Environmental and organizational correlates and motivations for provider-sponsored health plan ownership in the post-reform era

Katherine A. Meese • Larry R. Hearld • Stephen J. O'Connor • Mary Dale Peterson • Nathan W. Carroll • Bisakha Sen

Background: The 1980s to 1990s saw many health systems in the United States enter and exit the insurance market in the form of provider-sponsored health plans (PSHPs). Reforms and value-based reimbursement methods have stimulated health care organizations to reconsider PSHP as a logical strategy.
Purpose: The aim of this study was to examine market and organizational factors associated with PSHP ownership and motivations for engaging in PSHP after health care reforms. The resource dependence theory was used as a theoretical lens.
Methodology/Approach: A sequential quantitative to qualitative mixed-methods design was used. The quantitative analysis examined data for 5,849 U.S. hospitals. Results were synthesized with qualitative findings from 10 semistructured interviews representing eight health systems in five states.
Results: Organizational and environmental characteristics were significantly associated with PSHP ownership. Hospital and payer concentration, Medicare penetration, income, unemployment rate, government, and for-profit and metro area hospitals were associated with a lower likelihood of PSHP ownership. Salaried physician arrangements, clinically integrated network membership and adoption of other risk-bearing arrangements were associated with higher odds of PSHP ownership. Interviewees described PSHP as the culmination of the journey to value-based care and as a strategy to improve patient care, compete, and diversify revenue streams.
Conclusions: Both market and organizational factors are important considerations for hospitals contemplating PSHP ownership, and motivations for ownership cover a broad range of financial, competitive, strategic, and mission-based goals.
Practice Implications: Hospitals considering PSHP ownership must carefully evaluate their competitive landscapes and organizational resources to ensure optimal conditions for this strategy. PSHP ownership has high start-up costs and requires a long-term organizational commitment.

Key words: Health care, provider-sponsored health plan, provider-sponsored insurance, resource dependence theory, risk, value-based care

During the 1980s and early 1990s, Provider-sponsored health plans (PSHPs) in the form of health maintenance organizations were expected to become a dominant organizational strategy under the assumption that the purchasers of health care (namely, government and employers) would put increasing pressure on hospitals to contain costs (Bazzoli, 2004; Starr, 1982). However, given the consumer backlash against restricted choices offered by health maintenance organizations, poor utilization management, subpar payments from payers, and diminishing financial returns, as well as failure to manage capitated payments (Hurley et al., 2002; Lesser & Ginsburg, 2000), the organizational form lost traction by the early 2000s (Bazzoli et al., 2001; Hurley et al., 2002). Between 1996 and 2000, a decline in risk-bearing arrangements for hospitals was noted in almost all markets (Hurley et al., 2002). Reductions were noted in PSHPs as plans were sold to private health plans because hospitals failed to achieve the financial or operational benefits they had originally anticipated (Bazzoli, 2008).

The passage and implementation of legislation, such as the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act, has ushered in an era of new reimbursement methods and a heightened focus on population health management and value-based care, which has stimulated hospitals to contemplate health plan ownership as a logical strategy (Khanna et al., 2016; Rickert, 2016). However, the industry experienced the rise and fall of managed care relatively recently, which raises a question: What has changed? First, technology for managing population health and its attending financial risks has proliferated

Katherine A. Meese, PhD, Assistant Professor and Director of Wellness Research, Department of Health Services Administration, University of Alabama at Birmingham. E-mail: kameese@uab.edu.
Larry R. Hearld, PhD, Associate Professor and PhD Program Director, Department of Health Services Administration, University of Alabama at Birmingham.
Stephen J. O'Connor, PhD, FACHE, Professor, Department of Health Services Administration, School of Health Professions, University of Alabama at Birmingham.
Mary Dale Peterson, MD, MSHCA, Executive Vice President and Chief Operating Officer, Driscoll Health System, Corpus Christi, Texas.
Nathan W. Carroll, PhD, MHA, Assistant Professor, Department of Health Services Administration, University of Alabama at Birmingham.
Bisakha "Pia" Sen, PhD, Blue Cross Blue Shield Endowed Chair in Health Economics, Department of Healthcare Organization & Policy, School of Public Health, University of Alabama at Birmingham.

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in recent years (Furukawa et al., 2014). Second, health care reform has altered the dynamics of both the hospital and insurance industries by expanding access to care through the health insurance marketplace and Medicaid expansion and has encouraged hospitals to take on more risk in the forms of bundled payments, accountable care organizations (ACOs), and value-based purchasing (Chee et al., 2016). In addition, consumer preferences may have changed, as evidenced by the rapid growth of high deductible health plans in recent years (Claxton et al., 2016), possibly making new insurance offerings more palatable. Caution must be exercised when assuming that prior research findings regarding PSHPs are still applicable today. The purpose of this study was to examine the organizational and environmental correlates of PSHP ownership and motivations for ownership in the era after the passage of the ACA and other health reforms using a mixed-methods approach.

