PREMIER INC AT 2014 PIPER JAFFRAY HEALTHCARE CONFERENCE TRANSCRIPT

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On December 03, 2013, Premier, Inc. executives participated in a webcast discussion about the company with Piper Jaffray analyst Sean Wieland. The following transcript is an interpretation of the statements made during the discussion. The actual discussion may have differed slightly.

CORPORATE PARTICIPANTS

Susan DeVore *Premier, Inc. - President & CEO*
Craig McKasson *Premier, Inc. – CFO*
Mike Alkire *Premier, Inc. – COO*

PIPER JAFFRAY PARTICIPANT

Sean Wieland - *Analyst*

PRESENTATION

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

Well, everybody, thank you for joining us at the high noon hour. My name is Sean Wieland with Piper Jaffray. To my right is Susan DeVore, Chief Executive Officer of Premier. To my left is Craig McKasson, Chief Financial Officer of Premier. Thank you both very much for joining us.

You know, on Wall Street we call these bear hugs, and we appreciate them. And I just want to start off by saying that I have a ton of respect for you guys and the model that you have built and the Company that you have built. And my view, as I have written, is that I really believe that the group purchasing organization business model is perhaps the world's greatest business model. You are, of every company I have looked at in my career of analyzing companies, perhaps one of the most efficient allocators of capital. Show me a business that does a 50% return on invested capital and it's my job to question the sustainability of that business model.

So I want to start there. Tell me how do you maintain these great metrics? How do you maintain these margins as technology comes in and drives transparency and as the evolution of this business changes?

Susan DeVore - ***Premier, Inc. – President & CEO***

So something is sustainable, I think, one, if it works; and, two, if there isn't a better way to do it that delivers more value. So I think our approach is that we want to own the total cost problem, total quality and safety problem of these healthcare systems and use all of our data applications and our GPO contracts and our direct sourcing company and our specialty pharmacy in a diversified way to lower total cost.

So for us, it's not so much about whether one part of the model is the sustainable model; it's what are all the different ways you can drive supply chain cost down, make it more efficient, make it more transparent, make healthcare safer and higher-quality.

So it does have high margins, and it has high margins because the chassis is built. We do 1900 contracts. The contracts are built in the GPO. Every time we add a new one or every time we had a new member or new customer, it's on a fixed-cost chassis.

So it is a high-margin business. Our performance services business is high-margin, not as high as the GPO margin. And you know, Sean, we have a very diversified way of trying to solve the problem.

Craig McKasson ***- Premier, Inc. - CFO***

The thing I would add is that we actually agree with you, that a GPO by itself with no other pieces and parts is not sustainable, which is why strategically, years ago, we started to diversify the business to build the clinical capabilities. We think supply chain is a clinical process. If you are really going to get after reducing cost for healthcare systems, it's not just the price of the widget. You've got to get at how many of a particular thing you are using, all the other things that we talked about. So I don't know that we disagree with you from that standpoint.

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

Okay, well, let's get to what I think of as the kernel. I want to get to some of the other aspects of operationally how you are improving the efficiencies of the supply chain, because you are certainly doing a lot of good work there. I want to question you, though, on the core value proposition of the group purchasing model, which is ultimately to lower price. And it's my view that the GPO price is really the new list price. No one goes around and brags about how they saved 50% off of the rack rate of the Palace Hotel room last night. The rack rate on my room was like $1000 a night. No one pays that. Nobody pays list. And so it's like the GPO price becomes the new list price at which local vendor discounts are negotiated.

A study that I recently read said that over the past 20 years, supply cost inflation has been about 4% per year, which has been actually in excess of overall healthcare growth. And so I want to question you on -- is the GPO doing a good job at its fundamental purpose of lowering price?

Susan DeVore ***- Premier, Inc. – President & CEO***

So supply chain cost is driven by a lot of things. Price point is one of them. I would say GPOs do a good job of creating the friction, using the aggregated volume they have, to drive the price point down. I think the 4% you are seeing in growth in supply chain cost is largely driven by expanded utilization, more patients, more frequency, more variation and all those other things. Again, that's why it's become so important that you connect clinical data and resource utilization to price data.

