

Direct contracting strategies for employers

Brian Sweatman, FSA, MAAA
Shyam Kolli, FSA, MAAA



For employers sponsoring health insurance benefits for their employees, maintaining competitive benefits packages is key to attracting and retaining top talent.

As medical and prescription drug trends continue their indefinite rise, self-insured plan sponsors dissatisfied with the status quo are seeking out direct contracting opportunities with healthcare providers to lower costs, cede risks, enhance benefits, and improve employee satisfaction. This paper summarizes a few direct contracting strategies observed in the marketplace and identifies key areas for consideration as employers evaluate these options.

Shared savings

A shared savings arrangement is a transfer of funds between an employer and a provider intended to reward a provider for its performance against established cost and quality targets by "sharing" a portion of the savings. These arrangements may also include provisions requiring the provider to compensate the employer for failing to meet the established cost and quality targets, in which case the arrangement may be referred to as "shared risk." Providers are typically responsible for the medical (and, in some cases, prescription drug) spend for members attributed to them; members can be attributed to a provider based on enrollment or through an agreed upon algorithm that is used to establish the provider's responsibility for the patient's care.

There are numerous methodologies used to set cost targets, but they can generally be classified as either retrospective or prospective. A retrospective methodology is reliant on some sort of external information needed to measure the provider's performance against the external benchmark (for example, comparison to a market trend index). Consequently, retrospective methodologies result in cost targets that aren't known until the contract's performance period has concluded. A prospective

methodology establishes cost targets on an absolute basis (for example, trend = 4%) and is not reliant on contemporaneous external information. In contrast to retrospective methodologies, prospective methodologies have the advantage of knowing the cost targets before the contract's performance period has ended.

There are seemingly infinite combinations of measures and methodologies used to assess a provider's performance against quality targets, but the influence that quality performance has on the overall financial mechanism is generally classified as either binary or scalar. A binary approach requires achieving the quality target as a prerequisite for distributing savings to a provider, whereas a scalar approach measures quality performance as a percentage of the target and reduces savings for performance below 100% of target.

The following bullets contain a few important considerations for employers looking to establish shared savings or shared risk arrangements with providers:

- Contracts often include several risk management provisions (e.g., large claims exclusions, risk adjustment) that may create a disconnect between observed health plan trend and the trend used to assess the provider's performance—prudent employers will allocate resources to reconciling these differences and understanding their actuarial appropriateness
- The ease of negotiating a prospective methodology will be correlated to the provider's expected network penetration—higher network penetration results in the provider having a larger influence over fee schedules and utilization management, and, therefore, a higher tolerance for prospective trend accountability
- If the methodology relies on allowed claims data (i.e., paid claims plus member cost sharing), it is important to confirm that the third-party administrator (TPA) is willing to supply this information—otherwise, the methodology will need to incorporate provisions to address the limitations of having only paid claims data (for example, reflecting the expected change in paid claims due to benefit plan design changes over time)

Bundled payments

A bundled payment is a fixed-price agreement for a provider to perform a procedure or manage a condition and take responsibility for contractually defined related services for a specified period. In the case of a procedural bundled payment (for example, lumbar spinal fusion is a service that is suitable to a bundled payment), the contract may cover pre-operative and post-operative care in addition to the procedure itself. By assuming financial responsibility for these additional related services, the provider is incentivized to eliminate wasteful services and focus on efficient, cost-effective treatments.

There are several technical complexities associated with bundled payment contracts. In addition to identifying the covered services, the contract may also specify explicitly excluded services, diagnoses, and conditions that may cancel the agreement (thereby reverting payment to fee-for-service), or high-cost outlier provisions. Additionally, administration of this payment model can be complicated due to differences in prospective and retrospective designs and associated challenges in determining when a bundle has been initiated.

Considerations for employers engaging in bundled payment contracts:

- Employers offering narrow network options can enhance employee satisfaction by establishing bundled payment arrangements with providers that are considered leaders in the chosen specialty of focus (e.g., orthopedics) but may not be included in the TPA's network
- Historical claims data for the employee population can be used to identify procedures and conditions that may be good candidates for bundled payments due to high variability in observed claims costs
- Reducing (or eliminating) the member coinsurance for a service covered through a bundled payment arrangement could increase the likelihood of members utilizing the preferred provider
- The reasonability of the bundled payment price and any associated outlier methodologies could be analyzed by applying the contractual provisions to historical claims data and/or external benchmark data

Reference-based pricing

Reference-based pricing (RBP) is another option that some self-insured employers are exploring to combat rising healthcare costs. RBP methods limit the amount that employers will pay toward certain healthcare services. Employers generally negotiate contracts with providers to accept RBP rates. The upper limit or "reference rate" that the employer pays a provider is often a function of the price Medicare would pay for a given

healthcare service (e.g., 130% of Medicare). Members may still have the choice of utilizing providers that have not agreed to RBP, but they may be responsible for paying fees that exceed the RBP. RBP is generally used for services where there is wide variation in prices among providers, but less variation in quality and outcomes across the spectrum of providers. Some examples of such services include CT scans, laboratory testing, and joint replacement surgery.

