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Managing the Transition to Transformation: Health Care Provider/Payor Integration: 2016 Is Not the 1990s

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Based in large part on the changing dynamics in health care delivery being driven by the shift from the traditional fee-for-service payment system to alternative value-based, bundled and/or population-based payment models, the phenomenon of the Provider-Sponsored Health Plan (PSHP) that was so prevalent in the 1980s and 1990s, but largely fizzled out in the 2000s, has re-emerged as a viable option for health systems. While many of the factors that drove hospitals and health systems to establish PSHPs are again present in today's health care market, the drive to move away from fee-for-service payment systems has heightened the desire of many hospitals and health systems move back into the PSHP business in order to gain control of the full premium dollar. As discussed in a prior *Managing the Transition to Transformation* article, hospitals and health systems have already actively engaged in developing and implementing strategies to change the way care is delivered and coordinated in order to adapt to rapidly changing reimbursement models. As illustrated by the chart below, it is a natural progression for many of them to take the next step to more fully integrate and align delivery of care and reimbursement through the development or acquisition of a PSHP:

rovider/Payor Integration Chart

Elements of Change	Yesterday and Today (?)	
Care Focus	Sick Care	"H
Care Management	Manage utilization of cost within a care setting	M opt
Delivery Models	Fragmented / Silos; May be coordinated	Ri co
Care Setting	In-Office / Hospital	In
Quality Measures	Process Focused, Individual	Ou
Payment	Fee-for-service	

	Financial Incentives	Do more, make more	F
	Financial Performance	Margin per service, procedure (beds, physician, etc.)	

What Was Old is New Again

In the 1980s and 1990s, several hundred PSHPs were being operated by hospitals and health systems across the county. By the 2000s, the prevalence of PSHPs had dropped significantly. Many factors impacted the ability hospitals and health systems had to successfully operate a PSHP, including a fundamental lack of experience and understanding of the business of insurance (*e.g*. underwriting and risk management), the advent of risk based capital (RBC) requirements that required providers to maintain significant cash reserves and the inability to achieve scale and develop a cohesive provider network in the markets served. In regard to this last factor, most provider-based networks exhibited many of the following factors, which were antithetical to the success of a PSHP:

- Scrum among providers for the largest share of revenue
- Fee-for-service focused reimbursement creating incentives to do more
- Focus on achieving negotiating leverage with the payor
- Episode of care rather than population or outcome focus
- Interventional not preventive care
- Clinical integration to achieve antitrust compliance, not patient care improvement

While some PSHPs were able to succeed and thrive, most exited the health plan market by the end of the 2000s. However, a 2015 report by McKinsey & Company found that 107 health systems were operating PSHPs, and more recently, research by Atlantic Information Systems, Inc. has identified 270 PSHPs currently operating across the country. This is clear evidence that health systems have jumped back into the PSHP game with both feet.

What makes the modern PSHP experiment more likely to succeed than the PSHPs of the 1980s and 1990s? While many of the conditions that led to the rise of the PSHP in the past are present again in today's market place (including the presence of several dominant players making a concerted effort to continue consolidation and a radically changing reimbursement system), there are some key additional factors to consider:

- Unlike in the past, health systems are much further along in the process of developing true clinical alignment with other providers across the continuum of care. Many health systems have established expansive and integrated physician organizations and developed strong alignment (either through acquisition or contractual arrangement) with ancillary providers in their service areas that now exhibit many of the following factors:
    - Management of performance risk (based on what is done to mitigate diseases including the efficacy and types/place of treatments rendered)
    - Population focused, not individual focused

- Rational allocation of revenue and resources
- Value-based reimbursement and pay for quality
- Patient-centric focused with care coordination, prevention and wellness
- Meaningful physician leadership
- Clinical integration to achieve efficiencies and quality improvement

- The implementation of health information technology (HIT) and care management processes and protocols, combined with the expanded clinical network and alignment has put health systems in a better position to control cost and coordinate care than they have ever been before.

