New Opportunities for Provider/Insurers

Catholic Healthcare Organizations Are Well Positioned for Direct Contracting

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Congress and a number of state governments have recently taken steps to encourage the formation of provider/insurer networks and other forms of what may be described as "direct contracting" by providers with consumers. These legislative and regulatory initiatives fall into three general categories:

- Initiatives that make it easier for provider networks to take on full-risk contracts with little or no insurance licensing and less regulatory interference, as long as those contracts operate through legitimate existing insurance entities
- Initiatives that permit provider networks to contract directly with self-insured employers and other self-insured organizations, as long as such organizations meet certain definitions and insurance standards
- Initiatives that would permit direct contracting between provider networks and consumers either outright or through some as yet unnamed type of insurance facility

Congressional efforts to enable provider networks to contract directly with Medicare or Medicaid recipients culminated in the Medicare provider-sponsored organizations (PSO) provisions of the Balanced Budget Act of 1997, subject to guidelines to be developed by the Health Care Financing Administration (HCFA). Other efforts pending in Congress relate to the commercially insured population, specifically enabling provider networks to contract directly with self-insured employers under the aegis of the Employee Retirement Income Security Act (ERISA), again superseding state insurance departments.

Some states have not waited for Congress to act. A number of states are already seeking (or have sought) permission from the federal government to "direct contract" for Medicaid with provider networks. Other states have determined that provider networks may contract directly with self-insured employers without obtaining a state insurance license, as long as the employer (or a combination of the employer and the providers)

Summary Congress and a number of state governments have recently taken steps to encourage the formation of provider/insurer networks and other forms of "direct contracting" by providers with consumers. No group is better positioned than Catholic hospitals and medical centers, with their common heritage, not-for-profit status, and history of community service, to take advantage of direct contracting opportunities.

Provider/insurer configurations fall into three categories: self-policing networks that assume full-risk contracts from payers; joint ventures between provider networks and existing insurance companies or HMOs; and provider networks that establish their own insurance capability. Anticipated changes in many states' insurance application processes will make it easier for providers to choose the latter option.

The keys to a successful provider/insurer plan are differentiation from other insurance products in the market and a strong, consumer-friendly image. The involvement of physicians is vital, and the majority of physicians on any one hospital's staff should be members of the provider/insurer network.

Currently, the Medicare population, rather than the commercial sector, is a good choice for a beginning provider/insurer network to cover. While such networks may be driven by either physicians or hospitals, a joint initiative by physicians and hospitals is preferable. Successful implementation of highly evolved medical management systems and related operational support is also key.

has the proper insurance safeguards in place guaranteeing the insurance program itself.

How are providers responding to this more permissive legislative and regulatory climate? Across the United States, very few truly comprehensive, regional provider networks even exist, let alone have the capability to become provider/insurers at this time. Still, this important legislation places heretofore unavailable opportunities at the feet of providers, and such opportunities may galvanize providers—especially hospitals and physicians—to make a determined effort to become more regionally effective and to develop direct contracting capabilities of one sort or another.

Catholic Hospitals' Unique Position

No other group is better positioned than not-for-profit Catholic hospitals and medical centers to seize on the range of direct contracting opportunities, for several reasons:

- Catholic hospitals have a common religious and philosophical heritage.
- Catholic healthcare organizations have a clear history and mission of community service.
- Catholic hospitals are not-for-profit; they do not distribute dividends to stockholders.
- Many Catholic hospitals have loyal medical staffs.
- Catholic hospitals are connected to the overall Catholic community, including, in most metropolitan areas, an archdiocese as well as a large number of Catholic-affiliated charitable organizations. This establishes a regional presence.
- Most Catholic hospitals have sufficient financial resources as well as access to additional capital.

Three defining elements in combination could make a Catholic-sponsored healthcare provider/insurer network more competitive than any other network:

- Not-for-profit status
- Community image
- Geographic and population coverage

Provider/Insurer Configurations

The spectrum of provider/insurer possibilities can be divided into three levels. At the low end of the spectrum is a provider network that assumes full-risk contracts from payers and can be considered to be "self-policing," or able to assume "delegated authorities" from payers in areas such as credentialing, utilization management, peer review, and quality assurance. Examples are hospital-independent practice association joint venture arrangements.

