The Provider/Payor Convergence in Care Transformation

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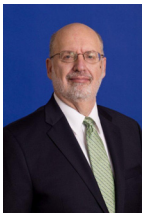

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Introduction & Overview

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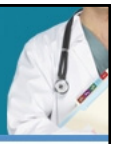
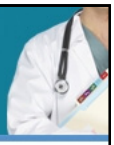
CARE TRANSFORMATION



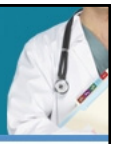
- Economics of Health Care Require a New Approach
- Participants in Health Care Recognize Compelling Need for Change in Care Delivery
- Not Whether, But When
- Result of Supreme Court and 2012 Presidential Election Do Not Matter on Care Transformation
- Financial Arrangements Are Critical

CARE TRANSFORMATION



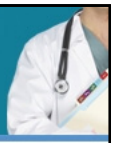
- Moving Away From Volume Based, Fee-for-Service Payment to System Paying for Value and Outcomes
- Triple Aim: Restrain Cost Increases and Achieve Better Quality for Populations and Individuals
- How to Get From Where We Are To Where System Needs to Be?
- How Will the Principal Commercial Players (Providers and Payors) Act and React?

Provider/Payor Convergence



- Today: Providers and Payors Converge (Meet) in Managed Care Contracting
  - Negotiating Contracts
  - Who Are Network Participants
  - How is Reimbursement Structured
  - Term. Covered Services. Other Common Contract Issues.

Provider/Payor Convergence (cont'd)



- What are Pressures Driving Transformation for Providers and Payors?
- What New Contracting Approaches Will Be Used?
- What New Provider/Payor Structures and Relationships Will Develop?

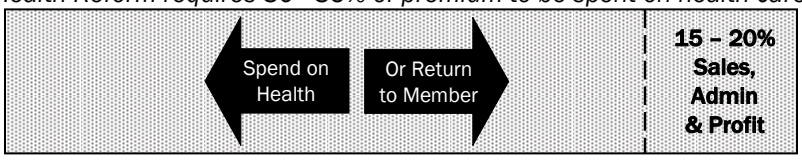
What is Driving Convergence?

- Pressures:
  - Less Reimbursement for Providers
  - Intense Private Sector Rate/Cost Pressure
  - Emphasis on Efficiency
  - Emphasis on Controlling Care Delivery
  - Elimination of Waste
  - Continuing Need for More Volume
  - Insurance Exchanges
  - Sense that Change is Coming – Better Get Ready

Pressures Driving Convergence

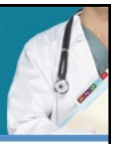
The Medical Loss Ratio Requirement Is Driving Convergence

Health Reform requires 80 - 85% of premium to be spent on health care



- **Insurers will be required to spend a minimum of 80 to 85% of premium on health care costs**
- **If they under-spend, the balance must be refunded to individual members**

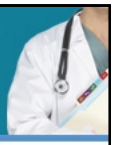
Contracting Changes



As Care Transforms –

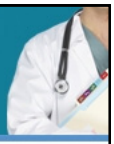
- New Contracting Between Providers and Payors
  - Changes in Contract Reimbursement
    - Shared Savings
    - Bundled Payments
    - Payment for Quantity
    - Pay For Performance
    - Medical Home Payments
    - More Shared Risk

Contracting Changes



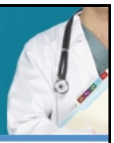
- Changes in Other Contracting Strategies
  - More Data Sharing
  - More Steerage to Limited Networks
  - More Member “Skin in the Game”
  - Rewards/Incentives for Healthy Lifestyle Choices
  - More Price Transparency
  - Disease/Care Management Programs
  - Mid-Level Navigators

New Structures/Relationships



- Also New Structures and Different Relationships
  - Joint Ventures
  - Private Label Products
  - Staff Model HMO's
  - More Consolidations

