



Better Together: Exploring Employer-Physician Collaborations to Deliver Quality Care

Stephen Parodi, MD; Norman Chenven, MD; and Michael Thompson
with Sophia Gomez, Toyomi Igus, Joy Scott, Ann Kempinski, and Margaret Rehayem

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ABOUT THE COUNCIL OF ACCOUNTABLE PHYSICIAN PRACTICES

The [Council of Accountable Physician Practices \(CAPP\)](#) is an affiliate of the American Medical Group Foundation. CAPP is comprised of leaders of multispecialty medical groups across the nation who are dedicated to advancing the key pillars that enable the transition to a value-based health care system, which include:

- Coordinated, person-centered care
- Outcomes-based payment
- Health information technology
- Physician leadership
- Quality improvement



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Chair, CAPP



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As early, successful participants in Medicare ACOs and Medicare Advantage, CAPP medical groups seek to accelerate the adoption of value-based payment models across all payers and purchasers to create a more outcomes-focused, economically sustainable U.S. health care system.

“CAPP medical groups and coalition employers are innovative leaders with a shared mission: high-quality care for our patients and employees. By working together, we believe we can best address the systemic gaps and challenges that remain in the American health care system, which will result in a healthier country.”

ABOUT THE NATIONAL ALLIANCE OF HEALTHCARE PURCHASER COALITIONS

The [National Alliance of Healthcare Purchaser Coalitions \(National Alliance\)](#) is the only nonprofit, purchaser-led organization with a national and regional structure dedicated to driving health and health care value across the country. Its members represent more than 12,000 employers and purchasers and 45 million Americans, spending \$300 billion annually on health care. They are a leading voice for employers across the country and provide relevant multi-stakeholder forums throughout the year so that employers, business coalitions, health plans, providers, pharmacy benefit managers, and other stakeholders can address comprehensive solutions at the national level. The National Alliance engages in several health care initiatives, especially in payment reform, episodes of care, oncology, advanced primary care, mental health, and hospital transparency. Through its eValue8™ health plan performance tool, it has set a bar for improved value, care delivery, and patient-centered outcomes.



Michael Thompson
President & CEO,
National Alliance

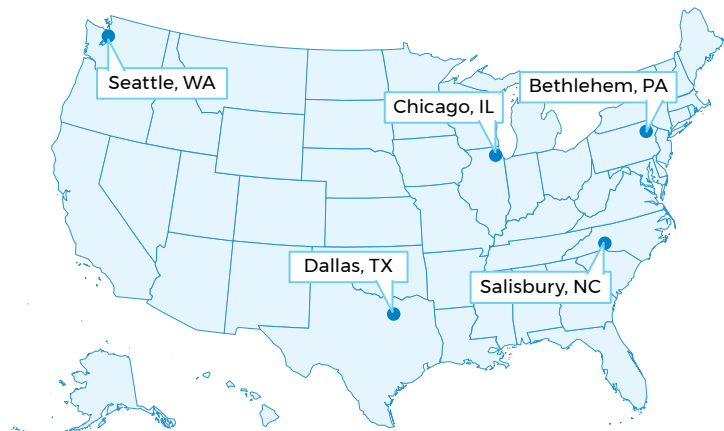
“As the largest purchasers of health care outside of the federal government, employers have been left with little choice but to chart their own course and drive for health care quality and value. Purchasers have always had the most balanced perspectives on the health care system – valuing the need to support and improve the health, well-being, and productivity of their workforces while needing desperately to manage the costs and value of a runaway system.”

Executive Summary

As the response to the COVID-19 pandemic clearly shows, the American health care system is poorly prepared to handle such emergencies in a systematic, organized way. Each marketplace has responded differently; hospitals and health systems were not equally prepared. Employers were faced with closing their doors, laying off staff, and grappling with how health care related to the COVID-19 outbreak will affect their bottom lines.

After the crisis subsides — as it surely will — the purchasers and providers of health care will both assess what could have been done better and what the problems were. Some may even start to envision solutions. Employers, physicians, and other health care providers all want better health care for Americans. So why don't they work more closely together to achieve their shared goal?

To start such a dialogue, the Council of Accountable Physician Practices (CAPP) and National Alliance of Healthcare Purchaser Coalitions (National Alliance) conducted a series of listening sessions in 2019 and 2020 to help physicians better understand what purchasers need and want from their care delivery system and physician networks; how they currently evaluate health care services; and their perspectives on national health care trends. The participants included human resource and benefit executives, and representatives from labor union trusts in those markets. Most of the employers were self-insured.



You spoke. We listened. CAPP and National Alliance listening sessions, Fall 2019 to Winter 2020.

ABOUT THE METHODOLOGY

The findings presented in this report reflect the content of five focus groups conducted between August 16, 2019, and January 24, 2020. Recruitment was conducted by local coalitions of the National Alliance of Healthcare Purchaser Coalitions, including Washington Health Alliance, Dallas-Fort Worth Business Group on Health, Midwest Business Group on Health, Lehigh Valley Business Coalition on Healthcare, and North Carolina Business Group on Health. Focus group participants represented small, medium, and large employers ranging in size from 200 to more than 250,000 employees, and they included private and public employers as well as large labor trusts. Nearly all participating employers were self-insured, sharing financial risk for providing health care benefits. Between 8 and 10 participants attended each discussion, representing a total of 38 employers.

Each discussion lasted approximately 2 hours and was facilitated by the same moderator. All discussions were

conducted during business hours at the convenience of the local coalition and were held either at a coalition office or the office of a coalition member. Discussions were audio-recorded to ensure accuracy in preparing the analysis. Each coalition received a grant of \$7,500 to offset the costs of recruitment and hosting. The final determination as to which employers were invited to participate in the discussion was left to the discretion of coalition leaders.

LIMITATIONS

As with all focus group research, data collected from these five focus groups does not represent a statistical sample and cannot be generalized with precision to all employers. Results are reliable for identifying the general views, beliefs, and challenges of employers but not for estimating the exact proportion of employers who share these views or engage in any particular practices.

Summary of Findings

“Why doesn’t the billed rate equal the allowable rate?”

What employer-purchasers want from health care

- Affordable coverage
- Simple, transparent financial transactions
- The right care, not more care
- A seamless and coordinated patient experience
- Increased and timely access to specialists
- Integrated behavioral health

“There is so much variability in how quality is even being measured, we don’t know who is good and bad . . .”

