White Paper

IDNs, Employers Exert Influence in New Contracting Models

Market Access Insights from the Editors at AIS Health

Several health industry trends are converging that result in shifting risk, and therefore control, among stakeholders. Self-funded employers and integrated delivery systems are weighing in on the market with very restrictive plan offerings. Market access strategies that incentivize prescribers and insurers must evolve to include other types of influencers. Proliferation of provider-sponsored health plans and value-based contracting makes it more complicated to determine which entity has control of coverage and reimbursement for a particular prescription. Understanding the perspectives of all stakeholders and the risk-bearing in new models is an important first step toward refining your approach.

IDNs, Employers Exert Influence in New Contracting Models

A wide variety of value-based contracts and accountable care organizations are now in play, but most have little or no direct impact on prescribing or drug coverage. That could be changing as specialty drugs represent almost half of all drug costs,[i] and these products tend to require more involvement and investment by the provider community.

Self-Insured Employers Join the Fray

While insurers, states and the Centers for Medicare and Medicaid Services (CMS) have spent the last decade experimenting with different provider contracting models, most self-insured employers have helplessly endured exorbitant premium increases year after year. In lieu of meaningful suggestions from the third-party administrators (TPAs) with which they contract for networks and claims processing, most employers have been forced to shift costs to employees via high deductibles and copays, as well as passing on a share of higher monthly premiums.

This hugely unpopular strategy has engendered widespread dissatisfaction among employees, fueling bitterness toward employers and insurance companies, and snarky reviews on Glassdoor. Very high deductibles are, in fact, not tenable for a large segment of the workforce and essentially negate the idea of an employee "benefit."

Approximately 60% of the commercial workforce (a third of all insured individuals) is covered by a self-insured employer group[ii] (see Figure 1).

Figure 1. **Medical Membership by Sector**

SOURCE: AIS's Directory of Health Plans, July 2018

Traditional market access strategies for this group target pharmacy benefit managers (PBMs) in a general way — under the assumption that any access gained via the PBM channel gets your drug in front of most members of employer self-insured groups.

But what happens when an employer goes "off script" and contracts directly with a provider entity? Recently, some self-insured employers have followed the lead of other payers and ventured into new accountable care organization (ACO)-style arrangements in which they contract directly with providers for medical services in efforts to decrease spending and increase member satisfaction.

Results vary, but most such agreements are basically "side deals" incentivizing providers, and do not override the basic fee-for-service infrastructure of the benefit — usually.

Additionally, most value-based care initiatives address specific medical or surgical procedures for a defined population, so any impact on prescribing is limited. Value-based initiatives with a focus on pharmaceuticals tend to concentrate in the PBM arena.

Glossary of Provider Contracting Models

Accountable Care Organizations (ACOs)—This term is bandied about to refer to a variety of different models, with varying degrees of risk to the provider. There are some formal programs being evaluated by CMS that utilize the name "ACO" in the program title, but the term is used as a catchall description for variations on the following arrangements:

- **Upside risk**: a provider group is generally paid via a traditional FFS model, but also accepts incentive payments in return for submitting certain data to the payer or staying within certain cost or outcome parameters.
- **Shared risk**: A provider accepts bundled payments for a specific set of services (e.g., cardiac, knee replacements) for a population, waiving patient cost-sharing requirements for patients who use them as a preferred provider. Also referred to as Centers of Excellence.
- **Downside risk**: Any agreement in which a provider entity stands to either gain or lose money based on utilization and outcomes within a patient population.

Note: Providers in a region—related or unrelated—sometimes align with one another to present themselves as an "ACO," with a plan to coordinate care, collect data, etc. Such offerings are publicized frequently, but it's important to clarify that such entities are basically just announcing that a provider combination is open to negotiate with payers; there is no impact of such an arrangement until a payer is on board, whether an at-risk insurer or self-funded employer group.

