Reality BCBS
Provider-Sponsored Health Plans
“Do You Live in Reality…or Star in Your Own TV Show?”
Presented to HFMA, Lone Star Chapter

August 21, 2014

Confession………………
“My Guilty Pleasure.”
Top Five Reality Shows

#5 Project Runway – Starring Heidi Klum and Tim Gunn.
• Premise: Centered around the fashion industry.
• Goal: Glamour and fame...
• Lesson Learned: All about the “look” and how you “present”.

1 Source: Per Time, Inc.
Top Five Reality Shows

#4 Newly Weds
- Premise: Centered around “star couple” life as newlyweds.
- Goal: Glamour, fame, and insights on human interaction.
- Lesson Learned:
  - Glamour and fame…yes.
  - Human interaction – not successful.
  - (Both are remarried with kids.)

#3 The Bachelor
- Premise: Supersized dating show.
- Goal: Popularity Contest, human Interaction, and only one-winner.
- Lesson Learned: How to reinvent yourself to win “the prize”.
Top Five Reality Shows

#2 American Idol
- Premise: Celebrity maker – I want to be a star!
- Goal: Be a big winner….or one of the top 5.
- Lesson Learned: Takes talent, determination, perseverance, risks.

#1 Survivor
- Premise: Real world voyeurism with $1 million dollars at stake, divide contestants into tribes…get voted off the island….last man/woman standing wins.
- Goal: Survival….winner takes all.
- Lesson Learned: You need others to stay in the game at least temporarily and ironically when all is said and done….survival alone is not always what it is cracked up to be…
Key Take – A – Ways

• **Survival** is key.
• Glamour and fame – temporary.
• Look good and “Own it baby.”
• Real life is not always as it appears and neither is reality TV – no retakes.
• Huge risks and rewards.
• Winner takes all does not always feel like a “true win”.
• Reinvention can be “key” to success.
• High $$ stakes game.

Reality Show Newcomer to Watch

Orange is the New Black
I. Background and Context
II. Market Realities
III. Market Reactions
IV. National Landscape
V. Provider Organization Perspective
VI. Provider Integrated Core Advantages
I. Background and Context

**Key Issues**

A major driver of activity, whether in developing their own health plan or establishing strategic payor partnerships, has been the need for providers to have greater control in managing the premium dollar in order to maintain financial viability.

- The transition to value-based payment systems has also resulted in the shift of risk from payors to providers.
- Providers are assuming more of the traditional payor core competencies, including disease/utilization management and performance reporting.
- In many markets, commercial payor consolidation and their resulting market power contribute to minimal revenue growth for providers.
- Providers are striving to gain greater control of revenue, manage clinical processes, and preserve/grow their patient base.
- The current environment presents an opportunity for provider/payor relationships that are less transactional and more strategic.
I. Background and Context

Continued Shift to Value – Providers Are Seeking More of the Premium Dollar

As reimbursement shifts from volume to value, accessing nontraditional components of the premium dollar will become increasingly important for providers.

Potential revenue sources:
- Enhanced delivery and management of hospital/physician services.
- Administrative/medical management services.
- Care management fees.
- Health plan profits.

II. Market Realities
II. Market Realities
The Healthcare Bubble

Analysis indicates that the majority of cost growth is due to the utilization of services and new treatments (e.g., pharmaceuticals, medical device costs).

Sources of Growth in Healthcare Spending

When Does the Healthcare Bubble Pop?

- Relative to excess cost growth, the effect of the aging population is secondary.
- The magnitude of federal and state budget imbalances creates intense pressure for Congress to control costs.

Congress has three tools to manage healthcare costs:
- Reduce provider reimbursement.
- Limit governmental liability.
- Raise taxes.

Sources: Congressional Budget Office, Budget and Economic Outlook: Fiscal Years 2011 to 2021.

NOTES:
Excess cost growth refers to the number of percentage points by which the growth of spending on Medicare, Medicaid, or healthcare generally (per beneficiary or per capita) exceeded the growth of nominal gross domestic product (per capita). Figures are annual averages.

II. Market Realities
Seeking Value

CMS and other payors are simultaneously seeking both a reduction in healthcare expenditures and an improvement in the quality of care.

Insurance Reform  Coverage Expansion  Increased Quality Reporting and Data Collection

Key ACO Reforms
CMS establishes the Center for Medicare and Medicaid Innovation (CMMI) to evaluate new payment structures.

