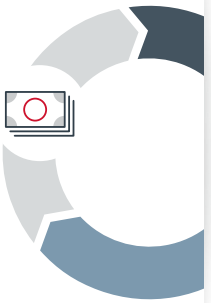
Preparing Health Plans for 2022 and Beyond

Determining the future path from six key inflection points

Advisory Board

Early in the pandemic, plans had a head start to reshape the ecosystem through their relative financial stability. Now, as recovering sectors explore new strategies, health plans must consider the ripple effects of their actions.



EXPENSES

Future care behaviors and needs are still uncertain, encouraging further site of care innovation

"It's a conundrum trying to understand how we're doing from a clinical, quality, and cost trend perspective, behind the smokescreen of Covid. We still rely on 2018-2020 data; we still don't know what's permanent."

REVENUES

Coverage swings did not fall evenly across plans, and purchasers want increasingly impossible tradeoffs

"The current job market means employers want to recruit top talent with benefits that are both comprehensive and affordable. They're pushing us hard to re-route or even exclude coverage for high-cost drivers, and it may challenge our brand identity."

STRATEGY

Plans and disruptors alike are experimenting with a range of partnerships and acquisitions to diversify their growth options

"There is a growing cornucopia of non-traditional competitors, from Big Tech to digital-forward health plan startups, commoditizing the front end of care. We all have this angst that we must go up the chain and be involved in health care delivery itself, and now they're creating ways to get care without needing insurance. Is it just a matter of time before they commoditize us?"

Strategic points of inflection that will shift industry structure for years to come

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01

The trajectory of: Value-based payment

Risk-based payment models will continue to grow, but who participates is an open question. The pandemic has done little to shift long-standing barriers in hospital financial needs, but plans have made headway with independent physician groups. Plans must now think about how the growing array of models fit together in a complex ecosystem.

POTENTIAL FUTURE SCENARIOS

Scenario 1 — Industry-wide reimbursement standard

Both public and private payers funnel most of their payments through true (downside) risk models. Payments include both physicians and hospitals across a wide range of specialties. Most patient care is reimbursed under value-based models, and acute care models adapt to match new business models.

Scenario 2 — Next-generation physician compensation

Risk-based contracting continues but is primarily focused on physician practices (particularly primary care and multi-specialty groups), plus a small number of health systems. Health plans deepen their relationships with physicians as a result.

Highlights from executive conversations

"We must think about how to organize the **delivery system as a whole** around value, with a wider range of stakeholders engaged. There's a push to have all members attributed to a PCP, and have all PCPs integrated within a broader organization incentivized to manage total cost. But where do vendors and specialists and high-cost drugs fit? It's also technically difficult to attribute the impact on cost savings across more stakeholders—the more we share savings and align incentives across everyone, the smaller the reward for any one component and the harder it is to go up against existing revenue streams for providers."

"Our biggest challenge is working with systems that already have **majority market share.** No incentive program will ever equal the financial value of a new patient for them, so we talk to them about other ways to improve margins through greater profitability. We struggle because we don't have a big enough panel size to get providers' attention, and we can't pressure too hard because we still have to have the big systems in our network."

"As an industry, we need to work to make data collection processes and metrics more standardized. Risk-based payment performance is a **data governance** challenge more than anything. We all need timely, accurate, and granular data to identify specific members and the doctors they're working with—so we can get useful information to our providers in VBCs and fairly negotiate quantifiable indicators of performance."

"In the transition to risk, providers have an **outsized sense of their capabilities** and usually can do a fraction of what they say they can. We take the time figure out if provider has basic prerequisite abilities in order to be successful in our program model. We want to support the growth of ACOs, but we have to balance any upfront financial support with the need to guarantee improved cost management."

CONSIDERATIONS FOR STRATEGY LEADERS

- What tradeoffs are we willing to make in order to advance the shift to risk?
- How will we coordinate broader, lower-stakes value partnerships with targeted, significant value models?
- Where will our array of models struggle with future challenges like high-cost specialty drugs or unaddressed behavioral needs?

