



# Aggregated Purchasing of Health Care Services: Lessons Learned and Blueprints for Success

Dozens of employer-led coalitions have attempted to aggregate their combined insured employees and dependents to lower prices and improve quality. Catalyst for Payment Reform launched an extensive examination of employers' efforts at aggregated purchasing.

This two-part report focuses both on successes and failures and provides guiding principles or blueprints for employers who want to consider aggregate purchasing in their own markets. Part 1 is titled "*Why Employer Attempts at Aggregated Purchasing Fail (and why some survive!)*" and Part 2 is titled "*Employer Blueprints for Durable Aggregated Purchasing Models.*"



**The  
Commonwealth  
Fund**

This research was supported by the  
Commonwealth Fund



The Commonwealth Fund, a national, private foundation based in New York City, supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund, its directors, officers, or staff.

# Full Report: Aggregated Purchasing of Health Care Services – Lessons Learned and Blueprints for Success



## Part 1: A Tough Crop to Till – Why Employer Attempts at Aggregated Purchasing Fail (and why some survive)

Introduction – The Unravelling of Haven Healthcare.....	3
Aggregated Purchasing Strategies – Is Failure a Foregone Conclusion?.....	4
Those Who “Tried and Failed” – A Brief History.....	4
Special Soil, Sabotage & Sand Traps.....	7
Those Who “Tried and Survived”.....	9
Employers Can Find Success in Aggregated Purchasing – But Is It Worth the Effort?.....	12



## Part 2: Planting Something New – Employer Blueprints for Durable Aggregated Purchasing Models

Introduction.....	14
A Delicate and Difficult Crop – Summary Findings from Report #1.....	15
What Is Aggregated Purchasing and Why Should Employers Pursue It?.....	16
Building a Greenhouse for Your Employer-Aggregated Purchasing Model.....	17
A Strong Foundation – Pre-Conditions/Requirements.....	18
Sturdy Walls – Strong Partners Create Durability.....	19
Weather-Proofing – Strategies to Withstand Incoming Storms.....	22
Easier Gardens to Till – Off-the-Shelf Models; Aggregated Purchasing for Other Services.....	23
Considering Off-the-Shelf Models – Health Plans Versus TPAs.....	23
Considering “Less Exotic Plants” – Aggregated Purchasing for Health Care-Adjacent Services.....	25
Employers, How Will Your Garden Grow?.....	27
Appendix A: Aggregated Purchasing Decision Grid.....	29
Reading the Grid by Row – Two Examples.....	33
Reading the Grid by Column – Employer Scenario.....	35
Appendix B: Report Methodology.....	39

# A Tough Crop to Till – Why Employer Attempts at Aggregated Purchasing Fail (and why some survive!)

Part 1 focuses on examples of those who “tried and failed” juxtaposed against those who “tried and survived” to create an inventory of the local market conditions and endogenous leadership requirements to build and sustain success.



# INTRODUCTION – THE UNRAVELING OF HAVEN HEALTHCARE

In the tumultuous week of January 6, 2021, when a mob breached the US Capitol and consumed the news cycle for the next 72 hours, it would have been easy to miss the news announcing the disbandment of Haven Healthcare. Haven, a joint effort by Amazon, Berkshire Hathaway and JP Morgan Chase, had been a beacon for employers rooting for a solution that would "disrupt" the health care ecosystem and bring about greater health care access, simplicity and affordability. However, for those who took notice, the news was disappointing, but not surprising. The collapse of Haven creates the newest tombstone in a graveyard of attempts from employers to band together and aggregate their employee volume, with a goal of re-shaping health care from the buy-side of the market. Jeff Bezos, Jamie Dimon and Warren Buffet are three of the world's most powerful executives, wielding unparalleled insight into the inner workings of complex and emerging markets. Does Haven's failure spell doom for all employers who seek better value for their health care dollar?

**THE FIRST QUESTION TO CONSIDER IS WHY** these three giants of industry would be compelled to tackle the thorny web of US health care. The short answer is that health care cost inflation, driven predominantly by rising prices, has turned sponsoring health benefits for employees and their dependents into a weighty stone around the necks of even the most profitable businesses. As health care providers consolidated their market power through a decades-long trend of mergers and acquisitions, health plans and third-party administrators (TPAs), despite their own consolidation, saw their negotiating leverage erode, making them ineffective sea walls against the rising tide of health care costs.<sup>1</sup> Dissatisfied and frustrated with health plans' offerings, some self-insured employers have tried to regain control and reclaim market power by taking matters into their own hands.

**HOWEVER, THE PROBLEM FOR THESE EMPLOYERS IS SCALE.** On its own, even a behemoth like Amazon lacks the volume of covered lives in any single market to effect meaningful transformation. So, to increase their heft in the marketplace and capture the attention of health plans and providers, employers have attempted to band together, aggregating their covered lives at the local level to initiate solutions that achieve greater health care quality at a lower cost. We call this *Aggregated Purchasing*; employers' efforts to build and sustain this type of model spans over 30 years. Of the dozens who tried, few survived.

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<sup>1</sup> The health plans found more profitability through their underwriting and put their resources into their fully insured commercial business and Medicare Advantage.

# AGGREGATED PURCHASING STRATEGIES – IS FAILURE A FOREGONE CONCLUSION?

Catalyst for Payment Reform, with support from the Commonwealth Fund, launched an extensive forensic examination of employers' efforts at Aggregated Purchasing. In this context, Aggregated Purchasing refers to the procurement of medical benefits, initiated by a group of employers, for the purpose of gaining greater value than they could achieve individually from their insurance carrier or TPA.<sup>2</sup> Through review of published case studies, supplemented by interviews with business coalitions, health plans, vendors, and providers, we attempted to piece together the reasons why so many of these well-intended efforts fall apart. We focus on examples of those who "tried and failed" juxtaposed against those who "tried and survived" to create an inventory of the local market conditions and leadership requirements to build and sustain success.

## THOSE WHO "TRIED AND FAILED" – A BRIEF HISTORY



### The Rise and Demise of the Buyers Health Care Action Group

With its launch in the early 1990s, The Buyers Health Care Action Group (BHCAG) was one of the earliest attempts at aggregated purchasing and has become the textbook "cautionary tale" for employers seeking to aggregate their volume and subrogate existing health care market dynamics.<sup>3,4,5</sup> In Minnesota's Twin Cities, 14 large, self-insured employers launched BHCAG to introduce "managed competition" into the market. BHCAG's strategy was to organize providers into *care systems*, built around groups of primary care physicians and affiliated specialists and hospitals. BHCAG enlisted support from HealthPartners, a local managed care organization, to administer and pay claims.

In its early days, BHCAG found notable success: market prices declined 15-20%, and virtually all Twin Cities PCPs participated in a care system. Yet by 2001, the purchasing coalition began to

<sup>2</sup> Note that for the purposes of this report, aggregated purchasing of other benefits, such as pharmacy or data analytics, are excluded from the definition, as these activities do not have a direct impact on the cost of medical benefits.

<sup>3</sup> Jon Christianson et al, "Early Experience With A New Model Of Employer Group Purchasing In Minnesota," *Health Affairs*, November/December 1999.

<sup>4</sup> Jon B. Christianson and Roger Feldman, "Evolution In The Buyers Health Care Action Group Purchasing Initiative," *Health Affairs*, Vol 21, No 1, January/February 2002.

<sup>5</sup> Jon B. Christianson and Roger Feldman, "Exporting the Buyers Health Care Action Group Purchasing Model: Lessons from Other Communities," *The Milbank Quarterly*, Vol 83, No. 1, 2005 (pp. 149-176).

fray at the edges, then quickly fell apart. As a disruptor to the marketplace, BHCAG faced opposition on multiple fronts:

- Health plan sabotage: Health plans saw BHCAG as a direct competitor, and aggressively lowered prices to lure employers away
- Large employer defections: the two largest BHCAG employers underwent mergers; their new corporate administrations required a uniform benefits plan, incompatible with the BHCAG model
- Administrative burden: providers were frustrated with lack of enrollment growth and the complexity of the payment system; similarly, employer enthusiasm waned under the expense and effort of managing the product

### *The BHCAG "Offspring" Meet a Similar Fate*

In its heyday, BHCAG's early success spawned multiple copies in markets across the country. All, unfortunately, met similar fates.<sup>6</sup> In 1996, in Des Moines, the dominant market insurer pursued aggressive pricing to lure away employers; employers also grew frustrated with poor service from the coalition's TPA, faced hospital capacity constraints, and eventually turned to Consumer Directed Health Plans (CDHPs) as an easy way to achieve low costs with minimal effort. In Sioux Falls, South Dakota in 1994, providers resisted organizing into care systems and balked at being sorted into tiered cost groups. An initiative launched in St. Louis, Missouri, in 1998 faltered because the coalition did not require a full replacement of employers' existing health plans; with low member uptake, providers quickly lost interest. An employer purchasing coalition launched in 1999 in Denver, Colorado, lost traction before launching, when the leading employer was acquired by a larger company who scrapped the project.



### **PacAdvantage Spirals to its Death**

In 1998, the Purchaser Business Group on Health (PBGH)<sup>7</sup> took over California's state-run small group purchasing pool, the Health Insurance Plan of California (HIPC), and renamed it PacAdvantage. PacAdvantage operated an insurance "exchange" for small firms who would otherwise be priced out of the market. PacAdvantage offered unrestricted employee choice, placing no minimum on how many employees had to select a particular product, and an online "health plan chooser tool" to help enrollees select among available plans according to their preferences.<sup>8</sup>

At its peak in 1998, PacAdvantage offered a choice of 21 different HMO and POS plans to its 150,000 enrollees; yet by 2006, the initiative virtually ceased operations when all but three insurers pulled out of the exchange. Researchers agree that adverse selection caused PacAdvantage's downfall. Risk screening failures turned PacAdvantage into a high-risk pool, which caused premiums to go up, which then led members to abandon the exchange if they could find cheaper insurance on the individual market. This created what actuaries call a "death

<sup>6</sup> Christianson and Feldman, *The Milbank Quarterly*, 2005.

<sup>7</sup> Formerly the Pacific Business Group on Health

<sup>8</sup> John Grgurina, "Employer Purchasing Pools: California's Experience Making Health Insurance Available to Small Employers," Wisconsin Family Impact Seminars, 2003. [https://wisfamilyimpact.org/wp-content/uploads/2014/10/s\\_wifis18c03.pdf](https://wisfamilyimpact.org/wp-content/uploads/2014/10/s_wifis18c03.pdf)

spiral.”<sup>9</sup> Health plans believed that PacAdvantage was essentially “a dumping ground for bad risk” and began to exit the exchange en masse.<sup>10</sup>

While on its surface PacAdvantage is a cautionary tale about risk adjustment, there were other structural factors that underpinned its demise. PacAdvantage's reluctance to restrict employee choice of health plan created unwieldy administrative burden for employers, who were compelled to manage multiple plans for a handful of employees.<sup>11</sup> Also, insurance companies *and* brokers saw the exchange as a competitive threat, prompting the former to underprice premiums outside the exchange, while the latter refused to offer PacAdvantage to their small group clients.<sup>12</sup> As early as 1998, analysts found no difference in price between PacAdvantage and the outside market; within another 6 years, PacAdvantage ceased to exist.<sup>13</sup>



### The Health Transformation Alliance Goes Big and then Pivots

In 2016, a new model of aggregated health care purchasing emerged; but unlike previous local endeavors, the Health Transformation Alliance (HTA) set out to harness the purchasing power of jumbo, national employers, pooling their volume to lower costs and drive innovation.<sup>14</sup> Originally, the HTA issued an RFP to health plans and TPAs across the country, inviting them to submit their best local health care solutions. From HTA's perspective, the problem for employers lay in the inconsistency of health plan performance at a national scale. Through the creation of national marketplace, employers could pick and choose from a mosaic of local “best of breed” solutions.

