The Emerging Role of Provider Owned Health Plans in Private Exchanges

By Tony Brice, CEBS, GBA and Eric Parmenter, CLU, ChFC, RHU, REBC, CEBS, SPHR, MBA

The volume-to-value movement in health care delivery, called Value-Based Care (VBC) is transforming the way health care is delivered in the U.S. by aligning incentives for health care providers around quality outcomes and the total cost of care, rather than volume-based fee-for-service (FFS) reimbursement. This trend is also prompting the growth in Integrated Delivery Networks (IDN's), hospital and physician groups organized through integrated technology, finance and common protocols to coordinate care. In addition, IDN's are starting their own insurance companies in order reduce the dependence on large health insurance carrier negotiated rates for revenue and to capture the whole premium dollar, with the potential to drop new margin to the bottom line as VBC begins to yield savings. While these health insurance entities, called Provider-Owned Health Plans (POHPs), have existed in certain markets for many years, they are increasing in number and in integration with Value-Based Care.

The introduction of Private Health Insurance Exchanges (P-HIX) subsequent to the passage of the Affordable Care Act (ACA) is another trend, one that is slowly transforming the way that a growing number of employers deliver healthcare benefits to their employees.

This narrative explores the convergence of these trends that influence the delivery of employer sponsored health care benefits, which in turn contribute to the further the growth of Value-Based Care, Provider-Owned Health Plans and Private Exchanges.

Provider Owned Health Plans

According to a McKinsey study, 107 health systems operate health plans covering 18 million members, which represents eight percent of the insured membership in the U.S.[i] These health systems, who like many others, are experiencing downward pressure on margins in the wake of the ACA and related payment reform, and look to their health plan business to recover lost or expected losses from FFS revenue. Exhibit I below lists the largest 25 POHP's in the U.S. by total enrollment.

Exhibit 1: Top 25 Provider-Owned Health Plans By Membership[ii]

	Provider Owned Health Plan	Total Enrollment - 2014
1	Kaiser Permanente	9,813,694
2	Maricopa Integrated Health System (MIHS) and Indirectly: Dignity Health, Ascension Health, and Tenet	834,314
3	UPMC	700,961
4	Intermountain Healthcare	591,830
5	Tufts University School of Medicine	568,854
6	New York City Health and Hospitals Corporation (HHC)	500,000
7	Henry Ford Health System	424,374
8	CDPHP	406,066
9	Texas Children's Hospital	395,401
10	Boston Medical Center	393,897
11	Group Health Cooperative	357,322
12	Community Health Network of Washington	351,190
13	Partners HealthCare	343,084
14	Sentara Healthcare	337,511
15	Mohawk Valley Medical Associates	328,534
16	Presbyterian Healthcare Services	286,814
17	IU Health (50% ownership)	284,668
18	Geisinger	282,400
19	The Carle Foundation	279,416
20	ProMedica	273,007
21	SSM Health	268,766
22	Harris Health System	262,394
23	University of Louisville Physicians (51%) and others	236,330
24	Inova	232,911
25	Baptist Health (25%), Baptist physician group (25%), and BCBSA (50%)	225,000

The oldest and largest POHP is Kaiser with membership of over 9 million, serves as the model for VBC with over 50 years of success. The Kaiser-Permanente Health Plan was founded by Henry J. Kaiser following World War II and is a completely integrated health system and health plan that is based upon coordinated care, aligned incentives and quality outcomes.

The platform on which many of the POHPs are built follows the Kaiser model through a clinically integrated network (CIN). Clinical integration enables health systems to: (1) increase quality, (2) reduce cost and waste in the current system to maintain margins, (3) sustain independence for physicians not ready for hospital employment and (4) position providers to take on higher levels of accountability to effectively manage utilization and the health of populations in the future.[iii] This is accomplished through a cooperative physician-led delivery model that is dependent upon technology, patient engagement, and risk assumption.

