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Joint venture health plans: Recent trends and key considerations

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Joint venture health plans have recently been growing in popularity. Several payers have announced new joint venture arrangements and are hopeful these partnerships will provide sustainable vehicles for delivering value-based care. In this article, we discuss recent trends, potential benefits, and considerations for providers and payers considering these arrangements.

Background and recent trends

Provider-payer joint ventures have existed for several years, often in the form of "narrow network plans" or "high-performance networks." In a narrow network plan, a health plan places preferred providers into a "tier" with lower member cost sharing. Members who seek care from these providers benefit from the lower cost sharing in exchange for a more restrictive network of providers.

Providers typically participate in joint ventures to help secure patient volume and revenue. Often, providers agree to give the payer a larger discount and/or share in financial risk. This helps the payer meet premium pricing goals and attract membership. Additionally, if the provider is recognized in the target market, the co-branding by the payer and provider can improve the marketability of the product.

In recent years, joint venture health plans have been increasing in prevalence. Emerging structures include provider/payer joint ownership of a new health plan, narrow network products offered to individuals on Patient Protection and Affordable Care Act (ACA) exchanges, and shared provider/payer financial risk for a product. The contractual reimbursement and structure of each joint venture depends on the specific arrangement negotiated between each provider and payer.

Joint venture health plans versus ACOs

The differences between an accountable care organization (ACO) and a joint venture health plan depend on the structure of each partnership. In some cases, there may be virtually no significant differences, such as in the case of an ACO sponsored or operated by a health plan. In many cases, two potential differences involve the organizations' structures and financial arrangements.

ORGANIZATIONAL STRUCTURE

One difference between ACOs and joint venture health plans involves the way the organizations are typically structured. In an ACO, hospitals, physicians, and other providers voluntarily join together to provide coordinated care for a specific population. ACOs are usually not insurance companies and contract with payers for a specified population. The level of support provided by the payer varies significantly—which might require the ACO to develop care management initiatives, financial reporting processes, and other functions traditionally performed by a health plan.

By contrast, in many joint venture arrangements, the health plan retains the traditional insurance functions and the provider focuses more exclusively on population health management. Depending on the arrangement, the provider system may receive more ongoing support and partnership with the health plan under a joint venture agreement. In some of the emerging joint venture arrangements, executives have cited greater collaboration toward the goal of delivering high-quality, value-based care.

FINANCIAL ARRANGEMENTS

Both ACO and joint venture arrangements typically require provider rate concessions, or risk sharing, in return for potential increased volume to the provider system. The reimbursement arrangements for both ACOs and joint ventures can be extremely complex and are highly dependent on the specific circumstances of each arrangement, requiring careful review of all of the contract parameters, interactions, and nuances.

ACO arrangements usually have an element of financial risk, either upside-only, or a two-sided risk arrangement. Most ACO contracts include a financial target (e.g., a trend target or per member cost target). An ACO will share savings (and potentially losses) based on a combination of financial performance (the ACO's actual performance relative to the target) and quality metrics. Many ACO arrangements are layered on top of contracts that a payer has already negotiated with providers in the ACO. For example, an ACO provider often has a fee-for-service contract with the payer, but then may also share savings or losses based on the ACO's overall financial performance.

By contrast, many joint venture agreements amount to rate concessions from the provider system. Such arrangements may be more straightforward to administer than an ACO's financial targets and settlements. Some joint venture arrangements include a risk-sharing settlement (in addition to the negotiated reimbursement level), making the arrangement more similar to an ACO.

Considerations and concerns

In considering a joint venture, providers and payers will both need to evaluate the potential risks and benefits of such a partnership. We highlight key potential benefits and considerations.

CONSIDERATIONS FOR PROVIDERS

- **Volume/discount trade-off.**

  From the provider perspective, the primary benefit may be increased volume and steerage to the network's providers through more limited provider networks, lower premium rates and/or member cost sharing than broad network plans, and incentives for the provider to capture out-of-network leakage.

  Before entering a joint venture agreement, providers should carefully evaluate whether the contract is likely to increase volume significantly enough to offset the rate concession. As with all risk-sharing arrangements, joint venture health plans are not "one-size-fits-all." Payers often seek significant rate concessions from the provider and the joint venture may also involve other financial guarantees and loss sharing.

