Change of plans

Squeezed by soaring medical costs and other demands for their revenue, providers are continuing to sell off their health plans

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Provider-owned health plans seem to be dropping like flies, with at least five changing hands in as many months.

A top healthcare rating firm spells out why in a new report issued last week: Member medical costs soared in 2007, while other areas critical to providers’ success—such as information technology upgrades and construction projects—need capital, squeezing health systems on both ends.

The message is that unless you are a well-integrated system with lots of cash, staying in both the health insurance and provider business is becoming increasingly difficult, according to A.M. Best Co., which authored the report.

"In this day and age, the system needs a very good demographic and a strong balance sheet to support both the provider side and the health plan side," said Eva Sverdlova, senior financial analyst at A.M. Best and author of the report. "The rift between the haves and the have-nots is getting larger."

A.M. Best combed through the finances of 16 provider-owned health plans that it rates annually, and the results backed up previous A.M. Best surveys of nearly 100 provider-owned plans. "From year to year, we see that the more integrated and involved the system is and the better the flow of patients, the better the results," Sverdlova said.

The rating agency also highlighted an alarming trend that is shaking the healthcare industry: soaring medical costs that can swiftly throw a smaller health plan dangerously off-course financially.

Climbing costs
Serious illnesses, catastrophic accidents, life-threatening cancers, rare diseases, expensive experimental treatments and complicated twin and triplet pregnancies pushed medical claims costs to new highs last year, according to the report. "A smaller health plan has much more fluctuations," Sverdlova said. "Just based on several claims, their medical-loss ratio could jump 5% to 7%.

Overall, the median medical-loss ratio—the percentage of medical expenses over premium revenue—for provider-owned health plans was 89.3% in 2007, an increase of 3% from 86.7% in 2004, and higher than the healthcare industry’s median, according to A.M. Best.

But the trend upward isn’t just confined to provider-owned plans. Earlier this year, major publicly traded insurers warned of higher than expected medical costs, causing their shares to plummet. In July, Minnetonka, Minn.-based UnitedHealth Group reported a medical-loss ratio of 83.2%, an increase of 2.9 percentage points over the prior year.
Indianapolis-based WellPoint, the largest U.S. health insurer by membership, in March reduced its 2008 profit outlook, citing higher than expected medical costs. WellPoint also announced at the time that it had set aside $175 million to boost reserves for high 2007 claims.

Some provider-owned plans analyzed by A.M. Best had to reach into capital and surplus to cover the losses of high claims, according to the new report.

That trend of higher medical costs could continue into the next year, and plans are attempting various strategies to rein in costs, including changing their re-insurance arrangements and stepping up disease-management and other cost-control measures.

Jack Friedman, chief executive officer of Providence Health Plans, a Portland, Ore.-based insurer owned by not-for-profit Providence Health and Services, says he’s seeing higher medical claims in 2008 than last year.

Friedman attributes the trend to expensive specialty drugs coming on the market without clear evidence-based practices on their use. Imaging is another area where costs are climbing.

In response, Providence Health Plans, which has about 270,000 members, is requiring prior authorization for expensive imaging such as CT scans and MRIs. It has also started an end-of-life profile for all oncologists to follow that provides evidence-based protocols on use of imaging and cancer-care drugs and other treatments for the terminally ill.

In addition, the health plan has brought many disease-management programs in-house, and is harnessing its integrated network of hospitals, clinics and other care centers to keep tabs on patients, sometimes using nursing consultations by phone for patients with chronic conditions, thereby lowering emergency department costs and hospital stay days and saving money, Friedman said. "National plans don’t have that local community network to draw on,” he said. “It leads to better levels of cooperation.”

Even so, Providence Health Plans’ medical-loss ratio is climbing and today hovers around 90%, Friedman said, though he adds he is not worried because the health plan’s administrative costs remain low. Providence Health Plans had $38 million in net revenue in 2007, and made up 20% of the total revenue of Providence’s Oregon region, according to financial statements.

