ECG MANAGEMENT CONSULTANTS

Payor/Provider Trends

HealthTechNet

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Agenda

I. Introduction
II. Reimbursement Trends
III. Payor/Provider Collaborations
IV. Narrow Networks
V. Questions and Discussion

Today's Speaker

twelter@ecgmc.com

703-522-8450

Terri Welter

Principal

Terri is a Principal in ECG's Washington, D.C., office and head of the firm's Contracting and Reimbursement practice. She has extensive experience in managed care and provider/payor reimbursement and collaboration. She recently has been closely involved with assisting health systems, hospitals, medical groups, and other providers with developing and executing the types of arrangements needed to successfully react to healthcare reform and establish contracting structures that facilitate hospital/physician and payor alignment and CI. Terri is a frequent national speaker on the topics of evolving provider payment vehicles, accountable care organization (ACO) development, and provider-owned health plan strategies.

I. Introduction

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About ECG

For more than 40 years, ECG has been creating customized, implementable solutions to meet our clients' specific challenges.

ECG has worked with more than 40 of Becker's Hospital Review's 100 Great Hospitals in America and more than one-third of *U.S. News & World Report*'s Best Hospitals.

Becker's Hospital Review 100 Great Hospitals In America

BEST HOSPITALS U.S.News & World Report RANKINGS

Our experience and scale are recognized in the industry.

Named a ***Top 20*** largest healthcare management consulting firm by

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BOSTON


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I. Introduction

Example Managed Care Clients

EXTENSIVE BREADTH AND DEPTH OF EXPERIENCE NATIONALLY

Sutter Health

TEXAS Health and Human Services Commission

University of Michigan Health System

Northern Arizona Healthcare

Intermountain Healthcare

SSMHealth

Regional Health

Children's Hospital LOS ANGELES
We Treat Kids Better

NavicentHealth
Everything about us is all about you.

CADENCE HEALTH

Carle Clinic

CarilionClinic

Presence Health

MERCYHEALTH

University Hospital
Newark, New Jersey

I. Introduction

Questions

1. How do rate negotiations compare to 3 and 5 years ago? Are they more difficult and/or more complex?
2. Is the market really shifting from FFS to value? How quickly? In what form or fashion?
3. How prevalent are narrow networks? Network tiers? What are the typical concessions and product types?
4. What is the impact on a hospital's financials when it moves to value?
5. Are providers and payors developing more meaningful partnerships? And if so, in what form or fashion?
6. Are there regional or local market variances in terms of the nature of negotiations, the movement to value, or otherwise?
7. Others?

II. Reimbursement Trends

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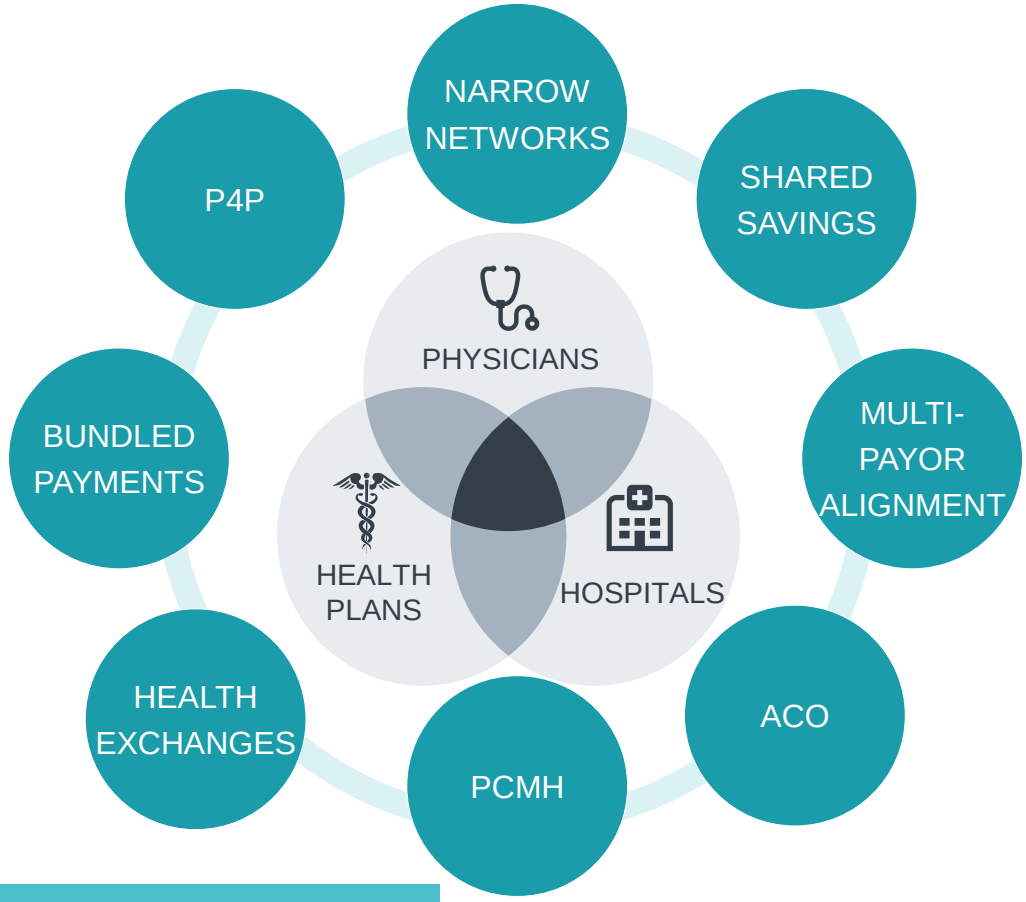
The Market Is Shifting to Value-Based Systems

