

## FEATURE STORY

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## assessing health plan ownership

Healthcare providers have unprecedented opportunities today to own and operate health plans, but they need to understand the full ramifications of such a strategy.

Lately, it seems that not a week goes by without an announcement that a provider organization intends to either acquire or start its own health plan. About one in five hospital networks currently operate health plans, and according to a recent survey of 100 hospital leaders, another 20 percent are exploring doing so.<sup>a</sup>

### AT A GLANCE

- > In the emerging healthcare environment, providers will require many capabilities of traditional health plans simply to remain viable.
- > Providers that are contemplating entering the health plan business should consider the likely strategic, structural, and cultural effects of such a strategy on their organizations.
- > Providers that own health plans will need to determine how they will differentiate themselves in the markets to foster patient loyalty and which insurance lines of business they will pursue (e.g., individual, small group, large group, or other).

The proliferation of provider-owned plans raises a number of questions. Why are providers interested in becoming payers? What factors in the marketplace are encouraging this trend? And what important factors should leaders evaluate in making this decision?

### Same Dilemma—But New Circumstances

This isn't the first time that hospitals and hospital systems have traveled this path. During the 1980s, when insurance companies began to experiment heavily with managed care, some provider organizations saw an opportunity to develop their own, competing plans.

A handful of provider-payer organizations succeeded—such as Geisinger Health System in Pennsylvania, Marshfield Clinic in Wisconsin, and Henry Ford Health System in Detroit—while many others closed. Many

a. Rabin, R.C., "Hospitals Look to Become Insurers, as Well as Providers of Care," *Kaiser Health News*, Aug. 26, 2012.

hospital-based health plans could not weather the financial risks associated with health insurance. Facing a changing environment in the 2000s, these health systems divested their health insurance operations.<sup>b</sup>

The emerging healthcare marketplace presents a very different set of circumstances from the years prior to 2000. Today's marketplace has seen:

- > A transition away from fee-for-service toward payment based on outcomes and efficiency
- > A movement toward a focus on population health management
- > The emergence of new structural models—often involving consolidation and/or affiliations—to achieve greater economies of scale
- > The emergence of new care delivery approaches, such as integrated behavioral and physical health services aimed at improving the health of populations

These circumstances suggest that hospitals and hospital systems have an important impetus for acquiring or starting a health plan: In the emerging marketplace, they require many of the capabilities of traditional health plans simply to remain viable *as a provider*. For example, population health capabilities such as chronic disease management or wellness programs, once the purview of health insurers, are migrating to become core competencies of health systems.

Today's providers also view the opportunity to acquire or start their own health plans as a way to "cut out the middleman." Ezekiel Emanuel and Jeffrey Liebman—both of whom have served as advisers to President Obama on healthcare policy—have boldly predicted that accountable care organizations (ACOs) will make the U.S. health insurance industry extinct by 2020.<sup>c</sup> Others see

an opportunity to remove insurance companies from the payment flow. As Sarah Kliff, who covers healthcare policy for *The Washington Post*, notes: "Insurers have decades of experience in the complex work of setting premiums.... Now a growing number of large hospital systems are betting that, with a little help, they can do that just as well—or even better.... Seeing health insurance companies as the middlemen, these hospitals are only too eager to squeeze them out."<sup>d</sup>

Some also see the establishment of the state-based insurance marketplaces, also called exchanges, under the ACA as a further impetus for providers to own health plans. When consumers began to compare pricing options for airlines flights on the Internet, it led directly to a commoditization of the marketplace on the basis of price. It is reasonable to assume that the state-based insurance marketplaces may have a similar effect on health insurance over time. In many markets, insurers are pressuring providers to cut their rates substantially for "narrow network" products offered on the exchanges, in trade for the potential of higher patient volume in those plans. If health insurance is moving in the direction of commoditization, providers may see an opportunity to offer their own plans in the marketplaces—and perhaps better control their own destiny.

Reduced administrative hassle is cited as a contributing factor. For example, an executive at North Shore Long Island Jewish Health System recently told HealthLeaders Media that his organization has enjoyed a financial advantage from having its own plan, largely from being able to pay its hospitals and physicians relatively easily for their services under the plan.<sup>e</sup>

b. Bob Herman, "Providers Becoming Payors: Should Hospitals Start Their Own Health Plans?" *beckershospitalreview.com*, Jan. 30, 2013.

c. Emanuel, E.J., and Liebman, J.B., "The End of Health Insurance Companies," *The New York Times*, Jan. 30, 2012.

d. Kliff, S., "Is This the End of Health Insurers?" *washingtonpost.com*, July 5, 2013.

e. Letourneau, R., "NY Hospital Joins Payer Fray," *HealthLeaders Media*, Aug. 5, 2013.

