Pursuing a Provider-Sponsored Health Plan: Key Considerations

Introduction

Under the long reign of fee-for-service reimbursement, negotiations between providers and payers have followed a predictable pattern. Providers argue the proposed rates are not enough to cover their costs, while payers claim their customers cannot bear additional premium increases. Inevitably, both sides tend to walk away unhappy.

With the new emphasis on value over volume, provider-payer negotiations now often include some discussion of alternative payment models (APMs), including pay-for-performance adjustments to fee schedule rates, per-member-per-month payments for care management services, shared savings arrangements, and episodic payments. A recent survey of commercial payers, Medicare Advantage (MA) plans, and state Medicaid programs, conducted by the Health Care Payment Learning & Action Network, showed nearly one-third of all healthcare dollars are in shared-risk arrangements.

For many providers, APMs are new terrain. It takes time and commitment for physicians and health systems to build the infrastructure and master the competencies required for value-based payments. These include reliable health information exchange; near real-time data analytics; adoption of, and adherence to, evidence-based guidelines; and robust care management programs. During this development phase, providers look to partner with payers, moving from no-risk to shared-risk models.

For those provider organizations that have deployed required infrastructure and developed necessary competencies—or those with a definite plan to accomplish this—bearing greater risk in exchange for greater control over premium dollars is an attractive and manageable proposition. A provider-sponsored health plan, or PSP, offers these organizations the opportunity to reap the benefits of efficient operations and effective population health management strategies.

The PSP Opportunity

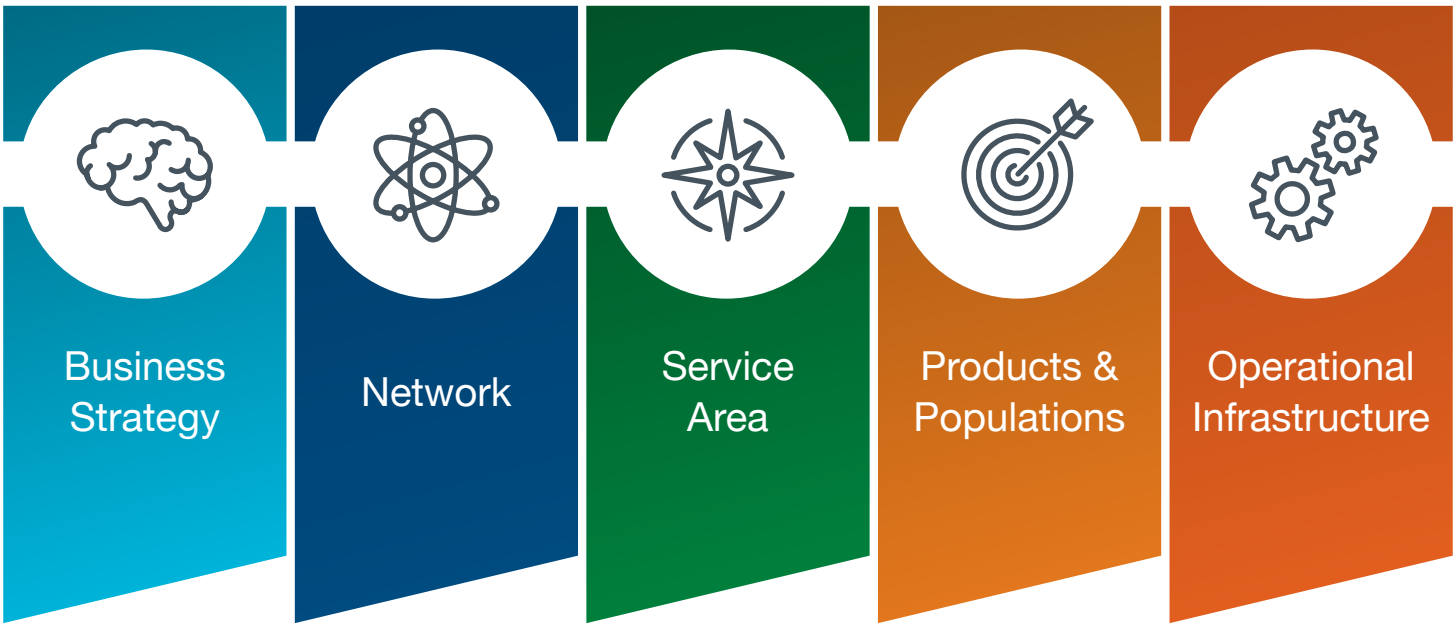
A PSP is a state-licensed health insurance plan owned in whole or in part by a provider organization (e.g., health system, physician practice, clinically integrated network, or accountable care organization) that leverages relationships to gain efficiency in coverage and treatment of its insured population. Rather than contracting with a payer for a percentage of premium (i.e., capitated rates), a PSP contracts directly with the purchaser (e.g., CMS for MA, a state Medicaid program, an employer) and thus controls the full premium.

