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Analysis of Integrated Delivery Systems and New Provider-Sponsored Health Plans

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Many of the earliest and most prominent health insurance companies, such as Kaiser Permanente, Geisinger, and HealthPartners, were formed by provider organizations that under careful care coordination and conservative practice, were able to offer comprehensive benefits from a limited network of providers at competitive prices. Responding to incentives under the Affordable Care Act and other trends in their local markets, health systems in the United States have formed dozens of new health insurance companies or acquired existing health plans since 2010. This project examined the goals of these health systems in entering the health insurance business, and through interviews, data analysis, and case study research, looked at these and other questions: Are the new health plans growing and moving toward profitability? Are they having impact on competition, cost, and quality in their respective markets?

INTRODUCTION

Since 2010, provider systems established 37 new health insurance companies and acquired five existing health plans. The renewed interest by provider systems in owning their own health plans grew out of longstanding strategies to gain market strength and more control over premium revenues, and in response to payment changes under the Affordable Care Act (ACA) and other market trends.

Some of the provider systems operating new plans are the largest in their respective regions. About half of the new health plans are selling Medicare Advantage products only, while some others saw their best business opportunity as selling to individuals and small groups through exchanges and other channels.

While it is not unusual for a startup health plan to lose money in its first years, only four of the new plans were profitable in 2015. Some reported significant losses, and five have gone out of business. It has generally been a difficult time for health plan startups, as demonstrated by the demise of most of the health insurance cooperatives formed under the ACA and the large losses posted by companies like Oscar and Harken Health. Some of the new provider-sponsored plans were badly hurt by having to make large contributions to the ACA risk adjustment pools. They had little claims data to demonstrate the health status of their enrollees, while their major competitors had years of detailed data to establish that their enrollees were more expensive to cover.

Among the plans that went out of business was HealthSpan Integrated, the former Kaiser Permanente plan in northeast Ohio. The new owners did not have a good sense of the business opportunity or challenges. They were unable to turn around the plan and its clinics, which had lost $143 million and 50,000 enrollees in the previous five years. The brand of the new plan was unfamiliar and the clinics were not modern or well located.

Few new plans have gained enough enrollees to achieve economies of scale in plan administration, to gain ability to manage risk, or to have an impact on competition and price in their local markets. As of September 2016, four of these health plans had between 50,000 and 100,000 insured enrollees, and four others had between 25,000 and 50,000. The others were much smaller. Some are also administering benefits for their own employees on a self-funded basis or for other self-funded employer groups.

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For these new health plans to succeed, they must deliver on a value proposition of providing high-quality care at a lower cost. Most have not and only a few are making progress in that direction. Many of the provider systems are pursuing their health plan strategy at the same time they are forming clinically integrated networks and Accountable Care Organizations (ACOs). However, it appears most provider systems have not aligned these two strategies. Many new provider-sponsored health plans set their prices lower for group and individual coverage to be competitive in their local markets and to gain market share. However, they do that mostly by paying their own providers below market rates, not by reducing utilization and costs through better care management.

As part of this research, case study analyses were conducted on three of the new health plans: CareConnect, owned by Northwell Health of Long Island, NY (formerly North Shore-LIJ); Innovation Health, a joint venture of Inova Health of northern Virginia and Aetna; and Memorial Hermann Health Plans in Houston. All three are the largest provider systems in their core service areas. CareConnect and Innovation Health (operating under two licenses) are the biggest of the new cohort of provider-sponsored health plans, while Memorial Hermann (also with two licenses) had less than 35,000 insured enrollees in 2016. None were profitable in 2016, and CareConnect needed to reserve $120.7 million for payments to the small group risk-adjustment pool.

For the 2017 benefit year, Innovation Health was offered as the lowest cost Silver Plan in its area, but it will not be offered on Healthcare.gov for the 2018 benefit year. CareConnect had been the low-cost plan in the past, but raised its prices by about 27 percent. Memorial Hermann does not sell on the Healthcare.gov exchange, and its Silver Plans are significantly more expensive than two competitors in 2017. Of the three, CareConnect appears to be the furthest along in aligning its health plan and its other population health strategies.

OVERVIEW

Beginning with the first Kaiser Permanente health plan in northern California in 1945, provider-sponsored health plans have offered employers and individuals a combination of health care delivery and finance in a single organization. In exchange for a fixed monthly premium, enrollees could have access to comprehensive health care through a panel of employed or contracted physicians and hospitals. The early provider-sponsored health plans offered an implicit tradeoff: in exchange for a lower premium, enrollees would have better coverage, with less cost sharing, but only receive care from a limited network of providers. That was in contrast to the predominant model of insurance at that time, where insurance might cover only 80 percent of the provider's bill, but an enrollee had access to virtually all physicians and hospitals.

Some of the provider-sponsored health plans grew to become highly regarded health insurers, including Kaiser Permanente, which now operates in 10 states; Health Alliance Plan in Michigan, owned by the Henry Ford Health System; HealthPartners in Minnesota; Dean Health Plan, now part of the SSM system in Wisconsin; and the insurance companies of the University of Pittsburgh Medical Center in western Pennsylvania.

Since 2010, provider systems have formed or acquired 42 health plans. That number both overstates and understates the level of new plan activity. On one hand, several of the new companies created two health plans in order to operate in two adjacent states. For example, Catholic Health Initiatives (CHI), the second largest Catholic hospital system in the country, acquired two existing health plans (Soundpath Health in Washington state in 2012 and QualChoice in Arkansas in 2014), and started new Medicare HMOs in five states in January 2015. Alternatively, provider systems created two health plans, one with an HMO license and a second licensed as an accident and health insurer in the same state, because they wanted to offer a variety of benefit plans and thought there were strategic reasons to operate under different state rules. In addition, at least one of the newly licensed health plans (Aultman Health Insuring Corporation) is a reorganized or newly licensed version of an existing health plan. On the other hand, at least six provider-sponsored health plans that were formed since 2010 have failed already, or been sold, and the owners of several others are looking to sell. For example, two hospital systems in Georgia formed a Medicare Advantage health plan and then closed it after two years.

Those provider systems were responding in part to new incentives introduced or emphasized by the ACA. Most of them anticipated that in the future they would be required to accept additional financial risk and be accountable for improving the health of an identified population of patients. They were strengthening their capacity to analyze data on care utilization and cost, while implementing new systems of care coordination. Starting a health plan was a vehicle to apply these new capabilities. The ultimate goal was to attract new patients while generating savings that would drop to the system's bottom line.

This research focused on those new health insurers, looking at their early results, their chances of future success, and their impact on competition, cost, and quality in their local markets. As was noted above, some have already failed, and the analysis also discusses what appears to have gone wrong for them. It also looked at related strategies that these systems were pursuing, including forming ACOs for contracting with Medicare on a limited risk basis (and with Medicaid and commercial payers in some cases), and establishing clinically integrated networks.

APPROACH TO RESEARCH

Three principal methods were used in this research. First, more than 25 interviews, mostly in-person, were conducted with leaders in provider systems and their sponsored health plans, as well as academics, consultants, and others who have specialized knowledge and a broader perspective on the strategies that provider systems are pursuing and the organizational vehicles they are using. Second, the author and the Robert Wood Johnson Foundation (RWJF) staff assembled and analyzed a data set containing information on about 145 provider-sponsored health plans operating in the United States in 2015 and 2016. The data were mostly drawn from the annual and quarterly statements that health plans submit to their state insurance regulators, following the format of the National Association of Insurance Commissioners (NAIC). The contents of the spreadsheet are described below. Third, case studies were prepared on the experience of these three provider-sponsored health plans:

1. CareConnect, an accident and health insurance company formed by the Northwell Health system (formerly known as North Shore-Long Island Jewish) in Long Island, NY;
2. Innovation Health, a joint venture insurance company and separately licensed HMO owned by Inova Health in Falls Church, VA, and Aetna Health; and
3. Memorial Hermann Health Plan, an HMO and a separately licensed accident and health insurance company opened by the Memorial Hermann system in Houston, TX.

For each case study, three-to-five leaders in the health plan and provider system were interviewed, as well as other knowledgeable observers of that market. Additional data on enrollment and pricing of those plans and their competitors were gathered and analyzed, including enrollment by line of business and the comparative prices of Silver individual health plans sold on the exchanges in each area.

As noted above, some of the new plans failed in a short time, and additional research was conducted to get a sense of what went wrong for them. This part of the research focused on HealthSpan Integrated, the former Kaiser Permanente plan and clinics in northeast Ohio, which was acquired by the Mercy Health system of Ohio.

HISTORY OF PROVIDER-SPONSORED HEALTH PLANS

Even before the term health maintenance organization was coined in the 1970s, most of the earliest prepaid health plans were formed by physician clinics and hospitals. Kaiser Permanente got its start as a company clinic to workers in shipyards and steel mills in the 1930s and 1940s and opened to the public in 1945. Doctors and citizens formed Group Health Cooperative in Seattle in 1947. Seventy years later, Group Health Cooperative will become part of Kaiser Permanente. Group Health in Minnesota, now part of the HealthPartners organization, was established in 1957. In the 1960s and 1970s Kaiser Permanente began to expand to places like Colorado and the Mid-Atlantic (Maryland, Virginia and Washington, DC) region. The Henry Ford system in Detroit formed Health Alliance Plan in 1979.

The growth of these health plans coincided with the expansion of employer-sponsored health insurance after World War II and in the 1950s. Those plans, offered through Blue Cross and Blue Shield companies or life insurers like Prudential and others, allowed employees and their dependents to receive care from the physician or hospital of their choice. The patients would pay the bill and then submit it to the insurer for reimbursement, typically 80 percent of the charges. As employer enrollment in HMOs began to grow in the 1970s, state Blue Cross Blue Shield plans and national insurers like Prudential, Aetna, and CIGNA, responded by adding their own HMOs to offer additional options to employer groups.

Multi-specialty group practices and integrated physician-hospital systems formed new HMOs through the 1980s. Operating their own health plan meant that they had full control over the premium dollar. If they practiced conservatively and delivered care in the most appropriate setting, they could keep the dollars remaining within their systems. In most cases, the providers continued to contract with other health plans and to treat their enrollees and fee-for-service patients. Only a few very large plans, like Kaiser in California, could afford to have a mostly exclusive relationship between their health plan, hospitals, and physicians.

While most provider-sponsored plans began by serving employer groups in their areas, some were responding to the new business opportunities created by the Medicare Risk program (now in its third iteration and called Medicare Advantage) and by the decision of many states to move large numbers of Medicaid recipients into managed care arrangements. Those developments started a new wave of activity by provider systems opening new insurance companies. In states like Illinois and Texas that launched Medicaid managed care initiatives, state medical societies lobbied to include provider-sponsored health plans as contractors. In Illinois, many

soon went out of business after the first attempt by the state to impose mandatory enrollment failed to gain altitude.

Note that many of the new plans are not organized as HMOs but are licensed as accident and health insurance companies, which are regulated differently, depending on the state, from HMOs. One fundamental difference: in most states, an HMO can share risk with provider organizations through capitation contracts, but accident and health insurers may not. In many states, a third statute regulates nonprofit health service plans, usually the remaining nonprofit Blue Cross Blue Shield plans.

CHARACTERISTICS OF PROVIDER-SPONSORED HEALTH PLANS

The data on about 140 provider-sponsored health plans that were prepared for this research includes directory information and the date each company commenced business as a health insurer. For each company, the data also include financial information, such as capital and surplus, revenues and net income, use of capitation payments to providers, and enrollment by major lines of business: individual, group, Medicare, and Medicaid. Most of the data are for 2015, with some financial data from 2014 and some enrollment data for the third quarter of 2016. For this part of the analysis, the data are segmented into five periods: health plans formed before 1980; from 1980 to 1989, from 1990 to 1999, from 2000 to 2009, and from 2010 to the present.

Almost all the companies in the data set are licensed in their respective states as HMOs or accident and health insurers. Three Prepaid Health Services Plans (PHSPs) from New York state are not regulated by the New York Department of Financial Services as either HMOs or accident and health insurers, but are subject to similar financial regulation and reporting requirements overseen by the New York State Department of Health.

California health plans do not file the NAIC statements, but do submit similar reports with financial and enrollment data to their state regulators. There are several California provider organizations that operate under limited Knox-Keene licenses, meaning they can contract with full-service health plans, accepting significant financial risk for the utilization and costs of a defined group of enrollees. (California's statute for licensing pre-paid health plans is known as the Knox-Keene Act.) These limited plans are not full-risk insurance companies and are not included in this analysis. Neither are networks of providers that contract with health insurers to offer a limited network benefit plan, but are not separately licensed by the state. The Vivity health plans in California are an example of that kind of arrangement. A group of seven well known southern California hospital systems, including Cedars-Sinai Health System and UCLA Health, formed Vivity as a limited (or integrated) network plan offered to employer groups in partnership with Anthem Blue Cross of California. The notion is for the provider systems to set their pricing so that the benefit plans can be price competitive with Kaiser Permanente.

