CONFIDENTIAL MEMORANDUM

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Centers for Disease Control and Prevention

From: Hal Andrews
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Date: December ___, 2007

Re: Proposed Collaboration with Wal-Mart

This Confidential Memorandum outlines a framework to allow Wal-Mart to apply its motto **"Saving people money so they can live better"** to both its associates and its customers in reducing the cost of *healthcare* and promoting *health*. We believe that Wal-Mart can realize more tangible benefits in more numerous ways than almost any other entity based on its dual role as the largest employer in the United States and its retail market share. Even so, we believe that the general concepts discussed below are applicable to every large employer, particularly those with a diffuse workforce.

Proposal: We propose that Wal-Mart sponsor the development and implementation of a healthcare delivery and financing model that will produce continuous value through improved health and rational payment for healthcare services. At its core, the value proposition will be driven by information. In furtherance of promoting community health and wellness, members of a community (however defined) need information about behaviors that improve health for everyone in the community. In furtherance of reducing the cost of healthcare services, community members need information about the cost, quality and convenience of those services.

Recommendations: We believe that Wal-Mart should consider implementation of each of the following:

- Underwrite the cost of the Partnership for Prevention's Ranking of Preventive Services (http://www.prevent.org/content/view/43/71/) for all Wal-Mart associates and their dependents, regardless of whether those associates are eligible for coverage;
- Require every Wal-Mart retail clinic partner to provide the Preventive Services to any consumer at a price not to exceed 200% of the benchmark cost of such services;
- For Wal-Mart retail clinic partners who are hospitals or health systems, require each such hospital or health system to utilize the Data iSight reimbursement methodology to reprice **all** hospital claims for **all** uninsured patients at a price not to exceed 200% of the benchmark cost of such services;

- Design and implement a "Wal-Mart High-Performance Provider Network" of hospitals for steerage of patients requiring tertiary care services, utilizing (i) Data Advantage's analytic tools in a way that appropriately balances cost, access and quality of services and (ii) benefit design to deliver increased volume to the "High-Performance Network" providers;
- Design and implement a "Wal-Mart Standard Provider Network" of hospitals for basic acute care services, utilizing (i) Data Advantage's analytic tools for network design, and (ii) Data iSight's reimbursement methodology to reward hospitals for quality and efficiency by reimbursing every claim at a predetermined margin over the benchmark cost of that claim;
- Expand from the current retail clinic model (nurse practitioner-based) to a multi-tiered approach to include basic ambulatory care (physician-based) and wellness counseling; and
- Sell "Wal-Mart Health Insurance" to its consumers in the form of a Wal-Mart brand wrapper around a standard insurance plan from one of its current ASO vendors, with a benefit designed around promoting health

Requirements. We believe that the following elements are necessary to implement our recommendations:

- A multi-disciplinary team to direct implementation, manage partner relationships, review performance data and lead continuous improvement;
- An expanded retail clinic model that provides increased scope and intensity of service, with primary care physicians in a more prominent role;
- A Wal-Mart sponsored health insurance cooperative or partnership with one or more health insurers to "wholesale" a healthcare insurance benefit;
- Program and content guidance from the Centers for Disease Control and Prevention for wellness advice and counseling;
- Collaboration with a direct-to-consumer wellness company, such as Virgin Life Care; and
- A reimbursement methodology that promotes rational pricing for healthcare services

Throughout this Memorandum, we attempt to differentiate the elements of the proposal that accrue primarily to Wal-Mart associates and those that can benefit other members of the community, a few of which are summarized as follows:

Return on Investment for Associates	Community Benefit/Savings
Immediate, direct decrease in claims cost through Data iSight reimbursement methodology	Improved retail traffic from higher intensity of service level offering
Improved associate awareness of health and healthy behaviors	Improved community awareness of health and healthy behaviors
Improved relationship with local businesses through health insurance purchasing cooperative	Lower health insurance premiums through health insurance purchasing cooperative
Increased productivity from better overall health and better access to convenient healthcare services	Increased convenience for primary care and improved steerage of insured patients to local hospital
Improved public perception of Wal-Mart as employer re: better/more health benefits	Access to Dossia
Improved decision support for consumerism	Investment in community health (parks, greenways, health fairs) through CDC-led initiative
Flexibility in network design – any willing provider or High-Performance network	Flexibility in network design – any willing provider or High-Performance network
Ability to compensate physicians for improving health and wellness instead of treating sickness	Ability to compensate physicians for improving health and wellness instead of treating sickness

Background. As the largest employer in the world, Wal-Mart theoretically has more purchasing power than any other entity, yet Wal-Mart's health plan premium trend is not satisfactory. Despite a comprehensive network of hospitals, ambulatory providers, and physicians, which has resulted in extremely low out-of-network utilization, Wal-Mart's premium trends are ___%.