Why employers struggle with evaluating health care providers

- Limited discretion to design networks
- Lack of resources and reliable tools to evaluate and compare provider quality
- Can’t see what’s working, only what’s not
- Distrust of health plans, consultants, and providers

“If physicians and employers could say, out loud . . . we’re a part of a system that’s broken, we’re going to explore some fundamental change, then maybe we might be able to get something to happen.”

High-priority areas for physician-employer collaboration

- Focus on achieving a coordinated care experience for patients so that an illness is not economically and emotionally devastating, and medical outcomes are optimized
- Advocate for transparency on price and quality measures
- Build models of care that integrate behavioral health with medical care

“[The hospital consolidation] is not sustainable anymore . . .”

Employers’ experience of national health care trends

- Fee-for-service payment system is problematic, but commercial payers slower to adopt value-based payment models
- Consolidation of smaller providers into larger groups and health systems, coupled with capital expansion, driving cost increases
- Rise of specialty service vendors, with mixed results
- Some innovative employers are trying a range of strategies with mixed results:
 - Centers of excellence
 - High-performing provider networks that demonstrate lower total cost of care and high quality
 - Reference-based pricing strategies
 - Bundled pricing arrangements
 - Narrow networks
 - High-deductible plans

“Where are our dollars going? Right now, we really feel like we don’t have much control over how we are spending them.”

Barriers and constraints to developing employer-provider partnerships

- Lack of transparency
- Distrust in providers
- Lack of quality metrics to evaluate providers
- Unwillingness to disrupt current physician-employee relationships
- Lack of internal resources
- Need for multi-regional solutions
- Union impacts
- Contractual constraints
- Potential employee push-back
- Market dominance

The full report that follows provides an in-depth evaluation of the listening session findings and additional opportunities for collaboration.

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INTRODUCTION

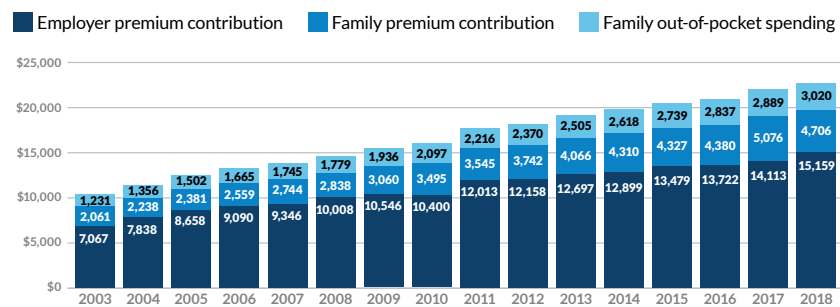
Americans who have health insurance are covered either through public programs, such as Medicare and Medicaid, or through private health insurance paid for by employers, labor unions, or individuals. Over the last half-century, private health insurance programs have grown and account for over 30% of the nation’s health expenditures, while public federal and state programs and individuals pay for the rest.

All payers have felt the relentless rise in costs, but purchasers of private health insurance have experienced the [highest](#) cost increases in recent years.¹

For workers and families enrolled in employer-sponsored coverage, year-over-year health care cost increases continue to outpace inflation and wage increases, despite an overall [slowdown](#) in health care inflation² since the 2008 recession. According to the Peterson-KFF [Health System Tracker](#), since 2007 the average out-of-pocket costs for an enrollee with employer coverage has grown by 58% — more than double the increase in average wages over the same time period from 2007 to 2017.³

Total health spending by and on behalf of a family of four with employer coverage tops \$22,000, on average⁴

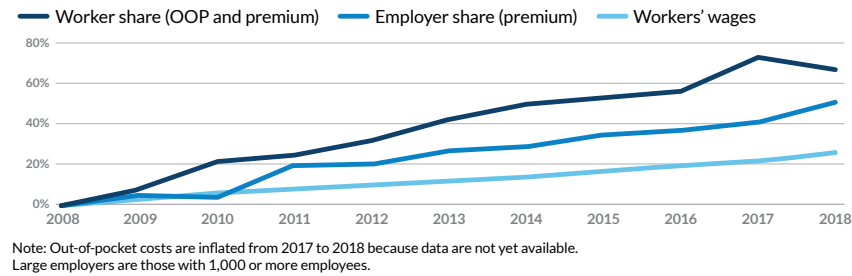
Health spending by and on behalf of families with large employer coverage, 2003–2018



Note: Out-of-pocket costs are inflated from 2017 to 2018 because data are not yet available. Large firms have 1,000 or more employees.

- 1 Altman, Drew. [“Private Insurance’s Costs Are Skyrocketing,”](#) *Axios*, Dec. 16, 2019.
- 2 Martin, Anne, et al. [“National Health Care Spending in 2017: Growth Slows to Post–Great Recession Rates; Share of GDP Stabilizes,”](#) *Health Affairs*, Vol. 38, No.1, Dec. 6, 2018.
- 3 Rae, Matthew, et al. [“Tracking the rise in premium contributions and cost sharing for families with large employer coverage,”](#) Peterson-KFF Health System Tracker, Aug. 14, 2019.
- 4 [KFF analysis of IBM MarketScan Commercial Claims and Encounters Database and KFF Employer Health Benefits Survey, 2018;](#) Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017.

Cumulative growth in premiums and out-of-pocket spending for families with large employer coverage, 2008-2018⁵



Employers, unions, physicians, and other health care providers say they share the same goal: to improve and maintain the health of Americans. So why aren't physicians and purchasers working more closely together to achieve that goal? Can better partnerships between providers and private payers of care spur much-needed change in the U.S. health care system?

THE PROJECT: LISTENING AND COLLABORATING FOR BETTER CARE

To answer those questions, the Council of Accountable Physician Practices (CAPP) recently partnered with the National Alliance of Healthcare Purchaser Coalitions (National Alliance) in an effort to hear directly from employers about their goals for workforce health and wellness and their struggles to achieve quality care at an affordable price. CAPP contracted with Public Values Research, a third-party market research firm based in Pasadena, California, to conduct a series of objective focus groups, also known as listening sessions, with health care purchasers across the country. The purpose of this research was to understand the context in which employers make health care purchasing decisions; what they want for their employees in terms of care delivery; their perceptions and understanding of current national health care trends and innovations; and the barriers that undermine a direct, collaborative relationship between the buyers and providers of care.

The results will be used to foster direct communication and partnership between purchasers and health care providers to determine ways to work better together to achieve better health outcomes for patients and employees.

