Health Plan Consolidations: Contracting and Other Implications for the New Market Place
HFMA TX OK Red River Show Down
September 25, 2015
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II. Market Trends and Consolidation

III. Implications for Providers

IV. Provider-Sponsored Health Plans

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Market Trends and Consolidation
II. Market Trends and Consolidation

Drivers of Change in the Market Impacting Provider Organizations

These forces are pushing providers to deliver high-quality care at a lower cost.
In January 2015, HHS announced its adoption goals for the next 3 years.

**HHS Projected Adoption Goals — 2016 and 2018**

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee-for-Service (FFS) Linked to Quality (CAT 2–4)</th>
<th>Alternative Payment Models (CAT 3–4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>85%</td>
<td>30%</td>
</tr>
<tr>
<td>2018</td>
<td>90%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Source: www.hhs.gov.

HHS plans to associate 90% of Medicare payments to quality or value and 50% to alternative methods by 2018.
Innovative payment models, such as bundled payments in which Medicare provides a set amount for a particular episode of care, are shifting from voluntary to required.

Voluntary BPCI Participation by State (August 2014)¹

July 10, 2015: CMS Proposes Knee and Hip Surgery Bundled Payments

- This includes DRGs 469 and 470.
- Hospitals paid under the IPPS and physically located in the 75 MSAs selected for participation are required to participate.
- Bundles start at admission and continue for 90 days following discharge.
- Based on quality and episode spending performance, hospitals may receive an additional payment or be required to repay Medicare for a portion of the episode spending.

Source: Centers for Medicare & Medicaid Services (CMS), Health Care Advisory Board interviews and analysis.

¹ Medicare Bundled Payments for Care Improvement.
Payment systems are being designed with an end-state vision of evolving from isolated episodes of care to a more collaborative approach with greater accountability.
II. Market Trends and Consolidation
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.

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>SOLUTION (to scale)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Growing Operating Costs</td>
<td>» Increased collaboration</td>
</tr>
<tr>
<td>Mounting Regulatory Mandates</td>
<td>» Horizontal integration</td>
</tr>
<tr>
<td>Declining Reimbursement</td>
<td>» Vertical integration</td>
</tr>
<tr>
<td>Changing Payment Models</td>
<td>» Increased purchasing power</td>
</tr>
<tr>
<td></td>
<td>» Coordinated services</td>
</tr>
<tr>
<td></td>
<td>» Cost cuts</td>
</tr>
</tbody>
</table>

Source: AHA 2015 Environmental Scan.

Clinical Affiliations
Regional Collaboratives
Accountable Care Organizations (ACOs)
Clinically Integrated Networks (CINs)
Mergers or Acquisitions
II. Market Trends and Consolidation

Provider Consolidation

As reimbursement to physicians flattens or declines and uncertainty over reform continues, physicians are increasingly becoming employed by hospitals and health systems.

Growing Trend

» Newly trained physicians see health systems as a “safe haven” from uncertainty.

» Health systems see primary care as a necessary investment to lock in future business.

» Smaller multispecialty groups are dissolving as select specialties pursue hospital employment to improve compensation levels.

Percentage of U.S. Physician Practices Owned by Physicians and Hospitals, 2002 to 2013

1 Source: Medical Group Management Association (MGMA) 2002 to 2013 Physician Compensation and Production Surveys, reports based on previous-year data.
II. Market Trends and Consolidation
Prevalence of ACOs

Accountable care organization (ACO) growth continues to accelerate as providers seek to position themselves in the market. Recent literature suggests approximately 606 ACOs exist across all 50 states.

Growth in ACO Formation

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

ACOs are now located in all 50 states and the District of Columbia. California leads all states with 58 ACOs, followed by Florida with 55 and Texas with 44.

