Saving the Exchanges?
A Case for the Provider-Owned Health Plan
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Introduction
There is a lot of talk about the future of Obamacare. Many fear the exchanges are in a death spiral and, if left to current market forces, will eventually implode. Guaranteed issue laws and a weak individual mandate, among other ACA regulations, set insurers up for potential large losses, which is why many large national carriers are simply opting out.
And while it is true that you can’t provide affordable guaranteed coverage for anyone at any time without getting the healthy to join in and spread the costs, even if that “basic math” gets worked out in Washington, we still have the issue of continually escalating underlying health care costs.

While many would see this current healthcare situation as hopeless, I see an opportunity for a subset of insurers to step in and not only survive, but thrive in the exchange environment. I argue that having a provider-owned health plan in every exchange market would not only help to stabilize the exchanges, but also significantly influence the future delivery of health insurance in this country for the better.

Consider these three thoughts:

• The individual consumer is increasingly becoming the insurance purchaser and they typically don’t buy an insurance company, they buy a provider network.
• Providers in the community deliver emergency health care needs for all even if a segment of the population lacks health insurance.
• Lowering the cost of care is most easily accomplished when you own the major cost center, the hospital.

Because of these dynamics, provider-owned health plans are in a unique position to create products that capture the value of lower cost through much needed improvements in health care management and delivery.

**The rise of the individual health insurance consumer**

In the simplest terms, the role of the health insurance company is to negotiate deals with healthcare providers and charge their customers premiums to be able to cover services delivered by providers. And if all goes well, they keep a little of the premium for themselves.

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The employer group market has been the primary insurance vehicle for working adults and their dependents in this country. Successful insurance products have been driven by broad choice of provider and ease of use. Since employers are trying to meet the needs of many employees, this means having every provider in the network. This ultimately means the insurer has less negotiation leverage with hospitals, so prices go up.
Enter health care reform and the creation of the health exchanges. Whereas an employer was trying to meet the needs and desires of all employees, the individual consumer is now the decision maker. They no longer need a choice of providers; they only need their provider. For the price-sensitive shopper, they may accept any provider.

This new market dynamic sets the stage for the rise of the provider as insurance entity. In the expanding individual market, a provider-owned health plan can thrive for two reasons:

- First, unlike standard insurance companies, they can capture the margin on the increased hospital volume derived from their health plan, which helps keep premiums competitive. The goal of the provider-owned health plan is the financial health of the overall system, and that is often about gaining loyal customers to ensure future volume.
- Second, since health plan and provider are one entity, they can give themselves a better deal compared to their traditional insurance company competitors, so long as they maintain adequate margins for the system.

These two points highlight why the national insurers were unwilling or unable to succeed on today’s exchanges. They don’t have the health delivery system to capture the margins they need when the population is sicker than expected. They may have been unable to convince a provider network to give them a great deal for their exchange-based business in a narrow network, or were not willing to upset other competing providers who they still need in their large employer networks. Finally, since a national insurer has a large portfolio of products, it makes financial sense for them to abandon the exchanges and concentrate on their more profitable lines of business. For provider-owned health plans, it is a different story.

**Providers can’t opt out**

Consider the scenario where the health care exchanges implode and many lose their coverage. Where will the uninsured patients go when they need emergency care or cancer care? To the emergency room. And who will treat them? Their local provider network. And who will pay? Good question. This describes the system we had for the uninsured before health care reform and the exchanges. Returning to this system would be a major detriment for the provider. Providers would be back to accruing high amounts of uncompensated care and playing the collections and patient bankruptcy game. Unlike standard insurers, providers don’t have the option to opt out of a market or refusing to provide care.

An alternative for providers is keeping the exchanges alive through their own health plan. It’s better to receive reimbursement through up front premium dollars than to go after it through collections on the back end. If the provider is the only exchange insurer in the region, it will be guaranteed volume and so will be able to cover its costs, and maybe even earn a little margin. If there are two or more provider-owned health plans competing on the exchanges, the community benefits even more. This competition will keep each plan’s premiums in check, encouraging provider networks to improve efficiencies through better care management.
Lowering the underlying cost of care

The heart of the problem with the ACA and recent iterations is that it was not about health care reform, it was about health insurance reform. Politicians were discussing who was going to pay the premium, not ways to realistically lower the premium. The only way to truly lower the premium is by lowering the underlying cost of care. I recently wrote a paper on how a health plan, such as those that are provider-owned, could create products to always encourage its members to make the best decisions in regards to where to get care, and from whom, to ensure the lowest cost. I estimated that savings of 20% or more could be achieved through some simple benefit and network changes.

A provider-owned health plan is in the best position to meaningfully lower costs because the system owns the most expensive component in the cost equation: the hospital. And, by acting as a true integrated delivery and financing system, it can pass the value of gained hospital efficiencies directly to insured members. Our firm, Axene Health Partners, helps hospital systems lower their length of stay by providing benchmarks, actionable analytics, and clinical support to help them improve their underlying processes and performance. The result is improved care management and lower cost. While the provider is investing resources to lower the cost of care, why not share this value with their community instead of a national insurer? As a provider-owned health plan, they can.

Conclusion: The future of health insurance?

While large national insurers make decisions on whether they can succeed on the individual market exchanges, providers can fill the void with products built around their own systems. In the short-term, this allows providers to serve this market while avoiding the uncompensated care issues that plagued the pre-Obamacare days. If there is coverage across the US for most citizens, provider-owned health plans could literally save the exchanges.

The long-term opportunity is even greater. As the large employer segment that dominates today’s US commercial insurance market can no longer afford premiums, they will be looking for alternatives. When this happens, provider-owned health plans, already operating successfully on the exchanges, will be in prime position to offer the narrow, efficient, high quality provider networks that the employer needs.
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