FCA | VENTURE PARTNERS

Investment Area of Interest:

Third Party Administrators in Healthcare

November 2020

A Crash Course in Employee-Sponsored Healthcare

A Third Party Administrator (TPA) is a company that handles an organization's health plan administration tasks. TPAs are a result of the increasing costs associated with the administration of employee health benefit plans. To better understand how and why these administration costs and plans became so expensive, it's imperative to know a brief history of the United States' healthcare benefit history. After World War II, the US economy faced an incoming wave of inflation. To combat this, the US government imposed the 1942 Stabilization Act in which employers were not allowed to raise wages to keep inflation at bay[i].

Instead of raising wages to make their positions more competitive and attractive to potential and current employees, employers began administering employer-sponsored healthcare to incentivize workers. As the '50s rolled in, labor unions began rallying for widespread coverage among employers and these benefit package prices began to rise as demand skyrocketed. It became abundantly clear changes needed to be made to the healthcare system as low-paid employees and retirees could not afford healthcare. In 1965, President Lyndon Johnson created the first official Medicare and Medicaid programs to address these issues.

As expenses for health coverage continued to rise, the early '70s forced employers to retract benefits packages. In response, President Richard Nixon initiated the Health Maintenance Organization Act of 1973 which required all businesses with more than 25 employees to be enrolled in a federally certified Health Maintenance Organization program. With this law's passing, the most common type of plan switched from indemnity plans to HMO and Preferred Provider Organizations (PPO). HMO plans require patients to choose one primary care provider. If the patient wants to see a specialist, that specialist would need to be in-network and to have been referred by the primary care physician. A PPO plan differs from the HMO in that it gives you more flexibility. It allows you to seek out any health care professional without a referral both inside and outside of your network. However, if a patient chooses to visit with a healthcare provider outside of the network, the fees will be higher.

In addition to these new types of plans, it is important to note the rise of High Deductible Health Plans (HDHP) during the '60s to the '90s. They allowed for employers to maintain cheaper health plans while leaving the high out-of-pocket deductibles and copays with the employees [ii]. This saved companies money for a while, but employees complained of remaining high health care costs and employers were still spending an immense amount of money on health insurance. In 1993, President Bill Clinton proposed the Health Security Act, which, among other things, would have required employers to provide health insurance, but the bill's dramatic reshaping of the health care industry was ultimately rejected.

Finally, in 2010 President Barak Obama signed the Affordable Care Act into law which subsidized and mandated healthcare for all US citizens and offered lower prices for coverage based on income levels. As it became mandatory for all citizens to maintain coverage, employers began relying heavily on HDHP's as they cut costs for the employer due to cheaper premiums for each employee. In conjunction with these HDHP's, employers began implementing Health Reimbursement Arrangements (HRA) and Health Savings Accounts (HSA) alongside the employees' typical plans. These HRA's and HSA's are tax-deductible stipends employers give to their employees for medical-related expenses. While the reception was initially favorable, employees soon expressed their dismay with their HDHP's as the out-of-pocket deductible costs, maximums, and rapidly growing premiums were more than many of them could pay [iii]. A brief visual representation of these costs to the employee can be seen in Figure 1. In addition, since 2000, insurance premiums have risen three-fold while wages have remained relatively stagnant. Figure 2 shows this trend.

HDHP/HRA and HSA-Qualified HDHP Features for Covered Workers, 2019

Annual Plan Averages For:	HDHP/HRA		HSA-QUALIFIED HDHP	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
Premium	$7,103	$21,002	$6,211	$18,433
Worker Contribution to Premium	$1,345	$6,729	$990	$4,376
General Annual Deductible	$2,583	$5,335	$2,476	$4,673
Out-Of-Pocket Maximum	$4,822	Not Available	$4,492	Not Available
Firm Contribution to the HRA or HSA	$1,713	$3,255	$572	$1,062

NOTE: Firms were not asked about out-of-pocket maximums for family coverage in 2019. Deductibles for family coverage are for covered workers with an aggregate amount. 25% of covered workers enrolled in an HDHP/HRA and 18% of covered workers in an HSA-qualified HDHP are in a plan with a separate per-person amount. When those firms that do not contribute to the HSA (55% for single coverage and 55% for family coverage) are excluded, the average firm HSA contribution for covered workers is $768 for single coverage and $1,433 for family coverage. One percent percent of covered workers are enrolled in a plan where the firm matches employee HSA contributions. For HDHP/HRAs, we refer to the amount the employer commits to make available to an HRA as a contribution. HRAs are notional accounts, and employers are not required to transfer funds until an employee incurs expenses. Thus, employers may not expend the entire amount they commit to make available. Covered workers enrolled in a plan where the firm matches any employee HSA contribution are not included in the average contribution (One percent for single coverage and one percent for family coverage).

