Power to the Employers

Unlocking Healthcare Affordability

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Introduction

It's a scenario that *feels* out of control: Healthcare costs have been escalating for decades with no end in sight. Employers are facing a median 7% rise in rates for 2024.[1] Employees shelled out one quarter of their take-home pay for healthcare premiums in 2020, up three-fold since 1980.[2] Healthcare costs are the top concern for middle-income American households, outpacing inflation.[3] Yet despite having the most expensive healthcare system in the world, we have nowhere near the best outcomes to show for it.

Persistent increases continue, driven by high unit prices, a lack of transparency and conflicts of interest inherent among traditional insurance carriers, whose earnings are tied to total costs. While healthcare costs outpace wage growth, companies are left hamstrung, as the "promise of the next decade" in value-based care remains unfulfilled:

- Networks largely remain unchanged, offering increased choices of doctors and hospitals through padded directories and higher premiums.
- Unit costs continue to increase but bear no substantial link to premiums or hospital network quality.[4]
- Health system consolidation exacerbates rising healthcare costs in the private sector as physician-hospital integration leads to an average price upswing of 14% for the identical service.[5]
- Misaligned incentives lead to over-utilization – and often misguided use – of care.

Costs continue to rise:

From 1999 to 2022, family health insurance premiums surged by 290%.[7]

The average yearly family premium for employer-based health insurance stands at $22,463, with employees contributing $6,106, or over $500 per month.[8]

Nearly half of people in the commercial sector had a premium increase of over 8% in 2022, while the cost-of-living increase was between 1% and 2%. From 1999 to 2022, family health insurance premiums surged by 290%.[9]

- Lack of pay increases for primary care physicians leads to occupational shortage, resulting in challenges around access and ultimately driving prices up.

These systemic inefficiencies have left employers to either bear the burden themselves or resort to cost-shifting, wherein already cash-strapped employees shoulder large portions of total premiums. With no real industry innovation, the trend of escalating healthcare costs continues to pummel employers and employees (while benefiting insurers). But it doesn't have to. Collectively, employers are the largest purchaser of healthcare in the United States, providing benefits for over 153 million people.[6] By recognizing their

