Generally, the U.S. healthcare system has been arranged in such a way that healthcare providers and payors are separate entities, communicating only when necessary. Providers furnish healthcare services to patients, and bill the payor for the services. In recent years, however, healthcare providers are increasingly operating health insurance plans for consumers, acting as both provider and payor.¹ Health systems are defined as “organizations, institutions and resources whose primary intent is to improve health.”² These health systems comprised 13% of nationally offered health insurance plans in 2014. ³ This number is expected to grow, as 19% of new entrants on the health insurance exchanges in 2016 will be provider-sponsored plans. ⁴ Some of the primary factors contributing to this trend are the value-based reimbursement reforms included in the Patient Protection and Affordable Care Act (ACA)⁵ and the Medicare Access and CHIP Reauthorization Act (MACRA),⁶ where reimbursement is becoming more dependent upon cost-effectiveness and quality of services provided rather than simply the amount of services provided.⁷

Health systems may be able to benefit from this era of reform by ensuring cost and quality efficiency due to the ability of controlling premium dollars and patient care through the entire healthcare process.⁸ Through greater network control, provider-sponsored health plans may fully align around increasing care quality and coordination, and decreasing costs,⁹ by giving providers the incentive structure to focus on population health instead of volume of services provided. Additionally, as new market opportunities arise through government initiatives, such as the Medicaid expansion under the ACA, provider-sponsored insurance may be well suited to serve the new patients in these markets.¹⁰

This Health Capital Topics article will discuss the current environment for provider-sponsored health insurance, present some of the advantages and disadvantages associated with provider-sponsored health insurance, and discuss potential future developments on this topic. Provider-sponsored health plans are a recurring trend in the U.S. healthcare industry. Providers previously attempted to venture into the health insurance market in the 1990s; however, the large majority of these plans failed.¹² Common problems faced by early provider-sponsored health plans included: (1) low capitalization; (2) absence of actuarial, underwriting, and marketing expertise; (3) enrolling patients with high risk due to adverse selection; and, (4) difficulty in competing with local large commercial insurers.¹³ The providers continuing to operate health insurance plans, such as University of Pittsburgh Medical Center (UPMC) and Geisinger Health Plan (GHP), have “special circumstances or unique market structures that are not easily replicated.”¹⁴ For example, the UPMC’s health plan had the opportunity to build off of a solid foundation due to receiving over a quarter of its members from UPMC and the University of Pittsburgh.¹⁵ Additionally, GHP encompassed 17 predominantly rural counties in Pennsylvania and divided its members into two types: individual and group subscribers.¹⁶ GHP developed a community rating system based on these two types,¹⁷ allowing it to balance high-risk subscribers against low-risk subscribers.¹⁸ The efficiency of this operating model assisted GHP in sustaining its success over competitors.¹⁹ While this history suggests that providers may face significant obstacles in operating provider-sponsored health plans, the current healthcare climate contains numerous differences from the healthcare climate of the 1990s.²⁰ Today, there is an increased role of incentivizing quality-focused care, such as Medicare’s increased payment of 0.5% for voluntary participation in the Physician Quality Reporting System (PQRS) program from 2012 to 2014; physician providers not participating in the PQRS program will see payments decrease by 1.5% in 2015 and by 2% in the years following 2015.²¹ Generally, there is now a stronger link between care outcomes and reimbursement, providing an advantage for payors to manage care from a closer distance.²² Also, designing clinical care programs has improved due to technological advancements, allowing for a heightened awareness of care quality.²³ Next, consumers today are more willing to accept narrow networks,²⁴ which provider-sponsored health plans tend to utilize.²⁵ Lastly, providers today encounter weaker entry barriers due to

