Optional Pre-Conference Workshop: Strategic Positioning for Success - Challenges and Opportunities for Medicare Advantage Plans

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Hank Osowski, a Founding Member and Managing Partner of Strategic Health Group is an experienced health care executive and strategist who has provided leadership to commercial, Medicare and Medicaid health plans for more than three decades. He has led several engagements for the firm’s clients on the key challenges of Dual Integrated Care programs in California, Wisconsin, Michigan, Illinois, New Mexico and Hawaii. He has also provided leadership to more than seven client plan development undertakings for commercial, Medicare Advantage and Medi-Cal business startups in California.

Formerly the senior vice president of corporate development for SCAN Health Plan, Hank was a key member of the senior leadership team that turned the company around from a “near death experience” into an exceptionally strong financial position and one of the largest nonprofit Medicare Advantage plans in the country. He led SCAN’s expansion into seven additional California counties and as well as its first out-of-state expansion into Arizona where Hank then served as President of SCAN Health Plan Arizona and SCAN Long Term Care. He has also led the organization’s strategic planning efforts and initiated an innovation development regimen to seek improvements in care coordination practices and future care outcome protocols.

Prior to SCAN, Hank served as a Principal in a national health care consulting organization providing a range of strategic, financial and development services for health plans, physician groups and hospitals. He also served as vice president International Operations for American Family Life Assurance Corporation where he directed the development of start-up operations in the United Kingdom, Germany and Italy, as well as the financial turnaround of the company’s Canadian operations.

Hank began his California career as a member of the senior management team responsible for the turnaround and financial survival of Blue Cross of California. In this capacity, Hank led the financial improvement of the individual and small group division and provided leadership to the organization’s strategic planning efforts.

A frequent speaker on critical issues facing the Medicare and Medicaid programs, including the challenges of supporting programs for the Dual Eligible populations, the principles for structuring effective long term care programs as well as opportunities for strengthening a Medicare Advantage plan’s market position. His views on some of the challenges facing the healthcare industry have been published in “Managed Care Contracting & Reimbursement Advisor”, “Payers and Providers” and “Becker’s Hospital Review.”
Roderick Kersch
Roderick is the Vice President of Sales & Marketing for InComm Healthcare & Affinity (IHA). Rod has over 25 years of experience in the acute healthcare space at fortune 500 companies with over 20 years in a leadership role. Rods career efforts have exposed him to logistical, behavior and financial trends across the entire US market. His involvement has led to market leading returns in 22 of those 25 years. He earned his B.A. in Business and Political Science from the University of Nebraska at Omaha.
Carlos Vargas
Carlos is the Director of Sales for InComm Healthcare & Affinity (IHA) and manages health plan client relationships and new business development efforts within the western US market. Carlos has over 15 years of experience in the areas of key account management, product development, operations, business development, marketing, and sales. He earned his B.A. in Computer Science and Mathematics from William Jewell College and holds a MBA in Business Administration from Webster University.
Challenges and Opportunities for Medicare Advantage Plans

Medicare Marketing, Sales & Product Summit

San Antonio, Texas
March 20, 2017

Representative Clients
Outline of Discussion

• Overview of Current Environment
• Understanding Critical Challenges
• Exploring Opportunities for Success

Current & Projected Medicare Landscape

Current 57.9 million with 19.4 million in MA plans (33.6%)

Figure 2

Share of Medicare Beneficiaries Enrolled in Medicare Private Plans, by State, 2016

National Average, 2016 = 31%

NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.

Source: Authors' analysis of CMS State/County Market Penetration Files, 2016.

Prospects Through 2020

# Turning Age 65 ('000's)

Source: U.S. Census Bureau Projections
The 65 and Over Population Will More Than Double and the 85 and Over Population Will More Than Triple by 2050

Millions of Beneficiaries

Number of Individuals

2012 2032 2050

Age 65+
Age 65 - 74
Age 75 - 84
Age 85+

The 65 and Over Population Will More Than Double and the 85 and Over Population Will More Than Triple by 2050

- **Uncertainty and distractions abound**
  - ACA and Medicaid
- **Medicare “not going broke” even though there are long-term financial challenges**
  - Net Medicare spending in 2016 about $591 b; projected to grow to $1.1 t by 2026
- **New leadership/new direction?**
  - Dr. Tom Price, Secretary HHS
  - Seema Verma, CMS Administrator

Current Medicare Environment

• MA has about one third of beneficiaries but only accounts for 27% of Medicare spending
• Politically recognition that MA already moves providers toward “value-based” payments is complicated
• Potentially significant changes to MA if ACA is “repealed and replaced”
  – Increased spending?
  – Increased beneficiary costs?
  – Better benefits?

