OLIVER WYMAN

Health & Life Sciences

POINT OF VIEW

JULY 2015

PAYER-PROVIDER PARTNERSHIPS: THE FUTURE OF INSURANCE PRODUCTS

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Some of the most compelling health insurance products being launched today are based on a partnership between a payer and a provider. Here's why partnered products matter—and how to make them a core part of your strategy.

The concept of a health insurance product built around a single provider system, multi-specialty group, Accountable Care Organization (ACO), or Clinically Integrated Network (CIN) may still be in its infancy, but it has already proven its worth. These "partnered products," as we think they should be called, may look at first like little more than just another flavor of a traditional narrow network. But in fact they are much more. The single system dynamic creates the opportunity for deep partnership around the clinical and financial model, member experience, and marketing that a multi-system approach typically cannot provide.

MARSH & McLENNAN COMPANIES

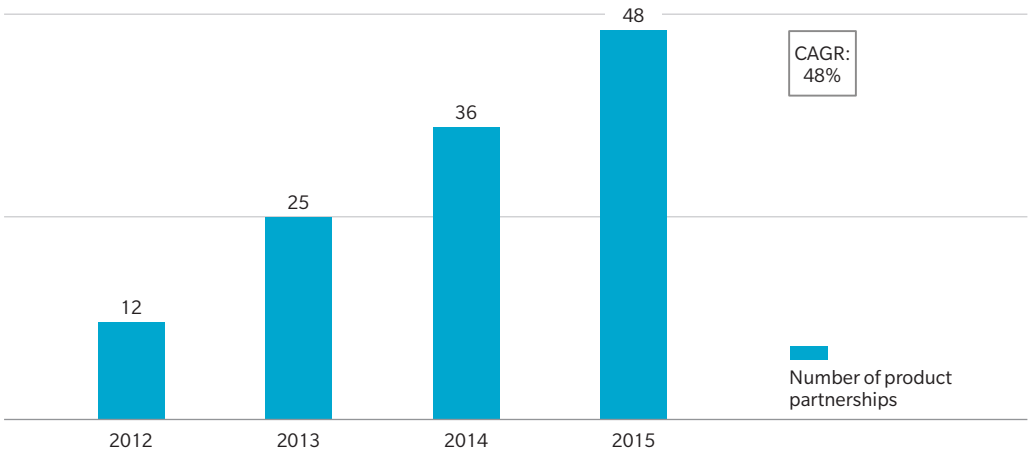
Some of the early-mover partnered products have been strikingly successful:

- In New Hampshire, ElevateHealth, developed by Dartmouth-Hitchcock, Elliot Health System, and Harvard Pilgrim, is achieving cost savings of 15 to 20 percent and passing them on to its customers in the form of lower premiums
- Align, a partnership between Kaleida Health and Blue Cross Blue Shield of Western New York set out to wrap a health plan around a clinically integrated network and lower costs by at least 6 percent
- Innovation Health, a partnership between Inova and Aetna, has developed commercial and Medicare Advantage HMO and PPO products in Northern Virginia, as well as self-insured group products. The first year of product launch in 2013 was a success, achieving growth of 140,000 members

Oliver Wyman estimates value-based product partnerships have doubled in last two years.

We could cite many more success stories, and based on Oliver Wyman research, value-based product partnerships are accelerating, having doubled in last two years and growing at an annual rate of 48% since 2012 (See Exhibit 1). Yet we still encounter payers and providers that balk at the idea of partnered products. Payers tend to regard ACO or CIN productization as too complex a process to be rolled out broadly, requiring near-perfect clinical partners, exclusive (or at least first-mover) relationships, and an unachievable level of collaboration. Providers, for their part, share similar concerns about selecting the right partners—or finding a way to negotiate with payers that doesn't fall into familiar, unproductive, antagonistic patterns.

Exhibit 1: Oliver Wyman Analysis of value-based product partnerships, 2012 through July 2015



Source: Oliver Wyman analysis. Estimates of product launches based on monitoring announcements by both payers and providers since 2012. 2015 figure includes 5 partnerships announced in 2015 but set to launch on January 1, 2016. Data set not exhaustive.

There may have been reason to feel this hesitancy two or three years ago, when payers and providers alike were uncertain about how partnered products differed from traditional narrow network products and few players had experience in solving the challenges they pose. But now ACO- and CIN-based products have become more sophisticated and the problems are much better understood. In our work with both payers and providers, we have seen an emerging consensus on how to build, market, and manage partnered insurance products. Productization is becoming a tool that can and should be used by a much broader group of ACOs and CINs than would have been practical only a few years ago.

