HealthScape Advisors

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Four Pressures Shaping Health Plans in 2024

Health plans are confronting significant pressure to their financial sustainability, including rising costs, new regulations, and increased competition. Rising medical costs remains an ongoing challenge, with medical expenses outpacing projections in 2023 driven by factors such as post-COVID demand, network challenges, high-cost conditions and specialty pharmaceuticals. In fact, large publicly traded National plans have tempered profit expectations citing rising medical costs as a notable challenge. According to recent industry reports, Humana's Q3 2023 medical loss ratio (MLR) reached 87.4%, up 1.9% year-over-year (YOY) whereas CVS Health (Aetna) reported MLR of 85.7%, up 2.3% YOY. Consequently, CVS Health (Aetna) revised MLR expectations to 86%, exceeding the prior range of 84.2%-85.2%. Rising medical costs are expected to continue putting pressure on profitability.

In addition to the significant pressures plans face with rising medical cost, we have identified four additional pressures facing health plans in 2024 which will force plans to adapt and evolve to stay ahead of the curve:

1 An Eroding Commercial Market	Plans face challenges to growth and continued shift from fully insured to self-funded arrangements
2 Increased Regulatory Complexity in Government Programs	In contrast to the fully insured commercial market, government programs offer significant growth opportunities but at the cost of complex and evolving regulatory demands
3 Continuous Administrative Cost Pressures	Suboptimal operating models due to lack of scale and the demand for new capabilities and services threaten profitability
4 Increased Competition from Cross-Regional Health Super Systems	Mega-mergers are reshaping and driving adoption of value-based care (VBC) models, requiring plans to keep pace with advanced capabilities

However, each of these pressures reveal new market opportunities and a set of strategies that health plans can deploy to improve competitive market positioning, expand and grow, and mature or innovate capabilities.

1 An Eroding Commercial Market

From 2018 to 2022, growth in government programs such as the Individual / Affordable Care Act (ACA) (48%), Medicare (5.7%) and Medicaid (7.7%) has significantly outpaced growth in employer-sponsored insurance (0.46%). In this period, while the employer-sponsored market stagnated, enrollment in self-funded plans increased 7%, reaching ~65% of commercially covered lives. This signals a shift in employer coverage away from fully insured products and towards self-funded arrangements.

These trends have put downward pressure on the fully insured market, many health plans' most profitable segment. Single-state and regional health plans are particularly vulnerable because they often lack the scale to succeed in self-funded and government lines of business.

Level-funded enrollment increased in small groups (3–199) from 6% of enrollees in this segment in 2018 to 38% in 2023. In its most recent quarterly earnings reports, CVS Health (Aetna) noted that level-funded plans' enrollment grew by 12% over the past two years.

Employer-sponsored insurance, the backbone of the insurance market with ~158M members, faces an affordability crisis. Premiums have risen 22% since 2018, following a 20% increase in the previous five years (2013 – 2018), leaving many employers increasingly dissatisfied with health plans' inability to control costs. At the same time, self-insured products have driven down market with the availability of stop-loss insurance and a proliferation of vendors that offer buy-up services to help manage utilization and cost and improve members' experience.

More recently, level-funded plans have increased in popularity and provide small group plans the opportunity to participate in self-funded arrangements. Level-funded plans use health status as a factor in rating and underwriting but are not required to provide all the essential health benefits that are mandatory for fully insured plans because they can be classified as self-insured plans. Level-funded enrollment increased in small groups (3- 199) from 6% of enrollees in this segment in 2018 to 38% in 2023. In its most recent quarterly earnings reports, CVS Health (Aetna) noted that level-funded plans' enrollment grew by 12% over the past two years.

