Employers as Health Care Change Agents: The Time Is Now

Presenters:
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Executive Summary

Employers and other stakeholders attended BHCG's seventh Delivering Value Series symposium of 2022 (in-person and via webinar) to hear from key influencers and stakeholders who are leading the charge for a more active role for employers in changing the health care landscape in Wisconsin and nationally.

Those in attendance learned why strategic investors are betting on employer-focused solutions; how accountability and alignment are necessary for mutual success; what a regional health system is doing to embrace change while still managing day-to-day in the status quo; why what's happening in Wisconsin is resonating nationwide; and what success looks like now.

BHCG C-Suite Perspective – Todd Smasal, Northwestern Mutual

- **Role and responsibility of employers/BHCG members in driving health care change**
  - Not easy but very important for employers to find solutions for health care quality and affordability challenges their members face – can't sit on the sidelines
  - Fifteen years ago, made the decision to become part of BHCG to work with fellow employers to help influence better health care (cost and quality)
  - Employers have responsibility not only for members but also to the community to help ensure SE WI has the best health care in comparison with other places

- **Appreciate the partnerships that have been formed with:**
  - Health systems
  - Centivo – on the verge of making major breakthroughs; switched to Centivo as administrator 1/1/22 (picked up 35% of plan member lives in Centivo markets)

Rivka Friedman, Head of Healthcare Innovation, Morgan Health

- **Morgan Health**
  - Haven – health care joint venture between JP Morgan Chase, Amazon and Berkshire Hathaway; folded during Covid
    - JP Morgan Chase decided to go it alone (spends $2 billion annually on health care)
  - Morgan Health is a wholly owned business unit of JP Morgan Chase
    - Mission statement – charged with improving the quality, equity and affordability of health care for employees and dependents and across the country:
      - As a strategic investor (invested in Centivo)
      - Through health care innovation (launches pilots in innovative health care delivery and payment solutions, test with own employees and then scale across the system)
- **What should employers' role be?**
  - Employers are now responsible for health care (pay majority of costs) – should drive health care value on behalf of employees and dependents (responsible for 20%, more or less)
  - Responsibility to drive consumerism by sharing better information about what they are buying and what it costs (value)
    - Translate it into better shopping for health care – working with providers and carriers
    - Have many tools to drive better value (create ecosystem)
      - Access to advanced primary care
      - Value-based specialty care
      - Build incentives into networks for value
    - Looking for better outcomes, less disparities and drive health care value for employees/dependents
    - Thinking about quality and equity at a very high level and granularly
      - Align performance measures and address gaps
      - Decrease disease prevalence across race and income
- **A lot of companies focused on data and tools to build networks and drive consumerism**
  - Looking at many and identifying key ingredients that work
  - How can we leverage and what is our role?

Lisa Bielamowicz, MD, Gist Healthcare

- **Gist is small DC-based advisory firm**

  - Works with hospitals, health systems and large physician groups to help them think about the future and drive change
  - Looks to put together all the complex market forces to understand what matters
    - Helps employers think about strategy to prepare for the future
- **How is the provider community thinking about value?**
  - Lots of challenges – payment change, new care models
  - Health care costs (tough economic conditions) will fuel change more than anything else
- **Ten years ago, lots of optimism (ACA, etc.)**
  - Doctors and hospitals expected to make the transition to value-based care (integrated networks, less expansion)
  - Defined contributions for employees – fueled by data (EHR, etc.) to make better decisions
- **Health care is not recession-proof; five forces accelerated change (pandemic also accelerated things, i.e., virtual visits)**
  - Economy
    - Inflation
    - Consumer confidence – concerned about health care because of high deductibles
  - Labor costs have gone up 20%
    - Labor shortage
  - Demand has changed – where they go (outpatient shift)
  - Disruptive competition – entrance by retail giants (insurers made money as demand shifted to other places)
    - Scale doesn't matter – everyone is pinched with negative margins
      - Will force changes in volume, etc.
  - Policy – shifting from paying for value to cost control
- **Outpatient volumes came back**
  - E.g., 60% of hip replacement done in outpatient settings
  - Costs are half – good for consumers, bad for hospitals
  - Emergency department use – people learned not to go for small things (use telemedicine, etc.)
- **Trends affecting value**
  - Medicare risk program has produced minimal cost savings
  - Value-based care is only a fraction of revenue for providers (<10%)
    - Hard to change how you do business
  - Biggest health systems' revenue is still a fraction of other health care companies' (carriers, etc.) revenue
    - UHC is biggest employer of physicians in the country, etc.
    - Looking for more business as demographics change (aging of America, etc.)
    - Want to manage aging
    - Making big bets on Medicare Advantage – how to best manage
  - Need to transform the system as millennials age (less healthy than their parents)
- **Strategy is to own the platform**
  - Health systems without hospitals – insurers manage the relationship

    - Free market fragmentation – consumer-driven referrals
    - Health systems as platforms – regional health systems merge to provide full continuum of services and manage risk
        - Goal is to build lifelong relationships (not just quality-driven)