With the assistance of the National Alliance and its local member coalitions, CAPP convened a series of five listening sessions during fall 2019 and winter 2020. These listening sessions were conducted with purchasing coalitions in Dallas, Texas; Bethlehem, Pennsylvania; Chicago, Illinois; Seattle, Washington; and Charlotte, North Carolina. The participants included human resource and benefit executives, and representatives from labor union trusts in those markets. Most employers were self-insured.

What follows is a report of the findings from these sessions and recommendations for both the purchasers and providers of care — and fodder for further discussion and research.

⁵ [KFF analysis of IBM MarketScan Commercial Claims and Encounters Database and KFF Employer Health Benefits Survey, 2018](#); Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017.

Section 1: What Employers Want from Health Care

In describing what they want most for their employees, most employers in the sessions expressed the importance of coordinated, seamless patient experiences that are personalized as well as affordable. Everyone wants easy access to timely care and appointments with physicians and specialists. They want preventive care instead of crisis care and a total health or “holistic” approach to care, one that includes mental health and its impacts on other health issues. “The system works when you’re sick but doesn’t keep you healthy,” one employer said. Unfortunately, this kind of care experience is not yet the norm. The purchasers frequently noted that health care lags behind other industries that increasingly strive to create “frictionless” customer experiences.

AFFORDABLE COVERAGE

As of 2019, annual deductibles for individual coverage averaged [\\$1,655](#) and 45% of workers with coverage in small firms faced deductibles of \$2,000 or more, yet surveys suggest that most Americans don’t have more than \$400 in savings to pay an unexpected bill or expense.⁶ During 2018, one-fifth of adults had major, unexpected medical bills to pay, with the median expense between \$1,000 and \$5,000, according to an annual survey conducted by the [Federal Reserve Board](#). In addition, 24% of respondents reported going without some form of medical care in 2018.⁷

The majority of employers in the sessions expressed deep concern and frustration with the health care industry, citing rising costs, inconsistent pricing, and the lack of transparency around cost and quality:

“What I show my executive team every year is that the health of our population is declining and at the same time our costs are going up at twice the rate,” explained one employer. “So, they’re trying to figure out what it is we’re getting; what are we buying? The outcomes are terrible.”

SIMPLE, TRANSPARENT FINANCIAL TRANSACTIONS

Beyond affordability, employers want simplicity in billing and estimates, as well as price transparency. Employers and employees who need and want to understand the cost of care can’t determine the prices for specific services, and when they can find price estimates in advance of receiving the service they don’t understand why there is such variability between service providers:

“Why doesn’t the billed rate equal the allowable rate?” one employer asked.

Participants reported that the cost of a given medical procedure can vary by more than 100% from one provider to another and that specialty drug prices can be astronomical. They described cases in which a medication is covered under the medical plan, as opposed to the pharmacy plan, because it is administered in the hospital. Without understanding the site-of-care cost implications, employers are just told what the cost is and not given a choice to reduce that cost:

6 [2019 Employer Health Benefits Survey](#), Kaiser Family Foundation, Sept. 25, 2019.

7 [Report on the Economic Well-Being of U.S. Households in 2018 - May 2019](#), Board of Governors of the Federal Reserve System, May 28, 2019.

“There is no reason to be charging someone three times more than the average cost [of a drug] and potentially bankrupting a member,” one employer said.

Another employer expressed similar frustration: “I just feel we’re at the mercy of the pharmaceutical companies.” While that may be true, pharmacy benefit managers also play a key role in driving up costs.

If providers could supply up-front estimates of the out-of-pocket costs for recommended care, [surprise billing](#) would cease to be as big of a problem as it is,⁸ and employees would be better equipped to manage their personal budgets.

THE RIGHT CARE, NOT MORE CARE

Overtreatment was also a concern among purchasers, especially for those who offer comprehensive coverage. They wonder about the drivers of overutilization. **Are there provider profit motives to recommend unnecessary services?** Again, the lack of transparency and information about the care being provided in their communities creates challenges.

A SEAMLESS AND COORDINATED PATIENT EXPERIENCE

Despite the national movement toward better-integrated care and system consolidation, **employers in the sessions report that their employees still do not receive coordinated services, placing added burdens on the employer to advise and assist their employees in navigating the system.** Patients have problems managing the costs of care and understanding how to get the care they need. The employer purchasers described employees seeking their assistance with getting needed care, feeling overwhelmed while trying to handle complex medical problems such as cancer, and being unable to anticipate and understand the financial impacts of recommended care.

Health care purchasers, who are themselves patients, voiced strong opinions about the lack of care coordination. **Care coordination is a “must have” but rarely delivered service by providers or the plans:**

“I’ve been diagnosed with cancer,” explained one focus group participant. “The system now is very fragmented. So, if somebody is coming out of an appointment, or some sort of screening or diagnosis, in many cases they’re given a piece of paper that tells them: You need to do this, you need to do that, you need to follow-up. And there isn’t necessarily an easy way to do that.”

This lack of care coordination in their local health care systems places real burdens on employers to act as care navigators as well as financial managers for their employees. To help their workers, many employers contract with third-party care navigators:

“There’s a lot of work that [patients] have to go through in order to figure out where to go next and what’s covered and what’s not. That’s something that is a big enough challenge for us that we’re actually looking outside of a provider group to figure it out.”

“I think [patients] need to have somebody to be the quarterback . . . If care gets complicated, you may need other resources.”

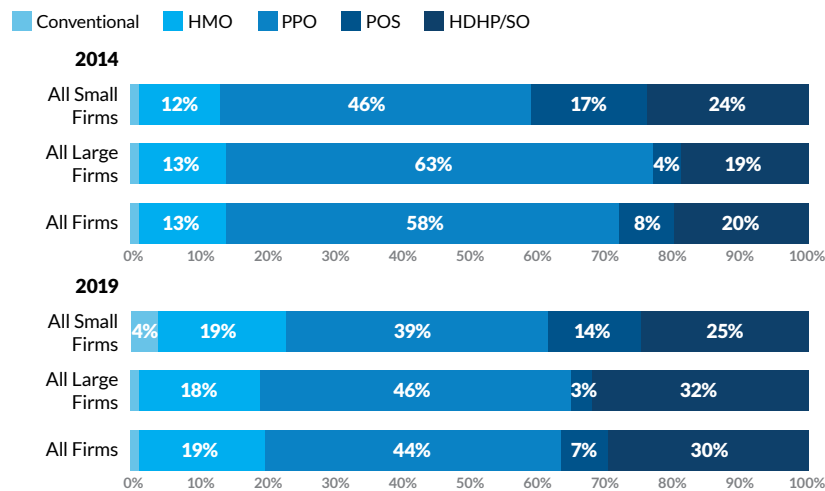
8 Pollitz, Karen. “[Surprise Medical Bills](#),” Issue Brief, Kaiser Family Foundation, March 28, 2016.

