Provider Opportunity in the Direct-to-Employer Market

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ABSTRACT

Major venture capital investment has created increasing fragmentation in healthcare delivery for employers and employees. At the same time, the pandemic has exacerbated challenges for both, while simultaneously creating opportunities for new strategies. Providers can engage in direct relationships with employers, creating new products and promoting market diversification while supporting employers in their challenge to recruit and retain employees and reduce cost. Future success will be built on moving from segmentation to integration, focusing on each patient as the basic unit of service, critical to a diversified market strategy of direct relationships with employers.

KEYWORDS

Benefits, Carriers, Employer-Sponsored Health Plan, Intermediaries, Outcomes, Pandemic, Third-Party Administrator, Value-Based

INTRODUCTION

Providers face unprecedented challenges maintaining both fiscal and operational stability – conditions existing before but exacerbated by the pandemic. This current environment offers the potential for new strategies, often discussed but rarely prioritized, as a method for gaining market share while meeting market needs. Primary among these strategies is direct provider – employer relationships, often referred to as “direct contracting.” This paper proposes an approach to establishing direct employer relationships for programs and services; not as a replacement to current strategies, but as a tool for market expansion.

Accomplishing a successful direct to employer strategy requires first understanding the role of employers in providing health benefit coverage, why they do so, what challenges they face, what they expect from providers, their priorities, and factors that create different employer characteristics when viewed as a potential market. The specifics of how a given provider organization directly approaches the employer market can vary based on variable characteristics – their own and the relevant employer market. However, success depends on meeting certain principles and conditions that hold true no matter the product or employer market. The authors offer foundational principles and approaches based

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on their decades of experience in successfully creating and maintaining direct employer – provider programs, including new challenges and opportunities based on recent market dynamics.

The processes for direct provider – employer relationships outlined in this document involves many players and components, defined as follows:

- **Employer** includes any company or organization that offers a health benefit plan to the individuals they employ. The organizations may be for profit or not-for-profit and are segmented by size and risk bearing capability.

- **Providers** for this purpose refer to health systems, physicians – employed and independent practices – and other traditional healthcare delivery outlets. Not included in this category are non-traditional companies offering single or a limited scope of specialized services focused on the employer market.

- **Intermediaries** covers a broad spectrum of companies. The first category represents those companies that directly manage employer health benefit plans including national and regional carriers (such as United Health Care, Aetna CVS Health, Cigna, Anthem and other Blue Cross affiliates, Harvard Pilgrim Health) and third-party administrators (such as Contigo Health, Meritain Health, UMR Inc., Health Plans, Inc.). Note that many third-party administrators are owned by carriers. The second category are companies that consult with and broker services to employers. They include major national/international consulting houses (such as Mercer LLC, Willis Towers Watson, Aon) and brokerage houses (such as Health Rosetta, Arthur J. Gallagher & Co., HUB International, USI, Lockton). Consultants and brokers are differentiated by their compensation method – fees or commissions – although those lines have been blurred in recent years.

- **Carrier** (Health Insurance Carrier) are entities that contract with healthcare providers to offer plan administration to employers. A portion of their book of business is fully insured, but for major carriers most of their lives covered are through Administrative Services Only (ASO) employer agreements where employers maintain all or a significant portion of the cost of care risk.

- **Third party administrator** (TPA) is a firm hired by employers to manage their health benefit plan in lieu of carriers. TPAs are not registered as insurance companies with state departments of insurance and do not take cost of care risk.

- **Cost of Care Risk** represents the portion of a health benefit plan directly attributable to medical claims submitted by providers – generally at least 80 percent of total plan costs. Employers may fund that risk directly or through a third party stop loss company.

- **Medical Cost Trend** refers to the percent increase in the cost to treat patients from one year to the next, assuming benefits offered remain the same.

- **Employer Vendor** is a company offering health delivery services to an Employer sponsored health plan. Some examples include digital musculoskeletal services companies, mental health and/or substance abuse treatment companies, diabetes management companies, and claims data analysis companies. These offerings are frequently referred to as “point solutions.”

- **Employer Sponsored Health Plan** (“plan”) includes health insurance offered to employees and their dependents as a benefit of employment.