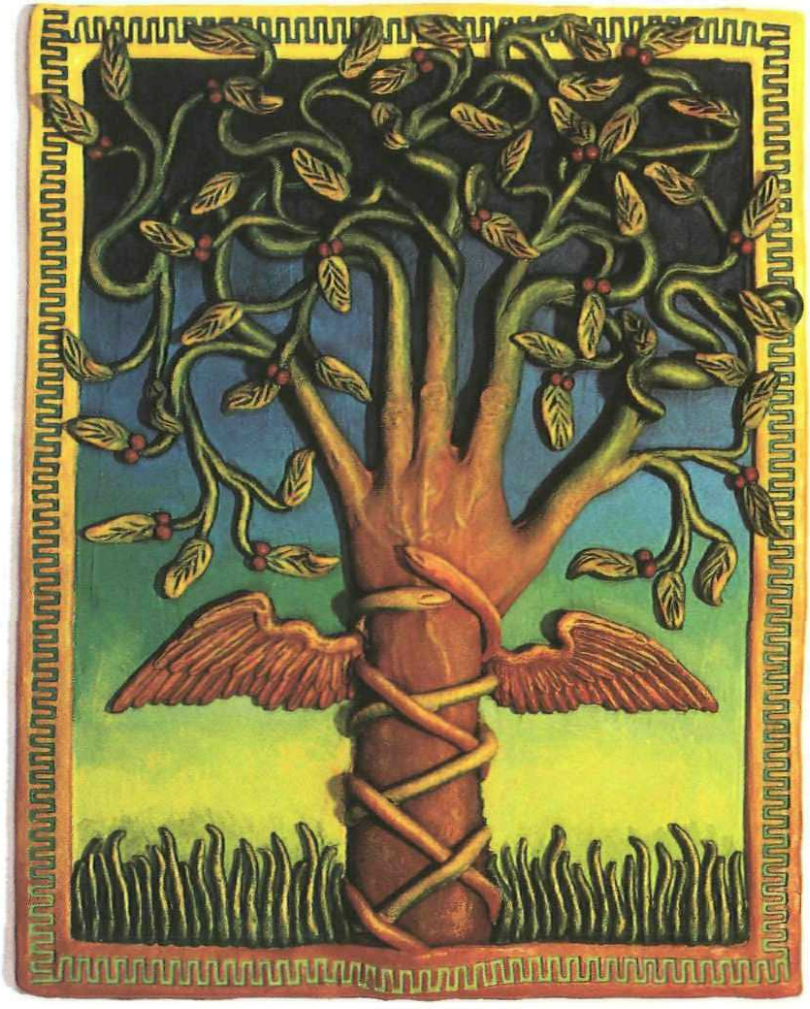

Illustration by Amy Vangsgard

Although most experts do not consider this low end of the spectrum to constitute a provider/insurer network, the assumption of a full-risk contract—especially with delegated authorities—is an excellent way for physicians and hospitals to prepare for the evolution into a provider/insurer.

The middle end of the spectrum represents a joint venture between a provider network and an existing insurance company or health maintenance organization (HMO). In some markets this kind of arrangement can have advantages for both the providers and the insurance entity. A provider network that enters into a joint venture with an existing insurer does not have to obtain its own insurance license. In addition, the existing insurer can presumably process claims, conduct marketing, and undertake other support activities that the provider network would otherwise have to develop from the start.

However, the significant disadvantage of such a

venture is that the provider network may limit its flexibility and marketing presence by tying itself to an established insurance entity. This disadvantage can be mitigated if the provider network and the insurance entity give their insurance program a new name.

At the high end of the provider/insurer spectrum is the establishment by a provider network of an insurance capability in its own right. This can be accomplished either through independent start-up licensing in a given state or through the full-scale acquisition of an insurance company by a provider network.

