

Provider-sponsored health plans: Tug o' war between providers and insurance

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As the Centers for Medicare and Medicaid Services (CMS) continues to encourage value-based care in Medicare fee-for-service, interest among health systems in taking more risk and possibly starting their own managed care organizations (MCOs) has grown significantly. Health systems often see many strategic advantages in MCO ownership including revenue diversification, opportunities to enhance market share through steerage, and better control over reimbursement.

While there are many examples of health systems that have launched highly successful MCOs, success can be elusive when the motivations of the care delivery system conflict with the motivations of the MCO.

A provider-sponsored MCO and its parent health system can team together to create a unique player in the health insurance landscape, whether it be individual or small group Patient Protection and Affordable Care Act (ACA) products, fully or self-insured large group products, managed Medicaid, or Medicare Advantage (MA). They must leverage their relationship and maximize the value of each entity to be successful and truly impact the local market. Leveraging this relationship to enhance the value of the entire enterprise seems to be the greatest challenge. This paper discusses the levers and how they can impact the success of each organization.

Note that this paper is a follow-up to the Milliman paper “[Provider strategy: Control vs. contracting](#)” by Courtney White.

Major levers

A balancing act is required to maximize the value and profitability of both the health system and the MCO. The major levers affecting this are brand and the local community, steerage, and contracted reimbursement rates. These major levers then have a significant impact on the premium rates the MCO offers in the market.

Brand and the local community

In most cases, the brand of the health system is generally stronger than the brand of the MCO. Because the MCO is centered around the health system, it tends to be focused regionally, or even locally. Health systems have been in the community for years, built trust, and developed their brands (e.g., burn unit, cardiac care, maternity, trauma care, or well-known or only specialty) based on

this history and the performance of the hospital(s) and affiliated providers. The health system usually includes serving the community in its mission statement. The MCO's goal is to leverage the health system brand and position itself as a direct link to the health system and its great care in the community; however, the MCO may not be perceived with the same level of trust given preconceptions about insurance companies.

The health system may also contract with other MCOs to continue to build its market share and diversify its payer mix. This can erode the impact of the health system brand to the provider-sponsored MCO. Likewise, the MCO will also contract with other providers to ensure its members have access to all the appropriate specialties and levels of care as well as offer a network that meets access and adequacy requirements throughout the service area. This contracting strategy has less impact on the health system brand as it would continue to be the flagship health system for the MCOs. Each organization needs to balance its internal strategy and goals while maximizing the value of the overall entity. Ideally, each organization would only contract with the other; however, this is rarely feasible while meeting network access and adequacy standards. Alternatively, narrow networks or tiered network benefit plans, which use incentives to motivate use of a particular health system or affiliated providers, are examples of ways the MCO can distinguish the value of the health system in its product. These networks and products would need to be carefully coordinated through both the MCO and health system.

We recognize that MCOs and health systems may have competing goals. MCOs want to keep claim costs and/or trends low to produce lower premium rates, which attract more members. Health system revenue is driven by delivering high-quality and high-value healthcare services.

This dichotomy can put pressure on the success of the MCO if the MCO's contracted rates with other hospitals are lower than the health system or if the health system's contracted reimbursement rates with other carriers are higher than with the MCO. Because both organizations are contracting with each other's competitors, they need to collaborate on how to best position the MCO from a competitive position while maintaining confidentiality regarding their own contracts. Ideally, the MCO should receive favorable (i.e., lower) reimbursement terms from the health system to create the competitive premium rates in the market to attract membership. While this may lower reimbursement to the health system for members changing from a competing MCO with higher reimbursement, increasing MCO membership serves to lower the MCO's administrative costs. This contributes to the bottom-line overall profitability of the combined entity. While there are other dynamics like brand, benefit offering, competitor strength, member satisfaction, network, and quality that influence a buyer's decision, cost remains the primary driver, especially in the individual and small group ACA markets.

Steerage

Typically, a health system's strategy for introducing an MCO is to diversify the payer mix and increase utilization to its hospital(s) and affiliated providers. The MCO can use its networks, benefit design, and even utilization management processes to steer members to the health system. Of course, they need to balance the steerage with clinical input, geography, provider referral patterns, and patient needs, while ensuring the member receives the highest quality of care. The utilization management staff at the MCO and the care coordinator at the health system can work together to create the best outcome for the member.

