

# Employers and the Delivery System

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## Great Expectations or Strangers in the Night?



NEBGH  
April 24, 2013

# Overview

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- ❑ Employers and the delivery system have much to gain from a more engaged relationship
- ❑ More contact will result from the acceptance that costs have to be controlled, the shift to a more managed consumerism model and the changing provider landscape
- ❑ Both sides need to spend time understanding each other – one person's waste is another's income
- ❑ It will be more *realpolitik* than *cumbaya* – incentives trump intention every day of the week
- ❑ But there is a common goal: follow the money but respect the mission

# What the Delivery System Needs to Know About Employers

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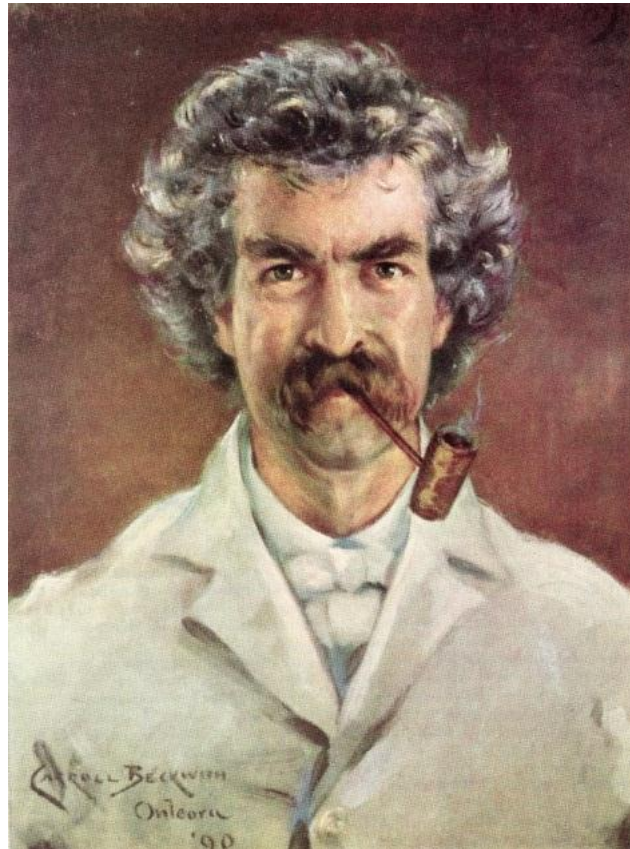
- ❑ Balance cost control and health/productivity improvement with ability to attract talent
- ❑ Differ by size, market segment and culture
- ❑ Have neither clinical nor deep delivery system expertise
- ❑ Vast majority work through brokers/consultants/carriers
- ❑ Designers, Buyers and Fiduciaries
- ❑ Somewhat accidental tourists traveling in a strange land

