

Issue Brief

Employers as Drivers of a High-Performance Healthcare System

Summary

- Employers provide healthcare coverage for more than 150 million Americans, nearly half the nation.
- Costs to provide that coverage continue to rise without a commensurate improvement in quality outcomes.
- Employers have a growing interest in finding ways to become better purchasers of healthcare such that it results in healthier employees and reduced costs.
- The Peterson Center on Healthcare and Catalyst for Payment Reform are building on existing efforts to help employers learn, test and implement best practices that promote a healthcare system that emphasizes patient outcomes and experience instead of the volume of care provided.

Beyond the obvious benefits that good health bestows on individuals, a healthy workforce is a tremendous asset to employers and to society as a whole. Most Americans receive private coverage through employment-based plans and costs continue to rise without a commensurate rise in quality. That creates a strong incentive to support and empower employers to adopt more effective purchasing strategies that will deliver high-quality care at a lower cost to their employees.

The trend toward provider payment that rewards health outcomes, rather than service volume, is part of the solution. However, fundamental improvement of a system with a long history of inefficient care delivery requires other activities as well. The Peterson Center on Healthcare sees motivated, nimble private-sector employers as an important leverage point, both at the level of individual companies, and for system-wide redesign. As such, the Center is entering into this critical area of the healthcare system to accelerate adoption of what works. In its first initiative as part of this effort, the Center is partnering with Catalyst for Payment Reform (CPR) to help employers learn, test and implement best practice strategies for purchasing and benefits design that can help secure higher quality healthcare at lower costs for their employees.

This issue brief examines the healthcare marketplace employers access; the health-promoting experiments underway to reward high-performance care; and the opportunity both the Center and CPR see to spread and scale what has a track record of working.

The potential payoff of better healthcare performance extends not only to employers, employees, retirees, and their families, but also to purchasers in the public sector and individual markets. Lowering the overall cost burden generates savings that can be used to fund new investments, raise wages and redirect tax revenue to other important public investments.

Health and Economic Imperatives

In 2015, healthcare spending in the U.S. reached \$3.2 trillion, a 5.8 percent increase over the previous year, and totaling 17.8 percent of the gross domestic product, according to National Health Expenditure data from the Centers for Medicare and Medicaid Services. These figures represent a significant acceleration in the rate of growth compared to the slower pace of previous years. Healthcare expenditures are exceeding inflation as they move steadily upwards.

Although per-capita health spending in the U.S. exceeds that of any other wealthy nation,¹ our healthcare system does not provide quality outcomes that match this investment. Average life expectancy is shorter in the United States than in most other developed nations, and rates of infant mortality and death from preventable diseases are higher.² This pattern plays out at the provider level as well, where dramatic price variations are decoupled from clinical results. A study by the Blue Cross Blue Shield Association, for example, found that a knee replacement at one hospital in Montgomery, Alabama, could cost around \$11,000 while at another in New York it can approach \$70,000. That trend holds true even within the same city; a knee replacement can cost almost \$17,000 or more than \$61,000 in Dallas, depending on the hospital.³

A significant portion of healthcare costs are borne by employers, who provide coverage for some 150 million people, nearly half the nation.⁴ However, because individuals in the labor force are on average healthier than the overall population, the share of total costs paid by private business is significantly lower than half. Nonetheless, in 2015, private businesses paid about 20 percent of the nation's total healthcare bill—representing a \$637 billion annual

commitment.⁵

Total premiums for family coverage now average more than \$18,000 a year (employer and worker shares combined), a 20 percent increase since 2011 (and a 58 percent increase since 2006). As costs rise, many employers have redesigned their benefit package to require more cost sharing. Workers are now paying an average annual premium of \$5,277 for family coverage, compared to \$2,973 ten years ago.⁶ Deductible and co-payment requirements have also grown considerably more expensive. High-deductible plans, defined by the IRS as plans that require families to pay at least the first \$2,600 of their medical costs annually before receiving any insurance reimbursement, are increasingly common.⁷