SOURCE: KFF Employer Health Benefits Survey, 2019

Figure 1.

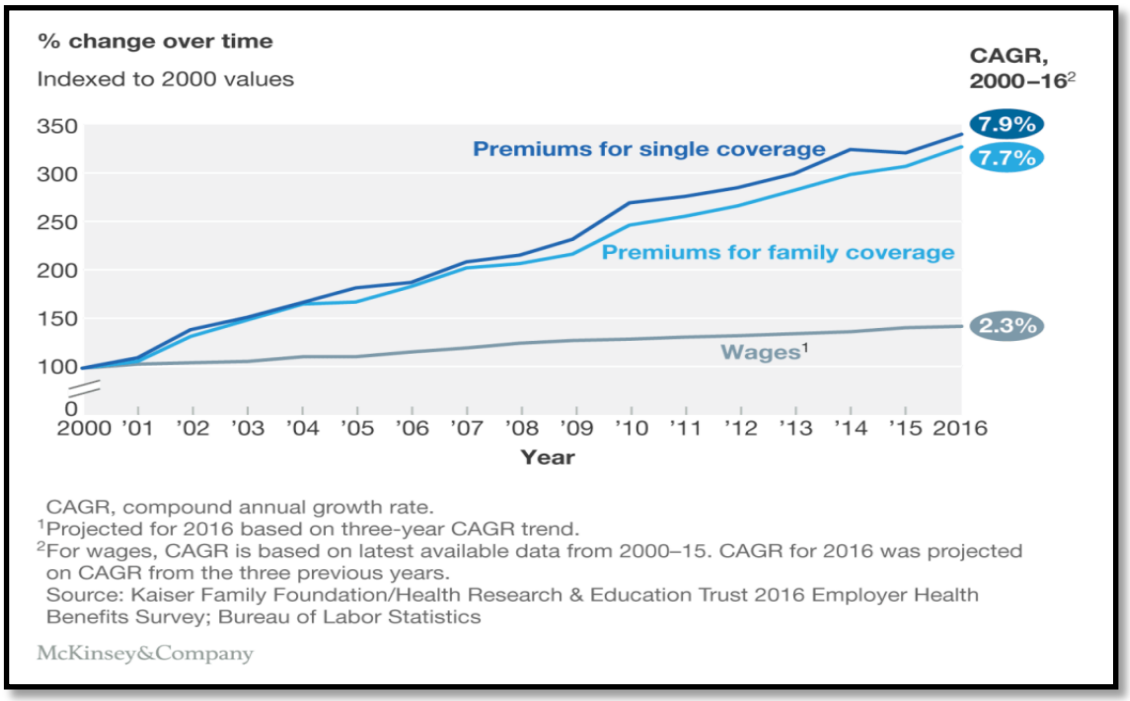

Figure 2.

In 2020, with over 49% of healthcare in the US being employer-sponsored, many companies have heard their employees' frustrations with rising costs and declining benefits. Businesses have seen their profits deteriorate and their employees' dissatisfaction increase. Partially in response, the prevalence of self-funded employer-sponsored healthcare has grown by a third since 2000. With such a large portion of healthcare spend being funded by employers themselves, TPAs have gained the spotlight of healthcare investors around the world due to their necessary role in the claims management process for these plans.

The Origin of TPAs

In the late 1960s and '70s, entrepreneurs began to enter the insurance business and capitalize on its growth potential. They saw an opportunity to take the administrative and claims management tasks off the insurers' hands for a fee. Companies like Sedgwick began as small regional claims administrators for large insurance companies. As business picked up and more large insurance firms began outsourcing their health plan administration, these small regional TPAs expanded internally and geographically. Then, as self-funded plans began to increase in popularity in the '80s, TPAs began handling claims management and administration for employers looking to save money on heightened insurance costs.