Reimbursement from health plans to hospitals and physicians is shifting to value-based; however, the pace of transition and the payment methodologies are variable.

Healthcare Payment Innovation Public and Private Sectors

- The federal government and many states have expressed their intent and started the process of establishing programs to distribute a material amount of payments to providers through alternative models.
- Health systems are taking steps to transition from volume- to value-based payment methods.
- The Health Care Transformation Task Force, composed of large U.S. health systems, insurance companies, and employer groups, announced a goal of shifting 75% of its business to performance-based contracts.[1]

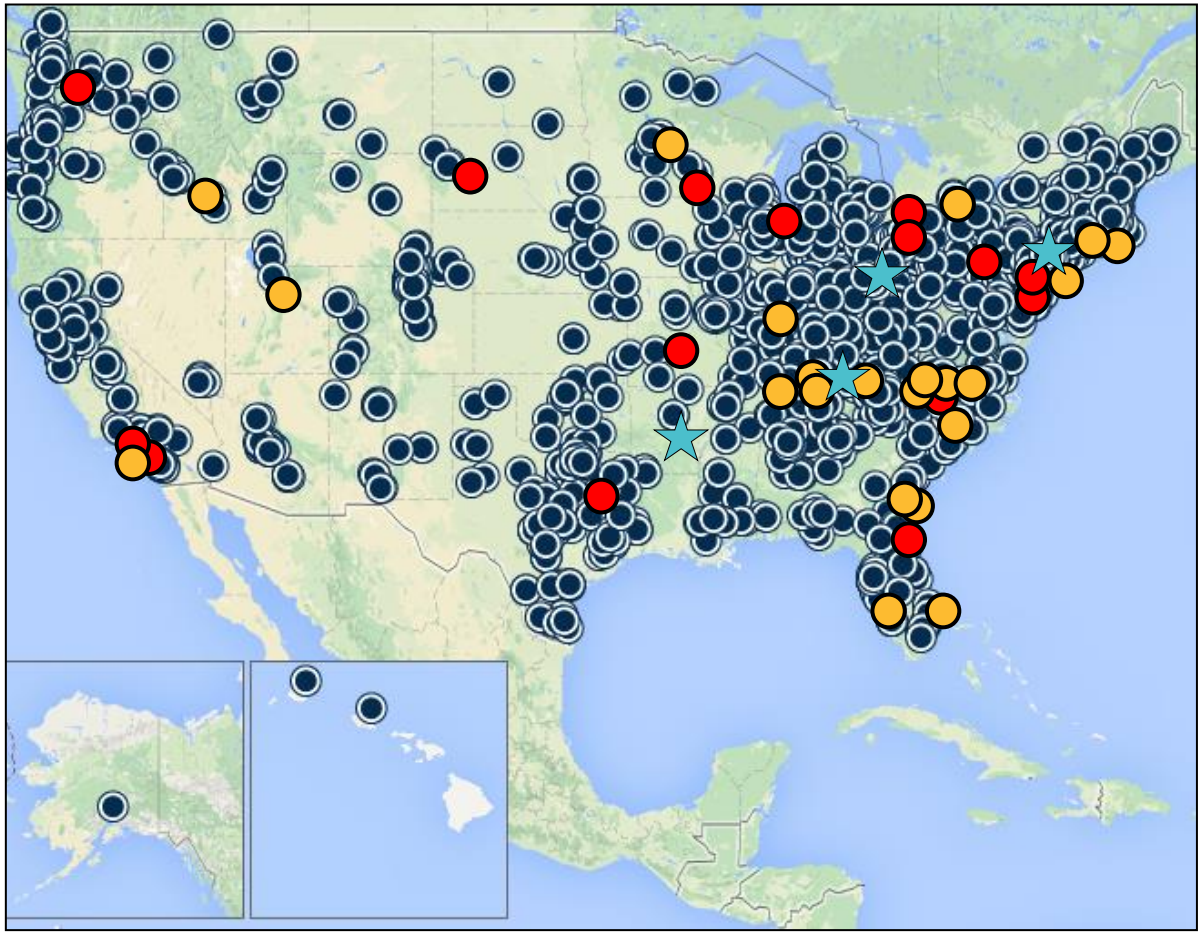
[1] *Modern Healthcare*, January 28, 2015.



