BDC ADVISORS

LEADING CONSTRUCTIVE CHANGE

VALUE-BASED CONTRACTING

STRATEGIES FOR EFFECTIVELY NEGOTIATING VALUE-BASED CONTRACTS IN THE NEW RETAIL MARKET

PIONEERING STRATEGIES ▪ PRACTICAL APPROACHES ▪ CONSTRUCTIVE CHANGE

Objectives

LEARNING TO SWIM UPSTREAM…

- Goals of Effective Value-Based Contracting
- Pros and Cons of Key Arrangements
- What's Required to Make the Transition
- Successful Implementation Factors
- How to Define Risk for Your Organization
- Incorporating the Right Safeguards to Mitigate Contract Risk

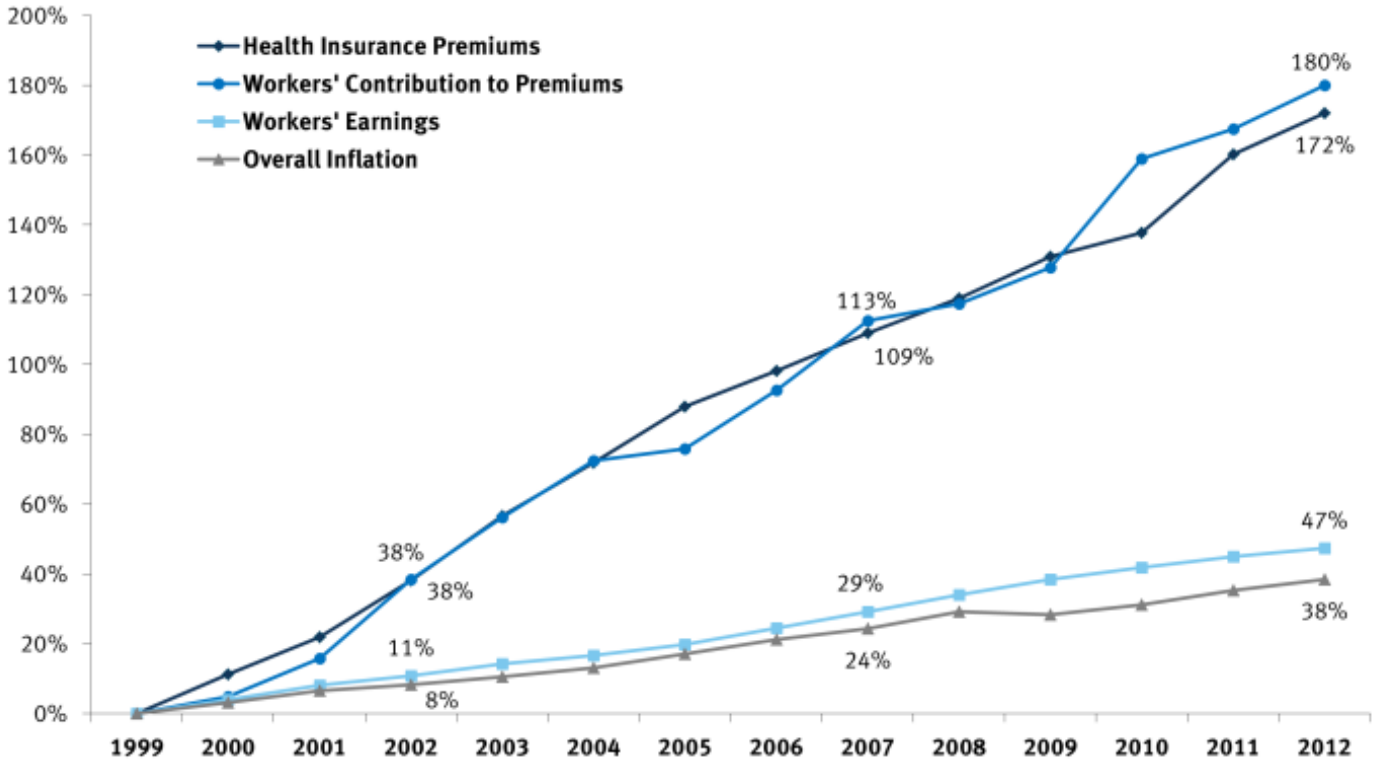
Today's Discussion

- Prologue
- The New Insurance Market
- Learning a New Language
- Health Plan Strategies
- Tactical Considerations

The most disturbing graph in our industry

Families are paying more and more for their health care.

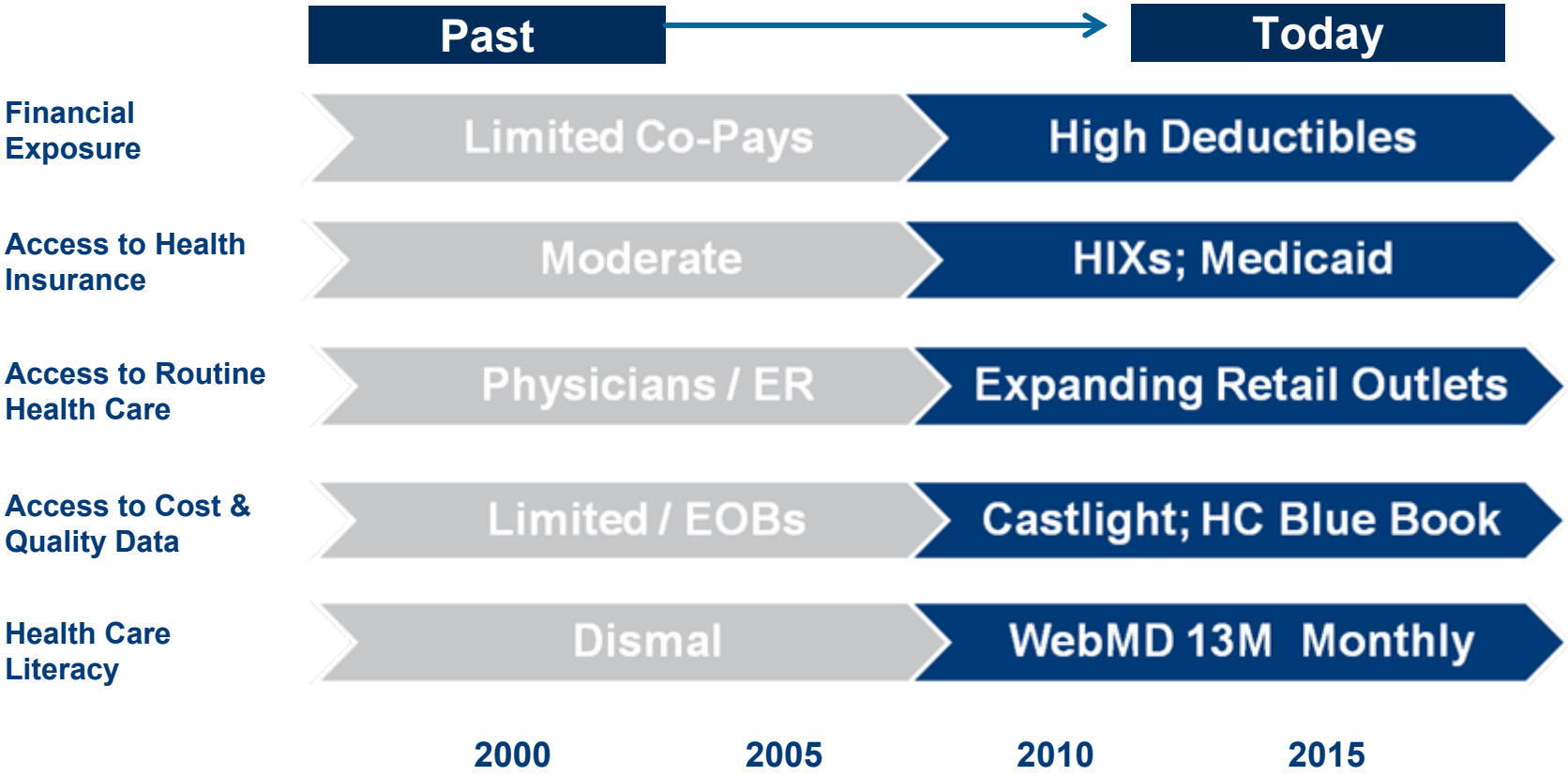
Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2012



