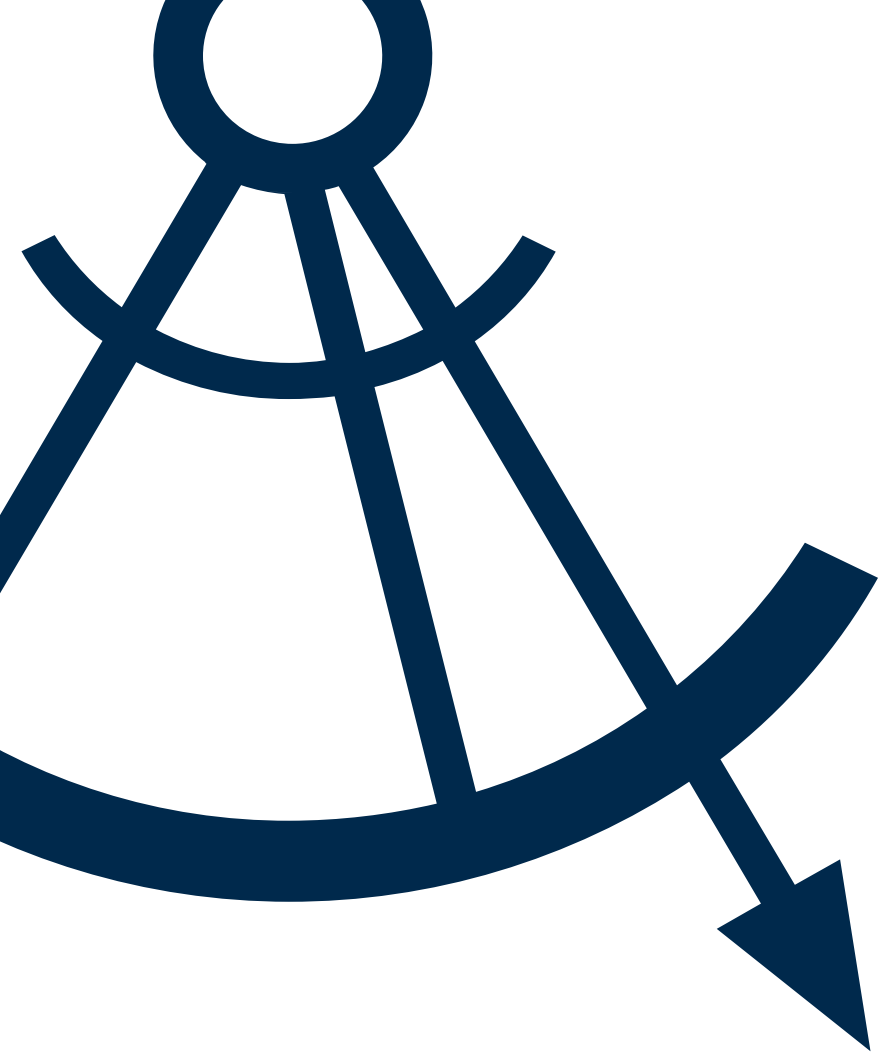


Unlocking the Value of Provider-Sponsored Health Plans

New Market Opportunities Offer Leverage

CHARTIS

In an increasingly challenging and competitive healthcare environment, the line between payers and providers has blurred as healthcare entities are trying to more effectively own and control the healthcare dollar. Optum now has more physicians under direct or contract employment than any other healthcare entity in the U.S. Perhaps the best-known integrated payer-provider organization—Kaiser Permanente—recently announced a deal with Geisinger,[1] itself a large enterprise with a delivery system and its own health plan base.

These dynamics are by no means new—provider-sponsored health plans (PSHPs) have gained interest from health systems for decades. Though the number of plans has waxed and waned over the years, there are currently more than 200 PSHPs in the United States, with more than 26 million members.[2]

TO DATE, PERFORMANCE AMONG PSHPS HAS BEEN MIXED

Examples of successful models of such combined payer-provider enterprises notably have PSHPs that have achieved meaningful scale in membership, developed the necessary capabilities for population health management, improved the quality of care delivered, and elevated the member/patient experience. But many other organizations have struggled to achieve the anticipated value of an integrated payer-provider enterprise. This has been largely due to the sheer complexities of launching, operating, and scaling a health plan in an often-crowded competitive market.

And yet an even bigger barrier to success has been a lack of alignment around the role a PSHP has within the provider-led organization, what defines its "success," and what is required to achieve that success. A PSHP can serve as a platform through which a health system develops a "toolbox" of capabilities needed for population health management and strong performance under value-based reimbursement models. It can also provide leverage in negotiations with other payers.

