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What role can commercial payers play in improving hospital financial resiliency? A big one.

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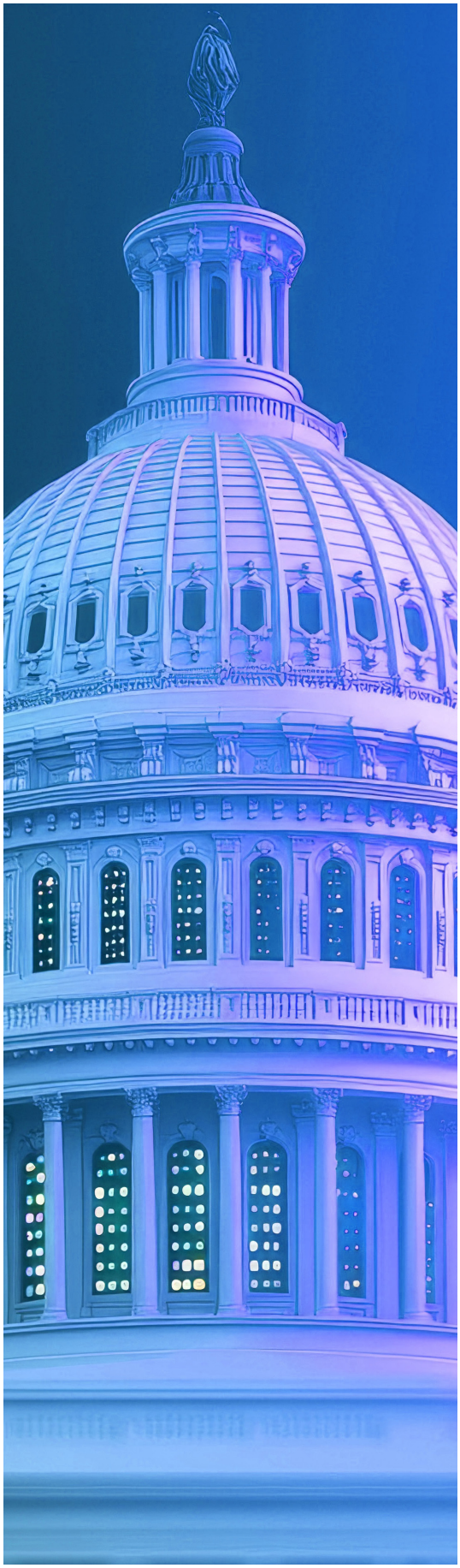

To maintain and expand access to care, one of the biggest—and most complex—levers states can pull is the commercial health care payer market ("commercial payers"). States have differing levels of authority over commercial payers, but all states can spur commercial payers into action to improve hospital resiliency. Ultimately, commercial payers drive major market dynamics and shifts because of their ability to incentivize or disincentivize clinical behaviors.

"Commercial insurance payment decisions will increasingly have a profound impact on both the health of all Americans and the nature and adequacy of the hospital and physician delivery systems that serve them."[1]

States may need a deep understanding of 1) their regulatory authorities, and 2) commercial health insurance payer mix in terms of integrated delivery networks (IDNs)[2] versus independent commercial health insurance payers to maximize the impact commercial payers can have on the financial resiliency of hospitals.

Regulatory authorities

Since state government serves as the primary regulator of commercial health insurance, determining the scope of authority a state has is the first step. Some states have a significant amount of regulatory authority over commercial payers and can approve, disapprove, or modify payment rates that commercial payers can use in rate negotiations with providers (namely, hospitals and health systems).[3] With this authority comes an opportunity to review rates for needed services across the state or to disincentivize the expansion of services that are duplicative. These decisions can be supported by robust data analysis to align state needs with payer market dynamics. Other states have less authority but can help coordinate insurance changes and tailor reforms to state needs.[4]

The Insurance Department and Health and Human Services agencies (e.g., public health and Medicaid) may want to collaboratively build a strategy that will ensure access to care by improving hospital financial resiliency that uses this powerful function to move payers in the direction that best aligns with the state's goals. These agencies may work in tandem to not just set the goals and negotiate the rates, but also monitor the impact on an ongoing basis.

