HealthScape Advisors

Assessing Joint Venture Models

for Provider-Sponsored Health Plan Products

Introduction

Health systems are well-attuned to the potential pitfalls of launching a provider-sponsored health plan (PSP) without the right mix of expertise, capabilities, and capital. Health plans, on the other hand, are actively seeking partners that can deliver tight network alignment, care continuum integration, and strong local brands grounded in clinical excellence.

Given these dynamics, it's no wonder that the industry has recently seen a spike in the number of joint ventured health plan products (JVs). In fact, more than 40 providers have launched or acquired health plans, and between 2015 and 2017, every new provider-sponsored health plan formed was a payer-provider joint venture, according to a recent **Health Affairs article**. The healthcare media has developed its own version of newspaper wedding announcements, with daily pronouncements of marriage such as those between **Oscar and Cleveland Clinic**, HealthPartners and Bellin/ThedaCare, or Aetna and a host of health systems. The headlines tout the promise of highly integrated partnerships, but in truth, the mechanics of each joint venture ultimately determine its success in the marketplace.

Unfortunately, many of these pronouncements are often followed by declarations of trouble in paradise. News of operating losses and less-than-ideal financial outcomes are not uncommon in the early years of JV partnerships, but our experience shows that is to be expected. The true downfall of many JVs goes beyond health plan filings and P&L statements.

HealthScape continues to observe that too many of these JVs fail to fully capitalize on promises because the partners are incompatible or unable to coexist under the same roof. In the long run, this causes many of these JVs to unravel and disappear from the market landscape.

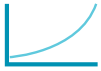
However, there will be select JVs that, as the classic Stephen Stills song suggests, learn to "love the one you're with" by treating the new combined entity as a departure from the adversarial relationships that still permeate a sizeable portion of payer-provider contracting. This constitutes a shift to a new paradigm of mutual respect, shared commitment, and aligned interests, all of which are hardwired into the structure of the JV. Organizations that make this shift will enjoy new revenue streams, enhanced margins, and captured share.

Key Drivers of Increased Joint Venture Health Plan Popularity

It is evident from the spike in market activity that an increasing number of organizations believe JVs to be a key business expansion strategy. What's driving the strategic importance of this new directional traction?

Shift to Value-Based Care

Economics of Risk-Adjusted Payment

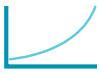


Enabled Risk & Cost Sharing

Speed to Market

Shift to Value-Based Care

Health systems want to monetize investments in infrastructure made in response to the shift to value-based care. They are looking for new revenue streams to attach to investments which have been made in a comprehensive strategic continuum, such as workforce expansion (e.g., primary care employment), technology development (e.g., EMRs and data warehouses with sophisticated backend analytics), service expansion (e.g., behavioral and post-acute care), and extending facilities into the markets being served (e.g., alternative sites of care, including urgent, retail, and virtual health). Many of these investments threaten the financial margins of traditional fee-for-service payment. One of the clearest ways to align to this new business model is to capture a larger share of the premium dollar.



Enabled Risk & Cost Sharing

Meanwhile, health plans are hoping to leverage capabilities that enable risk sharing and address a growing trend of consumerism, such as proprietary technology for member portals, care management tools, and pricing tools. Health plans are also seeking ways to expand membership to lower administrative costs around front, middle, and back office operations. The move into JV models is one way to accrue membership, spread costs, and recoup investments for both parties.

Economics of Risk-Adjusted Payment

Another key driver of the recent interest in JVs is the economics of risk-adjusted payment. Both health plans and health systems are becoming more incentivized to focus on accurate and complete documentation of member/patient diagnoses. There are new opportunities for information sharing to ensure that data collected by health systems is transmitted to the health plan, through various systems, and fully reported to the government without data leakage. Failure to do so could have financial consequences for both organizations.

Speed to Market

Finally, speed to market is another attractive feature of JVs, as it allows health systems to latch onto an established administrative chassis, and likewise, allows health plans to leverage an existing network and local care model to minimize the risks of market expansion. Health plans, in particular, have launched or acquired "internal consulting groups" (e.g., Aetna Accountable Care Solutions or Optum's consulting division, including The Advisory Board Company) to install the technology and integration practices that help the complex JV health plan effort function. Health systems can leapfrog into mature health plan capabilities through the JV, rather than assuming risk from experimenting with outsourced models or taking on the significant risks associated with build models.

