Today's Provider-Sponsored Health Plans: What Boards Need to Know

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With the recent rounds of health insurance company merger and acquisition activity, many hospital executives and their boards may be wondering if a provider-owned plan might make sense for them. There certainly will be some who observe that provider-sponsored health plans (PSHPs) are not new. Others may say, "This sounds a lot like what we tried and failed to do with health maintenance organizations (HMOs) in the 1990s." While all of these observations are true, the health care environment has changed dramatically over the past 25 years.

Today there is more interest in value-based care than ever before. The U.S. health care system is increasingly tying reimbursement to quality, an important difference from what was happening in the 1990s. HMOs of the past eventually fell out of favor largely because they limited use of health care services through "gatekeeper" approaches. In contrast, today's provider-sponsored health plans are not focused on imposing across-the-board limitations on service utilization. Instead, the focus is on preventive care and on identifying and encouraging access to the most effective interventions for a given condition, while discouraging access to the least effective interventions. The PSHPs we have worked with usually build their plans around smaller, more limited networks of providers, so they can more closely coordinate care within and across those networks. Understanding how successful provider-owned plans have evolved since the 1990s can help ensure that boards are best prepared to contribute to key strategic decisions about starting a PSHP.

Governance with a Dual Focus: Intertwined Insurance and Clinical Knowledge

Providers who have been successful in accepting greater financial risk for patients and populations have also embraced the need to find and/or develop frontline leaders and advisors with both insurance and clinical experience. Running a PSHP is very different from running a hospital or health system and, while there are some similarities, there are more often greater differences. Unfortunately, many of the provider-run plans that failed in the 1990s failed to make this key distinction, and put leaders and advisors into key roles who were ill prepared to understand the insurance business.

For example, operating a successful health plan requires managers and counselors who have expertise and experience in:

- Actuarial and financial disciplines and how to price plans to meet insurance commissioner reporting requirements and identify capital inadequacies.
- Marketing and sales practices that are often bounded by state and federal regulations surrounding what information can and cannot be used in health plan selection advertising and communications.

While there is no one recipe for PSHP management and governance success, to make these decisions boards must be prepared to examine and be educated about the pros and cons of having separate or shared resources. While it is more common to see a completely separate PSHP senior management team, the decision to share resources, whether financial systems, case managers or human resource professionals, differs widely.

Approaches to governing PSHP boards also differ. In some cases, there is overlap among select members who are also on the hospital's or health system's board. In other cases, the PSHP's chief executive may be the only shared board resource. Regardless of the organization's construct, today's PSHP boards have come to understand how the finances of one organization can and will impact the hospitals that are part of a PSHP's network. Dealing with decreases in inpatient utilization and increases in primary care visits is a typical example. In a hospital-only world, this outcome might be viewed as less than desirable, but in a health plan world this is often a principal objective. Boards that understand how these intertwined results can positively impact their community's overall population health, quality metrics and per-member, per-month reimbursement trends have a much greater ability to work together to drive shared objectives. Most importantly, boards that are contemplating a PSHP need to realize that making this decision requires serious, detailed education for board members. Every PSHP is unique. Boards that opt to either affirm or pass on this strategy and investment can only make an informed decision after they honestly assess their board's knowledge gaps and then actively build education programs to close their deficiencies.

Knowledge is Power: Leveraging Data/Analytics

Perhaps the most important factor that makes the PSHP model more viable today is providers' greater access to data and technology. In the 1990s, health care providers were at a disadvantage relative to insurers. Providers simply did not have access to clinical and financial data about the populations they were taking responsibility for. In fact, many of the PSHPs that failed in the 1990s often did not know when they were in financial trouble and did not have the chance to course-correct.