The strategy seemed promising, but HTA's marketplace never fully materialized. While the HTA maintains a robust membership today comprising over 50 members responsible for 4 million covered lives<sup>15</sup>, its medical benefits solution has mostly disintegrated.<sup>16</sup> Instead, HTA offers aggregated purchasing for pharmacy benefits and data analytics solutions. The medical benefit model never gained traction because HTA member employers were unwilling or unable to move covered lives into the niche solutions.<sup>17</sup> Benefit managers resisted the complexity of administering different health plans in every state. Moreover, from the perspective of the national carriers, the prospect of picking up an extra 5,000 lives in one market was offset by the prospect of losing just as many in another. Health plans, like cable television providers, benefit from selling a “package deal.”

<sup>9</sup> Jill M. Yegian et al, “Health Insurance Purchasing Alliances for Small Firms: Lessons from the California Experience,” California Health Care Foundation, 1998. <https://www.chcf.org/wp-content/uploads/2017/12/PDF-HIPClessons.pdf>

<sup>10</sup> Leesa Tori, “Insurance Exchanges: Lessons From The Life And Death Of Pac Advantage,” *Health Affairs*, September 22, 2011. <https://www.healthaffairs.org/doi/10.1377/hblog20110922.013952/full/>

<sup>11</sup> Weinberg and Kramer, *Pacific Business Group on Health*, 2011.

<sup>12</sup> Jill M. Yegian et al, California Health Care Foundation, 1998.

<sup>13</sup> “Insurance Markets: What Health Insurance Pools Can and Can't Do,” California Health Care Foundation, 2005. [https://www.cga.ct.gov/ph/tfs/20070101\\_HealthFirst%20Connecticut%20Authority/20080501/What%20Health%20Insurance%20Pools%20Can%20And%20Can%27t%20Do.pdf](https://www.cga.ct.gov/ph/tfs/20070101_HealthFirst%20Connecticut%20Authority/20080501/What%20Health%20Insurance%20Pools%20Can%20And%20Can%27t%20Do.pdf)

<sup>14</sup> Louise Radnofsky, “Companies Form New Alliance to Target Health-Care Costs,” *The Wall Street Journal*, Feb 4, 2016.

<sup>15</sup> <https://www.htahealth.com/>

<sup>16</sup> HTA does offer Accountable Care Organizations (ACOs) in Chicago, Phoenix and Dallas.

<sup>17</sup> CPR interview with business coalition, December 2020.



## SPECIAL SOIL, SABOTAGE & SAND TRAPS – AGGREGATED PURCHASING IS A TOUGH CROP TO TILL

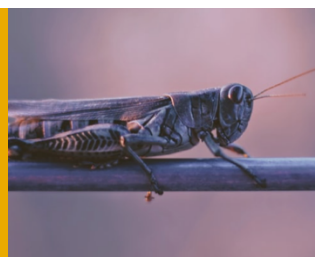
From BHCAG to Haven, a tour through the garden of failed aggregated purchasing strategies is a sobering journey. Although the examples span decades, markets, and strategic approaches, when taken together, three common pitfalls emerge. First, aggregated purchasing demands structural prerequisites within a health care market ("**special soil**"), which are increasingly rare. Second, disruptive innovation is vulnerable to **sabotage** from those who benefit from the status quo. But third and importantly, employer initiatives often stumble from self-made "**sand traps**" derived from *employers'* logical fallacies or tunnel vision. CPR's interviews with health plans, vendors, and purchaser coalition leaders reveal how these pitfalls cause purchasing efforts to die on the vine.



### Special Soil

Provider competition is the first condition of "special soil" necessary for an aggregated purchasing solution to thrive. If a single health system enjoys a monopoly, it gains nothing from collaborating with employers. The second condition is the accumulation of enough patient volume to capture providers' attention. Employers therefore need significant local market presence, generally must be self-insured, and must have their headquarters in situ so that leadership can be directly involved and committed to the initiative's success.

CPR could not find examples of aggregated purchasing strategies that failed due to provider monopoly. However, there are multiple examples (e.g., BHCAG and Denver) where a lack of employer commitment - or the acquisition of committed employers by non-committal national firms - depleted momentum and hastened collapse. In interviews, health care vendors and coalition leaders emphasized the importance of access to C-suite decision makers. According to one vendor, "there are some markets we will never tap into, because there *aren't* CEOs located there."<sup>18</sup> In an era when provider consolidation has eroded competition in 75% of hospital markets, and the employees of the largest self-insured employers are scattered across the country, the Special Soil conditions for success are exceedingly rare.



### Sabotage

Aggregated purchasing models are intended to disrupt and re-shape health care markets, and consequently, are targets for players who profit from the status quo. Health plans will slash their prices to undercut new health care products (BHCAG and PacAdvantage); an end run around brokers or consultants may incite retaliation (PacAdvantage); and powerful, expensive health

<sup>18</sup> CPR interview with TPA vendor, December 2019.



systems will do whatever necessary to prevent employers, health plans, and vendors from steering plan members to competitors.<sup>19</sup>



### Sand Traps

It's clear that even under the best circumstances, launching an aggregated purchasing solution is challenging. Nevertheless, many obstacles that shut down past efforts were either avoidable or self-created. "Employer Sand Traps" stem from a low tolerance for risk, an unwillingness to confront trade-offs, and a reluctance to cooperate across company lines.

The first trap "*Uniqueness Syndrome*" is a belief among employers that the needs of their plan members are unique, and that the employer must therefore retain control of network, benefit and plan design. Uniqueness Syndrome partially explains the dissolution of Haven Healthcare, where in a letter to JP Morgan employees, Mr. Dimon explained his plans for a post-Haven world: "We'll ...work to design programs tailored to specific needs of our individual employee populations and local markets."<sup>20</sup>

A second sand trap, "*Misalignment Syndrome*" speaks to the mis-matched incentives between organizational leaders charged with managing costs, and those responsible for purchasing health care services. HR departments (the latter group) are frequently reluctant to implement plan design changes that restrict employees' choice of provider, out of fear of employee abrasion. From the perspective of HR benefits managers, the risk of employee turnover and dissatisfaction with benefits outweighs the cost of including expensive, low-value providers through an open access PPO network. Thus, it shouldn't be surprising that a mere 4% of U.S. firms offer narrow networks and only 5% removed high-cost hospitals from their networks.<sup>21</sup> Misalignment syndrome persists despite research showing that only about 1% of employees who leave their jobs are driven by dissatisfaction with benefits.<sup>22</sup> But although employees are unlikely to *quit* over dissatisfaction with their health care benefits, it doesn't mean they're indisposed to complain. As one health plan executive told CPR: "HR doesn't get credit when things go well and gets lots of pain when things go badly. They just don't want to take the risk."<sup>23</sup>

For employers concerned about abrasion, there *is* an escape hatch: offering a slice solution instead of full replacement, giving plan members the *option* of enrolling rather than a mandate. But this option requires benefit managers to administer multiple health plans, products and benefit strategies, and many benefit managers find this complexity untenable.

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<sup>19</sup> For more information on health systems exercising monopolistic behavior to retain market control, see:

<https://www.sipconline.net/files/Hospital%20Dominance-By%20Bruce%20Shutan.pdf>

<sup>20</sup> Emily Flitter and Karen Weise, "Amazon, Berkshire and JPMorgan Will End Joint Health Care Venture," *The New York Times*, January 4, 2021. <https://www.nytimes.com/2021/01/04/business/haven-amazon-berkshire-hathaway-jpmorgan.html>

<sup>21</sup> 2020 Employer Health Benefits Survey" Henry J. Kaiser Family Foundation, October 2020. <https://www.kff.org/report-section/ehbs-2020-section-13-employer-practices-alternative-sites-of-care-and-provider-networks/attachment/table-13-10/>

<sup>22</sup> "2019 Retention Report," The Work Institute, 2019. [workinstitute.com/retentionreport2019](http://workinstitute.com/retentionreport2019)

<sup>23</sup> CPR Interview, TPA vendor, December 2019

The third employer sand trap is "*The Catch 22 of Jumbo Employers*." Coalitions of employers need the jumbos' member volume to capture the attention of providers and health plans; they may also need them for their resources and name recognition. The problem with jumbos is their entrenched belief that – by virtue of their size – they can command any health care cost concession or value proposition on their own. Consequently, jumbo employers are a perpetual flight risk, able and willing to defect from the coalition and go it alone. The same applies to regional branches of national firms, who are one re-org away from being swept into a nationalized benefits package in the firm's efforts to improve efficiency. Jumbo employer defections account in part for the demise of BHCAG and some of its offspring; they also underpin Haven's disbandment: being a jumbo employer can enable Uniqueness Syndrome.

## THOSE WHO "TRIED AND SURVIVED"

And yet, despite all challenges and opposition from within and without, some aggregated purchasing strategies persist. However, of the handful of multi-employer models in operation today, only a fraction operates in the mold of BHCAG. More to the point, multi-employer models succeed because they find unique ways to avoid the constraints of special soil, the risk of sabotage, and their own temptation to fall into sand traps.



### The Alliance – The Last Standing Domino

The Alliance, in Madison, Wisconsin, is one of the only business coalitions in the country to successfully administer its own directly-contracted provider network. Founded in 1990, The Alliance today boasts membership from approximately 285 employers who are responsible for over 100,000 covered lives. Their network includes 135 hospitals, 23,000 practitioners, and 7,000 medical clinics across Wisconsin, and some counties in Illinois, Minnesota and Iowa.

In the early 1990s, the state of Wisconsin introduced managed competition as its purchasing model, which encouraged providers to organize into single-system HMOs.<sup>24</sup> The HMOs offered below-market rates to their own plans, but then shifted costs to the rest of the market. Self-funded employers, disinterested in fully insured products, decided to forge their own directly-contracted network, and The Alliance was formed.

If past were prologue, the provider HMOs would be expected to sabotage and obstruct. They had no incentive to offer their "friends and family" rate to self-insured employers, and what's more, The Alliance's product was technically a competitor. There are two reasons why the HMOs ignored the opportunity for sabotage. The first is that the HMOs understood that some large, national, self-funded employers would never accept a fully insured product. Second, the HMOs had an ulterior motive: to keep the national health plans out of Madison.

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<sup>24</sup> These HMOs were similar in structure to the product model ACOs in operation today, or the Kaiser model.

