FEATURE

Evaluating Market Dynamics

HOW INVESTORS, HEALTH PLANS AND PROVIDER SYSTEMS ARE CLAMORING FOR PIECES OF THE SELF-INSURANCE PIE AND WHAT IT MEANS TO YOU

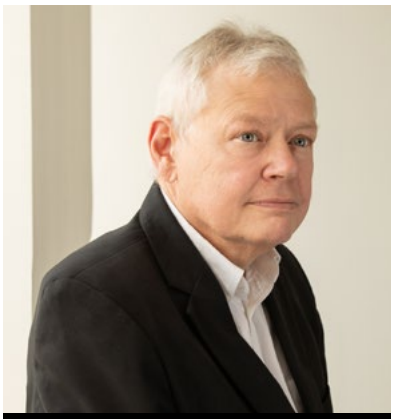
A convergence of market developments is re-shaping the self-insurance landscape with game-changing implications for improving results, insiders suggest. One noteworthy trend is that the investor community recognizes the unique and rising value of companies that serve self-funded employers and influence their decision-making process. But that's just the tip of a larger iceberg.

Two other active players are part of that mix. They include national and regional health plans that are aggressively acquiring many of these vendors to pump up their presence with administrative-services-only offerings. Their need to move beyond fully insured arrangements, of course, took on some urgency since the Affordable Care Act's passage.

Large provider systems also are dotting the horizon, leveraging massive infrastructure they built to handle Medicare and Medicaid markets for direct-contracting arrangements. Experts say many of the most efficient systems were forced into learning how to control costs and quality by the Centers for Medicare & Medicaid Services.

Whatever will become of these market dynamics, the consensus is that more investment in primary care will be increasingly vital in the years ahead alongside aligned incentives, integrated and value-based care that's fully transparent, and white-glove service.

Written By Bruce Shutan



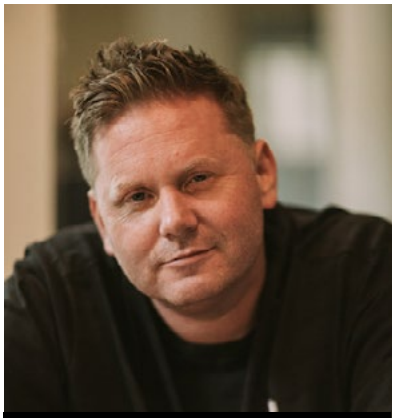
Joe Cunningham

GROWING NEED FOR TRANSPARENCY

Sometimes both of these forces muscle their way to the top. Joe Cunningham, M.D., founding managing director of Sante Ventures, sees regional battles between the BUCAHs and provider health systems jockeying for reputational market leverage and ownership of independent primary care practices. The upshot is that entities with no shortage of capital are able to jack up prices. Any academic center that is also involved in teaching and research, he adds, will have higher fixed costs and, therefore, tend to be more expensive. They also generally have market leverage to command higher prices.

Since insurance carriers and medical providers alike have a financial stake in rising prices just like any for-profit industry, it's easy to understand why health care costs continuously outpace inflation, observes Matt Dale, CEO of Point Health. But as the C-suite becomes more involved in health plan management, he says corporate executives are going to demand transparency at both the carrier and provider level.

Before this approach is able to gain meaningful traction, Dale says "there needs to be a tool that allows people to shop for medical care in a similar way that they're used to shopping for everything else that they buy."



Matt Dale

He recalls a recent case that epitomizes the need for transparent shopping. One of his clients, a health insurer, instructed someone who needed rotator cuff surgery to shop the routine procedure at a local hospital, which quoted him $68,000. Under his defined benefit, the insurance would have paid just $3,000, while he would have been responsible for $65,000 out of pocket. When Point Health approached the hospital about their cash price, the quote was cut in half. Upon further investigation, a surgery center 30 minutes away agreed to do it for less than $10,000.

"That example is happening hundreds of thousands of times a month on all types of procedures," Dale laments. However, as patients make more prudent choices built around value, he's hopeful that a tipping point will be reached where hospitals will offer more competitive pricing for fear of losing business.

FOCUSING ON FLEXIBILITY

One avenue to greater cost savings may be more flexible products and services. Health plans are looking to acquire pieces of the delivery system that can be folded into smaller TPA operations, which are easier to accommodate add-on services, notes Michael Taylor, a principal with MT Healthcare Consulting. In the case of UnitedHealthcare, he says the UMR TPA operates alongside Equian, which was added under the health plan's Optum unit, to expedite payments more efficiently for employers that decline a full-service offering.

