The Range Of Provider/Insurer Configurations

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Introduction

In the past few years, health care providers have begun to seriously explore the possibilities of forming various kinds of provider/insurer entities. As most people in the health care industry now know, various states as well as the Federal Government have been working on one form or another of legislation and/or regulations that would permit health care providers to either (1) become insurers in their own right or (2) at least be able to contract more directly with consumers by taking on "full-risk" contracts from HMOs and insurance companies while, commensurably, assuming additional "delegated authorities" with respect to such contracts with minimal interference from state insurance departments.

Although the various legislative and regulatory initiatives range widely, they tend to fall into three general categories:

- Initiatives which make it easier for provider networks to take on full-risk contracts with little or no insurance licensing and with less regulatory interference as long as those contracts run through legitimate existing insurance entities.
- Initiatives which permit provider networks to "direct contract" with self-insured employers and other self-insured organizations as long as such organizations meet certain definitions and insurance standards (in other words, as long as such organizations are truly "self-insured").
- Initiatives which would permit "direct contracting" between provider networks and consumers either on an outright basis or through some as yet unnamed type of insurance facility.

Much activity has taken place in the past two years in Congress relating to legislation which would permit provider networks to "direct contract" in one form or another with consumers. Since 1995 a number of bills have been introduced in this area, and they relate to both the commercially-insured population and the government programs. Recent activity has revolved around enabling provider networks to direct contract with Medicare or Medicaid recipients, subject to guidelines to be developed by HCFA, without the provider network itself having to obtain an insurance license in a given State. Other efforts in Congress relate to the commercially insured population, specifically enabling provider networks to direct contract with self-insured employers under the aegis of ERISA, again superseding state insurance departments.

Some states have not waited for Congress to act. For example, a number of states are already seeking or have sought permission from the Federal Government to "direct contract" for Medicaid in relation to provider networks. In the commercial sector, the State of Illinois Department of Insurance and a few other states have already determined that provider networks may direct contract with self-insured employers without having to obtain a state insurance license, once again as long as the employer (or a combination of the employer and the providers) have the proper insurance "backstops" in place guaranteeing the intrinsic viability of the insurance program itself.

In still other circumstances, providers themselves are not waiting for any state or Federal action. For example, several physician networks in various states have attempted to form their own HMOs, securing licensing under existing state laws, etc. In addition, a few hospital networks throughout the country have either purchased insurance companies directly or applied for their own insurance and/or HMO licensing. In still other instances, hospitals and physician's have joined together to jointly develop a direct insurance capability either through the acquisition of an insurance license or through some other kind of affiliation with an existing insurer.

The instances of outright brand new insurance company formation by providers are relatively rare (the term "insurance company" here is used broadly to include indemnity insurers, HMOs, etc.), and true successes are even more infrequent. Very few of the physician owned HMOs have been able to become successful and compete
effectively against existing entrenched insurance interests. Hospital-owned insurance entities have not been around long enough to judge, and there are so few of them that they have not had time to be successful on any kind of large scale.

This article will attempt to categorically describe the various major provider/insurer configurations as well as those configurations that can be reasonably anticipated. This article will also comment upon the qualitative characteristics, advantages and disadvantages of each type of configuration as well as elements essential to the viability and long term success of provider/insurer configurations from the viewpoint of providers and provider networks.

First, though, let us look briefly at the groundbreaking legislation passed by Congress this past summer.
I. Configurations Limited To "Full-Risk" Contracting Between Provider Networks and Independent Companies or HMOs

Full-risk contracting occurs when providers take on master capitated contracts in one form or another from existing HMOs or insurers. There are several gradations of full-risk contracting and several types of configurations, depending on who is doing the contracting as well as the scope of the contract itself.

The first point that needs to be made is that there are four general categories of full-risk contracting by provider type:

- Contracts which are "full-risk" for physician services only; usually the "master contract" is held by a physician group or network that is either strictly primary care or is dominated by primary care physicians.
- Contracts that are full-risk for hospital services only and which are held by hospitals themselves.
- Contracts in which hospitals and physicians jointly collaborate to hold a full-risk contract inclusive of both hospital and physician services.
- Contracts in which hospitals, physicians and other providers such as home health agencies enter into a contract which is both full-risk and inclusive of all provider categories, thereby becoming truly "global" in nature.

It is important to recognize that with respect to contracts between providers and existing insurers, even what many of the providers might regard as a "full-risk" contract will quite likely have some limitations. For example, full-risk contracts may exclude certain types of catastrophic illnesses as well as certain types of long term illnesses such as AIDS. These exclusions to the full-risk arrangement are usually spelled out explicitly in the contract itself, and such exclusions are fairly standard in such contracts.

Full-risk contracts may or may not come with "delegated authorities." Delegated authorities include activities such as physician credentialing, the credentialing of other types of providers, utilization management, quality assurance, claims administration and other similar functions. As a very general rule, the greater the risk being transferred to the providers or provider network, the more delegated authorities that are also transferred. For example, if a provider network is entering into a full-risk contract, the payer may "delegate" credentialing, utilization management, quality assurance and other functions to the network -- in whole or in part -- and the delegation or partial delegation of these functions is built into the economic arrangement between the provider network and the payer.

On the other hand, if a payer does not have confidence in the information systems infrastructure, management and other support capabilities of the provider network itself, the payer may retain control over credentialing, quality management and other administrative functions. This may be a permanent arrangement, or the payer may work jointly with the provider network to transition these functions over a period of time.

It is important to keep in mind that from the payer's perspective, the payer remains accountable to policyholders under full-risk contracting, regardless of how many authorities are delegated to providers. Therefore, it is not ever in a payer's interest to simply saddle health care providers with a contract that they cannot administer. There is a growing caseload of provider networks who fail to competently administer capitated or full-risk contracts; and, when a provider network becomes insolvent with respect to a full-risk contract, the consumers who are the insureds ultimately look to the payer to resolve the situation. Therefore, whereas in the recent past payers were willing to simply allow willing providers to take on just about any kind of full-risk contract, the payers are now becoming more discerning with respect to what types of contracts providers take on and, especially, what types of delegated authorities are transferred.

One arrangement that has been tried is the "administrative joint venture" in which providers, indeed, take on a full-risk contract but they rely greatly upon the payer's management and infrastructure -- at least for a period of time -- to provide the tools for proper contract administration. The physicians and providers are still expected to execute the vital "medical management" functions necessary to effect more efficient patient care delivery, but they do so using information tools and other organizational/management assistance from the payer with whom they are engaging in the full-risk contract.

Hence, in looking at full-risk contracting arrangements, it is important to look not only at the assumption of medical and patient care risk by the provider network, but also the degree to which the provider network takes on truly delegated authorities.

The facts in these situations follow what common sense would dictate: namely, that the more delegated
authorities a provider network takes on, the more a contract becomes truly “full-risk” inclusive of compensation for both the medical aspects of the contract and the administrative aspects of the contract. Most HMOs and insurers have invested large sums of money in their own infrastructure and management support systems, and there is a school of thought in the insurance business that encourages insurers to make these capabilities available for a fee to provider networks under what would otherwise be viewed as full-risk contracting arrangements. On the other hand, most sophisticated provider networks recognize that these services will nearly always be “marked up” to give the insurer a return on investment, thus building in additional costs. Thus, most provider networks that do have the sophistication and the financial capabilities to invest in infrastructure and management systems will want to take on as many delegated authorities as possible on their own, even if this follows a transitional period of some kind in which the insurer is helping the provider “get on their feet” from an administrative point of view.

The required effort and organization on the part of providers to administer full-risk contracts has been almost universally underestimated by the providers themselves. This seems to have been more true of physician-only networks than of physician-hospital networks or just hospital networks. Although little empirical information exists to explain these differences, one explanation is that hospitals and hospital systems had to develop sophisticated information systems and other infrastructure in order to be able to cope with DRGs and other prospective payment systems in the 1980’s. In addition, hospitals had to develop sophisticated financial information systems to support the multiple and challenging tasks involved in keeping track of information from a variety of payers throughout many hospital departments. Although hospital information systems still remain relatively unsophisticated when compared to the needs of highly evolved managed care, the fact that systems have been developed at all and are in place at many hospitals means that hospitals generally have more experience than physicians in managing information, reformatting information, etc.

