Health Plan Advisory Council

Health Plan Business 101

2019 snapshot of business priorities

The U.S. health insurance industry is one of the most complex in the world. A wide range of private insurers cover many different groups, from employees and individuals to Medicare and Medicaid beneficiaries. Successful health plans must carefully balance the needs, preferences, and priorities of members, purchasers, and provider partners to ensure affordable and appropriate care for their covered populations. This snapshot provides a glimpse at the health plan industry's **key strategic trends** and **frequently asked questions** in 2019.

What is top of mind for health plan CXOs?

- Grow and retain membership
- Drive appropriate utilization
- Contract with efficient, high-quality providers

DATA SPOTLIGHT

Who covers patients in the U.S.?

77%
Of Americans have coverage administered by private health plans, 2017

10
Largest plans cover over 165 million people, with an average of 300K covered lives per state, 2018

39
States where Blues plans have the largest market share, 2018

STRATEGIC TRENDS

What is currently influencing health plan priorities?

Purchasers prioritize convenience and usability for members

- Purchasers are fed up with high health care costs and are searching for plans with affordable, competitive benefits
- Plans are investing to improve the member experience by eliminating frictions and offering new benefits

Affordability depends on members to use products effectively

- Product structures like high deductible health plans push members to take on more responsibility for using their coverage effectively
- Plans are offering more tools and navigation support to help members understand options and tradeoffs

Value-based payment supports cost management but complicates network contracting

- Contracting with many efficient, high quality providers makes products attractive
- Encouraging new payment models to motivate efficiency requires plans to adapt rate negotiations

Source: Health Plan Advisory Council interviews and analysis

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What questions are health care professionals asking about health plans?

Top 5 FAQs in 2019

1. What types of insurance companies are there?

The types of insurers can be categorized into national plans, dominant regional plans, and provider sponsored health plans. National plans usually offer insurance in every state, across all different lines of business, and have 5 million or more members. Dominant regional plans often have the biggest market share in a given state. These tend to be the Blues plans and have around 1-2 million members. Provider sponsored health plans have an affiliated provider system with a plan subsidiary.

2. Is there a deadline for the shift away from fee for service to value based care?

There is not. CMS has continued to set standards to try and accelerate the shift to a value based model, but it is very much dependent on congresses' urgency and providers' willingness to change. On the government side, this is a congressional decision that relies on their regulatory powers. In the private sector, it's a negotiation between the health plan and provider they are contracting with.

3. What are short-term health plans?

Short-term health plans have limited benefits, but also have low premiums. Short-term plans are not compliant with the Affordable Care Act (ACA) and do not have coverage requirements. Pre-existing conditions are not ignored and applicants are subject to answering medical questions and receiving underwriting approval. Short-term plans last a year, but members can request two extensions.

4. What are Health Reimbursement Arrangements (HRAs)?

HRAs are an employer-funded, tax-advantaged health benefit used to reimburse employees for out-of-pocket medical expenses and personal health insurance premiums. HRAs are not a type of health insurance, but rather an allowance of tax-free money that employers can offer to their employees to use for a variety of health care purposes including directly paying for health care services, paying for cost-sharing, and purchasing short-term health plans.

5. Is it a conflict of interest for a physician to be employed by an insurance company?

Though providers and insurers may seem to be on opposing sides, there has been an increase in insurance plans buying provider practices with the purpose of increasing access to care and controlling spending. While some providers may find this to be a contentious relationship, it can also provide integrated care coordination and improved outcomes at reduced prices.

FOR MORE RESOURCES

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