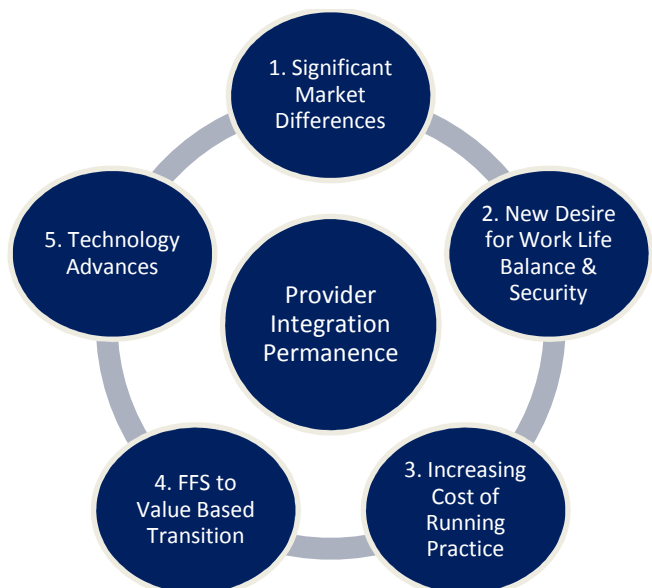


## Provider Integration: Not Just a Trend

Since the mid 1980's the healthcare industry has seen various cycles in which provider integration and alignment strategies have been developed and then unwound. Integration and alignment strategies are being aggressively pursued again today, dividing the industry in two camps. The first camp clearly sees history as merely repeating itself, while those in the second believe that these strategies will form the foundation of the future U.S. healthcare system.

HealthScape Advisors has done extensive research on this topic of provider integration and alignment through provider interviews and engagements in which we are assisting our clients to develop strategies in this area. Through our various interviews and engagements, it is clear that **the provider integration and alignment of today differs significantly from the past**, placing us squarely in the second camp. This article discusses the 5 most significant reasons for provider integration permanence and the impact to the various parties involved.

### 5 Major Reasons for Provider Integration Permanence



*Collectively, these factors drive provider integration and alignment permanence*

#### 1. Significant Market Differences Between Now and the End of the HMO Era

A common theme from our interviews is that employer group markets are in a much different economic era than they were at the end of the HMO era. In the late 1990's, employers were in a talent war and robust health benefits were seen as a differentiator. This competition drove the rapid expansion of unmanaged PPO products and a decline in narrower, lower cost managed care options. Today's long term economic view makes a repeat of the talent wars of the late 90's unlikely within the next decade. More importantly, healthcare today has become **unaffordable for employers, individuals and the U.S. economy overall**. Managed care companies have been unable to control costs using traditional health plan based medical management, disease management and network discount strategies.

Measurement	% Change from 1999 to 2011
Employer Health Care % of Total Compensation <sup>i</sup>	41% Increase
Health Insurance Premiums <sup>ii</sup>	160% Increase
Workers Contribution to Premiums <sup>iii</sup>	168% Increase
% U.S. GDP Devoted to Healthcare <sup>iv</sup>	25% Increase
National Health Expenditure per Capita <sup>v</sup>	88% Increase

## 2. Physicians Today Want Better Work Life Balance and More Security

We also heard in our interviews that physicians of today and the future have different perspectives on the industry. First, the concept of work-life balance has now become a generational issue. The next generation of physicians place a premium on flexible work arrangements. A recent recruiting survey confirmed what we heard in our interviews, showing that 64% of residents cited lifestyle as their top priority<sup>vi</sup>. These physicians are looking to an employment model to provide security and better work life balance.

Second, physicians are coming out of school with a larger amount of debt in a more challenging economy. The average debt coming out of school today has increased to \$161,000<sup>vii</sup>. This level of rising debt combined with the risks associated with independence is leading physicians to look for a steady paycheck and stability. **As a result, nearly half of physicians coming out of residency or fellowship chose to be employed in hospital owned practices in 2009** and very few are looking to venture into a self-employed, independent model<sup>viii</sup>.

## 3. Rising Practice Costs are a Barrier to a Return to Independence

Capital investments in new health information technology (IT) requirements are becoming an ever increasing barrier to private practice (either initially or for physicians seeking to return to this model). A recent study estimated that it would cost \$162,000 to implement an Electronic Health Record (EHR) system for a five physician practice, with \$85,500 in maintenance costs the first year<sup>ix</sup>. The high cost of implementing IT requirements, such as EHR to achieve meaningful use, coupled with the increasing costs of running a private practice are driving the need for a more integrated solution to reduce administrative cost and spread IT investments.

