The Growing And Evolving Role Of Provider-Sponsored Health Plans In U.S. Health Care

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Provider-sponsored health plans (PSHPs) are becoming increasingly prevalent in response to the changing dynamics and direction of the U.S. health care delivery system. The growth of PSHPs has, to date, helped providers diversify their business profiles while fostering development of the new skills needed under health care reform, including population health management. Standard & Poor's Ratings Services believes PSHPs are a viable means for providers to begin to address population health management (PHM), growing consumer involvement, and the accelerated development of desired risk sharing arrangements.

PSHPs increasingly represent and are an example of health care systems' evolution toward pluralistic models of care that move toward a value-based approach while not crowding out the still-dominant traditional fee-for-service model. A sampling of the larger systems that currently operate PSHPs (see table 1) shows that long-term participants and newcomers alike report that the skills PSHP operators learn are critical for long-term success as the entire health care delivery system moves toward value-based models of care and PHM.

Overview

- The development of provider-sponsored health plans benefits from incentives under health reform and the Affordable Care Act.
- Ownership of PSHPs contributes to providers' geographic and financial dispersion and can provide hospitals and health systems with access to skills and data we consider critical as health care reform evolves toward population health management.
- Credit and rating impacts from the development of PSHPs have been minimal to date.

A number of providers report that their traditional insurance partners are not willing to share risk with them. At the same time, providers are finding that their efforts to lower costs, improve quality, and address consumer needs for better information, pricing, and convenience, are benefiting these same partners as a result of reduced medical cost trends, as well as healthier and happier patients. Provider frustration with this is one of the key reasons behind the development of PSHPs as they want to benefit from their efforts. Other reasons include the basic business strengths of improved geographic and financial dispersion and, for most, enhanced profitability. Most of the providers we have spoken with highlight PSHPs as helping their organizations develop a true integrated delivery system capable of meeting the broad goal of improving quality at a lower cost—at least on an inflation-adjusted basis. As a result, providers are increasingly embracing PSHPs and have learned the hard lessons of the late 1990s, when many providers entered and exited the PSHP business often with sizable and embarrassing losses.
### Table 1

<table>
<thead>
<tr>
<th>Parent</th>
<th>PSHP</th>
<th>Domicile</th>
<th>Membership (000s)</th>
<th>Premium</th>
<th>Statutory Net Worth</th>
<th>RBC (ACL %)</th>
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</thead>
<tbody>
<tr>
<td>Baylor Scott &amp; White</td>
<td>Scott &amp; White Health Plan</td>
<td>Texas</td>
<td>165.40</td>
<td>675.00</td>
<td>86.31</td>
<td>441.73</td>
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<td>Boston Medical Center</td>
<td>BMC Health Plan</td>
<td>Mass.</td>
<td>342.60</td>
<td>1,775.86</td>
<td>204.24</td>
<td>329.65</td>
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<td>Carle Foundation Hospital</td>
<td>Health Alliance Medical Plans</td>
<td>Ill.</td>
<td>202.00</td>
<td>1,227.69</td>
<td>179.13</td>
<td>484.13</td>
</tr>
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<td>Geisinger Health System</td>
<td>Geisinger Health Plan</td>
<td>Penn.</td>
<td>282.40</td>
<td>1,610.82</td>
<td>170.45</td>
<td>303.98</td>
</tr>
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<td>Henry Ford Health System</td>
<td>Health Alliance Plan of MI (HAP)</td>
<td>Mich.</td>
<td>271.10</td>
<td>1,749.00</td>
<td>208.26</td>
<td>279.55</td>
</tr>
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<td>Intermountain</td>
<td>SelectHealth</td>
<td>Utah</td>
<td>730.00</td>
<td>1,886.38</td>
<td>444.82</td>
<td>630.82</td>
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<td>Marshfield Clinic</td>
<td>Security Health Plan of Wisconsin, Inc.</td>
<td>Wisc.</td>
<td>194.20</td>
<td>1,098.01</td>
<td>187.94</td>
<td>464.80</td>
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<td>Parkland Health</td>
<td>Parkland Community Health Plan</td>
<td>Texas</td>
<td>215.40</td>
<td>518.28</td>
<td>130.33</td>
<td>789.83</td>
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<td>Partners Healthcare</td>
<td>Neighborhood Health Plan</td>
<td>Mass.</td>
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<td>1,717.82</td>
<td>128.72</td>
<td>195.92</td>
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<tr>
<td>Presbyterian Health System</td>
<td>Presbyterian Health Plan</td>
<td>N.M.</td>
<td>300.50</td>
<td>1,447.83</td>
<td>243.55</td>
<td>626.83</td>
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<td>Providence Health System</td>
<td>Providence Health Plan</td>
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<td>440.30</td>
<td>1,102.06</td>
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<td>1,208.46</td>
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<td>Spectrum Health System</td>
<td>Priority Health</td>
<td>Mich.</td>
<td>585.40</td>
<td>2,542.00</td>
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<td>565.62</td>
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<td>SSM Health Care</td>
<td>Dean Health Plan</td>
<td>Wisc.</td>
<td>422.30</td>
<td>1,171.00</td>
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<td>431.91</td>
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<td>Temple University Health System</td>
<td>HealthPartners of Philadelphia</td>
<td>Penn.</td>
<td>202.30</td>
<td>909.73</td>
<td>79.19</td>
<td>313.53</td>
</tr>
<tr>
<td>UPMC</td>
<td>UPMC Health Plan</td>
<td>Penn.</td>
<td>2,630.00</td>
<td>5,400.00</td>
<td>744.00</td>
<td>403.00</td>
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<tr>
<td>VCU Health System</td>
<td>Virginia Premier Health Plan</td>
<td>Va.</td>
<td>179.00</td>
<td>816.32</td>
<td>167.54</td>
<td>550.63</td>
</tr>
</tbody>
</table>