Exhibit 1 summarizes characteristics of provider-sponsored health plans grouped by the decades in which they entered the insurance business. The first cohort, health plans established before 1980, includes the Kaiser Permanente plans in California, Hawaii, Colorado and the Mid-Atlantic, plus Group Health Cooperative in Seattle, Health Alliance Plan in Michigan, and HealthPartners in Minnesota. Note that Kaiser Permanente of California had $61.048 billion in revenues in 2015, as much as the next 35 large provider-sponsored health plans. Because Kaiser Permanente of California is so large, it greatly skews the arithmetic averages of the other health plans in its cohort, so medians were used instead. (Note that Kaiser Permanente opened health plans in north Texas, the Albany, NY area, and the Cleveland, OH area in the 1970s and 1980s, which were not successful and were later closed or sold to other operators.)

Only 12 health plans remain from the pre-1980 cohort. The median enrollment in those plans is about 251,000 insured enrollees, and most of them sell in all the major lines of health insurance business: commercial (individual, small, and large employer groups), Medicare Advantage (or Cost) and Medicaid. In 2015, Kaiser Permanente of California had the most enrollees by far, at 8.1 million. Most of the others in the age cohort have between 100,000 and 500,000 enrollees, but two plans have less than 100,000.

Similarly, the median revenue for these 12 health plans was $1.348 billion. All but two had 2015 revenues above $1 billion, and four health plans in this group had revenues greater than $2 billion: the Kaiser Permanente plans in California, Colorado, and the Mid-Atlantic, and Group Health Cooperative of Seattle, which became a Kaiser Permanente health plan in 2016.

The number of health plans in the more recent cohorts is larger, and 29 of the health plans formed by provider systems in the 1980s are still in business. That group includes

the Tufts HMO in Boston, Scott & White Health Plan in central Texas, and six provider-sponsored health plans in Wisconsin. The largest of the Wisconsin plans, measured by premium revenues in 2015, is Dean Health Plan in Madison, with $1.22 billion in premium revenues. These provider-sponsored health plans were formed during the 1980s, when Wisconsin encouraged HMO formation by offering HMO plans as a health benefit option to state employees across the state and by implementing mandatory HMO enrollment for low-income Medicaid recipients in most of the state.

In 2016, 43 of the provider-sponsored health plans formed in the 1990s are still operating. *Exhibit 2* shows that the median of capital and surplus for health plans launched in the 1990s was $51.6 million, and eight plans had capital above $100 million. Most states follow the NAIC Risk-Based Capital standards for setting the minimum level of capital for health insurers. The exhibit also shows that the dollar amount of capitation payments declines steadily as one looks at the health plans from oldest to youngest. The plans formed in the 2000s paid $128.7 million through capitation contracts in 2014, or 11.8 percent of medical expenses. The oldest plans paid 40.4 percent of their medical expenses through capitation. In 2015, Kaiser Permanente in California spent $55.055 billion on medical expenses and paid about half of that through capitation to the Permanente Medical Group and other providers.[1]

Many provider systems formed health plans during the Clinton era of the 1990s, when proposals for national health reform envisioned integrated systems of health care and insurance that would compete with each other.[2] Some consultants were advising their hospital clients that the world was moving toward full capitation, and several hospital systems concluded that the best way to control their destiny was to go a step beyond capitation contracting and launch their own health plans.[3] At the same time, states like Illinois, Michigan, and Texas launched ambitious plans for mandatory Medicaid managed care in large parts of those states. Medical societies lobbied their states to allow provider systems to form health plans, sometimes with lighter regulation than HMOs or health insurance companies, to contract for Medicaid recipients.

While the number of provider-sponsored plans currently operating is about 145, there have been dozens of provider-sponsored health plans that started, but then were sold or closed. In Ohio, there were 13 provider-sponsored health plans in 1998 but that number dropped to six in 2016 and most of them began after 2010. Similarly, Michigan had 13 provider-sponsored health plans in 1998, but only 8 in 2016.

Why did many provider systems, including some regarded as strongly successful, elect to leave the health insurance business? Here are some of the reasons:

1. The difficulty for provider-sponsored health plans, usually operating only in their home region, to compete against national insurance companies. A good example of this is Touchpoint Health Plan in northeastern Wisconsin, which was owned by the ThedaCare system in Appleton and the Beilin Health system in Green Bay. Touchpoint was formed in 1988 and had grown to 140,000 enrollees. It was popular with local employers and patients and received very high marks from National Committee for Quality Assurance (NCQA). However, its owners concluded that a regional health plan could not compete against national companies. Some of the largest employers in the area had switched from Touchpoint to national insurers that could simplify administration of their benefit plans in multiple locations. The hospitals sold Touchpoint to UnitedHealthcare in 2004, which merged it into its Wisconsin HMO.

2. Hospital owners decided to cash out and use their health plan equity for other purposes. For example, the University of Michigan sold its MCare HMO and MCaid Medicaid HMO to Blue Cross Blue Shield of Michigan and received top dollar for the plans. The University of Michigan had entered the health plan business in 1986, and the two HMOs had grown to 200,000 enrollees before they were sold in 2006. National insurers like UnitedHealthcare were reportedly making offers to MCare, and Blue Cross Blue Shield was willing to pay a high price to keep UnitedHealthcare from gaining a stronger position in the market. The hospital system can use the proceeds to finance acquisitions of other hospitals or clinics, or invest in health information technology.

3. Sometimes the business opportunity doesn't fully materialize. When Illinois implemented its first attempt to enroll large numbers of Medicaid recipients in managed care in 1997, the University of Chicago health system formed a prepaid health plan (not a full-risk HMO) called Family First to contract with the state, as did several other provider systems. The University of Chicago made investments anticipating that the Medicaid health plan could grow to 25,000 enrollees in a few years. Instead, enrollment in Medicaid managed care did not take off as planned, and Family First gained less than

3,000 enrollees. The University of Chicago closed the plan within a few years and sold the enrollees to another health plan.

4. Sometimes the health plan's managers and the health system's physicians and administrators are at odds and can't get on the same page. In 1994, Allina Health system in Minnesota was formed by the merger of the HealthSpan hospital system and the Medica HMO. Allina physicians expected better payments from the health plan and that the health plan would steer patients to Allina hospitals and physicians. But the health plan managers would not pay more because that would make the health plan uncompetitive with the other local health plans, and it continued to contract with other provider systems because it marketed the health plan as a broad network, consumer choice model. An activist attorney general forced the breakup of the combined provider system and health plan in 2001, citing concerns about excessive market power. Even without his intervention, it is likely that the organization would have split within a few years. Conflicts between the health plan and care delivery sides of the organization were also cited as a reason for University Hospital system in Cleveland to sell its QualChoice health plan in 2006 to Anthem, Inc. for what was a very good price.

5. For one national hospital company, Tenet Health, operating health plans is no longer considered a promising business strategy. As part of its acquisition of Vanguard Health Systems in 2013, Tenet acquired Vanguard's health plans and Medicare ACOs in Arizona, California, Illinois, Michigan, and Texas, with about 139,000 total enrollees. It sold Harbor Health Plan in Detroit in October 2016 and plans to sell its Texas and Arizona health plans in 2017. A Tenet executive explained, "The health plans business we acquired with Vanguard [Health Systems] is not a core element of our capabilities in value-based care. It's subscale and not profitable in aggregate, and it requires capital. So, we are exiting it."[4] Tenet is also selling its hospitals in non-core markets and home health agencies.

McLaren Health in Michigan is an example of a provider-sponsored health plan that has been successful. It was formed in 1999 when Michigan expanded Medicaid managed care to counties outside the Detroit area. Since then it has added other lines of business and expanded into most counties in the state. At the end of 2015, it had about 204,000 enrollees. McLaren health plan and hospital executives alike agree that a provider-sponsored health plan must be empowered to execute its business plan, even when that means not favoring the provider owners in pricing or including competing provider organizations in its network. Several other interviewees for this research made the same point.

Sometimes what goes around comes around. There is at least one example of a provider system that had its own health plan in the 1990s, sold it, and then re-entered the business in the past five years. The Memorial Hermann system in Houston owned a health plan in partnership with a Catholic hospital system, but sold it to Humana in 1999.

NEW PROVIDER-SPONSORED HEALTH PLANS

Exhibit 3 provides an overview of 37 provider-sponsored health plans that commenced their operations since 2010. The health plans are sorted by state, in alphabetical order. Below that table is comparable information about five health plans that were established before 2010, but have been acquired by provider systems since.

Much of the new health plan activity has come from a few provider systems. For example, CHI, the third largest nonprofit health system in the country, established seven of the new health plans and acquired existing plans in Washington state and Arkansas. The new CHI health plans are in markets where CHI has member hospitals. Most of them are Medicare Advantage HMOs with fewer than 1,500 lives as of the third quarter of 2016. For example, CHI's RiverLink Health Plan in Ohio is a Medicare Advantage plan, whose provider network is built around the Tri-Health hospitals and physicians. CHI is a co-sponsor of Tri-Health along with Bethesda, Inc., a Protestant health organization. RiverLink in Ohio grew to 443 seniors at the end of 2015; 1,129 as of the third quarter of 2016; and about 1,170 as of January 1, 2017. CHI also established RiverLink of Kentucky, built around the CHI providers in Louisville and Lexington. In May 2017, CHI announced that it would seek buyers for its Louisville hospitals, including Jewish Hospital. That plan had 1,023 seniors on January 1, 2017. In Arkansas, CHI acquired QualChoice Life and Health Insurance Company, plan with more than 10,000 lives and added QualChoice Advantage, a Medicare Advantage plan, at the beginning of 2015.

CHI, which is in merger talks with Dignity Health, another major nonprofit hospital system, announced in 2016 its intent to withdraw from some or all its insurance ventures. It was reported that CHI lost $106.9 million in 2016 on its insurance operations.[5] In Nebraska, where CHI opened HeartlandPlains Health Plan, the new health plan faced pushback from Blue Cross Blue Shield of Nebraska, the dominant local insurer. For several months, the local CHI providers were excluded from the Blue Cross Blue Shield network, reducing their revenues.

In other cases, existing health plans added a new health plan, such as adding an accident and health insurance company alongside their HMO or adding a new license in a neighboring state. For example, Gundersen Health Plan in LaCrosse, Wisconsin, added a Minnesota HMO license in 2014.[6] UPMC Health Plan in Pittsburgh added UPMC Health Coverage to offer more group plan options, and Sentara Health of Virginia added a North Carolina insurance company license to expand its presence there. Memorial Hermann Health Plan started by acquiring the dormant UniCare health insurance license in Texas from Anthem, and then added a second license in 2013, so it could offer both PPO and HMO plans.

Some provider systems added insurance companies to capitalize on a specific business opportunity in their area or to fill a gap. For example, Christus Health of Texas added an HMO currently focused on products for individuals; Northwell Health in New York sought to capitalize on the new opportunity to sell to individuals and small groups through New York's insurance exchange, New York State of Health; and Johns Hopkins Health added a Medicare Advantage health plan to its Medicaid health company.

Exhibit 4 shows total enrollment in the new health plans in 2014 and 2015 and enrollment by major lines of business as of September 30, 2016. Most of the new health plans had less than 10,000 enrollees as of September 2016. Four of them had 50,000 enrollees or more: Health First Insurance in Florida, CareConnect in New York, Innovation Health Insurance in Virginia, and Network Health Insurance Corporation in Wisconsin.

Some of the new health plans are joint ventures between provider systems and health insurers. One example is Innovation Health in northern Virginia, a partnership of Aetna Health and the Inova Health System. (Aetna's joint ventures are discussed in more detail below.) The Moses Cone health system in Greensboro, NC, partnered with Care N' Care Insurance of Texas to form a Medicare Advantage health plan called HealthTeam Advantage, and Anthem, Inc. and the Aurora system in Wisconsin have formed a new insurance company focused on employer groups. In New England, Tufts Health Plan formed a joint venture health plan with a group of hospital systems in New Hampshire.

A variation on the joint venture model can be found in the growth of two consulting firms that work with provider systems on health plan strategies and population health initiatives. Evolent Health, based in Arlington, VA, was formed by UPMC Health Plans and the Advisory Board in 2011. Evolent Health supports provider systems with plan administrative services, software, and data for population health management, and consults with provider systems that want to operate their own health plans. When it made its public offering in 2015, the company identified seven key partnerships where it was providing core management services to new or established health plans owned by provider systems. Examples include Passport Health, a Medicaid plan in Kentucky and Piedmont-WellStar Health Plan, a Medicare Advantage plan in the Atlanta area that closed at the end of 2015. The technology for plan administration is based on what UPMC Health Plans has developed. The initial public offering in 2015 established the value of the company at more than $1 billion. In the fall of 2016, Evolent acquired Valence Health, another consulting firm, based in Chicago that works with providers seeking to move toward value-based contracting and a health plan strategy. In the past few months, Evolent has announced new partnerships with Orlando Health in Florida, Carilion Clinic in Virginia, and Banner Health Network in Arizona.