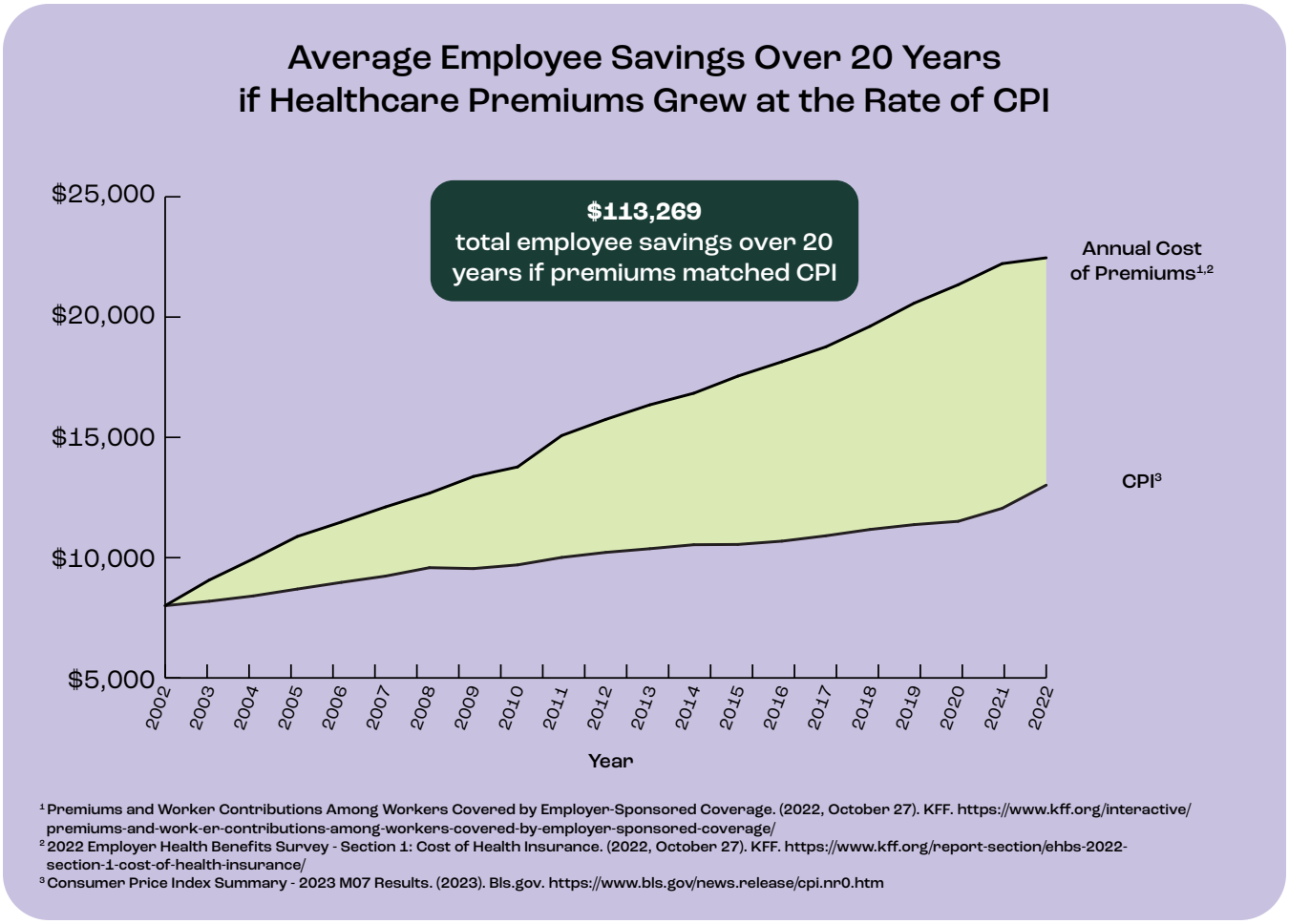

Figure 1. Over the past 20 years, the growth rate of healthcare premiums has continuously outpaced the growth rate of the consumer price index (CPI). The average family premium has risen from $8,003 in 2002 to $22,463 in 2022. After adjusting the 2002 cost of family premiums to the annual percent change in CPI, the 2022 cost would be only $13,014. If that money had stayed in employees' pockets, it would have amounted to $113,269, or $5,663 per year over the past 20 years.

opportunity as change agents, employers can use this purchasing power to drive real improvements, unleashing a cascade of positive impacts for their teams by:

- Understanding what their employees need and building plans to support it.
- Working with brokers who understand the short- and long-term implications of sticking to the status quo.
- Championing cost-effective care for employees right at the point of service.
- Saying no to opaque pricing without correlation to quality.
- Incentivizing the right care, not less care.
- Demanding transparency, not just with costs, but with incentives, rebates and more.

Why Current Benefits Approaches are Missing the Mark

Year after year employers have been presented with only minor variations of the same options that fail to improve the status quo. Even when sustainable options such as value-based care, which pays doctors according to patient outcomes, are touted as a way to improve patient outcomes, fee-for-service models remain the norm in the healthcare industry. For decades, neither the healthcare insurance industry nor government has controlled the cost trend, and there is no reason to believe that will change.

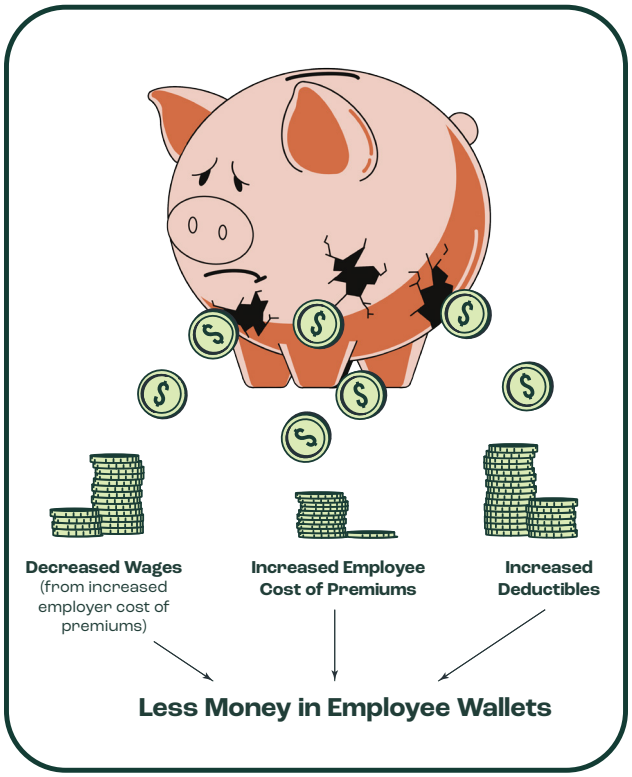

Figure 2.