But with a robust strategic plan and sufficient capital investment, a PSHP can also be a profitable stand-alone business, fueling a health system's growth and elevating overall financial performance.

IT'S TIME TO REEXAMINE HOW TO MAXIMIZE THE VALUE OF YOUR PSHP

Market conditions suggest that PSHPs will likely get more attention in coming years as their relevance and potential value increase. Specifically, a renewed focus on value-based care, combined with heightened financial pressures, is driving organizations to consider how to harness the combined power of both healthcare delivery and coverage capabilities to boost revenue, secure a strong market position, and enable a broadened impact for the individuals and communities they serve.

In this context, PSHP leaders and their provider sponsor counterparts should reexamine how to maximize the value of the PSHP. That could involve new growth tactics, such as moving into new markets or launching additional lines of business (LOBs). Or it could involve exploring partnerships or drawing down an LOB that has not been successful and has a poor outlook.

The resulting strategic plan for the PSHP will be separate from the provider side of the entity, but the 2 sides should be aligned—there is ample opportunity for the combined entity to achieve synergies and offer a differentiated, united healthcare experience to consumers in the markets they both serve. With a clear roadmap defined, a PSHP can achieve strategic, financial, and operating success—and realize its full potential value.

Market Conditions Have Introduced a Window of Opportunity for PSHPs

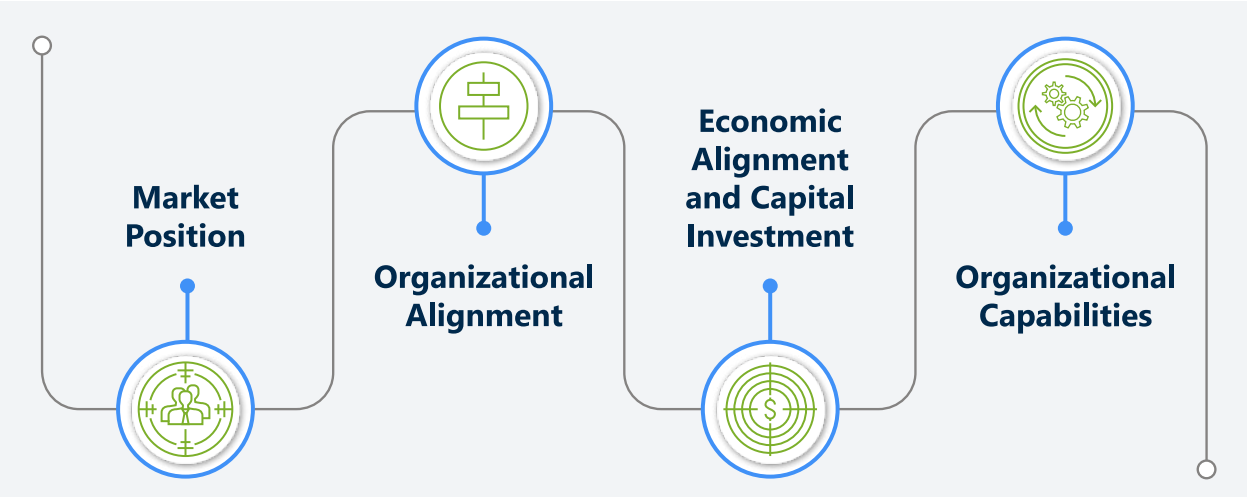
Several market dynamics have coalesced to create favorable conditions for PSHP growth. They also have underscored the importance of maximizing the potential value of PSHPs to support the larger organization's economics.

- **Persistent macro-economic challenges are leading federal and state regulators to explore stronger measures to ensure a sustained healthcare delivery system.** With healthcare as one of the largest contributors to the U.S. gross domestic product (GDP), current economic conditions are prompting renewed efforts around "bending the healthcare cost curve." This has led to a new wave of value-based care models, largely propelled by the refreshed strategic plan from the Centers for Medicare and Medicaid Innovation (CMMI) and its roadmap toward accountable care.[3] In 2021, two-thirds of Medicare Part A and Part B enrollees were in a Medicare Advantage plan or attributed to an accountable care organization (ACO). CMMI's goal is to raise this to 100% by 2030.
- **Healthcare providers that want to perform well under these models will need to develop and refine their population health management capabilities.** That includes understanding and analyzing the drivers of patient cost (both direct contributors, such as healthcare utilization, and indirect drivers, such as chronic disease status and socioeconomic position). And it includes developing ways to manage that cost through operational efficiencies, utilization management, care coordination across providers and provider sites, and engaging patients in their health and healthcare. Operating a successful PSHP requires all of these competencies—and provider sponsors can also leverage them to perform well under the growing number of value-based contracts in the market.
- **Prolonged, challenged health system financial performance has intensified the need to improve margins.** Some patient volume and activity has returned as the pandemic has receded. However, resulting increases in revenue have not kept pace with rising operating costs—which are largely driven by the workforce crisis and continued erosion of payer mix, which is likely to worsen with Medicaid redeterminations later in 2023. The 3 largest credit ratings agencies (Moody's Investor Services, S&P, and Fitch) shifted their outlook forecasts for not-for-profit healthcare organizations to negative in late 2022, and several large and multi-state health systems had their credit ratings downgraded.[4]

