THE GOVERNANCE INSTITUTE
A SERVICE OF nrc HEALTH
DECEMBER 2022
System Focus

Aligning Interests in Health Plan Joint Ventures

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Continued healthcare transformation and the drive for higher-quality, more-affordable patient care is creating unique strategic rationales for payers and providers to rethink historically contentious relationships and consider previously unexplored avenues to work together. An example of this trend is seen in the increasing number of health systems that are entering into health plan joint ventures, which aim to capitalize on the strengths of each party to reduce costs and advance value-based care, while simultaneously generating additional patient volume and revenue for the health system.

What Is Driving the Surge in Partnerships?

There are a variety of reasons health systems and payers are exploring opportunities to align with one another more closely. From the health system perspective, ownership in a health plan offers an opportunity to drive additional patient volume to the system, including through the use of narrow network strategies. Additionally, health systems, which have been facing continued revenue strain coming out of the pandemic, are viewing an equity stake in a health plan as an opportunity to diversify their revenue stream and share in the premium and administrative income earned by the plans. Ownership in a health plan also allows the health system a seat at the table when the plan is deciding product expansion, entrance into new markets, and local employers to target for plan contracts.

Using a joint venture model for getting into the health plan space also helps limit risk for the health system and drastically increase the speed of entering the market. Many health systems have tried to own and operate a health plan of their own, but doing so requires standing up significant administrative operations and often large capital investment. In contrast, a joint venture with

an existing payer provides the opportunity to bring an experienced partner to the arrangement with existing back-office function, and to share the risk and capital costs of the venture, including some recent joint venture models that are requiring the health system to bring little to no initial capital to the new venture.

Payers, on the other hand, are looking for more collaborative approaches to work with providers in order to further align quality and financial incentives. By sharing in the success of the joint venture, health systems are further incentivized to provide efficient and quality care and eliminate unnecessary services. Payers also see value in leveraging the health system brand that may already have patient loyalty, thereby giving the joint venture plan immediate credibility and a source of members in an increasingly competitive market. A health system partner also provides an accelerated strategy for contracting with providers in new markets, as the health system will almost always be required to cause its network of affiliated providers to enter into provider agreements with the new health plan.

Key Considerations in Developing a Health Plan Joint Venture

Providers and payers must take care, from the outset of a potential deal, to clarify their overarching objectives and focus on key strategies that can lay the foundation for a successful partnership. Among other strategies, parties should take time to identify the best-suited partner, clearly identify the strategic objectives and allow those objectives to drive the structure and deal terms, understand the likely regulatory restraints on the arrangement, and set mechanisms to support and adapt the joint venture for long-term success.

Pick the Right Partner

As a first step, the health system board and senior leaders should conduct an assessment of the system's strengths and weaknesses to determine what it is bringing to the table, and what it needs the payer to contribute. From the provider side, payers are often looking for health systems with strong capabilities for patient care management, widespread adoption of data use and analytics, a strong provider network, and real engagement in and commitment to value-based arrangements. From the payer side, providers are often looking for a partner that can bring the full back-office operations and most, if not all, necessary capital. Health systems are also frequently looking for a partner that has the strength to immediately challenge an existing dominate payer in the market.

Let the Objectives Drive the Structure and Deal Terms

No two health plan joint ventures are the same because they really need to be customized to the strengths of the individual parties and the characteristics of the market. Therefore, it is important to avoid jumping directly into preconceived deal terms such as governance control, management and non-compete agreements, or to fall back on past or default agreements that may not apply to the unique venture under discussion. If the parties have effectively identified the key objectives and each partner's strengths and weaknesses, the parties can let those objectives drive the structure.

➜ Key Board Takeaways

- Health plan joint ventures present an opportunity for health system boards to accelerate efforts to adopt value-based care, while simultaneously creating additional revenue streams for the system.
- Health system boards and senior leaders should take time to identify what it needs from the joint venture partner (e.g., capital, administrative functions), and what value the system is providing (e.g., provider network, brand, loyal patient base), and use that information in selecting its potential partner and identifying the material deal terms.
- Providers and payers have been in adversarial positions for a very long time and that will not change overnight, so boards should ensure that the system and its potential partner are transparent about their objectives and how each party will be measuring success, and then include mechanisms to measure and respond to the joint venture's performance.