Operational diversification is another reason providers might be interested in owning health plans. Trevor Fetter, president and CEO of Tenet Healthcare Corporation, based in Dallas, identified this benefit as another reason his organization was compelled to acquire the health plan operations of Nashville-based Vanguard Health Systems.<sup>f</sup> It is widely believed that by adding a health plan, a hospital can generate more revenue, thereby allowing for reinvestment in the system and the community. Leaders at Geisinger Health System in Danville, Pa., in particular note that having both provider and insurer revenue streams allows for more smoothing of financial performance over time.<sup>g</sup>

Finally, as health systems exhibit more of the basic characteristics of an insurer—including serving a large enough population from an actuarial point of view and communicating options and strategies for patients to manage their own care—the barriers to becoming an insurer are reduced.

### A Spectrum of Opportunities

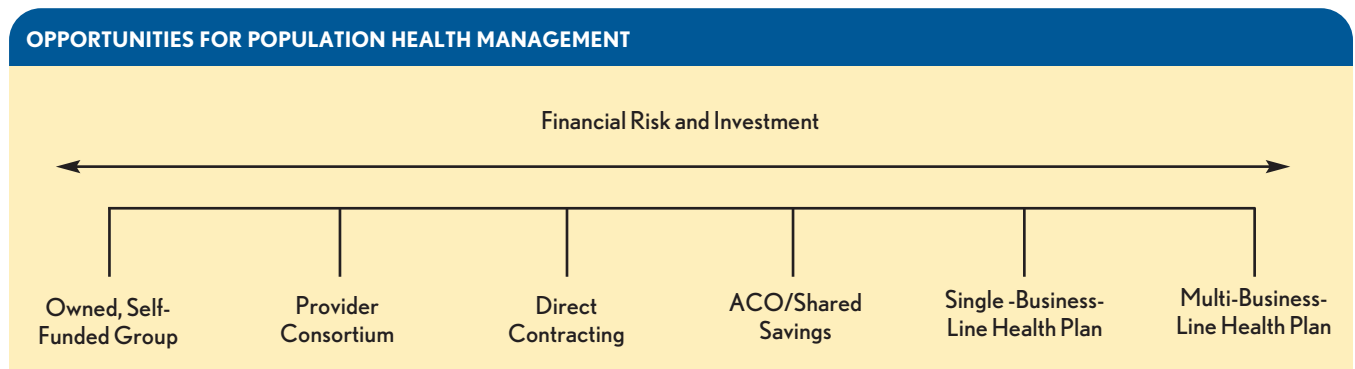
In the emerging environment, providers potentially have a spectrum of opportunities to experiment with population-based health management and financial risk, including numerous arrangements less intensive than

running a health plan. These opportunities could include medically managing one’s own self-funded group of employees and dependents; numerous hospitals are beginning to experiment with population health in this manner. Some organizations designed their health plans first specifically for their own self-insured populations. Examples cited in *The Washington Post* and HealthLeaders Media stories referenced here include Columbia, Md.-based MedStar Health and North Shore Long Island Jewish Health System.

Another option is to participate in a shared savings arrangement as part of a multiprovider network for local self-funded employers, such as the Boulder Valley Care Network in Boulder, Colo., which shares risk with the self-insured Boulder Valley School District. Presbyterian Healthcare Services in Albuquerque, N. Mex., is accepting financial risk for population care by directly contracting with Intel, a large self-funded employer.<sup>h</sup> Participation in an ACO or other shared savings arrangement is another way in which a provider develops actuarial and care coordination expertise. Some providers—such as Billings Clinic in Billings, Mont., and Partners HealthCare in Boston—have acquired single-business line health plans. At the farthest end of the spectrum is the decision to run a multi-business line health plan.

f. Kutscher, B., “Betting on Change,” *Modern Healthcare*, July 1, 2013.  
g. HFMA, *The Value Journey: Organizational Road Maps for Value-Driven Health Care*, October 2012.

h. Evans, M., “Slimming Options,” *Modern Healthcare*, July 15, 2013.



### Implications of Getting into the Health Plan Business

Providers that are contemplating entering the health plan business should first consider how this strategy is likely to affect their organizations strategically, structurally, and culturally.

