

# INSIDE EMPLOYERS' NEW HEALTH CARE PLAYBOOK

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Last year, U.S. employers spent nearly \$700 billion on employee health care services, and costs keep rising. To try to control these costs and to improve the quality of care, an increasing number of companies are cutting out commercial insurers and striking deals directly with health care providers. That can help rein in costs by eliminating the margins skimmed off by insurers and, when done well, can dramatically improve quality.



Companies including Walmart, GE, Boeing, and Lowe's have all pursued these arrangements, partnering with carefully vetted providers to design programs for their associates. The programs, such as bundled surgical care that covers start-to-finish costs, have saved the companies millions of dollars and allow employees to get back to their lives and work faster.

Not every company has Walmart's scale, resources, and clout, but smaller firms too can make direct-to-provider arrangements work. The key is to know what you're looking for and how to partner effectively. Here we'll describe two broad approaches:

- a *centers of excellence* (COE) strategy, in which employers often tap into a purchaser coalition that helps them identify best-in-class providers and create bundled-care contracts for a defined episode of care
- an *accountable care organization* (ACO) strategy, in which an employer works with a provider to craft coverage that may pay a set amount per associate for a given period and that usually links reimbursement to the provider's performance on quality and cost metrics

As you move forward, you'll benefit from working with a third-party administrator (TPA) that has expertise in crafting and managing innovative employer-based, and especially self-funded, benefit plans. Most such plans today, in fact, are managed by TPAs. In addition to facilitating the initial contract and managing the ongoing relationship with a provider, the TPA often serves as the principle point of contact and navigator for employees as they connect with the selected provider.

It's important to choose the right TPA at the outset. Ask these questions to gauge a prospective partner's capabilities:

- *What is your process for identifying qualified providers?* Look for expertise in finding value-driven providers who have experience in direct, at-risk contracts with employers.
- *Do you evaluate the quality of physicians as well as the overall provider system?* The correct answer is "yes."
- *Do you have experience in managing both the contracting process with providers and the ongoing administration of direct-to-provider programs, including paying bundled claims and other types of at-risk pricing?* Require "yes" answers and ask for specifics.
- *Do you have existing agreements with providers in the geographic areas we're targeting that excel in the medical services we're seeking? Can we access those providers?* Seek a TPA that answers "yes" to both.
- *How do you assist employee-patients as they seek out and engage with a selected provider?* Find a TPA that holds employees' hands throughout the process.

Whichever model you pursue — COE or ACO — remember that engaging in a direct-to-provider relationship is a strategic decision and that senior leadership needs to be on board every step of the way.

What follows is a guide for evaluating that decision, with advice on how to start and who to partner with. Obviously, the process is complex — it can take six months to a year to identify and contract with a single provider — but these are the essential steps.

## STEP 1: GATHER DATA AND SET GOALS

Start by clearly defining the management goals for your medical benefit plan. Presumably you want to cut costs while maintaining or improving quality. (In our experience, higher-quality care is always cost-efficient in the long run, even if some elements are more expensive.) And you want a plan that will satisfy current employees and help attract new ones.

Bear in mind that COE and ACO strategies involve narrow networks of only your selected health care providers. Consider how important having many provider options is for employee recruitment and retention (surveying your workforce can help you find out). If employees feel that the selected approach limits their choices too much, you may save money but pay a price in terms of employee satisfaction.

If you do pursue a direct contract, you'll want to get a clear picture of what you're spending on health care, which will help you evaluate alternatives. You'll also want to understand where your current benefit plan costs may be out of line. Find out how your total cost per employee compares with the industry average. If your company is spread across multiple locations, knowing your costs at each one will help you prioritize, focusing on the highest-cost areas first.

Next, figure out which medical conditions are costing you the most money. Grouping annual costs by major diagnostic categories will reveal where your employees' highest health care costs lie, and suggest the type of direct-to-provider approach that might be best. High-cost categories often include cardiac disease, orthopedics, cancer, digestive disease, and neurology. If these are the sources of the greatest expense in your employee plan, a COE program that provides bundled care for defined surgeries may be the best option, as these categories often require surgical management. If your costs accrue more in managing general or chronic conditions, such as diabetes, an ACO strategy may be the better bet. Some employers, including Walmart, are using both approaches.

