Smart approaches to top-level decision making

REPRINT Fall 2013

Strategic Financial Planning

hfma
healthcare financial management association

hfma.org/sfp

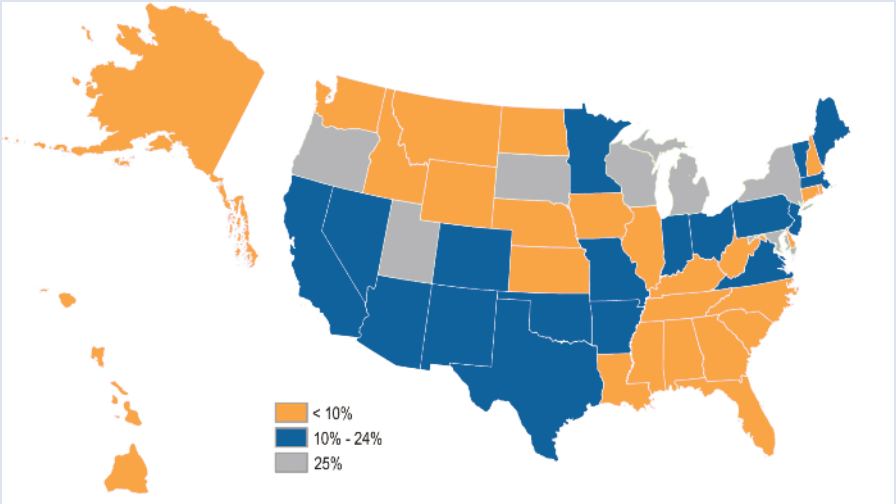
Should You Enter the New Wave of Provider-Sponsored Health Plan Development?

By Chris Myers and Kara Fleming

Careful consideration of local market realities and organizational capabilities is required to determine if a health plan strategy makes sense for a health system.

A provider-sponsored health plan is one that is owned by a hospital and/or physicians, rather than by shareholders or policyholders. After several waves of health plan development and divestiture over the past 40 years, health systems are showing renewed interest in starting health plans. The following observations about the current state and strategic outlook for provider-sponsored health plans can help inform health system leaders who may be exploring the development of a health plan.

Percentage of Community Hospitals with an Equity Position in an HMO by State (2011 data)



Source: Navigant analysis of *AHA Hospital Statistics*, 2013. Used with permission.

The Past and Present

Over the past century, there have been at least four cycles of provider-sponsored health plan development. Most of these developments were in response to government actions, such as the 1973 federal HMO Act and the 2010 Affordable Care Act.

Today, more health systems are developing (rather than divesting) health plans, perhaps signaling a new post-reform wave of provider-sponsored plan development. Recent examples of providers developing or purchasing health plans include the following:

- Sutter Health applied for an HMO license (2012).
- Catholic Health Initiatives bought a majority stake in Soundpath Health (AvMed) (2012).
- Piedmont Healthcare and WellStar Health System announced a partnership

to start a health plan (2012).

- MemorialCare Health System (Los Angeles) purchased certain assets of Universal Care and formed Seaside Health Plan (2012).
- Cooper University Health Care plans to take a 20 percent stake in AmeriHealth New Jersey, which is part of IBC (2013).
- Catholic Health Partners announced an initial agreement to purchase Kaiser's Ohio operations—both health plan and physicians (2013).

In contrast, a smaller number of providers have divested health plans in recent years, including the following:

- Sisters of Mercy sold Mercy Health Plans to Coventry (2010).
- Catholic Health East sold its stake in Keystone Mercy/AmeriHealth to Independence Blue Cross and BCBS of Michigan (2011).
- Dean Health System, including Dean Clinic and the Dean Health Plan in Wisconsin, announced its plan to sell to its longtime partner SSM Health Care (2013).

Historical Waves of Provider-Sponsored Health Plans

	Wave I: Pioneers	Wave II: HMO Act Passed	Wave III: DRGs to Clinton	Wave IV: Medicare + Medicaid Managed Care	Wave V: Post Reform?
Era	1910s-1960s	1970s	1980s-mid 1990s	2000s	2010s
Examples	> Kaiser > Group Health Cooperative of Puget Sound > Health Alliance Plan of Michigan	> Rush-Presbyterian's Anchor HMO > Michael Reese Health Plan > Many others, including the two above, were sold	> Presbyterian (New Mexico) > Spectrum (Priority Health) > Intermountain (SelectHealth) > Many others that have been sold or closed	> Very few new entrants > Expansion of existing plans to Medicaid and/or Medicare	> Catholic Health Initiatives > Sutter Health

Source: Navigant. Used with permission.

Five Largest Provider-Sponsored Health Plans by Total 2012 U.S. Medical Enrollment

Health Plan (Sponsor)	Total U.S. Medical Enrollment	U.S. Market Rank
1. Kaiser Foundation Health Plan	8,851,000	7
2. UPMC Health Plan (University of Pittsburgh Medical Center)	737,000	49
3. Healthfirst (consortium of hospitals in NYC)	693,000	52
4. Health Alliance Plan (Henry Ford Health System)	646,000	57
5. Priority Health (Spectrum Health)	577,000	64

Source: Navigant analysis; Data from *AIS's Directory of Health Plans: 2013*. Total medical enrollment includes fully funded and self-funded enrollment, both commercial and government sectors and is based on 2012 data. Used with permission.

Five Observations

Beyond that activity, a few clear patterns are evident regarding the distribution, ownership, and market position of provider-sponsored health plans.

Approximately one in eight hospitals operates a health plan. As of 2011, 13 percent of U.S. community hospitals (or 640) had an equity position in an HMO—the same percentage as four years earlier. That said, provider ownership of health plans varies significantly by region (see the exhibit on page 1). Northern states tend to have a higher percentage of provider-sponsored health plans than those in the South, perhaps due to the higher proportion of taxable hospitals there.

