Today's Provider-Sponsored Health Plans: What Boards Need to Know

by Phil Kamp and R. Todd Stockard

With the recent rounds of health insurance company merger and acquisition activity, many hospital executives and their boards may be wondering if a provider-owned plan might make sense for them. There certainly will be some who observe that provider-sponsored health plans (PSHPs) are not new. Others may say, "This sounds a lot like what we tried and failed to do with health maintenance organizations (HMOs) in the 1990s." While all of these observations are true, the health care environment has changed dramatically over the past 25 years.

Today there is more interest in value-based care than ever before. The U.S. health care system is increasingly tying reimbursement to quality, an important difference from what was happening in the 1990s. HMOs of the past eventually fell out of favor largely because they limited use of health care services through "gatekeeper" approaches. In contrast, today's provider-sponsored health plans are not focused on imposing across-the-board limitations on service utilization. Instead, the focus is on preventive care and on identifying and encouraging access to the most effective interventions for a given condition, while discouraging access to the least effective interventions. The PSHPs we have worked with usually build their plans around smaller, more limited networks of providers, so they can more closely coordinate care within and across those networks. Understanding how successful provider-owned plans have evolved since the 1990s can help ensure that boards are best prepared to contribute to key strategic decisions about starting a PSHP.

Governance with a Dual Focus: Intertwined Insurance and Clinical Knowledge

Providers who have been successful in accepting greater financial risk for patients and populations have also embraced the need to find and/or develop frontline leaders and advisors with both insurance and clinical experience. Running a PSHP is very different from running a hospital or health system and, while there are some similarities, there are more often greater differences. Unfortunately, many of the provider-run plans that failed in the 1990s failed to make this key distinction, and put leaders and advisors into key roles who were ill prepared to understand the insurance business.

For example, operating a successful health plan requires managers and counselors who have expertise and experience in:

- Actuarial and financial disciplines and how to price plans to meet insurance commissioner reporting requirements and identify capital inadequacies.
- Marketing and sales practices that are often bounded by state and federal regulations surrounding what information can and cannot be used in health plan selection advertising and communications.

While there is no one recipe for PSHP management and governance success, to make these decisions boards must be prepared to examine and be educated about the pros and cons of having separate or shared resources. While it is more common to see a completely separate PSHP senior management team, the decision to share resources, whether financial systems, case managers or human resource professionals, differs widely.

Approaches to governing PSHP boards also differ. In some cases, there is overlap among select members who are also on the hospital's or health system's board. In other cases, the PSHP's chief executive may be the only shared board resource. Regardless of the organization's construct, today's PSHP boards have come to understand how the finances of one organization can and will impact the hospitals that are part of a PSHP's network. Dealing with decreases in inpatient utilization and increases in primary care visits is a typical example. In a hospital-only world, this outcome might be viewed as less than desirable, but in a health plan world this is often a principal objective. Boards that understand how these intertwined results can positively impact their community's overall population health, quality metrics and per-member, per-month reimbursement trends have a much greater ability to work together to drive shared objectives. Most importantly, boards that are contemplating a PSHP need to realize that making this decision requires serious, detailed education for board members. Every PSHP is unique. Boards that opt to either affirm or pass on this strategy and investment can only make an informed decision after they honestly assess their board's knowledge gaps and then actively build education programs to close their deficiencies.

Knowledge is Power: Leveraging Data/Analytics

Perhaps the most important factor that makes the PSHP model more viable today is providers' greater access to data and technology. In the 1990s, health care providers were at a disadvantage relative to insurers. Providers simply did not have access to clinical and financial data about the populations they were taking responsibility for. In fact, many of the PSHPs that failed in the 1990s often did not know when they were in financial trouble and did not have the chance to course-correct.

Today, providers can choose from a variety of technologies and data sets to both build insurance products and assess their performance in meeting clinical guidelines and financial performance metrics associated with those products. Advances in big data technology and predictive modeling have evolved to a point where providers can independently apply proven actuarial analysis

continued on page 5