Provider-Sponsored Health Plans—Traditional health insurance models that include in their networks some entities that are owned by the same organization that owns the payer. Typically, the owned providers are supplemented by non-owned providers to create a network offering that has enough geographic and clinical coverage. The ability to share data with owned providers is the major advantage for these insurers. However, questions remain around how to align incentives when the umbrella company stands to gain by increased utilization of its provider affiliates.

Narrow Networks—Typically initiated by insurers, this offering covers only services provided by a small, exclusive network of providers. This aggressive design allows payers to reduce overhead costs, while the selected providers gain more market share in exchange for lower payments. In this arrangement payers also gain more predictability than is found in a large network where they might see huge cost variations among providers for the same set of services.

Direct Primary Care—Under this system, a physician group, PPO network or health system allows patients to pay a monthly fee directly to a provider. The patient receives most preventive and acute care services at no additional charge. It typically is paired with some sort of catastrophic insurance policy for events that cannot be cared for by the participating providers. It's not an insurance product, but often is more appealing to members than the high-deductible plan they get through an employer.

Employers that contract directly with a provider typically still need a vendor for claims processing. Some IDNs already have a payer arm and represent about half of all health insurers (see Figure 2).

The proportion of members enrolled in these provider-sponsored plans nationally has remained static over the past five years.[ii] IDNs have made inroads in the Medicare Advantage and individual markets, where price sensitivity is great enough to incentivize individuals to embrace a narrow network, and in small-group plans that can tolerate geographic limitations.

But opening themselves up to more employer direct contracting could be one way to gain market share — a worthy goal. Increasing membership is key to lowering costs, but geographic barriers will preclude some other forms of expansion.

