

**An inventory of health plan offerings at academic health centers in the United States:
A technical report**

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Abstract

Introduction

Employee wellness is a topic of great interest to academic health centers (AHCs) towards which they dedicate valuable resources. Wellness has been associated with access to employer-sponsored health insurance. Yet, there is sparse coverage in the literature about the health insurance plans that AHCs offer their employees. In this inventory, the authors identify health plans offered to AHC employees to create a baseline understanding of plan offerings and to propose a common language for discussing and studying these plans.

Methods

In 2020, the publicly accessible benefits websites of 85 AHCs in the United States were reviewed to identify the health plans offered by each AHC to their own AHC employees. From each website, the authors extracted the type of insurance plans offered; any mentioned insurance companies; health plan names, names of third-party administrators (if applicable), and links to plan documents. Based on the extracted data, each AHC was assigned a model based on their health plan offerings.

Results

The 85 AHCs, of which 55 were state institutions and 30 private institutions, offered three primary models of health plans: self-insured plans (n=39); fully-insured plans (n=33); and state-based plans (n=25). Twelve AHCs offered multiple health plans with eight providing both a fully-insured and a self-insured option. For those offering self-insured plans, 36 partnered with a third-party administrator to provide logistic support (e.g., claims processing) and provide an expanded provider network. Three self-insured AHCs relied on a university-affiliated administrator. The majority of AHCs (n=76) offered employee wellness programs.

Discussion

This article characterizes AHCs based on the health plans offered to their employees with the most prevalent being self-funded plans. This information fills a gap in the literature, by providing a baseline understanding of plan offerings that can be utilized for future discussion and studying of AHCs, including in relation to wellness.

Introduction

In the United States (US), employers with more than 50 full-time employees are required by The Patient Protection and Affordable Care Act (ACA) of 2010 to provide their employees with health insurance or face penalties.¹ Today, over 157 million individuals in the US are covered by employer-sponsored health plans.² As large employers, academic health centers (AHCs) offer their employees health plan benefits. Access to employer-sponsored health insurance has been associated with employee wellness,³ an issue of great importance to AHCs. Yet, the literature provides sparse coverage about the health insurance plans that are offered to AHC employees. In this inventory, we aim to identify health plan offerings at AHCs in order to create a baseline understanding of plan offerings and to propose a common language for discussing and studying these plans, especially amongst AHC executives, administrators and researchers in order to ultimately improve wellness and population health.

AHCs are described as “academic institutions that include a medical school, one or more additional health professions schools or programs, and an owned or affiliated hospital/health system”.⁴ AHCs are often anchor institutions in their communities, commonly employing tens of thousands of individuals as the AHC works to achieve success in their missions of patient care, research, education, and community engagement.⁵ As a benefit of employment, AHCs offer their employees health insurance. For example, employees at Vanderbilt University are provided a choice of two Aetna health plans,⁶ and at the University of Florida employees may choose from health plan options provided by the state of Florida or select GatorCare, a health plan self-funded by the University.⁷

Access to health insurance has been associated with wellness. Researchers have identified that health insurance confers a myriad of benefits to health plan enrollees, including those related to health outcomes for specific health conditions, overall health, and mortality.^{3,8-10} Wellness is an important topic for AHCs as evidenced by their investments in wellness programs. For example, at University of Utah Health employees can enroll in WellU Employee Wellness Program, which provides access to nutrition and health coach consultations, personal training, and a range of health-focused educational offerings.¹¹ To further support wellness, AHCs have begun hiring wellness leaders into their executive ranks. In 2017 Stanford Medicine was one of the first AHC to create a chief wellness officer position and since then 20 additional organizations have followed suit.¹²

This emphasis on wellness and its relation to health insurance suggests a need to understand the health plan offerings at AHCs. A better understanding of how AHCs provide health insurance to their employees can inform and contribute to AHC wellness efforts and allow for informed cross conversations between AHC executives, administrators and future researchers. Yet, little is published in the literature about the specifics of how AHCs provide health insurance and related wellness programs to their own AHC employees. While researchers have broadly examined employer health plans,² information specific to AHCs is absent. For example, the Robert Wood Johnson Foundation published a report of self-funded health plans in the US, which describes the specifics of that particular type of health plan, but the report does not take into consideration other offering types and does not focus on AHCs.¹³ For these reasons, we set out to inventory the

health plans made available to AHC employees across the US to identify and characterize the health plan models offered at AHCs and the related wellness programs.