A PSHP in this analysis is defined to mean that a hospital or a multihospital system has equity ownership of a health plan that bears full risk for a defined population of patients, whether a Medicaid-managed care, Medicare Advantage, or a commercial plan. This plan could exist at the hospital, system, or network level and could also include joint venture arrangements. This has also been termed *first-dollar risk*, meaning that the full financial risk falls to the hospital (Peterson, 2016). There are several payment models that involve a hospital taking on degrees of risk for a population of patients, such as value-based payment models, ACOs, bundled payments, or shared savings and shared risk arrangements (Grauman et al., 2014; Hurley et al., 2002). Although these arrangements exist between providers and payers, they may differ from PSHPs as the provider may not have any equity ownership in the arrangement. In addition, some of these arrangements may rely on virtual alliances that involve a different level of risk than a full ownership model with greater legal entanglements, personnel requirements, and financial risk. "Hospitals" in this analysis will refer to independent hospitals, as well as members of multihospital systems.

Theory

Prior academic research on PSHPs favors the transaction cost economics argument that suggests the primary aim for health plan ownership is to reduce the cost and effort associated with transacting with other payers (Burns & Pauly, 2002). Yet, a hospital is unlikely to significantly reduce the transaction costs of searching, bargaining, and coordinating with payers by forming its own PSHP. Transaction costs may actually increase overall as the hospital will likely continue to contract with its existing payers and will also have new regulatory burdens imposed by the hospital's designation as a payer.

The resource dependence theory (RDT) highlights the efforts of an organization to reduce dependence on other organizations within its environment for vital resources needed for survival (Pfeffer & Salancik, 1978). RDT suggests that organizations will seek to maximize autonomy; however, because organizations rely on exchanges with other organizations to acquire resources, they are constrained in their ability to do so. The more dependent an organization is on another actor for a necessary resource, the more likely the organization is to be controlled by that actor. This theory has been frequently applied to the health care industry (Yeager et al., 2014), specifically in explaining possible causes for organizational innovation and strategic choice in health care (Alexander & Morrisey, 1989; Banaszak-Holl et al., 1996). Dependence is the inverse of power, where one entity has power over another entity that is dependent upon it for resources (Emerson, 1962). Interdependence occurs when two actors each has power over each other (Pfeffer & Salancik, 1978). Four key actors with whom hospitals have dependent or interdependent relationships for necessary resources will be examined: commercial insurance companies, the Centers for Medicare and Medicaid Services (CMS), patients, and physicians.

In many studies of organizations and the environment, including those using RDT (Yeager et al., 2014), the environment is typically characterized along the dimensions of dynamism, munificence, and complexity (Dess & Beard, 1984). Dynamism, which is sometimes characterized as turbulence or uncertainty (Yeager et al., 2014), is generally concerned with changing conditions that create instability or unpredictability (Dess & Beard, 1984). Munificence refers to the availability of necessary resources in the environment. Complexity refers to environmental conditions that may complicate decision-making and is often characterized by measures of competition (Dess & Beard, 1984; Yeager et al., 2014).

Relational Dependencies on Other Actors in the Environment

Commercial insurance companies. Hospitals and commercial insurance companies have an interdependent relationship, and which organization has more power varies as a function of the environment. Most hospitals are dependent on a variety of health plans for their survival through payments for patient care. The insurer holds power over the provider in many forms, such as steerage of patients to that hospital rather than to competing hospitals, selection of the provider as an in-network or preferred provider, and negotiation of favorable reimbursement terms. Similarly, insurance companies depend on hospitals. If a popular hospital no longer accepts a certain insurance, that insurance plan may become less appealing to employers seeking coverage for their employees. Given decreasing reimbursements from payers, hospitals are pressured to pursue new strategies to exercise a measure of control over reimbursement levels. Establishing a health plan is one strategy a hospital might pursue to gain more autonomy over reimbursement. However, there are some constraints to doing so. If a hospital operates in an environment with a dominant health plan, it is likely that the hospital is dependent on one insurance company for the majority of its patients. Thus, it is expected that hospitals in an environment with fewer insurers (high concentration) are less likely to enter into a PSHP because doing so could prompt an insurer to steer patients to a competing hospital or to drastically reduce reimbursement rates. Conversely, providers in environments with a greater number of insurers (lower insurance concentration) are less dependent on any

one payer and thus have more freedom to pursue a PSHP. Insurance markets are highly concentrated, and in 43% of metropolitan areas examined, one insurer had a 50% or greater market share (Robeznieks, 2017). With such dominant players in the health plan market, PSHPs may struggle to garner the large enrollment numbers needed for successful risk pooling (Eyestone et al., 2014). We expect that greater insurance concentration will be associated with a lower likelihood of PSHP ownership (Hypothesis 1).

Centers for Medicare and Medicaid Services. Hospitals are adapting to government payment structures that reward efficiently coordinated care and well-managed patient outcomes, avoiding unnecessary readmissions and complications. Hospitals are preparing themselves to survive in an environment that requires them to assume risk by managing patient outcomes to capture full reimbursement. If the hospitals will be managing some degree of risk for Medicare and Medicaid patients under value-based purchasing, these same risk management skills could be applied to a PSHP. Organizations with a greater share of revenue at risk for CMS penalties may be more likely to develop risk management skills and apply them enterprise-wide in ways that facilitate PSHP development. We expect that hospitals with a greater share of Medicare and Medicaid discharges will be more likely to own a health plan (Hypothesis 2). Another consideration for a hospital's dependence on CMS is related to the expansion of Medicaid at the state level under the ACA. We expect that states that did not expand Medicaid represent a more dynamic environment. Hospitals in these states face uncertainty regarding funding changes resulting from ACA mandated reductions in the DSH (disproportionate share hospital) payments that enhance CMS reimbursement to hospitals serving indigent patient populations (Cunningham et al., 2016). Nonexpansion states did not have uniform solutions to replace or offset those payments. RDT suggests that, in more dynamic environments, organizations pursue organizational autonomy through the least constraining route possible, such as using non-ownership-based arrangements that do not permanently alter the organization's boundaries (Drees & Heugens, 2013). In a more dynamic environment, hospitals may pursue less constraining organizational arrangements such as shared savings programs or virtual alliances instead of PSHPs. Thus, it is expected that hospitals in non-Medicaid expansion states are less likely to own a PSHP (Hypothesis 3).