- Medicare Value-Based Purchasing (VBP) Program begins for specific conditions.
- Voluntary ACO payment program begins and expands.
- Physician registration for federal electronic health record (EHR) incentive program begins.
- EHR meaningful use incentive payments begin.
- Payments reduced for high readmission rates and hospital-acquired conditions.

Voluntary bundled payment pilot begins.

- Bonus payments established for Physician Quality Reporting System (PQRS) reporting.

II. Market Realities

Impending Reimbursement Changes

CMS recently implemented the VBP Program, which promotes quality and efficiency improvement.

- CMS’s VBP Program redirects inpatient reimbursement from poor-quality-ranking hospitals to higher-quality-ranking hospitals and is mandatory for those that provide inpatient services to Medicare patients.
- A hospital’s performance is based on selected Inpatient Quality Reporting (IQR) measures and compared against external and internal targets.
- The program’s DRG base-rate adjustment and payment adjustment began in FY 2013 (October 2012 to September 2013).

<table>
<thead>
<tr>
<th>Program Component</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Measures</td>
<td>• Two domains: clinical process of care and patient experience of care.</td>
</tr>
<tr>
<td></td>
<td>• Five clinical process categories (12 metrics) and one patient experience category (eight dimensions).</td>
</tr>
<tr>
<td></td>
<td>• Each metric scored on achievement against national averages or improvement against baseline performance.</td>
</tr>
<tr>
<td></td>
<td>• Metrics may be removed or added to the list in subsequent years of implementation.</td>
</tr>
<tr>
<td>Financial Impact</td>
<td>• Withhold of 1% from inpatient DRG base rate in FY 2013, ramping up to 2% by FY 2017.</td>
</tr>
<tr>
<td></td>
<td>• Payment made based on total performance scoring on a linear curve against all other hospitals.</td>
</tr>
</tbody>
</table>

Calculation of the VBM Using Quality Tiering Approach

<table>
<thead>
<tr>
<th>Quality/Cost</th>
<th>Low Cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>+2.0X%¹</td>
<td>+1.0X%¹</td>
<td>0.00%</td>
</tr>
<tr>
<td>Medium Quality</td>
<td>+1.0X%¹</td>
<td>0.00%</td>
<td>-0.50%</td>
</tr>
<tr>
<td>Low Quality</td>
<td>0.00%</td>
<td>-0.50%</td>
<td>-1.00%</td>
</tr>
</tbody>
</table>


¹ X is undefined because the program must be budget-neutral and therefore will depend on the total sum of negative adjustments in a given year.

Reimbursement is being increasingly tied to value, even for Medicare FFS payments.

CMS will phase in the application of a value-based modifier (VBM) for physician services in 2015.

- The program uses existing PQRS and EHR meaningful use measures, along with select total per capita cost metrics, to measure physician performance.
- There are a total of 62 preliminary measures for the VBM program.
- The application of the modifier will start in 2015 for groups of physicians with 100 or more eligible professionals. All physicians and physician groups will be subject to the VBM in 2017.
II. Market Realities

Value-Based Reimbursement

As more risk is introduced into payment methodologies, providers are moving toward greater integration and scale to efficiently develop capabilities for value-based models.

The Risk Continuum Associated With Various Reimbursement Structures

- FFS
- Bundled Payment
- Payment for Episodes of Care
- Gain Sharing
- Global Payment With Performance Risk and P4P
- Global Payment With Financial Risk

Clinical and Financial Integration

Complexity/Broader Capabilities Required

Greater Risk/Potential Upside


1 Medical homes that receive extra dollars for patient management.

II. Market Realities

Commercial Payor Consolidation

The consolidation of health plans has led to a negotiating imbalance between fragmented providers and a few large insurers.