© Health Capital Consultants

(Continued on next page)
the creation of the health exchanges, allowing them to market themselves more easily to consumers.26 Numerous advantages flow from the coupling of a healthcare system and payor system. First, financial and quality advantages arise when controlling premium dollars throughout the entire healthcare process, as providers are able to retain any savings generated from improved efficiency.27 Since reimbursement is shifting from fee-for-service reimbursement toward value-based reimbursement (as discussed above), provider-owned insurers may see gains through increased control of costs incurred through the healthcare delivery process by focusing on efficiency in caring for patients.28 This cost control may work to stagnate national healthcare expenditure, which have risen significantly in recent years and are projected to grow at an average rate of 5.8% per year until 2024.29 Additionally, provider-sponsored plans often see similar or improved profit margins in comparison to other health insurers.30 Average profit margins for provider-sponsored plans rose from 3% in 2010 to 3.2% in 2013, whereas average profit margins for traditional health insurers fell from 4.5% in 2010 to 3.2% in 2013.31 These growing profit margins for provider-sponsored health plans may be attributable to the plans’ growth in premium revenue, which, at 5.5% in 2013, was faster than the insurance industry overall.32 Although there are many benefits to having provider-sponsored health plans, providers should also be cognizant of potential drawbacks. First, positive profit margins may not be realized in the short term.33 Given the heavy regulation and complexity of actuarial predictions in health insurance, provider-owned insurers may not see positive margins until five to seven years after creation.34 Additionally, the expertise required for maintaining compliance with insurance regulations is a heavy burden,35 as even long-standing national insurers have been penalized for failing compliance standards.36 Recently, Highmark Blue Cross Blue Shield of Delaware was fined $383,000, and Aetna Health Inc. and Aetna Life Insurance Co. were collectively fined $100,000, due to violations regarding claims payment and mishandling complaints and inquiries from the Department of Insurance.37 Providers that manage health plans will also have to overcome the tension between the typical payor and provider value creation.38 Payors typically create value by “negotiating reduced reimbursement rates with providers, lowering utilization rates, or both,” while providers typically create value “through pricing and by increasing asset utilization.”39 Other tensions may arise after providers begin sponsoring health plans as well. For example, once Catholic Health Initiatives entered the insurance market, Blue Cross Blue Shield of Nebraska ended its contract with Catholic Health Initiatives.40 Similarly, the CEO of Memorial Hermann Health System, Dan Wolterman, echoed that sentiment, stating that insurers are “not happy” about Memorial Hermann Health System entering the insurance market.41 Another risk is the current economic climate.42 The climate may be misleading as medical cost inflation is currently low,43 making the insurance market seem less risky than it has in the past. Further, interest rates are low, allowing easier funding of capital required.44 However, provider-owned health plans may be under financial threat if medical cost inflation and interest rates rise.45 In light of the contemporary push toward value-based care, provider-sponsored health plans may have a unique advantage compared to traditional insurers, in that a primary aim of provider-sponsored health plans is to become more integrated into the communities they serve through the provision of high quality and affordable health insurance.46 This allows provider-sponsored health plans to more effectively managed population health, as firsthand knowledge of the community’s healthcare needs will be available to the provider.47 Although health systems have previously attempted, and some have failed, to succeed in the insurance market, the current era of healthcare reform may drive greater success for provider-sponsored health plans.

11 “Mississippi Provider-Sponsored Medicaid Health Plan Playbook” Mississippi Hospital Association, December 12, 2014.
continued on next page
Mr. Cimasi holds a Master in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Institution of Chartered Surveyors (FRICS – Royal Institution of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&amp;A – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a national and state transport expert and industry top expert of several books, the latest of which include: “Advisor’s Guide to Healthcare – 2nd Edition” [2015 – AICPA]; “Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services” [2014 – John Wiley & Sons]; “Accountable Care Organizations: Value Metrics and Capital Formation” [2013 - Taylor & Francis, a division of CRC Press]; and, “The U.S. Healthcare Certificate of Need Sourcebook” [2005 – Beard Books].

Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious “Shannon Pratt Award in Business Valuation” conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows. In 2011, he was named a Fellow of the Royal Institution of Chartered Surveyors (RICS).

Todd A. Zigrang, MBA, MHA, ASA, FACHE, is President of Health Capital Consultants (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 20 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 1,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of the “Advisor’s Guide to Healthcare – 2nd Edition” [2015 – AICPA], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: The Accountant’s Business Manual (AICPA); Valuing Professional Practices and Licenses (Aspen Publishers); Valuation Strategies: Business Appraisal Practice; and, NACVA QuickRead. In addition to his contributions as an author, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter, and is current Chair of the ASA Healthcare Special Interest Group (HSIG).

John R. Chwarzinski, MSF, MAE, is Senior Vice President of Health Capital Consultants (HCC). Mr. Chwarzinski’s areas of expertise include advanced statistical analysis, econometric modeling, as well as, economic and financial analysis. Mr. Chwarzinski is the co-author of peer-reviewed and industry articles published in Business Valuation Review and NACVA QuickRead, and he has spoken before the Virginia Strategic Group Management Association (VSGMA) and the Midwest Accountable Care Organization Expo.

Mr. Chwarzinski holds a Master’s Degree in Economics from the University of Missouri – St. Louis, as well as, a Master’s Degree in Finance from the John M. Olin School of Business at Washington University in St. Louis. He is a member of the St. Louis Chapter of the American Society of Appraisers, as well as a candidate for the Accredited Senior Appraiser designation from the American Society of Appraisers.

Jessica L. Bailey-Wheaton, Esq., is Senior Counsel of Health Capital Consultants (HCC), where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. Ms. Bailey is a member of the Missouri Bar and holds a J.D. from Saint Louis University School of Law, where she served as Fall Managing Editor for the Journal of Health Law & Policy.

Kenneth J. Farris, Esq., is a Research Associate at Health Capital Consultants (HCC), where he provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services, and tracks impact of federal and state regulations on healthcare exempt organization transactions. Mr. Farris is a member of the Missouri Bar and holds a J.D. from Saint Louis University School of Law, where he served as the 2014-2015 Footnotes Managing Editor for the Journal of Health Law & Policy.