## STEP 2: CONSIDER SIZE AND GEOGRAPHY

The next considerations are employer size and geography. A company's size affects the resources it can bring to bear and its attractiveness to providers; its location can inform which type of model it uses.

**Employer size.** Most premium-based plans that provide full coverage for employees don't offer direct-to-provider arrangements, which is why direct relationships typically require self-funding. Self-funding, however, can be financially risky. Because bigger employers are better able to take on this risk, by virtue of their size, many of them use self-funding because of the added control over employees' coverage it affords. Research shows that while just 20% of companies with 50 to 199 workers are self-funded, that number increases to 50% for those with 200 to 999 employees and to 91% for those with 5,000 or more. Thus bigger employers are more able than smaller ones to engage in direct relationships and craft innovative programs.

Bear in mind that a company's leverage in its negotiations with providers depends partly on how many patients the employer does or would send their way. Therefore, companies must determine whether they have enough employees in a location to support a cost-effective and mutually beneficial arrangement.

In addition, these programs are generally managed by a TPA as a "carve-out" to standard benefit plans — meaning employees still have their standard plan, but the care of certain conditions is handled outside of that plan — which makes managing the standard plan more complicated. Smaller employers may have a harder time getting conventional carriers to cooperate with such approaches in self-funded arrangements.

That said, self-funding and the direct relationships it can support are within the reach of many smaller and midsize firms. A few tested strategies can help. Regional coalitions are emerging that facilitate direct-to-provider employer programs within their communities. They support or directly purchase the best medical services on behalf of their members, and negotiate competitive bundled or other at-risk pricing that rewards providers based on value. The aggregate size of a group of employers, coupled with the psychological impact of employers banding together, can provide leverage in negotiations with providers. Often, these coalitions also offer administrative support that simplifies the management task for individual employers.

There are dozens of purchaser coalitions in the U.S. — 40 of them within National Alliance of Healthcare Purchaser Coalitions — and they provide a smorgasbord of resources and services. What they broadly have in common is a focus on helping employers use their clout to improve the value of the care their employees receive. (For more detail, see our article "How Employers Are Fixing Health Care.")

Additionally, smaller employers can benefit from the work already done by TPAs that have developed programs for larger employers. Generally, these administrators design contracts in a way that simplifies the process of bringing on additional employers. For example, Health Design Plus, the TPA founded by one of us (Ruth), creates direct contracts with centers of excellence in such a way that even smaller employers can join these initiatives and tap the programs' benefits. In one case, a midsize employer reached out to Geisinger Health System to explore such an arrangement; building on the contractual groundwork laid by Walmart and Health Design Plus, this group is now in the late stages of designing its own contract with Geisinger.

As an emerging model, alternative TPAs have entered this market to provide options for employers that have 100 to 2,500 employees. The best of them are independent TPAs that underwrite their clients, process and pay claims, and take risk. They often provide digital tools that go beyond legacy companies' basic portals, streamlining members' experience. Promising examples include Apostrophe Health, which focuses exclusively on direct-to-provider plans, and WellNet Healthcare, which expects to be offering such plans beginning in the second quarter of 2019.

**Geography.** A company that is concentrated in one area may benefit particularly from an ACO model, while one with more distributed operations may do better with a COE approach — although some concentrated employers use a COE model. ACO contracts are almost always with local providers within a relatively small region (30 to 45 minutes' driving time), as the ACO providers generally cover all care for members — in this case, a company's employees and their dependents. COE arrangements that offer travel-care programs can span much larger geographies; some big employers have just one COE provider covering employees living in several states. Geisinger, for example, provides spine surgery for Walmart associates from Pennsylvania, Ohio, New York, and 12 other states, and weight-loss surgery for associates from Maine, North Carolina, Georgia, and 15 other states.

While employers need to figure employees' travel costs into these programs, they can expect that COE providers will be willing to negotiate a competitive price since these programs expand the providers' patient pool.

## STEP 3: CHOOSE PROVIDERS

Now you can begin selecting providers. Start by evaluating publicly available cost and quality data (good resources include the [Leapfrog Group](#), [CareChex](#), and the Centers for Medicare & Medicaid Services' [Hospital Compare](#)). That analysis can quickly narrow your choices.

