EXPANDED OPTIONS WITH HOSPITAL AND PROVIDER-OWNED ENTITIES

Written By Laura Carabello

Hospitals and health systems are queued up to serve employers with better options for high-quality care at more affordable costs, allowing for more customized and personalized benefit packages that address the specific needs of an employer's workforce, according to some industry observers.

Experienced teams at these provider organizations are adept at managing costs for employees with expensive medical conditions, such as cancer or chronic diseases, and offering new strategies to manage pharmacy spending. They also tout their capabilities for virtual-first health models to offer more accessible, convenient services that may also integrate mental health support. With access to AI and data analytics, many are creating personalized wellness programs, identifying high-risk employees and guiding plan members to high-value providers, which helps to improve outcomes and lower costs.

It is also worth noting that hospital leaders nationwide face a growing concern when it comes to the patient experience. According to reports, complaints are on the rise, and federal data show the problem is only intensifying. During contract negotiations, employers should be aware that, according to the latest State Performance Standards System report from CMS, complaints against hospitals have surged by 79% over the past five years and topped 14,500 in fiscal year 2024. That increase is straining the oversight

Barbora Howell

system designed to ensure hospital quality and safety, while also revealing frustrations from patients about their care experiences. Provider-owned entities are particularly sensitive to these issues and are striving to dispel these sentiments.

Barbora Howell, CEO and founder, TrueClaim, asserts, "TPAs are essential in vetting these plans—not just for pricing, but for their operational flexibility and tech stack. AI tools are invaluable in analyzing network performance, identifying gaps, and modeling future cost trends."

Her organization evaluates provider-owned plans based on their integration capabilities with TPAs and commitment to data transparency: "When they align on those fronts, we're happy and able to form deep partnerships that benefit self-insured employers."

Johns Hopkins Medicine cites three distinct benefits of the Provider-Sponsored Plan (PSP) model:

1. Enhanced Patient Relationships

Members of a PSP are the same patients that health system clinicians see every day in their offices. This relationship facilitates trust and collaboration with members. By affiliation with a local health system, the PSP benefits from established familiarity, enhancing members' adherence, self-care and better health outcomes.

2. More Integrated Approach

PSPs are uniquely positioned with direct access to the health system. Using care coordination and care management strategies, PSPs are able to more deftly assist with communication between primary care providers and specialists and improve information sharing. This enhanced integration can improve the quality of the care and reduce costs, while providing an optimal experience for members and patients.

3. Inherent Value-Based Care

PSPs break the constraints of fee-for-service payment models with an inherent value-based structure, incentivizing care to be delivered efficiently and effectively, including using virtual and team-based care. PSP payment incentives are better aligned for investing in preventive care and quality improvement.

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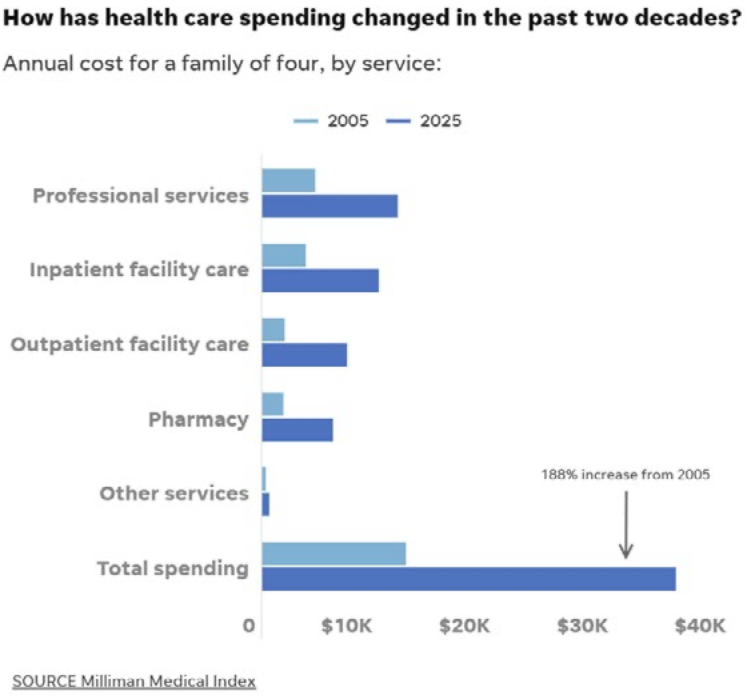
Advisors throughout the marketplace also point to these advantages:

- Custom and narrow networks. Self-insured employers can design custom provider networks in collaboration with the PSP, allowing plan sponsors to steer employees toward preferred providers and facilities that offer high-quality care at a lower cost, which can result in significant savings.
- Data and analytics. The employer gains direct access to healthcare data from the provider, offering transparency into how and where healthcare dollars are being spent. This allows for data-driven interventions and strategies to improve employee health and manage costs.
- Value-based incentives. The partnership moves away from the traditional fee-for-service model, whereby the provider is incentivized to focus on preventive care, wellness programs and better patient outcomes vs. the volume of services delivered.



