Healthcare providers take on the payor role

The strategy for providers depends largely on the market

Battles between care deliverers and insurers over who should own the various pieces of the U.S. healthcare value chain are nothing new. To take just one example, aspiring integrated delivery networks (IDNs) have for decades looked at health system acquisition, integration, and management of “the doctor piece” of the healthcare value chain as the holy grail of a successful healthcare organization. An equally disruptive period of value-chain struggles is now under way, as the IDNs try to combine clinical operations with taking on risk traditionally borne by payors, or “the insurance piece.”

Understanding how (and why) earlier battles were waged and taking a closer look at what actually constitutes the insurance piece provide some perspective for IDNs contemplating the move — and for insurers that may fear it. Past examples of healthcare systems that successfully became IDNs, such as Sentara Healthcare, which serves Virginia and parts of North Carolina, and Scott & White, which serves central Texas, indicate that a couple of factors are critical if a healthcare network is to take on the role of insurer in addition to that of provider: The market has to be just the right size, and the competitive dynamics have to be the best in that market. Only if those factors are in place is an IDN in a position to compete head-to-head with insurers.

The U.S. healthcare industry in the 1960s and 1970s absorbed two major shocks almost simultaneously: the introduction of the Medicare and Medicaid programs and the commercialization of big innovations in the science of care, including medical devices such as CAT scanners, new antibiotics, and lasers. Rapid expansion was the necessity, as the number of citizens covered by health insurance and the range of services exploded. As the dust began to clear, though, attention became focused on organizing the system rather than just expanding it. With Kaiser Permanente as a model for a fully integrated system that employed the doctors and owned the hospitals and the insurer, the concept of the IDN emerged as a similar structure that local and regional provider systems could pursue, beginning, in most cases, with hospitals acquiring and/or hiring their own physicians. This period is littered with CEO casualties — some of these leaders merely floated the idea and lost their posts faster than you could say “corporate practice of medicine” (the shibboleth
of the day). Many of the earliest successes came from the opposite direction; though doctors and patients alike tended to view hospitals as business entities more concerned with profits than patient care, it was far less controversial for established doctor groups to acquire hospitals. A number of well-established IDNs were formed this way, including Pennsylvania’s Geisinger Health System and Texas’s Scott & White, which recently merged with Baylor Health Care System.

A few visionaries in the 1970s, though, did succeed in adding the doctor piece to their hospital organizations. These leaders, many of whom trained together at the University of Minnesota, held strong beliefs that health maintenance organizations were, ultimately, the answer. The doctor piece was a necessary first step — and these visionary leaders were not shy about saying that insurance was also a piece of the value chain that would be needed for an integrated delivery and payment system. Sentara Healthcare, which started a managed care plan in Norfolk, Va., and the surrounding area in 1984, was and is a leading example of this approach, offering a health plan alongside its integrated hospitals and doctors.

But building an IDN by starting with the doctor piece or by adding it to an established hospital system led by a visionary doesn’t tell the full story. Market size, location, and population density were critical factors in the success of many of these early (and now mature) IDNs. The diversity and vigor of competition, along with branding strength, were also crucial determinants. To oversimplify a bit, many of these markets met these criteria:

• In cities with populations of more than 100,000, but not major metropolitan areas
• Insulated from outside competition, but accessible to outlying referral markets
• Competitive, but with a dominant player that has a superior brand (whether doctor-driven or hospital-driven)

Of course, IDN formation was almost never easy and intangibles such as trust and open communication were also vital to success. But by the early 1990s, IDNs had reached a tipping point and virtually every hospital began hiring/acquiring doctors as part of their IDN development.

**Accountability for patient care is key**

Looking back, though, the compelling argument for combining the doctor and hospital/facility segments of the value chain was *accountability*. Quality was the original driving value for IDNs; cost later became equally important. But integrating and controlling all key aspects of care was always critical to success as well. The IDN needed to be accountable for all of the patient’s care, not just the portion that took place in a hospital facility. Most of the leading systems that emerged and consolidated starting in the 1980s succeeded using this approach.

Accountability will also drive the development of the new battle over the healthcare value chain. Now that the battle is focused on the insurance piece, the continuing maturation of IDNs is being turbocharged by mandates and incentives around population health rather than aggregate, transactional underwriting (one of the key capabilities of insurers). This trend, combined with sophisticated and interoperative information technology, is changing the nature and calibration of the value chain. Traditional insurance underwriting will always have a role, but IDNs are influencing underwriting parameters and actuarial factors through their bedside and population-based care management, including prevention, especially in markets where mature
IDNs are making good on the promises of their business model and their new capabilities. IDNs that effectively manage care and prevention should reap the benefits of that performance — not only in payment for care rendered (“price taking”), but also in money saved by keeping their members healthy and providing the right level of coordinated treatment.

But just as market structure and competitive dynamics shaped the first major shake-up of the value chain, so too will they factor into the coming battle. Further, emerging regulatory models make providers increasingly accountable for cost — transactional and overall. If traditional underwriting is less relevant, then what is the best response for IDNs?

The maturation of IDNs is being turbocharged by mandates and incentives around population health.

We believe that market structure and dynamics provide a good first-cut basis for assessing overarching payor strategies for individual IDNs. The lessons from the doctor piece apply, along with some other initial rules of thumb.

• The same markets that were most amenable to consolidating the doctor piece will be most conducive to consolidating the payor piece. They are nearly self-contained, are of moderate size, and have at most two well-branded players.

• Large, urbanized markets will defy efforts at dominance because of the complexity of travel and commerce patterns and the range of competitors.

• Smaller, largely rural markets lack critical mass and develop as satellite referral areas, perhaps less amenable to even basic IDN features.

Clearly, many of the medium-sized “Goldilocks” markets that gave rise to some of the earliest and most successful IDNs will see some of the most rapid and effective consolidation of the payor piece. Here, IDNs can be truly accountable for care and cost — and want to be. They will work with insurers and others to buy or lease the administrative capabilities they need, but they might develop new relationships for actuarial and underwriting services.

However, there aren’t that many just-right markets; perhaps 200 or so exist in the United States. For that reason today’s insurers are likely to continue to play major roles, particularly in more complex and urbanized markets. Intermediation may be the name of the game in such markets. Since urban IDNs will struggle mightily to find large, coherent, and stable patient bases, customers will need products that allow relatively free flow across providers. This is precisely what health insurers have always done and done well (in addition to underwriting). Insurers could, for example, stitch together best-of-breed, all-inclusive “products,” such as open-heart surgery or joint replacements, and make them available to all comers in a given market. However, if delivery systems can provide truly superior cost/quality/engagement value for consumers through bundled care products, they will likely be a part of the “risk play” around these products. The new clinical IT systems across IDNs...
in large markets will probably present as many challenges as opportunities while the workaday reality of interoperability is tested. Until a massive wave of even greater provider consolidation occurs, New York, Chicago, and other major urban markets are likely to be good places for insurers to assert their historical capabilities.

With accountability comes risk, of course. There is no guarantee that IDNs that add the payor piece will succeed. Those that do succeed will profit. Those that don’t will provide valuable lessons to us all. Similarly, insurers that find profitable ways to serve the emerging IDNs will succeed — whether their efforts involve a scaled-back range of services or a new focus on intermediation and customer service. The U.S. healthcare system isn’t at risk of losing its pluralism anytime soon.