Patients. Patients depend on hospitals to treat their health conditions. Hospitals are dependent on patients to choose the hospital for their care. Ownership of a health plan may give a hospital more power to direct patients to its own facilities. However, this strategy relies on a patient's ability to afford or access commercial insurance, among other factors. Greater financial resources in the community represent a more munificent environment with more potential customers for the PSHP, making the formation of such plans more likely. Specifically, we expect that hospitals operating in environments with lower unemployment and higher income per capita are more likely to own a health plan (Hypotheses 4 and 5).

Physicians. The existing literature on PSHPs suggests hospitals are heavily dependent on physicians to make a health plan successful (Meese & O'Connor, 2018). Hospitals operating in environments with more physicians per capita may have a broader selection of physicians, which aligns with the goals of value-based care and thus may be more likely to own a PSHP (Hypothesis 6). In addition, a hospital with more salaried physicians may have more latitude to experiment with new organizational forms and a better ability to align physicians with its strategic priorities. Salaried physicians are more dependent on the hospital for their total compensation (compared to private practice physicians who may generate income from a variety of sources); thus, hospitals may have more leverage to enforce certain behaviors. We expect that hospitals with salaried physicians will be more likely to own a PSHP (Hypothesis 7).

Method

Study Design

The study employed a mixed-methods sequential quantitative to qualitative design (Ivankova, 2014). Quantitative analysis was conducted to determine the market and organizational characteristics associated with a hospital's ownership of a health plan. These results informed the questions and interview protocol for the qualitative portion of the study. The results from the quantitative and qualitative strands were interpreted and integrated during the final phase of the study.

Data

The quantitative strand of the study analyzed data from the American Hospital Association (AHA) Annual Survey, Area Health Resources File, and Kaiser Family Foundation reports on Medicaid expansion, payer concentration, and Medicaid and Medicare penetration at the state level. Data for the year 2017 were used because new 2017 AHA survey questions more accurately capture the phenomenon of PSHPs compared to previous iterations. Surveys prior to 2017 asked whether hospitals had equity ownership of a health plan, which was unclear whether this included self-insuring its own employee population while using a third-party administrator such as Blue Cross. The 2017 survey asked specifically whether hospitals own a Medicaid-managed care, Medicare Advantage, a commercial plan, or a plan on the health care exchange, which more accurately captures the PSHP strategy. An analysis of the 2014–2016 data revealed that there was no statistically significant difference among years, reducing the benefit of including earlier data, especially considering the long-term nature of this strategy. The sample includes all United States-based acute care hospitals but excludes long-term care hospitals and federal government hospitals (e.g., Veterans Affairs).

Significant relationships from the quantitative analysis were used to identify different types of hospitals to interview. Purposive sampling was used to identify hospitals based on variations in geographic location, PSHP ownership status, Medicaid expansion, PSHP type, and profit status. Institutional review board approval was granted by the University of Alabama at Birmingham. Interviews lasting 45 minutes were conducted via telephone or in-person and recorded

verbatim, except for two interviewees who declined recording. Interviews concluded when the study achieved saturation, meaning the information gathered from additional interviews failed to elucidate new phenomena and the major themes of the study were successfully uncovered. The research questions focused on the motivations for a hospital or multihospital system to pursue PSHP ownership and executive perceptions of historical and current facilitators and barriers to market entry for their own organization and for others in the industry. Interviews were conducted with a total of 10 executives, each of whom represented one of six multihospital systems, with a PSHP or two health systems without. Each of the 10 interviewees was either an executive of the PSHP or had intimate knowledge of the PSHP's strategy and operations. The hospital systems were in Alabama, Delaware, Pennsylvania, Texas, and Utah, as well as one large multistate system. All were state government-owned or not-for-profit, except the for-profit multistate system.

Dependent variable. To measure ownership of a PSHP, a binary variable was constructed with 1 representing PSHP ownership and 0 representing no ownership. A PSHP was considered ownership of at least one of the following: Medicare Advantage, Medicaid-managed care, a commercial plan (large group or small group), individual, or health care exchange plan.

Independent variables. The main independent variables of interest were selected to represent the four relational dependencies proposed in this study, including commercial insurance companies, CMS, patients, and physicians. Lastly, the model included several control variables, which may be associated with PSHP based on prior research. The operationalization of variables is listed in Supplemental Digital Content 1 (http://links.lww.com/HCMR/A84).