Government and commercial payors are expanding reimbursement models to include care coordination and management.

II. Reimbursement Trends

Regulators: Bundled Payments



- **Medicaid** BP Programs
  - Arkansas
  - New York
  - Ohio
  - Tennessee
- **Employer** BP Programs
- **Commercial** BP Programs

Innovative payment models, such as bundled payments are shifting from *voluntary* to *required*.

Source: Centers for Medicare & Medicaid Services (CMS), https://innovation.cms.gov

Medicare Bundled Payments for Care Improvement (BPCI).

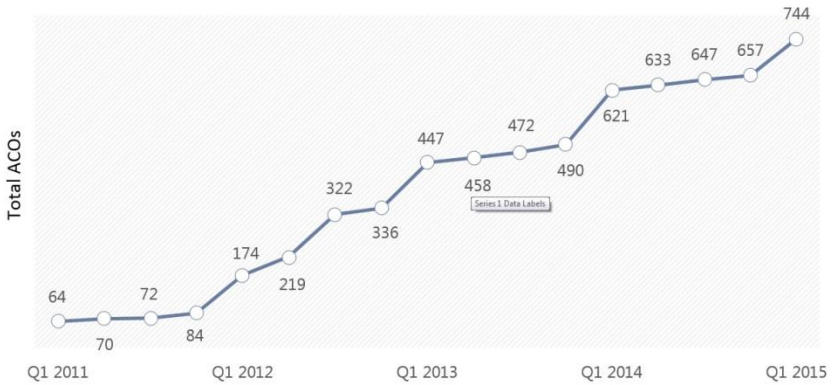
II. Reimbursement Trends

Prevalence of ACOs

ACO growth continues to accelerate as providers seek to position themselves in the market. Recent literature suggests approximately 750 ACOs exist across all 50 states.

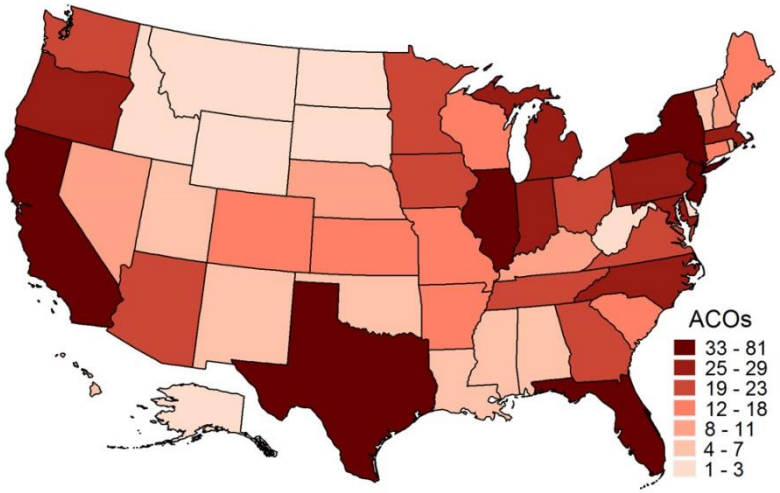
Growth in ACO Formation

Number of ACOs From 2011 to 2015



Historically, hospitals were the main sponsors of ACOs. More recently, there has been a dramatic increase in physician groups sponsoring ACOs.