What a TPA Does

A traditional TPA acts as an outsourcing company that addresses administrative tasks related to a company's health insurance benefits. TPAs are used by large insurance companies or a business that is self-insured to complete administrative tasks that might otherwise be time-consuming or cost-ineffective. A large insurance company may use a TPA to improve efficiency with issues such as asymmetric information, low specialization, claims management and customer service, and low profitability that stems from the aforementioned issues. To relieve the burden of these maintenance issues, large insurance firms will outsource these administrative tasks to save time and increase profits. However, the most common use of a TPA is the role it plays for self-insured companies.

As discussed above, costs have risen dramatically in the US in recent years – since 2000, healthcare premiums have increased by more than three times[iv]. Because of these rising costs and therefore loss of profits, companies began funding their employees' medical care themselves. This would work by the employer being responsible for paying the medical bills of the employee with an agreed-upon contribution from the employee. In 2000, just 60% of businesses with over 200 employees were self-funded. Today, over 80% of businesses with over 200 employees are self-funded. In addition, nine in 10 employees at businesses with over 5,000 employees are now covered by self-funded insurance[v].

TPAs, for the employer self-funded insurance plan, will, at its basic level, provide the employer with claims adjudication, customer service, eligibility maintenance, and health insurance ID card production. Many TPAs also help employers with plan design as well as appropriate plan recommendations for employees. They may also advise on legal precautions, stop-loss reinsurance, and plan onboarding for employees[vi]. Often, TPAs will partner with an insurance company, and that insurance company would be the middleman between the TPA and the provider. This ASO (administrative services only) relationship allows the TPA to give the employer access to the network of the insurance company, while expenses are still paid by the employer. Essentially, rather than assigning an in-house team to create these insurance plans, administer them, process claims, and critically manage them, companies will hire a TPA to handle the tedious work of their self-funded plans. Figure 3 depicts a typical TPA, however, in most cases, the insurance company sits between the TPA and the provider.

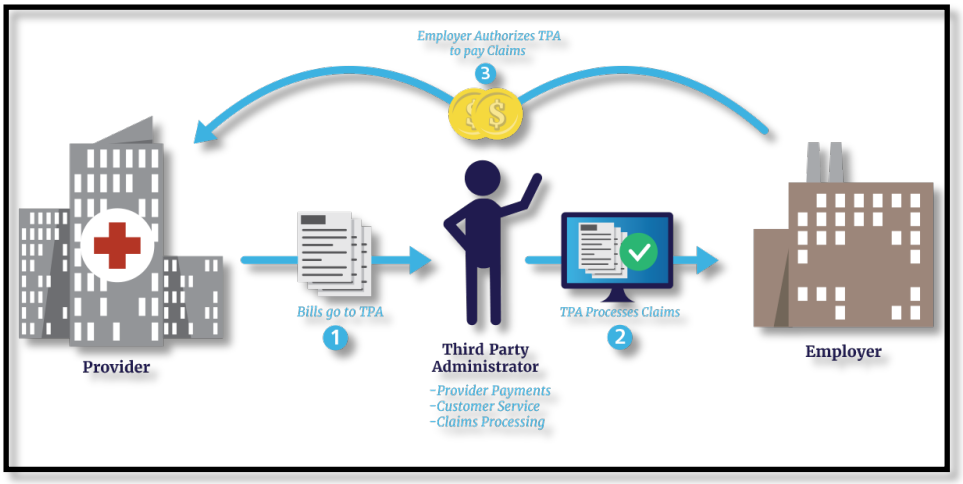

Figure 3

How Big is the Market?

Since TPAs are necessary for the administration and maintenance side of the self-funded health insurance system, they prove to be a cornerstone for this type of employer insurance that is only rising in popularity. With over 80% of businesses over 200 employees being self-funded, the demand for administrative outsourcing services is high. Since 2015, the TPA market size in the US has risen by over 4.8% per year since 2015. The TPA industry is $240.5 billion in revenue per year and is the 35th largest market size in the US[vii]. It is also estimated that over $40 billion is collected in profit for TPA services. Market concentration is quite low, however, with the top 10 TPAs accounting for only 3-5% of the total huge market size[viii]. A look at one of larger players is illustrative of the history of the industry as a whole.

