organizing for the ‘second curve’
combining health plans and provider systems

The changing healthcare environment offers strategic advantages to provider systems that own health plans, but such integration requires significant preparation.

The continuing transformation of the U.S. healthcare system to a value-based market has created new opportunities for provider systems that own health plans. As a result, an increasing number of systems have made the decision to “cross the crevasse” and secure their own insurance licenses. Futurist Ian Morrison has described this type of dynamic as moving to the second business curve, where disruptive market factors or technologies force a change to an industry’s business model.

Health systems increasingly are becoming insurers—launching accountable care organizations (ACOs), building payer partnerships, initiating private-label products, and even launching their own health plans. Recently, health systems as diverse as MedStar Health in the Washington, D.C.-Baltimore area, Sutter Health in California, North Shore-LIJ in New York, WellStar in Atlanta, and Partners HealthCare in Boston have all acquired or launched health plans in their markets.

Now these health systems—and others like them that will secure licenses in the future—face the challenge of how to “think like a health plan.” They need to integrate their insurance ventures with their provider business models, while keeping in mind that a substantial segment of the enterprise continues to be driven by fee-for-service economics.

**Strategic Advantages**
Provider systems that own health plans gain strategic value in four key areas. Recognizing these advantages helps to integrate the health plan into the system’s overall goals and build support for a unified business vision.

---

**AT A GLANCE**

Provider systems should ask four questions as they seek to incorporate health plans.

> Is the health plan on track to build critical mass quickly enough?
> Does the plan balance provider and health plan business priorities?
> Is the provider system willing to let its health plan compete freely in the market?
> Is the provider system’s overall vision understood and backed internally?
A direct relationship with the ultimate payer. If a health system seeks to be the ultimate provider of care to people who live in a given service area, why would it want to give away premium dollars to an intermediary? Yet most provider systems have traditionally operated through brokers or other commercial health plans. The launching of public and private health insurance marketplaces and the reforms mandated by the Affordable Care Act (ACA) have disrupted those intermediaries and created a consumer-oriented healthcare market. As a result, owning a health plan and establishing a direct buyer relationship gives provider systems a competitive advantage and an opportunity to build lasting brand loyalty for all of their system’s programs. The health plan serves as the connector to the end-user, whether that user is an individual consumer, an employer, or a health plan member.

A counterweight to the negative financial results of hospitals. Rating agencies such as Fitch and Moody’s see geographic and product diversity as key credit strengths. The experiences of systems such as Presbyterian Health Services in New Mexico and Sentara in Virginia indicate that health plan profitability frequently is counter-cyclical to the profitability of provider operations. With the exception of a few down years, these plans have been consistently profitable and have been the major contributor to health system profitability in some years when hospital margins were depressed.

Better physician alignment. Provider systems with health plans have the ability to offer leadership opportunities for their medical staff in the effort to enhance health plan quality and resource stewardship. Medical staff can be included in the governance of the health plan to a degree they would not enjoy with larger commercial payers. Medical staff also have opportunities to test new payment mechanisms, care management models, and disease management protocols. By developing physician leaders who are committed to the enterprise’s vision, the health plan helps shift organizational emphasis from short-term maximization of revenue to longer-term value enhancement.

Support for new business ventures and ACOs. Health plans provide a built-in market for new outpatient business ventures, home care and durable medical equipment, and lab and pharmacy services as long as the new products are competitively priced. An increasing number of plans provide claims processing, medical management, and clinical informatics services for ACOs, or design and run private-label insurance products for other hospital systems.

Options for Integrating a Health Plan
We believe the successful provider systems of the future will increasingly envision themselves as population health management systems. Some systems that own health plans, in fact, may already be operating this way. In a population health management system, a health plan can be an engine that drives health system integration and growth.

The measure of success under this vision will be the performance of the overall system, not that of individual units. Health plan premium growth will supplant inpatient revenue as the system’s key revenue driver. Hospitals, outpatient businesses, and physician services will transition over time from revenue centers to cost centers. The speed of this transition will depend on the organization’s philosophy, the competitiveness of the plan in the local market, and the ability of management to sell and implement its vision in a culture traditionally dominated by hospital business silos.

Within this general framework, we see at least two different business models for provider systems with health plans to consider.

Operate the health plan as a division of an integrated holding company. This model has been adopted by most hospital systems with health plans. It recognizes the need for combined operating statements for the health system, but treats the health plan as a separate business entity under the system umbrella. All staff functions—including human resources, finance, sales and marketing, and IT—report directly to the health plan CEO and are not matrixed to their counterparts at the system level. Under this model, the
A health plan is considered part of a diversified business portfolio. (See a case study of this business model as it was implemented at Summa Health, a health system in the Midwest, at hfma.org/summahealthcasestudy).

