If a Health Plan Ran a Health System

By Jeff Radtke, Kevin Thilborger and Meltem Kutik

Today's healthcare payer/provider relationship is one in which one profits at the expense of the other — an expense for a payer is revenue for a provider. This dynamic results in these entities having goals and priorities that often put them at odds with each other. If, however, a health plan ran a health system, they could align the goals across the payer/provider space to focus on wellness while driving profitability through this unified approach to health.

By taking a step into the hospital, payers could manage the entire consumer healthcare relationship and transform the healthcare landscape.

As health plans shift from just selling insurance to providing healthcare through the acquisition of physician groups, pharmacy benefits managers (PBMs), pharmacies, post-acute facilities and other outpatient services, health plans are in position to manage healthcare costs by owning the consumer relationship outside the four walls of the hospital. By taking a step into the hospital, payers could manage the entire consumer healthcare relationship and transform the healthcare landscape.

Streamlined Backend Processes

The complexity of the payer/provider relationship is confounded by contract negotiation, billing, denials and payment process. For payers, owning a health system could create a dynamic where they pay themselves for the services provided in a fee-for-service model or in a risk-based model, they profit by keeping consumers well. This could simplify financial processes such as billing, collections and third-party fees paid to a clearinghouse.

Denials management, appeals processing and insurance authorizations are time consuming for both hospital and insurance staff and could be virtually eliminated. Cost savings could be realized by reducing the amount of labor needed for these tasks. Similarly, the cost of bad debt collections could also be reduced through simplified financial processes that make price transparency easier to achieve, making it easier to manage consumers' expectations on cost.

Despite growing demand from consumers and the federal government, achieving price transparency is still a significant challenge for healthcare organizations. However, if a payer operated a health system, it would

not be necessary to have different rates for each insurance plan; instead, the payer could set a standard fee for all services performed at its health system. This additional level of transparency could eliminate the variability and confusion that often adds unnecessary stress for consumers during their healthcare experience. To simplify payments even more, the bundled payment model used by providers and payers today could be passed along to consumers. In this way, there would be a single charge for a procedure or surgery instead of requiring consumers to calculate the total amount of each aspect of a procedure or service.

Healthier, More Satisfied Consumers

With a payer operating a health system, the efforts around wellness that both payers and providers are taking to create healthier communities can be unified. Wellness efforts for insurers are often related to things like preventive screenings, employee health screenings, health coaching and smoking cessation programs, but if they operated near a health system, the programs could create a more holistic approach to wellness both inside and outside the four walls of the hospital. This continuous healthcare education for the consumers could improve outcomes, enhance consumer data collection and enable providers to make more informed, cost-effective healthcare decisions that benefit consumers.

Consumers' dissatisfaction in their financial experience in the healthcare industry often stems from difficulty receiving authorization for a procedure, understanding the myriad of bills they receive and attempting to correct inaccurate billing. A unified organization would give them a single place to go for all their healthcare billing related questions and could create a simplistic financial experience. For instance, if they don't know the cost of a procedure there's less confusion between the cost listed on a healthcare provider's website, the rate their insurer negotiated and how much they'll ultimately end up paying depending on their coverage. And if there is confusion about cost, rather than having to go back and forth between the insurer and provider, there would be a single point of contact to communicate with.

Clinician Alignment

Today, appropriate documentation of the care is critical for reimbursement by payers. At times, the required documentation can put physicians, who are focused on clinical outcomes or aren't aware of the cost of a service, at odds with health plans who are focused on cost. With a unified organization, physicians could become more integrated into the insurance aspects of care delivery which could offer insights on cost and health plans could have a new perspective on why a given procedure should be reimbursed. With alignment around goals and objectives between the two parties, incentives could be aligned across the organization so that physicians are more cost-conscious regarding the care they're providing to consumers and can identify solutions that are both high quality and financially responsible.

In addition to improving consumer experiences, clinician experiences could also be improved. Physician burnout is often tied to the amount of time they spend in front of the computer documenting care rather than providing care. Much of this documentation is needed for appropriate reimbursement. With aligned expectations around how care should be delivered from both parties, physicians could be relieved of some of these tedious tasks.

Lowering the Cost of Care

In order to lower the cost of care delivery, payers are acquiring physicians and ancillary providers to help consumers achieve their wellness goals and simultaneously reduce the need for care within the hospital setting. However, the care provided within the hospital is critical to fully owning the healthcare relationship. Without a hospital, insurers are not involved in providing care for chronically ill consumers when they are in the hospital, making it more difficult for them to manage their entire healthcare relationship, which is critical for outcomes and driving down the cost of care.

This payer/provider organization can offer more direct to consumer healthcare services that cut out many of the intermediaries that add cost. However, lower costs will not be enough to attract consumers, providers must compete for employee contracts in a way that encourages them to continually improve quality and create a differentiated consumer experience so that they become the provider and insurer of choice for employers as well.

For payers, the opportunity to not only be the insurer of choice, but the provider of choice in a market offers the chance to truly create a differentiated healthcare delivery model. This will enable them to meet the needs of consumers in new ways while increasing their profitability.

Key Takeaways

For health plans seeking to improve wellness and increase profitability, the ownership of a hospital can be a valuable addition. To develop a hospital into a high value asset you should:

Think differently.

Recognize the evolution of your organization from insurer to wellness advocate and look for ways to implement technology that will enable 360-degree views of your patients to create a more holistic healthcare experience.

Plan differently.

Develop a strategic plan that aligns goals and objectives across the insurance and healthcare setting. Additionally, consider how technology can serve as platform to engage stakeholders and provide data and insights to the entire organization.

Act differently.

Make strategic investments in areas such as process automation, artificial intelligence and patient engagement platforms so you can own the entire healthcare experience for consumers and realize efficiencies to drive growth.

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