David Burda:

Welcome to the 4sight Health Roundup Podcast, 4sight Health's podcast series for healthcare revolutionaries. Outcomes matter, customers count, and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sight Health. It is Thursday, June 18th. Today is National Fishing Day. If you know me, you know that I love to fish. And as soon as we're done taping this podcast, I'm gonna slip out to one of our local ponds to celebrate before I have to get back to work. So before they stop biting this morning, we're gonna talk about provider-sponsored health plans with Dave Johnson, founder and CEO of 4sight Health, and Julie Murchinson, partner at Transformation Capital. How's that for a quick introduction? Hi, Dave. Hi, Julie. How are you two doing this morning? Dave?

David W. Johnson:

The summer solstice is upon us when the days are long, the nights are cool and all is right with the world. Good to be with you both today.

Burda:

Yeah. Same here, Dave. Julie, how are you?

Julie Murchinson:

Oh, well, I think I have to agree with Dave. It's pretty amazing. There's so much energy in the air, right? The Knicks, the World Cup, there's just, things are feeling good these days.

Burda:

Yeah, yeah. A lot of positive vibes. Thank you. Okay, before we talk about provider-sponsored health plans, let's talk about fishing. My favorite topic other than healthcare. Dave, everyone has a fish story. What's yours?

Johnson:

Well, my best fishing story actually belongs to my wife. We went on a week-long fishing trip to Belize in the mid- 1990s. Terry had never been fishing before. And the absolutely first fish that she ever caught was a 70 pound tarpon. <Laugh> Almost as big as she was. <Laugh> , the guy fishing with her tried to claim the tarpon had bit his line first. <Laugh> But as Jimmy Buffet said, "The husbands quacked about fishing. Who caught what and who sat on their butt?" And this guy was sitting on their butt while Terry was catching the tarpon, so.

Burda:

Wow. Wow. Someday you have to show me that picture because that, that sounds great. Thanks. Julie, do you have a good fish story you wanna share?

Murchinson:

Well, I probably sit on the other side of the continuum from you guys because I am a scuba diver. Oh. So I like the fish themselves and they're, you know, to watch an enormous school of Barracuda just, like, hovering in the water together or, like, they're just, they're beautiful creatures, but, you know, I don't fish them, so, sorry.

Johnson:

I once got into a massive staring contest with a massive Barracuda. <Laugh> And I, I wasn't sure what to do. <Laugh> You know, it was looking at me and I was looking at him. I probably scared the fish as much as it scared me. And finally, I just, you know, made a bunch of moves and it, it went away. But people say that's exactly the wrong thing to do. You know, if you got something shiny, the Barracuda may come for you, so…

Burda:

Did the Barracuda read one of your columns, Dave? What was the, what was the beef there? <Laugh>

Johnson:

This was in my investment banking days. What's that?

Murchinson:

Maybe it was your head. Could've been your shiny head.

Johnson:

Yeah. <laugh> Well, I think my, my goggle was what probably caught its attention more than my head, which- <laugh>

Burda:

Probably right.

Johnson:

But, but thanks, Julie. Appreciate it.

Burda:

As this exchange just illustrated, there are fish stories and there are fishing trip stories. And those are two completely different things. So I'll just say this. The one thing fishing taught me is patience and patients to work on a problem until you can figure it out. And that comes from untangling miles and miles of fishing line over the years. Tangled is a good word to describe our topic today and that's provider-sponsored health plans. I don't think we've ever talked about them on the show, but thanks to a new study in the Journal of the American Medical Association, we will. Researchers from Massachusetts General Hospital and the Harvard Medical School analyzed data from the American Hospital Association's annual hospital survey. They figured out that the number of hospitals that owned health plans rose from 692 in 2018 to

834 by 2023. That's an increase of a little more than 20%. Those hospitals with their own health plans in 2023 were more likely to be affiliated with a medical school and 39% of them were private not- for-profit hospitals. Only about 4% of them were private for- profit hospitals. That says something, I'm not sure what. Running an acute care business and a health insurance business under the same corporate umbrella often is referred to as a pay provider business model. It's a form of vertical integration, but rather than insurers owning providers, it's providers owning insurers. Now, if you look at the line chart in the JAMA study, you'll notice that the pace of hospitals getting into the health insurance business accelerated in 2021. That's the same year Guidehouse the healthcare management consulting firm came out with its pay provider market index of where the pay provider business model can best quote disrupt incumbent hospitals, health systems and health plans, close quote. Coincidence? Dave, what do you think of provider sponsored health plans? Do they create the right incentives to move us forward in terms of value to consumers or do they create the wrong incentives to maintain the status quo?