The impact of these trends will intensify as the population ages, especially if the growth of healthcare costs returns to traditional levels, as it is expected to do. Some economists believe the cumulative impact of such upward pressure is damaging U.S. competitiveness on the global marketplace.⁸ Rising costs can also erode the family budget and force families to cut back on needed healthcare.^{9,10} The burden is also evident in the significant increase of adults who are “underinsured”—that is, they have insurance coverage, but their out-of-pocket costs are so high that they are at risk of not seeking the care they need, or incurring substantial debt to secure it. According to the Commonwealth Fund, 23 percent of adults, ages 19 to 64, were underinsured in 2014.¹¹

The relationship between high levels of cost sharing and healthcare decision-making is complex and often inconsistent, but most current benefit designs ask consumers to pay more across the board, without regard to the value of a given service (with the exception of certain preventive services, which are exempted from any deductible). The consumer response is equally indiscriminate: “Considerable evidence suggests that higher cost sharing reduces the use of appropriate and inappropriate services in similar proportions and reduces the use of high-value services required to manage chronic diseases,” observes a discussion paper produced for the National Academy of Medicine.¹²

Separate and apart from the issue of non-value-based benefit designs that are widespread in the employer based system are issues related to the health status of the workforce. Unhealthy workers are inevitably less productive. Full-time employees who are overweight, obese or have chronic health conditions miss an estimated 450 million days of work, resulting in absenteeism that costs the American economy more than \$153 million annually, according to the Gallup-Healthways Well-Being Index.¹³ That contributes to “presenteeism” as well—that is, workers who are on the job but not healthy enough to devote their full energies to the tasks at hand.

“The high percentages of full-time U.S. workers who have less than ideal health are a significant drain on productivity for U.S. businesses.”¹⁴

Independent of benefit designs and health status of workers, there is a different sort of pressure on the system: the largely tax-free status of health insurance. The 100% tax exclusion gives employers and employees an incentive to substitute health benefits for wage increases and is considered by many to be regressive and inflationary. To lessen the impact on costs and the inappropriate utilization of healthcare, the Affordable Care Act included a so-called “Cadillac tax” on high-cost employer health plans, which is currently slated to take effect in 2020. However, analysts disagree on whether such a tax will give the private sector a reason to develop more efficient benefit plans, or simply fuel more cost-shifting.¹⁵

Each of these trends has appropriately been the subject of much in-depth research and debate. Together, they point to the need for bold experiments and pioneering approaches to strengthen the connection between cost and the value of the care it buys.

Value-Based Purchasing Strategies

Employers have not historically led a push to overhaul healthcare payment,¹⁶ but their interest in leveraging resources to support innovations that measure, report and reward excellence in healthcare delivery is growing. Value-based purchasing, as it is known in the industry, is the umbrella under which purchasers are rethinking benefit design and provider payment strategies.¹⁷

“Value-based purchasing involves the actions of coalitions, employer purchasers, public sector purchasers, health plans, and individual consumers in making decisions that take into consideration access, price, quality, efficiency, and alignment of incentives.”¹⁸

No single strategy is likely to emerge given the influence that employee health status, the local economy and the healthcare infrastructure, among other factors, have on the benefit and payment strategies that are optimal for any given employer. However, a number of innovative benefit design and payment reform strategies have demonstrated promise from both a quality and cost-performance perspective.¹⁹

- **Value-Based Insurance Design:** Rather than using the blunt instrument of higher cost-sharing for all health services, value-based insurance design makes it less expensive to seek evidence-based treatments, including preventive services that lead to improved outcomes. Such a plan may also penalize the use of inappropriate health services, often incorporating an education component so that patients are better positioned to make

informed medical decisions.²⁰

In 2002, Pitney-Bowes became one of the first U.S. employers to adopt value-based insurance design. Two years later, after lowering copayments for asthma and diabetes medication, the company reported \$1 million in savings from reduced disease complications.²¹ Patients were also more likely to adhere to medication regimens, and the per-person cost for plan participants was 23 percent below the industry benchmark.^{22,23} Caterpillar, CVS Caremark, and Marriott International are among other large employers who have implemented similar approaches.²⁴

