HealthScape Advisors

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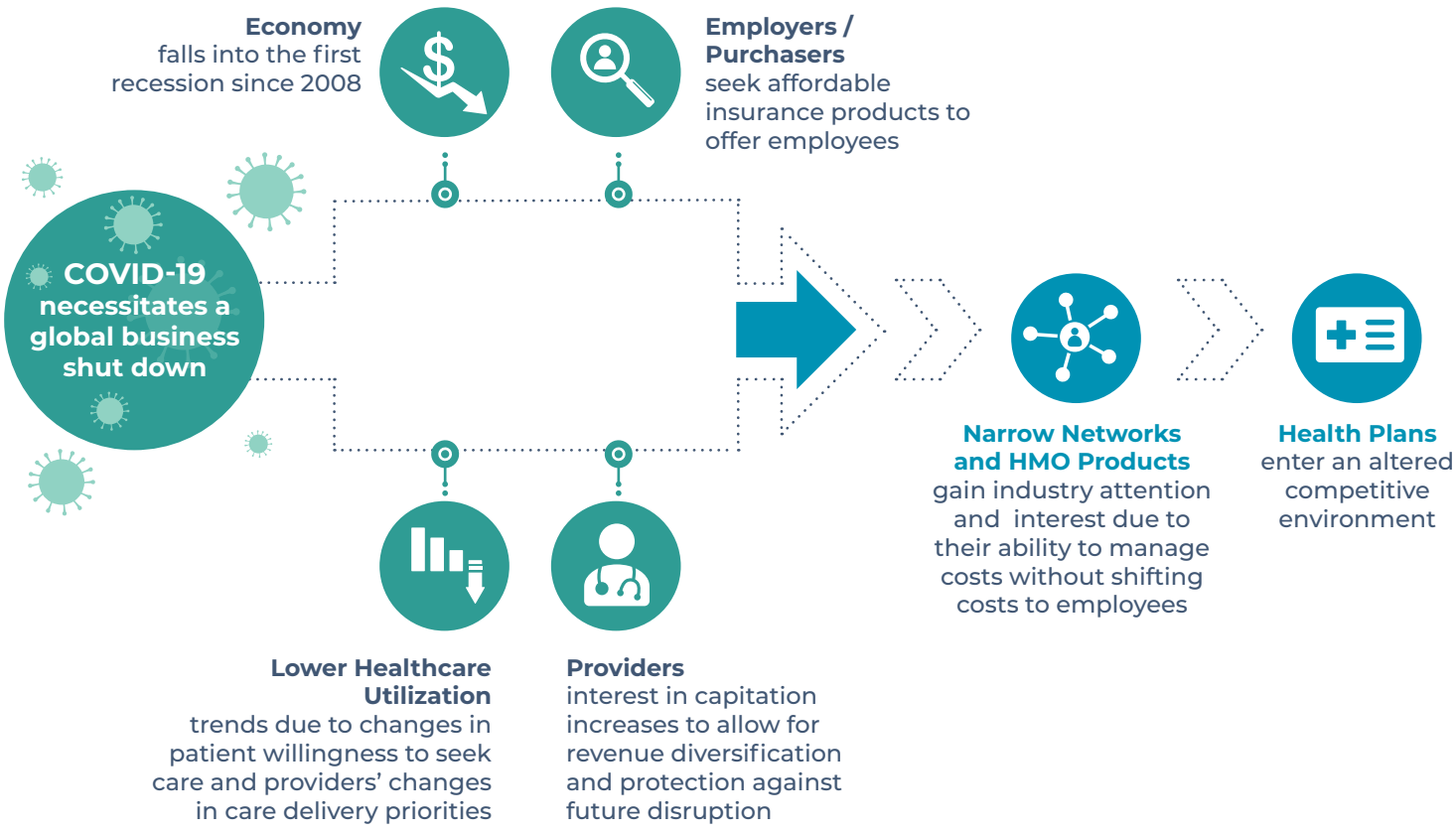
HMOs: An Emerging Competitive Front in a Post-COVID World

As the world collectively addresses the COVID-19 crisis, we believe it is important for healthcare leaders to understand and plan for longer-term changes to the industry. In this Executive Brief, we will discuss our perspectives on how the economic environment may accelerate the trend towards increased demand for Health Maintenance Organization (HMO) products in commercial insurance markets over the next 1 – 2 business cycles - noting heightened competitiveness and innovation in the HMO space.