Level-funded plans pose a dual threat to health plan margin. First, they act as a gateway to self-insured offerings for larger small group markets, eroding the traditional market base. Second, targeting ACA Small Business Health Options Program (SHOP) plans could siphon favorable risk groups from this market, as such groups would be attracted by potential savings offered in level-funded arrangements. UnitedHealthcare indicated in its most recent analyst day report that level-funded plans produce an average savings of 17% for employer groups. Siphoning the healthier risk from the market could potentially leave the SHOP exchanges with a sicker population due to adverse selection, furthering margin pressure unless plans file for premium increases. At the same time, level-funded plans also represent a strategy to retain groups that might otherwise switch carriers for a self-insured offering.

What Should Health Plans Do?

Diversify product portfolios and capabilities

Health plans need to develop a set of strategies to protect and maintain commercial market enrollment and share and to diversify their product portfolios and capabilities.

Plans should explore opportunities to improve commercial member retention. They can become a one-stop shop with expanded offerings into specialty benefits (e.g., dental, vision and supplemental, life and disability), while ensuring competitive product offerings and administrative simplicity for employer groups.

Plans should build an effective pathway to retain groups considering a shift between fully insured and self-insured options. This may include adding level-funded products to the portfolio and building third-party administrator (TPA) capabilities with competitive pricing and solutions specifically for the self-insured market. Additionally, plans must pair level-funded and self-insured strategy with a complimentary approach to stop loss to create a singular experience and potentially capture additional margin.

To protect against revenue loss from the commercial markets, health plans must strategically expand into non-commercial markets (e.g., Medicare, Medicaid and Individual / ACA). Success in government lines of business require distinct capabilities as plans must ensure not only an operating model that enables scalable and sustainable performance but also the ability to navigate evolving regulatory demands (as detailed in the next section). Given the potential for significant capital outlay for market entry or expansion, plans should investigate opportunities to build strategic partnerships with experienced players.

2 Increased Regulatory Complexity in Government Programs

As baby boomers age into Medicare at a rate of 11K per day, Medicare enrollment is expected to increase to ~76M Americans by 2031; an increase from 64M today. While Medicaid enrollment is expected to decline in 2024 as states resume annual Medicaid redeterminations, enrollment is projected to climb back to nearly 94M Americans by 2031. Although this rapid growth of government programs creates financial opportunity for health plans, it is not without operational or business risk.

Health plans face a critical balancing act: maintaining market share and driving growth while navigating increased (and evolving) regulations from Federal and State agencies. Plans must look both inward at operational capabilities and organizational structure, and outward at regulatory guidance and competitors' actions to strike the optimal balance between growth and performance with regulatory compliance.

The Centers for Medicare & Medicaid Services (CMS) faces increased public scrutiny related to Medicare Advantage (MA) plans' potentially deceptive marketing and sales practices, prior authorization policies / practices and utilization of supplemental benefits funded by Federal rebate dollars. Some health systems (many in rural geographies) have stopped or are threatening to stop accepting MA patients, citing poor reimbursement and frequent denial of coverage, exacerbating access challenges in already underserved communities. CMS' recent proposed rule for CY 2025 has several regulations that focus on beneficiary protection and equity, including changes to broker compensation, equitable utilization management policies and practices and reporting and evidence requirements for supplemental benefits. Other legislative actions could create additional operational and reporting requirements for prior authorization.

In the intersection of these two programs, regulations in CMS' CY 2025 proposed rule would drive greater integration of Medicare and Medicaid plans for those enrolled in dual special needs plans (D-SNPs), requiring that beneficiaries have the same carrier parent organization providing coverage for Medicare and Medicaid services. Regardless of the fate of this proposed rule, regulators have indicated that a shift towards integrated models for dual eligibles is both appropriate and inevitable, as we have seen with the evolution of the Medicare Medicaid Plan demonstrations and evolution to HIDE and FIDE models in nearly 20 states.

Managed Medicaid plans continue to manage pressures and evolving priorities from State Medicaid agencies and increasingly, from CMS. The fallout from the 2023 post-public health emergency redeterminations will continue into 2024 as states take varying measures to add eligible members back to Medicaid rolls. As of December 2023, nearly 12M Medicaid members had been removed from state managed Medicaid plans across the country, with greater than two-thirds of these disenrollments related to procedural issues (i.e., not due to lack of qualifying for Medicaid). Federal regulators have increased scrutiny of state agency actions to ensure procedural disenrollments are appropriate. These enrollment swings due to regulators' policies and pressure will likely create financial and operational uncertainty for plans through 2024, or until rolls stabilize.