Johnson:

<Laugh> Yes. <laugh> That's an interesting to statistic you mentioned, Dave, that only 4% of health plans are owned by for- profit hospitals. That's probably because the for- profits are less likely to fall in love with the concept, not the reality of Payvider operations. Having said that, I have a confession to make. I have drunk historically the Payvider Kool-Aid. , I thought integrated delivery was the path to high value patient-centric delivery if you could get the incentives right, but now I'm not so sure. Let's start with Business School 101. As you mentioned, the Payvider model is a form of vertical integration integrating the different business functions within markets. By definition, vertical integration is much harder than horizontal integration where companies stamp out the same product or service in different markets, think Starbucks or for-profit hospitals, but vertical integration does offer the promise of end-to-

end production control. Think Apple under Steve Jobs. So there is this constant debate over which is the better strategic approach. And of course, healthcare <laugh> with its perverse payment incentives and, unique operating cultures, make already hard vertical integration even harder. In my experience, provider-owned health plans, when there's a conflict, the jump balls almost always go to the providers. The plans in essence become mechanisms for creating volume and incremental revenues not for achieving the bigger, more impressive goals of lower cost, better care outcomes and so on. Integrated health systems like Intermountain and Corwell, that have had some success, have put their health plans and hospital operations, provider operations, their payer and provider operations into the same organizational structure reporting up through the C-suite. So there's somebody to look at resource allocation, settle the jump balls, and, make sure that the overall system is in balance. Often the payvider systems that succeed, including Intermountain and Corwell, have massive market shares, have strong market shares in both their provider and payer operation. That combination can create value for self-insured employers and does in many cases. At the same time, it can also lead to market dominance and drive up costs, which also happens. So pretty much everything you need to know about provider market behaviors is that almost all health systems have expansive revenue cycle operations and at best rudimentary cost accounting capabilities. How is it possible to manage the total cost of care like payers should strive to do without knowing fundamentally how much that care costs? So that conflict or that irony is the core problem with the Payvider model. Intellectually it's remarkably attractive, but when you get into the day-to-day operations, it's still largely dominated by, how do I get paid the most money for doing the most things? So the bottom line, some pay providers can deliver on the promise of better outcomes, lower costs, and greater customer experience, but most will not. Paraphrasing Shakespeare, the failure of Payvider business models is not in the stars but in themselves.

Burda:

The Bard applied to healthcare. I like it. I like it.

Johnson:

Yeah. It's, it's so funny that he used the word Payvider in the 1600s, right? Yeah,

Burda:

And that's why he was way ahead of this time.

Johnson:

Way, way ahead of this time. <Laugh>

Burda:

Thanks, Dave. Julie, any questions for Dave?

Murchinson:

Okay, Dave, get at your crystal ball. 10 years from now, are we gonna look back at Payviders as some mechanism that actually move the market forward or, I don't know, a more transitional structure that health systems employ just to diversify revenue or, you know, maybe something else? <Laugh>

Johnson:

I think, like, the answer to Dave's question, my answer is yes. It's such a great question. The current system over the next 10 years, your timeframe, Julie, will be disrupted by a series of macroeconomic and market forces that I believe will push US healthcare toward value and consumerism. It will be messy. The most powerful of those transformative forces will be better buying of healthcare services by self-insured employers, including governments. They'll get a bigger return for the large investment they make in healthcare purchasing. And

as this process unfolds, you'll see many incumbent providers fail and as well as many incumbent payers. The most vulnerable are those that are dependent on fee-for-service payment providers and administrative services only contracting payers. So when the dust settles, vertical versus horizontal, kind of where we started this, my sense is that horizontally integrated providers for the most part will outperform the vertically integrated ones. A few of the vertically integrated pro-providers will make the transition, but I think as, you know, self-insured buyers become better purchasers, the commodified nature of most healthcare service will reveal itself and that lends itself, to more horizontal integration than vertical integration.