Crawford was founded in Columbus, GA in 1941 by Jim Crawford. The business began as an attempt to research and make milk truck deliveries more efficient. By 1946, he had transitioned the business into a claims adjustment firm and began training his employees with the technical and ethical skills he believed would result in the company's slogan, "Top quality, promptly." In 1950, the company purchased a small claims adjusting firm in Baton Rouge, LA. This was their first of many acquisitions and allowed them to spread their name and brand. In 1957, they expanded to London, and then to Canada in 1967. In 1968, Crawford became a publically traded company (NYSE: CRD.A) with its first public valuation of $3.6 million (over

$418 million in 2020). From then on, Crawford used capital to expand their business dealings to cover rehabilitation, risk management, and catastrophe support, just to name a few. Most importantly, in 2006, Crawford made their most expensive acquisition yet for Broadspire Company. This group had a strong footing in global TPA services and medical management services. This acquisition allows them in 2020 to be the largest publically listed independent provider of claims management and outsourcing solutions globally[ix]. Outlined below are the profiles of the largest three traditional TPAs.

Traditional Legacy TPAs

sedgwick

A TPA that offers claims administration and related cost management services in the areas of healthcare, workers' compensation, short and long-term disability, FMLA and other employee absence programs.

Founded- 1969

An outcomes-focused approach that includes identifying top-performing providers, coordinating the claims process and using clinicians, physicians, pharmacists and other clinical healthcare specialists to help improve the employee's overall health and well-being.

Reduces costs associated with administrative duties involved in the claims management sector while advising employers on a more patient-focused approach to healthcare plans.

Private Company
$6.7 billion valuation in 2018
$3.5 billion in revenue in 2019

27,000 Employees
Memphis, TN
https://www.sedgwick.com/

Provider of administration services based in Blue Ash, Ohio. The company provides TPA services, enabling its clients to process their claims correctly.

Founded- 1983

Allows members flexibility, affordability, high-touch customer service and access to health care professionals when and where employees need them.

UMR emphasizes monitoring health plans and comparing metrics against benchmarks in order to adjust plan to be the most cost saving and productive plan it can be.

Private subsidiary of United Health
$830 million in revenue in 2017

Blue Ash, OH
https://www.umr.com

Crawford helps organizations of every size, every type, and in every geography, meet the needs of their customers while reducing costs and overhead through a variety of third party administration activities.

Founded- 1941

Instead of a one-size-fits-all approach, Crawford's clinical professionals select the best-fit services and craft personalized care solutions based on gathered patient data to support better health outcomes for all of their patients.

With a data-driven approach, Crawford is able to increase the efficacy of the claims process and recommend more effective treatments to keep patients happy and healthy.

Public Company (CRD-A)
$418 million market cap in 2020
$1.05 billion in revenue in 2019

6,687 Employees
Atlanta, GA
https://www.crawco.com/

With the top 10 TPAs holding so little market share, this leaves ample room for TPA innovation and disruption. Recent years have seen TPA-like startups beginning to steal market share and shedding light on many traditional TPA shortcomings and opportunities for improvement and innovation.

Weaknesses of the Traditional TPA

Despite the availability of software that could automate many of the tedious and monotonous business practices that go along with administration services, traditional TPAs rely heavily on manual operations. These procedures usually involve time-consuming email chains, excel spreadsheets, and long phone calls to deliberate the claims process. In addition to these inefficiencies, the claims process is further slowed by the employees' lack of understanding or experience providing quick and accurate documentation[x]. Employees may fill out the wrong paperwork, return the wrong forms, lose necessary documents, or take extended amounts of time to gather their materials.

Companies like Collective Health and TPA Stream argue traditional TPAs have out-of-date and unintuitive user interfaces. Many innovative and disruptive 'TPA 2.0' companies are choosing to focus their attention on user accessibility and efficiency. Rather than calling a support hotline or waiting days to see the progress of a claim, these start-ups are revolutionizing the speed at which claims are received and processed as well as how easy it is for users to check and understand the progress of their claim and other account details. Many of these TPA 2.0s have extremely accessible user interfaces, including mobile apps, in which patients can check on every step of the claims process and have a detailed record of payments and transactions. As the smartphone becomes the hub for more and more of patient activity, TPA 2.0s are paving the way for how easily health plan data/information can be accessed by a patient. Additionally, while observed in a few top traditional TPA companies, many TPA 2.0's are stressing the importance of anonymized and secure data for future treatment recommendations and patient care profiles. The use of anonymized data for treatment research and the construction of personalized health benefit plans is no doubt a pivotal part of the future of healthcare.