Analytic Strategy

There were 5,849 hospitals included in the final analysis, excluding hospitals with missing data (n = 338). Independent-samples t tests and Pearson chi-square tests were used to test differences between PSHP and non-PSHP hospitals. Multivariate logistic regression was used to formally test the study hypotheses. Results are presented as average marginal effect (AME), which is interpreted as percentage point difference in the likelihood of PSHP ownership associated with that variable. A Huber–White sandwich estimator was used to address the heteroskedasticity of standard errors. Tolerance levels did not indicate multicollinearity. For the qualitative strand of the study, we conducted thematic analysis using a deductive approach to coding the transcripts. The interview protocol served as an initial codebook for the main themes of the study. However, an open-ended axial coding process allowed for new themes to be identified. The findings from the qualitative portion were used to clarify and explain the quantitative findings (Ivankova, 2014).

RESULTS

Quantitative Results

The descriptive statistics and results of the independent-samples t tests and Pearson chi-square tests can be found in Table 1. Out of 5,849 hospitals in our sample, 949 hospitals (16%) had a PSHP, whereas 4,904 (84%) did not. PSHP hospitals differed significantly on almost every organizational and market factor examined. Results of the logistic regression are presented in Table 2 and are grouped by the four actors in the environment from whom the hospital seeks to reduce dependency, along with labels for dynamism, munificence, and complexity.

For insurance company dependencies, greater market competition (lower concentration) was associated with a higher probability of PSHP ownership (AME = −0.009707, $p < .0001$), supporting Hypothesis 1. For CMS dependency, hospitals with a greater share of Medicare and Medicaid discharges were not significantly more likely to own a PSHP. Similarly, Medicaid expansion was not associated with a higher probability of owning a PSHP. Thus, Hypotheses 2 and 3 were not supported. For patient dependencies, hospitals operating in environments with higher unemployment rates were less likely to own a PSHP (AME = −0.0202, $p < .001$), supporting Hypothesis 4. Hospitals operating in environments with higher income per capita were less likely to own a PSHP (AME = −0.0011, $p = .004$), which was directionally opposite to what was predicted in Hypothesis 5. Physicians per capita was not associated with PSHP ownership, not supporting Hypothesis 6. Relative to hospitals without any salaried physicians, the probability of owning a PSHP was greater among hospitals that reported having any salaried physicians (AME = 0.0317, $p = .001$), supporting Hypothesis 7.

Qualitative Results

The research questions for the qualitative strand of the study focused on the motivations for pursuing PSHP ownership and executive perceptions of historical and current facilitators and barriers to market entry for their own organization and for others in the industry. Four main themes were identified: power/control, moving from volume to value, physician interdependencies, and financial considerations. In the following paragraphs, subthemes and supportive quotes are presented for each of these themes.

Control and Power

A major theme from the qualitative analysis was the pursuit of a PSHP as a means of control—of resources such as premium dollars and patients, but also control over *how* hospitals compete. This control was aimed at reshaping the balance of power in the interdependent relationships with payers.

Control over the premium dollar. The desire to control the premium dollar as a means to survival was a motivator for pursuing PSHP ownership as a well as taking on increasing levels of risk for patients more generally. A PSHP offers hospitals an avenue for controlling the premium dollar for at least a subset of their patient population. A payer typically controls the entire premium dollar paid by the member in terms of choosing where to spend it, how much to spend, and what to do with the leftovers. Similarly, when a hospital has a

TABLE 1: Descriptive statistics and chi-square test for categorical variables

Variable		With PSHP		Without PSHP		χ^2
		n	%	*n*	%	
Medicaid expansion	Expanded Medicaid	621	65%	2832	58%	20.617*
	Did not expand	328	35%	2092	42%	
Salaried physicians	Yes	584	62%	1405	29%	386.975*
	No	365	38%	3519	71%	
Clinically integrated network	Yes	651	69%	965	20%	957.861*
	No	298	31%	3959	80%	
Profit status	Not for profit	791	83%	2300	47%	439.185*
	Government, non-Federal	98	10%	1075	22%	
	For profit	60	6%	1549	31%	
Teaching status	Teaching hospital	438	46%	1351	27%	131.587*
	Non-teaching hospital	511	54%	3573	73%	
CBSA type	Metro	689	73%	3228	66%	20.835*
	Micro	126	13%	716	15%	
Neither metro nor micro	Neither metro nor micro	134	14%	980	20%	

Variable	With PSHP			Without PSHP			*t*
	n	Mean	*SD*	*n*	Mean	*SD*	
% Population on Medicare (state)	949	13.56	2.06	4924	13.73	2.07	2.31*
% Population on Medicaid (state)	949	19.69	4.42	4924	20.07	4.49	2.41*
HHI–hospital	949	5885.23	3640.1	4924	6242.82	3529.04	2.78*
HHI–payer	949	3523.83	1945.24	4924	4023.04	2187.33	7.09*
MDs per 1,000 people	949	2.89	2.74	4924	2.43	2.33	–4.85*
Income per capita in thousands	945	48.54	15.46	4904	45.63	13.61	–5.39*
Unemployment rate	949	4.21	1.19	4924	4.51	1.37	6.87*
% Medicaid patient days	949	9.16	9.28	4924	9.05	10.8	–0.32
% Medicare patient days	949	21.25	13.35	4924	22.38	18.34	2.23*
Adjusted patient days	949	115,714	137,571	4924	63,938	83,413	–11.20*
Count of risk-bearing arrangements (0–4)	949	1.3	1.06	4924	0.33	0.71	–27.12*

Note. PSHP = provider-sponsored health plan; HHI = Herfindahl–Hirschman Index; CBSA = core-based statistical area.
*$p < .05$.