As of 2014 fiscal year-end. Source: statutory filings for 2014 or from providers directly.

The benefits of integrated systems are not lost on traditional insurance companies because they are also moving closer to providers, either through joint ventures, accountable care organization (ACO) strategies or, in some cases, though direct investment in provider organizations to also create integrated networks. As a result we see a blurring of the lines between insurance companies and providers, depending on local circumstances.

The development of more robust PSHPs has had, at most, a mild credit impact on ratings to date. We believe the expansion of these organizations is still in a relatively early stage, although a few PSHPs have been around for decades. We see the growth and development of PSHPs, value-based payment methodologies, and consumer participation as emblematic of the broader evolution in the sector. We believe the offering of a fully integrated delivery system is a potential means of differentiating oneself from the competition.

### The Credit Benefits And Risks

While we view the credit impact of PSHPs as mild so far, we believe creating integrated systems of care and developing the wide range of capabilities that operating a PSHP implies is a plus for health care providers as it develops essential skills increasingly needed for success. However, we are cognizant of the increased insurance risks...
providers are taking, and we expect that system-wide operating performance will be more volatile over time due to
PSHPs. To date, there have not been any ratings changes due to the growing development of PSHPs since the
development of the Affordable Care Act (ACA). It’s quite possible that sustained weak financial performance of a PSHP
beyond normal issues of start-up and scale, could lead us to view it as a credit negative. However, we believe the
positive role a PSHP plays in supporting the core clinical delivery enterprise, gaining more and earlier access to the
premium dollar, and providing data access across the care spectrum can be critical credit rating strengths. Many of
the providers we have spoken with have emphasized that the knowledge that comes with operating a PSHP extends well
beyond the narrow confines of the health plan itself into all aspects of how the entire delivery system is operated.

Health system credit ratings continue to be based on overall systemwide performance, including the acceptance of
insurance risk. We allow for some growing pains at the PSHP, such as start-up and early stage financial setbacks for
PSHPs in their developmental stage. In addition, when the PSHP has a much broader primary service area than the
delivery system, we believe the added geographic dispersion and opportunities for further revenue dispersion and
delivery system growth are strengths, assuming operations are profitable.

From a balance sheet perspective, we have seen a variety of relationships between the PSHPs and their corporate
parents, all of whom tend to be larger and stronger financially (see table 2). In many cases the parent is the effective
financial backstop and the plans retain relatively thin risk-based capital levels, while in other cases the PSHP retains all
of its accumulated capital even as it remains loyal to the broader integrated delivery system vision.