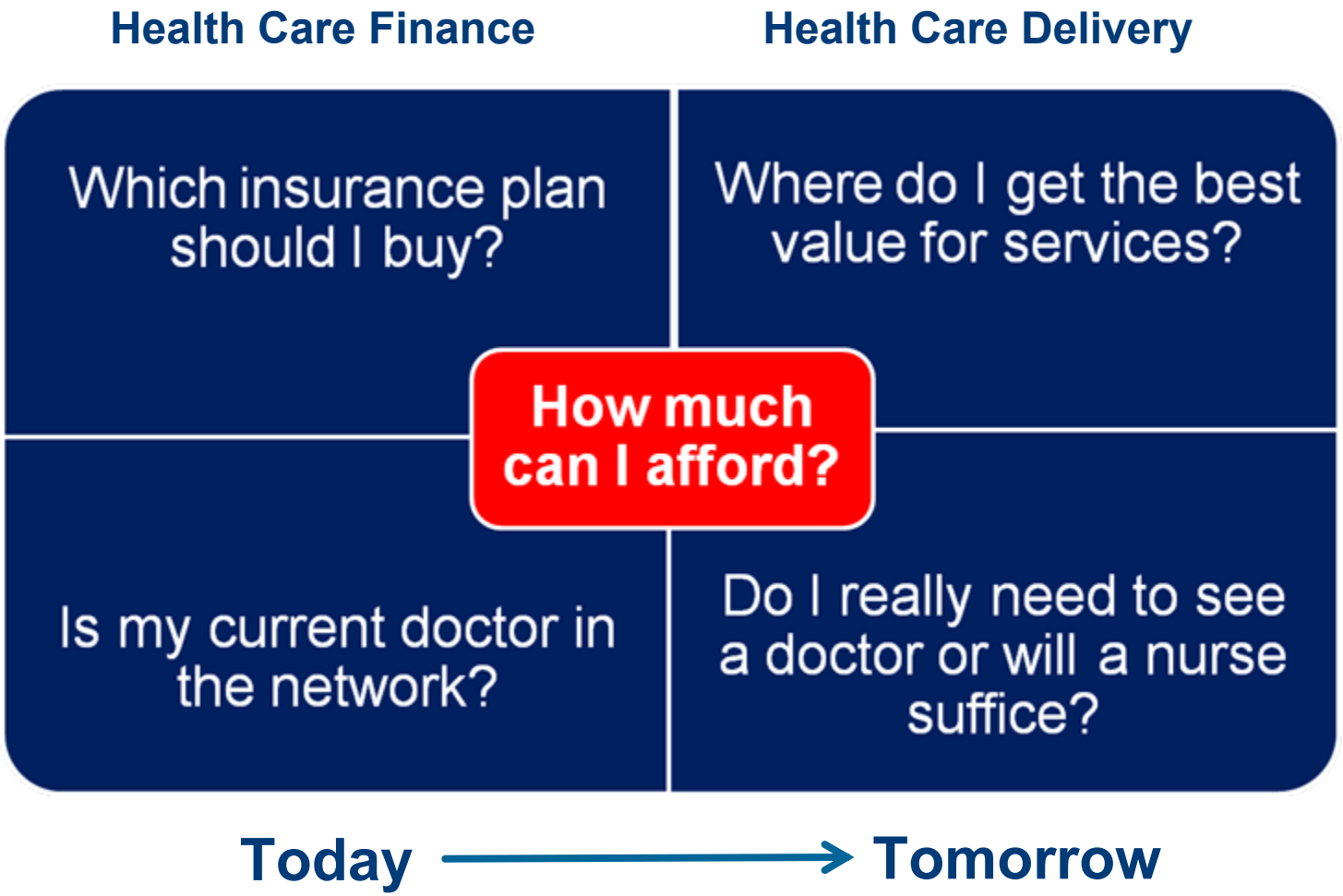
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2012; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2012 (April to April).

Greater financial responsibility and greater choice is pushing the whole market toward greater consumerism

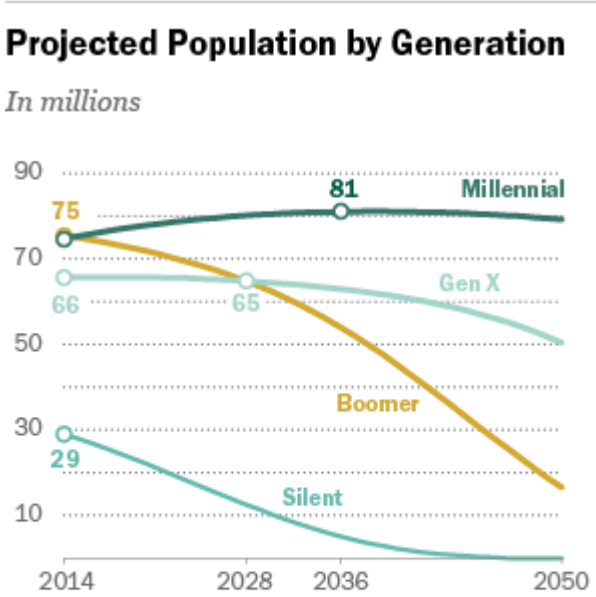
Multiple dimensions in health care have led to a tipping point…



Consumers are no longer protected from understanding true costs and quality trade offs



Gen-Xers and Millennials will be attracted to mobile apps and web-based tools that give them choices and make it easy.



Millennials

- First digital-native buyers.
  - They have high expectations for a digital experience
- Base brand value based on digital experience even more than personal
  - And they are more likely to trust a tech vendor than an insurance company.
- Minimal patience for "going through hoops"
  - They will demand intuitive, integrated buying experience
- They are still mainly employees, not individual buyers
- They still don't understand health insurance very well

Source: Pew Research Center, http://www.pewresearch.org/fact-tank/2015/01/16/this-year-millennials-will-overtake-baby-boomers/; Array Health Solutions, 2015.

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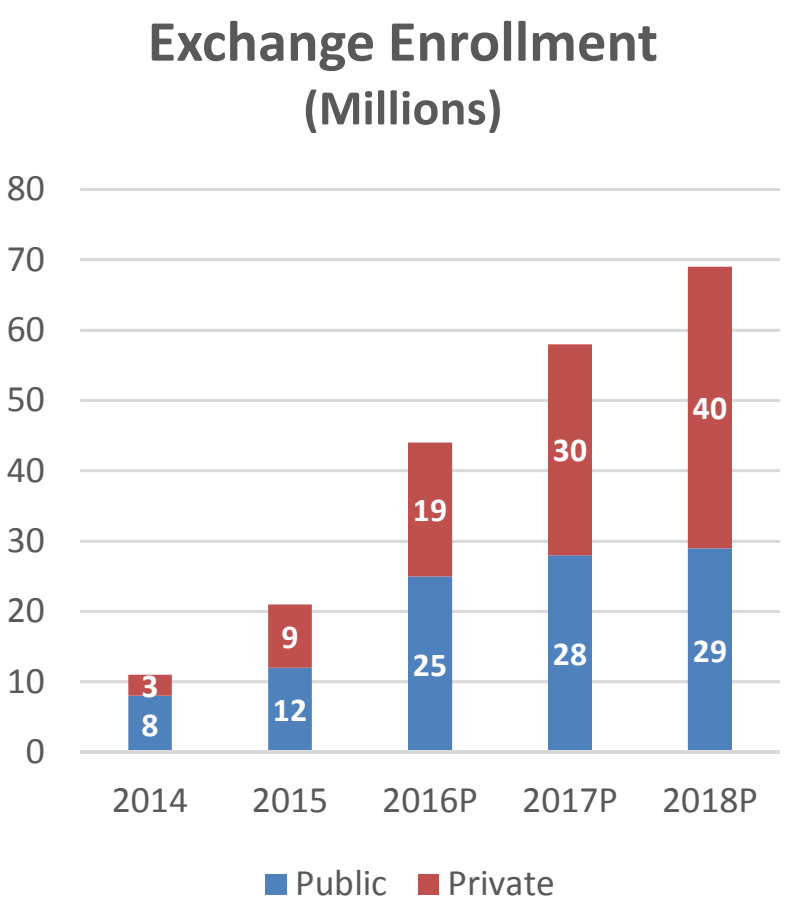
The growth of public and private exchanges is heating up competition in the health insurance market.