<table>
<thead>
<tr>
<th>Healthcare Payor Consolidation, 1992 to Present</th>
<th>Result</th>
<th>Reported Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>QualChoice, Atrium, WellChoice, Lumenos, Anthem (nine others, including seven BCBS plans), and WellPoint (Cobalt/United Wisconsin RightChoice, five others).</td>
<td>WellPoint, Inc.</td>
<td>34 Million</td>
</tr>
<tr>
<td>FiServ Health, Sierra Health, Amett, John Deere, PacificCare (including Pacific Life), Oxford Health, Great Lakes, Definity, MAMSI, Golden Rule, and 12 others.</td>
<td>UnitedHealthcare</td>
<td>28 Million</td>
</tr>
<tr>
<td>HMS Health (PPOM, Sliam’s Lake, Mountain Medical), Chickering, New York Life (NYLCare), Prudential HealthCare, US Healthcare, and four others.</td>
<td>Aetna Inc.</td>
<td>16 Million</td>
</tr>
<tr>
<td>KMG America, CHA, CorpHealth, Memorial Hermann, ChoiceCare, PCA, Emphesys, Care Network, and Group Health.</td>
<td>Humana</td>
<td>11 Million</td>
</tr>
<tr>
<td>GreatWest, Sagamore Health Network, ChoiceLinx, Managed Care Consultants, and Healthsource (CYN, Provident, CentraMass).</td>
<td>Cigna</td>
<td>10 Million</td>
</tr>
</tbody>
</table>

Large Payors Continue to Grow

Health Plan Consolidation Dominant Health Plan

Deeper Contracted Discounts to Dominant Plan

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.
II. Market Realities
Commercial Payor Purchase of Provider Organizations

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</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>
</tbody>
</table>


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.

II. Market Realities
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 particular revenue stream.
- Early results indicate that the savings from alternative delivery models (like patient-centered medical homes [PCMHs]) will come from reductions in ED visits and hospital admissions.
- Primary care and pharmaceutical expenses have typically increased as part of this model.

**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 PCMH are employed.
III. Market Reactions

Provider Concerns

Providers are increasingly pushed toward the development of a health plan to share in the surplus created by reductions in cost and utilization.

Health systems are focused on eliminating waste from the system, leading to decreased utilization.

Payors are currently reaping the rewards for population management efforts.

Providers must position themselves to also realize returns for improved value.

Better management of the premium dollar offers an opportunity to align incentives and maintain financial viability.

“Utilization will fall for reasons outside of our control, including Medicare and other reimbursement changes. If we’re not in a position to control the premium, we’ll be a commodity on the spot-market. We have to get the surplus to align with where the market is going and maintain a viable business.” – Senior Executive, West Coast Health System
III. Market Reactions

Historical Context

For larger, more advanced provider organizations, provider-sponsored health plans are not a new concept.

- In the 1980s and 1990s, innovative healthcare providers created their own health insurance plans in an effort to develop a vertically integrated care financing and delivery system.
- As they confronted the risks and challenges of being in the insurance business, many of these providers sold their plans to larger plans or shut them down.
- Historically, the hospital functioned as a health system’s core business.
- At the time, sales and/or shutdowns of provider-sponsored plans were largely due to the following:
  - State regulations requiring large reserves.
  - More effective uses for the money set aside for insurance reserves (e.g., new construction to support increasing patient utilization).
  - Patient preference for large networks.
  - Limited resources for marketing that would allow the smaller plans to compete with the national giants.

The increased focus on clinical integration and population health management sets apart the more recent trends from historical experience.

Renewed Interest

There has been a recent resurgence in interest in the development of provider-sponsored health plans, largely due to changes in reimbursement and health insurance exchanges.

<table>
<thead>
<tr>
<th>Reimbursement Implications</th>
<th>Health Insurance Exchange Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In response to mounting pressure to reduce costs, provider organizations are seeking access to all patient care-related data to manage patients better, which they can obtain by offering their own plans.</td>
<td>• The health insurance exchanges offer an opportunity to expand or gain market share for a provider organization.</td>
</tr>
<tr>
<td>• The shift of many Medicaid beneficiaries and dual eligibles into managed care is prompting providers to consider sponsoring their own health plans in an attempt to boost revenues.</td>
<td>• In what is essentially a new market, providers with insurance arms can more simply pursue what is largely new business in exchanges, rather than facing the prospect of having to steal business from another organization.</td>
</tr>
<tr>
<td>• Organizations are also searching for alternate sources of income to make up for the anticipated loss of revenue that will come from increased disease management and care coordination.</td>
<td>• Provider-owned health plans can set their own prices. Insurers entering a new market, on the other hand, must negotiate new contracts with providers and may lack the customer base and leverage to negotiate price with independent providers.</td>
</tr>
<tr>
<td>• Payment reforms such as shared savings/loss models and bundled payments are forcing providers to reengineer care delivery and giving them experience with managing financial risk.</td>
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</table>

Provider organizations are increasingly forced to think like insurers.
III. Market Reactions

Renewed Interest (continued)

The renewed interest also stems from changes and enhancements to provider organization infrastructure.

