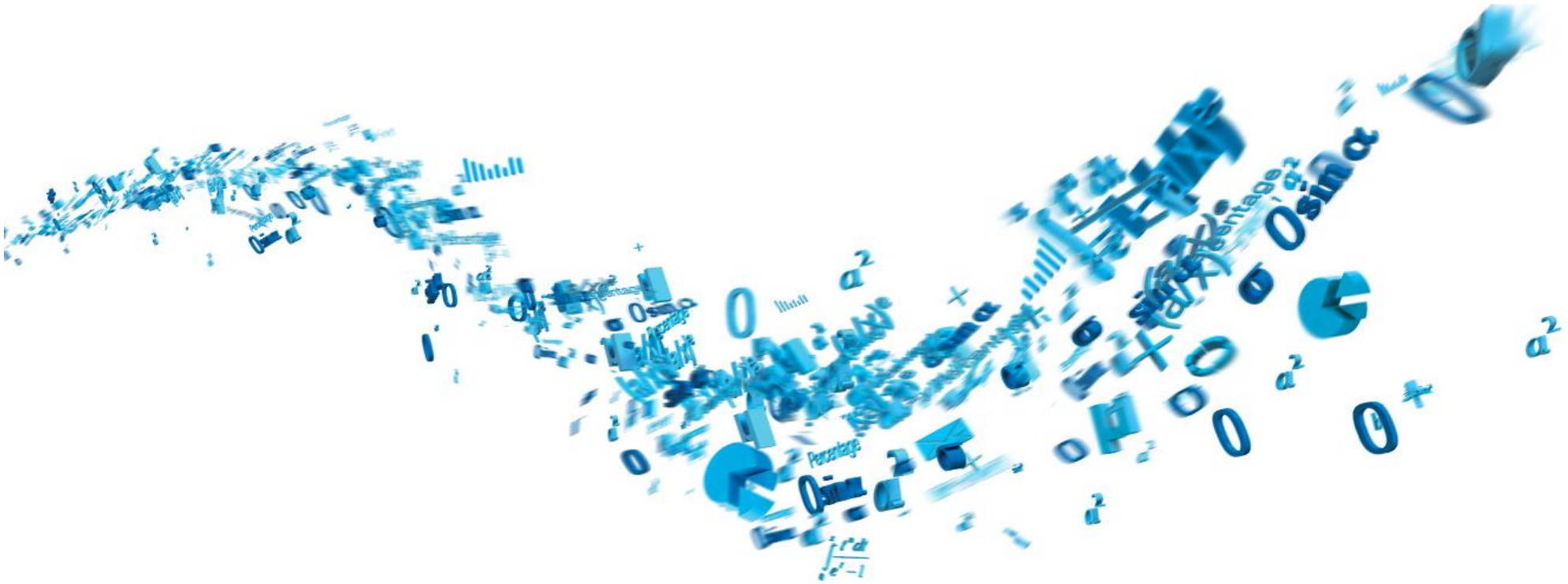

Healthcare Market Opportunities Lunch and Learn:
Evolving Financial Risk Relationship Between Payers and Providers

October 17, 2019
Insurance Conference on Financial Reporting (INCON)

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AON
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Content

Section 1

Aon’s Managed Care Services

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Aon's Managed Care Services

Our team is uniquely positioned to work with Managed Care Organizations, offering program design and placement services supported by strong analytics and strategic risk advisory.

Our Managed Care broker team has extensive first-hand experience in the following market segments:

- Health Systems
- Provider Organizations and Management Services Organizations
- Managed Medicaid health plans
- Medicare Advantage/Medicare SNP health plans
- Commercial health plans
- Accountable Care Organization's/Clinically Integrated Networks

Additionally, we are able to leverage a wide range of experience and knowledge in the following areas:

- Healthcare reform
- Provider contracting including a variety of reimbursement methodologies and value based incentives
- Claims administration and auditing
- Health IT
- Risk Management
- Actuarial and analytics
- Complex and chronic disease management
- Network solutions
- Captives

Moving beyond the transaction and being a strategic advisor to clients is one of many ways we differentiate ourselves from other reinsurance brokers.

Section 2

Managed Care Overview

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Managed Care - State of the Market

So, what is a Managed Care Organization (MCO)?

- A **risk bearing entity** focused on providing appropriate, cost-effective medical treatment via an integrated delivery system model (e.g., regional health organizations, including ACOs, Provider Organizations and HMOs).

