What Employers *Really* Want

HEALTH CARE PURCHASER AND PROVIDER GROUPS LAY GROUNDWORK FOR MORE CONSTRUCTIVE PARTNERSHIPS TO IMPROVE OUTCOMES, CUT COSTS

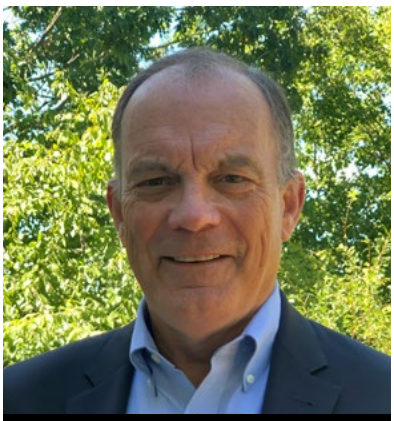
Written By Bruce Shutan

Critics of the nation's health care system often lament that key stakeholders are disconnected from one another and decisions are made in silos. But members of two such groups, health care purchasers and physicians, have engaged in strategic discussions over the past year or so to change the narrative. Their considerable influence and insight offer self-insured employers a path to better collaboration on improving care delivery, clinical outcomes and value.

It's all part of a joint effort by the National Alliance of Healthcare Purchaser Coalitions, a nonprofit representing more than 45 million Americans whose members spend $300 billion a year on health care, and Council of Accountable Physician Practices (CAPP), which represents leading medical groups and health systems that include more than 80,000 physicians. Leaders of these organizations were featured at SIIA's national virtual conference last fall.

The most recent of two reports rooted in that outreach offer employers several recommendations. Takeaways include the need to develop integrated behavioral health models; work directly with provider groups to ease delivery of care; require an action plan to weed out waste, fraud and abuse; adopt alternative payment models that hold provider groups more accountable for cost and quality; and determine how telehealth can be scaled with alternative payment models for behavioral health, primary care consultations with specialists, partnerships with safety-net providers, and care for patients living beyond in-network service areas.

A FULLER UNDERSTANDING AND APPRECIATION


Michael Thompson

Employers that talk directly with medical providers can collaborate and better understand each other's perspectives in a way that's not possible when they're at the behest of middlemen. "Providers often don't have a full appreciation of what employers are really looking for," notes National Alliance President and CEO Michael Thompson.

He says they may perceive that the aim is just about saving money but overlook their desire to improve the care and wellbeing of employees for which a stronger partnership is being sought. The trouble is that it's inherently difficult for many employers to be highly vested in direct relationships when oftentimes their employees are spread across the country, according to Thompson. That's why he says the need for aggregation and collaboration across employers or within markets is so important.

"We're finally getting some communication between the customer that's paying for all this care and the provider," reports CAPP Vice-Chairman Norman Chenven, M.D., who's also founding CEO of Austin Regional Clinic and president and CEO of Covenant Management Systems.

By talking directly to employers, he says providers gain a much better understanding of their pain points and can resolve problems more effectively. But the desire for these conversations depends on who's having them. For example, he says a high-end specialty group may not be as eager as, say, an orthopedic group with a surgery center that wants to talk about a center of excellence and bundled payment.

One of the National Alliance's most high-profile members, the Midwest Business Group on Health (MBGH) conducted some of its own focus groups with employers, providers and physician groups. The MBGH conducted some of its own focus groups with employers, providers and physician groups.

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Notable findings were that value-based and enhanced care, as well as access to quality data on hospital and physician practices, are top of mind. However, there are serious obstacles that must be overcome. Most MBGH members, about 40% of which have 1,000 to 10,000 employees, don't have direct provider contracts, and therefore, lack any influence over designing networks and alternative payment models.

"Self-insured employers want to have a say-so, and they are often left out. Yet, they're the real payers of health care," explains MBGH President and CEO Cheryl Larson. "They are the ones that are paying the bills, and the PBMs [pharmacy benefit managers], health plans and others are intermediaries." Third parties worry that sharing information with their employer customers will disclose proprietary provider discounts, which she says is why the data is kept under wraps. But this prevailing attitude flies in the face of growing calls for complete transparency.

PAIN POINTS AND OPPORTUNITIES

Thompson cites three pain points and opportunities for self-insured employers. One is that cost-sharing strategies over the past two decades have eroded the affordability of primary care for many employee populations. As such, there's a need to deliver better value that supports the health and wellbeing of employees while also reducing costs.