Most provider-sponsored health plans are operated by tax-exempt health systems. In fact, none of the four largest (by staffed beds) taxable health system chains—HCA, Community Health Systems, Universal Health Service, or TENET—operate a large health plan (although TENET will, once it finalizes its acquisition of Vanguard Health System); neither do most others.

Two notable exceptions are: Ardent Health Services, which operates Lovelace Health Plan in New Mexico, and IASIS Healthcare, which operates Health Choice Arizona. Many taxable systems focus on smaller markets and favor

contracting rather than competing with large national insurers. To date, Wall Street seems to favor separation of the provider and payer industries, perhaps due to the inherent conflicts within.

Most provider-sponsored health plans are operated by community, rather than academic, health systems. Few academic medical centers (AMCs) operate a large commercial health plan, ostensibly due to concerns regarding adverse selection. In fact, University of Pittsburgh Medical Center (UPMC) is the only AMC that operates a health plan with more than 500,000 covered lives. Most AMCs that do sponsor health plans focus primarily on Medicaid. High-cost hospitals with relatively low proportions of primary care physicians and a focus on high-intensity inpatient services seem to be a poor match for a successful managed care organization.

Most provider-sponsored health plans have not expanded beyond the geographic service area of their sponsoring organizations. Rather, most remain primarily local. In fact, only one provider-sponsored health plan is among the 10 largest health insurers in the United States and only six have more than one half million lives (see the bottom exhibit on page 2).

Beyond Kaiser, only three provider-sponsored health plans are number 1 or number 2 within a state, in terms of 2012 total medical enrollment: Health Alliance Plan (number 2 in Michigan), Presbyterian (sponsored by Presbyterian Healthcare Services and number 1 in New Mexico), and SelectHealth (number 1 in Utah).

Some conditions seem to sustain provider-sponsored health plans. Three market conditions appear favorable:

> A larger and integrated provider sector: This makes it easier for one provider system to offer a comprehensive and exclusive provider panel.

> More employees from local and regional rather than national employers: National employers are more likely to contract with national provider-sponsored health plans, given the dispersion of their employee workforce.

> Taxable, rather than tax-exempt, regional health insurers: Taxable insurers may be less likely to engage in costly price wars with provider-sponsored health plans, given quarterly earnings pressure, thus enabling them to thrive.

States with these favorable conditions and successful provider-sponsored health plans include Colorado (Kaiser), New Mexico (Presbyterian), Utah (Intermountain), and Wisconsin (Dean).

Pros and Cons for Provider-Sponsored Health Plans

Option	Pros	Cons	Recent Examples
1. Acquire an HMO license	• Control	• Time • Expense/capital • Risk (new business)	• Sutter Health
2. Buy and rebrand an existing plan	• Control	• Time • Expense/capital • Risk (new business)	• Partners • Vanguard/DMC
3. Partner with another provider	• Speed • Access to experience/skill • Reduces risk	• Control • Complexity	• CHI and AvMed • Piedmont and WellStar
4. Partner with an insurer	• Speed • Impact • Access to experience/skill	• Control • Impact on relationship with other insurers	• Aetna (with Banner, Carilion and others) • AmeriHealth New Jersey and Cooper

Source: Navigant. Used with permission.

Pros and Cons

Looking forward, compelling arguments both for and against provider-sponsored health plans exist, as summarized below. Pros include the following:

> Provides an important distribution channel, as more business becomes individual or retail, as opposed to wholesale

> Enables more control of the premium dollar, further alignment of incentives between hospitals and physicians, and opportunity to benefit from transformation of the delivery system

> Facilitates greater focus on population management and wellness, supported by claims data

> Enables greater opportunity to bend the cost curve, including on own employees

> Extends the organization's brand

> Enables local governance and reinvestment of profits in local community

On the flip side, here are some cons to health systems forming their own health plans:

> Competing incentives, given today's reimbursement model

> Different core competencies for payers and providers

> Increased capital requirements and regulatory oversight

> The limited scale of most newer provider-sponsored health plans

> A history of many failures (although there are a few notable successes)

While many of these arguments are the same as in the 1980s to mid-1990s, today's operating environment is

different in a number of significant ways, most of which seem to favor provider-sponsored health plans:

- Business shifting from wholesale (group) to retail (individual): Evidence of this is the development of the health insurance marketplaces, the growth of managed Medicaid, the growth of Medicare (including Medicare Advantage), and more individual financial responsibility for health care.
- Evolving payment models: Society is focused on lowering healthcare costs, and payment is increasingly tied to value.
- Growth of health systems: Health systems are generally larger and more integrated with physicians than before.
- Growth of health system employee base: Health systems account for a growing percentage of the employee workforce in many markets.

At the same time, however, the government insures a greater percentage of total lives and large national insurers continue to grow and consolidate.

The Future

As health system leaders carefully consider whether a health plan strategy makes sense, they should weigh the pros and cons of four strategic options (see the exhibit on page 3):

- Acquire an HMO license.
- Buy and rebrand an existing plan.
- Partner with another provider.
- Partner with an insurer.

Time will tell if today's provider-sponsored health plans will be sustainable or ephemeral. We anticipate growing interest in health plans by health systems pursuing population management strategies in markets with favorable market conditions, as well as growth and expansion of select mid- to large-sized existing provider-sponsored health plans. However, whether these can develop the capabilities and achieve the scale necessary to compete effectively with well-capitalized national insurers in an evolving marketplace remains to be seen.

Chris Myers is a director, Navigant's Healthcare Provider Strategy practice, Chicago (cmyers@navigant.com).

Kara Fleming is a director, Navigant's Healthcare Payment Transformation practice (kara.fleming@navigant.com).