Trinity Health Insurance Exchange Efforts:
Working with Insurers

Health Insurance Exchange Summit
May 1-3, 2013

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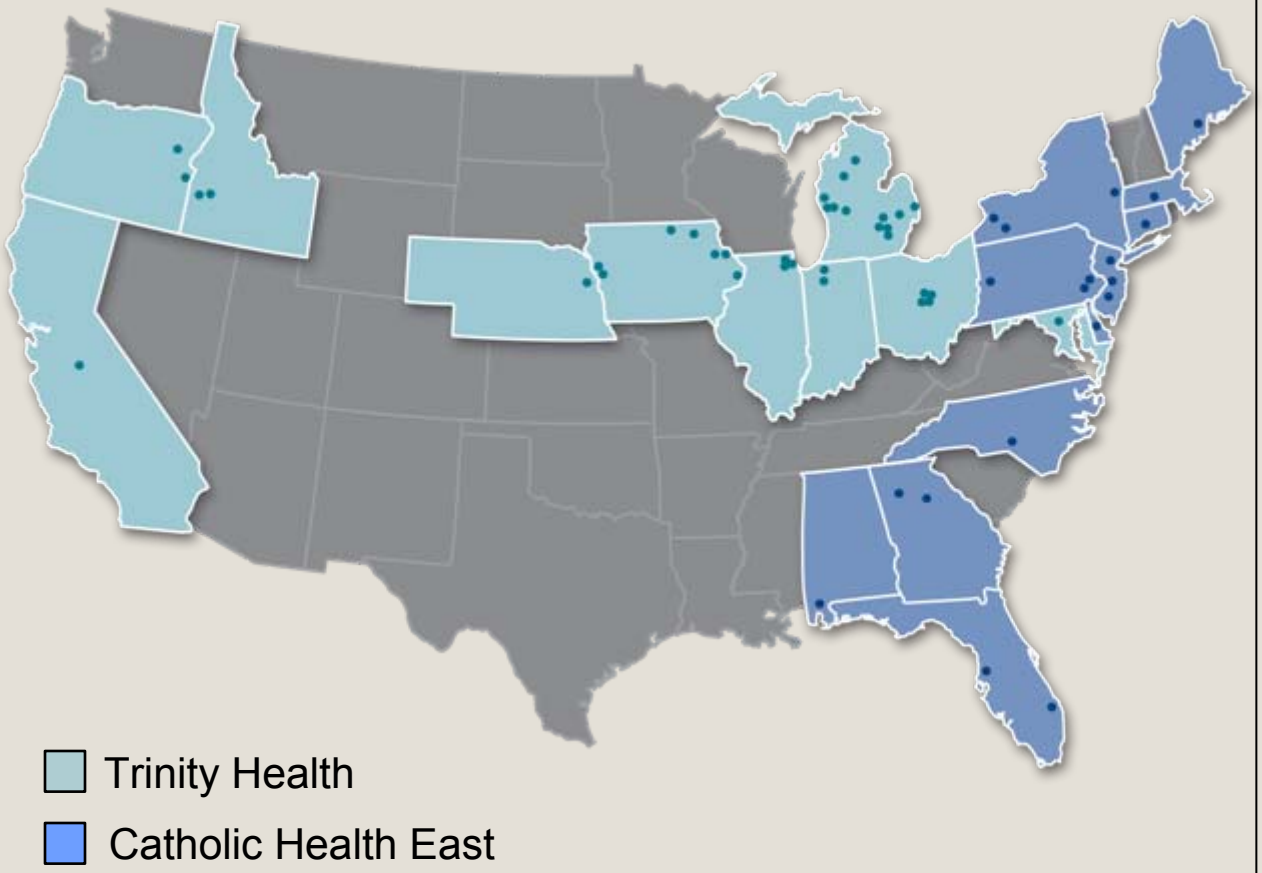
Trinity Health & Catholic Health Care East Overview

Combined Organization Will Serve 21 States Nationwide



- Operating revenue $13.3 billion
- 82 hospitals
- More than 87,000 employees
- 4,100 employed physicians
- 89 continuing care facilities
- 2.75 million annual home health/hospice visits
- $1 billion in Community Benefit Ministry

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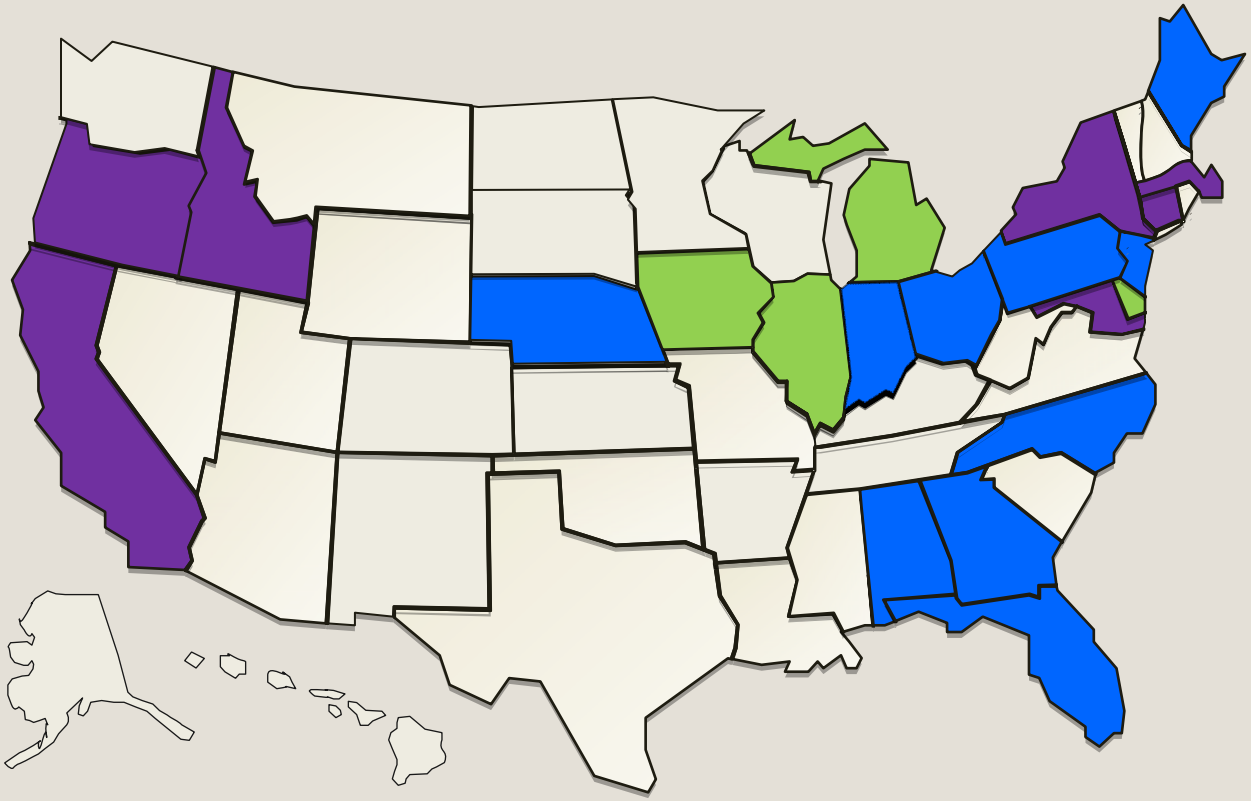
Exchange Model in Trinity Health and CHE States