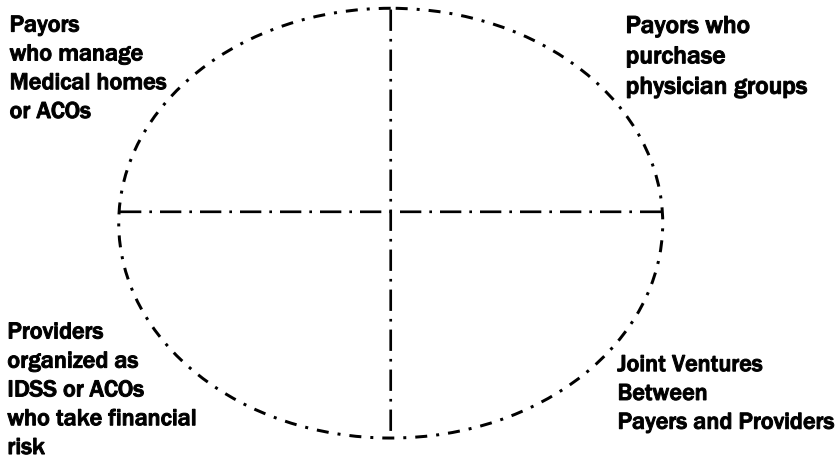
New Structures/Relationships



- Partnerships in New Businesses
  - Humana Buys Concentra
  - United Buys Monarch
  - Wellpoint Buys CareMore
  - Highmark Buying West Allegheny
  - Providers Taking Risk
  - Davita Buys Primary Care Group

Convergence: Blurring the Lines Between Payor and Provider

Creating new competitors



Convergence

Presentation Today –

- Deeper Exploration of Convergence
- What is Happening?
- Why is it Happening?
- Is it Just a Trend or Sign of Long-Term Change?

Provider Perspective

Presented By:
Henry Miller, Ph.D.
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Questions to Consider

- What do we mean by provider/payer convergence?
- Why take the initiative?
- Why take the initiative now?
- Can a provider be successful when it takes on payer activities?
- What decisions need to be made?
- What does a provider need to do better to be successful?
- What are the risks?
- What are the rewards?

What is Provider/Payer Convergence and Why Do It?

- Provider/Payer convergence means:
  - Increasing control over the financing of healthcare
  - Assuming payer-type risk and (hopefully) sharing payer-type rewards
- A provider takes on more risk to gain greater control
  - Greater control is critical in a time of declining reimbursement and threats to financial survival
  - Control over both reimbursement rates and the delivery of care can be increased
  - There are rewards also – 15 percent of payers' premium dollars are used for administration and profit – providers can get a piece of these dollars

Why Take the Initiative Now?

- Some history:
  - After passage of the HMO Act of 1973, several hospitals created HMOs – most failed
  - Activity accelerated for a time in 1990s as PHOs were organized, but slowed as the experience of the 1970's was repeated
- Today, there is greater opportunity for hospitals to partner with insurers and to pursue new models like ACOs
- Health reform and environmental change have created opportunities:
  - Medical loss ratio requirements in PPACA are encouraging health plans to find partners to share risk
  - Health insurance exchanges are opening up new markets
  - Funding is available for IT/EMRs and health information exchanges – the heart of improving care coordination
  - PPACA encourages the development of ACOs
  - There is a generational shift in the physician community
  - Financing is somewhat more readily available
  - Providers are more experienced with managed care, capitation and coordination of care
  - There is a public mandate to control costs and improve quality

Successful Hospital-Based Payers

- There are several hospital-based payers that can provide insights into independent approaches to merging provider and payer activities:
  - Geisinger – Eastern Pennsylvania system with seven general acute care hospitals and three specialty hospitals (Built an especially effective care management approach that truly merges provider and payer goals)
  - UPMC – Western Pennsylvania system with twelve general acute care hospitals and three specialty hospitals (Took advantage of Medicare and Medicaid managed care opportunities to support development of commercial base)
  - Sentara – Coastal Virginia system with ten general acute care hospitals and one specialty hospital (Initially took advantage of proximity to military bases in Norfolk/Hampton Roads, VA)
  - Presbyterian - New Mexico system with eight general acute care hospitals (Took advantage of weak insurance competition to create own insurance entity)

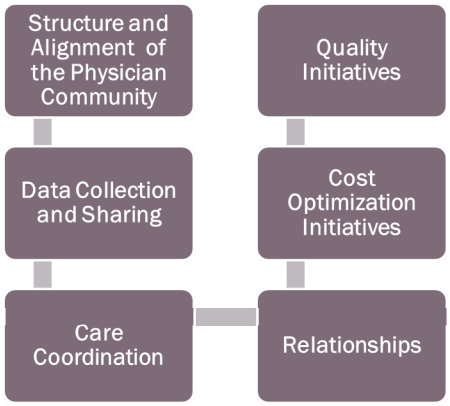
What Decisions Need to be Made?