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Private exchange operators as of October 2014

> 1 in 4

Share of employers Aon Hewitt shows are considering moving to a private exchange in the next three-five years.

Prominent Employers Using Private Exchanges

For Active Employees:

Walgreens petco SEARS Olive Garden

For Retirees: (Medicare Advantage, Medigap plans)

IBM GE CATERPILLAR®

Sources:
(1) KFF.org (April 2014, February 2015); Obamacare Facts; http://kff.org/medicaid/issue-brief/how-is-the-aca-impacting-medicaid-enrollment/
(2) CBO, "Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act," The Budget & Economic Outlook, 2014-2024, Appendix B.
(3) Accenture, "Are You Ready? Private Health Insurance Exchanges are Looming;" privatehealthexchange.com; Health Care Advisory Board interviews and analysis; "More Employers Shifting Health to Private Exchanges," Forbes.com, October 8, 2014

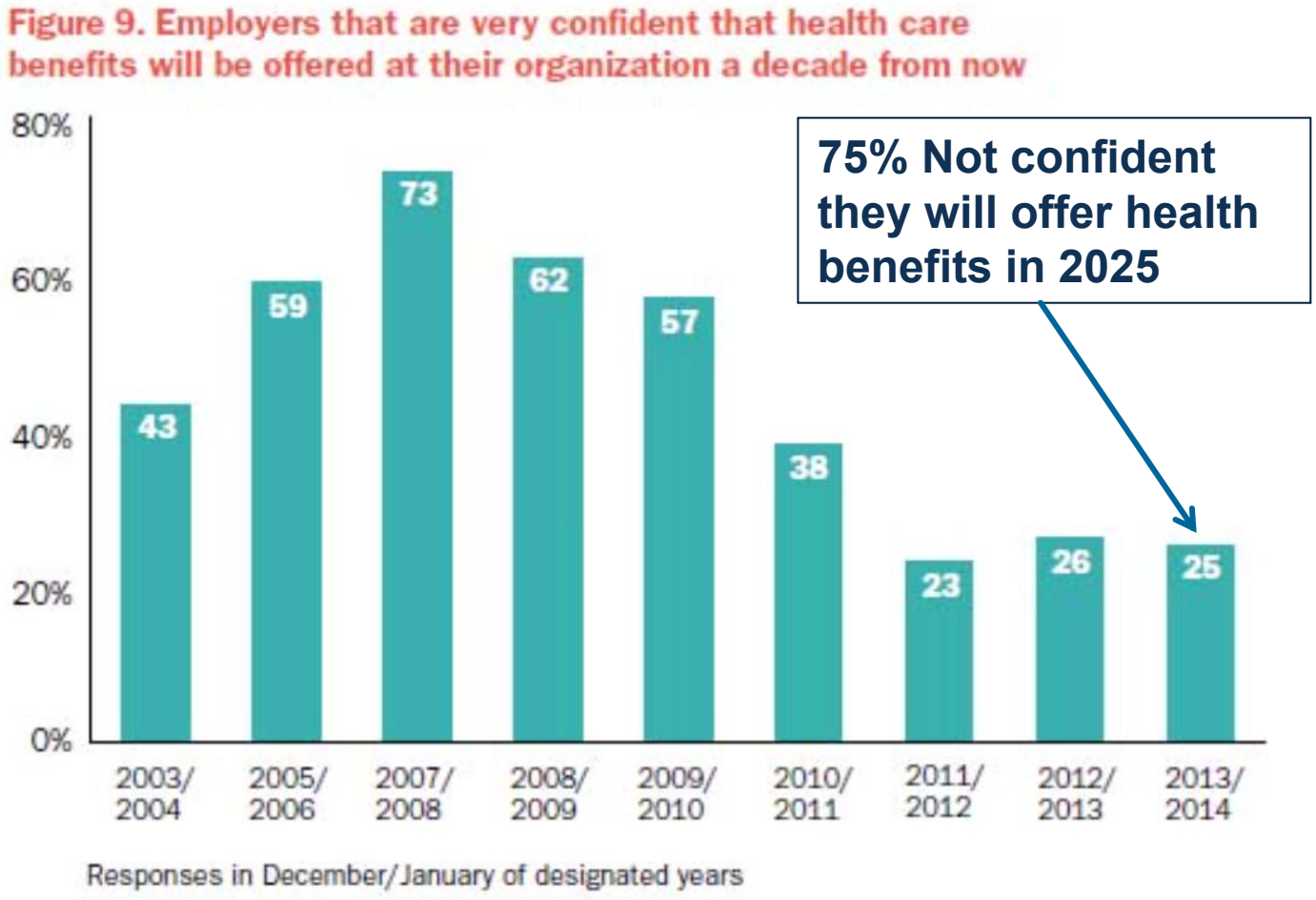
The transition from defined benefit to defined contribution pension plans.

Percent of Fortune 500 Companies offering new employees a defined benefit plan

Source: “Fewer Employers Offering Defined Benefit Pension Plans to New Salaried Employees,” *Workforce Management*, October 3, 2012

Are health benefits going the same way?

Employers confident that their organization will offer health benefits 10 years from now

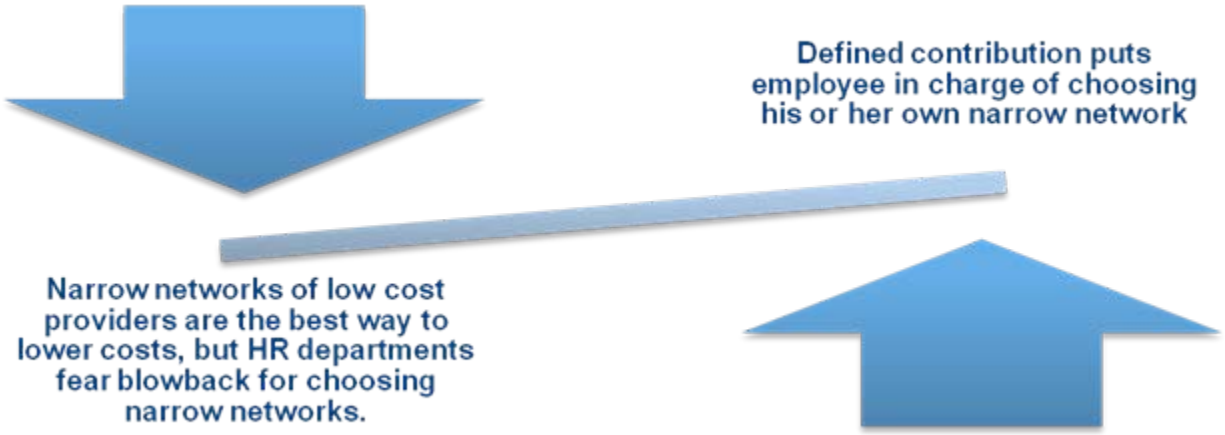


Source: 19th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care (2014)

The evidence for this shift in health insurance is circumstantial, but powerful.

Companies

- Seeking high returns to shareholders over employee benefits
- Already have the (positive) experience of dropping defined benefits for retirement, and thus it will be easier to do with health care
- Have been shifting financial responsibility for health care cost to employees for a decade
- Running out of strategies for lowering health costs

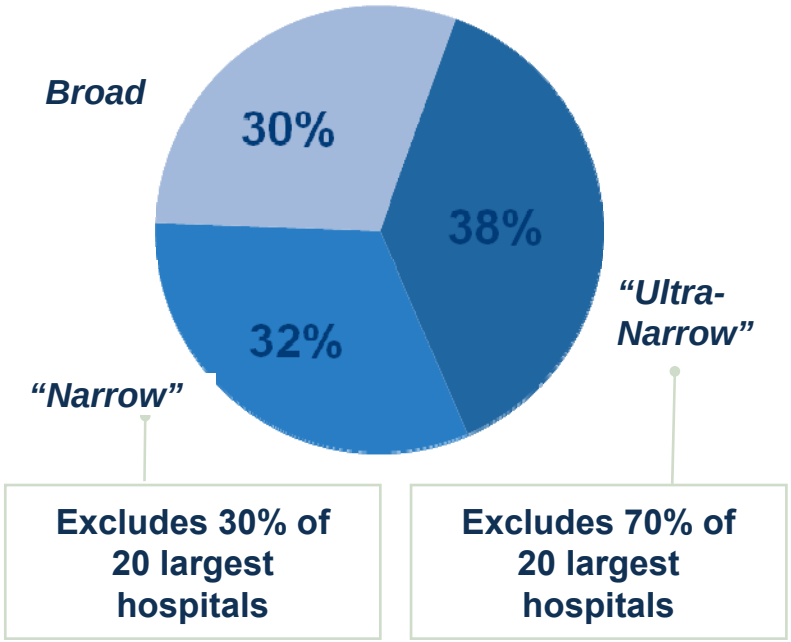


Public and private exchanges are dominated by narrow networks with high deductibles