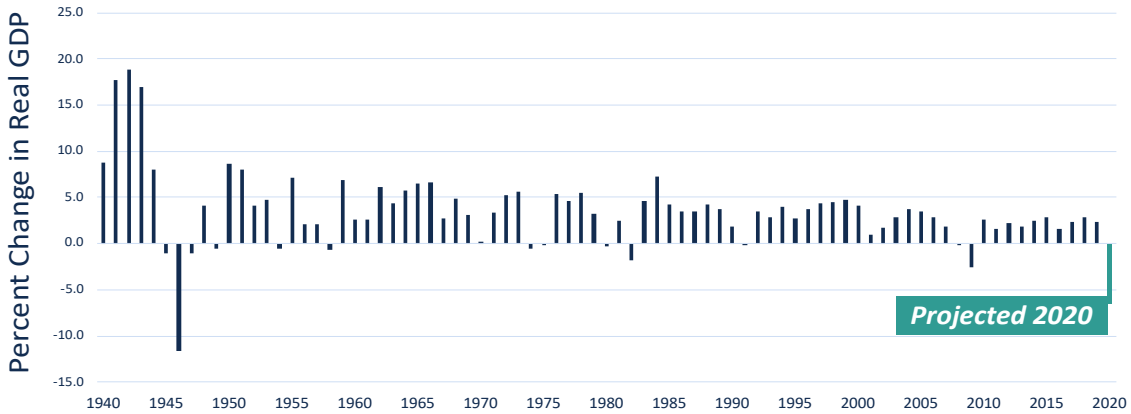
Figure 1: Lifecycle of Emerging HMOs



ECONOMIC IMPACT OF COVID ON EMPLOYER HEALTH BENEFITS STRATEGIES

The COVID-19 crisis sharply tipped the U.S. economy into a recession, ending the longest economic expansion in U.S. history. In June, the Federal Reserve projected U.S. gross domestic product (GDP) to contract by 6.5% in 2020, marking the largest single year decline in (GDP) in the last 70 years.

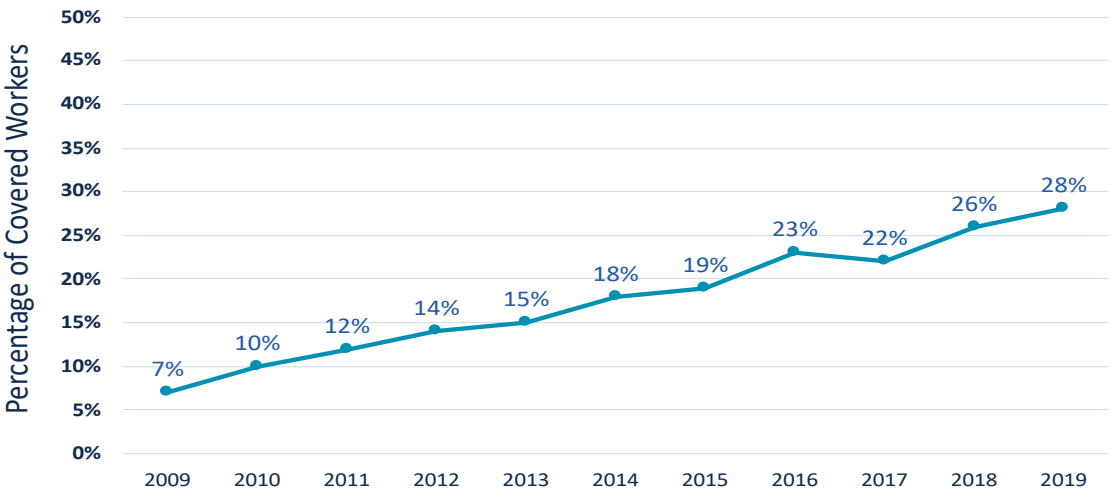
Figure 2: Percent Change in Real GDP: 1940 – 2020 (Projected) [1, 2]



In response, we expect employers will pursue a broad range of health plan designs to defend against continued growth in healthcare costs. Over the last decade, employers largely mitigated medical trend through a variety of tactics including evolving benefit designs, transitioning to self-funded arrangements, shifting healthcare costs to employees through high deductible plans (See Figure 3) and increasing payroll deductions. In parallel, employers disproportionately selected products that offered employees broad provider networks with unrestricted access to the delivery system.