  It will be extremely difficult for providers to apply a "business as usual" approach and see meaningful recovery on margins and liquidity. Creative strategic and operating changes are needed. While a PSHP should operate successfully as a health plan on its own, it also can diversify revenue streams for the larger organization and thereby reduce risk. It can also offer the provider side of the entity direct experience in managing population health, optimizing healthcare utilization, and enhancing consumer/patient relationships and engagement. These factors all will help the provider perform better under value-based reimbursement contracts with other payers.
- **Disruptors and new entrants are disintermediating traditional referral channels, drawing consumers/patients away from legacy healthcare organizations.** Some of these entities are combining payer and provider services and offering lower-cost alternative care models and access options. These offerings are usually supported by advanced digital platforms, which are increasingly popular among commercial consumers. Competing head-to-head with these entities' unique offerings may not be realistic for legacy healthcare payer and provider organizations. But investing in PSHP growth initiatives, tailoring plan design, adding LOBs (such as Managed Medicaid or Medicare Advantage), and extending the PSHP's reach beyond its provider sponsor's network could help preserve and grow the patient population the combined organization serves.

Realizing a PSHP's Value Will Require Performance Across 4 Dimensions

Given the heterogeneity of PSHPs, provider sponsors, and market dynamics, there can't be a one-size-fits-all strategic approach for PSHPs. However, any combined PSHP-provider entity will need to focus on and perform across 4 key dimensions to ensure the success of the PSHP and maximize the potential value achieved.



1. Market Position

PSHPs will need to identify target populations and geographies—which can extend far beyond their provider sponsor's network boundaries. And they will need to develop and market competitive plans to grow membership.

This includes:

- **Evaluation of potential target markets and populations**, which should include assessing the competitive landscape and considering forecasted market changes.
- **Development of tailored plan design(s) and competitive pricing** to offer an attractive alternative in markets traditionally dominated by national insurers.
- **Understanding of the sales channels** that directly impact membership and market position, including existing and/or needed relationships with brokers.
- **Clarity around minimum necessary scale** for the plan overall and/or specific LOBs—this should include astute assessment of viable pathways to achieve that growth over a defined timeframe.

2. Organizational Alignment

While a PSHP will have its own specific strategic plan and growth tactics separate from that of its provider sponsor, the 2 parts of the organization must be aligned.

This includes:

- **Agreement on how the PSHP will be best leveraged to support overall financial performance.** Ideally, both payer and provider sides of the organization will have strong strategic plans to drive each business, but the intersection between payer and provider can drive additional value for both.

  Careful analysis is required to determine how best to maximize that value. Leaders can apply targeted pricing strategies, service utilization management efforts, administrative cost reduction, and other strategies, but they should customize those strategies to the market, member/patient base, and organizational capabilities. No single playbook exists, underscoring the need for leaders on both the payer and provider sides of the entity to work together to chart the best path forward.
- **Processes through which PSHP leaders can communicate** with provider-side leaders to optimize the member/patient experience.

3. Economic Alignment and Capital Investment

Economic alignment between a PSHP and its provider sponsor will minimize friction across the organization. In addition, a capital investment plan will ensure the organization can develop the necessary organizational capabilities and support growth endeavors.

This includes:

- **Approaches to optimize member access to services**, as well as in-network provider referrals, in geographies served by both payer and provider.
- **Capital commitment to support PSHP growth strategies**, including expansion into additional markets and the launching of new LOBs.

4. Organizational Capabilities

The combined payer-provider entity will need a set of organizational capabilities to attract and retain PSHP members and ensure a positive member/patient experience.

