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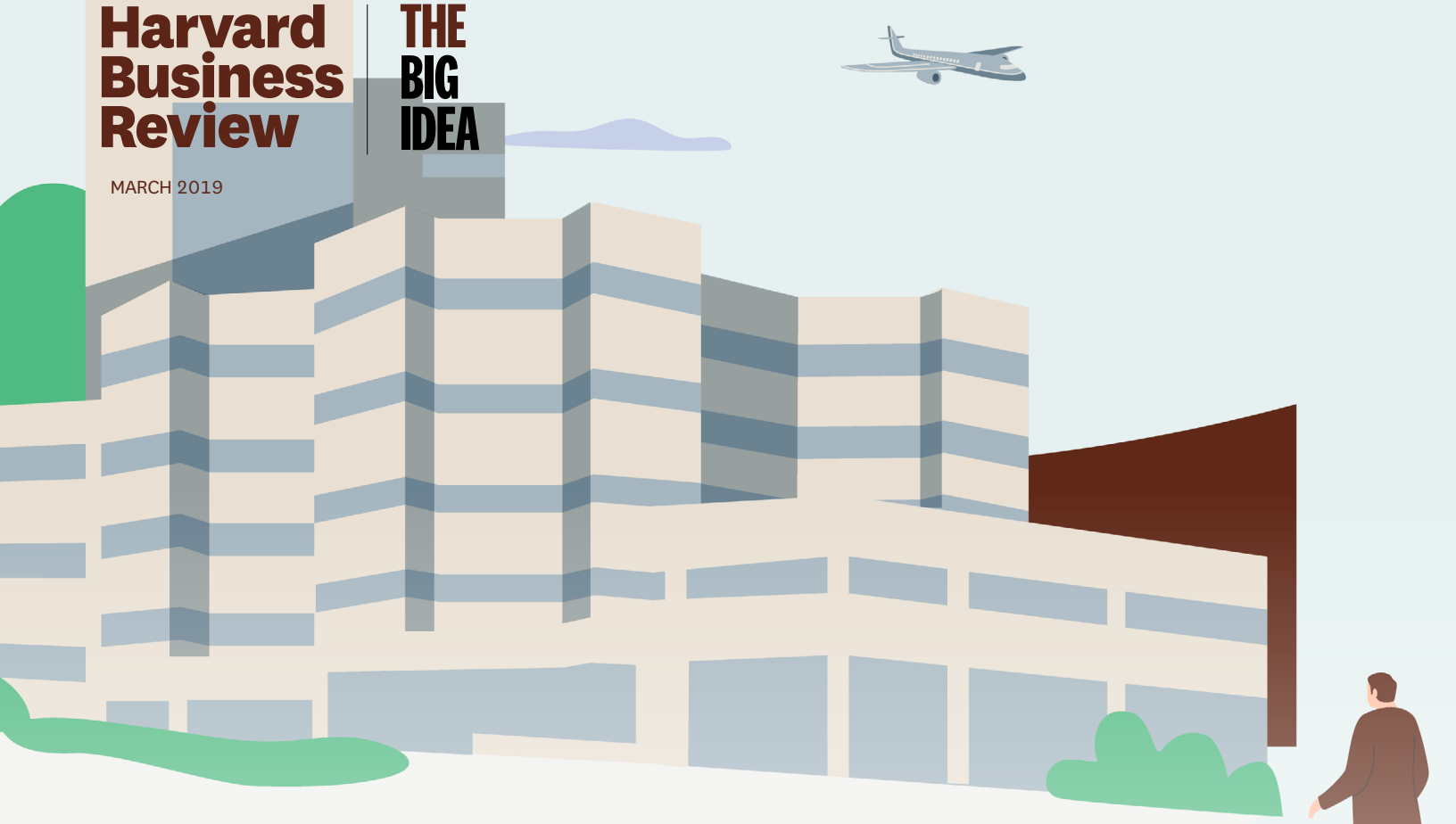

TRANSFORMING HEALTH CARE

Half of Americans get their health insurance through work, costing companies nearly $700 billion a year. Yet quality is all over the map. Can employers find a better way?

by Lisa Woods, Jonathan R. Slotkin, MD, and M. Ruth Coleman

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HOW EMPLOYERS ARE FIXING HEALTH CARE

WALMART HAS EMBRACED A NEW APPROACH TO IMPROVE THE QUALITY OF CARE AND LOWER COSTS. THE RESULTS HAVE BEEN DRAMATIC.

BY LISA WOODS, JONATHAN R. SLOTKIN, MD, AND M. RUTH COLEMAN

A 56-year-old man who works at Walmart — we'll call him Bill — had been suffering from mild neck pain for years. Recently the pain had worsened, and his wife noticed a subtle tremor in his hands. An MRI showed some narrowing of the spinal column along with disc degeneration. A local surgeon explained that Bill's best option was spine surgery.

Bill had two choices. He could have the surgery at his community hospital and absorb deductibles and co-pays. Or he could enter Walmart's travel surgery program and fly with his wife to a top spine center in another state, all costs covered. Bill opted for the travel plan.

Two weeks later the couple headed to Danville, Pennsylvania, for an evaluation at Geisinger Medical Center. The team there immediately noticed Bill's tremor and some shuffling as he walked. They suspected the problem wasn't his neck. A neurologist saw him that day and confirmed the team's suspicions: Bill had Parkinson's disease.

The team conferred with Bill's local doctors to map out a plan of care. The next morning Bill and his wife flew home, and he began treatment, which was covered under Walmart's standard plan. He paid exactly zero for a correct diagnosis and avoided potentially dangerous surgery that wouldn't have helped — and Walmart saved about $30,000 by averting the

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For the past 29 years **Lisa Woods** has worked in a variety of benefits roles at Walmart. Today she's in charge of the design and strategy of U.S. benefits, including the Centers of Excellence program created in coordination with teams at Health Design Plus, Geisinger, and other providers. "When you start a project like COEs, you feel like the innovative scientist behind the curtain," she says. Now that meaningful data on outcomes is available, Woods wants to open up about what Walmart has learned. "It doesn't mean we have all the answers, but we want to share and teach," she notes. "Our goal is to create positive changes in the health care space. It's become a mission. It's that important."

Jonathan R. Slotkin, a neurosurgeon, directs spine surgery at Geisinger Neuroscience Institute and is the associate chief medical informatics officer at Geisinger Health. This means he not only operates on patients but also focuses on digital transformation, the reengineering of care delivery, and the design of novel methods of health care payment. According to Slotkin, Geisinger's partnership with Walmart and Health Design Plus shows that providers don't have to be stuck in a fee-for-service system — and that providers, employers, and third-party entities don't need to be at odds. "Geisinger focuses on innovating with the patient at the center," he says. "Walmart's health care transformation is likewise centered on its associates and customers. There is a perfect cultural marriage between what Geisinger and Walmart are trying to do. The alignment is truly there."

A nurse, **Ruth Coleman** founded Health Design Plus in 1988. Her experience has shown that building direct contracts between companies and providers is a great way to achieve quality patient care. She calls the 30-year growth of this approach remarkable. "I'm a child of the sixties," she says. "That's why I started HDP — taking care of patients the right way is the best way to get good outcomes while reducing employer costs." As for the potential of partnerships like the one HDP has with Walmart and Geisinger, Coleman doesn't mince words: "This could revolutionize health care."

unnecessary procedure. Bill's symptoms have dramatically improved, and he's returned with new energy to his hobbies and work.

. . .

For competitive companies, providing quality coverage is good business. It helps attract and retain employees (good health plans are a sought-after benefit), and workers who receive good, affordable care are more satisfied and productive. But that coverage is expensive, and costs are rising. Employer spending on health care services increased by 44% per enrollee from 2007 to 2016, reaching an annual amount of nearly $700 billion in 2017 — roughly what the Pentagon spends on defense. Walmart alone spends billions of dollars a year on health care for its associates (as the company refers to its employees).

Much is at stake: Various actors in the health care ecosystem, some large insurers and providers among them, benefit from an arrangement that layers on administrative costs and rewards volume, not value. Yet business as usual is unsustainable for those absorbing the costs and experiencing the uneven quality of care. Pioneering employers and providers are in a position to upend the status quo and change expectations about what affordable, quality care can and should be. What follows is an account of our experience with one important effort, among several being tried, to find a better way.

Walmart and other innovative companies, including Lowe's, McKesson, GE, and Boeing, are disrupting how employers pay for care by taking insurers out of the equation and contracting directly with leading health systems. Working closely with providers such as Geisinger, the Mayo Clinic, Johns Hopkins, and Virginia Mason, and with the help of specialized consultants, they are crafting bundled payment arrangements that cover the cost of an employee's care for certain episodes from start to finish — all the procedures, devices, tests, drugs, and services needed for, say, a knee replacement or a back surgery. They're also, in most instances, picking up the tab for any necessary travel, lodging, and meals for the employee and a caregiver, thus democratizing destination care programs that have historically been reserved as an executive perk. Bill is one of many notable successes of Walmart's six-year-old Centers of Excellence program, which covers several common surgeries, cancer evaluations (to confirm the diagnosis and treatment), and, through the integration of an earlier initiative, organ transplants.

COE programs are at the vanguard of U.S. companies' efforts to control health care costs while providing employees with superior care, and results have been dramatic. Working with teams at our respective organizations, we have played key roles in crafting Walmart's initiatives with Geisinger and other clinical partners: Lisa as the senior director of strategy and design for U.S. benefits at Walmart, Jonathan as the director of spine surgery at Geisinger's Neuroscience Institute, and Ruth as the founder of the third-party administrator Health Design Plus. As we'll show, the resulting bundled care programs have saved the company and its associates tens of millions of dollars and produced better outcomes than conventional care has. To the best of our knowledge, the data we provide below is the most thorough and transparent on employer-purchased care ever published. Drawing on this experience and that of other companies and providers, we offer guidance that many employers, even midsize companies, can apply.