Source: Health Affairs, Leavitt Partners Center for Accountable Care Intelligence, www.healthaffairs.org.
## II. Market Trends and Consolidation
### Provider-Sponsored Plans

**Payor purchase of provider organizations has occurred in limited fashion, but is noteworthy.**

<table>
<thead>
<tr>
<th>Payor</th>
<th>Provider</th>
<th>Purchase Price</th>
<th>Transaction Date</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humana</td>
<td>Concentra</td>
<td>$790 Million</td>
<td>October 2011</td>
<td>Humana’s acquisition of Concentra, a privately held healthcare company with $800 million in annual revenues, gives the payor more than 300 medical centers in 42 states where Concentra delivers occupational medicine, urgent care, physical therapy, and wellness services to workers.</td>
</tr>
<tr>
<td>Neighborhood Health Plan</td>
<td>Partners HealthCare System, Inc.</td>
<td>N/A&lt;sup&gt;1&lt;/sup&gt;</td>
<td>August 2011</td>
<td>Partners, the largest hospital and physician network in Massachusetts, acquired Boston-based not-for-profit insurer Neighborhood Health, which has more than 240,000 mostly low-income members. Under the Letter of Intent to bring the payor and provider together, Neighborhood Health would become a member of Partners.</td>
</tr>
<tr>
<td>WellPoint</td>
<td>CareMore Health Group</td>
<td>$800 Million</td>
<td>August 2011</td>
<td>WellPoint gained a competitive edge in the senior healthcare market by acquiring the for-profit Medicare contractor CareMore, which pioneered a model of providing integrated coordinated care at its 26 clinics throughout California, Nevada, and Arizona. CareMore staffs its clinics with physicians, physical therapists, and case managers to provide care for about 54,000 patients, most of whom have several chronic conditions.</td>
</tr>
<tr>
<td>UnitedHealth Group (OptumHealth)</td>
<td>Monarch HealthCare</td>
<td>Undisclosed</td>
<td>August 2011</td>
<td>UnitedHealth Group acquired the management arm of Monarch that includes 2,300 physicians based in Irvine, California. Monarch offers access to 20 hospitals and more than 30 urgent care centers. The deal positions OptumHealth as a formidable presence in Southern California, adding Monarch to its previous takeover of two smaller groups.</td>
</tr>
<tr>
<td>Highmark</td>
<td>West Penn Allegheny Health System</td>
<td>$528 Million</td>
<td>April 2013&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Highmark, a Pittsburgh-based insurer, acquired West Penn Allegheny Health System, forming the Allegheny Health Network. Pennsylvania’s Insurance Department established conditions on Highmark’s acquisition, giving the state authority to review and sometimes approve Highmark’s financial support for West Penn Allegheny.</td>
</tr>
</tbody>
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<sup>1</sup> Partners did not provide any up-front money, but it will contribute an unspecified sum to furnish grants to more than 50 community health centers affiliated with Neighborhood Health.

<sup>2</sup> Source: Modern Healthcare — “Highmark completes West Penn Deal, announces new system”

Since the early 1990s, the gradual consolidation of health plans nationwide has led to five dominant payors as we recognize them today.

<table>
<thead>
<tr>
<th>Healthcare Payor Consolidation, 1992 to 2014</th>
<th>Result</th>
<th>Reported Medical Enrollment¹</th>
<th>2014 Revenue (in billions)²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Care Partners, Medica HealthCare Plans, XLHealth, FiServ Health, Sierra Health, Amett, John Deere, PacifiCare (including Pacific Life), Oxford Health, Great Lakes, Definity, MAMSI, Golden Rule, and 12 others.</td>
<td>UnitedHealthcare</td>
<td>45.9 Million</td>
<td>$130.5</td>
</tr>
<tr>
<td>AmeriGroup, QualChoice, Simply Healthcare Holdings, Atrium, WellChoice, Lumenos, Anthem (nine others, including seven BCBS plans), and WellPoint (Cobalt/United Wisconsin RightChoice, five others).</td>
<td>Anthem, Inc.</td>
<td>38.5 Million</td>
<td>$73.9</td>
</tr>
<tr>
<td>Prodigy Health Group, Coventry Health Care, HMS Health (PPOM, Sloan’s Lake, Mountain Medical), Chickering, New York Life (NYLCare), Prudential HealthCare, US Healthcare, and four others.</td>
<td>Aetna Inc.</td>
<td>23.7 Million</td>
<td>$58</td>
</tr>
<tr>
<td>KMG America, CHA, CorpHealth, Memorial Hermann, ChoiceCare, PCA, Emphesys, Care Network, and Group Health.</td>
<td>Humana</td>
<td>14.2 Million</td>
<td>$48.5</td>
</tr>
<tr>
<td>GreatWest, Sagamore Health Network, Choicelinx, Managed Care Consultants, and Healthsource (CYN, Provident, CentraMass).</td>
<td>Cigna</td>
<td>14.8 Million</td>
<td>$34.9</td>
</tr>
</tbody>
</table>