- **Centers of Excellence:** Often used by employers to navigate dramatic variation in quality and cost for specialty surgeries such as joint replacements, cardiac surgery, or cancer treatment, Centers of Excellence require payers to contract with providers who have a demonstrated quality track record and who agree to deliver care at a lower or flat fee. The Employers Centers of Excellence Network, launched by Pacific Business Group on Health in 2014, has shown promising results for reducing readmissions and spending on procedures for conditions that could be treated through other medical pathways.²⁵ Better outcomes, coupled with lower out-of-pocket requirements, encourage consumers to choose Centers of Excellence for their procedures. Walmart, for example, has eliminated out-of-pocket costs for its employees when they seek certain surgeries at six designated healthcare centers around the country.²⁶ Strategies to safeguard against treatment overuse, such as having back surgery where evidence does not support its efficacy, are often built into the financial arrangements.²⁷
- **Reference Pricing:** Designed to encourage price sensitivity among consumers, reference pricing establishes a cap for certain well-defined health services, such as screening tests, imaging, cataract removal, knee arthroscopy and pharmaceuticals. Consumers typically have online access to the reference price, which is generally the local marketplace median, along with a list of prices charged by different providers. While they are free to go anywhere for services, their benefit plans will not reimburse for costs that exceed the reference price.²⁸ A study at the Safeway grocery store chain found that after reference pricing was introduced employees received the same number of laboratory tests, but their insurer paid less for them, with average per-test spending falling by almost one-third.²⁹ Likewise, the California Public Employees Retirement System (CalPERS) estimated that two years after introducing reference pricing, it had saved \$2.8 million for joint replacement surgery, \$1.3 million for cataract surgery, \$7.0 million for colonoscopy, and \$2.3 million for arthroscopy.³⁰
- **Bundled Episode Payments:** As the frontrunner in the pursuit of payment reform, bundled episode payments have been growing rapidly under Medicare and are gaining interest from the private sector. Under this strategy, payers and providers agree on a single fee for an episode of care. Typically, the care includes well-coordinated hospital and outpatient services either for a specific clinical condition (such as a coronary artery bypass graft or a hip fracture) or a package of procedures delivered within a prescribed time period.³¹ Bundled episode payments give providers an incentive to deliver efficient care because they reap the associated benefits, while assuming the financial risk of cost overruns; quality performance may be a component of the payment as well. A study of the Pennsylvania Employees Benefit Trust Fund found that bundled payments for total knee and hip replacements helped to improved clinical outcomes and drove down costs outside the hospital setting by an average of \$4,189, reflecting improvements in pre-operative and post-discharge services.³²

Obstacles to Spreading Value-Based Approaches

Despite their promise, value-based purchasing strategies have faced significant barriers to spread and scale efforts. There are a myriad of reasons this is the case, but principally, they include: lack of transparency, lack of experience in implementing optimal purchasing practices, and lack of capacity and administrative support to execute them.

Lack of Transparency

Lack of price transparency has long been cited as a challenge for purchasers to understand and intervene in inappropriate and inefficient pricing practices of providers and manufacturers. In contrast to virtually every other product on the market, price tags are rarely attached to healthcare, whether it is delivered through a clinic, a physician's office, a hospital, or a laboratory.

Private sector purchasers negotiate individually with health plans, generally without knowing what contractual arrangements those plans have in place with other purchasers. Traditional competitive bidding processes are undermined by their inability to compare price and quality across "suppliers" and uncertainties about the volume of "goods" that will need to be procured.³³

Standardized measures of healthcare quality and its relationship to cost, if they were available, could help inform decision-making, strengthen provider accountability, and drive innovation. While many metric sets are already under development or in use, the purchaser's perspective has not been well-represented in discussions, and no consensus has emerged as to which measures matter most in value-based purchasing.³⁴

Additionally, consumers lack the information they need to compare the cost of services across providers. A report by the U.S. Government Accountability Office identified a mix of health and legal factors that block transparency:

Consumers don't generally know in advance how much care they will have to buy, nor who will provide it, and insurers concerned about proprietary information and anti-trust regulations don't share their negotiated provider rates.³⁵ There have been many efforts over the last five years to make price information more widely available, particularly through the larger health insurance plans. However, they have not been a panacea, in part because consumers often assume that higher prices are a marker of quality.³⁶