Exhibit 5 shows financial results for the new health plans in 2015. Only a handful of the plans posted positive net income in 2015, with UPMC Health Coverage having the best results. A few plans posted very large losses, including Land of Lincoln Health, a cooperative formed under the ACA, which has since gone out of business, and HealthSpan Integrated, the former Kaiser plan in northeast Ohio, which has also closed its doors. Land of Lincoln posted a loss of $90.8 million in 2015, and HealthSpan Integrated lost $217.6 million.

HEALTH PLAN FORMATION STRATEGIES

Why the renewed interest by provider systems in entering the health insurance business? For the most part, the reasons have not changed in the past 40 years. First, provider systems want more control over premium dollars, sometimes described as getting to the "top of the health care food chain." The CEO of a provider-sponsored health plan noted that as health plans get larger and

exert more market power, providers are at risk of being reduced to price takers at the bottom of the food chain. Even when provider systems have full capitation contracts, they typically receive 80 percent or less of the premium dollar and the health plan keeps the rest for marketing, overhead, and profit. Second, at a time when inpatient volume is flat or even declining in some local markets, some provider systems see operating an insurance plan as a way of gaining additional patients and the revenues that accompany them.

Put another way, some provider systems start a health plan as a defensive move because they are losing patients to other provider systems. For example, Vivity Health was formed by Los Angeles area hospital systems working with Anthem Blue Cross because they were losing patients to Kaiser Permanente. Similarly, the Sutter health system in northern California was also losing patients and decided to start its own health plan. Third, they see business opportunities in certain lines of business, especially Medicare Advantage. As of September 2016, 22 of the 41 provider-sponsored health plans listed in *Exhibit 4* are operating Medicare health plans, and Medicare is the primary or only line of business for 17 of them.

Another explanation frequently cited is that patients and employers like doctors and hospitals more than insurers, and hold them in higher regard. Establishing a provider-sponsored health plan is way of leveraging that regard. For example, will a plan enrollee prefer to receive health advice from a nurse employed by a local provider versus a nurse in a remote location calling from a national insurance company? Some are skeptical that those preferences would influence the purchasing decision of an employer or an individual.

At least four important factors have changed. First, providers cited the enactment of the ACA in 2010 as a reason for launching a health plan. Specifically, the law introduced a series of initiatives to change provider payment methods and to refocus attention on what is broadly called population health. The ACA created incentives for health systems to focus on improving the health of a defined population of patients and delivering care more efficiently. In other words, payers like Medicare are moving to payment methods that reward *value* instead of *volume*. This is most clearly seen in the changes made and initiatives launched for Medicare, such as bundled payments and the different kinds of ACOs. The ACO concept is simple: a provider organization contracts with Medicare to provide comprehensive care to a defined population of seniors. If that is done at less cost than in the previous year while meeting quality benchmarks, the ACO and its participating providers will share in those savings. Note that the bar keeps rising. As an ACO is successful in reducing costs, the spending benchmark for the next year is also reduced.

Successful ACOs built up their capabilities to assemble and analyze data on their patients to identify those using large amounts of care and to implement care management practices and systems to reduce the cost of care provided.[7] One example is reducing unnecessary readmissions, emergency room visits, and use of post-acute care through better discharge planning and follow-up. Using those same capabilities and practices, some provider systems have sought to scale up and take most or all the utilization risk for those patients by operating an insurance plan. If they are successful, they keep all the savings generated, not just a share.

The second change cited by several interviewees is the availability of robust data sets detailing the utilization and cost of care, and powerful tools to analyze the data. Information systems, including electronic medical records, that are now in wide use, enable provider systems to analyze utilization patterns and identify high utilizers of care and gaps in care management. A former executive at Evolent Health gave as an example the potential of using data for risk stratification in order to identify patients who need the most support and attention.[8]

Third, Medicare, which is usually the payer for 30-40 percent of a system's patients, has changed. In the past, Medicare was generally paying providers on a fee-for-service basis, so there was no incentive to manage utilization. Today, Medicare is a leader pushing providers to move toward value-based payment and care delivery. CMS has announced a goal of 50 percent of Medicare payments being tied to quality by 2018. The enactment of MACRA in 2015 (the Medicare Access and CHIP Reauthorization Act) creates important financial incentives to move to payment methods that reward quality.

The fourth change is more of an updated version of a popular strategy from the 1990s. Provider systems formed a variety of networks, known by names such as physician-hospital organizations, independent practice associations, and group practices without walls. The notion was that competing providers, retaining separate ownership and governance, could form partnerships for care delivery. Those partnerships, in turn, would contract with health plans or perhaps with large self-funded employers. While a few of those succeeded, most never demonstrated that they could provide significant additional value to insurers or employers.

In this decade, similar partnerships are referred to as Clinically Integrated Networks (CINs).[9] Many hospital systems, including the three analyzed in the case studies that follow, have established CINs. A CIN can negotiate contracts on behalf of providers that are otherwise competitors. In order to pass muster with the Federal Trade Commission (FTC), participating providers must agree to accept evidence-based practice guidelines, must participate in development and enforcement of the guidelines, and must invest in the time and information technology, including electronic medical records, needed to operate as an integrated network.

Just as in the 1990s, the question is whether these new CINs can demonstrate significant added value. In Wisconsin, most of the hospital systems joined one of two large CINs. The Ascension hospitals, one of the two largest systems in the state, joined together with the Froedtert/ Medical College of Wisconsin and other systems to form Integrated Health Network of Wisconsin. The Aurora system, the other largest system, joined together with the University of Wisconsin Health system, Gundersen in LaCrosse, Beilin in Green Bay, and ThedaCare in Appleton to form a CIN called AboutHealth.

Both CINs built up an infrastructure of staff with population health expertise and data systems, and both succeeded in getting some contracts with payers. However, it appears that neither one could get enough new contracts and revenues to support the new infrastructure. In September 2016, Integrated Health Network laid off about 40 percent of its staff, saying that it was transferring those duties to the member systems. A few months later, University of Wisconsin Health dropped out of AboutHealth.

There are four basic approaches for a provider system to take when it seeks to enter the insurance business:

1. Build: A provider system, possibly partnering with other providers, builds a new health plan from the ground up or by renting pieces of the machinery. This is the most common approach for the current cohort of new health plans. Examples include Northwell CareConnect and the two Crystal Run health plans, all in New York.

2. Buy: A provider system acquires an existing health plan. Examples include the Tenet/Detroit Medical Center hospitals acquiring a Medicaid HMO called ProCare in 2014 and renaming it Harbor Health Plan in Michigan and the Mercy Health system in Ohio buying the Kaiser Permanente health plan and clinics in the Cleveland-Akron area and creating HealthSpan Integrated. (Tenet has since sold Harbor Health Plan, and Mercy Health closed HealthSpan Integrated.)

3. Partner: A provider system and a health insurer form a joint venture health plan, with the health plan supplying most of the administrative services needed. Innovation Health in Virginia, a partnership of Aetna Health and the Inova Health system, is an example of this.

4. Evolve: A provider system that operates a successful Medicare ACO or a rental-preferred provider network uses that experience and those assets to start a health insurance company. Memorial Hermann Health Plan and Health Insurance Company in Houston can be viewed as an example of this approach. A few years ago, QualCare, a preferred-provider network owned by hospital systems in New Jersey, did the groundwork to create a new Medicare Advantage health plan – but stopped short. CIGNA acquired QualCare in 2015.

What is necessary for a new provider-sponsored health plan to succeed? The CEO of a major provider-sponsored health plan in western Pennsylvania summarized it this way: “To be successful, a provider-sponsored health plan has to create a value proposition that includes better quality care and a more affordable network of providers. Going forward it must maintain that added value. A hospital system that operates a health plan only to bring more patients to its hospitals won’t be sustained.”[10]

A consultant to provider systems echoed the need to demonstrate the value of integrating care delivery and insurance. “A provider system’s brand name will not add much to sales of an insurance plan unless it is accompanied by the demonstrated ability to manage clinical care more effectively.”[11] He also noted the importance of engaging physicians in the new health plan and giving them opportunities to earn more through population health initiatives. Some of the new health plans start by paying physicians below market rates, creating internal conflicts and obstacles to success.

Another observer of health plan and provider markets suggested that effective care delivery organizations can enjoy the benefits of owning a health plan without assuming the risk or making the necessary investment. “The risk of owning a health plan is significant. If a provider system can deliver great care while saving money, does it need to start a health plan? Why not continue to provide efficient, high-value care for multiple payers and enjoy strong margins?”[12]

To launch a successful health plan, a health system needs a large population base and annual revenues. One consultant suggested that a local population of at least one million is needed and that the hospital system should have $1-2 billion in revenue.[13] He further suggested that provider systems should move carefully into assuming both upside and downside risk, perhaps beginning by gaining experience through some of the Medicare ACO models. Finally, he cautioned that some provider systems invest in building a large infrastructure, but don't have sufficient enrollment over which to spread those expenses. For that reason, and others, partnering with an existing health plan and using its infrastructure may be a more promising approach.

In order to reach a size that enables a health plan to gain economies of scale and to better manage risk, many health systems will move administration of their employee health plans into the new insurance company. A few bought contracts or blocks of enrollees to jumpstart their growth. In 2016, the Memorial Hermann Health Plan in Houston bought about 14,000 Medicaid managed care enrollees from Molina Healthcare, which will take place in 2017.

One of the factors that seems to motivate provider systems is whether the major payers in the area are open to value-based contracting, including accountable care/shared savings programs, primary care medical homes, and payments to providers to use technology and care processes to make patient care more efficient. One consultant leader observed that independent Blue Cross plans in many states seem less inclined to engage in value-based contracting with provider systems, so there are more examples of those provider systems pursuing their own health plan strategy.[14] At the beginning of 2017, Aetna Health announced that it would form four joint venture health plans with provider systems. The first was Innovation Health in northern Virginia, which has been in operation since 2013. Since then Aetna has announced that it will form joint venture health plans with Texas Health Resources, the largest hospital system in the Dallas-Fort Worth area, Banner Health, the largest system in Arizona, and Allina Health, the largest hospital system in the Twin Cities. In each state, an independent Blue Cross plan is the number one or two insurer in the area.

DESIGN ISSUES AND CASE STUDIES

This section presents results from three new provider-sponsored health plan case studies. The interviews and background research on these health plans focused on a series of issues needing to be addressed in putting up a new health plan.

1. What is the business opportunity and which lines of business should the new plan enter? Can a health system leverage its public image as a trusted provider by starting an insurance company?
2. What is the best way to put together the infrastructure needed to operate the health plan?
3. Where will the initial capital come from and how is governance of the new organization structured? Does the system have a realistic view of how much capital will be needed to sustain the plan for early years of losses?
4. Will the new health plan administer benefits for employees of the health system? What are other ways of seeking to get to scale?
5. How will the new health plan price its products, particularly for individual and group plans? Is that pricing based on discounts granted by the provider owners or by savings generated from reduced utilization and better quality?
6. Is the health plan strategy aligned with related health system initiatives, such as forming a clinically integrated network and contracting with Medicare as a shared savings ACO?
7. What are the specific challenges that face new provider-sponsored plans as well as any health insurance startup in the current environment?
8. What impact has the new plan had on competition and price in its local market?

In the case studies that follow, data on the revenues and net income, and the impact of the ACA risk-mitigation programs are compiled from NAIC annual statements.

Building a Health Plan: Northwell CareConnect

CareConnect was formed in 2013 by the North Shore-LIJ (Long Island Jewish) health system, now known as Northwell Health, and its first enrollees joined in 2014. Northwell is the largest provider system in New York state, with 21 hospitals, mostly on Long Island, but also in New York City and Westchester County. In 2015, it had operating revenues of $8.722 billion.

The system is the largest provider in much of Long Island and in parts of Queens. As such, it is seen as an essential provider by most health plans and commands high fee-for-service payments. Northwell already had significant managed care experience, both as a provider system and as a plan sponsor. It is one of the sponsor hospitals of HealthFirst, which is primarily a Medicaid and Medicare Advantage health plan. HealthFirst is the fifth largest health plan company

in New York, with 2014 revenues of $5.93 billion. Before starting CareConnect, Northwell developed a joint product with UnitedHealthcare in New York based on a first-tier network of Northwell facilities and providers, but got only a handful of enrollees. That experience soured Northwell on the possibility of a joint venture health plan.