The table in Figure 1 shows how a traditional preferred provider organization (PPO) plan steers plan members to in-network providers through benefit design.

FIGURE 1: BENEFIT DESIGN STEERAGE

Benefit Provision	In-Network	Out-of-Network
Deductible	\$1,500	\$3,000
Coinsurance	20%	40%
MOOP	\$4,000	\$8,000
ER Copay	\$250 ¹	\$250
PCP Copay	\$25 ¹	N/A ²
SCP Copay	\$40 ¹	N/A ²

¹ Not subject to deductible and coinsurance.

² Subject to deductible and coinsurance.

Figure 1 shows the clear financial incentive for the member to choose an in-network provider. In addition to the lower member cost sharing, the member also benefits from lower unit costs for services subject to coinsurance provided by in-network providers versus out-of-network providers.

A key component of this steerage is how the network is defined. It generally includes hospital(s) and providers to meet regulatory requirements for network access and adequacy. This would include having a sufficient number of providers and types of providers to deliver the contractual benefits to the covered members within a designated service area. This means there are enough providers for the membership base, all types of providers necessary to deliver the care (e.g., all physician specialties and tertiary hospitals) are represented, and there is not a geographic barrier for accessing care. A provider-sponsored MCO could choose to limit its network to health system providers; however, the health system may not include every type of provider and/or may not have a broad enough geographic reach, so the network can be strategically supplemented to meet the regulatory requirements. The larger the health system is in provider and geographic breadth, the more limited the network can be to drive services to the health system.

Another approach is a tiered network. Many hospitals will use this approach for their employee benefit plan. The table in Figure 2 shows another example of a tiered steerage approach.

FIGURE 2: NETWORK AND BENEFIT DESIGN STEERAGE

Benefit Provision	In-Network		Out-of-Network
	Tier 1	Tier 2	
Deductible	\$0	\$1,500	\$3,000
Coinsurance	0%	20%	40%
MOOP	\$0	\$4,000	\$8,000
ER Copay	\$100 ¹	\$250 ¹	\$250
PCP Copay	\$0 ¹	\$25 ¹	N/A ²
SCP Copay	\$20 ¹	\$40 ¹	N/A ²

¹ Not subject to deductible and coinsurance.

² Subject to deductible and coinsurance.

In this example, the Tier 1 network may be comprised of the health system's hospital(s) and affiliated providers while Tier 2 would include the other providers necessary to meet the network access and adequacy requirements. This provides additional incentives for the members to use the health system. Note that the out-of-network benefit design would function similarly to the PPO example in Figure 1 above.

Contracted reimbursement rates

There are varying ways to structure the reimbursement rates. Value-based care arrangements such as bundled payments, risk sharing, or global capitation can provide attractive terms to the MCOs while incentivizing the health system to be efficient in the type of care, level of care, and place of service as well as improving quality. The MCO and the health system will want to strategically structure the terms to leverage the synergies between them in order to achieve their respective goals.

When comparing contract terms between providers (for the MCO) and payers (for the health system), care should be given to ensure the comparisons are valid. Comparing the yield (or discount) can be misleading because of the variance in billed charges by provider and the mix of services performed, and thus a deeper analysis is needed. The analysis should identify the “effort” of each provider and/or payer by incorporating a relative value unit (RVU) and/or converting all terms to a reference-based price, such as a percentage of Medicare-allowed. Yields can be misleading due to billed charge levels and/or case mix.

Measuring the premium impact

There can be confusion around the how the interaction between the MCO and health system ultimately impacts the competitiveness of the MCO in the market. The table in Figure 3 shows the illustrative premium rates impact of steerage to domestic providers and domestic reimbursement advantages versus market competitors.

Key assumptions:

- Domestic providers of the health system represent 75% of the medical costs incurred by the MCO.
- The domestic hospital(s) of the health system contract at 15% below the market rate while other hospitals are contracted at 10% above the market rates. This assumes the MCO cannot compete with the national carriers or the Blue Cross Blue Shield (BCBS) plans due to the volume.
- Professional and other—ambulance, durable medical equipment (DME), and home health—are contracted at market rates.
- Prescription drug contracts are 5% above the market rates, again due to lower volume compared to the national carriers or the BCBS plans.
- Administrative costs are 3% lower than the market due to less resources and smaller staffs leading to less overhead.