We measure all of our employees, actually, a part of their variable pay is tied to their ability to lower the supply chain expense ratio in our hospitals. And we target 2% to 3%.

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

Say that again?

Susan DeVore ***- Premier, Inc. – President & CEO***

Our entire employee base is partially paid their variable comp based on their ability to lower the outcome in supply chain. Supply chain cost per discharge needs to go down by 2% to 3% a year. So I can't speak for the industry at large, but for our members, we're focused every day, every year, every month on how do you lower supply chain cost in total.

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

So you get paid by the supplier, of course, is the business model. And so who is really your customer? Is your customer the hospital or is your customer the supplier?

Susan DeVore - ***Premier, Inc. – President & CEO***

Our first and primary customer is the hospital. We are all about how do you help hospitals and health systems and ACOs and all these integrated delivery systems lower their cost of care and improve their quality and outcomes. But we also help suppliers do this more efficiently. We have a big channel. We have a 57% footprint. If they negotiated every contract with all 2900 of our hospitals every time, there's a lot of inefficiency in that.

So I think for them, the efficiency of contracts, T's and C's, pricing negotiations, those kinds of things make it a good value proposition for them, too.

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

Okay. Let me just remind the audience, this is a full contact event. So if you have any questions, throw your hands up and we would be happy to take them.

So when the Safe Harbor provision of the anti-kickback legislation was put into effect to allow GPOs to exist, there were no GPOs that were public. They were owned by member hospitals, and the excess profits of these organizations were dividended back to the hospitals. Fast forward 20 years later, there are now two public GPOs where the margins really now belong to shareholders. And in your case 80%, roughly, are still the hospital's, but still, 20% are investors. And that will likely grow over time. Do you think that the OIG envisioned, or the original Safe Harbor clause envisioned the notion that someday these GPOs would be for-profit companies? And how do you think about the oversight of your business? How do you think about OIG, not just specifically to the transaction itself of the IPO but, more broadly speaking, considering that these are now public companies?

Susan DeVore - ***Premier, Inc. – President & CEO***

I can't speak for the OIG, but I don't think the OIG was so concerned about capital structure. I think actually there are lots of other models of admin fee type systems -- think of AARP, think of eBay, think of all these other systems. That is more complicated in healthcare because of the Medicare fraud and abuse statutes. So I think really what they were trying to do with the Safe Harbor was make it possible to have an admin fee-based model in healthcare and not run afoul of the Medicare fraud and abuse.

Capital structure to me means access to capital to reinvest to deliver more applications and more services, to drive costs down and quality up. Our model does require that all the returns that our shareholders get flow through their Medicare cost reports, which I do think the OIG is concerned about. And I think, at the end of the day, the OIG and the federal government and state governments as they relate to healthcare are most concerned about how do you drive costs down and how do you drive quality and safety up.

So I think it was really put in place to enable an admin fee model, irrespective of capital structure.

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

Okay. I wanted to run through some of my -- and I think you had great answers to those -- some of my concerns overarching on the GPO business. But let's move, if we can, to some efforts that are in place to really improve the efficiencies of the overall healthcare supply chain. Let me start by asking, do you think that the healthcare supply chain is an oligopoly?

Susan DeVore - ***Premier, Inc. – President & CEO***

I think the healthcare supply chain is very fragmented. It has not been verticalized yet in healthcare. And I think there's a lot of variation in it. So no, I don't think so.

Sean Wieland *- Piper Jaffray & Co. - Analyst*

What are your efforts around improving transparency in the healthcare supply chain, your push back on the gag orders that are in effect? My view is, without that transparency, you don't have an efficient marketplace. So talk about your efforts around improving transparency in the healthcare supply chain, specifically around price, but also with a view on quality.

