Are some of Kaiser's regional ambitions starting to pay off?

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Summary

Kaiser operates in multiple regions with a variety of models, membership scale and density. Historically, the California core, with its remarkable scale, has generated a lot of profits while the regions which lack these advantages have needed help from the mothership to survive.

Yet, in the first half of 2022, Kaiser's regions collectively achieved an operating profit while the California mothership experienced an operating loss. Why is this? Over the past few years, Kaiser has consciously turned to outsider executives to turn around its regional operations by focusing on basic operational improvements (including care management) and book-of-business restructurings which have proved largely successful. At the same time, the California mothership appears to have suffered from an operating cost surge (potentially the lingering effects of Covid on care delivery costs, especially in hospitals) which it was unable to pass through to its plan clients.

While California's problems may be temporary, the success of the regions—particularly those with hybrid models that partner out for hospital care—may well be more sustainable. Longer-term, the advantage of internalizing the hospital cost center may be in doubt given continuing pressures on hospital operations and growing opportunities to carve out care from the hospital. California may need to learn how the Kaiser regions do business.

1. The Kaiser model

By fusing health insurance with care delivery, Kaiser Permanente[1] should theoretically have a powerful ability to both control costs and provide a cohesive care experience. Insurance operations and care delivery each require their own high fixed cost infrastructures, however, so success for a vertically integrated, exclusively partnered[2] model critically depends on covering enough lives in each market. Otherwise, operational scale won't be competitive and higher-end care must be referred out to other providers. Kaiser does this in some regions, where it operates hybrids (in which hospital care is sourced through partnerships rather than owning the hospitals outright) where Kaiser's clinical preferences may have little influence.

2. The regional challenge

In the mature market of California, Kaiser's scale-enabled operating leverage has historically made a lot of money. Elsewhere, Kaiser has struggled. Operations launched or acquired in Ohio, Texas, Kansas City, Connecticut and North Carolina long ago have all been shuttered (most by 2000 though Ohio lingered until 2013). Kaiser still operates in six regions outside of California (Northwest,[3] Hawaii, Colorado, Georgia, Mid-Atlantic[4] and, most recently, Washington state which Kaiser entered when it purchased Group Health in 2017[5]). Having presences outside of California is essential for Kaiser to have a voice in national healthcare policy debates and, perhaps more importantly, be competitive with national accounts. However, much of the economic records of these operations[6] have been awash in red and the California mothership has had to send massive subsidiaries to its underperforming regional children.

Take a look at Georgia. Over the past decade, Kaiser in Georgia has experienced a cumulative $1B in underwriting losses.[7]

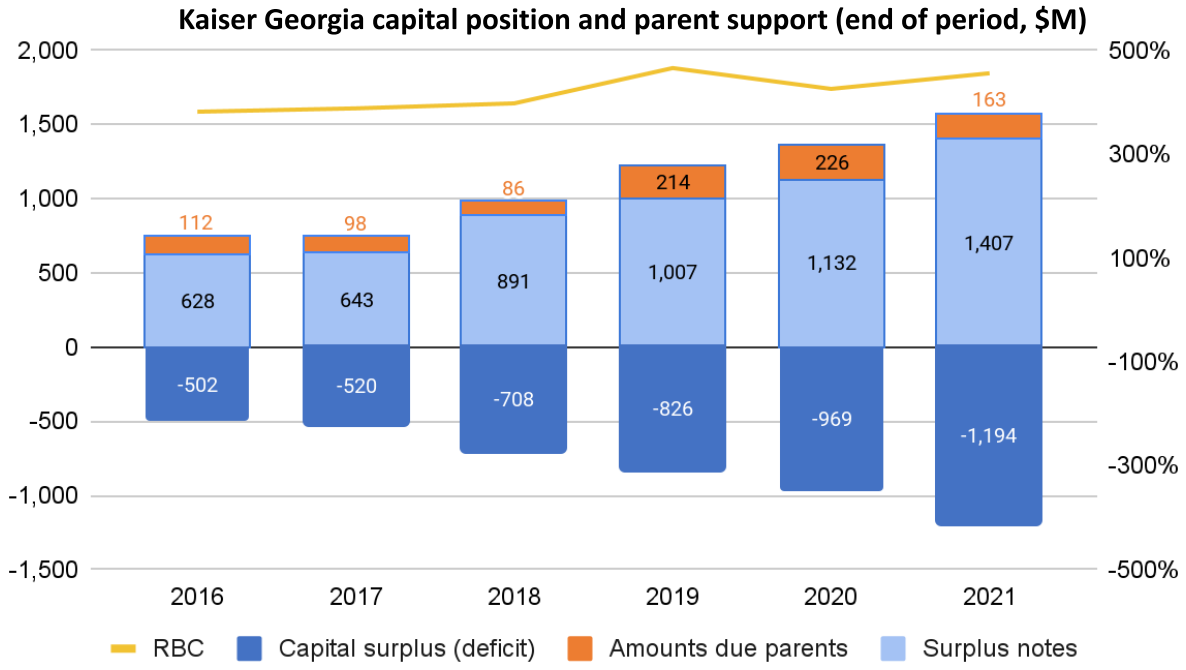

Figure 1. Kaiser Georgia operation increasingly dependent on financing from the parent

