WHITE PAPER

Healthcare Provider Consolidation
Who are the Real Beneficiaries?

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October 1, 2013
Abstract

A movement to consolidate healthcare providers is once again in full force. Most health systems that employed physicians in the 90’s hope to prevent making the mistakes that rendered the previous alignment a huge flop. Increased business pressures for independent physicians over the past two decades have created a new desire to vet health system employment. Government regulations, fines and penalties, expensive electronic medical records, the potential for bundled payments and fear of being left out of the income stream are some of the driving forces today. Yet most health systems do not have a successful track record of managing medical practices. So, is the current provider consolidation movement a calculated strategy to give hospitals more leverage with payers or is there a sincere interest in providing higher quality, lower pricing and full transparency for the healthcare consumer? Coppola (2003) developed the managed care quaternion (MCQ) in part to bring attention to the key stakeholders – payers, patients, providers and employers. The success or failure of current provider consolidation may depend on a health system’s view of the stakeholders as ‘significant’ or ‘insignificant’. The employers are the largest stakeholder group purchaser or payer for health services (Coppola, 2011). An enlightened employer response or the failure of employers to respond to healthcare provider consolidation will determine the real beneficiaries.
The Impact of Provider Consolidation

Provider consolidation is terminology used widely in the healthcare arena and generally refers to physicians leaving the private practice of medicine to become employees of a hospital or healthcare system. An interim form of provider consolidation is hospital formation of a clinically integrated network (CIN). These networks currently allow physicians to remain independent, yet align with a health system for the dual purpose of promising better coordination of care for the consumer while gaining leverage to negotiate fees as a group.

In essence, these entities are legally allowed to play hardball with self-funded employers and payers. A real concern is that absent a system of checks and balances, CINs may become anticompetitive. An evolution of the emerging integrated model may invite federal investigations for alleged anti-trust violations, resulting in a legal opinion that the CIN become a financially integrated physician employment model or immediately disintegrate the anticompetitive network.

Neither option would be particularly appealing to employers. While employment of the network physicians would provide the hospital with even more leverage, dissolution of a CIN with large market share could cause major disruption with managed care organizations, payers and patients.

While reimbursement rates will increase with many CIN models, it remains to be seen if quality will transcend from the bottom (denominator) to the top (numerator), a quality over cost equation (quality/cost) and provide better healthcare and value.
A tremendous amount of healthcare provider consolidation is underway nationwide. Yet there is no health services research that concludes consolidation, in and of itself, equates to better healthcare and wellness, improved access for patients or lower healthcare costs. In fact, there is growing awareness that the current practice of medicine, particularly in many hospitals, is fragmented, inconsistent and overpriced.

So why should provider consolidation be a topic of concern? Gottlieb (2013) suggests that much of the consolidation is occurring solely for economic reasons. Independent physicians fear an uncertainty of how they will be paid in the future. Absent economic fears, many established physicians would prefer to remain in private practice. Many hospitals are prepared to seize the opportunity to offer physicians guaranteed salaries and productivity incentives with the primary goal of shoring up hospital referrals and keeping beds full. O’Malley, Bond, and Berenson (2011) believe the strategy is generally designed to stabilize declines of inpatient revenue, ensure referrals for outpatient tests and surgeries, and decrease the health system operating cost profile.

However, the change truly needed in today’s healthcare landscape must include a focus on all stakeholders, not just the physician and protecting the hospital’s economic status. Efforts should focus on developing models of wellness, higher quality, increased access, new payment methodologies, evidenced-based medicine, outcomes accountability and lower cost of care for patients and employers. Health systems with little or no stakeholder perspective have a tendency to become isolated with their self-serving, internally focused, bottom-line approach.
According to O’Malley et al. (2011), observations confirm that physicians who become employees of a fee for service health system are more likely to increase referrals to their new health system employer. Continued employment with the health system may depend on becoming a referring team player. Many health systems require employed physicians to send patients to hospital-employed physicians even though higher quality physicians may be available in the community. Hospitals that assume ownership of medical practices typically expect a physician’s ‘power to refer’ patients for admissions, ancillary services and outpatient surgery to offset major health system risks of owning and operating medical practices (Minich-Pourshadi, 2011).

Monopolistic hospitals expect local physicians, patients and employers to seek healthcare services exclusively from their hospital and ancillary providers. Such systems are disengaged from the true needs, wants and desires of the local healthcare consumer. Armed with the perceived market power of a consolidated model, these health systems anticipate increased negotiation leverage with commercial insurance carriers. Yet many of the ‘true payers’ are community based self-funded employers that depend on commercial carriers to develop competitive provider networks and process their claims at reasonable reimbursement rates. Unfortunately, win-win fee negotiations between a health system and insurance carriers increase healthcare cost for local employers and their covered members.

When health systems negotiate higher reimbursement rates, both patient/consumers and employers lose. The higher fees are passed through by the insurance carrier as the network / third party administrator (TPA) to local self-funded employers. A major problem with this model is that local consumers of healthcare services, both patient and
employer, have no voice when the health system and carrier negotiate reimbursement rates.