Geographic Distribution of ACOs



ACOs are now located in all 50 states and the District of Columbia. California leads all states, followed by Florida and Texas.

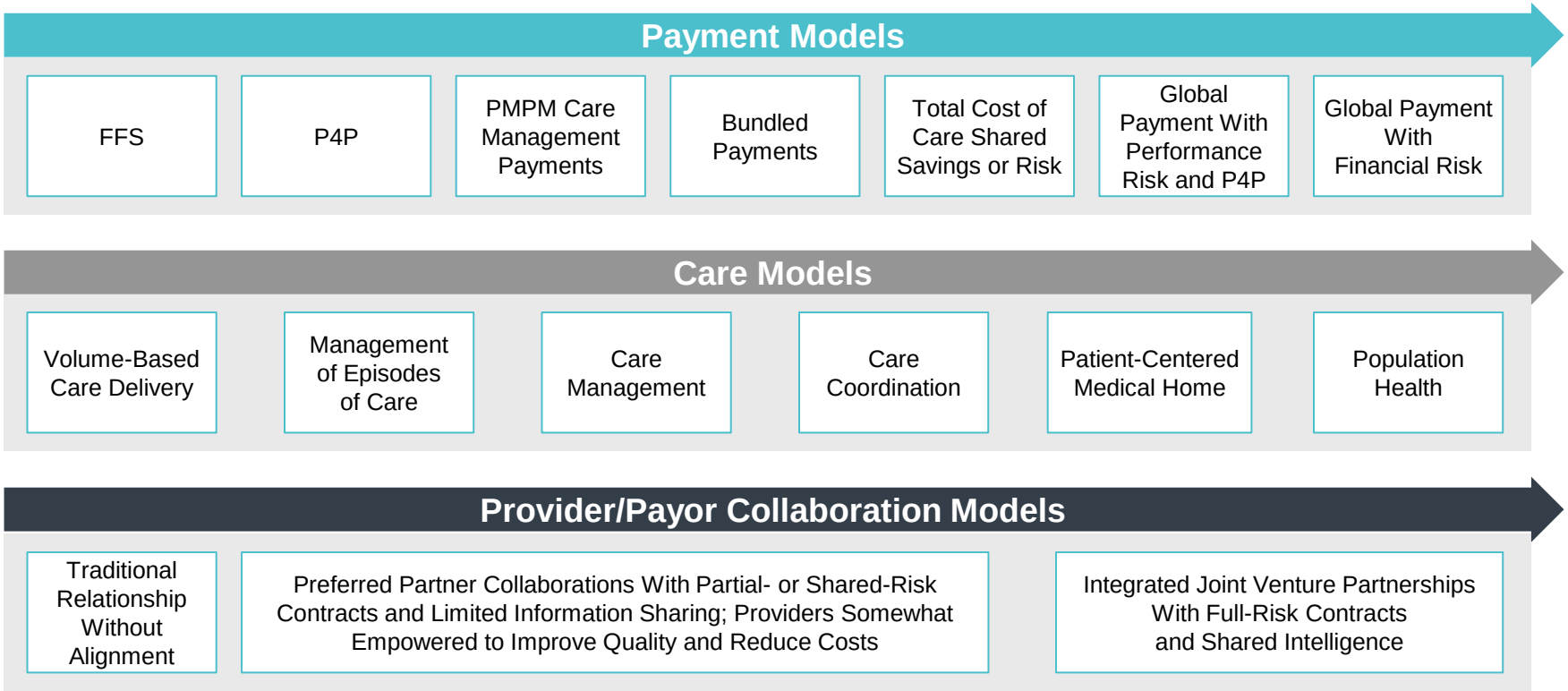
Source: *Health Affairs Blog,* Growth And Dispersion Of Accountable Care Organizations In 2015, *www.healthaffairs.org*.

II. Reimbursement Trends

FFS to Value

The impact of moving to value on a hospital's financials is largely dependent on the structure of the arrangement, whether it has transformed the delivery system to effectively manage and coordinate care, and whether it has systems to measure clinical and financial performance.