Consolidation among hospitals and physician practices has created larger potential networks to mitigate patient concerns about limited choice and access to services.

Larger, consolidated provider organizations are also more likely to have greater access to capital to support the required insurance reserves and marketing costs.

Enhanced EHRs and supporting systems provide better patient data and information for population health management, referrals, and clinical decision support.

Range of Provider/Payor Collaborations

Provider strategies are contemplating a range of payor collaborative models, a thoughtful network strategy, and models for building appropriate insurance capabilities.

The models to the left are commonly pursued by hospital systems that are prepared for value-based reimbursement but not ready to join the insurance business.
## III. Market Reactions

### Value of Provider-Sponsored Health Plan

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

<table>
<thead>
<tr>
<th>Value Proposition</th>
<th>Keys to Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides a growth and distribution channel if the provider chooses to enter new markets.</td>
<td>Create a singular, long-term strategy for the provider and health plan, with separate operational plans as required.</td>
</tr>
<tr>
<td>Allows the provider the option to contract with other providers, diversifying revenue streams.</td>
<td>Align the incentives/objectives of delivery and financing.</td>
</tr>
<tr>
<td>Facilitates greater focus on population management and wellness, supported by claims data.</td>
<td>Build a structure (organizational, technology) to easily share data and industry knowledge.</td>
</tr>
<tr>
<td>Enables more opportunity to bend the cost curve, through greater control of the premium dollar, especially with an employee health plan.</td>
<td>Develop a cohesive branding and marketing strategy.</td>
</tr>
<tr>
<td>Extends the provider’s brand to new patient populations and new geographies.</td>
<td></td>
</tr>
<tr>
<td>On the health plan side, an understanding of provider operations will distinguish the provider-sponsored plan from other non-provider-sponsored health plans.</td>
<td></td>
</tr>
</tbody>
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## IV. National Landscape
IV. National Landscape Overview

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, according to the American Hospital Association.
- A 2011 survey of 100 hospital leaders by The Advisory Board Company found that 20% of them intended to market an insurance plan.
- As of 2012, 62% of the top 100 integrated not-for-profit health systems have health plans, while 70% of the top quartile have health plans.²
- There are four primary populations/products commonly considered by provider organizations as they develop health plans:
  - Employee health plans.
  - Medicare Advantage (MA).
  - Direct-to-employer narrow networks.
  - Health insurance exchange products.

¹ Estimate of 100 based on Premier, Inc., reports. Premier is an alliance of hospitals, non-acute care facilities, and healthcare suppliers.

Employee health plans often offer a viable first-generation opportunity.

IV. National Landscape Provider-Sponsored Health Plan Relationships

<table>
<thead>
<tr>
<th>Provider-Built Health Plan</th>
<th>Provider-Purchased Health Plan</th>
<th>Health Plan-Purchased Provider Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carle Physician Group (CPG) owned Health Alliance Medical Plans, Inc. (HAMP) before becoming incorporated into The Carle Foundation (CF).</td>
<td>Partners HealthCare acquired Neighborhood Health, a not-for-profit MCO.</td>
<td>Humana owns Concentra with 300-plus medical centers in 42 states.</td>
</tr>
<tr>
<td>Intermountain Healthcare launched its first health plan in 1984, growing into the current plan, SelectHealth.</td>
<td>Vanguard Health Systems’ Detroit Medical Center purchased ProCare Health Plan, Inc., a Medicaid HMO.</td>
<td>WellPoint owns CareMore, a Medicare contractor with 26 clinics throughout California, Nevada, and Arizona.</td>
</tr>
<tr>
<td>Geisinger Health Plan began as a rural, prepaid health plan offered to Geisinger Medical Center employees and residents before growing to serve a 44-county area in Pennsylvania.</td>
<td>Catholic Health Initiatives purchased a majority stake of Soundpath Health, an MA provider.</td>
<td>UnitedHealth Group (OptumHealth) owns the management arm of Monarch, including 2,300 physicians based in Irvine, California.</td>
</tr>
<tr>
<td>HVMA was part of the Harvard Community Health plan, a staff model MCO, until becoming independent in 1998.</td>
<td>MemorialCare Health System purchased certain assets (i.e., staff and managed lives) of Universal Care and applied for a license to operate Seaside Health Plan, focused on managed Medi-Cal members.</td>
<td></td>
</tr>
<tr>
<td>HealthPartners was founded in 1957 as a cooperative, an HMO with staff physicians and freestanding hospitals and clinics, and now is an integrated system.</td>
<td>Catholic Health Partners recently announced an initial agreement to purchase Kaiser Permanente’s Ohio operations – both health plan and physicians.</td>
<td></td>
</tr>
<tr>
<td>Sutter Health has applied for a license to operate an HMO by 2014, offering a commercial product to employer groups.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Piedmont Healthcare and WellStar Health System are partnering to develop a plan offering MA, commercial, and self-funded products by 2014.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Providers may build or buy health plans, contract for the necessary infrastructure, or partner with existing insurers.
IV. National Landscape