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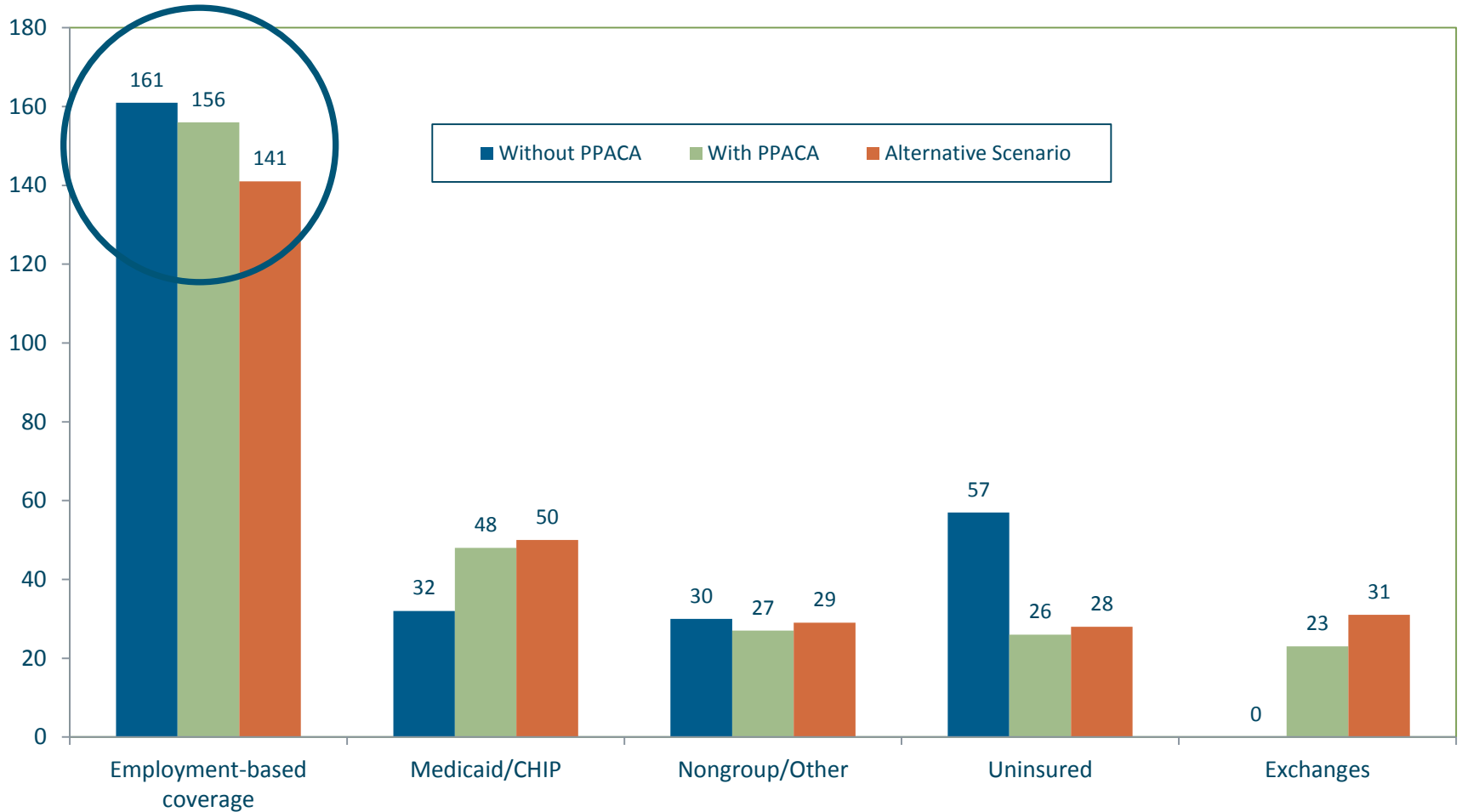
**Will Employers Use Health Reform  
as an Exit Strategy?**

# “Reports of My Death have Been Greatly Exaggerated”

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# For the Next Decade Will Be 3x Size of Medicare



# ESI Works in Mysterious Ways

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- ❑ Innovators & early adopters are actually few in number
- ❑ But responsible for significant innovations - managed care, pay for performance, provider performance transparency, disease management, health and wellness, etc.
- ❑ Fast followers far outweigh laggards - “everyone wants to get in the door second”
- ❑ New ideas can be generated by employers themselves or by intermediaries responding to employer needs
- ❑ Employers are still in the game, activated and powerful

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**Shift in Employer Approach as  
Profound as Change in Delivery  
System Re-Organization**