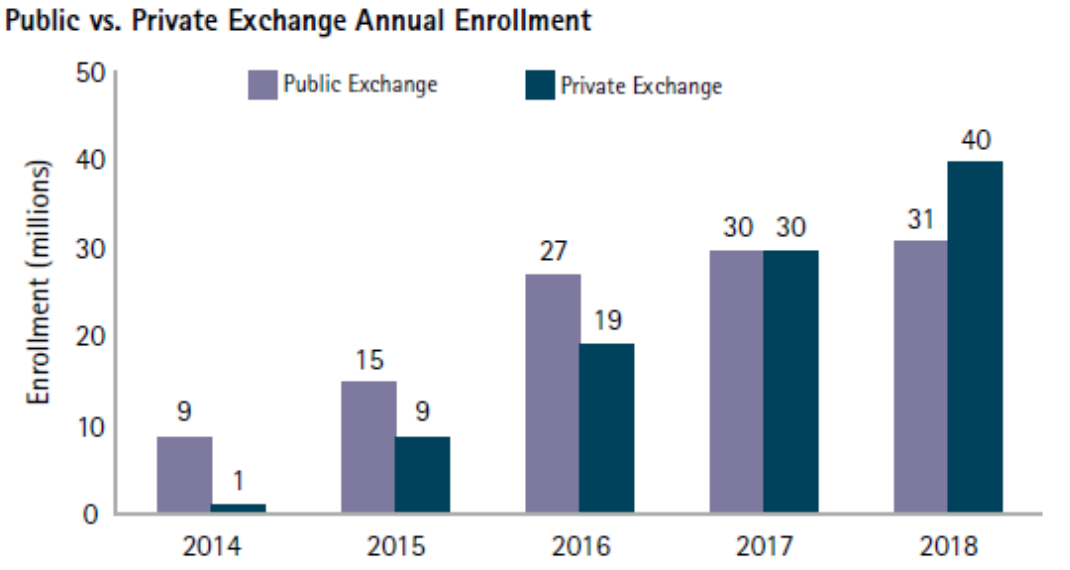
According to Navigant Consulting, 72 provider-sponsored plans participated in the public exchanges in 2014, representing 25% of all insurers on marketplaces in the US.[iv] The placement of POHP's in private exchanges, however, has not kept pace with the public exchanges. This lag may be due in part by the reluctance of large insurance carriers to participate side-by-side with POHP's for concerns of diluted market share and potential adverse selection. In addition, P-HIX's are more likely to emulate the types of plans offered by a typical mid-to-large corporation with more than one location. Hence, their platforms are most likely to

offer one or more of the following carrier/networks: Aetna, BlueCross BlueShield plans (including Anthem), United Healthcare, Cigna, Humana, and Kaiser.

Private Exchanges

Exhibit 2 below suggests that P-HIX's will enroll up to 40 million people by 2018. Employers may be attracted to these exchanges by a compelling opportunity: to convert employer cost to a defined-contribution approach with more control over increased employer funding, to fully outsource health benefit plan communication, enrollment, administration and compliance at a reasonable cost and a reduction in staff cost and expanded choice of health plans, voluntary benefits and spending accounts, which guided decision-support.

Exhibit 2: Public vs. Private Exchange Enrollment Projections



Source: Private Exchange: Accenture analysis, based on data from: U.S. Census, Bureau of Labor and Statistics, Kaiser Employer Health Benefits 2012 Annual Survey. Calculations exclude post-65 retirees and individuals.

Public Exchange: Congressional Budget Office 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage, CBO's February 2013 Baseline, depicts average monthly enrollment, including spouses and dependents for individual and SHOP.

The value proposition that the exchanges bring to employers can be compelling and much has been written promoting both the administrative and cost advantages. The P-HIX can offer turn-key enrollment, plan management, brokerage services, and risk transfer mechanisms that enable employers to take a giant leap for the plan management exit door, without abandoning plan sponsorship. Defined contribution arrangements, the most prevalent contribution approach for P-HIX's, provide a fixed subsidy toward health insurance premiums while the employee makes up any shortfall through payroll contribution.