While continuation of several of these trends is likely, we expect to see advancements in the designs of these models. Aetna, for example, launched new plan designs in 2020 that offer alternatives to traditional HDHPs, referencing research on HDHP enrollees that indicate 86% fail to meet their annual deductible and a minority (18%) contributed to a health savings account in the last 12 months. More broadly, we expect employers will favor solutions that reduce total healthcare costs over solutions that maintain costs while shifting financial responsibility to employees. As a result, we project employers to increasingly pursue narrow networks such as Exclusive Provider Organization (EPO) and HMO products in which medical costs can be tightly controlled, administrative expenses are low and member cost sharing can be limited.

Figure 3: Percentage of Covered Workers Enrolled in a High Deductible Plan [3]



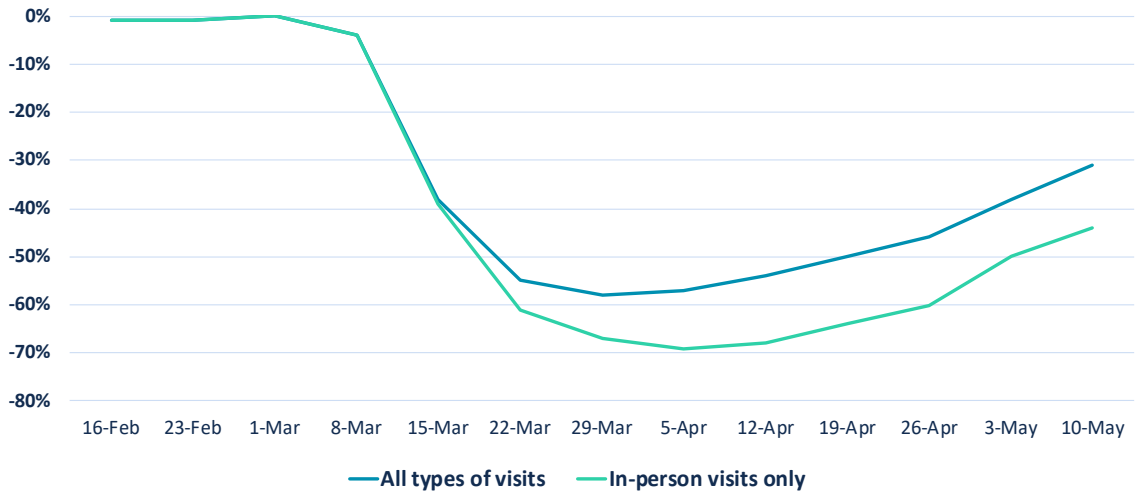
Notes: June 10, 2020: FOMC Projections materials, accessible version, [2] Gross Domestic Product, 1st Quarter 2020, [3] Kaiser Family Foundation, 2019 Employer Health Benefits Survey, September 25, 2019

HEALTHCARE UTILIZATION IMPACT OF COVID-19 ON PROVIDER PAYMENT STRATEGIES

For providers, the COVID-19 pandemic is transforming traditional business models as unprecedented declines in elective procedures and office visits threaten financial viability of many practices.

Despite a rebound in practice visits driven in part by increased adoption of virtual visits (e.g., video, telephone), total practice volume was down 30% in May 2020 compared to February baselines.

Figure 4: Decline in Practice Volumes by Type of Visit (in-person and telemedicine)[1]



Nationally, primary care practices are expected to lose $15.1 billion in revenue in 2020 due to COVID-19 impacts on practice volumes, or roughly $67K per full-time physician.

To mitigate the revenue impact of declining volume and the changing mix between in-office and virtual visits, providers across the country are actively pursuing opportunities with commercial insurers to increase both the level and predictability of revenues earned through value-based and capitated arrangements. Shifting revenue away from the traditional fee-for-service model will protect providers in the event of a re-emergence of the COVID-19 virus and will afford providers greater flexibility in delivering necessary care to patients.

However, to grow capitated revenues, providers will need to increase their participation in HMO networks. In select markets, health plans will be able to capitalize on provider appetite for capitation by expanding HMO networks at competitive capitation rates, thereby enhancing the value proposition of HMO network products.

Recent comment highlighting the financial disparity between value-based care and fee-for-service providers:

"...I think what this crisis has shown is that people who are engaged in these relationships (value-based) where they're accountable for the care of their members and they directly financially benefit when members are healthy, have performed much better. I mean, there's the cash flow dynamic which is, they typically get a percent of premium or some kind of primary care capitation amount for every member that they see. And so, they get that every month and that's cash flow. So, they don't have the cash flow challenges that truly fee-for-service doctors have, which is a big deal."