Payers responding to premium sensitivity

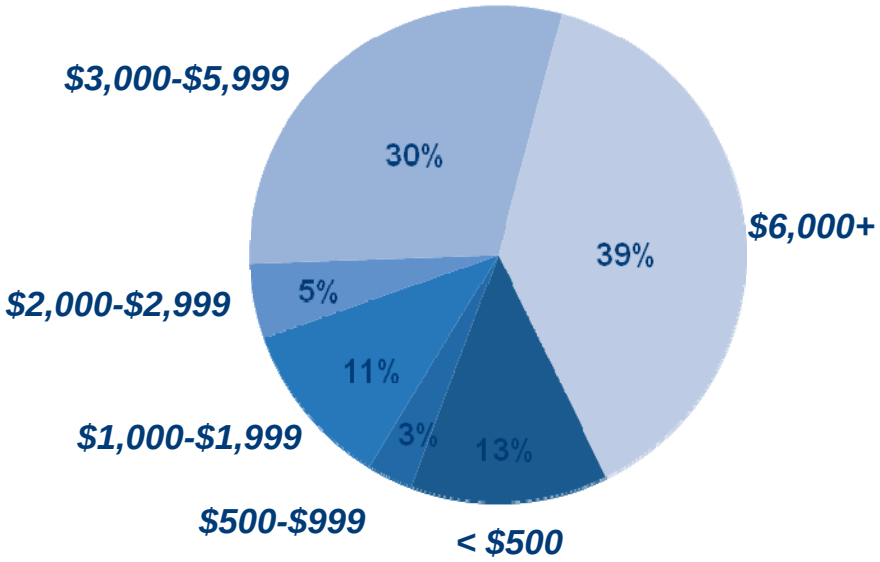
Majority of Public Exchange Plans Exclude >30% of Largest Hospitals

20 Urban Markets, December 2013



Annual Deductibles of Individual Plans Selected on eHealth

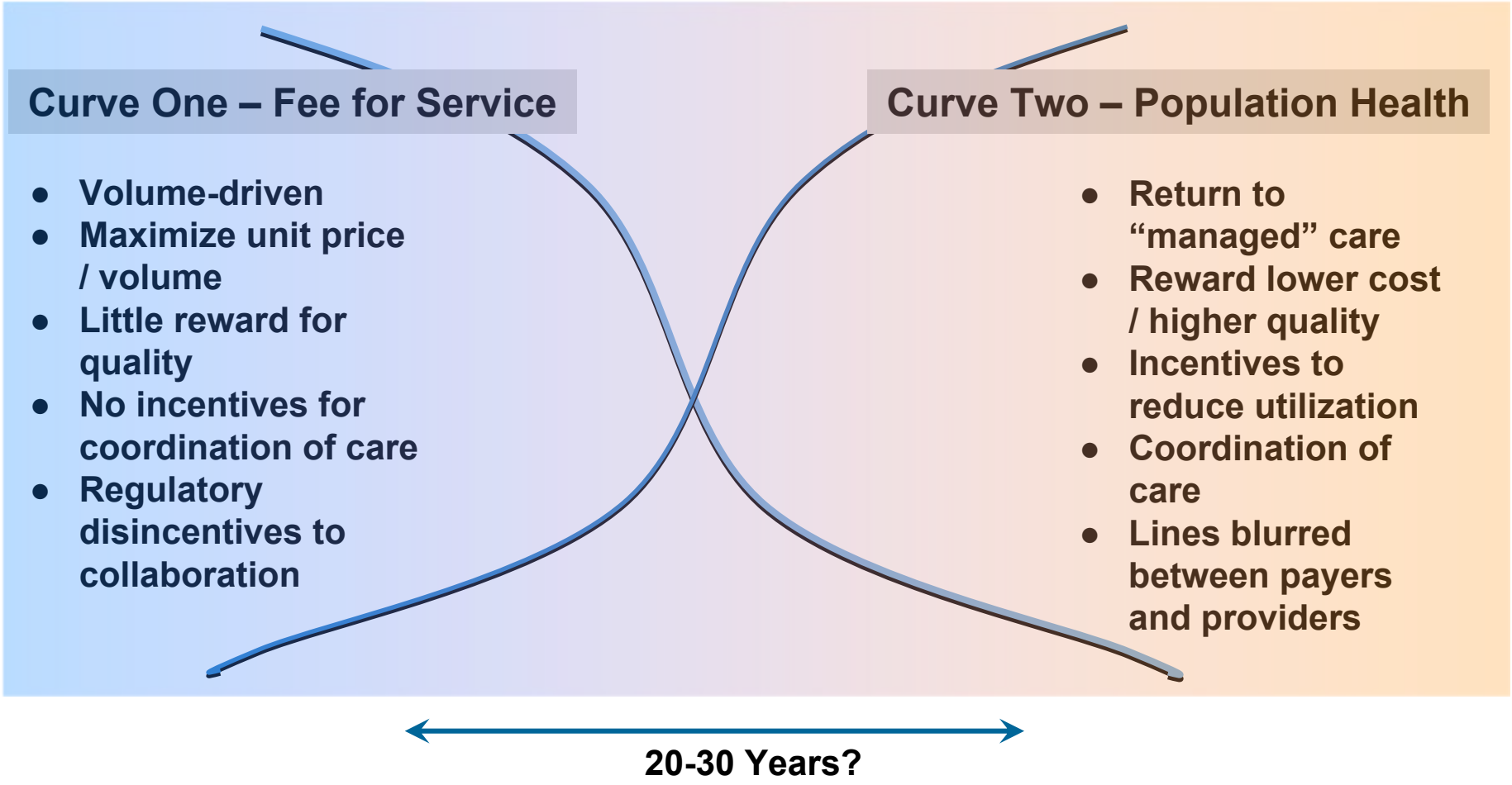
October 2013 – March 2014



Source: Gottleib S, "*Hard Data on Trouble You'll Have Finding Doctors in Obamacare*," Forbes, March 8, 2014, www.forbes.com; McKinsey & Company, "Hospital Networks: Configurations on the Exchange and Their Impact on Premiums," December 2013; Breakaway Policy Strategies, "Eight Million and Counting: A Deeper Look at Premiums, Cost Sharing and Benefit Design in the New Health Insurance Marketplaces," May 2014; eHealth, "Health Insurance Price Index Report for Open Enrollment and Q1 2014,"