WHAT'S DRIVING COMPANIES

Employers provide the lion's share of health care coverage in the United States. They insure 49% of Americans, while government entities (principally Medicare and Medicaid) cover another 35%. (The remaining population is self-insured or uninsured.) Walmart itself, the largest private employer in the world, provides coverage to more than 1.1 million U.S. associates and their families under its self-funded plan.

Expense isn't the only problem employers face. Like other health care purchasers, companies struggle with tremendous variation in cost and quality from one provider to the next. Walmart associates live in every state, and costs for the same service can vary by more than 50% from region to region and sometimes even within a community — and they often have little relation to quality. At the extreme end, costs vary more than tenfold; a 2011–2012 survey, for example, found that hip replacements ranged from $11,100 to almost $126,000 nationwide.

Such variation makes it hard for companies to accurately budget their health care expenses. And although employers shoulder much of the growing cost, employees are absorbing a large and increasing burden too. Nationally, workers' out-of-pocket expenses (beyond premiums) have increased in parallel with employers' costs; according to the Health Care Cost Institute, they topped $5,600 per person, on average, in 2017.

At the same time Walmart, like most other employers, has had limited control over the quality of care workers get, given the wide variation in outcomes for common procedures among different providers. This isn't a new problem. Nearly 30 years ago Walmart founder Sam Walton was taped at a meeting of his senior leadership, excoriating the health care industry for gouging payers like Walmart and, by extension, their employees, himself included. Walton challenged his team to do something about it. "These people are skinnin' us alive," he said. "Not just here in Bentonville but everywhere else, too.…They're charging us five and six times what they ought to charge us.…So we need to work on a program where we've got hospitals and doctors…saving our customers money and our employees money. We haven't even started to do that. And if we don't get it done this year, I'm gonna get real upset. I mean real upset."

That impassioned speech is still talked about as a defining moment for the company — the point where Walmart turned its formidable procurement capabilities to the challenge of buying affordable, quality health care. The company didn't get it done that year, of course, but it did start on a decades-long project. There's a direct line from Walton's 1991 call to arms to Walmart's Centers of Excellence program today.

Companies have long used traditional measures, such as increasing employees' share of expenses and limiting their access to specialists, with mixed success, and to workers' frustration. Only recently have growing numbers taken a more active role in the development of their health plans, applying their purchasing power and procurement smarts to do an end run around insurers and negotiate directly with providers. According to a Willis Towers Watson survey, although just 6% of employers had such relationships in 2017, 22% said they either planned to contract directly or would consider doing so by 2019.

These relationships can take many forms, and they use a variety of payment schemes, including payment of a set amount per enrollee over a defined period (so-called person-year arrangements); shared-risk contracts, such as an accountable care organization (ACO) model, which commonly reward hitting quality and cost targets, penalize missing them, and split any savings or additional expense between payer and provider; and bundled payments — the single-price, soup-to-nuts coverage Walmart has negotiated with providers for specific, defined episodes of care.

WALMART'S ACO INITIATIVES

Accountable care organizations, or ACOs, are clinically integrated collaborations among doctors, hospitals, and other providers. They seek to decrease costs and improve outcomes through careful coordination aimed at eliminating duplication and errors, by applying best practices to reduce unwarranted variation, and by emphasizing preventive care. They often involve shared-risk contracts, which pay a set amount per enrollee for a specified period of time. These contracts may also reward good performance on clinical and cost goals and penalize falling short.

Beginning in 2016 Walmart has added accountable care plans, or ACPs, to the medical benefits associates can choose from. It currently has 11 ACOs in select markets, including Mercy, in Missouri, Oklahoma, and Arkansas; Memorial Hermann Health System, in Houston; and Ochsner Health System, in the New Orleans area. Some of these are also Walmart Centers of Excellence providers. ACPs cover many medical services with a co-pay ($35 for primary care and behavioral health, $75 for specialist and urgent care) and no deductible. Members choose an ACO provider for all routine primary care. They are covered for out-of-network medical emergencies but pay the full cost of any nonurgent out-of-network care. ACP members also have access to Walmart's Centers of Excellence program.

Walmart has developed not just bundled coverage but also ACO arrangements with selected providers. In each case the driving principle has been to secure the highest-quality care at the best price. Bundles, as we've seen, are well suited to travel surgery programs; ACOs work well for broader coverage, including primary care for associates in a local market — say, the community within a 45-minute drive of a given provider.

In this article we'll focus on how the travel surgery program works and the results it has obtained so far.

GETTING STARTED

All employers are trying to control health care costs, but a single-minded focus on cost containment would be shortsighted. From the start Walmart, like the providers it partners with, has explicitly pursued health care *value* — lowered costs coupled with

better outcomes. It would do little good to secure bargain-priced care if that didn't help people resume their lives and return to work.

Walmart had traditionally used various insurance carriers to manage its health benefits, but those companies were huge and often had limited ability to innovate and to negotiate on Walmart's behalf for high-value deals. In 2012, building on its experience with a long-term relationship with the Mayo Clinic for organ transplants, the company set out to develop similar arrangements with other providers for an expanded set of conditions. Early in the discussions its benefits plan leadership zeroed in on the procedures with the greatest opportunity for improvement: common and expensive surgeries (those costing more than $20,000, on average) with high variation in cost and clinical outcomes across providers. Heart and spine surgeries meet those criteria. What's more, they're risky procedures that, done poorly, can have a devastating impact on a patient's health and well-being; in the case of spine surgeries, evidence suggests that a large number aren't even necessary. Walmart launched its heart and spine surgery programs in 2013. It went live with joint replacements (hip and knee) in 2014, certain cancer evaluations in 2015, and bariatric, or weight loss, surgery in 2016.

The benefits team knew that crafting and administering these complex contracts and running the travel program's ongoing operations would require specialized expertise — a third-party administrator. TPAs provide care management, claims administration, and benefits structuring, generally at a fee of 2% to 4% of the cost of the total plan management, depending on their exact role. Although they offer full benefits administration, they generally don't take on insurance risk, and they are small and flexible enough to craft customized programs for single employers.

Health Design Plus, or HDP — a TPA founded in 1988 by coauthor Ruth Coleman — was instrumental in developing and managing Walmart's program, including its bundled care contracts.

SELECTING PROVIDERS

Companies that rely on traditional insurance generally view doctors' offices and hospitals as mere vendors of care. It's different with the COE providers Walmart associates use. Walmart and the HDP team sought true partners — providers that would share the company's vision for the program, take a team approach to care, and include patients and their families in decisions.

The process started with a review of health benefits data to identify providers that had delivered significant amounts of high-quality service to Walmart associates. Publicly available information on the quality of care from these and other providers was also evaluated. On the basis of this analysis, Walmart reached out to potential hospital partners. Medical centers in targeted regions throughout the country were selected according to the distribution and needs of associates. The company focused on integrated systems, in which care is closely coordinated across constituent provider organizations and clinicians. The assumption (which has largely been borne out) was that the hospitals in such systems would be better aligned than others, would resonate more fully with Walmart's health care mission, and would be better equipped to take on bundled rate contracts. Providers participate in bundled pricing much more readily now than in 2012, but many health systems had to be eliminated from consideration because they were unwilling or unable to commit to the model.

THE VALUE TO PROVIDERS

As one of the physicians leading Geisinger's destination care program, I'm sometimes asked by other health care providers why a health system would enter into an agreement with employers in which it is paid less for services than it would be in a conventional fee-for-service arrangement. The answer, in short, is that clinicians, patients, and the business itself can benefit. (For more information, see "What Makes Geisinger's Destination Care Program Tick," on page 23.)

On the clinical side, the exercise of creating and running efficient, high-touch, multidisciplinary bundled-care programs leads to process improvements that diffuse to clinicians and patients throughout the organization and to patients outside of the programs — an important "halo effect." What's more, frequent scheduled collaborations (including an annual in-person summit) with the other health systems providing care to participating employers encourages valuable sharing of outcomes data and best practices, improving everyone's performance. The data clearly shows that patients win too.

On the business side, travel care contracts with employers, particularly big ones like Walmart, bring in new patients, usually from far beyond a system's local population. These patients represent true business growth. In addition, direct partnerships with employers generally establish stable, set payments for services, in contrast to Medicare and conventional fee-for-service arrangements, where reimbursements can shift — often downward. Finally, participating in these programs can increase a system's visibility to other employers, helping attract new business.

For more on the impact of these programs on systems such as Geisinger, see the HBR.org article "Why GE, Boeing, Lowe's, and Walmart Are Directly Buying Health Care for Employees."

— Jonathan R. Slotkin, MD

We've found that good integration and a willingness to build bundles are necessary but not sufficient. Becoming a COE provider can suddenly increase patient volume. Some providers have assumed that the main challenge would be ensuring adequate surgical capacity. In fact it has to do with the support team — having enough nurse practitioners, navigators, and other staff

members to manage patients throughout the process. We've had to pause referrals to some medical centers so that they could better prepare for an influx of patients.

Success with bundled contracts turns out to be a good indicator of the capabilities and character of a hospital and its providers; it shows that a provider is motivated and able to integrate the work of a diverse clinical team around a patient's needs, align incentives to improve value, and track outcomes to inform continued improvement. Walmart and HDP found that providers with those capabilities were more likely than others to meet key selection criteria, including:

- strong quality indicators, such as low complication rates, good performance on patient safety metrics, and systems for measuring quality, including at the individual physician level
- evidence-based, integrated care delivery
- patient-centered, collaborative, team-based decision making
- a willingness to construct competitive bundled prices

Although bundled pricing is critical to the program, we intentionally put it last on our list. Walmart decided that no center would be selected if the first three criteria weren't met, no matter how attractive the price.