The Payment and Care Delivery Continuum Shifting Toward Risk — and Closer Partnerships



II. Reimbursement Trends

Provider Collaborations and Partnerships

As providers increase the amount of risk being shared with payors, further collaboration through innovative alignment models among providers has become a key element in both decreasing costs and improving overall health for a population.

ISSUE

- Growing Operating Costs
- Mounting Regulatory Mandates
- Declining Reimbursement
- Changing Payment Models

SOLUTION (to scale)

- » Increased collaboration
- » Horizontal integration
- » Vertical integration
- » Increased purchasing power
- » Coordinated services
- » Cost cuts

Clinical Affiliations

Regional Collaboratives

ACOs

Clinically Integrated Networks (CINs)

Mergers or Acquisitions

Source: AHA 2015 Environmental Scan.

II. Reimbursement Trends

Payor Consolidation: 2015 Megamergers

Context: the new 'Big Three"

Premiums controlled by leading plans

Rank	Company	Premium	%
1	UnitedHealth Group Inc.	$115,302,000	20.21%
2	Anthem Inc.	$68,389,300	11.99%
3	Aetna Inc.	$49,562,000	8.69%
4	Humana Inc.	$45,959,000	8.05%
5	Cigna	$27,214,000	4.77%
	Total Premiums for Health Insurance	$570,576,663	

Source: "State Insurance Regulation: Key Facts and Market Trends 2014". Company premium data extracted from 2014 Financial Statement.

By comparison, 4 airlines control over 80% of domestic flights:

Delta
United
American
Southwest

Consolidation in the insurance segment results in three firms potentially controlling 53% of total premium buys.

III. Payor/Provider Collaborations

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By the Headlines

In response to these market factors, we see the following happening: (1) providers and payors becoming one or (2) providers and payors choosing to work together.

Providers and Payors Becoming One (Vertical Integration)

How CHI is building and buying its own insurance plan
Could purchasing a payor now save money in the future?

***WSJ*: Why hospitals are launching insurance plans**
20% of hospital leaders intend to market an insurance plan.

UnitedHealthcare sets aside $5 billion for acquisition of physician practices

Providers and Payors Working Together (Integration Among Competitors)

Introducing Anthem Blue Cross Vivity (9/17/14)
Anthem Blue Cross partners with seven L.A. and Orange County health systems to launch Vivity, a new offering that uniquely aligns care.

Aetna and Inova Health System establish new health plan partnership in Northern Virginia (6/22/12)

Independence Blue Cross and DaVita HealthCare Partners announce joint venture (4/8/14)
Tandigm Health's innovative coordinated care model provides higher-quality care, lower costs.

New Philadelphia collaboration promotes innovation in healthcare (5/27/15)
Eight Philadelphia-area institutions are coming together in an initiative aimed at making the region a global leader in healthcare innovation.

UnitedHealthcare expanding telemedicine to reach 20 million members (5/15/15)

Across the country, 107 health systems now have a majority equity stake in a health plan.

III. Payor/Provider Collaborations

Two recent studies shed some light on provider-sponsored plans

Health Plan Alliance℠

Health Plan Alliance members manage risk. It is our business. And we are good at it. What is challenging is when we take on risk in a market where uncertainty and variability make it nearly impossible to anticipate with reasonableness the level of risk.

Dennis Bolin, Member Engagement/Chief Marketing Officer, Health Plan Alliance

From a recent study, the analysis yielded 3 primary findings:

- Provider-sponsored plans can be financially successful
- Core line of business can influence profitability with MA and Medicaid-focused plans performing well.
- Scale and tenure can boost profitability with many high performing plans having 100,000 or more members in their core line of business.

Source: "*Provider-sponsored health plans: positioned to win the health insurance market shift* Deloitte Development LLC, 04/12/2016

Here are five things to know about provider-led health plans, according to the report.

1. Between 2010 and 2014, the most recent year for which data is available, the number of providers offering health plans has steadily increased from 94 to 106.
2. Enrollment in provider-led plans grew to 15.3 million in 2014, up from 12.4 million in 2010. However, most provider-led health plans remain comparatively small in terms of enrollment. Only five healthcare providers owned plans that covered more than 500,000 lives in 2014.
3. Financial performance of provider-led plans remains mixed. Of the 89 plans analyzed for the report, more than 40 had negative margins in some or all of the past three years.
4. Like other insurance carriers, most provider-led health plans have struggled to achieve profitability in the individual market on the public exchanges.
5. Based on the study's findings, the authors concluded that although offering a health plan may be an attractive opportunity for some systems, it is not without risk.