- There's considerable discussion about the "Triple Aim" of healthcare:
  - Manage per capita cost
  - Improve population health
  - Improve the patient experience
- Providers that pursue provider/payer convergence have their own Triple Aim:
  - Financial survival
  - Better hospital/physician alignment
  - Reputation enhancement
- Decisions:
  - Go it alone or partner with a payer?
  - Sufficient financial and patient base to absorb risk? How much risk would you take?
  - Resources and skills to be successful?

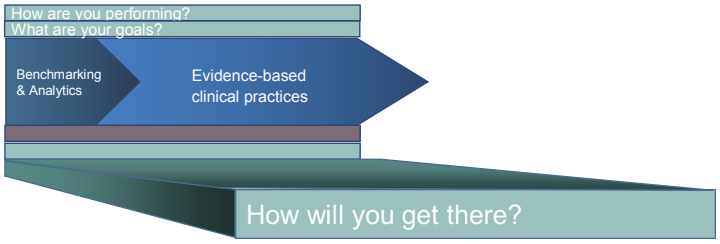
Needed for Success

- Providers need to do several things better to be successful:
  - Focus on population-based and patient-centered care
    - Population-based care requires addressing health risks and preventive care and improving chronic care
    - Patient-centered care requires care coordination
  - Stronger hospital/physician relationships are critical
    - Evidence-based care is a real issue
    - Physicians' objectives and hospital's objectives must be aligned
  - Avoidable costs need to be reduced
    - Readmissions need to be controlled
    - Prometheus should be investigated
  - Data sharing is a priority
    - EMRs are critical to successful care coordination
    - Involvement in Health Information Exchanges is also needed
- Two areas deserve special attention – physician alignment and care coordination

Physician Alignment



Assessing Care Coordination



Risks and Rewards

- The financial risk of going it alone is daunting – do you want to "bet the farm"?
  - Use of a health plan partner limits financial risk, but also limits control and scope of effort
- Other risks:
  - Potential adverse selection
  - Increased regulation
  - Diminished reputation
  - Diminished physician support
- Rewards:
  - Increased financial stability
  - Increased control
  - Greater independence

Payor Perspective

Presented By:
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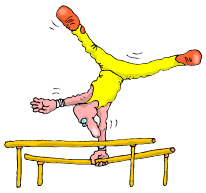
What is "convergence"?

- Paths are no longer parallel
- A new, common agenda is forged
- Payor and provider goals more aligned



Why converge with a provider?

- Diversification
- Health care reform
- Rising cost of care
- Solidify networks
- Customer demands

Examples of convergence

- Payor/provider convergence takes place through acquisitions and other relationships
  - Humana
    - Concentra acquisition
    - Norton Healthcare ACO (KY)
  - United/Optum
    - ACO with WESTMED Medical Group (NY)
    - Monarch Healthcare acquisition (CA)
    - Sharp Healthcare branded Medicare Product (CA)

Examples of convergence (cont.)

- Highmark
  - Acquisition of West Penn Allegheny Health System (still pending)
  - Affiliation with Premier Medical Associates
- WellPoint
  - CareMore acquisition
  - CA ACO pilots with HealthCare Partners and Sharp Healthcare

Examples of convergence (cont.)

- Other payor/provider created ACOs
  - Aetna: Banner Health in AZ
  - Blue Shield of CA: Hoag Memorial and Greater Newport Physicians; John Muir Health
  - Blue Cross Blue Shield MI: Trinity Health
  - Cigna: Granite Healthcare Network; Weill Cornell Physician Organization in NY, and Cigna Fairfax Family Practice Centers in VA
  - Wellmark Blue Cross Blue Shield of Iowa: Genesis HealthSystem ACO; Iowa Health

Examples of convergence (cont.)