ACA and the legislative environment continues to reshape the health care market by engaging providers, managed care organizations, insurance companies and other health care service entities to:

- reduce cost
- improve quality
- accept a financial stake in the outcomes

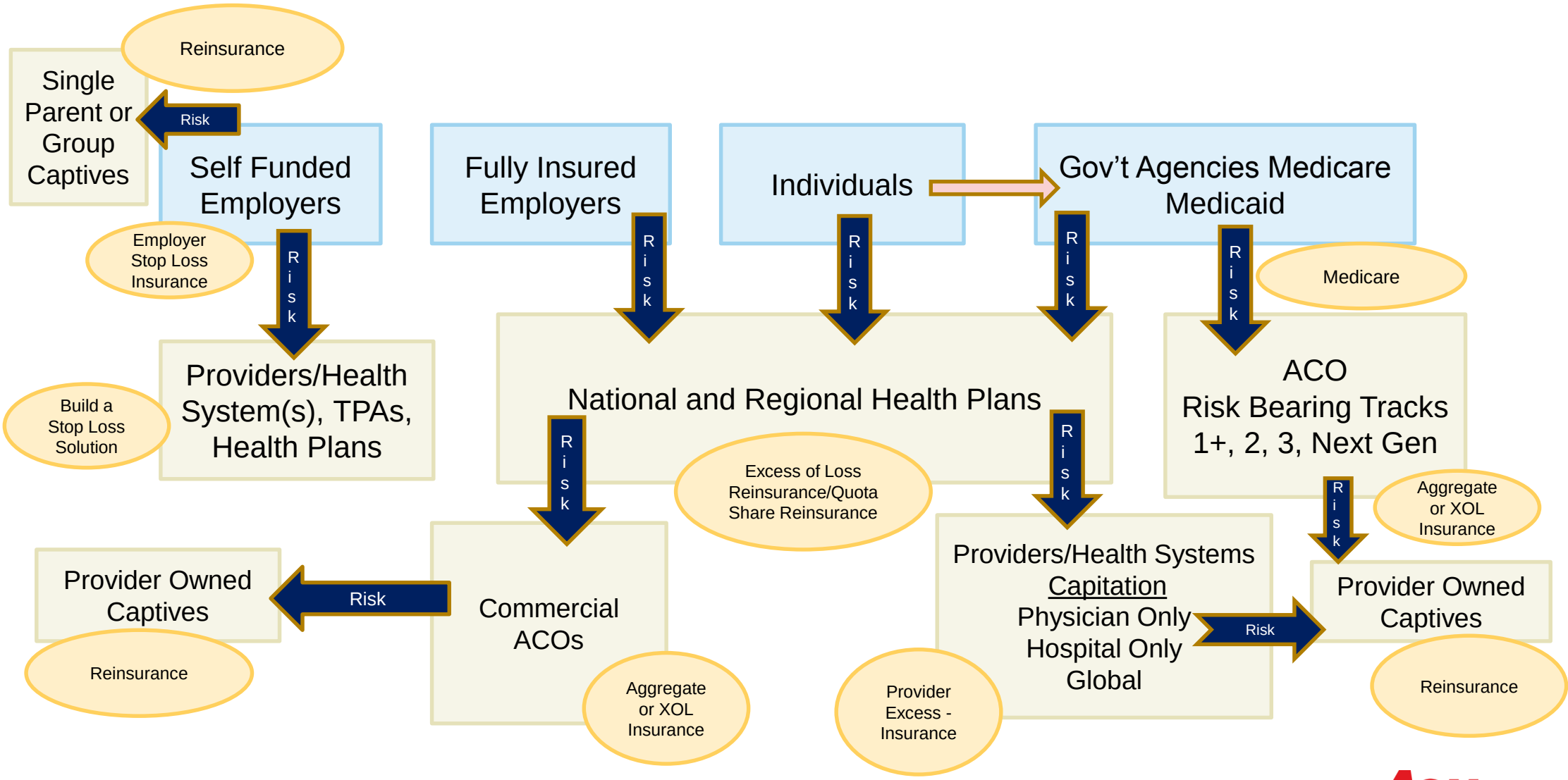
Regional health organizations are developing new networks and contracting strategies with local health plans and employers. **Many of these organizations are taking financial risk and looking for risk programs.**

Many HMOs are focusing on:

- Maintaining and growing membership by evaluating their current product offering and developing new capabilities to offer the self-funded health market
- Shifting/sharing risk with local provider organizations and employers