UNDERSTAND THE DIFFERENCE

Hospital and Health System-owned Health Plans

Unlike traditional health plans, which operate as intermediaries between patients and providers, provider-sponsored health plans (PSHPs) are health insurance products directly owned and operated by a provider entity, such as a hospital, health system or physician group. PSHPs aim to coordinate care, advance health and align provider and payer incentives.

American Hospital Association Trustee Services contends that PSHPs offer a good way for hospitals and health systems to take on risk as they move toward value-based care, often beginning with plans for their own employees. They suggest that health plan products are a new way for health systems to control their destinies as their revenue shrinks. Taking on risk is one way to avoid the ups and downs created by payment shifts in the move to bundled payments.

The PSHP market is diverse, with a broad range of players operating in different geographic regions, each with unique strengths. Advisers at Alvarez and Marsal suggest that large PSHPs benefit from scale,

integration, and access to advanced technologies, while mid-market and small PSHPs capitalize on their agility, deep community engagement, and personalized care models. Regardless of size, PSHPs are increasingly focused on delivering value-based care, improving patient outcomes, and addressing the social determinants of health.

DIRECT-TO-EMPLOYER CONTRACTING

Direct contracting models bypass traditional intermediaries, allowing employers to contract directly with a curated group of providers to offer healthcare at negotiated rates, often with more transparent pricing and a focus on quality outcomes. The employer then pays claims out of its own funds, often managed by a Third-Party Administrator (TPA) that coordinates claims processing and network access.

Small and large employers alike want to ensure their workforce achieves and maintains optimal health to maximize productivity. By working directly with a healthcare system, these companies can control costs and maximize the value of employee benefits.

Essentially, these arrangements represent a partnership: Employees have the opportunity to work more directly with their providers, better communicate their needs and create a personalized approach to health improvement that enhances satisfaction with the benefit plan.

Successful implementation of the partnership requires employers to navigate detailed contracts that clearly outline expectations, outcomes, and responsibilities for both employers and the health systems. It is important to strike the right balance between cost and care quality, especially with employer demands on providers to scale their services to meet expectations for increased service levels. As with all healthcare partnerships, the need for technology integration is essential to manage contractual arrangements.

Bruce Roffé

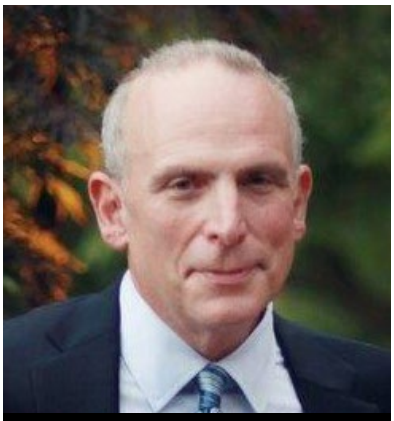
"Hospital-owned health plans and direct contracting organizations can contain medical costs by leveraging integrated care models, emphasizing preventive care, and utilizing data analytics to identify high-risk patients," says Bruce D. Roffé, president and CEO, H.H.C. Group. "Examples include identifying high expense patients using ICD-10 Stop-loss Trigger Diagnosis Codes as well as other cost control monitoring tools, such as FairHealth data. "

Roffé points to the importance of direct provider-payer alignment that reduces administrative overhead and enables value-based reimbursement strategies, adding, "Negotiating bundled payment models and promoting site-of-service optimization—such as shifting care from inpatient to outpatient settings—can further reduce expense. Additionally, investing in care coordination and chronic disease management improves outcomes while lowering long-term costs. These organizations are uniquely positioned to align financial incentives with clinical performance, driving efficiency and enhancing patient care."

ENTER THE WORLD OF PROVIDER-SPONSORED HEALTH PLANS

Meet the Health Plan Alliance, comprised of the nation's leading provider-sponsored health plans. The organization includes leaders in 10 of the top 20 U.S. markets and covers underserved rural areas. Members range in size, from less than 50,000 members to more than 1 million members and operate in all lines of business. While there are varying business models, they are all regional health plans with strong provider ties. Overall, there are several advantages for employers to contract with these plans:

- Local advantages and their ability to bring everything to the table – including level-funding opportunities.
- Local network, local service and local care management – including relationships with local brokers who live and work in the same community.
- Cost containment and the ability to deliver services on a local basis that can't be matched by the nationals
- Customization, with a nimbler approach to benefit design.
- Focus on the employer partnership mindset – treating employers as strategic partners.