Favorable conditions for a peace treaty were not the only factors The Alliance had in its favor. The Alliance also operated in a competitive provider market, with a cadre of large, local employers among its membership. Although The Alliance came to those first two factors by fortune, it also made several smart strategic decisions that buffered against self-induced employer sand traps. First, every employer in The Alliance could select its own TPA and implement its own benefit design; this offered each employer the flexibility to customize to the unique needs of its members, and thus defuse the risk of Uniqueness Syndrome. Second, although The Alliance offers tiered network products, employers can also select a broad PPO network – and at a price point below what the national health plans can offer. As such, The Alliance avoids the Misalignment Syndrome – it only has to manage one network platform, which can be customized by its members – *and* the trappings of the Jumbo Employer Catch 22.

With such a small sample, it's impossible to know how to attribute The Alliance's success to its strategy vs. good fortune. It's possible that The Alliance's model can work in markets outside of Wisconsin. The Savannah Business Group on Health also operates a directly contracted network comprising two competing health systems. A few other regional groups indicate plans to implement The Alliance's model, leveraging The Alliance's technical capabilities and leasing its claims processing technology. But the other examples profiled here, *ECEN* and *Equity Healthcare*, avoided the pitfalls by circumventing market constraints, or working directly with health plans, respectively.



#### **ECEN – The “No Market” Market Solution**

The Employers Centers of Excellence Network (ECEN) launched in November 2014, sponsored by four jumbo employers and engineered/facilitated by California's business coalition, PBGH. The early ECEN model executed direct contracts with four medical centers across the country for joint replacement and spine surgery. ECEN deploys a *prospective* episode bundled payment model, a single case rate that covers the procedure, plus all related pre- and post-procedural care.<sup>25</sup> Importantly, the ECEN *benefit design* includes travel and accommodations for plan members, allowing someone living in Little Rock to receive a spine surgery in Baltimore. Today, ECEN, now owned and operated by the Contigo Health TPA, offers its Centers of Excellence program for oncology and bariatric surgery alongside orthopedics, through contracts with 17 medical centers in 14 states.<sup>26</sup>

The ECEN model surpasses the “special soil” market requirements by introducing competition that transcends local conditions. The absence of market boundaries also enables the model's expansion to any interested/willing employer, obviating a need for a constituency of locally based, self-insured employers. Because ECEN operates as a carve-out rather than a full network replacement it defends against the risk of health plan sabotage, but also offers an

<sup>25</sup> For additional information on episode bundled payment models, see CPR's "Bundled Payment Options in the 2020 Marketplace: A Guide for Employers and Other Health Care Purchasers," <https://www.catalyze.org/product/bundled-payment-options/>

<sup>26</sup> <https://contigohealth.com/employers/solutions/ecen> & CPR Interviews.

incremental, lower-risk approach to network and benefit design – only a handful of plan members will require orthopedic surgery in a given year. With a lower risk of plan member abrasion, the ECEN model can avoid Misalignment Syndrome.



### **Equity Healthcare – Smart Purchasing Yields Big Savings**

Equity Healthcare (EH) purchases medical benefits on behalf of the portfolio of companies under the Blackstone Group – a private equity firm. At present, EH purchases benefits for 60 Blackstone companies who represent over 200,000 covered lives; the average size is 2,000 employees. Blackstone does not require its companies to purchase benefits through EH – although most do; eligible companies must have at least 400 covered lives and be self-insured. Companies can continue with EH after Blackstone has exited its investment, which the overwhelming majority do. Employers also retain autonomy around benefit design, although EH offers recommendations based on best practices and tailored to the company's profile. There is minimal variation in designs among the Blackstone companies.

When Blackstone companies convert to EH's health model, they save an average of 15% in health care costs over the first three years and achieve a Net Promoter Score (NPS) >70.<sup>27</sup> Some of the savings come from the companies' adoption of the recommended defined contribution benefit design that expands plan member choice but fixes the company's contribution to the most efficient offering (this is true despite the fact that the actuarial value of the benefit designs in EH is relatively rich at 80%). The remainder of the savings come from EH's approach to the delivery system. EH chooses just two national carriers to carry out its program and offers member companies their choice of these two vendors. Some of Equity's savings come from volume-based discounts on health plan administrative fees, but the majority are derived from Equity's bespoke clinical model that the carrier administers, which dramatically reduces the waste embedded in traditional health plans' care management protocols.

By customizing health plan programs to each unique employer population, offering concierge customer service, and prohibiting broker and consultant shell games, Equity delivers double-digit savings to its portfolio companies and the highest NPS in carrier-delivered service. And the model survives because, beyond the savings and NPS scores, Equity's strategy bypasses the pitfalls that cause so many other ventures to fail. Because Equity contracts with national health plans, the model sidesteps the "special soil" requirements for a direct contracting model. By working through the health care ecosystem rather than around it, Equity avoids inciting sabotage. Still, avoiding employer sand traps requires grit and determination, and it's here that Blackstone's ownership of its portfolio companies becomes invaluable: through direct conversations between Blackstone's c-suite and executives at each portfolio company, Blackstone/Equity can extinguish employers' impulses to act like "Uniqueness" or "Misalignment."

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<sup>27</sup> NPS scores are calculated as the difference between the proportion of plan members who would recommend or promote a health care product vs. those who would not. For reference, the average NPS score for a health plan is 27% <https://www.retently.com/blog/good-net-promoter-score/>



## EMPLOYERS CAN FIND SUCCESS IN AGGREGATED PURCHASING – BUT IS IT WORTH THE EFFORT?

Make no mistake, disrupting the balance of power within a health care market is no small feat. It requires employers of disparate industries to band together and tackle a segment of the economy for which they have provisional (if any) expertise. As evident in the legion examples in our cemetery of Aggregated Purchasing efforts: this work is hard, and smart and capable leaders can easily fail.

**THE INSTANCES OF SUCCESSFUL AGGREGATED PURCHASING** led us to three conclusions for employers seeking to effect change from inside the market:

1. Employers need the right market, or a solution that avoids local market constraints entirely
2. To avoid sabotage, employers are better off working within the system than against it
3. Employers should enter these endeavors with eyes open wide to their *own* self-destructive impulses, hedging against them through solutions that offer:
  - a. Employer flexibility and choice,
  - b. Ease of implementation and administration, with limited exposure to member disruption/abrasion, and
  - c. A viable model that does not rely on the heft of jumbo employers to support its weight.

CPR's pending companion report offers blueprints for employers who want to take advantage of lessons from the past to build their own aggregated purchasing models. But it's equally important to recognize that some vendors and health plans offer accessible, off-the-shelf products, which supplant the need to build from scratch. For example, the ECEN model has been copied by multiple centers of excellence vendors, obviating the need for any employer to replicate it independently.

A final point to consider: if employers want affordable health care, they may also need to change the game from the outside – by working with state and federal regulators to combat the anti-competitive forces that have made health care markets so untenable. While this is new territory for most employers, it may arguably be the best way to create more fertile soil.

# Planting Something New – Employer Blueprints for Durable Aggregated Purchasing Models



In Part 2 Catalyst for Payment Reform examines the success factors behind viable aggregated purchasing models and lays out guiding principles for employers who would strive to achieve similar success in their own markets.

## INTRODUCTION

Employers are in a perpetual state of crisis in their struggle provide affordable health care benefits for their employees. Many have tried every cost-saving solution that's come to market: disease management products promising better outcomes for diabetics, digital apps purporting to help with weight-loss; there's telehealth, care navigators, consumer directed health plans... the list goes on. Some have done little to nothing, assuming that health care costs are beyond their control. Inaction, or limited action, comes at a cost. Health care inflation continues to climb at 167% of the consumer price index (CPI).<sup>28</sup> Perhaps the projected rate of health care cost inflation in 2021 – 4.4 percent – sounds modest; but consider that the rates of overall inflation and worker earnings hover close to zero.<sup>29</sup>

Meanwhile, recent claims-based provider pricing studies from the RAND Corporation uphold the long-held contentions of most health economists and policy makers:<sup>30</sup>

- Health care prices, not utilization, drive increases in health care spending
- These prices are uncorrelated with the quality of care

Frustrated by the continued erosion of health care affordability many employers believe that they have exhausted every existing option to reduce the cost of health care services - short of advocating for major health policy reforms. Some have attempted to take matters into their own hands: pooling the volume of their covered lives with other health care purchasers, these employers venture to recapture market power by maneuvering around health insurance companies and negotiating their own contracts with local providers.

We call these employers' efforts *aggregated purchasing models*, and CPR profiles them extensively in the first installment of this research, *Insert Report #1's Name Once We Have One*. In the first report, CPR provides a forensic examination into the root causes of their success and failure. We found many (many) instances of failure, but also examples of success, where employers not only executed and sustained an aggregated purchasing model, but also effectively altered market dynamics and rebalanced negotiating power back a bit toward employers. Our research – through primary and secondary sources, and which included in-depth interviews with purchasers, providers, health plans, and other health care vendors – identifies the reasons why these aggregated purchasing models so frequently fall apart, and why in some markets, employers persevered.

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<sup>28</sup> Peter G. Peterson Foundation, "Why Are Americans Paying More for Healthcare?" <https://www.pgpf.org/blog/2020/04/why-are-americans-paying-more-for-healthcare>, April 2020.

<sup>29</sup> Mercer, "Health Benefit Costs Expected to Grow 4.4% in 2021, Mercer Survey Finds," <https://www.mercer.us/our-thinking/healthcare/health-benefit-costs-expected-to-grow-4-point-4-percent-in-2021-mercerc-survey-finds.html>, October 1, 2020.

<sup>30</sup> Whaley, C. et al: "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans," *The RAND Corporation*, September 2020. <https://employerptp.org/wp-content/uploads/2020/09/RAND-3.0-Report-g-18-20.pdf>

## A DELICATE AND DIFFICULT CROP – SUMMARY FINDINGS FROM REPORT #1

Creating and sustaining an aggregated purchasing model is fraught with precarity; in CPR's earlier report, we compare the endeavor to cultivating a fastidious and delicate garden, at risk of collapse from obstacles and threats that fall into three categories:

### 1. A NEED FOR SPECIAL SOIL

**Structural pre-requisites over which employers can exert little to no influence.** These include the degree of existing provider competition and the composition of local employer groups in a given market. In highly consolidated markets with little to no provider competition, employers may lack leverage to negotiate more favorable contract terms. The second factor, employer composition, speaks to the need to represent enough volume to attract and retain providers' attention. But that's still insufficient. Beyond amassing enough covered lives, participating employers must be self-insured, and, PREFERABLY, with local headquarters so that leadership can be directly involved and committed to the initiative's success.

### 2. SABOTAGE

**The threat of external competitors who benefit from the status quo.** Given that aggregated purchasing models bypass health plans and may exclude some health systems, those excluded parties have a vested interest in thwarting their progress. Report #1 found several examples of aggregated purchasing models that disintegrated when disintermediated stakeholders (usually health plans, but sometimes brokers) quashed early successes.