Start-ups Challenging the Traditional TPA Model

Many insurance and healthcare-focused companies are buying up innovative or disruptive TPA start-ups just to harvest their technology and apply it to their operations. Since many large, incumbent insurance companies have the capital but lack the technology, it is relatively cheap and efficient for them to purchase the technology and team from startups rather than to build it themselves. Says one analyst: "While many of the early insurtech companies that have reached scale compete directly with incumbent insurers, we expect the next wave of insurtechs to partner with incumbents to digitize and enhance the insurance value chain. We see areas of scalable opportunities to include infrastructure, underwriting and risk pricing, and claims automation." As shown by the small sample of tombstone ads below, the recent demand for this tech is abundant.

Innovation and Disruption in the TPA Industry

As seen above, innovative health benefits companies are being bought up by larger insurance companies that lack the technology to compete with emerging TPA-like start-ups. Traditional Health Insurance and TPA companies rely on slow, costly, manual options for sorting through claims and maintaining customer accounts. Seeking to earn their piece of a large amount of market share available, TPA-like startups have sought to change how the system of employer health benefits functions. Below, three different types of TPA-like startups will be outlined with multiple example company overviews.

TPA 2.0s

The companies outlined in this section are all TPA-like start-ups that take the traditional TPA business model and refocus its priorities. They all focus on improving efficiency through automation and quicker claims management. They also stress the importance of transparent and dependable customer service to ensure satisfaction, complete care, and efficiency. With a straightforward user interface and personalized benefit management, these companies are at the forefront of this evolving industry.

TPA 2.0 Companies

Developer of a cloud-based TPA platform designed to streamline the administration of short and long-term disability, FMLA and other employee absence programs.

Includes private communication with a trained care guide, provides data to find quality medical care at the best price, also books appointments and sets multiple reminders as the date approaches, enabling users to effectively find affordable medical providers to fit their needs.

Establishes new in network circle where physicians agree to lower, upfront, transparent costs so that they are paid promptly and fairly.

Private Company
$4.15 million raised to date in 2020

15 Employees
New York, NY
https://flumehealth.com/

Developer of an innovative, online health insurance platform designed to offer health care plans for self-insured employers.

The company's platform offers wellness coaching and telemedicine facilities which connects healthcare providers with patients to solve various health issues, enabling employers to leverage health insurance plans and services and increase their returns. [NOT SURE WHAT WAS ORIGINALLY MEANT HERE]

Operating in select parts of the United States, Apostrophe's Intelligent Health Benefits cut waste with simplified provider payments and pass the savings onto our customers by connecting them with the best and cheapest providers.

Private Company
$30.58 million valuation in 2020
$16.10 million raised to date in 2020

54 Employees
Denver, CO
https://www.apostrophe.health/

maestro health

Developer of an online employee health and benefits platform designed to simplify and personalize how people shop, enroll and live with their benefits. This enables employers to streamline integration of care management to drive down costs.

The company's online employee health and benefits platform MaestroEDGE is an all-in-one, tech-meets-service platform that offers four key components of employee health and benefits, including HR Management, Benefits Marketplace, Benefit Accounts and Self-Funded Insurance.

By blending administrative services, clinical care management, cost management, we help employers optimize their benefit plans to drive better outcomes at a lower cost.

Subsidiary of AXA
$155 million valuation in 2018
$66 million raised as of 2018

272 Employees
Chicago, IL
https://www.maestrohealth.com/

EMPYREAN

Provider of human resource technology and services intended to deliver compliant health and welfare benefits. This TPA-like business allows clients to reduce cost and provide a higher level of service to their employees.

The company's health benefit platform scales, adapts and integrates to fit the client's unique workforce, industry, and strategy and makes enrollment, administration, compliance and other human resource functions accessible through a unified interface.