Summary

- **Federal**
  10 States
  (NE, FL, AL, GA, IN, PA, NJ, ME, NC, OH*)
- **Partnership**
  4 States
  (IA, IL, MI, DE)
- **State**
  7 States
  (CA, OR, ID, MD, CT, MA, NY)



Federally-Facilitated Exchange

State Led Exchange

Federal-State Partnership Exchange

Non-Trinity Health/Non CHE State

*OH has indicated it will perform plan management functions and QHP certifications

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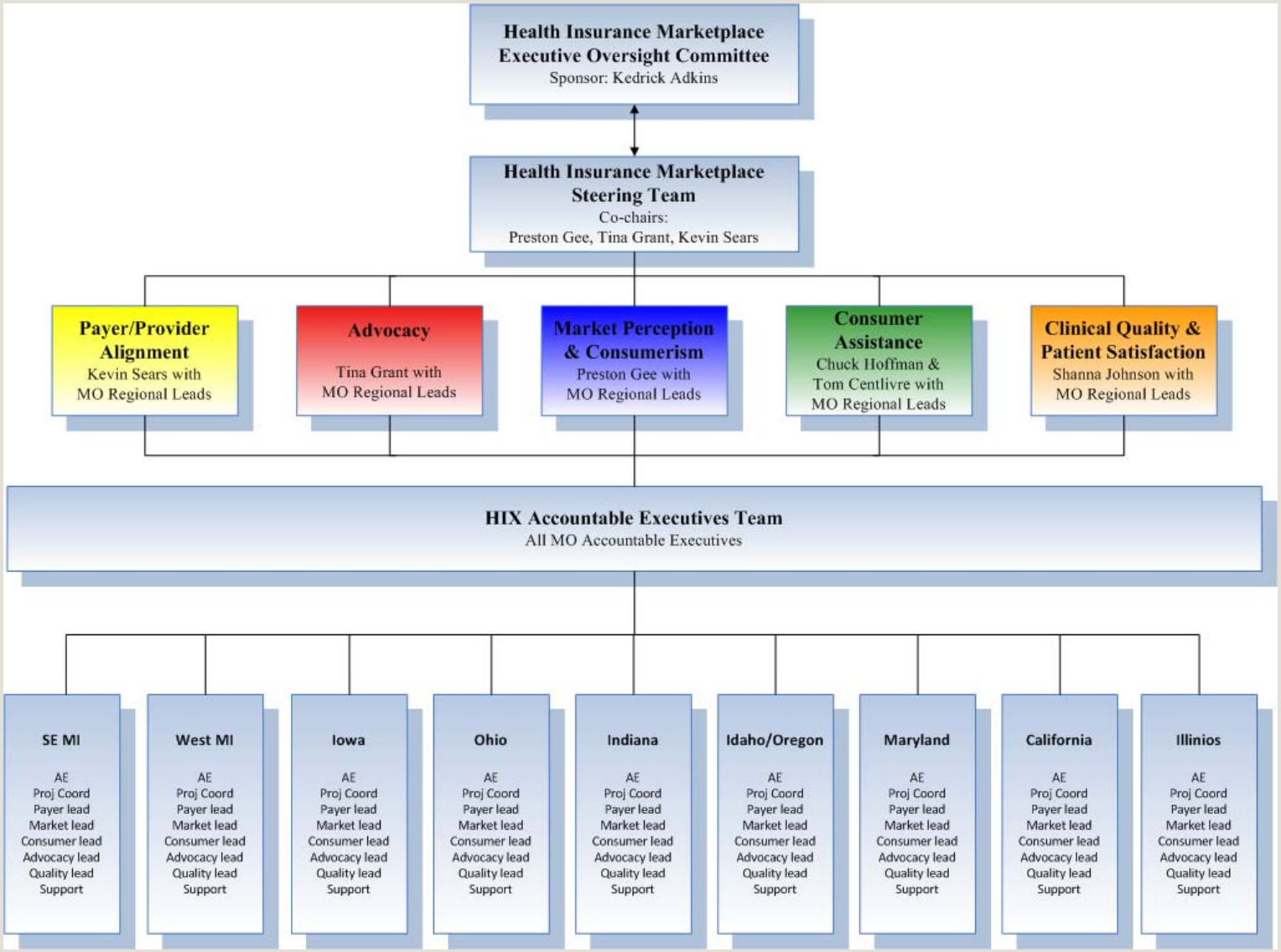
Health Insurance Exchange Program Structure



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For Each Market an Exchange Pricing Perspective Was Developed…

For each of the markets…

Market approach to exchange pricing and network design

=

- **Market considerations**
  - Consumer preference and behavior
  - Trinity role in market and ability to take on volume
  - Payer market dynamics (e.g. which is likely to perform well)