The Influence Of Health Care Reform And The ACA

Health care reform and the ACA have transformed and will continue to transform the U.S. health care delivery system.
This transformation is resulting in new opportunities and challenges for providers, insurers, physicians, and consumers,
as greater levels of clinical integration, value-based purchasing, risk sharing, and cost sharing take hold. The shifting
landscape is affecting all industry participants and is one of the major forces spurring the growth of PSHPs, which have
evolved through several periods of development and retrenchment over the past few decades. A number of the
organizations we have highlighted started their plans many years ago.

Standard & Poor’s believes that well-established PSHPs are reasonably well-positioned to facilitate integration between
patients, physicians, and hospitals, although new plans need to attain sufficient size and scale to achieve this role. We
believe this type of integrated approach is one path to improve the health of individual patients and larger populations
of patients, while also helping differentiate their related health care systems larger "brand" and clinical services. PSHPs
establish a direct link with the health care consumer as the market increasingly becomes more retail and consumer
oriented with consumers assuming a larger financial stake in their own health care through higher out-of-pocket costs.

We believe the role of narrow networks is growing and that the rise of PSHPs aids that growth. We also believe PSHPs
can benefit from their own efforts to lower costs, improve quality of care, and better serve consumers who use their
services. Many providers believe the reluctance of insurance companies to offer more robust risk sharing deals is one
of the key motivators for providers to start, purchase, or refocus their strategy toward PSHPs. It also enables them to
become more capable of managing risk, counter the market clout of traditional insurance companies, reduce operation
risk by increasing overall business dispersion, and engage patients directly in a way that embodies the movement toward value based purchasing and population health management.

The ACA’s main provisions, which focus on expanding access to medical coverage and addressing cost containment through payment and delivery system reform, create a ripe environment for PSHPs and dovetail with larger health care reform efforts that are already underway. The law is prescriptive about insurance expansion because its lays out a framework for establishing health insurance exchanges (the health insurance marketplace) and expanding Medicaid coverage (via traditional and alternative subsidy approaches). With regard to payment and delivery system reform, the law is less prescriptive and instead relies on pilot programs, demonstration projects, and incentives to spur market-based reform through both private sector engagement and state Medicaid reform efforts.

When these initiatives were taken together with the various means to pay for the ACA, most providers and insurers realized that while there would be increased funding in the health care sector, per-unit reimbursement would decline either outright or at a minimum on an inflation-adjusted basis. As a result, many providers embarked on major cost-containment initiatives. For the most part, these efforts have been successful as overall health care costs showed a record low growth trend for the most recent five-year reportable period (2009-2013), according to the Centers for Medicare & Medicaid Services (CMS). Furthermore, the reported increase of 3.6% for 2013 reflected the lowest growth since monitoring began in 1960.

How much is attributable to lower payments and resultant delivery system change versus the weak economic fundamentals of the recent period is uncertain. But there is already evidence of an uptick for 2014 (a period that coincided with the onset of ACA-driven expanded access and sustained payroll growth). CMS expects the combined effects of the ACA’s coverage expansions, faster economic growth, and population aging will fuel health spending growth this year and thereafter (6% per year for 2015 through 2023). The CMS projections occurred before the recent changes to the Sustainable Growth Rate formula.

The success of the recent wave of cost containment is giving way to a second generation of cost-cutting initiatives, involving direct attention to medical management and service rationalizations within markets. These developments aid the rise of PSHPs as well as the growth of insurance companies purchasing or aligning with health care providers. Incentives to encourage greater preventative health measures and improve the overall quality of care are gradually changing the sector. The slow but accelerating growth of value-based payment methodologies such as Medicare value initiatives, medical homes, bundled payments, and reference pricing, and away from traditional methodologies is driving cost containment, more efficient use of resources and widespread initiatives to improve quality through best practice definition and promulgation. However, this change is very gradual because fee-for-service is still the norm in many markets, and we expect a long period where pluralistic models exist in parallel despite the differing incentives of each model.