The health system should identify what outcomes it needs from the arrangement for it to be deemed a success, and then negotiate a deal structure around those terms. For example, if a health system is exploring a joint venture health plan as opposed to standing up its own plan largely due to the lower capital requirements, the health system will need to lead with capital call terms, dilution terms, and distribution rights. Given the capital that health plans require, succeeding on minimizing the health system's obligation to fund the plan may require material concessions on governance and other rights. However, if the health system is entering into the arrangement to minimize capital outlay and for purposes of relying on the payer's experience running plans, conceding some control may be in the joint venture's best interest.

Similarly, many health systems pursue health plan joint ventures to drive additional volume to the system. However, in return for such volume, payers often expect concessions on provider rates and risk-sharing. Additional terms for the system to consider in light of its overall objectives include the joint venture changing business lines, expanding service area, adding additional members (including other provider members), financial consolidation, exit options, transfers of member equity, and non-competition restrictions.

Consider Regulatory and Legal Issues Early

It is important to think through regulatory concerns that may result from the joint venture or may crop up as strategic objectives evolve. Some of these regulatory issues may be new issues that the health system partner has not had to address before while operating as a provider. Such issues include:

- Antitrust limitations (e.g., firewalls)
- Data and information sharing
- Marketing restrictions
- Related-party arrangements
- Fiduciary duties
- Taxes, tax-exemption, and unrelated business income tax (UBIT)
- Department of Insurance involvement/approval
- State procurement processes

Establish Measures of Success and Processes for Adaptation

Unlike more typical transactions, for joint ventures the deal isn't done—nor is it a success—once the papers are signed. Rather, health plan joint ventures are ongoing partnerships that must be prepared both to measure their achievements (and understand their failures) and adapt to changing circumstances, regulations, and market forces. Embracing this concept is a challenge for just about every entity, but it's even harder when the partners come into a venture with opposite measures of success—with providers often focused on increasing capacity and utilization, and payers measuring medical loss ratios. Therefore, an important step for the partners is to define success and identify shared metrics that can help determine whether goals have been reached. These measurements should be specific, reliable, meaningful, and, most of all, lead to specific actions that can be taken to pursue additional positive results or correct underperformance. Such measurements should go beyond basic measurements, such as revenues and profitability, but also include common metrics, such as net promoter scores, as well as include interviews and other key parties to identify whether the joint

venture is continuing to achieve the partners' individual missions and the goals they identified at the beginning of the initiative. Information gained should be shared with all parties in the joint venture. Not only does such transparency strengthen communication and trust, but it also enables all partners to participate in the development and implementation of solutions even in areas where they do not have direct responsibility.

Prepare for the (Possible) End

Unfortunately, some joint ventures will come apart, whether because of a failure to fulfill initial objectives, material changes to the market, or even because of disputes between the parties. This possibility should be contemplated during the initial negotiations that created the venture. Some business teams take approaches that create unnecessary difficulties should the partnership need to end. For example, in one approach, the parties are on such good terms during the initial negotiations that they fear that focusing on possible separation issues might sour the discussion, leaving no plan for how to address the end of the venture. In another approach, the business teams are so intent on making the partnership work that they create limited options for ending the joint venture or establish significant penalties for whichever party pulls the exit cord first. Instead, potential partners should preemptively discuss the circumstances in which the joint venture will end, neither poisoning nor sweetening the exit well. Attempts to do either may indicate that there are fundamental discrepancies between the partners, their goals, their leadership styles, and their cultures that should be taken into account before deal negotiations continue.

Conclusion

Health plan joint ventures are on the rise because they often make strong business and clinical sense during this period of healthcare transformation. With effective planning, up front, by health system boards and senior leaders these joint ventures can increase the likelihood that they will achieve their objectives.

The Governance Institute thanks Brad Dennis, Partner, McDermott Will & Emery LLP, for contributing this article. He can be reached at bdennis@mwe.com.