KaufmanHall | Industry Flash Report

MANAGED CARE

October 2018

Overview of the Managed Care Sector

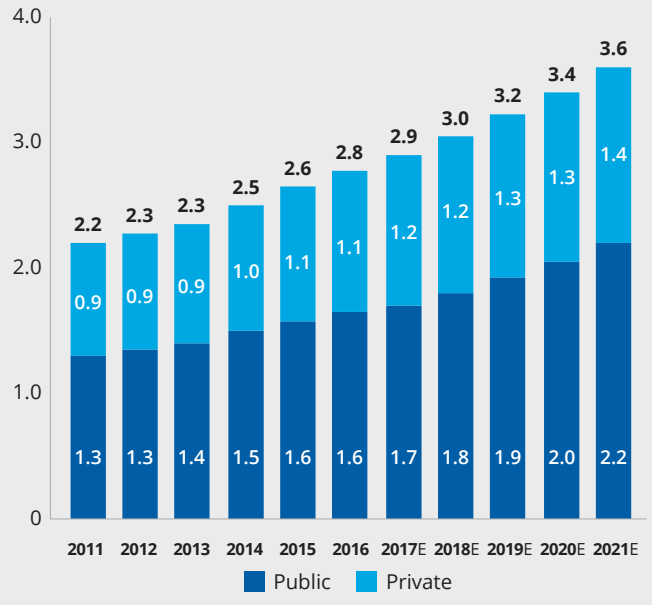
Consistent membership and premium growth by U.S. payer markets is expected to continue, according to new Kaufman Hall research. Premiums for the U.S. managed care market were estimated at $2.9 trillion for 2017. From 2011 to 2016, the industry grew at a compound annual growth rate (CAGR) of 4.6 percent, as enrollment increased at a CAGR of 2.3 percent and implied price per member increased at a CAGR of approximately 2.3 percent. The industry is projected to grow at an annualized rate of about 6.6 percent from 2016 to 2021 (1.1 percent enrollment CAGR and 4.3 percent price CAGR).

A number of factors are expected to drive growth, including increased Medicare enrollment by Baby Boomers, continued government funding of marketplace enrollees, and increased enrollment in employer-sponsored plans. The outlook may change depending on federal policy changes relative to the Affordable Care Act (ACA), but further initiatives to limit or replace the ACA are not anticipated to be imminent.

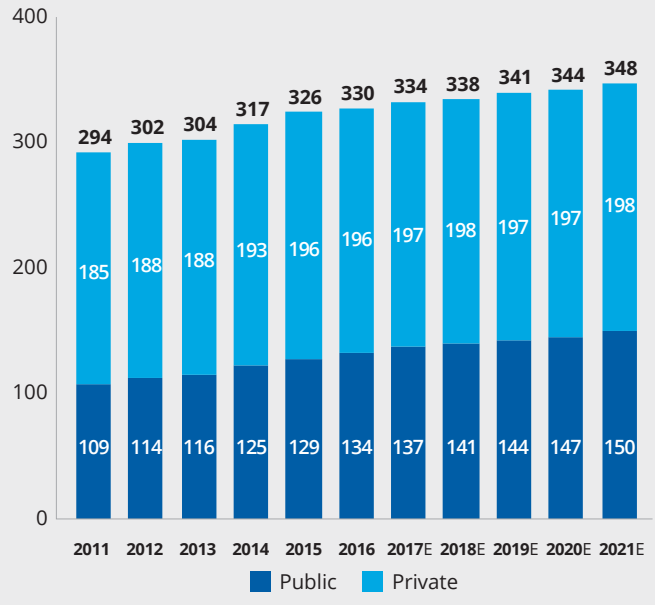
Key trends for the U.S. managed care market include:

- Enrollment in public managed care plans is expected to grow from 109 million in 2011 to 150 million in 2021—with the Medicare and Medicaid portions comprising 65 million and 77 million, respectively.
- Government-sponsored programs—such as Medicare Advantage and Medicaid/Managed Medicaid—are seen as primary drivers of revenue growth by the 12 remaining major health plans (Cigna, Aetna, etc.).
- Medicare Advantage offers the best combination of revenue growth and margins; in 2017, one in three Medicare beneficiaries (19 million people) were enrolled in a Medicare Advantage plan.
- Risk-bearing capability has become a key competency of high-performing integrated health systems.

