Direct Contracting: How Employers Can Reduce Their Healthcare Spend

By Bill Lacy, President and CEO, Association for Corporate Health Risk Management (ACHRM)

As healthcare costs continue to rise and the new Health Law (ACA) accelerates this trend, Employers as the Payers for healthcare are seeking strategies to contain their healthcare costs. A Preferred Provider Network organized and administered by a health insurance carrier or commonly referred to as a PPO, can offer broad access; however, it is like a **third rail** for Employers for containing their healthcare costs.

Over the past three years, ACHRM has offered over 100 educational events bringing together over 1,000 Employers and national thought leaders to find solutions in containing healthcare costs. Our association has found PPOs to be an ineffective model for the following three reasons:

- First, traditional PPO structures do not provide price transparency for prices being charged for healthcare services. Many times the consumer as well as the Provider do not know the actual price until after the transaction is consummated or sometimes many never know. Hence, healthcare is not really a free market in the United States.
- Second, there is no correlation between the price being charged for healthcare services and the Patient's experience or quality outcome. Imagine purchasing a meal at a restaurant or an automobile and not being provided a price schedule or a refund if you're not satisfied. As consumers, we know we expect to pay more for a Mercedes as compared to a Yugo, but we don't have this same knowledge when selecting healthcare service Providers.
- Third, the health insurance carrier acts as the intermediary collecting payments from Employers, processing insurance claims, and negotiating payments with healthcare Providers, but if does not share pricing information with the Employer. The Employer has become accustomed to hearing the costs paid to healthcare Providers by insurance carriers as "discounts," but is rarely (or never) given a basis or metric explaining what the "discount" is based upon. We just get a false feeling of success when we hear significant discounts of 20, 30, or 80%. The harsh reality is the prices have been marked up so high prior to the "discount," that Employers get caught into the practices that we might experience with retailers that mark up prices and then offer sales of 20, 30 or 80% off.

The Employer experiences and cost containment case studies, which ACHRM has seen in its community, have been centered on healthcare facility charges. While facility charges may only represent approximately 8% of total medical claims, total charges can be upwards of 40 or 50% of total healthcare spend. In addition, we have also seen Employer benefits that go beyond healthcare costs, which can be considered total value or the relationship between quality outcomes and costs.

As Employers are taking charge of their healthcare costs and employing the same discipline that they apply to other management decisions, ACHRM is seeing more Employers transitioning from fully-insured to self-funding; becoming more active in the selection of their Third Party Administrator and Stop Loss Carrier; rewriting their health insurance Plan to more effectively fit their health risk profile; and demanding (and analyzing) their health insurance claims. During claims analysis, we are finding Employers are discovering the significant variances in rates being charged for comparable services and the lack of consistency of payments.

It's not just Employers who are challenged by the current PPO model. Many healthcare service Providers find the PPO model difficult to implement. The current structure offers inconsistent and unpredictable cash flow to the healthcare service Provider. ACHRM has found great things can happen when healthcare Providers and Employers work together.

Direct Contracting or the agreement between these two parties offers Employers – small and large -- powerful new opportunities to control their healthcare spend.

Direct Contracting:
The process when a self-insured Employer negotiates an agreement directly with a healthcare Provider. The Provider can range from lab companies, outpatient radiology centers to entire hospital systems. This contract allows the employee/ Patient in-network access to Providers that could have been considered out-of-network (resulting in increased shared cost for the patient and employee). A growing number of self-insured Employers are bypassing health plan administrators and contracting directly with Providers in efforts to limit the increases in their health care costs. Contracts are typically negotiated at a discounted rate from the Provider's usual charges. Many include quality measures that are required to be at a certain level or penalties are implemented. Direct contracting keeps the Provider accountable while going around the middleman – the health insurance company. Direct contracting is financially beneficial in most instances and should be approached with trusted partners.

While there are broad measurements of healthcare outcomes such as Leap Frog, the most effective measurement of healthcare outcomes is based on the individual Patient's (or employee's) and his or her dependent's experience. A direct relationship between an Employer and healthcare Provider lays a foundation for improved quality outcomes as data from employee experiences can be gathered and reported to the healthcare Provider. These experiences can also be linked to payment rates and improve accountability.

Direct Contracting can also be a catalyst for new revenue sources, such as wellness services. As healthcare Providers are building continuums of care, Employers are seeking more effective ways to prevent health issues and sustain greater well-being among their workforce. Employers' and healthcare Providers' objectives are aligned making direct relationships beneficial.

