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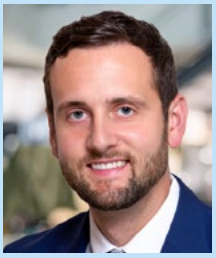
Payer Trends Health Systems Should Watch Closely in 2024

Joyjit Choudhury
Managing Director



John Poziemski
Managing Director

Webster Macomber
Senior Vice President

Health system leaders focused on the day-to-day needs of their organization can sometimes lose sight of key developments in other sectors of healthcare. But in an interconnected healthcare ecosystem, understanding the trendlines their payer counterparts are facing is an essential task.

For starters, while some health system leaders might be under the impression that payers are still riding the highs of early pandemic profits, **the current outlook is not quite as rosy**.

According to data from the National Association of Insurance Commissioners, health insurers' profit margins fell to 3.3% in the second quarter of 2023, well below both the pandemic heights of 5.3% in the second quarter of 2020 and the 4.5% pre-pandemic levels in the second quarter of 2019.

By another measure of profitability, the average medical loss ratio (MLR) in 2022 was 88% in the large group market, 86% in the individual market, and 83% in the small group market in 2022, all up significantly from 2020, according to the Kaiser Family Foundation.

For some regional payers with strong market presences, the historical pricing advantage on the commercial business has eroded as the "BUCAs"—shorthand for Blue Cross Blue Shield (BCBS), UnitedHealth, Cigna, and Aetna/CVS—have grown their market shares in recent years.

According to a recent article in The Economist, the combined revenue of the nine largest healthcare companies—a mix of insurers, IT companies, retailers and others—equated to nearly 45% of national healthcare spending in 2022, up from 25% in 2013.

These national organizations—which include all of the BUCAs except not-for-profit BCBS plans—have expanded into other aspects of the healthcare supply chain by purchasing clinics, pharmacies, and other more lucrative services, *The Economist* notes. As vertically integrated systems lock up covered lives, accessing lives covered in value-based care arrangements is getting harder.

In addition, **payers have a very difficult time growing their commercially insured business** in the current market environment. Payers often describe organic membership growth as a "rock fight" over diminishing available populations, given flat or declining commercially insured populations in most regions.

Over time, the proportion of employer-sponsored commercial enrollees has gradually shifted to self-insured. According to a 2023 analysis from the Kaiser Family Foundation, 65% of enrollees are self-insured—which means the fully insured base for a given payer is typically in decline or flat at best.

As a result, many payers are rethinking what it takes to compete for new accounts and are considering prioritizing inorganic growth strategies. The shrinking commercial insurance market is also a major challenge for providers, who are highly dependent on commercial insurance for profits.

In many markets, **employees are bypassing payers and working directly with providers—also known as Direct-to-Employer (DTE) activity**. When employers make DTE arrangements, they take revenue and membership scale—and one of the few profitable lines of business—away from payers. For providers, developing a sustainable employer strategy predicated on demonstrating added value will be critical to long-term success—and could undermine the historic intermediary positioning of payers.

On the flip side of the coin, payers are becoming more involved in care delivery—threatening the core business of providers. Payer activity in care delivery includes both virtual platforms and brick and mortar services, and is sometimes augmented by patient navigation and services related to improving the patient experience of care.

Payers, providers, and even Medicare beneficiaries are also starting to experience challenges with Medicare Advantage (MA), a segment that has experienced high growth in recent years. According to enrollment data from the Centers for Medicare & Medicaid Services (CMS), total MA enrollment has increased by nearly 9 million since 2019. But looming challenges may threaten continued growth:

- A number of insurers are considering cutting benefits in 2025 if CMS proceeds with planned rate cuts.
- Many providers are raising concerns about issues with MA plans that include high rates of denied claims and limited benefits for beneficiaries.
- Some providers are going out-of-network with MA plans due to these concerns.
- Meanwhile, some industry experts are warning senior citizens about the costs associated with switching back to traditional Medicare after enrolling in MA plans. Their concerns are creating political and regulatory scrutiny and raising the bar for risk adjustment and Star ratings.

These market dynamics are important to keep in mind as payers increasingly try to negotiate collaborative arrangements with health systems. These efforts can include developing and agreeing to contract terms that share financial contributions and rewards equitably or developing value-based care partnerships in MA and other lines of business. Payers need the active cooperation of providers to sustain their MA business, and providers need to keep as much of the commercial employer business as possible to sustain themselves financially.

The challenges that all payers are facing—including intense competition from national plans for both commercially insured members and MA enrollees and an eroding commercial base overall—are also **creating an existential crisis for provider-sponsored health plans (or PSHPs)**.

Many PSHPs are not well-scaled to begin with. Given both intense national competition and employers' shift toward more remote workers that favor or require national networks and services, some PSHPs are struggling to remain relevant. In addition, few PSHPs have the resources or institutional support for replacing aging, outdated technology platforms and enabling infrastructure.

As a result, many PSHPs are pursuing a range of options to remain competitive, from partnerships with payers to "virtual integration" alignments with organizations that can provide access to up-to-date technology platforms.

PSHPs also have the opportunity to think deeply about the inherent advantages of their model—including better informed provider network design and integrated value-based care models—and drive initiatives to make the most of those advantages.

From a provider standpoint, engaging the real purchasers of care—whether they are employers or individuals—is a mission-critical priority, given the continuing financial pressures of the acute care business. Taking time to "walk in the shoes" of payers—who have deep experience with, and access to, those purchasers—is an important step in that journey.

Questions? Contact Joyjit Choudhury (jchoudhury@kaufmanhall.com); John Poziemski (jpoziemski@kaufmanhall.com); and Webster Macomber (wmacomber@kaufmanhall.com).