Health plans theoretically lower the costs of healthcare benefits effectively and efficiently while promoting the health of the insured population. In reality, most health plans deliver two things: (i) information technology scale to process large claims volumes and (ii) networks of hospitals, ambulatory care providers and physicians who have contracted to provide services at some cost less than the chargemaster in exchange for steerage of patients. If the theoretical role of health plans were reality, Wal-Mart should have (i) flat to declining costs for the claims processing function that its health plan providers deliver, and (ii) substantially lower (if not flat) costs of care from the network providers.

In response to the failure of health plans to reduce or limit costs on a consistent basis, many large employers, like Wal-Mart, have self-funded health benefits ("self-funded employers"). In so doing, self-funded employers have eliminated any incentives for health plans to promote health. Less obviously, self-funded employers effectively create the incentive for health plans to deliver networks that are comprehensive (to provide "choice" to employees) at considerable incremental costs. The result is that self-funded employers have allowed health plans to aggregate several commodities (marketing, claims adjudication, usual and customer repricing, provider networks) at a

premium price ($66 pmpm, in one case) while removing all incentives for health plans to reduce costs.

In a world that emphasizes network coverage over cost containment, Wal-Mart's size effectively creates diseconomies of scale for healthcare purchasing. The health plan promise to Wal-Mart is lower pricing through networks, which depends completely upon the payer's market leverage in each market. Because Wal-Mart is in every market, no payer (other than Medicare) can deliver consistent pricing across all markets with any rational, geographic price adjustments (again, other than Medicare's wage-index formula).

Two other factors compound the diseconomies of scale for Wal-Mart. One is the utilization of physician-owned ambulatory care providers, which leads to over utilization of services. The other is disease management programs for which Wal-Mart pays a fee for each of its insured though fewer than 20% are managed.

Wal-Mart has adopted what is, until now, the only rational strategy, which is to attempt to allocate its pricing diseconomies of scale to a number of large national health plans. Without duplicating its networks, Wal-Mart has no way to compare the effectiveness of one payer's network in a market against another payer's network in the same market.

The network strategy is particularly harmful in rural markets, particularly in the southeastern United States. While Blue Cross Blue Shield plans deliver comprehensive network coverage, in many cases the pricing under the network agreements is not based on any rational pricing mechanism.

In most rural markets, there is only one hospital in a radius of 20-40 miles. The typical rural hospital operates fewer than 150 beds, has fewer than 4,000 discharges, and generates net revenues between $20-40M. The payer mix for the typical rural hospital is approximately 50% Medicare, 15% Medicaid, 10% self-pay and 25% commercial. The geographic isolation of the rural hospital provides it with market leverage against the commercial payers, which are comprised of the state Blue Cross plan and three or four other national health plans. The rural hospital leverages its monopoly-like status by contracting with commercial payers on a percentage of charges basis. Viewed in isolation by the payers, contracting on a percentage of charges basis is not a problem because the total spend (some portion of the 25% of commercial patients) is low in comparison to the spend for the entire plan. Even payers who negotiate DRG-based case rates for inpatient typically allow the percentage of charges methodology to determine reimbursement for outpatient utilization.

For example, see Appendices 1, 2 and 3 - Wal-Mart Northwest Alabama Hospitals. It is almost certain that every hospital on the Appendices participates in the Blue Cross Blue Shield of Alabama network. As depicted on Appendix 1, the hospitals in northwest Alabama provide services across all DRGs at charges between 153% and 484% in excess of their costs. Appendix 2 depicts the variation in charges for providing a

diagnostic colonoscopy, and Appendix 3 depicts the variation in charges for providing a lipid panel, both of which the Partnership for Prevention recommends. Assuming that Blue Cross reimburses some, if not the majority, of claims from these hospitals on a percentage of charge basis, Wal-Mart costs are hugely variant. From an analysis of actual claims, Data Advantage can analyze what hospitals in every state are the low-cost provider. As importantly, Data Advantage can analyze what hospitals in every state provide higher quality services. With that information (and help from a benefits consultant), Wal-Mart can effectively design provider networks for the desired balance of quality and cost while reducing its ASO fees.