When it comes to the provision of care, all the participating purchasers agreed: Their workers deserve a health care experience that addresses as many of their care needs as possible, without multiple appointments and missed work time, and without company benefit managers having to act as case managers.

The participants also unanimously agreed that providers are in the best position to help their workers navigate the system. Employers want their network providers to have information about their employees' benefits at the point of care, so that care decisions can be aligned with financial resources. They cited examples when providers did not appear to know whether the employee had met a deductible or out-of-pocket maximum, which might affect the worker's decision to get care. This inability to track and accumulate out-of-pocket spending may lead to surprise billing, another source of employee complaints and dissatisfaction with their benefits.

Employers also would like to better understand the overall "care journey" of their patients. In one market, employers took a tour with a startup medical group, which demonstrated how patients move seamlessly through the system. The session participants were impressed by the site visit and did not seem aware that many elements of the demonstrated care coordination are also offered by other providers in their market.

Distribution of Health Plan Enrollment for Covered Workers, by Plan Type and Firm Size, 2014 and 2019⁹



⁹Enrollment in plan type is statistically different between All Small Firms and All Large Firms within year ($p < .05$). NOTE Small Firms have 3-199 workers and Large Firms have 200 or more workers. HMO is health maintenance organization. PPO is preferred provider organization. POS is point-of-service plan. HDHP/SO is high-deductible health plan with a savings option, such as a health reimbursement arrangement (HRA) or health savings account (HSA).

A few employers noted that integrated care delivery models such as Kaiser Permanente offer coordination and better health outcomes. Employers in some markets support the expansion of such integrated models. However, some commented that their employees would not want a limited-network managed care plan, even though they, as employers, recognized the cost savings as well as the care navigation and coordination components of the model.

⁹ [KFF Employer Health Benefits Survey, 2019](#); [Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014](#).

TIMELY ACCESS TO CONVENIENT CARE

Access to care emerged as a serious concern among purchasers, particularly those with workforces located in rural areas. Purchasers reported that people sometimes had to wait weeks for an appointment with a primary care physician and lived or worked hours away from specialists. They also wondered why more of a patient’s medical concerns could not be taken care of all at once, rather than via multiple appointments.

While purchasers would like physicians to provide more telehealth options when clinically appropriate, they also wanted their workers to have other convenient options to seek care outside of regular business hours. Unnecessary emergency department visits occur when people can’t find available primary care or urgent care options. Telemedicine was discussed as a possible solution to the lack of timely access. However, some voiced concern that telehealth services were not always provided by the same physicians that the patients regularly see, making it difficult to get people to use the service. The biggest barrier to using telemedicine from third-party vendors, they said, was getting their workers to register for the service.

INTEGRATED BEHAVIORAL HEALTH

The biggest access concern was related to inadequate mental and behavioral health services, which was cited by purchasers across every focus group as a serious gap — even a crisis — in health care delivery. They see rising demand for such services, even among younger employees:

“Depression is vastly underdiagnosed,” said one participant. “There are folks out there who are coming to work likely depressed and maybe they tried to seek care at some point. Maybe they had trouble finding it and gave up. And now they are not showing up to work.”

Participants reported several problems with current behavioral health services, including limited access to psychological counseling, limits on the number of sessions employees can have, and poorly trained practitioners who do not practice evidence-based treatment. Many mental health providers do not take insurance. Behavioral health services for children and adolescents were a particular concern because of the difficulty in finding qualified practitioners.

Some employers connected behavioral health with poor chronic-disease management, such as diabetes control. Antidepressants and other medications, as well as online mental health applications and emergency suicide resources, were viewed as inadequate by the majority of participants. Finally, several employers said they believed **primary care doctors should be trained to screen for mental health issues, identify patients who might be at risk, and then connect the person to the right provider for services.** The availability of integrated and/or coordinated behavioral health services with primary care was of great interest to employers, but none were aware of an approach that they thought worked well.

Section 2: How Purchasers Evaluate Plans and Provider Networks

Physician groups want to understand how they can differentiate their care systems and offerings for purchasers, yet information about how employers make decisions regarding benefit packages — and particularly in how they evaluate and select medical groups and health systems — is hard to secure. Therefore, this question was a key objective of the focus groups. The participant comments support national research findings that most purchasers either have limited discretion in designing their provider networks or lack the resources, data, and metrics to evaluate provider quality.

DATA AND REPORTING

When asked which specific data they use or would like to use to evaluate providers, most health care purchasers reported that they do not have a reliable tool for evaluating quality:

“There is so much variability in how quality is even being measured,” one large employer explained. “We just don’t know who is good and bad . . . How do you harness that data and then how do you leverage it in a good way to help your members?”

Some who have asked for data said they encountered resistance from medical groups and health systems that don’t want to provide information on their quality and costs. **In lieu of quality metrics, most purchasers reported that they focus on total cost, utilization, geographic coverage, and employee satisfaction, measured through surveys or informal feedback from workers:**

“We’re not driving a lot of our decisions on benchmarking. We’re really driving the decisions based on what our population is telling us they need and what they are experiencing year over year,” one participant explained.

Another said: “I’d love to get to a place where I can say, ‘I looked at my population, we’re 20% diabetic now. We went to 22% last year. Get that [down] to 15%, and I’ll pay more.’”

Frustrated with the current state of data available from health plans, third-party administrators of self-insured plans, and providers, many employers feel limited in their ability to create a more customized provider network and/or change benefit design without consultants and other vendors. Employers are charged for customized reports, and often can’t get data in the form they want it.

Without access to transparent and reliable data and sufficient staffing to conduct independent analyses, many employers rely on health plan staff and consultants to make provider and network recommendations. Very large employers, who have the financial ability to hire multiple consultants and conduct in-house analysis to balance consultant bias, are the exception. **Even then, when asked if they trust their consultants to evaluate provider quality and to recommend the best care delivery options, employers expressed skepticism.** In one group, an employer suggested that consultants get “kickbacks” from health plans for recommending specific plans and providers. This statement was met with tacit agreement from other participants in the group.