Cost-Shifting Further Erodes Wage & Business Growth

There are three paths that result in less money in employee wallets: decreased wages, increased employee cost of premiums and increased deductibles. With the rising costs of healthcare premiums, employers are forced to either absorb these heightened expenses or allocate more of employees' compensation to cover them, which translates to lower and fewer wage increases. Simultaneously, rising premiums and deductibles pose a dual threat to healthcare affordability, forcing employees to spend more of their own money out of pocket. All of these factors ultimately hurt employees, where a 10% surge in insurance premiums has been shown to result in a notable 2.3% wage reduction for employees.[10]

Healthcare Consumerism Hasn't Gone as Expected

Between 2010 and 2021, the average healthcare deductible nearly doubled.[11] In theory, the intent of higher deductibles was to incentivize patients to avoid low-value care. However, this premise has simply been proven false: Not only do patients often lack the necessary information to make fully informed decisions, but many also don't have the convenience to take time out of their days to do so.[12]

In fact, rising deductibles have been shown to do something far worse: scare patients

away from necessary care altogether, including preventive measures, checkups, and ongoing condition management. Forgoing or delaying routine care has long-term health consequences, such as increased emergency department visits for preventable complications and decreases in early detection and treatment of life-altering conditions.[13] The U.S. Department of Health and Human Services found that adults enrolled in an employment-based HDHP were more likely to experience financial barriers to care compared to others.[14] As an added blow, deductibles exacerbate health inequality by disproportionately burdening low-income patients, hindering access to crucial medical services.

The Broad Network Myth

While the allure of large national networks can be tempting, it frequently translates to substantial financial burdens for employees and employers alike who are paying for the power of choice, rather than the power of quality. In fact, working with a curated network can take bad choices off the table entirely, ensuring employees have the choice only to see doctors who meet exacting standards.

Although some might argue for the power of choice, up to 82% of patients, when seeking specialty care, go wherever their doctor tells them, which makes the relationship with a primary care physician all the more valuable.[15] Additionally, consumer behavior studies show that while choice has value, too much choice can cause "decision paralysis." Our brains try to take a shortcut or avoid the choice entirely. For instance, people actually buy more often from shops that provide fewer choices due to simplified decision making.[16]

It is also worth noting that when employees were asked directly, 73% said they are willing to trade off or forgo features in a plan for a health plan that is 10-30% less expensive than their current plan.[17] This includes broad network access, changing primary care physicians, changing specialists and more.

Higher Costs Do Not Mean Higher Quality[18]

In healthcare, higher costs do not necessarily suggest higher quality care. In fact, in competitive markets, hospitals with higher prices had no significant difference in mortality rates, meaning higher prices are not translating to better care and better outcomes.[19]

Then what do higher prices lead to? Some believe it leads to higher profits for both for-profit and non-profit entities and higher bonuses for executives who are paid the most in any sector. If these higher costs are not producing better care for employees, employers are simultaneously losing money and failing their workforce.

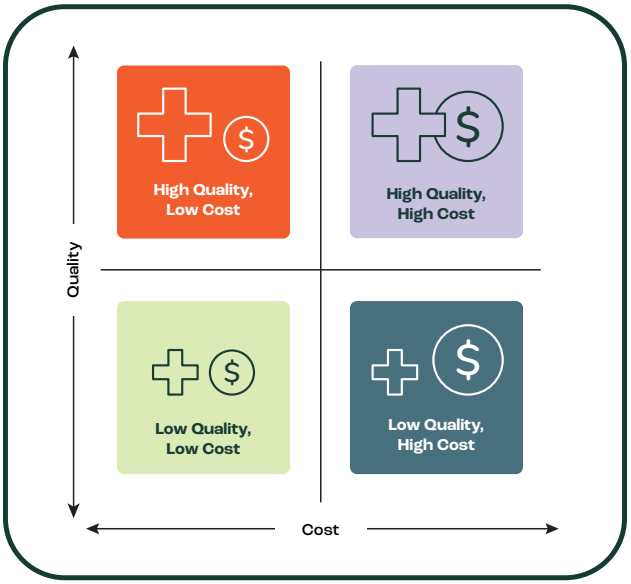

Figure 3.