¹ 2015 Q2 Quarterly Earnings Reports.
² Modernhealthcare.com — Mergers and Acquisitions

Much of past consolidation activity has involved smaller health plans, most of which have focused on Medicaid and Medicare Advantage.
The recently announced mergers and acquisitions among the nation’s top payors represent a significant acceleration in consolidation activity and expansion.

**AETNA — HUMANA**
- Announced July 3, 2015
- $37 billion

**ANTHEM — CIGNA**
- Announced July 24, 2015
- $48 billion

**Combined Enrollment**

**Combined Revenue**

*NOTE:* Data taken from previous slides' figures.

If approved by the Department of Justice, UnitedHealthcare will find itself among the “Big Three” health insurers.
III. Implications for Providers
III. Implications for Providers

» Aetna acquires Humana for $37 billion.
» Anthem acquires Cigna for $54 billion.
The consolidation of health plans has led to a negotiating imbalance between fragmented providers and the dominant large payors.

- **Health Plan Consolidation**
  - Deeper Contracted Discounts to Dominant Plan
  - Dominant Plan Offers More Attractive Fees to Purchasers

- **Dominant Health Plan**
  - Weaker Provider Negotiating Power
  - Lower Costs for Dominant Plan
  - Greater Number of Provider Claims Reimbursed at Deeper Discounts

**Diminishing Commercial Revenue Stream**

**Commercial payor consolidation has placed additional pressure on provider organization revenues:**

- **Risk**
- **Metrics**
- **Product Development**
- **Data Requirements**
- **Rates**
- **Market Share**
III. Implications for Providers
Strategic and Tactical Provider Response

1. Increased and Proactive Review of Contracts
2. Accelerate Value-Based Arrangements
3. Develop or Participate in a CIN or ACO
4. Consider Provider-Sponsored Plans
IV. Provider-Sponsored Health Plans
Providers need greater control over the premium dollar in order to maintain financial viability.

- Risk shifting from payors to providers
- Providers assuming traditional payor core competencies
- Market power from payor consolidation contributing to minimal revenue growth for providers
- Providers striving to gain greater control of revenue, manage clinical processes, and preserve/grow their patient base
- Opportunity for provider/payor relationships that are less transactional and more strategic
As reimbursement shifts from volume to value, accessing nontraditional components of the premium dollar will become increasingly important for providers.
IV. Provider-Sponsored Health Plans
Hospital Utilization

Past value-based reimbursement pilots have demonstrated that cost savings largely come from declines in inpatient service utilization, which will impact hospital margins.

**Performance Summary From a Patient-Centered Medical Home Pilot Project**

- Everyone likes costs savings until it comes out of your revenue stream.
- Early results indicate that the savings from alternative delivery models will come from reductions in ED visits and hospital admissions.
- Primary care and pharmaceutical expenses have typically increased.

