Purchaser Pressure: The Emerging Role of Employers in Driving Value in Healthcare

by David Lansky, PhD

Reprinted with the permission of the Society for Healthcare Strategy & Market Development of the American Hospital Association from **Futurescan 2018-2023: Healthcare Trends and Implications**. For more information on the publication visit, shsmd.org/futurescan.

As medical costs consume an ever increasing share of businesses' profits, self-funded employers and public purchasers of health insurance are becoming more aggressive than ever before in direct contracting with providers.

Their heightened interest in this strategy is the result of growing dissatisfaction with insurers' lack of progress in improving the value of health care. Employers have found that working directly with physicians and hospitals creates opportunities to:

- improve the quality of patient care and outcomes;
- enhance the patient experience;
- increase price transparency;
- steer employees to narrow provider networks; and
- manage costs more predictably.

For example, the Cleveland Clinic, Johns Hopkins Medicine, and the Employers Centers of Excellence Network offer travel surgery programs that allow employees from large companies such as Walmart to receive high-quality, appropriate care with no out-of-pocket costs (Johns Hopkins Medicine 2015; Slotkin et al. 2017; Zeltner 2012). And a number of large employers, including Boeing and Intel, have had success in contracting directly with provider organizations to manage the health of an enrolled population, leading to rapid improvements in the providers' quality performance and predictable multi year costs (DeVore and Cates 2015; Evans 2015; Mecklenburg 2016).

How Much Will Employers Push the Market?

Despite the initial successes, significant barriers impede more widespread adoption of direct contracting:

- Employers value the one-stop shopping that working with a comprehensive health plan provides.
- Employers prefer a "hands-off" relationship when it comes to decisions about their employees' provider network and access.
- Businesses do not have the bandwidth to build a complete network and negotiate numerous contracts.
- Most companies do not have the competence or confidence to evaluate and oversee direct provider relationships.
- Employers believe few healthcare organizations are capable of assuming risk and orchestrating complex care arrangements.

Nonetheless, I believe the trend toward direct contracting between employers and providers will grow slowly but persistently.

I also anticipate that there will continue to be strong interest in direct arrangements with accountable care organizations (ACOs), as well as increased use of episode-based payments and direct contracts for spine, maternity, cancer and orthopedic care.

What to Expect in the Future

Moving forward, new employer-driven contracting and payment arrangements are likely to have several common features, reflecting the experiences and values that employers bring to the market.

Accountability for quality. Leading businesses will increasingly select providers on the basis of quality, outcome, cost and utilization data as they strive to offer their employees the best possible care while controlling overall medical expenses. Employer-sponsored ACOs and bundled-payment arrangements generally have higher quality standards than do those sponsored by commercial health plans. Employers also frequently evaluate the performance of individual providers to be included in a preferred network.

New financial arrangements. Employers' direct contracts with providers are built on new reimbursement models and new approaches to consumer incentives. Companies are looking for predictable, multiyear, total-cost-of-care contracts that are based on either a global budget for a population or a prospectively determined price for an episode of care.

Many health plans have trouble administering these models and prefer to offer products that build on the existing fee-for-service claims payment systems they operate at scale. This is one area where physicians, hospitals, and other healthcare organizations can establish

a more responsive and accountable relationship with the employer customer. Businesses will expect providers to assume financial risk in meeting negotiated budget targets for total spending for an enrolled or attributed population; providers will both have an opportunity to capture savings when they outperform the target and risk losses if they fail to meet it.

For episodes of care, employers also prefer contracts with prospectively negotiated prices that reflect the total cost of care across all services and providers. Today, most purchasers accept that they must negotiate shared-savings approaches as a first step toward shifting providers into taking on risk and entering into direct contracts; however, they ultimately expect that a competitive market will produce efficiencies that return all savings to the patient and employer—the ultimate payers.

These shared-savings models will not be based solely on efficiencies; employers feel strongly about their moral and fiduciary responsibility to their workers and their workers' families and will not distribute financial gains until the contracted providers have passed mutually agreed-upon quality thresholds. Often these standards will reflect specific concerns of employers or their communities.