PSHP, it assumes control over the whole premium dollar for its health plan members: "[PSHP] just improves the amount of that premium spend that ultimately can go into your health system."

Control over patient market share. Interviewees also discussed the management of risk and PSHP as a means of gaining patient market share. There was a common fear that as employers and insurers look for better solutions, they will steer their members to whichever hospital has the lowest prices:

> *Their perception was that the way the government was headed was going to put health systems more and more at risk and that you needed to learn how to manage risk within your health system, or you are going to be at risk*

TABLE 2: Relationship between market and organizational factors and provider-sponsored health plan (PSHP) ownership

	Ownership of any type of PSHP *n* = 5,849		
	Average marginal effect	**95% Confidence interval**	
Insurance companies			
Herfindahl–Hirschman Index–hospital[a]	–0.00365*	–0.0000062	–0.0000073
Herfindahl–Hirschman Index–payer[b] [C]	–0.00971**	–0.0000141	–0.0000053
CMS			
Medicaid expansion (0, 1) [D]	0.0026	–0.0185	0.0238
% Population on Medicaid (state)	–0.0011	–0.0035	0.0013
% Population on Medicare (state)	–0.0095**	–0.0140	–0.0050
% Medicaid patient days	0.0004	–0.0005	0.0014
% Medicare patient days	0.0004	–0.0003	0.0010
Patients			
Income per capita in thousands [M]	–0.0011**	–0.0018	–0.0004
Unemployment rate [M]	–0.0202**	–0.0283	–0.0120
Physicians			
MDs per 1,000 people [M]	0.0003	–0.0042	0.0048
Salaried physicians (0, 1)	0.0317**	–0.0042	0.0048
Controls			
Count of other risk-bearing arrangements (0–4)[c]	0.0594**	0.0506	0.0681
Clinically integrated network (0, 1)	0.1297**	0.1118	0.1476
Profit status (not-for-profit, referent)			
Government, non-Federal	–0.0682**	–0.0929	–0.0436
For profit	–0.1167**	–0.1405	–0.0928
Teaching status (0, 1)	0.0089	–0.0119	0.0298
Adjusted patient days	0.0000	0.0000	0.0000
CBSA indicator (referent, non-metro/micro)			
Metro	–0.0290*	–0.0584	0.0004
Micro	0.0006	–0.0311	0.0322

CMS = Centers for Medicare and Medicaid Services; [C] = complexity; [D] = dynamism; [M] = munificence.

[a]The Herfindahl–Hirschman Index for hospital competition is the square of the market share of each hospital within a market, summed for all hospitals within that market. We measured the market using adjusted patient days and defined a hospital's market as the health service area in which it is located.

[b]The Herfindahl–Hirschman Index for insurer competition is measured as the square of the market share of each insurer within a market, summed for all insurers within that market. The market was measured at the state level. These data were taken from Kaiser Family Foundation reports (Kaiser Family Foundation, 2018).

[c]Accountable care organization membership, risk-based contracts with employers, bundled payments, and shared risk agreements with providers.

*$p < .05$. **$p < .01$.

of just being a commodity—that you were something that insurance could buy from anybody. They are going to go with the lowest bidder….

A PSHP allows a hospital to steer patients into its own facilities for care, both increasing market share and mitigating volume losses if a competing insurer shifts patients to a lower

cost competitor. Assuming that a hospital can fill some of its beds with its own health plan members, other payers will make up a lower percentage of their patient mix. This lessens the percentage of volume that is subject to the whims of a single payer. Lastly, control was described as a way to ensure survival and relevance. Specifically, the concept of controlling destiny was mentioned as a way to prepare for a future industry that will force hospitals to take on more risk:

> *Because of everything that was going on in the market, it just wasn't good. You'd rather just be in complete control of your destiny and just take a population on full risk.*

Lessening payer power. In addition to gaining more control over market share and dollars, a PSHP was also seen as a direct mechanism for lessening the bargaining power of payers. Control of the premium dollar and increases in market share have been longstanding goals of hospitals. There was a sense that the competitive landscape is growing increasingly challenging compared to prior years and that this increasing intensity of competition was creating more pressure for hospitals to adapt to survive. There was also a belief that receiving decent payments from payers used to be simpler. Given the current prevalence of claims denials, administrative hurdles for reimbursement, and declining payment rates, interviewees discussed PSHP ownership as a mechanism for lessening the power of insurers over the hospital. Interviewees frequently mentioned commercial insurers in their discussion of risk in general and PSHP specifically:

> *It all depends on the market and depends on competition. If you really broke down what they're doing, you would notice that 200,000 Medicare Advantage lives solves a lot of problems and keeps a lot of national insurers at bay. So, it's very difficult to get into the market, and they can sort of control the whole dollar.*

> *Our CEO just thought we needed to be farther up this chain on where the dollars are coming from. Can you disintermediate insurance companies? Can you just make Blue Cross irrelevant?*