Methods

Data collection

In 2020, we reviewed the publicly accessible benefits websites of AHCs to identify the health plans offered by each AHC to their own AHC employees. In this process, we did not review the benefits information of employees of affiliated hospitals. Thus, the benefits of hospital employees that do not receive benefits directly from the AHC or its partner university are not included in this study. On each website, we focused on the insurance benefits information present on the webpages and any available insurance policy documents, such as statements of benefits, for the most recent year available. If insurance information was unavailable from the AHC's website, the affiliated university's benefits website was accessed using the same approach (For a complete listing of all reviewed sites see Supplemental Appendix A). This data was checked for any changes in August 2021. As this study was a review of AHC websites, we did not seek review by an institution review board or seek consent from the websites.

For each health plan offered by an AHC, we extracted details, including, but not limited to the type of plan offered; any mentioned insurance companies (e.g., Aetna, UnitedHealthcare); health plan names (e.g., Trojan Care at the University of Southern California), names of third-party administrators (if applicable), and links to plan documents. We also identified if an AHC offered employees a wellness program as defined by health.gov,¹⁴ an incentive for participating in the program, and if employees were invited to complete a health screening.

Site selection

Our inventory focused on AHCs based in the US that were members of the Association of Academic Health Centers (AAHC) in 2018 (n=86) (See Appendix A for a complete member listing). The AAHC is a 501(c)(3) non-profit organization that advances health and well-being through the vigorous leadership of AHCs. Included AHCs represented a broad range of organizations based in 35 states and the District of Columbia, all of which were affiliated with a school of medicine, either allopathic or osteopathic, and a teaching hospital. As our intent was to understand the types of health plan models present in American academic health centers (AHCs) versus characterize all of the AHCs in the US, we did not aim to create a comprehensive data set. Instead, we worked towards data sufficiency, which is the point at which we could derive a clear and coherent understanding of key models and could identify no additional nuances or insights.^{15,16} We felt that we reached data sufficiency well within the 85 AHCs reviewed.

Data synthesis

We compiled the details of the plans offered by each AHC in an Excel spreadsheet. We reviewed the data and assigned a working classification of each AHC based on their health plan offerings. We met via conference call several times to refine and define the classifications resulting in a proposed set of health plan models and related definitions.

To ensure relevance, in May 2020, via conference call, we presented our preliminary classifications and definitions to the AAHC President's Council on Health Plans and Population Health. These 10 external stakeholders included CEOs from 10 AHCs located throughout the

US. Council members briefly reflected on the inventory and informally discussed whether the models corresponded with their experiences leading AHCs. Their feedback informed minor refinement of final models and our thinking on the potential implications and uses for the models.

Results

We obtained health plan information for the employees of 86 AHCs. Based on our review, we excluded the Uniformed Services University of the Health Sciences, a federal institution that is unique in that it offers benefits through the US government. Thus, our models are based on 85 AHCs. Of these AHCs, 55 were state institutions and 30 were private institutions. In the minority of cases (n=18), we identified insurance information on the AHC website. For the majority of plans, we expanded our search to the affiliated university's website. For example, the University of Rochester Medical Center's website links to health benefit information on the University of Rochester's main website.¹⁷ Thus, these models are applicable in the majority of cases to the university at large. In two instances, we were unable to access health plan information for the AHC or their parent university via websites. Thus, we requested and received the information from the benefits department of the two AHCs.

Overall 76 (93%) of AHCs offered employee wellness programs. Of these programs, 44 offered health screening for participants. Thirty-two programs provided incentives for participating, which included direct cash payout, deductions in healthcare premiums, and funds for additional wellness experiences (e.g., massages, fitness class fee waivers). In two instances, we were able to locate outcomes data on the websites examined. For example, the University of California System's website on wellness links to a systemwide WellBeing Report¹⁸ which includes outcomes data on vaccination rates, well-care visits, and screening for the last three years. It is unclear if participants included in the report participated in the wellness programs offered by the University system. Stanford University provided two self-report outcomes on its wellness website related to the program's impact on healthy lifestyle changes and the employee's work experiences.¹⁹

We identified that AHCs offered three models of health plans: fully-insured plans; state-based plans; and self-insured plans. See Table 1 for descriptions of each model and their frequency and Table 2 for a summary plan models offered by risk posed, administration, and information access. Notably between 2020 and 2021 we did not observe changes in the models offered by the included AHCs.

Table 1: Descriptions of health plan models offered at 85 academic health centers (AHCs) in the United States and the number of AHCs offering the model

Model	Descriptions	Count* of AHCs offering the model
Fully-insured	The AHC contracts with a health insurance company at a fixed premium cost generally based on number of employees enrolled.	33

State-based	AHC employees have access to health insurance through an arrangement controlled by the state in which the AHC is located.	25
Self-insured	The AHC self-funds the healthcare plan made available to their employees and contracts with a third party administrator to administer benefits.	39

*The number of AHCs do not sum to 85 as 12 AHC offered more than one model

Table 2: A summary table of plan models offered at academic health centers (AHCs) by risk posed, administration, and information access

Model	Financial Risk	Plan Administration	Information Accessibility
Fully-insured	Insurance company	Insurance company	Insurance company
State-based	State	Variable*	Variable*
Self-insured	AHC	Third-party or affiliated administrator	AHC

*We observed that states selected a variety of third party administrators, however, we deemed an analysis of these administrators to be beyond the scope of this project.

