Competition among healthcare providers and pressure to lower costs has never been higher. There also has been a tsunami of value-based care transformation commitments recently announced by the Centers for Medicare and Medicaid Services (CMS), numerous insurers and provider groups. As a result, the momentum for health systems to move away from long-standing volume-based, fee-for-service (FFS) reimbursement models and toward value-based models of care and reimbursement has never been stronger.

While value-based reimbursement models are incredibly diverse, they have one thing in common: they transfer varying amounts of financial risk and clinical control from healthcare payors to healthcare providers. As market competition continues to increase, hospital and health system executives are wrestling with questions like, “How much risk is the right level for my hospital or health system?” and “How far along the value-based spectrum should my clinicians and board of directors go, given my local market dynamics?”

For a growing number of executives, the answers to these questions are ending with a decision to explore a provider-sponsored health plan (PSHP). A key market penetration strategy, PSHPs enable health systems to take full clinical and financial responsibility for their patients’ healthcare—from influencing which physicians will provide patient care to how much that care should cost. PSHPs disintermediate traditional payors so that patients and employers can deal directly with providers that are both their insurers and caregivers.

Today, there are more than 120 PSHPs – from well-known national players like Kaiser Permanente to regional leaders like Driscoll Children’s Health Plan in Texas to local market players like Alliant Health Plans in Dalton, Georgia.

The idea of a health system taking full clinical and financial responsibility for patient care may seem overwhelming at first, but a closer look reveals that “risk” is in fact less risky than most perceive. The reality is that taking on more risk can ultimately yield more benefits. Study after study has shown that 30 percent to 40 percent of all medical expenses are wasteful and that 30 some cents on every healthcare dollar goes to administrative costs, not patient care. PSHPs are in an ideal position to reduce this waste and administrative overhead – thereby lowering overall insurance costs and improving healthcare quality.

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**IMPROVING HEALTHCARE INDUSTRY METRICS**

- **Waste:** 30–40% of all medical expense is waste.¹
- **Quality:** 50% of medical care is substandard.²
- **Preventative Disease:** 75% of total medical costs are for preventable conditions.³
- **Administrative Cost:** 31 cents out of every healthcare dollar goes toward administrative costs, not to provide medical care to people.⁴

Research has shown that provider-sponsored health plans can be more efficient and effective than traditional health plans.⁵ By establishing their own policies and practices, PSHPs can improve their organization’s metrics.

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¹ Institute of Medicine reports ² New England Journal of Medicine ³ Centers for Disease Control ⁴ Richard Clarke, Wall Street Journal ⁵ Commonwealth Fund
Benefits of Provider-Sponsored Health Plans

Provider-sponsored health plans have the unique advantage of being united by a mission that eludes traditional insurers – to become more fully integrated into the communities they serve by providing medical care, high-quality affordable health insurance, employment, education and more. PSHPs also have a shared commitment to improving the health and well-being of their members, who also happen to be their neighbors.

Additionally, PSHPs offer:

**More effective population health management** - Provider-sponsored health plan leaders have firsthand knowledge of their community’s healthcare needs and preferences, giving them an advantage in designing plans that deliver more customized local care. Critical decisions around what care to provide and what amount to pay for this care are both under the PSHP’s control. With more tightly integrated clinical and financial performance data and metrics, health systems are better positioned than traditional insurers to improve outcomes and lower costs with respect to specific patient populations.

**Higher financial reward** - Providers who offer health plans are often in the best position to benefit from first-dollar capture. Since a certain amount of inpatient costs are fixed – beds, facilities and staff – costs of incremental care often are less for a provider organization than for a traditional payor.

For example, an episode of care might cost a traditional insurer $50,000. However, a health system sustains out-of-pocket costs that are limited to the variable costs associated with providing care. In many instances, the variable cost of care often is less than 30 percent of the total amount billed to an insurer. Furthermore, up to 15 percent of an insurance company’s costs are administrative. In a PSHP, administrative dollars stay with the provider organization that runs the health plan. In addition, recent studies suggest that PSHPs are more efficient, paving the way for the provider-sponsored payor to offer lower premiums, create additional incentives or pass savings on to members.

**Greater network control** - When patients see a provider outside the plan’s network, it often is because their choice or the primary care physician’s referral is outside the system. Given a PSHP’s long-standing relationship with its physician community, the plan often is much more successful in changing provider behavior. In the case of referrals, PSHPs can clearly play a much stronger role in encouraging primary care physicians to issue referrals for healthcare needs.
services within the same system. This can help improve care coordination and promote patient-centered care, while still satisfying patient preferences and health needs all within network. With more patients staying inside the PSHP’s network, health systems improve market share and remain competitive.

**Lower-cost local plans** - The Accountable Care Act’s (ACA) public exchanges became the forum for tens of millions of newly insured individuals to shop for and buy healthcare insurance. In the private healthcare marketplace, the costs of employee healthcare have gone through the roof. In 2003, it cost employers $12,400 per year on average to insure one employee and their dependents. Ten years later, it cost $21,300 – almost double. As a result, many employers have embraced value-based payments and are looking into PSHPs in an effort to further control costs and reduce their employees’ out-of-pocket expenses. Other employers are now having their employees purchase their own healthcare insurance on private exchanges.