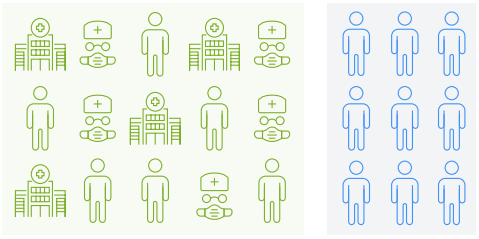
Required capabilities include:

- **Ability to adjust product design** as needed to better match market demand, better compete against other products in the market, and ultimately drive membership growth and engagement.
- **Advanced risk and medical management.**
- **Population health management capabilities**, including cost and utilization management.
- **The ability to maximize administrative and organizational efficiencies** where applicable.
- **A strategy to leverage the combined brand** in markets where both payer and provider play.
- **PSHP partnerships with other providers and organizations** to either fill gaps in services of its provider sponsor or to ensure network coverage in markets where its provider sponsor does not operate.

Alignment, integration, and coordination between the payer and provider sides of the entity—primarily contained in the Organizational Alignment, Organizational Capabilities, and Economic Alignment dimensions above—are crucial to unlock the value available to both sides.

Despite distinct strategic plans and some separate business operations, taking advantage of the overlap between the payer and provider sides of the organization will help each side reap benefits and achieve synergies.

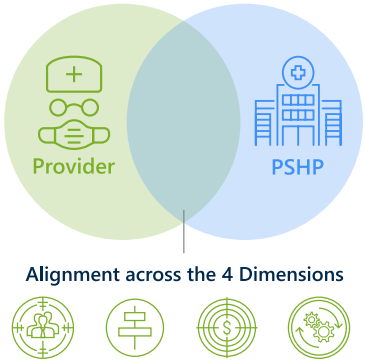
While the PSHP's presence can and should overlap with the provider sponsor's delivery system, it can also serve as a driver of growth into new markets and populations.



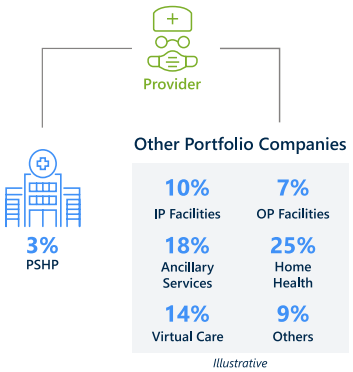
Overlapping Service Areas/Populations

Market Expansion Opportunities

If well aligned, health plan and provider parts of the business can achieve meaningful value together.



If positioned well, a PSHP can positively impact the larger organization.



Key Considerations for 2 Example PSHP LOBs

Certain foundational elements are required for any PSHP LOB, but depending on the LOB and competitive market dynamics, different nuanced issues and considerations apply. It is imperative to tailor the approach for each LOB, avoiding a one-size-fits-all approach. Outlined below are examples of the considerations organizations should examine around LOB-specific issues within each of the 4 dimensions for a Medicaid product and a commercial product.

1. MEDICAID PRODUCT

Market Position

- Some states have limited the number of Medicaid managed care organizations (MCOs) or required plans that can be offered statewide. That practice may spread to other markets where the rules are currently less restrictive. This could increase competition to be selected for the short list of Medicaid providers in a given state and could require a broader provider network strategy if state-wide coverage is required.
- Since Medicaid programs and coverage requirements differ by state, a PSHP may need to design several Medicaid plans if seeking to operate in multiple states.
- Managed Medicaid enrollment is sometimes determined by member choice but also by auto-assignment, which is often guided by an algorithm that considers primary care provider (PCP) alignment, plan performance, location, and other factors. Understanding how members are assigned and then accordingly optimizing PCP alignment, plan performance, and accessibility/service across the provider side of the entity will be important to maximize potential plan scale.

Organizational Alignment

- Medicaid patients often have more difficulty accessing specialty care appointments compared to private/commercially insured patients.[5] A PSHP's provider sponsor and affiliated physicians must make a commitment to serve Medicaid patients in the markets in which they both operate.
- Some states are looking for a higher degree of joint accountability between a plan and provider in new contracts to support the advancement of value-based care. Demonstrating strong alignment, coordination, and joint accountability will be increasingly necessary for the joint entity to secure contracts with a state.

Economic Alignment and Capital Investments

- Provider performance incentives linked to Medicaid member access to services and the service quality and experience for those members can help optimize the Medicaid member/patient experience, establishing the plan as a preferred, high-performing plan—boosting retention in cases where members choose plans, and encouraging the state to prioritize the plan in cases where members are assigned.

Organizational Capabilities

- Additional support services are needed to serve the Medicaid population. For example, transportation services are likely needed in suburban and rural areas.
- Translation capabilities and culturally responsive clinicians, staff, and administrators are also required at the PSHP and provider (the latter can be located at the site of care and/or available through virtual support services).

