Convergence in Healthcare: Providers, Employers, and Health Plans

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Healthcare in the United States has experienced a tremendous amount of reform and innovation, especially in the past 10 years, with an emphasis on improving value. Value in healthcare is driven by increasing quality of care while reducing cost. The evolution of quality measurement has been proactive and voluntary within national organizations, such as the National Quality Forum. Reform has been less voluntary through government mandates, such as the Affordable Care Act (ACA).

One trend occurring at an accelerated pace right now that will create more changes, and ideally more value for consumers, is convergence. Convergence is not necessarily a new trend in healthcare—an industry in which providers, employers, and health plans have typically operated in their unique areas, serving consumers (ie, patients, employees, or members) in a different way, typically without crossing into each other’s domains. The exceptions to this, which is not our focus here, are organizations such as Kaiser Permanente, which has served as a health plan, an employer, and a healthcare provider for more than 60 years.

To give convergence some significance, let us look at its definition. According to the Oxford’s Learner’s Dictionary, convergence is (1) to move toward a place from different directions and meet, (2) to move toward each other and meet at a point, or (3) to become very similar or the same. I propose defining convergence in healthcare as:

1. The collaboration of payers and providers to provide population health management, and
2. Divergent healthcare organizations becoming similar organizations.

For the purpose of this article, providers are defined as physicians and hospitals, unless otherwise noted.

The United States currently has approximately 5600 registered hospitals, hundreds of health plans, and thousands of large employers. Convergence can be broken up into many categories, but this article focuses on the 3 areas of:

1. Health systems having their own plans
2. Health plans having their own providers
3. Employers directly contracting with providers.

I have excluded employers that employ their own providers, because many large employers have employed physicians and/or other advanced practice providers in their own clinics to service their employees for many years, so this is not necessarily a new trend. However, methods that bring providers to the workplace, such as primary care onsite healthcare clinics, are expanding as employers look at new ways to keep productivity in the workplace high, with less absenteeism.

The 3 Convergence Trends

The trend of health systems having their own health plans has become more widespread in the past 2 years. Since the passage of the ACA, providers are assuming more risk, including health systems acquiring health plans in increasing frequency. Some providers purchase a health plan or acquire a plan through a merger and acquisition. An estimate by PricewaterhouseCoopers suggests that 50% of health systems have a health plan license or intend to apply for one to create their own plan.

This trend is not without tension between health plans and providers. Providers are becoming more concerned about the ability to negotiate reasonable reimbursement rates, especially with several of the largest national health plans merging during the summer of 2015. The consolidation of large health plans in itself may continue to push health systems to develop their own health plans. Conversely, some health plans have become owners of providers. One of the largest examples is Highmark health plan, which owns Allegheny Health Network, a large health system in Pittsburgh, PA. More recently, Optum, a subsidiary of UnitedHealth Group, announced that it bought MedExpress, which operates 141 urgent care clinics in 11 states, to expand its ownership of providers.

The last convergence trend is employers directly contracting with providers. Although this is not a novel concept in some markets where large employers exist, it
is a new trend when a large employer, such as Boeing, directly contracts with 2 accountable care organizations (ACOs; ie, Providence-Swedish Health Alliance and UW Medicine) in its Seattle, WA, market as a healthcare option for employees during its annual open. With more than 700 ACOs currently in the United States, the trend of employers directly contracting with ACOs will likely become more pervasive.9

**What Is Driving the Success of Convergence?**

Why is convergence occurring, and what are its drivers? The ACA has been a catalyst for convergence, because of the development of new payment models—including ACOs, Medicare Shared Savings Payments, and bundled payments—an increased focus on population health management, and the shift of reimbursement from volume to value. Value-based payment models are suddenly making providers more accountable and innovative in managing their patients.

The further evolution of population health management has been another driver of convergence, as we try to coordinate better care, focus on wellness and prevention, and provide better ways for patients to self-manage their healthcare. With the increasing cost of healthcare even before the ACA, providers, employers, and health plans were already trying to find ways to reduce the cost of care for the populations that they serve.

How will various organizations be successful in this convergence movement, and how will patients reap the benefits? The answer is, through data and collaboration. Success will depend on who can assimilate the most accurate information regarding the populations the organizations serve (ie, information about the cost of healthcare, including labor, supply, medical device, and drug cost), and who can better assimilate administrative (claims data) and clinical data (electronic health records) in meaningful ways to improve the health of the populations they serve, to create value.

Sharing more data across groups in a more transparent approach will become very important, so that even patients will be able to understand the information more clearly. Leadership at the top of every healthcare organization, especially the physician leader, must drive these standards for agreed-on data sets of clinical quality and outcomes that are transparent to all.

One certainty in all this is that organizations that were historically in silos are now being pushed to create more value for the consumers they serve in a way that will translate to more organizations transforming into other segments of healthcare they were not previously in. For those involved in benefit design, these convergence trends will add complexity to their work. Ultimately, however, the beneficiaries of all this will be the patients we all serve in one way or another.

**Author Disclosure Statement**

Dr Scott has no conflicts of interest to report.

**References**