Besides creating CareConnect, the health system has pursued other growth strategies. It expanded its presence in Manhattan when it acquired Lenox Hill Hospital in 2010. In 2014, North Shore-LIJ acquired Phelps Memorial Hospital and Northern Westchester Hospital, both in Westchester County. Since then, it established a free-standing emergency department at the former St. Vincent's hospital site in Lower Manhattan. It is known as Lenox Health Greenwich Village, linking the center both in branding and in referrals, and transfers to Lenox Hill Hospital. In another strategy to expand its geographic presence and build up referrals, Northwell formed a partnership with GoHealth Urgent Care clinics. That chain currently has 34 clinics in the five boroughs and Long Island. GoHealth has similar partnerships with local hospital systems in its other major markets in Portland, OR and northern California.

Implementation of the New York health insurance exchange, along with the mandates and subsidies for coverage, created an opportunity for new health plan entrants. Two other health plans started at the same time in New York as CareConnect: the Health Republic cooperative and Oscar Health Insurance. Northwell decided to begin with commercial products for individuals and groups, having concluded that both the Medicaid managed care and Medicare Advantage markets were already too crowded to enter. Census estimates for 2015 show about 227,350 seniors in Nassau County. About 58,300 of them, or 25.6 percent, were enrolled in a Medicare Advantage plan in January 2017, which is not a high penetration rate.

In 2013, the health plan was formed with $25.7 million of capital. Many leaders of CareConnect come from the health plan world, with the CEO coming from UnitedHealthcare and Empire Blue Cross Blue Shield. To establish the health plan, Northwell built some administrative functions and contracted for others. Certain core functions involving customer contact, such as call centers, were built in-house. Other functions, like premium collection, were contracted out. Like other health plan startups, CareConnect's administrative expenses are relatively high. In the first nine months of 2016, CareConnect spent $60.8 million for plan administration expenses, which is 23 percent of premium revenues and $72.72 per member per month.

In 2014, CareConnect gained 11,662 enrollees and grew to 69,374 at the end of 2015. By the third quarter, enrollment reached 100,000, with 70,500 in small group plans and the rest in individual plans. As many as 30,000 of the enrollees came to CareConnect from Health Republic, the insurance cooperative in New York that flamed and crashed toward the end of 2015. Northwell was not a contracted provider to Health Republic, so its losses were mostly for emergency department visits and were less than some other providers when state regulators shut down the failed insurance cooperative.

CareConnect did not begin, as many provider-sponsored plans do, by enrolling hospital employees into the new health plan. Only in the past year did Northwell offer CareConnect as a plan option for system employees. Almost all the system's employees remain in a self-funded plan for which UnitedHealthcare provides administrative services.

Few new health plans are profitable in their first years, and that was the case for CareConnect. It lost $31.8 million in 2015 and $27.2 million in 2014. Health plan executives say that the health plan is on track to show an operating surplus, except for a huge obstacle in the road. The ACA created a three-part mechanism to mitigate losses for insurers that took a chance on entering or expanding their individual and small group business. The "3 Rs"—reinsurance, risk adjustment, and risk corridors —were designed to protect insurers who enrolled a population that was sicker than average and consumed more care than was budgeted. In concept, those insurers with sicker enrollees would get payments, while other insurers that enrolled a healthier population, one that was below average in its care utilization, would contribute to those pools.

Based on the risk profile of the CareConnect enrollees in 2015 and how that compared to other health insurers in the state, the largest of which is Oxford Health, CareConnect paid $13.3 million to the small group market risk-adjustment pool. Oxford Health received payments of $315.4 million. A reporter for *Modern Healthcare* summarized the issue this way: "Some insurers argue that the risk-adjustment formula favors bigger payers with more claims experience. . . . Small companies have said they don't have as much claims data, and therefore their membership base looks healthier than it is."

Based on its small group enrollees and operations in the first three quarters of 2016, CareConnect recorded a reduction to premium revenue of $89 million to be paid to

the risk-adjustment pool for New York. Without that liability, the company would have come close to breaking even on operations in 2016. (It showed a loss of $93.8 million for the first three quarters. Its annual statement for 2016, filed on March 1, 2017, showed a loss of $157.5 million. Of that amount, $110.8 million was in small group business and $42.4 million was from individual business. It also showed that CareConnect had recorded a liability of $120.7 million for the risk-adjustment program, subject to change as new information becomes available.)

Most of the money that CareConnect contributes to those pools is likely to go to the Oxford Health Plans, a UnitedHealth Group company. Note that Oxford Health Insurance, one of four UnitedHealth Group health plans operating in New York, had operating income in the first three quarters of 2016 of $376.2 million on revenues of $3.924 billion. It has a very large share of the small group market, and the average risk factor for its enrollees is very high. Besides the obvious pain of paying so much to the risk-adjustment pool, Northwell had to contribute $80 million in additional capital during 2016 to comply with state solvency requirements. Those dollars diverted to the health plan are not available at budget time when hospital administrators and different divisions of the health system compete for increased budgets for staff or spending on other initiatives. That is the kind of challenge that raises questions in other units of the health system about the wisdom of pursuing a health plan strategy.

The ACA risk-adjustment program functions as a zero-sum game. For every dollar benefiting a health plan, another health plan must give up a dollar. There may be a silver lining to the risk-adjustment cloud, at least for 2017. The New York State Department of Financial Services adopted an emergency regulation in September 2016 that authorizes the Superintendent of Financial Services to create a "market stabilization pool" if she determines that the transfers of funds under the ACA risk-adjustment mechanism for small group plans would adversely affect the stability of the small group market in the state. The stability fund would capture some of the money received by health plans under the ACA risk adjustment and distribute back to health plans that paid in and were adversely impacted. Some observers suggested that CareConnect would have sharply reduced its presence in that market in 2017 if it did not obtain relief from the state.

What impact has CareConnect had so far? In Nassau County in 2017, CareConnect competes against five other health plans selling individual coverage on the New York State of Health exchange. Based on a single male, age 40, *Exhibit 6* compares the monthly premium and the annual deductible of the lowest priced Silver Plan offered by each of those companies for the 2017 and 2016 benefit years. In 2016, CareConnect's EPO (Exclusive Provider Organization, meaning no out-of-network benefits) plan was the lowest price Silver Plan in Nassau County, followed closely by Fidelis Care. However, CareConnect increased its premiums by about $100 a month for 2017, and it is now roughly in the middle of the price range. It increased its premiums for small groups by 23 percent, much of which was needed to cover the anticipated transfer of risk-adjustment dollars. Fidelis Care, which increased its monthly premium for individuals by about $51 and HealthFirst, which increased its premium by only about $31, are now less expensive than CareConnect in Nassau County.

CareConnect executives said they believe that their small group option is the most affordable in the market and that its individual plans are the most affordable of the commercial plans that include Northwell providers in their network. Fidelis Care and HealthFirst both include Northwell hospitals in their provider networks, but are primarily Medicaid plans.

Has CareConnect affected competition in the New York area? According to a leader of employer purchasers, the Greater New York area is an area with good competition by health plans selling to employers. The four large companies are sometimes referred to as BUCA or CUBA: Blue Cross, UnitedHealthcare/Oxford, CIGNA, and Aetna. National employers are primarily working with those four companies, often as administrators for their self-funded group plans.

Local observers that were interviewed representing employer purchasers and hospitals commented that Northwell providers are well-regarded, and the system is seen as investing in the analytics and other capabilities needed to make the transition to population health management. Other New York systems are viewed as not investing, and still dependent on fee-for-service payments.[16]

Those observers welcomed the new competition that CareConnect and the other startups bring to the local health plan market. Still, one questioned whether the commercial market was the right place to start, compared to Medicare Advantage, for example. A commercial population generally commands a lower monthly premium and there are fewer opportunities to save money. That is, fewer commercial enrollees have chronic conditions or are experiencing avoidable hospitalizations. Commercial plans

often pay more to specialists, and there may be opportunities to reduce spending there – but at the possible consequence of alienating those specialists.

Has CareConnect gained significant market share? Enrollment in CareConnect was 100,000 as of the third quarter of 2016, with about 70 percent of that in three counties: in Nassau and Suffolk counties on Long Island, and Westchester, north of New York City. (Enrollment reached 112,000 at the end of 2016, with much of the growth coming from large employer groups.) About 65,000 enrollees were in small group plans, and about 29,300 were in individual plans. Almost all the small group business was sold outside of the exchange while about 40 percent of the individuals bought coverage on the public exchange. Note that, according to CareConnect leaders, the health plan mostly sells Platinum and Gold plans, so that would mean that a lower than average proportion of enrollees received subsidies to buy their coverage.

Based on New York supplements to health plan statements for the third quarter of 2016, there were about 84,500 enrollees in individual plans (called Direct Pay in New York) in those counties, and CareConnect had 27 percent of them. Empire Blue Cross Blue Shield has 30 percent and Oscar had 28 percent. The number of individuals with insurance coverage in those counties grew from about 16,600 in 2012, before implementation of the ACA.[17] Most of those individuals were covered by Empire Blue Cross Blue Shield.

Enrollment in small group plans in those counties has decreased since 2012, from 304,800 to 219,000. Still, the UnitedHealthcare companies (including Oxford Health) continue to dominate that market. CareConnect had 21.1 percent of the small group enrollees in those counties in 2016, while UnitedHealthcare/Oxford had 90 percent in 2012 and 76.7 percent in 2016.

Has the health plan strategy helped to move the Northwell system to a greater focus on population health? As Northwell was establishing the health plan, it also created Northwell Health Solutions as a center for analyzing data on care quality and cost, and for launching initiatives to improve care management. In 2015, Northwell was approved to begin a Medicare Shared Savings Program ACO in January 2016. It is one of 100 new Medicare Shared Savings Plan ACOs that started their participation in 2016. It had already participated as a provider in a Pioneer ACO with Montefiore Medical Center in the Bronx. In addition, it has entered ACO-like arrangements with commercial and Medicare Advantage payers, including Empire Blue Cross and Blue Shield and Humana.

Northwell Health Solutions formed a clinically integrated network comprised of Northwell employed physicians plus other affiliated practices to offer to payers like Aetna and HealthFirst. Like other hospital systems it is analyzing its protocols for care coordination and follow-up after discharge, as well as practices within the hospital. Some of its hospitals, including North Shore University in Manhasset, were subject to the Medicare 1 percent penalty for an excessive rate of hospital-acquired conditions. North Shore and other hospitals in the system were also penalized for a high rate of readmissions for certain admission categories, such as pneumonia and heart failure. It launched several initiatives to reduce emergency department use and to improve transitions of care, as well as sharing information with physicians about their performance. It is assembling those improved capabilities as part of a move to value-based contracting with key payers, while also applying those improved capabilities to CareConnect enrollees.

In a recent step toward aligning those population health initiatives with CareConnect, the health plan named the head of Northwell Quality Solutions as its Chief Medical Officer. Still, it would be correct to say that in its first years, CareConnect was able to offer competitive pricing for its health plans by reducing payments to Northwell physicians and facilities. (Health plan leaders said that CareConnect pays community physicians more than its key competitors.) As it moves into its next stage of development, it hopes to achieve the kind of clinical integration that will lead to higher quality and lower costs.

Health plan leaders said they had not detected any significant pushback from health plans who might be upset that Northwell was now in competition with them. While the health plan has grown, its numbers are still relatively small in the region. Further, the Northwell system is seen by many employers as a “must-have” provider, which would make it difficult for a health plan to exclude Northwell from its network. Finally, Northwell hopes that other health plans will appreciate the value of the capabilities it is building for care management and population health.

Joint Venture Strategy: Innovation Health

Inova Health is the largest hospital system in Fairfax and Loudon Counties in the northern Virginia suburbs of Washington, DC. In 2015, the system had operating revenues of $2.972 billion. It is in a very well-educated and affluent area, with median household income of $113,208 in Fairfax County in 2015. Penetration by Medicare Advantage

plans is low here. About 125,600 people (11% of the population) in Fairfax County are 65 and older and less than 15 percent of them are in Medicare Advantage plans.

The system includes five general acute care hospitals, a pediatric specialty hospital, freestanding emergency departments, urgent care clinics, ambulatory surgical centers, and more than 400 employed physicians practicing in dozens of sites around the region. The system grew through mergers, acquisitions, and construction of new facilities. In 2008, Inova sought to merge with the Prince William Health System, which has a large hospital in Manassas, but withdrew in the face of a challenge from the FTC. Prince William affiliated a year later with the Novant Health system of North Carolina. There is no public hospital in these counties, so the Inova system provides much of the indigent care in the area and operates specialized clinics for persons with HIV/AIDS. It also has launched the Inova Center for Personalized Health, focusing on genomic and translational medicine, and has partnerships with the University of Virginia for research and education.