Susan DeVore *- Premier, Inc. – President & CEO*

Yes, and I wouldn't even limit this discussion to just supply chain. I will start there, but I will talk about performance services, too, which is our other segment.

So we believe transparency is the great equalizer. It keeps competition where competition should be. It creates the friction that you need to create. It keeps everybody focused on how do we do this most efficiently. And so we are proponents for transparency. We have 10 or 15 people full-time in Washington. We were supportive of the physician payment sunshine act, which disclosed relationships. We also have pushed very hard, in fact helped write the legislation regulation, for unique device identification so that you could actually know what a device was from one vendor to the next, and it would have a common identifier. It's amazing to me that in healthcare, you can't get stuff off the shelf as fast as you can peanut butter or dog food off the shelf.

So we fought hard for that. We also fought hard for the elimination of gag clauses, which are the confidentiality agreements that suppliers try to maintain to protect their price points. So in the supply chain side we are supportive all of that.

On the performance services side, we also have made a decision publicly to publish all of our methodologies and all of our formulas. There are no black boxes in all of our databases, because we think the industry at large needs to understand how to measure cost and quality and safety and outcomes in healthcare, and the only way we are going to improve this entire system is to have transparency as to that, too.

So we are believers in transparency, and we think it will cause behaviors to change. We actually have a collaborative called QUEST where 350 of our hospitals have come together and said, okay, we're going to measure cost the same way, we are going to measure harm the same way, we are going to measure mortality the same way, we are going to measure evidence-based care the same way. We are going to measure patient satisfaction the same way and we are going to measure readmissions the same way. And all of us are going to agree to be transparent with our results on all of those measures inside the cohort because we want to learn from each other, we want to share with each other, we want to find out who is best performing, who is worst-performing.

And that really helps us build solutions and applications and revenue streams because we can focus the effort on where the problems are systemically across multiple health systems.

Sean Wieland *- Piper Jaffray & Co. - Analyst*

How do you get these manufacturers to give up their gag orders on disclosing of price?

Susan DeVore *- Premier, Inc. - President & CEO*

Actually, it's not the manufacturers you have to get to do it; it's the health systems you have to get to require the manufacturers to do it. And so it's interesting because we have a large committee that is our 30 largest health systems. So this committee accounts for over 50% of our purchasing volume. And we said to the committee, we need to figure out what the floor is on some of these physician preference items. So we want you all to submit your pricing and we will figure out where the friction is and where the variation is.

And we learned a couple of things. One is a lot of variation – 50% to 200% variation in the price. Second thing we learned was the variation in price wasn't directly related to the size or scope or reputation of a facility. So we were surprised by the pricing in some places versus another. And it didn't appear to be completely rational.

And the third thing we learned was that some had signed the confidentiality agreements and didn't really know the extent to which they had limited their ability to share the data. So they couldn't share the data.

So it's an awareness thing. It's a negotiation thing. But we push very hard to have transparency.

Mike Alkire ***- Premier, Inc. – COO***

So, Susan, could I add to that?

We talked a little bit about this, this morning. So these 20 to 30 systems all for the most part had gag clauses. And they all believed that they had the best price. So we sat around the table and said, well, one of you has the best, are you willing to ante up? And there is a lot of pride sitting around the room.

So once we were able to have them work with their suppliers, to Susan's point, everybody became transparent. Today I would tell you that 90% of those entities don't have gag clauses in a lot of those categories, because they do understand this notion of national markets. If you bring more value to that supplier, be it commitment, be it consolidation, or if you can take cost out to help them drive efficiency, you should actually get a better price.

Susan DeVore ***- Premier, Inc. - President & CEO***

It was funny; we asked them to raise their hand if they thought they had the best price, and they all raised their hand. And we said, no, really; who really thinks you have the best price? And they all raised their hand.

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

And some of them, you said there was a 50 to 200 --

Susan DeVore ***- Premier, Inc. - President & CEO***

Percent variation.

