

Health Care Industry Post

News and analysis of current issues affecting health care providers and payers

The quest for vertical integration Assessing the rewards and the risks

As health care reform continues its rollout in the US, restructuring the delivery system is a growing focus. With a surge in demand for care as a result of the Patient Protection and Affordable Care Act (ACA), declining reimbursement rates from Medicare and Medicaid, and pressure for greater transparency in cost and quality, many health care organizations are assessing the potential rewards and risks of mergers, acquisitions and other forms of integration. As of June 2014, health care had seen nearly \$319 billion in mergers and acquisitions for the year.¹ This figure includes both horizontal and vertical integration (see the box on page 2 for a definition of terms).

In this rapidly transforming environment, health care enterprises are expected to transcend traditional boundaries as they move toward responsible, cost-efficient and transparent systems of care to create greater value for purchasers. Providers and payers alike need to evaluate the strategies available to them to achieve these ends, and determine the level and form of integration most likely to position them for sustainable success. In this *Health Care Industry Post*, we look at today's vertical integration landscape and key considerations moving forward.

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¹ www.forbes.com/sites/alexadavis/2014/06/24/no-slowdown-in-sight-for-2014s-ma-frenzy/



Building a better
working world

Considering the full spectrum of integration initiatives

The post-ACA environment has yielded numerous trends inspired by reform but driven by the market. Stakeholders across the health care industry are adding scale to maintain or to increase leverage in contract negotiations – and moving to capture more of the health care dollar by deepening or expanding service lines through acquisitions, alliances, joint ventures and partnerships. Spurred by the rise of accountable and value-driven care, as well as the proliferation of expensive care coordination technologies, numerous independent hospitals have sought partners to help fund related capital requirements and strengthen their financial positions. Also, many health care systems have actively sought strategic additions to expand their markets or build out existing networks. At the same time, health care payers are narrowing provider networks for ACA plans and are exploring acquisitions of provider capabilities. High-deductible health plans are contributing to the rise in these narrow networks as more health care costs are pushed to consumers, who are seeking lower-cost options.

Exhibit 1 on page 3 illustrates the continuum of today's integration models. At one extreme are the least-integrated entities, represented by solo physician practitioners, small physician groups and stand-alone community hospitals. Their ranks are rapidly diminishing. Current industry statistics indicate that only 18% of physicians are solo practitioners,² while just 39% of community hospitals are independent facilities.³ Participating in integrated care requires significant capital investments in new medical and administrative technologies. Many of those who are "going it alone" do not have the resources needed to survive in the new environment – and are being driven by financial realities to seek new business partners.

Movement to the right on the continuum next leads to horizontal integration, represented by independent physician associations, single-specialty groups and hospital chains – similar

2 www.ama-assn.org/ama/pub/news/news/2013/2013-09-17-new-study-physician-practice-arrangements.page

3 www.aharesourcecenter.wordpress.com/2013/03/15/number-of-system-affiliated-vs-independent-community-hospitals-1999-2011/

Defining the terms

The terms "horizontal integration" and "vertical integration" are derived from industrial economics. They were developed to help categorize the complex structures of industry. In health care:

- ▶ **Horizontal integration** is found when two or more like entities, such as two hospitals or two health plans, join forces. Organizations that provide similar services to a different set of customers consolidate at the same point on the supply chain. This affiliation helps groups of like providers or payers gain economies of scale, increase negotiating power with suppliers and vie for market share in a potentially less competitive environment.
- ▶ **Vertical integration** occurs when an entity acquires or develops capabilities to reduce reliance on upstream suppliers or downstream sales channels. It is a move up or down the supply chain – up to control costs and supplies or down to gain more direct access to customers. For example, a hospital system may acquire a physician group, skilled nursing facility or retail clinic to extend its patient care services. Or, it may acquire payer capabilities, enabling more control over the financing of health care.

entities consolidating to gain economies of scale and negotiating power.

Moving farther right, one sees the recent trend of hospitals employing physicians as a primary step toward vertical integration. According to the American Medical Association,⁴ nearly 42% of primary care physicians are employed by hospitals today.

Integration deepens in the next two stages, represented by multispecialty group practices and by hospitals acquiring multispecialty groups to form clinically integrated delivery systems and adding to post-acute capabilities. It is at these two stages that most accountable care organizations (ACOs) are formed, with providers beginning to assume some of the financial risk historically borne by health care payers.