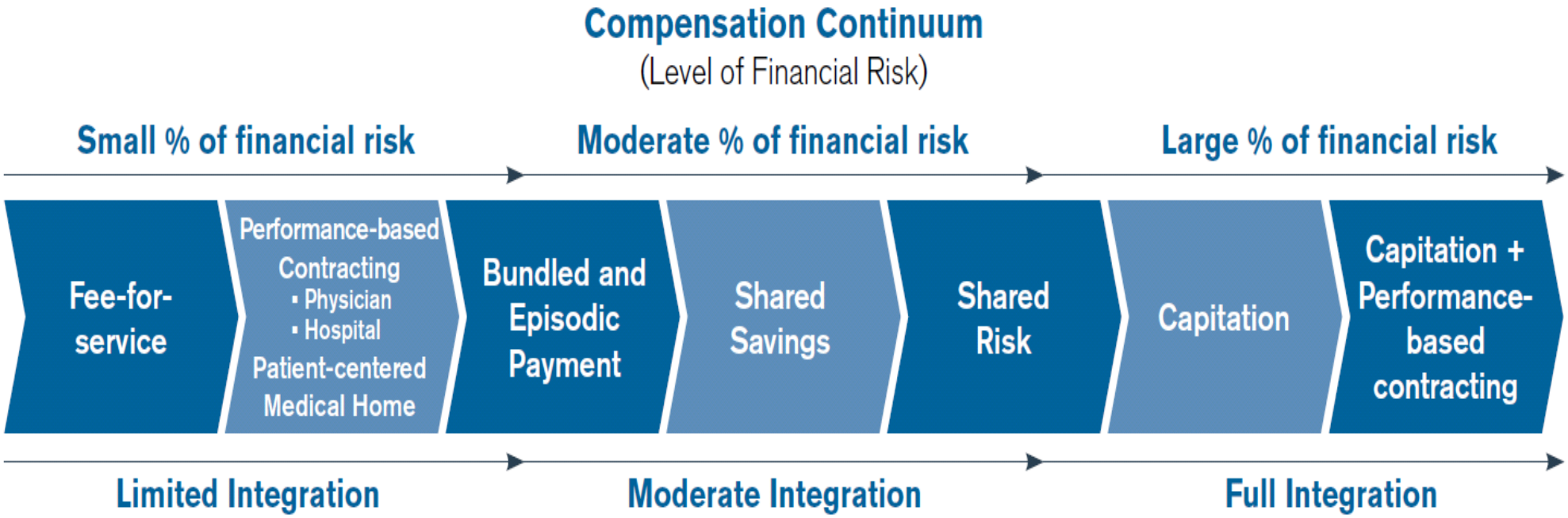
Resulting in: *Opportunities to create broader risk programs for Managed Care Organizations.*

Managed Care Risk Flow



Market Shift – Value-Based Contracts

Value-based contracts: Instead of health systems and providers being paid by the number of visits and tests they order (fee-for-service), their payments are based on the value of care they deliver.



Source: UnitedHealthcare

As the level of Financial Risk increases, health systems and providers will look to Aon for solutions to help mitigate risk, evaluate capital solutions and leverage existing assets.

Value-Based Contracting will Provide Specific Opportunities for Providers, Health Systems and ACOs

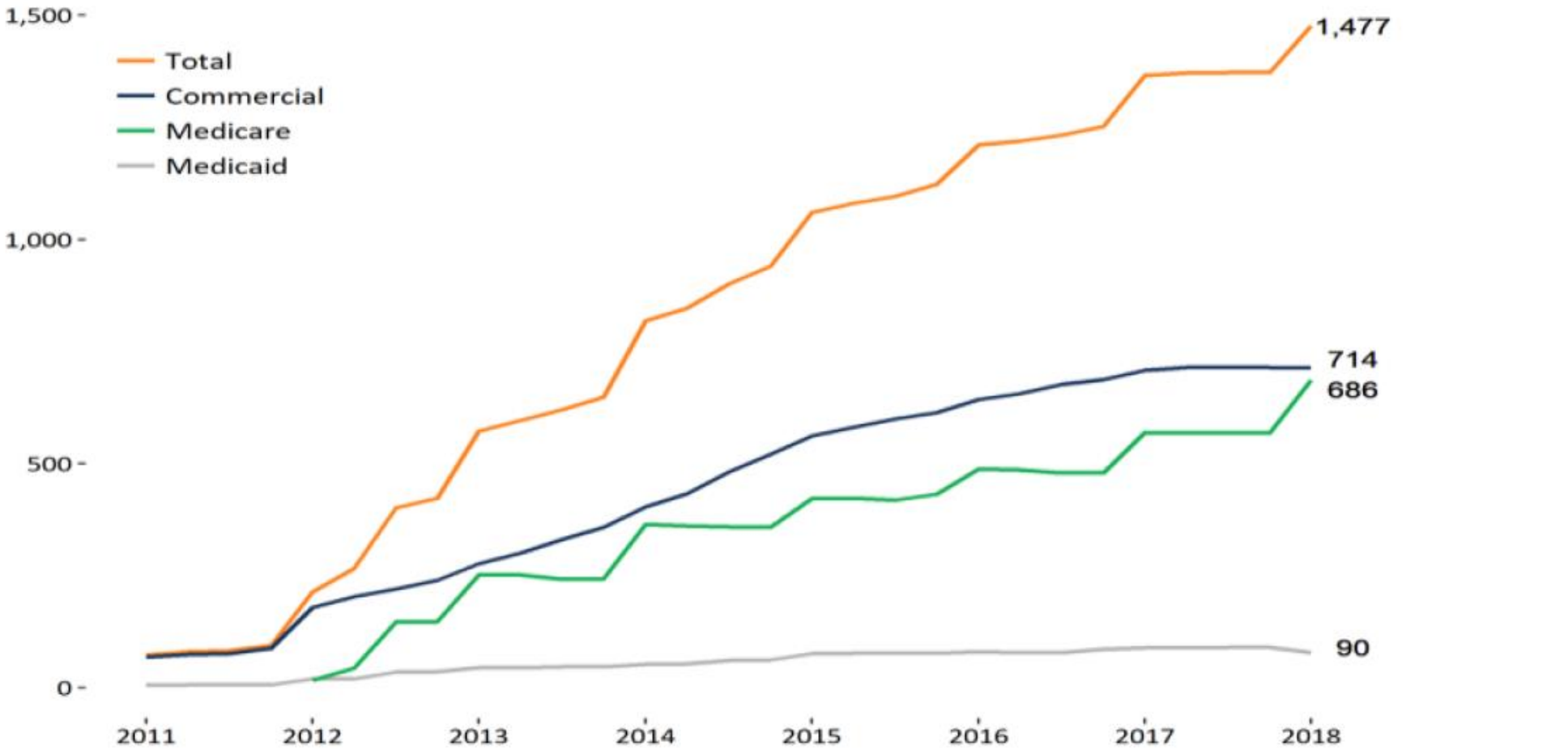
- More Capitation – Commercial, Medicare Advantage and Managed Medicaid
- Risk contracting direct to employers
- ACOs development and expansion, value-based care programs, and pay-for-performance initiatives
- Provider-sponsored health plans
- Strategic private labeled product offerings between Providers and national payers (e.g. Blue Cross, United, Cigna, Aetna)