**Operate the health plan as part of an integrated company.** Under this model, the provider system’s goal is to become an integrated operating company. As in the first model, the health plan includes all of the usual business functions to meet ACA and insurance regulations. However, because the business vision is to operate the health system as a single entity, there is a matrixed management structure.

The heads of selected health plan functions (e.g., human resources, finance, sales and marketing, and IT) have direct-line reporting relationships to the system’s department heads, who have responsibility for the health system’s performance as a whole. There is only a dotted-line reporting relationship to the health plan CEO, even though the people filling these roles will spend the vast majority of their time interacting with the CEO’s office on plan business. (See a case study of this business model as it was implemented at Health First, a health system in central Florida, at hfma.org/healthfirstcasestudy).

The business model the provider system chooses will be influenced by its strategic vision, operating philosophy, market requirements, and competition. Organizations that select the second model should be prepared to double down on internal communications, given that the change will likely be unsettling to people who are accustomed to working in organizations with traditional straight-line reporting authority.

**Factors in the Degree of Integration**

The degree of integration between a provider-owned health plan and the provider system will be influenced by market and product selection, utilization and care-management delegation, and the breadth of the health system’s physician networks. In some instances, health plans will need to offer products covering geographic areas that extend well beyond the service areas of the hospital or medical staff. In other instances, the provider system may organize a clinically integrated network (CIN) for staff in which they contract with commercial plans that are competitors of the system’s own health plan—recognizing that the system will not remain viable on its health plan’s business alone.

In Kaiser Permanente, a totally integrated system, the hospitals and each of the seven independent, self-managed medical groups in Kaiser’s markets are connected by mutually exclusive partnerships and contractual relationships, and share a common vision and social mission. Obviously, such a close relationship could work only with medical groups that operate on global budgets and prospective payments, and in which physicians are full-time employees.

If a provider system launches a CIN, it will need to work through how to integrate clinical and cost performance responsibilities with its health plan. The most direct question is whether the CIN should have the flexibility to contract with other commercial health plans or whether it should be dedicated exclusively to the system’s own insurance products.

**The Need to Function as a Unit**

Health plans are subject to comprehensive regulatory requirements at both state and federal (for Medicare Advantage plans) levels, and provider-sponsored plans need to be able to isolate financial performance from that of their provider-system partners. Rates, medical loss ratios, and equity reserves are all subject to close scrutiny. In addition, plans operate with less financial flexibility than do provider systems, due to their very different cost structure.

About 50 percent of a hospital’s costs are labor, meaning a provider system can reduce staff and labor costs if it is not meeting budget and performance targets.

On the other hand, 85 to 90 percent of an insurance company’s budget is for medical claims, while
only 4 to 5 percent of its costs are labor. A plan that misses its medical expenses budget by 5 percent because of several unexpectedly complicated and costly cases could incur large losses that cannot be offset by staffing cuts. The specialized business functions of a health plan—e.g., finance, risk management, network development, marketing and customer relations, utilization and medical management, and claims processing—clearly require different skill sets than does hospital management. (See the exhibit below)

**Keys to Plan-Provider Alignment**
A provider system should address three key variables when seeking to align a health plan within its organization.

**Transfer pricing.** Many hospitals jumped into the managed care market for the wrong reason in the 1980s and 90s, launching health plans with the primary goal of putting patients in hospital beds. They charged their own health plans a higher rate for hospital and healthcare services than they charged competing plans in the market. In turn, the higher rates made their own plans uncompetitive.

Few businesses in other industries charge a subsidiary business more than they charge the subsidiary’s competitors for services provided. If a health plan is to compete in a market, the amount it pays hospitals and physicians must be on a par with its competition. The same is true for the rigor with which the plan applies its utilization and quality management metrics. If the health plan is less strict with its provider system’s medical staff in the enforcement of care management protocols, or pays them higher rates than they would receive elsewhere the market, the plan/provider alignment may be unsustainable.

**Open-contracting strategy.** A successful health plan must have an attractive hospital and physician network to meet the needs of its customers in the marketplace. The products of some provider-sponsored plans serve markets that are much broader than the health system’s core hospital and physician markets. This scenario requires the plans to contract with hospitals and physician groups outside the provider system. Few provider systems have the breadth of geographic coverage and services necessary to be competitive as a stand-alone health plan network.

**Compensation.** Developing an appropriate compensation policy is, of course, critical to making the health system’s vision a reality. Summa Health and Health First, two provider systems that own health plans, have different organizational structures but share a common goal and vision of becoming a population health management system. Both systems manage their healthcare networks and health plans through an executive team, the members of which are employees of the health system in addition to having operational responsibilities in the health plan. Financial rewards are determined by a system compensation committee, with executive salaries and bonuses based on achievements relative to system goals—not the results of individual business units.