A more strategic investment in this area, which he calls "advanced primary care," involves patient-centered medical

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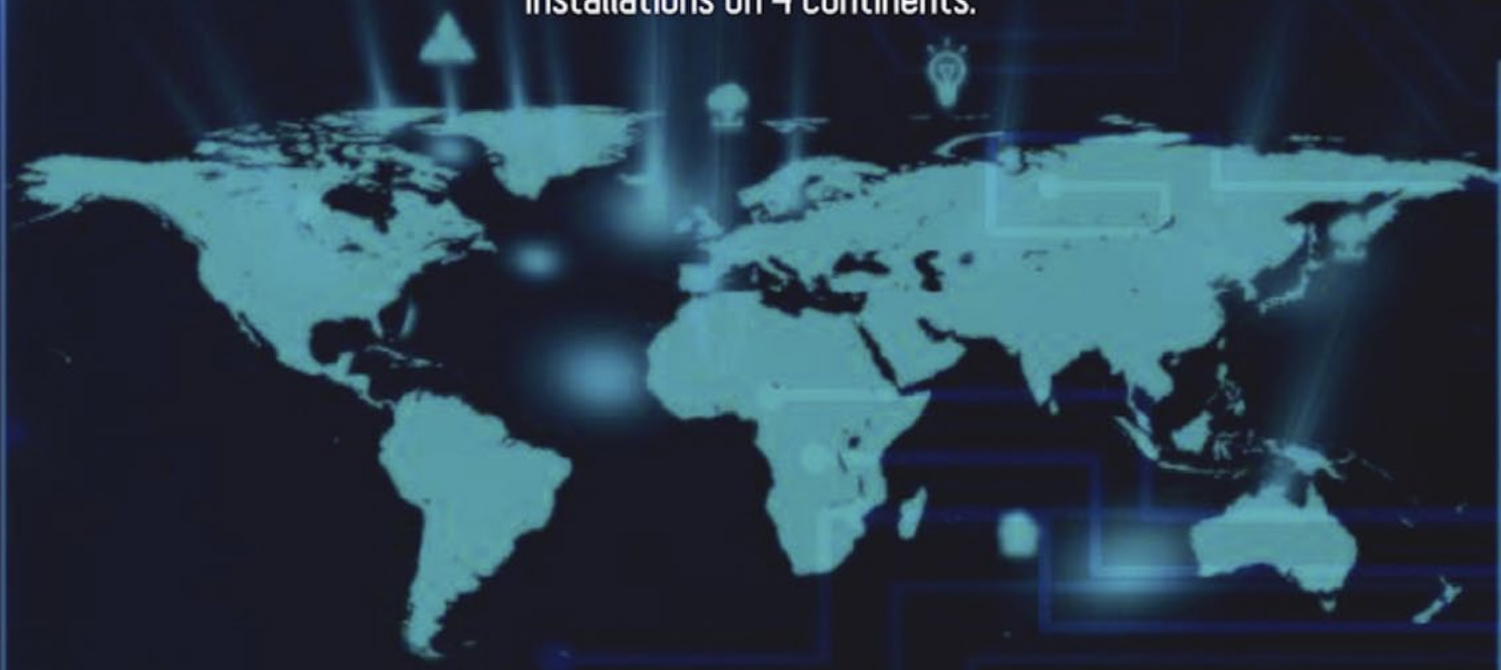

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homes and direct primary care, both of which add high value to purchasers and patients alike. The idea is that by spending more on primary care there will be a more meaningful downstream impact on health outcomes and cost.

"We really want to work with providers that understand what purchasers need and that are committed to that higher performing level of primary care," Thompson explains.

Another major concern is that as health care systems consolidate, the issue of opaque hospital pricing has gone largely unchecked with significant variations from one market to the next. RAND's margin and overhead analyses of hospitals provides substantial insight that can be used to move the needle on pricing transparency and fairness, according to Thompson.

Moreover, he says the employer community will need to be active on the policy front to help prevent more hospitals and health systems from becoming a monopoly or oligopoly.

"We don't see a strong correlation between the hospitals that are charging the most versus those who are performing the best and achieving better outcomes," he reports. "Employers increasingly will need to be more value-oriented in how they are contracting, even for procedural type care."

He believes regional centers of excellence have more of an impact than facilities with a national focus in terms of performance, price and consumer experience.

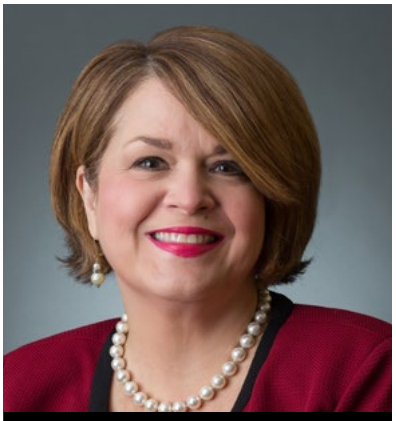
An important consideration along the road to reference-based pricing is that "sometimes unit costs can miss the boat if you don't consider the full course of care and outcomes of that care," Thompson observes.