# Cost Is Issue #1

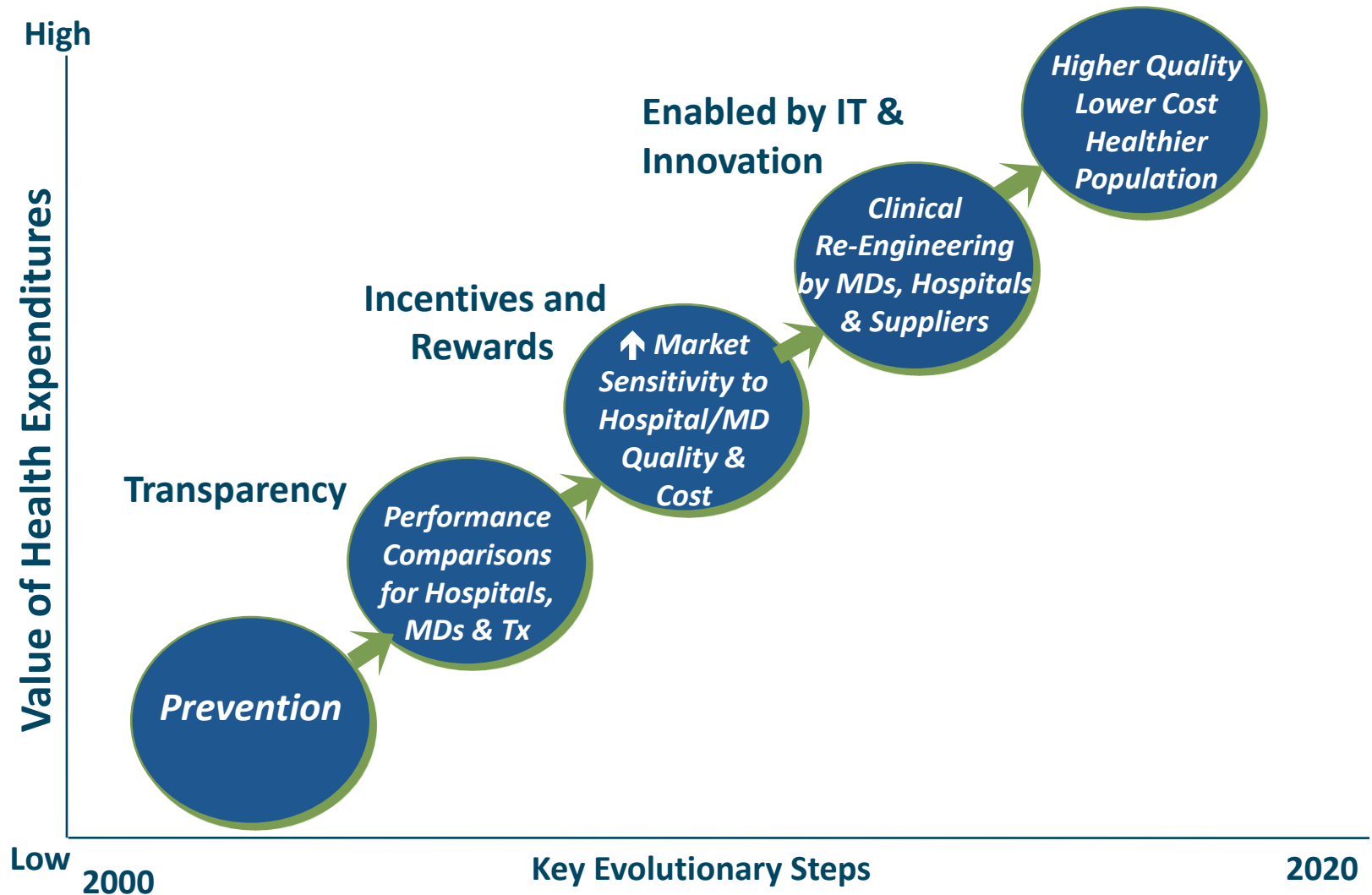
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**Health Status**

**Reducing Waste  
in System**

# Value-Based Purchasing Framework



# Employers Frustrated with Inability to Change

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His proud sponsors were:



# In a Paradigm Shift, Shift Happens

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## OLD –

- “We pay 80% of costs and leave it to health insurers and providers to manage the rest – it’s up to employees to decide how engaged they want to be in their health”

## NEW –

- “We will protect employees financially against catastrophic expenses and help them stay healthy....but the vast number of healthcare decisions in the middle need the same level of engagement that employees have in other important decisions in their lives....and enough of their money has to be at stake to get them engaged with enough information available to inform them.”