**EMPLOYER ROLE IN PROVISION OF HEALTHCARE**

Employers remain the largest single source of health insurance coverage for the US population. According to the 2020 US Census, “private health insurance coverage continued to be more prevalent than public coverage at 66.5 percent and 34.8 percent, respectively. Of the subtypes of health insurance coverage, employment-based insurance was the most common, covering 54.4 percent of the population for some or all the calendar year, followed by Medicare (18.4 percent), Medicaid (17.8 percent), direct-purchase coverage (10.5 percent)” (Keisler-Starkey & Bunch, 2021). Although more recent
statistics are difficult to access, as of 2016, employers also remained the single largest payer in terms of dollars. “In 2016, an estimated 48.0% ... by public insurance, and 9.4% ... by out-of-pocket payments” (Dieleman, Cao, Chapin, Chen, Li, Liu, Horst, Kaldjian, Matyasz, Scott, Bui, Campbell, Duber, Dunn, Flaxman, Ditzmaurice, Naghavi, Sadat, Shieh, & Murray, 2020).

Clearly the employer market should be a focus for providers seeking to stabilize and grow their market share. But providers’ view of employers as their largest market has long been obscured by the dominance of intermediaries, in this instance predominantly traditional Carriers serving as consolidators. Consolidation occurs through many employers – for a single provider it may be thousands – contracting with a carrier to manage their benefit Plan and represent them to providers through their managed care contracts. Carriers make the employer market accessible for providers, but the resulting consolidation skews the perceptions of what is important to employers. Consolidators drive the agenda on how to manage critical employer issues such as access and cost – often based on what serves the intermediary’s best business interest, which may or may not meet employers’ needs.

Enter direct employer-provider relationships as a vehicle for providers to gain closer access to their largest market. Direct employer-provider contracting relationships are not new. Both authors have created them for decades. However, direct relationships are maturing and gaining traction as employers look for solutions to support their employees and decrease the spend of their medical plan. The 2021 Large Employers Health Care Strategy and Plan Design Survey from the Business Group on Health found that 9 percent of employers were engaged in directly contracted primary care models, while another 17 percent were considering doing so in 2022 – 2023. Simultaneously, reliance on guidance from intermediaries seems to be declining with only 21 percent of large employers agreeing with the statement that they were “going to defer to their partners by, mak(ing) adjustments as the market changes and implement what my health plan(s) and PBM present as the latest developments” (Mulvany, 2020).

Carriers have represented the employer market to providers for decades. Health systems invest in sophisticated departments to negotiate the most advantageous agreements with carriers, seeking the best terms, including price and price structure. Carriers need providers for their primary asset – the broadest network with the best “discounts.” Providers need carrier contracts to access patients for their services. But as employers reduce dependency on intermediary solutions, an opportunity exists for forward thinking providers to step into more direct relationships with their largest market.

“In April 2022, health spending accounted for 18.1% of GDP” (June 2022 Health Sector Economic Indicators Briefs, 2022). The size of this market means that a growing number of other intermediaries beyond carriers participate in supporting health plan management, with the most common being the broker or consultant. Often providers view these intermediaries as barriers, but in fact can be partners in creating valuable relationships with employers. These intermediaries know and often have a strong relationship with the employers in their market as well as carriers and Third Party Administrators serving those employers. Many will be inextricably tied to their existing traditional relationships, but some will see the benefit of a new offering as a method for differentiating themselves in their market.

In fact, increasingly brokers/consultants engage with organizations such Health Rosetta, which include direct contracting efforts as a vehicle to improve benefits and reduce cost.

UNDERSTANDING EMPLOYER MARKET DYNAMICS

Understanding the market is critical to creating attractive employer solutions. Having treated the carrier market as synonymous with employers, providers struggle to understand employers’ healthcare challenges and the general health benefit ecosphere. Given its size, it is not surprising to find that the employer market is not a monolith. Flexibility necessary to implement strategies to manage health care value, usually depends on employer size. Management of cost of care risk – the cost of medical claims – represents the greatest driver.
Employer market structure breaks down at a high level into a few segments: fully self-funded (the largest employers that are at total risk for cost of care) have the greatest flexibility; partially self-funded (mid-sized employers who offset part of the risk to a re-insurer or stop-loss carrier) have flexibility, but less than fully-self funded; and fully insured (usually the smallest employers buying full insurance coverage from a carrier) have virtually no flexibility. Multiple sub-segments exist within these groups, but for purposes of direct contracting, it is most important to understand the major categories and how flexibility based on risk assumption drives their ability to engage in creative solutions.

