OLIVER WYMAN HEALTH

The business of transforming healthcare

TAKEAWAYS: PUTTING THE HEADLINES IN PERSPECTIVE

What recent market moves mean for retail health, private exchanges, ACOs, and physician compensation

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4 TAKEAWAYS:
WHAT CVS HEALTH-TARGET DEAL MEANS FOR RETAIL HEALTH

by Graegar Smith, Principal, Oliver Wyman

CVS Health completed in December 2015 its acquisition of Target's pharmacy and clinic businesses for approximately $1.9 billion. With the completion of the transaction, CVS Health acquired Target's 1,672 pharmacies across 47 states and will operate them through a store-within-a-store format, branded as CVS/pharmacy. In addition, a CVS/pharmacy will be included in all new Target stores that offer pharmacy services. Seventy-nine Target clinic locations will be rebranded as MinuteClinic, and CVS Health will open up to 20 new clinics in Target stores within three years of the close of the transaction. Oliver Wyman Principal Graegar Smith, with Senior Consultant Chris Tanner, explains why it's telling that a company of Target's size and overall retail sophistication chose to exit its pharmacy business:

1. RETAIL PHARMACY IS AN INCREASINGLY DIFFICULT AND COMPETITIVE MARKET

- Labor cost increases, drug cost increases, insurance reimbursement changes and reductions, regulatory requirement increases, and risk management requirement increases (and risk tolerance decreases) are all significant challenges in the retail pharmacy market today.
- These challenges have been voiced across the industry. Walmart executive Greg Foran noted in an August earnings call that a major contributing factor to the company's underperformance was lower than expected pharmacy reimbursements. "Reflecting industrywide trends, we are seeing reduced reimbursement rates from Pharmacy Benefit Managers, which is negatively impacting gross margin. We are also seeing a lower mix of higher-margin cash transactions, reflecting a marketplace shift in which more customers are now benefiting from greater drug insurance coverage. While we are taking a number of actions to lessen the impact, we expect to have pressure on pharmacy for the rest of the fiscal year."
- While divestures can occur for a variety of reasons, Target's move is likely a reaction to these mounting pressures, plus a need for cash/dollars to reinvigorate its brand.

2. SCALE AND BUYER POWER REMAINS AN EFFECTIVE HEALTHCARE INDUSTRY STRATEGY

- For CVS, this could be a significant growth opportunity, expanding its footprint in both pharmacy and care delivery through retail clinics, and accessing perhaps a new and different consumer base.
- The pharmaceutical value chain has seen significant consolidation across drug manufacturers and PBMs, and pharmacies continue to be part of that movement. This of course is old hat for many who have watched the steady increase in consolidation across the healthcare spectrum, from hospitals to payers and pharma companies. This also indicates that other players in the pharmacy business might be struggling and looking for scale to offset higher operating costs or greater buyer power.

3. SCALE PLAYS MAY BE HARDER TO RUN AS A RESULT, CREATING FRICTION FOR OTHER CONSOLIDATORS

- As the FTC considers approval for the potential Walgreens-Rite Aid merger, CVS's move consolidates the pharmacy industry even further. Given Target's exit, Walgreens might see further resistance from regulators who will find it hard to believe that cost efficiencies outweigh the effects of duopoly pricing. As the healthcare market shifts towards value-based payments, it will be critical that payers implement effective initiatives and compensation models that improve cost and quality performance. The above learnings can help payers work with existing physician compensation models for both employed and independent physicians in order to drive change.

4. FUTURE OF RETAIL HEALTH IS STILL BRIGHT

- Finally, as headlines have focused on the acquisition, this deal could also represent a new partnership between Target and CVS that will continue to define the future of retail healthcare. While nothing has been announced, this deal presents an opportunity to drive benefits for both players. In the words of CVS's president, "This strategic relationship supports the highly complementary customer base, brand, and culture we share."
- As two major pharmacy players are quickly emerging (CVS + Target vs. Walgreens + RiteAid), both driven to reduce costs as quickly as possible, they have to differentiate to win in the eyes of consumers, as well as providers and payers. Similar to Coca-Cola and Pepsi, pharmacy players will need to define what makes them special if they eventually hope to drive customer traffic based not only on convenience and cost.