### 3. SAND TRAPS

**Self-induced hazards that employers bring on themselves.** Even with optimal external conditions in place, aggregated purchasing models can collapse due to the tendencies and impulses of their own employer constituents. Employers lack experience with partnering with each other to procure health care benefits, and their internal structures and incentives can inadvertently steer them away from a collaborative health care strategy. In Report #1, we identify three employer "syndromes" that commonly obstruct aggregated purchasing models:

- a) *Uniqueness Syndrome*: a belief among employers that the needs of their plan members are unique, and that the employer must therefore retain control of network, benefit and plan design.
- b) *Misalignment Syndrome*: the orthogonal positioning of incentives within an organization that pits the goals of a finance department (reduce costs) against the motivations of HR benefits procurement leadership (RECRUIT/retain happy employees). This misalignment creates resistance to initiatives that narrow employees' choice of provider,



but also to models that require HR to administer complex benefit designs or products specific to a local health care market and unavailable nationally.

- c) *The “Catch 22” of Jumbo Employers*: the trade-off that purchasing groups face when they rely too heavily on the volume of large, multi-site employers. Jumbo employers tend to believe that, by virtue of their size, they *don’t* need to collaborate with other employers, and can achieve the same value or cost concessions independently.

Notably absent from this list of pitfalls are legal and regulatory constraints. As part of our research for this project, CPR worked with legal experts to examine laws and regulations that could potentially impact employers’ ability to engage in aggregated purchasing efforts. No one will be surprised to learn that the laws governing and adjacent to aggregated purchasing of health care services are both voluminous and convoluted, and it is prudent for employers to engage legal counsel to help navigate the law and ensure compliance. But the good news is that our extensive legal analysis failed to find any instance where legal issues proscribed employers’ collective action. In fact, some laws can facilitate aggregated purchasing efforts – for example, by enabling health care cooperatives or other similar entities.<sup>31</sup>

Moreover, despite the obstacles and hazards from without and within, some aggregated purchasing models persist and thrive; when they do, they have the potential to create radical and sustained shifts in health care market dynamics. In this report, Catalyst for Payment Reform examines the *success factors* behind viable aggregated purchasing models and lays out criteria and blueprints for employers who would strive to achieve similar success in their own markets.

## WHAT IS AGGREGATED PURCHASING AND WHY SHOULD EMPLOYERS PURSUE IT?

The term is worth unpacking. In this context, the word “aggregated” refers to the amassing of lives across multiple employers, and “purchasing” refers to the procurement of health care services through direct negotiations with health care providers. This last point is particularly salient, as there are other models considered in this report that also require employers to aggregate -- but for the purpose of procuring *other* health care related services, such as pharmacy benefits, data analysis services, or even discounted administrative fees from health insurance companies. The report also discusses the merits of models under which employers can act independently of each other, pooling their volume through an external aggregator (like a health plan, or TPA vendor) that offers a high-value health care product. Overall however, the bulk of this report is dedicated to describing the necessary ingredients and best practices for

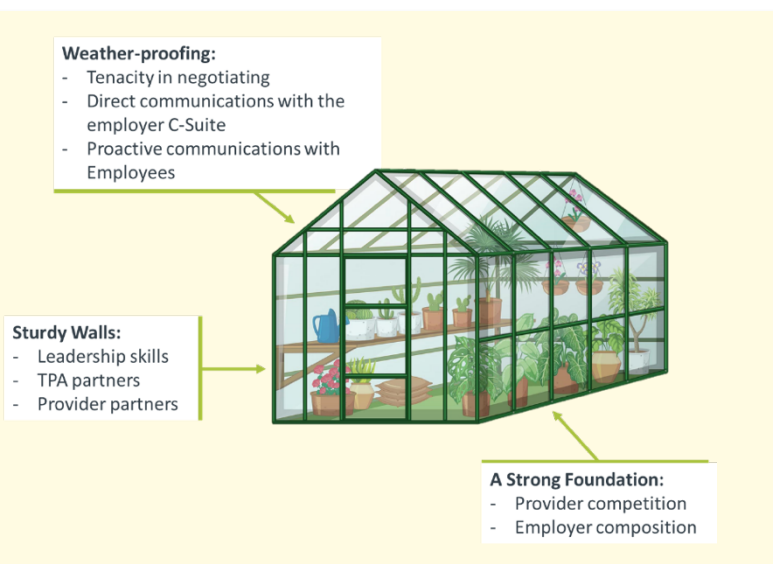
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<sup>31</sup> Colorado Revised Statute [10-16-1001- 10-16-1016](#) states that “Colorado’s health care system should build on the strength of the employment-based coverage arrangements that now exist in this state; and... in order to help control health care costs, consumers should be empowered to organize to directly negotiate health care prices with providers.”

employer-led aggregated models that include building a provider network with local physicians, hospitals and health systems.

It is fair to ask: given the challenges of cultivating an aggregated purchasing model, why focus there and deprioritize the lower-hanging fruit? The answer is two-fold. First, because externally aggregated "off-the-shelf" models require minimal employer input, our attention to them focuses on when and why to implement them. There is less to say about "how." But second and more importantly, our research shows that there is inherent value to employers in forging ongoing relationships with providers as opposed to outsourcing negotiations to a proxy. The value of employer-driven aggregated purchasing extends beyond the cost savings: connections between employers and providers can also uncover opportunities for innovation in care design, payment models and access, which result in better clinical and experiential outcomes for patients.

## BUILDING A GREENHOUSE FOR YOUR EMPLOYER-AGGREGATED PURCHASING MODEL



Having established (a) that aggregated purchasing models are vulnerable to exogenous constraints and internal instability, but (b) they *also* have the potential to generate significant and sustainable value to employers and their plan members, we progress to the question of *how* to build a model that can survive exposure to the elements. The "greenhouse" employers construct around an aggregated purchasing model comprises a series of strategic decisions that position the model to weather adversity and sustain its partnerships.

An *aggregated purchasing model* that establishes contract terms between employers and a local health care provider (or group of providers) requires the following elements:

1. **A STRONG FOUNDATION**  
Pre-conditions/requirements necessary for the model to take root.
2. **STURDY WALLS**  
The skills, resources and leadership needed to administer the model effectively, and the partners chosen to participate in it.

### 3. WEATHER-PROOFING

Strategies designed to mitigate against risk and navigate through challenges.

In this next section, we discuss the *blueprints* – i.e., features and design elements – that strengthen aggregated purchasing models, creating protections that enable these arrangements to grow and thrive.

## A STRONG FOUNDATION – PRE-CONDITIONS/REQUIREMENTS

As noted previously, an aggregated purchasing model is more likely to succeed in locations where providers must compete for market share, and where there is a substantial volume of local employers with leadership vested within the community.

**THE FIRST REQUIREMENT, PROVIDER COMPETITION**, speaks to the incentive for collaboration that exists when providers stand to gain (or risk losing) patient volume. But provider competition is more complex than the *Herfindahl-Hirschman Index* of a given health care service area.<sup>32</sup> For example, *Peak Health Alliance*, in Summit County, Colorado, successfully launched an aggregated purchasing model with the sole hospital in its service area, St. Anthony Summit Medical Center, which is part of the Centura Health Network.<sup>33</sup> Although St. Anthony itself faced limited local competition for physician services and emergent care, utilization analysis showed that many patients were travelling to Vail for elective procedures, or to Denver – where there are several large competing health systems alongside Centura – for tertiary or quaternary care. Also, its competitor in Vail was planning to open a new hospital in Summit County. Peak Health Alliance could therefore address St. Anthony's need to retain patients locally and Centura Health's desire to retain patients with high-acuity care needs, to negotiate a new contract and fee schedule with St. Anthony's in Summit County.

Furthermore, brokering higher-value care from a hospital does not necessarily hinge on renegotiating fee schedules; employers can work directly with health systems to establish deeper accountability for cost and quality outcomes. For example, General Motors' (GM) direct contract with The Henry Ford Health System (HFHS) in Detroit was anchored around a shared risk payment model, holding HFHS financially accountable for managing total cost of care and meeting performance targets on clinical quality measures.<sup>34</sup> If successful, this model will deliver cost savings to GM even without concessions on hospital prices.<sup>35, 36</sup>

Markets with provider competition might seem *more conducive* to aggregated purchasing, but a lack of competition is not an insurmountable obstacle. The employer criteria, it turns out, are

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<sup>32</sup> Herfindahl-Hirschman Index (or HHI) is a commonly used measurement of market competition, calculated as the sum of the squared market shares of each individual firm in a defined service area. <https://healthcostinstitute.org/research/hmi-interactive>

<sup>33</sup> "Summit in Sight: Peak Health Alliance Targets High Prices in Trailblazing Effort," *Colorado Health Institute*, November 2019, [https://www.coloradohealthinstitute.org/sites/default/files/file\\_attachments/SummitInSight.pdf](https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/SummitInSight.pdf)

<sup>34</sup> "The Road to Direct Contracting: General Motors Company", *Catalyst for Payment Reform*, January 2021.

<sup>35</sup> CPR Interview, Henry Ford Health System, September 2020.

<sup>36</sup> We will need to procure approval from General Motors prior to publication.

much more fundamental. In Report #1, we cite multiple examples of aggregated purchasing models that dissolved because of internal conflict and employer defections.<sup>37</sup> The tendencies ("Syndromes") that cause employer defections is a risk that purchasing groups can never completely mitigate; however, a purchasing group that meets the following criteria will be better positioned for success:

#### ALL EMPLOYER MEMBERS ARE SELF-INSURED

Although it is *possible* to build an aggregated purchasing model for fully insured and individual products (Peak Health Alliance achieved this feat) it is significantly more complex to execute. In general, most aggregated purchasing models require employers to be self-insured, and necessitate a sufficient volume of covered lives to capture the attention of providers and/or external aggregators.

#### MOST EMPLOYER MEMBERS HAVE LOCALLY BASED HEADQUARTERS

Those with experience in this space unanimously assert the importance of involving executive leadership who retain ultimate decision-making authority during the creation and administration of aggregated contracting models. Furthermore, a regional branch of a national company is at perpetual risk of being undermined by a central corporate office's decision to implement uniform, national benefit design.

#### ITS CRITICAL MASS OF COVERED LIVES DOES NOT HINGE ON THE PARTICIPATION OF "JUMBO EMPLOYERS"

As noted, the "catch 22" of relying on jumbo employers – organizations with >20,000 employees – is that while they contribute significant volume of covered lives, they hold an entrenched belief that they can achieve independently any negotiated deal achieved by the purchasing group. As such, they are perpetually at risk of defection. This is not to say that jumbo employers should be excluded from aggregated purchasing models, but the coalition that *depends* on jumbo employers is at much higher risk of fragmentation.

#### CONFLICTED PARTIES ARE EXCLUDED FROM LEADERSHIP

Employers may want/need to formalize their aggregated purchasing model with a governing structure, including but not limited to, a board of directors, by-laws, decision-making or voting rights, etc. The governing body ideally would exclude employers with financial ties to health care providers (health systems, provider groups, health plans, etc.), or that are providers themselves, to avoid conflicts of interest.