HOW PARTNERED PRODUCTS CREATE VALUE

The most significant value of partnered products centers on enabling a faster pace of transformation to value-based care.

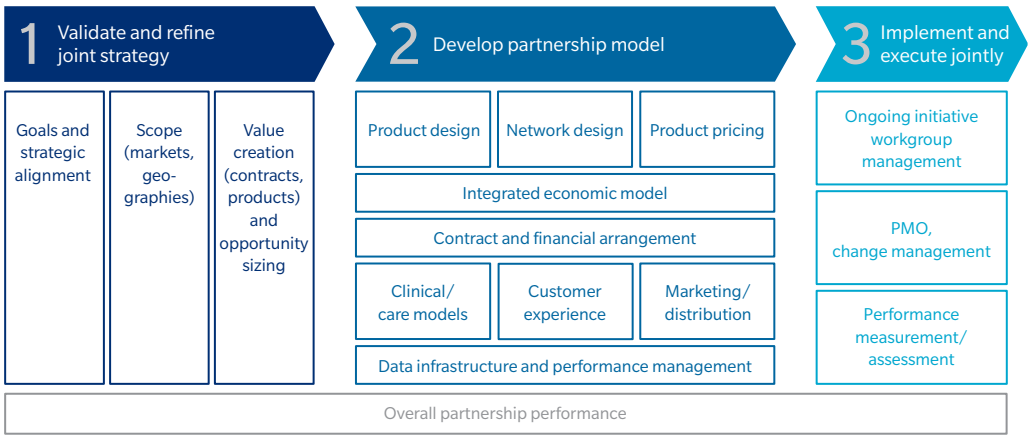
The movement in recent years from fee-for-service toward a value-based approach in U.S. healthcare has led to a huge increase in numbers of ACOs and CINs. Based on Oliver Wyman's most recent update, almost 70 percent of the U.S. population now live in localities served by accountable care organizations, and 44 percent live in areas served by two or more. However, value for consumers, especially in terms of health insurance product pricing, has been elusive.

This newly developed value-based care infrastructure can serve as the foundational chassis for payer-provider partnered products. Partnered products offer an opportunity to quickly develop and launch a lower-cost product backed by a high-quality integrated provider network, with the added advantage of tying the insurance product to the reputation of the healthcare provider partner. Products anchored on a cohesive network structure give members and providers incentives to keep care within a well-coordinated system, which makes them better able to reduce unnecessary care, improve outcomes, and align payer and provider economics around value and total cost of care.

When combined with well-designed care models, a service strategy, innovations in consumer experience, and proactive education about the product's benefits and provider network, partnered products represent a significant opportunity to avoid the past pitfalls of narrow network products while bringing a low-cost, high-quality option to market. Critically, a partnered approach avoids the risk of significant member disruption and patient confusion that has characterized today's typical approach of cherry-picking low-unit-cost practices and facilities, many of which may lack historical relationships and referral patterns.

While these shorter-term considerations bring critical value, the potential benefit of partnered products extends much further. Our experience in creating multiple partnered insurance products (See Exhibit 2) persuades us that their most significant value is in enabling a faster pace of transformation to value-based care. An aligned product and network design gives both sides what they need to truly transform: The health plan can afford to market aggressively at a reduced price because it has the confidence that the provider will actually be able to have an impact on costs, and the provider can move faster in transforming its clinical model, knowing that the health plan has strong incentives to help replenish revenues with new patients to offset lost volume of services.

Exhibit 2: Oliver Wyman HLS has a codified, proven approach to help payers and providers accelerate their partnerships and collaboratively bring products to market



Source: Oliver Wyman Analysis

For many reasons, partnered products are very different from traditional insurance products. They require a different development approach, a different kind of financial analysis and market research, and a different approach to network development. Most important of all, they require ongoing management and committed leadership support. If there is one characteristic mistake payers and providers make when developing partnered products, it is treating the process more like a typical contracting effort than a true partnership negotiation. Seeing the product partnership for what it is—a new, significant step toward payer-provider alignment—will help both payer and provider understand how they need to approach the process. Without this partnership mindset, we've seen both parties get trapped in zero-sum negotiations lacking a clear financial framework, becoming mired in historical relationship "baggage." In our experience facilitating and developing product partnerships over the past several years, a clear plan and playbook are critical.