Evaluating the Joint Venture Model

Organizations considering entering into a joint venture health plan must carefully weigh both the benefits and risks associated with this type of partnership. The evaluation conducted by each partner helps to align interests and begins to inform how the partnership is structured.

On one side, joint ventures have the potential to offer a variety of unique benefits, some of which could not be repeated through a contracting strategy alone. These benefits include:

New Market Penetration

Affords an opportunity to rapidly "productize" or generate a revenue model around health system capabilities in areas like brand recognition, patient relationships, and access points, as well as to amplify health plan capabilities in areas like distribution channels, administrative efficiency, technology services, and analytical insights.

Capital Sharing

Spreads the requirements for risk-based and startup capital across multiple partners.

Speed to Market

Represents a faster and lower execution risk pathway to acquire capabilities to enter the market by leveraging the respective strengths of each partner.

Clinical Performance

Allows full claims visibility and exchange of electronic medical record (EMR) data to enable more effective closure of clinical and diagnostic gaps.

Quality Performance

Creates incentives for data sharing and integrated medical management initiatives that seek to improve the efficiency and outcomes of care delivery.

Member Engagement & Lifetime Value Strategies

Enables a longitudinal view of patient care, or a "lifecare" approach, through a membership structure that relies on wellness and prevention strategies to produce results over a longer timeframe.

Click to read our recently published whitepaper on the "Lifecare Model" and how consumerism is driving this new strategic platform.

While the benefits may sound enticing to an organization that is considering market and business expansion, they must be weighed against the potential risks:

Roles & Responsibilities

Confusion around division of responsibilities may result in a situation where care delivery and financial results are sub-optimized.

Financial Risks

Market cycles or under-performance in key functions could produce losses for both parties. Health systems are no longer insulated from premium pressures or medical management challenges, while health plans can no longer criticize the cost of workforce, technology, therapeutics, and facilities, and label it as a "solvable" equation.

Leadership Risk

Ceding operations to a small staff—recruited from the outside as neutral parties with limited loyalty to either of the partners and a limited understanding of how to leverage the parent organizations' resources—runs the risk of slow execution and missed opportunities.

Product Performance

Performance of the product in the market presents shared financial risks for both parties. If enrollment numbers miss projections, the product could fail to meet its expectations around revenue and administrative costs.

Risk Score Accuracy

Product economics could become distorted by lower than anticipated population risk scores. Discrepancies and/or underpayment may be a direct result of provider coding ineffectiveness, plan encounter reporting errors, or a combination of both.

Quality Performance

A significant enough portion of plan revenue is tied to quality bonus payments to impact profitability. Established plans that fail to meet and exceed guidelines may find themselves behind projected revenue per member.

Medical Loss Ratio (MLR) Management

Health systems must manage to MLR targets for their attributed at-risk lives. If the health system were to overestimate capabilities to bend the cost curve through control of excess utilization, both parties would be on the hook for operating losses from the JV product.

Market Competition

Although largely outside of the JV partners' control, competitive pressures in the market may also depress pricing power, which in turn hurts the ability of plans to build margin into premium structure or expand benefits with actuarial soundness.

Where Should Health Systems and Health Plans Start?

This is a lot of information for both health plans and health systems to consider. So, how do you determine if a JV is the right approach? Certain indicators about an organization and its surrounding market point to the JV model as a strategy worth considering.

Local market indicators that can be evaluated include:

- Do viable partnership options exist?
- Do the partners have a strong brand position in the market?
- Are there other provider-sponsored plans or JVs that have achieved success with consumers in the market?
- Will consumers accept narrower provider networks?
- Are there signs of dissatisfaction with current players due to service lapses or alignment issues?
- Are there cost pressures on individuals and employers based on premium increases from year to year?
- Are there brokers that are looking to expand their product portfolio and would view the JV as an attractive product addition?

*Several **organizational indicators** can be assessed, which include:*

- What is the brand equity that the partners can bring to the table?
- Does the organization have a culture and leadership conducive to partnership?
- What are the unique aspects of the care management or care delivery model that would allow for incremental success in medical management?
- Does the infrastructure and health technology exist to support execution?
- What levels of operational performance have been achieved in other, potentially similarly designed, products?

Meanwhile, the potential partners need to reflect on their own readiness to enter into a JV arrangement.