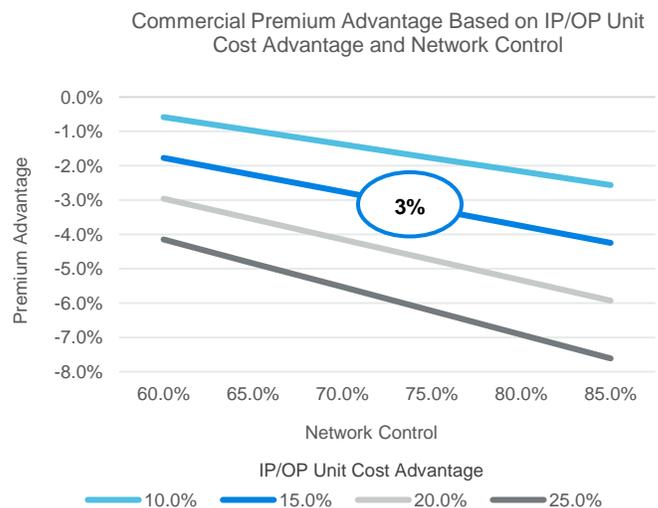
FIGURE 3: PREMIUM ILLUSTRATION

	Premium Mix	75.0% Domestic	25.0% Non-Domestic	100.0% Total
IP	14.5%	85%	110%	91.3%
OP	25.1%	85%	110%	91.3%
Prof	22.6%	100%	100%	100.0%
Other	1.6%	100%	100%	100.0%
Subtotal	63.8%			94.6%
Rx	16.2%	105%	105%	105.0%
Subtotal	80.0%			96.7%
Admin	20.0%			97.0%
Total	100.0%			96.7%
Premium Difference				-3.3%

In this example, the 15% contract advantage for hospital services equates to a 3.3% premium advantage in the market. Many combinations of assumptions can be reflected in the illustration above; however, the point is that a large contract advantage from the health system can be quickly offset by less favorable contract terms for other providers.

The graph in Figure 4 shows the premium rate sensitivity to the domestic provider unit cost advantage and network control (or leakage).

FIGURE 4: HOSPITAL UNIT COST AND NETWORK CONTROL SENSITIVITY



The colored lines in Figure 4 show the domestic hospital contract advantage while the horizontal axis shows the network control. Using the scenario in Figure 3 above, a 15% domestic hospital contract advantage and 75% network control (or 25% leakage) produces about a 3% premium advantage.

Our sensitivity analysis shows that, for every 5% change in the domestic hospital contract advantage, the premium rate advantage changes by about 1.4%. Thus, if the domestic hospital contract advantage increased from 15% to 20%, then the premium rate advantage would increase from about 3% to about 4.4%.

Similarly, our sensitivity analysis shows that, for every 5% change in network control, the premium rate advantage changes by about 0.5%. So if the network control increased from 75% to 80%, then the premium rate advantage would increase from about 3% to about 3.5%.

These dynamics are important to understand as the MCO and health system develop their network and benefit plan strategy and work together to maximize the value of the health system for the MCO while meeting the strategic goals of the health system.