Other complexities influence potential product offerings. For example, fully self-funded employers usually have multiple locations, and may not be willing to take on a different structure for one location versus another which may necessitate the ability to provide offerings for multiple geographic locations. Mid-sized employers have less leverage with carriers to create direct arrangements but may be in fewer locations making the product offerings less complicated. Both large and mid-sized employers currently engage in direct relationships to further their company’s health care goals, with solutions often unique to their size, location(s), and particular needs.

An important dynamic of the employer market is the dual nature of direct relationships. Direct relationships are of little value unless members on the employer plan (employees and their covered family members) utilize the services offered. Providers wishing to create successful employer relationships need to offer tools to improve employee engagement. They will have significantly greater success by including programs addressing issues such as employee communication and promotion, participant operational and engagement support, patient navigation, and a clear demonstration of value to the person using the service – not just the employer. The latter may include information about reduced cost to the participant, enhancements to support the patient and family member, improved convenience, and demonstrated quality of the services in which they engage.

However, the most important driver of employee utilization involves the monetary impact experienced by the end user of offered services. Employers frequently structure their benefit financial components (i.e., deductibles, co-payments, out-of-pocket maximum amounts – known as “accumulators”) to incent employees to use the directly contracted services. Incentives like 100 percent benefit for a contracted service versus standard benefit for other providers, help to create steerage to selected providers. However, disincentives in the form of increased employee payment for use of a non-directly contracted service are significantly more effective in achieving steerage than positive financial incentives. For example, some employers have created benefits structures allowing for 50 percent benefit with no out-of-pocket maximum amounts if employees choose to use a provider outside of the directly contracted program. This means that if the employee does not use the direct contract provider, they pay 50 percent of what is billed to the employer, and that amount will not be capped, even if they use a provider on the standard network panel. In these circumstances, it is not unusual to see increased utilization of the directly contracted provider of at least two-fold over incentive only differentials. When possible, it is wise to negotiate disincentives for not using the provider product as part of the program, while offering enhanced employee communication to improve employee relations and success of the program.

Potentially the greatest barrier for executing direct relationships involves provider perspective. Obviously, providers live and breathe healthcare. It remains a central focus of their lives, no matter what part of the industry they inhabit. Healthcare is so complicated that intense focus is necessary for success. However, employers’ view of healthcare varies widely. Given that most are in a non-health related business segment, their goals, interest, and attention focus on their primary business. The requirement to offer health benefits to attract and retain employees ranges in perspective from a necessary evil to a vehicle for advancing the wellbeing of their team members. Employers recognize that health benefits are costly, unpredictable, and often the most unmanageable part of their business.

Understanding an employer’s business and how their challenges effect their healthcare offerings to employees is critical to understanding solutions that will work for them. Challenges can vary based
on predominant industry in a region (Silicon Valley represents a dramatically different landscape than Pittsburgh manufacturing), the regulatory environment in which they operate, their demographics – age, sex, education, physical labor versus sedentary work – and increasingly a centralized versus virtual workplace with dispersed worker locations. Health benefits play a different role for a heavy construction or trucking company that require drug testing several times per year (with high failure rate and thus turn-over), a manufacturing company with moderate physical requirements but repetitive actions, and an educational institution with sedentary work habits and more mature work force. However, especially in the current low unemployment environment, employers must offer benefits that address the issues important to employees – no matter the industry or location.

Recognizing the impact of cost to employers for health benefits in the US is not new. Medical trend (as a critical measure for employers of increase in their cost of health benefits) is predicted to reach 4.4 percent in 2022, atypically less than current inflation but the base on which that medical trend sits is significant. The average cost per employee for medical coverage for 2023 is predicted to rise to $13,800 (Aon: U.S. Employer Healthcare Costs Projected to Increase 6.5 Percent Next Year, 2022) with current annual cost for family coverage running greater than $22,000. (2021 Employer Health Benefits Survey, 2021). For many employers, that cost constitutes half or more of the average salary for an individual employee – a significant burden for employers attempting to compete in a global economy.