Classic “Curve One” / “Curve Two” business model dilemma

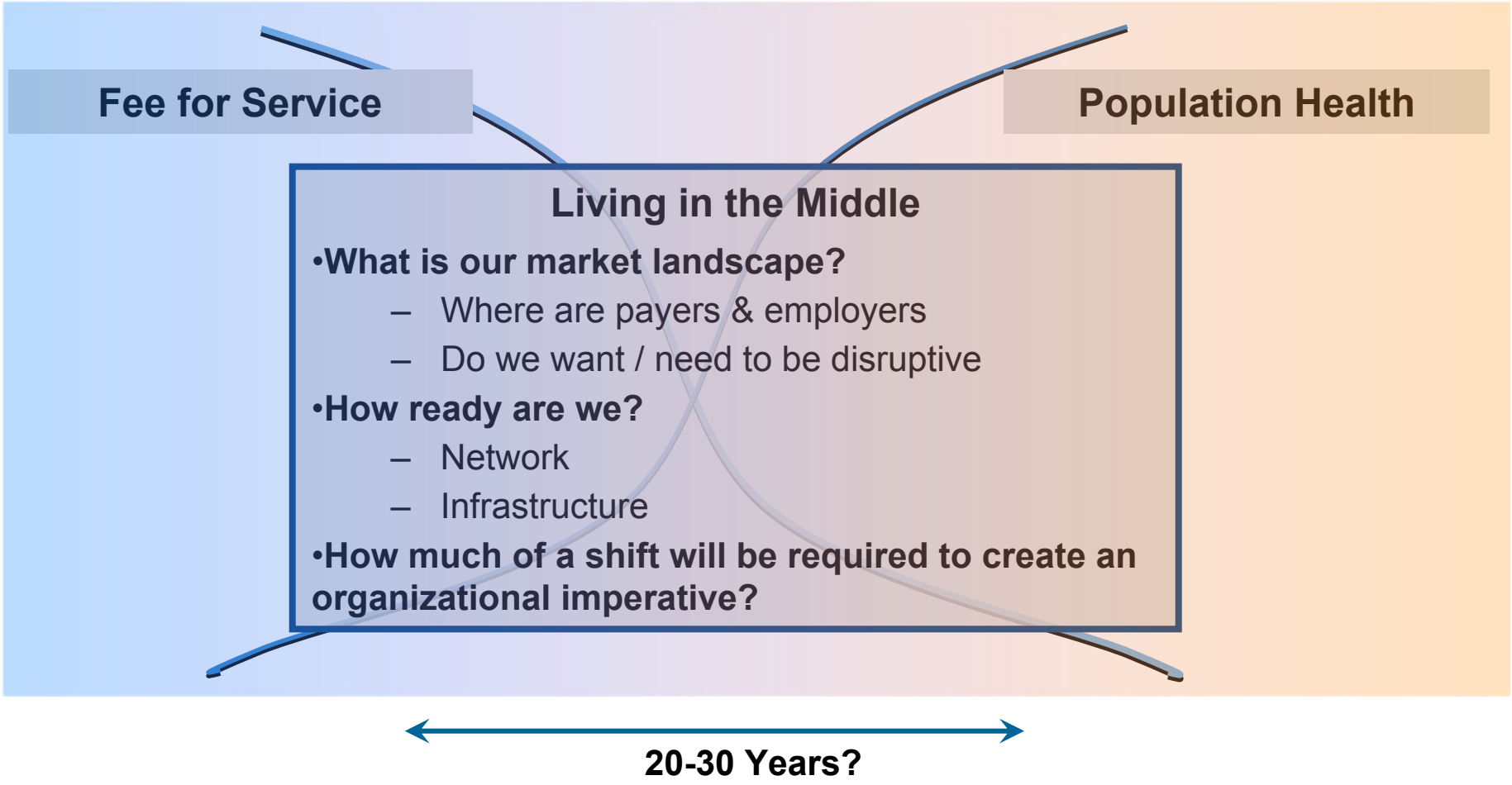
We’re shifting one business model to another, but this evolution will take years.



Source: Complements to Ian Morrison, The Second Curve: Managing the Velocity of Change; 1996.

Classic “Curve One” / “Curve Two” business model dilemma

Strategic questions are: How do we “live in the middle?” How do we build new skills? How fast should we move?



Source: Complements to Ian Morrison, The Second Curve: Managing the Velocity of Change; 1996.

Strategic clarity is imperative

Key Questions to Ask:

- Do we have a clear point-of-view about our tolerance for risk and the pace at which we want to move?
- Did we go through an organized process to align all constituencies around our value proposition?
- Do we have a clear plan for organic growth to replace the losses that will result from reduced utilization?
- Have we budgeted for appropriate management infrastructure?

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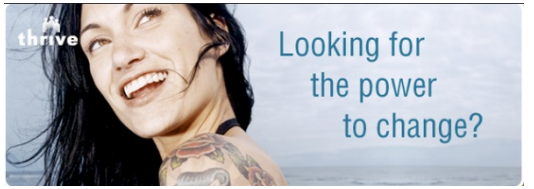
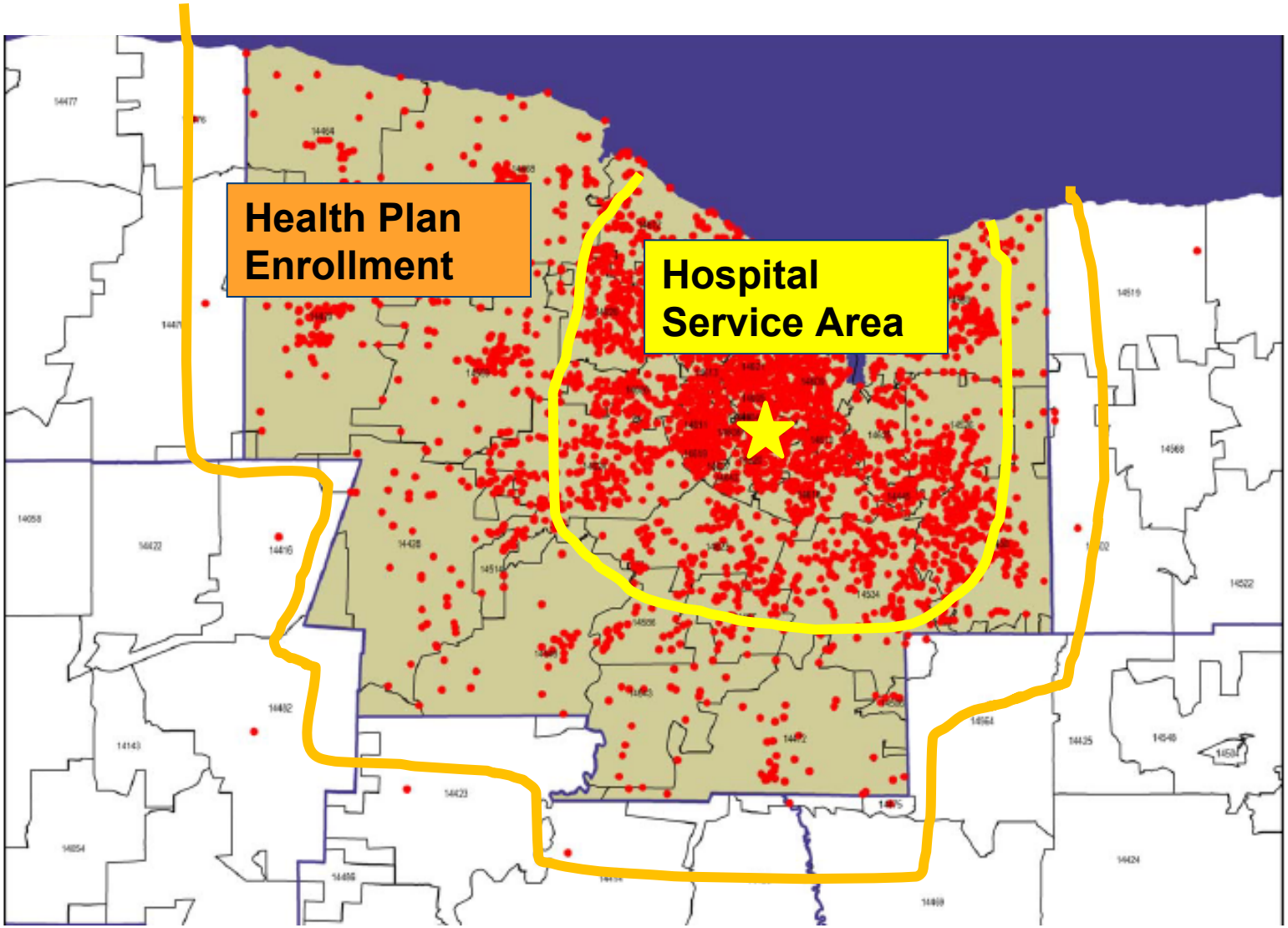
Providers and plans speak different languages

Language	Provider System	Health Plan
Customers	Doctors Patients	Members Employers
Revenue	Billings / Charges	Premium
Costs	Physical Plant, Clinical and Other Labor, Supplies, Drugs	Medical Claims, Admin Expense
Risk	To be Avoided	Foundational
Utilization	More is Better	Less is Better
Product	Episodes of Care	Longitudinal Care Management Financial Services
Marketing	Attract High Acuity Patients	Attract Young & Healthy

Provider systems and health plans have different market positioning



Aligning delivery network with population served



Measuring success: New management metrics

Health plans monitor three unique metrics of financial success that are specific to the industry.

