The Performance of Provider-sponsored Health Plans:

Key Findings, Strategic Implications

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Executive Summary

For most hospitals, navigating the transition from volume to value-based payments requires planning about how to engage with third-party payers. A key consideration is whether a hospital should sponsor a health plan or enter into shared-risk arrangements with one or more local non-provider-sponsored plans.

In this study, the research team sought to compare the performance of provider-sponsored health plans (PSHPs) versus the three largest non-provider-sponsored health plans (NPSHPs) in their markets, based on publicly reported data for the period 2011-2013. There were 50 PSHPs, including one that competed in multiple markets, and 86 NPSHPs, many of whom competed in multiple markets. Six factors involving 10 performance measures were examined: quality, member satisfaction, medical management, enrollment, administrative costs and financial performance. The data capture process was challenging; in many cases, publicly reported data about health plans was neither current nor complete.

The findings indicate that the performance of all health plans—PSHPs and NPSHPs—varies widely and changes frequently from year to year. Better performance in PSHPs is associated with meeting certain enrollment thresholds (about 400,000 enrollees). Overall, PSHPs tend to have lower enrollment than their local NPSHP competition but perform better on quality and member satisfaction. PSHPs allow more visits and admissions than NPSHPs, which accounts for slightly higher administrative costs, premiums and lower margins.

The growing concentration of large regional carriers and national plans can be problematic to PSHPs: many of these are national investor-owned or well-entrenched not-for-profit and not-for-profit mutual Blue Cross plans that operate in multiple markets. They benefit from scale not achievable to locally run PSHPs. Thus, these regional and national plans are able to price their premiums lower than their competitors, including PSHPs, to grow their enrollment and keep competitor enrollment low.

The implications for hospitals and health systems considering sponsorship of a plan are significant: market opportunities must be carefully assessed, the achievability of a scalable enrollment evaluated carefully by targeted lines of business, and the financial and strategic risks associated with this strategy weighed against the institution's overall mission and aims. Some hospitals and health systems will sponsor a plan as a function of their aim to be an integrated system. Others will choose to enter into shared-risk arrangements with NPSHPs. And all providers will increasingly assume more insurance risk in coming years as payers shift to them responsibility for delivery effectiveness and cost control.

Background: Three Trends Driving Hospital Interest in Health Plan Sponsorship

In recent months, increased attention has been given by hospitals and health system leaders to the potential they might benefit from owning a health insurance plan. This interest is driven by three major trends:

1. **Payers, especially Medicare, are shifting financial (insurance) risk to providers.** NPSHPs, Medicare, Medicaid and employers are accelerating their efforts to shift financial risk to provider organizations vis-à-vis a variety of alternative payment programs like accountable care organizations, bundled payments and others. At the same time, penalties for avoidable readmissions and under-performance on value-based purchasing pose significant financial and reputational risk for hospitals and health systems. The transition from volume to value-based payments requires competencies in care coordination, network design and administration, contract negotiations, risk sharing arrangements with physicians, performance measurement and so on. As a result, some health system leaders believe these capabilities require them to sponsor their own health plan. Others believe lower risk strategies, such as shared savings programs, accountable care organizations, bundled payments and others are more conducive to their risk tolerance and strategic aims.

Of late, Medicare has played a more central role in the transfer of risk to hospitals and health systems. In January 2015, the Department of Health and Human Services (HHS) announced that at least 50 percent of Medicare's payments to providers will be based on alternative payment programs by 2018. In July, HHS announced a proposed rule to take effect Jan. 1, 2016, the Comprehensive Care for Joint Replacement program, mandating a bundled payment for joint replacement providers in 75 markets impacting approximately 800 hospitals. Medicare is allowing provider organizations to assume risk; NPSHPs and large employers are building on this effort.

The shift of financial risk from payers to providers requires hospitals and health systems to manage access, utilization across the care continuum, physician participation and performance and other activities typically done by insurers. It is understandable that many believe owning a plan a reasonable consideration.