Physicians, on the other hand, have operated by and large on a small scale, independently, and with unsophisticated infrastructure or none at all. Within the universe of medical practices, only a very small percentage of practices even today possess anywhere near the kinds of information systems and other management infrastructure to be able to undertake highly evolved managed care administration, and those that do tend to be larger group practices. The medical practice industry remains fragmented with small and independent operating units, notwithstanding publicity about some high profile group practices and PPMs (physician practice management companies). These MSO kinds of companies have really not penetrated much market share in relation to the total universe of physicians; moreover, many of those PPM companies who have acquired medical practice assets are often in a continued state of development of information systems and related infrastructure, delivering much less than is promised when the initial deals are made with the physicians themselves.

Therefore, one needs to recognize that although many types of providers are attempting to take on full-risk contracts, the ability to singularly and independently administer such contracts remains generally quite limited throughout the industry both on the hospital and on the physician side, but especially on the physician side. Some collaborations between hospitals and physicians have produced more viable, more timely results in the areas of infrastructure and management; however, true collaborations of this kind are rare at the present moment.

What are the essential elements needed for a provider network to be able to administer a full-risk contract? Regardless of who the contracting entity is, the following elements appear to be essential:

- The ability to intelligently but fairly credential the providers in a full-risk contracting network.
- In physician networks, the ability to structure medical management/ quality assurance committees by specialty, with those committees meeting regularly to review existing utilization patterns and also to develop treatment protocols.
- In hospital networks, the ability to assemble physicians and key hospital personnel to be able to (1) regulate utilization across the network and within the hospital and (2) develop or adopt “critical paths” by DRG or by encounter type.
- The development and implementation of an information systems infrastructure that can “uplink” patient encounter data from the operating unit level (whether it be a medical practice, a hospital, a home health agency, or all of the above) and reaggregate that information into intelligent medical management tools that permit both utilization and quality management within the network as well as the development of treatment protocols and critical pathways.
- In physician-hospital networks that are collaborating on a full-risk managed care contract, an understanding and acceptance of goals that are developed as well as specific financial arrangements which provide mutual as well as respective motivations on the part of all parties to successfully execute and administer the contract.
• Full disclosure by payers of all demographic and medical characteristics of the population being insured under the full-risk arrangement, and cooperation by the payers with the provider network so that risk parameters can be identified.

• An adequate cost accounting and cost finding structure within the provider network, especially relating to the more costly items such as specialists procedures, diagnostic tests and any kind of hospital encounter.

A weakness in or inattention to any of the above areas can seriously hamper the provider network with respect to effective contract administration. If the information tools are not present, for example, physicians are not going to be able to police their colleagues, much less engage in any sophisticated managed care behavior such as the development of treatment protocols. Even having advanced information tools available is no guarantee of effective risk contract management; an unfortunate fact of life in many provider networks is that one of the more challenging tasks is to persuade physicians to attend meetings, analyze data, and literally change the way they think about practicing medicine.

Hospital-physician relations can be a significant barrier to the development of managed care infrastructure capabilities with respect to full-risk contracting. For example, if the end goals and end rewards are not mutually and respectively accepted by both physicians and hospital executives, attempting to practice efficient medical management will inevitably create conflicting loyalties, arguments about what “effective” medical management really means and incessant quarreling about such issues as referral patterns, hospital outpatient utilization and other issues where the control of money always lies just beneath the surface.

In full-risk arrangements with physicians, hospitals must always place themselves in a position where their goals are such that the hospital executives can genuinely feel free to encourage the physicians to direct and engage in those policing, medical management and protocol development activities that fundamentally change the state-of-the-art of the practice of medicine itself and the delivery of patient care on a system-wide basis, thereby living up to the potential of successful full-risk contracting. Otherwise, the underlying motivation on the part of all parties to engage in highly evolved managed care will not ever be present, causing the opportunities in full-risk contracting to be limited and the potential of such contracting never to be reached. Therefore, effective contract administration requires not only technical support and infrastructure tools but also the motivation and will-power to engage in such activities.

It is vital that any provider network -- whether physician-driven, hospital-driven or some other configuration thereof -- recognize that negotiating the medical risk aspects of a full-risk contract is not the only negotiation that takes place. Negotiating (1) the specific types of "delegated authorities" and (2) the financial implications and arrangements with respect to such authorities are important elements of full-risk contracting discussions. Because it is not uncommon for insurers to charge in the range of 25% of every premium dollar for underwriting medical risk and for what they call "contract administration and profit," providers and provider networks should recognize that it is always in their best interest to take on as many delegated authorities as they can competently administer and, simultaneously, be compensated for doing so.

Some provider networks have taken the philosophy -- wisely -- that contract administration activities should be undertaken strictly on a "breakeven" basis without generating a profit on such activities in their own right. The philosophy here continues with the notion that providers should be making bonuses and net profits with the intelligent management of patient care and the efficient delivery of health care services, and that insurance functions inclusive of utilization and quality management should be undertaken as a management support service that does not make money and is not "marked up." This approach presupposes that a provider network is fundamentally better positioned to engage in medical management and other sophisticated managed care administrative functions than an insurer, as long as the provider network is properly organized and is supported by the proper infrastructure. Theoretically, then, functions that are taken over by the provider network from the insurer and are no longer marked up by the provider network can be accomplished more efficiently and, in the end, actually free up dollars which can be put into more patient services, more provider bonus pools, lower premiums or a combination of all of these.

Unfortunately, very few provider networks have reached a scale and degree of sophistication to be able to take on delegated authorities in such a way as to free up net dollars. It is this author's strong belief, however, that this will happen as: (1) provider networks become larger, thereby creating more economies of scale, (2) these networks become more organizationally sophisticated in their ability to assemble and motivate physicians and other medical talent to undertake advanced "medical management" and (3) competition from the aggressive "direct contracting" kinds of networks forces a restructuring of both the concept and the implementation of full-risk contracting itself.

The two most prevalent forms of full-risk contracting are: (1) physician-only full-risk contracts and (2) hospital-physician full-risk contracts under the aegis of PHOs. Physician-only full-risk contracts tend to cover only physician services and not hospital services. Many of these contracts are undertaken between insurers and primary care physicians, who hold the "master" contract and whose responsibility it is to administer all physician services under
that contract, including specialty services, etc.

Multi-specialty physician group practices and IPAs have also engaged in full-risk physician contracts that, most commonly, leave the hospitals out of the contract. Once again, the idea of these contracts is to draw a circle around all physician services and allow physicians to administer those services on behalf of insured populations. Although some of these contracts have been quite successfully administered, many have not. Several problems have occurred with respect to physician full-risk contracting:

- Some small and medium-sized primary care physician groups have taken on full-risk contracts for defined populations without understanding what is involved in medical management.

- Primary care physicians too often continue their old practice patterns and old referral patterns, not realizing that referrals to specialists and, in some cases, to hospitals can greatly impact the financial performance of the contract.

- Many medical practices taking on full-risk contracts simply do not have the infrastructure and information tools to administer those contracts.

- Many IPAs and physician networks taking on full-risk contracts, likewise, do not have the infrastructure tools or do not know how to use the tools they have; in some cases, management tools were simply not available and in other cases were available and were not utilized. This could either be the fault of physicians themselves, the fault of management of an IPA (or group practice) or a combination of both.

- Physicians may not have been alert enough or sophisticated enough to be able to negotiate a proper capitated rate in the first place. The payers cannot always be blamed for poor rate setting in rate negotiations. Even though payers are, of course, trying to be as competitive as possible in their respective market, it does not make logical sense that a payer would negotiate a full-risk capitated rate with physicians in which the physicians are destined to fail from day one, since the ultimate liability for medical loss excesses often falls back on payers, especially if the IPA or group practice becomes insolvent.

Full-risk contracting by physicians most often fails because the physicians do not know what they are getting into, do not realize the extent to which they need to change their practice behavior, do not have the tools to undertake advanced medical management and do not have or are unwilling to invest the capital to put sophisticated information systems and other infrastructure in place. This is not to say that full-risk contracting on the part of physicians is always a failure. Some larger group practices have quite successfully engaged in full-risk contracting, and a few have gone even to the point of "global" contracting in which they take on not only physician medical risk but hospital and ancillary risk. (More commonly, however, full-risk contracting by such groups is restricted to physician-only risk).