Remembering that employers are struggling to recruit and retain qualified staff, the ability to cost shift to employees has run its course. The percentage of employers engaging in full replacement High Deductible Health Plans (HDHPs) as the only option for employees has fallen in the last several years to 25% in 2020, down from 30% in 2019 and 39% in 2018 (Mulvany, 2020). “Despite rising costs, most employers are not planning to increase employees’ share of coverage costs in 2023, such as by raising deductibles or co-pays” (Miller, 2022).

**CURRENT EMPLOYER FOCUS**

Creating a successful approach to employer direct relationships starts with understanding their current issues and focus. Of major concern always is the cost of providing health benefits. Although medical trend is lower than current overall inflation the cost of health benefits remains significant for employers facing rising costs in their core business. As one major national employer indicated to the authors, “healthcare is the only item that our company buys that we don’t know what we are buying, how much we are paying for it, the quality of the service we’re purchasing, why cost for the same service can vary from one to ten X in different parts of the country, and how to accurately predict the cost for budgeting purposes.” They are also concerned about the ability of the employees to afford healthcare since, cost shifting to employees is not a viable option especially in a time of challenging recruitment and retention.

Controlling cost is always a component of employer programming but is often not the primary driver in programs chosen by employers to enhance their health benefit plan. As such, successful interaction with the employer market begins with understanding their cost drivers. According to the Business Group on Health’s 2022 survey, cancer has overtaken musculoskeletal conditions as the highest cost area in employers’ health plans (Cancer Now Top Driver of Employer Health Costs, Says Business Group’s 2023 Health Care Strategy and Plan Design Survey, 2022). However, the top areas of highest cost remain consistent, including cancer, musculoskeletal care, cardiovascular conditions, diabetes, and high-risk maternity. Growing in the last few years exacerbated by the pandemic are mental health concerns and management of long COVID. A strategy begins by examining the organization’s ability to address these focus areas but also by gaining understanding of how employers in the targeted market experience and plan to address them. For example, employers with an average employee age of fifty will likely not have major high-risk maternity costs, whereas one with an average age of thirty may, but may not have high cardiovascular costs. Another consideration is that employers may have
already engaged a vendor in a service area (e.g., digital musculoskeletal) to reduce cost and improve prevention, creating opportunity to partner with vendors to integrate provider services.

A critical component driving employer healthcare solutions in the last several years comes from investment in new and emerging healthcare ventures. Venture capital investment in healthcare has increased significantly in the recent years, driving the availability of non-traditional healthcare offerings. Across 2020, US digital health companies raised $14 billion in venture funding (DeSilva & Zweig, 2021). This funding fuels offerings to employer health plans in that many of these investments are in companies that offer employers “point solutions,” or programs meant to address a single or limited clinical area. General telehealth, digital primary care, digital physical therapy, digital mental health, and substance use disorder solutions are just a few of the market entrants gaining traction with employers as part of their health benefit offerings. The vendors for these programs are most often not traditional providers, but companies created (and often venture funded) to address specific health issues. Their engagement often results in moving care away from traditional providers.

In addition to high-cost clinical conditions, the ability to attract and retain staff drives employers to offer benefits which are not typically a provider focus. Employers often now refer to their benefits team as their “health and wellbeing team,” clearly going beyond the realm of treatment and management of disease. Large employers now focus on offering benefits addressing expanded mental health, women’s health (including fertility), social determinants of health, health equity (including transgender and neurodiversity benefits) (2022 Large Employers’ Health Care Strategy and Plan Design Survey, 2021) “Nearly half of all employers with 500 or more employees – and about two-thirds of those with 20,000 or more employees – say that addressing health equity and the social determinants of health will be an important priority over the next 35 years” (Health Benefit Plans and Survey: Mercer US, 2021).

APPROACHING DIRECT EMPLOYER RELATIONSHIPS

Providers have numerous opportunities to engage in direct employer relationships, some of which are identified in figure 1. However, it is important to examine a few of the prevalent but not always accurate assumptions and principles regarding direct provider employer relationships. It is a common assumption that, since CEOs and CFOs of large local and regional employers are often on health system Boards, they will play a critical role in building direct employer relationships. In reality, Board members focus on driving their core business, not on their employee health benefit program. Engaging at the CEO or CFO level rarely results in productive direct relationships. Direct engagement with the employer’s health benefits team – which may be in Human Resources or a distinct benefits division – is critical as they are key to engaging partners to execute the benefits strategy. Engaging Board members rarely provides greater benefit than an introduction.