These fundamental industry changes are often linked to the transference of risk to the provider community from the payer community, either directly though capitation contracts (which pay prearranged monthly amounts without regard to resource utilization) or PSHPs, or indirectly through a range of risk-sharing arrangements. In turn, this drives better cross-sector collaboration, care coordination beyond the episodic/acute phase, and ultimately greater focus on the overall health of patients. A concurrent development has been the rise in consumer participation, which is poised to
become more relevant for product design and distribution and will reshape customer outreach and engagement strategies. We believe PSHPs can help delivery systems adapt to all these changing needs.

We have also seen larger insurance companies increasingly engaging with providers in the full continuum of value based reimbursement arrangements, including pay-for-performance, shared savings, bundled payments, shared risk, or population based payments. In many instances the insurer is providing the infrastructure and operational competency needed to support and develop these arrangements. In some instances, such an arrangement could serve as a precursor to an insurer contributing financially to the arrangement in the form of a joint equity stake – perhaps further binding the relationship – leading to joint marketing, product development, and distribution efforts.

The Benefits Of Provider-Sponsored Health Plans

Given health reform incentives, we believe that PSHPs will continue to proliferate. Standard & Poor's already rates several hospitals and health systems that own PSHPs, including the sample of 16 health plans sponsored by not-for-profit hospitals and health systems in table 2. These plans are aligned with a variety of organizations including health systems, stand-alone hospitals, and academic medical centers. Taken together this group of PSHPs, collectively generated premiums of more than $25 billion in fiscal 2014 and support a membership base of more than seven million—a large absolute number, but in our estimate, also a relatively modest share of the insurable market.

### Not-For-Profit Hospitals And Systems With PSHPs

<table>
<thead>
<tr>
<th>Parent§</th>
<th>Rating</th>
<th>Outlook</th>
<th>Total Operating Revenue</th>
<th>Unrestricted Reserves</th>
<th>Unrestricted Net Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baylor Scott &amp; White*</td>
<td>AA-</td>
<td>Stable</td>
<td>5,123.0</td>
<td>3,076.2</td>
<td>4,405.0</td>
</tr>
<tr>
<td>Boston Medical Center</td>
<td>BBB</td>
<td>Stable</td>
<td>2,828.7</td>
<td>828.1</td>
<td>1,111.8</td>
</tr>
<tr>
<td>Carle Foundation Hospital</td>
<td>A+</td>
<td>Positive</td>
<td>2,057.7</td>
<td>1,197.6</td>
<td>1,331.4</td>
</tr>
<tr>
<td>Geisinger Health System</td>
<td>AA</td>
<td>Stable</td>
<td>3,977.0</td>
<td>2,622.3</td>
<td>2,395.4</td>
</tr>
<tr>
<td>Henry Ford Health System</td>
<td>A-</td>
<td>Stable</td>
<td>4,676.9</td>
<td>1,193.7</td>
<td>1,309.0</td>
</tr>
<tr>
<td>Intermountain</td>
<td>AA+</td>
<td>Stable</td>
<td>5,573.4</td>
<td>5,116.5</td>
<td>5,444.1</td>
</tr>
<tr>
<td>Marshfield Clinic</td>
<td>A-</td>
<td>Stable</td>
<td>1,978.6</td>
<td>553.5</td>
<td>873.6</td>
</tr>
<tr>
<td>Parkland Health</td>
<td>AA</td>
<td>Stable</td>
<td>1,851.2</td>
<td>508.2</td>
<td>1,244.9</td>
</tr>
<tr>
<td>Partners Healthcare</td>
<td>AA</td>
<td>Negative</td>
<td>10,892.4</td>
<td>6,647.3</td>
<td>5,623.8</td>
</tr>
<tr>
<td>Presbyterian Health System</td>
<td>AA</td>
<td>Stable</td>
<td>2,507.8</td>
<td>1,809.6</td>
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<tr>
<td>Providence Health System</td>
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<td>Stable</td>
<td>12,360.2</td>
<td>5,805.2</td>
<td>7,537.6</td>
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<tr>
<td>Spectrum Health System</td>
<td>AA</td>
<td>Stable</td>
<td>4,107.8</td>
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<td>SSM Health Care</td>
<td>A+</td>
<td>Stable</td>
<td>4,823.9</td>
<td>2,241.0</td>
<td>1,782.2</td>
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<tr>
<td>Temple University Health System</td>
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<td>Stable</td>
<td>1,391.4</td>
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<td>UPMC</td>
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<td>11,319.5</td>
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<td>VCU Health System</td>
<td>AA-</td>
<td>Stable</td>
<td>2,242.2</td>
<td>1,534.8</td>
<td>1,609.0</td>
</tr>
</tbody>
</table>

Fiscal year 2014 data shown. *Based on irregular 9-mo. fiscal year. §Corresponding parent shown in table 1.