# Active Consumer Model

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## More use of financial incentives

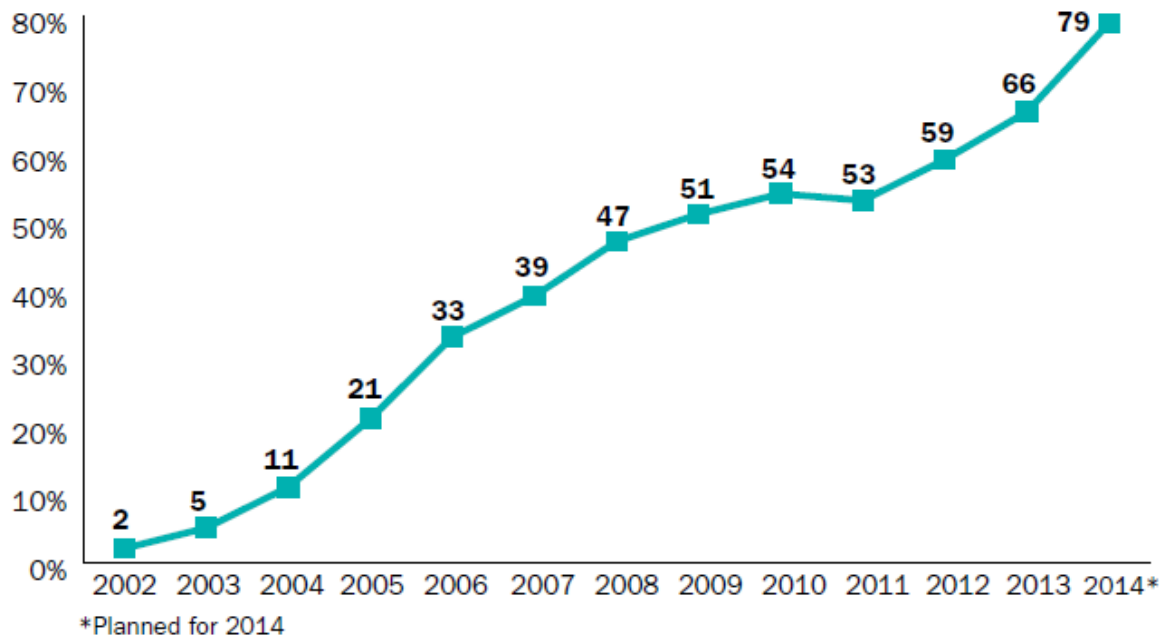
- High-deductible plans
- Value-based insurance design

## More attention to the delivery system

- Performance-based networks
- Price (value) transparency
- Involvement in payment reform
- Disruptive innovations that drive value

# Consumer Directed Health Plans...On the Rise

- ❑ Since 2011, CDHPs have increased 25% with another 20% expected in 2014
- ❑ More validation that CDHP has positive impact on purchasing & utilization behaviors
- ❑ With the 2018 excise tax, employers view CDHP as a future cost mitigation strategy



2013 18<sup>th</sup> Annual NBGH/TW Survey

# Robust Incentive Strategies Making National News

## When Your Boss Makes You Pay for Being Fat

- Michelin moved from a \$600 incentive towards deductible to a \$1,000 penalty toward outcomes



April 5, 2013 – Wall Street Journal



April 5, 2013 – Wall Street Journal

## Honeywell Penalizes Employees for Not Utilizing TDS

- Honeywell changed from \$500 TDS participation incentive to \$1,000 penalty
- TDS enrollment jumped from 20% to 90%