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

-- Percent variation, not basis point variation. Percent variation?

Susan DeVore ***- Premier, Inc. - President & CEO***

Percent variation.

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

And therein lies the problem, right, in that. So where are we, if zero is zero transparency and 100 is total transparency, where you think we are in that spectrum of driving total transparency in the supply chain?

Susan DeVore *- Premier, Inc. - President & CEO*

I will tell you, with our spend analytics application and with our quality applications, we have a lot of data. Right? We have a lot of data. And we as the third-party custodian of the data and the benchmarking have an ability to make it transparent without it being applied directly to an identified place. So we can mine the data, all the data, to figure out where there is excess blood utilization, where there is excess imaging use, where there is price variation, where there is consistency of pricing. We can actually see that in the data. And so I would say that Premier is pretty far along in our ability to see the data.

I think, in terms of the marketplace transparency of all the pieces and parts and the complexity of that with multiple payers, multiple health systems, multiple ways of packaging services in hospitals, it's not as transparent. And I think it's not as transparent for a lot of reasons, sometimes because commercial payers don't want it to be transparent, sometimes because competitive hospitals and health systems in markets don't want it to be transparent.

Sean Wieland *- Piper Jaffray & Co. - Analyst*

Okay, I would like to talk about couple of more recent events, the recent contract with PharMerica. Tell me what that's all about.

Susan DeVore *- Premier, Inc. - President & CEO*

So PharMerica joined a company called Innovatix. Innovatix is a company that Premier owns 50% of, and the greater New York Hospital Association owns 50%. Greater New York is one of our largest owners. And we have had a partnership with Innovatix, a 50-50 partnership, for, I don't know, Craig, how many years?

Craig McKasson *- Premier, Inc. - CFO*

15.

Susan DeVore *- Premier, Inc. - President & CEO*

Many, many years. And it's our way of going to the non-acute alternate site marketplace. PharMerica has 90 facilities. We have a very good alternate site pharma portfolio and a very good food portfolio. And in alternate sites like nursing homes and these smaller physician offices and other locations a lot of commodity goods, food and pharma, are the big buy.

Craig McKasson *- Premier, Inc. - CFO*

The other driver that really interested PharMerica in terms of its relationship with Innovatix was the things that we are doing around accountable care organizations. And so the alignment with hospital systems with these non-acute facilities was very much part of their decision-making process as they look forward.

Susan DeVore *- Premier, Inc. - President & CEO*

Yes, and that's why we view all this as connected. To us, supply chain and all of our performance services stuff are connected to our population health stuff because, at the end of the day, the only way the industry is going to lower cost and improve outcomes and quality is to actually integrate the data and the actions that they take as providers in the whole continuum.

So over the years, we have been building all the pieces and parts. We think alternate site is a faster growing than acute care. Again, we can mine all the data and see the movement from inpatient to outpatient. We've got big collaboratives of health systems working on population health and ACO development.

The reason we bought a specialty pharmacy is not to be in a pure-play specialty pharmacy business, but because we think pharma intervention in accountable care is going to be the most efficient, best outcome intervention. So we bought a specialty pharmacy so that all these IDNs wouldn't have to build or buy their own; they can brand it their own and deliver that service and keep those patients connected in an ACO kind of world.

So we view it as all interconnected. And that's the bet we are making, that at the end of the day these health systems are going to have to have integrated data to take care of patients across the continuum.

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

And roughly what kind of gross volume would come from the PharMerica deal? Is it a meaningful part of --

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Susan DeVore ***- Premier, Inc. - President & CEO***

I don't know the numbers.

Craig McKasson ***- Premier, Inc. - CFO***

I'm trying to remember what their volume was.

Susan DeVore ***- Premier, Inc. - President & CEO***

It's significant -- it's probably significant to Innovatix, and we are a 50% owner of Innovatix.

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

Does it begin with a B?

Craig McKasson ***- Premier, Inc. - CFO***

No, it's hundreds of millions (contract spend related to PharMerica).