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What Should Health Plans Do?

Balance strategic and sustainable growth with regulatory compliance

Plans must shift from a "growth at all cost" mindset for government programs to a view focused more on sustainability of these lines of business, including the ability to manage and comply with new and evolving regulations. For many plans, an evaluation of operating model capabilities – including but not limited to care model, network management, sales and distribution and strategic partnerships – may reveal opportunities for operating model evolution to better align with market pressures and regulatory headwinds. This is a notable shift from the historical focus solely on growth to instead balance growth with sustainability.

This operating model must also enable flexibility to adapt to uncertainties and changes facing these government programs, such as enrollment fluctuations due to ongoing Medicaid redeterminations following the end of the public health emergency and proposed CMS rules. For example, in order to comply with CMS' proposed rule on supplemental benefit reporting, plans will have to ensure that they are receiving required utilization information from numerous benefit vendors and integrate this information in personalized reporting for each beneficiary. This activity is a significant change from the current vendor oversight operating model occurring today in most health plans.

Given the imperative towards integration, plans should evaluate their market position in both Medicare and Medicaid to determine whether current membership is at risk or whether these regulations could represent a strategic growth opportunity. Depending on their position and the market landscape, plans must take steps to preserve enrollment / share or be prepared to capitalize on this opportunity. If participating in only one of these markets, plans should evaluate capabilities and regulatory requirements / timelines to determine whether market entry makes sense.

3 Continuous Administrative Cost Pressures

Continuous administrative cost pressures are driving health plans to explore new ways to achieve operational scale. In particular, small and medium sized plans are burdened with inefficient operating models and technology platforms while simultaneously experiencing increased demand for new capabilities and services. This dynamic is further widening the profitability gap between larger national plans that thrive through existing scale and the ability to invest in innovation and new solutions. To close the divide, regional plans are seeking solutions beyond their four walls, exploring partnerships consolidation options and diversification into high margin businesses. While partnerships offer a path to achieve scale, plans must evaluate the trade-offs of varying levels of horizontal integration, ensuring alignment with their strategic objectives to curate a partnership model that aligns with priorities of all parties involved.

A recent market example is the recently announced affiliation (not acquisition) between Blue Cross and Blue Shield of Vermont (BCBSVT) and Blue Cross and Blue Shield of Michigan (BCBSM) in which BCBSVT will transfer its BCBS license to BCBSM. Under this arrangement, the plans will generate savings through shared technology and vendors while allowing each organization to maintain local governance and branding. In another example, Sentara and AvMed recently joined forces to achieve economies of scale while preserving their shared not-for-profit mission. The acquisition will bring Sentara's leading care coordination capabilities to AvMed's market and deliver affordability as well as additional capability investments across their combined populations and networks. As cost pressures continue to mount, we expect to see a surge in partnerships and affiliations leveraging creative joint operating models that balance synergy with brand autonomy.

Increasingly, sub-scaled plans (plans often limited to one regional area) are exploring innovative partnership strategies to create scale while preserving their mission and identity.

In addition to partnership models, health plans can harness the power of Artificial Intelligence (AI) to optimize cost structures. Health plans are already deploying AI across functional areas and lines of business, including risk assessment and performance impact analysis in underwriting, expansion of digital chatbots in contact centers and use of prior authorization and utilization management workflows. These intelligent workflows allow employees to focus on higher value tasks, driving operational efficiencies. Effective AI deployment requires health plans to develop robust data governance and security strategies to proactively mitigate potential risks. However, health plans need to balance investment in AI's value creation potential with market risk and adoption in a rapidly evolving space.

What Should Health Plans Do?