Some smaller medical groups have been able to take on full-risk contracting successfully when an insurance company, HMO or hospital (in a PHO type of structure) gives the group a helping hand with administrative support or enters into some sort of administrative joint venture with the group. This kind of outside support has been provided to IPAs in some instances where full-risk physician contracting has been successful. At the same time, very few IPAs or POs have been able to enter into full-risk contracting without either raising significant capital among their members (which is rare) or taking in some kind of partner.

The most common partners with physicians entering into full-risk contracting are, of course, hospitals. Generally speaking, hospitals and physicians have always been viewed as logical contracting partners for the following reasons:

- The provision of most health care services -- particularly acute care services and routine medical services -- is carried out by and large between hospitals and physicians over a "continuum" of care (it should be acknowledged that the home care industry can be regarded as a recent and important player in highly evolved managed care).

- Most hospitals have capital and are willing to invest capital for important elements such as information systems, management, and other managed care "infrastructure." The vast majority of physicians are simply unwilling to invest the amounts of capital needed for the establishment of full-risk contracting capabilities, although there are a few notable exceptions.

- In any highly evolved managed care effort, hospitals and physicians really do need to work together to "re-engineer" the practice of medicine. It is not enough for physicians themselves to change their referral
patterns and develop their own treatment protocols, because the hospital component of cost is so very high in many medical episodes. Therefore, paying attention to the hospital component of staffing, supplies, workflow and other matters can be an important element in reducing cost, and one of the most common ways of accomplishing this is for physicians and hospital staff to collaborate in the development of "critical paths."

- There are often significant administrative and marketing cost savings that motivate hospitals and physicians to collaborate on a managed care contract. This is especially true if the contract contains "delegated authorities" for the hospitals and physicians.

- Increasingly, payers are interested in full-risk contracting with as few provider entities as possible as long as those entities (a) are able to administer their end of the contract and (b) as long as the provider network covers a large enough geographic and population catchment area to make the overall effort worthwhile.

The most common vehicle for full-risk contracting by hospitals and physicians in collaboration with one another has been the PHO, which has become somewhat of a controversial entity in itself. Although at one time PHOs were widely regarded as the answer to providers' challenges with managed care contracting, they have been found to have a number of limitations in many instances:

- Many single-hospital PHOs have been too limited in geographic and population coverage.

- Single-hospital PHOs often do not have the capital to invest in complex systems and administrative support.

- Many PHOs do not have enough members of the medical staff as members to make them worthwhile.

- Many PHOs have been criticized by physicians for "stacking the deck" in favor of hospitals from the point of view of control of governance, contracting, rate-setting, allocation of receipts and bonus pools.

- Some PHOs have jumped into risk-contracting without really understanding the full process and without obtaining the necessary time commitments on the part of a large enough number of physicians to be able to effectively assume delegated authorities and undertake other medical management efforts.

One approach to hospital-physician collaboration that seems to be supplanting the more traditional PHO approach in many markets is a partnership or joint venture between a hospital/hospital system and an independent IPA or PO. There have been numerous instances where established physician IPAs were able to get together with hospitals or hospital systems and work out a joint full-risk contracting approach. These instances often involve far different revenue sharing and management arrangements than traditional PHOs. Some positive features of these kinds of arrangements are as follows:

- When an independent, established IPA or PO is coming to the table to discuss joint contracting efforts with a hospital, it is likely that the physicians have already accomplished at least some basic degree of organization among themselves. This is contrasted with many PHOs which start out by attempting to bring together widely disparate individual members of their hospitals' medical staffs who have never collaborated in any fashion.

- Some IPAs and POs are established enough in their own right to (a) have management and at least some infrastructure in place and (b) have had experience with managed care contracting, including full-risk capitated contracting with respect to physician services. Even if this management staff and this contracting experience are regarded as rather basic, the established physician organization brings to the table a great deal more than is the case with most PHOs which may just be starting out with an effort to organize independent physicians.

- Existing IPAs and POs that have already engaged in some medical management experience have the advantages of understanding what that is all about prior to getting involved with hospitals. Furthermore, the acts of conducting credentialing, utilization management, quality assurance and other efforts such as treatment protocol development forces physicians in an IPA or PO to work together, attend meetings and focus on the important points at hand. This kind of experience can be an enormous advantage for hospitals attempting to collaborate with physicians, since the physicians already understand the basics of managed care and risk management.
Many hospitals historically tended to view independent physician organizations as a threat rather than as a potential ally. In the last two or three years, however, this thinking has changed among most enlightened hospital executives. For one thing, attempts to organize their medical staffs into PHO structures have often been frustrating. Second, it is well known among physicians and hospital executives that the medical community views PHOs with a great deal of skepticism for a variety of reasons. Third, the attainment of large physician numbers in a contracting federation with a hospital or hospital system is often much easier through an IPA structure than through a PHO structure.

Physicians often feel that it is important for them to be able to negotiate with hospitals on a partnership or "parity" basis and that this is much better done through an organization that they own and control as an independent entity which can come to the table to meet hospitals on a more equal basis than might otherwise be the case. A number of hospitals and hospital systems have dramatically revised their thinking in this entire area and have taken proactive steps to approach existing IPAs and POs toward the goal of establishing a contracting federation. In some instances, the respective organizations establish a limited liability corporation which has as its "members" a hospital system and an IPA. In other instances, hospitals and IPAs have established a PHO through some type of merger in which the hospitals and physicians own the PHO in equal portions but where the physicians have a great deal more control than they might otherwise have had in more traditional, older types of PHO structures.

The ultimate struggle for ownership and control of managed care contracting between hospitals and physicians is, of course, linked to money. Money flows in two ways to providers under most full-risk master contacts. First, there is usually a division of the total capitated rate among "physician services" and "hospital services" respectively. In addition, there is then the creation of a "bonus pool" or "incentive pool" that may itself take on several different forms and have several different components.

The struggle over control of the allocation of money can be enormously complicated in hospital/physician contracting federations. Just the definition of what medical services are categorized as "physician" services versus "hospital" services can be a major bone of contention especially as it relates to outpatient and ambulatory services where a hospital is providing medical care that can also be obtained in a physician's office. When physicians or IPAs own surgicenters and diagnostic centers, the allocation of capitated dollars in these activities can also become a difficult negotiating item.

The issue of relative capital contributions can be decisive. Physicians often want a hospital to pay for just about everything in the belief that they -- the physicians -- are bringing value to the table by virtue of an organized IPA or PO. Leaving aside the fact that this can bring up a whole series of legal/regulatory issues, hospitals often insist that physicians make at least some investment in the venture in cash. Likewise, when funds are going to be borrowed from an outside source to capitalize the venture, hospitals generally like to see physicians or the physician entity "on the hook" -- at least to some extent -- with the hospitals themselves.

Most contentious of all can be the allocation of bonus pool monies. On the one hand, physicians realize that the largest single source of bonus pool money comes from reduced hospital utilization, especially reduced inpatient utilization. Since they themselves are the people making the decisions about whether or not to hospitalize a patient, physicians often feel that the majority of savings with respect to the so-called "hospital incentive pool" should go to them. On the other hand, hospital executives assert that even though hospital utilization may decline under a full-risk capitated contract, the hospital still needs to maintain a good, basic competent staff and keep facilities up to date. In addition, the hospital may incur expenses for infrastructure, marketing, administration and other activities related to the contracting venture and may feel a legitimate need for a return on these investments, all of which benefit the physicians as well as the hospital.

It is beyond the scope of this article to suggest compromises that might be explored among the parties when hospitals and physicians attempt to collaborate in a master full-risk contract. What can be said here is that there is no substitute for a full understanding on the part of all parties concerning the true implications of what it means to be a "partner." True partners understand what each party brings to the table. They understand the respective strengths and weaknesses of each party and the added value of each. True partners also understand what it means to take financial risk in a business venture, and there is no question that a full-risk managed care contract is a business venture. In the health care industry, partners who happen to be health care providers also need to understand that the payers and consumers do not really care who controls bonus pools or even how the capitated dollar is divided among providers. What the payers and consumers want from providers are (1) responsiveness, (2) value, and (3) comprehensiveness of services.