For example, beginning in 2004, Rhode Island used its regulatory authority to enact price controls and affordability standards.[5] Or, more recently, New York state had robust authority over rate setting and increased insurer accountability measures during the COVID-19 pandemic to ensure patient access to care and remove inefficiencies for those on the front line.[6] Pointing to an earlier example, the state required commercial insurers to increase primary care and care coordination spending[7] and, through price controls, slow total commercial health care spending growth.

Other states lead by influence if they do not have a robust regulatory authority. Building partnerships between the state, providers, payers, and the community is key to forming relationships that can improve hospital resiliency by implementing strategic, operational, and financial solutions relevant to the state's environment.[8]

For example, in 2019, Pennsylvania successfully fostered a successful partnership among these stakeholders, which resulted in the launch and implementation of the Pennsylvania Rural Health Model (PARHM). PARHM is an alternative payment model jointly supported by the Center for Medicare & Medicaid Innovation and the Commonwealth of Pennsylvania, and, in this model, participating hospitals transform the way care is delivered to succeed financially under a global budget payment mechanism with commercial and governmental payers. Now, hospitals have a predictable revenue stream and they are paid a fixed amount upfront, regardless of patient volume, enabling rural hospitals to invest in population health and preventive care to serve the specific needs of the community.[9]

Since the state did not have the regulatory authority to require commercial payers to participate in PARHM, the Insurance Department, Department of Health, and Department of Human Services worked together to convene the payer and provider communities, collaboratively devised a payment methodology, and implemented this alternative payment model.[10] As of January 2024, no hospitals participating in this model have closed, and the model is expected to reap $35 million in savings when the demonstration concludes at the end of 2024.[11]

Although there are limited examples at this time of states using this approach, it is an opportunity for state leaders to consider it as a potential lever to enhance hospital financial resiliency. With many hospitals nationwide facing financial challenges, new solutions that are tailored to meet states' specific needs are critical.

Commercial payer mix

States can assess what proportion of payers in the state are associated with an IDN compared to an independent payer. The payer arm of an IDN inherently has a different value proposition to achieve hospital financial resiliency than an independent payer, and understanding the mix across the state is critical to aligning incentives. Since IDNs own and operate both the provider and payer arms, they have an incentive to ensure the financial resiliency of hospitals and can leverage their payer-power to do so. Crafting the business case to support hospital financial resiliency is more integrated in their mission—at least, for the hospitals they own and operate. On the other hand, independent payers may need a more straightforward return on investment (ROI) argument to be motivated.

Analyzing the state's levers with respect to the state-based insurance exchange, Medicaid Managed Care payment arrangements, and network adequacy can help craft an impactful value proposition for commercial payers to engage. To move commercial payers in the desired direction, consider the following levers:

Leverage Medicaid Managed Care experience: Many Medicaid programs have experience designing value-based care payment arrangements with commercial payers for their managed care products. State insurance agencies may collaborate with their Medicaid agency to understand trends and success stories that could be implemented more broadly across commercial products, which can also help the state more holistically understand the total cost of care by member, patient, or consumer.

Utilize the state-based exchange to drive improved patient outcomes and reduce cost: States that have a state-based insurance exchange may want to consider ways to use the exchange for care coordination, quality, and spend tracking. Adding language to product requirements that drive commercial payers into state-determined types of payment arrangements will improve hospital financial resiliency.

Assess network adequacy: When making the case to independent payers about ROI, exploring network adequacy is key and will level the playing field with IDNs (e.g., without an adequate network of hospitals, they cannot sell their product in a state). Since hospital closures affect network adequacy, payers will be concerned about the viability of their products in the market.

Conclusion

After identifying the payer types across the state and crafting a value proposition tailored to the payer types, assessing the environment will support hospital resiliency. To better understand the commercial payer market, states may conduct an environmental scan of the current commercial payer landscape. Key considerations include existing relationships, strengths and opportunities, and focus areas. Another consideration is post-COVID-19 pandemic changes and emergency preparedness funds/spending.

The three state agencies (Insurance Department, Department of Health, and Department of Human Services) working collaboratively to fully engage commercial payers are more likely to find successful outcomes.

Acknowledgments

Margaret Ostafin, Hailey Adler
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Endnotes

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