Although employers adopt the private exchanges for different reasons, the current wave of consolidation among the health insurance carriers, if approved by regulatory bodies, creates more opportunity for POHP's to fill the void of fewer choices on P-HIX's. The lack of VBC on P-HIX's in the early stages is notable and an opportunity exists for P-HIX's to offer innovative

value-based insurance designs, innovative care management techniques, delivered through narrow CIN's with greater risk-sharing on the part of health care provides.

Value-Based Health Care

Value Based Care (VBC) is defined as a: holistic, system-level approach to creating a culture of health for organizations and their employee populations across the health care continuum. VBHC strives to remove barriers and align both financial and nonfinancial incentives (for both patient and provider) to preventive health and health improvement. VBC extends beyond health care benefits to include the design, implementation, and continuous evaluation of high-value approaches for improving employee health, well-being and productivity while reducing the need for high-cost medical services[v].

The manifestation of the VBC principles surface in value-based benefit designs where "the total value and total return (e.g., improved clinical outcomes, improved productivity and lower total health-related costs) are weighed against the cost of a specific design element (e.g., lowering copays for a specific drug class)"[vi]. Mark Fendrick and John Z. Ayanian refer to a concept called "clinical nuance" to describe application of value based principles in health plan design. "To encourage a shift from volume to value, insurance benefits and payment models must be redesigned with the basic tenets of clinical nuance in mind. These tenets recognize that 1) medical services and providers differ in the amount of health produced, and 2) the clinical benefit derived from a specific service depends on the consumer using it, who provides it, and where it is delivered."[vii]

Value-Based Health Inspires Provider Owned Health Plans as a Viable Exchange Solution

The transition from volume-based health care to VBC was ignited by the payment reform efforts included the ACA and subsequent Medicare payment reform. The Medicare Shared Savings Program (MSSP), born from the ACA, provides incentives for Accountable Care Organizations (ACO: health care providers that deliver coordinated, patient-centric care). By aligning provider incentives, across all payers, Medicare or commercial, the goal is to improve both quality and health outcomes, and of course, lower cost.

In order to drive these value-based principles and payment reform in general, the Department of Health and Human Services (HHS) has publically announced a significant transition of Medicare payments for hospitals and physicians to alternative payment models, such as ACO's, bundled payments and other risk-sharing models:

- About 20% of Medicare payments are now tied to performance
- The initiative will seek to have 30% of such payments through alternative payment models by the end of 2016, and 50% by the end of 2018[viii]

Most recently, the Centers for Medicare and Medicaid Services (CMS) announced a Medicare Advantage Value-Based Insurance demonstration project in seven states, which, if successful, will most certainly invigorate the commercial market to follow suit.

Competing on the Exchanges Necessitates Inclusion of POHPs

To compete on the public exchange, it is widely believed that commercial health plans like BlueCross BlueShield plans, United, Cigna and Aetna will continue to offer more narrow-network products and pursue risk-sharing deals with healthcare providers. Health systems are responding to this movement to risk and value by investing in population health business models in order to survive and eventually thrive under risk-sharing arrangements, enabling them capture patient lives from Commercial and Medicare plans, including those through exchanges.[ix]

Healthcare providers can expect the commercial insurance companies to dramatically increase the pressure on hospitals to either conform to their model of health management or to otherwise prove a better model. The recent consolidation trend among the large insurers will exert pressure on providers to entertain new contract payment terms. The hospitals, themselves, will continue to consolidate. In the first quarter of 2015, provider M&A deals were up 5% over the previous quarter.[x]

According to the 2014 Towers Watson National Business Group on Health survey, 18% of employers are already offering high performance or narrow networks. “In Massachusetts’s unsubsidized Commonwealth Choice program, the narrow-network, low-overhead Network Health Plan accounts for nearly 40 percent of total enrollment.”[xi] There is recognition that narrow networks will be the spark to ignite the private exchange value proposition.

For an exchange to attract an employer’s business, it must be able to achieve what the employer could not achieve on its own, like avoiding unpredictable or unacceptable annual increases in cost. Therefore, a private exchange will not tolerate insurance carrier partners that are unable to deliver a competitive price to the member employers.