+

- **Financial implications**
  - Maximum "discount" based on price / volume trade-offs
  - Impact on other lines of business
  - Sensitivity to key factors

Many Consumers Are Open to Network Restrictions for Reduction in Premiums

N=28,972

Future Individual market based on network and cost-sharing

%

X Percent of consumers selecting this option

50% of those who bought richer products opted for the most restricted network possible

45% of all consumers selected Bronze or Silver plans with network restrictions

SOURCE: McKinsey Consumer Exchange Simulation 2011

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Trinity Contemplated Many Factors in Approaching Health Insurance Exchange Positioning

	Description
1 Size of individual exchange market	▪ Coverage shift projections under reform ▪ Inpatient and outpatient utilization particularly for previously self-pay segment
2 Size of potential narrow network	▪ Consumer willingness to participate in narrow network at different premiums ▪ Which payers will create a narrow network
3 Trinity share of narrow network	▪ Payer's ability to steer volume ▪ Consumer behavior in loyalty to preferred providers (volume gained in narrow network vs. volume lost if excluded from network)
4 Trinity collectible revenue	▪ Actuarial value of narrow network product and bad debt from patient obligation portion ▪ Out-of-network charges (if excluded from network) and bad debt from patient obligation portion
5 Trade-offs compared to today	▪ Current contribution from self-pay and small group segments ▪ Incremental contribution in exchange, with positive impact from newly insured and negative impact from price discount on previously commercial volume

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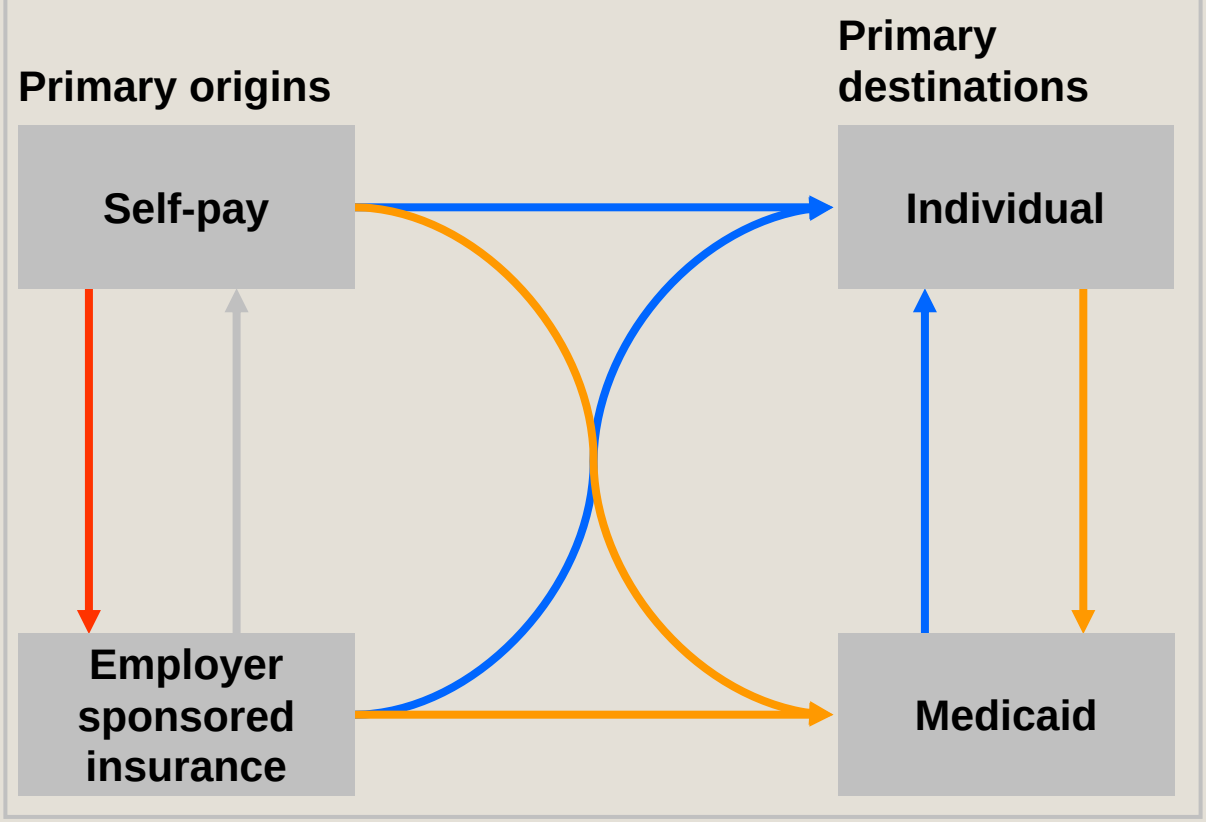
1 Coverage Shifts in the Market

Principal shifts among major coverage categories



Key questions to consider,

- How large will the individual market be?
  - What portion will come from previously self-pay populations?
  - What portion will come from previously small-group populations?
  - Will products be offered on and off exchange?
  - What portion will purchase off-exchange?
- How will Medicaid expansion influence size of market?

