

Provider strategy: Control vs. contracting

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Healthcare reform has been a leading topic of debate in the last three presidential elections and will likely make headlines again leading up to 2020.

Many of the mechanisms used in prior legislation focused on health insurance reforms such as no preexisting condition exclusions or lifetime limits and use of age curves, community rating, and risk adjustment. The mechanisms were intended to grow the individual (and small group) market by covering the previously uninsured and the young, healthy population, which were expected to improve risk selection and reduce premium rates. The reform goal was to improve access and affordability. While the reforms achieved, at least in part, the goals of improving access and affordability, simply reducing premiums or rate increases does not necessarily translate into reducing the underlying costs of healthcare.

In addition to the insurance reforms, the Patient Protection and Affordable Care Act (ACA) also created the Center for Medicare and Medicaid Innovation (the Innovation Center). One of the first episode-based initiatives of the Innovation Center was to create the Bundled Payments for Care Improvement (BPCI) initiative in 2013. By accepting a fixed price for a defined episode of care, participating providers were accepting three components of risk exposure:

1. **Utilization risk:** The risk that patients may require more or less resources than expected.
2. **Morbidity risk:** The risk that patients are more or less healthy than expected.
3. **Performance risk:** The risk of providing more or less efficient care.

In exchange, the providers receive more consistent and predictable cash flows for the procedures and an opportunity for a higher yield or profit by delivering the care more efficaciously.

Following the ACA, Congress enacted the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA replaced the Sustainable Growth Rate (SGR) formula, which established payment rates for physicians treating Medicare patients, with the Quality Payment Program, which focuses on performance-based payment adjustments and creates incentive programs for participation in innovative payment models.

Both BPCI and MACRA are examples of the federal government's recent attempts at using value-based payments to incentivize providers to improve the patient experience and the health of populations as well as reduce the costs (the Triple Aim). While the approaches are considered innovative, the concept of using incentives in these programs is not new to the Medicare program. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) created the Medicare Risk program, which evolved into Medicare+Choice from the Balanced Budget Act of 1997 (BBA) and ultimately became Medicare Advantage in the Medicare Modernization Act of 2003 (MMA). The premise of each of these programs was for the federal government to pay a fixed or risk-adjusted per capita amount (or capitation) to cover the costs of benefits and administration, leaving insurers with a reasonable profit. These programs control annual cost increases through methodologies tied to the Medicare fee-for-service (FFS) program cost trends. Thus, while these capitated programs targeted health insurers, many providers took advantage of the opportunities to take risk by becoming provider-sponsored health plans or contracting with health insurers on a percentage of revenue basis. In this light, the efforts of the Innovation Center can be seen as expanding the number of channels through which providers can accept risk.

Figure 1 shows a continuum of risk for providers. Generally, the risk and opportunity to the providers start small in a program that they serve on a FFS basis. These small steps may be quality bonuses or upside risk only and then transition to full risk sharing (upside and downside risk). As providers move along the continuum, both their potential risks and opportunities increase. Provider organizations accepting full risk sometimes form their own health plans as vehicles for accepting and managing risk contracts.

This paper discusses the opportunities, challenges, and risk to providers as they move through this continuum, considering whether to start a health plan or to continue to contract on a value-based care basis.

Competencies of a health plan

While health plans and providers operate in similar environments, their core competencies are different, and in the case of a provider-sponsored health plan, the ones they share may be in direct competition with each other. For example, a health plan's utilization management (UM) is focused on discharging patients to the most cost-effective setting while a hospital has an incentive to keep them admitted. Given the potential for this competition, it is important that provider-sponsored health plans establish governance protocols and clearly define the divisions of responsibilities.

As the owner, the provider wants input on the strategic direction of the health plan. The health plan evolved from the provider with a specific set of goals and the provider wants to ensure the goals are preserved; or if they do change, that the health plan's new goals are consistent with its owner. Provider representation on the health plan's board would accomplish this. It would be

common for the health plan board to include executives from the sponsoring provider as well as leaders from other key providers in the delivery system.

The management of the day-to-day operations of a health plan are different from those of a provider. Health plans have contracts with members, providers, and vendors while providers have responsibilities to their patients and contracts with their vendors. The different requirements create the need for different management teams.

Figure 2 shows the major functions of a health plan and how they might be shared with a provider owner.

Note that the diagram in Figure 2 represents just one example of an organizational structure. Each organization would need to review its current staffing to identify strengths, weaknesses, and "fit" for health plan responsibilities versus hiring specific individuals for specific health plan needs.