U.S. Managed Care Spending ($ trillion)



U.S. Managed Care Enrollment ($ million)



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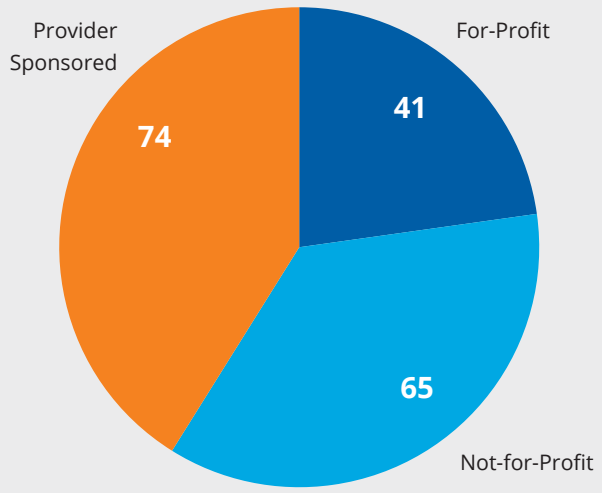
Managed Care Universe: Increasing Number of Provider-Sponsored Plans

A review of U.S. plans identified 180 plans, of which 74 are provider-sponsored plans.

180 Health Plan Entities as of August 2018



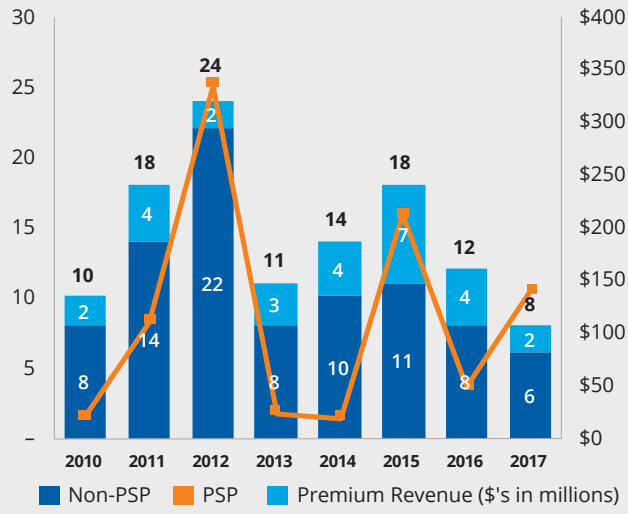
The number of transactions involving PSPs has increased, as providers have been actively revisiting their managed care strategies.

- Acquirers favor government-sponsored programs, such as Medicare Advantage and Medicaid/Managed Medicaid
- Recent 2018 announced/closed transactions include:
  - WellCare Health Plans/Meridian Health Plan acquisition (announced May 2018)
  - UnitedHealth Group/Peoples Health acquisition (announced June 2018)

M&A Transaction Activity (announced deals)

Managed care consolidation has continued in recent years, as the largest insurers have sought member growth, use of cash, scale, and diversification.

Number of Deals, 2010-2017



A Key Question for Health System Executives:
How can our organization best begin managing population health under risk-based payment arrangements?

The options:

- **Create an ACO/partner with a payer.** Jointly develop value-based arrangements/products (e.g., narrow network, private exchange, shared savings)
- **Partner on an existing PSP**. Work with providers that currently have risk-bearing and health insurance capabilities to create new and expanded offerings
- **Build/buy a health plan.** Acquire or create a risk-bearing organization, health insurance product, and plan capabilities

Health system executives should also review physician alignment, next-generation ACO capabilities, IT infrastructure, and other capabilities related to population health management. For more information, please access Kaufman Hall's report *Key Considerations in Partnering for Population Health* here.

Sources: Capital IQ, Public Filings, CMS, and Kaufman Hall analysis.

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Implications for Providers and Payers

As the country makes the shift to value-based care, providers are contemplating how best to start managing population health under risk-based payment arrangements. Health systems are considering whether their chances of succeeding in the emerging business model would be enhanced by partnering, developing, acquiring, or otherwise participating in provider-sponsored plans (PSPs). These plans often are owned and controlled by one or more hospitals or health systems, and can be a significant strategic asset in certain markets. However, the decision about whether to participate in risk-based payment arrangements is a complex one. Given the great variability from market to market, careful evaluation, planning, and execution are essential. For PSPs to be successful, they must have appropriate scale and be underwritten, operated, and marketed in a manner consistent with the organization's overall strategic plan.

Kaufman Hall is actively working with health systems across the country to help them assess their position and marketplace, and determine the optimal partnering strategy. Increased collaboration across the formerly rigid verticals of insurers, providers, and clinicians is opening up access to broader value-based initiatives and collaborations. The unique goals and objectives of each organization must drive the level of integration desired in a partnership—from joint ventures to mergers—to ensure that the benefits of greater scale and capabilities contribute to the long-term viability of health systems.

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