Five Strategies for Health Systems Repositioning for Changes in the Commercial Insurance Market

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Since the announcement of the Patient Protection and Affordable Care Act (“PPACA”), health plans have explored various approaches to new commercial products that seek to reduce costs across the care continuum, and in turn, reduce increases in premiums. This is (potentially) good news for consumers of healthcare.

Unfortunately for providers, one trend has become clear in the near-term – steep increases in commercial rates are a thing of the past. Health systems, in particular, will either need to embrace population health management models as health plans introduce shared savings or bundled payment revenue arrangements, or prepare for deep cuts in fee-for-service revenue. Now more than ever the linkage between financial and market strategies is key in determining how to maintain/grow the health system’s commercial business.

Health plans will be working to tailor cost-effective networks for their customers and prepare for the state health insurance exchanges (“the Exchanges”). In addition, they are adjusting to key medical loss ratio (“MLR”) provisions under PPACA: 1.) the provision requiring health plans to spend a minimum amount of premium dollars on medical expenses, and 2.) the calculation of MLR, which includes quality improvement costs as part of medical expenses. These provisions have incentivized health plans to work more closely with providers to create value-based networks as they attempt to minimize risk and cost and improve quality.

With all this change, health system leadership is now faced with understanding, selecting, and operationalizing a vast menu of commercial products. Below are five strategies that can help health systems better position themselves for success within the rapidly changing commercial landscape:

1. Leverage the organization’s physician alignment strategy. A health system’s physician alignment strategy and payer strategy should be directly linked. Furthermore, there should be a clear direction from these strategies on how physicians and hospitals will be incentivized and compensated within a population management framework. Without a robust physician alignment strategy and a roadmap to care integration and coordination, health systems will have difficulty demonstrating value to health plans and employers.

2. Create consistency across health plan population management products. Understanding the array of commercial products is essential to the overarching payer strategy of an organization. With employers seeking reduced premium...
increases, and health plans competing for their business, health plans have tried to differentiate themselves through nuanced product offerings. At their very core, these products all seek to achieve the same goal — bend the cost curve by incentivizing cost-effective quality care. However, structure, process, and clinical benchmarking for these products are varied and disjointed. To maximize success, health system management should be ready to take the lead and put forth their own internal measures, criteria, and care coordination plans developed through their physician alignment and integration initiatives. By creating consistency among the programs and limiting the administrative burden of varying measures and processes, management and physicians will be able to better focus their efforts on the goals of the organization.

3. Consider narrow networks as a way to market the system’s value proposition. As health plans seek to stabilize the premiums for employers, they have opted to develop networks that utilize the most cost-effective healthcare providers in the region. Often times, health plans will offer some level of exclusivity to the health system (i.e., through a narrow network arrangement) in exchange for a discounted price for services and care coordination. This discount should be accompanied with incentives for reducing costs (i.e. shared savings) to align incentives between the health plan, hospital, and other providers. Although this arrangement creates a vehicle to strengthen and grow commercial market share, the uptick in business rarely outweighs the discount agreed to by the providers in the short-term. If a health system makes the decision to become the center of a narrowed, discounted network, the goal should be to further advance and showcase the system’s integration capabilities and not necessarily to drive additional short-term profitability. Benefit design must be structured to encourage use of the health system’s physician network through reduced co-pays or co-insurance, as well as advantages for keeping within the health system’s network of facilities. Once the health system can demonstrate value to the health plan and employers in the short-term, the system should be able to leverage those successes into significant growth in market share and, potentially, increased profitability in the long-term. Utilizing this same formula in “private label” offerings with self-insured employers, or even for the employees of the health system itself can be a path to clear market leadership.

4. The value proposition should include the ability to accept and manage risk. With the new MLR provisions under PPACA limiting profits, health plans are faced with managing the same amount of risk with less financial reserves. As a result, health plans are increasingly motivated to shift more risk to health systems as they attempt to reduce their exposure. In addition, PPACA allows health plans to include quality incentive programs as part of medical expenses, and in turn, they are able to push the MLR higher to remain compliant. The quality improvement programs then create the platform for shared savings arrangements. Health plans are implementing a number of shared savings programs that are typically linked to a population’s MLR or other medical expense target. In general, if medical costs are less than an agreed upon target, the health plan will fund a pool which may be paid to the providers should they also meet select quality criteria (which fulfills the quality improvement qualification). While achieving cost savings and quality metrics is essential to the shared savings program, the health system’s willingness to take risk from the health plans is also critical as it will determine how large the shared savings pool may become. In other words, if the system is not ready to accept downside risk along with the upside risk, shared savings revenue opportunities will be minimal. Health systems with experience in capitation are especially well
positioned to differentiate themselves from their competitors and increase market share.

5. **Develop a strategy specific to state health exchanges.** While the Exchanges are still under development, health plans are beginning to position themselves to capture a share of the newly insured market. Health plans are approaching providers with steeply discounted rates that are well below any traditional commercial products. Health systems should be cautious with these new contractual arrangements as the Exchange products will also be offered outside the Exchange. Although there are a number of theories on how employers will respond to the Exchange and insurance subsidies under PPACA, it is clear that employers will have to make a serious economic decision about their businesses’ health care costs. Should a significant number of local employers elect an Exchange product, the impact on revenue to the health system could be substantial. In preparation, health systems should create a sub-committee that will develop an Exchange-specific strategy. As part of building the Exchange strategy, the sub-committee would be charged with outreach to local employers and vetting the various contract arrangements with payers.

In the past, health systems could rely upon steep increases in commercial rates to drive their financial performance, but with employers demanding more sustainable pricing for healthcare, providers will increasingly feel the squeeze. As commercial margins decline, health systems will need to refocus their efforts on value-based care as way to differentiate themselves from their competitors and increase market share. In some cases, this may mean committing to discounted networks and managing risk. To accomplish this, a comprehensive payer strategy that also incorporates the organization’s physician alignment strategy, population health capabilities, as well as operational improvement efforts will be critical to the success of any health system.

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