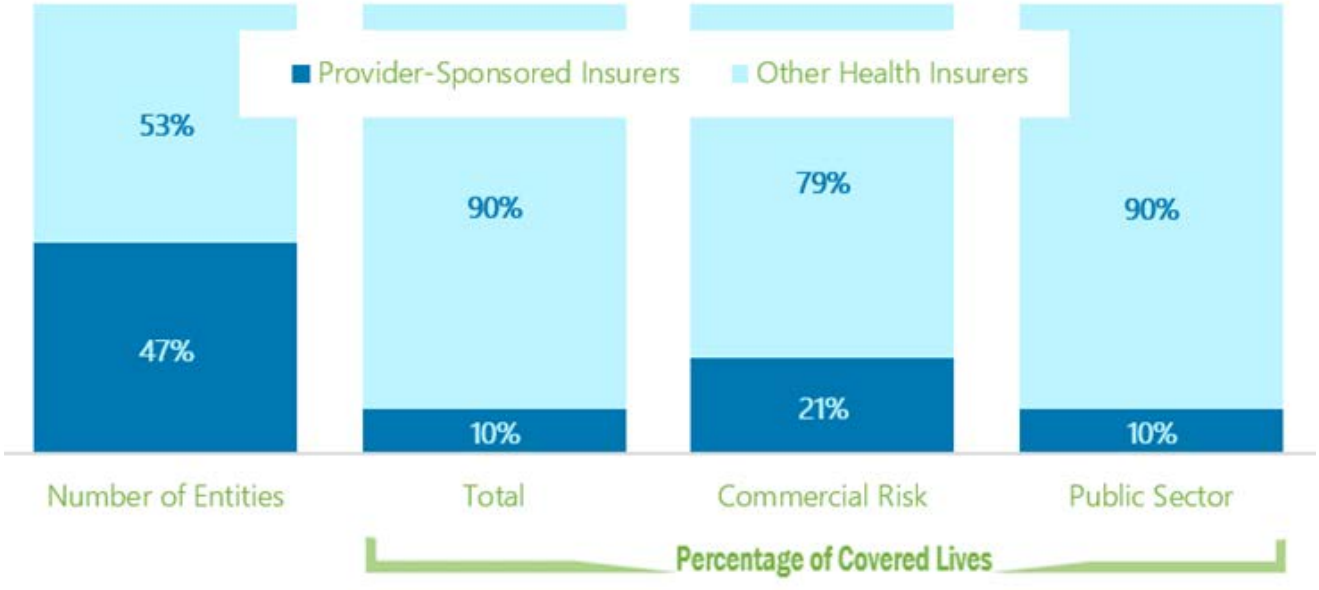
IDNs Have Much to Gain

While independent hospitals and small physician practices continue to struggle, close or be acquired, integrated health care delivery systems are becoming larger and more numerous. By various means, providers are linking vertically and horizontally in efforts to seek scale and reduce costs. The promised benefits of scale, however, are not showing up, and IDNs are still plagued by the same economics that drove them together.[iii]

Value-based contracting provides welcome opportunity for these entities, allowing them direct access to payers and patients alike, sometimes cutting out or going around the traditional middlemen.

Even when there is no existing payer component, IDNs that have achieved a critical level of integration within a defined market can create an offering that is an alternative to a traditional open-access health plan with a broad network. In this type of structure, the IDN essentially performs as a complete but narrow

Figure 2. Provider-Sponsored Plans as a Percentage of Medical Insurance Market



SOURCE: AIS's Directory of Health Plans, July 2018

provider network to serve a specific population of a self-insured employer group.[iv] This type of arrangement is sometimes referred to as a Super-ACO.

This provider contracting model can be viewed as a new type of health plan that leverages the advantages of narrow networks and provider-sponsored plans. At AIS Health, we see this phenomenon as a natural evolution of the various accountable care models that have been floated to this point.

Brighton Health Plan Solutions is partnering with health systems to offer private-labeled benefit plans to the self-insured employer market. CEO Simeon Schindelman touted this initiative at the AHIP Institute & Expo in June 2018, attesting that these offerings are being well-received by self-insured employers.

Even large national employers are willing to place a regional offering on the menu wherever they have a significant number of employees. Schindelman says IDNs compete successfully with one another, as well as with nationwide, open-access options.

In some benefit plans, he says, the cost difference is so stark that employees have been able to get a narrow-network option without any contribution toward the premium.

When traditional payers are in control, utilization drops but costs continue to spiral due to increases in unit costs for services, procedures and products. Many experts contend that more competition in insurance markets is one solution.

Alain Enthoven, professor emeritus at Stanford University, explains that new mechanisms to help high-value providers win business will allow profits to come from volume, not unit cost, and this scenario is beneficial to providers and payers alike.

Self-insured employers and IDNs are two health care stakeholders arriving late to the party, and not in a party mood. Feeling ignored by the

Figure 3. States With Highest Concentration of Lives Covered by Provider-Sponsored Health Plans

SOURCE: AIS's Directory of Health Plans, July 2018

status quo, they are exploring how they can work together to deliver health care economically.

Unprecedented Influence

Both stakeholders have a great deal of control over choices made by their populations, as well as incentives. Employers, as noted above, have much to gain by keeping the workforce satisfied with health care options and letting them keep more money from their paycheck.

The promised benefits of scale are not showing up, and IDNs are still plagued by the same economics that drove them together.

The types of IDNs that seek to contract directly with employers typically are well-known and trusted providers in their region, with enough reach vertically and horizontally to make a viable offering.

If an employee is offered a narrow network plan that nevertheless includes their favorite hospital and PCP, they are comfortable. And if it saves them potentially thousands of dollars per year, even better.

Employer-IDN contracts have the ability to garner continued savings, and premium reductions, year-over-year because of their unique characteristics:

- Members declare loyalty to the IDN, which sets them up for treatment compliance.
- PCPs and specialist physicians establish long-term relationships with patients, which leads to reduced costs over time.
- Systems allow access to more member, clinical and other data, more smoothly.