2. **The consolidation of health insurers poses a significant threat to the viability of local hospitals and health systems prompting consideration of plan sponsorship.** NPSHPs have significant leverage over providers, especially plans that dominate markets and enjoy the scaling advantages of a multistate or national business. Among the investor-owned plans, the pending consolidation of Aetna with Humana and Anthem with Cigna, along with

UnitedHealth Group will result in three organizations each with premiums of more than $100 billion and combined membership of 132.5 million—44 percent of total U.S. enrollment in the individual, group and government markets. In addition, among not-for-profit NPSHPs, the formidable strength of the 36 Blue Cross plans is likely to continue, especially in states where they already dominate.

By contrast, all but a handful of PSHPs operate in a local market, with Kaiser the most notable exception. For hospitals and health systems, consolidation among NPSHPs means difficult contract negotiations and disintermediation with physicians aligned with the hospital.

3. **The success of prominent integrated health systems that sponsor health plans draws interest among hospital and health system leaders.** The names Kaiser, Intermountain, Presbyterian, Meridian, Geisinger and others are widely recognized as integrated systems that successfully own and operate their own health plans. Their successes are frequently spotlighted in trade media and elicit frequent inquiries from health systems considering plan sponsorship. Health services researchers see integrated health systems that sponsor their own insurance programs as a useful mechanism for balancing the delivery of care and its financing, since these organizations necessarily assume insurance (financial) risk in setting premiums and in negotiating payments with their own hospitals and physicians. Many hospitals are pursuing a path to become a fully integrated health system reasoning that assuming full risk for population health management and care coordination via sponsorship of a health plan is necessary to their mission. And many health system leaders believe that in shared savings programs with insurers, the savings achieved is not equitably shared with providers.

As a result of these considerations, many hospital boards and leadership teams ask…

- Should our hospital/health system own a plan or partner with one or more in our market?
- On what basis should the opportunity be assessed? How does a decision to sponsor a health plan align with mission?
- And what conditions or events in a market prompt rethinking of the strategy?

The American Hospital Association and Navigant Center for Healthcare Research and Policy Analysis Study

In late 2014, officials from the American Hospital Association (AHA) and the Navigant Center for Healthcare Research and Policy Analysis, Washington DC, determined to collect data that could inform discussions in local hospitals and health systems addressing these questions. A key aim was to create a decision framework and catalyze an informed conversation around how providers might configure themselves to manage risk and create more value—whether through sponsorship of a plan or other shared-risk arrangements.

Study objectives

Specifically, the study had three objectives:

1. Assess the performance of PSHPs versus NPSHPs with whom they compete in local markets. Key questions: How well have PSHPs performed relative to the NPSHPs with whom they compete on the basis of available publicly reported data about clinical, operational, member service and financial performance? What internal and external market factors contribute to differences in performance?
2. Identify attributes of high-performing PSHPs that should be considered as a health system evaluates its strategy to sponsor a plan or otherwise. Key question: What factors explain the distinctions between PSHP and NPSHP performance?
3. Develop a systematic way for hospital and health system leaders to assess the risk and potential enterprise value in their decisions about plan sponsorship and other provider-sponsored risk determinations.

Definitions

Because the empirical literature and trade association information varies widely in the use of and context for key terms used in this study, the research team used these definitions:

- *Provider-sponsored health plans (PSHPs)* – health plans wholly owned by a hospital or integrated health system licensed by the appropriate state regulatory agency/department that contract with employers, individuals or Medicare and Medicaid. Note: several recent studies have been conducted using different definitions lending to confusion about the term (see Appendix A).
- *Non-provider-sponsored health plans (NPSHPs)* – all other health plans wholly/partially owned by investors and/or not-for-profit sponsors that operate across one or many markets (regional/national).
- *Performance* – the clinical, administrative, operational and financial results of a health plan's performance as captured and reported by officially recognized state agencies, i.e., state department of insurance filings, National Committee for Quality Assurance (NCQA), consumer satisfaction score (CSAT) and others.[1]

[1] Consumer satisfaction score (CSAT) is a component of the NCQA health insurance plan rankings and includes: "Getting care" "Satisfaction with physicians" and "Satisfaction with health plan services."