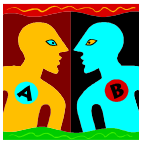
- Other models
  - Blue Cross Blue Shield NC and UNC Health Care - Carolina Advanced Health
  - United's NOW clinics
  - Blue Cross Blue Shield and Humana retail clinics in Florida
  - United's agreement with BioIQ for home screening kits
  - WellPoint's focus on PCPs with patient centered primary care initiative

Data and analytics are critical

- Data drives a successful convergence
  - Providers need data to deliver coordinated and targeted care
  - Payors are entering the external data analytics business
    - Optum's Accountable Care Solutions
    - Humana acquires Anvita Health

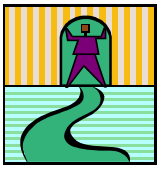
Convergence with a competitor

- What happens when a provider converges with your competitor?
  - Optum's acquisition of Monarch Healthcare in Southern CA
    - Reactions of Anthem Blue Cross and Blue Shield of California: Divergence!
  - Need for defensive contract language



The new path brings challenges

- New legal and operational challenges for insurers entering the provider space
  - Medical malpractice
  - Clinic licensure
  - Practitioner licensure
  - Corporate practice of medicine
- At the same time, opportunities for support services firms



Will we survive convergence?

- The big question:
  - Is there a future for both of us?

Insurer–Provider Convergence: Where Does It All Lead?

Presented By:
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Agenda

- ***Ready***: What are the current drivers of insurer-provider convergence?
- ***Aim***: What does convergence mean for providers and health insurers right now?
- ***Fire***: What will convergence mean for providers and health insurers someday?

Ready: What are the current drivers

- *Providers: Life Can't Go On Like This....*
  - *Revenues Down*: Declining reimbursement across the board, and Medicare and Medicaid populations will only increase = longer hours for same pay, or same hours for less pay
  - *Expenses Up*: Increasing capital needs for technology and integration capabilities
  - *Changing Attitudes*: 46% of physicians expressed interest in employment and 71% of hospitals report an increase in requests for employment(1)
  - *Changing Payor Expectations:* Market moving to emphasis on quality alignment, care coordination, and prevention

(1) – "Physician Alignment in an Era of Change," HealthLeaders Media/Intelligence, September 2010

Ready: What are the current drivers

- *Insurers: Who Knows What Life Will Bring, So Position, Position, Position … and Profits*
  - *Positioning*: Hospitals have a head start
    - In 2007, 61% of physician practices were physician-owned and 34% were hospital-owned(1)
    - In 2010, that flipped: 39% were physician-owned and 55% were hospital-owned.(2)
  - *Positioning*: PCP's are already in short supply and shortage will become even more acute in 2014; try to preserve access for members

(1) MGMA Physician Compensation and Production Survey: 2007 Report based on 2006 data

(2) MGMA Physician Compensation and Production Survey: 2010 Report based on 2009 data

Insurers (cont'd)

- *Positioning*: Changing cost trend is key to profitability, changing provider behavior is key to changing cost trend, and managing providers directly may be key to changing behavior.
- *Positioning*: Vehicles for building market share in target markets and for leveraging the best practices of certain targeted groups.
- *Positioning*: The value/quality/prevention paradigm means provider systems will be taking on more risk, and insurers have the tools providers need to take on risk, i.e., actuarial tools, performance analytics, claims data, etc.

Insurers (cont'd)

- *Profits*:
  - MLR rules require insurers to spend 80-85% of premiums on claims.
  - Must squeeze profit out of remaining 15-20%
  - Convergence is a way to still get a piece of the other 80-85%

Aim: What Does it All Mean Now?

- Convergence not dependent on PPACA
  - Macro-economic forces driving paradigm shift from volume-based, sickness model to value-based, prevention model *not* likely to go away.
  - A health system this high in cost and this low in overall quality is simply too ripe for market disruptors not to develop, regardless of PPACA.
  - "Great Recession" affecting priorities of the consumer, i.e., choice still matters, but access and affordability just as important/more important?

Aim: What Does it All Mean Now?

- But with PPACA, convergence is accelerated, fluid and a high-stake proposition
  - If 30 million more insureds are coming on-line in 2014, providers and insurers are compelled to visualize and create their strategies/platforms now (or yesterday)
  - Questions abound, e.g., what will employers do, what will individuals do, where will the caregivers come from, where will the insureds come from, where will the capital come from, what should our strategy be…?
  - Convergence is a capital-intensive proposition and making expensive bets in an unstable environment is a high-stakes game

Aim: What Does it All Mean Now?

- Insurers and providers must decide how to play the integration paradigm from a convergence perspective
- Capital, capital, capital!
  - Different convergence strategies will drive different levels of cap needs, but obviously those with capital to deploy are best prepared to navigate paradigm shift.
  - Sufficient capital is simply your driver's license; when and how and where capital is deployed is your steering wheel, and the road ahead is under construction and enshrouded by fog.