Proposed Medicare Changes

• Restructuring benefits and cost sharing
• Eliminating “first dollar” Medigap coverage
• Further premium increases for high income beneficiaries
• Shifting from defined benefit structure to “premium support system”
Challenges and Priorities

• Not Included in my analysis
  – Economic demographics, especially growth of elderly poor
  – Industry Consolidation (or non-consolidation)

Challenges and Priorities

• Revenue Compression and Tightening Margins
• Fraud/Whistleblower investigations
• Network adequacy and accuracy
• Increased competition for Beneficiaries
Revenue Compression & Tightening Margins

- MA continues to be a target for revenue reductions
  - Even though repeal of ACA will add more $’s pressure on payments to MA plans will continue
  - CMS inching toward “competitive bidding”
  - No easy choices for Administration and Congress
  - Will take political will and compromise
- Accelerated move to “Value-Based” payments
  - Will “private” solutions gain traction
- Pharmacy Costs likely to continue driving cost trends
- Are we prepared to answer the question “are taxpayers getting value from Medicare Advantage?”

Whistleblower & Fraud Investigations

- MA continues to be a target for risk score inflation activities
  - DOJ joining whistleblower lawsuits against United, Humana, Aetna and many others
  - Mixed messages from CMS
  - Even actions which are legitimate to improve accuracy of risk scores can appear to be inappropriate
  - Not clear where the path leads
Network Adequacy and Accuracy

- Driven by the ACA and real or perceived deficiencies, plan networks are becoming the focus of intense scrutiny.
- On average, plans only include about 50% of the hospitals in its service area.
- Broad networks generally have higher premiums; No material difference in Star ratings by network size.
- About two thirds of Beneficiaries are in medium to large networks (30%-70% of market hospitals), 18% in broad networks (71% plus) and 15% in narrow networks (<30% of market hospitals).

Increased Competition for Beneficiaries

- Mixed political support for MA (private payer solutions).
- Accelerated move by CMS to “Value-Based” payment mechanisms
  - Rapid growth of ACO models, physician payment schemes and other CMS initiatives.
- MA losing share to Med Supplement alternatives.

Estimated Senior Switching Behavior (Deft Research)
Three Key Strategic Opportunities

• Beat the nationals market by market
• Duals are a long-term opportunity
• Unfunded retiree liabilities require innovative solutions

Importance of “Local” Plans

• A local plan achieves success
  – By understanding and being responsive to the needs of its communities
  – By building a close relationship to the physicians who coordinate their enrollees’ care
• 5 Star plans are “local” plans
• Local plans are key to MA’s success
Compete Market by Market

- Get on the ground and know everything you can about the market
- Reach out to your providers and other influencers to build “partnerships”
- Be a trusted source of objective information and support for beneficiaries and other influencers
- Critical strategy especially for ethnic populations

Own Your Markets

- Be the “brand of choice” in your community through partnerships and outreach
- Make a personal connection to your members and community
  - Use real members and local images
  - What is important to the communities you serve
  - Use your marketing dollars wisely
- Get away from “me too” stock images and messages
Dual Eligible Demonstrations

- There are over 10 million Duals; only about 377,000 involved in demos
- Financial Alignment Demos may or may not continue, but the Duals’ challenges for states and federal government aren’t going away
- Not all Duals are expensive, but most require coordination of their care
- Duals represent a significant revenue and growth opportunity
Dual Opportunities

• Build expertise in care coordination models that work for complex Medicare populations
• Engaging health systems as partners in the transformation of Dual programs (*not just vendors*)
• States and Plans as Partners/Collaborators not Adversaries?