More than 500 Medicare, Medicaid and commercial ACOs have formed since 2010. Although most ACOs are led by hospitals or physicians, in many markets, payers such as Aetna, Cigna and United Healthcare are sponsoring ACOs in order to engage their provider networks in a more collaborative way.

At the far right of the continuum, health systems are integrated both clinically and financially. Prime examples of this model are Kaiser Permanente, the University of Pittsburgh Medical Center and Geisinger Health System. The past two years have seen considerable activity in this space (see Exhibit 2 on page 3).

4 www.ama-assn.org/ama/pub/news/news/2014/2014-07-31-resource-group-practice-negotiations.page

Tracking the two waves of integration

In understanding today's integration activities, it is helpful to consider the fate of key consolidation initiatives over the past five decades. While the potential benefits of integration are appealing, realizing them has been a challenge for many organizations. As shown in Exhibit 3 on page 5, many vertical integration ventures have been discontinued (indicated in gray) after either disappointing results or a strategic change in direction. While the environment has evolved, the core lessons of past endeavors are relevant, as many organizations are once again pursuing the benefits of deeper integration.

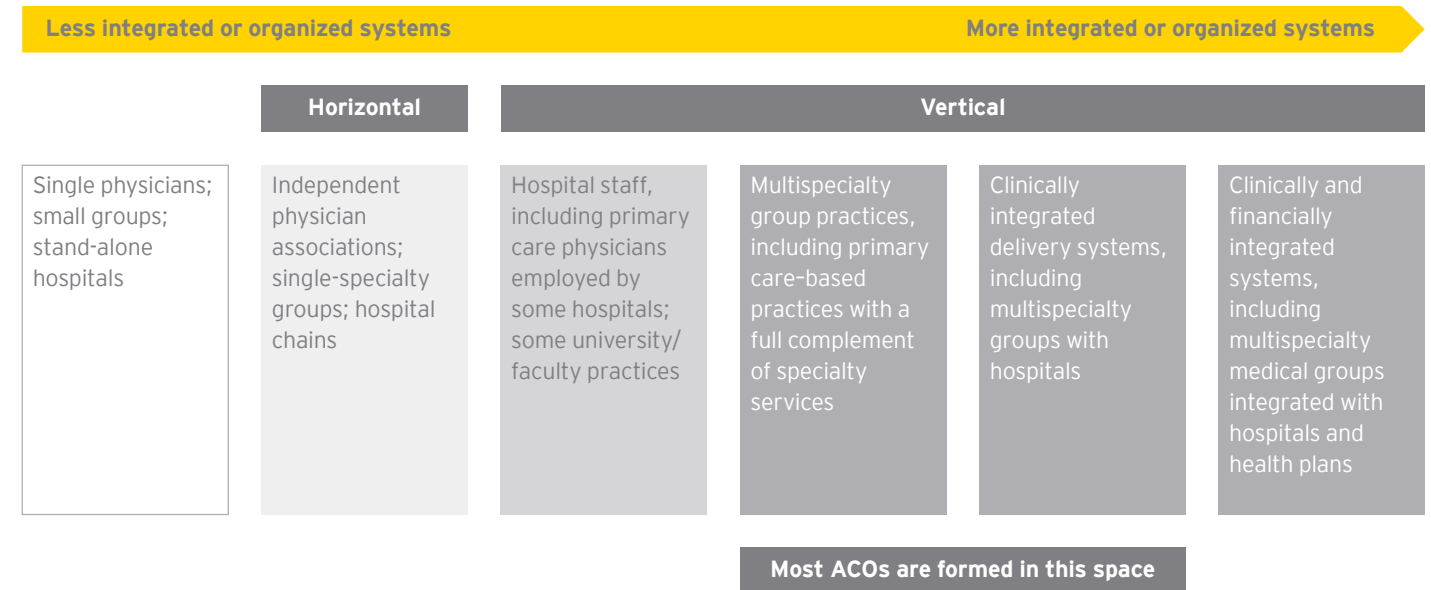
The first wave, 1980-2000

The path toward integration began in 1945 when the Permanente Health Plan, providing both health insurance and access to hospitals/providers, officially opened to the public. Integration activity accelerated in the 1980s and 1990s with the growth of the managed care industry. Managed care organizations grew membership, consolidated and implemented techniques for controlling health care costs. Large managed care organizations used their leverage to negotiate lower-cost provider contracts.

