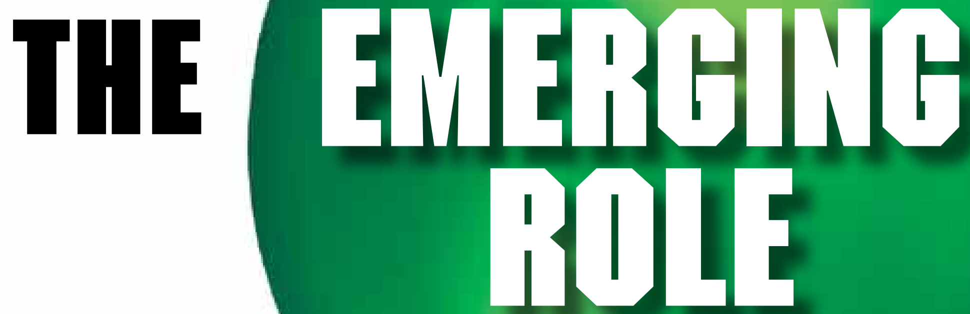

THE EMERGING ROLE OF PROVIDER-OWNED HEALTH PLANS IN PRIVATE EXCHANGES

Health plans owned by medical care providers are showing up more often on private health exchanges and may help these exchanges remain viable in the future.

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by | **R. Anthony Brice, CEBS,** and **Eric M. Parmenter, CEBS**

A move toward value-based care (VBC) encouraged by health care reform, growth in the use of private health insurance exchanges and the rise of provider-owned health plans (POHPs) are among trends transforming health care delivery in the United States.

VBC aligns incentives for health care providers around quality outcomes and the total cost of care, rather than volume-based, fee-for-service reimbursement. VBC is prompting the growth in *integrated delivery networks*—hospital and physician groups

TABLE

Top 25 Provider-Owned Health Plans by Membership

Provider-Owned Health Plan	Total Enrollment in 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 Cane 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

Source: Kaiser Family Foundation.

organized through integrated technology, finance and common protocols to coordinate care.

In turn, many of these integrated delivery networks are starting their own insurance companies, or POHPs. The goal of POHPs is to eliminate providers' dependence on large health insurance carrier-negotiated rates as their primary revenue source. While POHPs have existed for many years in certain markets, they are increasing in number and represent a viable option on both public and private exchange platforms.

This article explores how POHPs may help assure the long-term competitiveness and sustainability of the private exchange market for both small and large employers.

Provider-Owned Health Plans

According to a McKinsey study, 107 health systems operate health plans covering 18 million members, which represents 8% of the insured membership in the United States.[1] These health systems, which like many others are making less money in the wake of the Affordable Care Act (ACA) and related payment reform, look to their health plan business to recover revenues lost or expected to be lost by moving away from a fee-for-service payment model. The table lists the largest 25 POHPs by total enrollment.

The oldest and largest POHP, Kaiser Permanente Health Plan, has more than nine million members and serves as the model for VBC with over 50 years of success. Henry J. Kaiser founded the health plan following World War II with a goal of delivering coordinated care and quality outcomes through an integrated health system and health plan.

Many POHPs are built on the Kaiser model, which uses a clinically integrated network. A clinically integrated network enables health systems to:

- Increase quality
- Reduce cost and waste in the current system to maintain net profits
- Sustain independence for physicians not ready for hospital employment
- Position providers to take on higher levels of accountability to effectively manage utilization and the health of populations in the future.[2]

Clinically integrated networks achieve these results through a cooperative network of physicians reliant on technology, patient engagement and risk assumption to control utilization, cost and quality.