Creating Care Models That Work

In order for healthcare coverage to change for the better, employers must recognize their power and seize the opportunity to create and reward systems that are getting it right. Taking the necessary steps can propel healthcare outcomes while restoring healthcare affordability for employers, employees and their families.

Start with Primary-Centric Care

Most patients want stronger relationships with their doctors and believe their health would improve if they regularly worked with a trusted provider.[20] Primary care-centered health plans nurture that critical relationship and set a foundation for better outcomes and lower costs.

But while other countries have adopted a primary care physician-centered model, the U.S. demonstrates a concerning lack of investment in primary care, despite the substantial evidence showing this focus consistently achieves better patient outcomes, reduced disparities and overall cost savings.[21] Even a short-term investment will often have tremendous payout, since increased primary care usage means conditions are less likely to go undiagnosed, resulting in a lower need for costly and invasive interventions caused by worsening symptoms without proper treatment. In turn, patients experience lower rates of emergency department visits, avoidable hospitalizations, and specialist services, saving them – and their employers –thousands of dollars annually. For example, implementing a primary care patient-centered medical home program was shown to have returns of $6 in savings per dollar invested by the third year of implementation.[22]

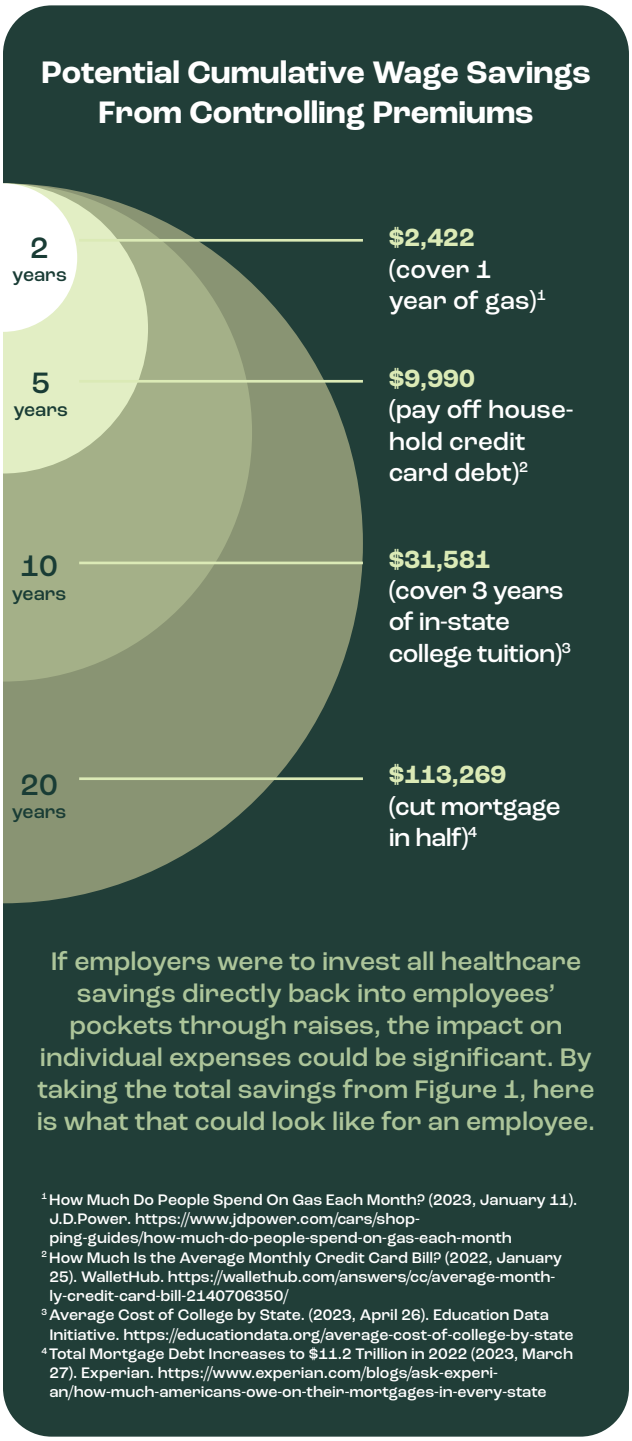

Figure 4.