Bringing in leadership from the California mothership between 2015 and 2017[8] and a wrenching shift in hospital partnerships from Piedmont to Emory in 2018 did little to alter course. Accumulated capital for the Georgia operation has long been negative (and driven further negative by additional losses each year) and the parent has had to provide capital to fund the losses (and meet regulatory risk capital requirements) in the form of subordinated surplus notes and additional liquidity in the form of stretching of accounts payable owed the parent.

The case is similar in Washington. Kaiser entered the market in 2017 with the acquisition of Group Health (GH)[9]. Kaiser promised a billion dollars in investments to support a major modernization and a bold strike for market share. Kaiser did see growth in the HMO membership immediately after entry in 2018, but since then, overall membership has gradually been falling away[10] and financial losses have been accumulating. And, just as is the case with Georgia, Washington has become increasingly dependent on the parent to stay financially afloat, including recently resorting to subordinated surplus notes.

3. An "iron law" of Kaiser operating leverage

This ugly financial record can be seen partially as a result of Kaiser's inability to achieve the required density and scale of operations to support dual insurance and care delivery infrastructures. Net underwriting margin is positively correlated with local market share (measured as share of all lives covered in the counties in each state included in the operation's service area) across Kaiser's regions and California mothership[11] for the years 2017 to 2021 and the first half of 2022 (see Figure 3).

Both Georgia and Washington are at the lower end of market shares for Kaiser operations which partially explains their difficulties. But they are not exceptions. In fact, all of Kaiser's regions outside of California saw net underwriting losses in both 2017 and 2018 with the sole break-even exception of Georgia.[12]

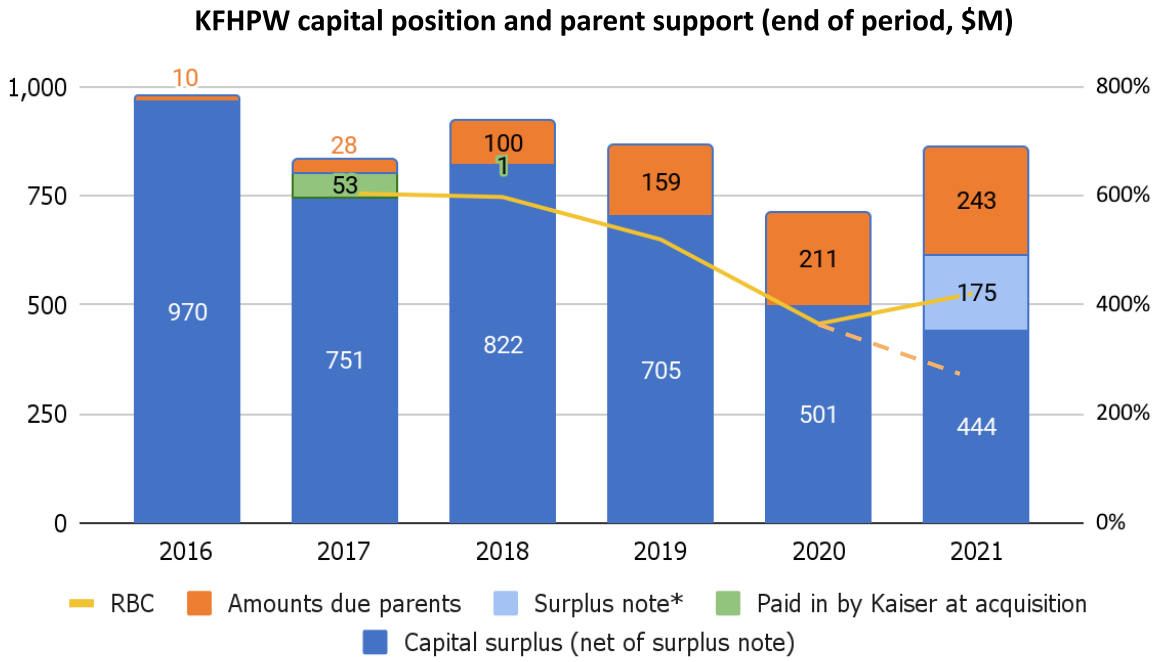

Figure 2. Kaiser Washington (KFHPW) finances increasingly precarious and needing parent help[13]

Statistical analysis of the drivers of net underwriting margin is one way to roughly size the importance of density (market share) and the ability of the local market to provide scale (measured as population within the target market) to support Kaiser's infrastructure heavy model.[14] See Appendix B for regression results. These two factors (plus a "dummy" variable for California[15]) appear to explain around 30-40% of the variation across all of Kaiser's regions between 2017 and 2021.