### STURDY WALLS – STRONG PARTNERS CREATE DURABILITY

Launching an aggregated purchasing model requires multiple partners, including a governing body to negotiate on behalf of its employer constituents, skilled third-party administrators to administer and pay claims, and health care providers to deliver care. CPR's interviews with

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<sup>37</sup> In Report #1, see Haven Healthcare, the Buyers Health Care Action Group (BHCAG) and the "BHCAG Offspring"



employers, providers and TPAs who have participated in these types of models reveals the skills, resources and experience required of each participating entity.

## LEADERSHIP SKILLSET AND RESOURCES

Enabling multiple employers to join forces and launch an aggregated purchasing model requires some form of governance structure for shared decision-making, and to administer and execute the strategy. To this end, the purchasing group needs leadership, charged with organizing employer constituents, negotiating terms with providers, and sustaining the model long-term. Beyond establishing a governance structure, these employer collectives need leadership with the following skillset and resources:

### ACCESS TO CLAIMS DATA

This is critical if employers want to negotiate with providers on prices and fee schedule. In some markets, like Colorado, a robust all-payer claims database (APCD) can provide rich data and benchmarks on facility, physician and ancillary service prices. Also, the RAND Corporation's Hospital Price Transparency studies now include data from hospitals in 25 states, enabling comparison of inpatient, outpatient and professional service prices against Medicare rates. Earlier efforts at aggregated purchasing leveraged participating employers' claims data to estimate local hospital prices – which requires a sufficient volume of data from self-insured employers. This may still be necessary in markets lacking alternative data sources.

### EXPERIENCE IN PROVIDER CONTRACTING

Health plans retain robust teams of professionals charged with brokering contracts with local providers. Even though *health plans'* success at negotiating affordable health care prices is questionable, it will behoove employers to recruit staff or consultants who are familiar with the process, strategy and quid pro quos of negotiating provider contracts, and who understand alternative payment models, network adequacy, transparency, quality metrics and claims data.

### TECHNICAL INFRASTRUCTURE TO ANALYZE AND RE-PRICE CLAIMS

The Alliance, in Madison Wisconsin, maintains the largest and most long-standing aggregated contracting model. They attribute some of their success to their custom-built claims repricing and data warehouse technology. This software internally enables The Alliance with flexibility to customize provider contracts and advance innovative payment models like episode bundled payment. Many TPAs lack these capabilities, and as such, outsourcing to them would limit The Alliance's flexibility in deploying alternative payment models to their lowest common denominator TPA partner. The claims repricing function also serves as the intake for the data warehouse, which is used by The Alliance to provide consultation to its member employers on ways to maximize the value of the network through benefit plan design.

## CHOOSING TPA PARTNERS

The mention of lowest common denominator TPAs provides a segue to a broader discussion of TPA partnerships for aggregated purchasing models. The first question to answer is: should the purchasing group procure a contract with a TPA as part of its aggregated purchasing model?

The answer from seasoned experts is a resounding NO. There *are* reasons why picking a single TPA makes sense: it creates greater cohesion in benefit design, makes the program more streamlined to administer, and as discussed further on, there are capabilities and resources that TPAs will need to have to manage their responsibilities effectively. However, in interviews, leaders of successful aggregated purchasing models told CPR unequivocally that retaining participating employers' choice of TPA is core to a program's success.

The reasons are two-fold and they tie directly to the pitfalls of aggregated purchasing. First, restricting the choice of TPA(s) will likely trigger *Uniqueness Syndrome*: participating employers will have unique and divergent demands specific to their plan members, which cannot be accommodated by a single TPA. Or – even if such a TPA could be identified – requiring constituents to change administrators presents yet one more obstacle that can provoke defections or attrition by inertia. Second, anointing a single TPA can provoke *sabotage* or obstruction from those passed over for the job. At best, excluded TPAs will attempt to hold onto their existing business and dissuade their clients from joining the new option; at worst, they may actively try to thwart its success (see Report #1 for examples).

**HENCE, ALLOWING EMPLOYERS TO CHOOSE THEIR OWN TPA's, BUT ISSUE SPECIFICATIONS** or strong recommendations around TPA capabilities is the recommendation from leaders of successful aggregated purchasing models. Ideally, employers should select TPAs that can do the following:

1. Administer customized benefit design
2. Maintain strong data integration capabilities
3. Manage and coordinate multiple vendors
4. Offer navigation services to help plan members identify high-performing providers, as needed
5. Have experience managing contracts that include alternative payment models, such as shared savings, bundled payment, partial and full capitation

Although most TPAs can check the first three boxes, few will offer the sophistication conferred in the fourth and fifth, but by issuing these recommendations, the purchasing group can set expectations among its participants and guide them toward more capable partners.

## **CHOOSING PROVIDER PARTNERS**

The choice of which providers to select as partners may be a luxury afforded in only in certain markets. For purposes of network access and adequacy, some markets will offer limited choice of provider partners, and in other markets the only feasible option may be to partner with *all* willing providers. With that aside, in markets where there is a choice of provider partner, here are the recommended attributes and capabilities to seek from provider candidates, culled from interviews with both employers and providers who have experience negotiating direct relationships:

## TECHNOLOGY, CAPABILITIES AND INFRASTRUCTURE

- Capabilities for better patient experience, including navigation support, after-hours access to care, and integration with onsite clinics.
- Operational infrastructure for population health management that includes uniform IT systems and an internal utilization management program.
- History of success in value-based contracts that include downside risk – in particular within the context of Medicare Advantage (which has robust shared accountability models).

## CULTURE AND STRATEGY

- Commitment to culling/curating provider network and holding individual physicians and facilities accountable for performance and outcomes.
- Culture that supports transparency and accountability to employer customers for cost, quality, and patient experience results, and requires providers to compete for business.
- Physician-anchored as opposed to facility-anchored system; a commitment to healthier patients rather than full hospital beds.

## WEATHER-PROOFING – STRATEGIES TO WITHSTAND INCOMING STORMS

Murphy's law predicts that if something can go wrong, it will. Even under the best circumstances, with favorable market conditions, the right composition of employers and ideal delivery system partners, launching and sustaining an aggregated purchasing model will be challenging. Leaders who persevered in sustaining aggregated purchasing models offer the following best practices to help these fragile endeavors persevere:

### BE PREPARED FOR PROLONGED AND UNCOMFORTABLE DISCUSSIONS WITH HEALTH CARE PROVIDERS

Confronted with data demonstrating distortions in their prices, hospitals and health systems are prone to deny the legitimacy of data, argue that their patients are more sick, old and uninsured than their competitors' patients. This points to the importance of amassing as much defensible data as possible and recruiting leaders who have experience in provider contracting. On the flip side, local employers have more leverage in provider negotiations than they might suspect. After all, when providers negotiate with health insurance companies, the providers have an automatic public relations advantage. But this advantage fades when providers negotiate directly with local employers advocating directly on behalf of patients. Especially in a local community, providers have an incentive to cooperate with employers and avoid tarnishing their reputation.

### KEEP OPEN LINES OF COMMUNICATIONS WITH THE C-SUITE

This is another point of unanimity among health care purchasers, providers and vendors: the success of any health care product model (including employer-aggregated purchasing) requires buy-in and ongoing conversation between the purchasing group and employer CEOs and CFOs. Alignment between the purchasing group and its constituents' c-suite prevents – or at least

mitigates – misalignment syndrome, by engaging decision-makers who retain a broader perspective on the long-term viability of a health care services procurement strategy.

### GET OUT IN FRONT OF EMPLOYEE COMMUNICATIONS

An employer who fails to prepare a proactive member education campaign around its new benefit or network designs, is setting itself up for employee abrasion and disruption. Taking the brave step of foregoing a traditional health plan PPO in favor of a new model will be futile if plan members do not understand the potential returns of lower premiums.

## EASIER GARDENS TO TILL – OFF-THE-SHELF MODELS; AGGREGATED PURCHASING FOR OTHER SERVICES

At this point, two things should be clear: that purchasers can recapture market power and procure higher-value health care by pooling their volumes and working directly with health care providers; and also: it's **not easy**. The optimal conditions for administering an aggregated purchasing model are rare, the work is hard and success uncertain. As such, many employers will gravitate away from cultivating their own aggregated purchasing model, opting instead for an off-the-shelf model from an external aggregator – i.e. a health plan or TPA. Others will choose to collaborate with other employers, but for a narrower band of services.

### CONSIDERING OFF-THE-SHELF MODELS – HEALTH PLANS VERSUS TPAs

Foregoing an aggregated purchasing model does not require a return to the status quo. Many health plans and SELECT TPAs offer innovative network and benefit designs that encourage plan members to select high-value providers who are held accountable for cost and quality outcomes through alternative payment models.

#### HEALTH PLAN OPTIONS

Most large health plans offer some form of “high-performance network” (HPN) in at least some of their markets. Health plan HPNs promise cost of care savings through two assumptions:

1. Provider contracts that include down-side (two-sided) risk will encourage providers to make more financially prudent care decisions – e.g. ordering lower-cost imaging studies or referring patients to ambulatory surgery centers rather than inpatient facilities for minor procedures.
2. Providers will accept lower unit prices and deeper discounts in exchange for the increased patient volume channeled to them through the HPN product and the greater control they will have over where their patients seek care.



National HPNs may appeal to some employers because they obviate the need to switch carriers or administer multiple health care products. But there are several potential problems with this strategy. First, the evidence that providers deliver greater cost-of-care savings – even when held financially accountable for outcomes – is mixed.<sup>38</sup> Also, it's questionable whether providers will accept deeper discounts in exchange for volume. Providers only benefit financially from inclusion in HPNs when, prior to the HPN's establishment, enrollees were seeking care from the provider's competitors; many providers fear that the only their existing patients will enroll in the HPN, essentially cannibalizing existing business. The third problem may be the most challenging. Health plans risk alienating providers by excluding them from high-performance networks. In fact, in some markets, powerful providers have contract clauses that *require* a health plan to include them in all networks, and in the top tier of tiered networks, whether or not they meet the criteria for inclusion.

### TPA PRODUCTS – FROM THE “MARKET MAKERS”

As an alternative to health plans, a new cadre of independent TPA vendors (who are not subsidiaries of major health insurance companies) recently entered the marketplace with innovative network and benefit design products. We call these TPAs “market-makers” to differentiate them from traditional TPAs (“market-takers”) whose value proposition is their ability to process claims accurately and on time. *Market-making* TPAs analyze quality data and contract exclusively with physicians and hospitals who achieve better clinical outcomes and patient experience. Some networks serve all patient needs from primary to tertiary care – this is the HPN model. Some TPAs also offer centers of excellence models (COEs), which operate as a carve-out from an employer's primary health plan or TPA for discrete episodes of care (e.g. joint replacement or bariatric surgery). Many COE products include a travel benefit and transport patients out of their home service area to a designated facility. Finally, there are TPAs that offer reference-based pricing (RBP). Under an RBP model, a TPA sets a maximum price it will pay to providers for health care services, which is usually expressed as a percentage of Medicare rates. If a provider charges more and balance bills a patient, the RBP vendor will negotiate payment on the patient's behalf.