- ***Medical-loss ratio (MLR)*** - Total medical claims expenses divided by total revenue. Provides a snapshot of how much of the premium dollar was actually spent on health care during the reporting period. PPACA requires that health plans have an 80 percent MLR in the individual and small-group market (85 percent for Medicare Advantage).
- ***Underwriting margin*** – This metric is total net income before taxes divided by the total medical claims expenses and operating expenses. Measure of plan profitability

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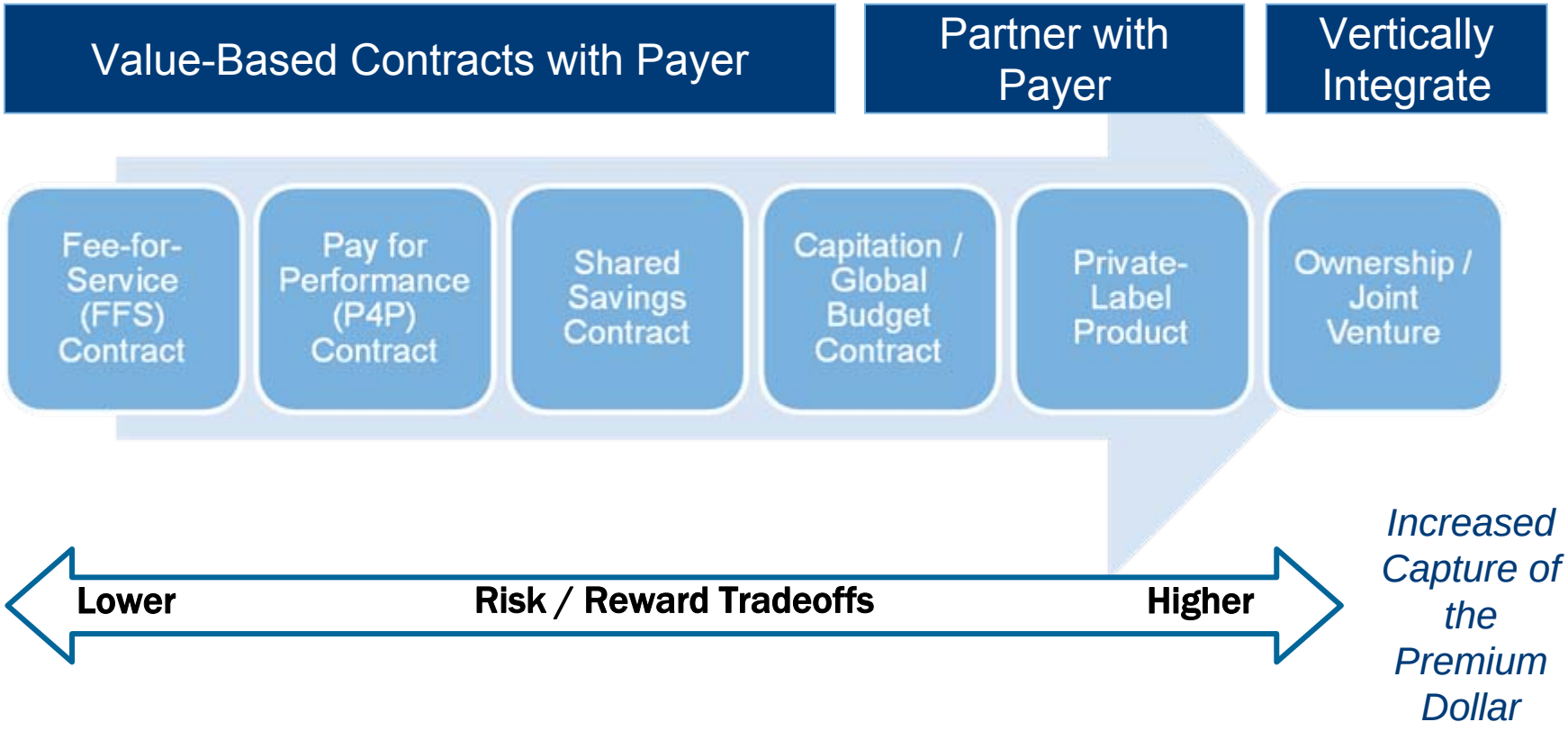
Pros and Cons of Key Arrangements

As providers and payers come together to embrace value-based contacting and improve quality, there is a continuum of shared risk to be considered.



As you might expect, most health plan shared savings programs don't share much of their savings.

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% of Total Benefit Returned to Health System

		% annual change in Rev/ RAF Score					
		-5%	***-3%***	***-1%***	***1%***	***3%***	***5%***
% annual change in TMC	***-5%***	31%	36%	39%	41%	43%	44%
	-3%	21%	31%	36%	39%	41%	43%
	-1%	0%	21%	31%	36%	39%	41%
	1%	0%	1%	22%	31%	36%	39%
	3%	50%	0%	2%	22%	31%	35%
	5%	50%	50%	0%	4%	22%	31%

Unlikely Scenarios (Actual MLR < 72%)

Below Budget Floor

Within Risk Corridor

Above Budget Ceiling

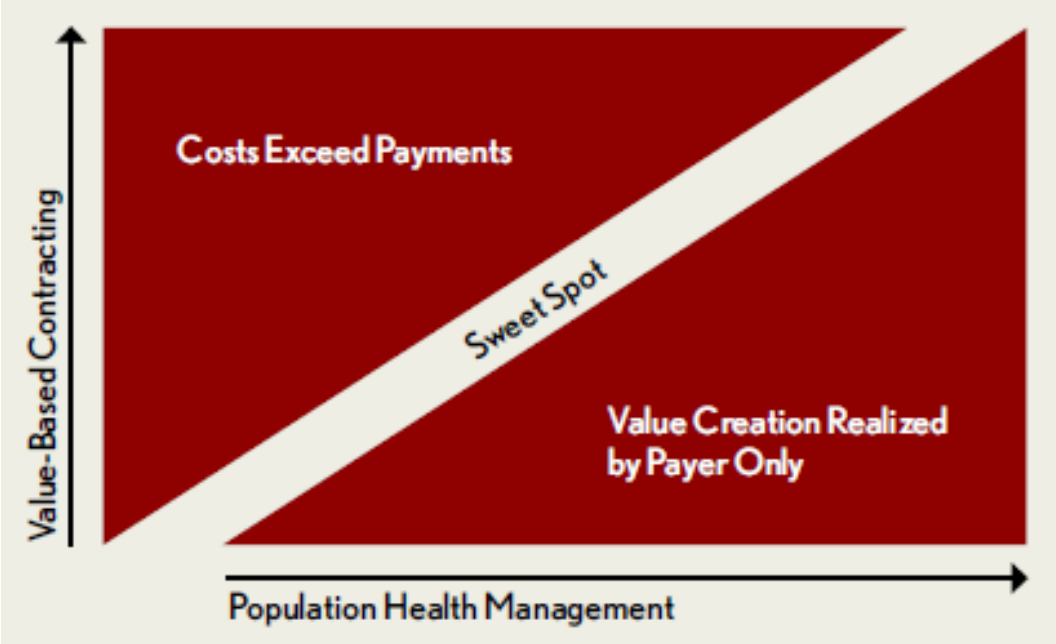
- Note: Assumes total benefit = total $ less than 80% MLR.

Source: National health plan proposal to BDC Advisors client; BDC Advisors analysis

Health systems need to find the "Sweet Spot" in negotiating value-based contracts with payers.

The VBC challenge is to align the contracting structure with population health management so that the value created (cost savings) accrues to the provider.