“One lesson learned from the 2014 open enrollment is that consumers are looking for cheaper premiums, even if that means accepting a narrower provider network and higher deductibles and other cost-sharing.”[xii] Narrow networks are the trademark of POHPs, but the true value of the POHP is produced through a clinically integrated network of hospitals and physicians aligned to improve health outcomes.

In order for Exchanges to survive and thrive they must demand that the managed care networks, the healthcare providers and benefit plan administrators improve health outcomes and reduce healthcare “trend.” Narrow networks will provide a short term relief, but population health must be the long term goal. For example, a clinically integrated provider owned health plan is able to embed care coordinators in its physicians’ practices. These practices working with a robust technology platform are incented to adhere to the clinically integrated protocols in order to manage patient’s health risks. The research of D. Edington has shown us that patients labeled as high risk may have over 60% higher annual health costs than a similarly aged medium risk patient.[xiii]

Bruce Sherman, Medical Director at Buck Consultants noted in the June 15, 2015 edition of *Employee Benefits Advisor* that, among other things, “an exchange offering should be able to provide reporting to demonstrate improvements in the quality of evidence-based care delivery’…and ‘reductions in health care costs should not be a function of reduced utilization of appropriate services”[xiv].

Currently, “provider-owned plans cover less than 10% of the entire privately insured market, but their membership is growing. Total enrollment jumped to 19.1 million people in 2013, a 4% increase from 2012 and a higher growth rate than for other types of plans.”[xv]

Premier Health Plan in Dayton, Ohio launched its individual Medicare Advantage product on 1-1-15. Relying on a nine county narrow-network in Southwest Ohio, it attracted 7,000 enrollees during the initial Open Enrollment period. Chris Schubart, the VP of sales suggested that “the Premier Health brand and the data-driven integrated care model bring a sustainable solution to controlling health costs that this market is missing”.

Conclusion 2020: Changes in Employer Purchasing Behaviors for Employer-sponsored Healthcare Lead to POHPs

High Performing Plans Prefer Value-Based Arrangements

The vision for healthcare in 2020 is becoming clearer in the wake of the recently announced mergers of Anthem/CIGNA and Aetna/Human. In its March 2015 release of *Issue Brief,* the National Business Group on Health[SM] suggested moving from fee-for-service reimbursement to value-based purchasing arrangements as the number one recommendation for health plans to transform health care[xvi]. It further cited its own 2014 survey indicating that employers with “the lowest healthcare spending trends in 2014…were more likely than their peers to cite the availability of non-FFS payment arrangements and Patient Centered medical Homes as key factors in choosing a health plan vendor”[xvii] . A provider-owned health plan is the only mechanism that can deliver all the components of value based care in a model that integrates the payer, the provider and the patient.

Provider Owned Health Plans Will Fuel the Growth of the Private Exchange Industry

Because POHPs assume responsibility not only for the cost of care but the health plans designs, providers and population health mechanisms that are needed to bend trend, the non-integrated payer-dominated private exchange solutions are destined to produce uncompetitive products. Value-based POHPs will be the only health plan solution ready to step in and provide private exchanges a cost-competitive alternative to volume-based PPO plans that rely strictly on lower provider discounts to attract business. Provider discounts will no longer be the metric by which health plans are judged. Private exchanges, with fully insured plans, will rely on pure premium cost as the ideal metric. Self-funded plans participating in private exchanges will rely on the concept of “best-in-market”.

Best-in-Market POHPs Will Attract Large Self-Funded Employers to Private Exchanges

Large self-funded employers have spent the better part of the 21st century consolidating the administration and provider network components of their national health plans. And as the benefits departments that are responsible for managing these plans have shrunk, they have shied away from any solution that might be administratively burdensome. Hence, most national employers rely on a single insurance company/TPA/payer with a national provider network.