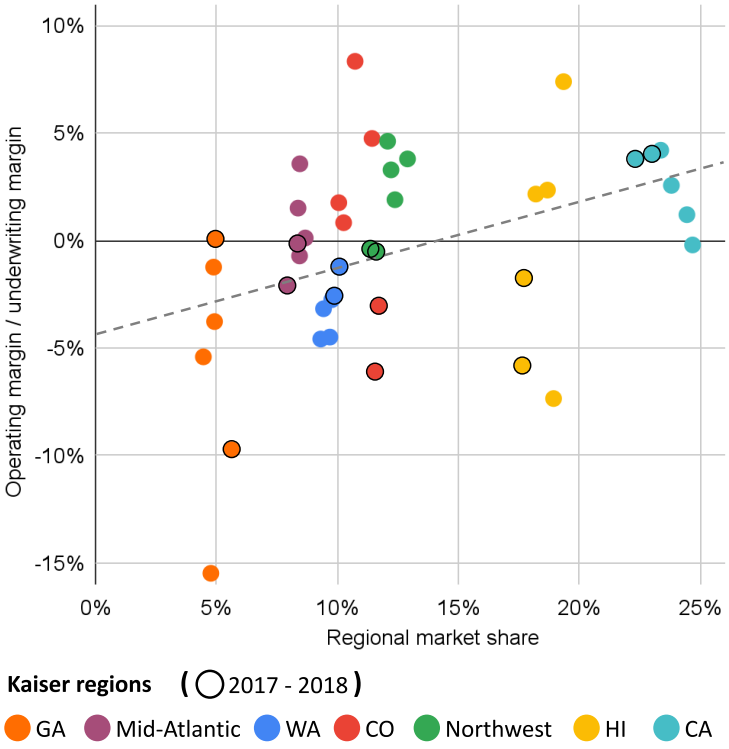

Figure 3. Performance of Kaiser at regional level appears linked to underlying market share[16]

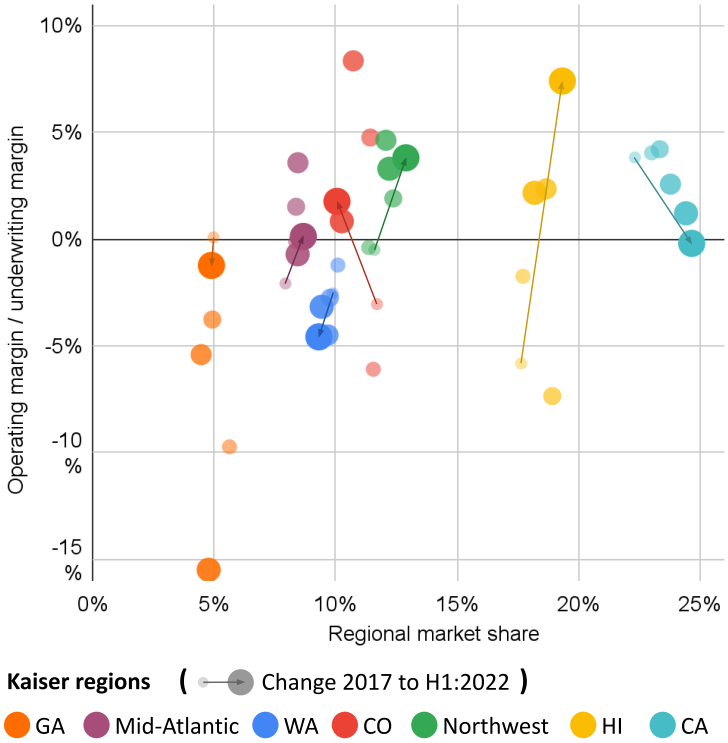

Figure 4. Performance of some Kaiser regions trending positively, California seems to be struggling

4. Converting an "iron law" into more flexible steel

While a lot of underwriting performance is effectively "engineered in" by market share and potential operating scale, there is still a lot of scope for local strategic choices. Although Kaiser was seeing underwriting losses pretty much everywhere outside of California in 2017 and 2018, there were some remarkable and sustained improvements since, especially in Northwest (Oregon) and Colorado starting in 2019 and in Hawaii in 2020 (though the initial positive trajectory may have been helped by Covid, it has accelerated in H1:2022 faster than in other regions).

