The Academy
The Health Management Academy

THE ACADEMY LUMERIS STRATEGIC TRACKING SURVEY

Q3 2018 SPECIAL TOPIC REPORT: PROVIDER-OWNED HEALTH PLANS

SEPTEMBER 2018

Lumeris

PROVIDER-OWNED HEALTH PLANS

INTRODUCTION

As health systems increasingly participate in value-based care contracts and assume additional risk, many provider systems are developing their own health plans to better manage their patient populations and control the total cost of care. Additionally, as health systems face continued financial pressure due to rising costs and shrinking operating margins, health systems are diversifying their revenue streams with many moving upstream into the payer environment to capture a greater portion of the healthcare dollar.

This report discusses the findings from The Academy Lumeris Q3 2018 Strategic Tracking Survey special topic around provider-owned health plans, and details health systems' expected growth of their current health plan(s), as well as the competencies needed for providers to successfully operate a health plan.

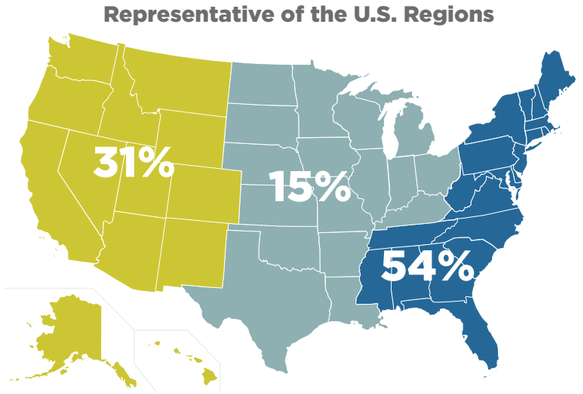
METHODOLOGY

In August 2018, The Health Management Academy (The Academy) conducted the sixteenth round of phone interviews for its quarterly strategic survey among Leading Health System executives, including: CEOs, COOs, CFOs, CMOs, CNOs, and CSOs.

The survey for the interview consisted of:

1. A tracking section that provides insight into trends around primary strategic areas; and
2. A special topic area that allows for an in-depth look into a timely developing issue

PROFILE OF PARTICIPATING HEALTH SYSTEMS



MEDIAN REVENUE

$4.4 BILLION

OWN OR OPERATE **173 HOSPITALS** WITH **35,059 BEDS**

SINGLE-STATE SYSTEMS: **61%**
MULTI-STATE SYSTEMS: **31%**

KEY FINDINGS

1. For those health systems with a provider-owned health plan, almost all (89%) anticipate an increase their health plans' covered lives in the next year, with the majority (56%) expecting a significant increase of +10% or more.

2. Competencies around infrastructure and analytics, understanding cost and pricing, care management, and optimizing scale are crucial for providers to be successful in owning and operating a health plan.

3. Common barriers for providers starting their own health plan include developing payer competencies, competing with established payers, and the capital investment required to develop the infrastructure and launch a new plan.

PROVIDER-OWNED HEALTH PLANS EXPECTED TO GROW

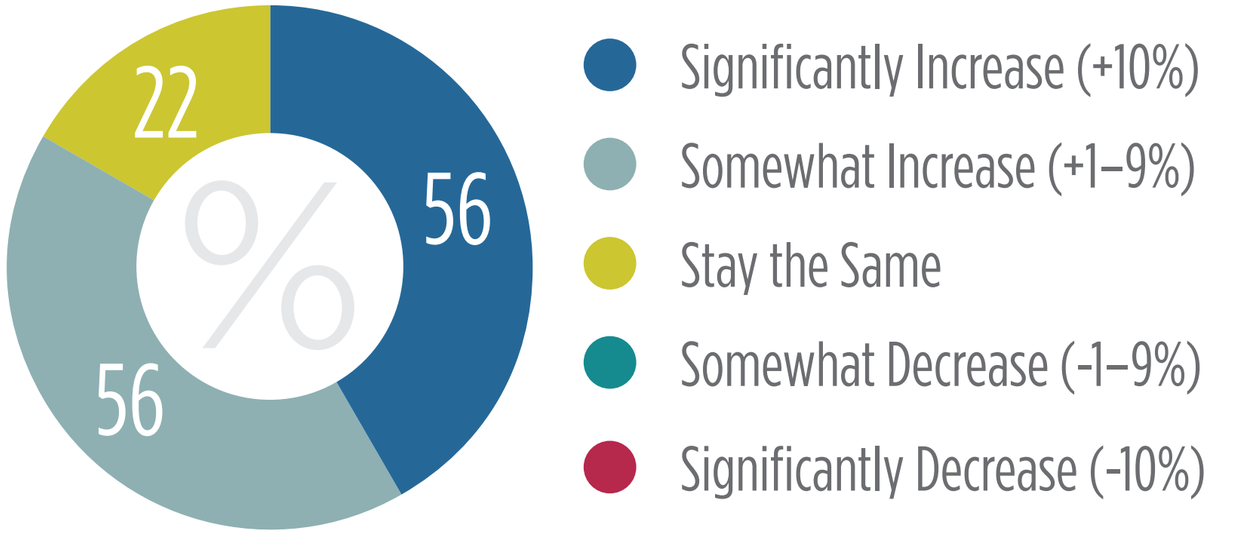
Providers own and operate various health plans, including commercial plans, Medicare Advantage plans, Medicaid Managed Care plans, and/or an employee health plan. Some health systems that don't own their own plan participate in joint ventures with established insurance providers to operate a plan. Among the various plans the number of covered lives varies, ranging from approximately 1,400 covered lives to over 10 million.