Use case for delaying care due to costs

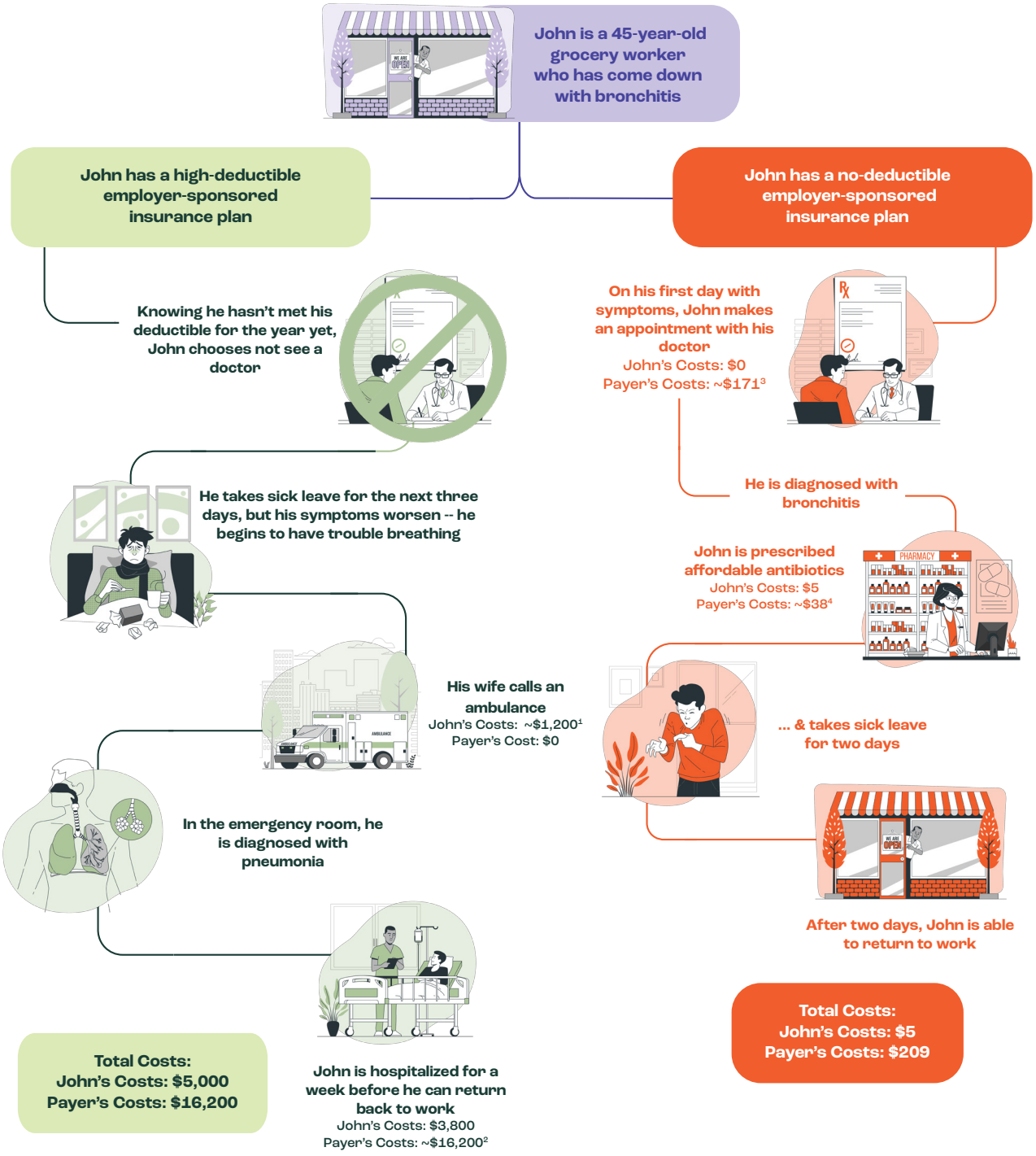

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Figure 5.