Prominent Provider-Sponsored Plans

A number of the more prominent provider-sponsored plans have experienced significant growth over multiple decades and offer a wide variety of products.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Headquarters</th>
<th>Number of Hospitals</th>
<th>Plan(s) First Established</th>
<th>Target Markets</th>
<th>Covered Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Henry Ford Health System (HFHS), Health Alliance Plan (HAP)</td>
<td>Detroit, Michigan</td>
<td>6</td>
<td>1978</td>
<td>Group-Insured Commercial, Individual, Medicare, Medicaid, Self-Funded, Network Leasing</td>
<td>670,000</td>
</tr>
<tr>
<td>Carle Foundation, HAMP</td>
<td>Urbana, Illinois</td>
<td>2</td>
<td>1980</td>
<td>HMO, POS, PPO, MA, Health Insurance Exchange</td>
<td>330,000</td>
</tr>
<tr>
<td>Scott &amp; White, Scott &amp; White Health Plan</td>
<td>Temple, Texas</td>
<td>12</td>
<td>1982</td>
<td>Individual and Family, Employer-Sponsored, MA, Medicaid HMO</td>
<td>215,000</td>
</tr>
<tr>
<td>Intermountain, SelectHealth</td>
<td>Salt Lake City, Utah</td>
<td>22</td>
<td>1984</td>
<td>Individual and Employer HMO, Individual HSA, MA, Medicaid</td>
<td>600,000</td>
</tr>
<tr>
<td>Sentara Healthcare, Optima Health</td>
<td>Norfolk, Virginia</td>
<td>11</td>
<td>1984</td>
<td>HMO, PPO, Medicaid HMO, Individual and Family Plans</td>
<td>450,000</td>
</tr>
<tr>
<td>University of Pittsburgh Medical Center (UPMC), UPMC Insurance Services</td>
<td>Pittsburgh, Pennsylvania</td>
<td>20</td>
<td>1998</td>
<td>HMO, PPO, Consumer-Directed Plans, MA</td>
<td>1,800,000</td>
</tr>
</tbody>
</table>

Recent Activity

Provider-sponsored plan activity has:

Continued Plan Development and Expansion
- Larger health systems such as Piedmont Healthcare, Sutter Health, MedStar Health, Inova Health System, and North Shore–Long Island Jewish Health System have launched plans within the past year or plan to do so within the next year.
- Many existing provider-led health plans are diversifying their portfolio of products.

Health Insurance Exchange Efforts
- Provider organizations such as Sentara plan to offer a health insurance exchange product but potentially without a narrow network. Sentara leadership has noted that it cannot risk possible financial losses by marketing a plan that may be priced too low to cover patients’ medical expenses. Growth under those conditions would lead to losses.
- hCentive, the leader in ACA health insurance exchange technology, has announced relationships with providers with existing plans such as Geisinger, to help support provider-sponsored plan availability.

Increased Retail Presence
- A significant number of the provider-sponsored plans set to enter the health insurance exchanges will also sell their products from storefront locations, in an attempt to reach individuals who currently find it difficult to obtain access to care and insurance.
- Scott & White plans to pursue health insurance exchange shoppers by building mall kiosks to vie for consumers’ attention with Zumba videos or other health-related merchandise.
IV. National Landscape

Baylor Health Care System and Scott & White Healthcare

Key Points about Merged System

- Created the largest not-for-profit health system in Texas.
- Guided by leaders from both Baylor and Scott & White.
- Operations span 24 counties from northern suburbs of Dallas to Brenham, Texas.
- Inclusion of the Scott & White Health Plan.
- $8.3 billion in total assets.
- $5.8 billion in total net operating revenue.
- 46 hospitals.
- Over 500 patient care sites.
- Over 6,000 affiliated physicians.
- Over 36,000 employees.
- 225,000 health plan members.
- 5,216 licensed hospital beds.
- 5.3 million annual patient encounters.