Full-risk managed care contracting between health care providers and insurers is also beginning to involve other players such as home health agencies. Even though at this time hospitals and physicians are the major parties to such contracts, other types of providers such as home health agencies, rehabilitation companies and mental health professionals are going to want to come to the table. In point of fact, hospitals and physicians will want these other parties at the table, especially if they begin to take full-risk "global" health insurance contracts from payers which truly cover the full range of medical episodes. Whereas in the past home health care, rehabilitation medicine and psychological counseling might have been considered to be "fringe" services, these and other services can, in fact,
be vital to the successful administration of a full-risk contract that purports to provide comprehensive health care to a defined population.

Therefore, three major forces are expected to be at work with respect to full-risk contracting:

- Such contracts will become increasingly "global" in nature, encompassing the full array of health care delivery.

- As a result of this, the types of health care providers that become parties to such contracts and included in provider networks will expand.

- Provider networks will, increasingly, acquire the capability and the confidence to assume more "delegated authorities" and they will take on additional contract administration responsibilities, for which they will be compensated by the insurance companies by virtue of receiving a greater percentage of the premium dollar.
II. Configurations Involving Joint Ventures Between Providers and Established Insurers

In recent years, some provider networks have entered into a variety of types of arrangements with existing insurance companies and/or HMOs which involve more than an arms length full-risk contracting relationship. A few of these new kinds of arrangements will be described here, but before doing so it is important to point out the motivations on each side that lead to what can loosely be described as “joint venture” arrangements between providers and insurers. Some of these motivations are as follows:

- Provider networks may see opportunities in a specific market to develop a "proprietary" -- or what is often called "private label" -- insurance product. This is in line with efforts to be more directly responsive to consumers. In addition, a provider network that establishes a private label insurance product is also able to market both the network itself and the insurance product, thereby cultivating a singular image in the market. Most sophisticated provider networks realize that although name recognition and a reputation for quality are important in their marketing efforts, consumers are actually making decisions about insurance products based upon features over which the providers often have little control. Fundamentally, the private label concept is part of an effort to increase market share and enhance image simultaneously.

- Money is, of course, a major motivation in any business venture. Provider networks who joint venture with existing insurers are most likely in a position to take more financial risk than they otherwise would even in a full-risk contract, but the rewards also can be significantly greater. From the point of view of the providers, if they are confident that they can undertake highly evolved medical management while, at the same time, being successful in marketing an insurance product and preserving a reputation for high quality patient care with comprehensive services, the provider network can do well financially depending upon the specifics of the joint venture arrangement with the insurer.

- Some providers believe that they need to be a true partner with an insurer in order to obtain the information and medical management tools necessary to undertake highly evolved managed care. A partnership or a joint venture arrangement most often motivates all the parties to share information because they are now working toward a truly common goal as partners rather than having separate goals as providers simply contracting with insurers. This "mutuality of goals" in a provider-insurer partnership arrangement can eliminate duplication of certain efforts while, at the same time, bringing expanded and more sophisticated capabilities to the venture.

- From an insurer’s perspective, having a provider network as a true partner causes the providers to be more motivated than ever to participate in highly evolved managed care activities, even more so than might be the case with just a full-risk contract. This is especially true if the joint venture is truly a partnership in which the parties are at risk with capital, joint marketing efforts, etc.

- Some insurers believe that their liability exposure in managed care situations is going to significantly increase in the coming years. "Liability exposure" used in this context means exposure to lawsuits as a result of claims denials, strict utilization patterns, denials of physician or other provider membership in a network or on a panel, etc. In addition, it appears that there is a growing anti-HMO consumer movement as evidenced by the recent California ballot initiative and other legislation throughout various states. The thinking on the part of some insurers is that by having the providers in partnership with more of a team concept: (a) the providers themselves will be partially responsible for making the tough decisions regarding the allocation of resources and (b) the combined organizations will be able to market in a way that results in a more positive public image.

It is important to be able to distinguish between true joint venture arrangements and full-risk contracting arrangements. Some of the features that are necessary in order for a collaboration between providers and an insurer to qualify as a true joint venture are as follows:

- The provision of medical services needs to be comprehensive, at least as comprehensive as the schedule of benefits normally marketed by the insurer. In other words, in a provider/insurer joint venture arrangement, consumers should receive at least the same benefits vis-a-vis the benefits that they would have received from the insurer solely and directly. As a matter of fact, in order to market itself more effectively and create a
positive, differentiated image among consumers, it is advisable for provider/insurer joint ventures to actually attempt to expand the benefits schedule as much as possible.

- There should be true joint ownership of either an independent entity or, at least, a specific array of products. It is nearly always advisable in a provider/insurer joint venture for the parties to create a new, separate legal entity which they co-own on some basis and through which all activities and funds are channeled, including specially "branded" products. The alternative to the creation of a separate legal entity is the creation of a product that is particular to the joint venture. In this approach, the insurance company and the providers create a product that is, technically, developed under the aegis of the insurance company but which is actually developed and marketed by both the insurance company and the providers and in which the providers share substantial ownership as well as financial risk and reward.

- A true joint venture possesses legitimate financial risk-sharing by both the providers and the insurer. One of the distinguishing features between this approach and a simple "full-risk" contract is that risk sharing in a joint venture is total, meaning that: (a) financial risk for medical services is shared over the entire array of products and services and (b) at least some financial risk for product development, marketing, administration and reinsurance is borne by the providers as well as the insurer.

- Information systems and administration are unified under one team. In a joint venture there is no longer any incentive for an insurance company to withhold special information from providers; in fact, there is every incentive for the insurer to want the providers to be as successful as possible and to have as much highly formatted information as possible to undertake sophisticated medical management. Likewise, a true joint venture centralizes functions such as credentialing, quality management, treatment protocol development, marketing and claims administration under a team concept, recognizing that the configuration of committees and task forces will be weighted variously by committee depending upon the function to be performed. For example, the parties may all agree that the insurer will handle claims administration and that the task force responsible for that will contain only one or two representatives from the provider network. On the other hand, medical management and quality assurance may be weighted very much in favor of provider representatives on those respective task forces. The delineation of committee and task force composition is normally structured on a logical, functional basis in which those functions more naturally handled by providers tend to be associated with committees that have greater provider representation, while those functions more naturally handled by the insurer tend to be handled by committees more dominated by insurer representatives.

- The true joint venture seeks to market a health insurance product or array of products (a) as a combined entity and (b) in such a way as to differentiate the joint venture's products from all others in the market. Hence, in this kind of joint venture both the providers and the insurer are each conducting marketing efforts in a "push-pull" fashion that can, if undertaken properly, be extremely effective.

In any type of provider/insurer joint venture -- regardless of the specifics of ownership and control -- the goal of product differentiation in the marketplace cannot be over emphasized. It makes no sense from either the providers' or the insurers' points of view to go to the trouble of creating a joint venture in the first place unless there are some market positioning advantages of doing so. If providers are just looking for a greater share of responsibility in a managed care contract, they might as well stick to a full-risk contract that has delegated responsibilities with the accompanying compensation. Likewise, if an insurer is simply looking to transfer more responsibilities to providers and motivate providers to undertake more advanced medical management, etc, this can be accomplished through a full-risk contract in conjunction with delegated authorities.

It is the potential to accomplish something more ambitious in a given market that should be the fundamental motivating factor as well as the overriding objective in any provider/insurer joint venture. The mere existence of a joint venture is not in itself reason to undertake such a project. Consumers really don't care about new kinds of health care organizational schemes; they respond to differentiated products and services. Thus, any contemplated joint venture between providers and insurers in a given market should be undertaken only with some important market-based objectives in mind:

- An attempt should be made to create more comprehensive health care insurance products and services for consumers than are available from traditional insurers. Within each product area, the joint venture should attempt to structure additional services for consumers themselves which, once again, differentiate the joint venture from all other insurance products in the market. The very last image that such a joint venture wants to portray is of "just another insurance company" in the market.
• Several different programs should be offered, giving consumers a choice of programs with corresponding pricing variations.

• The provider network should have as wide a membership of providers as possible, especially physicians and hospitals and including "contracted" providers.

• The provider network should cover as much of a geographic population catchment area as possible, and the "defined" market should be geographically delineated to include a logical market definition area based upon people's living and working patterns. This is particularly true if the provider network and the insurer are going to cover commercial lives through the joint venture.

• Choice of physician by consumers should be paramount as a backdrop of all product development efforts.

