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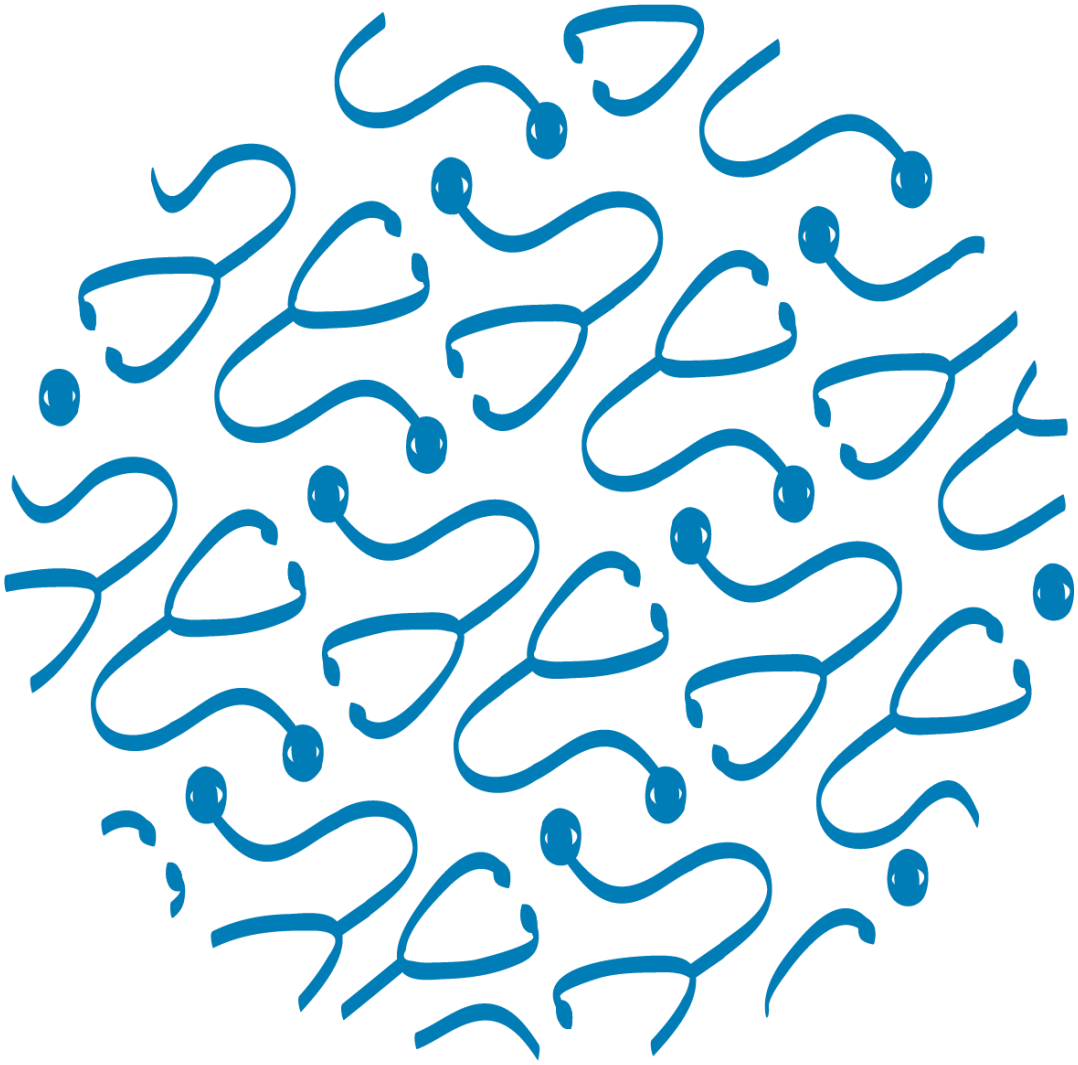
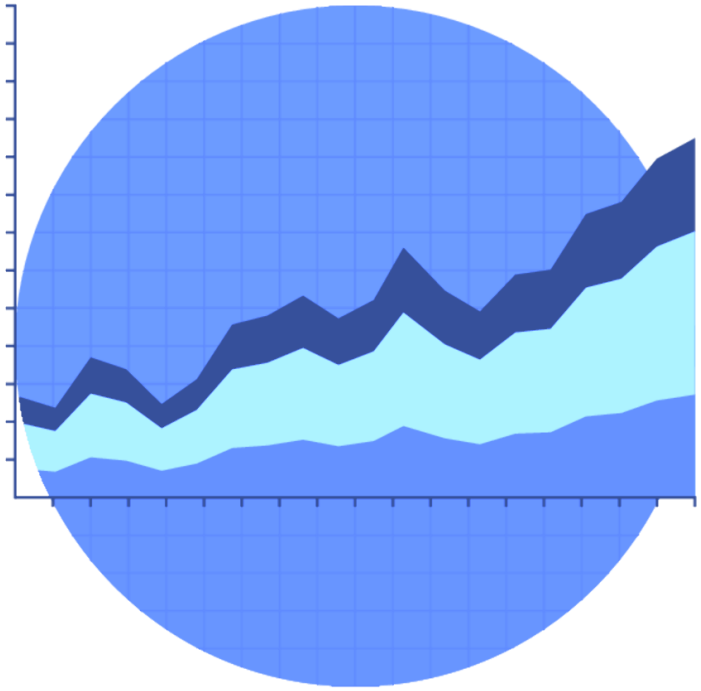