His organization has leaned toward "more episodic bundles as the way to shift pricing to being more of a market-based approach that is more inclusive and really doesn't reward health systems to make it up on volume with unnecessary care," he adds. "The days of thinking buying discounts delivers high value are over. What delivers value is engagement at a level of transparency and accountability, and realignment of incentives that move plans to eliminate waste and manage to the specifications of the people paying the bills."

A third major issue is high-cost claims whose frequency and severity have become more untenable for health care purchasers over the past decade. Much of it involves the specialty drug area where $1 million to $2 million-plus treatments for a single individual have a catastrophic effect. "Those are not bills that are sustainable for most employers," he says, noting how PBM pricing amounts to a shell game that preserves significant Rx margins. A key initiative at the National Alliance involves redesigning the market to better manage these claimants.

While predicting federal efforts to enhance health care benefits while making them more affordable and accountable to payers, Larson points to a "desperate need for change on the pharmacy benefits side." Unregulated PBMs and other intermediaries typically add 10% to 40% to the already high cost of drugs, she says, hoping for a legislative solution to stem the high cost of drug utilization fees, rebates and claw-backs agreements.

"We've got members of ours that are using a model that Caterpillar has offered for years, which is optimizing their PBM contracts to get rid of clauses that only serve the PBM," she says. "And they're doing direct contracting with retail pharmacies, formulary management and other things that take the misaligned incentives from PBMs out of the equation, which is what can creep up your cost."



Cheryl Larson

NEED FOR TRUST AND TRANSPARENCY

Larson sees the need for her members to develop partnerships with physician groups, noting that MBGH has made overtures to some state-based provider groups about ways to collaborate. She also touts the group's ongoing association with the nonprofit Catalyst for Payment Reform and believes pandemic challenges will help right some of the wrongs in fee-for-service medicine.

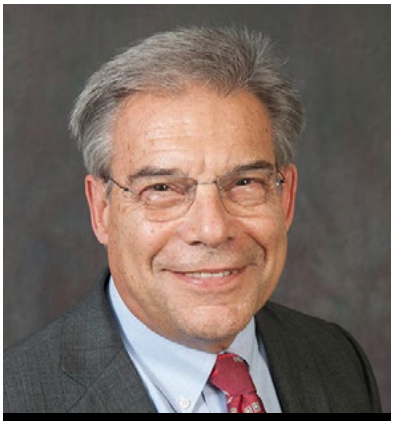
There are several objectives that come into play in addressing what employers really want. One, for example, is for large national companies with multiple worksites to embrace models that may work in one region, but are not present in others. Another is to ensure that behavioral health is integrated into medical benefits largely through telehealth, which became the primary conduit because of Covid-19 restrictions. Employers would like to see the application of this model continue post-pandemic because they recognize that many employees prefer a more confidential environment in which they feel safer.

It's also important that payment parity is in place to protect providers, who Larson says may earn higher fees from in-person visits. While many providers quickly adapted to virtual care, she notes that those who didn't suffered, which means it's critical to build a model wherein they're "reimbursed appropriately."

A big lesson from the pandemic is that telemedicine works when done properly, according to Chenven. He attributes the huge pre-Covid-19 resistance to employers and insurers fearing that physicians would convert typical nurse triage calls into a visit and the cost of care would rise if they paid comparable levels for telemedicine visits. "I actually think it would be the opposite," he observes. "When the emergency declaration allowed for telemedicine be paid at the same level as an in-person visit, we were up to 70% of our visits from 3% to 5%."

Any meaningful collaboration between self-insured employers and the provider community to move the needle on cost and clinical outcomes must be built on trust. "When we talk about employer pain points, waste is a big issue, so making sure the provider network is appropriate and the vendor solutions that they're offering are being accountable," Larson reports.

There's also the issue of inconsistency in the system, she says, noting the need to hold providers accountable for their outcomes. A RAND study for MBGH's sister coalition, Employers' Forum of Indiana, showed the commercial insurance market paid hospitals 250% to 350% or more on average than Medicare reimbursement rates, suggesting wasteful spending.



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Larson believes these findings, along with antitrust lawsuits over egregious billing practices such as the one against Sutter Health in Northern California, will help pry open the door for greater price transparency. They also could spark more evidenced-based agreements, she adds.

Chenven is heartened that employers are starting to recognize the importance of primary care and tethering it to behavioral health. "I just don't think employers had understood the inherent value there," he says. "And, frankly, the insurance companies should have been pushing this years ago."

Their chief concerns center around the need for trust and transparency with frustration mounting over the dramatic cost variation of procedures. He notes that the cost to the patient for an appendectomy, for example, could range from $500 to $5,000 from one hospital to the next with varying levels deductibles, copay and coinsurance across dozens of different insurance contracts.

Holding service providers more accountable may be the key to fighting inertia. "I don't think that the health care system is going to change unless employers understand what's going on and exert pressure on the brokers and health plans to help organize them," Chenven believes. "That's what they're being paid to do, and in my opinion, it's not working out very well."

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.