health care’s new game changer
thinking like a health plan

To meet new market expectations, hospitals and health systems are taking a page from the playbook of insurers in designing their approaches to population health management.

The shift toward value-based business models of care is blurring the lines between hospitals and health plans. Such models are prompting three significant trends:

> A renewed focus on managed care
> A resurgence of narrow, tailored, and high-performance network products
> A move toward total-cost-of-care contracts, private-label HMO products, and provider-owned health plans

Health systems must adapt their care delivery strategies to address industry-disrupting forces if they are to survive. For those that do change and learn to “think like a health plan,” disruption in the healthcare market provides opportunities to increase both market share and value through more efficient and effective care.

“Access, choice, efficiency, and a reasonable, predictable price are what the healthcare market increasingly demands,” says Bill Gil, CEO of the Medical Group Foundations of Providence Health & Services, Southern California, a leading regional player in the Los Angeles metropolitan market. The $12.5 billion regional health system—headquartered in Seattle, with sites in California, Washington, Alaska, Oregon, and Montana—has more than 3,000 affiliated physicians and owns a 500,000-member health plan in Oregon that offers a full range of commercial and government managed care products. “To be successful, provider systems will need to be positioned to meet these new market expectations,” Gil says.

AT A GLANCE

The transition for hospitals from having only a provider’s perspective to thinking more like a health plan will require strategic alignment on four fronts:

> Health plan alignment
> Hospital and physician alignment
> Leadership alignment
> Organizational alignment
Among Hospitals, New Interest in Health Plans

Disruption in the healthcare market is likely to increase in the next five years as the Affordable Care Act (ACA) rollout continues. As a result, health systems that sold their health plan licenses a decade or more ago to invest in other strategic projects are showing new interest in the insurance market.

Consider the following:

- An estimated 20 percent of health system networks offer either their own insurance product or a co-branded product, according to a 2012 Advisory Board survey.¹

- An American Hospital Association survey of 100 hospitals earlier this year found that 38 of the hospitals already owned health plans, while an additional 21 were planning to offer a health plan product in the next three to five years.²

- Since 2008, there have been 93 new or expanded Medicare Advantage plans approved by the Centers for Medicare & Medicaid Services (CMS), 30 of which are provider-sponsored. Of the new Medicare Advantage plans approved by CMS since 2008, 70 percent were provider-sponsored; approximately two-thirds of these were approved in 2013.³

The large-employer group health insurance market—which has served as the foundation of the fee-for-service business model—is likely to undergo substantial change. A 2013 study by AON Hewitt, AON Hewitt 2013 Health Care Survey, notes that most employers have been focused on year-to-year risk mitigation as their primary healthcare strategy. Since the passage of the ACA, employers have been adopting a new approach focused on requiring employees to either be more engaged in their health or face higher deductibles. In addition, employers are actively transferring risk to employees through private health exchanges. Today, only 2 percent of employers provide employees with a fixed-dollar subsidy to purchase healthcare coverage; however, 28 percent expect to move to a defined-dollar contribution approach in the next three to five years.

The healthcare market also has become increasingly intolerant of current pricing, and for the first time, there are significant choices for consumers as new bronze and silver plans abound on the health insurance exchanges, or marketplaces. Narrow and ultra-narrow hospital network products now constitute 70 percent of hospital networks on the exchanges, and the number of such products offered by carriers that participate on the exchanges increased from 25 in 2013 to 65 in 2014, according to the McKinsey Center for U.S. Health System Reform (“Hospital Networks: Configurations on the Exchanges and Their Impact on Premiums,” Dec. 14, 2013). Median premium prices of products on the exchanges are 26 percent less than traditional broad network products, with as much as a 35 percent price differential between some offerings. All new network products are designed to meet ACA requirements, which define the minimum number and types of providers and the maximum driving distance and wait time to ensure beneficiaries have adequate access to care.

