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WHITE PAPER

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Direct Contracting 101: Collaborations Between Employers and Health Care Providers

As employers continue to encounter escalating health care costs, many are exploring the “direct contracting” option, which allows for direct service and pricing negotiations with health care providers. While the direct contracting opportunity represents potential cost savings, these arrangements are highly complex and warrant thorough analysis and complete understanding.

This Jones Day *White Paper* provides an overview of direct contracting, outlines the benefits for employers and plan participants, and describes the practical and legal considerations involved.

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Costs continue to climb for employers that sponsor self-insured employee health benefit plans (“self-insured employers”). Adoption of high-deductible plans and narrow network products has done little to stem the tide. If anything, they have fueled employee dissatisfaction.

Meanwhile, health care providers are finding it increasingly difficult to differentiate themselves in an evolving and ever more competitive marketplace. Many providers looking to innovate and offer value to employers find themselves hemmed in by constraints imposed by large insurers.

Recently, forward-thinking employers and providers have sought to address these challenges by partnering in new and innovative “direct contracting” arrangements that bypass, to varying degrees, the role historically played by commercial payors and other third-party administrators (“TPAs”). Such arrangements provide new opportunities to collaborate on efforts to control costs and to address the specific needs of the employer and its workforce.

OVERVIEW OF DIRECT CONTRACTING

Historically, the relationship between a self-insured employer and health care providers has been an attenuated one. Self-insured employers typically engage a TPA for a bundle of services, including plan design, enrollment and customer/member service, claims administration, formation of networks, and negotiation of rates with network providers. TPAs are often subsidiaries or operating divisions of large insurance companies and are best equipped to offer the same networks and rates consistently across the range of plans they service with only minor variation. As a result, the specific needs or characteristics of a particular self-insured employer and its employee population are sometimes neglected.

In “direct contracting” arrangements, a self-insured employer and a provider organization—typically a large health system or provider network (accountable care organization or clinically integrated network)—directly negotiate key terms on which the provider will provide and manage the provision of care to the employer’s employees and dependents. These arrangements may apply to the entire spectrum of health care services for which health care benefits are provided, or they may be tailored to a specific subset of services, such as joint

replacement surgeries, cardiac catheterization procedures, or other high-volume, high-cost procedures.

Regardless of scope, at the heart of direct contract arrangements is a commitment by the provider to proactively and effectively coordinate and manage the provision of health care services to employees, with the goal of controlling the employer’s costs while improving quality of care and increasing employee satisfaction.

In a direct contracting arrangement, the employer and the provider usually seek to align their respective business interests by aligning their respective economic interests. For example, the employer may pay the provider a bonus for achieving certain agreed-upon quality and/or patient satisfaction metrics, such as hospital readmission rates, immunization rates, and infection rates. The parties may also agree upon a “shared savings” arrangement whereby the provider shares a portion of “savings” generated against a baseline for spending—savings the provider aims to achieve through its care coordination and care management efforts.

In more sophisticated direct contracting arrangements, the provider may also be responsible for sharing a portion of the downside financial risk created when its efforts to control costs or to improve quality or patient satisfaction fail. Alignment of incentives can be fine-tuned by measuring and encouraging both performance relative to cost measures and performance relative to agreed-upon quality and/or employee/patient satisfaction metrics.

The provider in a direct contracting arrangement often will assume responsibility for various TPA functions, such as complex case management or even member services. However, rarely does a provider take on all TPA functions. Accordingly, while a direct contracting relationship may to some extent eliminate the employer’s need for the full spectrum of services offered by a TPA, the employer will continue to engage a TPA to handle certain functions, such as claims administration, that require specific infrastructure and skill sets.

HOW DIRECT CONTRACTING BENEFITS EMPLOYERS

Direct contracting arrangements offer self-insured employers a unique opportunity to gain control over both the quality and

the escalating cost of health care benefits. Working directly with the providers of care, self-funded employers can design an arrangement that is custom-tailored to meet the specific needs of its employee population.

For example, a provider might agree to specific services designed to enhance employee satisfaction, such as basic primary care services at a convenient, on-site health center, urgent care services in close proximity to the employer's work site(s), or "concierge" style member services specifically designed to assist employees and their dependents with questions regarding benefits and to help them find the right provider for a given medical condition.

Similarly, the parties might choose to address areas of specific concern to the employer and its workforce by requiring adherence to measurable quality and patient satisfaction metrics.

Lastly, to address the paramount issue of cost, the employer and provider might negotiate reimbursement rates to be paid to the provider that account for the historical or (in the case of primary/preventative care) desired utilization of services by the employer's covered population.

Through direct involvement with the provider and regular monitoring and reporting on its performance, employers gain a level of transparency into costs and quality that is uncommon in typical TPA arrangements. With this additional information, employers can use their resources to secure the best combination of value and service for their specific workforce.

HOW DIRECT CONTRACTING BENEFITS PROVIDERS

For health care providers, direct contracting arrangements offer a chance to differentiate themselves in an increasingly competitive market. Direct contracting arrangements embody the belief that "health care is local" and can serve to build valuable bonds between health care providers and their local employer and patient constituents. They also create an opportunity to showcase providers' ability to control costs, coordinate care, and improve patient satisfaction in ways that cannot be done by large insurers or third-party administrators.

For health systems and fledgling networks of providers, such as accountable care organizations and clinically integrated

networks that are just beginning to make the transition from "volume to value," direct contracting can be a steppingstone to larger-scale value-based arrangements that involve taking on more risk and responsibility.