## CVS Imposes Health Penalty for Workers

- CVS will charge workers \$600 penalty for not completing biometric screenings



March 20, 2013 – NY Daily News

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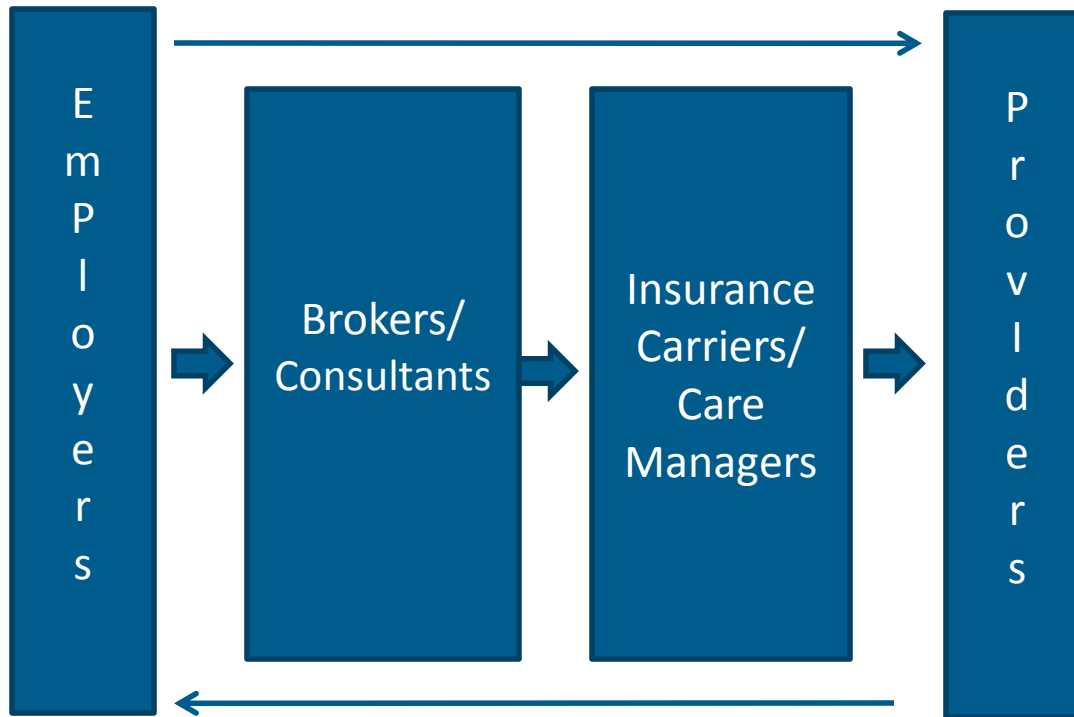


**Employer View of the Delivery  
System Transformation**



# Crossing the Purchasing Chasm

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**On the Surface, there is Absolutely Nothing Not to Like About a Delivery System that is Re-Organizing Itself Around the Triple Aim and Moving Away from Fee for Service to Pay-for-Value/Pre-Payment Models Along with Increased Transparency**

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**BUT.....**

# **Beyond the 1% of Mission-Driven Devotees...**

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**A legendary CEO once said about change:**

“It’s the hardest thing in the world. Talking to an engineer about doing things differently is like getting a root canal without Novocain.

So first, I try to dominate every market I can so I can control price. When that has played out, I try to change the regulations and bend them to their limit.

Only when those two fail do I do the actual hard work of getting people to change.

Don’t kid yourself – bureaucracies are built to resist change”

# Recent Press on Providers

## PROGNOSIS: PROFITS

95 Comments

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### As doctors flock to hospitals, bills spike for patients

 Recommend  114 people recommend this. Be the first of your friends.

#### Health Insurers Raise Some Rates by Double Digits

By REED ABELSON  
Published: January 5, 2013 |  1116 Comments

#### A Hospital War Reflects a Bind for Doctors in the U.S.

By JULIE CRESWELL and REED ABELSON  
Published: November 30, 2012 |  552 Comments

For decades, doctors in picturesque Boise, Idaho, were part of a

 FACEBOOK

### Prices soar as hospitals dominate cancer market

 Recommend  149 people recommend this. Be the first of your friends.

Ames Alexander, Karen Garloch & Joseph Neff  
aalexander@charlotteobserver.com, kgarloch@charlotteobserver.com and jneff@newsobserver.com

Health costs are rising...where hospital mergers allow the larger systems to use their size to negotiate higher prices.  
-Susan Voss, Iowa Insurance Commissioner

Novant-owned Presbyterian Matthews Hospital - 35% gross profit margin in 2010

## Nonprofit hospitals thrive on profits

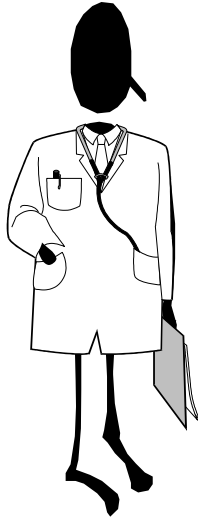
Hospitals in the Charlotte region are among the most profitable in the U.S. They have billions in investments and real estate. Experts say they should do more to lower patients' rising costs.