Retiree Exposure Opens Doors

• Retiree unfunded liabilities are growing
  – California’s retiree health care costs are more than $2 b; projected to grow to about $6 b
  – California today has unfunded liability of about $80 b
  – California may be the largest, but is not alone
  – Most states, counties and municipalities have similar challenges
Retiree Exposure Opens Doors

- Retiree unfunded liabilities are not likely to go away any time soon
- Can you work with local and state governments to craft an innovative solution
- Recognizing the challenges of MA only plans

Thank You

Questions & Discussion

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DEVELOPING EFFECTIVE MEMBER OUTREACH STRATEGIES THAT DRIVE MEMBER LOYALTY & RETENTION

Driving healthy outcomes through defined-spend and innovative payment solutions

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MEMBERS ARE CONSUMERS TOO!

Healthcare isn't anywhere near having a true retail Model. Its complexities outweigh other industries.
HEALTHCARE PERCEPTION CHALLENGES
(HIGH BARRIERS TO MEMBER ENGAGEMENT)

Health plans historically score very low on trust, service, and ease.

Gallup, Aug 3-7 Consumer View

A robust member engagement program must be designed to overcome these challenges and to influence members to make healthy behavior changes.

CONSUMER ENGAGEMENT (LESSONS LEARNED FROM DATA TO INFLUENCE MEMBER OUTCOMES)

U.S Healthcare system is the most expensive in the world with a total spend of $3 trillion or 18% of the National Economy of which top 20% represent 82% of Total Medical Spending (TME).

20% of Members Drive 80% of TME

Sources: Paterson Healthcare 2016

It is imperative for health plans to build intelligent member engagement programs that are designed to focus on the most costly members to improve quality scores and maximize financial benefits.
VOICE OF THE CUSTOMER: KEY COMPONENT TO DESIGN THE RIGHT MEMBER ENGAGEMENT STRATEGY

Reasons for Member Attrition:

- Loyalty issues – Members are indecisive
  - Perception of brand leadership and the value of organization

- Lack of personalized contact or engagement from plan
  - Not enough interaction or opportunities to provide feedback about what they need

- Competition offers greater wellness benefits
  - Strengthens pride in brand – brand recognition
  - Provides benefits and incentives in line with their members’ lifestyle

MEMBER SEGMENTATION IS A MUST...

To create a successful member engagement program

- Know the strengths and weaknesses of your members
  - Psychographics & demographics

- Define specific actions and goals – Establish the right reward

- Design programs to be personalized to a member’s health status

- Tie benefits and incentive rewards funds to specific behavior

- Communicate the program for easy comprehension to member base

- Structure program to contribute to an easily achievable end goal

- Include a cap on total funds
MEMBER LOYALTY IS THE NEW NORM…

As the healthcare market moves to self health management, plans are adopting solutions that give members personal access to programs that allow them to better manage and improve their health.

- A member-engaging wellness incentive rewards program has become a strategic imperative for many health plans to stay competitive and cut costs in today's market.
- Launch of new benefits or enhancements to existing benefits are also becoming a tipping point for health plans to improve healthy outcomes and minimize costs.

Health plans know that it is easier and more affordable to retain members than acquire new ones.

CONSUMERS ARE MORE LIKELY TO MAKE HEALTHY CHOICES IF REWARDED

- 96% would change their health behavior if they were rewarded
- 75% would have their blood pressure checked
- 48% of consumers reported that their health plan didn’t offer rewards
- 60% would participate in a wellness program if they knew about it

VALUE PROPOSITION (OVERCOMING MEMBER CHALLENGES WITH A SUSTAINABLE MEMBER ENGAGEMENT PROGRAM)

In understanding your members' needs and preferences, your plan will be able to launch meaningful member benefits/incentives that can be communicated through the right channels and ultimately help you achieve the right results.

CMS PROVIDED PLANS WITH AN OPPORTUNITY TO DESIGN INCENTIVE PROGRAMS TO DRIVE HEALTHY OUTCOMES

"Programs... that provide rewards and incentives to enrollees in connection with the participation of activities that focus on promoting improved health, preventing injuries and illness, and promoting efficient use of health care resources."