Noting a continuation of health care industry consolidation, Taylor points to the January 2021 merger of Tufts Health Plan and Harvard Pilgrim Health Care in his home state of Massachusetts. "That's going to give them more leverage with the provider systems" that he says are reaching out more directly to employer customers in hopes that to some degree they can "diminish the impact that carriers have both around the price they negotiate, as well as the services they need to provide."

Similarly, some of the larger consolidated provider systems such as Priority Health, Geisinger, and Baylor Scott & White have acquired health plans of their own. But since their margins are typically tight, Taylor believes many will "sort of stay on

WE ARE HERE FOR YOU

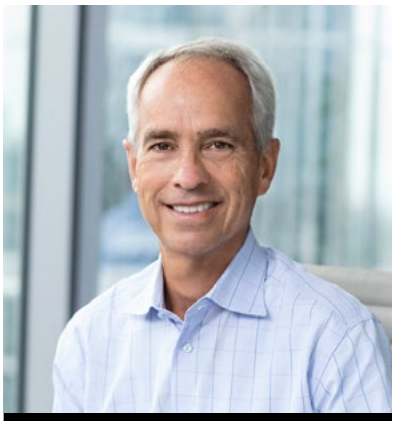
Now, more than ever, it is important to do business with partners you can depend on. For more than 35 years, self-funded employers have trusted Sun Life to deliver flexible stop-loss options and seamless claim reimbursement. Helping you make the best decisions for your business is our business. Our team of dedicated experts is ready to support you with innovative solutions, tools, and resources to help you manage your self-funded plan every step of the way. **Ask your Sun Life Stop-Loss Specialist about what is new at Sun Life or click here to learn more!**

STOP-LOSS | DISABILITY | ABSENCE | DENTAL/VISION | VOLUNTARY | LIFE

BRAD-6503-n

SLPC 29427 02/21 (exp. 02/23)

the sidelines for a bit" until the pricing of niche vendors stabilizes and health systems figure out how to fund these acquisitions.



Steve Cosler

WHITE-GLOVE ADVANTAGE

While scale breeds comprehensive offerings, it doesn't necessarily result in higher customer satisfaction. Smaller players that aren't part of the BUCAHs or large health plans will have some advantage because of the white-glove service they offer, observes Steve Cosler, an operating partner with Water Street Healthcare Partners, a strategic investment firm focused exclusively on the health care industry. "Health care is a very important benefit, and they're going to want absolutely the best service that they can provide to their own employees," he says, noting the implications for retention, especially in a tightening labor market.

One example involves the pharmacy benefits management field. He says Pharmaceutical Strategies Group bifurcated responses to an annual survey between PBMs to represent more than and fewer than 20 million members. While size matters when it comes to negotiations with manufacturers for rebates and purchasing massive blocks of generic drugs for network rates, he highlights a surprising result. The survey found that PBMs with 20 million or fewer members beat the larger group on satisfaction, even though they can't compete on scale. "They're competing and winning on service and innovation," Cosler says.

He sees a real opportunity for innovative TPAs and others that serve self-funded employers to be a part of that mix with large provider groups and boast a strong regional presence. "Somebody's going to have to process claims, administer the plan, do repricing, send out EOBs – all the things that go into running a health plan," Cosler explains.

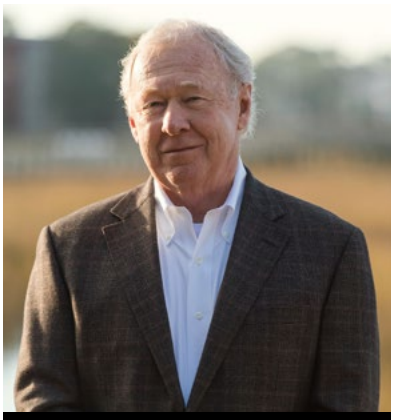
PRIORITIZING PRIMARY CARE

Such attention to detail can be a huge difference-maker. In order to prevent wasteful spending, Cunningham explains that the key to building credible care is aligning incentives so that patients aren't over-treated and wind up in the ER. Put another way, it's a matter of receiving the right care at the right time in places where the fewest ancillaries that don't really affect the outcomes to care can be needlessly ordered.

"It's about engaging the patient with a primary care provider that's going to navigate and advocate, and basically win their trust that the guideline treatment plan that they're putting forth is in their best interest," he says.

The marketplace recognizes this reality. For example, more of the BUCAHs and behemoth retail or e-commerce outlets have developed guideline or evidence-based primary care with aligned incentives, according to Cunningham. Driven by payers, he sees these arrangements in place at Optum, Cigna, Aetna, CVS, Walgreens, Amazon and Walmart – all of which are aggregating primary care and absorbing risk for patients.