McKinsey study as reported in *Becker Hospital Review*

IV. Narrow Networks

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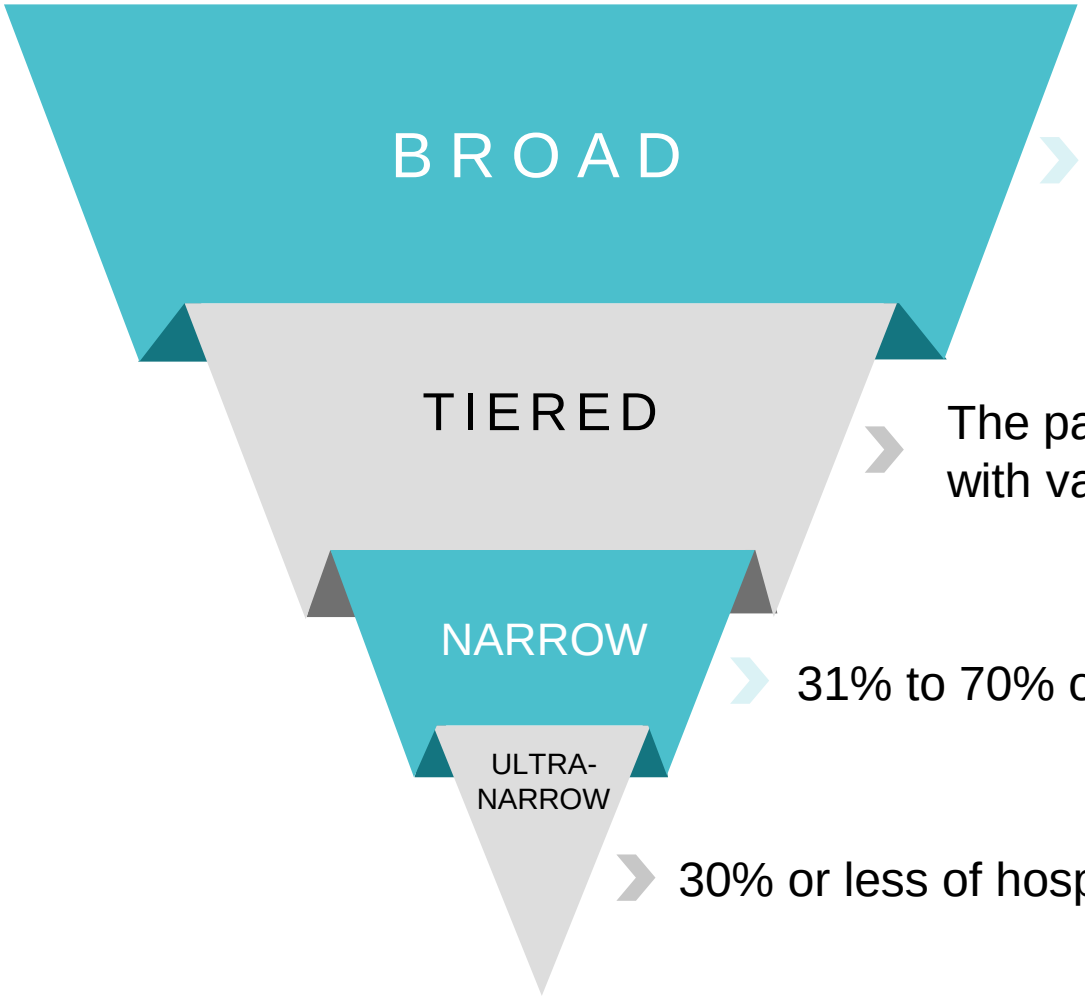
Definition

McKinsey defines network breadth by the percentage of hospitals that participate in the network.



