Provider-Sponsored Health Plans

November 2013
Learning Objectives

> Understand the reasons why a provider-sponsored plan may make sense for an organization
> Understand the key capabilities required to implement and manage a provider sponsored plan
> Learn the 4 ways to acquire the expertise and the pros and cons of each
Change is Coming…Or is Here in Some Cases

Massive Shift in Payment Models

- 2010: 22% P4P / Full Risk Bearing / ACO, 78% Fee-for-Service
- 2015: 53% P4P / Full Risk Bearing / ACO, 47% Fee-for-Service
- 2020: 80% P4P / Full Risk Bearing / ACO, 20% Fee-for-Service

Source: Oliver Wyman

Likelihood of Hospitals Gaining Payer Capabilities in the Next 5 Years* (N=192)

- Source: L.E.K. interviews and the L.E.K. Strategic Hospital Priorities Study 2012

Bed Count

<100 100-299 300-499 >500

Percent of Respondents

Likelihood Scale:
- 1 - Not likely at all
- 6 - Very likely

Mean
Provider-Sponsored Plans as part of the Value-Based Spectrum

Value-Based Care $\equiv$ \(\text{(Access + Quality = Outcomes)}\)

Cost

VALUE-BASED DELIVERY SPECTRUM

- P4P
- PCMH
- CLINICAL INTEGRATION
- SHARED SAVINGS
- BUNDLED PAYMENTS
- SHARED RISK
- CAPITATION FULL RISK
- PROVIDER-SPONSORED PLANS

Financial Opportunity & Incentive Alignment
Plans Span the Country

Likely over 100 plans in operations today
Why Value-based Care

- Strengthen relationships with physicians
- Protect or enhance market share/position
- Increased control of network usage
- Financially benefit from bending cost curve
- Not as financially risky as it seems
- Refocus mission to population management from acute episodes
- Advance / accelerate quality initiatives
Why Provider-Sponsored Plans?

- **Mission**: Can impact what care is delivered and how it is delivered.
- **Market Share**: Can significantly affect market share.
- **Alignment**: Incentives are fully aligned around quality, costs and coordination.
- **Quality**: Providers in charge. Provider sponsored plans more efficient and effective.\(^1\)
- **Broader sphere of influence**: Affect care for patients not receiving care at facility
- **Alternative revenue stream**: Generate revenue beyond care delivery.
- **First Dollar control**: Delivery organizations will be in charge of clinical care and not be financially dependent on non-care giving entities
- **Lower costs**:
  - 30-40% of all medical expense is waste.\(^2\)
  - 75% of total medical costs are for preventable conditions.\(^3\)
  - 31% healthcare is administrative cost

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**Different Approach By Business Line**

- **Hospital**
  - Specialists
  - Primary Care
- **Employees**
  - Medicare
  - Medicaid
- **Commercial**
  - Shared Risk
  - Full Risk
  - Health Plan

Source: 1) Commonwealth Fund. 2) Institute of Medicine reports. 3) CDC 4) Richard Clarke, Wall Street Journal
Why Provider Sponsored Plans – A Story
### Why Provider Sponsored Plans – A Story

![Image of a baby in medical equipment]

<table>
<thead>
<tr>
<th></th>
<th>Before</th>
<th>After</th>
<th>Net</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Birth hospital</strong></td>
<td>84,244</td>
<td>553,479</td>
<td>469,235</td>
</tr>
<tr>
<td><strong>Transport (staff only)</strong></td>
<td>22,199</td>
<td>-27,222</td>
<td>-49,421</td>
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<tr>
<td><strong>Tertiary (NICU) hospital</strong></td>
<td>958,467</td>
<td>209,829</td>
<td>-748,638</td>
</tr>
<tr>
<td><strong>Delivery system total</strong></td>
<td>1,064,910</td>
<td>736,086</td>
<td>-328,824</td>
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</tbody>
</table>