Cleveland Clinic + oscar

CASE STUDY

Cleveland Clinic and Oscar Health – Two Partners with Complementary Capabilities

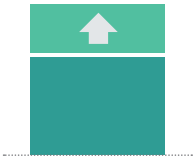
In June 2017, Cleveland Clinic and Oscar Health formed a joint venture partnership to offer two co-branded health insurance plans in five counties in northeastern Ohio, with the expectation of offering individual plans on- and off-exchange in 2018.

This marks Oscar Health's expansion into the Ohio market, as well as Cleveland Clinic's debut on the health insurance market with a product bearing its name. As of January 2018, this co-branded health plan has enrolled more than 11,000 members, which was a higher than expected market share and accounted for almost 15% of the individual health insurance market in the northeastern Ohio service area.

On its surface, the partnership appears to be an unexpected pairing of new and established organizations from two different states. However, a closer look reveals benefits and further strategic alignment in pursuit of consumer engagement for both parties.

Cleveland Clinic, one of the nation's premier hospital systems, is firmly established in the Ohio market. We project that this partnership will offer Oscar Health a unique entry into the Ohio market, while creating the potential for great market share growth. For Cleveland Clinic, partnering with Oscar Health represents a better option than starting its own health plan, while also empowering it to leverage Oscar's technology-focused plan management to enhance consumer engagement and disease management.

more than
11,000
members



Enrollment higher than expected

Cleveland Clinic + Oscar

CASE STUDY

Cleveland Clinic and Oscar Health— Two Partners with Complementary Capabilities (continued)

In a recent HealthScape Executive Briefing, we conducted an executive interview that resulted in a key insight—both organizations manifest consistent prioritization of consumer experience.

Oscar Health specializes in delivering a differentiated consumer experience through a user-friendly digital interface, simple plan designs, and an innovative wellness program. Cleveland Clinic focuses on patient-centered innovation
and strategy.

We believe this innovative, collaborative approach better positions the organizations for success.

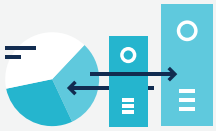
Our review of Oscar Health/Cleveland Clinic has uncovered that this partnership epitomizes an innovative joint venture approach. It operates on the belief that beyond continued opportunities to optimize incentive structures and information flows in support of value-based payment models, meaningful value will result from the introduction of aligned products and consumer-centric solutions, as well as the expansion and improvement of the business process governing the interaction of health plans, health systems, and consumers.

Constructing the Joint Venture

Once market conditions and organizational capabilities have been evaluated, there needs to be careful consideration of the business case for a JV model.

Key elements of this business case include:

1



Financial Scenario Analysis

Partners need to look at the potential benefits and financial feasibility of the investment against a rubric of their strategic objectives for entering the market. Even if the financial ratios, such as internal rate of return (IRR) and net present value (NPV), turn out positive, and the strategy appears aligned with objectives, there needs to be consideration of the "do nothing" approach—envisioning a future if the JV does not come to fruition. In this scenario, consider how the market might realign if the JV does not exist, as well as what alternative investments could be made and whether these alternatives would change the trajectory of growth for each partner.

2

Build/Buy Considerations

The partners should also consider whether they would be better off building or buying/outsourcing market entry, as opposed to partnering through a JV model. Parsing through decisions requires a careful consideration of cost, risk, and control, as demonstrated through the Medicare Advantage market entry operating model example on the following page.

Medicare Advantage Market Entry Example

Shorter-term ← → *Longer-term*

	FINANCIAL RISK	GENERAL RISK & COMPLIANCE	OWNERSHIP RISK
BUILD	**$$$** + Long-term financial opportunity with significant upfront risk	+ All risk internalized (e.g., compliance, execution, implementation, integration)	+ License and contract directly with CMS + Own member lives + Becomes a long-term strategic asset
BUY	**$$** + Upfront costs amortized over time	+ Purchase the necessary competencies from vendor(s) + Numerous vendor integrations with internal oversight	+ License and contract directly with CMS + Own member lives + Allows for choice to carve-in operations in longer term
PARTNER	**$** + Resources and investment shared across partners	+ Shared risk across partners + Potentially difficult to maintain partnership	+ CMS license and contract shared with a partner + Shared asset; lowest amount of equity

3

Partner Evaluation

Critical to the success of the JV will be identifying the right partner, and achieving fit will require significant focus on combining capabilities and coordinating activities. Once a partner has been identified, the diligence work can begin around enrollment projections and financial feasibility of the JV investment.

