



Several hundred health networks will become payors

“We shag every fly ball a health plan hits to us — an ACO here, a bundle experiment there. We were naive to believe that a series of joint ventures would result in some new Kaiser Permanente. Maybe it’s time we take the plunge and become an insurer ourselves. After all, we now have less than 10 percent of our volume at risk, and we know it needs to be upward of 60 percent over time.” — Health system CFO

This quote — from an actual CFO — neatly sums up the current stance of most healthcare providers. They are struggling mightily with the exploding implications of reform, which is leading to new segments, new channels, and changing economics. Pricing pressure is now the dominant trend in the healthcare world, as accountable care organizations (ACOs), public and private exchanges, and Medicare and Medicaid expansions continue to squeeze provider margins. Some providers addressed this challenge a decade or more ago. Kaiser Permanente fully integrated across both payor and provider sectors, and large integrated delivery networks (IDNs) with regional and national pull, such as Mayo Clinic, Geisinger Health System, and Sentara Healthcare, established their own successful HMOs.

Most larger IDNs are now developing ACOs, but with limited prospects for at-risk arrangements to account for more than 10 percent of their revenue in the short term. That is simply not enough to meet increasing pressures on providers to better manage care. The balance is further skewed by the rise of retail and consumerism, putting providers on the front lines of customer service.

A further shift in the balance of risk and reward among payors and providers is the new concept of bundles. In their strongest form, bundles are end-to-end, intensively managed care protocols that are offered at a fixed price with outcome warranties. Our surveys show that the demand side is ready for bundles — with consumers and employers receptive to and even eager about the concept. On the supply side, early results suggest savings of 20 percent or more, especially when high-cost, high-volume procedures are implemented first. Although payors are often willing participants, providers are leading the charge into bundled care. Yet in the traditional healthcare model, payors would reap the lion’s share of the gains from year to year. In a world with declining real prices, the opportunity for providers is significant, and the question is this: How will the gains from care management (versus global underwriting) be distributed?

In the current environment, we believe that many IDNs will respond by taking on the role of payors, reflecting their ability to improve care management, their need for improved margins, and their direct relationship with consumers. Reportedly, some 50 percent of U.S. health systems have applied — or intend to apply — for an insurance

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license. These IDNs will effectively shift from “price takers” in a traditional fee-for-service model to “risk takers,” allowing them to better capture value (see Exhibit 1).

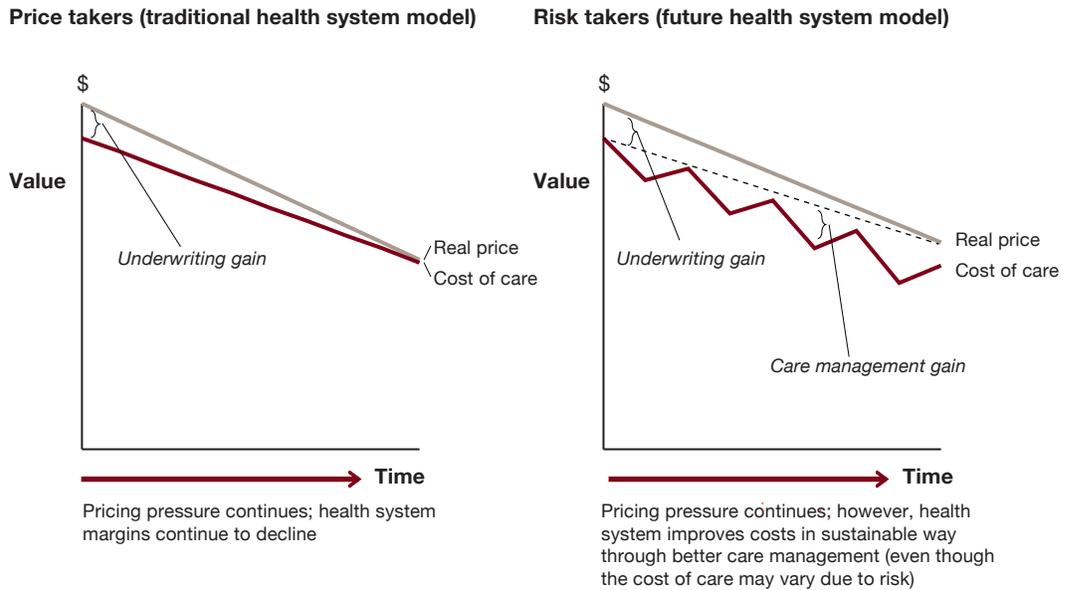
We estimate that 300 to 400 of the nation’s IDNs are in a position to consider exploiting risk-based opportunities. In each of the largest metropolitan markets, three to five provider networks would have the necessary shares and brand awareness to explore risk-taking arrangements — all of which, combined with pricing pressure, will drive further consolidation. In moderately sized markets, only one or two IDNs may have such strengths.

Many of these IDNs have already developed ACOs, but typically with very modest risk- and gain-sharing features. While ACO-like programs may succeed in putting about 10 percent of revenues at risk, the potential benefit of having 50 percent or more of revenues in play is enormous.

Local brand strength will be key to going to market with an increasingly retail state of mind. While service, quality, and pricing advantages from bundles and other initiatives will likely drive some market share gains, the name of the game in healthcare is likely to change from seeking larger volumes — or “growth from new services” — to focusing on margins and total operating surpluses, particularly as ambulatory care procedures continue to grow faster than inpatient services. Reducing utilization (frequency of care, modalities, and sites), managing care at the bedside, and customer service are imperatives.