In response, hospitals began to form networks intended to reduce costs and strengthen their negotiation positions with payers. For-profit hospital networks, such as Hospital Corporation of America, expanded rapidly through acquisition.

“While the potential benefits of integration are appealing, realizing them has been a challenge for many organizations.”

Exhibit 1. Shades of collaboration in the health care industry



Source: Accountable Care Facts, www.accountablecarefacts.org

Exhibit 2. Recent activity at the deepest level of vertical integration

Payers acquiring providers

- ▶ In Pennsylvania, Pittsburgh insurer Highmark acquired West Penn Allegheny Health System, the region's second-largest hospital group after UPMC. With the acquisition, Highmark joined Kaiser Permanente as one of the nation's largest private integrated systems providing hospital and insurance services.
- ▶ In Kentucky, Louisville-based Humana purchased Concentra, a company operating 300 stand-alone clinics. This acquisition underscores the value placed on primary care physicians and clinics in coordinating care and managing population wellness.
- ▶ In Florida, Florida Blue purchased Diagnostic Clinic Medical Group, a physician-owned multispecialty practice focused on ambulatory-care-based services. The acquisition is described as an opportunity to further the health plan's vision of patient-centered care by creating collaborative relationships with health care providers.
- ▶ In California, Anthem Blue Cross has announced a partnership with seven competing Los Angeles-area hospital groups. Although no actual integration will occur among the hospitals (horizontal) or between the payer and hospitals (vertical), they will share financial risk and co-coordinate care.

Providers developing health plans

- ▶ In New York, North Shore Long Island Jewish Health System started CareConnect, becoming the state's first provider-owned commercial health plan. As the health system's first foray into the insurance business, the new plan is competing against larger, well-established carriers on New York State's health insurance exchange.
- ▶ In Georgia, Piedmont Healthcare and WellStar Health System, two leaders in the metro-Atlanta health care market, formed Piedmont WellStar Health Plans. The two health systems were former players in a discontinued venture of the mid-1990s, Promina Health System.
- ▶ In California, the Sacramento-based Sutter Health network of physicians and hospitals launched its own health maintenance organization (HMO). This marks the second health plan venture for Sutter, which sold its HMO Omni in 1999.

Source: Accountable Care Facts, www.accountablecarefacts.org



While effective in countering the growing influence of managed care organizations, the larger health systems often found challenges in eliminating duplicative services and influencing provider behavior to reduce costs.

Some hospital systems attempted to disintermediate payers by forming provider-sponsored health plans. Many initially generated sufficient financial returns, but later struggled to effectively compete with the larger, better-capitalized, traditional health plans.

Some of the challenges faced by provider-sponsored health plans were specific to the era; they were rooted in the disjointed structure of the health care delivery system, a lack of enabling technology and the political sentiments of the time.

During this first wave of integration, physicians still tended to operate independently from each other. Hospitals experimented with employing physicians, but did primarily with the aim of increasing referrals to their facilities. Most hospital reimbursement was fee-for-service, and integrated entities' attempts to coordinate care were thwarted by the volume-based approach to payment and the inability to easily share patient information.

On the political front, Clinton-era reforms failed to become a reality, derailing for the time any chance of meaningful movement toward new

reimbursement models or greater coordination of care.

In addition to industry realities, newly expanded entities faced the enduring challenges of vertical integration: management of a new business venture, significant capital commitment, management distraction, insufficient scale and a lack of market acceptance.

The second wave, 2010-????

In the five years since the passage of the ACA, regulatory and market changes have created an environment more conducive to vertical integration. With the quest to reduce costs and improve quality, access and care coordination – all essential elements of health care reform – health care organizations are increasingly turning to consolidation opportunities to transform delivery systems and improve financial viability in the wake of declining reimbursements.