The advantage of vendor-convened network products is that they can bypass many of the foibles that plague health plans. For example, by virtue of its travel benefit, the COE model avoids constraints of highly consolidated, low-competition markets. Reference-based pricing and HPN vendors can frequently procure more favorable rates than health plans can – sometimes just because of the long-standing animosity between health systems and insurance companies. Equally important is the fact that these market-making TPAs are not bound to the anti-competitive practices (anti-tiering/steering) that some hospitals and health systems enjoy with major health plans and are therefore not contractually obligated to include high-cost providers in their networks.

One final option to consider is hypothetical but compelling: employer aggregated purchasing from the market-making TPAs. While we were unable to find existing examples of this,

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<sup>38</sup> Feore, J. and Sullivan, G. “Experienced Medicare Accountable Care Organizations Generate Savings,” *Avalere*, September 18, 2018. <https://avalere.com/press-releases/medicare-accountable-care-organizations-generate-savings-as-experience-grows>

employers could decide collectively to adopt an existing HPN, COE or RBP offered in a local market. Perhaps they receive discounted administrative fees in exchange for their collective volume, but more importantly, these employers telegraph to market providers and health insurance companies that prices are unsustainable and they will take their business elsewhere. It's worth noting that this option could also work if employers collectively align with a health plan HPN; this variation on the strategy still sends a message to providers, but health insurance companies may miss the signal because employers switch insurance carriers all the time. Group purchasing of off-the-shelf health care models poses *some* of the same risks inherent in the classic model: employers must overcome their individualist tendencies and avoid the three sand trap syndromes. But the important difference is a vendor or health plan retains responsibility for building provider networks and executing the contract. As such, employers are absolved of these responsibilities, and can continue to offer the health plan's or vendor's model, even if others abandon ship.

Some employers will resist any vendor-convened model, because they aren't available in every market, thereby requiring regional or national employers to administer more than one health plan/program. As noted in the description of "Misalignment Syndrome" in report #1, employers who operate nationally have gravitated toward limiting the number of health plan options, which may automatically disqualify the addition of a local solution.

Regardless of whether employers opt for a health plan or a vendor-convened model, they still must decide whether to replace their existing PPO or to offer two products side-by-side.<sup>39</sup> A full-replacement may reduce the administrative burden for an employer's benefits team, but it increases the risk of employee disruption and friction. If the options are offered side-by-side and plan members can select between a higher-cost PPO and a lower-cost HPN, the inverse trade-off applies. Ultimately, the decision hinges on individual employer tolerance for member friction versus its administrative resources and capacity.

## CONSIDERING "LESS EXOTIC PLANTS" – AGGREGATED PURCHASING FOR HEALTH CARE-ADJACENT SERVICES

As noted, the two components of aggregated purchasing models are a) who does the aggregating, and b) what is the purchased product. The previous section examines aggregation using an *external* aggregator (a health plan or TPA); this section examines options for *employer-led* aggregation – but for services adjacent to health care services, and which avoid direct negotiations with providers. The prevalence of employers who have launched and sustained aggregated purchasing models for health care-adjacent services – such as lower health plan ASO fees or pharmacy benefits – speaks to the lower energy and resources required to get them off the ground.

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<sup>39</sup> In the case of a COE vendor, the choice is to make the benefit optional versus mandatory.

## HEALTH PLAN ASO FEES

The mileage from collectively purchasing health care-adjacent services may vary, but it avoids many of the pitfalls that ensnare efforts to negotiate for broad medical services with providers directly. In Report #1, we profiled Equity Healthcare, which purchases medical benefits on behalf of the portfolio of companies under its umbrella private equity firm. Equity's model achieved an average savings of 15% over three years (and net promoter scores >70) not only through discounts on administrative fees, but also by using its pooled volume to create a bespoke clinical model that dramatically improves the efficiency of care management. Equity Healthcare's unique relationship with its constituent companies helps facilitate its purchasing model, but other employer coalitions, like the Health Action Council of Ohio also offer discounted ASO fees and bespoke customer service for its employer members who elect to participate.<sup>40</sup> The discounted ASO fee model, if applied to a national health plan, avoids the market constraints inherent in a local, employer-convened model, and absolves employers from cultivating skills in provider contracting, network design and claims repricing.

## PHARMACY BENEFITS MANAGEMENT (PBM) SERVICES

These reasons may also explain the prevalence of employer group purchasing models for pharmacy benefits management (PBM) services. Employers Health (formerly Employers Health Ohio) and the Health Transformation Alliance (HTA), both serve constituencies of nationally based employers and offer collective purchasing of PBM solutions. Unlike medical benefits, which may exclude certain providers from a health care network and disrupt utilization patterns, pharmacy services are much more like a commodity. It is much easier, therefore, to convince employers to rally around a single PBM administrator than around a single health plan.

## HEALTH CARE-ADJACENT SERVICES

Beyond ASO fees and PBM benefits, we've found instances of employers aggregating their volume to purchase services like claims analysis by data warehouses, dental and vision benefits, and even flu shots. Some employers have gone so far as to create their *own* care delivery infrastructure, such as the partnership between Aircraft Gear Corporation, who built their own near-site clinic, and 4 other local employers who utilize it.<sup>41</sup> What these models have in common is that they avoid market constraints, will not provoke sabotage by disrupting the status quo, and evade the trappings that prevent employers from collaborating with each other. On the flip side, however, these models do little to impact the cost of medical benefits, nor do they rebalance market power in employers' favor.

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<sup>40</sup><https://healthactioncouncil.org/>, CPR Interviews, July 2020.

<sup>41</sup> Catalyst for Payment Reform, "Pioneering a Near-Site Clinic: Aircraft Gear Corporation," November 2017. [https://www.catalyze.org/wp-content/uploads/woocommerce\\_uploads/2017/11/NearSiteClinicsAGC\\_CaseStudy\\_November2017.pdf](https://www.catalyze.org/wp-content/uploads/woocommerce_uploads/2017/11/NearSiteClinicsAGC_CaseStudy_November2017.pdf)

## EMPLOYERS, HOW WILL *YOUR* GARDEN GROW?

Employers and other purchasers of health care are operating within a market-based system that does not behave like a market. It too often diminishes effective competition, resists price transparency,<sup>42</sup> and demonstrates little elasticity of demand or supply. These bizarre conditions also compel widget manufacturers to cultivate expertise in health care services procurement. Most employers are inclined to forego the complexity and take what their health plan hands to them. They should know that this comes at a cost. Dollars spent propping up broad PPO networks that include high-cost, inefficient providers divert resources from an employer's research, development and infrastructure investments; rising out of pocket health care costs for workers cuts into their wages and strains the health and well-being of the US workforce and their families.<sup>43</sup>

As hospitals and health plans consolidated, their contract negotiations devolved into proxy wars fought between mega corporations, beset by decades of antagonism and zero-sum bargaining. Vendors (aka market-making TPAs) may have better luck at making in-roads, but at the end of the day, they are motivated by the same forces as health plans (profit) and may ultimately hit the same walls. What's more, vendors will only operate in markets where there is opportunity to bring their model to scale. The truly remarkable finding from CPR's research into employer-aggregated purchasing is how much opportunity exists for collaboration when conversations occur directly between employers and providers rather than by proxy. The commonality between employers and providers is their roots in their communities and their shared accountability for the health and well-being of individuals and families, which can – in many instances – outweigh the impulse to focus exclusively on revenue and profit margin.

Aggregated purchasing models are just one of myriad ways that employers can achieve better value for their health care dollar, though perhaps one of the most potentially powerful ones. While CPR's research demonstrates that aggregated purchasing *can* work in some markets under certain circumstances, launching a successful end-run around health plans, brokers, and powerful health care providers takes resources, tenacity, and structural prerequisites which may not be within every employers' locus of control. It's not for the faint of heart.

But for employers who persevere, the rewards are manifold. Beyond the cost savings, employers who engage in aggregated purchasing through direct negotiations with providers forge pathways to collaboration that can sustain and motivate innovative care designs and payment models, as well as goals for clinical quality. Embedded in the discussion of gardens,

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<sup>42</sup> Even with the passage of new federal rules requiring hospitals to publish their standard charges prominently on a publicly available website, hospitals still strive to hide their pricing data. See: Tom McGinty, T., Wilde Mathews, A. and Evans, M., "Hospitals Hide Pricing Data From Search Results," *The Wall Street Journal*, March 22, 2021. <https://www.wsj.com/articles/hospitals-hide-pricing-data-from-search-results-11616405402>

<sup>43</sup> "To Compete Globally, America Must Up Its Game," U.S. Chamber of Commerce Foundation (March 7, 2017) <https://www.uschamberfoundation.org/reports/compete-globally-america-must-its-game-at-2>; "The Business Roundtable Health Care Value Index, Executive Summary," Business Roundtable [https://www.businessroundtable.org/sites/default/files/The\\_Business\\_Roundtable\\_Health\\_Care\\_Value\\_Index\\_Executive\\_Summary.pdf](https://www.businessroundtable.org/sites/default/files/The_Business_Roundtable_Health_Care_Value_Index_Executive_Summary.pdf) (identifying a growing "health care tab").



greenhouses and finicky plants is a clear message to employers: you are more powerful than you might think.

In fact, the real challenge for employers is **not** figuring out how they will aggregate their volume of covered lives to launch an end-run around health insurance companies. Their challenge – or really their opportunity – is to determine *which* health care model(s) will deliver the greatest value to their employees and their families. The answer, unsurprisingly, is *it depends*. In Appendix A, CPR provides a “decision grid,” which summarizes the options covered in this report and evaluates their feasibility against employer constraints and preferences. The grid allows employers to consider which models are likely the best fit given the nature of their market(s), the composition of potential employer partners, and their own tolerance for disruption, administrative complexity, and collaborating with other employers.

So, with that in mind, here's something else to contemplate. Given the rampant dysfunction in the health care marketplace and given that all trend arrows point toward greater provider consolidation and price inflation, employers should consider that certain transformative solutions will rely on intervention from *outside* the market – i.e., state and federal policies. Historically, private sector employers have recoiled at the idea of regulatory strategies; after all, unfettered free markets underpin their *own* business models. But after decades of struggle to control health care costs with only marginal yield to show for it, employers should come to recognize that any health care solution they attempt to cultivate today will be farmed on an uneven playing field. Regulation or intervention from governing bodies to enforce fair play game rules will take time and determination but may ultimately be the only way to solve the health care affordability crisis at its root.

We write this report in what is (hopefully) the waning days of a global pandemic. At this juncture, many employers may find themselves overwhelmed by COVID-19's unprecedented and far-reaching impact on their organizations and employees. Protecting essential workers from infection, setting up employees to work from home and bringing employees safely back to the worksite are challenging enough. Add countless other emerging concerns and priorities such as laying off or furloughing staff and the growing mental and behavioral health care needs of a workforce worried about emotional, physical and financial wellbeing. But great upheaval creates soft soil. In the wake of this crisis, if employers act decisively and strategically, they may find opportunity to re-shape health care in a way that better meets their needs as well as the needs of employees and their families.