02

The trajectory of: Physician alignment

An array of non-hospital suitors—plans, private equity firms, service partners, and national groups—are aligning more closely with physicians through a variety of partnership models. While hospitals may lose power, plans need to prepare to navigate relationships with all manner of new stakeholders throughout physician networks.

POTENTIAL FUTURE SCENARIOS

Scenario 1 — Hospitals as loci of control

Current trend toward greater hospital employment, ownership, and influence keeps apace while other players operate around the margins, filling in specific care gaps and targeting niche populations. This gives systems the time and resources necessary to stay ahead of new entrants.

Scenario 2 — Fragmentation of market power

As more physicians join organizations rooted in value, with the incentive structures and assets to be successful, hospitals become increasingly commoditized. Systems will be reduced to their acute care value proposition, competing on unit price and relying on COE programs to capture shrinking volumes.

Highlights
from executive conversations

"We've been talking about **clinician shortages** forever, but we may actually be at a tipping point . We have to think about how we build new models of care delivery to support this lack of supply. There's such a fatigue from Covid that physicians are jumping to disruptor models and leaving gaps in local PCP groups."

"To some extent, we need to **embrace private equity and other groups** looking to enable physician practices. We're interested in the companies that are focused on the whole picture, the whole care continuum—that's good for the patient and for population management. But we're skeptical—and wary—of the organizations focused on using data to tweak administrative spending and revenues, rather than using clinical decision support to change practice patterns and mitigate inappropriate treatments."

"Our challenge is not the enabling vendors—it's the **variation in the physician community.** Our market ranges from groups still using paper records to mature organizations that want to go to full risk. We also work with practices owned by other health plans or the emerging national medical groups. It's truly challenging to provide the right tools and support—for things like care gaps closure and risk adjustment—to these different providers in ways that they can each use, without being too sophisticated for some and too redundant for others."

"We own a medical group and use it as a **learning lab for cost management innovation,** but the provider community sees it as a threat, even though our insurance products are still open access PPOs. There's no getting around the worry about competing objectives—from all parties. Eventually, the largest plans' moves on physician alignment are going to impact us all in network contracting capacity."

CONSIDERATIONS FOR STRATEGY LEADERS

- Which models of physician practice alignment and structure are most advantageous for our goals?
- What is the maximum capacity for physician participation in each model?
- How aggressively should health plans support physicians' shifts into various models, beyond outright ownership?

03

The trajectory of: Home-based care

The wave of investment in home-based care today, centered around start-up financing or grants, does not guarantee long-term, systemic change. The industry may exacerbate existing challenges around staffing supply, care fragmentation, and health inequities. Plans must weigh how their policies will impact network access and marginalized patients.

POTENTIAL FUTURE SCENARIOS

Scenario 1 — **Nonstarter**

Leaders lose today's momentum and don't dedicate enough sustained funding to spur a large-scale shift.

Scenario 2 — **Industry stressor**

Stakeholders rush to secure share in an increasingly competitive market. This siloed approach exacerbates existing challenges with fragmentation, workforce burnout, and inequity—even for those not competing in the home care space directly.

Scenario 3 — **Industry salve**

Stakeholders are deliberate in their approach to home-based care, and partner with the appropriate cross-industry stakeholders to not only maximize the value of their own offerings but prevent negative cross-industry ramifications.

Highlights from executive conversations

"We're looking at home care innovation for its longer-term strategic potential to successfully care for the growing senior population. This is not a way to quickly shift medical spend right now, but since we know the home is the space that gives many seniors the best outcomes and experiences, we have play here and **learn the ropes**—so that we're ready to deploy appropriate alternatives as they emerge in the market."

"We're still trying to figure out what home-based care services to deploy in our markets, especially for the Medicare Advantage population, and are looking at partnerships with a range of technology vendors, alternative sites of care, and innovative clinics. But above all we know that we want to make sure these options connect and integrate data, so that we're **building a cohesive experience** for the patient and their care team."

"We're working on a hospital-at-home program, but we're also finding more and more health systems are partnering with HHAs to provide the services together. As activity in the home care innovation space grows, payment can start to get complicated because it **intersects with other programs** like capitated primary care. How do I structure hospital-at-home so that it makes financial sense, when the risk is also going somewhere else?"