• The name and other "branding" features of the joint venture and its specific insurance products should be distinguished from the name of the insurance company. In some cases, a name associated with a provider network could be beneficial depending on specific circumstances.

• Emphasis should be placed upon community service and the benefit to consumers of this joint venture. Wherever possible, consumers themselves should share in the savings from highly evolved medical management and should be motivated to undertake preventive health care. In addition, some of the system savings freed up by improved management and lower utilization should be passed along to consumers either in premium reductions or expanded benefits. Every effort should be made to avoid the image of the joint venture as some kind of "sweetheart deal" between providers and an insurance company that is going to benefit only those parties.

The creation of a proper market image in a joint venture of this kind – backed up and underpinned by solid, consumer-friendly products – is the most important characteristic that will distinguish such an effort in the market and permit both the providers and the insurer to accomplish greater market penetration than would be the case with just a full-risk contract or some other more traditional managed care arrangement. Because perception and image are so vitally important in the health care industry today – especially in light of all the anti-HMO publicity of the last two or three years – it is advisable for a provider/insurer joint venture to have actual consumer representation on the board of the entity being created and even on key committees. It is beyond the scope of this discussion to suggest these kinds of steps in more detail except to say that listening to the concerns of consumers and structuring products and organizations accordingly is both common sense and good business policy.

A provider/insurer joint venture in which the hospital provider component contains not-for-profit community hospitals possesses some potential advantages over other types of configurations. First, most not-for-profit hospitals have a history of community service in the market itself. Second, not-for-profit hospitals do not have to make a profit on the insurance functions of a provider/insurer joint venture although, of course, they still need to be involved in a venture that attains a positive cash flow. Because not-for-profit hospital networks do not have pressure to generate a return on investment to Wall Street, they can focus on the mission at hand which is to provide health care services that contain true value and have appeal to consumers.

Dealing with the physician component of a provider/insurer joint venture arrangement can be quite challenging and should not be underestimated. Hospitals and insurance companies need to recognize and accept up front that it will simply not be possible to structure a differentiated array of health care insurance products at competitive prices without the active and enthusiastic involvement of physicians. Ultimately, it is the physicians themselves who must do the day-to-day work to improve the state of the art of medical management, and it is this advanced medical management that, in turn, creates efficiencies in the system. Although efficient hospitals and good home health agencies can also greatly contribute to system-wide efficiencies, "medical management" really means changing the way medicine is practiced by physicians, since physicians make nearly all of the decisions governing resource allocation and utilization.

Several general points can be made with respect to physician involvement in a provider/insurer joint venture:

• Involving physicians at the very earliest stages of conceptualization is most helpful. Any project in which the initial impetus comes from hospitals will automatically be viewed with suspicion by a great majority of physicians just based upon the historic tensions that most rank and file physicians and hospitals have experienced over the years. Wherever possible, hospitals and hospital systems should avoid getting out ahead of physicians with respect to provider/insurer joint venture discussions or else the physicians will always feel they are playing into a "stacked deck" in which the hospitals and insurance company are planning to take advantage of them.
• Physicians and hospitals who enter into discussions regarding a joint venture and who bring prior experience with full-risk contracts have a significant advantage over those providers without full-risk contracting experience. In fact, prior experience with full-risk contracting on the part of providers is almost an essential pre-condition to entering serious discussions about a true joint venture with an insurance company. Although it is theoretically possible to embark on a joint venture without prior full-risk contracting experience, numerous aspects of the project become more difficult and time-consuming without such experience. As stated previously, parties who have had such experience have often been able to work out their own political and financial differences and they share a history of actually functioning together in a collaboration to improve the state-of-the-art of medical management itself.

• A collaboration between an IPA and a hospital in joint contracting can become the basis for the provider side of a joint venture agreement with an insurance company. Once again, if the IPA (or PO) and the hospital or hospital network are already engaged in successful risk contracts with committee structures and administrative capabilities already in place, this is a significant advantage in joint venture projects with insurance companies over those provider networks that do not have either the experience or the structures in place. Even more fundamentally, in situations where physician networks and hospitals have experience working together, the physicians not only are less likely to view the whole joint venture concept with suspicion but are also more likely to actually embrace the concept and see its market potential and business potential for them.

In approaching a provider/insurer joint venture of any kind, one needs to be starkly realistic about the attitudes of physicians, or the project will fail. Physicians are not charities and do not operate their businesses as such; like it or not, this is a fact of life. Physicians do care about their patients but they view any project in the managed care arena -- especially ventures with hospitals or insurers -- with a question: what's in it for me? Most community-based physicians are in business to make money practicing medicine, and the view of many physicians around the country is that managed care efforts and government efforts are conspiring to limit or reduce their incomes.

On the other hand, the more enlightened physicians understand what managed care is all about and are receptive to going to the trouble to change the way medicine is practiced as long as there is something in it for them -- more patients, a more secure market position and, above all, greater compensation. For example, if physicians are going to go to the trouble to attend meetings and agonize over medical protocols, utilization standards and quality assurance and if all of these efforts create managed care bonus pools of one sort or another, then the physicians themselves want to get at least an equal share of such bonus pools. Anyone who has ever been involved in negotiating full-risk contracting arrangements with respect to the distribution of income between physicians and hospitals understands that a large number of issues can create stress and conflict not just in the initial negotiations themselves but also in the ongoing administration of the contract.

Hence, when physicians approach the concept of a joint venture among providers and an insurance company, many of them wonder why they should get into any kind of partnership arrangement with entities that many regard as two historic adversaries, and many of them wonder how they can ever be treated fairly in such an arrangement, notwithstanding what the other parties may say about the potential of the joint venture. As mentioned previously, the single best way to mitigate such perceptions on the part of physicians is for there to have been a past relationship already established and ongoing in full-risk contracting where the physicians (a) have already worked out some kind of acceptable ownership and governance structure with the hospital and (b) have already experienced financial rewards by virtue of participation in a bonus pool over and above what 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 equation. Other concepts envision the creation of a for-profit MSO which becomes the administrative arm of the joint venture and in which the physicians own a significant amount of stock. Physicians love to own stock in medical organizations, and they are often enthralled by the notion that at some time in the future this stock could be worth a great deal of money. This is the approach that the Wall Street MSO companies use to entice physicians into their fold.

Although some of these ideas may be good ideas in particular circumstances, there is one overriding financial motivation for physicians which, if structured properly, should cause them to consider the provider/insurer joint venture concept more seriously then they would other kinds of arrangements. The simple fact of the matter is that a provider/insurer joint venture has the potential for physicians to make a great deal of money simply practicing medicine in the right way. Physicians need to be shown that they can participate in significant financial benefits if medical management is conducted properly, given a population that is paying in constant premium dollars.

In structuring joint venture arrangements, both the hospital parties and the insurance parties to the arrangement need to recognize that it is the “here and now” financial potential of good medical management that will encourage physicians to think differently about the joint venture’s potential than they do about PHOs, 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 the insurance company has skimmed off their portion -- differentiates joint ventures from other traditional contracting arrangements.

No joint venture among providers and insurer can succeed without the involvement of large numbers of physicians in a geographic/population catchment area and without their enthusiastic participation in advanced medical management. The only way to obtain this participation, these large numbers and this kind of enthusiasm is to be able to bring the venture's potential down to the bottom line for physicians themselves inclusive of a structure of ownership and governance that renders them truly partners, if not the driving force behind the venture.

Turning to the issue of the relationship between the provider network and the insurance company, there are several different ways to approach a joint venture. The first issue to address is the relative ownership of the joint venture itself. The ownership of such an entity can be viewed with great importance or with little importance depending upon the point of view of the providers. For example, if a provider network sees ownership as inextricably linked to governance, then the provider network will probably want to have equal ownership with the insurance company in the joint venture. Likewise, if a provider network views a joint venture as some kind of stepping stone wherein the entity will ultimately be sold for what could be a large return on investment, then the provider network is going to be most interested in owning as much as possible of the joint venture on a parity basis with the insurance company.

On the other hand, not-for-profit community hospitals and community-based physicians who are interested more in the ongoing financial potential of actually managing care as well as the potential of increasing market position may not be as interested in the outright ownership issue with respect to the joint venture as they are in the issues of governance and operations. From a certain point of view, as long as providers are able to govern their affairs to their satisfaction and participate in bonus pools, premiums and other revenues to their satisfaction, the issues of who owns the stock in the joint venture, how that stock may be divided, or even what kind of entity the joint venture is in itself, may not be of major concern. In fact, as was mentioned previously when discussing physicians, providers in a provider/insurer joint venture need to recognize that the real value to them in a joint venture situation with an insurance company lies in their ability to free up a greater percentage of premium dollars for bonus pools and profits through advanced medical management itself.