Because so many of Wal-Mart's stores are in markets with only one hospital, Wal-Mart's focus on having providers in-network may actually be contributing to higher costs.

Proposal. We believe that Wal-Mart can turn the current model on its head. The differential between employer premium increases and hospital reimbursement increases has grown very large on an absolute dollar basis in the past decade, which is now manifested in the reserves on health plan balance sheets. The foundation of our proposal is that there is an average reimbursement per claim that would be higher for the provider and simultaneously lower for the employer.

With that foundational premise, we believe that instead of Wal-Mart's scale resulting in higher costs through the utilization of a commercial network strategy, Wal-Mart should utilize its leverage to create the Wal-Mart Provider Network and a Wal-Mart Health Plan. In addition, Wal-Mart should expand upon the current market concept of a retail health clinic to offer ambulatory care settings that range from a nurse practitioner to an ambulatory care center with physician offices and basic diagnostic capabilities.

Elements of the Proposal.

Wal-Mart Provider Network. Conceptually, Wal-Mart can create the Wal-Mart Provider Network (High-Performance and Standard) very easily. Assuming that Wal-Mart does not want to become subject to regulation by insurance regulations in the 50 states (or be subjected to the same sort of battle that frustrated Wal-Mart's banking initiative), Wal-Mart can convert its current relationship with health plans into the purchase of a commodity, namely an insurance policy, at a commodity price. Wal-Mart can purchase, either on a single-source or dual-source basis, a "wholesale" health insurance benefit and put a Wal-Mart "wrapper" on it. By simply converting associates to the "Wal-Mart Health Plan", Wal-Mart can implement a Wal-Mart Provider Network strategy, particularly in rural markets where Wal-Mart is typically one of the three largest employers (along with the school system and the hospital). The only areas (such as New York City) where Wal-Mart could not implement a provider network would be precisely the markets in which its associates and customers would not need one.

*Reimbursement Methodology.*National Care Network would provide a key component of the Wal-Mart Provider Network through its Data iSight cost-of-care based

reimbursement methodology for hospitals and ambulatory care providers. The Data iSight model is designed to provide a fair reimbursement for every claim, but in no event would it provide a reimbursement that is **less than the benchmark cost of care on a severity adjusted basis**. Based on our initial conversations with some of the largest healthcare systems in the nation, we are confident that hospitals will accept reimbursement calculated using the Data iSight methodology.

A key advantage of the Data iSight methodology is to allow Wal-Mart the flexibility of delivering the Standard Network or the High-Performance Network or a blended approach for hospitals and ambulatory care centers. Under the Standard Network, any provider willing to accept the Data iSight cost-plus reimbursement could participate. Under the High-Performance Network, Wal-Mart could select hospitals in any geographic area that provided the best quality at the lowest price. Because the Data iSight methodology is based upon benchmark costs, hospitals in both the High-Performance Network and the Standard Network would effectively receive a bonus for their efficiency. Finally, Wal-Mart could combine the two concepts, such as using Standard Network strategy in rural areas and a High-Performance network for tertiary care facilities.

Initially, Wal-Mart can reimburse physicians on the Relative Value Unit methodology that underpins almost every physician network agreement in the country. Wal-Mart can continue to pay physicians on a RVU model as it migrates to more of a capitation model that emphasizes health.

Health Insurance Cooperative. We believe that Wal-Mart could deliver the pricing benefit of the Wal-Mart Health Plan to local businesses through a health insurance cooperative (the "Community Health Co-Op"). Given Wal-Mart's pricing leverage with its sole-source or dual-source providers of the wholesale insurance product, Wal-Mart should be able to price the product below other plans; in rural markets, Wal-Mart would almost certainly deliver a price-point below prevailing market plans. Depending on assumptions about increased retail traffic from the co-location of healthcare services, Wal-Mart can presumably even buy down the premium cost.

We believe that Wal-Mart's sponsorship of the Community Health Co-Op would create tremendous goodwill among the business community, particularly in rural markets with an employer base that is characterized by businesses with fewer than 50 employees. In addition, the Community Health Co-Op could be utilized as a funding mechanism for the CDC community benefit initiative of infrastructure or programs to promote health. In lieu of utilizing municipal finance strategies to create a pool of capital, the Community Health Co-Op could allocate a certain portion of the insurance premium to the CDC-sponsored fund.