EVALUATING PROVIDERS

When asked more specifically about how they evaluate individual physicians or medical groups, the participants said they often assess the quality of providers the way their patients do – via word-of-mouth, public reviewing systems such as Yelp, or local provider advertising (e.g., top doctors ads, service-line advertising). They said **they have no way of knowing what’s working, only what’s not. They often form opinions based on complaints from their workers.** Complaints take up a lot of employer staff time and resources, and they weigh heavily on purchaser perceptions about the physician or medical group.

When asked if they knew how their local providers were being paid or if the payment incentives were aligned to incentivize outcomes, most said that **although they support the movement to pay-for-performance and value-based payment models, they generally do not know how their network physicians are compensated.**

The participants unanimously agreed that there is a lack of transparency from health plans about how they evaluate providers in their networks and a general reluctance to share health outcome data:

“Sophisticated employers will say, ‘I’ll pay more for quality [care].’ But the health plans don’t want to build a mechanism to allow employers to figure that out. They don’t want things to be transparent. And to track quality, you need data, which they [the plans have]. They don’t want to upset [their lower quality provider]. Keeping a doctor in their network is critical.”

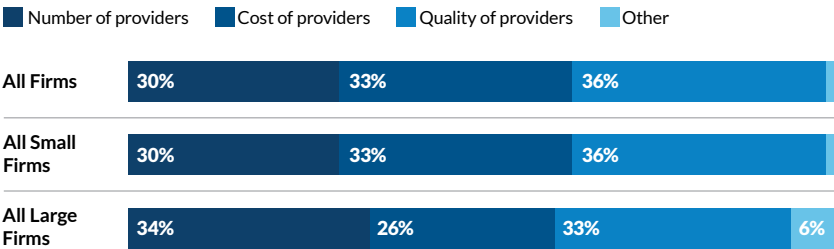
“There’s just a lack of transparency . . . trying to get [the plans] to be open about how it is that they’re contracting with those providers, and what that actually looks like – that’s not something they’re very open about.”

SIZE OF EMPLOYER AND GEOGRAPHIC COVERAGE

Large private employers and public agencies were more involved with provider selection than were small and mid-sized private employers. Several of the larger employers and public agencies reported that they undergo a request for proposals (RFP) process to select plans and review affiliated providers as part of that process, but they understand that the process is slow and inflexible, which can deter innovation.

Factors Important to Employers in Providing Network Choice ¹⁰

Among firms offering health benefits, most important factor in selecting a provider network, by firm size, 2019



Estimates for ‘Other’ are statistically different between Small and Large Firms (p < .05). NOTE Small Firms have 3–199 workers and Large Firms have 200 or more workers.

10 KFF Employer Health Benefits Survey, 2019.

For some large employers with workforces scattered across many geographic locations, the idea of having to drill down and curate networks seems like a heavy lift; such employers are reluctant to modify offerings and plan features for different regional markets.

SKEPTICISM OF PLANS, CONSULTANTS, AND PROVIDERS

Purchasers' trust in providers is also eroding as a result of reviewing claims for services that appear unnecessary and being put in the middle of payment disputes between health plans and providers. While employers want assurance that payments align incentives properly among all stakeholders, they feel that they usually do not get trustworthy information.

When possible, employers try not to rely solely on consultants and plans to inform their cost and quality evaluations. They want quality, affordable care, but what constitutes “quality” and “affordability” (to the employer or their workers) is difficult for most to determine. **As a result, they say that the purchase of “value” – that is, the cost and quality equation in health care – remains elusive:**

“You look at any quality network . . . All the criteria are different. So how do you know you’re really getting the right cost and quality? Because there’s no national standard, which I don’t understand – why there isn’t enough to measure cost and quality? You’d think we would be there by now, but we haven’t seen it.”

Employers seem more comfortable with adding new care options rather than removing ineffective ones, for example, adding a telehealth vendor to address emergency room utilization rather than raising the cost of emergency department copays. The rise and proliferation of third-party vendors selling “bolt-on” care services are the result of purchasers willing to pay for solutions to address gaps in care and patient navigation. (See section 3.)

For all of these reasons, **the adoption of network strategies that involve modifying the traditional approach (providing a wide provider network that emphasizes consumer choice) to a more guided or “curated” choice of providers has not been widespread**, but interest appears to be growing. To encourage utilization of centers of excellence, some of the participants suggested the feasibility of tiered networks or incentives – in which network providers are designated into levels, or tiers, based on the value, cost, and quality of the care they provide. They encouraged approaches to “nudge not shove” employees into choosing higher-quality services.

Section 3: Employer Experiences of National Health Care Trends

To better understand the context in which employers make decisions about benefits and services, the purchasers were asked to discuss trends they have observed in health care delivery and health care purchasing.

[Studies](#)¹¹ and [surveys](#)¹² suggest that commercial payers, including self-insured employers, have been slower to adopt value-based payment models. At the same time, some of the most innovative employers have been large, self-insured employers, including Walmart, General Motors, Boeing, Amazon, and the California Public Employees' Retirement System (CalPERS). They are adopting a range of strategies, such as incentivizing the use of:

- Centers of excellence— a team-based approach to addressing specific medical issues with leadership, best practices, research, support, and training — for complex, supply-sensitive procedures;
- High-performing provider networks that demonstrate lower total costs of care and high quality; and
- Reference-based pricing strategies, in which insurers set prices that they will pay for particular services, which would require enrollees to pay more if they use a provider whose price is above the reference price.

Smaller employers have offered plans with so-called “narrow networks,” smaller, higher quality networks that allow for lower premiums. Regional coalitions have helped to support innovation and coordination across employers, which can lower the administrative costs of value-based payment models.

CONSOLIDATION AND CAPITAL INVESTMENT

Multiple participants shared the view that the consolidation of smaller health care providers into larger groups and health systems, coupled with capital expansion, is driving cost increases:

“It is not sustainable anymore,” one participant said. “And I don’t think anybody in the health care industry thinks that’s true. They think [profits] are just going up and up and up.”

Some attributed rising costs specifically to hospital consolidation:

“They’re putting a lot of pressure on doctors to refer to hospitals,” one employer explained. “There’s a lot of fighting over dollars. That’s the way the incentives are structured. I believe that there are providers out there cooking the books. Somebody comes in with a low-grade case, and they are up-coded to a complex case because it pays more.”