BUILDING BUNDLES

By defining and pricing all the elements in an episode of care, prospective bundles (which are defined in advance and paid for soon after the end of each episode of care) cap costs and can improve quality. They should appeal to employers for those reasons alone. But they have other advantages, too. They encourage integrated care, reduce incentives to perform unnecessary care, and make it easier for employers to accurately predict their health care costs. And once the initial employer-provider negotiation is concluded, price discussions are largely off the table. This lets all involved focus on what's best for the patient.

As mentioned, employers rarely have the in-house expertise to negotiate bundled care contracts, and Walmart enlisted the help of Health Design Plus. In developing a bundle for, say, hip replacements, HDP identifies the procedure's standard billable components (which include imaging, tests, devices, and pre- and postsurgical inpatient care) and negotiates a total price with the provider. The negotiated rates typically average 10% to 15% less than prices paid under conventional insurance and traditional fee-for-service reimbursement. In some cases a bundle may cost slightly more than FFS, because it provides higher-quality care; unit cost reduction is far from the biggest driver of the COE program's financial success. High-quality, ethical providers have lower complication rates and provide less unnecessary care.

The transparency of the process means that all parties know precisely what is being bought and paid for. In the spine surgery bundled care program that Geisinger and other centers provide for Walmart associates, for instance, all episode-related inpatient care is included, but postdischarge skilled nursing and rehabilitation isn't. Bundles might include a second visit, depending on the type of care (weight loss surgery always involves two visits, for example). And although providers engage with associates far in advance of travel, the bundled payment starts when a patient arrives at the hospital and typically ends upon discharge for the trip home.

Being clear about the arrangement from the start prevents disputes later on about what's covered and what's not — the bane of providers when dealing with insurers. Of course, it's impossible to predict every contingency, so contracts need some flexibility. Patients might require unanticipated tests or have unforeseen complications, such as a previously undiagnosed cancer or a fall after arrival but before care. Provisions in the contracts address surprise costs and assure fair compensation for the provider (without shifting those surprise costs to the patient) — a feature that reinforces the sense that the employer and the provider are partners in patients' care, not adversaries jockeying to minimize their own costs. All procedures include a warranty: If a patient has complications and needs to return for further treatment within 30 days, the provider does not receive additional compensation for that care.

When managing bundled arrangements for employers, HDP oversees the entire process, from initial employee referral to discharge home and payment of claims. Although the provider ultimately decides what care is needed, if there are anticipated or actual charges outside the bundle, HDP approves payment on a case-by-case basis. Because the COEs are so carefully vetted and are regarded as team members, conflicts about charges are rare. The various clinical sites, along with HDP and Walmart, have frequent calls; during them, clinical feedback from the sites is occasionally used to expand (and more rarely to remove) covered services.

A known risk of bundled payment strategies is that they can create incentives for providers to perform more episodes of care. This can be mitigated in various ways, including having strict treatment criteria defined by the provider organization and selecting only providers with a track record of sound clinical decision making and integrity.

THE PROGRAM IN ACTION

Most Walmart health care benefits are covered by traditional self-funded plans managed by a major

carrier, but associates are encouraged through incentives and various communications to use the COE program for the surgeries we've described. Promotions across the company intranet, open enrollment materials, testimonial videos, benefits portals, and other channels tout the program's upsides: access to superior providers; all travel, lodging, and meals covered for the associate and a caregiver companion (except in the case of weight loss surgery); and (with a few other exceptions) no co-payments, coinsurance, or deductibles.

Associates who are eligible for the program can choose not to use it — but at a cost. Beginning in 2017, those opting for spine surgery outside of the COE network (to avoid travel, for example) had to pick up half the total cost; the amount climbed to 100% in 2019. The same applies to associates who want surgery even though the COE concludes it's not needed. In 2018 Walmart instituted a 50% co-pay for non-COE joint replacements. (These charges are always waived for emergent and urgent conditions.) The co-pays have driven a dramatic increase in utilization: After Walmart introduced the one for joint replacements, the number of patients choosing to have their surgery at a COE site increased by 113%.

Associates typically start to engage with the program when they are clearly on a path to surgery. The first step is to connect with HDP. A customer service team there conducts an initial triage; if the associate meets the basic criteria for the program, she is put in touch with a dedicated nurse-management team. Continuity of care is critical for good outcomes, so associates are accepted into the program only if a local physician — usually a primary care doctor — has agreed to provide follow-up care after the patient's return. The nursing team educates the associate about the process, evaluates her self-reported clinical status and symptoms, and, if she meets more-detailed program criteria, refers her to the appropriate provider. Program coordinators and specialist physicians at the COE take over at this point. They review the patient's records to determine whether surgery or a medical evaluation visit (in the cases of spine and bariatric surgeries) is appropriate; if so, the provider submits a plan of care to HDP and schedules a surgery or a nonoperative visit.

HDP handles all logistical and financial arrangements and communicates the details with the associate and her caregiver. The caregiver is much more than a companion; he or she must be an able adult who can meet specific support requirements and assist the patient after leaving the hospital and with travel home. HDP verifies that the caregiver has agreed to this role before the associate receives final approval.

Unless they choose to drive themselves, the associate and her caregiver board a flight a day or two before the surgery. They are picked up by a hired sedan at the airport in the provider's city and brought to a hotel experienced in hosting postsurgical patients. The next day they make a short trip to the hospital, where they connect with the navigators and nurse coordinators who will shepherd them throughout their stay. The associate also meets the treatment team for a medical evaluation; barring the unexpected, the surgery is performed the following day. Inpatient stays vary according to procedure and patient status but are generally a few days. The associate is discharged to the hotel, and after the medical team issues an all-clear, she and her caregiver are driven to the airport for their flight home.

The medical team communicates with the associate's local physician about her experience, clinical status, and follow-up care, and the COE provider remains available as needed. Most centers check in frequently with the patient and her local doctor to track her recovery. Payments now revert to the associate's standard benefits. A dedicated HDP nurse relays her status and care needs to a nurse at her insurance carrier, who arranges any additional care related to the episode in the rare cases when that's needed.

More than 5,000 associates have participated in Walmart's travel program, and the overwhelming majority give it high marks. Despite the disruption inherent in travel, HDP surveys find that more than 95% of patients are "satisfied" or "very satisfied" with the care and the overall experience. One associate said, "This has been the best medical experience of my life. This is the most important benefit of working at Walmart." The company and its COE clinical sites have received scores of similar, unsolicited testimonials.

Of course, some patients have been less thrilled; complaints from the small percentage who are "dissatisfied" tend to center on the decision not to move forward with surgery. In most cases these patients have been told by their local doctor that surgery can heal them; learning otherwise can be frustrating and disappointing. In other cases COE surgery isn't an option because of health issues such as obesity and tobacco use. Although we work with these patients on necessary lifestyle changes, the experience of being denied surgery and advised to lose weight or quit smoking doesn't always sit well.

Other challenges range from the merely inconvenient — travel patients have missed pre-op appointments because they were sightseeing — to the serious: One year we had to divert patients from several locations because of hurricanes and wildfires. Preparing

for the unexpected is a less obvious but critical part of running the program.

POSITIVE OUTCOMES

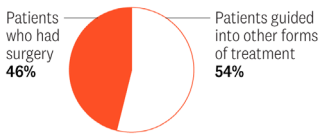
The happiness most participants report with their COE experience stems in part from its concierge aspect. But good outcomes and affordability also boost satisfaction. Patients receiving their care at the centers do better, on average, than other patients on a host of clinical measures — and recall that in most cases they pay nothing. We'll look now at data for three of the travel programs in turn. (Unless otherwise specified, the statistics given for them represent averages.)

1. SPINE SURGERY

Almost half of the Walmart associates who had spine surgery or a medical evaluation without surgery from 2015 to 2018 did so at a COE site. That group, totaling 2,300 patients, was divided equally between men and women, and most were 50 to 64 years old.

One reason for the good outcomes is the fact that, as we've discussed, the program heads off unnecessary or inappropriate surgeries in favor of more-effective, less dangerous, and less expensive treatments. It prevented more than half of the surgeries recommended by non-COE providers.

More Than Half of COE Spine Patients Avoided Surgery



Source: Walmart, Geisinger, and Health Design Plus HBR

Among associates who did undergo surgery, those at COE sites spent 14% less time in the hospital than those who went outside the program...

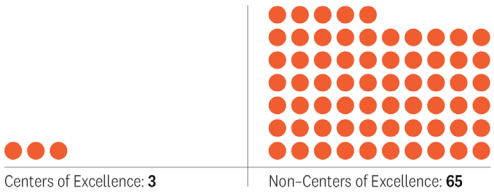
COE Spine Patients Had Shorter Hospital Stays

Source: Walmart, Geisinger, and Health Design Plus HBR

...and their likelihood of readmission was 95% lower.

COE Spine Patients Had Lower Hospital Readmission Rates

Rate of readmission per 1,000 patients



Source: Walmart, Geisinger, and Health Design Plus HBR

Because of the relatively good health status of COE patients postsurgery, only 0.6% of them had to be discharged to a skilled nursing facility for monitoring and rehabilitation, compared with 4.9% of patients receiving surgery outside of the program.

Few COE Spine Patients Required Postsurgical Care in a Skilled Nursing Facility

Rate of discharge to these facilities per 1,000 patients

Source: Walmart, Geisinger, and Health Design Plus HBR

Patients at COE sites returned to work sooner than non-COE patients, shaving 20% off their time away.

COE Spine Patients Returned to Work Sooner

Source: Walmart, Geisinger, and Health Design Plus HBR

The cost to Walmart for surgery at a COE site is about $2,400 (8%) higher than that at a non-COE site, but as we've just seen, the payoffs are considerable: earlier discharge, lower readmission rates, far less

utilization of skilled nursing facilities, and faster return to work. And the slightly higher cost per case is more than offset by the hundreds of surgeries that are appropriately avoided and by improved outcomes.