Moving From a Volume to Value Mindset

Interviewees discussed the importance of moving from a fee-for-service (FFS) mindset (volume) to a value-based mindset. The perception was that incentives are better aligned under a value-based model, meaning that what is good for the hospital is also good for the patients. Preventing an unnecessary hospital visit saves money under a value-based model, because less of the premium or capitated payment will be used for additional care. Therefore, high quality but low cost of care and reducing unnecessary care results in the best financial outcomes, in addition to being better for patients. However, under an FFS (volume) model, more care provided generates more revenue, regardless of whether it was preventable or unnecessary. Therefore, under an FFS model, what is good for the patient (staying healthy) and what is good for the health care system financially (providing as much care as possible) are at odds. Interviewees frequently interchanged the concepts of risk and value-based care, meaning that value-based contracts usually result in more risk for the health system. A PSHP is considered a value-based type of care model because it requires the organization as a whole to take on risk and also requires behaviors that provide high-quality and low-cost care, thus providing a better value for patients:

> *When you have a siloed delivery system and a payer system, the incentives are not necessarily aligned. When you can work collaboratively as a health plan and a provider, you can achieve higher quality outcomes and potentially lower the cost.*

Value-based care was a prominent feature of every interview. The general movement toward value-based care and away from FFS was mentioned as a motivator for PSHP more than any single regulation. The more generalized discussion of value-based care suggests that perhaps no single regulation has created a tipping point, but rather a slow accretion of policy, regulatory, and reimbursement efforts that have created a sustainable movement toward value. Many described the spectrum of volume to value-based care, and that various strategies for taking on risk, including PSHP, were part of the journey toward providing value-based care. A common theme among interviewees with a PSHP was that the degree to which they believed in the inevitability of health care moving fully to value-based contracts seemed to be related to the vigor with which they pursued risk-bearing models.

> *I think that when you have a national health insurer says, "Hey, you know, we're going to be doing most of our contracts in value-based formats." It's sort of like, okay, they're all saying the same thing. And it's not fee for service. And you can only hang on for so long.*

Normative motivations for pursuing PSHP. Although relational dependencies provide a helpful framework for decision-making, there are motivations that fall outside these strategic considerations. There was a recurring belief that moving toward value through risk-bearing arrangements and PSHP was ultimately better for patients. The consensus was that incentives are better aligned to keep patients healthy and to provide better care at lower cost. This reasoning seemed to supersede other strategic considerations. For example, one hospital enjoyed such strong market dominance that insurers were not able to contract around them. Therefore, they were in a very strong negotiating position and enjoyed favorable FFS terms. However, they still wanted to pursue risk because they believed it was better for patients:

> *We were dominant system and a dominant system can do well [in an FFS environment]. You don't really have to take risk, and so it was interesting that our CEO felt it necessary to do that. But I think she was*

driven by this perception that fee-for-service was not a good thing for patients.

Think of a Venn diagram, the intersection of two circles, that's the [health system] and [health plan] place. That's where people get the best outcomes. They get the most affordable health care, highest quality, best experience. If we can influence people to join the health plan, and connect to [our] clinical enterprise, they're going to get a better health outcome. And over the long run, everybody wins, they'll be happier, they'll be healthier.

Physician Interdependencies

Aligned physicians enable PSHP. Physician engagement and relationships were central to the discussion of PSHP. Interviewees indicated that they had at least some, if not all, employed physicians. The importance of a high-performing network of physicians that aligns with value-based care goals was a critical component for formation and success of a PSHP. The employment of physicians was discussed as an enabler to incentivize value-based clinical practices:

Our physicians and midlevel providers—every one of them is paid a salary. They have no incentive to do more services…there are no volume-based incentives for a provider or any employee.

PSHP as a tool for better physician engagement. To be successful, PSHPs need providers to deliver care in a way that aligns with the goals of the health plan. If a physician orders unnecessary tests, it can be costly for the health plan and reduce health plan success. The health plan or hospital may offer incentives to discourage these types of physician behaviors and create accountability through financial mechanisms and sharing health plan data and utilization patterns relative to peers. Lastly, the PSHP may provide a foundation for more trusting relationships with physicians relative to an external payer, perhaps given potentially different missions of PSHPs versus large national insurers:

I think the provider-sponsored plan is more provider focused. The health plan is very much driven from the [perspective of] "What is it that providers need to add value to the care of the member?" I think you're able to develop those relationships better, as a provider-sponsored health plan…. At the end of the day, I'm more worried about what's the right thing to do for the member. I can engage the provider on that level, as compared to a big national for-profit plan that is still driven by the bottom line and the amount of profit they can generate.

Financial Considerations

A PSHP can be used as one mechanism to diversify revenue sources and to offset potential threats to existing revenue sources, especially as the industry sees an increasing focus on population health:

Hospitals are struggling to always find more substantial revenue streams and diversifying revenue streams —something that every hospital CEO is thinking about.

If hospitals are successful in moving toward population health and value-based care, they should be seeing fewer patients due to avoidable and preventable illnesses, resulting in lower admissions. However, if a hospital has a PSHP, then the premium payments for health plan members might help offset those volume losses on the hospital side:

Part of population health is keeping people healthier. Keeping them healthier means there are going to be fewer people coming into our beds. So, partnering with a health plan to share those savings at least allows them to recoup some of the lost revenue through decreased utilization.