The Case for Provider-Led, Direct-to-Employer Contracting

In the Face of Rising Costs, a Potential Win for Health Systems, Employers, and Employees

February 2024



Introduction

It's a new year, and as is often the case around this time of year, many are looking forward to a fresh start. From an economic perspective, business leaders are hoping 2024 presents a glide path to relief from recent cost pressures driven by inflation, high interest rates, and a tight labor market. Unfortunately for self-insured employers who have grappled with rising health care costs, many benefits consultants are forecasting troubling news: Health insurance costs are expected to increase more in 2024 than they have in a decade, jumping up from a 5.4% annual increase in 2023 to an 8.5% increase in 2024.[1]

The burden on employers of providing employer-sponsored insurance (ESI) is already high. Kaiser Family Foundation (KFF) reports that average annual health insurance premiums in 2023 were $8,435 for single coverage and $23,968 for family coverage. Employers always shoulder the lion's share of those costs, covering 83% for the former and 71% for the latter.[2] With many of their employees already having to cope with added financial stress from inflation, these rising costs put employers in a tough spot.

Plenty of business leaders are actively seeking effective strategies to manage their health insurance costs. One option might be to shift a greater portion of those costs to employees through benefit plan design or contribution changes. However, this strategy for relief does not come without its tradeoffs; health insurance is one of the main benefits employees look for when choosing a job (or when choosing to remain in a job). In fact, consumer surveys have shown that, among US adults:[3]

- **46%** view health insurance as either *the* deciding factor, or at least a positive influence in choosing their job, and
- **56%** state that whether they like their health coverage is a *key* factor in deciding to stay at their current job.

So, while the benefit of providing insurance is a major cost to employers, it nonetheless remains an important recruitment and retention tool, as well as a critical aspect of compensation packages – factors that carry even more weight in today's tight labor market.

These market factors are leading some employers to consider more innovative solutions for lowering their healthcare spend, like directly contracting with providers. Direct-to-employer (D2E) contracting is an arrangement between a self-insured employer and a health care provider organization – typically a hospital, health system, or physician group – who work together to provide health care services to an employee population, as opposed to going through a commercial insurance carrier. Historically, employers have often taken lead in initiating discussions around D2E contracting with providers. However, with many providers today confronted with increased market pressures of their own – such as payer mix changes, new-to-market disruptors, and the growing presence of vertically integrated health plans – we believe there's a strong case to be made for why providers should be just as interested in exploring D2E contracts with employers in their markets. In this piece, we examine the different types of D2E arrangements that exist in the market; how D2E contracts differ from traditional commercial insurance; the benefits of this model to employers, providers, and patients; and what those who might consider D2E contracting should do to get started.