Very few areas of the United States are highly evolved in terms of HMO penetration with extremely low premiums, and even in those areas there is often a consumer backlash against HMOs. Thus, the costs of engaging in highly evolved managed care and medical management is relatively low compared with the premiums that can be obtained in most areas of the U.S. This is true both in the commercial sector and the Medicare sector. Some analysts believe that the potential of joint ventures that approach Medicare recipients alone is so great that dollars almost beyond imagination can be freed up. Of course, as competition increases and as the consuming market becomes more sophisticated, a certain portion of these windfalls from managed care will disappear, but even taking this into account it is expected always to be the case that highly evolved medical management of consumer-responsive health care insurance products will yield significant and ongoing positive cash flows. Hence, providers in a provider/insurer joint venture need to position themselves to participate fully in those positive cash flows on an ongoing basis. This creation of and participation in ongoing positive cash flows is where the real focus should be.

What distinguishes joint ventures from full-risk contracting is the presence of an explicit partnership structure with mutually agreed goals and activities along the full continuum of functions, including product development, marketing, pricing, medical management, etc. The degree to which the joint venture itself will be successful and will benefit providers marginally over and above any kind of full-risk contract hinges upon (a) the depth of the partnership attitude on the part of all parties as well as (b) the extent to which a partnership atmosphere is carried through into the detailed implementation of various facets of the overall project.

Turning to the issue of revenue sharing among the partners of a provider/insurer joint venture, there are several ways to approach this issue. Two broad categories of approach that seem to be common are as follows:

- Revenues are shared first to cover costs depending upon the functions which each party is performing, and then the remaining profits are split in some fashion.

- All costs and revenues are lumped in together and the parties simply agree on a "global split."

The first of these general approaches relies upon the assumption that the providers and the insurer will, respectively, divide up functions based upon both the appropriateness of the activity and the relative strengths of each party. For example, the insurance company is often more willing and better able to take on more traditional insurance functions such as claims processing, whereas providers take on credentialing, quality assurance and medical management. When the providers take on these functions, they are also assuming significant additional costs that had previously been borne by the insurer. Providers are, in this instance, entitled to revenues similar to those that might be realized in a full-risk contract with a number of delegated authorities.

It is commonly thought that the universe of premium revenues to be split for administrative overhead and profit are about 25% of total premium dollars. In a situation where providers are not assuming any responsibilities other
than providing medical care, the insurer would ordinarily receive the full 25% out of which they would allocate money for administrative costs and profit. In joint ventures, however, if the providers are performing a number of functions that previously had been performed by the insurer, the insurance company's allocated overhead and profit portion might be reduced to 10% or 15% of the premium, with the remainder of the original 25% going to the providers. Then, once the administrative split has been negotiated, the remaining 75% of premium dollars are allocated first to actual loss claims, second to the purchase of reinsurance and any other necessary "back stops," and third, to actual bonus pools based upon the differential between the total remaining premium dollars and deductions for loss payouts.

Under the second general approach to revenue sharing -- the so called "global" approach -- the parties do not necessarily concern themselves with an allocation of cost by function but, rather, draw a circle around the entire joint venture and just decide upon an overall formula "split." For example, if the parties are 50/50 owners in the venture, they might just decide to split all costs and profits down the middle. It is also possible that the parties may decide on global splits that are segregated between administrative overhead and medical overhead claims payouts, etc. They might decide, for example, to split administrative overhead on a 2/3 - 1/3 basis but split medical losses 50/50. Many other combinations are possible.

The split of bonus pools from medical management is sometimes tilted in favor of the providers in order to entice physicians to enthusiastically participate in the entire project. Keep in mind that in the traditional insurance business, an insurance company might take 25% of the total premium dollar, allocating 15 to 20% for administrative overhead and the remainder for profit. In other words, when constructing premium pricing in a more traditional insurance scheme, 75% or more of the dollars are assumed to be paid out in claims. Thus, in a joint venture if the insurance company gives the providers the majority of bonus pool dollars resulting from medical management -- while still building in some profit from the administrative side of their own designated activities -- then the insurance company may still be doing better than it would have otherwise since "net dollars" are being freed up through the medical management.

Another way of saying this is that advanced medical management is really at the heart of what makes a joint venture between providers and insurance work in the first place. The most important parties in terms of implementing the medical management process itself are physicians, followed by hospitals. Therefore, the generation of bonus pool dollars really begins with the process of motivating physicians to focus on the project at hand. From a certain point of view, if bonus pool dollars are generated it is because physicians -- and, to some extent, hospitals -- have earned these dollars through their medical management activities. Hence, if an insurance company can build in some profit margin from administrative activities and also capture at least some of the bonus pool dollars, the insurer is still coming out ahead even if its portion of the bonus pool on a percentage basis is much less than that of the providers. This becomes even more the case if the joint venture also creates net additional market share for all parties.

It bears repeating that the single most crucial element in forging a successful provider/insurer joint venture is the physician component. This is true with respect to both the numbers and geographic spread of physicians and in terms of obtaining the commitment of physicians to engage in appropriate kinds of advanced medical management. Insurers and hospitals should not even think about a joint venture unless they are willing to recognize and reward the essential role of physicians while, at the same time, accepting the fact that very little of the capital will be coming from physicians themselves. If physicians do contribute capital, the amount of capital coming from them can usually be expected to be a low percentage of the total capital required in the entire project, but the trade-off is that the physicians -- when properly motivated -- are the people who will make the entire project successful.
III. Configurations Involving the Establishment or Acquisition of 
An Insurance Entity By Providers

It is commonly held that the ultimate stage of evolution among healthcare providers is to become insurers in their own right. Eliminating the so-called insurance "middlemen" is thought to accomplish two significant objectives: first, the elimination or dramatic reduction of layers of interstitial costs and second, the establishment of a more direct relationship between providers and the consumers that they serve. Theoretically, both of these objectives should be attainable.

Regarding the reduction of costs in the system, there is no question that the middlemen do take a significant amount of the premium dollar for administration and profit. If providers can establish insurance entities that are specifically set up to break even and not necessarily make a profit on the traditional insurance functions, then costs could be reduced. In addition, it is often the case that providers who now contract with insurance companies and/or HMOs are duplicating some of the insurance company functions which both kinds of organizations perform simultaneously. For example, some provider organizations have risk contracts that permit the providers to handle such functions as credentialing, quality assurance and utilization management while, at the same time, the insurance entity holding the contract is "shadowing" the providers by performing virtually the same functions in order to make certain that the providers do their job correctly. Many people are asking the question: what if all of these administrative functions could be handled by a single provider/insurer network? Many believe that if the providers owned and operated their own insurance entity, then there would be no need for these "watch dog" kinds of duplicative efforts and the resultant costs.

Regarding the establishment of a more direct connection between providers and consumers, the direct ownership of an insurance entity on the part of providers would appear to have the strong potential to eliminate some of the backlash against managed care that consumers have evidenced in recent years. The thinking here is that by continuing to have middlemen involved in the health insurance process, providers are continuing to abdicate more and more of the practice of medicine to these insurers. The litany of state-by-state anti-HMO initiatives is too lengthy to discuss in detail here, except to say that during 1996 and 1997 what can only be characterized as a "wave" of anti-HMO legislation has permeated some 40 states and, to some extent, Congress. Recent surveys of consumers have revealed that many Americans believe that decisions about their medical care are no longer even made by physicians and hospitals but, rather, by business middlemen at insurance organizations who are motivated totally by a high bottom line profit and a good return on investment. If the middlemen could be taken out of the equation, the theory goes, then costs could be reduced, benefits increased, and providers would be more responsive to the needs of the consumers whom they are supposed to be serving.

Thus, by virtue of the economics, the politics, the public relations and the overall "mission" of healthcare providers, the timing would seem to be perfect for providers to become insurers and contract directly with consumers.