The following key criteria should be considered:

- ☐ **Aligned mission and strategic vision**
- ☐ **Degree of upside in market share growth through combined efforts**
- ☐ **Degree of cost savings that need to be generated to compete**
- ☐ **Level of risk experience**
- ☐ **Supportive technologies** *(e.g., telehealth, interoperable systems, analytics)*
- ☐ **Brand strength**
- ☐ **Cultural compatibility**
- ☐ **Value-based care infrastructure**

aetna + Texas Health Resources

CASE STUDY

Aetna Joint Venture Strategy—Achieving Vertical Integration

In January 2017, Aetna and Texas Health Resources (THR) formed a health plan—Texas Health Aetna—to offer fully insured and self-insured products to employers and consumers in the Dallas-Fort Worth area.

With equal ownership, the companies aim to improve care coordination and reduce waste/redundancy by combining THR's high-quality health systems and investment in population health management with Aetna's health plan expertise, care management capability, and analytics. Aetna's robust technology and data analytics will support THR's integrated clinical program, population health, and medical cost management.

Some highlights include:

1. Offering same/next day primary physician case, 24/7 virtual care, and a navigation platform upon enrollment

2. Coordinating clinical and claims data in real-time with ongoing data exchange to improve EHR integration for clinical outcomes, increase operational efficiency, and reduce medical/administrative costs

3. Managing high-risk members with locally-based care teams and holistic approaches to reduce medical costs

aetna + Texas Health Resources

CASE STUDY

Aetna Joint Venture Strategy—Achieving Vertical Integration

Aetna has also combined with health systems in other markets—Inova Health System in Virginia in 2012, Banner Health in Arizona in 2017, Sutter Health in Northern California in 2017, and Allina Health in Minnesota in 2017. In choosing its partners, Aetna has favored dominant health systems with integrated care models in the desired market; Banner and THR, for example, already have ACO agreements with Aetna. It has also opted for narrow networks that are attractive to health systems and employers because of their lower overall costs.

Aetna's strategy for partnership has seen some recorded successes.

For example, according to Brigitte Nettesheim, the president of Aetna's transformative markets, Aetna and Banner have experienced some notable financial and quality improvements:

11.5% *decline in medical costs*

24% *decrease in avoidable surgical admissions per 1000*

5% *improvement in the monitoring of patients' medication therapy after a heart attack*

4% *increase in generic prescribing*

11% *improved intervention for pediatric patients with recurring ear infections*

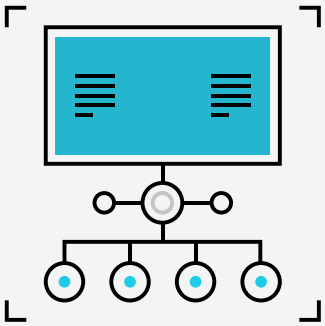
Source: Oliver Wyman Health Podcast: "Aetna's Brigitte Nettesheim Talks Payer-Provider Partnerships," April 25, 2017

Structuring the Joint Venture

It is essential to consider the structure of the partnership, including how to use organizational elements to foster shared goals. In contemplating the structure, partners will often consider the level of risk they are willing to accept, the level of capital they are willing to put at-risk, and the ability to present an affordable product that will be competitive with other offerings in the market.

These structural decisions will help design the best fit among various JV models. For example, if a health system prefers to put limited capital at-risk, they may seek a health plan partner that has capital to invest in the market. Alternatively, if a health system is willing to invest its own capital, but cautious about its ability to reach affordability levels, it may seek other health systems to join the JV and work together on managing patient care in the market.

A partner that is interested in taking low levels of risk may opt for a product-based partnership with a limited offering built around a specific product, versus the higher risk option of integrating the P&L in a jointly-owned insurance company with multiple products and lines of business. The structure does not always need to reflect a 50/50 split of fiscal responsibility. Partners can bring other valuable, non-financial assets, such as an established provider network, brand equity, and governance/leadership roles.