According to the latest data compiled in the AIS Health 2016 Directory of Health Plans, there were nearly 300 such plans operating across the country. AIS Health reported that 10.14% of all U.S.-covered lives were enrolled in a PSP; approximately three-million Medicare beneficiaries were enrolled in an MA PSP, representing 16.5% of all MA beneficiaries. The rapid growth in PSPs—both in terms of the number of plans and the number of enrollees—reflects the value many provider organizations have realized through the PSP opportunity.

Evaluating the Opportunity

Before considering a PSP, a provider organization must evaluate its infrastructure and competencies to manage risk. If an organization is unprepared to succeed under a shared savings arrangement, an episodic payment model, or capitated rates, a PSP is not a viable strategy. Instead, the organization should focus on building necessary infrastructure and competencies for effective management of risk.

For those provider organizations ready to manage risk, we have identified five key considerations in evaluating the PSP opportunity:



Business Strategy

As a precursor to any internal stakeholder discussions regarding a PSP, organizational leaders should evaluate market conditions:

- What are the current insurance market dynamics in the organization's service area?
- What are the current provider dynamics in the area?
- What are competitors' current and future payer strategies?
- What are the market share trends by service line?
- What are the current purchasers' (e.g., employers, individuals) perspectives?
- Is the market willing to accept a narrow network product in exchange for lower prices and improved quality?

Assuming leaders conclude market conditions are favorable (or at least not adverse), the next step is to engage stakeholders in considering key internal factors likely to impact the success of a PSP strategy:

- Are there competing organizational priorities that demand the attention and resources that would be required for a PSP strategy?
- Are there available resources to fund necessary plan infrastructure?
- Is a PSP consistent with overall brand strategy?
- Does the provider organization's brand carry weight with employers and individual consumers?
- Is the organization willing to provide price concessions to its own health plan in exchange for market share?
- How would the provider organization incentivize physician participation?
- Who is likely to object to the strategy and can those objections be overcome?

If a PSP strategy is not aligned with the organization's current business goals or doesn't make sense within current market dynamics, there is no reason to evaluate further. Instead, the organization should consider developing a plan for pursuing the PSP opportunity in the future or evaluating participation in shared-risk arrangements with payers.

Network

To attract potential purchasers, a PSP must maintain a strong network of hospitals, physicians, and other providers whose services would be offered through the PSP to meet plan members' health needs. That network would include, but would not necessarily be limited to, the sponsoring provider organization.

As the key to a PSP's success is effective management of the member population's health and healthcare expenditures, a strong contingent of primary care physicians and medical specialists (e.g., cardiologists, oncologists, neurologists) committed to patient-centered care is the critical component of a PSP's provider network. Unless the provider organization maintains a robust primary care provider network, the success of the PSP will be challenged, if not impossible:

- Does the organization presently employ, or have within its existing network, a sufficient number of primary care providers to manage the proposed populations?
- If not, are there a sufficient number of independent PCPs in the market willing to participate in the network?

Additionally, the provider organization may need to contract with other providers—including non-sponsor hospitals, outpatient surgery centers, urgent care clinics, and pharmacies—to satisfy network adequacy requirements. The business terms of these contracts should reinforce the provider organization's clinical integration strategy, such as compliance with evidence-based guidelines and participation in care management activities.

Service Area

Next, a provider organization must decide the PSP's service area, i.e., the communities from which the PSP will accept members. For example, a PSP applying to participate in MA must identify each county in which the plan will operate; a Medicare beneficiary residing outside the plan's approved counties cannot enroll in that plan.

While it is tempting to define the service area based on potential covered lives, a PSP should limit its service area to those communities in which it has a sufficient network of providers. For many a provider organization, the best option is to restrict its PSP's initial service area to a single community and expand to a broader region following initial proof of concept. Scaling up operations is significantly easier once the organization's competencies in population health management are tested, and relationships among PSP participants have matured.

Products and Population

Once a provider organization has evaluated its potential network and defined its initial service area, it should next consider which products and populations to target. We have identified, in the following table, those products and populations most often served by PSPs and, based on our experience, key considerations for each:

Population	Risk	Regulatory Burden	Minimum Lives	Potential ROI
Provider Organization's Self-Funded Employee Health Plan	No additional	Low	5,000 - 10,000	High
Local Employer's Self-Funded Employee Health Plans	Low	Low	25,000 - 50,000	Moderate
Medicare Advantage	High	High	1,000 – 2,000	High
Individual Market (Affordable Care Act [ACA] Exchanges)	High	High	1,000 – 2,000	Low
Fully Insured Commercial Plan	Medium	Moderate	5,000 - 10,000	Moderate
Managed Medicaid	High	High	5,000 - 10,000	High

Many provider organizations lay the foundation for their PSPs by developing the provider network to serve their self-funded employee health plan. In this case, the organization is not truly "at risk," as it already has responsibility for its health plan costs.