FIGURE 1: CONTINUUM OF RISK FOR PROVIDERS

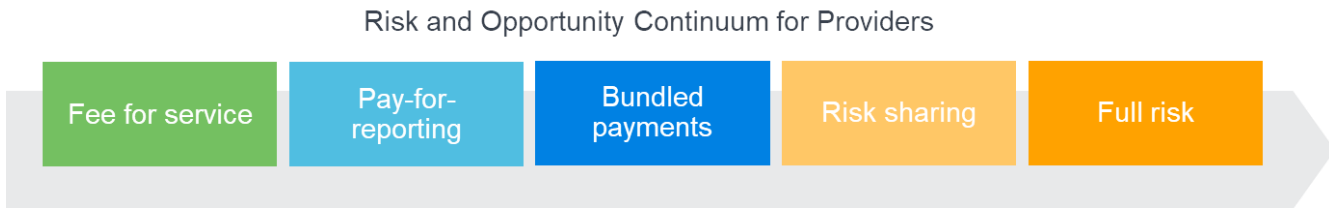


FIGURE 2: MAJOR FUNCTIONS OF HEALTH PLANS AND PROVIDERS



Health plan positioning itself for success

The composition of the local market is a key dynamic when considering the sponsorship of a health plan.

- Community mission or goals
- Coverage of key services—teaching hospitals, tertiary hospitals, trauma care, and centers of excellence
- Current contractual relationships with other payers and vendors
- Population demographics—individuals versus employers versus Medicaid versus Medicare-eligible
- Diversity of provider’s delivery system—freestanding facilities, medical group associations, etc.
- Geographic reach
- Health plan competition
- Membership potential
- Provider brand recognition
- Provider competition
- Regulatory oversight
- Taxes

Each health plan will structure its management team differently and leverage the provider owner to the extent it can, depending on talent levels available, market size, and provider breadth and strength. It is extremely important that the health plan and provider management teams be independent and able to make their own decisions based on the business challenges they face. The economies of scale and savings will occur if both entities are operating at their maximum effort and achieving the greatest efficiency within the structure. The vision and mission of each organization should be clear and each should coincide with the other. Checks and balances through shared board members are also important to ensure that the competing priorities and goals of each organization can be met.

Payers are placing a high value on value-based care programs. They are faced with the challenge of reducing their utilization and costs and for improving the patient experience and health of the population while trying to grow or at least maintain their income and revenue. This can require additional infrastructure and time for the provider, with any savings shared between the payer and providers. Owning a health plan keeps more of the savings in the provider system, albeit indirectly. The owner can then choose how to invest any savings (in higher reimbursement, richer benefits, administrative savings, community outreach, etc.) to meet the overall goals of the organization as well as to benefit the local community it serves.

Health plan potential challenges

The creation of a health plan does not come without challenges and potential consequences. The key is to understand the local market and identify potential challenges.

- Appetite for cost control through managed care
- Capital requirements
- Inability to secure competitive rates with competing hospitals
- Limited geographic footprint for membership
- Losses
- Low domestic utilization
- Overvalued branding
- Partners become competitors
- Risk tolerance
- Start-up costs

Contracting as the alternative

By their very definition, providers focus on treating patients. The vehicle for providing this care is contracts with health insurance payers. Traditional fee-for-service (FFS) contracts pay providers for each unit of service, so the more services rendered, the more payment received. In an effort to mitigate healthcare costs and trends, payers (including federal and state governments) have created value-based care initiatives, which reward providers for their efficiency and/or quality of care.

A dollar or less?

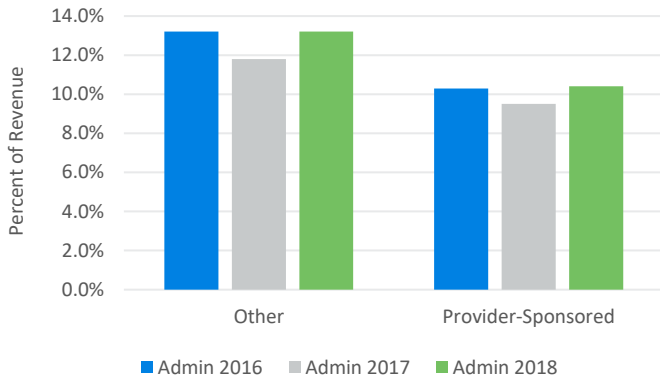
Providers considering value-based care or starting a health plan may be balancing the benefits of managing the full premium dollar versus a portion (say 85 cents) of the premium dollar. As a health plan, provider owners have control over how each dollar is spent. They may still choose to pay roughly 85 cents or more to the providers (themselves) and are now at risk for the administrative costs and for generating a profit.

We looked at 2016 to 2018 data from SNL to get a better understanding of how premium dollars are spent by health plans. We separated the health insurance industry into the top¹ provider-sponsored health plans and all other carriers.² The financial results show that the top provider-sponsored health plans have been able to better manage administrative costs versus other carriers with whom they compete. The graph in Figure 3 shows the 2016 to 2018 administrative costs as a percentage of revenue separately for the carrier types.

¹ Healthcare Finance (September 13, 2016). 25 biggest provider-sponsored health plans include some of the nation's biggest systems. Excludes subsidiaries of Blue Cross Blue Shield (BCBS) and others.

² Includes provider-owned subsidiaries. Excludes BCBS of Kansas as it files a blue blank annual statement.