A sample review of statutory filings indicates these health plans tend to have a relatively greater presence in government sponsored markets (managed Medicare / Medicaid), perhaps due to the opportunity as these types of
plans tend to be underpenetrated by the typical insurance company market leaders -- often Blue Cross/Blue Shield plans. Most of these PSHPs are sufficiently capitalized relative to their risk-based capital requirements and appear to have the capacity to support moderate growth and absorb some performance volatility without generating the need for parental capital support. However we do note that some PSHP are dependent on their parent for balance sheet depth, while others retain all their internally generated capital.

In the emerging health care reform environment, more reimbursement payments increasingly reflect value-based purchasing incentives and acceptance of insurance risk. Ownership of a PSHP allows the parent health system to gather experience in managing insurance risk and is considered a benefit assuming profitability or breakeven performance. While all providers indicate the internal pricing is done on a market basis, our analysis is focused on system wide results because the internal pricing is generally opaque to outside parties monitoring company performance. PSHP losses may be credit neutral if modest or deemed to be short-term in nature, although the presence of premium deficiency reserves at times can be substantial. Other key factors to consider include: strategic alignment across the system, enterprise wide balance sheet strength, operational capabilities, brand strength and scale, and (if successful) a healthier population.

PSHPs typically focus on operating within the general service area of their parent health system, which can be statewide and even multi-state. Within the traditional delivery system area they foster cohesive working relationships with all components of the health system--especially between the hospital and physicians. The intent is to use scale and aligned incentives to enhance quality and lower costs. In cases where PSHPs have a larger footprint than the traditional provider, the benefits expand beyond those in the core service area. For many systems, the larger PSHPs provide the health system an opportunity to expand its provider base into new markets with like-minded provider organizations. For some, the wider operations simply extend a profitable business line, diversify income, and help spread overhead. While the majority of PSHPs have a relatively concentrated market presence that overlaps the catchment area of their partner health systems, many appear to have achieved a sustainable operational scale and market penetration. Many other smaller PSHPs that have not achieved this scale may not have the same degree of sustainability initially, although those in the early stages can provide health care systems with critical risk management experience before they consider greater growth initiatives.

We think it's a credit positive when providers pursue performance-based or quality-based contracts, given that reimbursement will increasingly be linked to cost-effectiveness and quality. We think organizations that gain experience with risk-based contracts now will be better prepared in the future, even though fee-for-service models will not disappear. Early adopters, even on a smaller scale, can gain experience in putting the necessary processes, controls, and procedures in place to minimize risk associated with this strategy (e.g., incentives to reduce hospitalization could in turn reduce net patient service revenue and produce lower margins). While our analysis of provider credit strength might treat this as a positive to the enterprise profile and as a sign of adaptability to the new evolving health care delivery models, the analysis of financial performance would capture any unprofitable financial performance as a negative.

Accountable care arrangements are a separate initiative many providers are undertaking and most represent a virtual integrated attempt to implement value-based care. To some extent this is a return to the
integrated/provider-sponsored organization trend that we've seen in years past. In a few markets, insurers and providers have become vertically integrated, which changes the nature of competition in those markets. Compared with true vertical integration (generally facilitated via an acquisition), virtual integration--through formal and informal collaborations--appears to be gaining more momentum with health insurers and providers as well.

**Consumer Trends In Health Care And PSHPs**

PSHPs also dovetail with the emergence of consumer trends in the health care sector where greater individual decision making about health care options is usually accompanied by a greater financial contribution toward the overall cost of care. While this does reflect employers' concern that health insurance is absorbing too great a share of overall employee compensation, it also reflects the broader movement toward defined contribution benefit structures and less all-encompassing defined benefits. As it relates to the health care marketplace, this represents a growing trend toward a more retail environment from a product and distribution standpoint. It also demands greater flexibility from physicians, often hospital-employed, to have easier and greater availability to see patients at more convenient times and in more convenient ways--such as email consultations and telemedicine. The end result of these changes for healthcare providers is not clear, but most are concerned that a part of their core business could be eroded to new market participants and are therefore exploring a variety of options in this space to protect their interests, including PSHPs.

