

The Re-Emergence of Provider-Sponsored Plans

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 defined as a “health plan that is sponsored, led, and governed by local providers; inclusive of all care settings across the continuum of care; and grounded in the tenants of population health management to drive higher value through improved outcomes at a lower cost.”¹¹

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

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.

- 1 “The Growing And Evolving Role Of Provider-Sponsored Health Plans In U.S. Health Care” By Martin Arrick, et al., Standard & Poor’s Rating Service, June 8, 2015, https://www.spratings.com/documents/20184/908554/US_PF_Event_hc1082/d6246d0c-c3e0-4e17-b166-a8afd4b91fe (Accessed 12/22/15), p. 4.
- 2 “Primary Health Care and Public Health: Foundations of Universal Health Systems” By Franklin White, Medical Principles and Practice, Vol. 24, No. 2 (February 2015), p. 104.
- 3 “Provider-led health plans: The next frontier- or the 1990s all over again?” By Gunjan Khanna, PhD, et al., Posted on McKinsey & Company, <http://healthcare.mckinsey.com/sites/default/files/Provider-led%20health%20plans.pdf> (Accessed 12/22/15).
- 4 “2016 Individual Exchange Premiums” McKinsey Center for U.S. Health System Reform, November 4, 2015, http://healthcare.mckinsey.com/sites/default/files/McKinsey_2016-individual-rate-filings.pdf (Accessed 12/22/15), p. 3.
- 5 “Oncology Care Model” Centers for Medicare & Medicaid Services, <http://innovation.cms.gov/initiatives/Oncology-Care/> (Accessed 3/16/2015).
- 6 “Summary: H.R.2 – 114th Congress (2015-2016)” Congress.gov, <https://www.congress.gov/bill/114thcongress/house-bill/2> (Accessed 4/22/2015); “Medicare Access and CHIP Reauthorization Act of 2015” H.R. 2, 114th Congress, § 101 et seq. (January 6, 2015).
- 7 “Provider-Owned Health Plans” By Robert Belfort and Anne O’Hagen Karl, Manatt, Phelps & Phillips, LLP, Posted on Executive Insight, May 1, 2013, <http://healthcare-executive-insight.advanceweb.com/Features/Articles/Provider-owned-Health-Plans.aspx> (Accessed 12/22/15).
- 8 “The Financial Advantages of Provider-Sponsored Health Plans” By George Lynn, Posted on Healthcare Financial Management Association, May 4, 2015, <https://www.hfma.org/Content.aspx?id=30544> (Accessed 1/15/2016).
- 9 “Provider-Sponsored Health Plans: The Ultimate Value-Based Healthcare Plan” Valence Health, <http://www.hfma.org/DownloadAsset.aspx?id=38317> (Accessed 1/7/2016), p. 2-3.
- 10 “Provider-Owned Health Plans” By Robert Belfort and Anne O’Hagen Karl, Manatt, Phelps & Phillips, LLP, Posted on Executive Insight, May 1, 2013, <http://healthcare-executive-insight.advanceweb.com/Features/Articles/Provider-owned-Health-Plans.aspx> (Accessed 12/22/15).
- 11 “Mississippi Provider-Sponsored Medicaid Health Plan Playbook” Mississippi Hospital Association, December 12, 2014,