One Inova Health executive described the region as of one the most lucrative fee-for-service regions in the country. Inova Health's largest commercial payer is CareFirst, the Blue Cross Blue Shield plan for northern Virginia, DC, and Maryland. And because the Inova system is considered by many employers and others to be a "must-have" provider, it commands high fee-for-service payments. The Inova system had been a major provider to Kaiser Permanente, one of the largest health plans in the region, with more than a half million enrollees. However, the two ended their contracts in 2013, and Kaiser Permanente uses two other hospitals in northern Virginia.

Inova Health concluded that the current fee-for-service environment was not sustainable, particularly as key elements of the ACA were implemented. It expected that more care would be delivered outside of its acute care hospitals and a greater percentage of revenues would come from performance-based contracts.

To make the transition to an organization focused on population health, Inova Health determined that it should re-enter the health plan business. (In 1997, Inova Health bought the Virginia HMO of Principal Insurance, ran it for a few years, and then closed it.) Rather than attempting to build a new health plan, it decided to either buy a health plan or form a partnership with an existing insurer. If the health plan could grow to half a million lives, Inova Health expected it would lose some of its lucrative fee-for-service business. But it would also grab market share from other local hospitals and would have control over 100 percent of the premium.

Based on responses to a Request for Information, Inova selected Aetna as its partner in forming a joint venture insurance company. The new insurance company, named Innovation Health, was Aetna's first venture into establishing a new health insurance company with a provider system. As noted earlier, Aetna has also developed partnerships with provider systems that can be described as private label products. Aetna supplies the insurance license and the administrative systems, and the products are limited network plans based on the partner health system's care delivery network. For example, Aetna has a private label arrangement with Carilion Clinic, a five-hospital system in the Roanoke, VA area.

In both models, the emphasis is leveraging the positive image of the provider system in the local market. There is a general sense that people relate more positively to their medical provider than to their health insurance company. Aetna is not named and remains somewhat in the background.

Innovation Health was not the first venture by the Inova system in the insurance business. Its venture into health plan operation in the late 1990s was not successful. In 2012, Inova Health acquired a Medicaid health plan, now called INTotal Health, from Anthem, Inc. (Anthem was required to divest some of its holdings in Virginia as part of its acquisition of Amerigroup, a Medicaid company.) INTotal had about 58,400 Medicaid enrollees at the end of 2015.

This process of designing what became Innovation Health occurred at the same time as Inova Health's acquisition of the Amerigroup Medicaid HMO, but the company did not consider using that health plan as a vehicle for commercial and Medicare products. Based on interviews with Inova Health leadership, the Medicaid health plan continues to operate separately from the commercial plans.

Innovation Health operates under two licenses in Virginia: Innovation Health Plan for HMO plans and Innovation Health Insurance for PPO products. The governing board is made up of four members appointed by Aetna and four appointed by Inova Health. Aetna Insurance provides almost all administrative services to the health plans. Several of the key health plan executives moved over from Aetna. Each partner contributed capital to create the new company and then, as enrollment grew, added more capital to meet solvency requirements. Under a management services agreement, Aetna Health Management (AHM) provides a range of plan administration services to the health plans. Innovation Health Insurance incurred costs of $40.0 million to AHM in 2015 for plan

administration services and $26.3 million in 2014. Innovation Health has its own sales and marketing staff and works through local brokers and agents. As the health plan grows, some of the administrative functions may move in-house. Aetna manages the data on utilization and costs and it also supplies care management for enrollees served by providers outside of Inova Health.

When Innovation Health prepared to launch, Aetna offered its employer customers in the area the chance to move to the new company, to stay with Aetna, or to select a different plan. Many did switch to Innovation Health, including some of the large private employers in the area. Going forward, Aetna and Innovation Health have an agreement in place to not quote against each other.

Enrollment has increased quickly in the first years of the plans. The two health plans had a few thousand enrollees at the end of 2013 and grew to about 75,000 by the end of 2015. As of September 2016, combined insured enrollment in the two plans had grown to 100,000 lives. Both companies sell group plans, combining for about 43,000 lives. Innovation Health Insurance also sells to individuals, of which more than 56,500 were enrolled in September 2016. About 90,000 more are in self-funded employer groups.

Besides building the health plans, Inova Health also launched other population health and accountable care initiatives. It formed Signature Partners as a clinically integrated network in 2014 and 2015. Signature Partners is the vehicle for Inova Health's Medicare Shared Savings Program (MSSP) ACO, one of 10 MSSP ACOs primarily serving seniors in Virginia. The ACO network includes the Inova hospitals and physicians, other independent physicians in northern Virginia, and a group of providers in the western part of the state and in West Virginia. Signature Partners is also a first-tier network for Innovation Health, and enrollees using Signature Partners providers have lower cost-sharing. Health plan leaders said 75 percent of the physicians in the Innovation Health network are outside of Inova Health.

In 2015, the Signature Health Partners MSSP ACO had about 23,300 attributed lives and met the quality performance standards. However, its spending on those seniors was about $10.4 million higher (5%) in 2015 than the benchmark, and it did not earn shared savings. A leader in the ACO said that the average spending per senior was about $7,800 in the Fairfax area but much higher in the western part of the state, where the participating providers include rural hospitals and federally qualified health centers.

Innovation Health has ambitious goals for future growth, projecting growth to 500,000 enrollees, both insured and self-funded, in the next three years. Besides expanding its commercial business, Innovation Health plans to add a Medicare Advantage plan for January 2018, centered around the Signature Health Partners network. It also is exploring partnerships with other provider systems in the state, combining some measure of clinical integration with participation in the Innovation Health plans. If it expands statewide, Inova Health leaders project that enrollment in the health plans could reach 1 million.

Both Innovation Health companies were profitable in 2015. Innovation Health Plans reported net income of $3.4 million, or 4.3 percent of premiums, while Innovation Health Insurance, the bigger of the two, had net income of $3.1 million, or 1.5 percent of premiums. However, both reported losses in 2016. Innovation Health Insurance lost $26 million, and Innovation Health Plans lost $4.9 million. The plan owners had to contribute $10 million in additional capital to Innovation Health Insurance and $5.4 million to Innovation Health Plan.

The Innovation Health plans were net contributors to the ACA reinsurance and risk-adjustment pools based on 2015 and 2016 operations. Data from CMS for 2015 operations shows that Innovation Health Insurance would net about $300,000 in payment on the individual adjustments and would gain $2.1 million from risk adjustments for its small group plans. Innovation Health Plan is required to contribute $6 million to the risk-adjustment pool for its small group plans.

Based on its annual statement for 2016, Innovation Health Plan projects that it will pay in $9 million to the ACA small group risk-adjustment pool. Innovation Health Insurance will pay $37.3 million to the risk-adjustment pool, but should get back $5.3 million from the ACA Reinsurance program. These amounts are subject to a final reconciliation to occur in 2017.

What impact is Innovation Health having in northern Virginia? First, it has achieved significant market share in both the individual and small groups lines of business. Based on data assembled from two sources, it appears that Innovation Health has about 18.1 percent of individual enrollees in the area and about 23.8 percent of small group enrollment. Based on the NAIC data, Kaiser Mid-Atlantic has the most individual members in northern Virginia. (Note that Innovation Health added 21,000 individual members in the first three quarters of 2016, but we are not able to tell if those enrollees came from other health plans. Based on the same denominator, Innovation Health would have 28.6 percent of the individual market.) The data are from the NAIC statements for the Innovation Health

Plans, Kaiser Health Plans of the Mid-Atlantic, and CareFirst Blue Choice, the Blue Cross Blue Shield company in the region. The other source is a report by the Bureau of Insurance, Virginia Commerce Commission, prepared as part of the state's reviews of the proposed acquisitions of Humana by Aetna and CIGNA by Anthem, Inc.[18]

Has Innovation Health made the market for health insurance more competitive and has it had impact on premiums? *Exhibit 6* compares the premium in 2017 for a single male, nonsmoker, living in Fairfax County, and shopping for a Silver Plan at Healthcare.gov. Innovation Health's PPO plan has the lowest monthly premium at $295.50, with an annual deductible of $6,075. The most expensive plan is offered by CareFirst, with a monthly premium of $435 and a deductible of $3,500. The lower price of the Innovation Health plan helped it gain 21,000 new individual members during the open enrollment period for 2016 benefit plans. The results of the most recent open enrollment season will be reflected in the quarterly financial and enrollment report that Innovation Health files after March 31.

Innovation Health has introduced special diabetes Gold and Silver health plans, called Leap Diabetes Plans. Those plans, designed by Aetna, have lower co-payments for diabetes-related visits to specialists and offers a variety of personal care apps and devices. Enrollees can also earn financial rewards for getting an A1c blood test twice a year and linking their glucometer to an Aetna web site.[19]

Five other health plans are offering a mix of PPO and HMO plans in Fairfax County: CIGNA, UnitedHealthcare, Kaiser Permanente, Anthem HealthKeepers (primarily a Medicaid plan), and CareFirst Blue Choice. All of them are more expensive than the Innovation Health individual plans. Based on an analysis of rate filings for 2017 benefit years by the Virginia Bureau of Insurance, Innovation Health Insurance increased its premiums by an average of 12.1 percent. By comparison, Kaiser Foundation had an average increase of 25 percent and CareFirst Blue Choice had an average increase of 31.2 percent. For its small group plans, Innovation Health Plans reported an average increase of 11.7 percent, while Kaiser and CareFirst Blue Choice sought smaller increases.

Innovation Health has been able to keep its premium rates relatively low because some of the Inova providers made rate concessions for a period of up 10 years. That is not likely to be a sustainable strategy for the long term, and it underlines the importance of the health plan being able to reduce care utilization and generate savings to keep costs down and attract more groups and individuals. Inova has pursued its health plan and clinical integration strategies at the same time, but still has significant work to do to bring the two approaches into alignment. For example, Signature Partners Network provides care management services for those Innovation Health enrollees that are attributed to providers of Signature Partners Networks, about 25 percent of the total. Aetna staff provide care management for the others. That contradicts the notion that one of the assets of a provider-sponsored health plan is that enrollees will be more inclined to accept medical advice from their provider system, not the insurance company. Aetna also provides data to the Signature Partners Network and others about patient encounters, but some Inova Health leaders interviewed were dissatisfied with the timeliness and quality of that data.

Building on ACO and Population Health Strategies: Focus on Memorial Hermann

The Memorial Hermann system is the largest system in the Houston region with 12 hospital campuses and 2015 revenues of $3.8 billion. The flagship Memorial Hermann hospital is at the Texas Medical Center, while the other campuses ring the region, including developing areas like the Woodlands, Sugar Land, and Memorial City. Methodist Healthcare is the second largest system in the region, followed by Hospital Corporation of America (HCA), which is the largest hospital system in Texas.

While Memorial Hermann is the largest system in the region, the University of Texas M.D. Anderson Cancer Center in Houston is the largest hospital there, with net patient revenues of $3.745 billion. One local expert described Memorial Hermann, with its hospitals, physician clinics, and broad range of ancillary services, as the most developed integrated system in Houston.

Median household income in Harris County was $56,670, less than half of Fairfax County. Even with gains in coverage under the ACA, 25.8 percent of adults (740,000) between the ages of 19 and 64 still lack health insurance.

About 9.5 percent of the population (about 385,000 out of 4.092 million) here is age 65 or older. Penetration in senior plans is very high in Harris County with 57 percent of seniors (about 220,000 in January 2017) enrolled in a Medicare Advantage or Special Needs plan. The largest Medicare HMO plans here are SelectCare (41,400 seniors), HealthSpring, and Kelsey Seybold Plan Administrators. The Houston area has a long history of multi-specialty

group practices, like Kelsey Seybold and the former MacGregor Medical Association, (which closed its practices in 2002). Those practices took significant capitation risk, particularly for senior plans.

In the 1990s, several local provider systems had their own health plans. The Memorial Hermann system was a part owner in a Houston area health plan in the 1990s, though it sold that company to Humana in 1999. Currently, two provider systems own large Medicaid plans: Community Health Choice, owned by the Harris County Health District, and Texas Children's Health Plan, owned by that system. Note that the Memorial Hermann system is a major provider to Community Health Choice, seeing more enrollees than the Harris County hospitals and doctors.

The Memorial Hermann system has pursued several major initiatives in the areas of population health and performance-based contracting. Several years ago, Memorial Hermann formed a clinically integrated network called Memorial Hermann Physicians Network, known as MHMD. There are 3,500 physicians practicing in different programs and initiatives through MHMD, including about 150 employed by Memorial Hermann. That organization has been the vehicle for contracting as a Medicare Shared Savings Program ACO and for forming a commercial ACO in partnership with Aetna, marketed as Aetna Whole Health-Memorial Hermann Accountable Care Network. The University of Texas-Houston faculty practice group, with 800 physicians, also participates in some of the MHMD activities.