Walmart's Per-Patient Cost for Spine Surgery Was Higher at COEs Than at Non-COEs

But the company saved money overall because of surgeries that were avoided and better outcomes.

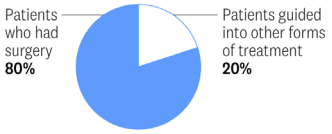
Source: Walmart, Geisinger, and Health Design Plus HBR

2. JOINT REPLACEMENT SURGERY

Eighteen percent of the Walmart associates who had joint replacement surgery from 2015 to 2018 had it at a COE site. Roughly two-thirds of these 1,836 patients were women, and most were 50 to 64 years old.

Here, too, COE specialists headed off unnecessary procedures, having determined that many patients would not benefit more from surgery than from more-conservative treatments, such as physical therapy, or had health reasons that rendered surgery inadvisable.

One-Fifth of COE Joint Replacement Patients Avoided Surgery



Source: Walmart, Geisinger, and Health Design Plus HBR

Among the associates who had surgery, those at COE sites spent 32% less time in the hospital than those who went outside the program.

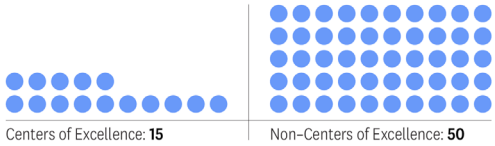
COE Joint Replacement Patients Had Shorter Hospital Stays

Source: Walmart, Geisinger, and Health Design Plus HBR

Because COE patients experienced fewer postsurgical complications, they were 70% less likely than non-COE patients to be readmitted.

COE Joint Replacement Patients Had Lower Hospital Readmission Rates

Rate of readmission per 1,000 patients

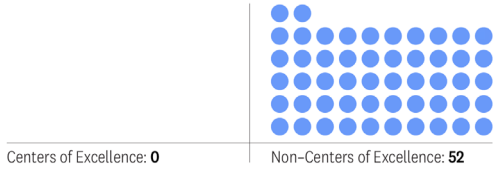


Source: Walmart, Geisinger, and Health Design Plus HBR

Given their relatively good health status postsurgery, none of the COE patients needed a skilled nursing facility after discharge, compared with more than 5% of the patients treated outside the program.

Zero COE Joint Replacement Patients Required Postsurgical Care in a Skilled Nursing Facility

Rate of discharge to these facilities per 1,000 patients



Source: Walmart, Geisinger, and Health Design Plus HBR

And because they were discharged sooner and recovered more quickly, the COE patients returned to work a week and a half sooner than their non-COE counterparts.

COE Joint Replacement Patients Returned to Work Sooner

Source: Walmart, Geisinger, and Health Design Plus HBR

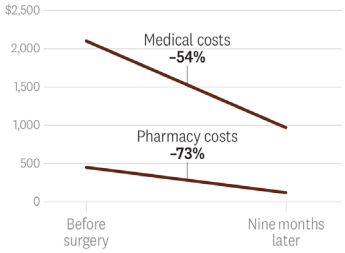
Walmart's cost per case is about 15% less at COE sites than at non-COE hospitals, and the savings from avoiding inappropriate surgeries and from better outcomes are great.

Walmart's Per-Patient Cost for Joint Replacement Was Lower at COEs Than at Non-COEs

Source: Walmart, Geisinger, and Health Design Plus HBR

Costs Dropped After COE Bariatric Patients Had Surgery

Average monthly spending per patient before surgery and nine months later



Source: Walmart, Geisinger, and Health Design Plus HBR

3. BARIATRIC SURGERY

As we've discussed, obesity can cause or exacerbate medical problems such as diabetes and high blood pressure. It can be expensive for employers and employees alike: Medical and pharmaceutical costs can exceed $10,000 per member per month. Bariatric surgery — which reduces the size of the stomach, routes food past it, or limits the amount that can be eaten — can help people lose weight and keep it off. Walmart covers 75% of the procedure's cost; patients pay the rest, along with their travel expenses. The surgery is offered only through the travel program, so we lack data comparing it with non-COE care. Still, early results are promising.

To date more than 300 associates have had the surgery. Three-quarters were women; the average age was 46. Before surgery the group's average body mass index was just over 50. (For reference, a 5'4" woman with a BMI of 50 would weigh 291 pounds; a 5'9" man with a BMI of 50 would weigh 338 pounds.) Six months after surgery the women had lost an average of 39 pounds, the men 45.

It's too soon to know definitively whether this weight loss reduces absenteeism or so-called presenteeism (working while sick), but preliminary data suggests so. We do know that it dramatically cuts pharmacy and medical costs. Those decreases reflect the profound impact of the surgery on patients' health: Complications of obesity drop sharply, as does the need for medication.

Sources of savings. To understand exactly how the COE programs save money, HDP has analyzed direct cost reductions, the effects of care quality and decreased complications on cost, and the impact of avoided costs, including surgeries recommended outside the COE program but not performed along with reductions in hospital readmissions, additional operations, and the use of skilled nursing facilities. For the 2017 benefits year we estimate that Walmart, Lowe's, and McKesson together saved $19.4 million through their spine and joint surgery programs (Walmart associates made up a majority of those patients). About one-third of the savings resulted from direct cost reductions; the rest came from the avoidance of unnecessary care and a decrease in complications.

WHAT'S NEXT FOR WALMART — AND FOR U.S. HEALTH CARE

We've focused here on Walmart, but a growing number of other companies have launched or are developing similar value-based, direct-to-provider programs, sometimes sharing models, partners, and resources, in conjunction with HDP or one of the several other capable TPAs operating nationally.

In tandem with the rise of these programs is the emergence of business coalitions that help employers connect with superior providers and advocate for value-based contracts. To that end Walmart has partnered with HDP and the Pacific Business Group on Health, a San Francisco–based not-for-profit employer-advocacy organization, to create the Employers Centers of Excellence Network, or ECEN. The state of Washington, through its Health Care Authority, has selected two hospital systems to cover hip and knee replacements and spine care for its employees, with clinical standards and bundled pricing informed in part by the Bree Collaborative. Dozens of purchaser coalitions exist in the United States, providing a smorgasbord of resources and services; nearly 40 can be found within the National Alliance of Healthcare Purchaser Coalitions, which serves 12,000 purchasers. What they broadly have in common is a focus on helping employers use their clout to improve the value of care for their employees. These employers' combined scale (NAHPC members alone cover 45 million Americans) strongly suggests that companies will become an increasingly powerful force in the transformation of U.S. health

care — and providers and commercial insurers should pay heed.

All this may look very complex — and when first approached, it is. We advise employers and providers contemplating direct employer-purchased care not to wait while they assess the feasibility, clinical benefits, and return on investment; we, and coalitions such as ECEN, have already done that work. As legacy insurance companies assume less and less insurance risk (while often operating at a notable surplus), it makes sense for health care purchasers and providers to connect directly, and many validated approaches for doing so exist. The right providers and an experienced third-party administrator can lift the burden from the employer. Although there will be demanding work up front, once programs are established the work becomes less complex, and even more of the burden is borne by the TPA and the providers. The return in both dollars and employee wellness and satisfaction is high.

Walmart CEO Doug McMillon has publicly stated that health care now represents one of the company's two most significant areas of innovation focus (digital transformation is the other). So, what does the future hold? Walmart's COE program ensures that associates get high-quality care; however, it is not realistic to think that employers can ask employees to travel for all types of care, or that travel is always the best approach. By design Walmart's program has focused on acute episodic surgical care. General medical and chronic conditions such as diabetes, high blood pressure, and heart disease are more common and, in aggregate, more costly in both dollars and employee health and well-being. Care for them is often best done by the top providers in patients' own communities. Walmart's ultimate goal is to bring a COE-level experience to the communities where its associates live, offering convenience, quality, and transparent, fair pricing. This will also allow the company to measure and continuously improve the impact of its programs on health.

Employers will shoulder a substantial portion of the cost of U.S. health care for the foreseeable future. Until recently they've had few options but to shift some of the growing cost to employees and fight for rate decreases. Those tactics have not stemmed rising costs and have done little to address quality. But as we and others have found, higher-quality care is reliably the most cost-efficient. The success of Walmart and other employers in improving health care value through direct partnerships can be a model for others, helping them address the cost-and-quality dilemma and drive change nationally. We urge other companies to act on Sam Walton's call to arms. ■

A BRIEF (AND INCOMPLETE) HISTORY OF VALUE-BASED PURCHASING BY EMPLOYERS

1997 Walmart contracts directly with the Mayo Clinic as its exclusive provider for organ transplant surgeries.

2010 Lowe's begins a program with the Cleveland Clinic to provide eligible full-time employees and their covered dependents with enhanced benefits coverage for qualifying cardiac procedures.

2010 Lowe's engages Health Design Plus to assist in designing and managing a Centers of Excellence program for heart surgery.

2013 Walmart launches COE cardiac and spine surgery programs at five hospitals and health systems.

2013 Intel and Presbyterian Healthcare Services debut Connected Care, an initiative with novel risk-sharing arrangements and a value-centered payment structure that includes bonuses for hitting certain quality and financial targets.

2014 Walmart launches COE hip and knee replacement programs.

2015 Boeing starts offering employees access to narrow-network local care delivery initiatives in several cities. This direct employer-purchasing arrangement has provided more than 15,000 employees with benefits, including low or no co-pays, same-day appointments, and access to expanded digital-health tools.

2015 Walmart launches a COE cancer evaluations program.

2016 Walmart launches a COE bariatric surgery program.

2018 Dallas Area Rapid Transit launches an accountable care organization offering with the Baylor Scott & White Quality Alliance. It emphasizes preventive care, measurable outcomes, and the involvement of providers with a population health-management perspective.

