Provider Sponsored Health Plans

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Under healthcare reform, payers are seeking to increase the quality of care delivery while simultaneously shifting incentives and more of the risk associated with managing healthcare costs to providers, physicians, and to the consumer. As these new policies are broadly implemented by governmental and private payers, healthcare providers are being asked to take greater responsibility for population health and total cost of care. As a result, many integrated delivery systems across the country find themselves asking the question: Is now the right time to create a health plan or to partner with other provider sponsored health plans?

The influence of the consumer on healthcare is emerging, and when insurance coverage is purchased at the consumer level through both public and private health insurance marketplaces (exchanges), choice of a provider brand that they know can be a powerful attractor to the individual and very strategic for a provider. When consumers select provider sponsored plans they are in essence making a decision to engage with that provider as their preferred or primary place of care. This upfront selection of a network by the consumer enables them to know and commit to a partnership with the physicians, hospitals and plan, and offers providers a new paradigm for patient and community engagement and market share strategies.

In the Midwest, several provider organizations have answered this question with a yes, and have made plans to, or have already implemented, a provider sponsored health plan. Numerous large integrated delivery systems in the Midwest have decided to either start up, join, or affiliate with a provider sponsored health plan. Several of these systems are highlighted in Exhibit 1. Two Midwest provider sponsored health plans, Health Alliance Plan and Priority Health, rank among the top ten provider sponsored health plans in the country (by medical enrollment), according to AIS’ Directory of Health Plans.

While all of these organizations have unique characteristics, they also all have a common structural component in their provider profile that allows them
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to successfully participate in a provider sponsored health plan—their ability to manage population health across the full continuum of care. When evaluating organizational readiness for pursuing the development of a provider sponsored health plan, hospitals, physician groups, and integrated delivery systems should consider the following attributes of a prepared organization and evaluate how their organization measures up:

Profile (Internal)

- You are a highly evolved network of healthcare providers with experience and success in managing financial risks of populations (i.e., risk-based quality payment programs, capitation, and percentage of premium, as well as payers and products such as Medicare MSSP or Medicare Advantage, commercial accountable care organization or health maintenance organization [“HMO”], and private and public exchange-based plans, self-funded, Medicaid, and dual eligible).
- Your capacity and volume is large enough to enable scale investment and risk assessment.
- You have engaged physicians and strong physician leadership in key positions and governance roles throughout the organization management.

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You have created care management and transitions of care programs with workflow redesign, clinical, and information technology, supporting the care providers and assisting them in quickly moving patients to the right care at the right time and place.

Your organization has installed and has proven analytics and reporting capabilities to monitor clinical quality, cost, outcome, and satisfaction measures used to create better outcomes and healthier populations.

You have a strong managed care department that has mastered contracting and understands the requirements needed for successful collaborative agreements.

You have relationships with stop loss carriers and understand your risk exposure and how to mitigate and position your products and your delivery network.

You have a deep balance sheet, and either have or can access cash reserves to meet requirements for growth and risk-based capital requirements.

Market (External)

You own the “top of mind” brand in the market and are one of the “must have” networks.

The market is fragmented with multiple payers, dominated by small to mid-size employers, regional, private and public exchange plans, and multiple governmental players: Medicaid, Medicare Advantage, dual eligible plans, etc.

You have or can establish relationships with providers other than your own to provide an attractive and well-coordinated network of care.

Payers are not actively seeking partner networks that create value through data, informatics, and continuous care redesign and those investing in people, shared clinical data, processes, and management of each patient population.

You recognize that to be successful, you need to attract new share and long-term commitment by creating value for the consumer payers with new products and innovative design; not through doing “more and more” through large networks, leveraged contracts, and rich benefit plans.

For the internal profile, how does your organization measure up against these attributes? Externally, do these market conditions exist in your primary service area? If the answer is yes to either of these questions then it may be the right time to assess your organizational and market readiness, and develop the appropriate strategy for developing and operating a health plan.

An early key strategic decision point is determining whether your organization should build its own or buy an existing health plan. Starting a health plan is a long, arduous, and expensive journey, so proper due diligence is critical before embarking down this path. An alternative strategy is to partner with an existing health plan. Within this strategy exist three sub-strategies: partner with a national commercial insurer (e.g., UnitedHealthcare, Cigna, Blue Cross and Blue Shield, etc.), partner with an existing local or regional provider sponsored health plan, or partner with a consumer operated and oriented plan (“CO-OP”). The sole CO-OP in Illinois, Land of Lincoln Health, is sponsored by the Metropolitan Chicago Healthcare Council, an organization that consists of 150 local healthcare organizations throughout the greater Chicago area. Any of these organizational models may be right for your organization; the key will be to assess existing capabilities, organizational, and community needs, and external market characteristics. The graphic [on the next page] summarizes the core strategic and operational criteria, and key considerations that should be assessed and evaluated when developing a provider owned health plan.

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Key Planning and Decision Points in Developing a Strategy for a Health Plan

A key advantage to operating a health plan or building products with a health plan is that it allows for greater control in attracting new members and deciding what and when to invest and develop, be it new products or expanded delivery networks. It allows organizations to build the skills and expertise necessary to succeed in effectively managing population health and total costs of care, while leveraging expensive organizational infrastructure and creating operational efficiencies through scale. However, it is not for the faint of heart or those without the financial wherewithal to get through the learning curve phase, so consider your opportunities and potential partners in such an endeavor carefully.