## APPENDIX A: AGGREGATED PURCHASING DECISION GRID

The grid below summarizes the models profiled in this report and catalogues the requirements and preferences employers should take into consideration when deciding on strategies to pursue to amplify the value of their health care benefits spend.

MODELS		MODEL REQUIREMENTS							EMPLOYER PREFERENCES		
		Your Market				Your Fellow Employer Partners			Yourself (Employer/Purchaser)		
		Sufficient Provider competition	Providers w required capabilities	Health Plan HPN available	Vendor available in market	Self-insured; sufficient # of covered lives	Head-quartered in Situ	Excludes conflicted parties	Potential Member Friction	Administrative Requirements	Collaboration on Health Benefits w Other ERs
External Aggregator: Health plan	HPN - Multil Option	●	○	●	○	○	○	○			
	HPN - Full Replacem't	●	○	●	○	○	○	○			
External Aggregator: Vendor	HPN - Multi Option	●	○	○	●	○	○	○			
	HPN - Full Replacem't	●	○	○	●	○	○	○			
	COE Model	○	○	○	○	○	○	○			
	RBP Model	◐	○	○	●	○	○	○			
Internal Aggregator: Employers	Direct Provider Contract	◐	◐	○	○	●	●	●			
	Vendor Solution	See "External Aggregator – Vendor"				●	●	●	See "External Aggregator – Vendor"		
	Health Plan	○	○	○	○	●	◐	○			
	ASO fee Discounts	○	○	○	○	●	◐	○			
	Other (PBM, Data, Flu Vaccines etc.)	○	○	○	○	●	◐	○			

● Required	◐ Recommended	○ Not necessary/Not applicable
■ HIGH	■ MEDIUM	■ LOW

### ROW HEADINGS: MODELS BY TYPE

The Row Headings describe the universe of Aggregated Purchasing Models under consideration. The models are organized according to *who* is doing the aggregating:

- EXTERNAL AGGREGATOR – HEALTH PLAN** models administered through a regional or national health plan.
  - High Performance Network (HPN):** A curated network of high-quality, lower-cost providers, both facilities and physicians

- i. **Multi-option product:** Employer offers HPN alongside a broad network, or in some markets but not others (relevant for multi-market employers)
  - ii. **Full replacement product:** Employer offers HPN as full network replacement and the only option presented to plan members at open enrollment
- 2. **EXTERNAL AGGREGATOR - VENDOR:** A third-party administrator of an alternative network or benefit design model
  - a. **HPN alternative-option product:** Employer offers a vendor-administered HPN alongside a traditional health plan's broad network, or in some markets but not others (relevant for multi-market employers)
  - b. **HPN full replacement product:** Employer offers HPN as full network replacement and it is the only option presented to plan members at open enrollment
  - c. **Centers of Excellence (COE) Model:** COEs operate as a carve-out from an employer's primary health plan or TPA for discrete episodes of care (e.g. joint replacement or bariatric surgery). Many COE products include a travel benefit and transport patients out of their home service area to a designated facility
  - d. **Reference-based Pricing (RBP) Model:** Under an RBP model, a vendor sets a maximum price it will pay to providers for health care services, which is usually expressed as a percentage of Medicare rates. If a provider charges more and balance bills a patient, the RBP vendor will negotiate payment on the patient's behalf.
- 3. **INTERNAL AGGREGATOR – GROUP OR COALITION OF EMPLOYERS: INTERNAL AGGREGATOR**
  - a. **Direct Provider Contract:** A model under which a group of self-insured employers pool their plan member volume to contract directly with local providers.
  - b. **Vendor Model:** A model under which a group of self-insured employers pool their plan member volume to purchase health care services from an independent TPA<sup>44</sup> (see External Aggregator – Vendor, for examples).
  - c. **Health Plan ASO Fee Discounts:** A model under which a group of self-insured employers pool their plan member volume to negotiate lower administrative fees from a health plan.
  - d. **Other (PBM, Data, Flu Vaccines etc.):** Models under which a group of employers pool their volume to purchase ancillary health care services – such as pharmacy benefit management contracts, data analytics, or even flu vaccine distribution.

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<sup>44</sup> i.e. TPAs that are not captives of national health insurance companies

## COLUMN HEADINGS: MODEL REQUIREMENTS

1. **YOUR MARKET:** The existence of structural prerequisites in a given locality.
  - a. **Sufficient Provider Competition:** Competition refers to the number of delivery system entities within a given market (including physician groups, hospitals and health systems) vying for business from health care consumers. For the purpose of this requirement, *sufficient* provider competition is defined as: **At least two competing hospitals or health systems.**
  - b. **Providers with Required Capabilities:** Refers to the list of provider capabilities that both providers and employers identified as important attributes to seek in employer-provider partnerships (e.g. population health management infrastructure; a strategy for driving revenue that does not depend on filling hospital beds, etc.).
  - c. **Health Plan HPN/Vendor Model Available:** An obvious prerequisite for implementing a health plan or vendor-administered model is the existence of such a model in a local market. The existence of provider competition and/or highly capable providers does not mean that curated market models are available.
2. **YOUR FELLOW EMPLOYER PARTNERS:** The assembly of other employer-purchasers able and willing to partner within an aggregated purchasing model.
  - a. **Self-insured; sufficient # of covered lives:** Most aggregated purchasing models require employers to be self-insured. They also need to amass collectively a threshold number of covered lives to capture the attention of providers and/or health plans. Threshold volume will vary by market, but CPR's research points to at least 5,000 covered lives.
  - b. **Head-quartered in situ:** CPR's analysis of the "catch-22 of jumbo employers" points to the risk of relying on regional branches of large (multi-regional) employers for the supply of covered lives – decisions from corporate head-quarters can easily undermine a regional branch's ability to participate in an aggregated purchasing model.
  - c. **Excludes conflicted parties:** Employers may want/need to formalize their aggregated purchasing model with a governing structure, including but not limited to, board of directors, by-laws, decision-making or voting rights, etc., The governing body ideally would exclude employers with financial ties to providers, or that are providers themselves (health systems, provider groups, health plans, etc.) to avoid conflicts of interest. The participation of providers as employer-purchasers in the aggregated group, as opposed to as governance, may not pose any conflicts.
3. **YOURSELF (EMPLOYER/PURCHASER):** Measures the degree to which employers and other health care purchasers are willing to accept trade-offs inherent in aggregated purchasing models.
  - a. **Potential member friction:** the degree to which the model will restrict plan members' choice of provider, and require plan members to change their health care utilization patterns.
  - b. **Administrative requirements:** the degree to which the model will require employers to manage >1 health plan product, either within a single market, or across markets.

- c. **Collaboration on health benefits w other employers:** the degree to which the model requires collective agreement among purchasers with respect to *health care services*, and forego some degree of autonomy with respect to their benefits strategy.

## VALUATIONS

The grid evaluates a series of purchasing strategies that employers can consider to enhance the value of their benefit dollar. Each model has inherent structural prerequisites, which are indicated through "Harvey Balls" under the columns "Your Market" & "Your Employer Partners":

- A **fully shaded circle (●)** indicates a required element, without which a given model cannot function.
- A **partially shaded circle (◐)** indicates an element that is "nice to have" but not essential to the success of a given model.
- An **empty circle (○)** either means that the element is not required OR that the element is not applicable to the model in question.

Each model *also* includes a rating of **HIGH** / **MEDIUM** / **LOW** to indicate the degree to which an employer must be amenable to *trade-offs* that exist in a given model. For example, a model that is likely to induce significant restrictions in plan members' choice of provider will be labeled "HIGH" in the category "*potential member friction*". An employer with a *low* tolerance for plan member disruption would be discouraged from pursuing this option. It is noteworthy that the same model may result in lower or higher degrees of disruption or administrative complexity depending on how it is administered. For example, a high-performance network that is offered as multi-option (i.e. members can select an HPN or pay a higher premium for a PPO) will produce less member friction than an HPN that fully replaces an existing health plan. There tends to be an inverse relationship between member friction and administrative complexity: efforts to preserve the status quo option to prevent member friction will result in the administration of multiple plan products.

This grid can be read horizontally (row-by-row) by an employer who is gauging which models are its best match, given its market, the existence of coalition partners, and its own tolerance/capabilities. The grid can *also* be read vertically (column by column) in the interest of analyzing which types of models demand which requirements under which circumstances.



## READING THE GRID BY ROW –TWO EXAMPLES

### 1. EXTERNAL AGGREGATOR: HEALTH PLAN HPN (MULTI OPTION OR FULL REPLACEMENT)

MODELS		MODEL REQUIREMENTS							EMPLOYER PREFERENCES		
		Your Market				Your Fellow Employer Partners			Yourself (Employer/Purchaser)		
		Sufficient Provider competition	Providers w required capabilities	Health Plan HPN available	Vendor available in market	Self-insured; sufficient # of covered lives	Head-quartered in Situ	Excludes conflicted parties	Potential Member Friction	Administrative Requirements	Collaboration on Health Benefits w Other ERs
External Aggregator: Health plan	HPN - Multil Option	●	○	●	○	○	○	○	MEDIUM	HIGH	LOW
	HPN - Full Replacem't	●	○	●	○	○	○	○	HIGH	LOW	LOW

● Required	◐ Recommended	○ Not necessary/Not applicable
■ HIGH	■ MEDIUM	■ LOW

- Market Requirements:
  - Provider Competition – **Required** ●  
An HPN typically requires at least two health systems in a market to distinguish it from a broad access PPO.
  - Providers with required capabilities – **not applicable/necessary** ○  
Ultimately, if the health plan administers the HPN, it is incumbent upon it to manage providers within it, and proffer resources and capabilities to bolster its success.
  - Health Plan HPN available – **Required** ●  
Even if all other conditions are perfect, if there's no health plan HPN available in a market, it's not an immediately viable model.
  - Vendor available in market - **not applicable/necessary** ○  
In this example, a health plan – not a vendor – administers this model.
- Your Fellow Employer Partners - **not applicable/necessary** ○
  - External aggregators like health plans obviate the need for employers to drum up sufficient volume on their own. Consequently, none of the criteria in the three columns under "Employer Partners" applies.
- Yourself (Employer/Purchaser)
  - Potential member friction: Multi Option (**MED**), Full Replacement (**HIGH**). An HPN offered as multi-option alongside a broad PPO poses a lower risk of member abrasion than if it fully replaces a PPO. An HPN offered as a full replacement of a PPO poses a high degree of risk of member abrasion, as it may exclude providers with whom plan members had existing relationships or that plan members want to be able to access.

- Administrative requirements: Multi Option (**MED**), Full Replacement (**LOW**). An HPN offered as multi-option requires administration of at least two products. If the HPN is the only option the employer makes available, their administrative burden will be lower.
- Collaboration on health benefits w other employers (**LOW**): regardless whether an employer chooses multi option or full replacement, administering a health plan's HPN does not require collaboration with other employers.