Consumers are also taking more ownership in the provision of their health care. Growing consumer participation in decision making has been the catalyst for the evolution of a true retail dimension to health care. Health care providers and payers are increasingly finding themselves in a position where they have to actually market to individual consumers as loyalty to a specific company or product may no longer be the most cost conscious or convenient option. This means a new mindset with regard to the product and services offerings of providers and insurance companies as well as their distribution network.

In the new marketplace, considerations of consumer convenience, pricing, and satisfaction, are emerging in ways not envisioned even a decade ago. For instance, urgent care centers offer consumers an alternative to expensive emergency rooms for minor medical needs. Consumers' growing attention to medical necessity and getting services in the lowest cost setting is influencing provider strategies and is making price more of a business driver. An outcome of the consolidation of the physician community into larger groups affiliated with hospitals and the growth in the physician employment model has been improved flexibility, allowing doctors to see patients at more convenient times and in more convenient ways.

Another growing trend in the marketplace is the increasing shift of the financial burden for health care costs to consumers. According to the most recent Kaiser Family Foundation survey, premiums for family coverage in 2014 were 26% higher than in 2009. This coincides with the rapid increase of employee enrollment in high-deductible consumer-driven health plans, which achieved 20% penetration in 2014 vs. just 8% in 2009. Indeed, narrow and ultra-narrow network arrangements are back-stopping many of the product choices that health insurance exchanges are distributing. This is playing a critical role in achieving a competitive product offering for a segment that has expressed its willingness to trade access to a specific doctor or hospital for a lower price.
The emergence of high deductible health plan (HDHP) offerings at both the employer and individual level has been a key trend in the past five years. For employers, these products have provided a means to limit their exposure to an ever-escalating medical cost environment by shifting an increasing percentage of the financial burden for medical coverage to employees and their dependents, through higher co-pays and deductibles. This, in turn, is spurring greater consumer awareness about choices and value trade-offs. While there is evidence that this form of value-based insurance design is lowering annual insurance cost growth relative to more traditional product configurations, there also appears to be a gap in user knowledge and decision tool support, and a lack of information to help consumers make choices. This is constraining consumers' willingness and ability to compare plans, hospitals, and doctors for quality and cost effectiveness. We believe providers and others are actively trying to find better ways to address these informational shortfalls, possibly through the growth of private insurance exchanges. Over time these trends should benefit PSHPs.

The establishment of the health insurance exchanges has hastened adoption of HDHP products. For this segment, as well as for most of the individual under-65 market broadly (except for lower actuarial benefit transitional plans), HDHP products backed by a narrow network arrangement are becoming increasingly prevalent offerings to a price-sensitive market segment. To date, the selection of a health insurance policy is price-competitive, although the role of cost in the provision of services as a driver of consumer choice is still in its infancy. Low-cost providers are not routinely able to use their cost position to generate increased business, although we believe that over time this will become increasingly important along with clearly demonstrated better health outcomes.

**More Change Ahead**

Over the next few years we expect employers will make fundamental decisions about their role as coordinators of benefits. Some may shift to a facilitator role and put more decision making responsibility on employees. But much still needs to be done from an operational standpoint (user engagement tools, information transparency, etc.) for employers to gain the confidence to move toward a more robust defined contribution model. Until then, we expect to see continued development of PHM expertise and structures such as PSHPs.

As we've seen, many changes in the evolving health care delivery system are pushing providers to adopt population health management strategies. One of the most potent is the emergence of PSHPs. These plans offer numerous benefits to providers including acquisition of PHM skills, understanding and management of insurance risk, and integration of medical operations with the end goals of improved quality at a lower cost. The U.S. health care system remains widely divergent in its delivery, scale, scope, and effectiveness. We see PSHPs as one tool among many to help accomplish the broad aims of health reform and the ACA and we expect continued growth and competition in this area.

Heena Abhyankar and Patrick Zagar provided research assistance for this report.