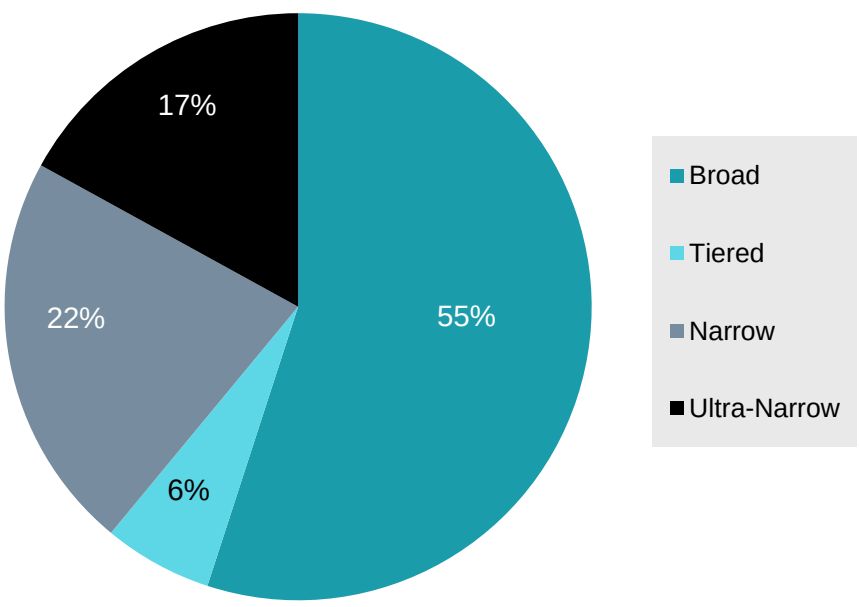
- More than 70% of all hospitals in a rating area participate.
- The payor has hospitals in different tiers with varying coinsurance rates.
- 31% to 70% of hospitals participate.
- 30% or less of hospitals participate.

IV. Narrow Networks

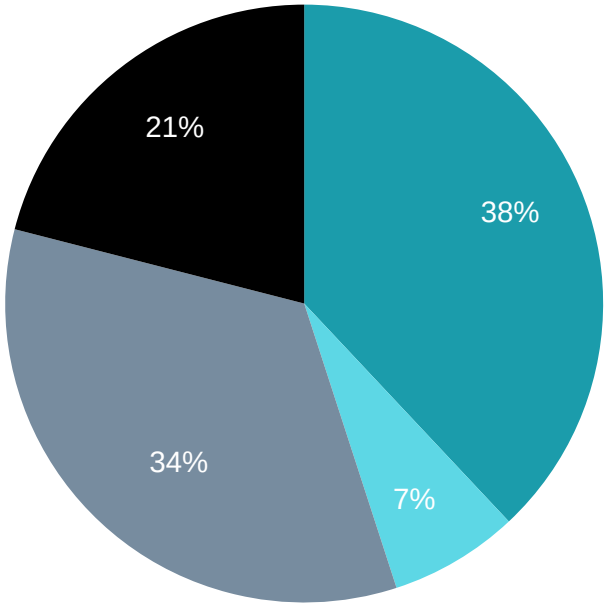
Prevalence — Health Insurance Exchanges

Narrow networks are occurring most frequently in the health insurance exchange market. In 2015, nearly half of the networks for plans were narrow, ultra-narrow, or tiered. Narrow networks are especially common in urban areas.

Types of Networks for Exchange Plans
Nationwide; n=2,864



Types of Networks for Exchange Plans
Largest City in Each State; n=372



The average exchange plan network includes 34% fewer providers than the average off-exchange commercial plan.[1]