Burda:

Interesting. I had this image while you were speaking, Dave, like the health plans like putting a moat around a castle, right? The castle's the health system, the moats, the health plan to protect yourself from change, but, you know, I think- Yeah. ... The castle's gonna fall anyways, right?

Johnson:

We've got catapults. The marketplace has catapults.

Burda:

Exactly. Thanks, Dave. Okay, Julie, it's your turn. What do you think of the Payvider business model? Does it create opportunities for market innovation or is the model not what the market really needs?

Murchinson:

Well, I think it's real and it has definitely been having a moment, but the market way overstates what it solves today anyway in most of these models. And a lot of these models are struggling because just owning a premium and care delivery doesn't automatically create innovation and

you're seeing the opportunity for these models to redesign incentives and referral patterns and UM and consumer experience at the end of the day. But, you know, I think that, scale really matters here and while obviously, you know, data infrastructure matters, and risk discipline matters, really kind of getting your head straight about what business you're in and how to operate it, I think has been a real issue for a lot of these models. And, you know, I guess I think the important divide is not really payvider versus nonpayvider. It's kind of the scaled risk manager versus the, you know, underpowered, integrated, you know, incumbent who has a foot in maybe two camps. And I think it's interesting. The Guidehouse data, there are a lot of examples of good, you know, they pointed out that Medicare Advantage members in some of the higher rate of plans had fewer hospitalizations and fewer ED visits, and, you know, avoidable hospitalizations, all the things that we wanna see. So it's not trivial, but the Providence example, right, my backyard is a massive counterweight. Like their plan covered, what, four, 450,000 members lost about 100 million dollars on a two- two and a half billion dollars in revenue and, you know, the system basically concluded it wasn't worth it. <Laugh> And they're supposedly being sold off for parts, which is crazy. I mean, really, really crazy. So that's just a relatively scaled plan and, and that wasn't enough. And they have good examples of much smaller plans. Well, I guess the Banner, Aetna, JV was about 350,000 members and they were able to generate savings in the kind of single to lower double digits, a much smaller plan, that Southwestern Health Resources plan, about 80,000 members and they saved, I don't know, almost $70 million. So there are some really good examples out there and there are some total, you know, burnouts like what's going on at Providence. But these, the good models seem to really be about execution to me and not just structure. So when I look at what I've seen more recently across the market, I guess I just see a lot more struggling than anything. On the operational side, you know, there's plenty of opportunity for the kinds of technologies and service solutions that I see every day that work with the larger plans, but a lot of provider-

owned health plans tend to build their own things in- house or, you know, they like everyone else is struggling with AI. We've seen a lot of payment integrity programs put to work in these plans because they're working across not just their own health system, but other health systems in the market and the providers in the market, and they don't have the right, they don't have the control that they need, in those models. And, you know, frankly, they need some good old-fashioned rate setting and to really understand how to manage risk-based capital. It's not for the faint of heart. If you look at, like, Corwell hired Humana to come in and run their plan. So you are seeing some of the cultural elements of what needs to happen in organizations like this happen, diversifying executive teams like Corwell did. And I also think culturally just the, the mission alignment and the vision alignment around the shift from we are running a nonprofit health system since most of these plans sit in the nonprofits, as you talked about, versus we are running a for- profit health plan business. Like these are two very different businesses. I think a lot of these provider-sponsored health plans haven't really figured that out. And at the governance level, it's probably the biggest issue, right? You, to really have the fiduciary responsibility for these plans. And to really get through the ownership conflicts, I just don't think, we've really gone deep enough to see what these plans could do. So maybe this is a controversial take, but, you know, if you look at even the Banner example, like, that's a JV, right? It's not an ownership model. So maybe there are other ways and models to do this that are more tightly connected than our freestanding health plans are, but can do a better job at some of the business that has to go on here. So I don't think the payvider is the market innovation that it was intended to be. I think it's, I don't know a lot of organizations adopting the label, but they still may not have the machinery to do it right.