Self-insured employers have the best chance for success when there's a direct relationship with medical providers across a fully transparent, integrated infrastructure that produces a product that's acceptable to their employees and dependents. So says Orlo "Spike" Dietrich, founder and CEO of Employers Health Network and operating partner of the Ansley Capital Group.



Orlo Spike Dietrich

"The only thing that's ever worked for me is sitting across the table with the provider leadership within my community and trying to figure out what's going right, what's going wrong and solving the problem together," observes Dietrich, who moderated a panel discussion on market dynamics at SIIA's virtual national conference.

Elite provider systems not only embrace value-based contracting along the road to greater accountability, Dietrich explains, but they're also willing to take on both upside and downside risk. When a hospital system reaches out to the employer community, he says it must be done around a product that transcends a network or TPA sale. That means offering a host of services that manage adjudication, pharmacy and specialty drugs, data and analytics, care management, etc. – not simply a network with discount pricing.

Amazon Care's virtual-first version of 24-hour primary care has worked well in the Northwest, according to Dietrich. "We've looked at it, and quite frankly, are very impressed," he says. Although the company hires its own primary physicians, he notes a great willingness to work with local provider systems.

Another firm that has had great success tying together primary and urgent care, as well as telemedicine, is Whole Foods, which is owned by Amazon. Their onsite clinics support and encourage primary

THIS YEAR MARKS COMPANION LIFE INSURANCE COMPANY'S 50TH ANNIVERSARY. WE HAVE A LOT TO CELEBRATE.

Fifty years of securing successes and overcoming challenges.
Five decades of developing a strong and stable company.
Half a century of building strong partnerships.

We're not only remembering our past. We're also looking to the future. Let us help you grow your business in the years to come. We can help give you the products and solutions you need.

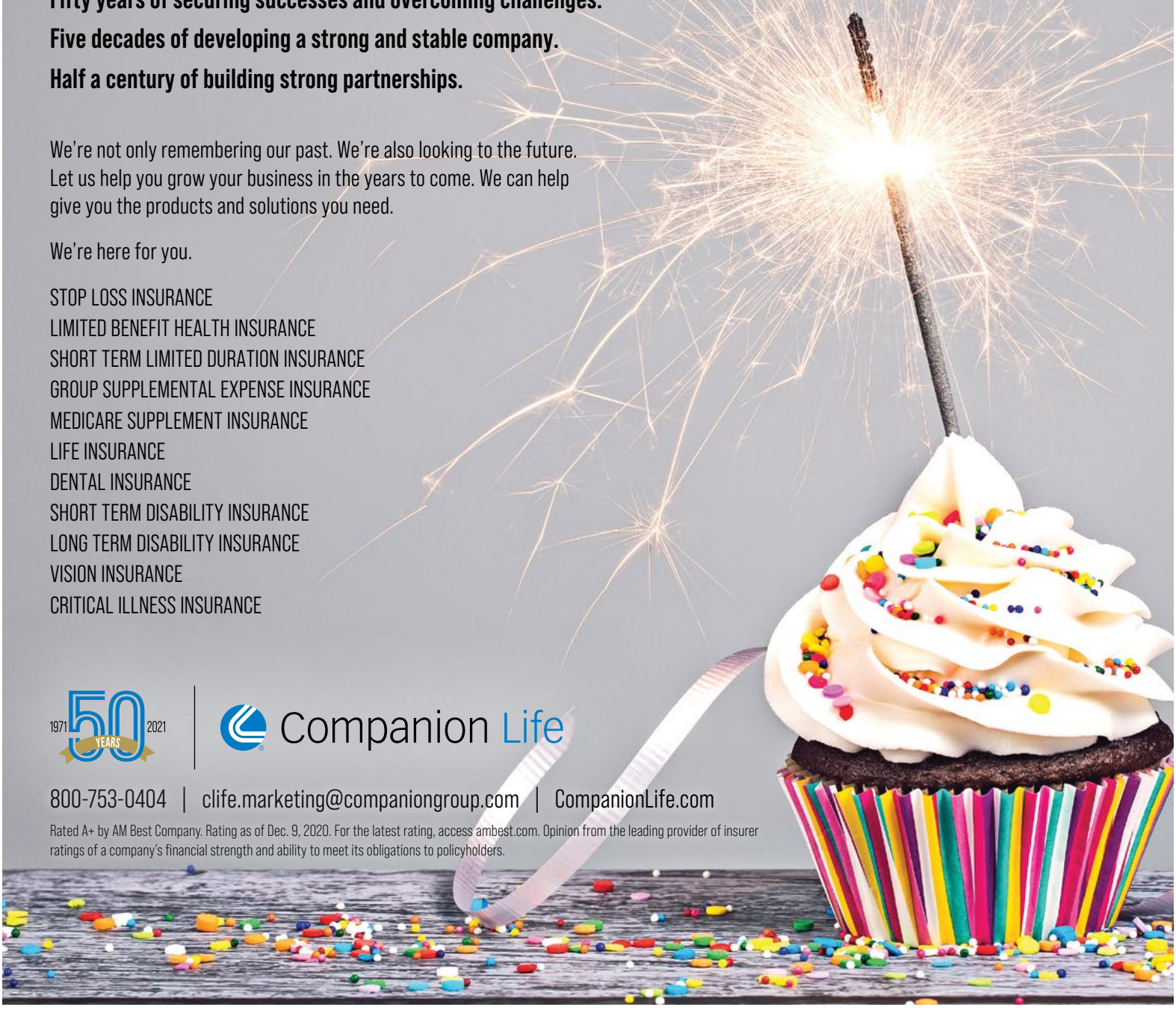
We're here for you.

