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?

EXECUTIVE SUMMARY

Provider systems established some of the earliest Health Maintenance Organizations (HMOs) and health insurance companies. They include Kaiser Permanente (now operating in 10 states), the Henry Ford system in Detroit and its Health Alliance Plan, Geisinger Health in Pennsylvania and HealthPartners in Minnesota, formerly Group Health. These health plans offered employer groups and individuals coverage of comprehensive health services from a limited network of physicians and hospitals. Enrollees paid a monthly premium that was often lower than competing insurance plans, whose coverage was usually less comprehensive.

Provider systems have continued to move in and out of the insurance business decades earlier, then exited a few years later. The renewed interest by provider systems in owning their own health plans grew primarily out of three motivations: (1) renewing longstanding strategies to gain market strength and more control over premium revenues; (2) responding to payment changes under the Affordable Care Act (ACA) and other market trends; and (3) seeking to apply the health system’s capabilities for managing and improving the health of patients across an expanded population and doing it at a lower cost than competitors.

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—as of April 2017—five have gone out of business. Two national health systems, Tenet Health and Catholic Health Initiatives, announced that they would sell most of their health plan operations. 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, a UnitedHealth Group company. Some of the new provider-sponsored plans were badly hurt by having to make large contributions to the ACA risk-adjustment pools or by the failure of the federal government to make payments under the risk corridor program. Some 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 other self-funded employer groups.

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 have made 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. 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.

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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