A 100% US based business, Empyrean relies on curated data to develop a personal and effective health plan for their clients, while keeping their data safe and secure.

Private Company
Acquired by Securian Financial Group for an undisclosed amount in 2019
$57.25 million raised as of 2019

567 Employees
Houston, TX
https://www.goempyrean.com/

Centivo is a new type of health plan for self-funded employers that is built to save 15 percent or more compared to traditional insurance carriers and is easy to use for employers and employees.

Facilitates partnerships between individuals and the primary care team so that members have a dedicated partner to help them get the care they need and brings cost sustainability to employers.

Centivo develops high-value networks in partnership with leading local healthcare providers and uses data analytics to refine the network and navigate members to the right providers.

Private Company
$68.55 valuation in 2018
$33.55 million raised to date in 2020

63 Employees
New York, NY
Centivo.com

Accolade Inc offers technology-enabled solutions that help people better understand, navigate, and utilize the healthcare system and their workplace benefits. it generates revenue through providing personalized health guidance solutions to members.

Accolade delivers full concierge and population health management through their entire set of personalized advocacy capabilities, including care management, member services, and provider services.

Reduces costs by giving employees 24/7 access to healthcare providers. Providers and experts are staffed to research and recommend the best treatment option possible. This results in less money spent on recurring doctor visits.

Public Company
$1.8 billion valuation in 2020
$653 million raised to date in 2020
$139 million in revenue current YOY

1,250 Employees
Plymouth Meeting, PA
https://www.accolade.com/

Startups Focused on ICHRA Administration

Rather than paying for expensive health premiums, employers can now choose to offer their employees an allowance for medical expenses which can be highly customizable and cost-effective. An Individual Coverage Health Reimbursement Arrangement (ICHRA) is a new form of health coverage. ICHRAs were made legal in January 2020, and were an update to the former small-business-only version of this type of a plan called a QSEHRA (Qualified Small Employer Health Reimbursement Arrangement). ICHRAS avoid high rates of group health plans and allow the employer to be very specific and efficient with money spent on employee health coverage. ICHRAs also allow the employer to choose which employee would participate in which coverage by separating employees into 'classes' such as full-time vs. part-time, hourly vs. seasonal employees, or they could separate them based on age or geography. Employers would then specify the amount given to the employee as an allowance for medical expenses per month, and the employee chooses their coverage options. To maintain and administer these plans, employees would hire a company that specializes in ICHRA administration and they would help the employee manage their allowance and find the best coverage for them. Since these health plans are very new, the industry for ICHRA plan administration is young and exciting resulting in many health tech startups entering the space. Below are just a few startups focused on ICHRAs that are taking market share away from the traditional TPA industry.

ICHRA Administration Companies

TAKE COMMAND HEALTH

Developer of an insurance management platform designed to provide unbiased health plan recommendations and manage employee ICHRAs efficiently and effectively.

The company's platform helps employers in empowering consumers with the right data in order to reimburse their employees tax-free for health insurance and medical expenses, enabling businesses to make better health insurance decisions.

A first to market platform for the new Individual Coverage HRA, a proven QSEHRA administration provider, and the only HRA platform to also offer individual insurance support

Private Company
$5.2 million raised to date in 2020
$2 million of venture funding from LiveOak VP in 2020

37 Employees
Dallas, TX
https://www.takecommandhealth.com/

PeopleKeep
benefits personalized

PeopleKeep provides personalized ICHRA benefits automation software that makes offering benefits simple, painless, and personal for everyone.

The company's software automates compliance and simplifies administrative tasks that ultimately empowers small businesses to reimburse employees for individual health insurance plans.

Enabling employees to buy their own health insurance, leading to annual savings of 20 to 60 percent compared with traditional employer-provided health insurance

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Private Company
$3.7 million valuation in 2018
$6.63 million raised to date in 2020

22 Employees
Salt Lake City, UT
https://www.peoplekeep.com/

Non-Traditional Health Plan Startups

The third type of TPA 2.0 company comprises those who have taken a drastically different approach to the employer's health plan. With the demand for innovative health technology on the rise in the United States, startups around the country are experimenting with out-of-the-box methods to make healthcare more efficient, effective, and cheap. Some start-ups are connecting patients with local healthcare provider startups. Others are focusing their services on preemptive care. And many are creatively rethinking how patients will purchase and pay for healthcare. Below are a few companies aiming to change the perception of what healthcare can and should do for patients. All of these companies have different approaches to efficient and effective healthcare, but many share the same themes of patient-focused care and benefit advisory services.

ichra

A subsidiary of Flyte HCM, Ichra.com is an easy-to-use service that allows for employers to fill out proper ICHRA application paperwork as well as offers ICHRA administration services.

