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next generation health care

employer-led innovations for healthcare delivery and payment reforms
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Frustrated by their inability to bend their healthcare cost curves, large employers are directly collaborating with provider systems to design new benefit programs.

After two decades of applying the usual levers in benefit design to improve employee health and rein in rising healthcare costs, large self-insured employers are starting to work directly with providers on benefit and plan design, and on innovative delivery system reforms.

There are clear reasons for this trend.

First, in the wake of the Affordable Care Act, most employers are projecting a 6 percent increase in their benefits costs in 2016—a full percentage point higher than general inflation.

Second, although the recent federal appropriations bill pushed back implementation of the “Cadillac Tax” on higher-priced benefit plans until at least 2020, the excise tax could affect as many as 50 percent of large employers’ most popular benefit plans by that date. Projections indicate the tax could shave about half a percentage point per year off of corporate profits—an estimated $10.9 billion per year over the next decade.a

Third, employers are the key stakeholders in the healthcare ecosystem. They are instrumental in arranging for coverage of the bulk of employee’s healthcare costs, although, to date, they have largely limited their influence

FEATURE STORY

to wellness and disease management programs and contract negotiation with insurance companies.

“The need to control rising health benefits costs has never been greater,” says Brian Marcotte, president and CEO of the National Business Group on Health (NBGH), which represents 71 of the Fortune 100 global companies. “More than 75 percent of our members are implementing strategies to add to or expand consumer-directed health plans or to add consumerism tools to help consumers better navigate the health system.”

Employer-Driven Collaboration Will Accelerate Delivery System and Payment Reform

Most large, self-insured employers have endured decades of increasing costs for health care and, at best, uneven quality and patient experience within the healthcare system. As a result, these employers have become frustrated both with their third-party administrators, whom they perceive as being unresponsive or unable to rein in medical costs, and with providers, whom they see as largely responsible for high claims expenses.

These types of frustrations have prompted corporations such as Intel, Boeing, Walmart, Lowe’s, Oracle, and other Fortune 100 companies to focus increasingly on working directly with providers to develop new benefit programs, in an approach that can be aptly be referred to as next generation health care.

City and state governments also are in the mix: The city and county of San Francisco have developed a direct accountable care organization (ACO) partnership with the Brown & Toland Medical Group and California Pacific Medical Center, a San Francisco academic medical center. The California Public Employees’ Retirement System developed a similar direct ACO contract for state employees in partnership with providers and insurers in Sacramento, Calif.

Under the direct-contracting model, employers with a concentrated workforce hope to institute a more efficient and effective approach that ensures employees have a high-quality healthcare experience, where optimal personal health and behavior is expected, supported, and rewarded. Compensation for providers is tied to value with the aim of reducing overall costs while improving the quality of care and the overall healthcare experience.

“Direct and deep” collaboration between providers and employers is seen as the most effective means of driving change in health care, according to a recent white paper published by Intel Corp. Promoting such collaborative efforts is a primary goal of the so-called “Super ACOs”—alliances, such as the Integrated Health Network of Wisconsin, composed of a number of like-minded provider systems organized to pursue population health management goals—that have started down the road toward direct employer contracts. These alliances work with regional employer groups that, in turn, aggregate multiple local businesses representing several thousand employees and dependents. Covering larger geographic areas than stand-alone provider systems, these Super ACO alliances are significant players and may prove to be interesting partners for regional or national employers with more dispersed employee bases.

In the move toward next generation health care, large employers are pursuing a five-pronged strategy to drive payment reform, care model improvements, and benefit redesign. The five elements of this strategy are as follows.

Value-based benefit design. Under such a benefit design, employees receive cost sharing or premium reductions if they take steps to improve their health or manage or participate in care through a chronic care management program.

These incentives are now standard parts of most benefit packages.

*High-performance or tailored networks.* Employees are encouraged to use a limited network of lower-cost providers that usually provide discounts in return for referrals or are deemed high performing based on efficiency and outcomes measures. There now are more than 400 commercial ACOs, the majority of which are built around some type of narrow, tailored, or high-performance network.

*Centers of excellence (COE).* A COE program involving bundled payments can promote high-quality care, a seamless care experience, exceptional service, and lower out-of-pocket expenses. Bundled payments now have been broadly adapted and implemented with direct contracts with health systems or large physician groups. Nearly 80 percent of all large employers participate in COE programs, with transplants being the most common, according to NBGH statistics, followed by bariatric surgery, total joint replacement, and cardiovascular/cardiac surgery (see exhibit below).

