Should doctors stick to examinations or also try running health plan networks for self-funded employers who are willing to bet that their clinical expertise could deliver the kind of operational efficiencies that other care delivery models cannot offer?

This decades-old question has been somewhat revived by health care reform and while some industry practitioners have gladly taken that leap of faith, a cautious backdrop remains.

“The upside with provider-sponsored plans is you tend to get longer-term deals because the providers will trade guaranteed and predictable volume for a defined premium or a defined benefit,” notes Paul Keckley, managing director of the Navigant Center for Healthcare Research and Policy Analysis, which has studied this issue as it relates to health insurance exchanges.
“The downside,” he continues, “is that provider-sponsored plans tend to cost more unless they have north of a quarter million commercial-equivalent lives,” at which point they become more comfortable with care management. “So you trade having some predictability and direct access to providers for a higher premium.”

This concept isn’t new and while it has shown promise for employers, expectations haven’t been met in years past, observes Peter Kongstvedt, M.D., a national authority on health care and senior health policy faculty member in the Department of Health Administration and Policy at George Mason University. He says the networks usually would include whoever was part of their physician hospital organization, most of whom were private physicians.

“What ended up happening was the health systems often did not provide discounts to the same level that they gave to insurers, or if they did, it usually wouldn’t be better and utilization would be higher,” he says. “Managed care companies also were doing the utilization management and negotiating pricing.”

Taking the Plunge

Several well-known companies have embraced the provider-run model. Within the past two years, for example, Boeing Commercial Airplanes contracted directly with providers at Providence Health & Services and Swedish Health Services on behalf of about 27,000 employees in the Puget Sound area, while Intel Corp. inked a similar deal with Presbyterian Healthcare Services to serve 54,000 manufacturing employees and dependents in Rio Rancho, N.M. Both arrangements reflect growing corporate frustration with “escalating premiums, spotty quality and poor retail service,” according to a 2014 article in Modern Healthcare.

Keckley also cites key contracts that have been pursued by Safeway and 3M, as well as Walmart, which he says is carving out its spine work and Lowes, which has an exclusive for heart care with the Cleveland Clinic.

Large employers will find value in these arrangements if an integrated delivery system tightly ties health plan and delivery strategies with its medical group to ensure that cost and quality measures are in alignment, notes Cathy K. Eddy, president of the Health Plan Alliance, whose 49 members are provider-sponsored and independent health plans.

But she says the size of self-funded groups with provider-sponsored health plans has been going down. “It used to be very large groups and then 200 was sort of the threshold,” she reports. “We have seen some that are smaller than that and I think probably health care reform has accelerated some of that.”

Smaller provider-owned plans with self-funding are offered at companies that used to manage many different plans in their HR department and then tried to simplify, Eddy adds. Consequently, local plans and coverage were dropped in favor of a single administrator. There’s now an apparent swing back among provider-owned networks to markets with a heavy concentration and an opportunity with private exchanges.

“When you’re selecting as an individual or family the network that works for you, that can be narrower than what a company needs to have to offer broader choice for their employees,” she says.

Eddy sees growing acceptance of narrow networks for greater cost control, which has been driven in part by public exchanges. “Employers used to want to offer as broad a choice as possible, but the tradeoff is you may not get the best pricing in doing that,” she explains.
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Catalyst for Change

Health care reform certainly has forced the issue. “Self-insured employers really are the catalyst for the kind of health reform that focuses on better health at a lower cost,” Keckley says. “And larger self-insured employers are becoming very astute at knowing how to look at clinical data and that doing more is not necessarily getting a better outcome. They’re using reference pricing, narrow networks, loading up on new models of primary care that also include mental health, prophylactic dentistry, optometric care, nutrition and even, in some cases, spirituality.”

A 2014 Advisory Board Company whitepaper suggests that “the shared leadership and vision inherent in provider-sponsored health plans allow for an enhanced capacity to coordinate care and lower costs, two critical imperatives under the Affordable Care Act.”

However, it was also noted that these plans have struggled to compete with regional and national health insurance carriers and despite the promise for value-based purchasing, there’s still considerable doubt about their long-term viability.