Value- and risk-based reimbursement models, too, are rapidly changing the face of the industry. Providers are accepting more risk through a variety of arrangements, from shared reward systems to compliance-contingent reimbursement programs, such as meaningful use. Simultaneously, payer revenue is becoming increasingly risk-based, dependent on factors such as quality scores

and documentable individual member health status. One result of the changes is that payer and provider incentives are becoming more closely aligned.

For payers, government and employer dissatisfaction and demands, along with the ACA, have created a challenging new world of pressures to manage medical expenses, serve a member base comprised more substantially of individual purchasers, and navigate new regulations and taxes that are negatively impacting profitability. Payers' ability to limit risk through underwriting is reduced, forcing them to better manage health service utilization. As a result, payers are exploring acquisitions of provider capabilities to better control costs and influence care delivery, as well as avoid disintermediation in the form of employer and government direct contracting with provider-led ACOs. They are also rapidly partnering with health systems to implement ACO-like payment methodologies that reward quality and care coordination and transition some financial risk to their provider network.

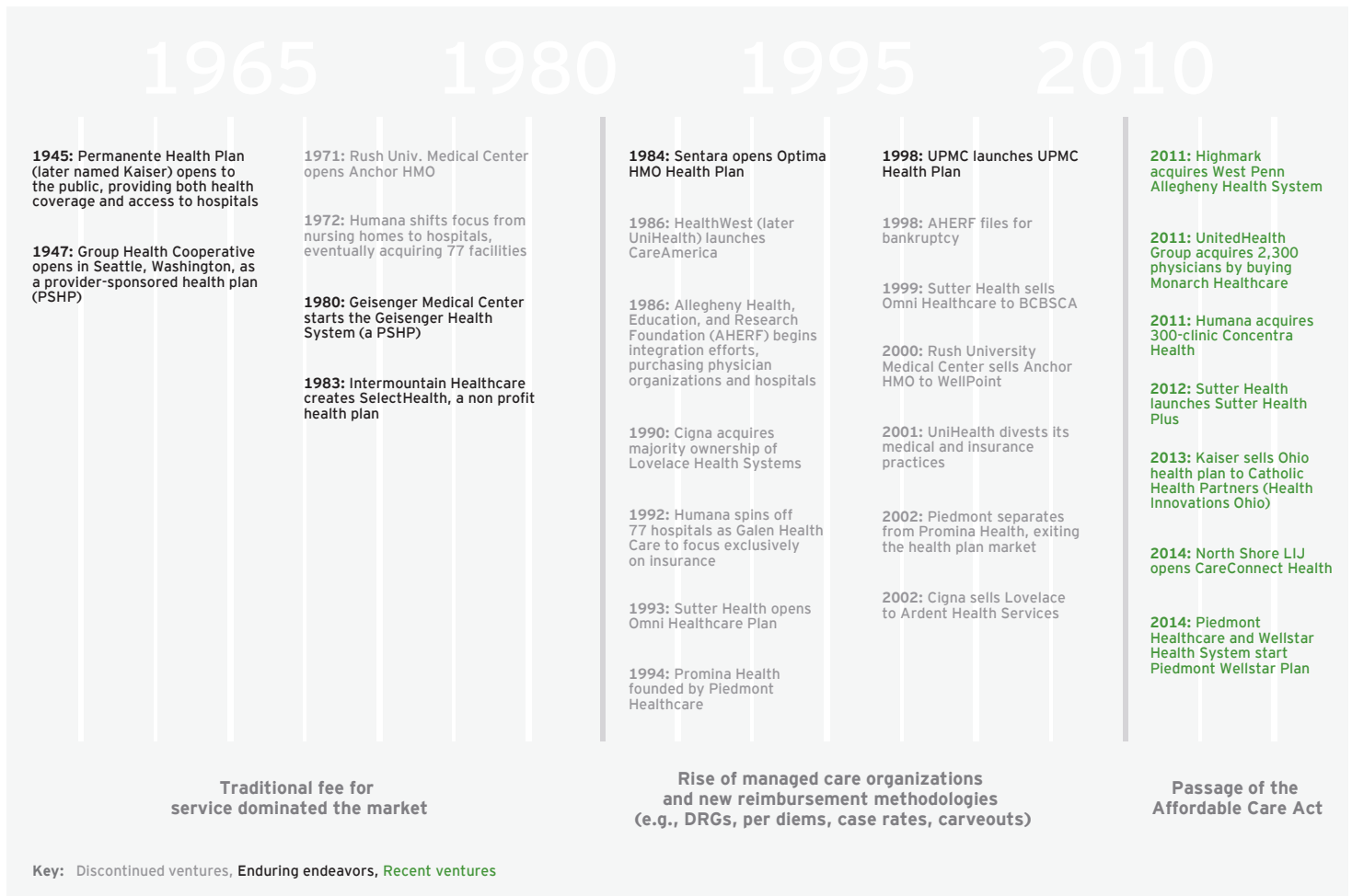
For health systems, accepting risk through either vertical integration or an ACO arrangement is again a viable prospect. Driven by financial and care coordination incentives, providers are rapidly adopting electronic health records (EHRs) and looking for opportunities to acquire ancillary care capabilities. They are positioning themselves for inclusion in narrow payer networks and alternative contract arrangements. As payments are increasingly tied to quality metrics, hospitals are focused on achieving clinical and operational excellence and responding to patient demand for price transparency. Many hospitals are attempting to acquire full continuum-of-care capabilities, and some are starting health plans to offset the risk of exclusion from narrow networks. As health care providers are increasingly paid based on outcomes, vertical integration presents an enticing opportunity to control more of the continuum of care – from initial physician visits through end-of-life care – and better impact outcomes.