- *Provider-sponsored risk* – a contractual relationship between a payer (Medicare, Medicaid, private health plan or employer) and a hospital/hospital + physicians/hospital + physicians + post-acute facilities in which the provider is responsible for costs while maintaining an acceptable level of quality and safety.
- *Risk* – risks that are assumed by providers in risk-based contracts can be financial (penalties/bonuses/capital invested in new capabilities, i.e., new processes for diagnosing, treating and managing populations) and reputational (brand/placement in network tiers/access to patients, et al.).
- *Market* – a geographic area recognized as a "metropolitan statistical area" (MSA) (metro and micro areas) outlined by the Office of Management and Budget (OMB) for collecting statistical information.[2] MSAs are designated regions with comparatively high population densities and commuting patterns that indicate significant economic integration.

Methodology

Based on these definitions, the inclusion criteria used to assemble the dataset identified 50 PSHPs (see Appendix B) that were compared to the 86 competing NPSHPs (see Appendix C) for which operational data for 2011-2013 are available. The study's parameters are:

- Plans for which these data were unavailable were excluded.
- For NPSHPs that operate in multiple markets, the publicly available data about these were analyzed at the market level to allow direct comparison to data reported by PSHPs with whom they compete.
- For purposes of scope, the three largest NPSHPs based on overall enrollment (commercial and/or government) were examined in each market.

Each data element was retrieved and verified from these databases:

- National Association of Insurance Commissioners (NAIC)
- Centers for Medicare & Medicaid Services (CMS)
- NCQA
- Provider financial statements and reports
- CitiGroup

Analysis

Results for each plan for the three-year period were captured using 10 widely accepted measures that relate to their performance on six factors: quality, member satisfaction, medical management, membership enrollment, administrative costs and financial performance (see Figure 1 on following page). Each comparison was analyzed to determine the degree of statistical significance (see Appendix C). For each plan, data were compiled by their lines of business, i.e., commercial, Medicaid and Medicare. In a few instances, a PSHP sponsors plans in all lines of business, but it is rare. Thus, sample sizes for PSHPs in Medicaid are smaller.

[2] U.S. Department of Commerce – United States Census Bureau defines metropolitan and micropolitan statistical areas as: geographic entities delineated by the Office of Management and Budget for use by federal statistical agencies in collecting, tabulating, and publishing federal statistics. A metro area contains a core urban area of 50,000 or more population, and a micro area contains an urban core of at least 10,000 (but less than 50,000) population. Each metro or micro area consists of one or more counties and includes the counties containing the core urban area, as well as any adjacent counties that have a high degree of social and economic integration (as measured by commuting to work) with the urban core.

Figure 1

Performance Factors and Key Measures

6 Factors	10 Key Measures	Range	Approach for Scoring
Quality	NCQA Composite Scores [3]	0 – 100	(+) Higher is better
Member Satisfaction	CSAT Scores (Customer Satisfaction)	0 – 5	(+) Higher is better
Medical Management	Medical Cost PMPM	200 – 1,500	(-) Lower is better
	MLR (Medical Loss Ratio)	0.5 – 2	(-) Lower is better
	Use Rate/1000 (Admits)	25 – 150	(-) Lower is better
	Use Rate/1000 (Phys Amb)	500 – 15,000	(-) Lower is better
Membership	Members	n/a	n/a
	Member Months	n/a	n/a
Administrative Costs	Administrative Costs	10 – 1,500	(-) Lower is better
Financial Performance	Cost/Premium Ratio	0.5 – 1.5	(-) Lower is better
	Health Premium PMPM	200 – 1,500	(+) Higher is better

The means, weighted means, medians, variance and trends across 10 key variables between 2011-2013 have been calculated.
PMPM = per member per month

Publicly reported data for each of the 10 measures for the period from 2011-2013 were collected and verified from January-April 2015. Each data element for each plan was validated against public filings. Weighted medians were used to assess cohort performance, and tests of significance applied to determine the validity of contrasts/comparions between PSHPs and NPSHPs. Values reported outside the range were rejected, such as a plan reporting zero percent medical loss ratio for a given year.