Taking advantage of this opportunity, however, requires the provider organization to re-structure its employee benefits plan to limit coverage to services furnished by PSP network providers or otherwise incentivize employees to select network providers. To accomplish this "narrowing of the network," the provider organization must begin planning several months prior to open enrollment.

MA is growing in popularity for PSPs. The risks and regulatory burden are high for MA plans, but the program is well-established; MA provides definite "rules of the road" for newly formed PSPs. In 2019, the number of MA plans available to individuals will increase from about 3,100 to around 3,700—and more than 91% of people with Medicare will have access to 10 or more MA plans, compared to approximately 86% in 2018. In light of this growth, taking on an MA plan may be a tremendous competitive advantage in a provider organization's local market.

Given the volatile political and legislative climate, taking on the individual market with an ACA Exchange product generally is not advisable for a new PSP. The individuals purchasing these products likely would require more monitoring and management than the provider organization can immediately provide.

PSPs have found it difficult to compete with large national payers to gain access to larger employers' self-funded plans and the fully insured non-ACA-Exchange market. Often, local governments or governmental entities (i.e., city/county governments, school districts) have political incentive to partner with local health systems. Entities such as these may prove to be fertile grounds for PSPs to plough as they work to expand this segment of their business. Additionally, there are sometimes opportunities for PSPs to "lease" their provider networks to commercial payers to serve specific communities.

Whether there is an opportunity for a PSP to contract with a state Medicaid program as a managed care organization (MCO) will depend on the manner in which the state administers its Managed Medicaid program. Typically, states look for MCOs that can deliver a regional or statewide provider network, making it difficult for a newly formed PSP to secure such an MCO contract.

Regardless of the product, provider organizations should also consider the number of lives that are expected to enroll in the plan. Based on actuarial recommendations, a PSP should target 10,000 enrolled lives to effectively spread PSP internal costs and any insurance risk.

Operational Infrastructure

The sponsor provider organization will face significant investments to build necessary health plan infrastructure including, but not limited to, the following:

- Statutory capital and surplus requirements
- Claims and operating systems
- Compliance programs
- Human resources with deep experience in health insurance
- Licenses and fees
- Sales and member enrollment
- Member services
- Network maintenance

The costs associated with these investments are significant—potentially ***millions*** of dollars—with no guaranteed return. Organizational leaders should work with their finance team and consultants to prepare a comprehensive business plan to assess the impact on the provider.

The sticker shock associated with these infrastructure costs, along with anticipated administrative challenges, may lead many provider organizations to abandon a PSP strategy. Also, the time required to deploy this infrastructure may prevent a provider organization from seizing a competitive advantage. However, there are alternatives to the go-it-alone PSP: forming a joint venture with an operational partner to handle contracting, compliance, utilization management, and various day-to-day plan activities.

Potential operational partners include commercial payers and related entities often referred to as population health services organizations. While the provider organization will have to share a portion of the premium with its joint venture partner, its remaining share likely will be more than the provider organization would earn under a capitated rate contract with a payer.

Four primary differences between a PSP and a joint venture health plan can impact a health system. These differences, presented in the following table, should be evaluated during the planning phase of any PSP strategy:

	Impact on Provider Organization: Provider-Sponsored Plan	Impact on Provider Organization: Joint Venture
Capitalization	Significant economic investments in statutory capitalization and infrastructure	Less than PSP; provider organization can leverage partners' current licenses
Infrastructure	Must develop from ground up	Provider furnishes network and care management; partner provides most insurance operations functions
Ongoing Economic Risk	100% born by provider organization	Risk is shared between provider organization and joint venture partner (i.e., 50/50)

The primary consideration when exploring the joint venture option is "fit," i.e., do the potential partner's goals and values align with those of the provider organization? Provider organization leaders should perform sufficient due diligence on potential partners to ensure alignment with the objectives and long-term success of the health plan, as well as verify potential partners' resources and abilities to manage the plan efficiently.

Final Thoughts

Provider organizations have spent decades developing strong connections with the communities they serve. Taking the leap into the payer space builds on those relationships, giving providers greater leverage to transform healthcare delivery and improve community health. Taking that leap before the organization is ready, or without appreciation of potential landmines, however, could result in long-term problems and significant economic risk.

PYA can assist your organization in evaluating its PSP opportunity, including each of the previously mentioned key considerations. Our executives have decades of experience assisting health systems and provider-sponsored plans with strategic evaluation, operational assessment and improvements, and joint venture implementations. Whether your organization wants to initiate an initial evaluation of PSP as a strategy, needs assistance executing its declared PSP strategy, or requires assistance improving and/or expanding its existing PSP, PYA can help.

For more information about APMs or PSP opportunities, please contact:

Bob Paskowski
Principal
bpaskowski@pyapc.com
(800) 270-9629

Martie Ross
Principal
mross@pyapc.com
(800) 270-9629

Aaron Elias
Manager
aelias@pyapc.com
(800) 270-9629