COPE HEALTH SOLUTIONS

Insurers Increase Participation in ACA Markets and Must Focus on Key Provider Partnerships

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The Affordable Care law has survived for nearly a decade despite efforts to upend it, including legal challenges (one pending[1] and another that went all the way to the Supreme Court), Congressional attempts to repeal it and executive orders aimed at weakening it. While fiery debate continues over the fate of the roughly 21 million Americans, who would lose coverage if the landmark law were invalidated[2], individual insurers experienced a highly profitable 2018, resulting in requirements to issue at least $1.3 billion worth of excess premium rebates to individuals who make up the 2.7 million ACA customers.[3] Moreover, premium costs for most ACA products are set to slightly decline in 2020.[4]

Based on these positive profit numbers, some individual insurers appear to be more optimistic about the ACA in 2019. Both large and small health insurers are planning to expand their ACA individual plan offerings for the 2020 health plan year, even as the overall individual insurance market has shrunk.[5] For example, insurers including Cigna Corp., Bright Health Inc., Molina Healthcare Inc. and Centene Corp., the biggest seller of ACA plans, plan larger footprints next year. Anthem Inc. is expanding in at least two of its states, California and Virginia[6].

As individual enrollment through the marketplace increases, the price sensitivity and historic health characteristics of enrollees in the individual market challenge insurers to create strong networks of high-quality health care providers. The number of Americans insured under a narrow network plan is likely to increase, as enrollees sacrifice choice for cost savings.[7] While the ACA market is becoming more sustainable (at least in the short term) for insurers and consumers, excluded hospitals and medical groups/IPAs could lose a small to large portion of their individual or Medicaid patient population. Further, narrow networks threaten to exclude teaching hospitals, specialized care hospitals and small rural hospitals in areas dominated by a single insurer.

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Payors in the individual market especially confront the challenge of identifying health systems and physicians capable of performing well under value-based care contracts that coordinate team-based, cost conscious care. These arrangements call for strong alignment and creative partnership between health plans, health systems and medical providers.

In turn, health systems, medical groups and IPAs must be ready to negotiate value-based payment agreements with health plans, including building internal population health management and quality care gap closure capabilities in order to improve their value in collaborating with ACA insurers. To enable a mutually successful negotiation season, consider these best practices:

- Evaluate what will make a health plan a good health system partner for a health system for a long-term contract. Cultural fit is a critical factor in a successful partnership. What benefit can the health plan provide to the partner hospital/health system after a risk agreement is in place? Do not look at the ACA marketplace population in a silo, but rather align your ACA marketplace strategy with your value-based payment and population health management strategies, including all of the items below, with your Managed Medicaid, Medicare Advantage and any other managed care lines of business.

- Understand the federal and state network adequacy requirements on insurers to identify potential network gaps. For a health insurer to offer a plan on the Marketplace, the plan must be certified as a Qualified Health Plan ("QHP"). A QHP must meet the network adequacy standards of the exchange on which the plan is offered. While the federal standards and many state standards are vague, e.g. "Maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure

that all services will be accessible without unreasonable delay…" some states such as California, have broadened access requirements on health plans.

- Strongly consider transitioning to value-based coordinated care (VBP) contracting to improve patient satisfaction, overall quality, and profitability. For health systems, VBP brings more opportunities to earn revenue for performing well on quality indicators from health plan partners. Under risk arrangements and by proactively coordinating care, health systems can increase patient engagement, reduce avoidable hospital utilization, increase quality outcomes and increase profitability. Look for opportunities for clinical redesign, such as e-consult and co-management by high performing specialists with primary care.

- Integrate quality metrics across care delivery "enterprises" to focus on clinical outcomes, patient/member experience and accessibility of services. As more payments are shifting to VBP arrangements, integrated delivery systems and health plans have significant revenue and membership tied to quality performance on key metrics – necessitating specialized resources and optimal coordination to manage credibly and effectively.

- Determine what the optimal "in-network" network of facilities and providers is for each VBP arrangement in order to maximize opportunity to "repatriate" from current out-of-network providers. Examine issues related to "leakage" to ambulatory care centers, with particular focus on physician-owned facilities.

- Influence specialists to better manage referrals and both total cost of care and network leakage. Using validated and shared cost (including current data from payors) and quality data, rank system specialists per specialty by performance and make it easier to access these specialists for high-panel PCPs across the network, including FQHCs.

- Empanel like-minded primary care providers, including hospitalists, to keep business in the hospital and with contracted specialists. Align physician compensation to incentivize performance based on credible individual physician data for their VBP attributed panels.

- Based on population mix and likely "churning" of lower-income patients on and off ACA coverage and into Medicaid, explore FQHC look-alike clinic opportunities to align coordinated care with optimized 'wrap-around' supplemental reimbursement[8].

- Consider post-acute care strategies with focus on increasing participation in adding Hospice beds for palliative care, release to home or skilled nursing facilities.

To optimally serve enrollees in the individual market, payers should work alongside providers to create meaningful relationships that enhance the value-based contracting process and adoption of required capabilities and processes.
"Co-opetition" is crucial for sustainable results and lasting partnerships in the ACA individual marketplace, along with other managed care lines of business.

Endnotes

[1] Texas, joined by 17 other states, sued the federal government over the ACA in 2018. Trial judge Reed O'Connor of the U.S. District Court for the Northern District of Texas invalidated the entire law late last year, finding that because Congress zeroed out the law's individual mandate penalty in 2017, the entire law became unconstitutional. That is linked to a 2012 Supreme Court ruling in which the high court upheld the law based on its penalty or tax status.

[2] If the ACA falls, that could spell the end of many politically popular provisions of the law, including protections for those with pre-existing conditions, certain free preventive services and coverage for dependent children up to the age of 26, with no credible plan in place to deal with the fallout.

[3] The Affordable Care Act sets limits on insurer profits, and in an effort to protect consumers, the law requires plans to spend a majority of premium dollars on actual care, or claims for their patients. Insurers in 2018 were highly profitable and arguably overpriced, which is why rebates are so large despite being averaged across less favorable years (2016 and 2017).

[4] "Premiums for HealthCare.gov Plans are down 4 percent but remain unaffordable to non-subsidized consumers", CMS Newsroom, Oct. 22, 2019

[5] "The Individual Market May Have Shrunk, But More and More Insurers Are Banking on Health Law's Profits", KHN, Aug 23, 2019

[6] Anthem plans to expand its ACA coverage in Virginia next year. Centene, which has 12 million enrollees nationwide, plans to expand into new ACA markets next year, after entering three new markets last year. Bright Health will offer ACA plans in six more states, on top of the four it now serves. Oscar, offered ACA plans in nine states and plans to enter Colorado, Pennsylvania and Virginia, as well as new areas of New York and Texas.

[7] Additionally, some states have expressed an interest in implementing a narrow network model for their state Medicaid beneficiaries

[8] FQHCs receive enhanced reimbursement that includes a "wrap around" payment covering the difference of the FQHC Prospective Payment System or "PPS" rate and the actual payment from the Managed Care Organization (MCO) on a per encounter basis.

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