INSIDE EMPLOYERS' NEW HEALTH CARE PLAYBOOK

Organizations big and small are contracting directly with providers for bundled care and other services. Here's how to get started.

by Jonathan R. Slotkin, MD, Nancy Jester, Lisa Woods, and M. Ruth Coleman

Last year, U.S. employers spent nearly $700 billion on employee health care services, and costs keep rising. To try to control these costs and to improve the quality of care, an increasing number of companies are cutting out commercial insurers and striking deals directly with health care providers. That can help rein in costs by eliminating the margins skimmed off by insurers and, when done well, can dramatically improve quality.

Companies including Walmart, GE, Boeing, and Lowe's have all pursued these arrangements, partnering with carefully vetted providers to design programs for their associates. The programs, such as bundled surgical care that covers start-to-finish costs, have saved the companies millions of dollars and allow employees to get back to their lives and work faster. (See "How Employers Are Fixing Health Care," on page 3.)

Not every company has Walmart's scale, resources, and clout, but smaller firms too can make direct-to-provider arrangements work. The key is to know what you're looking for and how to partner effectively. Here we'll describe two broad approaches:

- a *centers of excellence* (COE) strategy, in which employers often tap into a purchaser coalition that helps them identify best-in-class providers and create bundled-care contracts for a defined episode of care
- an *accountable care organization* (ACO) strategy, in which an employer works with a provider to craft coverage that may pay a set amount per associate for a given period and that usually links reimbursement to the provider's performance on quality and cost metrics

As you move forward, you'll benefit from working with a third-party administrator (TPA) that has expertise in crafting and managing innovative employer-based, and especially self-funded, benefit plans. Most such plans today, in fact, are managed by TPAs. In addition to facilitating the initial contract and managing the ongoing relationship with a provider, the TPA often serves as the principle point of contact and navigator for employees as they connect with the selected provider.

It's important to choose the right TPA at the outset. Ask these questions to gauge a prospective partner's capabilities:

- *What is your process for identifying qualified providers?* Look for expertise in finding value-driven providers who have experience in direct, at-risk contracts with employers.
- *Do you evaluate the quality of physicians as well as the overall provider system?* The correct answer is "yes."
- *Do you have experience in managing both the contracting process with providers and the ongoing administration of direct-to-provider*

programs, including paying bundled claims and other types of at-risk pricing? Require "yes" answers and ask for specifics.
- *Do you have existing agreements with providers in the geographic areas we're targeting that excel in the medical services we're seeking? Can we access those providers?* Seek a TPA that answers "yes" to both.
- *How do you assist employee-patients as they seek out and engage with a selected provider?* Find a TPA that holds employees' hands throughout the process.

Whichever model you pursue — COE or ACO — remember that engaging in a direct-to-provider relationship is a strategic decision and that senior leadership needs to be on board every step of the way.

What follows is a guide for evaluating that decision, with advice on how to start and who to partner with. Obviously, the process is complex — it can take six months to a year to identify and contract with a single provider — but these are the essential steps.

STEP 1: GATHER DATA AND SET GOALS

Start by clearly defining the management goals for your medical benefit plan. Presumably you want to cut costs while maintaining or improving quality. (In our experience, higher-quality care is always cost-efficient in the long run, even if some elements are more expensive.) And you want a plan that will satisfy current employees and help attract new ones.

Bear in mind that COE and ACO strategies involve narrow networks of only your selected health care providers. Consider how important having many provider options is for employee recruitment and retention (surveying your workforce can help you find out). If employees feel that the selected approach limits their choices too much, you may save money but pay a price in terms of employee satisfaction.

If you do pursue a direct contract, you'll want to get a clear picture of what you're spending on health care, which will help you evaluate alternatives. You'll also want to understand where your current benefit plan costs may be out of line. Find out how your total cost per employee compares with the industry average. If your company is spread across multiple locations, knowing your costs at each one will help you prioritize, focusing on the highest-cost areas first.

Next, figure out which medical conditions are costing you the most money. Grouping annual costs by major diagnostic categories will reveal where your employees' highest health care costs lie, and suggest the type of direct-to-provider approach that might be best. High-cost categories often include cardiac disease, orthopedics, cancer, digestive disease, and neurology. If these are the sources of the greatest expense in your employee plan, a COE program that provides bundled care for defined surgeries may be the best option, as these categories often require surgical management. If your costs accrue more in managing general or chronic conditions, such as diabetes, an ACO strategy may be the better bet. Some employers, including Walmart, are using both approaches.

STEP 2: CONSIDER SIZE AND GEOGRAPHY

The next considerations are employer size and geography. A company's size affects the resources it can bring to bear and its attractiveness to providers; its location can inform which type of model it uses.

Employer size. Most premium-based plans that provide full coverage for employees don't offer direct-to-provider arrangements, which is why direct relationships typically require self-funding. Self-funding, however, can be financially risky. Because bigger employers are better able to take on this risk, by virtue of their size, many of them use self-funding because of the added control over employees' coverage it affords. Research shows that while just 20% of companies with 50 to 199 workers are self-funded, that number increases to 50% for those with 200 to 999 employees and to 91% for those with 5,000 or more. Thus bigger employers are more able than smaller ones to engage in direct relationships and craft innovative programs.

Bear in mind that a company's leverage in its negotiations with providers depends partly on how many patients the employer does or would send their way. Therefore, companies must determine whether they have enough employees in a location to support a cost-effective and mutually beneficial arrangement.

In addition, these programs are generally managed by a TPA as a "carve-out" to standard benefit plans — meaning employees still have their standard plan, but the care of certain conditions is handled outside of that plan — which makes managing the standard plan more complicated. Smaller employers may have a harder time getting conventional carriers to cooperate with such approaches in self-funded arrangements.

That said, self-funding and the direct relationships it can support are within the reach of many smaller and midsize firms. A few tested strategies can help. Regional coalitions are emerging that facilitate direct-to-provider employer programs within their communities. They support or directly purchase the best medical services on behalf of their members, and negotiate competitive bundled or other at-risk pricing that rewards providers based on value. The aggregate size of a group of employers, coupled with the psychological impact of employers banding together, can

provide leverage in negotiations with providers. Often, these coalitions also offer administrative support that simplifies the management task for individual employers.

There are dozens of purchaser coalitions in the U.S. — 40 of them within National Alliance of Healthcare Purchaser Coalitions — and they provide a smorgasbord of resources and services. What they broadly have in common is a focus on helping employers use their clout to improve the value of the care their employees receive. (For more detail, see again our article on page 3.)

Additionally, smaller employers can benefit from the work already done by TPAs that have developed programs for larger employers. Generally, these administrators design contracts in a way that simplifies the process of bringing on additional employers. For example, Health Design Plus, the TPA founded by one of us (Ruth), creates direct contracts with centers of excellence in such a way that even smaller employers can join these initiatives and tap the programs' benefits. In one case, a midsize employer reached out to Geisinger Health System to explore such an arrangement; building on the contractual groundwork laid by Walmart and Health Design Plus, this group is now in the late stages of designing its own contract with Geisinger.

As an emerging model, alternative TPAs have entered this market to provide options for employers that have 100 to 2,500 employees. The best of them are independent TPAs that underwrite their clients, process and pay claims, and take risk. They often provide digital tools that go beyond legacy companies' basic portals, streamlining members' experience. Promising examples include Apostrophe Health, which focuses exclusively on direct-to-provider plans, and WellNet Healthcare, which expects to be offering such plans beginning in the second quarter of 2019.

Geography. A company that is concentrated in one area may benefit particularly from an ACO model, while one with more distributed operations may do better with a COE approach — although some concentrated employers use a COE model. ACO contracts are almost always with local providers within a relatively small region (30 to 45 minutes' driving time), as the ACO providers generally cover all care for members — in this case, a company's employees and their dependents. COE arrangements that offer travel-care programs can span much larger geographies; some big employers have just one COE provider covering employees living in several states. Geisinger, for example, provides spine surgery for Walmart associates from Pennsylvania, Ohio, New York, and 12 other states, and weight-loss surgery for associates from Maine, North Carolina, Georgia, and 15 other states. While employers need to figure employees' travel costs into these programs, they can expect that COE providers will be willing to negotiate a competitive price since these programs expand the providers' patient pool.

STEP 3: CHOOSE PROVIDERS

Now you can begin selecting providers. Start by evaluating publicly available cost and quality data (good resources include the Leapfrog Group, CareChex, and the Centers for Medicare & Medicaid Services' Hospital Compare). That analysis can quickly narrow your choices.

Also consider choosing providers that employees already use — assuming they meet quality criteria. This has two potential benefits: (1) Many employees may be able to stay with their current provider, reducing disruption and increasing acceptance, and (2) it can improve the employers' negotiating leverage because the providers will want to keep the company's employees as patients.

After identifying a provider for consideration, an initial discussion with the provider group's management at the highest levels is essential — ideally with a CEO, president, chief strategy officer, CFO, or chief of service (generally a lead physician). Buy-in at this level is important, as direct relationships can be disruptive for providers that don't have a lot of experience with them. The necessary internal change that the provider organization must make to deliver on these contracts can benefit from the "air cover" provided by senior leadership.

To gauge the provider's ability and willingness to partner with you, start with the questions below. Involving a TPA experienced with this type of contract can make this step easier.

- Are you interested in partnering in a direct, employer-to-provider relationship — either as a COE partner for acute episodic bundled care (such as surgery) or in an ACO arrangement that includes the management of chronic conditions such as diabetes?
- Do you have the structure and capacity to accept patients in these types of value-based, at-risk arrangements?
- Have you previously accepted bundled pricing or other forms of financial risk in health care contracts? (This could include taking a fixed price or agreeing to meet financial targets per patient during a specified period.)
- Do you have systems in place to provide data on cost and quality, including on safety and outcomes at the individual physician level?
- Do you have the people and systems in place to provide value-based

care, such as program-specific nurse navigators and the ability to engage patients in decisions about their health and treatment and outcomes that matter to them (things like quality-of-life measures as opposed to strictly clinical indicators)?