There are other variations besides these three. For example, one not-for-profit hospital system in southern California located a small California health insurance company from which the provider essentially "rented" an insurance license. The insurance company takes 10 percent of premiums for the rental of the license and the performance of claims-processing activities; the provider's team does all credentialing, quality assurance, and marketing. The insurance products themselves are "private-labeled" and marketed as proprietary products.

The provider system did this because the insurance application process was so lengthy and costly in California. However, the insurance application process will be changing in many states. First, with the passage of Medicare direct contracting, Congress has instructed HCFA to develop national guidelines for capitalization, reserves, reinsurance, and other elements of Medicare direct contracting programs. Although provider networks will still have to apply for a state insurance license in order to market the Medicare direct contracting programs, the new legislation makes it clear that if a state imposes regulations that are more strict that those of the federal government or if a state delays in respect to a provider network's application, the provider network can apply directly to HCFA for a waiver from a state licensing requirement. This waiver provision will most likely cause state standards to mirror the federal standards and engender widespread uniformity with respect to the underlying qualifications of provider/insurer networks that wish to create their own Medicare insurance products.

National uniformity is not expected to proceed as quickly in the commercial sector, partly because the insurance industry has successfully lobbied against passage of federal legislation similar to that passed with respect to Medicare. Thus the states are still expected to have purview over the licensing of commercial health insurance products, including licensing to provider networks. The good news, however, is that several states either have permitted or are about to permit direct contracting between provider networks and self-insured employers without requiring the provider network to obtain a state insurance license.

Self-insured employers do not fall under state insurance regulations. They fall under ERISA, passed in 1974, which explicitly supersedes state insurance regulations in this regard. Therefore, a provider network that contracts directly with a self-insured employer is, in effect, contracting with an entity that itself is exempt from state regulations as long as the self-insured employer meets federal standards under ERISA. The problem until now has been that many state departments of insurance have ruled that in a contractual situation between a provider network and a self-insured employer, even though the self-insured employer is not required to obtain an insurance license, the provider network would have to obtain such a license, or at least go through some form of state regulatory approval. There are two bills in Congress that would remove this roadblock to direct contracting with self-insured employers, one of which also expands the definition of "self-insured employer" to include confederations of small companies that are able to band together to become, in effect, self-insured.

When provider/insurer direct contracting in the Medicare and Medicaid programs becomes relatively widespread, pressure will increase to pass similar legislation on the commercial side. At that time, the Catholic Health Association and other Catholic-sponsored organizations will have an opportunity to use their significant political lobbying influence, particularly if Catholic organizations have demonstrated by that time their ability to develop and administer consumer-friendly Medicare direct contracting programs.

Essential Elements to Provider/Insurer Networks

Providers considering starting a provider/insurer network must consider some general principles. First, the network itself must cover a geographic area and population large enough to make the effort worthwhile, for both customers and providers. Furthermore, any effort of this kind is going to be expensive, requiring infrastructure and marketing dollars.

Also consider the following guidelines:

- In addition to the hospital, structure the insurance program as a not-for-profit entity, so

consumers understand that the providers are not making money in the insurance business but are compensated by providing medical care.

• Make certain that the regional Catholic hospital network covers as much of the area and population within a specified region as possible. By "network," a merger of Catholic hospitals is not meant or implied. The member hospitals can function as a confederation, achieving contracting and marketing unity through an affiliated joint venture organization (a number of alternatives exist). If there are not enough Catholic hospitals to cover the entire region, other not-for-profit community hospitals may be invited into the project.

• As early as possible in the planning process, recruit both consumer board members and physician board members. The project will not be successful without participation from both consumers and physicians.

• The insurance programs should stress comprehensiveness of services, freedom of physician choice by patients, accountability for quality, and cost-competitiveness. Make it clear to consumers that (1) this is a not-for-profit venture; (2) consumers will share any bonus pools through either lower premiums or more comprehensive services; and (3) freedom of physician choice is emphasized. This will distinguish the network from for-profit HMOs that limit consumer choice.