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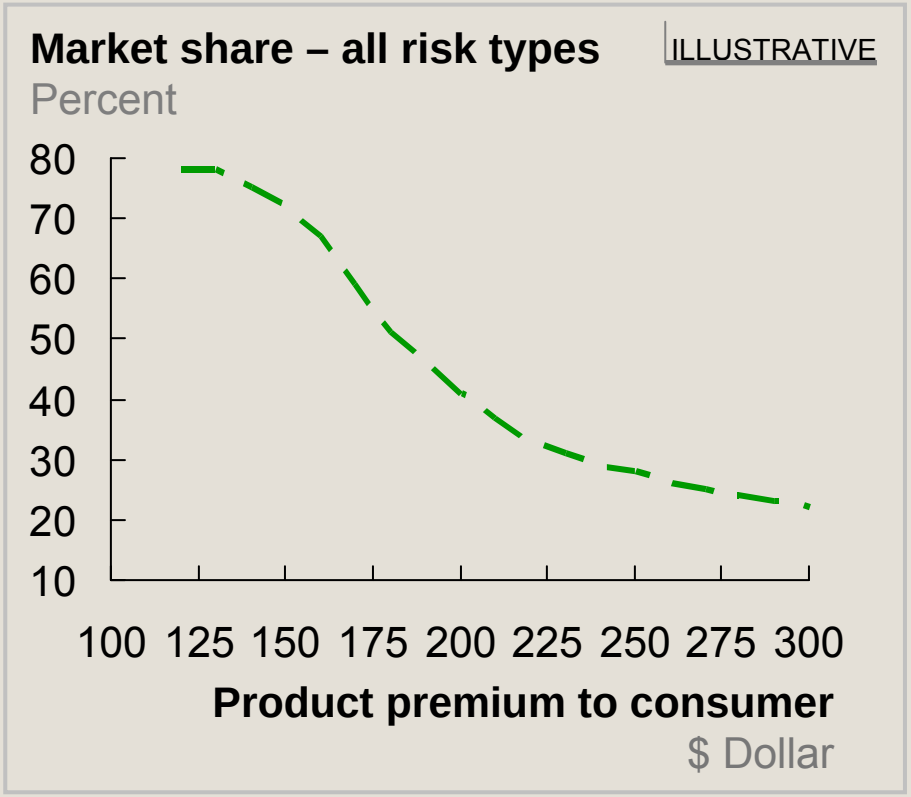
2 Consumers are largely driven by premiums



Key considerations when using price / volume trade-off,

- HMO vs. PPO products, different metal tiers, and other benefit design differences will have different consumer preferences
- Different payers will have different curves due to factors such as brand strength, market share, etc.

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3 Consumer Behavior in the Narrow Network

	Questions to consider
Payer's ability to steer volume	▪ What incentives vs. disincentives has the payer put in place for consumers to stay in-network vs. go out-of-network?
Consumer behavior	▪ For consumers with preferred providers, what is the willingness to switch to an in-network provider? What is the willingness to pay higher fees in order to stay loyal to preferred provider? ▪ What is the difference for inpatient vs. outpatient vs. ED visits?

4 Collectible Revenue

Participating in narrow network

- What is the price discount from current commercial rates?
- What is the *effective* actuarial value (taking into account the government subsidies) and the patient obligation?
- Of the patient obligation, what is the collectible rate (likely similar to current commercial collectible rate)?

Not participating in narrow network

- What is the amount to charge for out-of-network visits (e.g. pre-agreed upon rates with payer, UCR rates, etc.)?
- What is the payer vs. patient obligation?
- Of the patient obligation, what is the collectible rate (likely similar to current self-pay collectible rate)?

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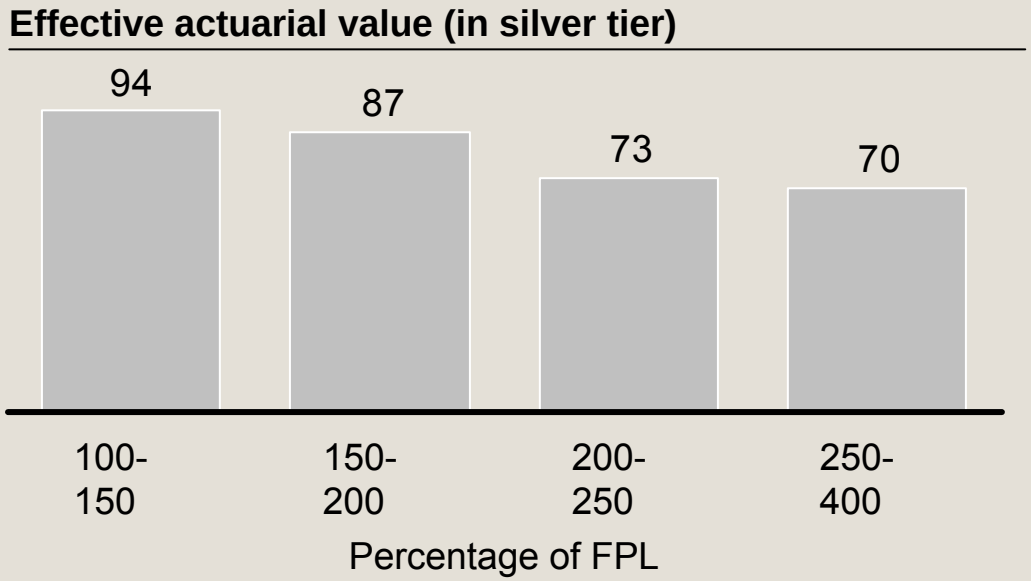
4 Effective Actuarial Value of Exchange Products

Premium subsidies

- Premium subsidies are intended to reduce the relative cost of health insurance and **based on the second lowest priced silver plan** (and can be used in any metallic tier)
- **Metallic tiers are based on actuarial value** – the portion of medical costs the plan is likely to pay for a defined population
  - Bronze: 60%
  - Silver 70%
  - Gold: 80%
  - Platinum: 90%

Cost sharing subsidies

- Cost sharing subsidies are **available only in the silver metal tier** and result in an effective actuarial value much greater than 70% for many consumers