As a result of both exchange movements – public and private – more and more insured individuals are selecting narrow network products. While a large part of narrow network popularity comes from the plans’ lower prices, they also often contain insurance products from community providers that already have strong and positive brand recognition among purchasers. PSHPs ideally are suited to offer narrow network products that address the desire for community based plans that both public and private exchange shoppers are demanding.

**Greater provider control** - Providing a health plan involves taking on many responsibilities, such as claims payment, customer service, insurance reporting and other administrative operations. However, the decisions around which services to provide and which to pay for are under the providers’ own domain. Beyond the 10 essential health benefits mandated by the ACA, PSHPs have the autonomy to expand their benefits packages to encompass more holistic offerings. This preventative approach can clearly help improve patient satisfaction and overall health outcomes.

**Better contract leverage for providers** - As providers and payors continue to struggle to negotiate fair reimbursement rates, PSHPs can offer providers increased market leverage. The ability of providers to enroll patients in their own health plan gives hospitals the option to refuse unrealistic contract rates from other payors, while ensuring patients still have access to quality care at a reasonable cost.
Determining if a Provider-Sponsored Health Plan is Right for You

Establishing a provider-sponsored health plan is a significant undertaking. Therefore, given the significant investment of both time and money, health systems considering the option are well-advised to conduct a comprehensive feasibility analysis that:

**Identifies the potential network size and types of providers** - What physicians would be participating in the plan? How strong is their primary care base and what specialties do they offer? What percentage of a physician’s patient base will likely be enrolled in your PSHP?

**Assesses local payor reaction** - Will independent payors still be willing to work with your organization, even if reluctantly? If not, can the organization function without those contracts?

**Analyzes the organization’s market position and local competition** - What is the delivery organization’s market share within its respective service area? How many other competitors are within the geographic area, and what degree of competitive advantage do your providers have over other local providers?

**Gauges consumer buy-in** - How will your region’s consumers and employers respond to a provider-sponsored health plan? Will the total population of potential consumers grow or shrink over time?

**Investigates the regulatory environment** - What existing legislation encourages or prevents PSHPs from realizing their potential? What unique Department of Insurance regulations in your state may come into play?

**Considers costs and financial position** - Does the provider organization have the cash on hand and a bond rating high enough to allow it to set aside the necessary reserves? What type of stop-loss insurance do you need and what types of care spend could your PSHP live with?

**Performs a physician alignment review** - What current or potential physician partnerships does the organization have to increase patients’ in-network options? How would the PSHP’s profits and losses be divided among these different entities? Who will govern these hospital and physician partnerships and their revenue?

**Evaluates different sales options** - Will your provider-sponsored health plan be sold to individuals or groups? Would it be more effective to sell the plan directly to consumers via exchanges? Will insurance brokers be used to sell the plan? Will the plan only serve a discrete population, such as Medicare or Medicaid, or a defined set of local employees, like a Multiple Employer Welfare Association (MEWA)?

Accurately and objectively analyzing these questions is crucial, not just to gauge the potential success of a provider-sponsored plan initiative, but to determine whether to ultimately move forward. The good news is that when this type of a feasibility analysis is conducted, organizations that pursue PSHPs are a step ahead in specializing their product offerings for their target market.
Establishing a Provider-Sponsored Health Plan

Taking on the roles of both an insurer and payor means organizations must take responsibility for multiple tasks that are outside of a provider’s traditional realm. This often involves implementing new organizational structures, staffing and technology. Numerous activities to support PSHP operations need to be accounted for, including PSHP specific sales, network management, medical management, member services, claims administration, financial and actuarial management, regulatory reporting and credentialing. In some cases, it may make sense to run some PSHP operations alongside similar health systems’ operations to encourage more holistic decision making.

However, outsourcing also is a viable option for PSHPs. Separation of responsibilities between a plan and its partners also creates a clear audit trail and ensures that providers that create plan rules aren’t then put in the awkward position of having to enforce them. No matter with whom you work, PSHPs should choose a partner that helps educate the plan’s employees about key aspects of its operations. Sound managed service partners also readily and regularly share operational metrics, conduct business intelligence and interpret data to help PSHPs improve performance.

![The opportunity to outsource various services is especially appealing to organizations that want to initially introduce PSHPs on a smaller scale. These organizations often begin by only offering the health plan to their internal employees or a target population – like a Medicaid Managed Care population in set service area. Clearly, pilots allow organizations to practice PSHP operations in a more controlled environment and to evaluate performance prior to marketing it to a broader consumer/member base. Organizations must understand that to be successful, your PSHP must ultimately grow to scale. While pilot efforts can help reduce the slope of an organization’s learning curve, they must be viewed as first steps. To truly assure a PSHP has the ability to change physician behavior, the volume of patients the PSHP sends through its doctors’ doors needs to be substantial.]'