Brian A. Kane, Chief Financial Officer, Humana[2]

Notes: [1]The Impact of the COVID-19 Pandemic on Outpatient Visits: A Rebound Emerges, [2]Humana Inc., Investor Relations

HMO PRODUCTS REPRESENT AN EMERGING COMPETITIVE FRONT

Two parallel trends– employer demand for narrow network products and provider demand for capitated revenues – offer health insurers a unique opportunity to leverage HMO products as a growth vehicle in commercial markets. As such, we expect HMO products to emerge as a competitive front as health insurers rush to offer lower premium plan designs that jointly provide a differentiated consumer experience and better positioning for providers to deliver convenient, coordinated care. Recent launches of new innovative plan designs in markets across the country signal a potential revival in employer demand for HMO products.

In January 2019, UnitedHealthcare launched the SignatureValue Harmony network, a narrow network of Optum physicians in southern California with premiums 20% less than comparable HMO offerings.

In 2020, Florida Blue launched an innovative HMO product called Truli for Health focused on the small employer market. Truli incorporates a focused network of anchor providers and unique a center of excellence model to provide access to high value tertiary care.

Notably, both products offer a fresh take on the traditional HMO model. HMOs of the future will leverage strategic partnerships with anchor health systems, provider groups and/or owned provider assets as core to the value they offer to the market. Well designed HMO products will represent attractive vehicles to enable accountable care at low premium price points. For incumbent plans with strong employer penetration, innovating and refreshing HMO products will be increasingly important to protect existing market share and support growth.

HMOS REQUIRE DISTINCT CAPABILITIES FOR HEALTH PLANS AND PROVIDERS

The capabilities and infrastructure required by health plans to scale HMO products are differentiated from the capabilities and infrastructure needed to administer traditional open access products. Due to the increasing relevance of HMO products, we recommend that health plans rapidly assess both internal capabilities and provider readiness to launch and operationalize these products. Health plans should assess business processes and capabilities in the following areas:

1. Pricing and Products Strategy

2. Distribution Channels

3. Provider Incentive Model Design

4. Encounter Data Processing

5. Clinical Delegation Infrastructure

6. Provider Readiness & Enablement

1. Pricing and Products Strategy

Plans should ensure HMO products offer a distinct value proposition within their commercial product portfolio, including rational pricing differentials against their own broad access and narrow network product alternatives. In HealthScape's experience, HMO products with traditional gatekeeper models should typically fall 15% - 20% below broad PPO product premiums. Consideration should also be given in the underwriting process to determine whether HMO products will be offered alongside other products (e.g., EPO, PPO) in the same employer group (and if so, under what circumstances).

> **Health plans should be mindful of how HMO products stack against internal products from a pricing and benefits perspective and ensure the portfolio of plan designs is rational for each market segment (small, mid-sized, and large group). For example, plans should ensure the HMO is priced competitively against high deductible products in the market.**

2. Distribution Channels

To drive HMO growth, insurers need to evaluate and optimize distribution channels and sales incentives. The structure of HMO products differ meaningfully from open access products, requiring health plan sales teams and external partners (i.e. brokers and consultants) to articulate a distinct value proposition for HMOs compared to the standard parameters of PPOs (e.g. PCP selection, referral requirements, premium vs. cost-sharing differences). In HealthScape's experience, health plans can struggle to arm internal and external sales teams with the appropriate training and messaging points to communicate the unique value of HMO products. To address these challenges, insurers need to invest in training and educational programs and materials to support HMO sales. In addition, insurers should implement sales incentive models that take into account the incremental difficulty in selling HMO products.

> **Sales incentive models that reward health plans sales representatives based on premium under contract or enrolled lives should be re-evaluated in the current environment, as they inherently disincentivize HMO products. Instead, plans should consider incentive models that are geared toward membership and margin rather than solely premium.**

3. Provider Incentive Model Design

While provider incentive models should be customized and tailored to the individual needs of providers, plans should be cautious of over-customization that could increase administrative cost, burden and complexity. Differences in provider capabilities to manage downstream utilization can limit provider participation if capitation models are too standardized across the provider network. However, meaningful variation in capitation models across providers will drive administrative inefficiencies within the network management and payment functions of a plan. Plans need to strategically design incentive models that meet four criteria: (1) the model can be efficiently administered, (2) the model delivers appropriate incentives for management of utilization across the continuum, (3) the model allows for broad provider participation in HMO networks, and (4) the model compensates for the value of the provider network in promotion of the product and member recruitment.