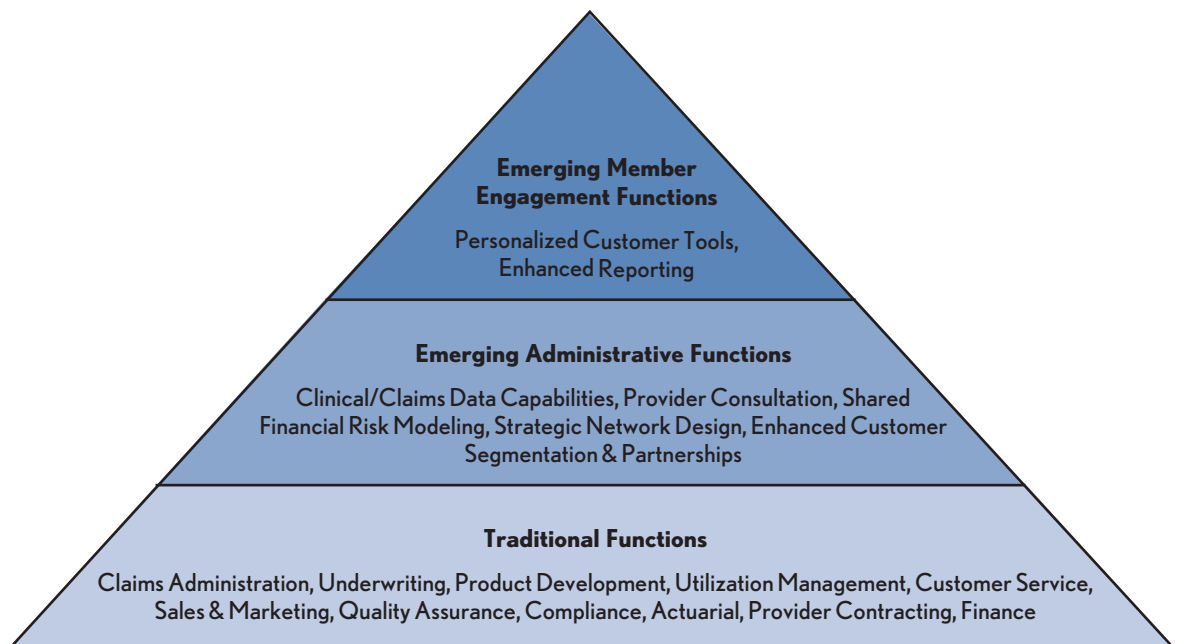
For example, acquiring a health plan can affect organizational structure at the highest level. Organizations must decide whether the health plan should have a separate leader and, if so, to whom that individual should report. Health system leaders also face a challenge in prioritizing investments in administrative systems for health plan operations vis-à-vis clinical systems.

Having a health plan begins to reposition an organization from a provider to a payer. As HFMA's Value Project has found, this shift can create barriers with respect to building provider networks and other forms of collaboration. Community providers begin to ask themselves why they should enable the success of a competing provider organization's plan.

The cultural challenges that may arise as a provider organization evolves into a provider-payer organization can be particularly daunting. For example, cost-containment mechanisms used by the health plan may not be well received by physicians and other caregivers in the organization.

Another important consideration is that providers have a tremendous amount of work to do to be successful in the transitioning payment environment. These efforts include data and systems investment, data analytics, protocol development, care management across settings and locations, change leadership, contract and risk management, and development of other capabilities. In the face of all of these requirements, as well as the disruptive environmental changes they are intended to address, some provider organizations may simply lack the additional bandwidth necessary to successfully add health plan operations. Such organizations may go so far as to perform a feasibility analysis and then reasonably decide against starting a health

### THE HEALTH PLAN OF THE FUTURE



plan, opting to concentrate instead on care delivery.

### Strategic Marketplace Differentiation

The health insurer business, like so many aspects of health care, is itself evolving. The administrative capabilities on which an insurer historically would build a reputation—claims administration and product design—are being augmented by an array of new capabilities such as customized patient engagement tools. As the insurance market begins to shift from a wholesale (e.g., employer-sponsored) to a retail (i.e., individual) environment, health plans should determine how to create a distinctive brand that is different from the past. For example, a competitive price position may become much more important in a more retail purchasing environment. Or a health plan might build a brand around its ability to provide personalized and high-tech service to members through features such as online booking, access to patient record information online, provider-level cost and quality information, up-to-date claims payment tools, etc.

A strategic consideration for provider-owned health plans is to determine how to establish bonds with patients that then translate into loyalty to the health plan. Indeed, regardless of whether they are provider-owned, insurance companies need to pursue new ways to foster member engagement and loyalty. Strategies include developing tools customized to plan members—providing capabilities, for example, to make cost comparisons, book appointments, manage benefits and pay claims online, and evaluate and manage personal wellness. As deliverers of care that interact directly with patients, providers that own health plans also may have an opportunity to foster loyalty among patients to a degree that may elude traditional carriers. Patients may be much more likely to develop bonds with their care providers than they would be with their insurance carrier, and these bonds may translate to member loyalty in a provider-owned health plan.