The validity of each measure was defined by industry norms and regulatory filing requirements at the state level. Ranges for each were assigned so that PSHPs and NPSHPs were gauged using the same criteria. Values reported by plans outside expected ranges were captured, and in some cases, missing data also discovered in public records.

Finally, market characteristics were considered using the Herfindahl–Hirschman Index (HHI), a tool used by the U.S. Department of Justice (DOJ) to measure the concentration of health plans and hospitals in markets. The HHI is calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. The HHI takes into account the relative size distribution of the firms in a market. It approaches zero when a market is occupied by a large number of firms of relatively equal size and reaches its maximum of 10,000 points when a market is controlled by a single firm. The HHI increases both as the number of firms in the market decreases and as the disparity

[3] NCQA uses measures of clinical quality (i.e., HEDIS®) and patient experience (i.e., CAHPS®) and standards from the NCQA Accreditation process to rank health plans. Scoring level: Composite scores; Rankings: Sum of weighted, standardized measures compared with the sum of weighted, standardized measures of all plans; Ratings: Weighted average of measures.

in size between those firms increases. The DOJ generally considers markets in which the HHI is between 1,500 and 2,500 points to be moderately concentrated and considers markets in which the HHI is in excess of 2,500 points to be highly concentrated.

Key Findings

Variability in the performance of all PSHPs and NPSHPs is significant and performance varies year to year. The data show wide ranging performance in each of the 10 data fields in both groups. Therefore, comparing all PSHPs to all NPSHPs (as reflected in Figure 2 below) does not tell a complete story about the performance of plans in either group.

Also, due to actuarial risks for populations covered (driven by utilization and costs) and the volatility of enrollment, the performance for all plans varies significantly from year to year. The three-year trends noted above suggest that plans make adjustments on a year-to-year basis that alter their performance profile. Therefore, for both PSHPs and NPSHPs, performance reports for a single year may be misleading or have limited value in assessing their overall performance.

Figure 2

All Provider-Sponsored Health Plans vs Non-Provider-Sponsored Health Plans (Weighted Means, Medians)

		2013			
		Mean		Median	
Factor	Measure	PSHP	Non-PSHP	PSHP	Non-PSHP
Quality	NCQA	83	80	84	80
	YoY Trend - 2011 - 13				
Member Satisfaction	CSAT	3.58	2.88	4.00	3.00
	YoY Trend - 2011 - 13				
Medical Management	Medical Cost PMPM	401	314	376	293
	YoY Trend - 2011 - 13				
	MLR%	0.92	0.84	0.91	0.87
	YoY Trend - 2011 - 13				
	Use Rate/1000 (Admit)	84	63	80	52
	YoY Trend - 2011 - 13				
	Use Rate/1000 (Phy Amb)	5,186	5,901	4,859	4,649
	YoY Trend - 2011 - 13				
Membership	Members - CEL	277,281	402,407	109,084	227,756
	YoY Trend - 2011 - 13				
	Members - Absolute	3,236,604	4,836,231	1,289,276	2,655,683
	YoY Trend - 2011 - 13				
Administrative Cost	Admin Cost PMPM	44	35	38	34
	YoY Trend - 2011 - 13				
Financial Performance	Cost/Premium Ratio	0.99	0.91	0.98	0.95
	YoY Trend - 2011 - 13				
	Health Premium PMPM	454	346	422	334
	YoY Trend - 2011 - 13				

YoY = year over year

PSHPs perform better than NPSHPs in quality and member experience (CSAT) but due to their smaller enrollments and desire to optimize access to physicians, medical management costs, administrative costs and financial performance vary unfavorably.