Common D2E Models (and examples of each)

D2E contracts come in a wide variety of forms and can be built around a range of health care services – from single-service arrangements such as administering vaccines, to full-scale, risk-based contracts. A few of the more prevalent types of D2E arrangements we see include:

More traditional models

Evolving innovative models, growing in prevalence

MODEL TYPE	DESCRIPTION	EXAMPLEs
Occupational Health Services	Encompassing various aspects of workplace health – including employee health assessments, injury prevention, and regulatory compliance. Common services provided by health systems to employers include medical evaluations, vaccinations, and other services tailored to the specific needs of the workforce.	**WellSpan Health** offers a variety of safety and preventative services to employers in their area, including **Gettysburg College** and its students and faculty, through their near-campus medical offices and the college's Health Center.[4]
Employee Assistance Programs	Confidential counseling and resources to address a variety of personal and work-related challenges – including stress, substance abuse, family issues, and mental health concerns.	**Cleveland Clinic** has an extensive Lifestyle EAP that they offer to eligible employees and dependents of thirteen Ohio-area public school districts to provide counseling services, workshops and seminars, referral services, and a 24/7 helpline.[5]
Wellness Programs	Includes design and implementation of wellness initiatives such as fitness programs, nutrition counseling, smoking cessation, and preventive health screenings.	**University of Pittsburgh Medical Center (UPMC)** offers a free screenings and education, via lunch and learns, to **32 employers** in their area, providing services from lipid panels and blood draws to EKGs, to help employers and their employees identify prevalent health issues.[6]
Telemedicine and Virtual Health	Partnerships to offer access to virtual consultations and services accessible through digital platforms. Can include video or phone appointments, online diagnosis and treatment, prescription refills, and remote monitoring of chronic conditions.	**Penn Medicine** recently published a study examining the cost of telehealth services provided to their **own employee population** through a service called Penn Medicine OnDemand, which showed significant cost savings compared to in-person care.[7]
Centers of Excellence (COEs) and Bundled Services	Through COE models and bundled services, employers pay a single, predetermined fee for a package of health care services related to a specific medical condition or procedure. Can help to ensure top-tier care for complex or high-cost medical needs, such as cardiac surgery, orthopedics, or cancer treatment, with simplified billing structure that may cover the entire care journey, including consultation, surgery, post-operative care, and follow-up visits.	Large employers including **Walmart**, **Lowe's**, and **Microsoft** participate in the Employers Center of Excellence Network (ECEN) through their membership in Purchaser Business Group on Health (PBGH).[8] The ECEN provides employees access to demonstrated high-quality care for elective surgeries at meticulously selected COEs across the United States, including providers such as **Mayo Clinic** and **Johns Hopkins**.
Onsite / Near-site Clinics	Includes facilities located within the workplace or close to the workplace, offering employees easy access to various medical services, including primary care, to enhance convenience of and access to care, reduce absenteeism, and improve productivity.	**Central Ohio Primary Care (COPC)** - one of the largest independent physician-owned primary groups in Ohio - and **JPMorgan Chase** have partnered to provide advanced primary care to 20,000+ of JPMorgan's employees and families in Columbus, Ohio, including three onsite advanced primary care centers and two near-site care centers.[9]
Concierge Medicine Services	A retainer practice model sometimes utilized by employers for top talent recruitment and retention, usually built around an annual membership fee in exchange for a "personalized medicine experience," including 24/7 communications, same-day appointments, home visits and workplace visits.	**Amazon's One Medical** recently entered a partnership with Health Transformation Alliance, a collective of large US employers such as **Coca-Cola**, **Boeing**, **Marriott**, and **Intel**, to expand access to its primary care services to 67 employers and nearly 5 million employees.[10]
Risk-based and Value-based Arrangements	Like value-based payment models structured through third-party commercial insurance carriers, these involve a payment structure where the healthcare provider's compensation is tied to the health outcomes or cost savings achieved for a group of employees. While the contract is directly between the employer and provider, an insurance carrier often still acts as a third-party administrator (TPA) managing claims and/or physician payment on behalf of the employer.	In 2019, **GM** began offering a new health benefit option (ConnectedCare) to its non-union employees in Michigan through a risk-based arrangement with **Henry Ford Health System**. The D2E contract covers hospital, outpatient, behavioral health, pharmacy and physician services in a seven-county area, offers same-day primary care appointments, specialist appointments within 10 days, extensive telehealth options, and an exclusive phone line for GM beneficiaries to schedule appointments and get answers to questions.[11]

***Figure 1**: Common D2E Models and Examples*

While some models, such as EAP and occupational health, are historically more common than others, we are seeing more employers and providers directly contracting for expanded services to provide an alternative option for care and help control costs. In all cases, D2E arrangements should be tailored to the specific needs of an employer's workforce.