Community collaboration. Businesses know that their employees' health is only partly dependent on medical care. Increasingly, they are looking for providers who can help promote the well-being of the whole person, including understanding and addressing the social determinants of health, engaging in community partnerships, and using the workplace as a venue for health education and support.

They want their provider partners to deliver effective workplace-based health programs, such as on-site clinics, wellness and disease management offerings and telehealth, as well as social welfare, mental health and other community services.

Many businesses express frustration at the slow rate of progress in addressing important health issues for their employees. These include managing diabetes, diagnosing and treating lower back pain, increasing appropriate birthing options, eliminating unnecessary cesarean sections and helping people overcome depression.

To combat the problem, payers and purchasers in some communities have identified health priorities and incorporated performance requirements in their contracts to focus providers on improving care in these areas. They have done so by specifying medical best practices and implementing communitywide measurement and benchmarking.

Favorable conditions for employer direct contracting. Will these approaches come into play in your area? In reality, many of these initiatives will happen slowly and inconsistently across the country. They are more likely to become viable in markets with the following enabling characteristics:

- **A small number of purchasers sponsor a significant proportion of the commercial insurance covered lives in a region.** In such markets, purchasers are often large companies or state agencies. In Seattle, Boeing covers more than 100,000 lives in a region with a population of about 4 million. Intel achieved similar buying influence in Albuquerque with only 4,000 lives in a population-based contract.

- **There is alignment and collaboration between big local employers and public purchasers.** The Arkansas Medicaid program has worked closely with Walmart on the design of its bundled-payment and medical home programs.

- **Providers are ready to take on risk and be accountable for delivering high-quality care.** Intel was able to work with the Presbyterian Health System in Albuquerque and Qualcomm could negotiate a partnership with Scripps Health in San Diego because the organizations had previously worked hard to build integrated, coordinated, and accountable systems of care to satisfy other market requirements, such as Medicare Advantage contracting.

Implications for Health Care Leaders

As businesses assume a larger role in shaping the way health care is purchased and delivered in the United States, hospitals and health systems must be prepared for the new market dynamics. Following are steps leaders can take to position their organizations for future success.

Determine your readiness. Begin the internal conversation about where you are best able to assume risk or offer bundled pricing. Compile performance data on your priority service lines or population to gauge your readiness to participate in the new pricing and quality models. Moreover, understand how you compare to regional or out-of-market competitors.

Talk to regional employers. Engage with employers and business associations in your market to find out what they are looking for from physicians, hospitals and health systems; how they evaluate providers; and what consumer incentives they will offer employees to enroll in new networks. Identify the largest local companies and the major national employers with a big footprint in your area to see if they are seeking partners in value-based contracting. Keep in mind that more than 50 regional business coalitions understand these models and are available to help broker relationships between interested employers and capable providers (National Alliance of Healthcare Purchaser Coalitions 2017).

Reap the benefits of value-based care. Employers rely on economist Michael Porter's formula for health care developing direct contracts with providers: *Value = patient health outcomes ÷ the total cost of care* (Porter and Lee 2013). The increased focus on reporting

outcomes, along with the new population- and episode-based payment models that require measuring aggregate medical expenses over time, will provide companies with the tools needed to implement the formula. Take advantage of the benefits that a health insurance market driven by value and competition offers, including less micromonitoring of care processes, more opportunity for innovation and better outcomes at lower costs with innovative uses of your workforce, technology or sites of care.

A good example is bundled payment for maternity care. Many companies do not want to pay providers more for performing cesarean sections than vaginal births or for delivering babies in the hospital instead of in birthing centers; they want providers to make greater use of midwives, doulas and other less invasive options (de Brantes and Love 2016; Health Care Payment Learning & Action Network 2016).

Engage in regional efforts. Most communities today have created organizations to help providers collaborate on the necessary infrastructure for accountable care without building everything themselves. Health information exchanges, data warehouses and all-payer claims systems, quality improvement resources, and common measurement and benchmarking are all candidates for collective investment rather than competition. A number of multipayer initiatives are also emerging that intend to standardize payment methods so that all providers have consistent incentives. Your region may be part of a Centers for Medicare & Medicaid Services State Innovation Models grant, mandatory joint replacement bundle initiative or Comprehensive Primary Care Plus demonstration that could provide a focus for direct contracting. You can accelerate the shift to value-based payment and take advantage of the chance to work directly with purchasers by helping to build a more efficient community structure for provider competition.