## 2. INTERNAL AGGREGATOR (EMPLOYERS) – DIRECT PROVIDER CONTRACT

MODELS		MODEL REQUIREMENTS							EMPLOYER PREFERENCES		
		Your Market				Your Fellow Employer Partners			Yourself (Employer/Purchaser)		
		Sufficient Provider competition	Providers w required capabilities	Health Plan HPN available	Vendor available in market	Self-insured; sufficient # of covered lives	Head-quartered in Situ	Excludes conflicted parties	Potential Member Friction	Administrative Requirements	Collaboration on Health Benefits w Other ERs
Internal Aggregator: Employers	Direct Provider Contract	●	●	○	○	●	●	●			

- Required      ● Recommended      ○ Not necessary/Not applicable  
 ■ HIGH      ■ MEDIUM      ■ LOW

- Market Requirements:
  - Provider Competition – Recommended ●  
Health systems have little to no incentive to collaborate with employers if they exercise a monopoly; however, some markets that seem ostensibly low competition may still prove fertile for provider negotiations – especially around models focused on cost containment instead of lower unit prices.
  - Providers with required capabilities – Recommended ●  
Although not a complete deal-breaker, providers who have the right operational infrastructure, are committed to curating their physician networks and amenable to payment reform will be preferred partners in direct contracting negotiations.
  - Health Plan HPN available – not applicable/necessary ○
  - Vendor available in market - not applicable/necessary ○
- Your Fellow Employer Partners – Required ●
  - The conditions specified for employer collaborators are all relevant and requisite for an aggregated purchasing model to operate effectively (see definitions for justification).
- Yourself (Employer/Purchaser)
  - Potential member friction: (**MED**). The answer here is less of a “medium” per se and more “it depends.” The amount of member disruption under an aggregated direct contracting

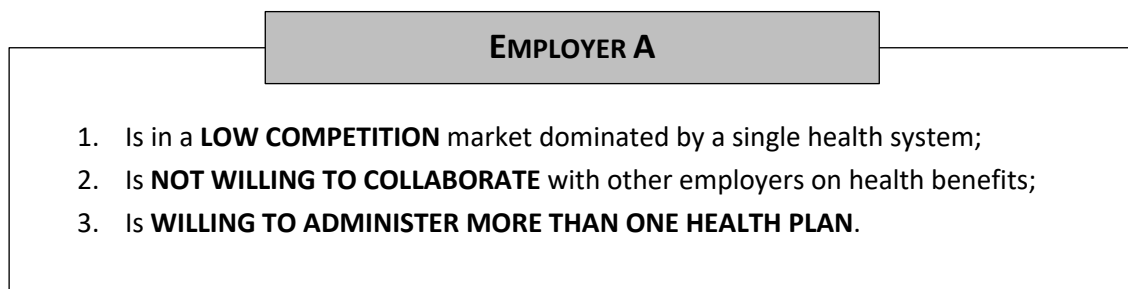
model depends on the size of the contracted provider network relative to a standard PPO. The Alliance in Madison, for example, contracts with nearly all eligible providers in their service area. But what is feasible will vary by market.

- Administrative requirements: **(MED)**. This will depend on whether an employer prefers to offer the employer-aggregated network as multi-option alongside a PPO, versus offering as a full network replacement.
- Collaboration on health benefits w other employers **(HIGH)**: An aggregated direct contracting model requires collaboration among multiple organizations and therefore obliges each individual employer to relinquish some degree of autonomy.

## READING THE GRID BY COLUMN – EMPLOYER SCENARIO

### SCENARIO – EMPLOYER A

This scenario profiles a hypothetical employer, who has the following constraints and preferences with respect to its benefits procurement strategy.



In this exercise, we will sequentially apply Employer A's constraints and preferences to the Summary Grid, and through process of elimination, identify which models are viable for this employer. As we cross models off the list, we shadow them grey.

## EMPLOYER IS IN A HIGHLY CONSOLIDATED MARKET DOMINATED BY A SINGLE HEALTH PLAN

SOLUTIONS		MODEL REQUIREMENTS							EMPLOYER PREFERENCES		
		Your Market				Your Fellow Employer Partners			Yourself (Employer/Purchaser)		
		Sufficient Provider competition	Providers w required capabilities	Health Plan HPN available	Vendor available in market	Self-insured; sufficient # of covered lives	Head-quartered in Situ	Excludes conflicted parties	Potential Member Friction	Administrative Requirements	Collaboration on Health Benefits w Other ERs
External Aggregator: Health plan	HPN - Dual Option	●	○	●	○	○	○	○			
	HPN - Full Replacem't	●	○	●	○	○	○	○			
External Aggregator: Vendor	HPN - Dual Option	●	○	○	●	○	○	○			
	HPN - Full Replacem't	●	○	○	●	○	○	○			
	COE Model	○	○	○	○	○	○	○			
	RBP Model	●	○	○	●	○	○	○			
Internal Aggregator: Employers	Direct Provider Contract	●	●	○	○	●	●	●			
	Health Plan ASO fee Discounts	○	○	○	○	●	●	○			
	Other (PBM, Data, Flu Vaccines etc.)	○	○	○	○	●	●	○			
		○	○	○	○	●	●	○			

● Required      ● Recommended      ○ Not necessary/Not applicable

If an employer operates in a highly consolidated market that lacks competition, every model that has "Sufficient Provider Competition" as a requirement (solid Harvey Balls) will be much more challenging to achieve or unavailable. This eliminates models involving HPNs. RBP and direct provider contracting may be possible, but employers should deprioritize. These models are shadowed in grey.

SOLUTIONS		MODEL REQUIREMENTS							EMPLOYER PREFERENCES		
		Your Market				Your Fellow Employer Partners			Yourself (Employer/Purchaser)		
		Sufficient Provider competition	Providers w required capabilities	Health Plan HPN available	Vendor available in market	Self-insured; sufficient # of covered lives	Head-quartered in Situ	Excludes conflicted parties	Potential Member Friction	Administrative Requirements	Collaboration on Health Benefits w Other ERs
External Aggregator: Health plan	HPN - Dual Option	●	○	●	○	○	○	○			
	HPN - Full Replacem't	●	○	●	○	○	○	○			
External Aggregator: Vendor	HPN - Dual Option	●	○	○	●	○	○	○			
	HPN - Full Replacem't	●	○	○	●	○	○	○			
	COE Model	○	○	○	○	○	○	○			
	RBP Model	◐	○	○	●	○	○	○			
Internal Aggregator: Employers	Direct Provider Contract	◐	◐	○	○	●	●	●			
	Health Plan ASO fee	○	○	○	○	●	◐	○			
	Discounts	○	○	○	○	○	○	○			
	Other (PBM, Data, Flu Vaccines etc.)	○	○	○	○	●	◐	○			

● Required      ◐ Recommended      ○ Not necessary/Not applicable  
 ■ HIGH      ■ MEDIUM      ■ LOW

Because Employer A is not interested in entering into a collaborative partnership around health care benefits with other employers, this also eliminates the option of aggregated purchasing of ASO benefits. Aggregated purchasing of ASO benefits requires a lower degree of collaboration than aggregated direct provider contracting, but the latter option was already off the table due to the lack of sufficient provider competition.



## EMPLOYER IS WILLING TO ADMINISTER MULTIPLE PLANS

SOLUTIONS		MODEL REQUIREMENTS							EMPLOYER PREFERENCES		
		Your Market				Your Fellow Employer Partners			Yourself (Employer/Purchaser)		
		Sufficient Provider competition	Providers w required capabilities	Health Plan HPN available	Vendor available in market	Self-insured; sufficient # of covered lives	Head-quartered in Situ	Excludes conflicted parties	Potential Member Friction	Administrative Requirements	Collaboration on Health Benefits w Other ERs
External Aggregator: Health plan	HPN - Dual Option	●	○	●	○	○	○	○			
	HPN - Full Replacem't	●	○	●	○	○	○	○			
	HPN - Dual Option	●	○	○	●	○	○	○			
External Aggregator: Vendor	HPN - Full Replacem't	●	○	○	●	○	○	○			
	COE Model	○	○	○	○	○	○	○			
	RBP Model	◐	○	○	●	○	○	○			
Internal Aggregator: Employers	Direct Provider Contract	◐	◐	○	○	●	●	●			
	Health Plan ASO fee Discounts	○	○	○	○	●	◐	○			
	Other (PBM, Data, Flu Vaccines etc.)	○	○	○	○	●	◐	○			
		○	○	○	○	●	◐	○			

● Required      ◐ Recommended      ○ Not necessary/Not applicable  
 ■ HIGH      ■ MEDIUM      ■ LOW

Since Employer A is willing to administer multiple plans, there is no need to exclude any additional models from the list of viable options; however, even if the employer was *unwilling* to administer multiple health plans, the option of aggregated purchasing for ancillary services would still remain – provided that the employer could find a sufficiently-sized cohort of other, self-insured employers who preferably have their headquarters in situ. Consequently, the two most promising models are a COE model and aggregated purchasing for other services that are not directly tied to medical benefits. The viable models are highlighted in yellow.

## APPENDIX B: REPORT METHODOLOGY

CPR used a mix of research techniques from literature review to qualitative research primarily in the form of key informant interviews. CPR conducted over 30 key informant interviews with purchasers, providers, health plans, and innovative third-party administrators. CPR completed interviews with each set of stakeholders before beginning interviews with the next group. This allowed us to hear one set of stakeholders' experiences without conflating it with information we heard from another set of stakeholders and allowed us to modify interview questions as needed. All interviewees received the interview questions in advance and were told that CPR will not attribute their comments and insights to themselves or their organizations in any final report. Senior CPR staff and board members conducted the key informant interviews. CPR also searched public websites, peer-reviewed published literature, trade journals, and grey literature, and trade press coverage of these efforts to gain additional context.

During the project, CPR sought expertise to understand the legal and regulatory barriers to employers engaging in efforts to amass volume of covered lives within a given market. CPR hired Hogan Lovells, LLC to examine federal and select state laws and regulations that impact employers' ability to engage in aggregated purchasing efforts. The scope of the federal legal analysis included general sections of ERISA law, rules for multiple employer welfare arrangements (MEWAs), fiduciary responsibilities under ERISA, administrative and enforcement requirements, applicable sections of the Internal Revenue Service tax code, the Affordable Care Act, federal preemption of state regulations, and other federal laws.<sup>45</sup> The scope of the state analysis included the impact of ERISA's preemption provisions, and specific applicable laws in California, Florida, Illinois, New York, and Texas.<sup>46,47</sup>

CPR assembled a 7-person advisory committee, composed of current and past executives of aggregated purchasing efforts, and held three advisory committee meetings between August 2020 and March 2021. We engaged committee members in multiple follow-up conversations for additional detail and clarification; some advisory committee members were also key informants whom CPR interviewed.

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<sup>45</sup> COBRA, Family and Medical Leave (FMLA), privacy and security provisions of HIPAA, the Mental Health Parity Act and Addiction Equity Act (MHPAEA), the Genetic Information Nondiscrimination Act (GINA), and the Children's Health Insurance Program Reauthorization Act (CHIPRA).

<sup>46</sup> A 50-state review was not feasible for this project. CPR selected these states because of their large populations.

<sup>47</sup> Applicable state laws included rules associated with MEWAs, group purchasing arrangements, incentives for group purchasing and other collective action, and impediments to collective action.