### Line-of-Business Strategic Considerations

Health plans require sufficient membership to be actuarially stable. Providers considering starting their own health plans will need to learn how to define each business line as insurers and regulators do. For example, providers generally think in terms of Medicare, Medicaid, and commercial payment. From an insurance perspective, “commercial” is further broken down among individual, small-group (50 employees), and large-group (50+ employees) purchasers. These distinctions are important because the potential financial performance, membership, and membership growth of each of these segments is unique.

**Individual purchasers.** Prior to the ACA, insurers typically enjoyed double-digit margins in the individual segment because it was underwritten, and individuals with prior medical conditions could be denied coverage, or their preexisting conditions could be excluded from coverage. This line of business usually represented a small percentage of the commercial book: Nationally, only about 5 percent of Americans are insured on an individual basis.

Numerous ACA provisions are reshaping the individual market. For example, as of January 2014, all coverage is “guaranteed issue.” Guaranteed issue will enable individuals with prior or chronic conditions to find coverage as individual enrollees; this provision also enables individuals to forgo insurance until a medical reason encourages them to purchase it.

Insurers anticipate that guaranteed issue of coverage will increase costs in this business line, but it is unclear by how much. That is partly because another ACA provision, the individual mandate, is expected to increase enrollment of young and healthy individual plan members. Given the weakness of the penalty for forgoing insurance, it is difficult to predict how many will enroll, and when.

Another ACA provision restricts the difference between an insurer's lowest and highest prices for members with the same benefits. Providers intending to offer health plans to the individual market must consider when, with what plans, and at what price position to enter this business line, and they will need to monitor financial performance closely.

**Small-group purchasers.** Typically, small-group business is highly regulated at the state level. It is often a "guaranteed issue business line," meaning that carriers authorized to sell health insurance to small groups must be willing to accept any small group. The administrative costs to health insurance companies are relatively high in this business line, given the high overhead associated with processing these very small accounts. The relatively high administrative costs, coupled with unpredictable medical loss ratios, have contributed to typically double-digit annual rate increases in this line of business.

The ACA exempts employers of fewer than 50 employees from requirements to offer coverage. As with the individual market, the exchanges are expected to facilitate comparisons among plans largely on the basis of price, putting pressure on plans and providers to contain premium rates in this business line. Offering narrow network plans is a strategy that is likely to contain rates in the small-group business line.

**Large-group purchasers.** The large-group segment (e.g., 50+ employees) offers health plans an opportunity to underwrite larger accounts. Large-group business is likely to deliver a higher margin than small group business while contributing significantly more health plan enrollment.

The ACA requirement that employers with 50 or more employees offer affordable health insurance will stimulate some growth in this business line. Larger employers increasingly seek plans with a cross-state or national provider network. Employers expect plans with more limited

provider networks to be offered at a substantially lower premium. Self-funding among large employers is becoming more prevalent. Provider-owned health plan leaders need to understand the composition and purchasing preferences of larger employers in their organizations' service areas.

### Other Considerations

Of course, organizations contemplating acquiring or starting a health plan should also consider numerous other external and internal variables and develop models that take these variables into account.

As health systems begin to model both the insurer and the provider sides of the equation, a key issue they must address is determining how to handle reduced opportunities for cost shifting between business lines.

Other market-specific considerations are addressed in the following questions:

- > What is the state insurance division's authority to review and set rates?
- > How does the state determine mandated benefits?
- > What is the status of the health insurance marketplace in the state?
- > How fragmented or consolidated is the state's health insurance market?
- > What rate position is required per business line? How sustainable is it?
- > How will the proposed health plan distinguish itself from its competitors on the basis of network breadth and quality, service, and member engagement?

Provider leaders also should explore four key questions with respect to additional internal variables:

- > What capital and ongoing financial commitments are required?
- > What is the internal readiness of the organization to start and maintain a health plan?
- > How will the organization build a provider

network of appeal to the market, at the right price point?

> Are leaders and staff prepared to take on the role of payer?

### A Balanced—and Informed—Strategy

Many aspects of the emerging marketplace, such as changing payment methodologies, are spurring providers' interest in becoming payers. To remain financially viable as providers, hospitals will need to develop capabilities that were once the purview of health plans, such as disease management programs, care coordination, and actuarial expertise.

These capabilities represent a necessary, but not sufficient, platform for running a health plan. To succeed with this strategy, providers interested in becoming insurers also must objectively and thoroughly assess purchaser preferences by segment, the greater marketplace context, and the internal readiness of their organizations. These internal and external assessments will help identify what is required to offer a viable health plan in a dynamic and transitioning marketplace. ●

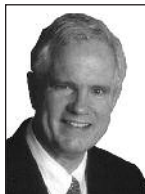
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