CHAPTER SIX

Direct Contracting—A Solid Approach to Savings for Employers

DEKE LAPE & BETH JOHNSON

Every renewal season, we were drowning in a pool of unanswered questions that had to be answered. What are we going to do about higher premiums, disgruntled employers, bewildered employees, and raging medical costs? We knew that we had to do something . . . something really BIG to change the course that the employee benefit industry took. We had to create a benefit system that made *everyone* happy.

Here is the story of what our company, Mitchell Insurance, did to WIN back the employees, employers, and medical systems . . .

After the 2012 fall renewal season, we became tired of the way in which we advised our clients on their employee benefits. In

fact, advising may not even be a fair statement. We were simply helping them manage increases from year to year by doing the same old thing: increasing deductibles and copays and passing more cost along to the employee.

We wanted to have something better to offer—something that was different and could make a difference for our clients. We wanted an innovative idea that we could put in front of a prospective client to differentiate us from the current broker who was most likely just doing the same thing we had done for years: managing the account from year to year and crossing fingers that rates wouldn't go up too much. This old way of doing business was unsustainable for us and, even more importantly, our clients. *Something* had to change!

Our first step was developing a direct contract with our local hospital system, Missouri Delta Medical Center (MDMC), that we could offer to clients and prospects. Ironically, the MDMC administration had been discussing the exact same thing, so the mutual timing of the idea couldn't have been better.

The contract, called "Top Tier Contract," was ready to roll out in the latter part of 2013 for groups that had renewal dates of January 1, 2014, or later. We began marketing the idea to some existing groups and prospects. In doing so, we found a high level of interest, excitement, and curiosity for it. We were able to include four client organizations into our Top Tier by January 1, 2014.

By late 2014 we had collected enough claim information on the participating groups to compare to prior years and the

performance of the plans became visibly apparent . . . THIS NEW APPROACH WAS WORKING!

All three parties involved in the Top Tier Contract—the employee, employer, and medical system—benefited from the direct connection to the local hospital. It became clear that this model had many benefits for all parties involved. In the following three sections we will explain how the employee, employer, and hospital/provider have all prospered.

Part 1: The Employee

Analyzing our old approach, we realized that more often than not we left out the most important piece of a health plan—the ***people***. Instead, we focused on the deductible, copays, prescription plan, or max out-of-pocket. While these things are certainly important, they don't compare to the most important piece of the equation. How could we ever expect to set up a successful employee benefit plan if we didn't include the ***people*** in the discussion, explaining to them how the plan works, why it works, and how they are the biggest piece of the puzzle?

The employees and their dependents have to understand every aspect of their plan so that they can become a part of the solution to make it successful for them. For this evolution to take place, we now realize that our job is to be transparent and to simplify the details that are often confusing and frustrating to employees. Our clients' employees must understand their health plan and know that they are at the center of the Top Tier Contract.

First, we design a plan that incentivizes the employee to access care at facilities who have agreed to be part of our program. We do that by significantly reducing the deductible and maximum out-of-pocket exposure if the employee utilizes the facilities within the Top Tier network. While a reduction in out-of-pocket costs is something that is easy for an employee to understand, it still takes some re-training and educating to make sure they understand how it works. Over the years, we have done a disservice to our industry by setting up plans that do not offer valuable incentives to employees. The difference in cost from facility to facility can be in excess of 500 percent, but the employee has never been incentivized to find the best value when seeking care. Why wouldn't we want to reduce the deductible and maximum out-of-pocket for employees who make a decision to have a procedure done at a facility that could potentially save their plan thousands and thousands of dollars? It's really common sense, but this simply isn't being done.

Second, we make sure we give the employees and their dependents benefits and opportunities to be part of the solution. One example is a diabetes value-based benefit. With diabetes growing at such a rapid rate, it is clearly one of the biggest claim drivers on our plans. Unfortunately, many medical plans are simply setting up members to fail by having benefits in place that make staying compliant with medication too expensive. We have eliminated that by having a benefit in place that allows employees to access diabetes medication and supplies at zero charge with no copay if they comply with the drug formulary set forth in the plan design. While this action definitely costs

our plans some claims dollars up front, it is a saver on the back end because more and more of our members are compliant with their medication, thus reducing the risk of major claims down the road—not to mention the impact of a healthier workforce!

In summary, the employees have to be made to feel like they are able to make a difference in how much their medical plan ultimately costs and what type of benefits they are offered by their employer. Employees are part of the solution by making good decisions on when and where they receive their care. The employer is putting a plan design in place that allows the employee to take advantage of reduced out-of-pocket exposure and first-dollar benefits all in an effort to eliminate the financial barrier our flawed system has created for someone to receive the care they need when they need it.

Part 2: The Employer

It's no secret that employers have been struggling mightily with the cost of their medical plans. As stated in the beginning, the strategy has basically been to shift cost by raising deductibles, copays and the maximum out-of-pocket limits or just simply by increasing the employee contribution to the plan. Then, we cross our fingers and hope for a renewal offer that is not worse than the one a year ago. We know this because we have lived it with our clients. So, how does the employer win in this new model?

The obvious answer is that the employer wins because the employees are going to seek care at facilities that charge less for their services. We know the employee is going to take advantage of this opportunity because they are heavily incentivized

through the plan design to seek their care at participating top tier facilities. When the employees do that, the cost of claims goes down dramatically and the medical plan is impacted in a very positive way. This is all true, and even by itself this is probably enough to make the employer win. However, the impact of this can be felt much deeper within each organization than simply in the medical plan cost.