Rick Koven

Rick Koven, a longtime consultant to the HPA who handles most of their commercial programming, describes the organization as "A group of about two dozen plans among their members who are working on their self-funded books of business together and are focused on self-funding. As a longtime fan of SIIA, I have been going to many, many national meetings. In fact, in the last three years, we've organized a field trip among some of these plans to come to the annual conference and participated as part of their focus on self-insurance."

Shawna Dandridge, chief program and strategy officer, HPA, further articulates, "The HPA has been around for about 30 years, a collection of about 50 provider-sponsored health plans from across the country. We're very, very careful about membership, so we don't allow any of the Blues, no BUCAs, no Kaiser, none of the big guys. And we do that because we really like to create intimate spaces where our member plans can come together and share, learn and feel validated."

The intention is to not include entities that are much bigger, that can come in and sort of take that information and stomp on our members or sort of clam-up our crew. The beauty of what we do is to get members in a room together and hear about this year's commercial strategy or how they are thinking about brokers. We just had a call last week on broker compensation, and they were sharing information across themselves."

Dandridge says they look like an association, but the HPA is a for-profit organization that is owned by the members – a characteristic that sets it apart.

"Most of our members are also shareholders, and we do give them back a sort of dividend when we are doing well," she continues. "When I introduce myself, I say: 'I'm Shauna and I work for you here at the HPA.' We really are here to serve the members."

Shawna Dandridge

Source: Health Plan Alliance

The organization also runs projects and will often pay for a consultant on behalf of the members so that one member doesn't have to foot the bill. For instance, this year they are running an AI accelerator with a group out of Silicon Valley.

"We paid a decent chunk of money to have them join us, and we've got about 25 plans who are coming together with regularity to really think about how they move the needle on AI," explains Dandridge. "There are other examples that demonstrate opportunities for members, and we are able to leverage our network in lots of really interesting ways. We've been talking about 'blue carding'* for years, as well as private exchange IRAs, and these types of possibilities. We've also discussed rebate aggregation on the pharmacy side, and so there's lots of opportunity here. We are an amazing group across the country, and we're pretty well plugged into the provider-sponsored space."

*NOTE: "Blue carding" refers to the BlueCard Program, a national and international network that allows Blue Cross and Blue Shield (BCBS) members to receive in-network benefits when seeking medical care outside of their home service area.

All of the HPA plans are connected to a health system that owns them, although there are some independent plans. Reflecting on 2025, Dandridge says, "This year and last year have been particularly disruptive for our members. They are hanging on by a thread. I think if we don't begin to have more honest conversations about what regulations and policy changes are doing to this group of our members, nationals are going to dominate the country."

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Dandridge decries this impact, adding, "I think if that happens, we lose a lot when it comes to community-anchored provider and payer systems that can't just pull out of a market when the dollars and cents don't make sense anymore. Our folks are absorbing the members when the big guys like Anthem, Aetna, and others say, 'We're not profitable here, we're going to leave.' Our little guys are left holding the bag; they can't just leave. So, they absorb all that unprofitable membership, and they really are trying to meet the community needs."

Koven expounds, "Within our group of 50, about half have active self-funded blocks of business that they're interested in growing in a sustainable and profitable way. We convene with those groups, share experiences and talk about the issues of the day. The strength of our members is their local presence: contracts with their local parent health system tend to offer very favorable contracted rates. They have a strong brand and can provide customer service at the local level. Traditionally, these contracts focus upon cost containment. This becomes an important asset to leverage into the self-funded market."

He cites a primary challenge to serve larger employers that are more likely to have multi-state out-of-area business with membership that's more geographically dispersed.

"That's an issue," he admits. "Traditionally, they went with the rental networks, the MultiPlans of the world and many use First Health. That had been the solution to provide contracting outside of their service area. But more recently, with the advent of national carrier leasing arrangements, a number of them have formed partnerships or just contractual arrangements with Cigna, Aetna and a little bit with United. It's not a perfect solution, but it's a solution."

Another important issue is their history of coming from the HMO prepaid route, as he explains, "They traditionally weren't used to unbundling, so I often say to them, 'You guys are like the fancy restaurant with the prefixed menu and the TPAs are like the Greek diner with page after page after page of things you can order.' I urge them to make that transition from the 'we do everything package deal' to the unbundling dynamics that we all know are very common."