**Making It Work**
We would argue that any provider system that owns a health plan is already in the population health management business. The health plan is
accepting a fixed payment for the members it serves, and a provider system increasingly will look to its health plan to guide implementation of the care protocols, disease management, and clinical informatics it needs to make the transition to payment models such as capitation and bundling. The health plan is segmenting the market and designing products to meet the needs of individual consumers as well as employers.

Making it all work will be challenging, and there are several key questions for provider systems to consider as they move forward.

**Is the health plan on track to build critical mass quickly enough?** Health systems launching health plans face the challenge of transitioning from fee for service to global capitation. The biggest risk for a system with a health plan is to get stuck between payment models. A plan without sufficient membership or the right population mix to support an adequate care management and clinical informatics infrastructure will not succeed as an insurance company.

**Does the health plan balance provider and plan business priorities?** Only a health system with the scale of a Kaiser Permanente can survive solely on its own health plan’s business. As noted, all systems must contract with a broad range of health plans in the market to grow and be profitable. Summa Health is an example of a health system that has successfully balanced owning an ACO, a large independent physician association, and a prospering health plan. In striving to balance their interests with the interests of ACOs or CINs, health plans should maintain appropriate control over areas of intellectual property—such as clinical informatics, utilization review, and disease management programs—that provide a competitive advantage in the market.

**Can the health plan compete freely in the market?** Most provider-sponsored health plans must be able to contract with other providers in the market, and other providers are unlikely to be cooperative contractual partners if they perceive that the provider sponsor has an unfair pricing advantage. Furthermore, plans and their provider sponsors should contract at arm’s length. A provider system and health plan may agree on a policy that internal pricing will be no higher than that of the plan’s most attractive external contract, for example. But a provider-sponsored plan should keep information about contract terms with competing systems confidential.

**Is the system’s vision understood and backed internally?** The notion that a provider system’s future financial health is dependent on its health plan’s growth will take time to get used to in systems that have long focused on their care-delivery silo’s community settings. Engaging staff in a grand vision of “value-based care” can be difficult when their daily tasks involve issues such as the census in 4West, the waiting time for ambulatory radiology, or the latest monthly medical loss ratio. The most difficult challenge faced in reforming delivery systems may be people’s instinct to crawl back into their silos where they feel safe and where responsibilities are clearly defined.

As much time as you spend communicating—and it never seems to be enough—you also should make time to reward collaboration and teamwork.

---

**About the authors**

**Bill Eggbeer, MBA,** is managing director, Provider Innovation Practice, BDC Advisors, LLC, Annapolis, Md., and a member of HFMA’s Maryland Chapter (bill.eggbeer@bdcadvisors.com).

**Martin P. Hauser, MBA,** is CEO, SummaCare, Inc., and chief government relations officer, Summa Health System, Akron, Ohio (hauserm@summacare.com).

**Steven P. Johnson, PhD,** is president and CEO, Health First, Rockledge, Fla. (steve.johnson@health-first.org).
Form Follows Function

Summa Health System is an integrated healthcare delivery system headquartered in Akron, Ohio, with over $1.4 billion in annual revenue and nearly 10,000 employees. Its organizational structure includes:

> A hospital division with a tertiary academic medical center, two community hospitals and a rehab hospital, multiple ambulatory care sites in three counties, two free-standing emergency departments, and various service line institutes

> A physician division that includes a physician-hospital organization (PHO), Summa Health Network, with 1,300 physician members; an employed multispecialty group, Summa Physicians Inc (SPI), with 300 employed physicians; and an accountable care organization (ACO), New Health Collaborative, with over 300 employed and independent physicians (each of these entities has its own distinct board that reports to the Summa Health System board [as shown in the accompanying exhibit]; there is significant overlap of membership among the three physician organizations, and for general purposes Summa Health System leadership groups the PHO, SPI, and ACO together under the broad category of “physicians” when discussing the organization)

> An integrated health services division—comprised of SummaCare, the system’s health plan; Summa Insurance Corporation; and Apex Health Solutions—that serves 237,000 members in six states with commercial fully insured and self-insured products; an individual product offering (IPO); a Medicare Advantage plan; and a business-process-outsourcing business that supports health plans and ACOs in multiple states

A Foundation for Development and Community Health Initiatives

The various divisions are operated as units of an integrated holding company under the overall control of the Summa Health System board. SummaCare and the insurance affiliates have the same mission as Summa Health System, but serve a broader market—and of course manage a different set of metrics—than do the hospital and physician groups. As noted, the various Summa Health divisions have distinct boards that include representatives from the system board and require super-majority votes for key policy and financial decisions.