If employers are able to flatten out or reduce what they spend on employee benefits, then positive reactions begin to take place within their organization:

- Net profit
- Employee wages
- Hiring of new employees
- Capital expenditures to increase productivity and sales

This list can go on and on, but it's a fact that the amount of money spent on benefits within organizations has been suffocating.

What are they getting in return in the current system?

- Confused and frustrated employees
- A non-transparent system in which employees have no idea of the cost of care from one place to another
- Limited claim data on their groups that makes it difficult to assess the needs of the employees and the direction they should go as a company

If an employer is going to have benefits be their second or third-largest line item in their budget, don't they deserve some kind of return on the investment? We want the plan to be a tool for attracting and retaining talented employees. The medical plans should be designed to allow the employees to access care with reduced up-front cost. This makes the employees happy and gives them the ability to get the care they need to help keep them healthy. The attitude of the employees becomes infectious in the work place in a positive way instead of a negative way.

Employers love happy employees. When employers are investing the amount of money they are investing in benefits, they ***deserve*** some ROI. The plan designs for the employee and the contracts we have in place with medical facilities deliver ROI. So, while employers win on the cost of claims, they are also benefiting from taking something that has been a frustrating experience for the employee and turning it into a positive experience.

Part 3: The Hospital/Provider

Many hospitals and providers are struggling mightily and are fighting hard for your business, for new patients, and for the privilege of helping you with your labs, x-rays, procedures, and any other medical needs that may arise. Most hospitals have come to the realization that they can't grow their income by raising prices, so their only real opportunity to grow revenue is by gaining market share. Not only do they want more market share, but they also want the most profitable market share. Hospitals desperately want their customers to be insurance-paying customers, as the reimbursement levels for the care they provide

is typically much higher than that of Medicare and Medicaid. Under our direct contracting model, this is where the medical provider not only sacrifices but also wins.

The sacrifice made by the provider is the lowering of their cost of care. The amount of that reduction can vary from provider to provider, but it is always developed as a percentage of Medicare. We want to develop the contract in that manner because it gives us an actual number that is known. This is in contrast to how insurance companies and providers show discounts in the PPO model. They will tout to insurance brokers and clients that if you go to certain providers, you will receive a 50 percent discount. Well, that may sound pretty good, but the question that needs to be asked is, "Fifty percent of what amount?" The current system simply isn't transparent enough for consumers to make an educated decision on what a medical facility is charging and where to get care.

The provider wins because in return for their reducing cost as described above, we are designing plans that steer the employees to the participating facilities. As described in the prior section, the employees are flocking to these facilities because their out-of-pocket exposure has been tremendously reduced. As a result, the hospitals are gaining the market share they desire, and this is generating more revenue for the participating facility.

Hospitals and providers also tend to have issues with their accounts receivable and being able to successfully collect the money owed to them by their patients, which are the employees. The vast majority of employer-sponsored medical plans have plan designs with high deductibles and max out-of-pockets. The

maximum exposure for the employee often exceeds $6,000 per person insured. While this sometimes isn't a large amount when compared to the entire cost of a procedure, it is a tremendous amount of money to employees living paycheck to paycheck, which is the case with most Americans. These types of plan designs make it extremely hard for the provider to collect the employee portion of the cost of the claim, forcing many of them to make arrangements for the patients to pay their balance over a long period of time. With our model, we have changed the plan designs to make it much more affordable for the employee to visit these facilities, thus making it easier for the provider to collect the money that is due to them.

Since we started working on this almost five years ago, we continue to strive to learn more about how we can do our part to help improve a system that simply isn't sustainable. In our experience, it is much easier to make progress when you have the employee, the employer, and medical facility all working together to find a solution. As we continue down this road, there are still improvements that need to be made, but we are happy to say it has been a model that has brought people together in a sincere effort to improve delivery of healthcare to the employees of the companies that make communities thrive at the medical facilities that are vital to our community. ***Win, Win, Win!!***

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Deke Lape is an employee benefits consultant with Mitchell Insurance, Inc., and also serves as the secretary/treasurer of the corporation. Deke has 20 years of experience in the employee benefits insurance and counseling/brokerage field. He has worked with employers of many industries, including manufacturing, not-for-profits, municipalities, education, and healthcare. He has extensive experience in both fully-insured and self-funded medical plan arrangements, consumer-driven plans, and worksite and ancillary benefits.

Deke is a 1997 graduate of the University of Missouri—Columbia. Since then, he has been active in his community as a member of St. Francis Xavier Church and serving on the Board of Directors of Missouri Delta Medical Center, YMCA of Southeast Missouri Board of Directors (past chairman), Sikeston Public Schools board of education (past president), and Sikeston Jaycees (past president). Deke and his wife, Jill, reside in Sikeston with their children Jay and Will.

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Beth Johnson is an employee benefits adviser and President of Mitchell Insurance Inc. As a healthcare strategist and consultant for nearly 25 years, Beth has a demonstrated history of reducing employer healthcare spend by creating partnerships between employers and local healthcare systems to bring about real change in how employees view and utilize their health plan. She has proven track record working with a variety of industries of eliminating barriers to care so employees receive the right care, at the right time, in the right place for the right price.

Beth is a 1992 Cum Laude graduate of the University of Missouri-Columbia. She is an active member in her community and currently serves as Vice-Chairman of the Missouri Delta Medical Center Board of Directors, is a past member of the Sikeston Area Chamber of Commerce Board of Directors and past Girl Scout troop leader. As a member of St. Francis Xavier Catholic Church, she is a current board member and past-president of the Parish School Board. Beth and her husband, Joe, reside in Sikeston with their children David and Kathleen.

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