*ACO direct contracts.* A small but growing number of large, self-insured employers are pursuing such contracts, thereby enabling their employees to be served by large regional providers. Such direct ACO arrangements have been pioneered by global enterprises such as Intel, Micron Technology, and Boeing, as well as a number of Silicon Valley technology providers that are negotiating deals in San Francisco Bay Area. About 11 percent of employers are negotiating directly with providers, according to a 2014 AON Hewitt employer survey, and nearly 40 percent say they are planning to offer or thinking of offering some direct ACO benefit option in the next five years.

Currently, employer-directed ACO contracts are in effect in Washington, Oregon, Idaho, Arizona, and...
California, Wisconsin, Missouri, and South Carolina. But the list is not exhaustive. Generally, these have been five-year agreements covering all costs for covered services regardless of whether provided by a participating provider or out-of-network. Although they can add significant commercial market share, employers have demanded significant price cuts in return for their business, and may make no adjustments for medical inflation or aging for the duration on the contract. Resolving issues of cross-vendor data exchange is proving critical to achieving goals for improved outcomes, enhanced patient experience, and reduced cost.

Employee clinics and intensive outpatient care. On-site ambulatory clinics, which fell out of favor in the 1990s, are making a reappearance as employers seek to reduce “presenteeism” (where employees show up for work despite being sick) and sick time, and to hasten employees’ return to work after treatment. Intensive outpatient care programs for high-cost patients with chronic conditions are being tested in Washington, New Mexico, and northern California and are showing promising results. A 2014 benchmarking survey by the National Association of Worksite Health Centers indicated that 75 percent of the 255 survey respondents had some sort of work-site health program in place, with the field tipping in the direction of primary care clinics.

Our research indicates that large, self-insured employers now employ a mix of these five strategic elements in efforts to bend the cost curve and improve employee health. The following case studies illustrate how three cutting-edge employers and employer groups are using multidimensional strategies to move to next generation health care.

Case Study: Pacific Business Group on Health—ECEN

The Pacific Business Group on Health—Employers Centers of Excellence Network (ECEN) is a value-based purchasing program launched in January 2014 with Walmart, Lowe’s, McKesson, and JetBlue as initial participants. ECEN’s value proposition offers high employee satisfaction, cost predictability, downstream savings, and, for participating provider organizations, an ROI within two years. ECEN initially has focused on total hip and knee joint replacement and a variety of spine procedures, including spinal fusion, total disk replacement, treatment for scoliosis, and laminectomy. A bundled payment rate is negotiated between employers and the COE participants, allowing for a set rate for joint replacement and spine procedures so that demonstrated high-quality care can be provided at predictable and reasonable costs.

ECEN selected seven participating health systems, including four for joint replacement and three for spinal procedures. Key expectations include:

- Bundled payment for standard episode of treatment
- Transparency of quality and cost
- Participation in a recognized standardized registry with public reporting
- Coordination with local referring and follow-up providers
- Accountability for outcomes
- Commitment to patient engagement and shared decision making

Providers were evaluated and credentialed at both the hospital and specific surgeon level, based on volume, quality, and outcomes data. ECEN focuses on the complete patient experience, providing continuous support from initial evaluation through postoperative return to home. Roughly 900 primary joint replacements have been completed since the program launched; 104 spine procedures have been referred to the ECEN, and 29 have been completed.

There are other COE bundle initiatives around the country. The Cleveland Clinic has assembled a direct-to-employer network of respected

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d. Mercy Hospital, Springfield, Mo.; Johns Hopkins Bayview Medical Center, Baltimore; Kaiser Permanente, Irvine Medical Center, Irvine, Calif.; and Virginia Mason Medical Center, Seattle, were selected for joint replacement. Mercy Hospital and Virginia Mason Medical Center also were selected for spine procedures, as was Geisinger Medical Center, Danville, Pa.
orthopedic practices across the country. In 2013, Walmart expanded a long-standing program covering transplants at the Mayo Clinic to also include certain cardiac and spine surgeries that will be performed at Mayo and five other leading provider systems. In 2010, Lowe’s began a program at the Cleveland Clinic for certain cardiac procedures.

The results of the previously cited NBGH survey provide a snapshot of all COE contracts.

Case Study: Direct Employer Contract—SHCA
The Stanford Health Care Alliance (SHCA) currently offers an ACO product, which features a custom network, to the employer groups affiliated with Stanford University. Stanford Health Care acts as the ACO, providing network and care management, member services, and related activities. The SHCA product is offered directly to the employer in conjunction with a third-party administrator that handles benefit determination, eligibility, claims payment, and other administrative activities.