"The reality is that if you’re an organization looking to develop a provider-sponsored health plan and you don’t have all the operational capabilities and physicians within your organization to deliver services to all of your members, you can build a provider network of physicians and augment internal operations with partner support. Doing so allows any organization to essentially cover all its members and offer all services that it needs to be successful.”

Phil Kamp
Chief Executive Officer
Valence Health
account for more than 1 percent or 2 percent of their total patient volume. Also, administrative costs associated with PSHP operations will become much more reasonable as things like claims processing, call center operations and medical management are spread across 5,000 members, rather than 500 members.

**Today’s Provider-Sponsored Plans Focus on Population Health Management, not Utilization Management**

One reason health maintenance organizations (HMOs) of the past eventually fell out of favor was due in large part to them limiting use of healthcare services through “gatekeeper” approaches. In contrast, today’s provider-sponsored health plans are not focused on imposing across-the-board limitations on utilization. Instead, the focus is on preventative care and identifying and encouraging access to the most effective interventions for a given condition, while identifying and discouraging access to the least-effective interventions. In addition, PSHPs usually focus on a limited network of providers so that they can more closely coordinate care within the network.

“It’s not utilization management, it’s population health management,” says Stockard.

**Today’s Providers have Unlimited Access to Technology and Data**

Another factor that makes the provider-sponsored health plan model more financially viable today is providers’ greater access to data and technology. In the 1980s and 1990s, healthcare providers were at a disadvantage relative to insurers. Providers and insurers alike simply didn’t have access to the vast amounts of data and powerful technologies that are available for in-depth data mining and predictive analytics. Today, in contrast, providers can choose from a variety of technologies and data sets.

“In an increasing number of cases, the data advantage has clearly flipped to providers,” Stockard says. “In most other cases, there is at least the potential for an equalized playing field.”

**Five important factors that distinguish today’s PSHPs from the HMOs of the past and make for greater potential for success:**

1. An increased focus on quality of care.
2. The availability of more data and technology to make key health plan decisions and operational course corrections.
3. Increased levels of direct patient participation in their health plan purchasing decisions.
5. CMS’ ever-growing preference for value-based reimbursements models that PSHP can uniquely deliver.

*“With HMOs of the 1990s, providers were basically paid on an age and sex basis. For example, Medicare would historically pay a set rate for all females age 70 to 74 in a certain market. That per-member-per-month rate was the total spend divided by the number of females in that group — that was it. If a provider got proportionately sicker patients in this group, that provider would lose money.”*

Todd Stockard
President
Valence Health
Changing Times Offer the Opportune Moment to Start Provider-Sponsored Health Plans

The exciting thing about starting a PSHP now is that a wider variety of tools and services are available that enable providers to shape their own destinies. In short, they no longer have to rely on private insurers to make critical strategic decisions for them.

Advances in big data technology and predictive modeling, for example, have evolved to a point where providers themselves can independently apply proven actuarial analysis without traditional insurance companies. This visibility into financial risk and the ability to account for it are becoming increasingly accessible to successful provider organizations in maintaining all of their risk arrangements. As we move more deeply into value-based care, providers likely will be managing a portfolio of risk arrangements. PSHPs will have the core capabilities well in-hand to diversify their risk portfolios more quickly and adapt to value-based models not yet envisioned.

Indeed, for those hospitals and health systems that take the time and effort to make use of these emerging services and solutions, the rewards of establishing and implementing a PSHP can far outweigh the risks. Acquiring the so-called “first dollar” gives such organizations a significant competitive advantage in their markets, as healthcare increasingly makes the transition from volume-based to value-based models of care and reimbursement.

PSHPs need not be the exception any longer. Patients, employers, physicians and elected officials are all demanding more accountability for healthcare costs and quality. In every way, the well-run PSHP more than addresses these demands. It also brings a local-mission driven approach to healthcare insurance that has long been missing. In the final analysis, PSHP are in direct touch with their members in countless ways that make members feel more like patients, neighbors and community members. Results for a PSHP are seen and felt much more immediately and personally as health outcomes improve. The PSHP can focus on the right types of care spend and care coordination activities, rather than simply getting caught up in less personal medical loss rations and the like.

“Today, PSHP’s can use data to affect outcomes and they can make it available to the doctors at point of care in order to make the right clinical decisions. I personally have always believed that the people who have the data win.”

Todd Stockard
President
Valence Health
About Valence Health

Valence Health provides value-based care solutions for hospitals, health systems and physicians to help them achieve clinical and financial rewards for more effectively managing patient populations. Leveraging 20 years of experience, Valence Health works with clients to design, build and manage value-based care models customized for each, including clinically integrated networks, bundled payments, risk-based contracts, accountable care organizations and provider-sponsored health plans. Providers turn to Valence Health’s integrated set of advisory services, population health technology and managed services to make the volume-to-value transition with a single partner in a practical and flexible way. Valence Health’s 600 employees empower 39,000 physicians and 130 hospitals to advance the health of 20 million patients.

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