Fire! – What Does It Mean Someday?

- Before offering my theory of what it all means, here's why it could still mean very little or something else entirely....
  - Election and SCOTUS could reverse PPACA and/or drive meaningful entitlement reform
  - An economic recovery could relieve the immediate economic pressures driving convergence and other macro changes
  - The Law of Unintended Consequences:
    Intervention + Complex System = Ooops!
    (ignorance, error, immediate interest, basic values, and/or self-defeating prophecies)

Fire! – What Does It Mean Someday?

- To tee up my theory, allow me to submit some propositions for your consideration:
  - Any model designed simply to squeeze costs out of existing system ultimately will;
  - Once all easy costs are squeezed, maybe some last few drops can be squeezed;
  - After the last few drops are squeezed, there can't be any more juice.

Therefore, "shared savings" and every other payment scheme designed merely to trim costs from the existing system can't continue.

Fire! – What Does It Mean Someday?

- Submitted for your consideration:
  - Payment models designed to reward "inputs" will result in more inputs (in order to generate more rewards);
  - Even if you only reward "good" or "smart" inputs, you are still rewarding *more* inputs (though they might be more worthy too).

<u>*Therefore*</u>, any payment plan based solely on addressing inefficiencies in current fee-for-service payment methodologies can only slow growth of spending. It can't reverse the trend.

Fire! – What Does It Mean Someday?

- Submitted for your consideration:
  - Due to the complexity of health care and imbalance of information, regardless of transparency efforts, beneficiaries will never have sufficient information to evaluate provider quality effectively;
  - If beneficiaries have freedom of choice of providers, they will always choose "brand" providers unless the economic "pain" tips the balance;
  - For more serious health issues, the degree of economic pain necessary to change beneficiary behavior is such that our society will not tolerate the resulting perceptions of inequality and lack of distributive justice;

<u>*Therefore*</u>, either beneficiary choice must be eliminated or the benefits of being a "brand" provider must be eliminated.

Fire! – What Does It Mean Someday?

- Submitted for your consideration:
  - Jury may be out on whether care management for episodic acute needs is more cost effective than management of whole person (preventative care), at least with small and mobile populations;
  - It is hard to argue that some preventative care can't prevent some chronic disease (though, again, evidence is lacking due (perhaps) to lack of proper population studies);
  - For an organization to manage a global budget effectively, it will need sufficient volume of covered lives in order to absorb outliers and capture benefits of statistically-significant trends of overall health improvement;
  - For an organization to manage total cost of care, as opposed to episodic care, it will need to control larger population and control that population over longer periods of time.

Therefore, assignment of beneficiaries will need to be in very large (likely larger than the 5,000 Medicare SSP numbers – perhaps 60,000-100,000) and beneficiaries will need to be locked in;

AND

Therefore, provider networks will need to grow in size and scope.

Fire! – What Does It Mean Someday?

- If you agree with those propositions, then:
  - "Shared savings" and every other payment scheme designed merely to trim costs from existing system won't continue.
  - Payment plans alone won't be able to meaningfully address inefficiencies in current fee-for-service system.
  - Either beneficiary choice must be eliminated or the benefits of being a "brand" provider must be eliminated.
  - Assignment of beneficiaries will be in very large numbers.
  - Provider networks will grow in size and scope.

Fire! – What Does It Mean Someday?

- And if you agree with those propositions, then:
  - Final system will be a small number of extremely large, regional provider networks.
  - Providers will begin taking the full risk of their populations, and their brands (not the insurers) will be the face of the industry to the consumer.
    - With provider networks and populations that large, why cede the risk margin to insurers? With risk margins so small and heavily regulated (some portion of 15-20%), why be a health insurer?

Fire! – What Does It Mean Someday?

- Insurers will morph into a business process outsourcing focus (think IBM), increasingly becoming service providers to
  - The larger provider networks that will increasingly take on the financial risk of health care delivery.
  - The employer-customers who previously purchased insurance products from the industry.
  - The federal and state governments in their continuing role as payers.

Q & A Session

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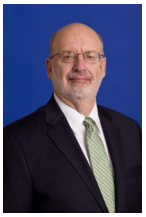

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