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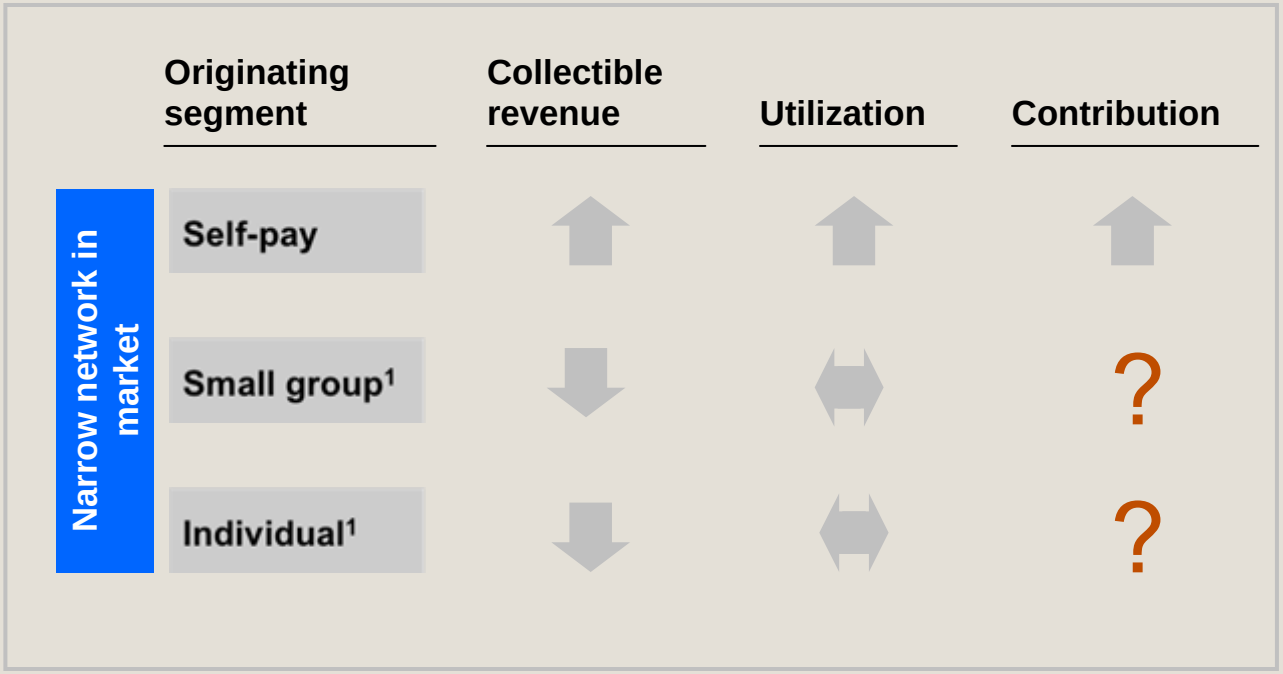
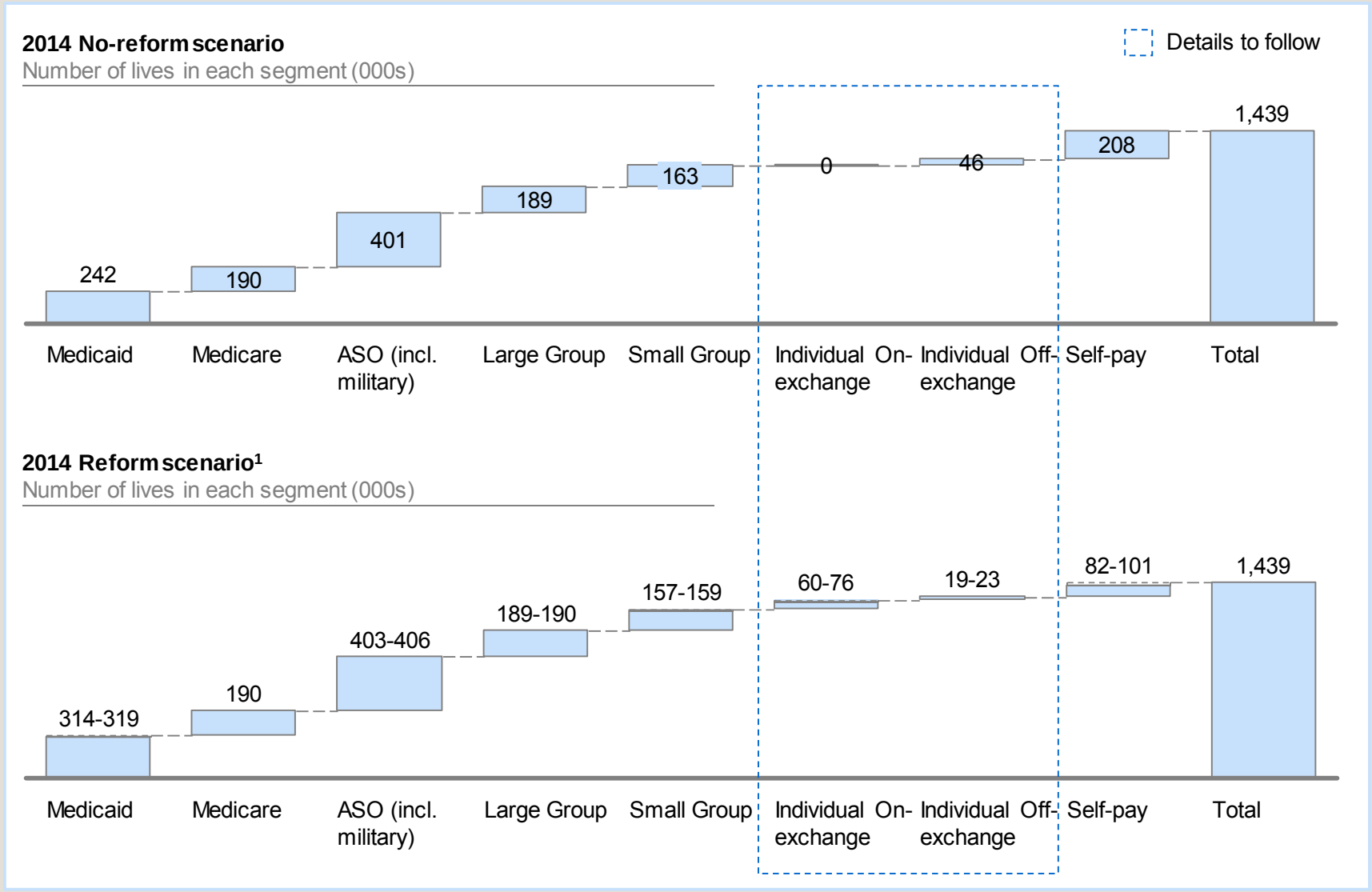
5 Comparing Narrow Network Participation with Current Performance



If market has narrow network, overall impact will depend on whether incremental volume and insurance coverage of previously self-pay will compensate for margin reduction from previously commercial segment