• The provider/insurer network needs to obtain the broadest insurance licenses possible if it ultimately intends to extend beyond Medicare recipients and into the commercial sectors. Simply obtaining an HMO license is not enough; growing numbers of people have come to think of HMOs as structures that spend enormous time and energy attempting to limit patient care and infringe on the doctor-patient relationship.

• The network should be self-regulating from the point of view of quality assurance and utilization management. This means establishing physician committees by specialty to develop treatment protocols, specialty referral rules, and other policies. In addition, task forces of physicians by specialty should work with hospital executives to develop relatively standardized critical pathways and reduce costs.

• The network should include or be associated with at least one tertiary teaching medical center.

> Product and image differentiation are the two elements necessary for success.

One principle underlies all these suggestions: product and image *differentiation.* Would-be provider/insurers must keep two primary marketing objectives in mind:

• The establishment of a strong, consumer-friendly image

• The creation of insurance products that are significantly differentiated from other insurance products in the market

Together these two elements give the provider/insurer the highest likelihood of success. A provider/insurer network that has a good public image but inadequate products will fail, as will a network that has good products but does not have a positive public image.

The Vital Role of Physicians

The involvement of physicians is absolutely essential to the success of any provider/insurer network. There are a number of ways to accomplish such involvement. The goal is not to acquire medical practices on a large scale or dictate that practices merge or reconfigure their organizations, but to have as many medical practices as possible as members of the contracting federation. This means the majority of the physicians on an individual hospital's medical staff should be members of the provider/insurer network.

How is this accomplished? When faced with the concept of a joint venture, many physicians wonder how they can ever be treated fairly in such an arrangement. Such perceptions on the part of physicians are best mitigated by established relationships in which, in a full-risk contracting environment, the physicians have participated in a bonus pool and earned more than they would otherwise have received in the routine practice of medicine.

Some joint venture concepts envision giving the

physicians majority ownership control of the provider side of the venture. Other concepts envision the creation of a for-profit medical services organization (MSO), which becomes the administrative arm of the joint venture and in which the physicians own a significant amount of stock.

In structuring joint venture arrangements, the parties need to recognize that the financial potential of good medical management will encourage physicians to have different attitudes about the joint venture's potential than they do about physician-hospital organizations (PHO), risk contracts, and other structures. In addition, the fact that a joint venture is really an arrangement among partners with the potential to participate in total premium dollars—not just premium dollars after an insurance company has skimmed off its portion—differentiates provider/insurer joint ventures from other traditional contracting arrangements.

Focusing on the Medicare population could be advantageous for provider/insurers.

What Markets Come First?

A provider network that wishes to become a provider/insurer in its own right must identify the specific segments of the consumer population to which products will be offered and design the insurance products. With the passage of Section 4001 of the Balanced Budget Act of 1997, which contains the Medicare+Choice Program, there are several reasons why focusing on the Medicare population could be advantageous:

- Congress has, in effect, given its blessing to the entire concept of "direct contracting" in the Medicare program. Accompanying this will be the development of national standards by HCFA that will provide guidance to provider/insurer networks.
- Older people are more likely than many other groups to be skeptical of HMOs and managed care. A provider/insurer network can convert this skepticism into a marketing advantage, especially if the network is not-for-profit, community service oriented, and consumer friendly.
- The Medicare population tends to be retired and live in specific hospitals' natural catchment areas.
- Marketing to the Medicare population can be less expensive than marketing to the general commercial population.

Some provider/insurer networks are also targeting the Medicaid population. Medicaid recipients tend to reside in or near natural hospital service area boundaries, and many states are encouraging the development by providers of Medicaid managed care programs and products. If the underlying reimbursement is structured properly and is accompanied by other reasonable features, then a provider-sponsored Medicaid program can be viable.