Private Exchanges

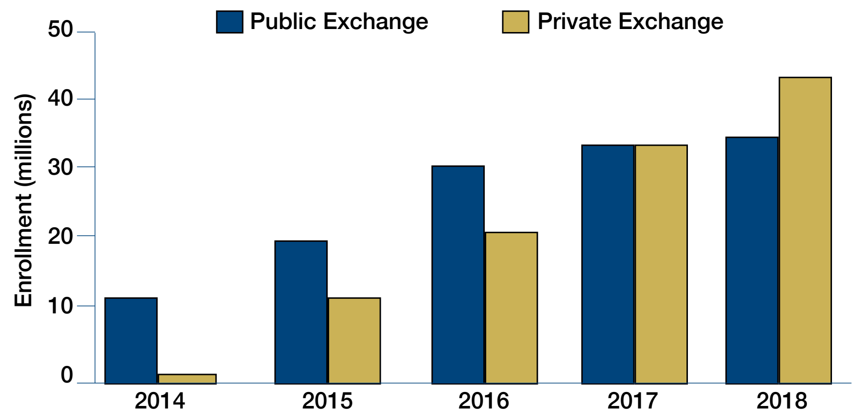
According to Navigant Consulting, 72 provider-sponsored plans participated in the public health insurance exchanges in 2014, representing

25% of all insurers on state and federal marketplaces.[3] However, POHPs so far represent a smaller percentage of plans available on private exchanges. It may be that large insurance carriers are reluctant to participate side by side with POHPs for fear of losing their market share or jeopardizing their loss ratios as lives migrate to the POHPs. In addition, private exchanges are more likely to offer the types of plans that a typical midsized to large corporation with more than one location provides to its employees. Private exchange platforms are most likely to include one or more of the following carrier/networks: Aetna, Blue Cross Blue Shield plans (including Anthem), UnitedHealthcare, Cigna, Humana and Kaiser.

The figure suggests that private exchanges will enroll up to 40 million people by 2018.

FIGURE

Public vs. Private Exchange Enrollment Projections



Source: Private exchange figures are from an Accenture analysis based on data from the U.S. Census, U.S. Bureau of Labor Statistics and Kaiser *Employer Health Benefits 2012 Annual Survey*. Calculations exclude post-65 retirees and individuals. Public exchange figures are from a Congressional Budget Office 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage, February 2013 *Baseline,* depicting average monthly enrollment, including spouses and dependents for individual and Small Business Health Options Programs.

Much has been written promoting both the administrative and cost advantages of private health insurance exchanges. For example, the private exchange can offer turnkey enrollment, plan management, expanded health plan choices and brokerage services that enable employers to take a giant leap for the plan management exit door without actually abandoning plan sponsorship. Defined contribution arrangements, the most prevalent funding approach for private exchanges, provide a fixed employer subsidy toward health insurance premiums while the employee makes up any shortfall through payroll contribution.

Although employers use private exchanges for different reasons, the current wave of consolidation among health insurance carriers, if approved by regulatory bodies, creates more opportunity for POHPs to fill the void left by fewer choices on private exchanges.

Value-Based Care (VBC)

VBC is noticeably lacking on private exchanges in these early stages, and an opportunity exists for private exchanges to offer innovative, value-based insurance designs (VBID). These designs work best when coupled with innovative care-management techniques and delivered through narrow, clinically integrated networks that feature greater provider risk sharing.

VBC is defined as a

> [h]olistic, system-level approach to creating a culture of health for organizations and their employee populations across the health care continuum. VBC 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.[4]

VBC principles surface in VBID 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)."[5] Mark Fendrick and

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John Z. Ayanian refer to a concept called *clinical nuance* to describe how value-based principles influence 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."[6]

Most recently, the Centers for Medicare and Medicaid Services announced a Medicare Advantage VBID demonstration project in seven states, which, if successful, will most certainly invigorate the commercial market to follow suit, ultimately producing a commercially viable VBID exchange product, tested and delivered successfully by POHPs.[7]

Competing on the Exchanges Necessitates Inclusion of POHPs

To be competitive on premium cost on public exchanges, commercial health plans like Blue Cross Blue Shield plans, UnitedHealthcare, Cigna and Aetna likely will continue to offer more narrow-network products and pursue risk-sharing deals with health care providers.