Potential Benefits of D2E Contracting

A win for employers

In D2E arrangements, payment is often built around a bundled fee or per member per month (PMPM) rate, with no additional cost for unplanned care or complications. Rates are also typically lower than commercial insurance rates. This isn't always the case; some studies have shown that the per patient cost for certain bundled services can be higher when performed at a COE versus a non-COE. Even so, D2E arrangements are still believed to lead to overall savings for an employer due to avoided episodes of care and better outcomes seen at COEs.[12]

Aside from saving on health care costs, better outcomes for the employee population can also translate to a more productive workforce with less workdays lost to illness. Recent Deloitte analysis goes into more depth about the criticality of a healthy and productive workforce on an organization's success, and thus, another reason why employers should be looking to explore innovative D2E models that have the potential to keep their employees healthier.[13]

Certain D2E models – like EAP, wellness programs, and concierge medicine – may not result in cost savings but could however enhance the overall benefits package and enable improved retention.

A win for providers

D2E contracting should be just as important a consideration for provider organizations as it is for employers, as it can represent new forms of revenue. Most of a provider's net patient revenue today flows through a commercial insurance middleman, with employee populations making up the bulk of that revenue. We recently wrote about why the time is now for providers to start thinking about diversifying their revenue streams – due to rate pressures from payers and the continued impact of industry convergence on their revenue that flows through payers today.[14,15] D2E represents one form of revenue diversification, with the self-insured employer now playing the role of 'payer.' From a provider's perspective, while D2E rates may be lower than commercial insurance rates, they are still usually higher than Medicare rates, and the mechanism for payment can be much more straightforward than it is through commercial insurance. Moreover, when factoring in the potential increase in downstream referrals that a health system might see from D2E models like onsite or near-site clinics, there becomes a clear case to be made for why a provider organization should be interested in exploring D2E contracts.

A win for patients

A compelling case for D2E contracting can be made from the patient's point of view as well. Onsite and near-site clinics can improve access and convenience of care for employees, while COEs can increase access to top-tier sites of care for specialty services. For consumers, using the brand-name provider also instills a higher level of trust in the support and guidance they receive (not jut from COES, but even for EAP and wellness programs).

Further, D2E services are typically associated with zero out-of-pocket costs, and employers often incentivize their employee population even further by covering travel costs for care. Consider **Purdue University**, for example, that arranges and funds travel and overnight accommodations for its employees who get hip and knee replacements done at Indiana-based **Franciscan Health** through their direct contract, in addition to a $500 cash payment following the procedure.[16]

In the right environment, a D2E contract can represent a three-way win for all parties involved – employers, providers, and patients.

Walmart is a classic and frequently cited example of D2E contracting done right. As the nation's largest private employer, Walmart began contracting directly with physician groups and health systems – including Mayo Clinic, Geisinger Health System, and Virginia Mason Medical Center – over two decades ago, for elective procedures such as joint replacements and spine surgeries. The results of their COE model speak for themselves:[10]

Post-Surgical Complications

Readmission rates from joint replacements via direct contracts **70% less** than industry average

Readmission rates from spine surgeries via direct contracts **95% less** than industry average