Trends in Risk Sharing…

- Payers reported their value-based care strategies led to reducing unnecessary medical costs by 5.6 percent. Twenty-four percent of respondents reported medical cost savings of 7.5 percent or higher.
- 77 percent of payers stated value-based care greatly or slightly improved care quality. 64 percent of respondents said value-based care greatly or slightly improved provider relationships.
- The decline of fee-for-service is moving faster than previously predicted. Currently, 37.2 percent of business is aligned with fee-for-service, compared to the 40.9 percent predicted for 2018.
- 43% to 58% of payers reported it is very or extremely difficult to get providers interested in participating in episode-of-care programs; agree on episode definitions; and reach a consensus on budgets, risk/gain sharing and performance metrics.
- The study found "commercial lines are leading adoption, advancement and innovation of value-based care models and strategies.“
- Will Employer based ACO contracts create the new wave in risk transfer in Healthcare with changes to the Stop Loss product?

Source: Change Healthcare 6-2019

ACO Landscape



Source:https://www.healthaffairs.org/do/10.1377/hblog20180810.481968/full/

Managed Care Products to Support Evolving Risk Strategies

Core Managed Care products include

- HMO Reinsurance
- Provider Excess
- Medical Excess
- Employer Stop Loss programs (designed to support the health plans offering)

These products are primarily excess of loss coverage and are triggered largely by medical claim losses incurred by a risk bearing entity within a 12 month incurred period.

Additional products include

- Aggregate Coverage – Limited Market Capacity
- Carve-Out Solutions (e.g., Transplant, Neonatal care)
- Specialty Excess (e.g., ACO Coverage, Bundled Payments)

These products are typically "first dollar" or aggregate coverages based on annual medical spend or are related to specific clinical criteria.

Quota Share Reinsurance

- Also being utilized by a number of managed care organizations as a means to free up capital to support other business initiatives (e.g., product expansion), while still meeting state Risk Based Capital (RBC) requirements.

Provider Excess Overview

How Provider Excess (PXS) Works

- Risk contract: percentage or PMPM prepaid to provider out of health plan (payer) premium each month
- Provider manages the population (and medical/Rx claims) assigned to its network
- Payers may offer excess coverage (PXS) in their risk contracts to ACO, providers, etc.
- Providers may seek coverage elsewhere if:
  - Excess coverage from payer is too expensive or inadequate
  - Provider has risk contracts with multiple payers and wants one PXS policy

Who Buys PXS

- Provider groups that enter into risk contracts with health plans, insurance companies, government entities, or directly with employers. These may include:
  - Physician groups
  - Integrated delivery systems
  - Health and hospital systems
  - Accountable Care Organizations (ACOs)
  - IPAs
  - PHOs

Provider Excess Overview (Continued)

How Provider Excess (PXS) Coverage Works

- Excess of loss per member – specific coverage
- Covered services follow risk contract with Payer - division of financial responsibility (DOFR)
- Professional, hospital, or comprehensive coverage
- Deductible range
  - – $10K to $1M based on coverage type and risk appetite
- Annual limits
  - – $500K to unlimited
- Coinsurance - 90%
- Standard Claim Basis - 12/18/19 (This schedule can be modified to meet provider's needs)
  - – Incurred in 12 months
  - – Paid in 18 months
  - – Submitted/Reported in 21 months
- Alternative funding options
  - – Aggregating specific deductible
  - – Retained corridor
  - – Experience refund
- Coverage available for all Product lines
  - – Commercial
  - – Medicare
  - – Medicaid

Section 3

Healthcare Industry Trends

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Health Care Market – General Overview

- Medicare Advantage plans proliferate in 2019, increasing competition
- Healthcare payments tied to value-based care on the rise, now at 34 percent
- Spending on Medicare Advantage Plans Nearly Doubled Over Last Decade
- Of the 649 Medicare ACOs:
  - 561 Medicare Shared Savings Program, with 82% not assuming downside risk
- CMS Driving Change - Under the new rule (Pathways to Success)
- Increased frequency of large medical claims (>$2M) continues to challenge the market
- Specialty drugs percentage of overall medical claims spend continues to increase
- Higher percentage of healthcare organizations look to reinsurance/capital solutions to support their risk and growth initiatives
- Alliances are forming to expand and enhance the quality of care and reduce cost
- Data management and analytics are key components of a successful Health Strategy