For physicians practicing today, health system employment has become an attractive option due to several factors, including investment needs to comply with EHR requirements, expensive malpractice insurance and administrative costs. Hospital-based physician groups are positioned to effectively coordinate patient care.

The varied and pervasive influences on the current health care market – from value- and risk-based

“With collaboration comes the opportunity to align incentives and share risk.”

Exhibit 3. A five-decade timeline of sample integration activity



Source: EY analysis, 2014.

contracting to payer underwriting limitations to EHRs to acceptance of cost control techniques – all converge to create an environment in which payers and providers benefit from improved collaboration. With collaboration comes the opportunity to align incentives and share risk. Given this environment, payers and providers alike should consider the best approach to assuming that risk. Their options include new contracting arrangements, partnerships or formal vertical integration through capability development or acquisition. However, while the environment for vertical integration has markedly improved, many risks remain.

Weighing the potential against the perils

To preserve and potentially expand their positions in the supply chain, today’s providers and payers are increasingly willing to accept more nontraditional risks through vertical integration. Some integration initiatives have been launched opportunistically to take advantage of critical capability shortages. This is evident in health systems acquiring primary care physicians, for example. Other integration moves are more defensive, such as a health system creating a health plan to protect access to its patient population.

In evaluating vertical integration as an opportunistic or a defensive market strategy, the following questions can serve as guideposts:

- ▶ What is the strategic intent of this integration initiative?
- ▶ What will be our primary line of business? For what do we want to be known?
- ▶ What is our desired competitive position?
- ▶ What will be the customer market’s reaction to our new position/offerings? How will this effort affect our brand? Will it increase consumer trust and loyalty?
- ▶ What will be our business partners’ reaction, particularly those whom we will partially disintermediate?



Exhibit 4. Potential benefits and risks of various types of vertical integration

Acquirer	Target	Benefit	Risk
Objective: Strengthen revenue streams			
Health system	Physicians	Increase referrals and admissions	Experience a decline in provider productivity after acquisition; do not gain physician buy-in
Health system	Payer	Increase patient volume and reimbursement rates through a restricted network and reduced payer margins	Experience health plan operating losses due to underestimating member utilization and unit cost
Payer	Health system	Capture enrollment through health system regional presence and brand	Acquire disproportionately high-cost members due to health system loyalty
Objective: Improve control of supply costs			
Payer	Health system, physicians	Improve ability to manage population health and control medical expense	Experience an erosion in financial viability and flexibility due to a capital-intensive investment while failing to improve health cost management
Objective: Defend against disintermediation or exclusion			
Payer	Health systems	Guard against integrated delivery system contracting directly with employers or government payers	Lose network breadth due to providers' reluctance to participate in the network of a direct competitor
Health system	Payer	Offset potential exclusion from narrow networks	Lose overall managed care volume due to commercial payers' unwillingness to contract with a direct competitor
Health system	Physicians	Avoid disproportionate admissions to competing health systems	Encounter physicians' unwillingness to modify referral or admissions practices

Source: EY analysis, 2014.