Today, providers can choose from a variety of technologies and data sets to both build insurance products and assess their performance in meeting clinical guidelines and financial performance metrics associated with those products. Advances in big data technology and predictive modeling have evolved to a point where providers can independently apply proven actuarial analysis

without the help or involvement of traditional insurance companies. When board members have insights into financial risk and the ability to account for it, they can help provider organizations decide if a PSHP makes sense and then ultimately help the involved hospitals better run their PSHPs and/or any other type of risk arrangements the organization might take on.

Because PSHPs are often smaller and, in many cases, more nimble than large national or regional health insurance companies, they can be much better positioned to use data and analytics to design and deliver new and more innovative health plan products and value-based reimbursement models. When boards are invested in these same metrics, their health care organization's ability to deliver community-tailored insurance solutions only increases.

Greater Patient Participation in Health Insurance Decision Making

The Affordable Care Act's (ACA) creation of public exchanges has allowed tens of millions of newly insured individuals to shop for and buy health care insurance. In the private health care marketplace, the costs of employee health care have increased substantially. In 2003, it cost employers $12,400 per year on average to insure one employee and his or her dependents. A decade later, those costs have almost doubled. As a result, some employers have embraced value-based payments and may be open to contracting directly with PSHPs in an effort to further control costs and reduce employees' out-of-pocket expenses. Alternately, other employers are now experimenting with allowing their employees to purchase health care insurance on private exchanges.

Better Price and Quality Transparency

HMOs in the 1990s were criticized for lack of choice. Today, consumers may be willing to embrace PSHPs if the price is competitive and providers offer higher-quality care. When making the decision, our experience shows that today's consumers typically take two routes: they either have an existing relationship with high-quality providers who are already part of a network they can access, or they believe their network has a stronger reputation for delivering exceptional care.

If we use the Medicare Advantage Star Rating System as a proxy for consumer-quality ratings, consumers 65 years and older clearly think PSHPs represent the highest-quality plans available (see Figure 1). As exchanges also help to make more price and quality data available, PSHPs have the opportunity to lead the way. As boards contemplate their hospital's ability to offer or participate in a PSHP arrangement, understanding how these quality metrics are chosen, measured and then communicated to all stakeholders is an essential skill set. Luckily, this same skill set can be transferred to other types of risk arrangements hospital boards may be contemplating—such as shared savings programs or bundled payments.

Centers for Medicare & Medicaid Services (CMS) and Other Recent Regulations Do Not Disadvantage PSHPs

The country's two largest health care payers and regulators, Medicare and Medicaid, are open to provider-run value-based care models generally and PSHPs specifically. For example, Medicare Advantage (MA) specifically puts providers at full-risk for the MA members who enroll in their plans. For providers who have MA contracts, either with CMS directly or in partnership with an insurer, becoming a PSHP is a logical next step. Medicaid also has expanded its managed care footprint across the country, and many states are putting both new populations and services into their Medicaid managed care models. For example, aged, blind and disabled Medicaid recipients are now being added to Medicaid managed care programs; and services like behavioral health are being added to the comprehensive offerings Medicaid managed care programs must provide.

When a hospital's revenues are significantly tied to Medicaid and Medicare reimbursement, boards need to be prepared to evaluate whether their organizations should step into risk by accepting fully-capitated arrangements or forming a PSHP to best serve specific populations.

Embracing PSHPs' Unique Differences

Some of the PSHPs that failed in the 1990s tried too hard to look and operate like large national or regional health insurance companies. They failed to embrace the unique benefits PSHPs bring to their members, affiliated providers and communities. They also failed to put a governing structure in place that helped them communicate their uniquely local value proposition.