Bernie Sherry, Ascension Wisconsin

- **Ascension – 19 states, large not for profit, faith-based**
    - Every market is different
    - Wisconsin (from Racine to Appleton) – 17 hospitals, 100+ health care facilities, 1,100+ clinicians
    - Came from Tennessee in 2016 (no coalitions in Tenn); met with Jeff Kluever and leadership of BHCG
        - Found out 40% of regional health care is through BHCG
        - Asked how many Ascension providers were considered value providers through UHC/BHCG – 70% (many providers cut out of network without looking at data at that time)
- **Made a commitment to build a network to create value across the state**
    - Moved from being hospital-centric to sites of care (extremely important, as is architecture)
    - Value is defined as great outcomes that are cost-effective
    - Had the data-backed value – met with stakeholders but couldn't get anyone to really listen about partnership
        - Partnership with employer, carrier and provider is critical and needs to be personalized – can then drive value
        - Carriers were not really carrying the message back to employers
- **BHCG and Centivo wanted the partnership and acted as a third party assessment of value**
    - Ninety percent of Ascension providers are in the high value category (200 PCPs)
    - Built sites of care that are geographically accessible
    - Focused on site of care
        - Unit cost is important but need to be tied to great outcomes to create great value
        - Continuity of care is important – staying in high performance network is key
    - Work very closely with Centivo team to create the platform
        - Payer, carrier, employer and provider come together every month to look at performance
        - Want to continue to improve value – the only way it works
        - Many stories of success because of the partnership and model – "positively disruptive"

Panel Discussion/Q&A

Todd Smasal, Northwestern Mutual; Rivka Friedman, Morgan Health; Lisa Bielamowicz, Gist Healthcare; Bernie Sherry, Ascension Wisconsin; Moderator – Dave Osterndorf, BHCG & Centivo

- **Q: Health care moves slowly but the pandemic showed us that doesn't have to be the case. How fast can we change? What should we expect?**
  - **A (Smasal):** Don't know the timeline but many of our companies are undertaking transformation of our business models and have a vision and anticipate how quickly we think we can get there, but we don't just wait for it to happen – we have to take steps, test, learn and modify our approach. Employers in the health care space have to be bold, not wait for something to be transformative. We need to partner to adjust.
  - **A (Friedman):** It is very easy to wait a long time to see any change. Worked at CMS and our success was middling at best. On the employer side, it is both easier and harder (bureaucracy and risk aversion). Change can be scary for large employers. Should keep two things as our North Stars: identify where the ground is soft for change (e.g. telemedicine, etc.) and use as opportunities for faster change; the second is opportunism (e.g., test concept in markets where Centivo is already there) – don't wait.
  - **A (Bielamowicz):** Health care is a slow moving part of the economy, but Covid proved that providers could do big things fast (agility and ability to pivot) like telemedicine, staffing in different ways, vaccinations, etc. Has energized the industry and gotten rid of layers of bureaucracy and decision-making and applied what has been learned to value. Most health systems are stuck in the middle with their value. Time to determine which direction you are going. Have to decide if value is the business model you are going for.
  - **A (Sherry):** Pre-pandemic, health systems were not very agile, but then had to set up testing centers and procurement had to change (access to PPE) – taught health systems we can create new directions at a much faster pace. In the heat of the pandemic, of our 900 providers, maybe one to two percent were trained on the virtual platform – but trained them in a couple of weeks and then drove about 70% of business through the platform. Will be as agile as we can be to create value if we have a willing partner on the other side (don't have a lot of extra resources).
- **Q: Why do employers have to do this (i.e. health care value improvement)? Why can't others like the government fix the problem?**
  - **A (Friedman):** We don't have a single payer system. The government is designing a system for Medicaid and Medicare recipients with a lot of differences from the employee population – majority with at least one chronic condition or more. The demographics are very different. A strongly held belief is that because the government pays less for health care, employers are paying more. When Medicaid and Medicare are not covering a typical health system's costs with enough room for margin and commercially insured lives have a lot more cash to burn, you have a system that looks a lot like what we have today. It's employers' cross to bear (no choice). The employer community has really leaned in to ask, "how can we make this better?" Employers have

made incredible progress, but it is not linear, comes in fits and starts. They spend a lot but not getting enough for it. Companies like Centivo are really driving value for the private sector with a unique model. They are showing there is a way that offers employees choice and puts the keys in employees' hands and helps build the idea "we are all in this together" as a collective.