STOP LOSS INSURANCE
LIMITED BENEFIT HEALTH INSURANCE
SHORT TERM LIMITED DURATION INSURANCE
GROUP SUPPLEMENTAL EXPENSE INSURANCE
MEDICARE SUPPLEMENT INSURANCE
LIFE INSURANCE
DENTAL INSURANCE
SHORT TERM DISABILITY INSURANCE
LONG TERM DISABILITY INSURANCE
VISION INSURANCE
CRITICAL ILLNESS INSURANCE

1971 50 YEARS 2021 | Companion Life

800-753-0404 | clife.marketing@companiongroup.com | CompanionLife.com

Rated A+ by AM Best Company. Rating as of Dec. 9, 2020. For the latest rating, access ambest.com. Opinion from the leading provider of insurer ratings of a company's financial strength and ability to meet its obligations to policyholders.



care access, Dietrich explains, noting the "superb" job of staying involved with care beyond the primary care clinic through the chief medical officer and his staff.

CREATING VALUE

With so much perversity in the U.S. health care system, corporate and medical executives have been forced into closer collaboration. There's a growing realization among providers about significant value in the self-insured marketplace. "Just name a large health system, and they have an initiative for direct employer contracting," Cunningham notes.

Providence St. Joseph is leading the charge, he says, along with Massachusetts General Brigham, the Cleveland Clinic, Mayo Clinic and Sentara Health. Others include Baylor Scott & White in Dallas, whose quality alliance for companies like American Airlines is doing leading-edge work, and Orlando Health in Orlando, which contracts with Disney.

When Cunningham was involved with primary care, caring for patients was a 24/7 responsibility. But many primary care offices now simply activate their voicemail at 4:30 and suggest patients go to the ER if they're having a medical emergency. "You're never going to win if that's the approach, and yet, that's way too common, currently with the independent groups," he warns, noting that organization and technology can help solve that problem as long as primary care physicians have support and call coverage.

Another issue to consider is that primary care is a low-margin business, he explains, even if it features a multitude of payers and maximizes efficiencies. And while some employers establish onsite medical clinics to widen access to primary care and create value, Cunningham says there are better ways to accomplish that objective such as telemedicine or direct primary care (DPC).

While believing DPC "is a great idea," Dietrich notes the importance of structuring the right incentives and support for physicians in those subscription-based practices beyond their office. What's necessary is to have an integrated and coordinated with the specialty community and inpatient environment, he adds.

The emergence of guideline-driven, evidence-based medicine delivery will slowly replace PBMs and other managed care-based utilization management, "which have become something of a shell game of volume discounts and rebates," Cunningham predicts.

A growing number of large provider systems have come to the realization that pursuing direct contracting arrangements with employers is a mutually beneficial arrangement, according to Cosler. Both parties, of course, are able to cut out insurance middlemen, but he also sees a wider path to innovative plan design and customization from an employer standpoint. For example, there could be a shared-risk arrangement and value-based care that ties a provider's compensation to outcomes.

But achieving these objectives takes time. "The movement to more value-based, risk-based contracts is glacially slow, and it really is disappointing," notes Taylor, who's a huge believer in realigning payment methodologies among providers. He'd like to see alternative payment mechanisms gain traction, but realizes they're much more complicated to administer than traditional fee-for-service and act as a barrier for employer-to-provider direct contracting.

There's also concern about health equity. "I worry that if you're not careful, some of these DPC models will be unaffordable to a large percentage of the population," he says. ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.