- The total enrollment in NPSHPs is on average higher than in PSHPs: mean 402,407 vs. 277,281; median 227,756 vs. 109,084. As a result, the costs of operating a PSHP can be higher, especially for those with the lowest enrollments.
- The NCQA Index is widely used to measure the quality of care provided enrollees. PSHPs perform better than NPSHPs consistently. Among all plans, NCQA scores are declining.
- The CSAT (customer satisfaction index) score is a measure of the membership experience. PSHPs perform significantly better than NPSHPs overall, and are trending higher at a faster pace than NPSHPs. Notably, CSAT performance is related to a plan's reputation.
- Medical management scores are problematic for PSHPs. PSHPs allow more visits and admissions per member than NPSHPs and, as a result, administrative costs and premiums are higher and financial performance is worse. This may be explained by two scenarios outside the scope of this study: the possibility that PSHPs attract sicker enrollees requiring a higher intensity of service, or the inverse relationship to enrollment scale whereby as plan enrollment increases, visits per member decrease.
- Medical loss ratios for PSHPs are significantly higher than NPSHPs: mean 92 percent vs. 84 percent; median 91 percent vs 87 percent.

Figure 3

LARGEST PSHPS VS LARGEST NPSHPS *"LARGEST" IS BASED ON ENROLLMENT FIGURES*

2013					
Factor	Measure	Largest PSHP Commercial Median	Largest Non-PSHP Commercial Median	Largest PSHP Government Median	Largest Non-PSHP Government Median
Quality	NCQA	86	84	86	81
	YoY Trend - 2011 - 13				
Member Satisfaction	CSAT	4.00	3.50	3.46	3.00
	YoY Trend - 2011 - 13				
Medical Management	Medical Cost PMPM	277	291	288	251
	YoY Trend - 2011 - 13				
	MLR%	0.88	0.91	0.91	0.89
	YoY Trend - 2011 - 13				
	Use Rate/1000 (Admit)	52	48	96	64
	YoY Trend - 2011 - 13				
	Use Rate/1000 (Phy Amb)	3,699	2,815	5,540	4,721
	YoY Trend - 2011 - 13				
Membership	Members - CEL	433,201	1,483,653	202,972	202,397
	YoY Trend - 2011 - 13				
	Members - Absolute	433,201	1,483,653	281,786	404,794
	YoY Trend - 2011 - 13				
Administrative Cost	Admin Cost PMPM	35.00	41.99	24.98	21.95
	YoY Trend - 2011 - 13				
Financial Performance	Cost/Premium Ratio	0.96	0.98	0.99	0.96
	YoY Trend - 2011 - 13				
	Health Premium PMPM	377	344	388	278
	YoY Trend - 2011 - 13				

YoY = year over year

Figure 4

Comparison By Lines of Business Among All PSHPs and NPSHPs

	2013					
Measure	PSHP Medicare Median	Non-PSHP Medicare Median	PSHP Medicaid Median	Non-PSHP Medicaid Median	PSHP Commercial Median	Non-PSHP Commercial Median
Use Rate/1000 Members (Admits)	253	224	96	149	54	47
YoY Trend - 2011 - 13						
Use Rate/1000 (Phy Amb)	9,118	16,735	5,879	7,536	4,115	3.687
YoY Trend - 2011 - 13						
Health Premium PMPM	901	818	308	390	366	271
YoY Trend - 2011 - 13						
Members	23,847	55,515	79,873	137,988	71,449	121,070
YoY Trend - 2011 - 13						

YoY = year over year

PSHPs with the largest enrollments compare more favorably to competitors. Many factors appear to play a role in discrepancies between the largest PSHPs plans and the rest, but enrollment (scale) is a key determinant. The majority of PSHPs have lower enrollments relative to their NPSHP competitors. But among plans with large enrollments—both PSHP and NPSHP—performance is equivalent. The largest PSHPs (at > 400,000 members each) perform better than the rest of the PSHPs on all measures of performance and compete favorably against the largest NPSHPs in terms of quality, member satisfaction, medical management, and administrative costs. Notably, they have worse financial performance.