Health systems are responding to this movement to risk and value by investing in VBC delivery models in order to survive and eventually thrive under risk-sharing arrangements. These models will enable them to capture patient lives from commercial and Medicare plans, including those offered through exchanges.[8]

Health care providers can expect commercial insurance companies to dramatically increase the pressure on hospitals to either conform to their model of health management or provide a better model. The recent consolidation trend among the large insurers will exert pressure on providers to consider new contract payment terms. The hospitals themselves will continue to consolidate. In the first quarter of 2015, provider merger-and-acquisition deals were up 5% over the previous quarter.[9]

According to a 2014 Towers Watson/National Business Group on Health survey, 18% of employers already are 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% of total enrollment.[10]

For an exchange to attract an employer's business, it must be able to achieve what the employer could not achieve on its own, such as avoiding unpredictable or unacceptable annual increases in cost. So a private exchange will not tolerate insurance carriers that are unable to deliver a competitive price to member employers. The availability of narrow-network plans may be what makes private exchanges financially viable.

"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."[11] 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.

For exchanges to survive and thrive, they must demand that managed care networks, health care providers and benefit plan administrators improve health outcomes and reduce health care "trend." Narrow networks will provide short-term relief, but population health must be the long-term goal. For example, a clinically integrated POHP is able to embed care coordinators in its physician practices. These physician practices, working with a robust technology platform, are offered cash incentives by the health plan to adhere to the clinically integrated protocols aimed at managing patient health risks. (Research by Dee Edington has shown that patients labeled as *high risk* may have over 60% higher annual health costs than similarly aged medium-risk patients.[12])

Bruce Sherman, medical director at Buck Consultants, noted in the June 15, 2015 edition of *Employee Benefits Adviser* 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."[13]

While provider-owned plans covered less than 10% of the entire privately insured market, a *Modern Healthcare* article in April 2015 reported, their membership was 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.[14]

Premier Health Plan in Dayton, Ohio launched its individual Medicare Advantage product on January 1, 2015. Relying on a nine-county narrow network in Southwest Ohio, it attracted 7,000 enrollees during the initial open enrollment period. Chris Schubart, the vice president 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."

Prediction for 2020: Changes in Employer Purchasing Behaviors for Employer-Sponsored Health Care Lead to POHPs

High-Performing Plans Prefer Value-Based Arrangements

The vision for health care in 2020 is becoming clearer in the wake of the recently announced mergers of Anthem/Cigna and Aetna/Humana. In its March 2015 release of *Issue Brief*, the National Business Group on Health℠ suggested moving from fee-for-service reimbursement to value-based purchasing arrangements as the No. 1 recommendation for health plans to transform health care.[15] It further cited its own 2014 survey indicating that employers with "the lowest health care spending trends in 2014 . . . were more likely than their peers to cite the availability of non-FFS [fee-for-service] payment arrangements and patient centered medical homes as key factors in choosing a health plan vendor."[16] A POHP is the only mechanism that can deliver all the components of VBC in a model that integrates the payer, the provider and the patient.

POHPs Will Fuel the Growth of the Private Exchange Industry

Because POHPs deliver all the components of VBC in an integrated payer/provider/patient model, they bring a competitive advantage to private exchanges. POHPs are more likely to bend the health care trend curve than traditional nonintegrated, payer-dominated, private exchange products. Value-based POHPs will be the only health plan solution ready to step in and provide private exchanges with a cost-competitive alternative to volume-based preferred provider organization (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. For fully insured plans, private exchanges 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/third-party administrator (TPA)/payer with a national provider network.

As noted, the advent of the private exchange helps employers streamline the day-to-day management of health plans as the exchange assumes the roles of arbi-

takeaways

- Although POHPs represent 25% of all insurers on public exchanges, they make up a smaller percentage of plans available on private exchanges.
- Consolidation among health insurance carriers creates more opportunity for POHPs to fill the void left by fewer choices on private exchanges.
- Plans that feature innovative care management delivered through narrow, clinically integrated networks—the kinds offered by POHPs—could make private exchanges more competitive.
- Narrow networks will provide short-term relief from costs, but improved population health—which VBC encourages—ultimately is what will result in lower costs.

