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Self-insured employers go looking for value-based deals

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"The idea isn't to hurt local systems. It's to make healthcare evolve into something better than what it is today."

Dan Ludwig (left)
Employee benefits director
Brakebush Brothers

Self-insured employer groups want to narrow the current large gap between commercial and Medicare payment rates.

A growing number of self-insured employer groups are pushing to transform how healthcare is priced, steering their employees to high-value providers and negotiating prices as a percentage of Medicare payment rates.

Faced with sharp premium increases—more than double the rate of inflation in 2019, according to the **Kaiser Family Foundation**—smaller and midsize employers increasingly want to identify lower-cost, high-quality hospitals and physician groups and design their health plans to encourage employees to go to those providers. They aim to narrow the large gap between commercial and Medicare payment rates.

Public and private employers in **Colorado**, Connecticut, Michigan, **Montana**, Texas and Wisconsin are adopting that approach. They're considering or launching group purchasing initiatives with narrow- or tiered-network plans; direct-contracting with providers, such as referring employees to designated centers of excellence for some procedures and conditions under bundled-payment deals with warrantied results; on-site primary-care clinics; and contracts with advanced primary-care providers.

North Carolina tried to tie hospital rates in its public employee plan to a percentage of Medicare rates but had to back off in the face of intense hospital resistance.

"I'm seeing a level of boldness on the part of our members that I haven't seen before in my 27 years here," said Cheryl DeMars, CEO of the Alliance, a Wisconsin healthcare purchasing cooperative. "There is a kind of movement afoot."

Purchasing group leaders say employers are eyeing these more aggressive measures to counter the formidable market power of consolidated hospitals and physician groups. In 2016, 90% of metropolitan areas had highly concentrated hospital markets, while 65% had highly concentrated specialist physician markets, according to the **Commonwealth Fund**.

These employer moves represent a big change from recent years, when employers held down health benefit spending by **shifting costs to employees** through higher deductibles and coinsurance. Employer groups say that strategy may have reached its limit as employees can no longer afford the high cost-sharing.

Even with that cost-shifting, business spending on employer-sponsored private health plans rose 7.2% in 2018, up from 5.5% in 2017, according to the **CMS' latest report on national health expenditures**.

"Employers are no longer looking to cost-shift to employees who are already strapped," said Morgan Kendrick, Anthem's senior vice president for national accounts. "They have a greater appetite for high-quality, more economically advantageous networks." Self-insured employers across the country provide health insurance to an estimated 110 million Americans.

A major factor accelerating this strategy was a **RAND Corp. report** on hospital prices released last May. Covering nearly 1,600 hospitals in 25 states, the report found that employer-sponsored health plans **paid hospitals an average of 241%** of what Medicare would have paid for the same inpatient and outpatient services in 2017. That was up from 236% of Medicare in 2015. Employers took note.

RAND plans to release an expanded version of its hospital price report this spring, covering more hospitals and states and adding prices for physician services. That report will combine the price information relative to Medicare rates with hospital safety grades from the Leapfrog Group, offering payers a one-stop shopping guide for selecting high-value providers.

Commercial payer prices relative to Medicare rates

For selected states studied by RAND, 2015 to 2017

The charts below are interactive: click or touch to see more.

Average relative prices

Anthem's home state innovation

A similar **RAND study** commissioned by self-insured employers in Indiana spurred action when researchers concluded that Hoosier companies paid hospitals an average of 272% of Medicare rates from 2013 to 2016.

In response, 12 self-insured companies asked Anthem Blue Cross and Blue Shield to develop new health plan options that would steer members to lower-cost, high-quality providers, as alternatives to their traditional PPOs with wide-open networks. Up to that point, Indiana employers had been reluctant to limit their workers' provider choices for fear of backlash, said Gloria Sachdev, CEO of the Employers' Forum of Indiana.

Anthem responded by rolling out **HealthSync**, a tiered-network plan that reduces members' cost-sharing if they use lower-cost hospitals and physicians.

Franciscan Alliance and Ascension St. Vincent are participating as preferred providers under financial risk contracts, while IU Health and Community Health Network are not. Major Indiana employers are offering the plan to their workers for 2020, which Anthem said would deliver premium savings of more than 10%.

In addition, in 2019 **Anthem started negotiating** hospital outpatient prices in Indiana based on a percentage of Medicare rates, rather than on discounts from retail prices. Employers' Forum members already had their inpatient prices negotiated that way. “We have a completely dysfunctional marketplace and this is a strategy to make it functional,” Sachdev said. “Will this lower hospital prices? We'll see.”

Following in some big footsteps

Jumbo employers like General Electric Co., Boeing Co., Lowe's and **Walmart** for years have steered workers to designated centers of excellence for certain procedures, and **have reported savings** to the company and employees, with high patient satisfaction. But smaller and midsize companies have been slow to adopt such approaches.