- The five largest PSHPs have average enrollment of 433,201—adequate to achieve administrative efficiencies on par with larger NPSHPs. Among the largest PSHPs, mean administrative costs are lower ($35.00 per member per month vs $41.99) but higher for median ($24.98 vs. $21.95).
- Quality, member satisfaction and utilization of physicians scores for the largest PSHPs are above the largest of NPSHPs, and the medical loss ratio below suggesting PSHPs with adequate scale (enrollment) may be operated somewhat differently than NPSHPs. These distinctions are greater in comparing commercial lines of business to government lines of business.
- Utilization rates vary by lines of business. PSHPs tend to have higher use rates in their commercial and Medicare lines of business than their NPSHP competition, but lower in Medicaid. The distinction might be due to enrollment (Medicare 23,847 enrollees for PSHPs vs. 55,515 enrollees for NPSHPs, and Medicaid 79,873 enrollees for PSHPs vs. 137,988 enrollees for NPSHPs) or other factors beyond the scope of the study. Notably, few hospitals/health systems sponsor a Medicaid plan so generalization is difficult.

Markets in which PSHPs perform best are those wherein the NPSHP concentration is lower. Some markets appear to offer more potential for PSHPs than others:

- Markets where the private insurance market is pluralistic and no single plan dominates (Plan HHI less than 1500)
- The largest PSHPs tend to be in smaller mid-sized markets

Conclusions

PSHPs compete favorably against private plans in markets where they are able to achieve adequate scale (enrollment) in the lines of business they pursue. A hospital or health system might sponsor a plan for other than financial reasons—to fulfill its mission as an integrated system, to incorporate core competencies necessary for population care management and risk taking, or simply to underwrite the medical costs of its own employee and dependent population.

To summarize the findings:

- Scale: Plans with larger enrollments perform better than plans with lower enrollments: In general, small enrollments correlate to operating losses, high administrative costs, and poor financial performance.
- Lines of business/mission: Variability in performance among PSHPs is significantly impacted by the lines of business pursued and market conditions (opportunity).
- Market characteristics: The relative scale (enrollment) of NPSHPs in markets where PSHPs compete is a major determinant of the success of the PSHP. It turns out that markets where PSHPs perform best are secondary urban markets—less than 500,000 population, where the hospital/health system enjoys strong market presence.

Clearly, the performance of all health plans is affected by these factors. For hospitals, the context in which they are considered is different than a NPSHP. Therefore, it may be reasonably concluded from this study that a hospital/health system might operate its plan efficiently but not be profitable, due to market conditions that do not allow it to achieve optimal enrollment.

Discussion

The performance of health plans changes constantly. And measures of plan performance are evolving in tandem. On Sept. 17, 2015, the NCQA announced a new methodology for rating health plans to align with CMS Star Ratings for outcomes and satisfaction.[4] Other rating agencies and regulatory agencies also produce reports about plan performance, so measuring overall performance of plans remains complicated and somewhat imprecise. Nonetheless, transparent information about the performance of health plans is likely to be a focus of regulatory and public efforts.

For hospitals considering sponsorship of a plan, the stakes will continue to be higher, so prudence in determining whether and how to sponsor a health plan requires thoughtful analysis.

Two assessments are necessary to this analysis:

Market opportunity analysis. The strongest plans, whether hospital sponsored or not, show consistent progress in enrollment growth in the lines of business they pursue. Enrollment growth is key to offering competitive plans at competitive premium rates—a disadvantage for most PSHPs. Enrollment growth while improving operating margins via tight medical management and administrative cost controls is critical for all health plans.