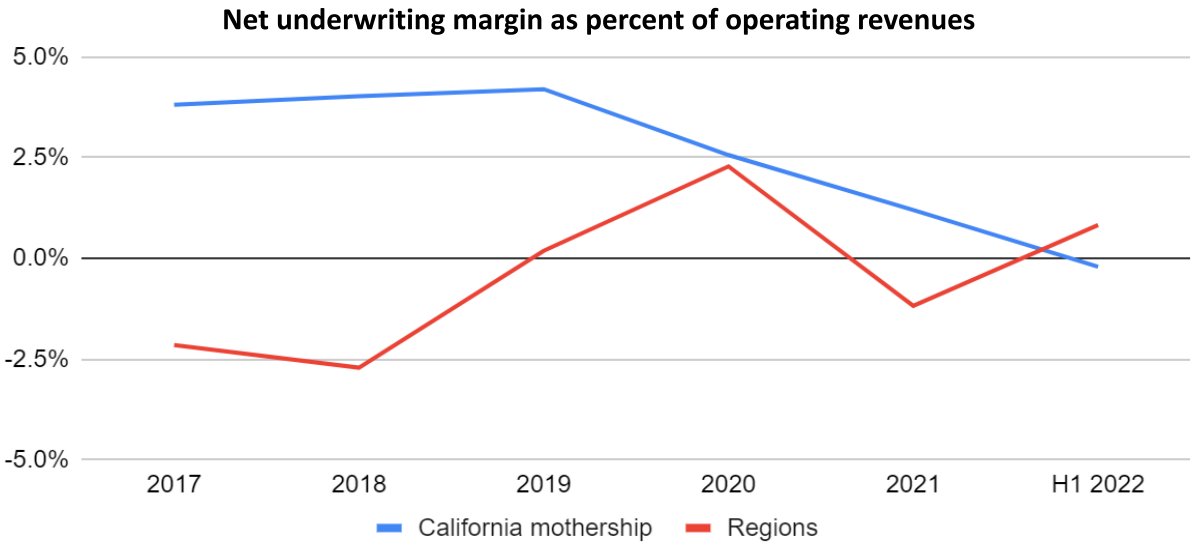

Figure 5. Net underwriting margin of Kaiser's regions improving while California sags after Covid

As a result, the economic drag that the regions have collectively placed on the Kaiser mothership has significantly decreased, which is a good thing as the mothership's economic performance has sagged significantly in recent years.

How did the regions which saw turnarounds in 2019 do it?

Broadly, it appears, through enhancing operations—improving the medical loss ratio with a combination of revenue increases and more tightly controlling medical costs and shrinking admin load—rather than fundamental changes in strategy. These changes increased net underwriting gain by $15 PMPM in the Northwest and a remarkable $60 PMPM in Colorado.

Change in key business metrics between 2018 and 2019
(all figures except membership are $ change in PMPM)

	Northwest	Colorado
Membership change (%)	2.1%	-2.2%
Operating revenues	$29	$38
Medical costs	$19	-$14
Admin	-$4	-$9
Net u/w gain [2018 actual ⟶ 2019 actual]	$15 [-$2 ⟶ +$12]	$60 [-$33 ⟶ +$27]

Figure 6. Kaiser achieved significant improvements in performance in key regions in 2018/2019

Let's take a closer look at the Colorado turnaround. Steps undertaken include:

- Exit from unprofitable Eagle and Summit counties (Frisco, Vail)
- Restructuring of the individual book of business with average premiums raised by 18% and membership decreasing by 16%
- Increase in premiums across other lines of business, albeit more modest (5% for commercial group products, 4% for Medicare Advantage on a PMPM basis) while keeping membership flat
- Sharply tightening medical cost management in commercial group (down 3% on a PMPM basis) and Medicare Advantage (down 5%)
- Reducing administrative expenses via a 20% reduction in salary costs through lay-offs, 30% reduction in marketing spend and 14% reduction across various other non-medical miscellaneous expenses.

The remarkable medical cost reductions no doubt required a lot of work—redesigning and increasing compliance with care pathways, reevaluating referral partners and repatriating specialist care back into the Kaiser system, increasing the capacity and performance of Kaiser's care delivery. This dramatic shift suggests two things: first, the Colorado care delivery arm (including the Permanente physician group) was underperforming and, second, significant efficiencies can be wrung out in a short time frame once the organization is galvanized. Cooperation on the part of Permanente with these changes must have been a critical prerequisite.

Within a single year, the aggregate net underwriting gain on commercial increased by $248M, on the Federal employee business by $25M and on Medicare by $133M. Since 2019, Kaiser Colorado has continued the "shrink to win" strategy, notably trimming commercial group lives but holding onto a positive underwriting margin.