Conclusion

In these challenging times, employers are driving vital changes in health care by:

- promoting new, disruptive models of care and reimbursement;
- fostering innovations that improve quality and lower costs;
- facilitating vital community partnerships; and
- demanding increased accountability from all stakeholders involved.

Ultimately, these will be elements of a more dynamic and affordable health system. The pace of change, however, will depend on the formation of new alliances among purchasers and motivated providers. By working together, we can accelerate a national commitment to delivering greater value to patients and to society as a whole.

David Lansky, PhD (DLansky@pbgh.org), is president and CEO of the Pacific Business Group on Health, where he directs efforts to improve the affordabilityand availability of high-quality health care.

References

Bree Collaborative. 2017. "Accountable Payment Models." Accessed October 11. www.breecollaborative.org/topicareas/apm/.

de Brantes, F., and K. Love. 2016. "A Process for Structuring Bundled Payments in Maternity Care." *NEJM Catalyst*. Published October 24. http://catalyst.nejm.org/bundled-payments-maternity-care/.

DeVore, B.L., and L. Cates. 2015. "Disruptive Innovation for Healthcare Delivery: Year 1 Report from Intel Corporation and Presbyterian Healthcare Services." Intel Corporation. Accessed October 11, 2017. https://www.intel.com/content/dam/www/public/us/en/documents/white-papers/healthcare-presbyterian-paper.pdf.

Evans, M. 2015. "Boeing Negotiates Directly with More Health Systems." *Modern Healthcare.* Published August 4. www.modernhealthcare.com/article/20150804/NEWS/150809961.

Health Care Payment Learning & Action Network. 2016. *Accelerating and Aligning Clinical Episode Payment Models.* Accessed October 11, 2017. http://hcp-lan.org/workproducts/cep-whitepaper-final.pdf.

Heartland Institute. 2016. "Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy." Published April 5. www.heartland.org/_template-assets/documents/publications/2017_qhp_issuer_contract_attachment_7_individual_4-5-2016_clean_v3.pdf.

Johns Hopkins Medicine. 2015. "Companies Pay for Employees' Surgeries at Johns Hopkins." *Managed Care Partners.* Published Winter. www.hopkinsmedicine.org/news/publications/managed_care_partners/managed_care_partners_winter_2015/companies_pay_for_employees_surgeries_at_johns_hopkins.

Mecklenburg, R.S. 2016. "A Better Way for Employers to Procure Health Care." *Harvard Business Review.* Published November 17. https://hbr.org/2016/11/a-better-way-for-employers-to-procure-health-care.

National Alliance of Healthcare Purchaser Coalitions. 2017. "Welcome to the National Alliance." Accessed October 11. http://nationalalliancehealth.org/.

Porter, M.E., and T.H. Lee. 2013. "The Strategy That Will Fix Health Care." *Harvard Business Review.* Published October. https://hbr.org/2013/10/the-strategy-that-will-fix-health-care.

Slotkin, J.R., O.A. Ross, M.R. Coleman, and J. Ryu. 2017. "Why GE, Boeing, Lowe's, and Walmart Are Directly Buying Health Care for Employees." *Harvard Business Review.* Published June 8. https://hbr.org/2017/06/why-ge-boeing-lowes-and-walmart-are-directly-buying-health-care-for-employees.

Stapleton, S.R., C. Osborne, and J. Illuzzi. 2013. "Outcomes of Care in Birth Centers: Demonstration of a Durable Model." *Journal of Midwifery & Women's Health* 58 (1): 3–14.

Woo, V.G., T. Lundeen, S. Matula, and A. Milstein. 2017. "Achieving Higher-Value Obstetrical Care." *American Journal of Obstetrics & Gynecology* 216 (3): 250.e1–250.e14.

Zeltner, B. 2012. "Walmart to Send Employees to Cleveland Clinic for Heart Care." Cleveland.com. Published October 12. www.cleveland.com/healthfit/index.ssf/2012/10/wal-mart_to_send_employees_to.html.