[4] http://www.ncqa.org

Based on assessment of the market opportunity, a hospital or health system might elect to sponsor a plan based on three possible scenarios:

- Hedge: Some health systems will sponsor a plan as a hedge against private competitors, believing it necessary to "keep them honest" or "learn key competencies" that would prove beneficial long term.
- Mission: Some will conclude plan ownership is fundamental to their mission as an integrated system, acknowledging the financial and reputational risks associated with capitalizing and operating the plan, and inherent tension when contracting with physicians and hospitals owned by the same sponsor.
- Financial contribution: Some see the potential financial contribution of the plan, given the dynamics of the market and their ability to sell an attractive set of products.

Organizational preparedness. The capabilities and competencies necessary to assume insurance risk are significant and often outside the skill sets and cultural predisposition of a hospital/health system's leadership and tradition. They also require substantial capital investment, talent acquisition efforts and structural changes to align the delivery and insurance interests of the enterprise equitably.

In some hospitals, many of these capabilities exist as the organization has entered into shared-risk arrangements with payers, or participated in accountable care organizations, bundled payment programs and others.

For most hospitals, there will be three options to acquire the technologies, tools, talent and processes needed: 'Go it Alone,' which most have done; 'Partner' with other provider organizations to achieve greater scale; or 'Contract' with a NPSHP to provide these services on a shared-risk basis.

The distinction between sponsoring a plan in which all these capabilities are necessary versus partnering with a plan is key: assuming insurance risk is a costly endeavor and a distinct business from operating a hospital and outpatient clinical services portfolio.

Final Thoughts

Hospital/health system-sponsored health plans can compete capably with NPSHPs, if market conditions are favorable, the operational capabilities to effectively manage the total cost of care for populations are in place, and sponsoring a plan fits with the organization's mission and vision. But assuming risk from payers does not require ownership of a health plan; other methods for risk sharing are also worth consideration given a hospital's strategic aim.

It is clear that a well-managed hospital/health system-sponsored health plan can operate efficiently but fail financially as a result of low enrollment. The leverage of NPSHPs that compete against PSHPs using low premiums to grow their enrollment is an ominous challenge. The ability to achieve scalable enrollment that increases over time is dependent on many factors outside the control of the hospital or health system, but aggressive pricing by NPSHPs is a major factor.

In some markets, therefore, collaborating with one or more plans is the most appropriate option; in others, a plan sponsorship strategy may be appropriate. But in all markets, hospitals and health systems must adapt culturally, operationally and strategically to the reality that the future necessitates that they assume risk

for outcomes and the total cost of care for the populations they will manage. They are destined to assume insurance risk, whether the insurance licensee is a NPSHP or not.

Hospitals and health systems must address the market's transition from volume to value. For some, sponsoring a health plan will be a useful strategy; for others, collaboration with one or more private plans a better route. For all…

Mission matters. Enrollment matters. Lines of business matter. Markets matter!

Appendix A:
Provider-sponsored health plans: Differences in number and definition

Studies (Citation)	Findings	Notes
AM Best	150+ PSHPs (The data set is comprised of both rated and non-rated (NR) provider-owned plans.)	*Modern Healthcare* notes that "this selection of provider-owned plans included several subsidiaries within the same insurer. As such, many of these statistics, may be skewed toward the well-established provider-owned plans such as Kaiser Foundation Health Plan and UPMC Health Plan."
McKinsey & Company Healthcare Systems and Services Practice	107 ("13 percent of all US health systems offer health plans in one or more markets—commercial, Medicare Advantage (MA), or managed Medicaid")	Sources listed: 2013 AIS database; 2014 HealthLeaders InterStudy database; CMS Medicare Advantage enrollment data and McKinsey analysis
Valence Health analysis	120+ (~125) Provider-sponsored plans operating today	No methodology included in white paper
Modern Healthcare "More health systems launch insurance plans despite caveats"	72 provider-sponsored plans included in Marketplaces (health exchanges); 90 total	698 hospitals with an equity stake in an HMO in 2013 (11 percent increase from 2012) – consolidated/ non-consolidated total
AIS's Directory of Health Plans	244 PSHPs 75 Provider-led plans are on Health Insurance Exchanges	AIS defines provider-sponsored health plans as: "Entities where hospitals, physicians, or integrated delivery systems actually own and have direct financial benefit from the health plan."