Average premiums and medical costs across Kaiser Colorado LOBs 2018-2019

	Share of members 2019 (%)	Avg premium (PMPM)			Avg medical costs (PMPM)		
		2018	2019	% change	2018	2019	% change
Individual	15	379	445	18%	333	337	1%
Group	62	442	464	5%	432	420	-3%
Total commercial (Group + Ind.)	77	428	460	8%	410	404	-1%
Federal employees	4	590	637	8%	558	524	-6%
MA	19	916	955	4%	910	866	-5%

Figure 7. Kaiser's Colorado turnaround a combination of premium increases and medical cost cutting

5. Who is bringing the carbon to this steelmaking?

Another interesting feature of the turnarounds is leadership.

Traditionally, Kaiser has usually recruited in its California operations for leaders to run the regions. Recently, however, Kaiser has started to use outsiders more systematically:

Ruth Williams-Brinkley became president of Kaiser Northwest in 2017. Williams-Brinkley worked in a variety of integrated delivery systems including Carondelet Network in Tucson, Memorial Healthcare in Chattanooga and, immediately prior to her time at Northwest, as CEO of KentuckyOne.

Ron Vance became president of Kaiser in Colorado in 2018. Vance learned his trade at Cigna as a leader of strategic alliances and head of payer solutions and then as a turnaround consultant with Alvarez and Marsal.

Kim Horn, who oversees the regions for Kaiser, appears to have become enamored with the results.[17] She moved Williams-Brinkley on to become President of Kaiser Mid-Atlantic in 2020, and Ron Vance moved to Kaiser Hawaii at the end of 2019 and then was named interim President of Kaiser in Washington in 2022. And, most recently, Kaiser added a new member to this "turnaround team," naming Pamela Shipley as President of Kaiser in Georgia. Shipley came to this role directly from Sharecare where she was Chief Operating Officer for a few years and, prior to that, from Centene where she was SVP with market P&L responsibilities.

These outsiders seem effective at catalyzing quick improvements in operating performance and then moving on.

In those regions where Kaiser owns hospitals, it has since replaced the turnaround leadership with insider California veterans (in Northwest, Williams-Brinkley was replaced by Jeff Collins, a veteran of Kaiser's northern California operation and, in Hawaii, Vance was replaced by Greg Christian who was chief operating officer of Kaiser's southern California operation). In Colorado, however, where Kaiser partners for hospital care, it has backfilled Vance with another outsider: Michael Ramseier, formerly of Beacon Health Options and, perhaps more importantly, President of Anthem in Colorado. Perhaps Kaiser has hypothesized that California experience is more relevant for the long-term management of Kaiser operations that have direct hospitals, while more traditional health plan experience (Anthem, and perhaps Centene if Shipley stays in the Georgia role longer) is more relevant where they do not.[18]

6. Why is California performance sagging? A hypothesis

Kaiser's operating margin in California fell in 2020, coinciding with the emergence of Covid, and has declined steadily since, most recently becoming an operating loss in the first half of 2022. Could Covid be responsible?

Theoretically, in pandemic surges, plans should do better financially given the large slowdown in elective care while providers struggle, followed by something of a reversal as delayed care rebounds. Because Kaiser is both payer and provider, it should be (again, theoretically) hedged through this cycle.

But perhaps the hedging is imperfectly synchronized: Covid has hit hospital economics hard both during the pandemic (added costs to treat the pandemic while still needing to pay for the capacity idled by reductions in elective care) and since (with rapidly mounting supply chain and labor market costs).

Contract repricing delays have temporarily shielded payers from having to bear these costs (and left them stranded with the hospital systems). A vertically integrated model like Kaiser's would need to pay these rapidly escalating care delivery costs but would find itself confined by health plan competition from raising premiums correspondingly.

Kaiser in California could be stuck in such a cost vice since it has the largest and most comprehensive hospital infrastructure of any Kaiser region. Of course, Kaiser also operates hospitals in its Northwest and Hawaii regions which have seen better performance, so there may be other issues specific to California. But even if this hypothesis is only partially true, it suggests that other regions which broadly partner for hospital-based care (e.g., Washington, Colorado, Georgia and the Mid-Atlantic) may have been temporarily shielded from hospital cost surges by the same recontracting delays that most plans have enjoyed. It also suggests that California might also get some relief in the coming year or two as competing plans and providers reprice their contracts and plans fold these new rates into premiums.

7. Will this newly flexible steel bend back?

The initial success of regional turnarounds in Northwest and Colorado predated Covid, and all of the regions overseen by Williams-Brinkley and Vance have continued to have positive underwriting margins since their tenure. However, given Covid's continuing and complicated perturbations, it may be too early to conclude whether these changes were (a) "one-time" optimizations that will last a few years before costs start to bloat again, (b) permanent retreats from growth into "profitable cores" (e.g., what appears to be the Colorado playbook so far with sharp reductions in commercial membership) or (c) the foundations for stronger platforms capable of future sustainable growth.