Also consider choosing providers that employees already use — assuming they meet quality criteria. This has two potential benefits: (1) Many employees may be able to stay with their current provider, reducing disruption and increasing acceptance, and (2) it can improve the employers' negotiating leverage because the providers will want to keep the company's employees as patients.

After identifying a provider for consideration, an initial discussion with the provider group's management at the highest levels is essential — ideally with a CEO, president, chief strategy officer, CFO, or chief of service (generally a lead physician). Buy-in at this level is important, as direct relationships can be disruptive for providers that don't have a lot of experience with them. The necessary internal change that the provider organization must make to deliver on these contracts can benefit from the "air cover" provided by senior leadership.

To gauge the provider's ability and willingness to partner with you, start with the questions below. Involving a TPA experienced with this type of contract can make this step easier.

- Are you interested in partnering in a direct, employer-to-provider relationship — either as a COE partner for acute episodic bundled care (such as surgery) or in an ACO arrangement that includes the management of chronic conditions such as diabetes?
- Do you have the structure and capacity to accept patients in these types of value-based, at-risk arrangements?
- Have you previously accepted bundled pricing or other forms of financial risk in health care contracts? (This could include taking a fixed price or agreeing to meet financial targets per patient during a specified period.)
- Do you have systems in place to provide data on cost and quality, including on safety and outcomes at the individual physician level?
- Do you have the people and systems in place to provide value-based care, such as program-specific nurse navigators and the ability to engage patients in decisions about their health and treatment and outcomes that matter to them (things like quality-of-life measures as opposed to strictly clinical indicators)?

In our experience, it's not unusual for fewer than half of providers contacted at this initial stage to answer "yes" to these fundamental questions. Equivocation or an outright "no" on any of them should be reason to reconsider or even disqualify a provider.

If both sides are encouraged by the opening discussion, typically they'll sign a nondisclosure agreement (NDA), which allows the free flow of information. Employers may share data on the number of employees in a given area and their demographics, the number of providers they expect to engage with, and the specific services they're seeking; providers must share data on costs and quality. An NDA also provides the first indication of a provider's approach to partnerships. It should be a worrisome sign if a provider struggles to finalize the language in the NDA or seems hesitant about sharing information after signing it. Transparency on cost and quality is a critical part of an effective direct relationship.

The next step is pivotal. The employer-TPA team has a call that includes the provider's lead physician and his or her team to better understand their approach to patient management, and to cover the program's goals and the employer's expectations in greater detail. This is the time to get a clearer sense of the organization's culture and

its ability to create and run a COE program, by delving deeper into and beyond the questions above. If all goes well, the provider completes a request for proposal from the employer that covers granular quality information, program process and support, financial stability, ownership and structure, potential conflicts of interest, bundled price, and other information.

Before you make a final decision, we strongly suggest that representatives from your company (typically including a benefits manager) and the TPA do an in-person visit. This will let them validate how the provider handles and measures safety and quality, get a closer look at the provider's approach to problem solving and partnerships, and further gauge the culture, including how staff — from the front desk to clinical leaders — interact with each other and with patients and families. We recommend the representatives physically walk the paths patients will take during their time at a hospital and — without management present — interview the staff involved in direct patient care.

If the provider passes these tests, it's time to craft the contract that will formalize the relationship. These contracts set roles, expectations, and requirements and are very different from those in typical managed-care agreements. As such, completing the agreement before making a final commitment to send patients is critical to ensuring that everyone is aligned with the program's mission and goals.

## FINAL STEPS

In your new collaboration with a provider, it's a good idea to launch a pilot program addressing one type of care (say, cardiac surgery or diabetes management). That said, before you move forward with a pilot program, we recommend discussing program expansion opportunities with the provider, because real value is created as multiple programs scale up. Development should be managed in stages, with new programs offered one or two at a time and design changes integrated as operations are optimized.

Finally, remember that the success of these programs depends on whether employees and leadership embrace them. To choose these plans over traditional ones, employees need strong incentives, such as ready access to same-day appointments, free travel, or — if the program is a carve-out — reduced or zero deductibles and co-insurance. And leadership expects to see a clear return on investment and improving performance over time. Direct-to-provider relationships have an impressive track record to date. Doing them well will encourage employees to buy in as well as boost credibility with leadership — both of which are necessary for the program to expand and flourish.

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