Source: Dr. Brent James, Intermountain health. HFMA ANI 2012
## Economic Example

### Startup

<table>
<thead>
<tr>
<th>Category</th>
<th>Build</th>
<th>Rent and Outsource</th>
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<tbody>
<tr>
<td>Implementation</td>
<td>$500,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>Claims Platform</td>
<td>$15,000,000</td>
<td>$15,000,000</td>
</tr>
<tr>
<td>Staff - comp, facility</td>
<td>$3,500,000</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>Legal/Consulting</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Other</td>
<td>$500,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>Outsourced Partner</td>
<td></td>
<td>$2,000,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$20,500,000</strong></td>
<td><strong>$5,500,000</strong></td>
</tr>
<tr>
<td>Risk Based Capital</td>
<td>$15,000,000</td>
<td>$15,000,000</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$35,500,000</strong></td>
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</table>

### Ongoing Financials

<table>
<thead>
<tr>
<th></th>
<th>Build PMPM</th>
<th>Annual*</th>
<th>Rent and Outsource PMPM</th>
<th>Annual*</th>
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<tbody>
<tr>
<td><strong>Total Premium</strong></td>
<td>$150.00</td>
<td>$180,000,000</td>
<td>$150.00</td>
<td>$180,000,000</td>
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<tr>
<td>Medical Costs</td>
<td>$132.00</td>
<td>$158,400,000</td>
<td>$132.00</td>
<td>$158,400,000</td>
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<tr>
<td>Ops</td>
<td>$4.25</td>
<td>$5,100,000</td>
<td>$3.75</td>
<td>$4,500,000</td>
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<tr>
<td>Admin/ Med. Mgmt</td>
<td>$8.50</td>
<td>$10,200,000</td>
<td>$6.50</td>
<td>$7,800,000</td>
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<tr>
<td>Premium Mgmt</td>
<td>$3.00</td>
<td>$3,600,000</td>
<td>$3.00</td>
<td>$3,600,000</td>
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<tr>
<td>Profit</td>
<td>$2.25</td>
<td>$2,700,000</td>
<td>$2.25</td>
<td>$5,700,000</td>
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</table>

* Assumes 100,000 members
## Economic Realities

<table>
<thead>
<tr>
<th>Plan</th>
<th>Type</th>
<th>State</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>Total</th>
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<tbody>
<tr>
<td>Geisinger Health Plan</td>
<td>Commercial</td>
<td>PA</td>
<td>14.0%</td>
<td>10.7%</td>
<td>1.5%</td>
<td>5.0%</td>
<td>4.5%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Health First Health Plans</td>
<td>Commercial</td>
<td>FL</td>
<td>4.5%</td>
<td>-0.2%</td>
<td>0.6%</td>
<td>4.5%</td>
<td>5.5%</td>
<td>2.9%</td>
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<tr>
<td>Providence Health Plans</td>
<td>Commercial</td>
<td>OR</td>
<td>6.6%</td>
<td>4.7%</td>
<td>2.1%</td>
<td>-1.1%</td>
<td>0.5%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Gundersen Lutheran</td>
<td>Medicare Advantage</td>
<td>WI</td>
<td>2.9%</td>
<td>1.7%</td>
<td>1.4%</td>
<td>1.3%</td>
<td>1.3%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Providence Health Plans</td>
<td>Medicare Advantage</td>
<td>OR</td>
<td>10.0%</td>
<td>10.1%</td>
<td>8.7%</td>
<td>9.9%</td>
<td>7.3%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Dean Health Plan</td>
<td>Medicare Advantage</td>
<td>WI</td>
<td>1.0%</td>
<td>0.0%</td>
<td>-8.0%</td>
<td>-6.6%</td>
<td>5.3%</td>
<td>-1.5%</td>
</tr>
<tr>
<td>Driscoll Children’s Plan</td>
<td>Medicaid</td>
<td>TX</td>
<td>-20.5%</td>
<td>-9.2%</td>
<td>12.4%</td>
<td>-0.2%</td>
<td>6.8%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Health Plan of CareOregon</td>
<td>Medicaid</td>
<td>OR</td>
<td>5.7%</td>
<td>6.9%</td>
<td>19.5%</td>
<td>7.5%</td>
<td>3.7%</td>
<td>8.5%</td>
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<tr>
<td>Children’s Mercy’s Family Health Partners</td>
<td>Medicaid</td>
<td>MO</td>
<td>1.2%</td>
<td>7.8%</td>
<td>12.9%</td>
<td>6.0%</td>
<td>3.1%</td>
<td>7.0%</td>
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<tr>
<td>Texas Children’s Health Plan</td>
<td>Medicaid</td>
<td>TX</td>
<td>4.90%</td>
<td>-1.80%</td>
<td>2.80%</td>
<td>1.90%</td>
<td>7.00%</td>
<td>3.30%</td>
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<tr>
<td>Mdwise</td>
<td>Medicaid</td>
<td>IN</td>
<td>0.2%</td>
<td>2.2%</td>
<td>1.5%</td>
<td>1.1%</td>
<td>0.4%</td>
<td>1.2%</td>
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<tr>
<td><strong>Average</strong></td>
<td></td>
<td></td>
<td><strong>2.5%</strong></td>
<td><strong>3.5%</strong></td>
<td><strong>5.3%</strong></td>
<td><strong>2.7%</strong></td>
<td><strong>3.8%</strong></td>
<td><strong>4.0%</strong></td>
</tr>
</tbody>
</table>