An alternative strategy, which is probably riskier from a public relations standpoint, is for Wal-Mart to sell the Wal-Mart Health Plan to its consumers. An analogy would be the federal government allowing individuals or small businesses to purchase a policy under the Federal Employees Health Benefits Plan. The potential

benefits to Wal-Mart are (i) ensuring participation in the Dossia initiative, (ii) more timely implementation as compared to a cooperative strategy, and (iii) more retail traffic (presumably similar to increased traffic from Humana Part D program). The risks include litigation and negative publicity in the event that Wal-Mart is perceived to deny benefits to members.

Ambulatory Care Facility Strategy. Regardless of which (if any) strategy Wal-Mart pursues regarding health insurance policies, Wal-Mart has the ability to guide associates and customers to better health through an outpatient model that promotes health and delivers health care in a more cost-efficient outpatient model.

The retail clinic model is perhaps the most powerful trend in healthcare today, but we are not convinced that the retail clinic is the panacea that it is touted to be. First, we believe the model exacerbates a clinical labor shortage to offer treatment of sickness at price points that are not dramatically different than similar services offered in a physician office. Moreover, in the absence of dramatic growth in consumer driven healthcare, the price point advantages of the model are invisible to consumers, meaning that the real hope of cost reduction is in decreased emergency department utilization. We think that this advantage is overstated as well, since a significant amount of inappropriate emergency department use is generated by uninsured or underinsured individuals who choose to access "free" care in a hospital or lack convenient access to retail clinics.

We also believe that it is critical to distinguish between the "hosted" retail clinic model, such as CVS/Minute Clinic and Walgreens/Take Care, and the "independent" retail clinic model, such as Redi-Clinic or The Little Clinic. As a strategy for retailers to realize incremental sales from waiting customers, the "hosted" model is brilliant. However, we view the "hosted" model as a "low-acuity sickness" model whose real purpose is retail "stickiness".

In contrast, we believe that the independent model is destined to fail. In our experience in ambulatory care settings, current healthcare financing schemes do not allow stand-alone clinics to generate a financial return attractive enough to create financial backing necessary for a national rollout. The issue that many retail clinic operators will inevitably face is the need to increase the revenue per visit above $60 even as they discover the difficulty of collecting larger amounts. We understand that some independent operators are beginning to realize this, and we believe that all independent operators ultimately will.

From the standpoint of the CDC, the retail clinic is a more cost-effective distribution channel for preventive services than hospitals and many primary care settings. From a financial perspective, however, the services that the CDC most wants to deliver have little, if any, margin; those that do cannot be delivered in the retail setting, such as diagnostic colonoscopy. Paradoxically, the appeal of the independent retail clinic to the CDC is completely unappealing to shareholders. As a result, we predict that the CDC would realize the most benefit from collaborating with the "hosted" retail clinic

operators because they are less likely to be concerned with the low margins from preventive services.

Assuming that Wal-Mart used its scale to implement a "hosted" retail clinic model, the CDC would clearly benefit most from a collaboration with Wal-Mart. From our perspective, Wal-Mart has a more ambitious goal than the other retail clinic hosts; Wal-Mart appears to understand the opportunity to impact health in a substantial way, which should have a much larger financial impact on the expense side (lower claims expense and absenteeism) than incremental margins from increased store traffic. If so, we believe that Wal-Mart should pilot an ambulatory care model in several rural markets that is substantially different than the ubiquitous nurse practitioner model.

Assuming again that Wal-Mart does not want to undertake provider liability, Wal-Mart should outsource the Wal-Mart Ambulatory Network to retail clinic operators or local hospitals. We believe that the Wal-Mart Ambulatory Network should deliver the following services, with every clinic delivering Tier I services and other clinics providing services appropriate to the market.

- Tier I - Health Education, Prevention and Behavior Management (in conjunction with the CDC and the National Commission on Prevention Priorities – www.prevent.org)
    - Patient advocacy services to assist associates and consumers to select hospitals for elective care, understand health insurance benefits (co-pays, deductibles, balance billing), utilizing Dossia, etc.
    - Immunizations and vaccinations
        - A free benefit under the Wal-Mart Health Network
    - Chronic disease and health behavior management (in conjunction with a partner)
        - Emphasis on self-monitoring and rewards for "good" behavior, such as the Virgin Life Care rewards platform
- Tier II - Acute minor walk-in care (probably in conjunction with a "RediClinic-type operator)
    - Nurse Practitioner – based services
- Tier III – Comprehensive Ambulatory Care, including scheduled specialty care (bring the urban specialists into the community)
    - Services to include walk-in acute care space, basic lab, x-ray, ultrasound (and digital mammography?), wellness technology, office space for visiting specialists
    - The specialist rotations will be key in decreasing absence for employees, and in encouraging new outpatient procedures to be performed at the local hospital (part of the requirement for specialist participation)