Finally, he points to reference-based pricing (RBP) as a solution to this problem since it obviates the need for a contracted network, saying, "As you can imagine, reference-based pricing is entirely anathema to their owner parent. There's been reluctance, but more recently -- at least for several of them -- that RBP is becoming a tool for the out-of-network claims that come in. I think you're going to see some more of that."

Local vs. National

Local plans hang their hats on quality, credibility and pricing, but Dandridge says the nationals have really been co-opting that approach.

"I think the nationals are starting to look or try to look more like our plans," says Dandridge. "Some of our member plans report that their customers are going to nationals because they're repricing in a way that's maybe not entirely honest. Then, they're coming back to our plans because our plans really deliver what they promise."

Managing the Drug Spend

"This is the ever question with our plans," notes Dandridge. "We have a pharmacy executive network that comes together with some regularity, and pharmacy costs are the biggest cost driver for our plans right now. Unfortunately, there's truly not a good solution to this across the board, although there's been some reinsurance on some of the cell and gene therapies."

She believes the conversation around pharmacy spend is really about PBMs, adding, "Frankly, there are some plays with Mark Cuban and cost-plus models for more transparency, but the entire system is

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built on rebates and all of our plans partner with PBMs who aren't transparent in what their pass-throughs look like and what rebates are looking like. Until there are broader system changes, we're going to continue to see things just tighten and tighten and tighten on these high-cost drugs."

Group Purchasing Organizations

For many years, the organization has had group purchasing arrangements and runs a vendor database, basically leveraging its buying power with the PPOs to get favorable arrangements and access discounts on a contract for its members.

"We know most of the vendors across the plans, so if someone's looking for a new claim system, I'll reach out and say, 'What's the leading claim system? Who's using what?" says Dandridge. "We can then connect them so they can hear experiences of other members and sort of feel comfortable as they enter procurement."

She says it can be really hard to get good GPO contracts in place because every plan is so different, and because they're connected to health systems, sometimes they're doing some contracting with their health system and leveraging the buying power in that way.

"But we have a number of interesting arrangements," she adds. "A GPO contract with Avalon around lab services and even one for reinsurance."

This approach has been very helpful for the plans, as Koven also points to a GPO with a stop-loss program and one that is basically an MGU that is owned by a southwest carrier that helps plans move through that continuum – a very longstanding and successful program.

Focus on Level-Funding:

As level funding gains in popularity, Koven says that surprisingly, "We see a lot of success with about six plans serving that market niche, and all the others interested -- either looking at it, developing it or launching it. Locally, level funding actually plays into plan strengths for serving smaller employers, offering bundled services that align with their typical mode of operations."

DIRECT CONTRACTING – NOT AN AT-RISK HEALTH PLAN SPOTLIGHT ON NORTHWELL DIRECT

Long Island, NY-based Northwell Direct provides an example of a for-profit subsidiary that is wholly owned by the Northwell Health System but is not a health plan. It acts as the employer partnership vehicle to provide employee health benefits and customized health services to employers across the tri-state area. Using RWJBarnabas Health (NJ), along with CT-based Nuvance Health System, a seven-hospital system in Connecticut in the Hudson Valley, which it recently acquired, Northwell Direct has broadened its network to minimize disruption for employers throughout the tri-state region.

Independent physicians are also a part of their network to access this direct-to-employer work that they couldn't do on their own. An individual practice or set of practices is too small to know how to interact and build the infrastructure to interact with employers. This includes smaller health systems like Garnet Health and the Optum physician groups.


Chelsea Glenn

Chelsea Glenn, chief growth officer, Northwell Direct, explains, "It is really important to emphasize that we are not licensed as an insurance company, and we don't offer insurance. I just want to be super crisp on that issue. We do offer health benefit solutions for self-insured employers."

This model is designed for a company's own employee health plans, where they bear the risk – the entity that pays the claims.

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"We're the network for care management and we're integrated with TPAs, PBMs and stop-loss," she continues. "So, we have the full package of solutions between what we directly provide with our partners -- but we aren't insurance, and we are not licensed as a health plan. We do support employee health plans across the self-insured employer space."

Northwell Direct maintains a list of core TPA partners that includes:

- PointC
- Personify
- IBA
- DH Cook
- Allied

"We are provider-owned, so we are provider-sponsored, working to provide solutions for employers for their employee health plans -- but we actually aren't the health plan," stresses Glenn. "We are fully owned by Northwell Health System, so that's our parent company. We're a subsidiary that deals with all of the employer partnerships and employer health benefits."