Serving the commercial markets presents different and, some would say, much greater challenges than attempting to serve the Medicare or Medicaid markets. Provider networks that intend to develop insurance products and market them to the commercially insured population need to be more comprehensive in scope and in membership, with respect to both hospitals and medical practices. In order to market commercial health insurance products to even one sizeable corporation, the network needs to cover the entire geography and population within a given region almost from day one.

Provider networks just starting out are probably well advised not to tackle the commercial sector. It is more practical for most provider/insurer networks to focus on the Medicare and Medicaid populations while building up the underlying membership in the provider network so that it does, in fact, become truly regional. Then the provider/insurer can expand to include self-insured employers and other targeted populations.

The implication here is not that marketing to the Medicare sector is easy; a provider/insurer network that focuses on this market is certainly not guaranteed success. Commercial insurers and established HMOs are also creating consumer-friendly Medicare managed care products, and

now that Congress has permitted Medicare direct contracting by providers, existing HMOs are not likely to wait around for new provider/insurer networks to encroach on their markets.

The Organizational Challenge

In general, provider networks are either hospital driven or physician driven, but hospital-driven efforts have two general advantages over other kinds of efforts. First, hospitals tend to have more capital than many other providers. Second, hospitals are accustomed to establishing information systems and other infrastructures, because of demands such as Medicare's prospective payment system.

At the same time, hospitals do face obstacles to leading provider/insurer networks. One is the wide variation in governance and management at most community hospitals. Although Catholic hospitals share more common ground than other unaffiliated not-for-profit hospitals, getting hospital medical staffs and boards to collaborate on projects of any kind is a big challenge.

Hospitals also face physicians' skepticism about hospital-driven efforts. The early PHO initiatives in the late 1980s and early 1990s did not help many hospitals in this regard, for too many hospitals tried to gain control over physicians. More recent PHOs, however, tend to be partnerships between physicians and hospitals, with greater collaboration and physician autonomy.

Some provider/insurer networks are physician driven. In a few cases, physicians have tried to start statewide HMOs as an offshoot of a state or regional medical society. Most of these efforts have not succeeded because physicians were unwilling to invest significant amounts of capital. Furthermore, the public image of a physician-only provider/insurer network is weak.

Consumers themselves have not taken the initiative to create provider/insurer networks, except in one instance. The State Employees Union of the State of New York is in the process of attempting to contract directly with providers and create their own proprietary insurance program.

A joint initiative by physicians and hospitals is the organizational structure of choice, since it can combine marketing and business practices with an understanding of the relationships between hospitals and physicians. Only physicians can engineer proper medical management and make decisions about proper and prudent practice and utilization patterns. Physicians can also perform an important marketing function for a provider/insurer network.

Providers need not merge assets or corporations in order to function as regional provider/insurer networks. In fact, hospital or organizational mergers may detract from the main purpose, which is to establish a "contracting federation" for the purpose of developing insurance products and engaging in managed care contracting.

The Operational Challenge

In the business of the assumption of risk by healthcare providers, success is measured in terms of the ability to install and utilize highly evolved medical management systems and related operational support. In other words, when it comes to assuming risk in one form or another, *implementation* is the key to viability and success.

Elements essential to highly evolved management of patient care include:

- A hospital-physician network that is large enough to cover a significant population and geography and accumulate capital, keeping the per unit investment as reasonable as possible
- Comprehensive information systems and tools for both retrospective and prospective medical management
- A unified patient medical record system, with systemwide retrieval capability
- Strong physician-directed medical management leadership
- Enrollee management support services
- Aggressive patient education, including prevention and wellness programs

Each of these elements requires coordination, expertise, and money.

In addition to the infrastructure and administrative support required to manage care for a defined population, the support and active participation of physicians—both leadership-level medical directors as well as rank-and-file physicians—is the defining ingredient necessary to reengineer medical delivery in a risk-assuming provider network. The mere aggregation of network participants is not enough, even if the network has installed sophisticated support systems. It is the intelligent, proactive application of these systems toward highly evolved medical management—responsibly implemented—that creates marginal value and permits the provider network to achieve economies and remain competitive over time. □

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