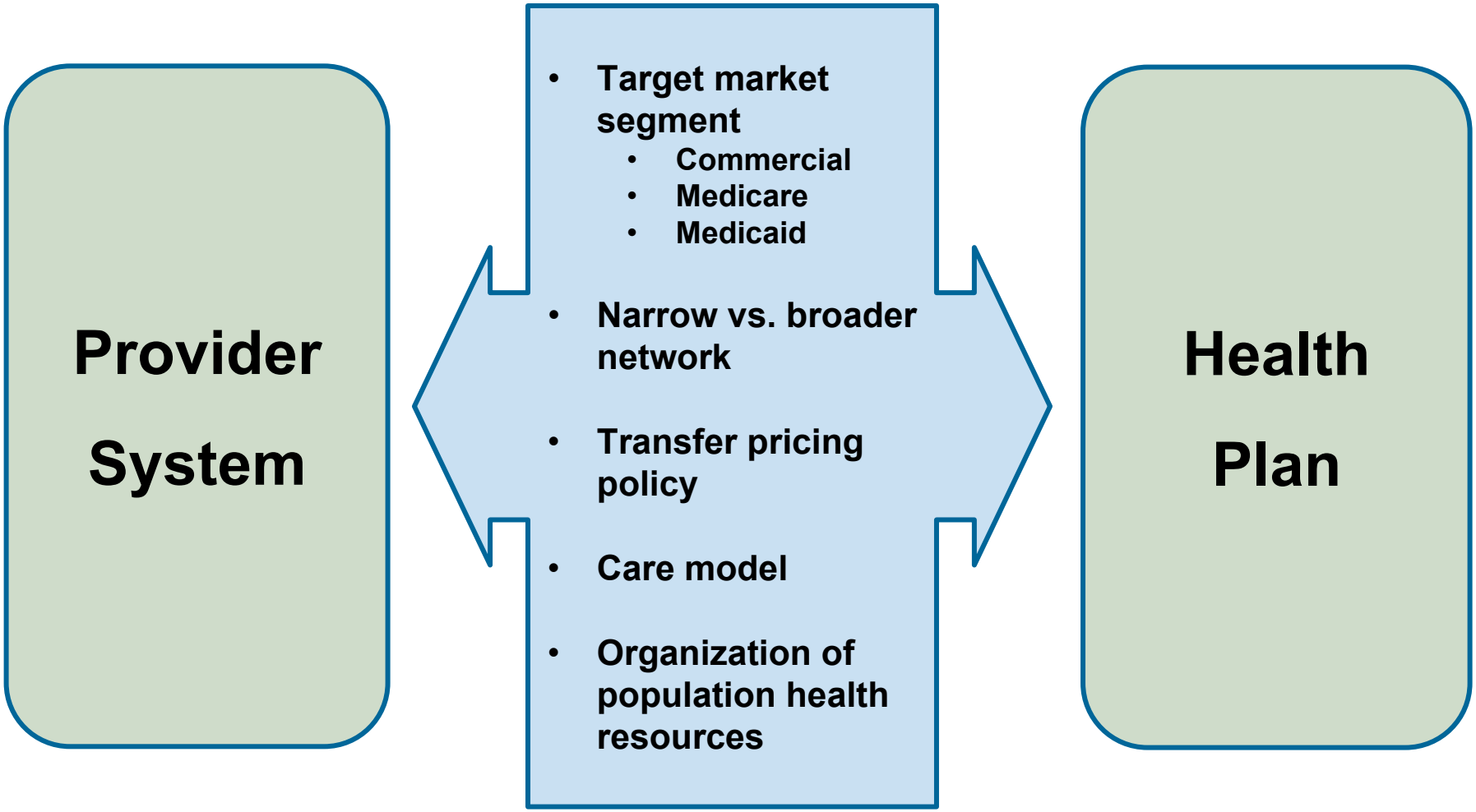
If contracts shift too much risk to provider and provider cannot reduce cost sufficiently, then costs exceed payments and provider loses money



If contracts don't shift enough risk to provider, and provider turns out to be very effective at managing cost, then value created accrues to payer and provider leaves money on the table.

Sources: "Finding the Sweet Spot in Value-Based Contracts" *hfm*, August 2015.

Key Integration Issues



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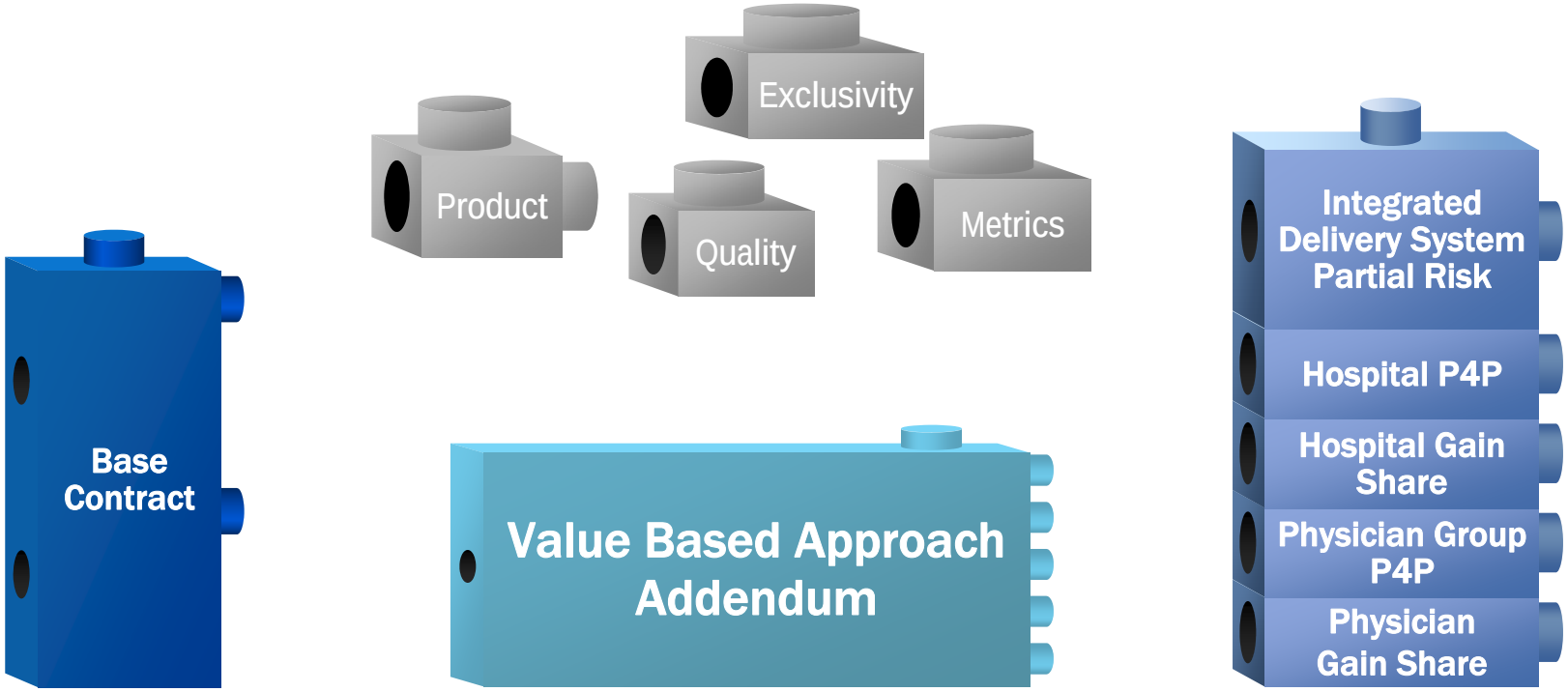
Goals of effective value-based contracting

New focus on financial terms of the provider contract…



Value based contract structure

Value-based contracts are designed to meet specific market and customer needs, but have common structural characteristics.

- Today's contracts are often structured as shadow capitation agreements. There are no prepayments. Billings continue just the way they always have under fee-for-service depending on what contracts are in place. Accountability is measured, and the incentive payments trued up after the contract period.
- Shared savings and/or global budgets can be expressed in a variety of ways:
  - ➔ Based on the provider system total-costs-of-care vs. peer group total-costs-of-care over a defined, usually inflation adjusted, measurement period;
  - ➔ As trends, where the provider agrees to hold their cost trend to a certain inflation measure; or
  - ➔ As a trend relative to the market, where the provider system agrees to beat market medical cost trend by a certain percentage.
  - ➔ Providers can agree to cost guarantees where provider performance for attributed beneficiaries is compared to a reference group of unassigned beneficiaries.
- Various incentives or guarantees can be either upside only or involve bilateral risk. The provider can have full exposure to up and downside risk, or can mitigate risk exposure through use of defined corridors.

