Risk-Sharing and Value-Based Approaches to Health Benefits

by | **Kitty Juniper**

Plan sponsors may have a variety of options—or combination of options—in how they pay for and provide quality health care benefits.

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Plan sponsors, including fully insured and self-funded employers and multiemployer plans, are considering alternative payment and health care delivery approaches that will drive down costs while providing high-quality health care to their employees. There are various options plan sponsors might consider in pursuing cost-effective, value-based health care solutions either through their own health plans, if they have them, or in collaboration with insurers and providers.

This article describes the following types of options: (1) shared risk, including private accountable care organizations (ACOs), population-based payments and capitation; (2) high-performing networks; (3) direct provider contracting; (4) on-site clinics; and (5) employee engagement tools.

There is no one size that fits all, and plan sponsors might combine different approaches, designing variations to fit their organizations. Even employers that are not self-funded can collaborate with brokers and insurers to incorporate some of these alternatives into their benefit packages as a way to reduce costs. By actively engaging in the process, plan sponsors might be surprised at the innovative outcomes they achieve.

General Considerations

Implementing new health benefit models takes time, financial resources, committed staff and third-party administrators (TPAs) or consultants. It is up to plan sponsors to demand alternatives. Results will not happen overnight, and solid partnerships with providers and others are key to making these models work. All parties need to be actively engaged and aligned with clear and measurable goals and committed to transparency, particularly with regard to sharing data.

Risk-sharing arrangements—where insurers, networks and providers are held financially accountable for health care quality and cost savings—are ways to align the parties' interests through agreed-upon financial goals and quality metrics. These arrangements can result in clinical integration and financial efficiencies. They rely, to a great extent, on data concerning the costs of providing the health care and the quality of care provided.

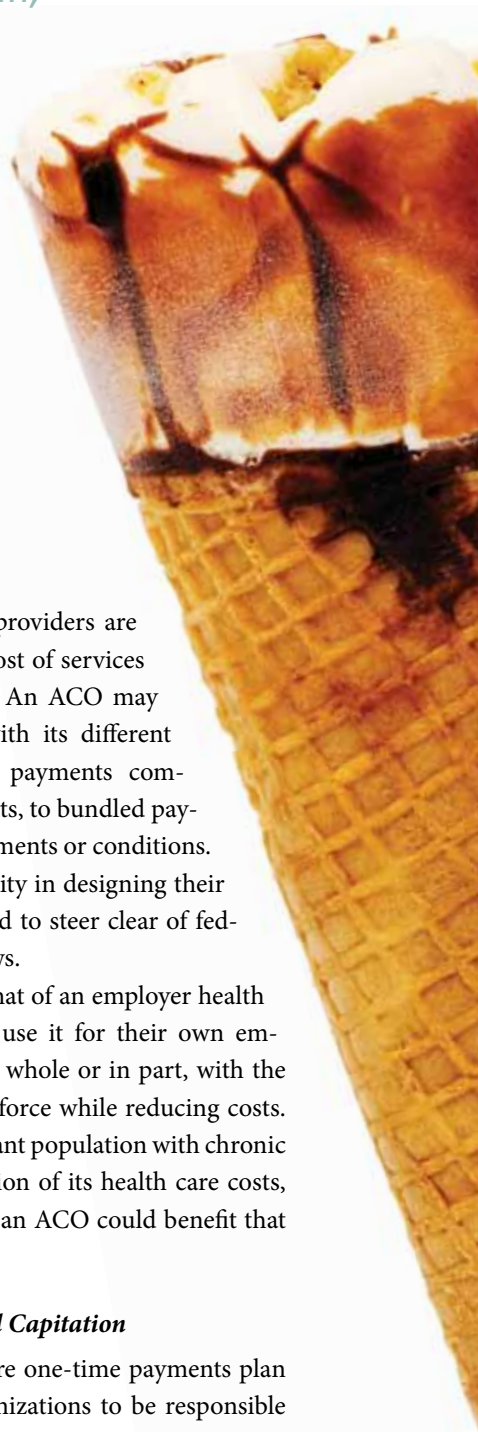
Health plans and insurers are releasing provider data but still are not consistently capturing and using data about individual provider costs, quality outcomes and adherence to evidence-based protocols. Nonetheless, when negotiating new or existing health care arrangements, plan sponsors should make their demands—"show us the data"—clearly identifying what they want to see. If the data does not exist, a time line for its production should be established. As the transparency movement toward disclosure of fees, costs and outcomes progresses, an increasing amount of data will be available to plan sponsors and providers to use in shaping their payment structures and benefit packages.