The authors have been surprised to find that major health systems do not believe that employers would want to talk with them or be open to sharing their needs and opinions about that provider. Experience demonstrates that most employers are interested and willing to discuss their programs and needs. They are a providers’ largest clients – large clients want to have influence over their suppliers that represent a significant cost to them. However, the approach to discussions with employers is critical. Employers have limited interest in hearing about all the wonderful new services created by the provider organization, nor how focused a provider is in delivering the best care. Any employer discussion should be a dialogue, starting with well-formed targeted questions attempting to understand their needs.

Questions should begin by understanding areas such as:

- Demographics and dynamics of their business and workforce.
- Structure of their plan (financial and position with the organization), their perception of the cost and perspective on the value of their health benefits to the company and employees.
Relationships with vendors, suppliers, intermediaries – for financing, clinical and non-clinical management, analytics, and strategy development.

Short- and long-term goals, vehicles they anticipate using and those that are of primary importance to continue, priorities for plan management, and workforce issues that could potentially be addressed through their health plan.

Pain points – for them and their employees. Areas of high cost and difficulties in clinical and access management.

Providers should be prepared to hear issues and experience that they would rather not, as oftentimes employers receive feedback from employees that are unhappy with provider services. Employer feedback is of significant value in gaining perspective on the needs of the employer market and viability for building solutions that fit direct relationships within that market.

A common assumption among providers is that they will see the patients from employers no matter what and are concerned that directly contracting for services with employers will disrupt their carrier relationships. Experience demonstrates that there are many opportunities to garner greater market share through direct contracting. Additionally, provider market share is being eroded through independent companies acting as point solutions and are decreasing their reliance on intermediaries acting as consolidators. Providers experience less risk by engaging directly with employers than in the past. In fact, not doing so creates the greatest risk – the potential for being left behind as competitors engage with employers or as point solutions, particularly virtual care, disrupts the market.

Additionally, direct relationships done well create potential to expand the market in ways otherwise unavailable. Employers may make a provider service available outside of their primary market, either due to employer design or through the provider demonstrating that their offering is exceptional in quality, service, and/or cost. Approaching defined services from a regional rather than a local basis is not new for employers. Finally, the opportunity exists for new partnerships that broaden opportunity, including new creative services targeted to a broader market through integrating services with point
solutions or through relationships with intermediaries such as brokers, consultants, or specialty providers such as TPAs.

Many providers engaging in direct relationships assume that their managed care department is the appropriate area to conduct direct contracting with employers, given their experience in contracting managed care relationships. However, the experience and skill necessary to engage in direct relationships differs significantly from those of a traditional managed care department. If successful, negotiations will occur at some point, but direct employer contracts first involve developing relationships, understanding issues and needs and then creating market solutions—products—to address them. In traditional managed care models, providers contract for services as they exist in the organization. The carrier or intermediary then translates those provider services to fit employers’ benefit plan offerings—they create the product for employers—which involves a great deal more than just executing a contract. Direct employer contracting requires providers to fulfill an intermediary role by adapting existing services or leveraging capabilities to create new services, to match employers’ plan needs.

Any provider desiring to engage in direct relationships should consider creating a separate “Direct Contracting” or “Employer Relations” department consisting of a few highly skilled market-oriented individuals separate from their managed care department. Those individuals require skills necessary to move the organization in this new direction. The department should report to executive level management providing enough gravitas to engage organizational focus and an ability to work across traditional organizational structures. It should have the ability to conduct negotiations and contracting, but more importantly create new products on behalf of the organization. Services already offered by the organization usually establish a foundation for direct contracting, but necessary adaptations may include operations, finance, legal, marketing, and communication.

Most importantly, the team must have the ability to see organizational services through an employer lens, understanding what from the employer’s perspective their needs, what fits and what does not fit, and how the organization must adapt to be viable in a direct employer market. As relationships mature this department may well be involved in the planning for and even creating of new services to fit the employer landscape which is diverging in focus from traditional healthcare organizations.