- The rise of alternative payment models in combination with consumerism and the infiltration of the digital age into the provision of health care have forced health systems to learn how to better manage patients through the continuum of care, and have also helped health systems to focus in on managing care for specific patient populations.

- As a result of the growing adoption of the Triple Aim by health systems, many administrative and care management costs that traditional payors are forced to incur in managing their health plans and networks are already in place thus creating a potential reduction in the PSHP's administrative costs. These cost savings can be passed along to PSHP members in the form of lower premiums and can create a competitive advantage for PSHPs.

- With the growth of narrow networks, health systems (and providers generally) can leverage brand and reputation with health care consumers, which can be a competitive advantage when marketing a PSHP to potential new members. The PSHP can also leverage its health system relationship.

Health systems have also learned lessons from the failures of the past. They recognize and understand that running a successful PSHP requires a very different skill set than running a provider organization. While it can be a challenging hurdle to overcome given the traditional adversarial relationship between payors and providers, the leadership of successful PSHPs (both on the health system and the PSHP sides of the fence) are aligned and understand that the purpose of a PSHP is to support the mission of the broader health system.

Build, Buy or Something Else?

There are a number of different ways for a health system to enter the PSHP market. No matter what approach a health system ultimately chooses to move forward with, it is absolutely critical to have a well-planned strategy and business plan in place before moving down the pathway to the development or acquisition of a PSHP. It is important to establish clear goals and objectives (*e.g.*, expanding the health system's mission, increasing ability to succeed in population health management and leveraging HIT) and to develop a strategy for the focus of the PSHP (*e.g.,* geographic scope, market segment focus, potential product offerings).

While building a PSHP from the ground up offers a health system with the maximum control and

influence over how the PSHP is structured and operates, it comes with a host of challenges and can result in a long runway to operationalizing the PSHP. For example, the licensing and regulatory process for establishing a new PSHP and developing Medicare Advantage and Medicaid products can be long and cumbersome. Additionally, if the past is a guide, health systems typically do not have the necessary skills and expertise required to operate a successful PSHP and will need to invest heavily on the infrastructure and human capital required to run the PSHP.

Buying (either in whole or in part) an existing health plan is a much easier proposition from a timing and regulatory standpoint, and typically allows a health system to get into the PSHP market much quicker. However, particularly in the current market, buying an existing health plan can be a costly endeavor. The ultimate success of an acquired PSHP is also linked closely to the ability of the health system's leadership team to manage the integration of the PSHP into the broader health system and get buy-in and alignment from the PSHPs leadership team on the PSHP's role in achieving broader mission of the health system. Aligning financial incentives for the PSHP and shifting the culture away from the traditional adversarial payor/provider relationship is critical to both the short and long-term success of the PSHP.

In addition to building and buying, health systems could elect to move forward with a hybrid approach. Several current PSHPs have been created through joint ventures with existing health plans or other health systems with pre-existing PSHPs. As is the case with buying an existing health plan outright, joint venturing with an existing health plan or PSHP typically provides for a much quicker entry into the market place and can be accomplished structurally in a variety of different ways (*e.g*., traditional joint ventures, virtual joint ventures, purely contractual arrangements). These hybrid models can be attractive to both health systems and existing health plans for a variety of reasons, including the ability to share risk, leverage beneficial attributes of both organizations (*e.g.,* health plan management expertise, population health experience, health system brand) and reduce regulatory hurdles to market entry.

Conclusion

As use of alternative payment systems continue to grow and traditional fee-for-service reimbursement phases out over time, the utility of a PSHP for a health system will likely continue to increase. By keeping in mind the fundamental principles listed below during the development of a PSHP, health systems will increase their ability to effectively integrate and align their PSHPs with the broader health system organization and should be well positioned to succeed in managing the transition to the new healthcare delivery and payment systems of the future.

- A well-designed foundation cannot assure success, but a poorly conceived foundation will almost always ensure failure.
- Seek a shared destiny and assumed accountability.
- Foster shared decision making.
- Use sound business and financial modeling.
- Promote meaningful participation in strategic and operational decision making.
- These developments do not happen overnight.

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