Simply put, ICHRA allows a business to offer its employees a monthly allowance of tax-free money to purchase individual health insurance.

Businesses choose the level of contribution they want to provide (how much or little) without any caps. That money is placed into a tax-free medical expense account for the employee to access when paying for health care-related expenses.

Private Company

7 Employees
Burnsville, MN
Ichra.com

SIMPLEPAY HEALTH

An employee health benefits manager that makes buying healthcare services as straight forward as buying a TV. No surprise copays, premiums, or unexpected costs.

Provider of payroll processing services. The company provides full service human resources outsourcing (HRO) and internet enabled payroll services, to enterprise-wide services including workers' compensation, employee benefits, time and attendance and human resources consulting.

Rather than paying confusing premiums or copays, SimplePay allows you to pay one fixed, agreed upon price, for your health services while the SimplePay Benefits Hub supplies around the clock member services and recommendation.

Private Company
Acquired by Centro HCM in 2020 for undisclosed amount

14 Employees
Cape Town, South Africa

sa•na

Developer of a health insurance platform designed to offer creative, patient-centered health benefits packages for employees which in turn save an employer money.

The company's platform tracks employees' health, offers medical advisory and connects them to virtual medical consultants, anytime, enabling small to medium-sized companies to make quality healthcare affordable, accessible, and understandable for their workers, both on and offsite.

Connects patients with innovative and patient-focused health startups in order to give patients more effective care and save employers money.

Private Company
$28.51 million raised to date in 2020
$80 million valuation in 2020

84 Employees
Dallas, TX
https://sanabenefits.com/

Caravan manages value-based payment programs and ACOs across the country, including the nation's largest. They are recognized as the nation's leader in accountable care and advisory services.

Allows for coordinated care for your community, leveraged CMS claims data to predict and prevent disease progression, increased patient engagement, and established new revenue with preventive care and efficient wellness visits.

The company 's partner hospitals are able to achieve high quality scores, new competencies and strong physician relationships that have traditionally been out of reach, while still reducing overall care costs.

Private Company
The company received an undisclosed amount of development capital from VSS on January 9, 2018. [WHAT IS VSS?]

144 Employees
Kansas City, MO
www.caravanhealth.com

mira

Developer for an advanced health delivery network designed for preventative and urgent care among those uninsured or underinsured.

The company' app offers an advanced health delivery network of uninsured and underinsured people so that they get affordable healthcare regardless of insurance status, enabling clinics to bring affordable prices to its members, who can't afford or don't have health insurance.

Simply, instead of paying high upfront costs and huge deductibles, Mira allows you to pay less now ($25-40 monthly premium) and pay as you go or might need healthcare.

Private Company
$2.7 raised to date in 2020

10 Employees
New York, NY
https://Talktomira.com/

bind

A forward-thinking provider of health insurance services intended to offer personalized health plans as per customer needs.

The company's platform focuses on preventive care, primary care, specialty care, and chronic care-related insurance services. It also provides information regarding insurance coverage, pricing, and treatment options, enabling clients to make optimal decisions regarding coverage plans.

It's health insurance without deductibles, coinsurance and the other barriers that get in the way. People choose their providers from a broad network. The amount they pay for care is clear in advance. Coverage answers are real-time.

Private Company
$187 million raised to date in 2020
$120 million valuation [Is this right? EV is less than cash in?]

279 Employees
Minneapolis, MN
Yourbind.com

river

A new approach to healthcare, this provider of essential healthcare and wellness services intends to help millennials live healthy lives.

The company's services include 24/7 access to doctors, nutrition services, urgent care visits, birth control and women's health services, enabling individuals to book essential health care services from the convenience of their home.