Appendix B:
Provider-sponsored health plans

ADVANTAGE Health Solutions	MDwise
AultCare Insurance Company	Mount Carmel Health Plan
Avera Health Plans	Neighborhood Health Plan
AvMed	Network Health Insurance Corporation
Bluegrass Family Health	Network Health Plan
Capital District Physicians' Health Plan	Optima Health Plan
CommunityCare HMO	Paramount Health Care
Cox Health Systems	Phoenix Health Plan
Dean Health Plan	Physicians Health Plan
FirstCare	PreferredOne Community Health Plan
FirstCarolinaCare Insurance Company	Presbyterian Health Plan
Geisinger Health Plan	Priority Health
Group Health Cooperation	Providence Health Plan
Gundersen Health Plan	QCA Health Plan
Health Alliance Medical Plans	Saint Mary's HealthFirst
Health Alliance Plan of Michigan	Samaritan Health Plan
Health First Health Plan	Sanford Health Plan
Health New England	Scott & White Health Plan
Health Partners	SelectHealth
Health Tradition Health Plan	Sharp Health Plan
HealthSpan Integrated Care	SummaCare
Hometown Health Plan	University Health Care d/b/a Passport Health Plan
Kaiser Foundation Health Plan	UPMC Health Plan
Kaiser Foundation Health Plan of the NorthWest	Viva Health
McLaren Health Plan Insurance	Western Health Advantage

Appendix C:
Non-provider-sponsored health plans (consolidated)

Aetna Health Inc. (a Florida Corporation)	Harvard Pilgrim Health Care
Aetna Health Insurance Company	Health Care Service Corporation, a Mutual Legal Reserve Company
Aetna Life Insurance Company	Healthcare Service
Anthem Blue Cross Life and Health Insurance Company	HealthNow New York
Anthem Health Plans of Kentucky	Highmark
Anthem Insurance Company	HMO Colorado
Blue Cross and Blue Shield of Alabama	HMO Partners, Inc.
Blue Cross and Blue Shield of Florida	Humana Insurance Company
Blue Cross and Blue Shield of Kansas City	Independence Blue Cross
Blue Cross and Blue Shield of Massachusetts HMO Blue	Medica Health Plans
Blue Cross Blue Shield of Michigan Mutual Insurance Company	Medical Mutual of Ohio
Blue Cross Blue Shield of Minnesota	Noridian Mutual Insurance Company
Blue Cross Blue Shield of North Carolina	Premera Blue Cross
Blue Shield of California Life & Health Insurance Company	Regence BCBS of UT – Utah
Capital Blue Cross	Regence BlueCross BlueShield of Oregon
Cigna Healthcare of Arizona	Regence Blueshield
Connecticut General Life Insurance Company	Tufts Insurance Company
Empire Healthchoice Assurance Inc	SelectHealth
Excellus Health Plan	United Healthcare Insurance Company
Group Health Incorporated	Wellmark of South Dakota

Appendix D:
Test of Significance: Significance at the 95% confidence interval

Performance Measure	Commercial (All Provider vs. Non-provider)	Government (All Provider vs. Non-provider)
Health Premium PMPM	Yes	Yes
Medical Cost PMPM	Yes	Yes
Admin Cost	No	Yes
MLR	Yes	Yes
Cost/Premium Ratio	Yes	Yes
Use Rate (Admits)	Yes	No
Use Rate (Physician)	No	No
NCQA	Yes	
CSAT	Yes	

Sources and Additional Resources

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