COMMENTARY

Provider-Owned Insurers

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Health policy experts have long touted the benefits of provider-owned insurers like Kaiser Permanente. As insurers, these provider organizations face incentives to control costs. Physicians are salaried, so they do not have incentives to recommend costly tests and procedures when less costly alternatives are available. Integration makes it easier to share information about patients and track quality, which improves the ability of the organization to manage patients with chronic conditions.

The spread of reimbursement schemes that shift risk from insurers to providers has many health system executives wondering at what point it makes sense for their systems to start selling insurance directly to consumers. However, the recent exit of several integrated plans and an antitrust ruling against 2 Chicago-area health systems that planned to start an insurer should give executives pause.

The Current Landscape of Provider-Owned Plans

Currently, there are over 100 provider-owned plans across the United States. They cover more than 26 million enrollees,[1] or about 8% of the population. Kaiser Permanente is the most well-known, but there are many other regional plans, including Sanford Health Plan in the Dakotas and Optima Health in Virginia.

Provider-owned insurers vary in terms of their relationships with outside providers and patients. Kaiser physicians provide care exclusively to the insurer's enrollees, and those enrollees receive care exclusively from affiliated providers. Most provider-owned insurers have open networks; for example, Sanford Health Plan's provider network includes some non-Sanford physicians and hospitals. Sanford physicians and hospitals treat patients insured by external payers in addition to plan enrollees.

A few commercial plans have attempted to reverse-engineer the provider-owned insurer model by opening clinics. Molina Healthcare operates primary care practices in 5 states; Oscar Health announced in June 2017 that it would partner with Cleveland Clinic to sell plans in 5 Ohio counties; and United Healthcare launched a subsidiary, Harken Health, that operates primary care clinics in 6 states. In the case of Harken, although the plan included features designed to attract younger enrollees, it posted disappointing enrollment numbers, so United will close that subsidiary in 2018.

Risks to Providers of Starting a Plan

Providers considering whether to start an insurance arm face a complex decision. A new provider-owned plan will probably attract many enrollees who use the system's hospitals and physicians and were previously insured by a commercial plan. Some of the revenue earned by the provider's new insurance arm will be offset by decreases in revenue from traditional insurers. Whether this shift results in a net increase in profits depends on how profit margins in the insurance market compare with margins in the market for provider services.

A provider-owned health plan that disproportionally enrolls existing patients will suffer from adverse selection. Once they join a provider-owned insurer, high-cost patients shift from being revenue generators to liabilities. A successful plan needs to attract enrollees from outside the system. New provider-owned insurers lack the capacity to process claims, necessitating the hiring of a traditional insurer to pay claims to unaffiliated providers. Due to their small scale and unique structure, provider-owned insurers may have to pay more for reinsurance to protect against large losses. These costs may erode the savings from eliminating insurers as middlemen between providers and patients. Health systems that become insurers also risk creating a more antagonistic relationship with traditional insurers, who are now competitors. For example, Blue Cross Blue Shield of Nebraska, the state's largest insurer, excluded Catholic Health's hospitals from its provider network for 10 months after Catholic proposed to start selling insurance in the state. Catholic Health exited the insurance market in early 2017.

Employers prefer to contract with insurers that have provider networks that are accessible to all of their employees. In major urban areas, insurers need networks than span thousands of square miles. The Indianapolis metropolitan area is 6029 square miles and Phoenix's is 9071. Provider owned insurers with only a handful of clinic locations will have trouble competing in the group insurance

market. Provider-owned insurers can expand their geographic reach by contracting with unaffiliated providers, but then they forgo the benefits of integration. Smaller provider-owned insurers will be at a disadvantage relative to large commercial insurers when negotiating reimbursement rates with outside physicians and hospitals. Mergers are another option for expanding network capacity, but these are subject to antitrust review. A federal judge recently blocked a proposed merger between Chicago's Advocate and NorthShore health systems, which planned to create a health plan. They argued that only a combined system had the geographic reach to offer a competitive product. The judge rejected as speculative the systems' claim that the plan would save area consumers over $200 million annually.[2]

Success Will Hinge on Ability to Cut Costs

Although some consumers appreciate the 1-stop shopping convenience of provider-owned plans, many are reluctant to enroll in plans that restrict their choice of provider. The ability of provider-owned insurers to attract enrollees and obtain favorable treatment from regulators hinges on their ability to cut costs. The RAND Health Insurance Experiment found that participants randomized to a provider-owned plan, Group Health Cooperative of Puget Sound, incurred significantly lower costs than those enrolled in fee-for-service plans.[3]

Provider-owned plans charge higher premiums in the Medicare Advantage market,[4] but our analysis of 2016 premiums in the individual market exchanges indicates that plans offered by provider-owned insurers are more affordable. The exchanges include a number of features, including market-level risk adjustment and standardization of benefits, that facilitate comparisons of premiums across plans. The **Figure** presents insurers' lowest cost silver plan for a single 50-year-old consumer in the 221 exchange markets in which at least 1 provider-owned insurer sells a plan. Seventy percent of provider-owned plans' premiums are equal to or less than the market-level median compared with only 48% of traditional plans' premiums.

CONCLUSIONS

Despite having features commonly associated with better quality and lower costs, provider-owned insurers have always operated in the shadows of the larger commercial and Blue Cross Blue Shield plans. (To paraphrase a joke about soccer in the United States, provider-owned insurers are the delivery system of the future—and always will be.) As a result of provider consolidation, there are more systems that have the scope and size to sell a closed-network product. The success of traditional insurers' narrow network plans indicates that consumers are increasingly willing to trade off restrictions on provider choice for lower premiums, and the exchanges facilitate price competition by standardizing benefits across plans. Provider-owned insurers are poised to thrive in this environment, but only if they can translate theoretical efficiencies into real savings.

TAKEAWAY POINTS

- Provider-owned insurers are numerous and cover 26 million enrollees.
- To compete in the group insurance market, health systems need a large and geographically broad provider network.
- Provider-owned insurers can expand through contracts or mergers, but both have risks.
- Most, but not all, studies indicate that provider-owned insurers have lower costs.

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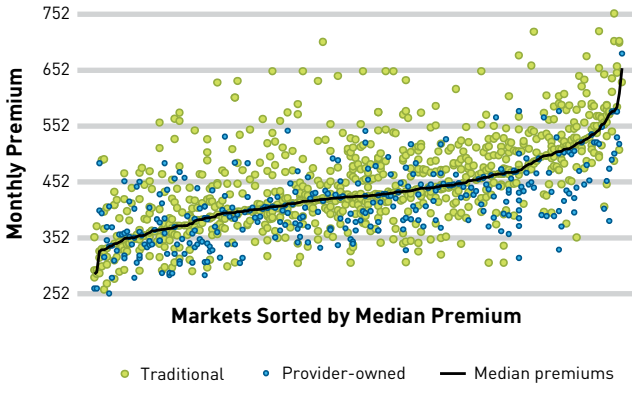
FIGURE. Insurers' Lowest Premium for Silver Plans Within Exchange Markets[a]



[a]Silver plan premiums for 50-year-olds in the 221 Exchange markets in which at least 1 provider-owned insurer sold a plan.