In our experience, it's not unusual for fewer than half of providers contacted at this initial stage to answer "yes" to these fundamental questions. Equivocation or an outright "no" on any of them should be reason to reconsider or even disqualify a provider.

If both sides are encouraged by the opening discussion, typically they'll sign a nondisclosure agreement (NDA), which allows the free flow of information. Employers may share data on the number of employees in a given area and their demographics, the number of providers they expect to engage with, and the specific services they're seeking; providers must share data on costs and quality. An NDA also provides the first indication of a provider's approach to partnerships. It should be a worrisome sign if a provider struggles to finalize the language in the NDA or seems hesitant about sharing information after signing it. Transparency on cost and quality is a critical part of an effective direct relationship.

The next step is pivotal. The employer-TPA team has a call that includes the provider's lead physician and his or her team to better understand their approach to patient management, and to cover the program's goals and the employer's expectations in greater detail. This is the time to get a clearer sense of the organization's culture and its ability to create and run a COE program, by delving deeper into and beyond the questions above. If all goes well, the provider completes a request for proposal from the employer that covers granular quality information, program process and support, financial stability, ownership and structure, potential conflicts of interest, bundled price, and other information.

Before you make a final decision, we strongly suggest that representatives from your company (typically including a benefits manager) and the TPA do an in-person visit. This will let them validate how the provider handles and measures safety and quality, get a closer look at the provider's approach to problem solving and partnerships, and further gauge the culture, including how staff — from the front desk to clinical leaders — interact with each other and with patients and families. We recommend the representatives physically walk the paths patients will take during their time at a hospital and — without management present — interview the staff involved in direct patient care.

If the provider passes these tests, it's time to craft the contract that will formalize the relationship. These contracts set roles, expectations, and requirements and are very different from those in typical managed-care agreements. As such, completing the agreement before making a final commitment to send patients is critical to ensuring that everyone is aligned with the program's mission and goals.

FINAL STEPS

In your new collaboration with a provider, it's a good idea to launch a pilot program addressing one type of care (say, cardiac surgery or diabetes management). That said, before you move forward with a pilot program, we recommend discussing program expansion opportunities with the provider, because real value is created as multiple programs scale up. Development should be managed in stages, with new programs offered one or two at a time and design changes integrated as operations are optimized.

Finally, remember that the success of these programs depends on whether employees and leadership embrace them. To choose these plans over traditional ones, employees need strong incentives, such as ready access to same-day appointments, free travel, or — if the program is a carve-out — reduced or zero deductibles and co-insurance. And leadership expects to see a clear return on investment and improving performance over time. Direct-to-provider relationships have an impressive track record to date, as illustrated in "How Employers Are Fixing Health Care," on page 3. Doing them well will encourage employees to buy in as well as boost credibility with leadership — both of which are necessary for the program to expand and flourish. ■

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WHY DO EMPLOYERS PROVIDE HEALTH CARE IN THE FIRST PLACE?

A historical perspective

by Melissa Thomasson

In 2017, Americans spent $3.5 trillion on health care — a level nearly equal to the economic output of Germany, and twice as much as other wealthy countries spend per person, on average. Not only is this a problem for the people seeking care; it's also a problem for the companies they work for. Currently, about half of Americans are insured through an employer, and in recent years companies have borne the financial brunt of rising costs. Frustrated, many employers have shifted the burden to workers, with average annual deductibles rising by more than 50% since 2013.

This isn't sustainable for anyone. So it's no wonder that firms like Amazon, Berkshire Hathaway, and JPMorgan Chase, as well as Walmart, have embarked on efforts to re-envision health care for their employees. Warren Buffett has even gone so far as to argue that health care costs hamper economic competitiveness more than taxes do.

How did the United States end up with such an expensive system? Unlike countries that have either government-provided health care or government-sponsored insurance, the U.S. system involves the interplay of employers, insurance companies, health care providers, consumers, and government. In order to understand the cost conundrum of America's health care system today, you have to understand where the system began — and how increasing costs and technological advances have created new pressures and incentives over time.

EARLY 1900S: THE FIRST HEALTH INSURANCE PLANS TAKE SHAPE

In the 19th and early 20th centuries, medical care was largely ineffective. Many hospitals were charity institutions that functioned as shelters for people who could not be cared for at home, rather than places for people with acute injuries and illnesses to be treated. Physicians usually ministered to paying patients at home, since hospitals could be breeding grounds for infection. Because the care these doctors provided was basic, families did not face unexpectedly high health care costs and did not need the financial protection offered by health insurance; the average annual per capita spending on health care was about $5 in 1900, the equivalent of $150 today.

In some European countries, health insurance developed earlier than in the U.S., but not because of the high cost of medical care. In 1883, German chancellor Otto von Bismarck enacted a health insurance system to stem socialist sentiment as he cemented German unification. The German system enabled workers to see a physician if they were sick, but, even more important, provided what we would today consider disability insurance: giving workers money if illness or injury prevented them from being on the job. In Britain, the 1911 National Insurance Act provided a sickness benefit and free medical treatment to British workers. Versions of these disability insurance

programs, referred to as "sickness insurance," also began forming in the U.S. around the same time, organized largely by trade unions and fraternal societies. While there was an early attempt during the Progressive Era to pass compulsory insurance at the state level, it never gained traction, and it died completely when anti-European sentiment rose during World War I.

In the first decades of the 20th century, medical treatment shifted out of the home; reforms in medical education led physicians to train and practice in hospitals, which housed state-of-the-art antiseptic surgical suites and new technologies such as x-rays. As more people sought treatment in hospitals, health care costs began to rise. By 1929, average annual medical costs per person were $108, equal to about $1,550 today. A stay in the hospital became out of reach for middle-class families.

Existing fire and casualty insurance companies were reluctant to offer medical coverage, because they viewed health as uninsurable and feared that people who might be more likely to need medical care would be the only ones buying insurance. This problem — known as adverse selection — was a big problem for insurance markets in the 1920s and 1930s (and still is one today). For insurance to be effective and affordable, both healthy people and people more likely to become ill must take part.

And that's why employers started playing an outsize role.

1930S: ENTER HOSPITAL PAYMENT PLANS

Employment-based insurance developed in the U.S. primarily because offering insurance to groups of workers mitigates adverse selection. Ironically, it was not insurance companies that figured this out. Rather, the problem was solved in 1929 when Justin Ford Kimball, an administrator at Baylor University Hospital, devised a means to alleviate the financial pressure the hospital faced from unpaid hospital bills. During his time as the superintendent of Dallas schools, Kimball had developed a sickness benefit program for teachers. In his new role at Baylor, he developed a simple plan based on insurance principles to help people pay their hospital bills, and recruited Dallas teachers to test his theory. Under Kimball's plan, Baylor would provide each teacher with 21 days of hospital care for a prepaid annual fee of $6. By selling health insurance to a group of employed teachers who were healthy enough to work, the plan ensured that the risk pool would not be overwhelmed by people who were likely to be sick.

Word of the Baylor plan's success spread rapidly, and at a crucial time for hospitals. As the nation sunk into the Great Depression, hospital occupancy rates plummeted to as low as 50%. Desperate for revenue, numerous hospitals began to form their own prepayment plans. Eventually, the American Hospital Association (AHA) developed a logo for these plans to use, and the "Blue Cross" plans were born.

In addition to stemming adverse selection, Blue Cross also helped control costs by limiting so-called moral hazard, which occurs when having insurance coverage causes people to increase their use of health care services. Blue Cross initially covered only hospital bills and paid hospitals a set rate for a finite number of covered days, preventing patients from overusing the system. Blue Shield, which separately provided coverage for physicians' charges, turned to a different method: paying a fixed dollar amount of a bill, with patients paying the difference. (This practice, called "balance billing," may sound familiar. While it is rare today for consumers who see in-network providers, it can result in high bills for consumers who venture out of network, or who go to a hospital that is in network but are treated by an out-of-network physician.)

Commercial insurance companies, which had initially been reluctant to offer health insurance, witnessed the success of the Blues in conquering adverse selection and moral hazard and soon began to compete with the Blue Cross plans by offering insurance to employee groups. By 1940, roughly 9% of Americans had insurance coverage for hospital expenses.

WORLD WAR II: THE RISE OF MODERN HEALTH CARE BENEFITS

In the 1940s, a series of events ensured the expansion of the health insurance market and its employment-based nature. The tremendous mobilization of troops and resources during World War II led to a huge decline in unemployment, which fell to a low of 1.2% by 1944. In 1943, President Franklin D. Roosevelt signed Executive Order 9328, which limited the ability of firms to raise wages to attract increasingly scarce labor. The offering of health insurance, however, was exempted from this ruling. As a result, firms began to offer health benefit packages to secure workers. Unions also negotiated for health insurance on behalf of workers — a right that was assured in 1948 and 1949 when courts ruled in favor of steelworkers in two similar cases regarding health care coverage, one of which was later affirmed by the U.S. Supreme Court. These rulings, during a time when union membership rates were at their highest, played a key role in expanding employer-provided health insurance and other benefits.

The tax treatment of employer-sponsored health insurance also fostered the rapid growth of coverage. Employers were permitted to deduct

health insurance contributions from their taxes as a cost of doing business, just like wages. But unlike wages, employer contributions to employee health insurance premiums were (and still are) considered exempt from employees' taxable income, a ruling codified in the 1954 Internal Revenue Code. The tax treatment of health insurance led more Americans to be covered, and the coverage became more generous. In 1952, just before these changes in the tax code occurred, 47% of households had group health insurance. By 1957, nearly 66% of households had employment-based coverage.