1 Small group and individual are categorized as commercial

Columbus: Reform Expected to Shift Lives to Individual Exchange



1 Two scenarios - Low employer opt-out, weak consumer uptake; High employer opt-out, strong consumer uptake

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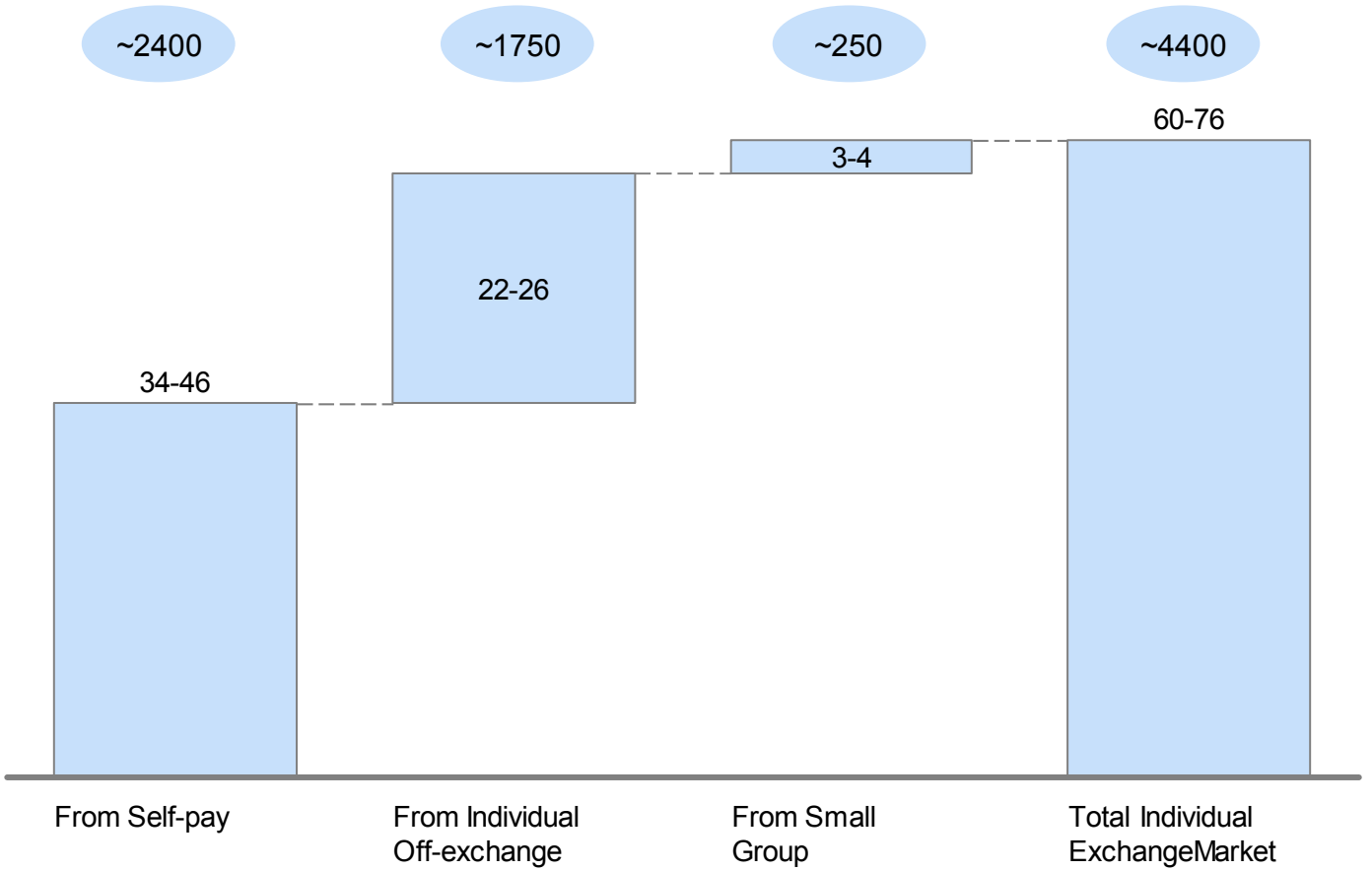
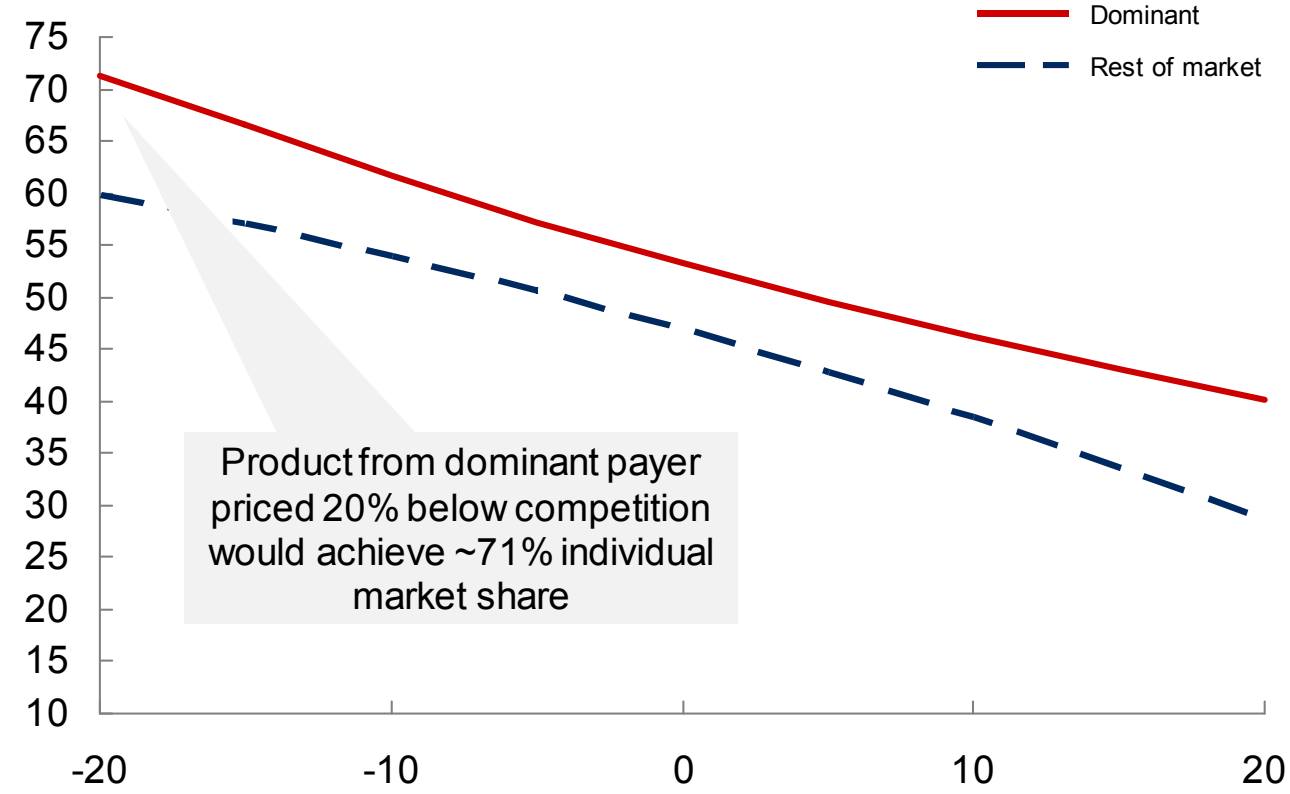
Shift From Self-Pay, Individual Off-Exchange and Small Group to Drive Columbus Exchange Growth