Much activity has occurred from the legislative and regulatory perspectives in this area in the past two years. In addition to the passage by Congress of Medicare direct contracting legislation discussed earlier, some states have applied for and received the necessary permission from HCFA to permit Medicaid direct contracting. On the commercial side, a handful of states have either permitted or are about to permit provider networks to "direct contract" with self-insured employers without having to obtain a state insurance license. Many other states are considering measures designed to make it easier for providers to obtain an insurance license and to capitalize and/or acquire an insurance company.

It is possible that if "direct contracting" becomes widespread, then provider networks will not have to acquire or start their own insurance companies -- they will be, de facto, provider/insurers without actually owning an entity known as an insurance company. Nonetheless, because of the regulatory and legislative complexities that would permit direct contracting to occur on a widespread basis -- to say nothing of the formidable lobbying muscle of the insurance industry -- it is expected to take several years for direct contracting (absent an insurance entity) to flourish.

Therefore, a number of providers have decided not to wait for permissive direct contracting legislation, but, rather, have formed and are forming licensed insurance entities. These entities can be divided into the following types of configurations:

- HMOs that are new start-ups by physicians and are physician-owned.
- HMOs and insurance companies that are new start-ups by hospitals and/or hospital networks.
- HMOs and insurance companies that are acquired by physicians where the underlying insurance entity
existed prior to the acquisition as a viable, state-licensed entity.

- HMOs and insurance companies that are acquired by hospitals and/or hospital networks and that existed as viable, state-licensed entities prior to the acquisition.

- Joint start-up or acquisition of insurance entities by hospitals and physicians -- and in some cases other types of investors -- acting in concert.

To date, the degree of success of these kinds of efforts varies widely, and it can be honestly stated that a number of these kinds of efforts have fallen significantly short of their potential or original vision. However, these efforts are all worth studying, for it is important to understand the possible shortcomings and, in so doing, better comprehend the scope of challenges involved in the start up or acquisition of an insurance entity by a provider network. In addition, there are a few notably successful provider/insurer networks.

Perhaps the most important place to start this particular discussion is to explore what is meant by "provider network" in these various configurations and how the creation of the provider network itself can have a far-reaching impact on the viability of the entire project.

Both the scope and the composition of a provider network in the context of insurance company formation are critical factors that, in this author's view, are so important as to be pre-determining. The following observations can be made:

- In terms of the issue of scope, it appears that a provider network needs to be large enough to offer a comprehensive array of medical services over a large geographic and population catchment area. Just as insurance companies themselves which are marketing to a given region feel compelled to sign up providers from throughout the region, so should a provider network include network members who can bring to the network both comprehensiveness of service while, simultaneously, covering the geography.

- Marketing to an entire region (with "region" here defined as an SMSA, state or other regionally defined market penetration area) is too expensive not to spread marketing costs over many providers in a provider/insurer configuration. This is a straightforward financial reason for the provider network to be large and to cover both the region's geography and the region's population.

- Whether contractually or through direct membership, the scope of a provider network that is going to become an insurer needs to include services such as tertiary care, home care, rehabilitation medicine and other kinds of medical services that would be covered by a complete health insurance policy held by a consumer.

- In terms of the composition of the provider network itself, early indications are that neither hospitals acting alone nor physicians acting alone can become successful provider/insurers. In most cases of physician insurance company or HMO formation, physicians have not been able to raise the necessary capital to be successful. In addition, physicians face a built-in public relations problem when they attempt to act as a physician-only network, in that such provider/insurer attempts by physicians run the risk of being viewed by the public as some kind of scheme for the physicians to simply make more money. Hospital-driven provider/insurer networks, on the other hand, are rarely able to gain the trust of enough physicians to make their network a truly regional presence, much less make the physicians enthusiastic about conducting the kinds of medical management and marketing efforts that are essential to success.

Although hospitals do, theoretically, have the capital to form a provider/insurer entity, they are wasting their precious capital as long as the large rank and file population of physicians remains skeptical of -- or even antagonistic toward -- a hospital-owned insurance entity. A provider configuration in which the hospitals and physicians can come to some partnership arrangement prior to forming or acquiring an insurance entity appears to be the approach with the highest probability of success.

Once the not insignificant issues of scope and configuration are addressed, a major crossroad then becomes: do the providers start a new insurance company from scratch or acquire an existing company? (It should be pointed out that even addressing this question presupposes that a favorable kind of joint venture with an existing insurance company has been evaluated and ruled out.)

Some of the factors influencing this important "make or buy" decision are as follows:

- A detailed market assessment needs to be conducted to measure the relative market share of all existing insurance companies and/or HMOs in the market at hand. This would include, of course, the identification of any other provider-owned insurance entities, including entities that may be in the start-up phase.
• The assessment of the insurance entities in the market should include the identification of each entity's relative market position, marketing strengths and weaknesses, market segments to which the entity sells its insurance products, description of the specific insurance products, relative pricing of each product, marketing approach, infrastructure, and any known expansion plans.

• Any existing joint venture arrangements between provider networks and insurers should be identified and described.

• A matrix should be created by major market segment listing the existing players and describing existing market penetration. The major market segments in this matrix are: Medicare, Medicaid, self-insured employers, commercial HMO and commercial indemnity/PPO. If possible, the size of each market segment in terms of population should be identified.

• An "opportunity prioritization" should be constructed indicating which of the above market segments should be focused upon and why. Where possible, the geography and population should be described and evaluated from the perspective of the provider network's market penetration potential.

• Provider/owned HMOs and insurance entities should be looked at carefully to evaluate whether an acquisition or merger is feasible and whether such a move is logical given the market opportunity priorities which the provider network wishes to pursue.

• A start-up budget and timetable should be prepared relating to the licensing and creation of a brand new insurance entity to address whatever market or markets are deemed to be high priority.

• The start-up program should then be compared with the concept of acquiring an existing entity, assuming that such an entity exists in the market that is deemed appropriate given market priorities.

The cost/benefit analysis involved in weighing the decision of whether to acquire an existing insurance organization or start a new one involves answering several fundamental questions:

• What are the comparative costs in dollars?

• What are the comparative costs in time? For example, an entity that already possesses the necessary insurance and/or HMO licenses has already gone through the sometimes lengthy state regulatory process. Although many states are attempting to streamline the acquisition of insurance licenses by provider networks, this can still be a costly, time-consuming process.

• Are there any advantages of existing market presence that an existing insurance entity might have? If so, would the existing entity consider selling, and what would be the cost? (It is important to keep in mind that for-profit companies with stockholders can be expensive to acquire.)

• How much actual insurance experience and claims experience does the existing insurance entity have?

• How much existing infrastructure and administrative support does the existing entity have versus starting an insurer with none of these capabilities in place?

It is difficult to generalize further on these points without knowing the specifics of a given market and a given circumstance. It can be said, however, that a provider network should carefully examine the possibility of acquiring an existing insurer before concluding that they should start a brand new insurance entity. The acquisition of an existing insurance entity can be an attractive option even if that entity is small and relatively inactive just by virtue of the fact that the organization has gone through the necessary regulatory approval processes. In an era when both regulatory and business factors are beginning to favor the establishment of insurance entities by providers, a savings of time which might otherwise be expended in the regulatory approval stage for a start-up insurer can -- in a circumstance where an existing insurer is acquired -- position the provider network ahead of competitors in a given market as long as other insurance business fundamentals are expeditiously addressed.

Turning to a discussion of the markets to be served and the products to be offered by a provider/insurer network, the first principle to be recognized is that both the insurance of defined populations and the delivery of healthcare services tend to be regional in nature. National insurers contract on a regional basis and, most often, market regionally. Likewise, provider networks tend to be organized regionally. It is advisable for provider networks...
to organize and operate -- at least initially -- on a regional basis for the following reasons:

- As stated above, both the provision of healthcare and the contracting in health insurance programs tend to be regional.
- Both hospitals and physicians know their own regional markets and interact with each other and among their peers in those markets.
- The practical aspects of attending meetings dictate that the initial organizing efforts be undertaken among network members within a reasonable geographic radius of driving time.
- Both the business and the medical management aspects of network formation and operation require that network members work closely together, once again being accessible within a proximate geographic radius.