<table>
<thead>
<tr>
<th>Metric</th>
<th>May 1, 2008 — March 31, 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Expense</td>
<td>↓ 17%</td>
</tr>
<tr>
<td>Inpatient Expense</td>
<td>↓ 12%</td>
</tr>
<tr>
<td>Generic Dispense Rate</td>
<td>↑ 10%</td>
</tr>
<tr>
<td>Pharmacy Expense</td>
<td>↑ 23%</td>
</tr>
<tr>
<td>Diagnostic Imaging Expense</td>
<td>↑ 9%</td>
</tr>
<tr>
<td>Primary Care Office Visit Expense</td>
<td>↑ 11%</td>
</tr>
<tr>
<td>ED Visits Per 1,000</td>
<td>↓ 15%</td>
</tr>
<tr>
<td>Bed Days Per 1,000</td>
<td>↓ 13%</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>↓ 12%</td>
</tr>
</tbody>
</table>

**NOTE:** Percentage of change is based on respective baseline.
Source: IQL 2010: AMGA National Summit on ACOs.

Hospitals face substantial risk to their revenue when value-based payment mechanisms such as the patient-centered medical home (PCMH) are employed.
The recent resurgence in the development of provider-sponsored health plans is largely due to changes in reimbursement and health insurance exchanges.

**Reimbursement Implications**

- Access *to all patient care-related data* to manage costs better.
- *Sponsor* managed *Medicaid* and *Medicare* plans.
- *Alternate sources of income* to supplement revenue loss from utilization reductions.
- Payment reforms giving providers experience with *managing financial risk*.

**Health Insurance Exchange Implications**

- Expand or gain *market share*.
- Exchange provides *new market*.
- Provider plans *set their prices*.
IV. Provider-Sponsored Health Plans

Value of Provider-Sponsored Health Plans

A health plan can serve as a strategic advantage for provider organizations as they grow and diversify their offerings.

**Value Proposition**

» Growth and distribution channel to enter new markets.
» Diversifies revenue streams.
» Focus on population management and wellness, supported by claims data.
» Opportunity to bend the cost curve by control of the premium dollar.
» Extends the provider’s brand to new patient populations and new geographies.
» Understanding both provider and health plan operations will distinguish the provider-sponsored plan from non-provider-sponsored health plans.
Some estimates indicate there are currently about 300 provider-owned health plans around the country, with more expected to be developed soon.¹

» In 2010, around 10% of community hospitals owned, or were part of systems that owned, health plans.¹

» A 2011 survey of 100 hospital leaders found that 20% of them intended to market an insurance plan.²

» **As of 2012, 62% of the top 100 integrated not-for-profit health systems have health plans.**³

» There are four primary populations/products commonly considered by provider organizations as they develop health plans:
  › Employee health plans (EHPs)
  › Medicare Advantage (MA)
  › Direct-to-employer narrow networks
  › Health insurance exchange products⁴

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¹ Source: American Hospital Association.
² Source: The Advisory Board Company.
³ Estimate of 100 based on Premier, Inc., reports. Premier is an alliance of hospitals, non-acute care facilities, and healthcare suppliers.
⁴ Source: CitiGroup Global Markets, Inc., The Value Imperative: Landscape Reflects Acceleration in Transformation.
Providers managing a health plan assume some of the traditional, fundamental payor core competencies.

Functions such as benefit and product design and pricing strategies often require the most development.
V. Tactical Response and Planning
Providers should first evaluate the payors and the corresponding products that are being offered in their market associated with the merging health plans.

Overlap of Contracts Across Merging Plans
- List of products licensed by health plan
- Identify overlap in products across merging health plans
- Define and continue to track enrollment and payor mix by plan/product

Comparison of Rates
- Conduct an analysis to calculate the variance in reimbursement across overlapping products
- Calculate the financial implication of transition to highest and lowest reimbursing overlapping products
V. Tactical Response and Planning
Proactive Review of Contracts (continued)

Contract Language
» Create a matrix of key contract terms by product
» Termination/renewal dates
» Notification requirements for termination/ initiation of negotiation
» Provisions related to assignment of agreement(s)
» Provisions related to change in ownership
» Provisions related to adding new products in which provider participates
V. Tactical Response and Planning
Develop a Plan of Action

Develop a Plan of Action

» Understand contract provisions and actions required to protect against unilateral transition to less favorable contract rates

» Proactively communicate your objectives with payor representatives and desire to initiate contact discussions

» Understand and diligently track requirements (e.g., formal notifications to the plan) to preserve contract rights
Questions & Discussion

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