2. COMMERCIAL PRODUCT

Market Position

- The commercial insurance market is crowded and competitive. Plan design and strategies to engage employers and individual enrollees will need to be tailored by market to achieve scale. Brokers often have great control and influence over sales channels, and the PSHP will need to determine how constrained their membership growth potential will be if they try to compete on local brand versus forming stronger relationships with brokers.
- Some commercial enrollees have multiple homes, and some work remotely, far from their employer's headquarters. Depending on the locations in which the members live and travel, as well as hiring patterns of local employers, a PSHP may need to develop partnerships with providers in markets beyond its core geographies.

Organizational Alignment

- For markets in which the PSHP and provider sponsor both operate, a coordinated effort should be made to emphasize to employers the attractiveness of a holistic, coordinated entity that offers insurance and healthcare delivery services. Branding should be coordinated and consistent. Physician relationships should be leveraged to grow membership.

Economic Alignment and Capital Investment

- Economic incentives and shared goals and metrics will be needed to encourage providers to serve the PSHP's commercial members, rather than giving preference to traditional commercial fee-for-service patients.

Organizational Capabilities

- Consumerism in healthcare has increased, and patient experience (encompassing convenience, quality, customer service, price transparency, and other elements) is more highly valued and considered when consumers make healthcare choices and decisions. PSHPs can and should offer members differentiated services, such as better appointment access and ease of scheduling, a faster authorization process for services or medical equipment (e.g., DME), tailored benefits and services for certain member cohorts, and proactive or timely intervention when problems arise.

Charting a Path Forward for Your PSHP

Current market dynamics have created a window of opportunity for PSHPs. To take advantage of that window, leaders in these organizations should reevaluate their strategic direction, operating model, and growth tactics. A comprehensive analysis of competencies in each of the 4 dimensions discussed and dedicated efforts to increase performance across those dimensions will be necessary for PSHP growth, financial performance improvement, quality improvement, and capitalizing on organizational efficiencies across the combined entity.

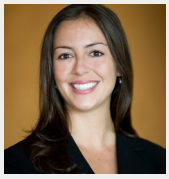
While it is likely that performance across PSHPs will continue to vary, PSHPs have the opportunity to position themselves—and their provider sponsors—for greater success in a future in which value-based care is the rule and not the exception. Failing to leverage this opportunity may sacrifice the chance to improve the financial and operating performance of the organization, and the health and healthcare of the members/patients it serves. It also may give other PSHPs and payers a strategic advantage as they have the time needed to grow membership and secure a stronger position in the market.

The history of PSHPs has clearly demonstrated that success is not easy or guaranteed—nor is there a one-size-fits-all approach to positioning and operating a health plan as part of a health system. But a strong leadership team can determine the right goals for the PSHP within the context of the broader provider-led organization. And they can determine and secure agreement around whether the combined payer-provider entity is ready, able, and willing to take the steps needed to make the PSHP successful and maximize the value enjoyed by both sides of the organization. If PSHP leaders and those on the provider side of the organization believe they can dedicate ample time and energy to strategic planning and performance across the 4 key dimensions, now is the time to act to capitalize on changing market conditions and gain an advantage over increasing competition.

AUTHORS

Colin Blaney
Director, Payer Advisory
cblaney@chartis.com

Alexandra Schumm
Principal, VP of Research
aschumm@chartis.com



Jade Christie-Maples
Associate Principal,
Payer Advisory
jchristie-maples@chartis.com

SOURCES

1. "Health System Kaiser Permanente to Combine With Hospital Operator Geisinger," The Wall Street Journal, April 26, 2023, https://www.wsj.com/articles/health-system-kaiser-permanente-to-combine-with-hospital-operator-geisinger-ee1c0edf.
2. Chartis analysis based on Clarivate's Decision Resources Group Managed Market Surveyor Data, 2022.
3. Centers for Medicare and Medicaid Innovation Center Strategic Direction, 2021, https://innovation.cms.gov/strategic-direction; https://innovation.cms.gov/data-and-reports/2022/cmmi-strategy-refresh-imp-report.
4. "Outlook for U.S. Not-For-Profit Acute Healthcare: A Long Road Ahead," S&P Global Ratings, December 1, 2022, https://www.spglobal.com/ratings/en/research/articles/221201-outlook-for-u-s-not-for-profit-acute-health-care-a-long-road-ahead-12573554.
"2022 Mid-Year Outlook: U.S. Not-For-Profit Hospitals and Health Systems," Fitch Ratings, August 16, 2022, https://www.fitchratings.com/research/us-public-finance/fitch-ratings-2022-mid-year-outlook-us-not-for-profit-hospitals-health-systems-16-08-2022.
5. Walter R. Hsiang, et al, "Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis," Inquiry, Jan.-Dec. 2019, https://pubmed.ncbi.nlm.nih.gov/30947608/.

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