Lack of Experience Implementing Optimal Purchasing Practices

Opaque pricing and the limits of available data are not the only barriers to optimal purchasing practices. Authors Galvin and Delbanco argue in *Health Affairs* that private-sector employers have not effectively leveraged their negotiating position with health plans. In part, this may reflect a lack of know-how: responsibility for employee benefits often rests with human resource managers who have limited knowledge of healthcare payment systems, or with outsourced consultants whose expertise does not extend to value-based purchasing. Many employers also lack the bandwidth to pilot innovation, the resources to encourage employees to make informed decisions about treatment options, or the willingness to engage in the long-term strategic and political work of influencing the healthcare system.³⁷

Lack of Capacity and Administrative Support

Other challenges to broader adoption of value-based purchasing strategies rest with health insurance companies—whether they are acting as insurers themselves or as third-party administrators for self-insured employers. They may not have the capacity to scale certain approaches, such as bundled payments; they typically want as uniform a structure as possible across their contracts; and they are wary of pushing their contracted providers to accept new forms of payment. Some providers are also likely to be resistant, especially if they believe they will see reduced compensation or lose business under new payment models. Employers, too, may be hesitant, especially if it means being “first out of the gate” in implementing strategies that have not been fully validated in the field.

Supporting and Sharing Best Practices

The Peterson Center on Healthcare's decision to engage on these issues reflects its belief that the current moment offers a unique opportunity to identify and test promising value-based purchasing strategies for employers and to scale what works.

Recognizing the challenges and opportunities of collaborating with the business community in its purchasing of healthcare, the Center is building on the many important efforts already underway. For example, a number of national and regional coalitions, including the [National Business Group on Health](#) and [Catalyst for Payment Reform \(CPR\)](#), offer their members educational and networking opportunities, as well as resources to support high-performance healthcare. The newly formed [Health Transformation Alliance](#) is bringing employers together to share relevant healthcare data and to pool resources in order to generate greater efficiencies in the marketplace.³⁸ The Employers Centers of Excellence Network, part of the [Pacific Business Group on Health \(PBGH\)](#), is negotiating bundled payment rates for certain surgical procedures and making them available to PBGH members and other self-insured employers.

“Competitive markets rely on informed, activated buyers to achieve improvements in quality and efficiency. Private sector employers are the key buyers in the health care market.”³⁹

To advance these kinds of efforts, the Center has made a significant investment in CPR, a not-for-profit organization that promotes an employer agenda focused on high-value healthcare. Through the Center grant, CPR is proceeding on multiple fronts to build and spread knowledge about levers in the hands of both large employers, including those who self-insure, and smaller firms, who have opportunities to build regional partnerships that can enhance their purchasing power. Key next steps in this initiative are to learn more about what is already happening in the field, to determine what works and how best to disseminate that knowledge, and to grow the constituency for value-based care.

Small, topic-specific collaboratives that bring together 5–8 like-minded employers to share experiences and learn from a subject-matter expert are an especially unique feature of the CPR project.

The caliber of the participating employers, and their willingness to be transparent, indicates a collective sense of urgency. The first collaborative to launch is focused on best practices in holding health plans accountable for their contracts with accountable care organizations. (ACOs are an alternative quality-driven delivery model that brings together groups of doctors, hospitals, and others to provide services and share financial responsibility.) Subsequent collaboratives will focus on mental health and specialty drugs, among other topics that employers have identified as pressing. Each collaborative will meet monthly for a year.

The “how-to” guides that will emerge from the collaborative discussions, along with case studies, reference tools and other resources will be available on CPR's newly launched [website](#), organized so that employers can access information based on their specific location, size and interests. Webinars, other web-based convenings, and online education courses will also be developed to educate employers about value-based purchasing strategies, offer guidance on quality measures, and grow and support advocates. By offering themselves up as a test bed for new approaches, CPR is helping foster innovations that can be refined, replicated, and scaled.

Employers' Contribution to a High-Performance Healthcare System

More than 150 million Americans, including employees, retirees and their families receive healthcare benefits through employer-sponsored plans.⁴⁰ As these costs rise without a corresponding improvement in quality, employers are increasingly seeking strategies to secure more effective care lower costs. Several large employers have led the way through innovative purchasing strategies and benefit designs, and our challenge is to expand the number of employers who know what works best and how to implement in their local contexts. Driven by a vision for a healthcare system that relentlessly improves outcomes and lowers costs, the Center and CPR see great potential for more employers to influence and shape the healthcare system that all Americans deserve and can afford.

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