11 Peck, Kristen, et al. “[ACO Contracts with Downside Financial Risk Growing, but Still in the Minority](#),” *Health Affairs*, Vol. 38, No.7, July 2019.

12 “[AMGA Survey Shows Increased Reliance on Risk-Based Revenue: External Obstacles Impeding Move to Value Remain Unchanged](#),” AMGA, May 21, 2019; Governors of the Federal Reserve System, May 28, 2019.

The same lack of choice occurs with the large health plans:

“The challenge for all of us who are Illinois-based is that Blue Cross Blue Shield is the big gorilla in terms of their discounting and the ability to contract with providers.”

REFERENCE-BASED AND BUNDLED PRICING

In response to rising health care costs, some employers reported trying reference-based pricing and bundled pricing for specific procedures. Under reference pricing, a maximum reimbursement rate is set based on the Medicare rate for a similar service or an average rate in the market. Bundled pricing that combines facility and physician payments, for example, is being used by purchasers to cap the costs of specific episodes of care — the coordinated care provided by a health care facility or provider for a specific condition or illness during a set time period.

Several employers explained that while they liked reference-based pricing, the strategy failed in their markets because providers refused to treat their employees:

“When it comes to reference-based reimbursement, the concern is that once you get critical mass in a region, the providers turn you off, stop taking patients,” explained one employer. “There literally was a memo that came from the top that told the doctors, do not accept anybody from [this plan].”

Rather than going to reference-based pricing for general services, employers were more likely to report that they had bundled pricing arrangements for specific medical procedures at recognized centers of excellence. Unlike reference-based pricing, these arrangements have worked well at controlling costs while offering employees access to higher quality care.

RISE OF SPECIALTY SERVICE VENDORS, WITH MIXED RESULTS

The participants reported that they are bombarded by direct marketing calls from third-party vendors offering solutions to bridge gaps in care:

“There are just a ton,” one employer said. “There are a bunch of different [vendors] that can do any little specialty you want help with. Your people aren’t sleeping enough, we can give you six different programs for that.”

The most common types of specialty services cited included telemedicine, wellness programs, and patient navigation, often provided by health plans. While the majority reported that their organizations use at least one add-on-service, satisfaction with these types of programs was mixed. **Employers who used navigation services offered by health plans were generally satisfied, although they questioned why those services could not be covered by the provider. Satisfaction with wellness programs and telemedicine services was tempered.** Several employers reported that wellness programs seem to attract healthy employees while workers who need the support are not sufficiently motivated to make substantive health changes. This was not surprising since [national research](#) has found that wellness programs generally do not work.¹³ Some suggested that **health and wellness should be managed by the primary care doctor, where patients have a relationship:**

13 Miller, Jake. “[Do Wellness Programs Work?](#)” Harvard Medical School, April 16, 2019.

“So [the question] is who has the best ability to improve and change behavior? And the trust is usually between the employee and the doctor.”

Several employers also raised concerns about the quality and usefulness of telemedicine provided by third-party vendors, which is not integrated with primary care and may not have the same quality standards:

“I feel like a lot of these carriers are coming along with bells and whistles. They’re not doing it actually to solve a fundamental problem in health care delivery. They’re doing it just so they can say, ‘Yeah, we’ve got that’ . . . I would ask them, so why are you doing that? Why aren’t you focusing more on the cost of health and quality?”

“When I see telephonic or video chat that actual consumers really like — usually you hear this story about pediatricians: ‘My kid’s pediatrician practice is awesome. I call them anytime I want to get a nurse on the phone or, or my pediatrician, they’ll talk to me by video.’ So that practice is doing it. Consumers really enjoy that and they’re getting some value out of it; they’re getting higher quality care from their individual physician practice. But United Healthcare coming along with some sort of an app on your phone — that doesn’t do anything.”

“We’re big advocates of provider groups leveraging [telemedicine] to help our patients have a better experience, a more efficient experience, and a more cost-effective experience. If somebody doesn’t need to leave work because they have some issue going on, and they can call their physician or do a video visit, after work or whatever, we would love to see that continue to grow.”

HIGH-DEDUCTIBLE PLANS

Employers have responded to the growing costs — driven primarily by drug and hospital [costs](#) — by adopting high-deductible health plans,¹⁴ often paired with Health Savings Accounts (HSAs), and by requiring workers to shoulder a larger share of the premium for [family coverage](#).¹⁵

Unfortunately, the shift to high deductibles coincided with growth in high-priced specialty drugs, spikes in insulin prices, and the emergence of facility fees — fees that are charged by hospitals for care provided at clinics that physicians don’t own — for outpatient services. **Deductibles grew faster than the promised consumer tools for comparison shopping.** While consumer-directed health plans — which couple high-deductible insurance plans with HSAs — worked for some higher wage, relatively healthy workers, they have resulted in care avoidance among other workers.

This trend seemed to be true among the research participants. **Private employers with either a well-paid, well-educated workforce, or a predominately young and healthy one, reported success with high-deductible plans.** For these employers, high-deductible plans were effective in stabilizing costs without negatively affecting health outcomes (when compared with population health statistics). To ensure that workers are using their high-deductible plans and not rationing necessary care, large employers contributed to their employee’s health savings plans. Several large,

14 Martin, Anne, et al. “[National Health Care Spending in 2017: Growth Slows to Post–Great Recession Rates; Share of GDP Stabilizes.](#)” *Health Affairs*, Vol. 38, No.1, Dec. 6, 2018.

15 [KFF Employer Health Benefits Survey, 2019.](#)

private employers indicated that they were so satisfied with high-deductible plans that their new employees would be given no other options:

“Switching to a high-deductible plan did amazing things to our consumerism and driving people to make smart decisions about when and how to use care. That was the ‘why’ and it’s worked,” reported one large employer with high-salaried employees. “We found that there wasn’t a drop off in any sense of people getting the right care when they need it. The overall health of the population has remained high, or at least at similar levels. We just got rid of waste.”

However, **public employers that had a mixed workforce — including older, less educated, and low- and middle-income earners — were less likely to offer these plans and were concerned that employees might forgo necessary medical treatment**, leading to more serious health problems. Similarly, large retailers and food-service employers with lower-paid workers sought plan designs with lower cost-sharing.

Regardless of the income and education of their workforce, most employers reported that the lack of price transparency and the complexity of medical alternatives make it difficult for patients on high-deductible plans to make informed decisions based on cost and quality. One employer recounted a conversation she had with an employee who was unable to determine the cost for a medical procedure under a high-deductible plan:

“If my car was in an accident, I take it to a collision place. The collision place says, ‘Here’s the price of the parts. Here is the price of the labor. Here is the bottom-line price.’ Why can’t I get that for my [medical] procedure?”