Health Care Market – General Overview

- Increasing use and interest in population health
  - Unprecedented use of technology and data/analytics by hospitals
  - Patient care is becoming better coordinated
- Increased focus on improving wellness, transparency, and quality of care
- Increase of alternative care delivery models (e.g., telemedicine, on-site clinics)
- Regardless, employers continue to focus on controlling healthcare related spending, with 113M+ self funded and ASO covered lives :
  - Small market: gravitating towards self-funded options to manage fees/taxes. Level funded is the product of choice.
  - Middle market: the Employee Benefit Research Institute report self funding has risen 19% over the past two years
  - Large market: moving from ASO platform to help control overall claims spend. Self-funded is the product of choice, but some also have selected fully-insured via a private exchange platform

Health Care Market – General Overview

- Shift to value-based care will gain traction
  - S&P expects the shift to value-based care to gain traction in 2019, as cost pressures mount, payers continue to drive change and non-traditional players enter the healthcare arena. "This increasing shift to a pricing model that is more dependent on quality and outcomes will be a major disruption to the health care industry, likely pressure sales growth and margins, and create new winners and losers."
- Non-traditional players continue to push into the healthcare arena
  - In the last year, Amazon has moved in through its partnership with Berkshire Hathaway and JP Morgan Chase and its acquisition of specialty pharmacy PillPack. These moves are creating further uncertainty for the industry. S&P warns the entry of non-traditional players "could provide certain players with a major opportunity, while shutting out others."
- Traditional players initiated several vertical healthcare mergers which were approved by regulators including Cigna-Express Scripts and CVS Health-Aetna.
  - S&P says "The creation of these healthcare verticals, which wield increased negotiating leverage on healthcare products and services pricing, will have significant implications for the industry. Players that can, with the use of healthcare data, demonstrate superior value or outcomes, will benefit. The ones that are not will struggle."

Section 4

Managed Care Market Review

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Health Care Market - “Deep Dive” on Three Group Medical Lines

Product	Comments	(Re)insurers	Distribution	Risks / Challenges
HMO Re / Medical XOL	▪ Ceded Premium: $350M+ & 750M+ ▪ ½ of US HMOs (~250) may buy reinsurance ▪ Number of commercial HMOs declining ▪ Annually renewable ▪ Sophisticated buyers (e.g. CFOs)	▪ Partner Re ▪ Summit Re ▪ HM Life ▪ RGA Re ▪ IOA Re ▪ Starline ▪ IronShore	▪ 25% direct ▪ 75% brokers	▪ Competitive market ▪ Large accounts make it tough to hit profit targets ▪ Acquisitions due to ACA ▪ Health systems growing and becoming more complex
Provider Excess	▪ Ceded Premium: $350M+ ▪ Providers are looking at take more risk due to PPACA / ACOs, but actual move to risk contracts has been slow ▪ Number of prospects continues to grow ▪ Annually renewable	▪ Partner Re ▪ Summit Re ▪ HM Life ▪ IOA Re ▪ Starline ▪ IronShore	▪ 95% brokers	▪ Control of provider – sometimes limited with HMO doing the contracting and management ▪ Claim lags can be longer than HMO ▪ Filings and compliance – P&C and A&H license required
Employer Stop Loss	▪ 2018 premium ~$21B ▪ Carriers write 88% of the market, MGUs 12% ▪ 95 carriers ▪ 60 MGUs	▪ Cigna ▪ UnitedHealth ▪ Sun Life ▪ Anthem ▪ HCC ▪ HM Life ▪ Symetra ▪ Voya	▪ 95% brokers	▪ Competitive market – price pressure ▪ Number of writers stable, but still new entrants ▪ Care management gaining interest from buyers ▪ Increased frequency of large claims

Keys to Success

- Underwriting and risk selection
- Strong distribution channels and relationships
- Specialized pricing module
- Strong network and discounts
- Service

Market Intelligence – Reinsurance by Segment

- Non-affiliated reinsurers write 15.7B
- 25 reinsurers:
  - various levels of customized risk, capital, care management and growth solutions

Most offer an holistic approach/platform

- One stop shop
- Meet a client's needs across the board
  - Managed Care
  - Traditional Medical
  - Capital
  - Employer Stop Loss

Managed Care

- 700M market
- Markets:
  - Summit Re
  - RGA Re
  - Partner Re
  - Swiss Re
  - Ironshore
  - Sequoia
  - HM Life
  - Starline
  - IOA Re
  - Optum
  - TMS Re
  - Others dabbling

Traditional Medical

- 5.9B
- Markets:
  - AXIS
  - Hannover
  - AXA XL
  - Transatlantic
  - Odyssey Re
  - Ren Re
  - Sirius
  - Navigators
  - Greenlight
  - RGA Re
  - Swiss Re
  - Others playing

Capital

- 9.1B
- Markets:
  - Canada Life: 6.2B
  - AXA XL: 450M
  - Hannover: 2.2B
  - RGA Re: 213M
- Other have explored capital motivated opportunities but have yet to jump all in:
  - Ren Re
  - AXIS