$35 subscription fee with no deductibles, copays, or surprise costs

Private Company
$1.6 raised to date in 2020
$4.6 million valuation in 2020

3 Employees
Dallas, TX
https://helloriver.com/

Conclusion

The trend toward more self-funded insurance is likely to continue as dramatic price increases for traditional insurance coverage drive employers to more cost-effective solutions. To pay and maintain employee health plans, employers have outsourced the administrative tasks to TPAs to save money and process claims efficiently. However, many legacy TPAs are out of date, costly, and inefficient. Seeing an opportunity to innovate, TPA 2.0s, such as Collective Health and Accolade, have gained popularity among investors because of their superior tech, patient-focused care, and simple user interface. In an age of growing reliance on technology, data, and automation, TPA 2.0s have a growing advantage over traditional TPAs. Realizing this, larger insurance companies have begun buying up both large and small TPA 2.0 tech startups to modernize their claims process.

In addition to TPA 2.0s, healthcare startups have begun specializing in ICHRA administration. Rather than paying high premiums for employees out of pocket, employers are now allowed to set aside medical expense allowances for their employees. These sums of money are tax-exempt and can be written off by the employer. The result is a tailored plan that the employee may personalize, and a cheaper, more effective plan given by the employer. As this new type of plan recently became legal as of January 2020, startups have begun specializing in administration and maintenance of ICHRAs and employers have begun opting to use them. This industry will only grow as more employers realize the cost incentives associated with such plans.

Finally, many startups have taken a different approach to health insurance in an attempt to revolutionize it. Non-traditional health plan startups may connect you to local startup health providers, specializing in preemptive care, or change the way how one pays for a doctor's appointment or surgery. Rather than all the unexplained and unexpected costs associated with healthcare, these companies often get rid of premiums and copays and make costs upfront to the patient.

FCA Venture Partners is exploring opportunities to invest in this space. TPA-like startups and disrupters are gaining the attention of investors and are attractive M&A targets for private equity firms and insurance companies. FCA is bullish on the potential for innovative TPA solutions to have a meaningful impact on runaway healthcare costs and be an attractive driver of value in the healthcare ecosystem.

[i] https://www.griffinbenefits.com/blog/history-of-employer-sponsored-healthcare

[ii] https://www.peoplekeep.com/blog/bid/143498/history-of-health-reimbursement-arrangements-hras

[iii] https://www.kff.org/report-section/ehbs-2019-section-8-high-deductible-health-plans-with-savings-option/

[iv] https://www.statista.com/statistics/1040175/third-party-administrator-insurance-claim-adjuster-market-size-usa/

[v] https://www.statista.com/statistics/1040175/third-party-administrator-insurance-claim-adjuster-market-size-usa/

[vi] https://www.hnas.com/content/hnas/self-funding/role-of-tpa.html#:~:text=A%20third%2Dparty%20administrator%2C%20or,service%20for%20the%20benefit%20plan.&text=A%20TPA%20like%20HNAS%20can,services%20to%20enrich%20your%20plan.

[vii] https://www.ibisworld.com/industry-statistics/market-size/third-party-administrators-insurance-claims-adjusters-united-states/#:~:text=The%20market%20size%2C%20measured%20by,is%20%24230.5bn%20in%202020.&text=past%205%20years%3F-,The%20market%20size%20of%20the%20Third%2DParty%20Administrators%20%26%20Insurance%20Claims,average%20between%202015%20and%202020.

[viii] https://www.everestgrp.com/2020-04-everest-group-predicts-significant-slowdown-in-revenue-for-third-party-administrators-as-needs-of-insurance-industry-shift-press-release-.html

[ix] https://www.crawco.com/about/our-story

[x] https://www.tpastream.com/tpa-inefficiency-is-a-problem-heres-how-to-fix-it/

FCA | VENTURE PARTNERS

Founded in 1996, FCA Venture Partners has a long history of investing in successful healthcare entrepreneurs. We are passionate about building sustainable businesses and providing strategic value to our portfolio companies.

FCA invests $1 - 6M in fast growing healthcare companies making processes in the industry faster, better, and cheaper while improving the quality of care and the patient experience.

With its location in Nashville, roots with Clayton Associates and the McWhorter Family, and deep involvement in the growth of the U.S. healthcare community, FCA Venture Partners is poised to take advantage of disruptive opportunities that help move healthcare forward.