Burda:

You said it's all in the execution. I'm just wondering, how do they do prior authorization, right? One side wants to get paid and the other side doesn't wanna pay you.

Murchinson:

It's all complex.

Burda:

But you're, you're living in the same house. Yeah. Interesting. Thanks, Julie. Dave, any questions for Julie?

Johnson:

Julie-you've personally lived in two of the best markets for integrated delivery, San Francisco with Kaiser and Seattle with Group Health now part of Kaiser. Has there been anything in your direct or indirect experience that has given you insight into why and how these integrated payvider delivery networks function well, in these markets when they fail in most others?

Murchinson:

When people think about Kaiser Permanente, I'm just gonna talk about them because they bought GroupHealth, so it's all- one and the same, right? So when they really think about KP, like I think about, "Oh, well, KP's an option in my employer benefit selection." Okay, well, that's a health plan. Well, yeah, but I'm driving by and going to KP medical offices and hospitals, so KP's also my provider. Like, there's a very integrated way that KP is in the market where a lot of these other provider-sponsored health plans are very separate in brand. So there's something there that really works for KP, but it's obviously not just at brand. Like what KP has done is they are one business model and they know where their bread is buttered. So they have mostly aligned incentives. They have strong primary care. They very seriously manage

their referrals and, I don't know, they operate in markets where consumers, like I just refer to and physicians understand the trade-off between, like, choice and coordination here and I know the docs know what they're signing up for. It's not like docs at most hospitals that aren't necessarily employed, or if they are employed, they are in the much more traditional hospital environment, right? And these docs know they're going to work for Kaiser Permanente. It's an integrated way of looking at care. There's the, the control levers are there and docs are salary. They're not necessarily paid in the way that other docs are paid at other systems. So it's just a wholesale business model change that I think makes, I don't even consider it a Payvider. It's on a different planet.

Johnson:

I think that Kaiser is more insurance company than, than provider, even though they do both. And maybe that's kind of what you're getting at that they can say no to doctors and, it’s interesting.

Murchinson:

Yeah, it's interesting because they are driven, even if you think about people who work for KP at the corporate level, nine times out of 10, those people work on the quote unquote health plan side, right? Yeah. But they really do. The health plan, like, is also running the provider organizations, even though those are technically separate legal entities, right? So it's a mindset as well.

Johnson:

And Kaiser doesn't work in every market either, right? No. So that's ... Yeah. So there's <laugh>-

Murchinson:

They learn that the hard way. <Laugh>

Burda:

Great discussion. Thanks, David. Thanks, Julie. Now let's talk about other big healthcare news that happened this week. Julie, what else happened that we should know about?

Murchinson:

Well, our friend, Matt Holt, who was pulling out, you know, of New Mountain Capital to develop Therows has just signed a $12 billion deal to acquire Ensemble Health and I suspect that is the first stop in his attempt to recreate what he was headed towards.

Burda:

Yeah, I saw that. That, that is big news. Dave, what's your big healthcare news of the week?

Johnson:

Revenue cycle, baby. <Laugh> well, my friend, Dennis Dolan, Mayo Clinic's CFO, just won the HFMA's most distinguished recognition; the Richard L. Clark Board of Directors Award for his lifelong career. And, I don't think anybody deserves it more. So way to go, Dennis.

Murchinson:

Nice.

Burda:

Yeah. And he's a fellow Viking fan, right? Right, Dave? <Laugh>

Johnson:

Yeah. Thanks for mentioning that. But yes, we suffered together.

Burda:

I hear you. Thank you. And thank you, Julie. That is all the time we have for today. If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. You also can subscribe to the Roundup on Spotify, Apple Podcasts, YouTube, or wherever you listen to your favorite podcasts. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.