bios

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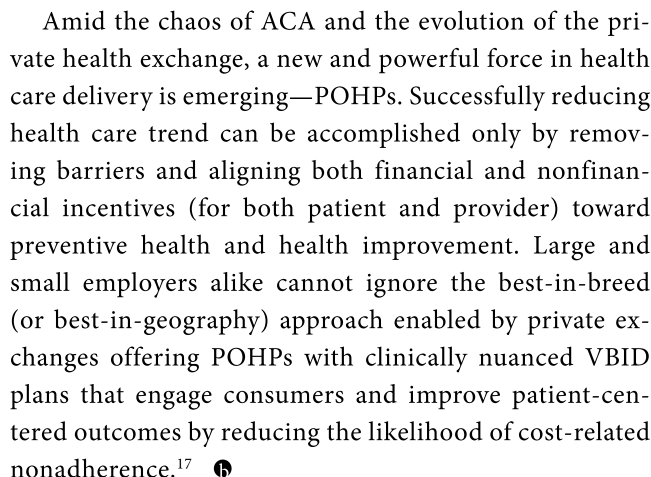
trator, enroller and call center. The justification for a single TPA/network becomes obsolete. Employers can turn to a private exchange with any multitude of health plan vendors, differing by geographic location and relying on a "best-in-breed" purchasing strategy. POHPs fulfill this strategy. Large employers with a high concentration of people in one city will have the option of a competitive local POHP 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



Amid the chaos of ACA and the evolution of the private health exchange, a new and powerful force in health care delivery is emerging—POHPs. Successfully reducing health care trend can be accomplished only by removing barriers and aligning both financial and nonfinancial incentives (for both patient and provider) toward preventive health and health improvement. Large and small employers alike cannot ignore the best-in-breed (or best-in-geography) approach enabled by private exchanges offering POHPs with clinically nuanced VBID plans that engage consumers and improve patient-centered outcomes by reducing the likelihood of cost-related nonadherence.[17]

Endnotes

1. Gunjan Khanna, Ph.D,. Ebben Smith, M.D., Saum Sutaria, M.D., *Provider-led health plans: The next frontier—or the 1990s all over again?*, 2015, McKinsey & Company.
2. Dennis Butts, Michael Strilesky and Matthew Fadel, "The 7 Components of a Clinical Integration Network," *Becker's Hospital Review,* October 19, 2012, www.beckershospitalreview.com/hospital-physician-relationships/the-7-components-of-a-clinical-integration-network.html.
3. Catherine Sreckovich, Leigh Pylman, Barbara Huang and Kurt Eicher, "Provider Sponsored Plans Establish Marketplace Presence," *Perspectives,* 2014 Navigant Consulting Inc.
4. Patricia A. Bonner, Ph.D., CEBS; Cindy J. Kabacinski, CEBS; and Neil Mrkvicka, *Value-Based Health Care Glossary of Terms,* 2012, International Foundation of Employee Benefit Plans.
5. Ibid.
6. A. Mark Fendrick and John Z. Ayanian, M.D., "Smarter Consumer Cost Sharing Using Clinical Nuance," *Harvard Business Review,* November 15, 2013.
7. Health and Human Services announcement, January 27, 2015.
8. Noam Bauman; Manish Chopra, Ph.D.; Jenny Cordina; Jennifer Meyer; Jessica Ogden; Saumya Sutaria, M.D.; and Frances Wilson. McKinsey & Co. "Winning strategies for participating in narrow-network exchange offerings." May 2013.
9. Modern Health Care's M&A Watch Report; http://www.modern-healthcare.com/section/mergers-and-acquisitions.
10. Jon Kingsdale, "How Small-Business Health Exchanges Can Offer Value To Their Future Customers—And Why They Must, *Health Affairs:* 31(2)275-283, 2012.
11. Paul Demko, "Provider plans price more aggressively on insurance exchanges," *Modern Healthcare,* August 23, 2014.
12. Edington. *AJHP*. 15(5):341-349, 2001.
13. Bruce Sherman, June 15, 2015, Employee Benefit Adviser; online at eba.benefitnews.com.
14. Bob Herman, "More health systems launch insurance plans despite caveats," *Modern Healthcare*, April 4, 2015.
15. National Business Group on Health® ; *Issue Brief*; March 2015.
16. Ibid.
17. University of Michigan V-BID Center, "Potential Role for 'Clinically Nuanced' V-BID Plans in Private Exchanges," March 2015, available at http://vbidcenter.org/private-exchanges-brief/12778.