Payer-Provider Consolidation

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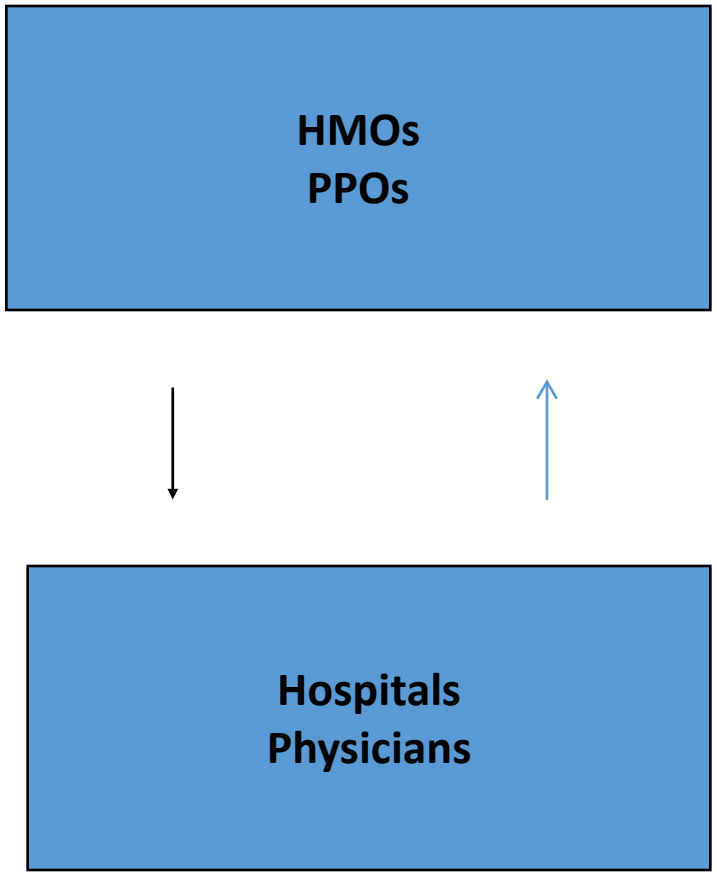
Vertical Integration
Payers & Providers

Buyers



Suppliers

History of Payer-Provider Integration

- 1930s & 1940s: Group/staff model HMOs (e.g., Kaiser, GHC, etc.)
- 1970s - 1980s: IPA model HMOs (e.g., Hill Physicians)
- 1970s – 1980s: Rural-based IDNs develop health plans (Geisinger, Carle, Scott & White, etc.)
- 1980s: insurers acquire primary care groups, investor-owned hospitals acquire insurers
- 1990s: insurers sell off primary care groups to PPMs
- 1990s: nonprofit hospitals get into insurer business in anticipation of capitated care
  partly stimulated by BBA ‘97 (Provider-Sponsored Organizations)

Hospital Sponsored Health Plans

- First wave interest peaked in mid-1990s
- Products rarely achieved substantial scale (failure to reach MES ~ 100K lives)
- Host of problems (Burns & Thorpe, 2000):

  Under-capitalization

  Inability to sufficiently grow & compete

  Substantial financial losses in early years

  Huge medical loss ratios

  No actuarial or marketing expertise

  Conflicting capital needs with rest of system

  Internal conflicts : cost minimization v. revenue maximization
- Viable in selected markets where a large plan dominates market (e.g. Lansing, Indianapolis)
- Exclusive affiliations with plans obviate value of plan sponsorship
- Provider plans die off in late 1990s and early-mid 2000s as market transitions to open-access

Provider-led Integration with Payors: Rationale

- Position themselves to manage risk-based contracts
- Position themselves to become ACOs
- Position themselves for population health management
- Gain some leverage over payers
- Never-ending effort to dis-intermediate payers
- Never-ending effort to manage care continuum and triple aim

Hospital Sponsored Health Plans: Research Evidence

- IDN investment in hospitals/MDs/health plans negatively associated with operating margin
- Hospital diversification into other business lines like health plans associated with higher debt-to-capitalization ratios
- Health plan investments to link with providers to serve the Medicare Advantage population linked to higher premiums

Sources: Burns, Gimm, & Nicholson (2005), Frakt, Pizer, & Feldman (2013)

NATIONAL ACADEMY OF SOCIAL INSURANCE

Report released
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Integrated Delivery Networks:

In Search of Benefits and Market Effects

Conducted for the Academy's Panel on Addressing Pricing Power in Health Care Markets

by Jeff Goldsmith, Lawton R. Burns, Aditi Sen and Trevor Goldsmith

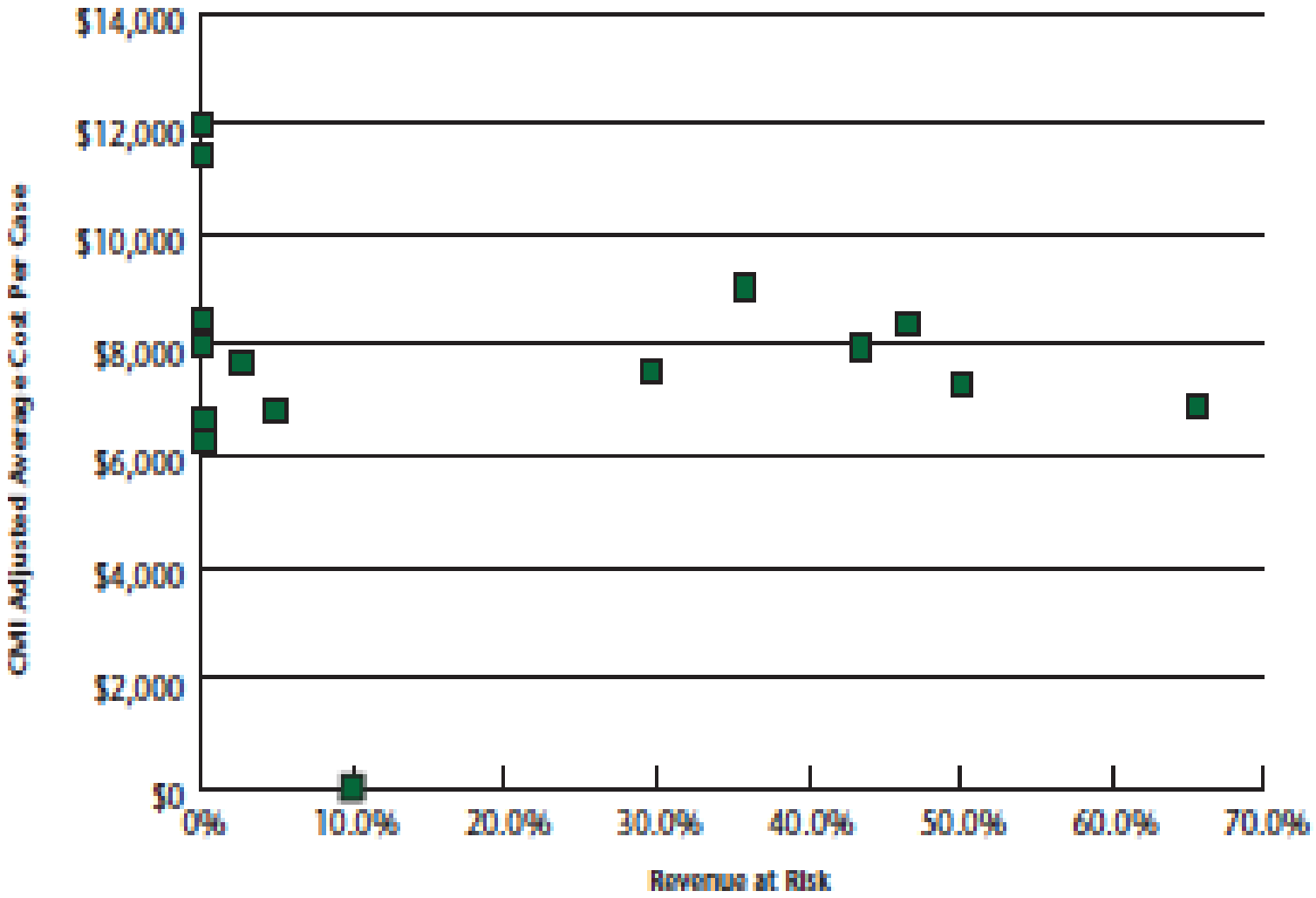
IDN Financial/Performance Analysis

To study IDN performance, we selected 15 nationally prominent IDNs that are dominant actors in their respective metropolitan and regional hospital markets. We attempted to cover all regions of the U.S. (though three of the sample are in Pennsylvania).

The sample:

- Advocate Health Care (suburban Chicago)
- Banner Health (principally Arizona)
- Henry Ford Health System (Detroit)
- North Shore–LIJ Health System (suburban New York)
- Aurora Health Care (Milwaukee/Wisconsin)
- Intermountain Health Care (Utah/Idaho)
- Penn Medicine (Philadelphia)
- Sanford Health (Dakotas)
- Sentara Healthcare (Virginia)
- BayCare Health System (Tampa/St. Petersburg)
- Sutter Health (Northern California)
- UPMC (Western Pennsylvania)
- Geisinger Health System (Central Pennsylvania)
- Johns Hopkins Medicine (Maryland)
- Presbyterian Healthcare Services (New Mexico)