The Memorial Hermann MSSP ACO has been one of the most successful. For 2015, it had 50,000 attributed lives and earned shared savings of $41.9 million. Only two other MSSP ACOs had shared savings of $30 million or more. In the first year of the MSSP program, the Memorial Hermann ACO had shared savings of $28.34 million. As the original MSSP ACOs reach the end of their contracts in the next year, Memorial Hermann will need to transition its Medicare ACO to the Next Gen ACO program or another arrangement in which it accepts some measure of downside risk.

The longtime head of the Memorial Hermann system retired in 2016 and was replaced by a physician who was an executive in the Kaiser Permanente organization in California. Some observers take that to mean that the "Kaiser way" will influence the future strategic direction of the Memorial Hermann system.

Memorial Hermann took the first step toward re-entering the health insurance business in 2011. It acquired the inactive UniCare health plan in Texas from Anthem, the for-profit Blue Cross Blue Shield company. It added a second license in 2014 so that it could offer both HMO and PPO products. It also formed a co-branded jointly marketed product with Aetna, as noted above.

Originally, Memorial Hermann assigned hospital executives to run the health plan. After a slow start, it brought in a new CEO in 2016, one with extensive health plan experience who had previoulsy served as an executive for a provider-sponsored plan. Most of the senior leadership team also came on in the past year. Memorial Hermann hired Trizetto to administer claims processing and payment and, at first, to run call centers.

Both Memorial Hermann health plans lost money in 2015. Memorial Hermann Health Insurance, the larger of the two, lost $9.7 million, or 19.3 percent of revenues of $50.2 million. Memorial Hermann Health Plan lost $8.3 million, or 45.9 percent of revenues of $18 million. While revenues increased in 2016, neither reported positive net income. Memorial Hermann Insurance Company showed a loss of $15 million, or 16.2 percent of revenues of $92.8 million. Memorial Hermann Health Plan reported losses of $10.9 million, or 19.6 percent of premiums of $55.7 million.

A benefits consultant in the Houston area commented that the Memorial Hermann brand is highly regarded, but attaching its brand to a health plan may not give a big boost to its market appeal, for at least three reasons. First, if the provider system offers a limited network, not including other well-known providers, employers may be reluctant to buy that plan, especially if it would require employees to change doctors or hospitals. Second, Houston is a market with world class providers, including the University of Texas MD Anderson Cancer Center, the Methodist system, and Texas Children's Hospital. Those providers do great marketing to tout their quality. Third, Memorial Hermann's brand may not have much added appeal to employers that are comparing Memorial Hermann to insurer brand names like Blue Cross Blue Shield, Aetna, and UnitedHealthcare.

The health plan market for individual coverage has been volatile in Texas, especially in Houston. Some new entrants to the individual market, particularly Community Health Choice, gained large numbers of individual members in 2015 and 2016. Community Health Choice, a Medicaid managed care HMO owned by the Harris County Health District, grew from zero individual members at the beginning of 2014 to about 120,000 in September 2016. Other insurers, including Aetna, CIGNA, and Humana, dropped out and did not sell individual insurance in the Houston area for the 2017 benefit year.

Note that Memorial Hermann Health Plan does not sell individual plan on the HealthCare.gov exchange, but only through agents and other channels. That means it is not an option for low-income persons who rely on the subsidies they can only get by buying through an exchange. *Exhibit 6* shows monthly premiums and annual deductibles for the lowest cost Silver Plan for each of the companies selling individual plans in Harris County. In 2017, three other companies offered Silver individual plans that are less expensive than those offered by Memorial Hermann. For both 2017 and 2016, Molina Healthcare offered the lowest premium Silver Plan, with Community Health Choice close behind. Molina added about 120,000 individual enrollees across Texas during the open enrollment period for the 2016 benefit year. It grew from 19,639 in September 2015 to 138,966 in March 2016, though enrollment dropped to 116,699 in September 2016.

For 2016, Memorial Hermann's individual premium for its least expensive Silver Plan was $317 for an HMO plan and $377 for a PPO plan. For 2017, the monthly premium for both HMO and PPO plans grew to $429. The deductible for the lowest priced plan was $4,500.

WHY NEW HEALTH PLANS HAVE FAILED

As noted, several of this cohort of newly opened or acquired provider-sponsored health plans failed within a few years. Here are some of the reasons:

1. In general, this has been a tough time for health plan startups. Two plans that have been widely covered, Oscar and Harken Health (a subsidiary of UnitedHealth Group), targeted millennials with special benefits and personal health apps. Both have suffered large losses, and Oscar withdrew its offerings in New Jersey, California, and Dallas after only a year or two. Harken Health dropped plans for a South Florida expansion in 2016, withdrew its individual plans from state exchanges in Illinois and Georgia, and announced in May 2017 that it would shut down the enterprise.

   Another kind of health plan startup was challenged, in part because it didn't have access to outside investors. Under authority of the ACA and with loans from the federal government, 23 health insurance cooperatives were formed. By 2016, all but seven of them had failed.[20] Some of them had been the most popular plans in their state, with a few enrolling more than 100,000 lives. There have been several analyses of what went wrong, including limits on product offerings, marketing, and the ability to seek outside investors.[21]

2. The co-ops and several other new health plans were especially hard hit by one or two of the ACA's 3 Rs. The 3 Rs—reinsurance, risk adjustment, and risk corridors—were supposed to mitigate losses for plans that enrolled a sicker than expected group of enrollees. The government never funded the risk corridor piece of it. After the first year, the federal government paid claims under the risk corridor program at the rate of 12.5 cents on the dollar. Many insurers had booked the full amount expected as a receivable and had set second year premium rates with an assumption that the risk corridor payments would arrive. Risk adjustment was also a serious problem for some, as was described in the discussion of CareConnect. Many of the new insurers, lacking claim history for their enrollees, were required to contribute to the risk-adjustment pool, in some cases very large sums.

3. Some did not have a realistic assessment of what the business opportunity was or could not reach an adequate enrollment to achieve economies of scale or operate profitably. Two examples of that are the Piedmont WellStar Health Plan, a Medicare Advantage plan formed by two Atlanta health systems, and HealthSpan Integrated, the name given to the former Kaiser Permanente plan in northeast Ohio when it was acquired by the Mercy Health system.

   In 2013, as Piedmont and WellStar were designing the new health plan, about 31.2 percent of the seniors in the area were in a Medicare Advantage health plan, suggesting room for further growth. (This is based on four large counties, Cobb, DeKalb, Fulton, and Gwinnett, in the Atlanta region.) The Piedmont-WellStar Health Plan opened for business as a Medicare Advantage health plan on January 1, 2014. It also sold individual plans and administered health benefits for about 35,000 employees and dependents of the two systems. The new health plan closed two years later, after enrolling 15,352 members, mostly seniors. It lost $11.4 million in 2014 and $24.4 million in 2015.[22]

   The health plan told providers that it was exiting the Medicare business "because of an inability to generate a large enough membership and the required premium revenues needed for long-term operations and sustainability."[23] It also noted that it was expensive to comply with Medicare Advantage rules,

especially when operating with a relatively small number of enrollees.[24]

Two observers suggested that the health plan overestimated the risk-adjustment factor of seniors that would enroll in the plan. In other words, it was expected that a significant number of seniors with chronic conditions who were higher than average utilizers of care would select the new plan. Under Medicare Advantage rules, that would generate higher revenues to the health plan and improve the opportunity for profit if it was able to manage demand for care. Others commented that the plan got the mix of enrollees that it expected, but that inadequacies in IT and coding systems resulted in lower risk scores and lower payments.

The Mercy Health system acquired the Kaiser Permanente health plan and clinics in northeast Ohio 2013. While the Kaiser plan was highly rated by Medicare, it had struggled to compete with other major insurers. In the previous five years, the Kaiser plan in Ohio had losses of $143.1 million, and its enrollment dropped by more than 50,000 lives. The Mercy system has only one hospital in the area, in Lorain, about 35 miles west of downtown Cleveland, so that brand is not well recognized.

To complicate matters further, the Kaiser health plan and clinics were renamed HealthSpan Integrated, a brand that was even less well known. It was the name of a Mercy Health company that administered plans for self-insured employer groups. Mercy extended the HealthSpan brand in 2013 as part of investing $250 million in the Summa Health System to acquire a 30 percent ownership share. HealthSpan was formed as a secular, auxiliary organization of Catholic Health Partners (Mercy Health in Ohio), so that Summa Health could continue to operate without complying with the Ethical and Religious Directives for Catholic health care services.

Another problem for the new health plan owners was a change in hospital referrals. Kaiser had mostly used Cleveland Clinic hospitals, while HealthSpan primarily was admitting enrollees to University Health facilities. While both systems are highly regarded, the Cleveland Clinic affiliation likely had stronger appeal to employers and some individuals.

Mercy Health took over a network of Permanente Medical Group clinics that, with a few key exceptions, had not been updated and were not in locations of high household incomes and rich insurance coverage. One interviewee commented that this had been a challenge to Kaiser, which decided that it could not justify the investment required to upgrade and relocate the clinics.

In 2014, HealthSpan Integrated lost $53.7 million, and its enrollment dropped to 74,800. The health plan's losses increased in 2015 to $217.6 million, and enrollment dropped to about 62,250. One observer commented that the loss of the Kaiser brand resulted in some of the enrollment loss, though enrollment had dropped sharply under Kaiser.

In the fall of 2015, HealthSpan/Mercy announced that it would shutter the clinics, expecting that many of the doctors and the real estate would move to the MetroHealth, Summa Health, and Mercy Health systems in northeast Ohio. In early 2016, Mercy Health also pulled the plug on the health plan, announcing that it would encourage enrollees to migrate to plans offered by Medical Mutual Insurance, one of the largest health insurers in northeast Ohio.

The MetroHealth system in Cleveland, the county health system, absorbed many of the HealthSpan doctors and took over some of the real estate. MetroHealth operates some of those sites as health centers, including a few with emergency departments, and has announced plans to add a small number of inpatient beds at those sites. This fits well with MetroHealth's new emphasis on population health management and its strategy of adding new clinic sites, and expanding its geographic reach in the region. MetroHealth has used its expanded geographic presence in a gain-sharing arrangement for Medicaid enrollees insured by CareSource, the largest Medicaid health plan in Ohio.

CONCLUSION

Dozens of provider systems have established their own health plans since 2010. Anticipating significant changes in payment in the future, they have embraced the notion of climbing to the top of the health care food chain by becoming health insurers. Some have started a health plan as a defensive move, seeking to replace patients they have lost to other systems.

Based on the analysis reported here, it is hard to identify any of the new cohort of provider-sponsored health plans that show strong promise. Five in that group have already failed, and two national hospital systems announced their intent to reduce or even end their ventures into the health plan business.

A few new plans have enjoyed some success, reaching enrollments of 100,000 in just a few years. However, almost all these plans continue to operate at a loss, in some cases reporting very large losses. When that happens, the provider owners must contribute additional capital to comply with solvency requirements, leaving less for investments in care delivery, new or improved facilities, or health information technology.

The key to success for provider-sponsored health plans is the ability to enunciate and then deliver on a value proposition: a provider system and its affiliated physicians and hospitals providing high-quality medical care at a lower cost, enabling the health plan to sell insurance at a lower price than competitors. Some of the new plans are among the lowest priced plans for individuals and small groups, and their presence is adding competition and benefits. But, so far, the plans reviewed in this research are only able to price competitively by paying their own providers below market rates. That is not a strategy that can be sustained for long.

Many of these provider systems are engaged in other initiatives around clinical integration, performance based-contracting, and population health improvement. These strategies are challenging, as is pursuing a health plan strategy, and success takes years to achieve. A few have been very successful, for example, as Medicare Shared Savings Program ACOs. Still, those capabilities have not yet been aligned with the health plan's operations.

As this report is being finalized in May 2017, the U.S. House of Representatives has passed its American Health Care Act (AHCA). If enacted, the law would change and reduce in many cases the subsidies for low-income families to buy insurance. It would also reverse parts of the ACA Medicaid expansion and cut Medicaid spending by more than $800 billion over 10 years. At the same time, the administration has taken steps that raise uncertainty in the market for individual insurance.

The changes in Medicaid could create new opportunities for health insurers, including those that are provider-sponsored. States facing reduced Medicaid funding might increase their use of managed care organizations to manage care for recipients, especially those who are aged or disabled. At the same time, states may press down hard on Managed Care Organizations (MCO) margins, to make the dollars go further. The continued uncertainty in the individual markets, combined with proposed changes in rules on mandates and essential benefits, makes that business opportunity riskier for health insurers. They may face problems of adverse selection as healthier persons exit the market altogether or select low-cost plans with very limited benefits.

