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Is Direct-to-Provider Contracting a Potential Silver Bullet for Achieving Value-Based Care for Employer-Sponsored Plans?

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Recent announcements, such as the one by General Motors (GM) in 2018 that it had engaged the Henry Ford Health System to provide healthcare services to a portion of GM's employees,[1] have once again raised awareness of direct-to-provider contracting by employers and plan sponsors. Direct-to-provider contracting is a strategy in which a self-insured entity negotiates a contract directly with a provider of healthcare services rather than through a third-party administrator (TPA), often with the goal of driving value-based care. As part of a value-based contract, the provider is held accountable for improving patient outcomes through achieving key quality, cost and utilization metrics on a wide range of services. This provides the "value" in value-based care for the self-insured entity.

It's tempting to see these recent announcements as a bellwether of the direction of value-based care in the United States, cutting out the middleman rate negotiation role of the TPA. TPAs come in all shapes and sizes, but many self-insured employer groups contract with large insurance companies to access their network and provider contracts in performing these administrative services. TPAs navigate the competing priorities between employers, who want to make the highest-quality healthcare available to their employees at the lowest cost, and providers, who want to offer the most effective healthcare services with the greatest degree of business efficiency. They do so by negotiating discounts with providers and developing networks, but TPAs charge a price for this service, adding a layer of cost.

It's not surprising that direct-to-provider contracting as a route to value-based care has been a popular idea among providers and employers for some time. Both parties appear to regard direct-to-provider contracting as an opportunity, although they have different reasons and different opinions on what this solution entails. Providers see an opportunity to increase volume from employers through a narrower network. And employers see an opportunity to more directly influence the delivery and costs of health care.

The interest that providers and employers have expressed for direct-to-provider solutions is complicated by the numerous ways these arrangements can be structured. Direct-to-provider contracts can take many different forms, some of which will work better than others for individual providers and employers. It might mean something like the GM deal, which involves contracting with a health system for only a small portion of GM's employee base. Alternatively, it might mean working with providers to establish onsite clinics, contracting directly with physicians to provide direct primary care (DPC), or developing a center of excellence (COE) model for specific procedures and/

or conditions. For the purpose of this article, direct-to-provider contracting is defined as an employer contracting directly with a health system to provide comprehensive healthcare coverage to its employees and its dependents. We do not consider onsite clinics, DPC, or COE models as part of our definition because those more narrow forms of contracting between employers and providers do not offer the same potential for large-scale, population-level cost savings across all covered services under employer-sponsored health plans.

GETTING FROM HERE TO THERE

The key challenge to direct-to-provider contracting is implementing a model that is acceptable to both the employer and the provider. According to a survey of large employers from the National Business Group on Health (NBGH), 11 percent of large U.S. employers have adopted direct-to-employer arrangements with health systems and providers for 2019.[2] But most of the remaining 89 percent of employers don't necessarily have the size and geographic concentration of an employer like GM and may face difficulties scaling up direct-to-provider contracting in a practical manner. So a critical question remains how far can it be grown beyond that 11 percent, and, further, what *exactly* is being defined as direct-to-provider contracting. The fundamental problem, which has yet to be adequately resolved, is how to implement a program that reflects both the objectives of providers and employers, especially when these items are often in direct conflict.

MAKING DIRECT-TO-PROVIDER CONTRACTING WORK

While the overall concept of direct-to-provider contracting makes sense, there are key issues that make it difficult to implement broadly in the employer market—the typical employer geography and employer commitment to the approach.

Some employers may not be geographically structured in a way that would make direct-to-provider contracting feasible. For example, an employer may have a geographically dispersed workforce without sufficient scale for direct-to-provider contracting in any one region. Additionally, the majority of an employer's workforce may be located in geographies where there is one dominant health system in the area, thus making negotiations difficult between the employer and the health system due to lack of competition.

In addition, employers will need to commit on a large scale to value-based, direct-to-provider arrangements for there to be any possibility for *meaningful* transformation within the U.S. health care system to a value-based approach. For example, over the long term, employers can't have only 10 percent of their employees in a value-based, direct-to-provider arrangement while the other 90 percent remain in traditional fee-for-service models. Sufficient scale is needed for direct-to-provider contracting to have a significant impact on cost and improved health outcomes.