Employers vary by state, however, in their willingness to push ahead forcefully, depending on the industry, worker expectations, the competitiveness of the hiring market, and senior executives' level of concern over health benefit spending, according to purchasing group leaders. An effort that attracted some attention last year called the Peak Health Alliance has employers grouping together to negotiate directly with hospitals and health systems in Summit County, Colo. The alliance plans to expand to other counties.

In 2019, less than 8% of employers said their plan network was narrow; 14% of firms with 50 or more employees said they're using tiered or high-performance networks; and about 1 in 5 encourages employees to use a center of excellence, according to a **Kaiser Family Foundation survey** published in September. But use of those strategies is growing, employer groups say.

Employers also are leaning on the insurers administering their plans to develop higher-value networks. In November, **the Blue Cross and Blue Shield Association** announced a new “high-performance” network plan for employers in 55 markets that will be available in 2021.

But hospital leaders warn that more narrow-network plans will lead to more patients getting hit with surprise, out-of-network bills, which already have triggered widespread public outrage and reform efforts in Congress.

"Limiting networks is why we're running into the whole issue of surprise billing," said Chip Kahn, CEO of the Federation of American Hospitals. "Patients will be burdened with having more difficulty finding network hospital services."

A wild card is the CMS' new rule, finalized in November, requiring hospitals to publish rates negotiated with payers for at least 300 "shoppable" services, starting in 2021. The American Hospital Association and other hospital groups are suing to overturn the rule. The CMS also has proposed a rule requiring health plans to publish their negotiated in-network rates as well as rates for out-of-network providers.

Experts say these CMS rules, if they survive legal challenges, could provide employers with rich data for selecting lower-cost providers.

Some hospitals back the change

Leaders of hospitals with lower prices and good quality measures welcome this movement by employers. Indeed, Beaumont Health System in Southeast Michigan, which had one of the lowest aggregate average prices relative to Medicare in the RAND study, has created a marketing unit to offer itself to self-insured employers as a narrow-network or center-of-excellence provider.

Ryan Catignani, the eight-hospital system's vice president of managed-care contracting, said Beaumont has directly contracted with 25 employer groups representing 4,000 members for a narrow network plan and is in talks with 400 more groups representing 75,000 members.

Fully insured groups can save more than 15% on premiums by choosing Beaumont's narrow-network plan, offered in conjunction with UnitedHealthcare, he said. Savings for self-insured groups depend on the individual group's claims experience.

He acknowledged, though, that it's not easy convincing Michigan employers to steer employees or limit their choice of provider because the dominant health plan, Michigan Blue Cross and Blue Shield, has traditionally offered PPOs with a broad network. "In Michigan, access is king and employers are still reluctant to limit employees," he lamented.

Dr. Robert Vissers, CEO of Boulder (Colo.) Community Health, a single-hospital system with 30 outpatient sites, is cautiously optimistic about employers' interest in organizations like his, which showed low prices relative to Medicare in the RAND study.

But he would prefer that payers contract with his system based on a global, per-member per-month payment arrangement rather than focusing on the cost of individual services.

Other hospitals and physician groups, however, have bristled at moves by employers to steer their workers based on price and quality measures.

Dan Ludwig, employee benefits director at Brakebush Brothers, a chicken-products processor based in Westfield, Wis., said a local health system called and complained when his 2,100-employee company started sending its workers to a provider in Appleton, 90 minutes away, for orthopedic, spine and podiatric care on a bundled-payment basis. That direct contracting deal saved his company more than $600,000 on nearly $9 million in health benefit spending in 2018.

“They asked, ‘Why aren’t you partnering with us?’ ” Ludwig recalled. “We said, ‘If you are better on quality and price, then let’s talk.’ The idea isn’t to hurt local systems. It’s to make healthcare evolve into something better than what it is today.”

Still, some business leaders remain reluctant to use their most powerful weapons to push back against provider demands for high rates, even refusing to exclude expensive, lower-quality providers from their plan networks. They fear unfavorable worker reactions or damage to their ability to recruit workers in an intensely competitive hiring environment.

“There is a lot of opportunity out there for employers,” said Chris Skisak, executive director of the Houston Business Coalition on Health, who is disappointed that his members have been reluctant to act. “But they aren’t getting the pressure from the C-suite to demand this. ”

On top of that, insurers serving as third-party administrators for self-insured employers may lack financial incentive to design plans that favor lower-cost providers because they often receive a percentage of total spending as their administrative fee. In addition, steerage strategies aren’t practical in markets with one dominant hospital system, or where systems have carved up the market by geography or clinical specialty, making it difficult to exclude anyone, said Katie Keith, a Georgetown University researcher who co-authored a **2019 study** on responses to provider consolidation in six markets.

Leaders of employer groups warn, however, that if they can’t work successfully with providers and insurers to slow healthcare cost growth and deliver higher-value care to their workers, the only alternative may be government-regulated rates through a Medicare for All or **other public health plan model**.

“Employers and consumers are reaching a fork in the road, realizing private-sector efforts to get costs and quality under control are floundering,” said James Gelfand, senior vice president for health policy at the ERISA Industry Council. “So a lot of people are saying if this doesn’t work, maybe we need to look at more government-centric solutions.”

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