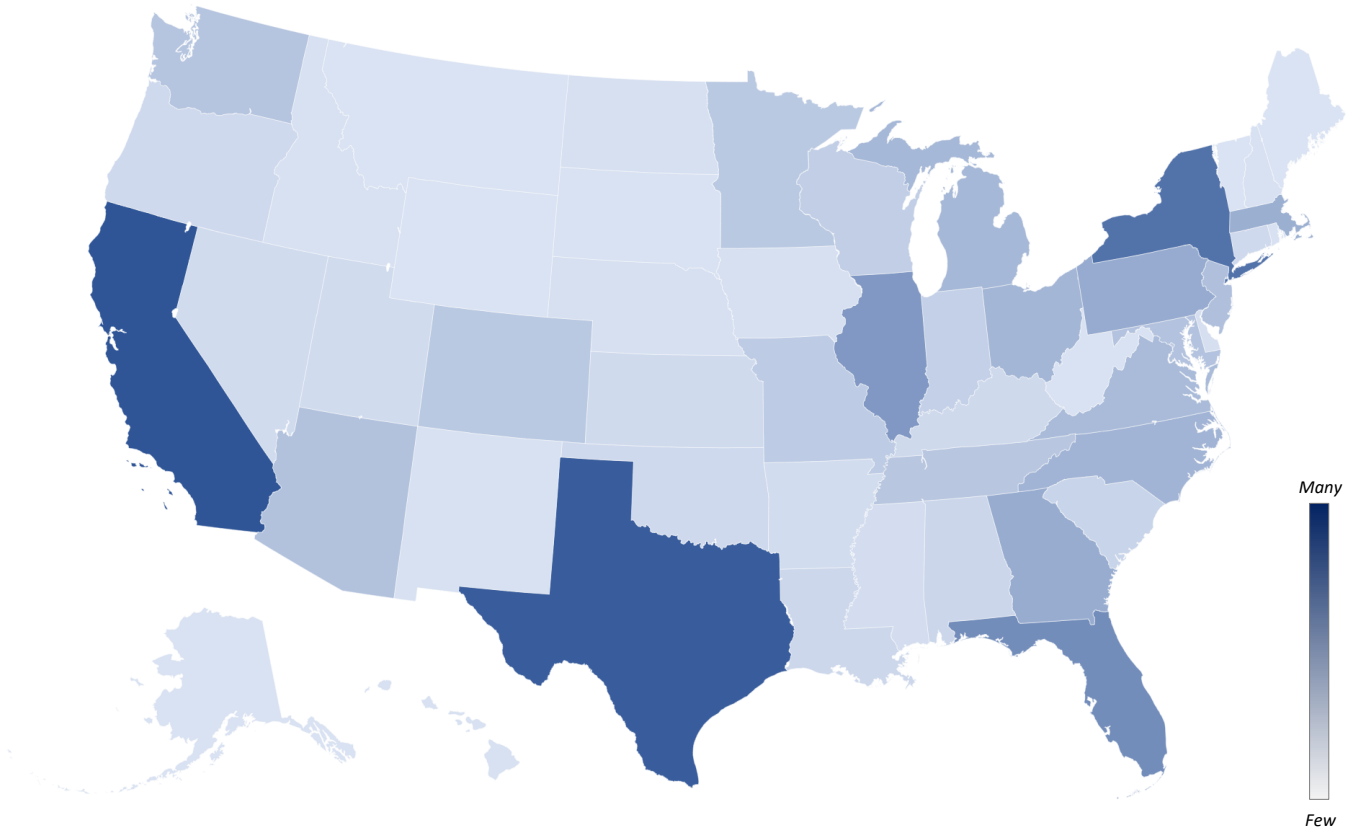
Return-to-Work Rates

Employee return-to-work rate from joint replacement or spine surgery **3 weeks sooner** than industry average

The arrangement represents a ***win*** for Walmart, with costs for services guaranteed upfront and a more productive workforce due to a faster return-to-work rate; a ***win*** for providers, who get paid faster than by going through the cumbersome process of commercial insurance; and a ***win*** for patients, who are able to access high-quality care for a complex medical need.

Characteristics of Ideal D2E Contracting Candidates

Figure 2: *Concentration of employers with 1,000 or more employees, across all states*



Source: *Deloitte Human Capital Labor Market Intelligence (LMI) Data*[1]

[1]*This data is sourced by consolidating self-reported occupation information from a variety of public-facing professional profile sites. The number of employees per state per company is calculated based on the number of available professional networking profiles in a given state for a company. For information on employer names and headcounts, contact Bill Docherty, Deloitte's Labor Market Insights Leader.*

The criteria for who should consider D2E contracting – from an employer's perspective or from a provider's perspective – will depend on market-specific conditions. Two factors that will almost always matter are scale and concentration. On the provider side of the equation, regional health systems are a good example of potential candidates with sufficient scale, due to their broader footprint and the range of services they can provide. Beyond scale though, providers who have built population health capabilities are in an even more unique position to leverage their expertise in managing specific populations to succeed in the management of an employee population via a direct contract. Some provider organizations (and some healthcare markets) are further along than others in the transition to value-based care (VBC) and effective population health management. Those that are further along may find a larger opportunity to achieve positive results in a D2E contract that includes a performance component (such as risk-based arrangements or COE models).