In addition, a PSHP can help hedge against unexpected financial losses. For example, a national insurer decision to reduce reimbursement rates would result in reduced hospital revenue. Alternatively, something like a natural disaster, which could cause substantial losses on the health plan side, would result in financial gains for the hospital under the FFS model. The COVID-19 pandemic of 2020 resulted in initial gains for health plans due to the cancellation of elective surgeries, which helped offset losses to the hospital from the inability to provide elective surgeries:

Our Medicaid health plan was losing millions at the beginning of our fiscal year (September) due to having many catastrophic cases and the State rate setters missing badly. We had to report a potential for a year-end loss [of tens of millions of dollars] in December…. Then came COVID—the hospital lost millions with no elective surgeries or procedures…. However, the health plan…began to see large positive margins and large increases in Medicaid membership. Because of the health plan, we did not have to furlough any employees in our system, and it looks like we might even make budget for the year as we are now back to doing elective procedures. It is just a very eye-opening example of diversification/hedging and how much that can help in crisis times.

In addition, interviewees mentioned the significant capital outlay and timeline needed for starting a PSHP. The cost of starting a health plan is substantial, with interviewees estimating that $30–$100 million are needed for startup capital and reserve requirements. Interviewees also suggested that the runway for success is at least 5–7 years or longer. Therefore, interviewees suggested that organizations interested in PSHP must have significant capital resources, as well as a long-term commitment to the PSHP strategy across the

organization. A synthesis of quantitative and qualitative findings is depicted in Supplemental Digital Content 2 (http://links.lww.com/HCMR/A85).

Discussion

Environmental Factors

We examined environmental factors that RDT implied could have an impact on hospitals' PSHP ownership decisions. Ultimately, we found mixed support for these environmental factors as determinants of PSHP ownership. Specifically, the dimension of complexity as operationalized by payer concentration was significantly associated with PSHP ownership. Greater hospital and payer competition (lower concentration) were associated with increased likelihood of ownership, suggesting that hospitals in markets with lower relative dependence on insurers may have fewer barriers to establishing PSHPs. Competition was reinforced in the qualitative findings as one of the market considerations that was mentioned by every interviewee. Measures of munificence were not consistently associated with higher plan ownership, contrary to our hypotheses. Higher unemployment rates were associated with lower likelihood of ownership as expected, though the income per capita and physician supply measures were not. It may be that characteristics that define a munificent environment may differ significantly for hospitals and the health plans they own. For instance, a high Medicaid payer mix has been consistently associated with worse financial performance for hospitals, but plans serving Medicaid beneficiaries have been profitable (McCue, 2012). For physician supply, hospitals may benefit from a large population of physicians, but health plan success hinges to a greater extent on the availability of certain kinds of physicians (e.g., primary care). Medicaid expansion as a measure of dynamism was not associated with PSHP ownership, though it is possible that other dimensions of dynamism do influence the ownership decision.

Beyond competitive dynamics, interviewees had little consistency about the influence of environmental factors on PSHP ownership, including population characteristics or Medicaid expansion. It is possible that the environmental variables we chose did not capture the environmental factors most relevant to PSHP ownership, even though the choice of measures was based on prior research in this area. The failure of the qualitative interviews to identify consistent environmental predictors suggests that environmental factors may be a lesser determinant of hospitals' PSHP ownership decisions. Another possibility is that individual environmental factors were lost in the flood of regulatory and reimbursement changes happening during the study period. Interviewees suggested that Medicare Advantage was a logical starting place for PSHP market entry, and therefore, Medicare Advantage reimbursement policies and terms may have a greater impact on PSHP ownership than Medicaid Expansion.

Organizational Factors

In contrast to environmental factors, organizational factors may have had a greater role in motivating PSHP ownership. For example, a hospital's participation in a clinically integrated network was associated with a nearly 13 percentage point increased likelihood of ownership, and profit status was also significant. Hospitals also had a nearly 6 percentage point increase in the likelihood of ownership for each additional type of risk-bearing arrangement they had, such as bundled payments, ACOs, or shared risk agreements with providers. Hospitals with salaried physicians were more likely to own a PSHP, which was also discussed by interviewees as an important enabler. By employing physicians, hospitals can recruit physicians, which aligns with the goals of the organization and PSHP and creates direct mechanisms to influence physician behavior.

Taken together, these findings suggest that a hospital's internal resources and strategic choices such as its mission, participating in an integrated network, employing physicians, and experimenting with other types of risk may play a greater role in facilitating PSHP ownership than the hospital's external environment. In terms of other organizational characteristics, interviewees frequently referred to the need for high levels of organizational commitment to a value-based strategy and significant financial resources as key considerations for starting and owning a health plan. This was evident in the higher likelihood of PSHP ownership for not-for-profit hospitals, as they may have more slack resources to invest in such a strategy given their ability to reinvest excess earnings back into the organization versus having to pass excess returns along to shareholders.