Susan DeVore ***- Premier, Inc. - President & CEO***

In the alternate site world, not much begins with a B.

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

Just checking. Okay, you recently acquired a company called Medius.

Susan DeVore ***- Premier, Inc. - President & CEO***

Yes, we did.

Sean Wieland *- Piper Jaffray & Co. - Analyst*

What is that all about?

Susan DeVore *- Premier, Inc. - President & CEO*

So we are going to describe it in detail in our second-quarter discussion because we did it right in October. It's a company that does data acquisition and data integration from electronic health records. It has been an engine we have been using in our Safety Advisor product, which is an infection control product that pulls data from EHRs. And we see a lot of uses for that capability going forward. And so we acquired it, but we don't have anything to talk about it yet, as it relates to the future -- and so we wanted to get further along in actually get some traction with it.

Craig McKasson *- Premier, Inc. - CFO*

The only thing I would add to that is that it's real-time data, so it's actually pulling that EHR data real-time. It's not a lagged type process.

Susan DeVore *- Premier, Inc. - President & CEO*

Yes, so our point of view about this is we have lots of data and retrospective data. We have near-real-time data. We have predictive data through our partnerships on the population health side. And we had Safety Advisor and real data coming from our safety application, but we want more real-time data.

Sean Wieland *- Piper Jaffray & Co. - Analyst*

Okay. Craig, immaterial from a financial perspective?

Craig McKasson *- Premier, Inc. - CFO*

Immaterial.

Sean Wieland *- Piper Jaffray & Co. - Analyst*

Okay. And the seven new customers on the bundled collaborative?

Susan DeVore *- Premier, Inc. - President & CEO*

Yes. So we think the natural evolution of reform is - to get from fee-for-service all the way to ACO's, there's going to be a thing called bundled payment along the way, which is federal, state and commercial insurers bundling hospital payments with physician and nursing home payments. And so a year or two ago, we formed a collaborative to go to work on bundled payment in the high-cost, episodic procedures like orthopedics, like cardiac. And we have several members in that collaborative.

Through the innovation center, they opened up another registration that ended November 1st. We had 6 or 7 more join the collaborative. It's now up to -- I can't remember the number. It's about 40 hospitals that are participating in this Bundled Payment Collaborative. And again, it's a diversification of our model. So we sell services one on one in consulting in a fee-for-service way. We sell SaaS-based applications. But we also have collaboratives that people pay a subscription fee to participate with other hospitals and do

the work at the same time, which is more efficient for us because it's kind of a one-to-many offering that they buy for a subscription. And so that's what that is.

Craig McKasson ***- Premier, Inc. - CFO***

And the only point I would add there, Susan, is one of the key underpinnings of those collaboratives is always getting back to transparency, them all agreeing to transparently share the data so you can actually make meaningful change.

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

Okay. Any last questions from the group? I'm going to say -- so one more for Craig. Relative to overall growth in the healthcare environment, you are either going to grow faster, in line or below overall health care spending. And how you think about your goals in terms of do you want to grow X-percent faster than the overall healthcare market?

Craig McKasson ***- Premier, Inc. - CFO***

Well, it's hard for me to necessarily predict the overall healthcare market.

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

That's why I'm not asking you to do that. I'm asking you to predict your growth relative to the overall healthcare market.

Craig McKasson ***- Premier, Inc. - CFO***

I think, given what we have seen the historical healthcare market do, we would anticipate that we have the ability to grow in excess of the overall healthcare market.

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

By how much?

Craig McKasson ***- Premier, Inc. - CFO***

Well, as you have seen from the guidance we've put out for this year, we are targeting 10% to 13%, so double digit growth is the level of growth we think we can achieve.

Sean Wieland ***- Piper Jaffray & Co. - Analyst***

The guy is a pro. With that, I will leave it there. Thank you very much, both of you.

Susan DeVore ***- Premier, Inc. - President & CEO***

Thank you.