1 Source: BaylorScott&White Health

“The combination of Baylor and Scott & White’s geographic diversity and reputations for clinical excellence strengthen both organizations during a time of significant change.”
– Jim Turner, Chair-Elect of Board, Baylor Scott & White Health.

“We are building a new national model for health care delivery engineered to meet the demands of health care reform, the changing needs of patients and payers and the extraordinary advances in clinical care.”
– Joel Allison, CEO, Baylor Scott & White Health.

IV. National Landscape

Tenet Acquires Vanguard

- $4.3 billion acquisition.
- Annual revenue: $15 to $16 billion.
- Texas revenue doubles: $3 billion.
- New health systems in Texas.
  – Baptist Health System – San Antonio.
  – Valley Baptist Health System – South Texas.
- Health plan.
IV. National Landscape
Catholic Health Initiatives’ Health Plan Acquisitions

Key Points: QualChoice Holdings¹

- May 2014 – CollabHealth, a CHI subsidiary, acquired QualChoice Holdings, parent company of QCA Health Plan, Inc. and QualChoice Life and Health Insurance Company.
- CHI, one of the nation’s largest non-profit health systems, operates St. Vincent Health System based in Little Rock, AR.
- St. Vincent, with more than 650 affiliated physicians, has been in QCA Health Plan’s provider network since 1999.
- QCA Health Plan is licensed in all 75 Arkansas counties.
- No substantial changes in QualChoice operations or in provider network participation are anticipated by the ownership change.

“We believe this is an important investment in the future of affordable health care options for the people of Arkansas.”

– Juan Serrano, CHI’s Senior Vice President of Payer Strategy and Operations.

Key Points: Soundpath Health²

- March 2013 – CHI acquired a majority stake in Soundpath Health, a provider-owned plan offering Medicare Advantage services in Washington state.
- CHI invested more than $24 million.
- Soundpath Health has about 17,000 members and more than 6,500 providers in its network.
- Soundpath Health operates across 9 counties in Washington state.
- Leaders of Soundpath Health do not anticipate changes in operations, personnel, or name due to the change in investor ownership.

“This investment from CHI is an ideal arrangement that increases capitalization and allows Soundpath Health to continue to provide quality service and value to our members and provider partners. This partnership will afford investment in new systems, resources and offer opportunities for continued expansion.”

-Christine Tomcala, CEO of Soundpath Health

¹ Source: Catholic Health Initiatives.
² Source: Soundpath Health.

IV. National Landscape
Recent Activity

“Private Label” Health Plans

- A select group of provider-sponsored health plans have been successful enough that the organizations now outsource their back-end payor resources and expertise to hospitals and health systems looking to develop a plan under their own brand that do not have the in-house capabilities necessary to do so.
- HAMP, founded in 1980 by the Carle Clinic, has begun to expand into Nebraska and Washington in this manner. Beginning next year, HAMP will partner with Confluence Health in Wenatchee to provide coverage for Medicare beneficiaries.

Technological and Advisory Services

- New and existing consulting firms are increasingly offering services to provider organizations to navigate the transition from FFS to value-based reimbursement. In some cases, these efforts include the development of a health plan.
- Evolent Health, founded in 2011, is a prime example. The company provides advisory services regarding value-based care delivery and IT systems that support population health management. Evolent currently has health system clients in a number of markets, including MedStar Health, which has used Evoluent’s technology to build its MA plan as well as its own health plan for the system’s 36,000 associates and dependents.
V. Provider Organization Perspective