Key Forces Driving Contract Innovation

- Absence of solutions to rising premiums in group health sector
- Employee backlash on high deductibles and cost-sharing burdens
- Increasing proportion of overall spend going to medications
- Specialty drugs = almost half of drug costs[i]
- Decades of hospital consolidation and M&A activity in hospital systems
- Provider-sponsored health insurers make up half of all insurance companies[ii]
- Growth in number of employers offering health insurance, and number of eligible employees[vi]

- Risks may be shared among the wider population of the IDN's own employees.

This level of influence and loyalty must be respected as a powerful force in directing employee/consumer options. In combination, IDNs and employers have the power to offer significantly tighter plan restrictions than prior models, while achieving higher member satisfaction.

Jury Is Still Out on Uptake

Despite some high-profile examples of direct contracts between employers and IDNs, many industry observers are skeptical about whether large employers will embrace this strategy on a widespread basis. But a recent study by Willis Towers Watson indicates that 13% of employers are considering direct contracting for 2019.[v]

One reason for the lack of consensus is that some regions are more ripe for direct contracting than others. AIS Health identifies 18 states in which provider-sponsored plans hold more than the average 10% market share (see Figure 3), with these plans in the number-one or number-two position in some markets, as measured by medical lives. These IDNs frequently control pharmacy benefits tightly via in-house units (see Figure 4).

Looking forward, as IDNs learn how to package their services as a health plan offering, it could be a short slide into offering a risk-based product. Providers have already bitten the bullet on being accountable to traditional payers via ACOs, etc., and narrow-network offerings are the next piece of the puzzle toward full-fledged plans.

A recent study by the Employee Benefit Research Institute indicates that the employer market is expanding, more people are eligible for benefits, and even small employers with 10 or fewer employees are now increasingly offering health benefits.[vi] Market trends could be driving IDNs toward a more prominent position in health insurance.

Challenges and Opportunities for Pharma

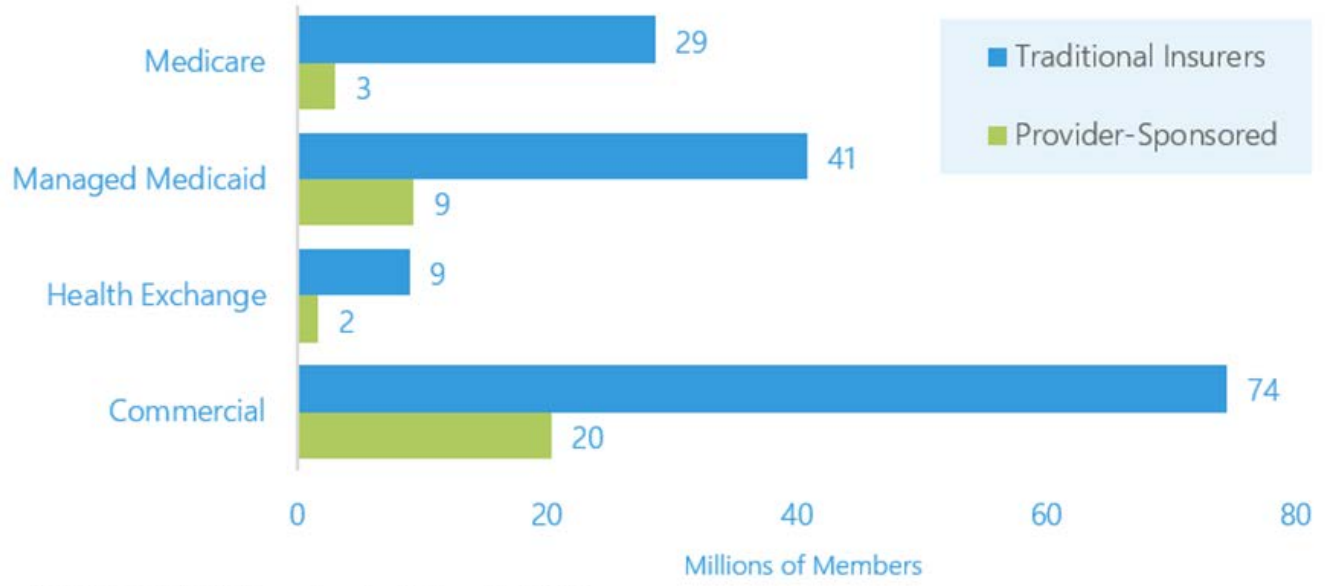
Pharmaceutical manufacturers have been on high alert since the first ACO rolled out, but most ACOs have minimal pharma impact. The latest employer-IDN contracts, however, are intended to control much more than one indication, which makes them a bit more alarming.