- <http://www.mhanet.org/Images/MHA%20PlaybookFinal.pdf> (Accessed 1/15/2016), p. 43.
- 12 “75 Provider-Led Plans Are on Exchanges; Can They Stand Toe to Toe with Carriers?” AIS Health, Vol. 5, No. 2 (February 2015).
- 13 “Integrated Delivery Networks: In Search of Benefits and Market Effects” By Jeff Goldsmith, et al., Report for the Academy’s Panel on Addressing Pricing Power in Health Care Markets: National Academy of Social Insurance, February 2015, p. 13-14.
- 14 Khanna, PhD, et al., (Accessed 12/22/15).
- 15 “UPMC Finds Success with Health Plan” By Cinda Becker, Modern Healthcare, Vol. 31, No. 23 (June 4, 2001).
- 16 “Geisinger Health Plan v. C.I.R.” 985 F.2d 1210, 1212-1213 (3rd Cir. 1993).
- 17 *Ibid.*, p. 1213.
- 18 “Community Rating and Sustainable Individual Health Insurance Markets in New Jersey” By Alan C. Monheit, et al., Health Affairs, Vol. 23, No. 4 (July 2004), p. 168.
- 19 “Provider-sponsored health plans rising to meet competition” By Anthony Brino, Healthcare Finance News, May 19, 2015, <http://www.healthcarefinancenews.com/news/provider-sponsored-health-plans-rising-meet-competition> (Accessed 1/20/2016).
- 20 Khanna, PhD, et al., (Accessed 12/22/15).
- 21 “Health Care that Works for Americans” The White House, <https://www.whitehouse.gov/healthreform/healthcare-overview> (Accessed 3/24/2015). “2013 Physician Quality Reporting System (PQRS): 2015 PQRS Payment Adjustment” Centers for Medicare & Medicaid Services, August 2013, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013MLNSE13__AvoidingPQRSPaymentAdjustment_083013.pdf (Accessed 3/30/15), p. 1.
- 22 “CMS: The 2,225 Hospitals That Will Pay Readmissions Penalties Next Year” The Advisory Board Company, August 5, 2013, <http://www.advisory.com/Daily-Briefing/2013/08/05/CMS-2225-hospitals-will-pay-readmissions-penalties-next-year> (Accessed 5/28/2014);
- 23 Khanna, PhD, et al., (Accessed 12/22/15).
- 24 *Ibid.*
- 25 “The Year of the Provider-Sponsored Health Plan” By Kevin Weinstein, Accountable Care News, Vol. 4, No. 11 (November 2013), p. 1.
- 26 “What the Future Holds for Provider-Sponsored Health Plans” The Advisory Board Company, April 14, 2014, <https://www.advisory.com/research/health-plan-advisory-council/members/white-papers/2014/provider-sponsored-health-plans#myth1> (Accessed 1/7/2016).
- 27 “More health systems launch insurance plans despite caveats” By Bob Herman, Modern Healthcare, April 4, 2015, <http://www.modernhealthcare.com/article/20150404/MAGAZINE/304049981> (Accessed 12/22/15).
- 28 Arrick, et al, June 8, 2015, p. 7.
- 29 “NHE Fact Sheet” Centers For Medicare & Medicaid Services, December 3, 2014, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html> (Accessed 1/29/15).
- 30 Bob Herman, April 4, 2015.
- 31 *Ibid.*
- 32 “Provider-Owned Plans Fare Well in Wake of the Patient Protection and Affordable Care Act” A.M. Best, Special Report, March 2, 2015, <http://www3.ambest.com/ambv/bestnews/presscontent.aspx?AltSrc=27&refnum=22273> (Accessed 12/22/15).
- 33 Bob Herman, April 4, 2015.
- 34 *Ibid.*
- 35 “Deciding Whether to Enter Provider-Sponsored Health Plans Requires Careful Up-Front Analysis” By Michael J. Finnerty, Healthcare Financial Management Association, May 29, 2013, <http://www.hfma.org/Content.aspx?id=17327> (Accessed 12/30/2015).
- 36 Khanna, PhD, et al., (Accessed 12/22/15).
- 37 “Health insurances companies agree to pay \$483K in fines” By Associated Press, Posted on The Washington Post, January 12, 2016, https://www.washingtonpost.com/national/health-insurance-companies-agree-to-pay-483k-in-fines/2016/01/12/979d7706-b911-11e5-85cd-5ad59bc19432_story.html (Accessed 1/14/2016).
- 38 Khanna, PhD, et al., (Accessed 12/22/15).
- 39 *Ibid.*
- 40 Bob Herman, April 4, 2015.
- 41 *Ibid.*
- 42 Khanna, PhD, et al., (Accessed 12/22/15).
- 43 “Medical Cost Trend: Behind the Numbers 2016” By PwC’s Health Research Institute, June 2015, p. 10.
- 44 “75 Provider-Led Plans Are on Exchanges; Can They Stand Toe to Toe with Carriers?” AIS Health, Vol. 5, No. 2 (February 2015).
- 45 Gunjan Khanna, PhD, et al., (Accessed 12/22/15).
- 46 Valence Health, (Accessed 1/7/2016), p. 2.
- 47 *Ibid.*



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