Smart approaches to top-level decision making

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When Providers Become Payers

By Don Briones

While every health system can benefit from a reexamination of their payer strategies, not all can realistically build or buy their own insurance products.

Health systems today face higher levels of accountability than ever before, and tomorrow will undoubtedly bring more of the same. As they pivot toward value-based orientations, health system leaders are being asked to find creative new ways to better control cost and quality. An increasingly popular route is investing in provider-sponsored health plans, that is, becoming a payer.

The potential to retain a larger portion of patient premiums by delivering cost-effective, high-quality care is naturally attractive to providers, especially as they observe how some early influencers have successfully built their own health plans and gained greater influence over the markets where they operate. While every health system can benefit from a reexamination of their payer strategies, not all can realistically build or buy their own insurance products.

Some health systems have more to gain from collaborating with plans—either through joint ventures or by creating clinically integrated networks (CINs)—than from direct competition. In either case, as organizations take on more risk, they must evaluate how much skin they should have in the insurance game.

Succeeding as a Payer

Investing in a provider-sponsored health plan does not make sense for every organization. So how can a health system effectively gauge its readiness to become a successful payer? The following framework contains four key

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factors that health system leadership must assess when making this decision.

Geographic reach. Having a comprehensive network is crucial for success as a payer. A critical mass of covered lives mitigates risk and also reduces plan costs. The key to building large-scale networks is attracting consumers and their employers with a comprehensive portfolio of services that serves the patient needs of the region. Depending on the market players, a health system's target region can be as narrow as a single state or in large states like California, a designated region of the state) or span across several states or markets.

Brand recognition. To establish itself as a payer, a health system must have a reputation as a trusted provider of quality services, with a name that consumers and employers in the region recognize. A household name drives members into a plan and helps with retention. This does not mean a health system needs be a nationally recognized brand. Local health systems are often well entrenched in their communities, with relationships that provide a solid foundation for launching a health plan. Health systems that do not enjoy brand recognition in their markets should consider partnering with organizations that do.

Capability to deliver. Provider-sponsored health plan failures typically occur because health system leaders make organizational decisions through the lens of the health system, not through the health plan. This leads to difficulties in integration of the provider-sponsored health plan within the health system and may inhibit the plan's ability to compete with more successful health plans in its market. Health system leaders must have the insight to think like a payer as they plan and execute their organizational strategies. Health systems must also have the financial capability to hire leadership and staff with material payer experience and expertise.

Skill set(s). Health plan operations require different competencies than those required on the health system/provider side. A health system must have the care models, functions, and capacity to follow through on its capability to deliver services, including a well-managed CIN, a mature care coordination model and well-documented high-quality outcomes, as well as functions such as utilization management, regulatory services and compliance, premium pricing, risk adjustment, actuary capabilities, and product design. If a health system wants to strike out on its own and develop a provider-sponsored health plan, it must have the financial capacity to invest in the unique skill sets required to effectively manage a health plan.

Health Systems Leading the Payer Charge

While there are many stories of provider-sponsored health plans falling apart, a few early movers have demonstrated that well-executed plans can reap big rewards. Collectively, these innovators provide a compelling case for making the leap. Two examples include the UPMC Health Plan and Inova Health.

UPMC. The UPMC Health Plan, which was formed roughly 15 years ago by the well-renowned University of Pittsburgh Medical Center (UPMC), now has close to 3 million members, including more than 500,000 UPMC employees. The plan grew 10 percent in the last fiscal year and is now the biggest medical and behavioral health services insurer in western Pennsylvania. UPMC's success as a payer is largely attributable to its strategic focus on midmarket and smaller employers who value having a local network—in other words, the plan has broad geographic reach in its regional market, and over time, it has maximized the UPMC name brand to grow its portfolio of insurance products and adapt them in response to the Affordable Care Act (ACA) and other industry game-changers.

Inova Health. Located in northern Virginia, Inova has a broad and deep provider network across the region. With the passage of the ACA, Inova leadership made decisions to be proactive in positioning the organization for value. Unlike UPMC, however, Inova elected to partner with a major area payer rather than compete. Together with Aetna, Inova established a brand new insurance entity, Innovation Health. Aetna contributes plan-specific skills and resources, while Inova serves up a robust provider network with broad geographic reach, creating a mutually beneficial arrangement that allows the joint venture to check all the payer success boxes. Innovation Health currently has 180,000 members and is on track to hit 1 million covered lives by 2020.

What Is Your Payer Strategy?

Both UPMC and Inova achieved strategic advantages and tighter control over outcomes by entering the insurance business. Each system handled its entrance in a unique way, confirming that there is no "one-size-fits-all"—every region and market is different. Instead of deciding on a strategy and then lining up the necessary resources to be successful in executing it, healthcare administrators need to begin this process strategically with an evaluation of their organizational readiness and market position both as a provider and health plan. The results of that assessment should be the deciding factor in the decision to pursue a provider-sponsored health plan or align with a payer. //

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