Twelve AHCs offered employees a choice of health plan models: eight AHCs provided a fully-insured plan and a self-insured plan; two AHCs provided a state and fully-insured options; and two AHCs provided state and self-insured models. For example, the University of New Mexico Health Sciences Center offers employees the option of the fully-insured plan through Presbyterian Health Plan or the option of UNM LoboHealth, a self-insured plan.²⁰

Fully-insured model

Thirty-three AHCs offered their employees traditional fully-insured plans. In this model, the AHC or affiliated university contracts with a health insurance company, at a fixed premium cost generally based on the number of employees and dependents enrolled. The contracted insurance company administers the plan and takes on the financial risks of paying healthcare expense claims made by covered individuals. By frequency, the top insurers providing fully-insured health plans to AHCs included: BlueCross products (n=16), Kaiser Permanente (n=7), United Health Care (n=5) and Aetna (n=5). Several AHCs providing this model offered employees a selection of health insurers. For example, employees at Georgetown University were offered the choice of plans from BlueCross, United HealthCare, or Kaiser Permanente.²¹ Thirty-one of these AHCs offered employee wellness programs. Of those programs, 21 included the option to participate in health screening with the majority featuring an incentive to participate (n=19).

State-based model

Of the 55 state AHCs, 25 of them provided employees the state-based model. In this model, health insurance is provided by the state in which the AHC is located with the state determining how the benefits are administered and their cost. For example, the University of North Carolina at Chapel Hill offers its employees the North Carolina State Health Plan for Teachers and State Employees.²² The AHC does not take on the direct financial risk of paying their employees' healthcare expense claims and does not bear the burden of administering the plan. For many AHCs offering a state-based model, detailed information about health benefits, including open enrollment, is provided on the state's websites. It was beyond the scope of this project to investigate the models of health plans offered by each state. In 23 instances, these AHCs offered wellness programs with nine of the programs offering a health screening and incentives to participate.

Self-insured

Thirty-nine AHCs offered health plan benefits to their employees with the self-funded model. In this model, the AHC takes on the financial risk of paying the healthcare expense claims of covered individuals. Within this model, we observed that the majority of AHCs (n=36) contracted with a third-party administrator (TPA) to administer plan benefits. The TPA provides the AHC a variety of support options, ranging from managing logistical tasks (e.g., claims processing, providing customer support) to extending provider networks. For example, LSUFirst, a health plan offered by Louisiana State University, has contracted with WebTPA to provide logistical support to its employees and with Aetna Signature Administrators to provide employees with coverage when out of state.²³ For AHCs offering this model, the majority contracted with major insurance companies to be their TPAs, with BlueCross being the most prevalent (n=20). Other major insurance company TPAs included Aetna (n=9) and UnitedHealth Care (n=5). Four AHCs partnered with TPA companies designed to provide logistical support only. For this model, we found that plans were often branded in alignment with the AHC using its name, logo, and/or mascot for websites and plan documents. For example, the University of Florida self-funds GatorCare, which leverages the name of the university's mascot.⁷ In three cases, AHCs offered a self-insured model with a university-affiliated administrator: Loma Linda University,²⁴ University of Pittsburgh,²⁵ and Yale University.²⁶ In this model, the plan is administered by an entity related to the AHC. For example, the Yale University offers its employees Yale Health, which is affiliated with the University. Nearly all self-insured plans offered employees wellness programs (n=31) with 21 of those programs providing personal health assessments opportunities and 19 featuring incentives to participate.

Discussion

In this inventory, we identified and classified health plans offered to AHC employees to create a baseline understanding of plan offerings and to propose a common language for discussing and studying these plans. Examination of health plans at 85 AHCs revealed that they can be classified based on financial risk, plan administration, and information accessibility, and fall into one of three general models: self-insured, state-based, and fully-insured. We also identified that almost all included AHCs offered employees wellness programs regardless of the insurance model offered.

Thirty three AHCs offered their employees health benefits using fully-insured plans in coordination with insurance carriers. This model affords the AHC the benefits of less direct financial risk and provides the stability of annual fixed costs. Additionally, the insurer bears the overall administration of the plan. While this model can be advantageous for AHCs, there is a wellness opportunity cost. In the fully-insured model, health claims data are processed and tend to be owned by the insurer. Thus, this valuable data may not be readily available to the AHC. This has the potential to hamper the AHC's ability to self-monitor the overall health of its employees, which may have implications for understanding employees' needs and measuring the impact of health interventions.