Managed Care Market Review

Market Capacity

- While capacity appears to be adequate, price hardening and greater scrutiny of client exposure has become the norm
- Market underwriters are segmented but consists of both those that will assume large risks > $10MM, as well as those that are focused on limits no greater than $2 - $5MM
- The reinsurer pool which has been stable for many years, has experienced several large reinsurers exiting while a few smaller reinsurers/underwriters have entered

Coverage Terms

- Increase in Limits and ADMs have modified risk exposures and driven premiums to higher but manageable levels
- Increase in retentions continue to be the most common means to offset rising premiums. With leveraged trends now exceeding 20%, it has become critical to properly assess the severity and frequency of high cost claims in order to create the most efficient return on risk
- Due to rise in first dollar claim expenses, Managed Care clients are asking for additional limits especially for Commercial and Medicare lines. Limits have also been affected by the significant rise in pharmacology expenses creating a stronger demand for expanded terms of coverage
- No significant change in coverage terms have been seen with the exception of risk mitigating features such as more frequent lasers and accumulator corridors for high cost pharmacy

Managed Care Market Review

Pricing trends

- Significant losses realized by most if not all reinsurers from 2016 through 2017 forced premiums to harden
- Pressure from increases assigned to inpatient charge master expenses have leveraged premiums
- Credit for favorable experience remains negotiable
- For 2019, the market continues to harden due to the historical increase of losses
- Reinsurers are focusing on clarifying data received and using lower completion factors to hedge against run off claims
- Markets are being more selective on business to retain and quote

Section 5

Employer Stop Loss

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Employer Stop loss: Market Comments

- **Market still growing…….$21.0B in 2018, average annual growth of ~10-15%**

- **Key drivers of Growth:**

  – Employers continue to see self-funding as a viable option to talk control of their health program, engage in cost management programs and directly benefit from the results

  – The financial volatility driven by the increase in frequency of large health claims and the high cost of existing and new specialty drugs continues to reinforce the need for stop loss coverage and those that have traditionally not purchased are purchasing

  – Small employer market has significantly migrated to the self funded market and are utilizing the level funding stop loss plans

  – New stop loss market entrants continue to perpetuate a competitive market and are driving new alternatives to attract additional market segments with the incorporation of captives, level funding and other plan and financing options

