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Increasing provider interest in health insurance: Why now?

Market forces (e.g., COVID and inflation-driven financial pressures), the uptake of value-based care throughout the industry, and payer encroachment on traditional provider activities are placing additional stress on providers' financial performance. How can a provider alleviate these pressures through a move into health insurance?

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Intro: Why now?

The first part of our four-part blog series on value-based care payment models discussed the motivating factors for providers to take on increased risk, including consumer expectations, cost pressures, regulations, and COVID-19. Providers, driven by these pressures, are shifting from traditional fee-for-service payment models to value-based ones, with those most committed attempting to shift upward of 40% of their revenue to be managed under value-based contracts. This is fueling increased alignment between payer and provider incentives, and encouraging providers to build capabilities, traditionally held by payers, to enable success in such contracts.

As providers continue to build capabilities for success in value-based care and invest significant dollars, they are realizing that value-based contracts, and even partnerships with payers, may not maximize their capture of the premium dollar. Furthermore, payers are actively building or acquiring care delivery assets and capabilities such as primary care, home health, and pharmacy services.

Although, provider-sponsored plans (PSPs) are not a novel concept, with many PSPs existing and successful for decades, the industry's acceleration toward value-based care is pushing more health systems to explore the development of their own health insurance business or further integrate existing plan assets.

Benefits of having a provider-sponsored plan

As providers and the industry head toward taking on additional financial risk, providers can anticipate several benefits from entering the plan space including a more sustainable and predictable revenue flow, fully capitalizing on current population health capabilities, leveraging a potential plan as a growth tool to enter new markets and grow attributed lives within current markets, and exerting greater control over their network and plan designs.

The COVID-19 pandemic has exposed the volatility of the traditional fee-for-service model for providers, with revenue streams severely impacted with each additional COVID wave. A provider-sponsored plan can mitigate some of this volatility, with a stable premium-based revenue model enabling providers to place more focus on long-term care model shifts and investments with the predictable baseline of revenue of a health plan.

Providers that have built value-based/population health care capabilities in order to capture more risk can further capitalize on these existing capabilities that can be shared with a health plan. Medical management, network management, and population health analytics—core competencies of a provider's value-based/population health care capability—can be leveraged to drive additional revenue through creating a health plan offering and capturing a greater share of the health plan premium dollar. In this effort, the provider will be able to efficiently integrate provider and payer capabilities and diversify revenue streams, thereby helping to alleviate the additional financial pressures facing both the provider and the industry at large. A health plan offering that leverages existing population health capabilities can also accelerate a provider's journey toward having more revenue in the value-based business, and also enhanced system operational and financial alignment, thereby improving overall performance within their value-based business.

Furthermore, a provider-sponsored plan can be leveraged as a market entry tool, enabling providers to expand into existing and new geographical markets. Interacting with the consumer across both the provider's care delivery and plan services creates a unique opportunity to grow consumer engagement with your system, develop broader consumer loyalty, and ultimately grow market share. This expansion can occur without an investment in expensive physical assets that are located in new markets. Leveraging a plan to establish a foothold in new markets can generate new, diversified revenue streams. Projected growth in the insurance market, especially the 6%+ annual growth in Medicare Advantage nationwide, makes an expansion into the health plan space more enticing as providers that have a dominant regional brand often enjoy strong community ties with the senior citizen population.

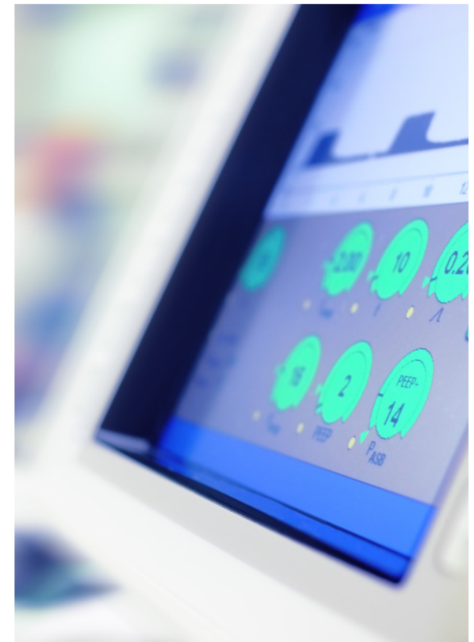
Lastly, entering the provider-sponsored plan market enables providers to maintain greater control over their network, patient experience, quality of care, and the care model. This should help drive patient outcomes and improve population health management, creating further value for patients and the provider. This benefit especially rings true for providers that struggle to negotiate beneficial value-based contracts, removing the friction from the struggle to develop win-win partnerships with payers.