It appears that trends in the new consumer healthcare markets may become similar to the trends in other consumer markets, such as automobile insurance, cable television, or cell phone plans, with a variety of product offerings reflecting different benefit packages at different price points, according to the McKinsey Center. Organizations that do not adapt to the emerging consumer market risk being left out of health plan networks, losing physicians to competing narrow-network groups and selective independent practice associations that do adapt, and losing patients, who are increasingly opting for lower-cost, narrow-network prices.

There also are substantial risks to the status quo from disruption in the Medicare Advantage health plan market, which now includes 28 percent of Medicare beneficiaries nationally. For the

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3. CMS enrollment data, cms.gov.
past few years, CMS’s outreach program has sent notifications to enrollees in low-performing plans, encouraging them to consider changing to better-performing plans. This year, the other shoe dropped as CMS announced that, as of Dec. 31, it would begin canceling all plans that have failed to achieve a three-star rating for three consecutive years under the agency’s Five-Star Quality Rating System.

**Transitioning to Thinking Like a Health Plan**

More and more, health systems are increasingly thinking like health plans as they seek to better manage population health. These organizations benefit from understanding a health plan’s core values, whether they are partnering with a commercial plan in a total-cost-of-care partnership or taking steps to offer their own health plan in the market.

A health plan is fundamentally a risk-selection business, wherein cost control and financial stability are core values. In the emerging consumer market of public and private exchanges, quality, cost, service, and convenience are the major value drivers. Hospitals and health systems, on the other hand, traditionally have focused on service delivery, for which the greatest system values have been access to the latest technology for treating illness and high-quality care delivered in the hospital domain. In the past, these organizations have focused less on the cost to employers and the affordability, access, and convenience they provide for consumers.

Generally, the health plan value proposition has aligned well with the objectives of the employer group market. Today, more than 70 percent of employers focus their healthcare strategies primarily on programs that improve health risk and medical costs, although this focus will change over the next three to five years: 48 percent of employers say they intend to shift focus to programs that do more to help employees manage their own health and achieve greater consistency in their performance at work. This new employer focus fits well with consumer market innovations that enhance wellness, self-care, personalized service, and convenience.

A successful population health system will need to keep a close eye on its core business, concentrating on the efficiency of hospital operations, because costs are major drivers in the selection of providers for new narrow-network products. A pluralistic physician strategy will be needed, balancing employed physician needs with voluntary staff as the system navigates the evolution from basic pay-for-performance contracts to global total-cost-of-care capitation, private-label partnerships, and provider-sponsored health plans.

“We are changing and will continue to evolve into a population health system,” says Barry Arbuckle, CEO of MemorialCare Health System, a not-for-profit integrated delivery system (IDS) in Southern California. Arbuckle notes that his organization is embracing this change while “not abandoning what got us where we are in the first place: the acute care hospital.”

Metrics of success should include a health system’s ability to document quality and performance, utilization, and financial metrics (see the sidebar on page 4), as well as regulatory metrics and quality ratings.

The goal of many advanced IDSs that are seeking to think like a health plan—such as Partners HealthCare in Boston, Sentara Healthcare in Virginia, Health First in Florida, Advocate Health Care in Chicago, and MemorialCare in Southern California—has been to move with deliberate speed toward becoming a population health system capable of managing risk for targeted populations of patients.

For many large IDSs, this strategy may mean that inpatient hospital revenues constitute less than 50 percent of their total revenue by the end of the decade, with revenues from their clinical network, medical groups, and health plan investments or partnerships being their main engines for growth. Developing the appropriate alignment of a health system’s business units will require a new cultural
COVER STORY

Measuring Success: Health Plan Financial Metrics

Health plans monitor four key metrics of financial success that are specific to the industry.

Medical-loss ratio (MLR). The MLR is the total medical claims expenses divided by the total revenue. This metric essentially provides a snapshot of how much of the premium dollar was actually spent on health care during the reporting period. The Affordable Care Act specifically requires that health plans have an 80 percent MLR in the individual and small-group market (85 percent for Medicare Advantage).