Local employers watching from the sidelines unintentionally enable their healthcare costs to spiral out of control. How does this happen? Employers want both a local network hospital and reasonable healthcare facility costs. Adversarial relationships between payers and health systems make these two goals difficult to achieve. The insurance carrier knows it will lose market share if it does not meet the health system demands for more money. The hospital makes sure that the battle is played out in the media against the big, bad insurance carrier. Most employers are not healthcare savvy enough to know how to deal effectively with this volatile situation. Employers lack in-depth knowledge and understanding of the complex, non-transparent healthcare system to protect themselves and their employees from cost increases.

Major employers play into the hand of the hospital by demanding that their insurance agent/broker move their coverage to another insurance carrier. Such abrupt, reactive decisions provide the hospital with the necessary leverage to achieve its goal. Fearing loss of market share, the tug-of-war eventually ends with an agreement reached and control remaining in the hands of the health system and the large insurance company. The hospital receives higher payments and the insurance carrier retains market share. And, after careful actuarial analysis, the insurance carrier passes on the increased costs to employers and covered members. It’s a win-win-lose strategy and one that is not sustainable in any market.
Although many health system consolidation plans are designed to drive up hospital volume and control reimbursement rates from payers, the economics of this approach signals little chance of long-term success or survival in the evolving healthcare market (Alexander, 2009). Such flawed health system strategies create opportunities for new healthcare delivery models to enter a volatile, high-cost market and present value-based alternatives to local employers. If local health systems are unwilling to provide a balanced win-win-win approach, financial incentives may become necessary for employers to persuade covered members to seek value-based healthcare from enlightened providers. The formal announcement of a major employer’s decision to seek value-based care from alternative sources may inspire the local health system to come to the table and discuss stakeholder concerns.

**Access, Quality and Cost of Care**

Access, quality and cost are components of the Iron Triangle (Kissick, 1994). Decisions regarding elective healthcare for employees and their dependents should include these three components. As healthcare consumers, we should try to keep all three in focus. Increased deductibles cause higher out-of-pocket costs for individuals who utilize health plan benefits. Many insured patients may need to tap into personal savings to pay for medical care. Some patients enter into long-term payment plans with health systems to fulfill their responsibility. Still, in other cases, healthcare expenses can lead to personal bankruptcies. An estimated 700,000 American families file for bankruptcy each year because of medical debt (Health Affairs, 2008). With the prevalence of expensive, high-tech, elective procedures available in the marketplace, it is critical that we all become informed healthcare consumers.
Increased healthcare spending leads to higher insurance premiums. According to Kovner and Knickman (2008), in 1960 U.S. health costs accounted for 5.2 percent of the gross domestic product (GDP). Kaiser News reported in 2012 that U.S. health care costs accounted for 18 percent of GDP. The Centers for Medicare and Medicaid Services (CMS) reports that annual U.S. health expenditures now total $2.7 trillion, which translates to $8,953 per person. This amount is more than 2.5 times higher than any other wealthy, industrially advanced nation (Shalby & Rolfes, 2012). The U.S. is off the chart in terms of comparative healthcare spending. While there are differing opinions on which industrialized nation has the best health system, there is consensus that the U.S. system is the most expensive.

**So, how can major employers effect change in a volatile healthcare market?**

Ideally we need access to an Expedia type product, inclusive of provider quality metrics, that will sort through healthcare pricing complexities, incorporate medical needs of the patient and provide facility choices to the healthcare consumer. Such an online service might function much like the Internet services we currently use to compare airline flights. Assuming airport accessibility, high quality and excellent airline safety records, the general determining factor used in booking a flight is ‘cost of the ticket’.

But major complexities in our current healthcare system and the need for personal attention to patient care needs prevent the design, development and implementation of a simplified decision-making tool. Healthcare must be approached in a more delicate and personal manner. Yet with higher deductibles and higher out of pocket expenses, patients need critical information before making important elective decisions. While patients
should consider access, quality and cost in healthcare decisions, most do not feel comfortable questioning healthcare providers, obtaining quotes and comparing treatment options without expert guidance. Most patients are not ready for a ‘solo flight’ in healthcare decision-making and need specialized educators/navigators to handle the system turbulence (Freeman, 2008). Without data analytics, resources, options, comparative pricing and effective tools to make good healthcare decisions, covered members will not become enlightened healthcare consumers and healthcare costs will continue to increase.

Many health systems, particularly one-hospital towns, have misused their market leverage to demand and obtain excessive commercial reimbursement rates (Pickert, 2013). These hospitals know that brokers and payers may be unable to sell insurance policies without the local ‘hometown’ hospital in network. But times are changing and it may be necessary for major employers to organize business coalitions or Business Groups on Value-Based Healthcare (BGVBH) to end these high level, closed-door fee negotiation sessions where the health system and insurance carrier walk away as the only winners.

So, who are the real beneficiaries of healthcare provider consolidation? It generally depends on local market dynamics. Without employer enlightenment, empowerment and involvement in an organized approach to play a key role in transformational change, the real fear is that healthcare costs will continue to soar with the traditional win-win strategy utilized by health systems and payers. A collaborative approach among employers, payers and local healthcare providers can provide the necessary balance to protect the interests of all stakeholders, most importantly, the patient.
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References