Direct Primary Care can be a powerful starting point for any size Employer. To have access to a primary care physician, registered nurse, nurse practitioner, or other medical professional, the Direct Primary Care model is typically offered on a PEPM (per employee per month) charge, and ACHRM has seen charges ranging from $50 to $100 PEPM across its footprint. Assuming a primary care Physician can address 60 to 80% of an individual's healthcare needs, the Direct Primary Care model can be an effective risk management tool. Direct Primary Care can be a valuable benefit for Employers with less than 50 employees who are not required to provide healthcare insurance but still want to offer a benefit. As compared to health insurance of +/- $1,200 PEPM, Direct Primary Care offers smaller Employers a cost effective benefit opportunity.

During the 10th Annual Healthcare Growth and Finance Conference in Charlotte, NC, one of the panelists quoted a compelling statistic. One third of Patient visits at hospitals are employees and their dependents; however, this represents 74% of the health system's total revenues. The speaker's recommendation to health systems is that as Employers "awaken" to this financial issue, the health systems will need to change their business models.

Direct Contracting will also assist with growing consumerism. As illustrated in a CNN segment (Morgan Spurlock: Inside Man) on January 24, 2015, it's almost impossible for the consumer to determine the actual price for a particular healthcare service. With limited or no price transparency for healthcare services and even less correlation to outcomes, the consumer is placed in a challenging position to make an educated decision in selecting healthcare services. Arguably, this could make exchanges destined for failure. Software and other information tools are being created and offered to Employers to help employees become more effective consumers. While these tools are a good first step for engaging employees, the information is based health insurance claims data, which unfortunately do not assure the future charge.

For both the Employer and healthcare Provider, Direct Contracting enables domestic and international medical travel. As reflected in the table below, ACHRM has developed various stages for implementing domestic and international medical travel based upon its educational and collaborative workshops and roundtables.

STAGES TO IMPLEMENT DOMESTIC / INTERNATIONAL MEDICAL TRAVEL

STEP 1: Transition from Fully-Insured to Self-Funded
STEP 2: Determine Your Health Risk Profile (Access & Analyze Your Health Risk Data)
STEP 3: Understand Your Healthcare Costs (Review Your Claims)
STEP 4: Customize Your Health Insurance Plan
STEP 5: Explore Your Medical Travel Opportunities
STEP 6: Negotiate a Direct Contract Between Your Organization and a Healthcare Provider

EVERY STEP*: Educate / Incent / Engage Your Employees*

In summary, as our country's healthcare delivery system continues to unbundle, disintermediate or reregulate and Employers assume more of the responsibilities once provided by health insurance carriers and healthcare service Providers, they will seek more effective delivery methods, and the current PPO structure will continue to change. Direct Contracting between Employers and healthcare Providers will continue to develop and become more commonplace. The benefits of Direct Contracting to the Employer can include the following: provides discipline similar to other vendors, aligns the purchaser/user with seller/Provider, offers cost price transparency; opens the door to domestic and international medical travel expanding healthcare options; increases competition, defines outcomes, value, and quality; and boosts employee options and satisfaction. Direct Contracting can also offer healthcare service Providers benefits as well. For example, this method offers Providers a closer relationship with their purchaser/user (aligning objectives); an opportunity for less complicated cash flow, the potential for increased patient volume, and lays the foundation for new services and market expansion. Like any new methodology, Direct Contracting does carry risks and should be pursued with experienced advisors.

About Bill Lacy and ACHRM:

Bill Lacy has 30 years' experience in executive and financial leadership positions. Currently, Bill serves as the President and CEO for the Association for Corporate Health Risk Management (ACHRM), a membership based organization comprised of progressive employers ranging in size up to 30,000 employees and Best-In-Class Sponsor Partners seeking education, a venue to collaborate, innovative methodologies, disruptive technologies and other resources to more effectively contain their organization's health care costs.

Prior to ACHRM, Bill held positions as CFO and COO for Business Health Services, a national Corporate Wellness and Behavioral Risk Management provider based in Baltimore, Maryland; and CFO for Planet Fitness PA based in Lafayette Hill, PA. Bill has also held executive positions with the Association for Corporate Wellness (ACW), Susquehanna (Equity) Bank, Exelon (PECO) Energy, Rainbow Industrial Products and NatWest, and Entre Advisors LLC.

Bill serves as Vice Chairman for the University of the Sciences' Board of Visitors, the Burlington County College Foundation Internship and Mentoring Committee as well as other Boards and Committees during his career. He earned his MBA (finance and marketing) from Drexel University and BS (math and economics) from Ursinus College.

ACHRM Corporate Health-Risk Innovation

*ACHRM is a unique employer-exclusive community, which provides a forum for collaboration with peers about a number of health promotion topics including: education, disruptive technologies and solutions, and new methods and techniques to reduce a company's healthcare costs and improve employee well-being and productivity. ACHRM offers attractive corporate membership opportunities for both small and large employers. Visit ACHRM's recently updated website (**www.achrm.org**) to register for upcoming workshops, webinars, and other events. Bill Lacy can be contacted at **(865) 979-2067** or by email at **wlacy@achrm.org**.*