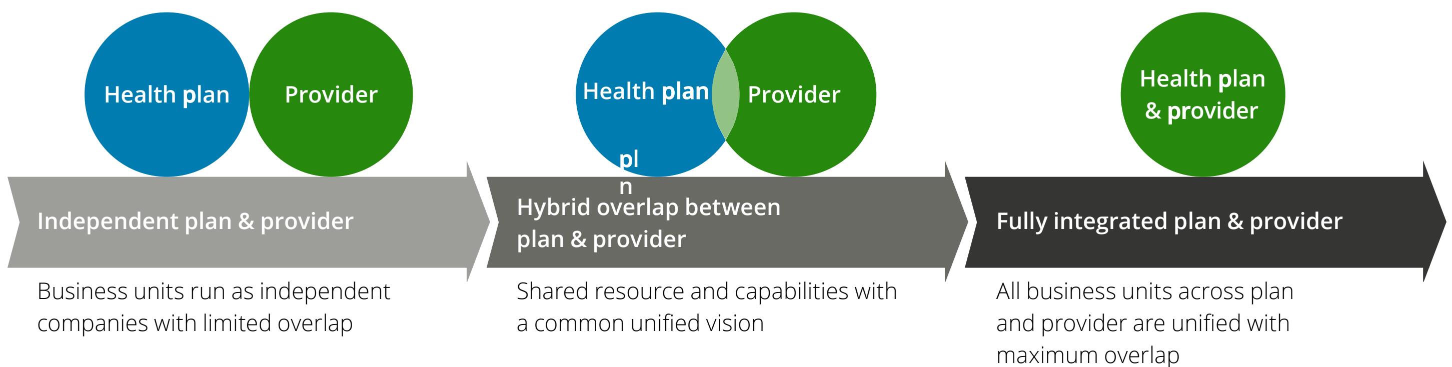
Options to expand into the provider-sponsored plan space

Providers have a multitude of options to expand into the provider-sponsored plan space, with varying degrees of integration seen between payer and provider functions of organizations with plans currently. These varying degrees of integration have all demonstrated success, leading to multiple case studies of successful provider-sponsored plans.

Regardless of the integration model, successful provider-sponsored plans tend to have a 50-50 revenue split, or greater, of plan-to-provider revenue. This represents a tremendous long-term growth opportunity for providers that have stagnated growth due to physical and geographical limitations. Successful plans identified by Deloitte have 500,000 to 12 million insurance lives. However, this growth did not occur overnight; most of these plans have been established for more than 30 years. Opportunities for providers to enter this space often occur in areas where they already share financial risk: their own employee base, Medicare/Medicare Advantage, and Medicaid.

Providers that have existing plan assets need to consider the opportunity for further integration of plan and provider capabilities. Further integration of capabilities, such as medical and care management, provider network, analytics, and consumer experience, can help improve the cost of doing business, align goals and incentives to drive better outcomes, create organizational synergies across consumer interactions/experiences, and achieve reductions in total cost of care.





Success factors and strategic considerations

Provider-sponsored plans have a few key success factors that typically indicate financial and strategic success. Lines of business that offer a high-margin opportunity, such as Medicare Advantage, enable providers to have a first point of entry that is target-rich, high-margin, and an expanding opportunity when launching the plan. Additionally, a provider that has a strong brand with deep community ties is able to attract a larger amount of members and achieve a scale suitable to profitability faster. Achieving 100,000 enrollees in one line of business typically achieves economies of scale in health plan capabilities, crossing a key threshold to be competitive with regional and national carriers in the markets the provider serves. Lastly, competitive health plan markets with no sole dominant player tend to offer greater opportunity for providers to break into due to the lack of leverage any sole plan has to quash competition.

High-margin opportunity

Markets such as Medicare Advantage are typically more lucrative opportunities for providers expanding into the plan space.

Dominant provider in the market

Providers who enjoy a strong hold over their regional market and a trusted band in the community can capture greater market share in the plan space.