Source: Compiled from publicly available financial statements that are submitted and available by the NAIC.
Coincidence? Provider-Sponsored Plans Lead The Way on Medicare Advantage Plan Quality

Number of 5-Star Rated Medicare Advantage Plans
Based on Part C Summary Ratings by CMS
2012 - 2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Provider Sponsored</th>
<th>Traditional</th>
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</thead>
<tbody>
<tr>
<td>2012</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>2013</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>2014</td>
<td>9</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: CMS Part C and D Performance Data: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html
Haven’t we seen this movie before

- First round in 1980s and 1990s
- Some successes, but many failures
- Challenges
  - Lack of expertise
  - “Wrong” people in charge
  - Bad deals from the outset
  - Lack of data
Why this time is different

> Data

> Affordable Care Act

> Expertise

> Technology

> Cost Pressures creating imperative
  • Macro at the country level
  • Micro at the provider lever

> Consumer Driven Healthcare
Making the Decision

- Mission and Goals
- Risk Tolerance
- Market Position
- Balance Sheet Impact
- Brand identification
- Payer pitfalls
Required capabilities

- Customer Service
- Invoice Management – Group/Broker
- Utilization Management – moderate pre-cert program
- Case & Disease Management – Complex Case Management
- Claims Management – adjudication, audit, recovery, mail
- Eligibility Management
- Data Integration – Trading partners
- Finance and Accounting
- Analytics and Reporting
- Provider Relations and Network Management
- Compliance
- Marketing
- Community Relations
- Quality Management
Options to Move Forward

**Buy**
- Acquire operating assets

**Partner**
- Formally partner with an existing plan

**Build**
- Start a health plan from the ground up.
- Likely a mix of internal and vendor provided operations

**Rent / Outsource**
- Work with reputable services firms
- Customize services to match need
- A la Carte approach or Total Outsource
Tactical Steps to Provider-Sponsored Plans

1. Develop Risk-based strategy
2. New Organization Formation
3. Network Development
4. Licensure
5. Build/Buy/Rent/Outsource Operations
6. Implementation
   1. Provider Relations/Network Development
   2. Plan Design
   3. Marketing/Sales Plan
   4. Care Management
   5. Operations
   6. Financial Planning and Reporting
   7. Technology Systems
7. Operate
Assessment and Business Case

Options

Provider-Sponsored Plan
Full Risk
Shared Risk
Shared Savings
P4P

Physician Alignment
- MDs in leadership; Strong PCPs
- Emerging PCP alignment; No PHO
- Little PCP connection

Market Position
- Dominant market leader
- Market leaders, but competition
- Not market leader

Payor Readiness
- Dominant payers in risk contracting
- Payers with limited risk contracting experience
- Adversarial relationships

Organization & Leadership
- Strong executive alignment
- Consensus-based leadership
- Divided leadership

Care Continuum
- Owned and tightly contracted SNFs
- Loose affiliations with SNF, LTC, HC
- No management or ownership