Providers and plans think differently about the math

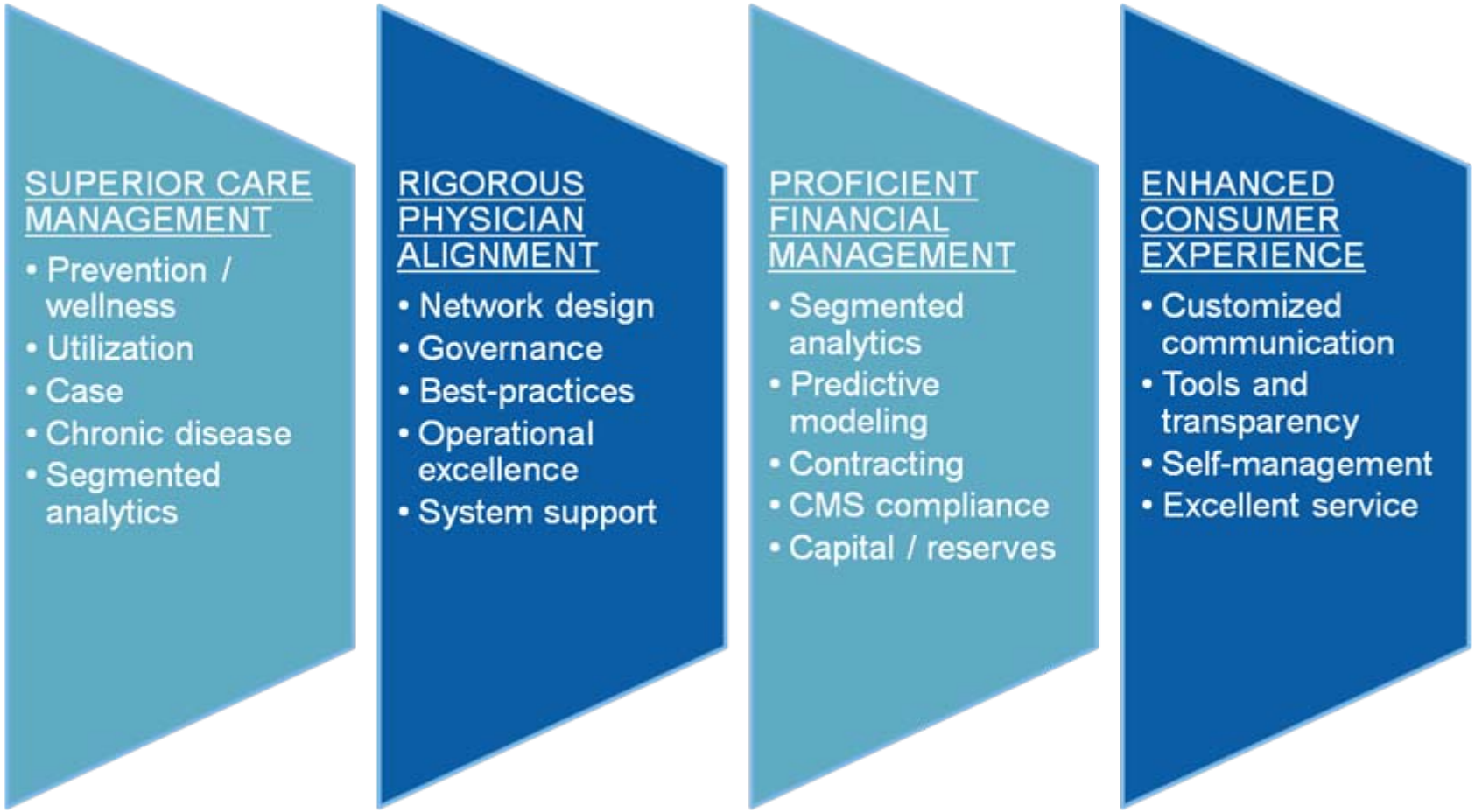
Contract Considerations	Provider System	Health Plan
Increased Patients/Members	What are the payer's incentives to steer patients? How many "net new" patients will be steered?	How many current members will move to the new product/contract?
Pricing	Does the payer's offering provide adequate benefits/incentives to steer "net new" patients and prevent leakage?	How much of a unit cost adjustment is needed to price competitively to steer members "immediately".
Unit Cost Adjustments	What is a reasonable unit cost concession based on other contracted payers? How can margins be preserved?	How much can leakage be decreased to compensate for unit cost adjustment?
Network Configuration	How will network tiers be defined? What incentives/disincentives will the patients have to move between tiers?	What is the tightest network needed to steer members?
Infrastructure	How much will the payer fund for network development, care management, clinical informatics, etc?	What incremental costs/minimum investment will be required to support the offering?
Marketing	What are the payer's commitments with regard to marketing? What about brand?	What non-incremental resources exist to market the offering?

Providers and plans think differently about the terms

Contract Considerations	Provider System	Health Plan
Steerage - Volume	How will the payer make the system "whole" if volume increased do not occur?	What protections can be put in place if volume estimates are not realized? Are there minimum guarantees that would still provide "skin in the game"?
Steerage - Mix	Will the contract contain anti-steerage language to prevent excessive patient shifting from high to low cost settings?	What protections can be put in place if excessive utilization shifts occur?
Attribution Methodology	What methodology will provide the greatest capture of revenue?	What is the accepted attribution methodology that is the easiest to implement?
Data Sharing	What contractual relief will the payer provide if reporting is inadequate or untimely?	What is the incremental costs/minimum investment required to provide adequate data?
Duration, Disputes, and Termination	What is the minimum contract term? Is there an "out"? How will patients be protected? How will the brand be protected?	What is the maximum contract term? How can an "out" protect both parties? How will the patients be protected?

In the end, execution trumps contracting …

Even with the best of contracts, ability to deliver is the key driver of success …



Appendix

Pros and cons of key arrangements

THE PAY FOR PERFORMANCE (P4P) CONTRACT

P4P contracts offer retrospective provider incentives centered around quality and cost of care initiatives. Measures of performance can include HEDIS scores, risk coding, readmissions, etc.

Pros	Cons
• Good starting point for provider-payer engagement • Provides financial resources for investment in care model / infrastructure • Low member threshold • Can be implemented quickly • Risk is usually upside only	• Establishing "right" measures • Payer data / reporting capabilities • May have low overall impact on healthcare costs

- ✓ **Used in conjunction with other payment models, including FFS, bundled, or capitated.**
- ✓ **Somewhat effective, but limited; requires large patient panel and large enough incentive for significant provider engagement.**

Pros and cons of key arrangements (Cont'd)

THE SHARED SAVINGS CONTRACT

Shared Savings contracts can incorporate any chosen metrics that are evaluated to reduce the cost of a particular service, with savings shared by both payer and provider.

Pros	Cons
• Aligns incentives for providers to reduce cost of care • Catastrophic protection for providers • Provider control of member experience • Attractive to payers	• Payers get half the benefit for none of the outlays • Payer data / reporting capabilities • High membership threshold • Timing of reconciliation • Diminishing returns over time

- ✓ **Used in conjunction with other payment models, including FFS, bundled, or capitated.**
- ✓ **Effectively engages providers.**

Pros and cons of key arrangements (Cont'd)

THE CAPITATION / GLOBAL BUDGET CONTRACT

Capitation contracts are prospective in nature and set a flat Per Member Per Month (PMPM) for a given set of services. A partial capitation contract sets a flat PMPM for certain services by certain providers. A full capitation contract sets a flat PMPM for total cost of care/all healthcare delivery services by all providers.

Pros	Cons
• Upside risk for providers • Improves cost predictability • Improves provider-payer engagement • Provider control of member experience	• Downside risk for providers • Payer data / reporting capabilities • High membership threshold • Timing of reconciliation

- ✓ **Effectively engages providers.**
- ✓ **Full capitation usually used with large provider systems.**

Pros and cons of key arrangements (Cont'd)

PRIVATE-LABEL PRODUCT

Private-label products require a competitive combination of price, benefits, and network configuration to attract customers to the provider system.

Pros	Cons
• Reduces risk of market uncertainty • Eliminates need for capital investment in infrastructure • Provides recognized brand	• Downside risk to providers • Payer data / reporting capabilities • High membership threshold • Timing of reconciliation

Pros and cons of key arrangements (Cont'd)

PRIVATE-LABEL PRODUCT

Private-label products require a competitive combination of price, benefits, and network configuration to attract customers to the provider system.

Product	Considerations
Small Group	Payer likely to require unit cost concessions and be protective of current margins
Individual Exchange	Payer likely to require unit cost concessions; reduces risk of market uncertainty while providing brand recognition
Medicare / Medicaid	Reduces risk, but erodes earnings potential / Allows early market entry while building expertise
Direct to Employer / Administrative Services Only	Reduces potential savings driven by providers / Provides strong national discounts needed to compete
Employee Health Plan	Reduces potential savings driven by providers

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