Below are various options that plan sponsors might consider whether using their own health plans or negotiating with brokers and insurers to produce cost savings. How they are structured will depend on the federal and state laws applicable to the plan sponsor, type of payment arrangement and pro-

takeaways >>

- Various health care delivery approaches can be combined in innovative ways to lower the cost and increase the quality of care delivery.
- Risk-sharing arrangements can result in clinical integration and financial efficiencies; when negotiating new or existing arrangements, plan sponsors should clearly identify what data they will need.
- A plan sponsor can develop its own ACO—a delivery system willing to take responsibility for managing the health of its assigned populations—or partner with one or more ACOs, directly or through insurers.
- Capitation minimizes risk to plan sponsors by paying a provider a flat fee, usually per member per month.
- Employers that want to use narrow, high-performing networks need to be sure to match their employee populations with the networks that best meet their needs.
- Several options, including direct contracting with providers and in-house clinics, can result in better coordination of care, financial efficiencies, better data gathering and reporting, higher reimbursements for providers and healthier employees.

One benefit of an ACO, like that of an employer health plan, is that plan sponsors can use it for their own employees and their dependents, in whole or in part, with the goal of creating a healthier workforce while reducing costs. Where an employer has a significant population with chronic disease that absorbs a large portion of its health care costs, the coordinated care involved in an ACO could benefit that group substantially.



vider organization. Plan sponsors should consult their attorneys to ensure legal compliance.

Shared Risk Options

Shared risk means plan sponsors, insurers, TPAs, providers or a combination thereof base partial reimbursement for services on the achievement of clearly defined and measurable goals for cost savings, quality or both. A plan sponsor may reward provider groups for improving quality and/or reducing costs by sharing part of any cost savings realized or otherwise providing incentive payments.

As partners, payers and providers engage up-front in budget planning and determining measurable financial and quality goals and their associated metrics. Risk pools or savings funds are created to reward each entity for its role in achieving the savings and quality goals. The extent to which savings are shared may be tiered in accordance with performance.

Shared risk models include the following:

Private ACOs[1]

Plan sponsors can consider developing their own ACOs or partnering with one or more, directly or through their insurers. ACOs are health care delivery systems willing to take responsibility for managing the health of their assigned populations. Working together, providers are responsible for the quality and cost of services provided to the ACO members. An ACO may use various payment models with its different providers—from fee-for-service payments combined with shared saving payments, to bundled payments for single episodes of treatments or conditions. While private ACOs have flexibility in designing their payment arrangements, they need to steer clear of federal and state fraud and abuse laws.

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Population-Based Payments and Capitation

Population-based payments are one-time payments plan sponsors make to provider organizations to be responsible for the health of the specified member population, with opportunities for sharing in resulting cost savings. The goal is to shift the focus from paying for services provided to em-

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ployees to keeping the employees healthy. Provider organizations have an incentive to reduce unnecessary costs and coordinate care, particularly for employees who require costly treatments. The California Public Employees' Retirement System's collaboration with providers in Sacramento is often cited as a successful example of this model.[2]

Capitation is another risk-based payment arrangement that has long been used successfully in California and is expanding nationwide as a result of health care reform. Capitation is used to minimize risk to sponsors by paying a health plan or provider a flat fee for each patient to whom it delivers care, typically on a per member, per month basis. Health plans often capitate payment (in full or in part) and delegate care to independent practice associations (IPAs) and downstream health plans. Determining the financial stability of the downstream provider is important. Depending on state laws and the extent of delegation, IPAs may need to obtain state licensing to accept the delegated risk.

High-Performing Networks

High-performing networks are narrow networks with providers that deliver high-value, well-managed care. Contracting exclusivity with selected provider panels should lead to greater volume for the few providers that agree to reduce their rates. The key is to match the employee population with one or more networks that will best meet patient needs.