She observes that everybody pays different prices, noting, "Historically, employers paid more, right? It costs more for a knee surgery if an employer is paying for it than if the federal government is paying for it. United, Cigna and all of these health plans that sit in the middle, they can help mediate and negotiate, but they aren't the end deliverer of that care, and frankly, the end price setter. It's the health systems and the providers who deliver the service and charge a rate for that service. What we are saying to employers is we absolutely hear you that it's too expensive, that it's unsustainable."

Given the fact that 50% of people are getting their insurance through their employer or through their family or husband/wife's employer, she says it is important to sit at the table with the provider and be part of that solution.

"The BUCAs can't solve it – they're just sitting in the middle," she remarks. "But if employers really want to address the total costs that they're having to pay with their employee health plan, they need to talk to the end providers. The ones delivering all the care. They're the ones taking care of those employee plan members who become our patients, and it's our prices. So, it's really just economics from that perspective. And then when you go directly and partner with a provider system like Northwell, we're fully integrated."

She explains that across their network, they are delivering the best quality of care that's fully coordinated, contending, "I can make an MRI $200 cheaper, but if you still get four of them, that's not saving the plan money because total cost of care is utilization and price. Our goal with employers is to partner with us directly -- we'll attack both of those levers with you because we want to sit at that table to help you solve this cost sustainability problem while ensuring quality."

Essentially, they are bringing direct contracting to employers at scale, enabling middle market employers that don't have the infrastructure, expertise and consultants of a jumbo group to have access to these specialized direct contracting opportunities with providers. They also ensure provider choice.

"For example, in the NY metro area, there's always an issue of someone having a cardiologist from Mount Sinai for 20 years and doesn't want to disrupt that relationship," she clarifies. "That's something we hear from employers, so our model features a preferred network with our preferred pricing and discounts as tier one, but we have a tier two, meaning you also have access to all of Anthem."

This translates into member access to all Blue Cross Blue Shield networks across the whole country, allowing for total member choice – although they may pay a little more out of pocket with a co-pay of $40 instead of $20. All of that benefit design is set by the employer, but Northwell Direct has a mechanism that allows for provider choice with that second tier. They also help to market the stop-loss, offering a preferred panel of 10 different stop-loss underwriters that understand their value proposition, pricing and the impact of their care management services.

"When the employer requests information through their broker, we can send that pool of underwriters all of the information that they would need to generate a stop-loss quote," she continues. "Then we bring that as part of the total package. And we often get pretty good terms from underwriting because our panel knows our model and believes in it."

FAVORABLE MARKET TRENDS

Financial advisors at Alvarez and Marsal forecast several market trends that are unique to the PSHP model compared to traditional health insurers, including:

1. Integration of Care and Insurance

A key feature of PSHPs is their ability to integrate care delivery and financing, enabling providers to have greater control over both the quality of care and the cost of care. By managing both the clinical and insurance aspects of healthcare, PSHPs are better equipped to address inefficiencies in the system, improve care coordination and reduce unnecessary medical interventions.

2. Value-Based Care

PSHPs are leaders in value-based care models, where providers are financially incentivized to improve patient outcomes while reducing costs. This model rewards providers for better managing care across the continuum, focusing on preventive services, chronic disease management and outpatient care to avoid costly hospitalizations.

3. Social Determinants of Health (SDOH)

Addressing social determinants of health (e.g., housing, food security, transportation) has become a major focus for PSHPs. Their ability to directly interact with patients and provide more comprehensive care allows them to incorporate non-medical interventions that can improve health outcomes and reduce healthcare costs. Many PSHPs offer prepaid cards for essential services such as food, housing, and transportation to better manage these factors.

4. Technological Investment

PSHPs are increasingly investing in technology to drive operational efficiency, improve care coordination and reduce costs. Investments in data analytics, telemedicine and AI are key to improving clinical outcomes, predicting patient risks and reducing hospital readmissions.

Joe Mangrum

ECG Management Consultants Joe Mangrum and Christopher Costa sum it up: "On the whole, PSHPs are better able than larger organizations to be nimble. Their ability to operate with a very narrow margin can help them grow membership through highly competitive premiums. Smart partnerships can expand their presence in a given region. PSHPs also have more opportunities to collaborate with their physicians—establishing good-faith relationships that can promote engagement."

While PSHPs can't be all things to everyone, they say these entities can be the best at what they do: in an increasingly consumer-centric world, they can be poised to thrive.■

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