 Recommend  89 people recommend this. Be the first of your friends.

By Ames Alexander, Karen Garloch and Joseph Neff  
aalexander@charlotteobserver.com, kgarloch@charlotteobserver.com, jneff@newsobserver.com

# Will Too Big to Fail Come to Healthcare?

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Doctors

Hospitals



Integration

Consolidation

Improved Outcomes  
Lower Costs

Higher Prices  
Unchanged Outcomes

# Medical Homes vs. Home Runs

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- ❑ Medical Home is a terrific concept
- ❑ Auditable savings comes from fewer hospitalizations and referral to higher quality specialists
- ❑ How possible is this in a super-busy practice with limited IT?
- ❑ Findings of Arnie Milstein's research – two key features for success:

***“personal zealotry in preventing urgent and emergent hospitalization for chronic illnesses; and equally zealous concentration of referral care with high-quality medical specialists who are sparing in their use of “supply-sensitive services as defined in the Dartmouth Atlas.”***

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**Disruptive Innovations May Be An  
Option To Break The Gridlock**



# Disruptive Innovations: A Sampling

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- Telehealth
- mHealth and self-triage
- Alternate sites of care – including convenience, on-site clinics
- Price and value transparency
- Direct contracting

# What's An Employer To Do?

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- Hope for the best but prepare for the worst?
- Trust but verify?
- Don't buy a pig in a poke
- If it seems too good to be true, it is

***OR***

- Do what the private sector does best – apply rigorous due diligence, critical reasoning and common sense to separate the wheat from the chaff and then use purchasing power aggressively to embrace innovation

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## Employer Checklist – A Draft

# DESIGN Checklist

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- Does my benefit design promote accountability for health and healthcare decisions?
- Are there significant financial differences for choosing high vs. lower value providers?
- Does the employee have the financial incentive and support to seek higher value services of all kinds – including innovations outside of the current delivery system?

# BUYER Checklist:

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- Is my TPA showing provider performance measures on quality and price?
- Are they paying for value in a robust and intelligent way?
- Is there a convincing strategy to address provider pricing power - what's at stake for the TPA if new forms of payment to provider organizations go badly?
- For disruptive innovations: is there true savings or am I looking at yet another unaudited promise of ROI?
- Can you answer the question “who loses and why will they?”

# FIDUCIARY Checklist

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- Are there sufficient protections for the lowest paid and the very ill?
- Is there enough education, information and support for my employees about health, quality and price?
- Are you using your purchasing power to drive the right change, including disruptive innovations?
- Do I have the right expertise and the right models to truly measure savings?

# LEADERSHIP Checklist



**C**ATALYST  
**P**AYMENT  
**R**EFORM

**Only 11 percent of payment to doctors and hospitals in the commercial sector today is tied to their performance**

[www.catalyzepaymentreform.org](http://www.catalyzepaymentreform.org)

## 2013 CPR Members

3M	Dow Chemical Company	Ohio Medicaid
<b>AT&amp;T</b>	eBay, Inc.	Ohio PERS
<b><u>Bloomin' Brands</u></b>	<b><u>Equity Healthcare</u></b>	Safeway, Inc.
The Boeing Company	GE	South Carolina Medicaid
CalPERS	Group Insurance Commission, MA	TennCare
Capitol One	<b>The Home Depot</b>	Wal-Mart Stores, Inc.
Carlson, Inc.	Marriott International, Inc.	Verizon Communications

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# History of the Future: Two Versions





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**Some Hope and Optimism**

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**Since We'll All Be Patients Someday, Maybe Self-Interest, Always a Dominant Force in our System Alongside Altruism and Service, Will Direct Us to True North**