Key Development Considerations

<table>
<thead>
<tr>
<th>Regulatory Requirements</th>
<th>Market Issues</th>
<th>Technical Capabilities</th>
<th>Strategic, Financial, and Operational Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What are the regulatory procedures, obstacles, and time frames?</td>
<td>• What are the relevant attributes of the current payor market?</td>
<td>• What factors and capabilities are indicators of success?</td>
<td>• What strategic benefits does the organization desire to achieve?</td>
</tr>
<tr>
<td>• What are the requirements for applying for the appropriate license?</td>
<td>• What is the size of the market?</td>
<td>• Is the provider network adequate in scope and scale?</td>
<td>• What are the resource needs?</td>
</tr>
<tr>
<td>• What are the requirements for network adequacy?</td>
<td>• How is it performing?</td>
<td>• What is the staffing (or outsourcing) model?</td>
<td>• What are the risks?</td>
</tr>
<tr>
<td>• What are the reserve requirements?</td>
<td>• What is the competition doing?</td>
<td>• Are the appropriate IT systems in place?</td>
<td>• What is the projected financial performance under various scenarios?</td>
</tr>
<tr>
<td>• What are the relevant reform mandates and matters?</td>
<td>• Is the organization positioned to collaborate with another institution?</td>
<td>• What processes will need to be redesigned to accommodate for a smooth transition?</td>
<td>• How will the action impact relationships with existing insurers?</td>
</tr>
</tbody>
</table>

Provider organizations take the following into account when considering the development of a health plan:
V. Provider Organization Perspective

Sponsored Plan and Partnership Growth Framework

For those provider organizations with an existing health plan, the following type of framework represents a set of typical expansion considerations:

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Advantage</th>
<th>Disadvantage</th>
</tr>
</thead>
</table>
| Geographic Expansion | • Membership growth.  
• Upside financial opportunity.  
• The core business and the provider’s expertise are utilized to maintain margins and drive performance. | • Increased financial risk.  
• Network adequacy issues may limit the geographies that can be entered. |
| Service Expansion  | Creates another channel for membership growth and additional patients for the provider. | • Competition.  
• Requires some operational integration with the plan.  
• Requires business development capabilities. |
| Product Expansion  | • Membership growth.  
• Upside financial opportunity. | • Competition.  
• Increased financial risk.  
• Additional capabilities required to manage care for a potentially complicated and costly population. |
| Partnerships       | • Volumes would increase to include non-provider organization patients.  
• Integration would further improve quality and cost efficiency. | • May require partnering with competitors, which may distract focus from the growth of core services.  
• Requires a long-term outlook to understand potential impact to both delivery and finance offerings. |

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. Provider Organization Perspective
Required Capabilities (continued)

Providers must also consider essential competencies that they have and/or will need to have in place to execute a population management strategy to support the health plan.

<table>
<thead>
<tr>
<th>Provider Competencies</th>
<th>Joint Competencies</th>
<th>Payor Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Organization/governance.</td>
<td>• Funds flow and distribution.</td>
<td>• Marketing and sales.</td>
</tr>
<tr>
<td>• Care delivery transformation.</td>
<td>• Incentive design and dissemination.</td>
<td>• Population data management.</td>
</tr>
<tr>
<td>• Clinical innovation.</td>
<td>• Network development.</td>
<td>• Premium pricing.</td>
</tr>
<tr>
<td>• Clinical standards.</td>
<td>• Payor contract restructuring.</td>
<td>• Benefit and product design.</td>
</tr>
<tr>
<td>• Alignment with provider partners.</td>
<td>• Nonclinical IT infrastructure, maintenance, and standards.</td>
<td>• Pharmacy network.</td>
</tr>
<tr>
<td>• Clinical IT.</td>
<td>• Quality and other performance standards.</td>
<td>• Claims administration and payment.</td>
</tr>
<tr>
<td>• Physician coaching.</td>
<td>• Performance reporting.</td>
<td>• Financial reporting.</td>
</tr>
<tr>
<td>• Disease management.</td>
<td>• Utilization management.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provider credentialing.</td>
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<tr>
<td></td>
<td>• Employee wellness programs.</td>
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</tr>
</tbody>
</table>

VI. Provider Integration Core Advantages

Provider-owned health plans have the potential of a unique advantage in improving market position by aligning with providers.

**Insurance Competencies** – Providers have a more direct link to insurance competencies that help with population management.

**Care Delivery Models** – The payor has a more direct link to innovative care delivery models and other clinical innovations.

**Aligned Incentives** – Financial, quality, and other performance incentives are more easily aligned.

**Premium Revenue** – Access to premium revenue and closer collaboration for premium revenue improvements (e.g., star ratings, Hierarchical Condition Category [HCC] coding).

**Membership Growth** – Opportunity to affect membership growth.

**Provider Reimbursement** – Mitigates erosion in provider reimbursement from other plans.
Questions & Discussion

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