Given all these challenges, it is likely that more of this new cohort of provider-sponsored health plans will reconsider their commitment to adding the capital, energy, and focus needed to sustain a health plan long enough to achieve success. For those reasons, and others, the prospects for success by these new health plans are not strong.

Appendix

Exhibit 01 Overview of Provider-Sponsored Health Plans, By Year of Commenced Business

Decade Commenced Insurance Business	Number of Active Health Plans	Median Enrollment, 2015	Median Revenue, 2015	Median Net Income, 2015	Median Margin, 2015
Pre 1980	13	245,559	$1,270,628,609	-$5,086,737	-0.5%
1980-1989	29	176,257	$829,904,664	$3,639	0.0%
1990-1999	43	73,201	$360,244,999	-$113,061	-0.1%
2000-2009	24	19,266	$121,895,218	$2,287,345	2.4%
2010-2016	33	4,084	$5,315,694	-$2,618,254	-25.5%

Exhibit 02 Capital and Use of Capitation by Provider-Sponsored Health Plans, By Year of Business Start

Decade Commenced Insurance Business	Median Capital	Median Capitation Payments	Median Medical Spending	% Paid Through Capitation
Pre 1980	$206,815,000	$19,005,193	$1,152,548,000	1.6%
1980-1989	$64,539,891	$83,803,294	$733,195,777	11.4%
1990-1999	$51,573,428	$9,177,360	$341,569,752	2.7%
2000-2009	$18,521,335	$4,073,510	$108,469,093	3.8%
2010-2016	$6,577,371	-	$6,982,257	0.0%

Exhibit 03 Overview of Provider-Sponsored Health Plans Formed Since 2010 (Sorted by State)

Health Plan	Owner/Parent	City	State	Commenced Business	2015 Enrollment	2015 Revenues	Largest Line of Business
QualChoice Advantage	Catholic Health Initiatives	Little Rock	AR	1/1/15	-	-	Medicare
Health Choice Arizona	IASIS Healthcare	Phoenix	AZ	4/2/13	4,481	10,146,711	Individual
University of Arizona Health Plan	The University of Arizona Health Plans	Tucson	AZ	1/1/14	8,249	17,772,137	NA
Stanford Healthcare Advantage	Stanford Medicine	Stanford	CA	1/1/14	83	459,272	Medicare
Sutter Health Plus	Sutter Health	Sacramento	CA	1/1/13	26,361	77,177,115	Group

Exhibit 03 Cont. Overview of Provider-Sponsored Health Plans Formed Since 2010 (Sorted by State)

Health Plan	Owner/Parent	City	State	Commenced Business	2015 Enrollment	2015 Revenues	Largest Line of Business
Health First Insurance Company	Health First Group	Rockledge	FL	1/1/16	-	-	Medicare
Piedmont-WellStar Health Plan	Piedmont and WellStar Health Systems	Atlanta	GA	1/1/14	15,352	115,587,827	Medicare
Land of Lincoln Health	Illinois Health and Hospital Association	Chicago	IL	4/9/13	50,280	147,398,319	NA
HealthPartners UnityPoint Health Insurance Company	HealthPartners (MN) and UnityPoint Health (IA)	West Des Moines	IA	1/28/16	0	0	Medicare
HarvestPlains Health of Iowa	Catholic Health Initiatives	Des Moines	IA	1/1/15	-	-	Medicare
RiverLink Health of Kentucky	Catholic Health Initiatives	Cincinnati	KY	1/1/15	433	3,055,853	Medicare
StableView Health, Inc.	Catholic Health Initiatives	Lexington	KY	1/1/15	77	588,221	Medicare
Hopkins Health Advantage	Hopkins Health Advantage Inc.	Glen Burnie	MD	11/21/14	-	-	Medicare
McLaren Health Plan Community	McLaren Health	Flint	MI	2/16/12	-	-	Group
Gundersen Health Plan of Minnesota	Gundersen Health - University of Wisconsin Health	La Crosse, WI	MN	2/15/12	948	5,315,694	Medicare
Care N Care Insurance Company of NC	Care N Care Insurance Company Inc.	Greensboro	NC	1/28/15	-	-	Medicare
HeartlandPlains Health	Catholic Health Initiatives	Omaha	NE	1/1/15	519	3,489,316	Medicare
Tufts Health Freedom Plan	Tufts Group	Concord	NH	4/27/15	-	-	Group
Clover Insurance Company	CarePoint Health	Jersey City	NJ	2/6/14	-	616,666	Medicare
CareConnect	Northwell Health (former North Shore LIJ system)	Great Neck	NY	10/1/13	69,374	124,605,078	Group
Crystal Run Health Insurance Company	Crystal Run Health Group	Middletown	NY	6/1/16	1,894	2,131,539	Group
Crystal Run Health Plan	Crystal Run Health Group	Middletown	NY	10/1/15	330	75,135	Group
Aultcare Health Insuring Corp.*	Aultman Health Foundation	Canton	OH	1/1/15	20,252	226,733,360	NA
HealthSpan	Mercy Health Group	Cincinnati	OH	7/30/13	12,330	53,647,920	Individual
Premier Health Insuring Corp.	Premier Health Partners Group	Dayton	OH	4/22/14	7,722	59,495,348	Medicare
Premier Health Plan	Premier Health Partners Group	Dayton	OH	3/13/14	2,726	8,176,903	Individual

Exhibit 03 Cont. Overview of Provider-Sponsored Health Plans Formed Since 2010 (Sorted by State)

Health Plan	Owner/Parent	City	State	Commenced Business	2015 Enrollment	2015 Revenues	Largest Line of Business
RiverLink Health	Catholic Health Initiatives	Cincinnati	OH	1/1/15	650	4,052,746	Medicare
UPMC Health Coverage	UPMC Health System	Pittsburgh	PA	8/1/14	6,866	27,538,452	Group
ClearRiver Health	Catholic Health Initiatives	Chattanooga	TN	1/1/15	282	1,963,766	Medicare
Christus Health Plan	Christus Health	Dallas	TX	3/1/12	7,668	21,160,832	Individual
Memorial Hermann Health Plan	Memorial Hermann	Houston	TX	4/25/14	3,686	17,985,376	Group
Prominence Health First (formerly St Mary's Health Plans)	Universal Health Services, Inc.	Reno	TX	2/19/14	499	3,618,428	Individual
Innovation Health Insurance	Aetna Group	Falls Church	VA	4/3/13	52,474	204,634,972	Individual
Innovation Health Plan	Aetna Group	Falls Church	VA	4/3/13	22,874	79,593,241	Group
Sentara Health Insurance of NC	Sentara Health Mgmt. Group	Virginia Beach	VA	11/21/14	-	-	NA
Network Health Insurance Corp.	Network Health Group	Menasha	WI	4/1/13	77,733	556,516,298	Medicare
Wisconsin Collaborative Insurance Company	Anthem Inc., Aurora Health	Milwaukee	WI	4/19/16	-	-	NA
Health Plans Acquired by Provider Systems After 2010							
QualChoice Life and Health Insurance Company	Catholic Health Initiatives	Little Rock	AR	1965	10,309	101,558,030	Individual
Harbor Health Plan	Tenet Health	Detroit	MI	2000	6,638	36,576,814	Medicaid
HealthSpan Integrated Care (former Kaiser Permanente Ohio)	Mercy Health Ohio	Cleveland	OH	1976	62,249	358,571,953	Group
Memorial Hermann Insurance Company	Memorial Hermann Health	Houston	TX	2001	13,125	50,221,939	Group
Prominence Health (former Soundpath Health)	Catholic Health Initiatives	Federal Way	WA	2008	21,158	155,193,903	Medicare

* AultCare Health Insuring Corp. is the successor health plan to an accident and health insurer, AultCare Insurance, which commenced business in 1989.

Exhibit 04 Enrollment in Provider-Sponsored Health Plans Formed Since 2010

				3rd Quarter 2016				
Health Plan	State	2014 Enrollment	2015 Enrollment	Individual	Group	Medicare	Medicaid	TOTAL
QualChoice Advantage	AR	-	-	-	-	1,848	-	1,848
Health Choice Arizona	AZ	430	4,481	10,912	-	-	-	10,912
University of Arizona Health Plan	AZ	233	8,249	-	-	-	-	-
Stanford Healthcare Advantage	CA	-	83	-	-	1,043	-	1,043
Sutter Health Plus	CA	8,307	26,361	972	44,292	-	-	45,264
Health First Insurance Company	FL	-	-	13,959	4,260	34,893	-	53,112
Piedmont WellStar Health Plans, Inc.	GA	9,349	15,352	-	-	-	-	-
HealthPartners UnityPoint Health	IA	-	-	-	-	-	-	-
Land of Lincoln Health	IL	3,461	50,280	-	-	-	-	-
HarvestPlains Health of Iowa	IA	-	-	-	-	389	-	389
RiverLink Health of Kentucky	KY	-	433	-	-	1,129	-	1,129
StableView Health, Inc.	KY	-	77	-	-	200	-	200
Hopkins Health Advantage	MD	-	-	-	-	4,706	-	4,706
McLaren Health Plan Community	MI	-	-	2,113	16,971	-	-	19,084
Gundersen Health Plan of Minnesota	MN	795	948	-	319	705	-	1,024
Care N Care Insurance Company of NC	NC	-	-	-	-	6,433	-	6,433
HeartlandPlains Health	NE	-	519	-	-	891	-	891
Tufts Health Freedom Plan	NH	-	-	-	1,063	-	-	1,063
Clover Insurance Company	NJ	-	-	-	-	18,996	-	18,996
CareConnect	NY	11,662	69,374	29,311	70,525	-	-	99,836
Crystal Run Health Insurance Company	NY	-	1,894	-	2,510	-	-	2,510
Crystal Run Health Plan	NY	-	330	1,343	1,384	-	448	3,175
Aultcare Health Insuring Corp.	OH	-	20,252	-	-	20,934	-	20,934

Exhibit 04 Cont. Enrollment in Provider-Sponsored Health Plans Formed Since 2010

				3rd Quarter 2016				
Health Plan	State	2014 Enrollment	2015 Enrollment	Individual	Group	Medicare	Medicaid	TOTAL
HealthSpan	OH	15,083	12,330	2,343	-	-	-	2,343
Premier Health Insuring Corp.	OH	-	7,722	-	-	9,372	-	9,372
Premier Health Plan	OH	-	2,726	5,672	711	-	-	6,383
RiverLink Health	OH	-	650	-	-	1,301	-	1,301
UPMC Health Coverage	PA	3,793	6,866	-	5,962	-	-	5,962
ClearRiver Health	TN	-	282	-	-	550	-	550
Christus Health Plan	TX	7,893	7,668	17,270	-	262	6,675	24,207
Memorial Hermann Health Plan	TX	-	3,686	2,106	4,292	4,083	-	10,481
Prominence Health First (formerly St Mary's Health Plans)	TX	-	499	3,115	12	1,422	-	4,549
Innovation Health Insurance	VA	38,641	52,474	56,566	16,846	-	-	73,412
Innovation Health Plan	VA	18,580	22,874	-	26,582	-	-	26,582
Sentara Health Insurance of NC	VA	-	-	-	-	-	-	-
Network Health Insurance Corp.	WI	70,584	77,733	32	1,133	64,063	-	65,228
Wisconsin Collaborative Insurance Company	WI	-	-	-	-	-	-	-
Plans Acquired Since 2010								
QualChoice Life and Health Insurance	AR	-	23,168	29,399	3,646	-	-	35,609
Harbor Health Plan	MI	6,034	6,638	2,813	-	656	8,229	11,698
HealthSpan Integrated Care (former Kaiser Permanente Ohio)	OH	74,819	62,249	2,204	-	15,524	-	17,728
Memorial Hermann Insurance Company	TX	10,572	13,125	6,030	14,083	1,157	-	21,270
Prominence Health (Soundpath Health)	WA	16,347	21,158	-	-	27,077	-	27,077

Exhibit 05 Profitability in 2015 of Provider-Sponsored Health Plans Formed Since 2010