Be that as it may, the idea is to steer patients into hospitals and their affiliated medical groups or independent practice associations (IPAs) at the expense of local competitors – an application that has succeeded for small and medium-sized groups, according to Tom Partlow, CEO of onsite medical clinic provider Acorn Health Solutions and an advisor to telemedicine leader CirrusMD. He doubts large employers are all that eager to abandon one of the big PPO networks “in favor of a more limited provider-centric, provider-derived network.”

Replacing the Middleman

While there was a spirited movement afoot nearly 20 years ago to cut out the middle man (i.e., insurance carriers or plan administrators), most of those attempts failed miserably “because you can’t cut out the middleman,” Kongstvedt explains. “You need to replace the middleman and you better be a better middleman than you are replacing. It’s not so easy to do.”

A licensed and board-certified internist, Kongstvedt believes his fellow physicians aren’t always adept at managing a physician network unless there’s strong physician leadership involved. As such a partnership approach may make the most sense. For example, he sees a reemergence of practice-management companies recruiting independent physicians and IPAs run by physicians.

“These days, most of them are associated with one or two payers,” he says. “In California, there’s a huge one called Hill Physicians Group that doesn’t contract with all the payers. It’s sort of a hybrid of an IPA and a group practice without walls. They’ve been around for a while and they’re very experienced.”

Partlow cites two prominent health systems, also in California, that are adept players in the provider-owned health plan space: Western Health Advantage, a very narrow network owned by Dignity Health and Sutter Health, which is in the process of releasing a fully insured plan.

In certain situations, he believes this delivery system can work for self-funded plans, though he’s more inclined to question whether or not PPOs can even exist with reference-based pricing is on the upswing.

“For the independent TPA and freethinking, innovative plan sponsor, dump your PPO network,” Partlow suggests. “It’s an absolute rip-off. Go to 100-and-some-odd percent of Medicare. Put that in your plan document and that’s a very disruptive product, but it’s absolutely working and it’s saving plans a lot of money.”

One huge challenge for hospitals is to make a convincing enough argument that they will offer a comprehensive approach to wellness and disease management to keep employee out of their respective facilities.

“Ultimately, they’re going to end up on a spreadsheet driven by some broker or consultant and have to show how they’re going to deliver more cost-effective care than the local Blue Cross or Blue Shield program that has a contract with your facility,” Partlow opines. Without better rates, the thinking is “it’s just not going to play out when the claims start flowing.”

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### Figure 2 – Percentage of United States hospitals with an equity in health plans either through the hospital or through a provider–owned health plan, by bed-size group. Source: AHA DataViewer™, February 2015.

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Most provider-sponsored plans are fairly small relative to large fully insured or ASO contracts, serving anywhere from 25,000 to 150,000 lives, explains Keckley, but their smaller scale could pay off down the road. He believes they offer “a more consistent level of care and if you build in the right safety and quality measures, you may actually save some money in the long term.”

Provider-sponsored plans typically feature more primary care services and visits, as well as more preventive diagnostics, which Keckley says “should pay off in earlier detection and avoidance of some big-ticket items long-term.”

But since health outcomes are often dictated by contractual agreements, he cautions that it could be difficult to reap the benefits of nutrition and exercise in the form of fewer heart attacks and other costly episodes or the onset of chronic conditions on a two-year contract when it could take five to seven years for improved outcomes to take hold. His advice to self-insured employers is to think about pursuing longer-term arrangements that look beyond the low-hanging fruit.

“If you’ve got a workforce that tends to be middle age and older, the turnover tends to be lower,” Keckley observes. “And if it’s in an industry where you don’t compete for talent as much, then typically the employer’s got a lot of leverage there and they can say, ‘I want a really good three-year deal. I want to lock in a certain number of my population at these outcome levels and I’ll go at risk with you.’ It’s more complicated that just simply saying, ‘I’ve got 5,000 employees, 12,500 commercial-equivalent lives and I’m going to sign an agreement for one year with you.’ That basically is the way the insurance industry operates.”

Bruce Shutan is a Los Angeles freelance writer who has closely covered the employee benefits industry for more than 25 years.