Focus on the Best, Get Rid of the Rest

Sometimes less is more, and that can be especially true when it comes to finding the right doctors and hospitals. While some might fear the removal of optionality, curated commercial models are grounded on providing more access to quality care, ensuring high standards are met while resulting in organic, long-term savings. In New York City, for example, a cesarean section can cost anywhere from $1,620 to $42,564 – a 26x differential.[23] Meanwhile, the $40,818 procedure at Weill Cornell with Blue Cross Blue Shield shows no discernable benefit over the $10,361 procedure at Mount Sinai.[24] By partnering only with high-quality providers that are equally committed to charging fair prices, employees get access to great care without the misappropriated costs.

However, not all employers have the size, scale or frankly, bandwidth to build their own network through direct contracting. Nor should they have to. Clinically integrated networks can provide for most healthcare needs in one system. They provide the foundation for coordinated patient care that puts value, not volume, at the forefront. Value-based care can be a win-win for everyone. It is a dynamic that supports both employees' health and the company's financial well-being, where incentives are aligned to promote better outcomes and lower costs. Hospitals and physicians are rewarded for doing the right thing — improving health, preventing chronic disease and helping patients make better choices.

By working with a network curated specifically to better align cost and quality, the journey to great care becomes not only more straightforward, but also better coordinated for a more holistic approach to health and wellness.

Break Down Barriers to Care

The promise of health insurance is often a far cry from the promise of healthcare coverage. Depending on the health plan design, using that insurance can come at a price that makes healthcare flatly unaffordable. Millions of insured Americans with employer-sponsored health plans face sky-high deductibles and bank-breaking out-of-pocket costs, making them "functionally uninsured" — meaning "on paper" they have coverage, but in actuality lack the financial ability to use it.

To change the system, we need renewed emphasis on the purpose of healthcare coverage to begin with: to keep people at their healthiest. That means ensuring people can actually go to the doctor by removing barriers to care, putting care prevention at the forefront, and coordinating care across providers. Effective plan design can:

- **Reduce care avoidance.** The utter lack of transparency across all aspects of the healthcare model have proven detrimental to people's health as well as their wallets, with more than 40% avoiding care due to price uncertainty.[25] Eliminating cost fears and unpredictability through plan design – like predictable copays and confusing "extras" like coinsurance – promotes the right care, not less care, and encourages engagement that leads to better utilization and, ultimately, outcomes.
- **Incentivize preventive and necessary care.** When people are encouraged – or rather, not discouraged! – to visit the doctor for prevention and necessary treatment, they are less likely to misuse typically more expensive care options such as urgent and emergency care centers, driving down costs for both employer and employee alike.

- Promote the primacy of primary care. Not only should a primary care doctor be at the epicenter of the healthcare journey, removing fear barriers to building strong primary care relationships can prove invaluable. While many people believe they have "free" primary care because they can go to their doctor once a year for a check-up or a flu shot, in fact, most primary care is not free but should be. For example, if someone is experiencing an ear infection but chooses to not have it looked at, the person's discomfort can escalate, causing muffled hearing and potentially costly complications due to the unchecked spread of infection. In an alternate scenario where the individual sees their primary doctor after being encouraged to, the physician can recognize the signs, leading to a swift diagnosis, appropriate treatment, and timely recovery.
- **Employ integrated virtual care.** Virtual primary care holds great promise as a solution for addressing spiraling healthcare costs, increasing the accessibility of quality primary care and resolving other barriers to care.

Don't Be Afraid of Alternative Payment Methods

There are lots of holes to poke in traditional fee-for-service models, opening up a number of payment alternatives, including reference-based pricing (RBP) and cash pay.

Reference-based pricing (RBP) offers baseline insurance coverage for services at a set price, typically based on a percentage of Medicare, regardless of the price charged by the provider. But while RBP is an all-but-guaranteed way to lower costs, it does not come without risk. Because RBP plans do not typically operate on contractual price agreements, plan members can be exposed to balance billing and disputes. At face value, this might sound like using patients as pawns in the duel between providers and vendors, but it is more nuanced than that, mostly because of the inefficiencies already plaguing the industry.

A 2021 Catalyst for Payment Reform study showed that less than 2 percent of RBP claims result in balance billing (though the number is closer to 10 percent for facility claims), and that in most cases, plan members do not end up fronting the bill.[26] Many proponents of RBP view it as a catalyst for systemic innovation because the model opens up a toe-to-toe fight with providers, instigating change from everyone involved.