Twenty-five AHCs offered their employees health benefits using a state-based health plan model. This represented just under half of all public AHCs in the sample. As noted, in many cases, the health benefits information for employees was based on external websites maintained by the state and its health plan processes. Similar to the full-insured plans, this may have implications for the sharing of claims data for interventions such as wellness programs. Notably, policy makers have highlighted the importance of health wellness programs for state employees because when compared to the private sector, state employees tend to have longer than average tenure in their positions suggesting that such programs may provide additional overall benefits for wellness and population health.²⁷ While it was outside the scope of this project, future researchers might consider more deeply exploring the state-based offerings to better understand the specific models provided. For example, 48 states provide state employees with a least one self-funded plan option and 29 states self-fund all available health plan options²⁸ for their employees. This suggests that self-funded plans may play an even larger role in the health plan landscape of AHCs than we have captured in this inventory.

The self-insured model was the most prevalent offering with 39 AHCs using this option to provide their employees with health benefits. This finding aligns with national data. In the US, companies with more than 200 employees cover 80% of their employees with self-funded health plans, and more specifically in healthcare, 74% of employees.² Additionally, since the passage of the Affordable Care Act and its emphasis on population health, more hospital and health care systems have moved towards self-funded plans and increasingly considered purchasing health plans themselves.²⁹ However, the large majority of those AHCs in our inventory offering self-funded plans were partnered with unaffiliated TPAs. Only three AHCs utilized an affiliated administrator. To better understand this trend, future researchers should consider engaging with AHC leaders to explore their perspectives on pursuing health plan ownership and to better understand the benefits of contracting with an unaffiliated TPA.

Many employers, including the large majority of AHCs examined in this study, have implemented wellness programs to improve employee health and consequently reduce medical costs.³⁰ Today, these types of programs are offered to over 50 million Americans.³¹ For example, the University of Illinois Urbana-Champaign offers its employees iThrive, a multifaceted wellness program. The University assesses the program's efficacy by analyzing health insurance claim data, in addition to other data sources.³² In 2020, the University learned that the program participants as compared to non-participants showed no significant differences in their utilization of health care, biometrics, or medical diagnoses.³³ These findings also align with a recent randomized controlled trial that investigated workplace wellness programs over a three-year

period at a retail business finding that there were no significant differences in self-reported health, clinical outcomes, or health spending.³⁴ However, although the findings in the literature are negative, they are still valuable such that they provide an evidence base to enable an informed approach for modifying existing programs or developing future initiatives to advance wellness among employees. Without access to health claims data, this evidence base is difficult to assemble.

Limited outcomes data were accessible. We encourage AHCs to consider making this information available in the future to facilitate research and to also inform health model participants. More specifically, due to the limited available outcomes data reported for AAHC wellness programs, we were unable to draw comparisons between the offered insurance models. Researchers could consider undertaking additional studies, such as case studies to closely examine and compare the characteristics and outcomes of AHCs in each model in relation to cost, quality, and access. These case studies could integrate data from a variety of sources (e.g., wellness program health screening data, qualitative interviewing of AHC administrators and employees) to provide a holistic understanding of the three identified models and allow for comparisons between them.

Our inventory had several limitations that must be considered when interpreting our results. First, we primarily focused on publicly accessible materials. It is possible that additional materials are available only to AHC employees. Second, we focused on AAHC members. While AAHC membership provides a broad range of AHCs located throughout the US, it does not represent every AHC in the US. However, we do believe that we reached information sufficiency such that the models identified are representative of the major models available at US AHCs. Third, health insurance offerings at AHCs are subject to change. Our findings are current as of August 2021. We did not include offerings for employees of affiliated hospitals that were not directly insured by the AHC or its partner institutions. To expand our findings, researchers might consider including this population. Finally, we were unable to examine the efficacy of these models.

Conclusion

Based on an analysis of 85 AHCs, we have presented three models of health plans offered to AHC employees. We propose that this inventory fills a gap in the literature, creates a baseline understanding of plan offerings, and provides a common language for discussing and studying these plans. As wellness has been associated with access to health care and is a topic of importance to AHCs, we briefly discussed the implications of these models in relation to wellness and considered how this new knowledge of how AHCs insure their employees could be leveraged in future research and practice.

Acknowledgements: None

Funding/Support: None

Other disclosures: None

Disclaimer: The views expressed herein are those of the authors and do not necessarily reflect the official policy or position of the Uniformed Services University of the Health Sciences or the United States Department of Defense.

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