Exhibit 7: Case Mix Index Adjusted Average Cost per Case v. Revenue at Risk



No relationship of IDN revenue at risk and IDN CMI-adjusted cost of care

Exhibit 8: IDN Performance: Flagship Compared to Competitor

Medicare Spending per Decedent in Last Two Years of Life

Hospital	Case Mix Index (CMI)	CMI-Adjusted Avg. Cost per Case	Total	Imaging	Tests
A Flagship	1.62	$7,109	$66,009	$1,157	$801
A Competitor	1.94	$6,926	$62,216	$961	$756
B Flagship	1.57	$6,448	$92,733	$1,642	$1,214
B Competitor	2.13	$9,160	$92,208	$1,613	$1,174
C Flagship	1.81	$6,902	$64,618	$743	$1,064
C Competitor	1.76	$6,877	$48,870	$572	$483
D Flagship	1.73	$8,501	$68,185	$748	$511
D Competitor	1.73	$5,713	$62,912	$759	$795
E Flagship	2.32	$11,110	$101,616	$1,636	$1,048
E Competitor	1.80	$10,241	$99,024	$2,095	$980
F Flagship	2.02	$9,069	$69,121	$944	$810
F Competitor	1.67	$5,455	$64,231	$789	$924
G Flagship	1.79	$6,809	$89,378	$1,088	$1,205
G Competitor	2.02	$9,069	$76,146	$780	$760
H Flagship	1.74	$7,267	$64,854	$838	$758
H Competitor	1.83	$5,737	$69,968	$1,027	$734
I Flagship	1.73	$7,236	$93,928	$991	$687
I Competitor	1.63	$6,128	$92,667	$1,242	$1,018
J Flagship	1.97	$7,659	$94,221	$1,708	$1,129
J Competitor	2.25	$8,343	$96,122	$1,705	$1,017
K Flagship	1.63	$8,269	$102,392	$1,652	$1,178
K Competitor	1.58	$7,703	$87,546	$1,216	$1,137
L Flagship	1.88	$12,110	$136,069	$1,416	$810
L Competitor	2.27	$11,309	$120,501	$1,377	$799
M Flagship	1.69	$8,770	$105,042	$2,293	$2,102
M Competitor	1.75	$9,654	$103,254	$2,176	$1,787
N Flagship	n/a	n/a	$83,948	$1,693	$1,169
N Competitor	2.22	$9,041	$80,524	$1,264	$786
O Flagship	2.13	$8,140	$86,281	$1,180	$891
O Competitor	2.21	$6,509	$87,059	$1,134	$630

Sources: American Hospital Directory, 2012, Dartmouth Atlas, 2010

Comparison of IDN flagship hospital and main in-market competitor on Medicare spend in last 2 years of life:

IDN flagship hospital with no revenue at risk was 6.8% less expensive than in-market competitor

IDN flagship hospital with some revenue at risk was 20% more expensive than in-market competitor

No apparent cost of care advantage conferred on IDN hospitals that operate their own health plan

Additional Findings

- No meaningful differences in clinical quality or safety scores between IDN flagship hospital and in-market competitor
  - readmissions
  - infection rates
  - complication rates
- No meaningful differences in patient satisfaction scores or Leapfrog Group hospital safety ratings between IDN flagship hospital and in-market competitor
- In 10 of 14 sites, IDN flagship hospital had higher avg. cost per case
- NOT CLEAR that IDNs can coordinate care, lower costs, and deliver value

Study Conclusions

- These 15 IDNs are big revenue generators ($73B

- They are also inscrutable institutions

  public information on hospital performance not aggregated at IDN level

  hard to tell what each of their business lines contribute to operating revenues

  cannot tell whether they have used their market power to grow their earnings

  cannot tell how the insurance vehicle is used by the IDN

Recent Payer-Provider Deals in Vertical Integration

Insurers Buying Physician Groups

- WellPoint acquires CareMore (26 clinics in Calif)

- Humana acquires:
  - Concentra - occupational medicine chain Concentra (2010)
  - SeniorBridge - home health provider and 1,500 care managers (2011)
  - NextCare - urgent care center chain (2011)

- UnitedHealth/Optum acquires:
  - Monarch medical group (2011)
  - network of 425 “affiliated” (e.g. employed)
  - network of 4,500 “contracted” physicians,
  - 300 nurse practitioners and physician assistants in 90 primary care and urgent care clinics

Payer-led Integration with Providers: Rationale

- Position for increased Medicare Advantage enrollment, which has been surging and will increase substantially with the retirement of the baby boomers, as well as for increased Medicaid enrollment following PPACA implementation in 2014.

- Develop networks to help manage the care of the sickest patients - - such as the chronically ill, the dual eligibles, and those with pre-existing conditions - - which are the target of several initiatives in the PPACA.

- Belief that the only way to manage risk contracts and satisfy the dictates of value-based contracting is by owning the front end of (ambulatory) care and incentivizing their employed physicians to treat enrollees cost-effectively

- Threat posed by hospital efforts to develop captive physician networks and ACOs which might have as their real goal limiting insurer contracting options and increasing the prices charged them. Insurers may be vertically integrating back into the physician market to develop countervailing power and/or avoid being locked out

Thank you for listening