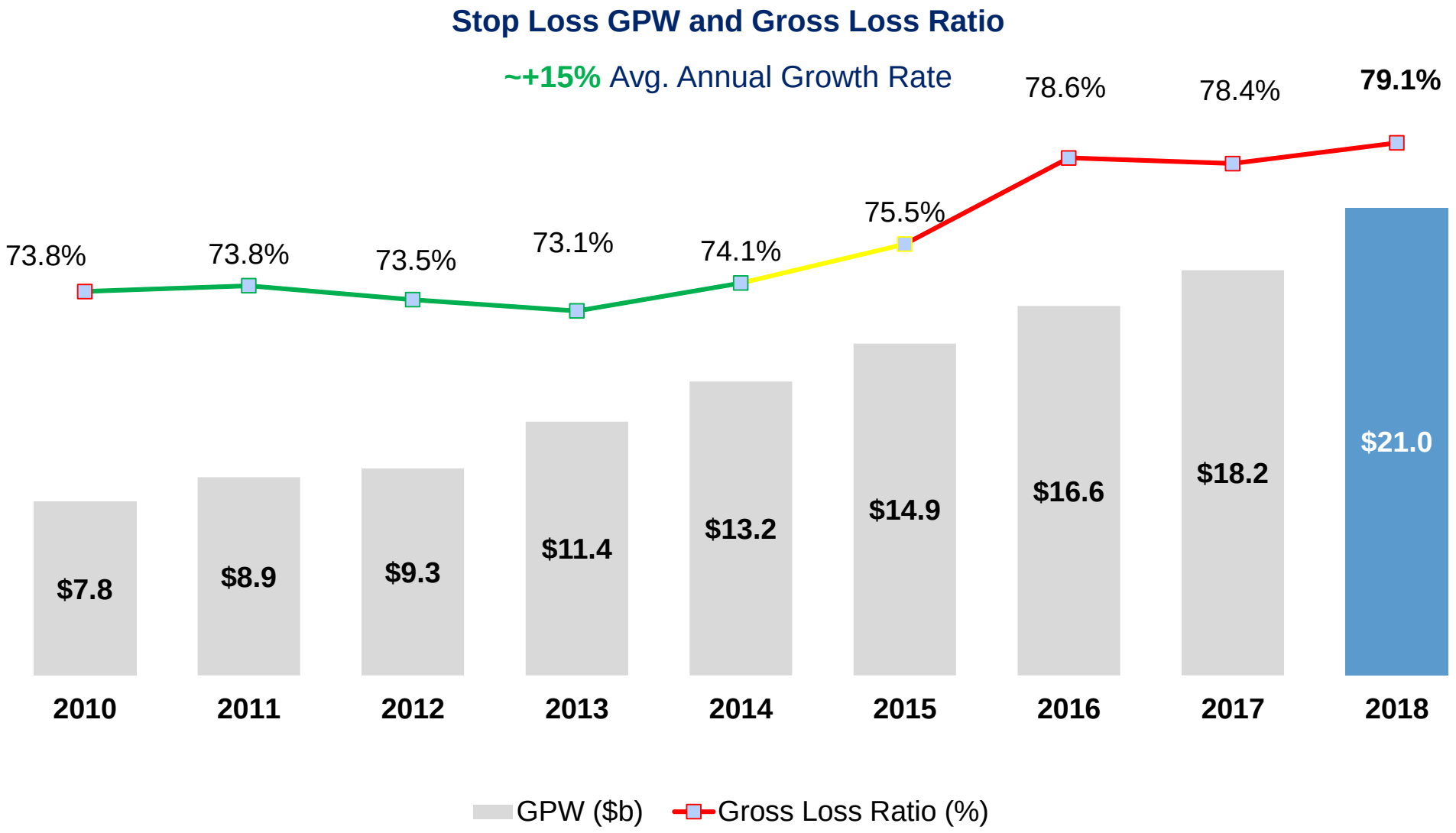
Employer Stop loss: Market Comments

- **Competition remains steady, with continued interest in the product/space**
  - Carriers and other entities are looking to enter
    - Short-tail, diversifies portfolio, annually underwritten
    - Deciding on right path: Build, Partner, Acquire
  - Regional health and Blues plans interested in the space
    - Look to partner with others vs. build their own platform
  - Panel programs gain traction:
    - Willis, Lockton, Marsh, Aon
  - Captives gathering momentum and support
    - Pareto (250M), Roundstone, Berkley
- **M&A**
  - Active market but fewer targets of interest remain
    - Value received from target (multi-line, strong teams, value added resources, distribution)
    - Most larger MGUs have already been acquired
    - Variety of entities looking to acquire (insurers, brokers, private equity, reinsurers)

Employer Stop loss: Market Comments

- **Industry Gross Loss Ratios need to start trending downward:**
  - Companies with poor underwriting results still active and able to gain support
  - Companies with good results are under siege
  - Increased interest around driving value and getting off the quote spreadsheet
  - With this being a short-tail product, carriers can impact results in one year
- **Drivers of loss ratios:**
  - Lasers: poor evaluation of ultimate risk, foregoing lasers, No New Laser options
  - Networks: understanding network benefit and correctly applying in the underwriting process
  - Distribution channels: stronger relationships typically drive better outcomes
  - Underwriting/risk selection: develop underwriters that know risk, not just quote
  - Claims management: ability to positively impact ultimate results, not just process claims
  - Total expenses: higher expenses, underwriters will compete by reducing net risk premium
  - Holding on: know when to say no: sometimes it is better to walk away

Employer Stop Loss Market Performance (2010 – 2018)



Source(s): SNL, Aon

Section 6

Captives: A Versatile Financial Tool

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Captive Benchmarking Report

Healthcare Services

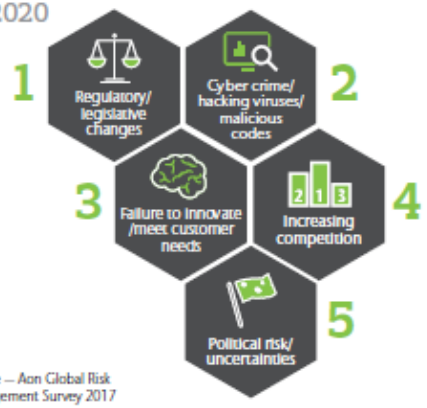
For more information please visit www.aon.com/captives

Today's healthcare services companies are facing complex and interconnected risks

We live in an era of unprecedented volatility. Trends around three major dimensions – economics, demographics, and geopolitics – combined with the exponential pace of technology change, are converging to create a challenging new reality for organisations. These forces create opportunities that we cannot even imagine, but also present new frontiers to be explored.

Top five emerging risks

by 2020



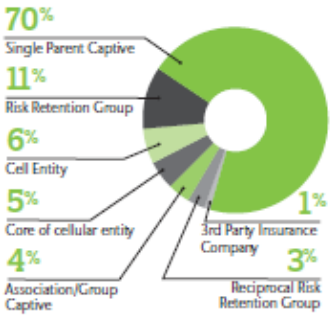
Source – Aon Global Risk Management Survey 2017

Headline numbers

117 insurance entities

$2.3bn in Gross Written Premium

Type of entity



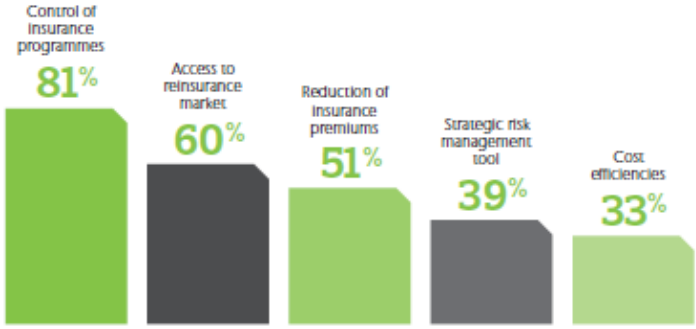
Source – Aon Captive Benchmarking Survey 2018