Individual lives by segment (2014)
Number of covered lives in market[1] (000s)



1 Market defined as Trinity's PSA
2 Average of low vs. high scenarios. In exchange, previously self-pay population with IP utilization of 63/1000 lives; previously commercial population with IP utilization of 73/1000 lives

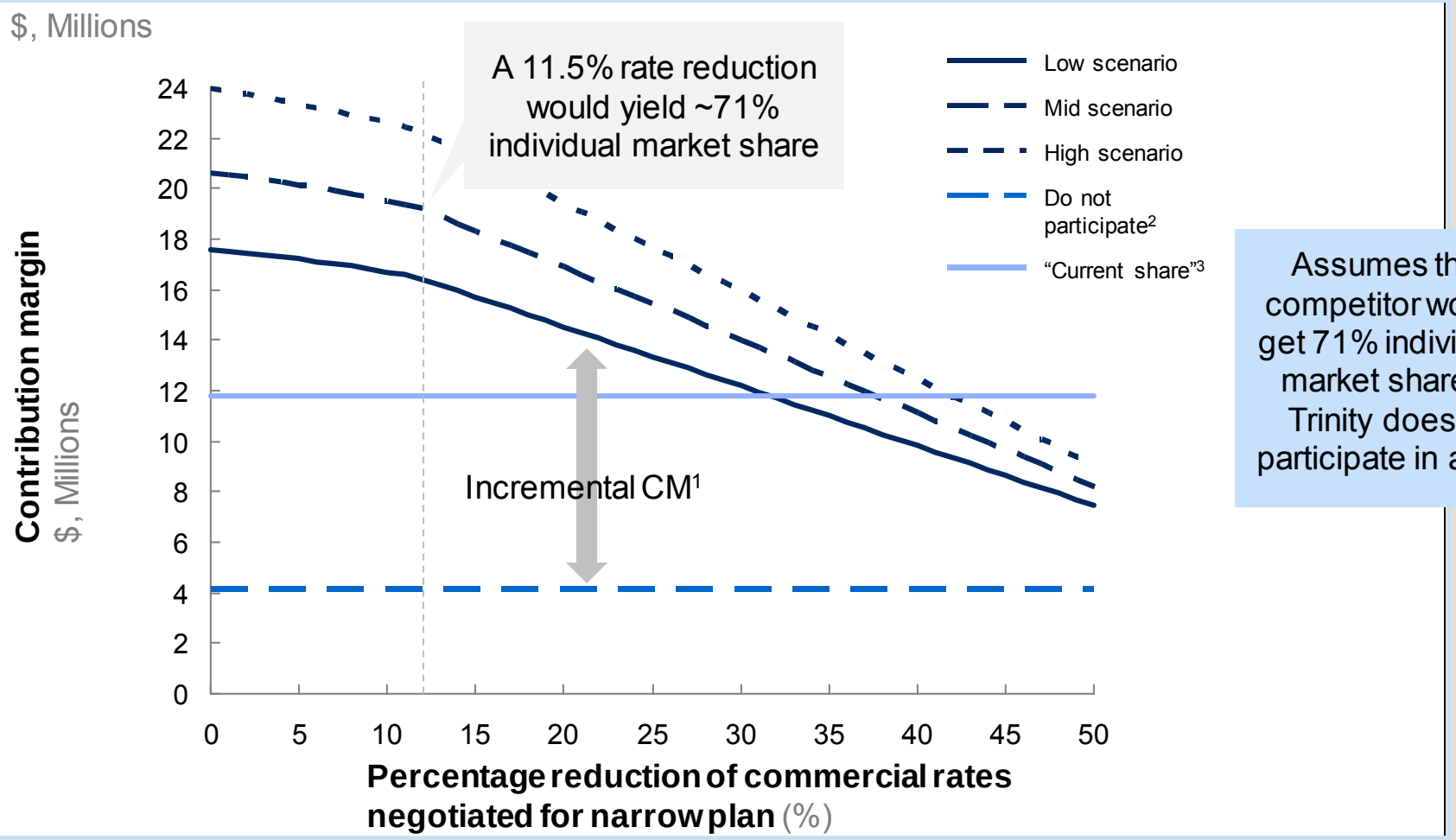
In Columbus, Trinity Contracted with Large, Dominant Payer



Contracted payer assumed to be the **dominant payer** as they have the largest commercial market share of any payor creating a narrow network offering

Projected Impact of Narrow Network Exchange Product on Contribution Margin

Contribution margin for decisions to participate and not participate in discount narrow plan



Assumes that competitor would get 71% individual market share if Trinity doesn't participate in a NN