Some important considerations for self-insured employers implementing RBP include:

- Benchmark analyses may help in determining the appropriate reference-based price. Setting the level too high may not result in desired savings and setting it too low may not attract enough providers.
- Providers currently being reimbursed higher than RBP and with significant market share may be reluctant to reduce prices to RBP levels unless there are substantial gains in volume that small to medium-sized employers may not be able to offer.
- It can be difficult to implement RBP in rural communities where there may be a limited number of providers.
- In the scenario where there is no negotiated RBP contract between employers and providers, employers may still pay RBP rates. However, balance billing may occur. Balance billing (if allowed in the state) can result in high costs for members if providers bill the difference between their charges and the RBP that the employer pays. This may result in potential litigation in some cases.
- Employers seeking to implement RBP should educate their employees so they can make the right decisions when seeking healthcare based on cost and quality.

Direct primary care

Direct primary care (DPC) is a relatively new primary care delivery and payment arrangement in the healthcare landscape. In this emerging model, self-insured employers contract with medical providers to offer primary care services to their employees based on fixed monthly fees. Rather than paying for specific services based on utilization, employers pay the DPC providers on a periodic basis for all the negotiated primary care services (i.e., a capitation). The DPC model eliminates some of the administrative burden for primary care providers associated with billing on a fee-for-service (FFS) basis and there is no insurance carrier involved. Because the DPC model focuses on preventive care and allows for faster access to primary care providers by offering same-day or next-day appointments, it strives to achieve better health outcomes and stronger relationships between members and the primary care providers.

Some key considerations for self-insured employers when implementing DPC include:

- Understand how the DPC model fits into the overall benefit structure and whether the employee will pay any share of the monthly fees.
- Identify the exact scope of services that will be covered under DPC, any cost sharing that members would pay while accessing DPC providers, and whether the cost sharing would accumulate toward the out-of-pocket maximums for the medical plan.
- Monitor emerging regulations around DPC and the ability of members to pay for DPC services using their health savings account (HSA) funds or to contribute to an HSA while being a member with DPC.
- Based on where the employees are geographically concentrated, determine if it makes sense to have the DPC provider on-site on the employer campus.
- Make sure primary care services are not being duplicated through both the DPC model and the traditional primary care FFS model to avoid any increase in primary care costs.
- Consultants with access to detailed benchmark data can assist in determining the appropriate level of fixed fees for DPC services and the scope of services covered.
- Periodically monitor the DPC model to understand how employees perceive the benefit and whether it is achieving intended objectives around costs and quality.

Network replacement

Employers seeking an aggressive solution to controlling healthcare costs may pursue a network replacement option in which the TPA (and its network) is replaced by an integrated delivery system. By contracting with an exclusive provider, employers are trading off employee choice of providers in exchange for more favorable pricing terms and/or enhanced population health management. Readers interested in learning more about challenges and opportunities presented by network replacement are encouraged to read Milliman's thought leadership on this topic.¹

Conclusion

There are numerous strategies for employers seeking to control the cost of health benefits without benefit reductions. The level of sophistication required to deploy the strategies presented above varies across the spectrum. Employers investing in these strategies should balance the potential return on investment with the potential risk (such as employee disruption or increased administrative costs) and any associated vendor fees. By using advanced modeling techniques, employers can mitigate risk and ensure a high probability of success for the chosen strategy.

¹ Gaal, M. & Gusland, C. (July 19, 2019). Is Direct-to-Provider Contracting a Potential Silver Bullet for Achieving Value-Based Care for Employer-Sponsored Plans? Retrieved May 5, 2020, from <https://www.milliman.com/insight/is-direct-to-provider-contracting-a-potential-silver-bullet-for-achieving-value-based-care>.



Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

[milliman.com](https://www.milliman.com)

CONTACT

Brian Sweatman
brian.sweatman@milliman.com

Shyam Kolli
shyam.kolli@milliman.com