Drive scale through collaboration and / or AI

There are multiple paths beyond traditional M&A and third-party service models including innovative partnership models and joint ventures that health plans can explore to remain profitable and compete with larger, at-scale carriers. In order to determine the appropriate model, health plans need to determine their core competencies and priority areas to preserve in a future collaborative model and identify operational strengths that can be potentially leveraged to create unique operating models with their peers, further enhancing scale. At the same time, health plans need to assess and scrutinize operational areas that drive the highest costs to inform opportunities for collaboration or AI deployment to reduce costs. Ultimately, an end-to-end assessment of the plan's mission, vision and capabilities, as well as target market needs and trends, will inform the guardrails for a successful operating model.

4 Increased Competition from Cross-Regional Health Super Systems

Over the past several years, the landscape of health system mergers and acquisitions (M&A) has undergone a significant transformation, shifting from predominantly intra-market consolidation to large-scale mergers between major health systems, many of which cross state lines. We have seen that this evolution is largely driven by a strategic focus on expanding VBC initiatives and health plan capabilities, signaling an intent to evolve into cross-regional risk-bearing entities.

Amidst mounting scrutiny from the Federal Trade Commission (FTC) on local M&A activity, several notable cross-regional mergers have emerged, including Kaiser-Geisinger, Atrium-Advocate-Aurora, SCL-Intermountain and Unity Point-Presbyterian (though now canceled, this merger was based on a similar strategy of scaling value-based and risk-based capabilities). These mergers have resulted in the creation of some of the largest healthcare entities in the country, better equipped to assume risk and distribute risk-bearing capabilities to other systems.

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The most prominent of these deals is the 2023 merger between Kaiser Permanente and Geisinger Health System via its new Risant subsidiary. In addition to these large deals over the past three years, cross-market hospital system mergers have been on the upswing. A 2009 – 2019 study discovered that among 1,500 hospitals involved in M&A activity, 55% were located in a different geographical area than the acquiring entity.

Provider systems have many strategic reasons to grow through acquisitions. They allow systems to share best practices, increase operational / shared service efficiencies and strengthen their negotiating position with health plans. Perhaps the most critical capability, however, is the enhanced ability to enter and succeed in value-based reimbursement models. CMS has established a goal to have 100% of traditional Medicare beneficiaries in a value-based payment model by 2030. Similar value-based targets are being implemented across various lines of business. In the commercial market, private plans are increasingly leveraging value-based agreements as a lever to address cost of care, and strengthen provider relationships through enhanced integration (e.g., data sharing). With major players driving the industry to adopt value-based care, enhancing risk-bearing capabilities remains a top priority.

What Should Health Plans Do?

Proactively navigate provider system complexities through strategic partnerships

As health plans adapt to the ever-evolving provider system landscape, understanding the advantages and implications of collaborating with large, cross-market system conglomerates with advanced risk-bearing capabilities becomes paramount. These partnerships offer health plans several benefits as conglomerates can serve as strong, reliable risk-bearing partners that can assume greater levels of downside risk and align incentives to achieve lower total cost of care. Additionally, such provider systems may also be better positioned and amenable to innovating value-based reimbursement models, including condition-based models and specialty care. However, plans must also consider the nuanced challenges with these partnerships. The emergence of regional networks, patched through cross-market mergers (e.g., Transcarent) may disrupt large national plan networks. Furthermore, the consolidated negotiating leverage of large conglomerate systems could negatively impact health plans' negotiating positioning.

Cross-market mergers have brought both challenges and opportunities to health plans. While studies have indicated that these mergers have led to price increases ranging from 6% - 17%, health plans can mitigate these pricing pressures on behalf of their members through adoption of a proactive and strategic approach to value-based contracting. Plans that capitalize on the advanced capabilities of sophisticated large provider systems to support overall medical cost reduction and improve patient outcomes through value-based reimbursement innovation will be most favorably positioned for success.

HOW HEALTHSCAPE CAN HELP

The shifting healthcare ecosystem puts immense pressure on health plans to anticipate, adapt and evolve their strategies. Our team supports plans navigate these shifting priorities with thoughtful, forward-focused solutions.

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