1 Incremental CM calculated as difference between participate and do not participate scenarios; it does not account for impact to overall financials
2 Assumes competitor will achieve 71% market share if Trinity chooses not to participate in narrow plan
3 Assumes 26% of IP and 21% of OP market (current share) at projected 2014 commercial rates with 73% actuarial value and 49% patient collection

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Incremental Contribution Margin Is Sensitive to 3 Primary Factors

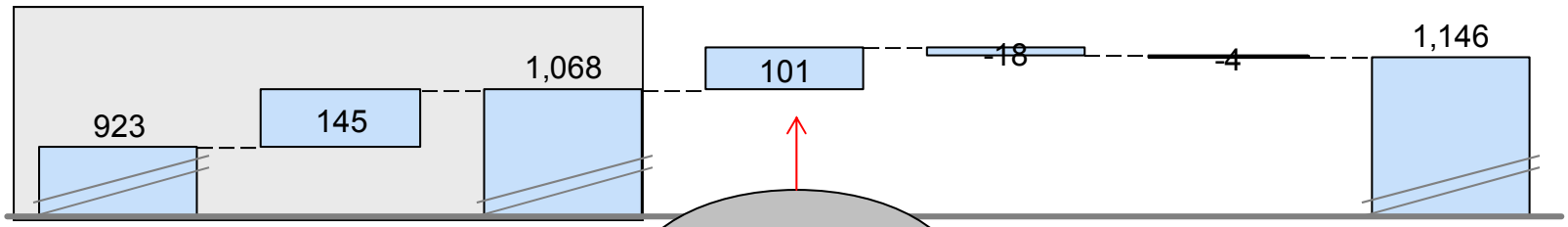
	Description	Assumption	Range for sensitivity	Impact on incremental CM[1]
Bad debt / collection for OON visits	• Assuming collection rate for OON non-ED visits is similar to self-pay collection rate	• 5%	• Up to 52% patient collection rate on 80% of charges (equivalent to NN revenue / case)	• ~($3.0M) at 52%
Market share on exchange	• Assuming contracted payer behaves as dominant payer and NN product will be 20% cheaper than competing product	• NN product with contracted payer will get 71% market share	• Down to 40% market share with 11.5% discount	• ~($6.5M) at 40%
Ability of competing provider to form NN	• Assuming Trinity competitor can form NN with dominant payer to achieve 20% exchange discount if Trinity does not participate	• Competing NN will have 71% market share • Trinity is excluded entirely from network	• Down to 40% market share at most competitive discount	• ~($3.5M) at 40%

1 (CM by participating in NN) - (CM by not participating in NN). Using mid-case with 11.5% Trinity discount

Reform Expected to Drive 370 bps Margin Improvement in Columbus

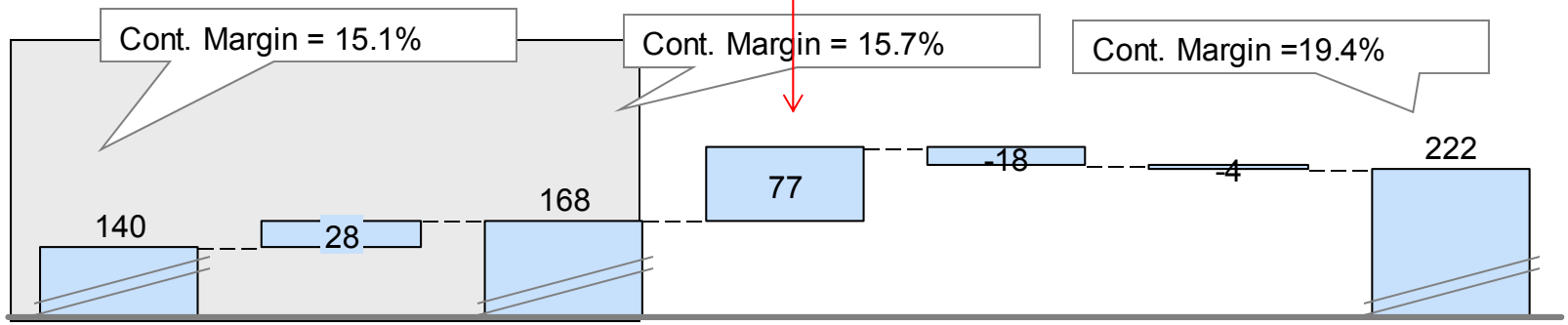
Scenario: Strong consumer uptake, medium employer opt-out, 11.65% Exchange discount

Collectible patient revenue, 2012-2016
$ Millions



Exchange Impact

EBITDA , 2012-2016
$ Millions



2011 | Population growth, price, and coverage | 2016 No Reform | Change in insured population and utilization | Medicare growth declines and penalties | Reductions in DSH payments | 2016 Reform

Note: Assumes Full Medicaid expansion


Q&A

Additional considerations in payer discussions

Questions for all narrow network products

- Is the payer looking for a **price discount** off commercial rates? How much?
- What is the proposed **length of the contract**?
- Is this an **exclusive narrow network**? If not, who are the other providers?
- Are **physicians included** in the narrow network? Which ones?
- Will this be the payer's only offering for the proposed segment or will there be **broad network options** as well?
- What will the **benefit design** of the product look like?
- How will the **premium** be priced?
- Is the payer willing to **co-brand** the product?
- Will other payers have narrow network products?

Segment-specific questions

Exchange products

- Which Exchange segments is the payer targeting (e.g. Individual, Small Group)
- Will the product be offered at every Exchange tier?
- Will products be offered on and off the exchange?

Each contract should also have language / terms to mitigate risk to Trinity

To mitigate risk, the following five protections are essential

Protection	Rationale
Anti-steerage language	▪ Prevents payer using benefit design to shift expected volume from high revenue service lines or channels
Inclusion in all narrow network products	▪ Prevents payer from forming exclusive relationships with other providers that may impact success of products including provider
Exclusive co-branding	▪ If payor agrees to co-branding with provider, prevents brand diluting by the payer
Automatic price increase if volume not delivered	▪ Protects provider from payers who do not enforce OON rates or use other levers to significantly reduce utilization
Segment specific language	▪ Protects provider from payers who try to extend rate decreases from one patient segment to another (e.g., Exchange to small group)