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ABOUT THE AUTHOR

GRAEGAR SMITH

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Graegar is a Principal in Oliver Wyman's Health & Life Sciences practice. Based in Chicago, he is an accomplished management consultant with more than 15 years of experience in business & operations strategy development for global institutions and market-leading private enterprises.

4 TAKEAWAYS:
PRIVATE EXCHANGES CONTINUE TO EVOLVE WITH LAUNCH OF FIDELITY HEALTH MARKETPLACE

by Sam Glick, Partner, Oliver Wyman

Fidelity Investments has announced the launch of Fidelity Health Marketplace to offer one-stop access to health and wellness benefits to small and midsized businesses and their employees. The platform offers employers the ability to choose from an extensive network of national and regional medical, dental, vision, and life benefits in addition to tax-savings options and access to wellness tools and programs. The launch comes on the heels of Fidelity reportedly leading a funding round for health insurance startup Oscar Health. Oliver Wyman Partner Sam Glick explains why Fidelity's moves indicate the market is recognizing that experience and integration matter in winning mainstream employers:

1. PRIVATE EXCHANGES ARE EVOLVING

- Round 1 of private exchange growth was about securing carrier participation and simply getting something to market.
- Exchange growth then slowed last year as exchanges penetrated "early adopter" employers.
- They're now realizing that experience and integration matter to win mainstream employers, and Fidelity's move is a great example of that – integrating health, retirement, and payroll, with consumer-friendly decision support – all behind a brand that both consumers and employers trust.
- Fidelity just led a $150M funding round for Oscar – they're clearly making bets on consumer-friendly healthcare. And it wouldn't be surprising to see Oscar on this platform. Other carriers will need to have consumer-centric plans in order to compete.

2. TRADITIONAL CHANNEL BOUNDARIES ARE BLURRING

- Fidelity is calling its new product Fidelity Health Marketplace – nowhere on the site does it use the term "exchange," although this is squarely positioned as an exchange competitor for the small-mid group market. Or is it a web-based software competitor to Zenefits? Or a small business private employer organization solution competitor to TriNet? Or a next-generation, technology-enabled competitor to traditional brokers? It's really some of each. The emphasis on new technology tracks with the

findings from our Benefits Selling/Oliver Wyman 2015 health insurance broker survey in which a solid majority of brokers said they believe that technology – in the form of enrollment/benefits administration technology or an online solution – is a critical component of their value proposition going forward.

- Health plans must embrace this evolution – no longer can they have channel management organizations that are siloed based on traditional group size dimensions. They must take the view of the customer and think about all of the different intermediaries competing for their groups.
- Currently, Fidelity is only offering one carrier to each employer – they clearly don't want to deal with risk-adjustment. Does this create an opportunity for carriers to go direct with something even better?

3. CONSUMERS MAKE HOLISTIC DECISIONS ABOUT THEIR LIVES – HEALTHCARE INCUMBENTS THINK HEALTHCARE IS DIFFERENT ONLY BECAUSE WE'VE STRUCTURED THE INDUSTRY THAT WAY

- People want to be able to get the services they need, where they need them, at a price they can afford. Whether this is funded through insurance, an HSA, Medicare, or retirement savings doesn't really matter to consumers – and services like Fidelity Health Marketplace can help to eliminate that complexity.
- That said, smart employers will look closely at how players like Fidelity are being compensated. Is it mostly through insurance commissions? And what kind (especially given that ancillary insurance commissions are higher than health insurance commissions)? HSA fees? Investment management fees? Directing funds toward their own mutual funds? Just like we saw in the early days of 401k plans, this is a market that's evolving rapidly, and how vendors are compensated will affect the kinds of solutions they propose to consumers.

4. PORTABILITY IS THE NEXT FRONTIER

- In an economy where the average millennial can expect to have 15-20 jobs in his or her lifetime, and the gig economy continues to grow, having benefits linked to a single employer is on the verge of becoming an archaic concept. According to the second annual "Freelancing in America" survey, more than one in three U.S. workers – 53.7 million Americans – are now freelancing.
- Who is competing to be the next benefits hub for individuals? Fidelity does this well in the retirement world, rolling over employer-sponsored 401k balances into personal IRAs when people leave their jobs. Will they try and do this for health benefits as well?
- This isn't easy – banks have seen this kind of lifetime relationship as the holy grail for some time but are now facing their own major changes. Just as digital

technology has destroyed established business models in music and publishing, such a transformation may now be on the horizon for financial services, with digital distribution platforms, new product providers, alternative sources of capital, and a growth in outsourcing fundamentally reshaping the industry.

