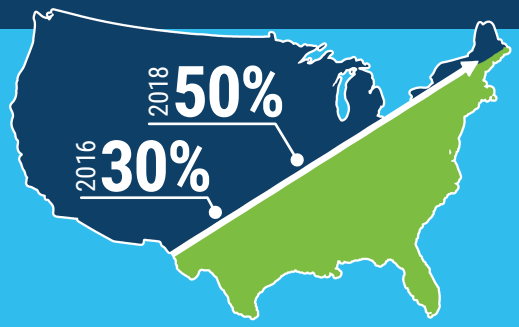
APM MEASUREMENT



Public and private health plans voluntarily participated in a national effort to measure the use of alternative payment models (APMs) as well as progress towards the LAN's goals of tying 30% of U.S. health care payments to APMs by 2016 and 50% by 2018.

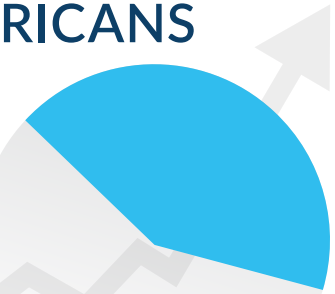
PARTICIPANTS

COMMERCIAL
26 HEALTH PLANS
90 MILLION COVERED LIVES
44% OF COMMERCIAL MARKET

MEDICARE ADVANTAGE
23 HEALTH PLANS
10 MILLION COVERED LIVES
58% OF MEDICARE ADVANTAGE

MEDICAID
28 HEALTH PLANS AND TWO STATES
28 MILLION COVERED LIVES
39% OF MEDICAID

REPRESENTING MORE THAN **128 MILLION** AMERICANS AND...



...NEARLY **44%** OF THE COVERED POPULATION IN THREE MARKET SEGMENTS

2016 RESULTS

IN APM CATEGORIES 3 & 4

% OF HEALTH CARE DOLLARS

22% COMMERCIAL

41% MEDICARE ADVANTAGE

18% MEDICAID

*Data from January 1, 2016 was collected over an 8-week period and aggregated to produce results based on the LAN's APM Framework.

The U.S. Department of Health and Human Services (HHS) announced in March 2016 an estimated 30% of traditional Medicare payments are tied to APMs that reward the quality of care over quantity of services provided. These results are separate from the results shown above.
* The results are based on contracts in effect on January 1, 2016 and represent estimated spending from January – December 2016.

ABOUT THE HEALTH CARE PAYMENT LEARNING & ACTION NETWORK

The LAN, launched in March 2015 by HHS, brings together public, private, and non-profit sectors to transition to successful APMs that improve health care quality. Through the LAN's collaborative structure, more than 6,500 participants are taking action towards APM adoption and implementation, a critical step in achieving the Triple Aim of better care, smarter spending, and healthier people. The LAN is working to increase adoption of APMs with the goal of tying 30% of U.S. health care payments to APMs by the end of 2016 and 50% by 2018.

APM FRAMEWORK

CATEGORY 1

Payments utilizing traditional legacy payments (e.g., fee-for-service) that are not adjusted to account for infrastructure investments, provider reporting of data, or provider performance on cost and quality metrics.

CATEGORY 2

Payments utilizing fee-for-service (FFS) payments are adjusted based on infrastructure payments to improve care or clinical services, whether providers report quality data or perform well on cost and quality metrics.

CATEGORY 3

Payments based on FFS architecture while providing mechanisms for effective management of a set of procedures, episode of care or all health services provided for individuals. Providers that meet cost and quality targets are eligible for shared savings; those who do not may be held financially responsible.

CATEGORY 4

Payments are structured to encourage delivery of well-coordinated, high quality, person level care within a defined budget. Per member per month (PMPM) payments are made to manage all of a patient's care and/or conditions.