With narrow networks, employees will have less choice of providers. Plan sponsors need to ensure that the networks provide sufficient access to affordable care, which can be provided by choosing networks that include a sufficient number of lower cost providers and facilities, e.g., ambulatory surgical centers rather than hospital outpatient clinics. Plan sponsors that choose provider networks that demonstrate high-quality outcomes may stand a better chance at gaining employee favor and buy-in to these limited networks.

Whether negotiating contracts for these narrow networks with plans and insurers or directly with networks, plan sponsors need to ensure that network providers routinely are assessed against the defined goals, with consequences for those that do not measure up. For instance, if evidence-based protocols agreed to by providers are in place, provider adherence to them (with tolerated deviations) should be reviewed and shared with plan sponsors. Based on this review, contractual consequences should be followed. All too often, data is not produced or review does not result in consequences to the deviating providers, since a keen analysis of performance data and sophisticated data systems are needed.

Direct Contracting

Employers have reported success in saving costs by contracting directly with providers and integrated delivery systems, either through high-performing networks, as discussed above, or for care for particular diseases and treatments. These arrangements appear to benefit both employers and providers. The latter can lower their costs in return for volume, while the employer eliminates the costs associated with contracting with a middle-person payer.

The extent of benefit may depend on the employer's size, the type of contract and compliance costs associated with any applicable federal or state employee benefit and insurer laws, which may result in prohibitive administrative and compliance costs. A plan sponsor should consult these laws prior to entering into direct contracting.

Direct contracting can be combined with various shared risk options geared toward the employee population. For instance, an integrated health system might provide a defined set of benefits for a capitated fee or a value-based payment. By accepting risk, however, providers may be legally required to obtain licenses to operate as health plans or insurers. In

California, provider groups that accept capitation for providing services outside of their scopes of practices need to obtain health care service plan licenses. Providers that directly contract with employers should have access to sophisticated information management systems to manage the risk and provide data to employers.

Direct contracting is an option for self-insured plans. Smaller employers can consider combining to form multiple employers welfare associations, consistent with federal and state laws.

On-Site Clinics

Employer on-site clinics that deliver primary care and ancillary services such as vision and dental care may be cost-effective for large, site-specific employers. Employers, themselves or through management services organizations, may provide turnkey operations for medical and allied health care providers to deliver care at the workplace. Employees lose less work time in traveling for certain health care treatments and have increased access to health care.

Employers also might be able to incorporate telehealth services in their on-site clinics, where cost-effective. State laws differ on the provision of telehealth services and should first be consulted.

Benefits and Costs

Successful implementation of the options above can take time and money. In the long term, though, they can yield substantial benefits to plan sponsors and providers. Depending on the models chosen, the following are some of the benefits that can result:

- **Clinical integration and quality improvement.** Where providers are forced to assume financial risk while maintaining high-quality care, better coordination of clinical care typically improves quality.
- **Financial integration and efficiencies.** Risk-sharing arrangements with providers and insurers that contain cost-containment mechanisms help to align the interests of employers and providers and create financial efficiencies.
- **Data and management services.** Improved information systems can result since effective data gathering and reporting are necessary to determine whether measurable goals were achieved for reimbursement.
- **Increased reimbursement.** Providers are rewarded where they successfully meet predefined goals.
- **Healthier employees.** By maintaining goals for patient health outcomes, the employee population overall should benefit.

<< bio

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Employer Tools

As partners in implementing new payment arrangements, employers can utilize various internal and external tools to contribute to the success of their new arrangements. Engaging employees by communicating goals and achieving buy-in is critical. In addition, employers can use outside services that assist employees in locating higher value physicians and facilities and disclose the prices of certain procedures, where available. Finally, through mobile apps and employer wellness and fitness programs, employers can help employees be responsible for their own health care. In the end, it is up to individuals to take control.

Endnotes

1. ACOs formed under the Medicare Shared Savings Program are not addressed here.
2. See, e.g., "Payment Matters: The ROI for Payment Reform," Robert Wood Johnson Foundation, February 2013.

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