Determining if the Provider-Sponsored Health Plan Path is Right for You

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Providers have historically lacked control over the ability to tie meaningful quality metrics to reimbursement, and some would put this at the top of the list of issues that hamper their success. After all, it is the providers on the frontlines of care delivery who can truly manage medical costs and quality for patients, as they have a unique set of controls only they can execute.

Couple that desire for more control with the industry's continual shift toward value-based care, and more and more providers are seeing the true value in assuming risk. Some are even wondering if they should launch their own health plans.

A provider-sponsored health plan (PSHP) represents the ultimate value-based care or risk arrangement. Simply defined, a PSHP is an organization of individual practitioners, ancillary service providers and/or hospitals that come together to design and run their own health plan. These provider PSHPs are completely responsible for all aspects of costs, quality, network configuration, benefit design and other activities associated with providing health insurance to their members. Those succeeding—well-known national players like Intermountain and Kaiser Permanente, regional leaders like Driscoll Children's Health Plan in Texas and Alliant Health Plans in Georgia, and the more than 250 other PSHPs currently operating in the U.S.—have showcased the potential for upside rewards. PSHPs can also offer some distinct advantages over other types of health plans, such as more effective population health management. Some studies suggest that PSHPs are more efficient, paving the way for lower premiums and other incentives that benefit their members.

But let's be frank: PSHPs are not for the faint of heart, and many of us remember PSHPs that failed in the 1990s. Becoming a traditional PSHP is a massive undertaking and requires getting to scale in a way that not all providers' market dynamics will support. While some groups will decide to move forward with the creation of a full-blown PSHP, others will find they're left with gaps to fill and aren't quite ready. Yet, they still want to take on more risk. So then what?

Evaluating Your Risk-taking Capabilities: Nine Critical Considerations

Fortunately, advances in technology, business intelligence and information-sharing platforms are opening new opportunities for new PSHP players. There are more tools available today to help all types of health care organizations aggregate the necessary capabilities to design, build and successfully run a PSHP. The question, then, becomes which ones you have in house, and which ones you need to contract for or otherwise acquire.

Organizations must honestly discuss and deeply analyze several key areas to determine if becoming a PSHP is a viable option. A comprehensive feasibility analysis should examine issues such as:

- The potential network size and types of providers you will need
- The organization's change management capabilities
- Your market position and local competition
- Potential local payer reaction
- Consumers' buy-in
- Your specific regulatory environment
- Costs and financial realities
- Different sales options
- Your insurance IQ

Accurately and objectively analyzing these considerations is crucial to gauging the potential success of your risk-taking endeavor and determine whether and how to ultimately move forward.

For those groups who identify capability gaps and aren't sure how to fill them, partnering with a third party could be a viable option.

A partnership with a traditional commercial payer, for example, can offer the license, capital, scaled infrastructure and expertise that eases your own administrative burden, and can provide advanced regulatory knowledge and insight. Such an arrangement requires careful consideration of the potential partner, as some provider independence will necessarily be lost. It's also important to consider how any new arrangements could impact your strategic relationships with other payers in your local market.

Industry Shifts Pave Way for Emergence of Neutral Payers

Other options have emerged as the health paradigm has shifted. While we're conditioned to think of payers as either state or federal government or the historical private commercial types, a new third category of payer has emerged in recent years. Purpose-built for a value-based care paradigm and for data-driven population health initiatives, these "neutral payers" have collectively raised $1 billion in capital to solve the unmet needs of providers and patients. Neutral payers offer a different approach for providers who might not be ready to launch their own PSHP and aren't keen on partnering with a traditional payer. Some key advantages and benefits to partnering with a neutral payer include:

- Innovative consumer technology
- Collaborative mindset and a desire to disrupt legacy incumbents which may lead to more favorable deal terms for providers
- Customizable approaches, such as cobranding or white labeling insurance plans with provider systems that have prominent brands
- Openness to exclusivity because there is no historical relationships to maintain
- Robust change management capabilities combined with on-the-ground physician and staff training and reinforcement
- A third party's ability to ensure incentives align with your physicians', staff's, and overall business's needs and goals

There are also potential challenges. Most neutral payers lack the brand recognition of their larger counterparts. Some have less of a track record and balance sheet, creating uncertainty about their longevity.

The good news is that after you conduct your feasibility study and weigh the advantages and benefits against challenges, you will be steeped in critical value-based care information and ready to take on greater amounts of risk, either on your own or with a partner. And for those groups that decide to pursue a full-blown PSHP or partner with a traditional or neutral payer, you'll have much of the information you need to fine-tune your risk taking appetite.

About Evolent Health

Evolent Health partners with leading provider organizations to achieve superior clinical and financial results in value-based care. With a provider heritage and over 20 years of health plan administration experience, Evolent operates in more than 30 U.S. health care markets, actively managing care across Medicare, Medicaid, commercial and self-funded adult and pediatric populations. With the experience to drive change, Evolent confidently stands by a commitment to achieve results. For more information, visit evolenthealth.com