The hybrid care delivery models in many Kaiser regions (own plan and providers but contracting for hospital care and thus decoupling Kaiser's cost structure from the hospital cost structure) likely created, as a result of natural delays in recontracting, buffers against the operating cost surge seen by hospitals. In time, Kaiser's hospital partners will seek new rates to reflect the new cost structures. But they will do the same with other plans as well, so presumably any hospital rate differential enjoyed by Kaiser can be preserved. Ironically, while hybrid models in the regions underperformed vs. the California mothership up until Covid, these same hybrid models were insulated from hospital cost structure shocks since Covid in ways that California was not.

In the coming months and years, the Kaiser hybrid operations will face some strategic choices about these partnerships: accommodate the increased rate demands, reshuffle the partnerships in search of a better deal, build their own hospitals (possibly) or aggressively pursue strategies to pull more care out of hospitals (e.g., hospital-at-home). The fact that the new executive leadership replacing the interim turnaround team (to date) in Colorado was a Kaiser outsider with a traditional health plan background offers some evidence that, in these markets at least, Kaiser will continue to outsource hospital care.[19] But the actual strategic choices will be demonstrated in time.

What is clear is that for the first half of 2022, the regions are collectively outperforming the California mothership, and for those regions which have been led by one of these outsiders for a few years, the underwriting economics remain positive. The regions that still saw negative net underwriting margins in the first half of 2022 (Washington and Georgia) saw leadership transitioned to outsiders in the past few months. That is quite a change from so many years prior when California was the one sending out the leaders and the capital backfilling checks.

Appendix A. Data sources and limitations

For this analysis, we relied on Annual and Quarterly Statement filings submitted by each of Kaiser's regional plans to the National Association of Insurance Commissioners (NAIC) and Kaiser's published reporting on their aggregate financials.

Kaiser's California operation does not submit comprehensive Annual Statements to the NAIC so the results for California are calculated as a residual of the aggregate results netted from the aggregated regional results. While this methodology is the only one available, it does have two issues:

- The costs of Kaiser's overall corporate infrastructure and any other costs not explicitly allocated out to the regions is implicitly loaded onto the California region. The administrative cost loads for each of the Kaiser regions are burdened with charges for services performed by Kaiser at the center so we presume the unallocated costs are mostly corporate infrastructure.
- The accounting methodologies used in Kaiser's aggregate public reporting may not precisely match those required by the NAIC in their reporting.

Therefore, the comparability of California's net underwriting margin vs. those of the regions should be regarded as high level.

Because the Permanente medical group and other care delivery assets (e.g., hospitals owned by Kaiser in California, Oregon and Hawaii) can (mostly) only treat patients covered by Kaiser, the Permanente revenues are captured as part of medical expenses in these reports. Each regional NAIC filing describes the financial flows between Kaiser the plan and Permanente the affiliated provider group. While it is possible in some markets that the care delivery operation serves other payers (e.g., the Washington provider group does see some Medicaid patients), these are marginal, and for the purposes of this analysis, we assume that the regional Kaiser (plan) financials provide a reasonable view into aggregate Kaiser economics.

Appendix B. An "iron law" of Kaiser economics

Statistical estimates of the value of member density and scale

We hypothesize that Kaiser's vertical model requires membership scale and density to be effective. We tested this idea using a statistical model through two primary predictive variables: Kaiser's local market share (as a fraction) and the total size of the market (for which we take the natural log to de-emphasize market sizes far past the range of critical mass). Our methodology below is not the only way to measure this relationship, but it is well-fitted for our purpose of estimating the relative amount of performance variability explained by these predictors.

Market share was estimated as the share of all lives (irrespective of insurance coverage) for which each Kaiser regional operation provides coverage in its service area. As Kaiser does not offer insurance coverage across all counties in the states in which each operation is active, we used data from CMS indicating where each Kaiser operation offered Medicare Advantage to determine which counties Kaiser provides coverage in, and we used Census data to calculate the population in each county each year. These county populations were summed to define the total market size each year for each Kaiser operation which is one of the variables included in the regression as well as the denominator for calculating Kaiser's market share.

We run a linear regression of underwriting margin across the 7 Kaiser regions for each year from 2017 to 2021 ($n = 35$) on these two variables, for which we expect positive coefficients (β_1 and β_2 below) to reflect advantages to scale. We also include a binary "dummy" variable for California to account for its unique relationship between market scale and underwriting performance.

$$(1)\ Underwriting\ Margin = \beta_0 + \beta_1 * Market\ Share + \beta_2 * \log_e Market\ Size + \beta_3 * CA$$

Model (1) explains about 34% of the variability in our sample of underwriting performance across Kaiser regions from 2017 to 2021, not accounting for any local management strategy or specific market dynamics. See Table 1.