All rewards for SummaCare’s senior team are determined by the Summa Health System compensation committee based on system goals and achievements, with small bonuses for individual unit performance. Organizationally, the insurance division and hospitals have separate finance, human resources, and IT departments with straight-line relationships to the division heads.

In the past decade, the health plan has created new shared savings opportunities for the medical staff. These incentives, which passed insurance commission scrutiny in the highly competitive Ohio market, have strengthened the medical staff’s engagement with the health plan. The plan provides ready markets for new clinical initiatives such as durable medical equipment, reference labs, and home care, and also provides support for the system’s community mission with prevention, inoculation programs, and a focus on wellness that extends beyond the plan’s direct membership.

Because SummaCare serves a broader market than do Summa Health System’s hospitals and physicians, it contracts with a variety of nonaffiliated providers to fill out its network in other geographic areas. And because it must have an attractive network comparable to its competition in Summa Health’s core market, it also contracts with some hospitals and physicians that are competitors of Summa Health. Similarly, Summa Health has contracts with a number of large payers who compete directly with its own plan.
An Engine for an Integrated Operating Company

Health First is the leading delivery system in Florida’s Space Coast and is one of the nation’s most innovative integrated delivery systems, with approximately $1.07 billion in annual revenue and 7,500 employees. The organization seeks to differentiate itself by using its health plan as the main engine to build a population health management system.

The system is headquartered in Melbourne, Florida, with four divisions:

> Health First Health Plans, which offers commercial group, individual, and Medicare Advantage products with 63,000 enrollees in Brevard, Flagler, Indian River, and Volusia Counties
> Health First Hospitals, which includes the 514-bed tertiary Holmes Regional Medical Center and three community hospitals with 1,100 voluntary medical staff
> Health First Medical Group, a multispecialty group practice with 240 physicians and 72 midlevel practitioners
> Health First Outpatient Services, which includes fitness centers, hospice, home care, medical equipment, ambulatory imaging, urgent care centers, and medical rehabilitation services

The system’s offerings all compete under the Health First brand. The system’s goal is to operate in the top 10 percent nationally in terms of quality and outcomes, and Health First’s Medicare Advantage plan has consistently earned 4-stars in quality ratings from Medicare. Steven Johnson, PhD, Health First’s CEO, explains, “We have established four coequal divisions and are working toward an integrated delivery network, population health management system vision using our health plan as the integrator. Currently, approximately 20 percent of our system’s revenue comes through the health plan. When we reach 40 percent of our revenue from the health plans, which is our goal, the hospital and outpatient business will transition to cost centers instead of being profit centers.” (See exhibit).

Increasingly, Health First is defining and measuring its performance in terms of per member per month metrics, and less in provider-centric terms of average daily census or outpatient visit volume.

“In our new vision we see ourselves as becoming one operating system spread across several delivery sites,” Johnson says, “a
little like Kaiser and Geisinger see member premiums being their revenue driver and their hospitals and outpatient centers being their cost centers.”

Health First modeled its organizational vision for an integrated population health management system after Kaiser Permanente, Intermountain Health Care, and Geisinger. “We’ve had all the components in place for several years, but they were highly siloed and destructured,” Johnson says. “All of our units tended to focus on getting patients either in or out of the hospital. Everything was very hospital-centric.”

Health First now operates as an integrated operating company that is run by a senior executive leadership team, known internally by the acronym SELT. This group includes all the normal C-suite positions. There is a separate IT department for the entire system, including clinical informatics for the health plan. The organizational structure is highly matrixed to break down operational silos. The system’s chief strategy officer, chief human resources officer, and CFO have direct-line oversight of their respective departments in the health plan, hospital, medical groups, and outpatient business divisions—even though these unit heads spend the bulk of their time working with the heads of the four divisions.

While Health First has a matrixed organizational structure at the system level, the health plan is a defined operating unit in which all normal health plan business functions—marketing, medical and risk management, claims processing, data analytics and predictive modeling, and network development—take place in the health plan business unit.

The health plan’s 63,000 members are largely concentrated in its Space Coast service area. There is adequate opportunity for growth, which will likely require the health system to develop a clinically integrated network (CIN) of physicians for broader contracting coverage. The health plan has also recently signed a deal with the Florida Hospital System, which is based in Orlando and is one of the nation’s largest nonprofit providers, to offer a private label health plan to its employees throughout central Florida. This agreement is likely to increase Health First enrollment by another 60,000 members through the provision of a full range of administrative and medical management services to a new plan called Florida Health Choice.

Since Health First is a health plan-centric system, it views other health plans—rather than other hospital systems—as its major competitors. Any CIN that may be developed, therefore, will be structured to be compatible with Health First’s business model of having its health plan as the major engine of system growth.