Health Plan	State	2015 Revenues	2015 Net Income	Margin
QualChoice Advantage	AR	-	8,596	
Health Choice Arizona	AZ	10,146,711	-1,101,749	-10.9%
University of Arizona Health Plan	AZ	17,772,137	-2,515,382	-14.2%
Stanford Healthcare Advantage	CA	459,272	-4,155,342	-904.8%
Sutter Health Plus	CA	77,177,115	-27,462,508	-35.6%
Health First Insurance Company	FL	-	-13,848	
Piedmont WellStar Health Plans, Inc.	GA	115,587,827	-24,412,545	-21.1%
HealthPartners UnityPoint Health	IA	-	-	
Land of Lincoln Health	IL	147,398,319	-90,800,168	-61.6%
HarvestPlains Health of Iowa	IA	-	6,965	
RiverLink Health of Kentucky	KY	3,055,853	-368,295	-12.1%
StableView Health, Inc.	KY	588,221	-472,155	-80.3%
Hopkins Health Advantage	MD	-	-8,599,857	
McLaren Health Plan Community	MI	-	-22,243	
Gundersen Health Plan of Minnesota	MN	5,315,694	-728,654	-13.7%
Care N Care Insurance Company of NC	NC	-	-1,403,523	
HeartlandPlains Health	NE	3,489,316	-1,866,953	-53.5%
Tufts Health Freedom Plan	NH	-	-6,516,167	
Clover Insurance Company	NJ	616,666	-	0.0%
CareConnect	NY	124,605,078	-31,834,462	-25.5%
Crystal Run Health Insurance Company	NY	2,131,539	-3,452,139	-162.0%
Crystal Run Health Plan	NY	75,135	-3,252,731	-4329.2%
Aultcare Health Insuring Corp.	OH	226,733,360	-3,928,339	-1.7%
HealthSpan	OH	53,647,920	-28,166,252	-52.5%
Premier Health Insuring Corp.	OH	59,495,348	-13,616,589	-22.9%
Premier Health Plan	OH	8,176,903	-5,330,135	-65.2%
RiverLink Health	OH	4,052,746	-1,157,347	-28.6%
UPMC Health Coverage	PA	27,538,452	7,730,735	28.1%
ClearRiver Health	TN	1,963,766	-1,283,887	-65.4%
Christus Health Plan	TX	21,160,832	-5,247,287	-24.8%
Memorial Hermann Health Plan	TX	17,985,376	-8,250,706	-45.9%
Prominence Health First formerly St Mary's Health Plans	TX	3,618,428	-2,618,254	-72.4%
Innovation Health Insurance	VA	204,634,972	3,111,954	1.5%

Exhibit 05 Cont. Profitability in 2015 of Provider-Sponsored Health Plans Formed Since 2010

Health Plan	State	2015 Revenues	2015 Net Income	Margin
Innovation Health Plan	VA	79,593,241	3,438,659	4.3%
Sentara Health Ins of NC	VA	-	-	
Network Health Insurance Corporation	WI	556,516,298	-5,683,514	-1.0%
Wisconsin Collaborative Insurance Company	WI	-	-	
Health Plans Acquired by Provider Systems After 2010				
QualChoice Life and Health Insurance	AR	61,879,954	-5,133,543	-8.3%
Harbor Health Plan	MI	9,232,984	321,759	3.5%
HealthSpan Integrated Care (former Kaiser Permanente Ohio)	OH	360,244,999	-217,563,001	-60.4%
Memorial Hermann Health Insurance	TX	50,221,939	-9,704,455	-19.3%
Prominence Health (Soundpath Health)	WA	155,193,903	-17,252,888	-11.1%

Exhibit 06 Comparison of Silver Plan Prices for Individual Health Plans, 2017 Plan Year, and Increase Over 2016

Care Connect
Garden City, Nassau County 11530
40-year old male single coverage
Exchange: New York State of Health, https://nystateofhealth.ny.gov/

Fidelis Care		
2017 Premium	$446.10	(+12.8%)
Deductible	$2,000	
2016 Premium	$395.41	
HealthFirst		
2017 Premium	$453.55	(+7.4%)
Deductible	$2,000	
2016 Premium	$422.41	
Oscar		
2017 Premium	$483.44	(+12.3%)
Deductible	$7,150	
2016 Premium	$430.44	
Care Connect EPO		
2017 Premium	$487.00	(+27.2%)
Deductible	$3,000	
2016 Premium	$383.00	

Affinity Health Plan		
2017 Premium	$493.55	(+18.3%)
Deductible	$2,000	
2016 Premium	$417.34	
Empire Blue Cross Blue Shield HMO		
2017 Premium	$510.38	(+9.3%)
Deductible	$5,250	
2016 Premium	$466.95	
Emblem Health		
2017 Premium	$589.68	(+14.6%)
Deductible	$2,000	
2016 Premium	$514.55	
UnitedHealthcare		
2017 Premium	$714.09	(+28.6%)
Deductible	$2,000	
2016 Premium	$555.39	

Innovation Health
Fairfax County, VA 22030
40-year old male single coverage
Exchange: Healthcare.Gov

Innovation Health Insurance Company PPO		
2017 Premium	$295.50	(+9.3%)
Deductible	$6,075	
2016 Premium	$270.47	
Innovation Health Leap Silver Diabetes PPO		
2017 Premium	$309.17	
Deductible	$6,300	
CIGNA Health and Life Insurance Company EPO		
2017 Premium	$313.29	
Deductible	$4,500	
UnitedHealthcare of the Mid-Atlantic HMO		
2017 Premium	$319.19	(+10.6%)
Deductible	$5,200	
2016 Premium	$288.48	

Kaiser Permanente HMO		
2017 Premium	$329.11	(+16.0%)
Deductible	$6,000	
2016 Premium	$283.65	
Anthem HealthKeepers HMO		
2017 Premium	$335.73	(+10.9%)
Deductible	$5,000	
2016 Premium	$302.64	
CareFirst BlueChoice HMO		
2017 Premium	$435.01	(+22.2%)
Deductible	$3,500	
2016 Premium	$356.04	

Memorial Hermann Health Plan
Harris County, TX 77096
40-year old male single coverage
Exchange: Healthcare.gov

Molina Marketplace HMO		
2017 Premium	$282.60	(+11.8%)
Deductible	$2,400	
2016 Premium	$252.67	
Community Health Choice HMO		
2017 Premium	$310.54	(+19.1%)
Deductible	$1,500	
2016 Premium	$260.66	
All-Savers Insurance Company EPO		
2016 Premium	$291.92	
Community Health Choice Kelsey Care HMO		
2017 Premium	$327.53	
Deductible	$0	
Aetna Life Insurance EPO		
2016 Premium	$345.13	

Memorial Hermann Health Plan HMO (not on exchange)		
2017 Premium	$429.04	(HMO & PPO) (+35.3%)
Deductible	$4,500	
2016 Premium	$317.03	(HMO)
Memorial Hermann Health Insurance PPO (not on exchange)		
2016 Premium	$377.19	
Deductible	$2,600	
Blue Cross Blue Shield of Texas HMO		
2017 Premium	$430.54	(+47.3%)
Deductible	$3,000	
2016 Premium	$291.97	
CIGNA Healthcare of Texas HMO		
2016 Premium	$276.10	
Humana Health Plan of Texas HMO		
2016 Premium	$375.02	

Sources: Analysis of data from Healthcare.gov and New York State of Health websites

Endnotes

1. Even in California, one of the few states where a high percentage of provider payments is still made to medical groups and independent practice associations (IPAs) through capitation, that proportion has declined sharply. Recent research from the California Health Care Foundation found that the number of commercial enrollees outside of Kaiser Permanente had fallen from 6.3 million in 2004 to 3.6 million in 2015, with most of them moving to PPO arrangements, where providers are paid fee-for-service. See Laura Tollen, "As Commercial Capitation Sinks, Can California's Capitated Physician Organizations Stay Afloat," California HealthCare Foundation, 2016.
2. Paul M. Ellwood, Alain C. Enthoven and Lynn Etheridge, "The Jackson Hole Initiatives for a Twenty-First Century American Health Care System," *Health Economics*, Vol.1: 149-168 (1992).
3. See, for example, The Advisory Board, *Capitation Strategy*, Washington, DC, 1994. In fact, by the end of the 1990s, the market in most states moved away from capitation, in part because of the anti-managed care backlash led by physicians and advocacy groups and because payments to Medicare health plans were generally flat, leading providers to drop their capitation contracts. Minnesota HMOs, for example, made 32.1% of their provider payments through capitation in 1993, about two-thirds of that through HealthPartners. By 2004, less than 1% of provider payments by Minnesota HMOs were through capitation arrangements.
4. *Becker's Hospital Review*, "Tenet to sell multiple hospitals, home health business," January 17, 2017. Accessed at: http://www.beckershospitalreview.com/hospital-transactions-and-valuation/tenet-to-sell-multiple-hospitals-home-health-business.html.
5. Melanie Evans, "Big Hospital Operator Retreats From Health-Insurance Foray." *Wall Street Journal*, December 15, 2016. https://www.wsj.com/articles/big-hospital-operator-retreats-from-health-insurance-foray-1481814003.
6. Gundersen Health and University of Wisconsin Health agreed in 2016 to merge their respective HMOs. Later that year, they entered into talks about absorbing Physicians Plus Insurance Company, the HMO of Meriter Health, a Madison, WI hospital acquired by UnityPoint Health in 2013. UnityPoint has partnered with HealthPartners to form a Medicare Advantage health plan in Illinois and Iowa, which enrolled its first seniors as of January 2017.
7. See, for example, David Introcase and Gregory Berger, "MSSP Year Two: Medicare ACOs Show Muted Success," *Health Affairs Blog*, September 24, 2015.
8. Interview with Carolyn Magill, formerly of Evolent Health, March 14, 2016.
9. The K&L Gates law firm published a useful summary of the position of the Federal Trade Commission on the elements required for competing providers to negotiate together with payers and pass antitrust scrutiny. http://m.klgates.com/files/Publication/fc2de2e2-eaf1-4c06-8f33-749bd4e6c152/Presentation/PublicationAttachment/140a0193-858f-40d6-b9c1-7b17fcd2afdb/Antitrust_Alert_03252013.pdf.
10. Interview with Diane Holder, CEO of UPMC Health Plans, April 7, 2016.
11. Interview with Thomas Cassels, The Advisory Board, November 9, 2015.
12. Interview with Walt Meyers and Kaiser Permanente Competitive Assessment Team, December 14, 2016.
13. Interview with Joseph Damore, Premier, November 29, 2016. Walt Meyers noted that some provider-sponsored health plans, like Sharp in the San Diego area, benefit from having a well-defined geography and can maintain the right balance of being a provider partner to the other local health plans while operating its own health plan.
14. Interview with Joseph Damore, Premier, Inc., November 29, 2016.
15. Bob Herman, "ACA's risk adjustment hammers small plans again," *Modern Healthcare*, June 30, 2016.
16. Interviews with Laurel Pickering, Northeast Business Group on Health and Greg Burke, United Hospital Fund, October 20, 2016.
17. Based on research conducted for Peter Newell and Allan Baumgarten, "The Big Picture V: New York's Private and Public Markets, 2012," United Hospital Fund, May 2014.
18. Eric Lowe and Glenn Watkins, "An Economic Analysis of the Market Structure and Likely Effect on Competition in the Commonwealth of Virginia as a Result of the Acquisition of Humana, Inc. by Aetna, Inc.," Virginia State Corporation Commission, Bureau of Insurance, March 15, 2016.
19. Michelle Andrews, "New Health Plans Offer Discounts for Diabetes Care," Kaiser Health News, November 17, 2015. Accessed at http://khn.org/news/new-health-plans-offer-discounts-for-diabetes-care/. See a summary of benefits for 2016 here: http://innovation-health.s3.amazonaws.com/SBC_2016_VA_GoldDiabetes_ON.pdf.
20. Phil Galewitz, "Seven Remaining Obamacare Co-ops Prepare Survival Strategies," *Kaiser Health News*, July 13, 2016. http://khn.org/news/seven-remaining-obamacare-co-ops-prepare-survival-strategies.
21. Tom Worstall, "The Problem With Health Care Coops: No Capitalists to Absorb the Losses," *Forbes*, September 26, 2015. https://www.forbes.com/sites/timworstall/2015/09/26/the-problem-with-health-care-coops-no-capitalists-to-absorb-the-losses/#eb51fc171552.
22. In its initial public offering documents, Evolent Health identified Piedmont WellStar Health Plan as its third largest partner or contract, accounting for 17% of revenues in the first quarter of 2015.
23. Andy Miller, "Hospitals retreat from insurance venture," *Atlanta Journal-Constitution* online content, September 25, 2015.
24. Note that Catholic Health Initiatives started five Medicare plans in different states, which combined had less than 6,000 lives in 2016. It administered all the plans from a central office near Seattle. Still, the administrative expenses of reporting and compliance are significant, especially spread across a small number of enrollees.

About the Author

Allan Baumgarten is an independent research analyst whose work focuses on health care policy, finance and local market strategies. He publishes *Minnesota Health Market Review* and reports in eight other states analyzing trends and strategies for health care payers and providers. He works with a variety of organizations to help them analyze the market competition and policy issues they face and to develop business strategies to meet the challenges of dynamic markets and health reform. His clients include health plans, provider organizations, government agencies and manufacturers of pharmaceuticals and other health products and services. For more information, visit **www.allanbaumgarten.com**.

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