Both market share and size are statistically significant, positive predictors of underwriting margin here. Percentage market share is associated roughly 1.2:1 with percentage margin. The negative estimated coefficient of the California binary (a 27 percentage point adjustment to margin) is consistent with the idea that our estimate for California's net underwriting results is a residual which includes the costs of the overall system management. It is also possible that regulatory floors on Medical Loss Ratio and diminishing returns to membership scale and density play a role.

Table 1. Effect of market scale on underwriting margin

	$Underwriting\ Margin$
$Market\ Share$	1.191***
	(0.003)
$\log_e Market\ Size$	0.182***
	(0.005)
CA	-0.272**
	(0.012)
$Constant$	-1.353***
	(0.004)
n	35
R-squared	0.342
Adj. R-squared	0.278

(p-values in parentheses)

*** p<0.01, ** p<0.05, * p<0.1

Can the value of turnaround management be statistically measured?

One common feature among the two most improved regions since 2017, Colorado and Hawaii, is that they were both led by Ron Vance. For fun, we tried sizing the value of outsider leadership within the model by introducing a binary "dummy" variable that indicates the years for which a given state was under Ron Vance's leadership ($Vance$ below).

$$(2)\ Underwriting\ Margin = \beta_0 + \beta_1 * Market\ Share + \beta_2 * \log_e Market\ Size + \beta_3 * CA + \beta_4 * Vance$$

This change alone adds a sizable amount of explanatory value to the model (from about 34% of the variance to about 55%). See Table 2. The predicted effect of Ron Vance leadership (β_4 above) is an additional 6 percentage points of underwriting margin holding constant the local market position. A bit divergent from the model's purpose of explaining the "engineered in" precedent for performance less local management strategy, but clearly indicative of a significant "Ron Vance effect."

Table 2. Effect of market scale on underwriting margin

	$Underwriting\ Margin$
$Market\ Share$	1.079***
	(0.002)
$\log_e Market\ Size$	0.197***
	(0.001)
CA	-0.262***
	(0.005)
$Vance$	0.064***
	(0.001)
$Constant$	-1.452***
	(0.001)
n	42
R-squared	0.545
Adj. R-squared	0.484

(p-values in parentheses)

*** p<0.01, ** p<0.05, * p<0.1

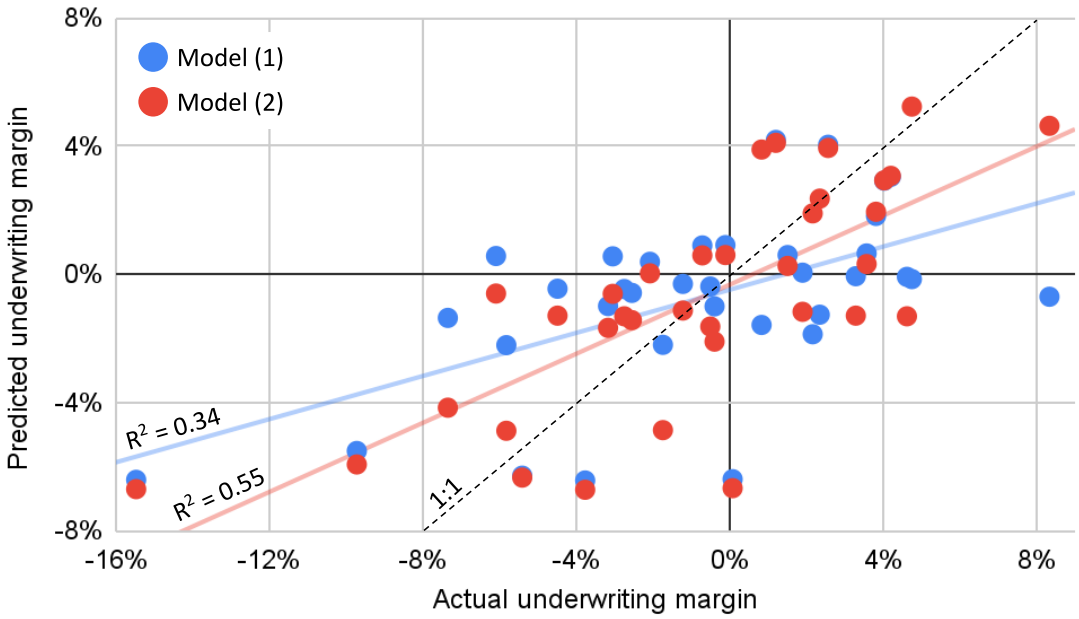

Figure 8. Regional net underwriting margin: predicted vs. actual values

Endnotes

[1] For brevity and simplicity, we will use the term "Kaiser" elsewhere in the paper to refer to both the integrated entity and to just the health plan arm (depending on context) and "Permanente" to refer to the care delivery arm. In fact, the legal ownership of various assets is more complicated with the Kaiser side of the business owning significant portions. However, the legal specifics are not essential here and we should assume that, in general, both the plan and the care delivery arms of the organization are effectively operating in strategic and tactical alignment.