Competitive plan environment

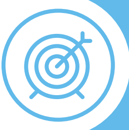
Regions where the plan marketplace doesn't have a sole dominant player present greater opportunity for providers to enter due to a lack of leverage any sole plan has to quash competition.

Provider-sponsored plans can differentiate their product from the marketplace based on an integrated set of capabilities instead of price. Integrating capabilities such as medical management, network management, population health analytics, and customer experience will drive better patient outcomes and customer experience, ultimately resulting in a reduction in the total cost of care for the patient. This is demonstrated as provider-sponsored plans typically tend to score better on member satisfaction and quality.

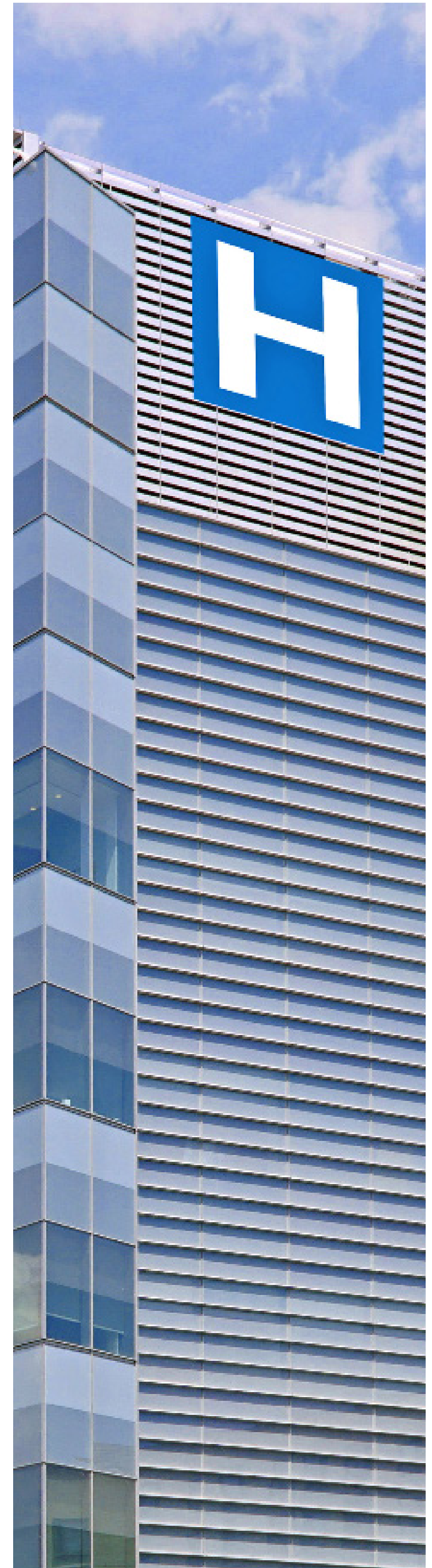
Current market forces are driving providers to think about greater integration between plan and provider capabilities through launching a provider-sponsored plan to diversify and expand revenue sources, gain access to full premium dollar, and grow consumer engagement with additional financial incentives. However, it is critical that providers enter the health insurance market with a targeted approach to reduce and manage financial volatility. The following are a few key questions providers can ask prior to launching their own provider-sponsored plan:

What insured populations does our provider system currently manage well, from both a care delivery and financial lens? What lines of business would our system like to target from a health plan lens, and why? What geographies can we serve with influence on care model, provider network, and incentive structures?

Does our organization have an existing network strategy? How do we assess the performance of our network? How will future partners fit in with the line of business/geographical strategy for our health plan vision?



How does a health plan strategy align with and assist in achieving enterprise goals?



Closing

Overall, market forces are driving the increased uptake of value-based care and, in turn, changing historical incentives for providers and health plans. Providers can further capitalize on this shift through launching their own provider-sponsored plan, albeit with a few key strategic considerations regarding understanding how to operationalize, knowing which markets could drive growth and financial performance, and aligning the provider-sponsored plan's strategy with the broader organization's strategy. However, the push for integration between payer and provider is not just limited to providers. Payers have begun their transformation toward entering the provider space through supporting providers in enhanced joint ventures and actively moving into the provider asset space, especially around virtual health and primary care services. The entrance of a new hybrid between payer and provider, will only further push providers toward taking on additional risk through value-based contracts and potentially launching their own provider-sponsored plans.

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