Local brand strength will be key.

Exhibit 1
Value captured by price takers versus risk takers



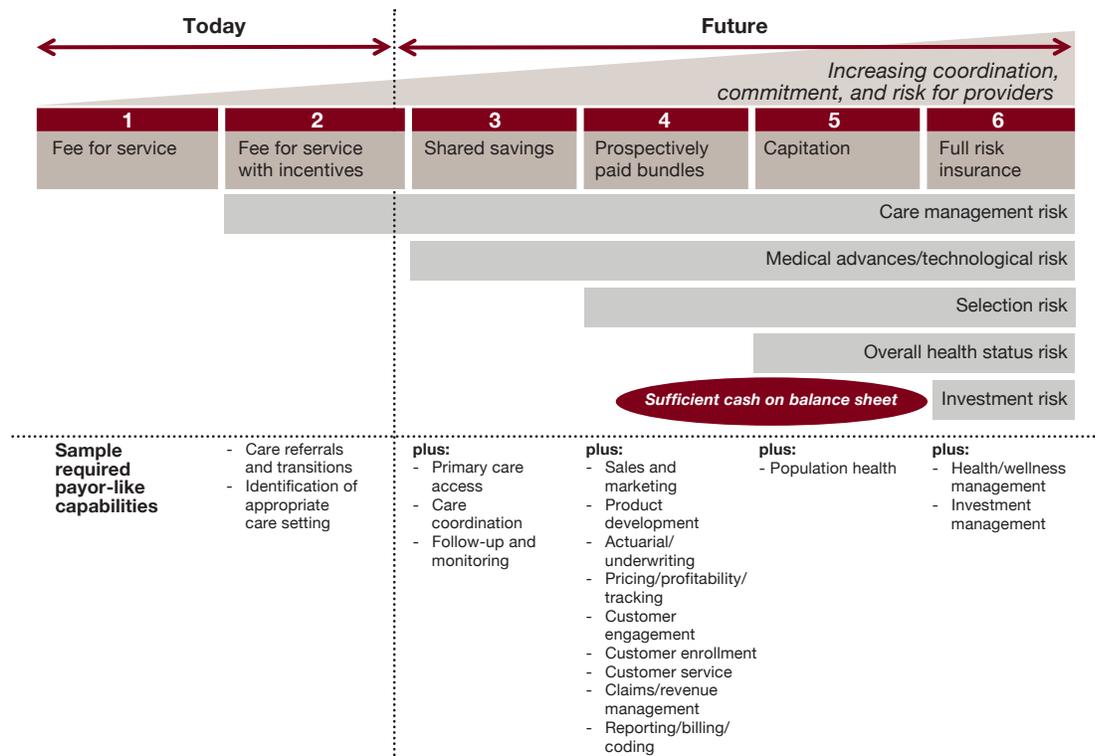
Source: Strategy& analysis

Of course, “becoming a payor” involves far more than hiring a bunch of actuaries and ponying up some reserve capital. The list of needed capabilities is long and daunting, including detailed plan design, claims processing, adjudication, customer service/relations, marketing, and sales, among others (see Exhibit 2).

There are many potential ways for providers to participate in the risk pool without simply replicating the functions of today’s payors. Each segment of the value chain and underlying capability is a candidate for a make/lease/buy decision. These analyses (and discussions with local payors) will likely be rather ad hoc in the early stages, depending heavily on local brand strength, cost position, and any existing in-house capabilities. The critical balancing act will be the right degree of risk sharing (from 0 to 100 percent), and will include not only rewards and penalties for day-to-day performance, but also the appropriate level of reserve capital and recourse.

Although today’s insurers may seem the likeliest partners, so far third-party administrators and other specialist firms are mostly filling this role because they are not viewed as future competitors. However, if momentum continues to build for “provider as payor” schemes, national turnkey solutions may appear, perhaps offered by spin-offs of large national insurers, which develop and sell a menu of administrative services and capabilities.

Exhibit 2
Spectrum of risk (and capabilities required)



Source: Strategy& analysis

In addition, once the technical issues of plan design and efficacy are settled, many questions will arise as to how these provider-as-payor entities will go to market. Should they be co-branded with payor partners? Should existing ACOs be rolled up into the new product offering? Should they be offered exclusively as the only way to receive preferred pricing from the IDN? Should they be sold as one option in a portfolio of insurance products that sales forces offer to local employers? What pricing strategy will move the most volume to the most profitable products? Are the products amenable to both public and private exchanges as sales platforms?

Today's payors need not view with alarm the possibility that leading IDNs will step into deeper parts of the insurance risk pool, though. Virtually all such new entities will need a robust set of support services that they must either buy or lease — “making” is not a realistic option, especially for those wanting to be first to market. Furthermore, most sizable employers are already self-insured and present limited opportunities for major underwriting gains.

Fundamentally, payors must appreciate the inexorable advance of consumerism and the growing retail mind-set in the healthcare market, and hone capabilities that mesh with the needs of provider brands in selling and managing. Today's largest and most successful payors will need to find profitable means to collaborate with and serve provider brands or risk losing significant pieces of their current businesses. Some will almost certainly fail, likely causing another round of consolidation (particularly among the Blues).

For providers, the stakes are even higher. As they evolve their operating models to assume greater risk and restructure themselves into new provider-payor entities, many will fail. Yet they have little choice — they must change or die. Moreover, providers that build the right capabilities and deliver care in a way that resonates with consumers will succeed, indelibly changing the U.S. healthcare landscape.

The existential question over the next 10 years; payor or not?

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