Operating-expense ratio (OER). The OER is the total operating expense divided by the total revenue. Essentially, this measures what percentage of every dollar coming in was spent on running the business. Provider-sponsored health plans have an advantage in that savings from clinical efficiencies can be returned to physicians as bonuses for meeting quality metrics and still count toward the MLR requirements.

Underwriting margin (net income before taxes). This metric is total net income before taxes divided by the total medical claims expenses and operating expenses.

Net-income margin. This metric is the bottom-line net income divided by total revenue (essentially, the profit margin).

Mindset where the hospital is no longer the center of care delivery, and where there is appropriate balance between physicians and medical groups and between ambulatory and inpatient hospital service lines.

For example, MemorialCare, which operates six hospitals and more than 200 ambulatory care sites across Los Angeles and Orange counties, has moved a number of its most profitable outpatient services out of the hospital organizational structure and into a new corporate structure under its medical foundation, MemorialCare Medical Foundation, the physician division of the health system. In this way, those that are directly responsible for ordering these services are also responsible for their management and growth. Services that were entirely delivered within the walls of the system’s hospitals—primarily radiology and surgery—are now provided in scores of community-based locations as well as through joint-venture partnerships in which MemorialCare Medical Foundation is a 51 percent stakeholder. The move has enhanced access, convenience, and the organization’s ability to offer market-competitive prices.

MemorialCare Health System owns Seaside Health Plan, which provides care to individuals with Medi-Cal, Medicare, and commercial coverage. In April, MemorialCare Medical Foundation also entered into an agreement with Anthem Blue Cross to offer Anthem’s Enhanced Personal Care program in the Orange County and Greater Long Beach region. The initiative is designed to provide comprehensive, coordinat-ed medical care to Anthem PPO members through an accountable care organization partnership, which also includes Edinger Medical Group, an affiliate of Greater Newport Physicians.

It is clear that as inpatient hospital revenue shrinks as a percentage of total revenue among hospitals and health systems, the shift in emphasis toward care provided in outpatient settings will occur at a pace that few providers have ever experienced. The exhibit at on page 5, which is drawn from the experience of an IDS in a major metropolitan area, shows historical and projected changes in the IDS’s sources of revenue from 10 years ago through the next decade. It also demonstrates how significant the transition is likely to be.

Requirements for a Successful Transition

As organizations progress to thinking more like a health plan, their efforts to coordinate the various components of an IDS—one focused on population health management—will require strategic alignment on four fronts:

> Health plan alignment that includes effective partnerships to enable the organization to manage total-cost-of-care commercial contracts, Medicare Shared Savings Program contracts, and private-label managed care offerings

> Hospital and physician alignment that ensures the organization can meet quality and patient satisfaction targets through the integration of clinical and financial performance metrics.
satisfaction metrics and deliver a continuum of care that includes pre- and post-acute, nursing, and palliative care services.

> **Leadership alignment** that balances the need for system integration and cost-effectiveness with the need to expand market share and optimize revenue.

> **Organizational alignment** that ensures operating units are positioned correctly from a business standpoint and salaries, incentives, and benefits are properly balanced.

The transition to thinking like a health plan also will require an emphasis on price transparency to allow consumers to compare prices not only for health plan offerings, but also for episodes of care as well as common procedures. Additionally, it requires a commitment to patient relationships with implementation of electronic health records, patient portals, and engagement with employers to encourage enhanced workforce health and performance.

“`The biggest mistake you can make in thinking like a health plan can be a failure to deal with the integration and system alignment issues up front,” says Arbuckle of MemorialCare.

“A lot of health systems are doing the right thing in going out and expanding their geographies and growing their medical staff so they can have the resources needed to offer managed care products,” Arbuckle says. “But because the alignment of resources can be contentious, they make the mistake of thinking they can deal with these issues less confrontationally later on. In our experience, this is never the case.”