Engaging in direct employer relationships takes commitment. However, the potential steady erosion of traditional care resulting from non-traditional market entrants such as point solutions may not be visible until significant loss of business occurs. Additionally, an employer may engage in a direct contract with another provider in the market where their employees reside, shifting business within the market, or compensate employees to travel to outside markets to use the directly contracted providers. Experience demonstrates that doing so can have a significant impact on providers in that market.

**CREATING A WINNING STRATEGY**

Employers remain focused on their business objectives, requiring engaged, appropriately skilled, present, and productive employees. Health benefits critically impact the ability of employers to attract and retain those employees, but health issues often detract from their employees’ ability to perform at the desired level. Offering services to employees in a manner demonstrably consistent with meeting corporate goals establishes a good foundation but providers not offering services based on what patients want and need will not be successful in establishing direct relationships with employers. Employers receive significant feedback from their employees regarding satisfaction or dissatisfaction with specific providers. Employers will not promote providers with whom employees are not satisfied.

Where is all this leading: to value. Of critical importance in direct contracting is recognizing that employers want value for their healthcare investment. Unfortunately, the term “value” in the provider lexicon has morphed to mean risk-based pricing strategies. To employers, risk pricing supports better
accountability and integration, but it is not the ultimate goal. A measurable representation of value from the employer’s perspective includes:

Outcomes + Member Experience
Annual Cost of Care

“Member experience” is best achieved by “delivering care through the lens of the patient. Too often providers rely on tools such as HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey scores to measure patient experience, but do not engage in activities common to non-health care employers to understand how their services are utilized and perceived by those using them. Secret shopping and walking around, actively listening for what patients experience and see (unfortunately not uncommonly dirty and cluttered hallways and rooms, staff not responding to people waiting to talk with them, call bells not answered, patients and families overhearing nasty comments about them or other patients, staff commenting or their challenges with the workplace and co-workers) provides a foundational understanding what it means to deliver care through the lens of the patient. Designing and implementing standard processes that supply ongoing feedback to improve patient engagement and outcomes such as leadership rounding, bedside report, clinical team huddles, and safety conferences offer daily opportunities to address the organization’s success at delivering value.

Of course, healthcare is not retail. It requires clinical as well as service-based skill in creating products for employers. Quality clinical care delivered in a non-patient centered environment can lose
its value to an employer market. In designing true value-based products for employers, three critical components should be addressed, measured, and demonstrated to employers:

- Evidence-based, integrated clinical care delivery
- Patient-centered collaborative decision making with an integrated team
- Appropriate & affordable risk-based price where providers are paid a fee per patient and are then responsible for treating the patient within that budget.

In creating national centers of excellence for employer direct contracts, the authors required centers to demonstrate how they actively integrated patients into the clinical decision-making process utilizing a multidisciplinary team focused on each patient. Although programs were surgical, engagement of medical and other clinical disciplines to support decision-making and creation of care paths was required for a provider to be selected. Delivering care through the lens of the patient means more to employers than showing courtesy, attentiveness, and good guest services such as scheduling and communication responsiveness. Although important, in an ever-increasing consumer environment, patients treated as an active member of the team, engaged in knowledgeable decisions regarding their care will demonstrate much greater satisfaction with their experience. When the care team integrates around the patient needs and effective and efficient care delivery, the results are game changing. The authors have seen dramatic impact in several hospitals not only to patient positive response and increased volume, but also staff performance and satisfaction with their job, impacting efficiency, lost work time, turnover and staff engagement.

In one situation, structuring the clinical service allowing staff to deliver care through the lens of the patient led nurses to indicate that they were more effective with greater job satisfaction. This situation resulted in turnover going from well above to well below organizational averages – critical in the current staffing environment. When staffing challenges occurred, the nursing staff stepped up and took responsibility for adjusting assignments and coverage to address them. In another example, a provider who modified their traditional offering for a direct employer relationship quickly found that those adaptations created significant value. As a result, the provider organization modified their standard offering for all patients to include: a digital pre-operative education offering, improved psychosocial assessment, service coordinators available to patients and family 24 hours per day, and interdisciplinary clinical team assessments for all patients. The program enhancements afforded the provider the opportunity to expand their direct to employer relationships and to demonstrate greater value in their carrier relationships as well, all achieved with minimal addition to staff.