  Whether the arrangement is a good fit for the provider will depend on the provider's risk tolerance, desire for increased market share, and perceived ability to succeed under the arrangement. If the provider already has the lion's share of the market, it may be nearly impossible to increase volume materially (and the joint venture may essentially result in the provider agreeing to lower reimbursement on services that the provider is already delivering). However, for a provider system seeking to increase patient volumes, a significant rate concession may make sense if the organization's risk tolerance is higher and the perceived benefit of the increased patient volume is greater.

- **Transfer of insurance risk.**

  Depending on the specific financial arrangement, joint ventures may transfer insurance risk from the health plan to the provider. For example, in some joint venture agreements, the provider may be responsible for sharing losses (in addition to the negotiated rate concessions). As with any new contractual arrangement, providers should perform a comprehensive review of the potential contract, clearly understand the risks they are assuming, carefully weigh the costs and benefits, and determine the appropriate amount of contingency funds to prepare for potential losses.

- **Importance of transparent data and reporting.**

  A potential benefit of joint venture agreements is the health plan's continuation of traditional insurance functions. Providers should seek to clarify what data and reports will be provided by the payer and evaluate the payer's administrative and financial processes. It can be difficult for providers to succeed under risk-sharing arrangements if there is a lack of transparency with data and reporting. As is the case in all arrangements that share risk between providers and payers, providers will need access to detailed claims and membership data as well to ongoing summary reports for their populations.

  If financial settlements are involved, it is crucial for the provider and payer to agree on the process and methodology ahead of time. The settlement processes for ACOs and joint venture agreements can be prolonged and require intensive negotiations, especially if the details of the calculation have not been specified in advance.

CONSIDERATIONS FOR PAYERS

- **More favorable reimbursement.** From the payer perspective, joint venture arrangements enable the payer to negotiate more favorable reimbursement arrangements. For payers, a key goal is to offer the co-branded product at a lower rate than broader network plans to increase plan membership.
- **Higher-quality, more cost-effective care.** In establishing joint venture arrangements, one of the goals is to increase care coordination and care management as providers and payers work closely together to manage the health of their populations. Through effective partnership with high-performing providers, providers and payers can work to move their populations along the path toward higher-quality, more cost-effective care.
- **Upfront efforts for new contractual arrangements.** For payers, implementing a joint venture agreement may require significant upfront negotiation and contacting work. As these joint venture arrangements are fairly new, health plans are often building new models and adapting them for each provider system's situation—which requires collaboration between financial, actuarial, and other leadership teams.
- **Significant ongoing financial and analytical support for providers.** In a joint venture agreement, a health plan should be prepared to support the provider system through detailed and summarized data and reports. Health plans should be prepared to provide ongoing financial and analytical support to providers as well as transparency and collaboration with any financial calculations and settlements.

Key questions

Providers and payers considering joint venture arrangements should consider several key questions:

- How much is the provider system's volume likely to increase?
- What is the provider's range of potential outcomes under the rate concession or risk-sharing arrangement? How does this compare with the current contractual reimbursement arrangements?
- What insurance risks are transferred from the payer to the provider, and how will these risks be managed?
- How will the responsibility for care management, ongoing data and financial reporting, and financial settlements be allocated? What additional resources will be needed from the provider and payer to perform these functions?
- What ongoing data and reports will be made available to the provider? What level of detail will be available, and how often will this information be provided?
- What are the key financial, strategic, and business risks for the provider and payer?

Results are still emerging

As joint venture health plans are still relatively new, whether they are good and sustainable vehicles for delivering value-based care is largely still to be determined. In order for joint ventures to be effective, providers and payers will need to work together to manage care more effectively by reducing unnecessary utilization, improving care coordination (through vehicles such as patient-centered medical homes), and improving the quality of care. It will be important to incorporate emerging experience and "lessons learned" from the new joint venture agreements as soon as the initial results from these arrangements are available.

Joint venture health plans fall loosely into the category of risk-sharing arrangements between providers and payers. The profitability of risk-based contracts and joint venture agreements for each party is often heavily dependent on contractual parameters and information sharing. As joint venture agreements are evolving and as many providers and payers are only beginning their journeys in sharing financial risk for their populations, it is very important to engage a skilled actuary or other financial professional to provide comprehensive reviews of the contractual terms and to identify and quantify potential risks.

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