## 4. Fee for Service is Fading and Unsustainable

The downfall of the Fee for Service (FFS) model is also at the forefront of many physicians' thinking. Unlike the 1990's when Medicare drove the survival of the FFS model, Medicare is now leading the charge towards value based models. In fact, Medicare's Accountable Care Organizations cannot succeed without value based reimbursement and value based reimbursement cannot succeed without coordination, alignment and integration across the care continuum.

## 5. New Advances in Technology Creating Connectivity

We also discussed the impact of technology in our interviews. Historically, there was limited connectivity between independent physicians and hospitals with limited to no commercialized software support for true clinical integration in the 90's. This lack of connectivity and commercially available solutions made it difficult

for integration to take hold when the last round of capitation and risk based models were in vogue. Today, there are many clinical and financial information systems and capabilities that support integrated care. Once those tools are adopted by a physician within an integrated model, **it will be very unlikely that the physician will reverse course and migrate back to independent practice.** The technological advances today make integration possible, and those advances will only become more robust and easier to use over time.

### *Implications to Your Organization*

All of these forces have come together to drive a permanent movement of physicians from the position of an independent business person to an employment based model. This shift has dramatic implications for independent physician practices, health plans and health systems that will strive to maintain their market relevance and value proposition either through employing physicians directly or by establishing highly integrated care coordination business partnerships to contain cost while improving outcomes. Although the permanent shift of the physician model in the U.S. creates uncertainty for every organization in the value chain, the movements in the market to date point to certain trends that will likely guide the industry in this transformative period:

- A new era of primary care and evidenced based clinical management will drive future cost containment and quality improvement trends
- Each market will differ significantly based on various factors, driving the need for multi-variant solutions and strategies by organizations that span multiple local markets
- These local business model solutions will be driven by new partnership and alignment strategies that will capitalize on the existing strengths and capabilities, creating a clinically integrated solution that is greater than the sum of its parts.
- The future market will involve new competitive dynamics granting market share to successful models and potential disintermediation or commoditization to those organizations that lag in their strategic transformation.

Industry participants recognize the uncertainties in formulating the strategies and business models that will allow their organization to succeed in the future. These uncertainties have led some organizations to hesitate to act until more is known about this transformative process. However, for others, the **aggressive activity in the market** has recently led to a new sense of urgency in their strategic response to the market. As shown in an Irving Levin report, there were 77 hospital M&A transactions in 2010, the largest number since 2001<sup>x</sup>. Additionally, payors are also actively pursuing such opportunities, for example with UnitedHealth Group's acquisition of Monarch Healthcare and Wellpoint's acquisition of CareMore. These M&A transactions make it clear that integration is aggressively being pursued and the level of activity is increasing.

In our next brief, we will discuss in more detail how the implications of the physician model in the U.S. and recent market activity will impact independent physician practices, health plans and health systems as they chart their course forward.

<sup>i</sup> [http://www.bls.gov/news.release/archives/ecec\\_031999.pdf](http://www.bls.gov/news.release/archives/ecec_031999.pdf), <http://www.bls.gov/news.release/pdf/ecec.pdf>

<sup>ii</sup> <http://facts.kff.org/chart.aspx?ch=2280>

<sup>iii</sup> <http://facts.kff.org/chart.aspx?ch=2280>

<sup>iv</sup> <https://www.cms.gov/nationalhealthexpenddata/downloads/tables.pdf>

<sup>v</sup> <https://www.cms.gov/nationalhealthexpenddata/downloads/tables.pdf>

<sup>vi</sup> Residents desire for hospital employment poses recruiting challenges for practices, American Medical News, October 24, 2011

<sup>vii</sup> Medical school enrollment on the rise, LA Times, October 24, 2011

<sup>viii</sup> MGMA Physician Placement Report: 65 percent of established physicians placed in hospital-owned practices, Fierce Practice Management, June 4, 2010

<sup>ix</sup> The Financial and NonFinancial Costs of Implementing Electronic Health Records in Primary Care Practices, Health Affairs, March 2011

<sup>x</sup> <http://www.levinassociates.com/pr2011/pr1102hospital>