> **Given meaningful site of service differentials on inpatient care, outpatient surgeries and specialty pharmacy, plans and providers should focus intensely on incentive models that reward the efficient delivery of services that fall outside many primary care and partial capitation payment models.**

4. Encounter Data Processing

HealthScape has observed multiple plans struggle with the integration of encounter data into those existing claims-based reporting and analytic processes that are crucial for business management and delivery of insights to employers. Plans typically need to build tailored analytic and reporting capabilities to sit on top of HMO product lines, which can require meaningful investment in time and platform configuration. Misalignment in employer reporting capabilities for HMO and PPO products can cause abrasion with self-insured groups that offer both product types.

> **Adoption of self-insured employers is a critical driver of volume within HMO product lines and will contribute meaningfully to provider engagement in HMO networks. Strengthening HMO reporting capabilities to mitigate perceived differences in HMO and PPO insights will be critical to appeal to ASO employers.**

5. Clinical Delegation Infrastructure

Plans and providers must also align on the appropriate operating model to manage population risk. Typically, services such as case management, condition management, transitions in care, and behavioral health are more effective when performed by those closer to the point of care. Depending on the maturity of the provider, utilization management and pharmacy management may also be delegated. Delegation decisions are typically formed along a multi-year journey where functions slowly migrate from the health plan to the delivery system. Plans need to begin by creating a convenient and effective PCP selection process to enable capitated payments and evaluate internal care management processes and capabilities to ensure they have the ability to administer hybrid delegated operating models with providers. In addition, plans need to launch a dedicated governance structure to oversee delegated functions and ensure compliance with regulatory requirements and industry best practices.

> **Shifting of clinical responsibilities from plan to provider will require parallel adjustments to capitation levels. Managing variation of clinical delegation across providers will support appropriate levels of standardization in capitation payments and will streamline internal resources and processes plans deploy to govern provider delivery of clinical management services.**

6. Provider Readiness & Enablement

Health plans should also assess the readiness of network providers to participate in capitated and delegated partnerships. They should further recognize that for many providers, these financial and clinical models are a significant and fundamental shift in business operations. As such, it is reasonable to assume that not all provider organizations will have the capabilities or resources in place to execute against these arrangements. Health plans should consider a formal, consistent process to assess the capabilities of each potential provider entity. In some cases, supplementing the provider's operations with third party partnerships may be most advantageous to successful performance under capitation.

> **To accelerate provider readiness to participate in capitated and delegated models, several plans are partnering with Management Service Organizations (MSOs) to provide support across many of the functions described above including, clinical program design, back-end administration, and data analytics.**

NEXT STEPS

The trends discussed in this Executive Brief are national; however, shifts in employer and provider behaviors will vary by market. To maintain a pulse on local markets, plans should monitor trends that may impact the pace at which markets tip toward narrow network and HMOs.

Pricing of commercial plans for the 2021 coverage year will be one critical factor. Despite a potentially favorable medical loss ratio (MLR) on commercial products in 2020, rising unemployment, premium holidays, and reduced gains from investment income will challenge plan balance sheets. Plans should closely monitor pricing trends of internal products and competitor PPO and HMO products to determine how aggressively employer markets may down shift to narrower or highly managed network products.

In addition, employer adoption of direct contribution vehicles should be monitored. In 2019, the federal government introduced Individual Coverage Health Reimbursement Arrangements (ICHRAs), which allow employers of all sizes to provide tax-free reimbursements to employees for purchasing insurance on the individual market. If the recession drives an unexpected boost in these vehicles, markets may shift more quickly to narrow network products that dominate consumer-driven markets.

Plans should closely monitor health system strategies to go direct-to-employer following the COVID-19 pandemic. We expect some systems will view the utilization disruption from COVID-19 as justification to capture more of the premium dollars to protect themselves from future revenue declines. For incumbents, HMO networks represent a strong competitive protection against provider disintermediation strategies.

Finally, health plans should monitor the willingness of large ASO employers to offer narrow networks in markets with high employee density. If market moving employers migrate away from their historical preference for broad access products, local providers will move more aggressively into narrow network products.

With these indicators of changes to come, it will come as no surprise if the industry sees a significant advancement in employer take-up of HMO offerings. 2020 has been a year of unprecedented disruption in all walks of life. While HMOs struggled to maintain their prominence in the 1990s, will this year mark the moment when they finally cross the tipping point and gain sustained market presence?

HEALTHSCAPE CAN HELP.

HealthScape has supported health plans across the country develop and optimize their network and product strategies in response to economic and industry shifts. Our expertise and execution-focused approach helps our clients to develop and implement these strategic solutions. Reach out to see how HealthScape can help you understand your local market's preferences and industry trends to stay competitive.

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