Figure 4. IDNs in Leading Market Positions and Pharmacy Benefit Affiliates

State	IDN/Payer	Rx Benefit Vendors
Utah	SelectHealth	In-house SelectHealth Prescriptions; Intermountain Specialty Pharmacy
Oregon	Providence Health Plan	In-house PBM, Providence Specialty Pharmacy Services; Credena Health
California	Kaiser Foundation Health Plan, Inc.	In-house PBM and Kaiser Permanente Specialty Pharmacy; AcariaHealth; Accredo Health Group; Anovo Rx Group Pharmacy; Biologics, Inc.; Coran CVS Specialty Infusion; Diplomat Specialty Pharmacy; Fairview Specialty Pharmacy; MMS Solutions; PANTHERx Specialty, LLC; Walgreens Specialty Pharmacy
New Mexico	Presbyterian Health Plan/Presbyterian Insurance Company	OptumRx; BriovaRx
Minnesota	Medica	CVS/caremark; Accredo Health Group, Inc.
Hawaii	Kaiser Foundation Health Plan of Hawaii	In-house PBM and Kaiser Permanente Specialty Pharmacy; MedImpact Healthcare Systems, Inc.; Accredo Health Group, Inc.; Anovo Rx Group Pharmacy; Coram CVS Specialty Infusion; Diplomat Specialty Pharmacy; Dohmen Life Science Services; Duke Specialty Pharmacy; MMM Solutions; PANTHERx Specialty, LLC; Walgreens Specialty Pharmacy
Michigan	Priority Health	Express Scripts Holding Co.
Colorado	Kaiser Foundation Health Plan of Colorado, Inc.	In-house PBM and Kaiser Permanente Specialty Pharmacy; Accredo Health Group, Inc.; Anovo Rx Group Pharmacy; CVS specialty; Diplomat Specialty Pharmacy; Walgreens Specialty Pharmacy
North Dakota	Sanford Health Plan	Express Scripts; Accredo Health Group, Inc.

SOURCE: AIS's Directory of Health Plans, July 2018

Figure 5. **Formulary Lives by Provider-Sponsored Plans vs. Traditional Insurers**



SOURCE: MMIT Formulary Analytics, July 2018

MMIT Analytics has identified 34 million covered lives at the formulary level that are controlled by a provider-sponsored health plan payer (see Figure 5).

Some of the characteristics that make employer-IDN deals unique may be viewed by pharma as advantages:

- The contracts are regional, so it's easy to identify members potentially affected and reach them at a local level. This is not as easy with traditional ASO lives, which are frequently located in far-flung regions and are hard to identify.
- Provider-based health plans have access to scads of data on the specific populations they serve, and tighter stats on disease incidence than a regular insurance actuary. This makes it easy for them to appreciate market access strategies that play into those needs.
- Prescribers for the population are employees of or are tightly affiliated with the entity making the deals, so they are less likely to push back after formulary and coverage decisions are in place.
- Health systems are likely to factor in the needs of uninsured/under-insured community members into the broader picture, e.g., via patient assistance programs.

Regardless of the rate at which employer direct-contracting takes off, or how much organic growth can ever be achieved by IDNs, self-insured employers and integrated delivery systems are two markets with significant vested interest in member satisfaction and costs.

These two stakeholders are determined to explore solutions together and separately, and they are especially influential regarding all aspects of health care utilization and access.

Citations

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