All of this is not to say that a multi-regional or even national provider network is not possible, especially among providers with a common background, philosophy, mission and governance approach. One obvious example of the potential for some kind of national provider/insurer network would be the Catholic hospitals and health systems throughout the U.S. These organizations all share a common heritage, are all not-for-profit and are all community service-oriented. It would seem to be feasible for these Catholic organizations to put together at least some elements of a national provider/insurer network, even if the common national elements turned out to be limited to the provision of infrastructure and other technical support services while leaving other functions such as marketing, credentialing, quality assurance and even insurance product design to regional or super-regional subsets which would have greater latitude in assembling their own types of provider networks given specific characteristics of respective regional markets.

Even though the formation of national organizations of provider/insurers appears to be in some instances to be an attractive and enormously potent possibility, significant political and logistical barriers exist in any large scale national effort. It is much more likely to be the case that regional provider/insurer networks form initially, perhaps later on linking together over a super-regional or national scale. The important goal from the perspective of providers is to encompass a region that is large enough to make the effort worthwhile while, at the same time, proximate enough to facilitate the logistical and organizational efforts so as to make the entire project able to be accomplished within a reasonable time frame.

In fact, it is highly unlikely that a provider network will be able to start out from day one with a full complement of members, even if the network is strictly regional. As with any other new type of enterprise or joint venture, the initial provider membership may constitute a percentage of what is ultimately desired. Health care providers who envision building a regional provider/insurer network are well advised to begin with the philosophy that a limited number of their counterparts will become the founding members and lead the early organizational and planning efforts. The goal of the founders, then, should be to educate and communicate enthusiasm to others, continually recruiting in new members until the membership achieves critical mass, if not full maturity.

Providers wishing to establish a provider/insurer network should not be discouraged by the relative degree of managed care penetration in their region, even if the region has a high percentage of HMO capitated type penetration. There is no market in the U.S. that is impervious to or insulated from the entry of a new provider/insurer as long as the provider/insurer network is structured properly and is consumer-friendly. In fact, many areas with high HMO penetration are experiencing anti-HMO consumer sentiments; in some respects, a highly evolved managed care market of this type could actually be a good place to start a provider/insurer network as long as the network's insurance benefits are consumer-friendly, cost-effective and comprehensive. If these elements are in place and if the provider/insurer network is able to cultivate a good general image and to differentiate itself and its products in the market, then the presence of HMOs and large insurance companies should not be intimidating.

The two most important policy decisions on the part of provider network that wishes to become a provider/insurer in its own right are: (1) identifying the specific segments of the consumer population to whom products will be offered and (2) the design of the insurance products themselves. With the passage of Section 4001 of the Balanced Budget Act of 1997, which contains the Medicare+Choice Program, the Medicare population could be considered to be a good market with respect to which a provider/insurer network should initially focus its efforts. There are several reasons why focusing on the Medicare population could be advantageous:

- With the passage of the new legislation 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, hopefully, result in providing guidance to provider/insurer networks.
- From a marketing and public relations point of view, the elderly are more likely than many other groups to be skeptical of HMOs and managed care in general. This skepticism can be converted into a potent marketing
advantage by a provider/insurer network, especially if such a network is not-for-profit, community service-oriented and consumer-friendly.

- By focusing on the Medicare population, a provider/insurer network does not need to be all-encompassing regionally. Such a network can effectively serve the Medicare population even if there are significant gaps in terms of geographic and population coverage by virtue of the membership of the provider network itself. This is because most of the Medicare population is retired; thus, every hospital has, within its natural service area, a number of Medicare recipients who stay in that area and are not commuting to work or engaging in other activities that affect the younger, commercially-insured population. It is quite possible, therefore, for a provider/insurer network to begin its activities by serving the Medicare population within the natural service areas of existing provider network hospitals, even though more hospital members of a regional network may be ultimately desired. This feature of the Medicare population has the practical effect of improving the organizational logistics and reducing the start-up time of a provider/insurer network.

- Marketing to the Medicare population can be accomplished less expensively than marketing to the general commercial population for a variety of reasons.

Some provider/insurer networks are also targeting the Medicaid population for many of the same reasons outlined above. Medicaid recipients tend to reside in or near natural hospital service area boundaries. 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. One hurdle that providers are going to face when confronting the commercial sector is the establishment of a more geographically comprehensive provider network than would otherwise be the case. Unlike the Medicare or Medicaid markets, the population to be served with respect to the commercial sector does not usually correspond to natural hospital service areas. For example, just because a company is located within a hospital's service area does not mean that employees and their families reside in that service area; as a matter of fact, this is rarely the case. Hence, while a provider network may be marketing to businesses that are headquartered in certain specific locations, the employees of those businesses may live quite some distance away, necessitating that physicians and hospital be located disparately from the headquarters of the company to whom the hospital in question may be marketing.

In short, provider networks that intend to develop and market insurance products to the commercially insured population need to be much more comprehensive in scope and in membership, both with respect to hospitals and medical practices. Whereas with the Medicare population a network can start with an initial provider membership that may not include every area of a region, this is not the case in a competitive commercially-oriented network. 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.

The practical effect of all of this is that provider networks just starting out are probably well advised not to tackle the commercial sector unless those provider networks are able to cover the regional geography and population from the beginning, as may be case in medium sized or smaller markets. It is much more practical for provider/insurer networks to focus on the Medicare and Medicaid populations while, at the same time, building up the underlying membership in the provider network so that it does, in fact, become truly regional. Then the provider/insurer can start with self-insured employers and other targeted populations. One needs to keep in mind that during the time such a provider network is building up its own membership, it is also in a position to accumulate capital for marketing expenses, which should not be underestimated particularly when marketing to the commercially-insured population. Any provider network that intends to do this must recognize that the existing insurance companies and HMOs are not going to sit by and permit the new provider/insurer network essentially take away their subscribers. In the commercial sector, an expensive marketing campaign is much more likely to occur for this reason.

This is not to say that marketing to the Medicare sector is easy, either. Many established insurance companies and HMOs already have products designed to target the Medicare population. With this in mind, the advantage of focusing first on the Medicare market becomes even more apparent. Even so, a provider/insurer network that focuses on this market is certainly not guaranteed success. Increasingly, commercial insurers and established HMOs are creating Medicare managed care products that are considered to be more consumer-friendly. Now that Congress had officially set in motion the permissibility of Medicare direct contracting by providers, the existing and HMOs are not likely to wait around for new provider/insurer networks to encroach upon their markets.

From an overall marketing point of view, it is vital that would-be provider/insurers keep two primary 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.

It is the presence of both of these key elements -- among others but above all others -- that gives the provider/insurer the highest likelihood of success. These two crucial elements absolutely go together: a provider/insurer network that has a good public image but has inadequate products is going to fail, as will a network that has good products but does not have a positive public image.

Above all else, health care providers need to make certain that they avoid doing anything that is associated with the negative perceptions on the part of the general public about managed care. In addition, everything must be done to create the impression that the concept of a provider-owned health insurance entity is beneficial to consumers and is not some kind of scheme to enrich providers at the expense of consumers or to take managed care service shortcuts at the consumers’ expense. What was written one year ago by this author still applies:

As important as it is to design health insurance packages that consumers want, it is just as important to avoid features that consumers find irritating, inconvenient or outright unacceptable. Some of these negative features include: restrictions on choice of primary care physician, undue restrictions on the ability of primary care physicians to refer to specialists, restrictions on the ability of patients to discuss program costs and treatment costs with physicians, and restrictions on the ability of physicians to discuss treatment options with patients and to refer patients to specialists who might be “outside the plan.” Prospective provider/insurers need to be at least as responsive to avoiding or minimizing these negative features of health plans as they are to designing the positive features of their product...

It is not enough for a provider/insurer to come along with one more managed care program that contains all of the negative features now present in the traditional insurance industry, even if the new program can be brought in at a lower premium dollar. Consumers are ever more conscious about the downside of HMOs and other managed care programs, and they are becoming more sophisticated about measuring the tradeoffs among cost, access and price. If a provider network can offer health insurance products designed around meeting the positive needs of consumers and avoiding the negative concerns, then the sophisticated provider/insurer will have accomplished a goal that will singularly differentiate itself from all other traditional insurers -- the goal of creating products that truly have higher value, keeping in mind all of the elements that constitute value itself.3

Footnotes

1. The author expresses appreciation to Mr. Ed Hirshfeld, Vice President, Health Law of the American Medical Association and Kathy Nino, Staff Attorney for the AMA for providing a summary of the key features of the Balanced Budget Act of 1997 affecting Medicare Part C.