The successful population health management system of the future will increasingly view premiums from health plans as its major revenue source and all health system service capabilities as cost centers. This perspective will be a marked change from a decade ago, when the business focus for most healthcare executives was on the hospital.

“Even though we roll all the profits and losses up as a system, it is a matter of constant education to get people to adapt to a population health mindset—and a lot of work along the way to make sure our incentives and benefits are aligned so that no one becomes disadvantaged,” Arbuckle says.

### Thinking of Making the Move?

#### Questions to Consider

Thinking like a health plan can be key to realizing the potential benefits of population health management. Healthcare leaders and board members whose organizations are making the transition to population health should start by ensuring they have constructive answers to the following questions:

> Is your organization’s leadership team and board buying into the vision of a population health system as a whole—or are people still encased in their own silos or focused primarily on the acute care hospital?

> Does your organization’s business plan reflect the growing influence of consumerism in the market, and do you have the right people in place to lead the charge?

> Has your organization effectively aligned with physicians to respond to market dynamics and adopt a more cost-effective care model?

> Are your leaders willing to be fully open and transparent with your medical staff regarding who is inside the cost curve and who is outside?
Key Competencies for Thinking—and Acting—Like a Health Plan

A high-performing clinical network is perhaps the most important success factor in taking advantage of market disruption.

The high-performing network will couple strong primary care alignment with programs of preventive care and a care model capable of robust chronic-condition and post-acute care management. Proper alignment of professional resources, with longitudinal tracking of patient health, can enable providers to think and act like a health plan in managing population health costs—without major new organizational structures or transfers of assets.

“If a provider system is positioned to meet market requirements on its own and cannot find a trustworthy health plan to partner with, the organization still has the option of developing its own plan,” says Bill Gil, CEO of Medical Group Foundations of Providence Health & Services. “The key is being able to meet market expectations.”

Factors to consider in developing private-label or health system-owned products include seven key competencies by which health systems will need to demonstrate that their products are comparable to or better than commercial offerings in the market.

Network strength. The organization should first determine whether the network will be provider-centric, narrow, or ultra-narrow. A key element of planning will be an effective strategy to sufficiently engage physicians so they will be comfortable endorsing the product offering.

Price. Provider-sponsored plans will need to provide better value—generally, lower-cost—than national payers that have products in the market.

Product. The Affordable Care Act has established a baseline for the benefit design. An aggressive focus on member outreach and physician engagement is recommended, particularly in Medicare Advantage and Medicaid Managed Care plans, which have been a “sweet spot” for provider-sponsored plans.

Care model design. An effective care model for designated populations will be the difference between a provider-sponsored plan that makes money and one that operates at a loss.

Distribution costs. This factor includes the decision of whether to rely on brokers or use an expanded, grassroots effort to recruit for Medicare Advantage or managed Medicaid offerings.

Service and member experience. Local excellence is an essential part of the package.

Brand. The branding should be sufficient to differentiate the local provider offering from national players and local Blue Cross products.

Provider-sponsored plans must achieve market parity or better with all these factors to be competitive.

Despite the recent cuts in the 2015 Medicare payment rates, Medicare Advantage remains a good investment opportunity for providers with high-performing clinical networks. Provider-owned Medicare managed care plans also have been consistently profitable over the years and have achieved superior margins to commercial plans, according to Centers for Medicare & Medicaid Services data. Both programs have a built-in safety net in that out-of-network care is paid at the discounted Medicare and Medicaid fee-for-service rates—not commercial charges.
Does your management team buy into the fact that, in the shift toward value-based business models and payment, a focus on “heads in beds” is misguided?

Does your organization have a long-term approach to population health management, so leaders are not simply making year-to-year decisions, or is the focus still on this year’s earnings?

Is your organization focusing its approach on the entire continuum of care so physicians and staff can effectively and efficiently manage patients across the continuum?

If your organization’s leaders are unable to answer most of these questions, you may still be thinking like a hospital company rather than like a health plan.

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