In Q3 2018, almost all health system executives (89%) reported anticipating an increase in the number of covered lives under their health plan(s) within the next year, with the majority (56%) expecting a significant increase (10% or more). Health systems attributed this to a variety of factors, including:

- Relative small size of health plans with room for growth
- Geographic expansion of existing plans
- Growth of aging Medicare eligible population
- Health system implementation of additional marketing/growth strategies

Health systems utilize a variety of metrics to measure the success of their health plan(s), commonly including star ratings, profitability, per member per month (pmpm) data, customer/member experience and satisfaction, medical loss ratio, administrative cost ratio, likelihood to recommend, number of covered lives, and market share. While executives report overall success on most of their metrics, profitability and risk scoring are areas in which multiple executives indicate challenges.

HOW DO YOU EXPECT YOUR HEALTH PLAN(S) COVERED LIVES TO CHANGE IN THE NEXT YEAR?



"We are anticipating a significant increase across all of our plans. This is a huge focus of ours. I think we will try to double Medicare Advantage. We are also pushing commercial growth." (CSO)

COMPETENCIES & BARRIERS FOR PROVIDER-OWNED HEALTH PLANS

Health system executives indicated a number of competencies that are crucial for providers to develop in order to be successful in owning and operating a health plan. These competencies are primarily focused around developing the skills and infrastructure needed to support the insurance business (e.g., sales, marketing, claims management, actuarial and underwriting expertise) as well as broader capabilities around managing care, understanding and controlling costs, and reaching scale.

In addition to developing these competencies, providers recognize additional barriers to starting their own health plan including the large capital investment required to launch a plan, network adequacy, competition with established payers, government regulation, and aligning physician compensation and incentives for managed care.

WHAT COMPETENCIES ARE/WILL BE MOST IMPORTANT FOR YOUR SYSTEM TO DEVELOP TO SUCCESSFULLY OPERATE YOUR HEALTH PLAN(S)?

Scale	"In order to survive, we have to continue to grow. 1400 lives is not enough to take on and manage risk, we have to develop the infrastructure in order to increase the number of covered lives." (CMO)
Skill	"We need to develop similar competencies that our payer partners have. We have been reliant on them sharing claims information, our ability to analyze that information." (CFO) "You need phenomenal underwriting capabilities. This is the most critical. In order to do it well you have to have a massive experience to assess populations. You need knowledge and experience in the market." (CFO)
Infrastructure/ Analytics	"You have to have a set of products and the infrastructure to grow and develop covered lives." (CSO) "Have to have pop health capabilities and interventions and an expansive primary care network. Data analytics and ability to provide real time data to the caregivers." (CEO)
Understanding Cost/ Pricing	"Understanding how to manage pmpm costs in delivery system to support the health plan success." (CNO) "Pricing strategy and understanding out-of-network risk." (CEO)
Care Management	"Managing care more aggressively. We still have silos in care management – we need to function across the continuum and we don't do as well as we should. Managing ancillary utilization is key." (CMO)

ABOUT THE ACADEMY

The Health Management Academy (The Academy) is a membership organization exclusively for executives from the country's Top-100 Health Systems and most innovative healthcare companies. The Academy's learning model identifies top priorities of health system leaders; develops rich content based on those priorities; and addresses them by convening members to exchange ideas, best practices, and information. The Academy is the definitive trusted source for peer-to-peer learning in healthcare delivery with a material record of research and policy analysis. Offerings include C-suite executive peer forums, issues-based collaboratives, leadership development programs, research, advisory, and media services. The Academy is an accredited CE provider. More information is available at www.academynet.com.

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ABOUT LUMERIS

Lumeris is a value-based care managed services operator for health systems and providers seeking extraordinary clinical and financial outcomes. Recognized nationally by KLAS in 2018 for Value-Based Care Managed Services, Lumeris aligns providers and payers across populations with technologies, processes, behaviors and information to achieve high-quality, cost-effective care with satisfied consumers — and engaged physicians. It was the third straight year Lumeris received the distinguished Best in KLAS award. For the past seven years, Lumeris with Essence Healthcare, its inaugural client and learning laboratory with more than 65,000 Medicare members in Missouri and Illinois, has received 4.5- to 5-Star Ratings from the CMS and produced the highest consumer and physician satisfaction scores in the industry along with significantly better clinical outcomes and lower costs. For more information, go to www.lumeris.com.

THE HEALTH MANAGEMENT ACADEMY EXTENDS ITS APPRECIATION TO LUMERIS FOR THE FINANCIAL SUPPORT FOR THIS PROJECT.