Motivations for PSHP. The various motives to own a PSHP were central to the discussion with interviewees. The most commonly mentioned motivator was the need to move from volume-based incentives to value-based incentives and the belief that a PSHP was the culmination of that journey. Interviewees reiterated that to be successful in owning a health plan, they must deliver efficient and effective care for a lower price while keeping patients satisfied and healthy. This allows them to price premiums competitively, reduce unnecessary care, encourage people to stay enrolled in their plan, and retain a sufficient margin. These mirror the aims of value-based care. Therefore, it is unsurprising that health systems see value-based care and a PSHP as incenting similar behaviors and responses. Whether under a value-based contract with a national insurer or managing the hospital's own PSHP, providing better care with a fixed amount of dollars is critical. If a hospital owning a PSHP can master population health management and high-quality, low-cost care, it is better equipped to adjust to an increasing value-based care model in the future. If the hospital is prepared for such a model, then the PSHP specifically can offer gains in market share and bargaining power, better clinician engagement, and financial hedging (Bannow, 2020) and control of the premium dollar relative to other risk-bearing arrangements.

There was also support for the idea that power and control over resources was a key motivator. There was a belief that if the hospital did not control access to patients through a health plan, it could be replaced by competing hospitals as payers look for low-cost options. Control of patients was seen as a means to usurp some of the power of insurers and to succeed in a competitive environment where incentives are

rapidly changing. This was supported by the quantitative findings that hospitals in environments with greater insurer concentration were less likely to own a PSHP. If a PSHP has the members, it can direct them to the hospital's network and not be at risk of an outside insurer directing patients to a competing hospital. Despite the mixed support for the importance of environmental factors in our results, the forces of power and control do seem to be primary considerations in hospitals' PSHP ownership decisions, consistent with the tenets of RDT. Control over the full premium dollar, which is financial in nature, was a strong motivator. However, it appears that this degree of control was more important than the earnings from the health plan. The motivators of staying relevant, avoiding disintermediation by other actors, keeping patients within the system, and doing what is best for patients were more prominent in the discussion than a profit or financial motive. This may explain why for-profit hospitals were less likely to own a PSHP than not-for-profit hospitals. Interviewees stated financial goals of breakeven, or making just enough to meet reserve requirements, and funneling as much money back into the providers and hospital as possible, or even losing money on the health plan to fulfill a mission of taking care of the community.

Despite the many contributions of this study, there are limitations to note. The AHA survey data are self-reported, which is susceptible to inaccuracies. Given the large sample size, it is unlikely that the small incidence of incorrect forms would materially change the results. Interviewees represented a geographically dispersed group of hospital systems with variation in organizational characteristics but were selected through purposive sampling, which can lead to bias. Though the directionality of relationships is supported by theory and the qualitative results, causality cannot be definitively determined due to the cross-sectional study design.

Practice Implications

This study highlights several important considerations for health care leaders considering PSHP ownership. First, PSHP ownership seems to be primarily a function of a hospital's internal organizational characteristics rather than its external environment. Administrators hoping to pursue PSHP ownership as a strategy are likely to have more control over organizational characteristics than environmental ones, opening this strategy to a wider range of hospitals. This conclusion comes with the notable caveat that PSHP formation may be facilitated by markets with greater competition among hospitals and insurers.

With respect to the organizational factors associated with PSHP ownership, our results suggest hospitals considering this strategy may do well to adopt an incremental approach to organizational change. For example, participation in a clinically integrated network seems critical, as supported by our quantitative findings. Failure to have such a network in place was for a major driver of the decline of PSHPs in the 1980s and 1990s (Shortell & McCurdy, 2010). Before investing in PSHP development, hospitals should refine their management of risk and the performance of their clinically integrated network through less constraining mechanisms, such as membership in an ACO, participation in shared risk or shared savings programs, or bundled payment arrangements. Our results suggest many hospitals owning PSHPs were engaged in these kinds of alternative risk-bearing arrangements as well, which can serve as a more forgiving practice ground for learning to manage risk than a PSHP.

Our results may also temper the expectations of leaders considering PSHP ownership as a means of improving financial returns. Health plan ownership is expensive, with interviewees estimating startup costs and reserve requirements at $30–$100 million. These estimates far surpass those noted in prior research, where estimates neared $12.4 million in 2020 inflation-adjusted dollars (Cavalruso, 1999). Allocating $12 million for a $100 million venture could result in detrimental losses to hospitals with little financial padding to make such a mistake. PSHPs are often competing with large national insurers for business and must initially price premiums low to attract members. Rates also must be adjusted in the first several years as the PSHP gains a better understanding of the health and medical care needs of its insured population. Therefore, the health system must be willing to stomach initial losses in the first few years. Interviewees suggested that the runway for success is at least 5 years or longer, requiring a long-term commitment from executive and board leadership. Even after the startup period, many hospitals with PSHPs did not cite financial returns as a reason for maintaining a PSHP. It seems that the PSHP strategy is directed more at ensuring long-term financial sustainability amidst changing payment models than about maximizing near-term profitability. Lastly, regulators should encourage policies that foster competition among hospitals and payers, thus creating conditions that can support the PSHP strategy, which may result in better and more efficient care.

This study used the lens of RDT to examine the motivations for hospitals to pursue PSHP ownership in the post-reform era. Except for competitive dynamics, environmental factors may be less salient than an organization's internal resources, experience, and strategic decision-making. The value-based care movement appears to have permanently altered the dynamics of payers and providers, perhaps creating a more sustainable future for the PSHP. This study found support for the idea that hospitals are motivated to pursue health plan ownership to gain more control over market share, the premium dollar, and their destiny and to fulfill their mission of providing better care. Hospitals also use PSHP as a mechanism to prepare for survival in a future where value-based contracts are increasingly common and to diversify revenue streams.

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