<table>
<thead>
<tr>
<th>Rewards &amp; Incentives Must…</th>
<th>Not Applicable…</th>
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<tbody>
<tr>
<td>Must be offered in connection with the entire service or activity (or a unit of the activity)</td>
<td>Charitable contributions</td>
</tr>
<tr>
<td>Be tangible and have a value that may be expected to affect enrollee behavior</td>
<td>Lotteries and drawings</td>
</tr>
<tr>
<td>Not exceed the value of the health-related service or activity itself</td>
<td>Must not discriminate against enrollees based on race, gender, chronic disease, institutionalization status, health status or other impairments</td>
</tr>
<tr>
<td>Ensure availability to non-Internet users</td>
<td>Rewards cannot be based on outcomes (e.g. weight loss)</td>
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CMS STAR RATINGS 2015-2016 RESULTS SHOW RELATIVELY FLAT

Plan 2015-2016 Star Ratings Results Comparison

Number of Contracts
2015
11
61
86
136
75
26
12
5 stars
4.5 stars
4 stars
3.5 stars
3 stars
2.5 stars
2 stars

Number of Contracts
2016
12
66
102
112
66
12
0

Source: CMS Star Ratings 10-12-2016

Market competition will continue to increase each year and plans must continue to invest to remain at the top.

STRONG MEMBER BENEFITS MATTER

Member Retention & Member Acquisition – Case Study

Prospect Challenge
STAR ratings for a large Medicare health plan were falling behind.

Challenge Drivers
Prescription drug plan and ease for members to getting prescriptions filled received 2 stars in 2013 and 2014.

Prospect’s Desired Fix
Improve the STAR ratings for the above categories to 3.5 stars.

Implemented Solution
Introduce an OTC benefit for their entire Medicare population to differentiate plan’s benefits offering from competitors.

Results
• Challenge drivers received 4 stars rating in 2015 and 2016
• Increased member growth by 5% and reduced member attrition significantly.

Customer Testimonial
“The only change in 2015 that could have had a member-wide impact and increase our STAR rating by two points was IHA’s OTC benefit.”
LOYALTY BENEFITS & INCENTIVE REWARDS: A WIN-WIN

Benefits and incentive rewards programs are a win-win for all parties involved:

- The member wins by gaining a new benefit or by earning rewards for behaviors that improve their health or helps them cut costs.
- The health plan wins by rewarding behaviors that ultimately improves their bottom line.

TAKEAWAYS

- To stay afloat in today’s competitive marketplace, the adoption of a health benefits and rewards platform is an important element in developing effective member outreach to drive brand loyalty and retention.
- Wellness incentive rewards need to complement a health plan’s program goals and its members’ lifestyle.
- Positive, tangible member experience improves loyalty and engagement, while maximizing retention and ROI.
- Consumer benefit-reward access is imperative – benefit delivery needs to easily fit into a member’s lifestyle.
IHA’S WELLNESS PRODUCT SUITE DRIVES MEMBER LOYALTY

Our suite of health plan-branded, wellness-enhancing payment solutions includes:

**OTC Supplemental Benefit Card**
- Provides members a plan branded card that enables them to purchase only CMS approved items at authorized retailers. Health plans load OTC supplemental benefit funds each month/quarter on the card.

**Directed-Spend Incentive & Rewards Card**
- Provide members with a plan branded reloadable reward card to purchase a wide range of pre-qualified items to encourage healthy choices and help achieve your program’s goals.

**Wellness Discount Program**
- Reward members by providing discounts on the purchase of designated items at the swipe of their OTC Network card.

**Premium Payments Program**
- Enables health plan members to conveniently make premium payments on their health insurance instantly at any CVS/pharmacy, Dollar General, and Family Dollar nationwide.
Optional Pre-Conference Workshop: Broker Channel Distribution Addition - Successfully Incorporating the Broker Channel Distribution to your Marketing & Sales Strategy

Jameson Keller, Vice President, Strategic Development
Agency RM

Ed Estey, Sales Manager, Senior Markets
Harvard Pilgrim Health Care
Jameson Keller
Vice President, AgencyRM

Jameson has over 16 years in Sales, and over 11 years working with insurance carriers in Medicare, Medicaid, and Individual Health insurance. He has been primarily focused on sales leadership, but has been heavily involved in Compliance, Marketing, Product Development, Strategy, and Training.