Current top ten risks

	% of respondents indicating as top ten risk	% with loss	% with plans in place
Regulatory/ legislative changes	61%	36%	48%
Damage to reputation/brand	58%	13%	49%
Increasing competition	47%	49%	44%
Cyber crime/hacking/ viruses/malicious codes	47%	16%	87%
Failure to innovate/ meet customers needs	44%	14%	50%
Failure to attract or retain top talent	39%	22%	68%
Economic slowdown/ slow recovery	35%	52%	24%
Third party liability (Incl. E&O)	35%	42%	67%
Business interruption	31%	17%	76%
Directors & Officers personal liability	29%	4%	68%

Source – Aon Global Risk Management Survey 2017

Top five reasons for setting up a captive



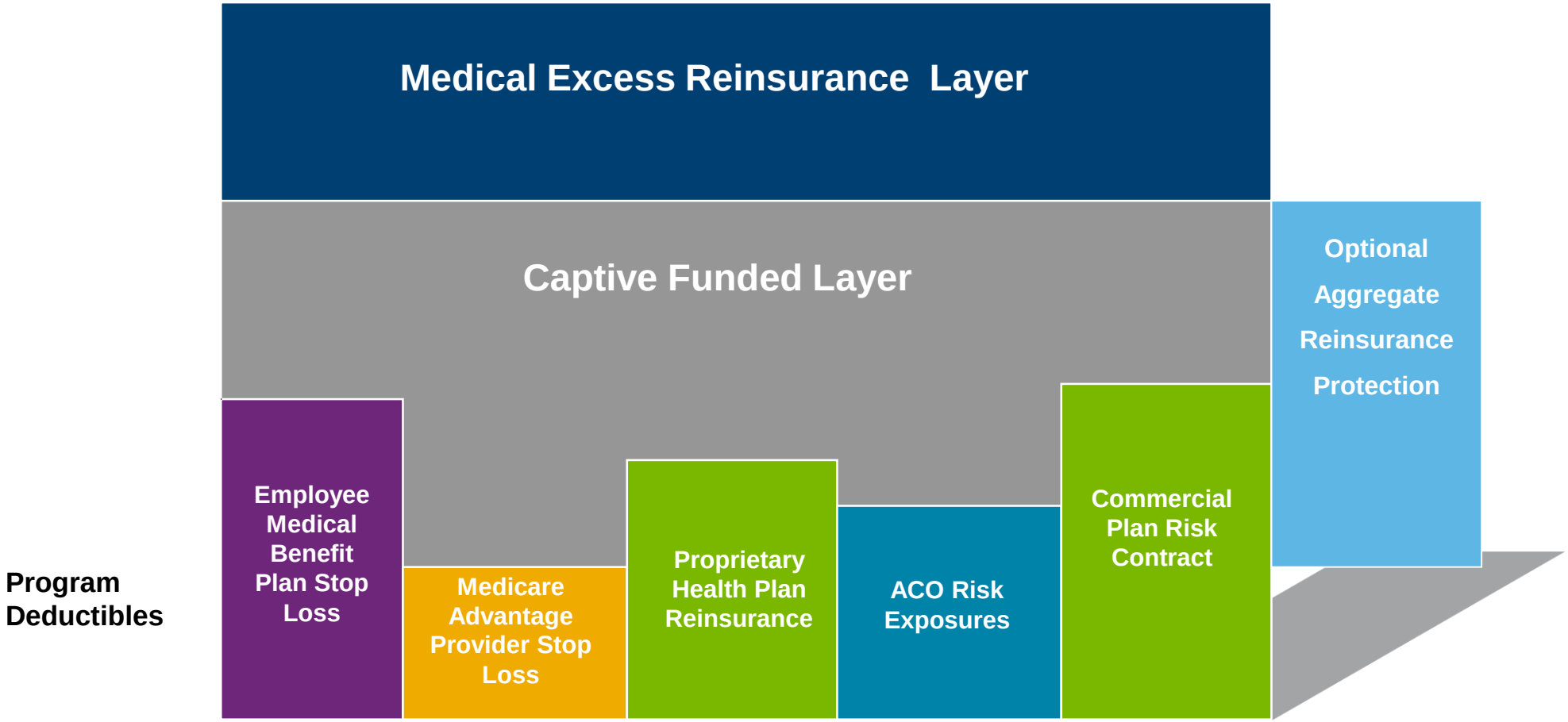
Source – Aon Captive Benchmarking Survey 2018

Lines of business written

- Medical Professional Liability (Facility and Employed Physicians / Staff) 67%
- General/Public Liability 30%
- Workers Compensation 17%
- Cyber Liability 9%
- Medical Stop Loss 9%

Distribution of Risk – Evaluating Use of Captive

Captive Reinsurance Program to Address Multiple Managed Care Risk Exposures



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Thank you!

For more information about Aon's Managed Care Services, please contact:

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