FIGURE 3: ADMINISTRATIVE COSTS

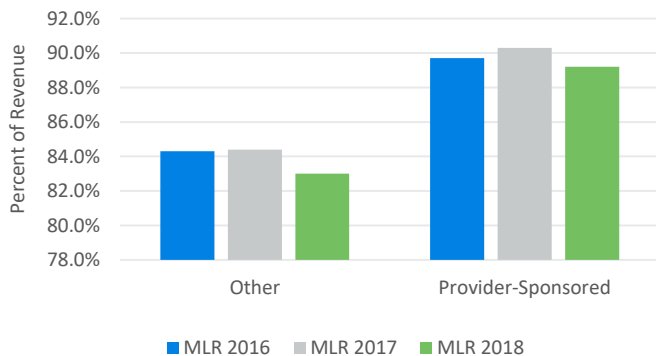


Source: SNL published 2016-2018 orange blank (health) annual statements as of October 2019. Does not include companies that file the blue blank or state-specific financial statements like New York.

Calendar year 2017 was lower than 2016 and 2018 for all carriers, which is attributed to the moratorium on the Health Insurance Providers Fee. On average, the provider-sponsored health plans' administrative costs as a percentage of revenue were 2.5% to 3.0% lower than other carriers. Note that neither the administrative costs nor revenue have been normalized for the mix of business.

While the provider-sponsored health plans have been more administratively efficient, the savings have not accrued to the bottom line. Rather, they appear to have been invested in services for their members through more payments to providers. The graph in Figure 4 shows the 2016 to 2018 medical loss ratios (incurred claims / earned premiums) separately for the carrier types.

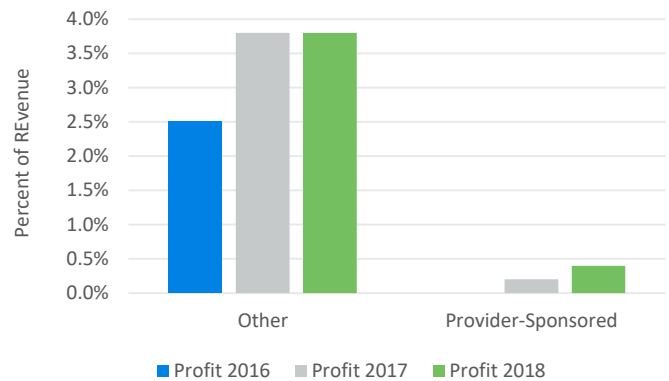
FIGURE 4: MEDICAL LOSS RATIO



Source: SNL published 2016-2018 orange blank (health) annual statements as of October 2019. Does not include companies that file the blue blank or state-specific financial statements like New York.

The higher loss ratios could be attributed to many drivers such as richer benefits, higher reimbursement rates to providers, or fewer managed care constraints (i.e., no pre-certifications), higher utilization due to adverse selection from brand awareness, more visits to ensure quality, and/or more referrals and ancillary tests. The claim payments underlying the 5.5% to 6.0% higher loss ratios offset the lower administrative costs and thus result in lower profits. The graph in Figure 5 shows the 2016 to 2018 profits as a percentage of revenue separately for the carrier types.

FIGURE 5: PROFITS



Source: SNL published 2016-2018 orange blank (health) annual statements as of October 2019. Does not include companies that file the blue blank or state-specific financial statements like New York.

On average, the provider-sponsored health plans' profits as a percentage of revenue were roughly break-even and 2.5% to 3.5% lower than other carriers.

This SNL data does not allow us to determine whether the higher loss ratios resulted in higher profits to provider owners of these health plans. From a health plan perspective, it would appear that the provider owners are not achieving the same returns on their investments as other carriers; however, provider-sponsored health plans may be achieving the returns through more services or higher reimbursed payments to the owners, which could lead to increased profits for the owner.

Operating a health plan may allow the owner to diversify the sources of profit; however, a value-based care contract with the right payer may achieve similar results with less investment and risk for the provider. To be successful, the provider would still need to properly code diagnosis for risk scores, monitor results, and manage the overall financial risk of the contract through reporting platforms; however, the provider's primary focus can be on its strengths of delivering care and improving quality and not be distracted by the challenges of operating a health plan.

The capital requirements of starting a health plan can be significant. The owner must cover start-up costs, fund losses in the early years, and fund or maintain capital and surplus above state minimums. This does not include the human capital invested by leadership and hospital staff spearheading the effort. A provider looking at value-based care payments may have to fund some new infrastructure and operational costs necessary to successfully manage the risk and achieve savings; however, it would be much smaller than the health plan investment. The provider needs to balance the investment in a health plan with the potential return versus the return of other investments such as expanding a hospital, building a stand-alone treatment center, or acquiring physician practices.

Summary

Provider incentives associated with value-based care initiatives are not new as government-sponsored programs like managed Medicaid and Medicare Advantage have been creating opportunities to lower costs and improve care for years. Nevertheless, the new value-based care programs like MACRA have drawn more attention to the ability of programs to bend the cost curve. Providers are uniquely situated to both direct and/or provide care for those in the healthcare delivery system through establishing their own health plans or contracting with existing payers. Providers need to weigh the incentives and challenges of each option and understand how they would be impacted. A provider owner should perform feasibility studies and model the interplay with a provider-sponsored health plan versus various value-based care contracts to fully understand opportunities and risks.



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