HOW TO SUCCEED IN PARTNERED PRODUCTS

The basic concept of a partnered product is simple, but execution can be tricky. Here are the key areas to watch out for:

Build an integrated financial model. Product partnerships represent significant win-win opportunities, especially for early movers. But for there to be full buy-in, both sides need to be able to quantify how the deal creates value for them. And that means that both sides need access to an integrated model that gives them visibility into key assumptions on financial drivers and allows both partners to review them and model scenarios in concrete terms related to how they think about their business (See Exhibit 3 for Case Study). Payers, for instance, need to quantify membership opportunity and impacts on premiums and margins; providers need the ability to translate metrics of lives at risk and attributed membership into patient volumes and market share. Each party has data and insights that can be critical in informing the other's evaluation of the financial value of a product partnership; without this way of reviewing the deal, neither side is going to be comfortable pulling the trigger on the partnered product, no matter how strategically interesting it is in principle.

Exhibit 3: Financial models are essential to rapidly explore risk arrangements and align on economic terms

KEY ASSUMPTIONS

- Risk arrangement terms
  - Maximum downside/withhold
  - MLR target
- Performance improvement
  - Risk coding and revenue improvement
  - Care management improvement

PROVIDER PERFORMANCE SCENARIO MODELING

Improving provider performance →

	WORST CASE FULL WITHHOLD LOST DUE TO HIGHER COSTS	SCENARIO 1 NO CHANGE FROM 2015 PERFORMANCE	SCENARIO 2 BASE CASE PERFORMANCE IMPROVEMENT	SCENARIO 3 OPTIMISTIC PERFORMANCE IMPROVEMENT
A. Total medical cost (PMPM)	$319	$259	$252	$245
B. In-system referral retiention	67%	67%	72%	82%
Target MLR	87%	87%	87%	87%
MLR performance	115%	94%	87%	80%
C. Risk arrangement gain loss (PMPM)	$(90.0)	$(16.8)	$0.9	$16.2
Effective total claims discount	*–28%*	*–7%*	*0*	*0*
Total provider revenue PMPM (A*B+C)	$124	$157	$182	$215

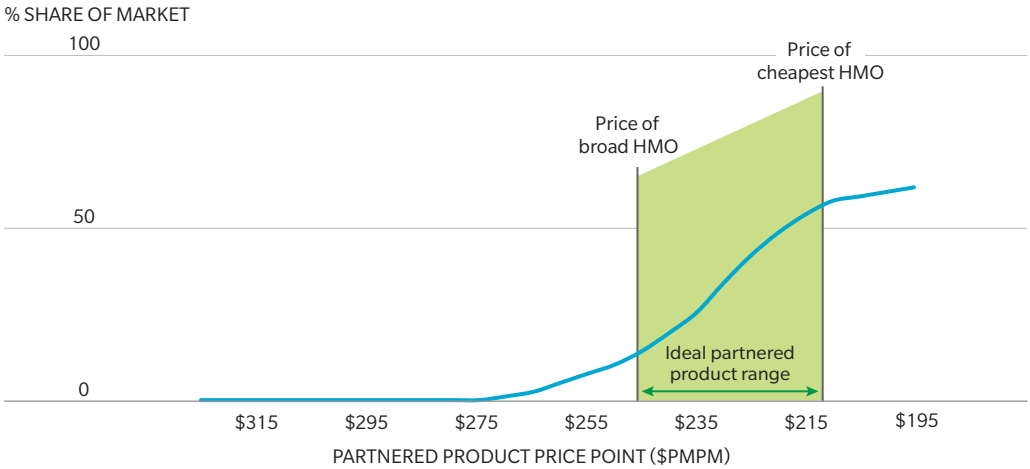
Source: Oliver Wyman Analysis; blinded example

Don't just contract—partner. It's tempting to approach a partnered product with the habits and perspectives that have fueled negotiations for decades: unit cost reimbursement rates, steerage, administrative cost load, etc. But a partnered product is very different from a traditional insurance product, and it needs to be created by a different kind of process—one that leads to true partnership and a strong ongoing relationship. Team members outside of the traditional contracting teams, including the C-suite, should be involved from the outset. This will enable a much more strategic conversation, with different tactics and tenor up to and including the CEO—need to be involved, different strategies and attitudes need to be deployed. It is not necessary to obsess over picking the "right" singular partner. In our experience, payers and providers are increasingly comfortable collaborating on specific initiatives, often targeting specific market segments (frequently Medicare Advantage, public and private exchanges, small employer groups) or patient populations, without committing to exclusive, enterprise-wide partnerships. Given how quickly the market is evolving and how much flexibility and experimentation will be needed, we think this is the right approach. Internal communications and building further organizational alignment and buy-in is crucial. Individual practitioners need to understand what they are doing and why, and core day-to-day operators need to be on board and invested in the success of the effort. This is particularly critical with multi-market provider systems that may delegate significant authority to local leadership.