Introduced in 2014, SHCA membership has grown almost three-fold and now covers a significant portion of these healthcare beneficiaries with a total enrollment of almost 18,000. SHCA is offered as a “slice product” alongside two other health plan options. Reaching beyond the university and its affiliated employer groups, the SHCA is in the process of implementing its first large commercial contract with a large Silicon Valley employer, and is in active discussions with several other large technology corporations. The contract will include an on-site clinic, a 24/7 call center staffed with nurses to answer immediate health problems or provide help with questions on billing or access, and visits with clinical practitioners through digital channels. Stanford Health Care maintains the pre-certification and utilization management for SHCA, which will provide up and downside gain sharing where performance measurement and payment are aligned with value and innovation.

Tom Williams, vice president and general manager for accountable care of Stanford Health Care, and former executive with Aetna and the Integrated Healthcare Association (IHA), explains employer frustration could create new market opportunities for well-organized providers. “Employers are frustrated with the consistent uptick in medical costs, and they are frustrated because they can’t figure out how to deal with the healthcare system in the same manner they deal with other suppliers,” Williams says. “Because healthcare costs have been unmanageable—or appear to be—employers want to fix it themselves rather than just relying on intermediaries. Instead of just putting new benefits plans out to bid with insurers, employers are taking things into their own hands engaging directly with providers.”

Although cost control is a primary concern, Williams says there are other improvements on the list as well. “Employers are very focused on getting control of costs, but they are equally concerned about taking the hassle out of the care process. They are interested in treatment options that are more accessible and require less time off the job, whether it is seeking—or receiving care.”

Case Study: Intel Corp.—Connected Care
Intel Corp., the global IT innovator, has been a leader in direct employer healthcare action. A decade ago, its cost trend was running above the national average and was projected to reach $1 billion by 2012. Intel set out to create a culture where employees would be engaged in wellness-oriented lifestyles. The company increased its focus on consumer-directed health plans, and over time 70 percent of its employees have migrated to these plans. Still, in 2011, there was a need to do more.

In Albuquerque, N.M., the site of Intel’s largest U.S. semiconductor manufacturing plant, the company developed a next generation health program in collaboration with Presbyterian Health Services to create a benefit plan and delivery system covering the company’s 3,500 employees and approximately 10,000
dependents. The new plan, branded Connected Care, addressed plan design, healthcare delivery, and value-based compensation holistically. The plan was designed to ensure the highest-volume members received the “highest touch care,” equal to service in the best private practice. To promote evidence-based treatment of chronic conditions, Connected Care covers 100 percent of preventive care, with 100 percent coverage on prescription drugs for asthma, hypertension, cholesterol, diabetes, and other chronic conditions. An on-site health clinic was expanded into a full-scale patient-centered medical home.

Much like Boeing’s preferred partnership option with the Providence-Swedish Health Alliance ACO and the University of Washington Medicine Accountable Care Network, described in the August 2015 issue of hfm, the Intel/Presbyterian Health Services collaboration includes a risk sharing contract covering the total cost of employee care.\(^e\)

The collaboration between Intel and Presbyterian Health Services that resulted in Connected Care initially was built around relatively small “skunk works” teams.

Presbyterian Health Services already had made a significant investment in healthcare IT and was using electronic health records and other digital information tools to coordinate care and increase the use of evidence-based medicine. An experienced managed care organization, it owned its own large health plan as well as contracting with others.

The core competencies included in the provider teams, supplemented by consultants where needed, included:

> Actuarial and payer finance modeling
> Underwriting analysis for the cost baseline
> Operations, legal, project, and account management
> Clinical management
> IT

To better align risks and rewards with desired outcomes, the collaborators developed a value-based compensation structure that included both shared costs and pay for performance, and addressed both cost and qualitative factors. The reimbursement model was based on a global per member per month (PMPM) target, similar to the Boeing Preferred Partner ACO option, with a

**INTEL CONNECTED CARE VALUE-BASED PAYMENT MODEL**

**Pay for Performance**

Eligible Claims $ \times \text{Agreed-Upon Rate (i.e., 15%-25%)} = \text{Claims $ Tied to Performance}

**Shared Cost Arrangement**

- **Shared Risk Above Target PMPM**
- **Corridor +/- 2%**
- **Top Boundary: +2%**
- **Target PMPM ($)**
- **Lower Boundary: -2%**
- **Actual PMPM within Corridor results in "no" savings or risk share.**
- **Shared Savings Below Target PMPM**

Note: PMPM = Per member per month
shared savings “corridor” under which Intel and Presbyterian share risks and rewards if they exceed or fall short of targets (see exhibit on page 6).