1946–1965: HEALTH CARE COSTS RISE

In the years following World War II, when the economy was strong, hospitals began placing an emphasis on expansion. In 1946, the Hill-Burton Act was passed, pumping billions of dollars into the construction of new hospitals. These facilities featured improved laboratories, operating suites, and equipment. With the advent of medical miracles like penicillin during the war, hospitals and physicians were eager to provide care, and Americans were just as eager to consume it.

But even as health insurance became more generous and more expensive, consumers were still insulated from health care costs, due to the reimbursement systems developed by Blue Cross and Blue Shield.

1960–1990S: AFTER THE INTRODUCTION OF MEDICARE, COSTS RISE AGAIN

Unfortunately, the health insurance system didn't change in response to increased expenses; in fact, a task force set up in 1963 by the AHA and the Blue Cross Association affirmed the use of a "cost-plus" reimbursement system, where hospitals were reimbursed for the cost of treating patients. Hospitals thus had carte blanche to charge patients at will, passing the bill along to insurers and employers.

The passage of Medicare in 1965 added even more fuel to the fire. To ensure physician participation in the program, Medicare reimbursed physicians based on a calculation of the "customary, prevailing and reasonable" fees within any given geographic area. With the program underwriting whatever fees doctors charged, the rate of increase in fees doubled. The rise in provider reimbursement costs combined with more patients obtaining health insurance for the first time proved to be expensive. Within four years of its implementation, Medicare resulted in a 37% increase in real health expenditures, with about half of that rise coming from the entry of new hospitals into the market and the other half coming from expansion of services. Between 1970 and 1980, health care spending increased at an average annual rate of 12%, leading overall expenditures to more than double.

In an attempt to stem medical cost inflation, Medicare switched from its cost-based reimbursement system to a system of fixed prospective payment in 1983. Under the new system, which most commercial insurance companies began following as well, Medicare reimbursed hospitals according to a predetermined fee schedule based on diagnosis. Under this system, a hospital's revenue was a function of patient admissions, and incentives for volume-based care took priority.

Moreover, evidence suggests that as insurance expanded the market for health care, it generated incentives for increased development of technology. While some of this new technology represented a significant improvement over current treatments, other innovations, such as proton-beam therapy for prostate cancer, did not improve outcomes compared to existing procedures, while costing the system substantially more.

By 1990, Medicare payment reforms had only somewhat slowed the rate of growth in health care spending, with the average annual growth rate falling from 12.1% in the 1970s to 9.9% in the 1980s. At this point, 61.3% of Americans had private health insurance. Employers were starting to feel the pinch of rising health insurance costs, and they began to seek ways to ease them.

Their primary method was managed care. Numerous types of these arrangements flourished, ranging from true health maintenance organizations (HMOs), which integrated finance and delivery of care, to looser networks of preferred provider organizations, in which providers agreed to utilization review and discounted their fees. But without any meaningful changes in the U.S. health care system, costs for insurers and employers remained high. And the coming consolidation in the health care sector didn't help matters.

2000 TO TODAY: CONSOLIDATION AND MORE CONSOLIDATION

Over the past 20 or so years, consolidation among both providers and insurers has reduced competition in health care. In 2016, 90% of metropolitan areas were considered highly concentrated for hospitals, with 65% concentrated for specialist physicians and 39% concentrated for primary care physicians. A recent report by the American Medical Association reports that 69% of markets have high insurance company concentration.

Less competition in markets causes prices to rise. One recent study shows that prices at monopoly hospitals are 12% higher than in markets with more competitors. Numerous regulatory barriers to competition exist in the pharmaceutical market, too, providing

very little pricing transparency for both physicians and patients. Instead of negotiating directly with drug companies, insurance plans rely on pharmaceutical benefit managers (PBMs) to act as their intermediaries. PBMs negotiate drug prices and rebates with manufacturers on behalf of the insurance plans and create a covered list of drugs behind the scenes. This lack of transparency makes it difficult, if not impossible, for consumers to compare prices. In addition, increasing consolidation among PBMs has led to higher prices for prescription drugs over time.

As a result of these trends, employers have shifted costs to employees; one common example is the implementation of high-deductible insurance plans, which increase consumers' out-of-pocket costs. High costs can hurt employees in other ways, too: there's evidence that as employer-provided health costs rise, employers are constrained in their ability to increase wages.

. . .

The history of health insurance in the United States is a lesson in good intentions with unforeseen consequences — along with an inability or unwillingness to act when the consequences become clear. The combination of government-provided and private health insurance, including the Affordable Care Act and Medicaid, now covers 90% of the population, but as long as health care providers lack competition and profit from volume-based care, it's unlikely that costs can be constrained. And when it comes to employer-based plans, costs are becoming untenable — and increasingly are shouldered by employees. ■

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TWO SURGERIES, TWO OUTCOMES

What Walmart's health care program looks like from the patient's perspective

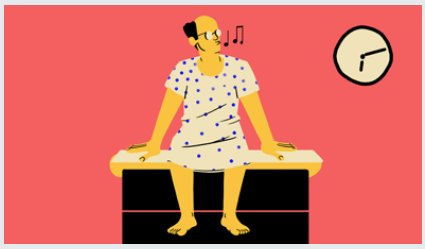
by Harvard Business Review Staff

Two fictional Walmart associates, Sean and Carla, have struggled with back pain for years. Both associates (as the company refers to its employees) recently had MRIs that came back abnormal. Sean opts to go to a surgeon affiliated with a local health system, using his traditional insurance coverage. Carla chooses Walmart's Centers of Excellence (COE) program for spine surgeries.

A COE program circumvents traditional insurance companies, connecting employers directly to health care providers. With the help of a third-party administrator (TPA), the two groups negotiate a bundled payment that entirely covers the cost of care — all the procedures, devices, tests, drugs, and services a person will need. The program also picks up the cost of travel, lodging, and meals for both the associate and a caregiver. For more information on COEs, see "How Employers Are Fixing Health Care," on page 3.

One of the best ways to understand the differences between traditional insurance and the COE program is to compare Sean's and Carla's experiences from start to finish. All the data included on the timeline is based on Walmart associate averages from 2018, and each patient's journey is representative of what associates experience with that health care option.

STEP 1: SCHEDULING SURGERY



PATIENT ONE

Sean sees a surgeon. A date for surgery is set.

PATIENT TWO

Carla contacts her traditional insurance carrier, where a health care adviser connects her with a TPA. The TPA team handles her intake, and a nurse gathers her relevant health history.

Next, a hospital that is part of Walmart's COE program is selected based on Carla's location.

A team at the hospital, comprising coordinators, doctors, nurses, and administrators, collects and reviews her MRI images and medical records. Carla is connected to the nurse navigator who will guide her through the care process.

STEP 2: HEADING TO THE HOSPITAL

PATIENT ONE

Sean wakes up early and his brother drives him to the hospital.

PATIENT TWO

Carla and her sister, who serves as her caregiver, **fly to an airport** near the hospital, where they are picked up by a **sedan service**. (There are eight spine centers in the U.S., so air travel is common for Walmart associates seeking treatment.) Carla then meets with her spine care specialists — surgeons, rehabilitation medicine physicians, psychologists, and an internist — along with her nurse navigator.

Doctors determine that spine surgery is the best option for Carla. This isn't always the case; **54%** of her colleagues who are referred to a COE for spine surgery don't need it due to better treatment options — or because surgery wouldn't fix their problem. Carla's surgery is scheduled for the next day.

KEVIN WHIPPLE

STEP 3: SURGERY

PATIENT ONE

Sean has surgery. He stays in the hospital for **2.9 days**, the average for associates using traditional insurance.

PATIENT TWO

Carla has surgery. She stays in the hospital for **2.5 days**, the average for associates using the COE program. Half a day in a hospital can cost anywhere from $1,000 to $5,000, based on national averages.

STEP 4: RECOVERY

PATIENT ONE

Sean is discharged from the hospital. His brother picks him up and he recovers at home. He's lucky — **4.9%** of associates who have non-COE spine surgery are discharged to a skilled nursing facility because they require additional rehabilitation.

PATIENT TWO

Carla is transferred to a local **hotel** with her sister. A nurse navigator stays in close contact with them during their stay. They are given a benefits card, paid for by Walmart, that allows them a daily stipend for meals and other expenses.

After postoperative visits with her surgeon, Carla is cleared to travel. (A mere **0.6%** of Walmart associates who use the COE for spine surgery are discharged to a skilled nursing facility for rehab.) She and her sister are driven to the airport by a **sedan service** and **fly home**.

The nurse navigator reaches out to Carla's primary care physician to communicate about the surgery, share a summary report, and confirm Carla's first follow-up appointment. The nurse navigator checks in regularly in case there are unexpected complications. (Patients who need to return to the COE for additional care do so at no charge.)

STEP 5: RETURNING TO WORK

PATIENT ONE

Sean returns to work after **90 days**. In total, Sean pays **50%** of his spine surgery costs, which for Walmart associates average around **$15,000**. As of January 2019, however, the surgery would cost him **100%**, or around **$30,000**; Walmart has changed its health benefits to encourage associates to use the COE program.

PATIENT TWO

Carla returns to work after **75 days**. To help Walmart and the COE program assess her experiences and recovery, she completes surveys three, 12, and 24 months after surgery.

In total, and including travel, Carla's surgery costs her **$0**. The cost for Walmart is **a little over $30,000** — more than Sean's and Walmart's payments combined in his case. But the COE is an overall cost saver for the company and its associates, because so many unnecessary surgeries are avoided and outcomes are better at program sites. ■

WHAT MAKES GEISINGER'S DESTINATION CARE PROGRAM TICK

A Q&A with interim CEO Dr. Jaewon Ryu

by Gardiner Morse

Before he arrived at Geisinger in 2016, Jaewon Ryu, an emergency medicine doctor with a law degree, held a raft of leadership roles in health care, insurance, and government, including at Kaiser Permanente, Humana, and the Centers for Medicare and Medicaid Services. He joined the Pennsylvania-based health system as an executive vice president and chief medical officer, and this December became interim president and chief executive officer when its former CEO David Feinberg headed to Google to lead its health care strategy.