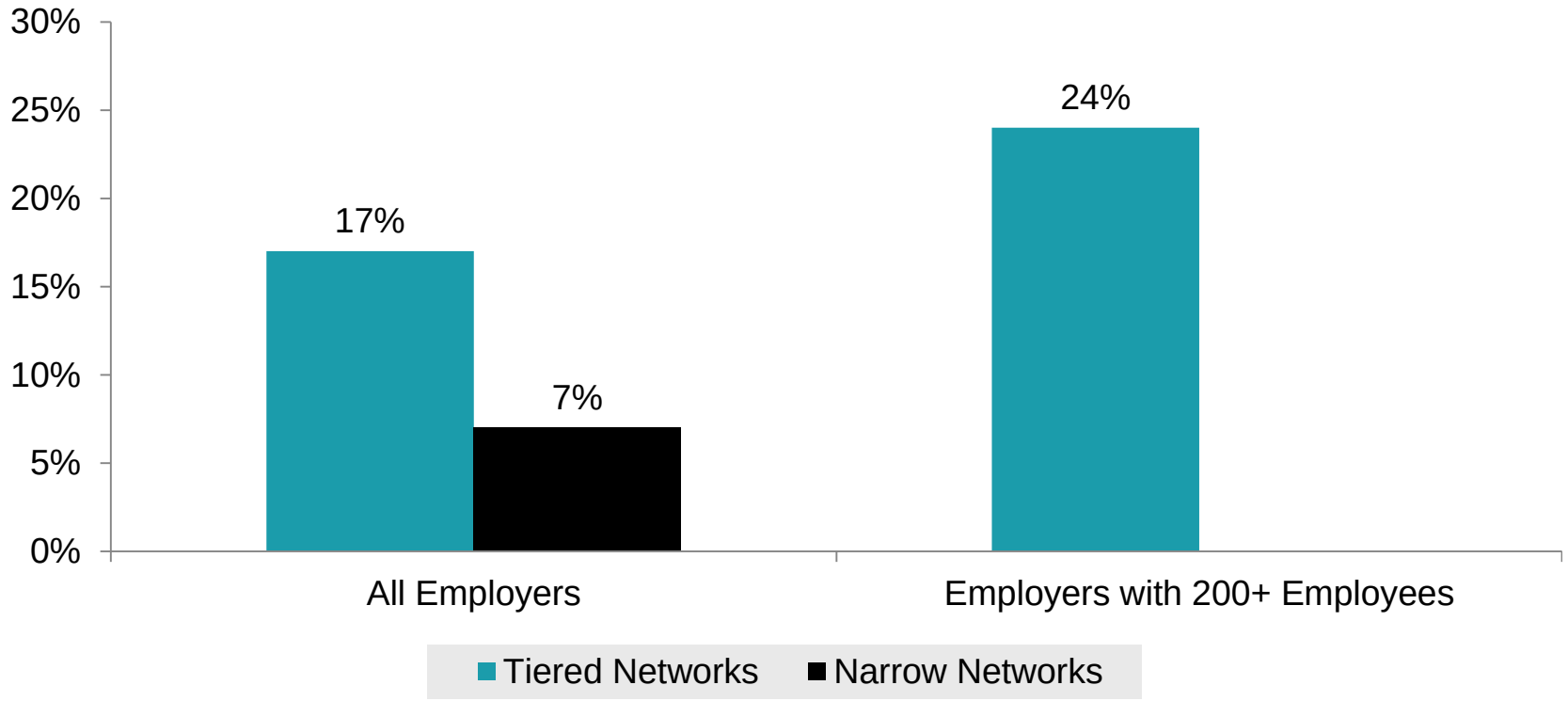
[1] Source: Avalere Health, "Network Design: Trends in Tiered and Narrow Insurance Networks," October 2015.

IV. Narrow Networks

Group Market

In the group market, tiered networks are more common than narrow networks because employers generally need more geographic coverage than individuals.

Percentage of Employers Offering Tiered- or Narrow-Network Health Plans[1]



[1] Source: Avalere Health, "Network Design: Trends in Tiered and Narrow Insurance Networks," October 2015. Available online at *http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1444082614_AH_Tiered_Network_White_Paper_v3.pdf.*

IV. Narrow Networks

Considerations for Providers

DON'T ASSUME VOLUME INCREASES

» Negotiate exclusivity, volume corridors, or shared savings in exchange for narrow network rate concessions.

OFFER APPROPRIATE RATE CONCESSIONS

» The right concession will depend on the circumstances.
» 10%–20% is typical.
» Providers may also negotiate more at-risk dollars in lieu of concessions or choose to opt out.

UNDERSTAND SUBSIDIES

» Collections may be easier for highly subsidized commercial members (e.g., people recently off Medicaid) than for less subsidized beneficiaries.
» Therefore, larger rate concessions may be appropriate for highly subsidized populations.

BEWARE OF REVERSE-ADVERSE SELECTION

» Healthy people—i.e., those who don't need much healthcare—tend to choose narrow networks.
» Healthy patient populations can lead to negative revenue adjustments in value-based contracts.

Regionally ranked hospitals are participating in fewer exchange plans, which tend to include narrow networks.

V. Questions and Discussion

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Answers to Key Questions

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