Integrated model

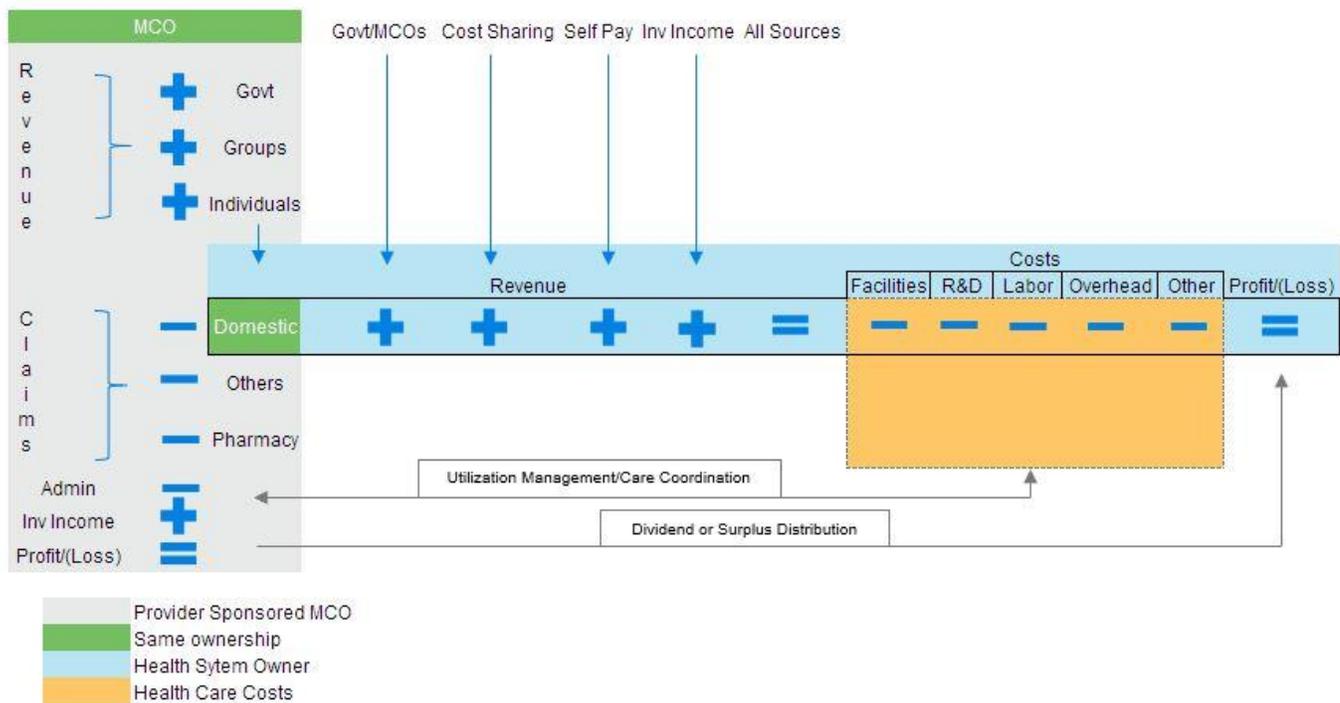
A provider-owned MCO creates complicated relationships, as the health system is both an owner and a contracted provider. In addition, the MCO and health system have contractual relationships with other providers and payers, respectively.

An integrated model is an important tool for the MCO and health system. The MCO should regularly monitor the health system reimbursement rates versus nonowner providers while the health system should continue to measure the profitability of its contracts with payers. This allows both organizations to test the sensitivity of changing market dynamics and develop a strategy to maximize the value of both organizations.

For example, the MCO and health system should understand how further steerage to the health system would impact the MCO's underlying costs and ultimately the premium rates and how it would impact the profitability of the health system.

The table in Figure 5 graphically shows an integrated provider-sponsored MCO.

FIGURE 5: INTEGRATED PROVIDER-SPONSORED HEALTH PLAN MODEL



For the MCO, Figure 5 shows the flow of premium revenue from varying sources and investment income offset by payments to providers, both domestic providers in the health system and others, and administrative costs. For the health system, it shows the varying sources of revenue from the government and other payers, member cost sharing, self-pay patients, and investment income offset by the costs to operate the health system.

The MCO and health system can synchronize utilization management and care coordination to drive efficiencies and improve quality for their patients. The MCO would also need to coordinate care with other providers.

The overall profit/(loss) of the health system would be driven by its operation and supplemented through dividends and/or surplus distribution from the MCO. MCO and health system regulatory and tax requirements should also be considered when structuring the MCO and contractual terms with the health system.

Many times, the MCO and health system interact more like other contractual entities rather than partners. They negotiate with each other, each targeting its individual opportunities and performing its own analyses. An integrated model helps MCO and health system senior leadership set strategy and understand the impact of decisions. Using the same source for evaluating decisions builds trust between the organizations, creates better understanding of challenges and opportunities, and provides transparency to analyses.

Summary

A complex balancing act is required to maximize the value and profitability of both the health system and the MCO. The MCO and the health system should work together to understand how to balance steerage, contracted rates, and premium rates for the benefit of the enterprise. Too often, the health system and the MCO work against each other trying to accomplish their respective goals, while ignoring what is good for the other.

Based on this unique dynamic, the MCO and health system should both understand the value of an MCO member. The MCO must continually monitor how and where they spend the premium dollar while the health system should be able to identify and monitor profitability from each payer. While both entities have their own business challenges and opportunities, they must leverage the relationship and maximize the value of each to be successful and truly impact the local market. The use of integrated models is necessary to report and project which organization is providing the services and how leakage impacts the bottom line.



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