Jameson is currently leading Strategic Development and Acquisition at a regional FMO. Prior to joining AgencyRM, Jameson has served in a variety of leadership roles at regional and national Medicare carriers in Oregon, Washington, and Texas.
Ed Estey  
Sales Manager, Senior Markets  
Harvard Pilgrim Health Care  

Ed Estey has been with Harvard Pilgrim Health Care for 20 years. He has been involved with direct selling to the senior population since 1991, working for Blue Cross Blue Shield in Boston, MA as a Team Leader in the Sales Department before joining Harvard Pilgrim Health Care in 1997. Since 2006 he has been one of the major contributors in the development and implementation of sales and marketing strategies for Harvard Pilgrim’s Individual and Employer Group Retiree Products as well as Harvard Pilgrim’s Celebrating 65 educational program.

Ed has a BS in Health Care Administration and a BS in Marketing from Stonehill College as well as a Certificate in Public Health from Harvard Extension School.

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Successfully Incorporating the Broker Distribution Channel to your Marketing and Sales Strategy

**ED ESTEY**  
SALES MANAGER, SENIOR MARKETS  
HARVARD PILGRIM HEALTHCARE

**JAMESON KELLER**  
VICE PRESIDENT OF STRATEGIC DEVELOPMENT  
AGENCYRM

**Background –**

- One of the nation’s leading not-for-profit health plans
- Strong brand presence known to offer top quality plans
- Harvard Pilgrim’s mission is to improve the quality and value of health care for the people and communities we serve
- Over 1000 employees across 7 different locations
- Serve over 1.2 million members nationwide
- Offering senior plans for over 30 years
Background –

- Regional FMO
  - Formed in 2014 as a spinoff of VibrantUSA (agency)
  - Primarily in WA, OR, ID. Do business in about 15 states.
- 650 contracted agents
  - 3.8 contracts per agent
- About 60,000 active enrollments
- Focus is service and technology.
  - Not just a contracting source!
- Heavy in carrier experience

Trade-offs and Benefits of Adding Brokers

**Benefits:**
- Face to face meetings
- Added benefits (i.e. choosing a PDP)
- Strong relationships
  - Assist with sales seminars, in-homes, etc.
- Outsource capability
- Less marketing needed

**Trade-offs:**
- Oversight and compliance
- Less control
- Business can be moved
- Financial impact
  - Commissions
  - Overrides
Vetting Brokers

- Initial meetings
- Past experience
- Contracting and licensing
- Training
- Minimizing CTM’s
- FMOs as contracted partners

FMO or Contract Direct

- Cost
  - FMO = Higher
  - Direct = Lower
  - What you delegate is what truly sets cost
- Relationship management
  - How many relationships can you sustain?
- Additional services and support
  - FMOs can bring a lot of capability to the table
Financial Impact

- Commissions and overrides
  - Do you follow the bench mark amount or pay less?
  - What level of sales activity do you pay an override?
- Timeliness of commission payments
  - Need a clear commission document outlining the commission schedule

Fostering Successful Partnerships

- Broker driven sales represent 30% of our business
- What is the right sales mix? It depends.
- How do you engage your broker channel to get more business?
  - Make it easy
  - TRULY Partner
    - Bring partners into the decision
  - Know your market
Make it Easy

- **Applications**
  - Complex = less committed
- **Training and Certification**
  - Sentinel Elite
  - SCAN
- **Broker Support**
  - FMO "back channels"
  - Direct – knowledgeable people
- **Electronic enrollments**
  - eHealth vs Aetna

Partner... No *really* partner

- Bring your FMOs and highest producers into the fold
  - Product development
  - Marketing
  - “Whine & Dine”
- **Protect the AOR**
  - Customer Service / Telesales can steal sales
- Don’t steal agents.
- Act like you care... Even behind closed doors
- Create mutual opportunities
  - Win/win
- Regional carrier = regional partners
Know your Market

• All markets are NOT equal
  ○ Product
  ○ Network
  ○ Broker focused or not

• The market includes the brokers!
  ○ They are your customer just as much as the beneficiary
  ○ How have they been treated?
  ○ What can you do that is different?

Questions?