In some ways Providence, which was one of the 16 provider-owned plans analyzed in the A.M. Best study, is a model of success. It has good reserves and capital, and enjoys an A rating from the agency. “The health plans that are getting better and better have very strong capitalization and a very strong health system,” Sverdlova said.

Still, Providence is raising premiums and expects double-digit increases in 2009, in the range of 11% to 13%, Friedman said.

Provider-owned systems don’t have as much leeway to raise premiums as national carriers, Sverdlova said, because they are tied to specific communities and slipping enrollment can become a downward spiral. “They don’t want to put that membership in jeopardy,” she said.

Many of the provider-owned plans that have changed hands in recent years were experiencing sliding membership. The harsh environment of eroding employer-sponsored coverage, high
medical costs and higher premiums also means an opportunity for bigger health insurers to add membership in desired areas by scooping up smaller provider-owned plans.

On Aug. 28, Halifax Health of Daytona Beach, Fla., announced it intends to sell its health plan, Florida Health Care Plans, to Blue Cross and Blue Shield of Florida for $85 million. As one of the oldest provider-owned health plans in the nation (it was founded in 1974) and among the most stable, the sale came as somewhat of a surprise. Florida Health Care Plans ranked 20th on an A.M. Best report of the top 99 provider-owned health plans for 2006 nationwide, with $15.9 million in net income. Kaiser Foundation Health Plan in Oakland, Calif., ranked first and Providence Health Plans was fourth.

**Membership down**

In 2006, Florida Health Care Plan had about 60,500 members, according to A.M. Best. It now boasts 57,000 members, down 5.8%.

For the Florida Blues, the buy gives it a new avenue into the Halifax provider network in east central Florida. "One of the reasons we decided to do the merger is this is a different model," said Barry Schwartz, vice president of network management for the not-for-profit Florida Blues. The health plan has both staff providers as well as a strong local provider network, allowing the Florida Blues to tap into both, Schwartz said.

"This is a risk business," Schwartz said. "We are in a more stable place and have better reserves. A lot of provider-owned plans have been operating on a shoestring over the years."

Medical costs are definitely trending upward, Schwartz said, adding to the pain. "The good risk members are leaving the health plans," Schwartz said. "They can’t afford it. Adverse selection may account for part of the rising medical costs."

Halifax Health officials declined to comment for this story. After paying down expenses and debt, the not-for-profit two-campus system will net about $45 million from the sale, which will be used to lower interest rates on existing debt and generate dollars for services, according to documents posted on the system’s Web site. The sale is subject to state and federal regulatory approval and is expected to close by year-end.

Humana, which has been a key buyer of provider-owned health plans, has said the acquisitions are part of its strategy of expanding provider networks and entering prime markets while adding new members to its 11.5 million enrollees nationwide. On its second-quarter conference call with investors on Aug. 4—the day Humana announced it intended to acquire Cariten Healthcare from Covenant Health, Knoxville, Tenn., for $245 million—Humana President and CEO Michael McCallister said as much. "As with our other recent acquisitions, we expect to benefit from expanded provider arrangements and an additional book of business that is well-positioned for future growth," McCallister said.

**Controlling Costs**

Humana does not expect medical costs to trend upward in 2009, officials said. Every Friday, a committee of executives at the Louisville, Ky.-based insurer meets to discuss strategies to monitor and control costs, said Jim Murray, chief operating officer, on the investor call. "I actually feel pretty good about what I see going forward," he said.

While integration between hospitals and their health plans is important, systems should be
cautious about becoming too insular, said Allan Baumgarten, a healthcare consultant who tracks health plans across states. “If you take a step back and say, ‘What are the most significant challenges for provider organizations?’ it would be investments in information technology and having capital for specialized centers such as cardiac, surgery and oncology,” Baumgarten said. “You want to attract and retain physicians and patients. Hospitals making those investments will have the best chance of success.”

At the same time, providers can run into inherent conflict with their health plan managers, making goal-sharing—which A.M. Best defines as crucial for success—difficult to achieve, Baumgarten said. “Why some providers get out of the business is because of these conflicts,” he said. “Remaining competitive in the insurance market is not necessarily what is in the best interest of providers and patients.”