[2] The mutually exclusive feature of Kaiser's model is important and explains why other vertical models such as UPMC which are not mutually exclusive (UPMC as a provider contracts with other health plans and UPMC the plan contracts with other providers) can succeed at smaller scales than Kaiser.

[3] Mostly focused on a set of counties in Oregon around Portland but also overseeing two counties, Clark and Cowlitz, in southwestern Washington state.

[4] Includes Washington, DC, selected counties in Maryland and selected counties in Virginia.

[5] Kaiser came to terms with Group Health in 2015.

[6] We focus here on net underwriting margin or operating margin as a metric of operational performance which does not include investment income (or, more recently, losses).

[7] Regional economics are derived from individual filings with the National Association of Insurance Commissioners (NAIC) for the Kaiser (insurance) operation. See Appendix A for more detail.

[8] Mary Wilson (who was Medical Director at Kaiser's Panorama City Medical Center in Los Angeles) as Executive Medical Director of Southern Permanente and Julie Miller Phipps (formerly running Kaiser's operation in Orange County) as President of Kaiser both in 2015. Subsequent leadership changes (e.g., Jim Simpson, SVP of Kaiser finance in California became President of the Kaiser Foundation Health Plan of Georgia in 2017) continued to draw from California talent.

[9] GH came to terms with Kaiser in 2015. GH's model looked a lot like Kaiser in terms of vertical integration of plan with aligned care delivery but lacked "Kaiser-grade" local market scale. They were in retreat, however: closing an owned hospital in Redmond in 2008, closing hospital services in its flagship Capitol Hill campus in Seattle after signing a deal with Providence in 2014, and starving the rest of the system of capital investments (in facilities, in computer systems, etc.).

[10] Kaiser in Washington has, as a result of the GH acquisition, a subsidiary affiliate called Options which offers a PPO product centered on Kaiser's network and reports out business operations separately. While Kaiser core HMO membership has floated between 5.1M and 5.2M since 2018, the Options membership has declined from 2.0M to 1.8M in 2021.

[11] Kaiser's California operation does not report results to the NAIC. Results for California are estimated as a residual by subtracting the operating results for individual regions from Kaiser's total financials. This residual will comprise both the California operation and all the headquarters expenses overseeing all of Kaiser. Given differences in data sources and this analytical strategy, the estimates should be regarded as pretty rough.

[12] 2017 was the one year it broke even (0.1% underwriting margin as a percent of operating revenues) while otherwise generating underwriting losses every other year over the past decade. Also, in 2018, Kaiser's HMO operation in Washington broke even but its sibling PPO business saw a net underwriting loss, so the overall Washington business was unprofitable.

[13] Surplus notes are issued by Kaiser parent to the Washington operation but subordinated to other liabilities so are considered capital for RBC calculations; "RBC" = Risk-based capital ratio. Average health insurance RBCs run between 600-700%. If levels fall below 200%, regulatory review can be triggered. RBC ratio in KFHPW was 422% at EOY 2021. It would have been 300% without the Surplus Note. Source: NAIC filings, Recon analysis.

[14] The importance of potential operating scale (measured as lives in each market) helps explain why in Hawaii, where Kaiser's share is closest to California's, a positive net underwriting has been difficult to sustain.

[15] Likely significant because of a variety of potential factors such as (1) the California net underwriting results include the costs of the overall system management, (2) regulations and perhaps Kaiser's non-profit status place ceilings on profitability which might otherwise be achieved and (3) the relationship between underwriting margin and market share and market potential are not strictly linear.

[16] Market share is calculated by region by year as the ratio of Kaiser lives to the total population in counties served by Kaiser MA plans with more than 10 enrollees. Source: NAIC filings, Recon analysis.

[17] This is perhaps not surprising given her background. She herself came to Kaiser as an outsider having been CEO of Priority Health before being recruited to run Kaiser Mid-Atlantic for 8 years and before ultimately being promoted to oversee all the regions.

[18] Given her time at Centene, it is also possible that Shipley may help Kaiser take on a larger role in Medicaid in Georgia as well.

[19] A further indication that Kaiser sees its operations in Colorado and Washington as distinct from others is the recent creation of a new board apparently to oversee the integration of the affiliated Permanente medical groups from each region into a single foundation (per reporting in Becker's). It remains unclear, as far as we can tell, to what extent the new structure will supplant the traditional Permanente governance in the regions. Given the importance of transformation within Permanente to improve performance, it does appear that this new structure provides Kaiser with enhanced control over its physician partners to drive the kind of changes that yield the kind of improvement in medical costs seen in Colorado in 2019.

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