"We have to figure out how to pitch this to self-funded employers, and to do that we need to show them a specific, **trackable ROI.** In general, we ask providers to come prepared with their outcomes data, to articulate their specific interventions and process metrics, to track interim progress—and test their model with us in our own pilots."

CONSIDERATIONS FOR STRATEGY LEADERS

- How will we collaborate with other payers on quality and efficacy standards for the range of home-based care services?
- What factors should determine which members should qualify for which services and account for equity considerations?
- How will we advocate to secure broader, equitable reimbursement models?

04

The trajectory of: Virtual care

Most of the pandemic's spike in virtual care came from traditional providers, but vendors are angling to transform their offerings to steal patient relationships—not just visits. As plans explore virtual-first products, they must ensure incentives are enough to influence consumers—and brace for fallout with local providers.

POTENTIAL FUTURE SCENARIOS

Scenario 1

Ubiquitous standard of care

Telehealth is used widely by both patients and physicians as a complement to in-person care. Virtual care delivery becomes a core skill across specialties, and becomes a means to maintain and reinforce existing relationships and referral patterns.

Scenario 2

Segmented supply and demand

Telehealth is used primarily by certain patient segments and the purpose-built vendors who target them, and "virtualist" specialty models emerge. Telehealth providers sell directly to employers or are closely aligned with (or owned) by insurers. Existing relationships and referral patterns are disrupted.

Highlights
from executive conversations

"More and more vendors in the virtual care space are popping up every day, but if they're not connected to the network or delivery system in some way, we won't create a frictionless experience for members in a way that's meaningful. It's time to **curate these vendors aggressively** and decide what types of requirements to put in place for practices in our network contracts. That means we may need to start mandating virtual or physical components for certain specialties, and standards for how providers connect."

"There is a special skill set required to effectively engage patients during a telehealth visit, and this will become apparent as we measure outcomes between specialties and between providers. We need to think about how to **benchmark virtual care appropriately**—compared to providers who do mostly in-person visits—to incentivize the greatest use of virtual care by the providers best suited for it."

"Our control over reimbursement levels is increasingly limited as states consider what their parity legislation will be once the federal emergency is over. For providers, until they reach a certain volume of virtual visits, they generally need to have the infrastructure for both in-person and telehealth services—which makes for a difficult financial model. We know we need to be **reasonable about unit costs for services,** so we're turning our attention to how to determine appropriate, quality virtual care."

"We're wrestling with how to **balance gatekeeping and incentives** that influence member behavior, and an **experience that is attractive and simple** for the consumer. Getting this right comes down to knowing what we're trying to achieve with virtual primary care: is it ED diversion, appropriate treatment selection, referral steerage,, expanding access to preventive care...something else? The answer is crucial for deciding on the product design."

CONSIDERATIONS FOR STRATEGY LEADERS

- How will we structure effective product design for virtual steerage without harming members or network partnerships?
- How will we determine criteria to evaluate appropriate, high-quality virtual care?
- How will we coordinate the care and experience for patients across physical and virtual providers?

05

The trajectory of: Price transparency

The market will soon be inundated with an unprecedented level of pricing information, but disruption to historic practices will depend on the usability of the data. New vendors are emerging to parse and package the data for end users, so plans must prepare to clarify the broader context of their rates to members, purchasers, and providers.

POTENTIAL FUTURE SCENARIOS

Scenario 1 — Distracting data chaos

Plans and hospitals limit rate disclosures, but vendors enable easy access to piecemeal, inaccurate information. Health care organizations must frequently contend with scrutiny on their rates, but only extreme outliers must budge.

Scenario 2 — Market disruptor

Vendors enable easy price comparison—while some consumers use these platforms directly, the more eager users are employers and risk-bearing physicians, who have a clear business motivation to steer employees and patients.

Scenario 3 — Market enforcer

Vendors enable easy price comparison, but other market inefficiencies prevent major shifts in share. The main users of price information are plans and providers themselves—but those with the greatest market power lock in their advantages.

Highlights
from executive conversations

"Our market is still **scrambling to figure out the logistics** alone. For us, it's not about the penalties and how that impacts whether we do this—it's about how to do this functionally. We're calling up our competitors and looking to vendors—I'm sure it's even more complicated for larger plans with many markets and contracts."