Other employers reported that they were offering classes in health care literacy or were hiring navigators to help patients make better decisions regarding their care.

Some employers also expressed concern that the lack of care management under high-deductible programs might lead to overtreatment and unnecessary procedures. Participants reported that since employees are paying out-of-pocket, they often see a specialist without first seeing a primary care physician, thereby reducing their costs to a single visit:

“I think what we’ve found is that the patient demand for whatever their personal reasons are to have access to an MRI, for example, because they can . . . I think it would be hard for physicians to say, well, you really don’t need this. They’ll just go down the street. Employees are going to make uninformed choices.”

VALUE-BASED PROJECTS AND DIRECT CONTRACTING WITH PROVIDERS

The employers in the sessions were aware of the value-based payment movement and of accountable care organizations (ACOs) — groups of doctors, hospitals, and health care providers who join together voluntarily to provide coordinated care under specific health plan contracts and through Medicare. Some employers were contracting with these entities. Those who have commercial ACO activity in their markets saw potential in the model, but few were requesting proposals from providers or engaging in direct contracting with ACO-type entities. Many expressed skepticism that these systems can produce high-quality results. **The majority of participants agreed that the fee-for-service payment system is problematic because it incentivizes providers to increase service volume regardless of health outcomes.**

Nevertheless, only a handful of employers reported that they were currently contracting with a local ACO. There was also a reluctance to participate due to lack of internal resources to manage such programs.

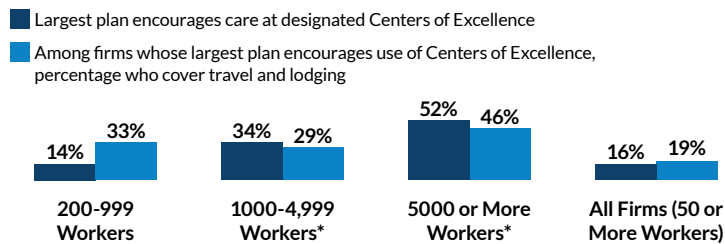
Generally, these employers were not aware of care delivery innovations in their local markets. They felt that value- and outcomes-based projects sound good but that they would only work if providers were willing and accountable, which is not always the situation in their marketplaces. They would also welcome health care “disruptors” – companies that are shifting the health care industry by significantly changing that the way care is delivered – if the innovations they bring provide a better care experience, convenience, simplicity, and competition, resulting in lower costs for the payers.

Those who had entered direct contracts with an ACO, with or without an RFP process, reported that they were able to review data on health outcomes and make site visits. In Seattle, for example, Boeing spearheaded direct contracting while other local employers took more of a wait and see approach before following Boeing’s lead.

Because employers – and the unions with whom some need to negotiate – want to provide the broadest network possible for their employees, there was generally not much interest in transitioning all employees to smaller, higher quality, narrow networks.

Percentage of employers by size who utilize centers of excellence¹⁶

Among firms offering health benefits, percentage of firms that encourage enrollees to receive care at a Center of Excellence, by firm size, 2019



*Estimate is statistically different from estimate for all other firms not in indicated size category (p <.05).
NOTE: Centers of Excellence are designated facilities to provide care for some conditions or procedures.

16 [KFF Employer Health Benefits Survey, 2019](#)

Section 4: Barriers and Challenges

We found that numerous barriers are preventing employers and providers from working directly with each other to close gaps in health care delivery. Those barriers are often the result of the ability of the health plans and third-party administrators to control the kinds of data and information that purchasers receive about their care delivery systems. Employers also have internal resource constraints that affect their ability to be more innovative or even more informed about the kinds of care delivery improvements they can support. Likewise, the way the American health care system has evolved over the years has not supported or encouraged providers and employers to engage in direct dialogue with one another.

While most of the barriers highlighted below are specific to direct contracting between employers and providers, other challenges apply more broadly to developing improved communications and alliances between the two parties.

Lack of price and performance transparency – The lack of price transparency for medical services and prescription drugs was a common concern among employers.

“Where are our dollars going?” one employer asked. “Right now, we really feel like we don’t have much control over how we are spending them.”

Lack of quality metrics to evaluate providers – There is a dearth of information about provider quality. Employers shared concerns about the quality and training of physicians, particularly specialists. Several employers reported that they want clinicians to follow best practices and evidence-based medicine but do not believe those standards are always met. The lack of quality measures to evaluate providers, along with the lack of data on price transparency, were both identified as key obstacles to direct contracting.

Distrust in providers – The sessions found that employer distrust of providers, including the belief that providers overcharge for services and fail to disclose costs, is a main barrier to developing a closer working relationship between health care purchasers and providers:

“I think it’s natural for [providers] to want to protect their businesses and to put their best foot forward and tell you everything you want to hear, versus having a kind of genuine honest dialogue about where we have strengths and where we have weaknesses.”

“No one is ever going to listen to insurance companies,” explained another employer, who was interested in building an alliance with providers. “But physicians and employers could say, out loud, ‘This needs to get better. We’re part of a system that’s broken, we’re going to explore some fundamental change.’ . . . But if no one’s willing to say, ‘I’m open to change,’ then we’re never going to change [the system]. If someone [providers] could just raise their hand, and say, ‘Hey, I’m part of the problem, but I’d like to fix it,’ that might loosen it up a bit.”

Unwillingness to disrupt current physician-employee relationships – Many employers expressed reluctance to use cost and quality data to shape provider networks if doing so would also mean disrupting a high proportion of the existing and longstanding provider relationships that their employees have.

Lack of resources to manage direct contracts – In addition to a lack of data, employers indicated that they do not have the resources to manage direct contracts, and they depend on consultants and plans to manage the process for them. Employers, even small municipalities and local public agencies, were not as reluctant to work with ACOs because those arrangements required less management on the part of employers.

Need for multiregional solutions – The employer discussions suggested that a key barrier affecting direct contracting opportunities is the need on the part of large employers for multiregional solutions. The exception was local public agencies that are geographically concentrated.

Union factors – Some employers stated that they have collective bargaining constraints and slow RFP processes, which deter them from considering many innovations, including direct provider partnerships.

Contractual constraints – So-called “gag clauses,” which prevent plans and providers from disclosing their negotiated rates, were raised as a contractual constraint to sharing information with others.