Using our DVP2 database (www.planning2.com), Data Advantage can model service demand to assist in deploying the most appropriate ambulatory care service

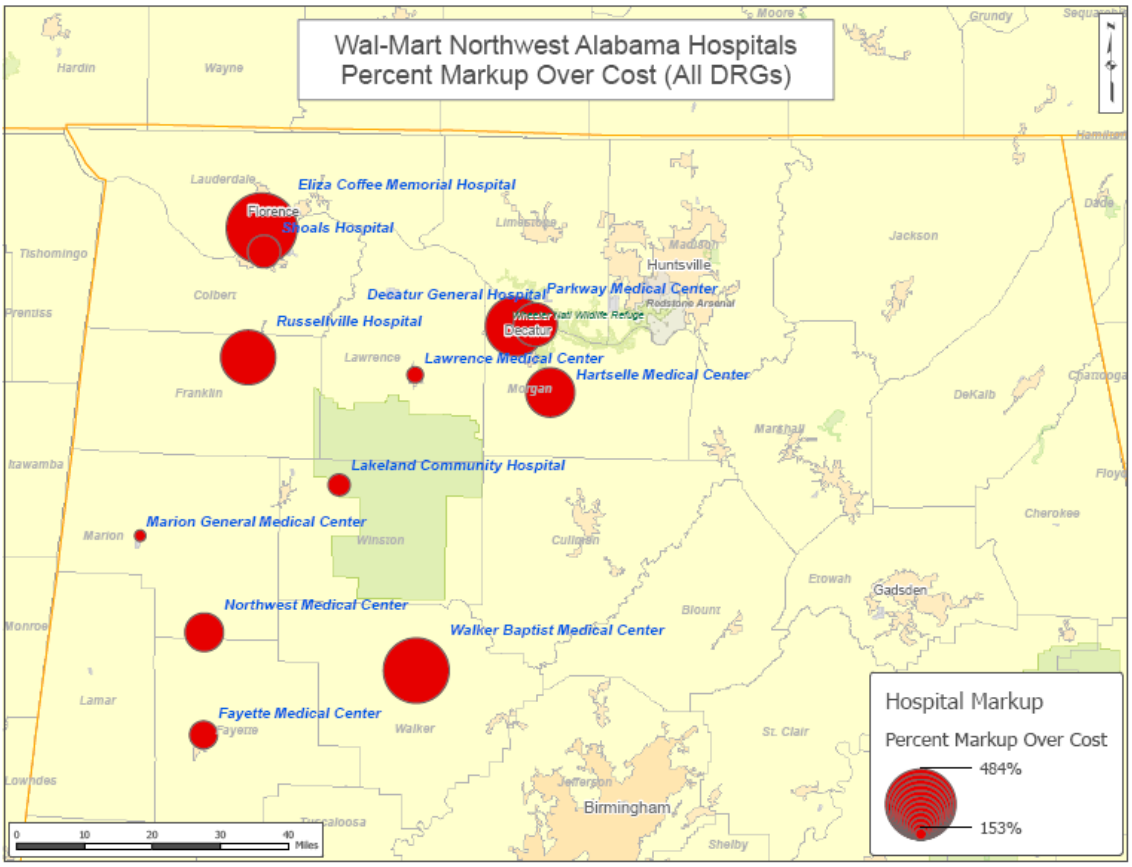
platform in each community. Depending on the scope of services to be provided (more diagnostics at a Super Wal-Mart, fewer at a standard Wal-Mart), the clinic itself may be on the Wal-Mart campus but not in the store itself (which will have ancillary benefits related to healthcare licensing and certification schemes but should not adversely effect store traffic). This would not, of course, prevent Wal-Mart from establishing a separate healthcare supply chain management entity to service clinics and hospital partners.