Unlike traditional insurers, provider-sponsored health plans seek to become more fully integrated into the communities they serve by providing medical care, high-quality affordable health insurance, employment, education and

Figure 1

Provider-Led Plans are Five-Star Medicare Advantage Winners

Source: Valence Health

Eight out of the 12 Five-Star Medicare Advantage Plans are Provider-Sponsored Health Plans (PSHP)

Five-Star MA Plans with Prescription Drug Coverage

- Kaiser Foundation HP, Inc. — PSHP
- Kaiser Foundation HP, of C0 — PSHP
- CarePlus HP Inc.
- Kaiser Foundation HP of the Mid-Atlantic States, — PSHP
- Group Health Cooperative
- Gundersen HP — PSHP
- Martin's Point Generations
- Healthspan Integrated Care
- Kaiser Foundation HP of the NW — PSHP
- Providence HP — PSHP

Five-Star MA-Only Plans

- Medical Associates HP — PSHP
- Dean HP — PSHP

more. PSHPs also are more committed to improving the health and well-being of their members, who also happen to be their neighbors. Additionally, our experience and some emerging data show that PSHPs offer:

- **More effective population health management:** Provider-sponsored health plan leaders have first-hand knowledge of their community's health care needs and preferences, giving them an advantage in designing plans that deliver more customized local care. As a result, with more tightly integrated clinical and financial performance data and metrics, PSHPs are often better positioned than traditional insurers to improve outcomes and lower costs with respect to specific patient populations.
- **Greater network control:** Patients, who receive care from physicians outside of their plan's network often do so because their choice of doctors (or the primary care physician's referral) is outside the health plan's provider network. PSHPs can play a role in encouraging the provision of in-network services. This would help improve care coordination, promote patient-centered care, and satisfy patient preferences and health needs within the network. With more patients staying inside the PSHP's network, member health systems also can improve market share and remain competitive.

Operating a PSHP is very different from running a hospital, a health system or a large physician group. An educated, knowledgeable board can help its providers examine critical questions about their organization's ability to take on both clinical and insurance risk and make a more well-informed decision to launch or participate in a PSHP. Clearly, there are many new processes, competencies and skills hospitals and health systems need to learn or acquire to effectively operate a PSHP. However, health care organizations and boards that are considering development of a PSHP don't have to go it alone; the more than 120 PSHPs operating today can certainly make the journey easier (see Figure 2).

The following questions can help boards that are interested in learning more about PSHPs:

- What have we learned thus far from our experience with taking on risk that would help us determine whether our organization might be ready to develop a provider-sponsored health plan?
- What skills, competencies and resources would we need to sustain a PSHP? Do we have them in our organization today or would we need to acquire them?
- Would we want to start by offering a more limited PSHP; e.g., for Medicare beneficiaries, Medicaid enrollees or perhaps our own-employees whom the hospital is already at risk for as a self-funded employer?
- What types of build, buy, partner, outsource and joint-venture decisions lie ahead and how can our board help facilitate those decisions?
- Do we have the data-gathering and analytic capabilities to operate a PSHP or other types of risk-arrangements? If not, what would it take for us to get them? What would our board need to lean to interpret this information in meaningful ways to help guide the hospital's ongoing investments and participation?
- How would we measure our PSHP's performance?
- What governance skills and competencies would we need to effectively oversee a PSHP and how do these differ from those needed for our other risk-arrangements?
- How should we structure our governing body to help address what at times may be conflicting points of view when hospitals either take on full-risk or opt to own a PSHP?

Clearly, PSHPs represent the ultimate business model for health care organizations to take on risk for care delivery and payment. PSHPs are not the only value-based care model. They are not for the faint of heart, nor are they for everyone.

Yet, as boards seek to provide sound advice at a time when the world of health insurance is making its most drastic set of changes in decades, they need to be prepared to ask the right questions and facilitate critical research to assure that their hospitals have crafted a strategy that addresses their community's demand for more accountable health care.

Figure 2

Five Important Factors that Distinguish Today's PSHPs From the HMOs of the Past and Make for Greater Potential for Success

Source: Valence Health

1. An increased focus on quality care
2. The availability of more data and technology to make key health plan decisions and operational course corrections
3. Increased levels of direct patient participation in their health plan purchasing decisions
4. Better price and quality transparency
5. Center for Medicare & Medicaid Services' (CMS) ever-growing preference for value-based reimbursement models that PSHPs can deliver