- ▶ Will our other lines of business exist mainly to support the primary one?
- ▶ Do we have the capability, bandwidth and financial resources to successfully manage this new venture?
- ▶ What is our exit strategy if the endeavor fails?
- ▶ How much harm would a failure cause? Is the harm an acceptable risk?

Thoughtfully considering these questions will help to address the common, enduring risks of vertical integration in the health care industry, including:

- ▶ **Developing organizational capabilities too far in advance of market demand.** Although this was more of a concern 20 years ago when resistance to managed care was strong, it can still be seen today and is specific to local markets. For example, where markets tend to be provider-dominated and generally resistant to managed care, an insurer-owned health system may be less likely to succeed.
- ▶ **Not clearly defining each entity's role within the system.** Management decisions will increasingly focus on intracompany transactions. Guidelines for the negotiation and objectives of those transactions, particularly if one entity is intended to benefit at the expense of another, must be established and broadly agreed to up front.
- ▶ **Taking on more than is financially feasible.** For either health plans acquiring provider capabilities or health systems venturing into the financing of care, the financial investment can be sizable and can tie up significant capital. For example, a health system that begins to offer insurance products will need to establish reserves based on regulatory requirements.
- ▶ **Attempting to compete with less scale than established competitors.** If the acquired capabilities come in the form of a start-up, then the organization will almost certainly be competing with a scale disadvantage. All else being equal, this means a less competitive cost position.
- ▶ **Paying for productivity gains that do not align with the acquired entity's new incentives.** The expectation may be erroneous that previously independent entities, such as physician groups, will be more productive once part of a system.
- ▶ **Lacking the ability to effectively coordinate care across the integrated delivery system.** It cannot be assumed that care will be managed in a particular way and that referrals will be kept within the system. The integrated entity's

culture and incentives must support the desired level of collaboration.

- ▶ **Not having sufficient capability to execute such new core functions as pricing, reserving and practice management.** Vertically integrated organizations involve managing an entirely new business – and a complicated one at that. They require a different mindset, skill set and knowledge base with a corresponding learning curve.

For organizations considering vertical integration, avoiding the mistakes of the past begins by assessing factors that drive success and failure. This assessment is typically organized as a rigorous due diligence process, carried out by a combination of external advisors and internal resources. It includes four key steps:

- ▶ **Step 1. Identify goals and risks.** Clarify your strategic intent and desired competitive position within the market context. Identify licensure requirements. Conduct a high-level analysis of capabilities, including patient services and network coverage, financial risk management, and payer or provider operations. Map risks to potential actions to mitigate them.
- ▶ **Step 2. Assess capabilities.** Identify the core capabilities needed to effectively manage population health and create a positive return on investment. Determine the level of capability maturity needed to successfully compete in your targeted market. Identify the capability gaps to be addressed before launching new products or services.
- ▶ **Step 3. Analyze the build-versus-buy options.** Evaluate the feasibility and level of effort required to develop required capabilities in-house. Assess the opportunities and associated risks of partnership arrangements. Determine the costs and advantages of acquiring existing capability providers. Conduct initial due diligence on acquisition targets. Develop a recommended approach to obtaining each capability.
- ▶ **Step 4. Develop the business case.** Determine the availability and cost of capital. Assess start-up costs, including capability investments, capital requirements, talent acquisition and marketing. Forecast cash inflows driven by patient and premium revenue and investment income. Estimate cash outflows based on the timing and magnitude of claims payments, capital and operating expenses, interest payments and taxes. Determine net present value and/or return on investment of the health plan investment.

Look before leaping

Vertical integration initiatives offer health care organizations an enticing opportunity to create financial, operational and strategic value. When evaluated and correctly executed, the strategies can help participants expand scope and diversify their market and revenue sources. Yet because vertical integration is so much riskier than its horizontal counterpart, all explorers in this new territory need to conduct a thorough, systematic assessment before moving forward. Understanding each risk, exercising caution and balancing opportunity pursuit with well-informed circumspection can help you make the right call.

EY can help

In today's dynamic health care environment, the rewards are many yet the risks are high. As you explore opportunities, our integrated payer and provider advisory team can support you – from strategy through integration.

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