Health IT
- All on common platform
- Most on EMR, limited connectivity
- Limited EMR, no connectivity

Financial Position
- Strong balance sheet, growing revenue
- Strong balance sheet; flat revenue
- Weak balance sheet; shrinking revenue

Expertise
- Current experience in risk management
- Past experience in risk
- Little or no risk experience

Valence Health
Provider Recruitment and Relations

- Provider network is required to submit for a Certificate of Authority to the Department of Insurance
- Map your network by type, location and specialty.
- Create contract templates – need legal assistance
- Credentialing processes
- Committee Structure – physician involvement
- Compensation Program
  - Physicians
  - Hospitals
  - Other
Operations

> Claims Processing
> Member Customer Services
> Provider Relations
> Network Management and Contracting
> Care Management
> Quality Management
> Finance and Accounting
> Reporting and Analytics
> Portals – Members and Physicians
> Regulatory Compliance
> Marketing and Sales Execution
Some examples

> Scott and White – Medicaid

> Alliant Health Plans – Commercial

> Dean Health Plan – Medicare Advantage
Scott & White (Now Baylor Scott & White)

- Founded in 1890’s as possibly the first “provider-sponsored health plan”
- Provided care for employees of the Santa Fe Railroad
- Scott & White Health Plans Founded in 1982 as a not-for-profit
- Initially aimed at employees, quickly grew to over 200,000 lives
- Added a Medicare Cost Plan in 1990s
- Currently serves over 250,000 members in several key markets
  - Commercial (fully insured, ASO)
  - Medicare Cost
  - Medicare Advantage
  - Medicaid
Journey into Medicaid

- Scott & White Healthcare not historically fully vested in Medicaid
- Access to specialty care and newer technologies not always available due to scarcity or cost
- Opportunity to enter into the managed Medicaid market was not well positioned for health plans not already in the program
  - Network adequacy
  - Systems interfaces
- Unique opportunity for a provider-sponsored plan to rapidly enter the program

**Black outline denotes overlap of Central Texas MRSA with Scott & White Health Plan’s existing service area.**
• Aug 2011  Bids Awarded by HHSC
• Sep 2011  Contract Execution
• Oct 2011  Network Information Due to TDI for Certification
• Nov 2011  On-Site Readiness Review
• Nov 2011  Marketing Materials Due to Fulfillment Vendor
• Dec 2011  Premium Rate Release
• Jan 2012  Premium Rate Finalization
• Jan 2012  Enrollment of New Members
• Mar 2012  Members Eligible for Services

Covered Medicaid Lives

Mar-12: 16,500
Sep-13: 36,000
Alliant Health Plans

> Commercial provider-sponsored health plan

> Jointly owned by Hamilton Medical Center and area physicians

> Dominant payer in Dalton, GA, <100,000 people

> Began 13 years ago, steady expansion

> Several strategic and operational opportunities for expansion
Medicare Advantage - Innovation

Health New England

- Owned by Baystate health
- 5-Star Rated Plan
- 7,000 Medicare lives
- Contract with Clinical Pharmacy firm to educate patients and care givers
- Reduced readmissions 36 percent via education and appointment adherence

Network Health

- Owned by Ministry Health Care
- 5-Star Rated Plan
- 135,000 lives across commercial and Medicare plans
- Place Care Managers in clinics not just hospitals
- Health Care Concierge program – assigned customer service representative
Multiple entity provider-sponsored health plan

- More lives = less risk
- Larger footprint = more attractive to employers
- Larger footprint = better positioned to compete in market with existing payors
- Less “leakage” = greater clinical control
- Greater access to expertise
Summary

> Risk is coming, decide what form and when

> No provider-sponsored plan is cookie cutter, but parts of other’s experiences can be reused

> Get the strategy, mission, objectives and governance right

> Know the market and the providers in the market

> Don’t be afraid to outsource, but maintain control over your core functions of network, quality and branding

> There’s no time like the present
Questions

> Phil Kamp, CEO, Valence Health
  • Information@ValenceHealth.com
  • www.valencehealth.com

> www.providersponsoredplans.com


> http://www.sherlockco.com/