Scale – and concentration – matter for the employer as well, who would need a large enough employee population living within a provider's geographic footprint to justify a D2E model. If an employer isn't large enough – or doesn't garner enough participation in a D2E model from their workforce – then a direct contract might not be worth the time, investment, and effort required to set it up. Moreover, if an employer has a geographically dispersed workforce, then most D2E models will be difficult to justify to their employees. Thoughtful, actuarial analysis that accounts for these factors and others (such as competitive landscape) is required to determine if the juice will be worth the squeeze.

If you were to consider just size, we believe there are plenty of employers large enough to be asking themselves if D2E contracting might be an option for them. Deloitte's Labor Market Intelligence data suggests that every state in the United States has ***at least one*** **employer with 1,000 local employees or more** (and 24 states with more than 20 employers of this size). Many of these employers, and providers in their markets, are potential candidates that we think should be probing further on D2E contracts.

To be clear, we don't think a headcount of 1,000 equates to a "*you must be this tall to ride*" requirement. In fact, in some markets, smaller employers have created coalitions and worked with group purchasers to build enough scale and sufficiently spread risk for D2E contracting to remain a strategic option worth considering.

Challenges (and Detractors) of D2E Contracting

Much has been written about D2E contracting, particularly in the last five-or-so years as VBC and alternative payment models have continued to gain traction. The benefits of such an arrangement seem so obvious – ***so why don't we see more of it?***

While our secondary research failed to produce any post-COVID statistics on the prevalence of D2E contracts, the results we did find would seem to indicate that it is the exception more than the norm; a 2019 survey from Willis Towers Watson found that only 6% of employers contracted directly with providers at that time, while 22% were considering it for their upcoming year of benefits and plan design.[17] We think it's unlikely that those figures are significantly different today, due in large part to a few key reasons:

1. Today's middlemen won't want to be sidestepped.

D2E contracting challenges the traditional business model of health insurance. When a self-insured employer contracts directly with a provider, health plans risk being excluded from the transaction altogether. Even when a self-insured employer uses a health plan as the TPA, the result is likely a less-profitable revenue stream for the health plan than what they would see from traditional premiums. Commercial insurance carriers are well-entrenched in the today's health care system, with established relationships with employers and agreements in place with providers – meaning a change to the status quo won't occur without some opposition.

2. There is real value that will need to be accounted for.

We acknowledge that D2E contracting won't be an option for every employer, nor every provider, due to its administrative complexity. Absent a health insurance carrier, someone will have to handle tasks such as claims processing, billing, benefits coordination, and member enrollment and management. While some provider organizations with more mature VBC capabilities may be better positioned to take on D2E contracts, the vast majority of arrangements will still require a TPA.

3. There is a perception that employees might not support it.

Direct contracts necessitate steering employees towards some providers and away from others. While it's true that health care consumers have shown an adverse reaction to limiting their choices in the past, a strong communications strategy that articulates the value of the arrangement to the employee can help overcome this challenge. In addition, D2E offerings can be an opportunity for providers to design unique, employee-focused services (like concierge medicine), thereby creating additional value and satisfaction among their workforce and greater differentiation in the labor market.

4. Health benefits managers have limited resources and no shortage of challenges on their plates already.

There is real legwork to be done to design and implement a direct contract, and for many employers, their HR teams are often too small to take this task on. This is where we believe providers can step in and take on a greater role. Provider organizations should be actively looking to partner with HR benefits managers to bring the business case to them, and to help them articulate the value proposition of such arrangements to their senior leadership.

5. The risk game requires scale.

Even with employer group sizes of 1,000 or more, there can be a lot of unpredictability of medical costs due simply to random variation. Providers taking capitated payments for employers could very easily get swamped by (*or* get lucky and win big based on the lack of) random events. Taking sensible risk requires actuarial insights and scale.

We don't find any of these reasons to be insurmountable. As payment models and care delivery models continue to evolve, our expectation is that future survey findings will point to a growing prevalence in D2E contracting. Granted, employer size and concentration will still dictate just how much these figures change, but we believe it's reasonable to expect this model to work for more than just 6% of employers.

Where to Start

For employers thinking that D2E contracting may be a viable cost-reduction strategy for their business, some analysis is likely required to confirm, as well as to determine what type of D2E model works best for the needs of their employee population. An assessment of current health care costs is a good first step. This should involve analyzing claims data to better understand utilization patterns and to identify where major costs lie. Also, don't forget the voice of the consumer – employee surveys, or some other mechanism to collect input from your employee population, can give an employer greater insight into their workforce's healthcare needs and preferences.