Geisinger is huge — it has 13 hospital campuses, two research centers, a medical school, and a commercial health plan — and is famously innovative. Its best-practice approaches have been widely adopted, and it is spearheading one of the largest DNA-based precision-health projects in the world. So it's little surprise that Geisinger is a pioneer in another area, so-called centers of excellence (COE) destination-care programs. In these arrangements, employers such as Walmart, Lowe's, and McKesson fly employees to selected COEs for complex care — with remarkable results. (See "How Employers Are Fixing Health Care," on page 3.)

HBR's Gardiner Morse spoke with Dr. Ryu about the benefits and challenges for providers of embarking on COE programs, and their implications for both employers and insurers. Following are edited excerpts of their conversation.

Why is Geisinger engaging in these arrangements with employers to fly their employees in for care?

Partly it's about growth. Being a destination-care provider for employers like Walmart allows us to reach a patient population that isn't already getting its care within Geisinger and is beyond our backyard. So it's a good way for us to expand the scope and reach of what we're doing.

But it also aligns really well with how we deliver care. We're big believers in developing best-practice protocols and then designing workflows to deliver them. We have developed care protocols for many clinical scenarios, including areas like cardiac surgery, spine surgery, chronic obstructive pulmonary disease, diabetes management, and many others, and they yield the best combination of quality and patient experience. It's a program that began years ago, and we've been refining the protocols and adding new ones ever since. It's a chassis, if you will, that these new centers-of-excellence programs can easily build on. We have the resources, culture, and processes already in place to develop,

say, a joint-replacement bundle with an employer. And doing that reinforces our culture and processes. There's a positive feedback loop.

Where does the destination-care program fit in that feedback loop, reinforcing how people work?
We've seen that sometimes after you go live with a protocol you can get what we call "beach erosion," where over time people can become less diligent or deliberate about making sure everyone follows the protocol. Being one of the centers of excellence for employers in programs like these helps prevent that erosion because it's yet another area where the protocols are applied. It keeps us on top of our game, as employers are paying close attention to how we perform. So the program reinforces their consistent use.

What would you say to other providers who maybe don't have smooth-running protocols like Geisinger's about the risks of these types of programs?
That's the ultimate question for any system that wants to embark on this journey. For us, it made sense because it was already ingrained as our approach to care, so there weren't the same start-up costs and culture-change challenges that you might see in an organization that didn't already have the culture and protocols in place. Also, we like reimbursement models like bundles where we're taking risk, because we tend to do better with those in driving overall value than we do under an episodic, per-widget model. But that's part of the calculus for any provider. Do you have the culture and operational programs and processes in place to succeed with this kind of model?

There's a huge opportunity for a provider that doesn't yet have these capabilities fully in place to pursue direct arrangements with employers as a way to jump-start the shift. Delivering value is the direction that health care is going — whether to patients, employer groups, the payers you're partnering with, or the government. Building the chassis I've been talking about positions any health system better for what's coming in the future, and what is in many ways already here. In time, every system is going to need to have this capability, and this kind of program is a way to get started.

I'm assuming doing programs like these reflects well on a provider?
Well, it can help the provider tell the story about the value they're offering. For instance, we work hard at making sure that we're not doing unnecessary procedures, so we find that a significant number of patients referred to us for a surgical procedure actually don't need it after all. We take a lot of pride in that because it shows that we're focused first and foremost on determining what is the best care rather than on how many procedures we can do. Data from Walmart shows that more than half of their employees referred to centers-of-excellence programs like ours for spine surgery end up not needing it. It can be more work to convince a patient that they don't need a procedure, but doing that results in the best care.

Let's talk about the challenges. This can't be easy.
That's right. Make no mistake — even if you have the chassis in place there's still a lot of work you need to do on the culture to go live with a program like this. We were lucky — we had a running start, if you will. But even so, it's not something you turn on overnight. We've been on this journey for more than a decade. It takes constant work and vigilance. For instance, even when you recruit physicians you need to make sure they are brought along into our organizational approach and don't introduce unwarranted variation into how we approach care.

It also requires constant attention to make sure your protocols are up-to-date and to assure that everyone's aligned with them. It turns out that if you follow evidence-based best practices reliably, great things happen for patients. So you need physician leadership that is committed to pursuing these protocols and tracking performance, and updating them as the science changes.

What's an example?
Well, the conventional wisdom that many doctors were taught in medical school was that patients should have nothing by mouth in the hours preceding surgery, and should be eased back on a clear liquid diet after surgery. So essentially you'd starve them before and starve them after surgery.

But so-called enhanced-recovery-after-surgery, or ERAS, protocols showed that patients do better if you give them enriched-nutrient shakes before and after. Complication rates go down, length of stay goes down, and they're up and mobile more quickly. It runs counter to the traditional teaching and so it makes some physicians uncomfortable, but we incorporated this into our own protocols and it's how we do many elective procedures now. It's easier to launch an approach like this systematically when your culture embraces the need to continuously seek better ways to do things and to do them more consistently.

Making sure everyone is on board and aligned must require real transparency about performance. How does that work at Geisinger?
We're firm believers in transparency. Data is probably more visible here than you'd see at just about any other health system.

Let me give you a snapshot of what that transparency looks like. A few years ago, we launched a primary care redesign program that focuses on closing gaps in care. If you're due for your mammogram or a colonoscopy, how often are we making sure that you get those preventive services? We track this at the level of individual providers. If you walk into any one of our primary care sites today, there would be a whiteboard where the whole team huddles every morning and the name of every provider in that clinic is listed on it. It has information about their appointment availability and also a score for how they're doing on closing care gaps, including any missed opportunities they might have had. Nurses are also listed there, with information about how effectively each is setting up patients for those care-gap actions. It's taken some work to get us to this point, and admittedly the transparency can be uncomfortable at first. But it helps us reinforce and support each other in driving for the best outcomes. And I think we could do even more.

How do you manage the discomfort that this transparency must cause? If a doctor isn't performing well, and it's visible to the team, that must create tension all around.
Well, partly there's a socialization that makes it acceptable. Transparency is part of our culture, but it does take a little time to get used to it. We really try not to do this in an embarrassing or "gotcha" kind of way. There's a lot of preprocessing and vetting with the clinical leaders and the teams around what we're going to measure and how we will track it, so people are more aware of the process and reasons for it. We try to do it in a very objective way — we're asking, "What can we do to learn from each other and improve the overall game?" We look at data such as the rate at which patients within a given primary care panel are landing in the emergency room or how often our emergency medicine physicians are ordering CT scans for nonserious head trauma, and look for outlier behavior. Sometimes the outlier behavior is justified. But shame on us if we're not asking why there are outliers.

Of course, from time to time you have differences of opinion about the accuracy of the data or to whom they're attributed. And if there's any question about their applicability at the level of individual providers we'll focus instead on the team. So we might identify teams that are behaving differently than others. That might be a good thing, or it might indicate a need for change — but let's have that discussion. I think that's the key: The data isn't the be all and end all, but it can serve to start the discussion, and framing it that way helps get acceptance.

Let's move on to the bigger picture. What kind of impact do you think programs like yours, where employers contract directly for care, will have at a national level?
I think programs like these are going to grow because they address the cost and quality problems employers are struggling with. But destination care for defined episodes like spine surgery is only a piece of where I think the industry is migrating. The broader approach that I expect we'll see a lot more of is employers directly partnering with providers for the totality of care for their employees — taking care of the whole person, and the whole employee population. In other words, an employer contracting directly with a provider in a prepaid model to take care of a population. We're already seeing some movement in this direction.

There will be some tension between employers seeking high-value care in these types of programs and consumers' desire for choice. You may get better value when an entity like Geisinger partners directly with an employer like Walmart, but, to get that, employers need to direct their employees to a smaller network of providers selected based on performance. If an employer wants to preserve employees' ability to have a phone book of providers to choose from, there's going to be a trade-off between employee choice and better value, since a lot of providers may not be as focused on quality and value in the ways we're talking about here.

How are commercial insurers responding to all this? I'd think they'd see it as a threat — but there's probably an opportunity in this for them too.
I think that's right. On the surface, it looks like a threat because it disintermediates them from the role they currently play in the relationship between employers and health care providers. But the opportunity for them is that insurers are good at identifying and contracting with quality provider networks. And they're good at pricing. Those capabilities will be very important as the industry moves this way. Even if the traditional role of the commercial insurer changes, employers still need to rely on someone to identify high-value providers and negotiate prices and develop contracts. Currently, third-party administrators do this, but it's a space commercial insurers are well positioned to move into.

What do you think the employer's role should be in moving employees toward higher-value networks?
I think they should be encouraging that shift, and some like Walmart are, for instance, by giving employees a broad choice of providers but telling them they'll need to pick up more of the cost if they choose a provider that's

not a Walmart center of excellence. A challenge is that employees' and even employers' perception of quality and value aren't always aligned with reality. Sometimes people equate fancy facilities with great quality, and of course those things aren't always correlated. But employers need to be looking at providers' data and driving people toward the best ones.

What's next for Geisinger?
We're looking to expand the centers-of-excellence, destination-care model to make it available to other employers as well. There's a scattering of local employers that are potentially interested in going down this path. That's the beauty of how the model was built. It can be adapted to serve local markets, and we get the opportunity to deliver care in the way we think is best, and we grow. The employer and employee/patient get value. I think that's a nice win-win-win.

Any final words of advice for employers?
Employers have an important role to play in getting better value out of their health care dollars. They have a tremendous opportunity to reward providers that deliver value. The more employers seek out and contract directly with the best providers, the more traction these types of programs will get — and everyone benefits. ■

About the author: ***Gardiner Morse*** is a senior editor at Harvard Business Review.

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The Real Secret to Employee Engagement

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