Cash pay is another alternative. While it was traditionally leveraged by the uninsured, underserved or disenfranchised, it is receiving renewed attention as a proactive measure to combat crippling medical costs and ongoing price transparency challenges. In a recent study, negotiated rates were higher than cash rate 60 percent of the time.[27] This opens up questions around price transparency and the leverage employers have to ensure they're paying fair rates for quality service.

Demand Real Transparency

There is huge price variation for medication and services. And until recently it was impossible, and in some cases illegal, for those prices to be disclosed. In some states, "gag rules" prevented local pharmacists from advising their patients that a drug might be cheaper without using insurance.

For example, if a copayment was $15 for a medicine but the medicine only cost $3.50, the pharmacists were, by law, not allowed to inform patients of this. The price transparency rule effective January 1, 2021, was intended to bring change to the way prices are disclosed, giving patients the information needed to make more informed decisions before accessing care. Yet by July 2023, only 36 percent of hospitals were complying.[28]

Understanding price variations is instrumental in addressing affordability challenges, especially in light of earlier discussions around the lack of correlation between price and cost. For example, evaluating the cost differential between well-regarded hospitals in the Northeast, one can find variations upwards of 50% on high-priced medical procedures. Not only does this information help patients make more informed decisions, but it also helps employers better evaluate the right provider partners while demanding change from others.

Transparency, however, goes well beyond pricing. Data transparency is another critical factor in the drive toward affordability, since understanding claims data allows employers to analyze patterns and plan utilization and enact cost containment strategies accordingly. Recently, there have been a number of lawsuits against plan administrators alleging a breach of fiduciary duty for not providing adequate claims data to employers. As a result, employers were not able to review whether their plans were being properly administered, nor could they properly evaluate the viability of their health plan.[29]

	New York		New Jersey		Pennsylvania	
Facility Name:	NYP/Weill	The Mount Sinai Hospital	Hackensack - Pascack Valley	Valley Hospital[2]	Thomas Jefferson Univ. Hospital	Hospital of the Univ. of Pennsylvania
County:	New York	New York	Bergen	Bergen	Philadelphia	Philadelphia
Major hip and knee joint replacement or reattachment of lower extremity without MCC	$75,136	$46,304	$61,077	$33,359	$42,796	$44,374
Septicemia or severe sepsis without mv >96 hours without MCC	$42,819	$23,334	$33,411	$17,938	$22,492	$20,647
Pulmonary edema and respiratory failure	$47,513	$28,426	$38,385	$21,506	$26,557	$26,302
Vaginal delivery without sterilization or D&C without CC/MCC	$24,298	$11,973	$13,290	$11,257	$13,480	$12,783
Cesarean section without sterilization without CC/MCC	$34,398	$16,766	$20,186	$15,576	$18,209	$18,668

Source: Turquoise Health.
[1] Valley Hospital Commercial Market data from a third-party dataset.

Conclusion

Employers have been the backbone of the U.S. healthcare system for nearly a century. But with this great power comes great responsibility – and the opportunity to improve quality and reduce costs by partnering with health plans focused on value-based care where quality is rewarded.

Changing a system as complex and convoluted as healthcare sounds daunting, but employers do not have to approach it alone. They can partner with healthcare innovators laser focused on providing the industry insights, technological resources, and network relationships necessary to seamlessly bring primary care-centric, curated networks to life, facilitating exceptional care for employees while demonstrating commitment to their company's financial stability and long-term success.

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About Centivo

Centivo is an innovative health plan for self-funded employers, with a mission to bring affordable, high-quality healthcare to the millions of workers who struggle to pay their medical bills. Anchored around a primary care-based Accountable Care Organization (ACO) model and fully integrated with one of the nation's first virtual primary care practices to receive Patient-Centered Medical Home (PCMH) Recognition by the National Committee for Quality Assurance (NCQA), Centivo typically saves employers 20 percent or more compared to traditional U.S. insurance carriers. Employees also realize significant savings through its free primary care, predictable copays and no-deductible benefit plan design. Centivo partners with companies employing over 50 people – from mid-sized organizations to the Fortune 500. For more information, visit centivo.com.

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Leveraging 20 years as a purchaser of data and data analytics, Charm Economics develops return on investment (ROI) models for small- to mid-sized MedTech and digital health companies. Charm translates insights from academic journals, white papers and public data sources to provide simple, clear, and evidence-based value propositions. For more information, visit charmeconomics.com.