Potential employee pushback – Employees often don’t want their employers to have detailed information about their health for fear of reprisals, so employers should consider their employees’ perceptions of direct partnerships with their health system:

“We have a lot of trust issues... even with these wellness physicals, people are like, ‘I’ll do it, but I’m not going to give you my data.’ So, they’re very protective.”

Provider and plan market dominance – Employers felt constrained by the dominance of either major health systems and/or insurance carriers in their ability to influence market changes.

Section 5: Conclusion

The findings from this project suggest that **purchasers are deeply frustrated with the health care system and their inability to control spiraling costs and the quality of health care delivery.** Health system consolidation, for-profit investors, the lack of price transparency for medical services and prescription drugs, and limited access to health metrics — among other trends — have taken control away from employer-purchasers, who are the primary payers of health plan benefits and services. Most purchasers that we spoke with reported that **they rely heavily on health plans and benefit consultants to make provider and network recommendations, because they lack the data and staffing resources to independently assess provider quality.** However, **they recognize that this reliance sustains an ineffective status quo.**

Despite the challenges, the listening sessions suggested that there may be opportunities for a strategic alliance between employers and provider groups, particularly those committed to value-based, accountable care. Purchasers and physician-led, multispecialty medical groups and health systems share the same goals for worker and patient care, including coordinated services, evidence-based medicine, convenient access, and appropriate levels of care delivered by skilled clinicians. Moreover, both purchasers and providers recognize that the system is broken, and that fragmented care is leading to poor care delivery and rising costs.

Physicians and employers must start to dialogue and collaborate to help shape a health care system that achieves their shared goals. To that end, CAPP and the National Alliance will continue to facilitate transparent conversations between purchasers and providers to explore opportunities to work together to improve health outcomes, control costs, and improve the patient experience.

Section 6: Opportunities for Employer-Physician Collaborations

“How can employers work better with providers and physicians?”

- Assess the level of benefit design with goals for access, convenience, and clinical quality:
 - Evaluate the impacts on affordability across all plans.
 - Determine strategy to reduce or remove financial barriers that hinder access to high-quality care.
 - Evaluate incentive strategies for employees to choose high-value providers.
- Determine the value of vendor add-ons, such as care navigators and telehealth (including for mental health), and whether providers and provider networks can offer these at the point of care as part of an integrated care experience.
- Introduce and/or expand narrower, high-performing networks through “tiering” and “steering.”
- Design alternative payment models so they include common quality measures and definitions, to inform tiered or high-performing networks and centers of excellence.
- Request proposals from local physician groups when looking for new services or solutions; don’t assume that health plans or national health vendors are better or more cost-effective in delivering high-quality care.
- Get better value from vendors by consulting with local physician groups and partners.
- Partner with local, appropriate physician groups to generate more employee engagement with preventive services and wellness.
- Offer to codesign care solutions with physicians to address challenging gaps in care and access.
- Build relationships with physician groups based on mutual transparency.
- Provide updated information on benefits coverage, programs, and services so physician groups can promote them.
 - Engage physician leaders directly to evaluate cost and quality data:
 - Partner with them to identify best sources of data on the employee group’s risk profile.
 - Measure total costs of care rather than discounted unit costs.
- Ask local physician groups if they can extend their models to serve smaller population centers.
- Evaluate which physician groups offer video visits, and manage patients’ progress with telehealth over time.
- To minimize resistance to change and build trust, involve union leaders in evaluating data outcomes; offer labor visits with physician groups and health systems.

“How can health care purchaser coalitions create better purchaser-provider collaborations?”

- Help build relationships between purchaser members and physician groups by providing opportunities for transparent conversation.
- Advocate for common quality measures across the supply chain, including payers and providers.
- Support members to find appropriate vendors and potentially negotiate reduced pricing, or group purchasing.
- Provide education and guidance on:
 - Locating local, high-value providers and innovation.
 - Understanding financial incentives in local delivery systems.
 - Finding the right vendors and reducing pricing for members.
 - Employing quality measures, such as National Committee for Quality Assurance (NCQA) and URAC accreditation standards.

“How can medical groups and health systems better support employers?”

Improve and enhance patient services:

- Prioritize clinical quality and patient experience of care when making operational improvements.
- Consider ways to better coordinate care in line with patients' benefits.
- Support the challenge of getting benefit information to the point of care, for example, regarding drugs on formulary, what's covered, and which other providers are in the network.
- Offer evidence-based behavioral health services, virtually or onsite; consider the integration of behavioral health with primary care.
- Determine how to provide pediatric care transitions to adolescent and young adult care.
- Provide simplified payment information so that patients understand what they will need to pay and why.
- Provide patients with clear, accurate information on insurance and in-network providers such as lab, imaging, and other services.
- At the moment of diagnosis, walk patients through information about the condition and care journey, and then deliver on it.

Provide employers with useful information:

- Work with partners and/or trade associations to make it easier for employer decision-makers to compare the quality of different medical groups.
- Create opportunities for employers to go onsite and follow the path of patients, and learn how the health system is improving end-to-end experiences for patients with different needs. (While some employers may welcome this, understand that many do not have the time to review all providers in their markets.)
 - Understand the employer's employee base (manufacturing, white collar, etc.) to promote appropriate services.
 - Describe patient care journeys for key conditions, such as diabetes, depression, and back pain; help them understand what care coordination and navigation look like when delivered by medical groups.

- Offer second-opinion services.
- Provide marketing materials that demonstrate services in action.

- Describe population-based efforts to address high-frequency and high-cost health conditions.
- Provide opportunities for primary care physicians to communicate with employees about maximizing their benefits and getting the best care.

Build trust and develop partnerships:

- Establish ongoing conversations between providers and employers to create mutual respect and transparency.
- Partner with employers to generate employee engagement with their health, via preventive and wellness services.
- Offer to codesign care solutions with employers that address their most challenging gaps in care and access.
- Collaborate with employers and vendors to promote new care options for patients, such as behavioral health and telehealth.
- If your group is ready for valued-based partnerships with employers, inform and engage employers to entertain such relationships.
- Develop partnerships to implement quality improvements such as tiered networks and centers of excellence.
- Be honest when showcasing your organization; avoid sales pitches and focus on what the group does well and how it can best support the physical and mental needs of the employer's population.
- Carefully consider the impact on employers and your relationship with them before trying to leverage your patients to put pressure on payers in disputes with a health plan.