Finally, employers engaging in direct provider relationships understand the concept of evidence. It is not unusual for employers to inquire as to the evidence-based sources used by providers, and the processes through which they are deployed. Several providers have been recognized inside and outside the provider community for their programs driving evidence and consistency through specific disciplines. One such example is ProvenCare employed by Geisinger Health (ProvenCare: How to Deliver Value-Based Healthcare the Geisinger Way, 2017) with its numerous spin-offs. Another is the Virginia Mason Production System whose primary goals include: “Patient Is Always First; Focus on Highest Quality and Safety; Engage All Employees; Strive for Highest Satisfaction; Maintain a Successful Economic Enterprise” (What is the Virginia Mason Production System, 2022). Both health systems were deeply engaged in these processes before entering into direct contracts – which made them highly attractive to major national employers.

Employers want transparency. With increasing sophistication in analytics, the ability for employers to both utilize their plan’s claims data and to purchase additional meaningful data has increased in recent years. Employers leverage their claims data to better understand what they are buying – both in terms of cost and quality of a given provider by service, and broader claims data to evaluate where they sit in the local/regional market. They increasingly are directing their employees to providers that meet their standards for both quality (including service) and cost. According to the 2021 Willis Towers Watson “Health Care Delivery Survey”, 21 percent of large employers offer a
high-performance network in their health plan. This number was expected to grow to 30 percent in 2022 (With Healthcare Cost Increases Returning to Prepandemic Levels, U.S. Employers Focus on Affordability and Wellbeing, 2021). Understanding the tools that employers use and how those tools impact their decision-making represents a critical component of a direct employer strategy.

Claims data does not, however, provide the ability to assess outcomes – a crucial element of value. EMR data, readily available to providers combined with claims and social determinants of health data can create a picture of a patient’s health status, health services received, and outcomes. The direct provider and employer relationship creates an opportunity for data sharing and analytics, and an opportunity to evaluate the total value of the healthcare product – important to employers as healthcare costs continue to rise with wide variation between the outcomes of care across geographies.

PROVIDER SERVICE OFFERINGS OF INTEREST TO EMPLOYERS

Numerous services can be adapted to direct employer relationships based on their need and priorities, with Centers of Excellence (COEs) serving as the most common vehicles. Employers and providers have worked together through COEs for years (Woods, Coleman, & Slotkin, 2019). Centers of Excellence (COE) programs like orthopedic and spine surgery, bariatric surgery, cancer care, cardiac procedures, and gastrointestinal procedures represent viable options for employer relationships – either directly or through specialty vendors. COE programs in direct relationships frequently carve out the benefit from the carrier managed plan, with benefit administration managed separately from the carrier – a critical consideration when offering direct contracting programs. Historically COEs were national in nature, with employees traveling significant distances for care. Increasingly they are more regional with employees less willing to travel due to the pandemic, which in turn expands the number and type of offerings viable for direct relationships. So where historically providers might offer procedures such as joint replacement, closer proximity to patients makes broader offerings such as treatment for carpal tunnel, sports injuries, rotator cuff repair, and other less costly procedures financially viable for employers. Increasingly programs for women’s health and fertility treatment are provided through direct relationships. Programs to address high volume chronic conditions such as diabetes also have traction, although they are less common and frequently addressed by employers through point solution vendors.

Employers are now focusing on other approaches, for example, direct primary care. Employer-based on-site and near-site clinics, especially primary care clinics, have trended for several years. According to the Mercer 2021 Employer survey, “Almost a third of all employers with 5,000 employees or more and four out of ten employers with 20,000 employees or more stated that they had an employer-sponsored primary care clinic” (Waddill, 2021). Given the potential liability exposure as well as state regulations, employers look to local or national providers to create, staff, and manage these clinics. The authors have seen health systems in both urban and rural settings create business units for creation and management of employer-based on-site and near-site clinics, allowing them to establish relationships that can lead to acceptance of other programs.

All these identified services fit traditional provider offerings, but still require adaptation for success in direct employer relationships. For example, employers expect that patient and family or caregiver services include clinical and non-clinical navigation and concierge services, involvement in remote care monitoring, coordination with providers outside the system, (frequently primary care providers for COE programs). If patients travel from a significant distance, transportation or lodging availability may be involved. Enhanced involvement of mid-level providers (e.g., Nurse Practitioners and Physician Assistants) can be central to creating successful operations and products with rapid response to patient need. Of course, traditional benefit management is critical, with providers often working with third party administrators to address those program requirements.