"The consumer focus is on total out-of-pocket costs from a medical event, but they can't just view published rates to know what they'll pay. For starters, a rate is not a rate is not a rate, since each payer may negotiate and measure rates differently. That's before adjudication to determine the plan-provider agreement on the reimbursement. Finally, the regulations don't specify how to bundle services. **What a third-party tools show is going to be chaotic.**"

"**Price in isolation is not useful**—it must be matched with clinical outcomes, especially if we're trying to drive consumer decisions once they've hit a deductible. The inability of consumers to effectively compare health care costs and quality is a barrier to lowering costs, so we must help make sense of the information coming out."

"It is unclear what will happen with rates overall. Yes, it's potentially a race to the bottom for providers from the largest payer in a market, but it's also a risk to non-dominant payers if providers can't afford to have all their other rates go down as well. The **squeeze has to come from somewhere.**"

CONSIDERATIONS FOR STRATEGY LEADERS

- What's our posture on the "spirit versus letter" of compliance?
- How will we create and promote non-unit-cost metrics to tell our "value story"?
- How will we manage new scrutiny, member confusion, and negotiating tactics?
- Which vendor business models will threaten or augment our contracts?

06

The trajectory of: Health equity

The past few years brought health equity into stark focus, but to make true progress, leaders must cement equity as a business goal. As plans build equity goals into provider payments and care management actions, they must standardize data collection and analysis to generate evidence for sustainable interventions.

POTENTIAL FUTURE SCENARIOS

Scenario 1

Solely mission imperative

Leaders continue to make investments in health equity, but efforts remain largely programmatic and pilot-based. Efforts are also siloed across the industry due to a lack of clear financial incentives encouraging specific behaviors.

Scenario 2

Emerging business imperative

Clear incentives cement health equity as a strategic imperative, with clear negative financial consequences enforced by the government, the market, or organization boards for falling short of industry-wide health equity goals.

Highlights from executive conversations

"I wonder if our desire to measure the impact of racial disparities is a form of **analysis paralysis that delays our ability to move forward** on interventions—we all recognize the problem. We need to parallel process and act more quickly in the places where we know issues exist, so we can start making an impact now, while we work to quantify the disparities with greater accuracy."

"There are so many directions you can go because there's so much progress we all need to make. But we can't forget to **start with the members themselves.** We've been doing conjoint studies with members to figure out what value-add SDOH-related services we should add so that we can give them a menu of options."

"We're planning to include **incentives on health equity metrics** in the near future. To do that, we're focused on building the basic capacity for measuring health inequities with our providers. We're structuring incentives around collaborative learning and sharing across each other—so that we can focus our collective attention on identifying the biggest equity priorities, understand the opportunities to improve and the potential approaches."

"We want to connect our outcome metrics to REAL (race, ethnicity, and language) data so that we can calculate health disparities in our membership and track progress from our interventions. We want to make sure that we're **setting up the right standards,** so that we can easily map data flowing into our data warehouse and ensure that other departments and external partners can use it as appropriate. So we're using HL-7 FIHR data standards and working with our provider groups to ensure they're using similar approaches."

CONSIDERATIONS FOR STRATEGY LEADERS

- How aggressively will we incorporate equity measures into provider evaluation and reimbursement?
- How do we balance standardized industry approaches to addressing equity issues with enabling tailored community leadership?
- What guardrails should we build as we use predictive analytics for social needs?

‘This all comes back to identity’

Health plans are increasingly trying to be everything to everybody. We obviously can’t all do that. We need to shift the paradigm around how we’re looking at these issues.

We often look at Big Tech as disruptors or antagonists to payers. But there’s enough money pouring in that we have reason to be interested in the solution, and currently they’re not facing the same regulatory and cost constraints we are, so they may spark solutions we can harness.

We need to be thinking specifically about what we want be good at—and where we should find partners. Since payers are enterprise channels, we’re well positioned to coordinate all the emerging solutions for our purchasers.

Everyone’s kind of a competitor and a partner at the same time. So, everyone’s a ‘frenemy’. **This all comes back to identity.**

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