Where does the hospital fit? First, in rural markets especially, Wal-Mart's size as an employer forces the hospital to cooperate. Second, Wal-Mart should be able to increase the number of insured patients in the area, reducing a hospital's bad debt. Third, depending on the service intensity of the Wal-Mart sponsored retail clinic, the utilization of hospital resources will improve, first through the reduction in unnecessary (and costly) use of the emergency department and second through steerage of profitable diagnostic business (CT scans, outpatient surgeries) to the hospital instead of physician-owned ancillary services (resulting in a reduction in inappropriate utilization for employers). Bringing urban specialists into the community would increase the volume and scope of services provided at the hospital, which would increase the hospital's revenue and profitability. Wal-Mart and Data Advantage could partner to offer the hospitals supply chain and clinical resource tools to increase operational efficiency and reduce costs. Finally, through deployment of DiS and its transparent cost-of-care based reimbursement, hospitals will have certainty that every Wal-Mart Health Plan customer will be a profitable one.

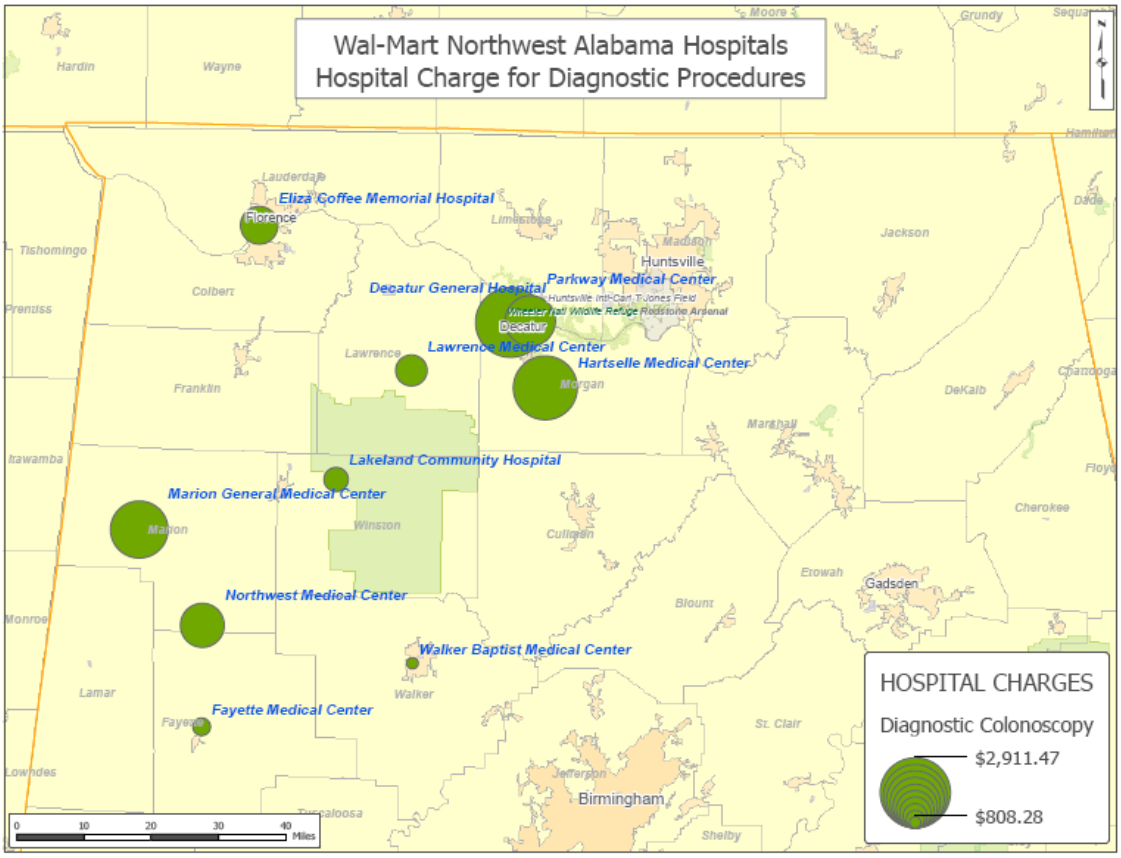
Summary

As employers, NCN and Data Advantage believe that the never-ending increase in the cost of healthcare, incomplete and inconsistent quality measurements, and lack of incentives to promote health and wellness are unsustainable. We believe that a radical change is necessary, and that only the employers have the ability to force change. We know that our role in initiating such a change is a small piece, but we believe it is crucial. We look forward to collaborating with the CDC and Wal-Mart to "**saving people money and improving their health so they can live better.**"

Appendix 1



Appendix 2



Appendix 3