Understanding providers’ staffing challenges, it is still important to employers that their employees are ensured access to care – an absolute requirement for providers engaged in direct employer relationships. Access not only means the ability to gain appointments or onto surgery schedules but
assumes items such as availability of providers to communicate with patients, review records, create plans, and deliver service; mid-level providers to coordinate care; and support staff to track and be available to patients and families over extended hours, prior to, during and after service delivery. Employers and employees making a commitment to a given provider do not expect delays in care, even though they understand providers’ staffing challenges. In fact, access issues can drive employers to engage in direct contracting as a vehicle for addressing them. Should delays become necessary, open, and transparent communication is essential, including plans for how to address current issues.

Finally, what future potential exists for direct employer relationships? Current trends dictate new strategies and potential services. According to the Business Group on Health, large employers remain concerned about quality of care and duplicative/unnecessary services). However, lack of integration between benefits solution providers (such as those offering point solutions) and especially lack of coordination between virtual care and community-based healthcare providers tops the list, with the latter indicated by 69 percent of respondents (2022 Large Employers’ Health Care Strategy and Plan Design Survey, 2021).

The future for providers seeking to engage with employers lies in moving from “carve out” to “integration.” Doing so means engaging both new or significantly reconfigured services and creating partnerships with vendors – particularly virtual point solutions. For example, the authors recently created an innovative employer focused solution for substance use disorder treatment. The product includes marrying an independent virtual care provider of services with a well-established traditional “bricks and mortar” provider, involving an intermediary to coordinate between them and other solutions to offer a broad scope of care for program participants. Both the virtual and traditional providers embraced the relationship, recognizing the value that each other brings in accessing the employer market – a challenge for each individually.

Another program involved integrating through a virtual provider assessment and management of musculoskeletal conditions that may be prior to, in preparation for, or in lieu of surgical treatment. Integrating those services with in-person providers already engaged in direct employer programs enhances the offerings that address one of employers’ highest cost areas. Providers must accept integration of non-traditional clinical services into the employer health plan. Employers trust and value the vendors offering those solutions who have developed organizationally to specifically serve the employer market – often far ahead of traditional providers in this space. However, opportunity exists to identify potential partners and create combined virtual and in-person care, demonstrating willingness and capability to integrate around patient need.

Will direct contracting arrangements replace carrier models? Of course not, but they can be a significant adjunct to traditional market access. Engaging in direct employer relationships offers potential for market diversification and growth based on existing services with potential for new and expand service offerings. However, doing so requires commitment, recognizing that success demands more than offering existing services in their current form to one more buyer. It requires understanding the market and employer needs and uniqueness, offering a broader array of services built around those needs, and potential partnerships with organizations not traditionally part of the service offerings.

Given current provider financial and staffing challenges does direct employer contracting require significant increases in clinical staff and extensive investment? A change in mindset is the most important requirement of successful direct employer engagements, accomplished through creation of a limited but highly focused team – not creation of major departments with extensive staff increases. Success requires seeing the market differently and adapting organizational strengths to meet a different market structure. In fact, if used wisely, learning from direct employer engagement presents the potential for greater efficiency and staff satisfaction in traditional care delivery. Gaining knowledge about employer needs and priorities, listening to their challenges and experience of their employees when accessing care, understanding the non-traditional providers they engage as point solutions and how to integrate them into traditional offerings all create the ability to expand the traditional provider market in new and unique ways.
REFERENCES


M. Ruth Coleman, as Principal of ValTrans Health, and Founder and Retired CEO of Health Design Plus (now part of Contigo Health), consults with healthcare organizations— including health systems, suppliers, and payors— on establishing and managing direct provider–employer relationships and creating value-based patient centered transformation. As a nurse starting at the bedside, prior to founding Health Design Plus in 1988 she served as healthcare and health plan executive, educator, and consultant, specializing in marketing, strategic planning, operations, quality/risk management and education. She created and managed direct provider–employer relationships, including full replacement direct contracted networks on behalf of employers as early as 1989 founded on documented quality, outcomes, and shared risk. She contracted bundled rates with providers as early as 1992 and has extensive experience bringing employers and providers together in partnerships that meet the “quadruple aim.” She holds a BSN from Widener University, and an MA from The Ohio State University.

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