Once the structure is solidified, focus should be turned to the division of responsibilities between partners. For example, health plans can deliver capabilities in the areas of health system contracting and network management, actuarial work, claims payment, enrollment, sales and marketing, member outreach, and traditional utilization management. Meanwhile, health systems may be charged with front line patient engagement, chronic care management, post-discharge management and transitions of care, ongoing practice and care delivery process improvement, and complete and accurate coding. The formal division of responsibilities allows each party to leverage their respective areas of strength and expertise, while defining a long-term roadmap for migrating responsibilities as partners show the ability to take on certain roles.

A particularly key area of shared responsibility is utilization management (UM). A JV will be most successful if they are able to move beyond traditional care management into advanced forms of UM. While UM can still reside on the health plan side, the health system needs to establish clear financial incentives for providers to engage in protocols and evidence-based practice. The provider compensation structure should be linked with the objectives of the JV to drive toward an MLR target that will support premium levels 10-15% below prevailing rates in the market, which we have found to be a level at which prospective members will consider a narrow network product offering over broad networks.

Finally, establishing key performance indicators (KPIs) and a continuous evaluation process for the JV upfront will be essential for ongoing success. These KPIs are likely a mix of clinical and business metrics, formed based on custom metrics and/or established performance tracking systems such as HEDIS, CAHPS, or Star Ratings. From a clinical perspective, the JV may track items such as hospital readmissions, unnecessary ED visits, inpatient admissions, or specialist visits on a risk-adjusted and population-normalized basis. On the business side, the JV should track leading indicators of financial health such as return on investment (ROI), governance committee participation or other metrics of citizenship in the venture, and fulfillment of business objectives or strategic plan that guided decision making.

The Future of Joint Venture Health Plans

Due to the recent wave of JVs, we have yet to see many of these partnerships play out over time.

A recent **Health Affairs article** cited operating losses for all new joint venture health plans that operated in 2017, but it is too early in many of these JVs to judge financial success, as losses are expected in the early years due to high administrative costs and limited membership. The financial success equation must ultimately consider more than the health plan P&L. It needs to evaluate financial impacts on the health system side and the opportunity costs of a "do nothing" approach to the market.

> ***The full financial promise for these JVs will not be realized if the partners do not pursue an integrated agenda with shared incentives, rather than resorting to the traditional adversarial model. We believe that true value is unlocked in united, collaborative partnerships built on enhanced alignment and integration as the vehicle to fundamentally change the way health plans and health systems interact.***

And yet, this also requires the greatest shift in competitive perspective. Health systems must recognize that premium is largely dependent on their costs, requiring direct price competition with the market. As a result, health systems will need to realign their infrastructure and systems to accomplish this maneuver, including evaluating the vestiges of legacy decisions around executive and doctor compensation, accentuation of high cost, high revenue platforms (e.g., inpatient hospital, surgical services, emergency department, etc.), and capital spending.

For health plans, the outlook must change from the historic economic model built around membership growth and underwriting gains/losses to a new economic model built around enablement and partnership services. Health plans should recognize what they bring to the table: capital resources, data warehousing and analytical tools, member engagement platforms, and a host of administrative capabilities including provider networks, distribution channels, benefit design, and managed care experience.

Ultimately, consumers will benefit from a renewed focus on continuum of care development, quality interventions, and navigation support that results in a system that delivers care from points of wellness to sickness, during and between encounters, and with the ease and convenience that are expected in the age of technological innovation. When approaching the opportunity of a JV health plan, it is important to consider your objectives for the partnership, the ability of the partner to deliver on their value proposition, the structure and business case of the partnership, and the ultimate positive impact on consumers. Only then can you achieve post-partnership success.

Is your organization considering a joint venture health plan?

Are you interested in evaluating your options? HealthScape has significant experience helping health plans and health systems assess build-buy-partner strategies, develop business cases, and design the best approach to accomplish business objectives. Contact us for more information.

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ABOUT HEALTHSCAPE ADVISORS

Where insight meets execution

We bring healthcare executives market-leading insights and actionable strategies that create sustainable value.

Why HealthScape

We are experts in healthcare.
We are committed to one industry, demonstrated by our award-winning data analytics platform and network of industry relationships.

We are innovating for tomorrow.
While we help our clients navigate today's dynamic climate, it's our focus on the future that sets us apart.

We are invested in people.
We are smart, resourceful, data-driven professionals, not just a brand. We create an environment of excellence and relationships based on follow-through and trust.

We execute solutions.
While we provide market-driven strategies and superior problem solving, it's our ability to help our clients execute solutions that moves business forward.

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