1. PLHP = PSHP
2. Share my views and experiences as they relate to this payer segment, and also present some suggestions that could be considered as we go ahead on expanding our presence in this segment.
3. Recd outline on meeting expectations. Taken that into consideration and structured the ppt
4. 3 parts
5. In the second part, I will cover 3 key technology and consulting capabilities that I believe we should obsess about as we go about growing our business in this segment.
6. Also I have deliberately not gone to the level prescribing specific point solutions that we should develop, but if these capabilities and ideas resonate with all today, we could very quickly get to that as well.
7. Rizwan I know that this is perhaps our first meaningful interaction and also JM indicated that I should do an introduction of myself, so I wanted to take a few minutes to present my professional qualifications as they relate to the discussion we are having.
8. Healthcare IT professional with 17+yrs of exp and most of my experience has been in client facing roles whether it was delivery, practice management or sales.
9. Specialize in areas of Data Management, DWH, BI and off late in Analytics and ML
10. Was hired to start and grow the Healthcare Data and Analytics business.

1. I wanted to begin by defining a PLHP/PSHP as one that is owned by a hospital and/or physicians, rather than by shareholders or policyholders.

2. This concept has been around for a while and off late health systems are showing renewed interest in starting health plans.

3. Over the past few years, forces have been aligning to make offering a health plan look increasingly attractive to health systems.

1. As the industry moves from a volume to value-based care model, payers are looking to shift the financial risk to providers through a variety of mechanisms such as ACO’s, bundled payments & others. The transition from volume to value-based payments requires competencies in care coordination, network design and administration, contract negotiations, risk sharing arrangements with physicians, performance measurement and so on. As a result, some health system leaders believe these capabilities require them to sponsor their own health plan.
2. Providers are in extreme financial distress and see the health plan business as additional source of revenue in addition to preventing the exploitation at the hands of the payers
3. Finally, with a desire to bring meaningful difference in the health outcomes of the patients they serve, providers are integrating with health plans so they can effectively control their entire healthcare journey

1. Today nearly 1 in 8 hospitals operates a health plan and this number across the country comes to 111.

2. Out of the 271Mn insured population, they cover 7% of the insured population.

Growing at CAGR of 6%, they have been growing at a rate faster than the industry rate of 2.7%. This growth has come as the Medicaid segment which contributes to 57% of the PLHP business, is growing faster than other segments.

3. PLHP’s are characterized by a relatively small membership base when compared with the nationals and blues and a localized presence, rarely crossing state boundaries. The top 10 PLHPs (excluding Kaiser) have 43% of the market and the next 10 another 20% of market share.

Consumers are taking a more active part in the healthcare decision making. As the recipient of their money via premiums, they also expect payers to be more accountable for the experience they receive on their healthcare journeys and also for the care outcomes.

Interestingly, Payers are uniquely positioned to see all the care activities of an individual, yet struggle to deliver to these expectations and build meaningful relationships. That’s because they haven’t really tried to engage with members in a meaningful and personalized manner

Member engagement for long has been recognized as the panacea for this problem. What member engagement really espouses is understanding your customer and their unique needs -personas, how uniquely they go about on their healthcare journeys and then guide them on those journeys through various interactions so that these are efficient, friendly and effective.

While some of the large payers have started recognizing and addressing this, most of the PLHP’s because of their limitations in technology, digital and analytics have struggled.

integrated health systems that sponsor their own insurance programs as a useful mecha­nism for balancing the delivery of care and its financing, since these organizations necessarily assume insurance (financial) risk in setting pre­miums and in negotiating payments with their own hospitals and physicians.

1. NPSHPs, Medicare, Medicaid and employers are accelerating their efforts to shift financial risk to provider organizations vis-à-vis a variety of alternative payment programs like accountable care organizations, bundled payments and others. At the same time, penalties for avoidable readmissions and under-performance on value-based purchasing pose significant financial and reputational risk for hospitals and health systems. The transition from volume to value-based payments requires competencies in care coordination, network design and administration, contract negotiations, risk sharing arrangements with physicians, performance measurement and so on. As a result, some health system leaders believe these capabilities require them to sponsor their own health plan
2. **The consolidation of health insurers poses a significant threat to the viability of local hospitals and health systems prompting consideration of plan sponsorship.**