Remember that you're not replacing network building—you're engaging in a different kind of network building. Instead of taking an outside-in approach—developing the network by excluding the provider partner's competitors, design the network inside out. Begin with the core ACO or CIN. Assess current referral patterns to identify key independent providers, ancillary providers, and others that need to be included. Quantify likely levels of out-of-network care—a key input for product pricing. (A typical population will generate at least 10 to 15 percent of out-of-system care just from ER visits and associated inpatient stays.) Ensure that the product meets state network adequacy requirements—which include factors such as specific driving distance and quota requirements for each physician specialty. Test market demand for the resulting network (See Exhibit 4). In some markets, you will discover that you can substantially improve uptake by including specific highly recognized providers and brands. In some markets, we've seen this sort of research lead to the creation of multi-partner joint ventures bringing together key provider systems—and generating strong early enrollment numbers.

Exhibit 4: Understanding the market's demand curve is critical in pricing and positioning a new, narrow partnered product

OLIVER WYMAN CASE STUDY: DEMAND CURVE OF PROJECTED PARTNERED PRODUCT (SHARE OF MARKET BY PRICE POINT)



Source: Oliver Wyman Analysis; blinded client example

Invest in clinical transformation. As we've discussed, the long-term goal of partnered products is to accelerate transformation to value-based care supported by new clinical models. That transformation requires extensive investment in new processes, new care plans, and upgraded technology. Providers frequently cannot fund transformation on their own, especially because they may have to wait several years to realize any return on their investment. If payers want to ensure that their provider partners can meet new demands on a tight schedule, they need to take a thoughtful approach to staging these investments, aligning on how to co-invest, and incorporating these assumptions into the overall financial model. For payers, it is also important to keep in mind that most providers need to manage their clinical and care management processes the same way for all populations. Rather than trying to negotiate or insist on product-specific changes in care process, we have found that a more effective approach is for the partnership to instead focus on how clinical changes can disproportionately provide value to the partnership. Key to this strategy is directing members to the practices or portions of the provider system that are furthest along in transformation.

Give adequate attention to payer operations. The partnership needs to make purposeful decisions around payer role and operations and how they might change for members of a partnered product. For a narrow network ACO-based product, utilization management for all in-network utilization is probably unnecessary. Case management and disease management programs might need to be tightly coordinated and tailored to align with the network design and the ACO's clinical capabilities. Other pieces of traditional "payer admin"—such as customer service around network, benefits, finding a provider, and out-of-network care—may in fact be more necessary, and new capabilities may be needed to drive improved customer experience. It is essential to balance these considerations and others against total administrative costs.

A NEW WAY OF DOING BUSINESS

It is crucial to remember that partnered products are not just new items to put into the marketplace—they are a new way of doing business. As you move forward with your partners, your organization and theirs will need to continually change and adapt. At the very least, in the early stage, payers will need to develop and negotiate contracts that respond to the needs and capabilities of healthcare providers operating under different models and under different market conditions. They will need to share data, maintain ongoing relationships with the clinical side of providers, and manage relatively complex performance- and outcome-based contracts. Providers will need to begin looking at some aspects of financial and clinical performance differently, according to parameters set in partnership. Our experience with companies launching their first partnered products persuades us that most can manage the transition to new processes smoothly once they understand the need for them and the benefits to be gained. Establishing a roadmap or process to illustrate the path toward partnered products helps facilitate these transitions.

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The most successful health plans over the next decade will be those that understand that healthcare is undergoing a greater change than it has faced in half a century. The transformation of care delivery has really only begun. And that means the need for health plans to rethink their role, redesign their products, and re-engage their customers has also just begun. Partnered products are a first step, not just in creating the next round of products for changing consumers, but as a first step in creating responsive, creative health plans that can evolve and grow with healthcare itself.

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