- Healthcare can learn lessons in this regard from industry leaders like USAA. Oliver Wyman had the opportunity to discuss with General Josue (Joe) Robles, retired CEO of USAA, his perspective on successfully leading the financial services firm through a period of momentous change in an era that redefined the customer experience in the digital marketplace.

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Sam's strategic projects focus on consumer-centric healthcare. He advises leading providers, health plans, employers, enablement companies, retailers, and venture capital firms on finding innovative, engaging ways to bend trend.

4 TAKEAWAYS:
WHAT PROPOSED MSSP CHANGES MAY MEAN FOR ACOS, INTENDED OR NOT

by Bruce Hamory, Chief Medical Officer, Oliver Wyman

At the end of January 2016, CMS published proposed changes to the Medicare Shared Savings Program (MSSP), including modifications to how accountable care organizations' cost benchmarks are re-calculated each year. If finalized in its current form, ACOs could see some big changes coming. Oliver Wyman's Chief Medical Officer Bruce Hamory, with Engagement Manager Lucy Liu and our Provider team, offers a perspective on the implications, intended or otherwise:

1. REGIONAL BENCHMARK APPROACH HELPS EXTEND SUSTAINABILITY OF THE PROGRAM AND GREATER INCENTIVES FOR STRONG PERFORMERS MAKE IT MORE FAIR OVERALL

- The region-based model is a significant change to the program, and one that we believe will be valuable in ensuring the ongoing viability of the MSSP program. Rather than the current model, where ACOs must continually beat their prior year performance (which can become increasingly difficult if not unsustainable for top performers), the regional approach starts the transition to a county-level rate.
- The proposal calls for an ACO's second- and third-year benchmarks to be re-calculated using not only the national FFS cost trend, but also regional FFS cost trends. Regions will be defined by counties, similar to Medicare Advantage and the Physician Group Practice demonstration sites. The second year re-basing will be 65%/35% national/regional; the third year will be 30%/70% regional.
- This means that the methodology sets the county rate using all beneficiaries in the county eligible for ACO assignment, so two ACOs operating in a given county would receive the same rate. For stronger performing ACOs, this creates larger incentives each year from beating the benchmark. If you're great, your better odds compound each year. If you're a low performer, and part of that is because you're in a high growth region, your benchmarks become a little more forgiving. This further levels the playing field for external local factors that drive trend higher or lower, much of which is out of the immediate control of the ACOs.

2. NON-UTILIZERS ARE FINALLY TAKEN OUT OF THE EQUATION

- The proposed changes would set FFS benchmarks based on only beneficiaries eligible for ACO assignment, rather than all beneficiaries – effectively excluding the low- and non-utilizers who never see a PCP.
- As Niyum Gandhi, Chief Population Health Officer at Mount Sinai Health System, explained, "While a $10K patient might inflate to $11K, $0 always inflates to $0," which was making the performance benchmarks highly stringent.

3. HIGH-PERFORMING ACOS WITH LARGE POPULATIONS MAY BE PRESSURED

- Regional cost benchmarks will be based on all Medicare beneficiaries in the county, so all ACOs in that county have the same regional trend applied.
- CMS determined that since most ACOs' assigned populations are far smaller than the overall FFS beneficiary population, this approach was preferred to customizing each regional benchmark by removing each ACO's own beneficiaries. However, for a dominant ACO that makes up a large proportion of its region's population, this methodology does not give the ACO due credit for its role in bringing down regional costs.

4. ACOS WILL START TO BEHAVE MORE LIKE MA PROVIDERS

- Under the new rules, an ACO's regional trend would be calculated using any counties where at least one beneficiary resides – and the median ACO spans eight counties.
- Where your patients live starts to matter. If you get a patient from a county with higher cost trend, your benchmark trend will be more forgiving if more of your patients live in counties with high cost trend rather than lower cost trend. It might discourage ACOs from serving rural counties, where inflation tends to rise more slowly.