To learn more about whether your organization should operate a health plan, please contact Mr. Jim Smith at 585-512-3900 or e-mail him at jsmith@thecamdengroup.com, or Mr. Greg Shufelt at 312-775-1700 or e-mail him at gshufelt@thecamdengroup.com. To explore partnership opportunities with Land of Lincoln Health, contact Mr. Dan Yunker at 312-906-6003 or email him at dyunker@landoflincolnhealth.com.

Exhibit 1

<table>
<thead>
<tr>
<th>Midwest</th>
<th>Location</th>
<th>Provider Description</th>
<th>Provider Sponsored Health Plan</th>
<th>Health Plan Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avera Health</td>
<td>Sioux Falls, South Dakota</td>
<td>Offers a range of acute care, specialty care, and wellness services at more than 300 locations</td>
<td>Avera Health Plans</td>
<td>Health plan coverage for 70,000 plus members</td>
</tr>
<tr>
<td>Detroit Medical Center</td>
<td>Detroit, Michigan</td>
<td>Academically integrated system in metropolitan Detroit; largest healthcare provider in southeast Michigan</td>
<td>ProCare Health Plan Inc.</td>
<td>Detroit-based HMO that covers Medicaid beneficiaries in Wayne County</td>
</tr>
<tr>
<td>Fairview</td>
<td>Minneapolis, Minnesota</td>
<td>Includes over 22,000 employees, 3,346 credentialed physicians, seven hospitals and medical centers, and over 40 primary care clinics</td>
<td>PreferredOne</td>
<td>Founded in 1984 and is owned by Farview Health Services, North Memorial Health Care, and PreferredOne Physician Associates</td>
</tr>
<tr>
<td>Gundersen Health System</td>
<td>La Crosse, Wisconsin</td>
<td>System consists of three hospitals, four nursing homes, 24 medical clinics, and a variety of other health clinics</td>
<td>Gundersen Health Plan</td>
<td>Products offered include: HMO, point of service, self-funded, Medicare Advantage, Medicare Supplement, BadgerCare Plus</td>
</tr>
<tr>
<td>Henry Ford Health System</td>
<td>Detroit, Michigan</td>
<td>System includes hospitals, medical centers, and the Henry Ford Medical Group, which includes more than 1,200 physicians practicing in 40 specialties</td>
<td>Health Alliance Plan</td>
<td>A health plan that provides coverage to individuals through robust disease management and wellness programs</td>
</tr>
<tr>
<td>Indiana University Health</td>
<td>Bloomington, Indiana</td>
<td>With 3,541 staffed beds this Academic Medical Center is comprised of hospitals, physicians, and allied services including hospital-based physician practices, and outpatient centers</td>
<td>MDwise</td>
<td>Works with the state of Indiana and Centers for Medicare and Medicaid Services to offer the Hoosier Healthwise, Healthy Indiana Plan, Indiana Care Select, and MDwise Marketplace health insurance programs</td>
</tr>
<tr>
<td>McLaren Health Care</td>
<td>Flint, Michigan</td>
<td>Includes 10 hospitals as well as ambulatory surgery centers, a regional network of cancer centers, assisted living facilities, and McLaren Medical Group</td>
<td>McLaren Health Plan</td>
<td>HMO offering products for employee sponsored groups (Commercial) and government sponsored plan (Medicaid)</td>
</tr>
<tr>
<td>Sanford Health</td>
<td>Sioux Falls, South Dakota and Fargo, North Dakota</td>
<td>Largest rural non-profit health system in the country</td>
<td>Sanford Health Plan</td>
<td>Non-profit offering commercial, Medicaid, and Medicare plans</td>
</tr>
<tr>
<td>Spectrum Health</td>
<td>Grand Rapids, Michigan</td>
<td>Includes nine hospitals, 130 ambulatory sites, two physician groups totalling more than 750 providers</td>
<td>PriorityHealth</td>
<td>600,000 plus members covered by more than 27,000 doctors and other providers and more than 110 acute care hospitals</td>
</tr>
<tr>
<td>Trinity Health</td>
<td>Livonia, Michigan</td>
<td>Includes 47 acute care hospitals, 432 outpatient facilities, 33 long-term care facilities, multiple home health offices and hospice programs, and 3,400 employed and residents</td>
<td>Mount Carmel Health Plan</td>
<td>A provider owned Health Insuring Corporation that operates MediGold; a Medicare Advantage program in greater central Ohio</td>
</tr>
</tbody>
</table>

This pathway to a provider sponsored health plan requires most organizations 18 to 36 months from readiness assessment and strategy development, through tactical and operational planning, and implementation.

Target Population  
- Assessment of market size  
- Feasibility of attracting market  
- Marketing approach

Structure  
- Joint venture partners, if any  
- Ownership structure  
- Governance

Regulatory  
- Approvals and licensure required  
- Timing

Financial  
- Cash reserve requirements  
- Expected premiums  
- Financial projections

Operational  
- Capabilities inventory  
- Enhancements required  
- Outsourcing requirements

(Author's name)