- **Q: When we think about changes, often there is a risk that goes along with it. Todd, you made the statement that for an employer, it's not a risk, it's a responsibility. What do you think employers can and should do when it comes to stepping into the heath care decision-making role for your people?**
  - **A (Smasal):** We are trying to bring to life patient stories and examples of life-changing care – it's profound. We are all looking for purpose in our work and that's my purpose. We hear about families impacted by the transformation we are undertaking, that's why we are more than happy to hear some of the noise from our members and help them understand where we are going. We've done a lot over the past 10 years to instruct and direct towards value. Onsite medical centers are an important part of our employee health system (manage them closely with a partner who has shared vision of value). We all can partner and look for continuous solutions to advance quality and cost efficiency in our community.
- **Q: Lisa, you hear a lot about collaboration from health systems around the country. Where do you see real examples (and when is it just a word)?**
  - **A (Bielamowicz):** It says a lot about how committed a health system is when you have the CEO coming to an employer forum. I ask them how they are doing with their own employees as one of the larger employers in the community – how are they managing their benefits and spend? Do they understand the nuances and how to manage high cost events? Do they recognize the faults in their own system?
- **Q: Bernie, in this model, some are your doctors are not going to be considered high performing. What do you want the employer community to do to help you deliver your best care and what should they stop doing?**
  - **A (Sherry):** Would ask employers who pick a value platform to realize you have to have relationship/partnership to really drive value. There's a lot of talk around transparency – that is the key to all of this – along each component. Be aware/understand how all this comes together. If you are not intimately involved with how value is delivered, get in the game. Stop sitting on the sidelines, get intentional. On the physician side – we know we aren't perfect – have a lot of things to work on but are committed to do that. Have physicians that are not in the high performance network, but we have an internal process to coach them and tell them if you want to continue to be part of our system, you must work to get into that value network. Give them good data and they want to be in the high performing group – a lot of times they don't have the information.
  - **A (Friedman):** At Morgan Health we have a team of data scientists doing exploration that is paramount to this effort – trying to understand the status quo (e.g., health equity analysis, etc.). Look at our own employee health care utilization data to try to understand and inform our internal stakeholders about what change could look like and what would work or not. The idea that employees want choice is not true for everybody. Should ask, "can we offer something different for people who want something

different?" and just see if people will come. Looking at where our employees are actually going for health care – not true that everybody wants to be able to go everywhere. Lots of alignment between high value providers and where people are going (can we cut some of the low value providers out and save money for everyone?).

- **Q: What do you see as the future in home care (i.e. return of the house call)?**
  - **A (Bielamowicz):** A perfect example of something the pandemic accelerated – should think of it as a spectrum – from texting your doctor all the way to "hospital at home" (full-on acute care in your home that is safe and high quality). Should ask provider partners how they are moving access in care closer to where employees live. Will continue to explode – question is, "who will control and coordinate it to create a truly integrated system of care?" Health systems are best positioned for that.
  - **A (Sherry):** Many systems are moving toward that – this is not traditional home health (innovating care at home, "hospital at home"). The payment system has not caught up with where the innovation needs to go – should continue to advocate for where it needs to go.
- **Q: Bernie, as we move closer to value-driven care, how has that helped or hurt the attraction or retention of your providers in your system?**
  - **A (Sherry):** Overall, as a network, it's sort of the culture in our system. In the past, we've had various levels of networks through working with carriers over the years – there's acceptance in this community. Value in health care delivery has been a topic for a long time but is now being amped up. We've been sharing data (from the carriers) for a while, but this model gives us more information from the employer so if put those two together, we can have a greater impact on value overall. Providers understand it's important and accept it.
- **Q: Dave, can you provide some foundational information about the BHCG/GNS Physician Value Study (and ask the panel their perspectives on the value of the study)?**
  - **A (Osterndorf):** BHCG did something truly unique – we are doing the most sophisticated and time and resource-intensive analysis to look at where the performance of physicians in the state is. It was the employers that did this, not a health plan or academic group. The Study showed some really interesting results – if we could move patients up to the top performing PCPs or improve the performance of those below, we could save 40% of the cost of care. Providers did not spend time criticizing the methodology but acted as partners.
- **Q: Is this the right role for employers to play? Is it of real value?**
  - **A (Smasal):** This isn't our first crack at trying to drive our employees toward value. We recognized in our first attempt to evaluate physicians that the method we was limited because the carrier was unwilling to take steps to really drive value and bring transparency to us as employers as to where the value really is. Employers should be at the center of that and have confidence in the evaluation and the methodology and then work with the physicians to figure out how we change this.
  - **A (Friedman):** I agree with you but stop short of saying employers have to do this. Most employers are focused elsewhere and are not going to spend the time and resources. Because of our Haven Health experience, we have a bias toward buying rather than building. But there are companies focused on doing this and Centivo is one example. We

don’t have to do it as an employer but need to pay attention to the results and be willing to act on those results. Employers have the responsibility and opportunity to capitalize on the data to drive behavior change.

- **A (Sherry):** From a health system standpoint, I can tell you I’ve created something of value, but when it comes from a third party, it’s affirmative – independent of what we might tell you or claim. It’s transparency to the highest degree. We aren’t going to refuse the data once we understand where it comes from.
- **A (Bielamowicz):** Recognize what’s special and unique about what you’ve got here. We see other employer collaboratives across the country, but to have something like BHCG that takes the initiative, effort and resources to pull together all of that data so you’ve got something with real transparency in the market that brings together the best partners is real momentum that you don’t see elsewhere.

Presentation slides, and a video recording of the symposium are available for review, along with an overview of BHCG is available.