Once you've understood what types of services you need, you can then think about who can provide them. The growing availability of price transparency data, as well as solutions and tools like Deloitte's MyRateFinder™ to leverage its power, can steer employers to low-cost, high-quality providers.[18] As discussed, scale is important. Considering the demographics of your employee population, you'll want to ensure that whoever you initiate discussions with has a network and facility footprint that adequately covers your workforce, is able to provide the range of services you require, and carries a reputation for high-quality care.

ConvergeHEALTH™ MyRateFinder™

Utilizing the extensive domain knowledge and proprietary analytics that turn information parity into a categorical advantage, MyRateFinder™ by Deloitte's ConvergeHEALTH™ can generates an empirical narrative to help inform and defend D2E pricing strategy.

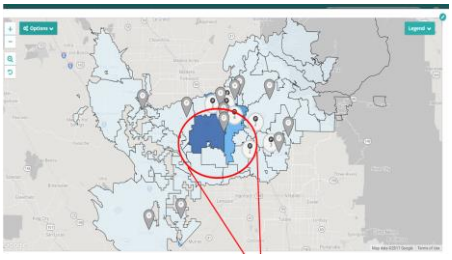
For interested providers, exploring D2E contracting starts with a thorough understanding of your payer contracts and competitive landscape. Many large health systems already hold risk-based contracts with dominant payers in their market and have goals of maximizing attribution within those contracts. A D2E offering can provide a new revenue stream, but it might also conflict with the incentives of your existing contracts. Providers should be careful to balance their portfolios to ensure they don't wind up competing against themselves. This should involve scenario modeling to understand the financial impact of moving certain employer groups from current payer contracts to a D2E offering, and what such a move would mean for the organization's top-line revenue and bottom-line margin.

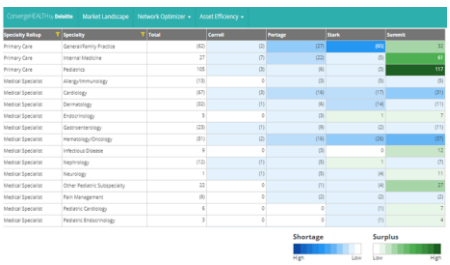
As for competitive landscape, providers must know what is currently being offered, and what gaps in care or access can be filled. Deloitte's proprietary Network Insight™ tool can give providers clear insight into their market landscape, including detailed demographic, hospital, physician, and health plan data to answer questions, such as:[19]

- *Is our footprint aligned with demographics of large, self-insured employers in our market? Do we have the right mix of services in the right locations to meet their care delivery needs?*
- *What services are likely to be in high demand over the near and long term? Are we positioned to meet those needs?*
- *How does our market footprint stack up against that of our competitors?*

ConvergeHEALTH™ Network Insight™

Deloitte's Network Insight™ uses detailed demographic, hospital, and physician data to help providers gain insight into their market landscape. Supply and demand data from Sg2 can be leveraged to inform projected volumes for different service lines, aiding providers in determining what types of services their D2E offerings might be built around.





Equally important for providers should be the partnerships they develop to bring D2E services to employers. You shouldn't try to own it all – at least, not out of the gate. As we mentioned before, absent a commercial insurance plan, providers will need to fill infrastructure needs such as claims administration, utilization and medical management, reporting and analytics, product pricing and sales, and customer service, to name a few. While some of these capabilities can be built over time, a flexible and white-labeled partner can often enable providers to move more quickly into D2E contracting.

CLOSING THOUGHTS

D2E contracting represents an attractive complement to typical health plan-provider arrangements and has the potential to reduce health care costs and improve health outcomes, if done right. We anticipate the trend of D2E contracting to continue to grow in the coming years and would encourage self-insured employers and providers to engage in discussions around how this model of health care financing might help them achieve their objectives. If they do, providers stand to become the system of choice within their communities, and employers might find some much-needed relief they've been looking for to escape today's cost pressures.

Reach out for a conversation

To learn more about how your organization can explore direct contracting arrangements, please contact:

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If you are interested in learning more, we invite you to read the other Deloitte articles referenced in this piece:

Advancing value-based care within health care strategy

https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/provider-sponsored-health-plans.html

Optimizing care model transformation and redesign

https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/care-model-transformation.html

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