The fundamental problem is how to implement a program that reflects both the objectives of providers and employers, especially when these are in direct conflict.

WHAT DO EMPLOYERS AND PROVIDERS WANT?

In an ideal world, an employer would like to have a single healthcare solution that it can administer across all the geographic regions where its employees live and work. The preferred provider organization (PPO) approach has tended to work well for employers because of the administrative simplicity of large open-access networks. While it's simpler, and provides plan participants with excellent access to health care, it unfortunately does not promote efficient health care utilization because providers are generally paid on a fee-for-service basis.

In this context, it doesn't take long for the challenges of employer direct-to-provider contracts to appear. If, for example, an employer's health benefits program touches 10 different markets then it might be touching 20 to 40 different health systems that account for the majority of health care services being delivered to plan participants. The requirements for negotiating 40 or more contracts with individual health systems quickly become onerous for most employers, and this is before considering professional services (e.g., primary and specialty care) that fall outside of individual health systems. It's simply not practical for an employer to negotiate this many arrangements.

Providers, for their part, also want to use their preferred models, which they would like to roll out uniformly across all the different employers they would serve. The number of employers whose employees are touched by a provider or health system can run well into the hundreds. Additionally, providers serve many other key populations: Medicare, Medicare Advantage, Medicaid, and individual commercial insurers as well as individual self-insured employers. Providers would prefer employers to engage in relatively standard models without extensive negotiation and customization efforts, in order to reduce administrative complexity. It's already complicated for them. If one employer

wants to negotiate an individual contract, and then another employer, and then 200 more employers, it quickly becomes onerous for providers too, whose primary goal is to deliver high-quality health care to patients, not to negotiate payment arrangements.

The essential conflict we see in today's healthcare market is a structural one. Employer-sponsored plans, one of the primary delivery methods of healthcare benefits in the United States, tend to be geographically dispersed, while the actual providers of healthcare services tend to be geographically concentrated. Each side has a model that addresses the problems from its own perspective and each side would like to utilize that model in a direct-to-provider contract. But the two models don't always mesh well on a case-by-case basis and likely require lengthy negotiations between individual employers and providers. This remains one of the most daunting barriers to growing direct-to-provider contracting.

CONCLUSION

Until now, a key role of TPAs and insurers has been to facilitate purchasing between employers and providers. In many ways, all the efforts toward direct contracting have been employer attempts to replace the rate negotiation role of TPAs and tap into more efficiency (i.e., higher value at lower cost) and transparency, and ideally achieve value-based care.

A compelling case can be made that direct-to-provider contracting is worth the effort for employers with enough scale in certain geographies, which is evidenced by marketplace activity. And alternatives to contracting directly with a health system, such as onsite clinics, DPC solutions, and COEs for specific procedures and/or conditions, have been effective at reducing costs and increasing efficiencies for some employers. These approaches may continue to gain additional traction. Conversely, a case can be made that there is a ceiling on direct-to-provider contracting as employers look to expand value-based approaches in geographies where they lack scale or market leverage. Developing unique value-based care contracts for each individual employer does not make sense administratively or financially for most provider organizations. And many employers are not sold on the concept of varying their programs across geographies due to the added complexity.

Direct-to-provider contracting is an idea that has the potential to be successful in specific instances, particularly when there is scale and geographic concentration, and when the objectives of employers and providers are aligned. However, like many other strategies, it's probably not a silver bullet for controlling costs or expanding access to value-based care for the vast majority of employer-sponsored plans. ■

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ENDNOTES

1 Henry Ford Health System (August 6, 2018). Henry Ford Health System launches "direct to employer" healthcare contract with General Motors. Retrieved Nov. 25, 2019, from *https://www.henryford.com/news/2018/08/direct-to-employer-announcement.*

2 NBGH (August 7, 2018). Large U.S. employers eye changes to health care delivery system as cost to provide health benefits nears $15,000 per employee. Press release. Retrieved July 9, 2019, from *https://www.businessgrouphealth.org/news/nbgh-news/press-releases/press-release-details/?ID=348.*