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BRUCE HAMORY
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Bruce is a Partner and Chief Medical Officer in Oliver Wyman's Health & Life Sciences Practice. He is a nationally known speaker on the topic of redesigning health delivery to improve value by improving quality and reducing costs.

4 TAKEAWAYS:
THE LAN FRAMEWORK & HOW WE PAY DOCTORS

by Parie Garg, Principal, Oliver Wyman

In January 2015, Health & Human Services Secretary Sylvia M. Burwell announced measurable goals and a timeline to move the Medicare program, and the healthcare system at large, toward paying providers based on the quality, rather than the quantity, of care they give patients. To make these goals scalable beyond Medicare, Secretary Burwell also announced the creation of a Health Care Payment Learning and Action Network (LAN). Through the LAN, HHS has been working with private payers, employers, consumers, providers, states, and state Medicaid programs, and other partners to expand alternative payment models (APM) into their programs. A LAN work group released an APM Framework White Paper, as detailed in a Health Affairs blog post. Here Oliver Wyman Principal Parie Garg shares considerations for physician compensation in light of the recommended framework:

1. WHILE CHANGING PHYSICIAN COMPENSATION IS NOT SUFFICIENT, IT IS NECESSARY TO STIMULATE AND SUSTAIN INNOVATIVE APPROACHES TO PATIENT CARE

- The first articulated guiding principle of the work group was to acknowledge that "changing providers' financial incentives is not sufficient to achieve person-centered care, so it will be essential to empower patients to be partners in healthcare transformation."
- Physicians are the lynchpin of the healthcare delivery system and control many aspects of downstream care delivery (which hospitals patients to go, which prescriptions they take, etc.). In order for there to be meaningful change, physicians have to view a redesigned compensation as a mutual benefit operation (beneficial to them and to the health system).
- Models where physicians have been excluded from the benefit have struggled to make meaningful change and recruit physicians. One doctor put it this way: "No physician is going to join an ACO if they aren't promised a share of the savings that they helped create."

2. THE CHANGE IN COMPENSATION NEEDS TO BE MATERIAL

- The upside from the alternative payment models needs to be substantial enough to garner physician attention. Past P4P models with ~5% of upside in return for measuring a large number of metrics have achieved limited success in true, sustainable behavior change, as this New York Times article reports.

3. POPULATION HEALTH-BASED MODELS SHOULD BE VIEWED AS THE END GAME

- Providers are struggling to transition from fee-for-service to fee-for-value. Current systems, processes, and mindset are geared towards fee-for-service rather than fee-for-value.
- New models will need to be built on the skeleton of the fee-for-service model (e.g. utilized work RVUs to settle on base payment and value-based metrics to provide an upside) and the shift should be gradual. Moving immediately to a population health payment model will be extremely difficult for most organizations.

4. NO MATTER WHICH MODEL YOU EMPLOY, COMMUNICATION IS KEY

- Regardless of the choice of APM, communication with physicians and the clinician team is essential to positive momentum. Even the best designed model can fail due to lack of understanding, fear of the unknown, and a general unwillingness to change.
- If a physician's take home pay is going to be impacted, but they don't know what to expect, there will be significant pushback – regardless of the durability of the model.

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PARIE GARG

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Parie has experience building value-based care delivery programs for health plans and provider systems and has guided several companies in the design and development of innovative care delivery models, with expertise in physician compensation and government programs.

ABOUT OLIVER WYMAN HEALTH

Oliver Wyman Health is a virtual community of innovators convened by the Health & Life Sciences practice of global management consulting firm Oliver Wyman.

As the healthcare world changes and leaders look for direction, guidance, and new ideas, Oliver Wyman Health offers a digital platform for diffusing proven value-based solutions. Our in-house team of experts as well as a range of external thought leaders provide practical insights on the business challenges of transforming healthcare from volume to value.

We invite you to share ideas and infographics, contribute novel approaches to the financing and delivery of healthcare, subscribe to receive updates on effective strategies, and connect with other healthcare industry professionals.

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