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Is Direct-to-Employer Contracting Right for Your Organization?

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The current health care delivery system does not operate as efficiently as it could, and employers and their members continue to face escalating costs, confusion on how to obtain needed services, and overall marginal patient satisfaction.

Health insurance used to be primarily an indemnity solution, where the carrier would pay the providers the total balance of all bills for services. Over time, things have become more complicated and expensive, and many new payment models have been created to address numerous issues; one of these is the health maintenance organization (HMO).

An HMO is a direct relationship between a doctor and patient, where the primary care provider (PCP) is the single point of contact keeping a patient healthy throughout their life. This model is simple, cost effective, and provides high patient satisfaction.

The Health Maintenance Organization Act of 1973 expanded the adoption of HMO products and solutions. However, there was a need for more flexibility and options, leading to the creation of the preferred provider organization (PPO), allowing for more in-network provider choices. Despite further significant changes to the health care system in the last 50 years, underlying cost inflation pressure has brought the HMO's simple patient-to-doctor relationship back to the forefront of the marketplace in the form of direct-to-employer or direct-to-provider contracting (DTE).

WHAT IS DTE

DTE contracting is a partnership between employers and their local health delivery system for covered services under an employee benefits plan. Many

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strategies implemented in recent years address cost inflation and range from very combative employer-provider relationships (e.g., reference-based pricing), to more collaborative arrangements like DTE.

This direct contract drives simplicity, accountability, and collaboration and creates a pay-for-value model. It augments a third-party insurer and allows the employer to directly impact benefits and the quality and price of the services delivered. Additionally, DTE reduces margin and provides a framework where both parties can better achieve their objectives.

DTE is not a new concept. This model has been used by hospital employee health plans for decades. "No-cost" medical services provided to hospital system employees (i.e., domestic services) eliminate significant cost inflation and markup of services that regular commercial patients deal with.

Similarly to an HMO, which acts as both a provider and insurer taking risk, DTE is efficient, cost effective, and provides great outcomes when deployed properly. HMOs allow employers to enforce quality guidelines while compensating providers with a fixed fee or capitation. However, DTE goes farther and enables the employer to compensate the providers based on medical outcomes, incentivizing the provider to meet mutually agreed upon quality standards and deliver better care. Essentially, DTE is a hybrid of the HMO and straight fee-for-service models that, when deployed correctly, pays for value.

Though still new to the marketplace, DTE is already being developed and marketed to commercial employers within the service delivery area of some health systems that qualify as Accountable Care Organizations (ACOs), meaning they deliver value-based care to Medicare and Medicaid patients. Ultimately, the goals of pricing medical services based on the value derived are to increase simplicity, quality, and satisfaction while decreasing costs.

SIMPLICITY

The DTE relationship significantly reduces the complexity for members while navigating their health care system. The PCP acts as the point person to ensure that patient receives the appropriate care in the right setting. This single point of contact directs the member where to go and what to do. The PCP is the best person to execute this task, as they know the patient, their needs, and how to achieve the right results, building a relationship based on trust.

QUALITY

With DTE, the PCP and all other clinicians within the delivery system work together. They all agree on care guidelines and referrals, standardizing care under evidence-based best practices to drive the best outcomes and significantly reduce waste, overtreatment, and ultimately costs. This coordination includes the employer-supported benefit plan. The providers understand the employer's goals, helping the employer and member reduce unnecessary services and drive meaningful results.

AFFORDABILITY

Employer win: The employer will have a direct relationship with the health delivery system. The system will provide the best cost position because they have 100% of the employer's patient volume. The health system aims to create and sustain healthy patients, making them more productive and engaged while working. The employer's members will receive excellent care when needed without confusion, increasing their appreciation of the benefits program.

Member win: Members enjoy a simpler plan with no barriers to receiving care. No deductible has to be met, no

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coinsurance required, and there are usually few co-pays for specialized services. With access to preventive health care, members no longer need to put off necessary care due to cost. The PCP acting as the quarterback of care makes navigation easier for the member, and the care delivered will be correct, standardized, and appropriate.

Health system win: The health system has a seat at the table with the employer, consultant, and payer, giving them a financial stake in delivering the most suitable and necessary care, significantly reducing overtreatment. They are paid to deliver valuable results, not for the number of services provided, freeing up resources. Additionally, the health system can rely on a dedicated volume of patients utilizing their services.

WHAT MAKES AN EMPLOYER A GOOD CANDIDATE FOR DTE

Setting up a DTE relationship is not ideal or possible for every employer. There are some criteria the must first be met and questions to ask before considering such an arrangement.

- Is the employer self-insured? If not, does the employer have the size, scale, and ability to self-insure? Some fully insured groups have used an exclusive provider organization network to achieve similar results, but self-insurance provides the best platform for success.
- Is the employer ready to engage in designing benefits based on current claims data and partnering with providers to control their total spending?
- How much of the employer's population's current health care is being delivered by one system? 50% or more of current spending should be with a potential partner.
- Does the system have the needed service line capabilities and partners to cover any gaps in care?
- Is the health system experienced with ACO contracting and willing to expand to the commercial market?
- Does the health system use evidence-based outcomes, and are they willing to take some risk in providing fee-for-value versus fee-for-service?

DTE is not a new solution, nor is it feasible for every employer. Depending on the employer's unique goals for the plan, there is an array of strategies available to help set up plans that are high quality, low cost, and achieve high patient satisfaction. However, for those groups that are good candidates, DTE is an effective strategy and should be explored. If you would like to learn more, reach out to an experienced employee benefits broker that can help you get started.