While continuing with its branded Connected Care program in New Mexico, Intel set out to scale the program by bringing the model to the Portland, Ore., market in a collaboration with Kaiser Permanente Northwest and Providence Health Services, Boeing’s partner in Washington state. During the October 2014 open enrollment for the program, which went live Jan. 1, 2015, more than 7,000 employees—approximately 36 percent of Intel’s Oregon workforce—signed up for the option. This was similar to the signup rate for Boeing’s preferred partnership ACO in Washington that was launched at about the same time.

In addition to having Intel’s largest employee population, Portland is a larger metropolitan area than Albuquerque and has a more diverse population. Therefore, an offering for the Portland area would require care coordination, with meaningful data exchange, across multiple institutions and their electronic health records instead of a single delivery system partner. These interoperability goals—specifically, cross-vendor data transfer—required coordinated processes and fluid communications as close to real-time as possible across the participating partners.f The at-risk compensation model provided a strong business case for Intel and its delivery system partners to build a foundation of meaningful data interoperability.

Intel has included interoperability standards in all of its healthcare provider contracts to ensure data can flow “securely and openly” among all members of the provider team, for clinical decision making “based on a comprehensive view patients medical history, current situation, and potential drug interactions.” Interoperability and fluid data exchange are designed to ensure providers have seamless, efficient workflows with comprehensive accurate clinical data at the point of care.

As of this writing, Intel is preparing to roll out Connected Care in Arizona, where it also has a large concentration of employees, in collaboration with the Arizona Care Network; it also is evaluating potential partnerships in the California market where it is headquartered. Significantly, Intel’s experience with Connected Care has shown that data exchange to promote care coordination can be implemented quickly if the right business case is present, and when established national interoperability standards and health information networks are used. Looking at the national picture, Eric Dishman, an Intel Fellow and general manager for Health and Life Sciences says, “The Connected Care experience in Oregon demonstrates that standards-based, cross-vendor interoperability, while not perfect, is achievable today. It shows data exchange can be implemented quickly when appropriate rewards and penalties are in place to promote care coordination.”

Still a Work in Progress
The direct employer contracts are long term, five-year deals, and the cost of participation in the collaborations has required participants to take a healthy discount on margins. Because

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Key Direct Employer Contract Terms

Several trends can be seen in contracts being established directly between large employers and health systems for value-based care. The following are examples of some common provisions:

- A five-year proposed term
- ACO membership that includes designated and attributed members and imposes no requirement for a minimum number of members
- Inclusion of all costs for covered services in allowed amount regardless of whether provided by a participating provider or out-of-network
- Assignment of a base year cost to physicians in the clinically integrated network that effectively remains constant throughout the term of the contract
- No adjustment for medical inflation or aging

Source: Boeing Co., Roper St Francis Health System, February 2016.

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bidding has been competitive, participants were in the position of having to protect their market share, which provided a compelling incentive to negotiate and accept a discount, win the business, and grow market share.

Joseph Gifford, MD, former head of the Providence-Swedish ACO Alliance Boeing contract, points out that the challenges providers may face in earning acceptable returns in direct employer contracting. Market experience, he says, confirms the difficulty of “squeezing juice” out of commercial contracts when the contracts are already lean to start with.

Brian Marcotte of the NGBH stresses that it is easy for employers to overestimate the potential for savings and have unrealistic expectations for results. Provider systems, in turn, may underestimate the risk involved in direct contracting given the margin discounts employers require, and the complexity involved in setting up an efficient care management system.

The 2014 Aon Hewitt Healthcare Survey reports that, although only a small percentage of employers currently have some form of direct healthcare provider agreement, nearly 30 percent of those surveyed plan to do so in the next three to five years.

David Lansky, CEO of Pacific Business Group on Health, predicts next generation employer ACO collaborations will include:

> Shared interest in disruption and accelerating adoption of new payment and delivery models
> Direct relationship with aligned provider systems
> A focus on raising the bar on performance
> Multiple, aligned interventions with regard to payment and benefit redesign
> Transparency on outcomes and clinical improvement
> Investment in testing, spreading, and scaling innovations

Employer interest in the new business model appears strong since the model has proved scalable. The experience of Super ACO alliances such as the Integrated Healthcare Network of Wisconsin in pooling smaller regional employers to contract for a regional ACO care model shows that an organization doesn’t have to be a national player to adapt the strategy to a regional market. But results to date indicate the challenges of aligning the financial and patient care goals of employers with the financial and business goals of providers are significant. Despite promising results, the direct employer-provider ACO approach remains a learning experience for even the most sophisticated participants, and still is best regarded as a work in progress.

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