The advent of the private exchange, as noted earlier, helps employers streamline the day-to-day management of health plans as it assumes the role of arbitrator, enroller, and call center. The justification for a single TPA/network becomes obsolete. Employers can turn to a private exchange with any multitude of health plan vendors, differing by geographic location, and relying on a "best-in-breed" purchasing strategy. POHPs fulfill this strategy. Large employers with a high concentration of people in one city will have the option of a competitive local provider owned health plan and a national network PPO plan like Blue Cross, while their sister location across the country will have an Aetna PPO option plus a different local POHP option.

Summary

Amidst the chaos of the Affordable Care Act with its community rating provision, small group self-funding, and the evolution of the P-HIX, a new and powerful force in health care delivery is emerging – Provider Owned Health Plans (POHPs). POHPs are the vehicles that bring value-based care models to reality. Building a value-based model on top of a payer-centric PPO network-based chassis is like trying to invent air travel by adding another horse to the wagon. Successfully reducing health care trend can only be accomplished by removing barriers and aligning both financial and nonfinancial incentives (for both patient and provider) towards preventive health and health improvement. "The growth of private exchanges provides ample opportunities to design and implement clinically nuanced Value-Based Insurance Design plans that engage consumers and improve patient-centered outcomes by reducing the likelihood of cost-related non-adherence."[xviii]

---

[i] Gunjan Khanna, PhD, Ebben Smith, MD, Saum Sutaria, MD; *Provider-led health plans: The next frontier—or the 1990s all over again?,* 2015 McKinsey & Company

[ii] Kaiser Family Foundation

[iii] Dennis Butts, MBA, Michael Strilesky, Manager, and Matthew Fadel, MBA, MSM, Senior Associate, Dixon Hughes Goodman, October 19, 2012, "*The 7 Components of a Clinical Integration Network", Becker's Hospital Review,* http://www.beckershospitalreview.com/hospital-physician-relationships/the-7-components-of-a-clinical-integration-network.html

[iv] Catherine Sreckovich, Leigh Pylman, Barbara Huang and Kurt Eicher, "*Provider Sponsored Plans Establish Marketplace Presence"*, *Perspectives,* 2014 Navigant Consulting Inc.

v Patricia A. Bonner, Cindy J. Kabacinski, CEBS, Neil Mrkvicka, Edited by Patricia A. Bonner, Ph.D., GBA; Value Based Health Care Glossary of Terms 2012 by the International Foundation of Employee Benefit Plans, Inc. ISBN 978-0-89154-711-2

vi ibid

[vii] A. Mark Fendrick and John Z. Ayanian, NOVEMBER 15, 2013 *Harvard Business Review*; Smarter Consumer Cost Sharing Using Clinical Nuance

[viii] Health and Human Services Announcement, January 27, 2015

ix Noam Bauman; Manish Chopra, PhD; Jenny Cordina; Jennifer Meyer; and Saumya Sutaria, MD, McKinsey & Co. Winning strategies for participating in narrow-network exchange offerings. May 2013

[x] Modern Health Care's M&A Watch Report; http://www.modernhealthcare.com/section/mergers-and-acquisitions

xi Kingsdale, Jon, How Small-Business Health Exchanges Can Offer Value To Their Future Customers—And Why They Must; doi: 10.1377/hlthaff.2011.1041 Health Affairs, February 2012 vol. 31 no. 2 275-283

xii Demko, Tom, Provider plans price more aggressively on insurance exchanges; Modern Healthcare, August 23, 2014

[xiii] Edington. *AJHP*. 15(5):341-349, 2001

[xiv] Sherman, Bruce; June 15, 2015, Employee Benefit Advisor; online at eba.benefinews.com

[xv] Bob Herman citing A.M. Best, Modern Healthcare; April 4, 2015; *More health systems launch insurance plans despite caveats*

[xvi] National Business Group on Health[SM] ; *Issue Brief;* March 2015

[xvii] IBID

[xviii] University of Michigan V-BID Center; March 2015: *Potential Role for "Clinically Nuanced" V-BID Plans in Private Exchanges;* http://vbidcenter.org/private-exchanges-brief/12778/