

Reinventing physician scorecard delivery

Pharmacist visits individual provider practices to discuss pharmacy data

BCBS Vermont’s Pharmacist Delivers Pharmacy Data to Providers

**Pharmacist Responsibilities**

- **Share pharmacy scorecard that compares their costs to peer benchmarks**
  - Sample scorecard metrics:
    - Formulary adherence rates
    - Total pharmacy costs

- **Present on provider-requested topics at practice lunch-and-learns**
  - Sample provider-requested topics:
    - Formulary diabetes drug options
    - Targeting members for MTM

**Pharmacist Program Results**

- **1,159** Providers reached by pharmacist, 2018
- **69%** Success rate in switching diabetes medication, 2018
- **$100K+** Saved by BCBSVT from members participating in MTM, 2018

---

1) Medication Therapy Management.

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Source: Blue Cross and Blue Shield of Vermont, Montpelier, VT; Chief Medical Officer Roundtable research and analysis.
Some plans putting steps together

Use claims, EHR data to revise access protocols, scope appropriate use

Nordic Health Plan¹ expands access to lower total cost of care (TCOC)

Initial UM Protocol
Implemented step therapy and prior authorization (PA) requirements to control spend on costly multiple sclerosis (MS) drugs

Segment Targeting
Identified patients most likely to benefit from rapid start on newer, more expensive therapies

Outcomes Analysis
 Analyzed ED and hospitalization rates for MS patients at different phases of step therapy protocol

Impact Assessment
Determined step therapy and PA delays increased TCOC; patients on cheaper drugs had more ED and hospital visits

Revised UM protocols to expedite access to new, high-cost therapies for right subset of MS patients

¹ Pseudonym.
Plans must prepare a portfolio of strategies for expanding, costly specialty drug applications—and systematically track broader “value”.

Expanding applications of costly specialty drugs will challenge plans’ existing financing mechanisms and ability sustain meaningful coverage. Plans will need to build new capabilities to prepare for increased and new demand by focusing eligibility criteria, incorporating pharmacist expertise, and expanding business criteria for determining “value” for a growing array of therapies.
1. From the invisible hand to the iron fist
2. Double-edged growth opportunities
3. A new era of referral management
4. Specialized management of specialty drugs
5. Enabling a community services network
A rising surge of medical spend

U.S. health care spending per capita, indexed to 2010


1) Actual and projected.
Finally ready for social action?

Social needs: a standard part of care conversations

Drivers of today’s SDOH¹ business imperative

New flexibility

CMS authorized plans to offer **supplemental benefits** for specific member segments and has further widened the scope of these benefits for 2020

Required screening

Screening for SDOH increasingly required under **transformation programs** (e.g. CPC+, NCQA’s² new Population Health Accreditation Program, CMMI’s Accountable Health Communities model)

Provider interest

**Health system executives** addressing SDOH due to shifting payment, cost, fundraising, and policy imperatives

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¹ Social determinants of health.
² National Committee for Quality Assurance.

North Carolina waiver marks official SDOH funding

Social determinants referrals a centerpiece of state’s Medicaid strategy

Health plan roles in North Carolina Medicaid’s Healthy Opportunities Pilot Program

Screen for eligible beneficiaries

Manage appropriate pilot services

At least one...

Health risk factors

- Adults and children with more than two chronic conditions, repeated ER use, hospital admissions
- High-risk pregnant women, infants, children

And at least one...

Social risk factors

- Homelessness, housing, food, or transportation insecurity
- At risk of witnessing or experiencing interpersonal violence

Pilot service organizations to provide:

- Tenancy support; housing quality and safety; legal referrals; security deposit and first month rent; short-term post-hospitalization housing assistance
- Food support and meal delivery
- Non-emergency health-related transportation
- Interpersonal violence-related transportation, legal referrals, and parent-child supports

$650M

Amount authorized for services and capacity building by CMS across the five-year pilot

An expanding definition of social determinants

Growing scope of drivers linked to outcomes

Kaiser Family Foundation’s framework for social determinants of health

Traditional health focus

Broader social context

Successes mixed for each plan

Pilot investments have varied impacts across the industry

Which social determinants intervention yields the biggest ROI for your plan?

Percent of respondents

n=86 respondent health plan leaders attending virtual Advisory Board presentation in June 2019

<table>
<thead>
<tr>
<th>Category</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>18%</td>
</tr>
<tr>
<td>Housing</td>
<td>9%</td>
</tr>
<tr>
<td>Transportation</td>
<td>28%</td>
</tr>
<tr>
<td>Community and social context</td>
<td>20%</td>
</tr>
<tr>
<td>Economic stability &amp; education</td>
<td>25%</td>
</tr>
</tbody>
</table>

Source: Health Plan Advisory Council research and analysis.
But no clear target for initial investment

Nascent field means plans must rely on limited evidence and risk tolerance

Evidence for impact and appropriate scope of social determinant interventions

<table>
<thead>
<tr>
<th>Strength of Evidence of Intervention</th>
<th>Entire membership</th>
<th>Rising-risk members</th>
<th>High-risk members</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health literacy support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health coaching</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language-concordant care²</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobile health clinics</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-emergency transportation²</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social cohesion interventions²</td>
<td></td>
<td></td>
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<tr>
<td>Low</td>
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<tr>
<td>Food security services²</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment income support²</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supportive housing program²</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1) Literature indicates that intervention reduces cost or utilization, or improves health outcomes.
2) High strength of evidence of impact of problem, despite lower evidence of intervention success.

Source: Care Delivery Innovation Reference Guide, Integrating Psychosocial Risk Factors into Ongoing Care, Population Health Advisor, Advisory Board; Health Plan Advisory Council research and analysis.
No perfect owner of social determinants

When the payer can’t pay and the provider can’t provide

Stakeholder barriers to supporting action on social determinants

- Inconsistent local presence
- Restrictions on spending
- Membership churn and insufficient market share limits ROI guarantee

- Discomfort with scope
- Limited bandwidth
- Uninformed about broader needs and resources

- Limited funding
- Ad-hoc detection
- Limited business capabilities

Source: Health Plan Advisory Council research and analysis.
## The new social network?

Adapt network management approach to suit product feature network

### Three key questions for network management

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Which partners do I include in the network?</td>
<td>To which members do I offer access?</td>
<td>How do I get members to use services?</td>
</tr>
<tr>
<td>2</td>
<td>Quality, licensed providers who meet clinical standards</td>
<td>Equal access for membership</td>
<td>Not an issue because overutilization occurs</td>
</tr>
<tr>
<td>3</td>
<td>Unclear due to diverse partners with varied standards</td>
<td>Targeted subpopulation</td>
<td>Challenging because members don’t know of features</td>
</tr>
</tbody>
</table>

*Source: Health Plan Advisory Council interviews and analysis.*
Long ignored, social determinants are garnering industry attention—but plans must be principled in collaboration and investments

Though the jury remains out on the long-term efficacy of direct plan investments in social determinants, regulators are increasingly prompting investments in tackling social determinants and systems are beginning to take note. As unilateral initiatives are risky, plans must consider where to invest directly or partner. Committed plans are showing early moves toward more deliberate coordination of efforts.
DARTing toward a change in course

Schematic of the DART mission

New skills to combat cost pressures

U.S. health care spending per capita, indexed to 2010

The financial case for a frictionless experience
Four priorities to guide member experience improvement

Product innovations for the non-provider network
How plans can show value when purchasers demand more than clinical care


1) Actual and projected.
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