PRACTICAL CONSIDERATIONS FOR DIRECT CONTRACTING

Direct contract arrangements are complex and require navigating and coordinating relationships between and among the employer, the provider, and the TPA. The provider may assume responsibilities and provide services typically provided by insurers and TPAs, such as case management, quality improvement, and even member service functions. An employer will want to be satisfied that the provider has the administrative capacity and expertise necessary to provide such services. In addition, the provider's responsibilities and functions may need to be carefully coordinated with those of an employer's TPA, in order to eliminate the chance of unintended "gaps" in responsibilities.

Establishing meaningful yet realistic cost and budget targets often requires a level of actuarial acumen that neither the employer nor the provider has. Consequently, the parties may need to engage a qualified actuary—not only to assist with the development of the financial arrangement but also to provide support when claims and other data must be collected and analyzed to assess the provider's performance.

Direct contracting arrangements are best suited for self-insured employers that have large numbers of employees within the provider's geographic service area. Regardless, network adequacy and capacity must be carefully assessed, in order to ensure that employees have convenient, reasonably timely access to care. If geography or the size of the provider dictates that other providers also participate as in-network or preferred tier providers, efforts to manage and coordinate care across all network providers may pose challenges that hinder the effectiveness of the arrangement.

The employer will need to consider plan design issues. Typically, employers have relied on their TPA for a self-insured plan design (often based on one of the TPA's own insured products). This permits the employer to draft plan documents and participant communications based on policies, evidence of coverage, summaries of benefits and coverage, and

other documents furnished by the TPA. With direct contracting, the employer will need to decide whether the benefit plan design for any narrow network it negotiates will have a standard or custom design and will need to draft plan documents and participant communications accordingly. While custom documentation can be more costly, the benefits achieved through a custom designed plan may well outweigh the added administrative expense.

Finally, successful direct contracting arrangements demand that both employers and providers gain a detailed understanding of the payor, administrator, and provider functions. Employers will need a greater understanding of how care is actually delivered and of the health needs of the employee population. Providers must understand the employer's benefit structure and the incentives it creates for employees in need of care and must realistically gauge their own ability to serve the employee population. Both parties need to learn about population health analytics and the metrics that are available for assessing the quality of health care delivered and any savings achieved.

LEGAL CONSIDERATIONS FOR DIRECT CONTRACTING

Employers and providers negotiating direct contract arrangements will need to ensure compliance with an array of legal issues, some of which may be new to them.

Sharing in the financial gains/losses generated by the arrangement could implicate state insurance laws, which vary from state to state. Depending on the state and the terms of the arrangement, a provider could be required to obtain a license to operate as an insurer or other type of risk-bearing organization. Likewise, a provider might be subject to other state licensure or permitting requirements, even potentially as a TPA or network administrator. In some cases, discussions with state regulators may be needed to resolve ambiguity in state laws before agreeing on final terms. Generally, insurance regulators are supportive of efforts to lower costs and improve quality, but they expect the parties to understand and ensure compliance with state insurance laws.

Employers and providers must also be attentive to issues that may arise under the Employee Retirement Income Security Act of 1974 ("ERISA"). For example, if the provider contracts directly with the self-insured plan to provide plan administrative

services, the contract will be subject to ERISA prohibited transaction rules governing service provider contracts. Under these rules, the compensation paid to the provider under the contract must be reasonable, and the contract itself must be terminable without penalty upon reasonably short notice under the circumstances to prevent the plan from becoming locked into an arrangement that has become disadvantageous.

The assumption of certain responsibilities may make the provider an ERISA fiduciary of the plan. In such cases, the contract must be structured to ensure that the provider will act in accordance with the duties of care and loyalty under ERISA, avoid conflicts of interest, and refrain from participating in transactions that are *per se* prohibited under ERISA's prohibited transaction rules. For example, a fiduciary generally cannot use its authority to cause the plan to pay compensation to itself or to another party in which it has an interest, as such payment may affect the exercise of its best judgment. Accordingly, if any part of claims administration is delegated to the provider, the parties should ensure that the arrangement is structured such that the provider is not permitted to use discretionary claims and appeals authority to direct the use of plan assets to pay itself or related parties.

Through a direct contracting arrangement, a provider may receive more information and data about employees and their dependents than is typical. The provider may also wish to share such data with others in order to effectively manage the care of the employee population. Accordingly, providers will need to be particularly sensitive to the limits imposed by Health Insurance Portability and Accountability Act ("HIPAA") and other federal and state privacy laws. A provider contracting directly with an ERISA plan to provide administrative services may be subject to HIPAA both as a business associate and as a covered health care provider and must therefore be particularly mindful of how it receives and shares protected health information. Similarly, the exchange of particularly sensitive information, such as information related to behavioral health and substance abuse treatment, can implicate laws that require more stringent data protections than HIPAA.

As with any other group health plan, the employer must ensure that the plan is designed and administered in accordance with applicable laws, including ERISA, the Affordable Care Act (a.k.a. "Obamacare"),¹ mental health parity rules, HIPAA, COBRA,² genetic information nondiscrimination rules, the Americans with Disabilities Act, etc.

Finally, as with any payor contracting arrangement, the parties should be cognizant of potential antitrust issues. Provider systems or networks that contract jointly for independent physicians must be particularly careful to develop and maintain a robust antitrust law compliance program, especially if the arrangement involves negotiating rates and terms that will apply to providers who are otherwise competitors. Certain risk-sharing arrangements among providers and/or significant clinical integration may enable competing providers to contract jointly under the antitrust laws, but establishing such arrangements can be complex and providers should undertake them only with the assistance of experienced counsel.

THE UPSHOT

As the health care marketplace transitions from volume to value, direct contracting arrangements offer a unique opportunity for employers and health care providers to work together to achieve affordability, quality, and patient satisfaction. However, there is no “one-size-fits-all” approach, and the potential complexity of such arrangements should not be underestimated. Accordingly, leaders on both sides of the table should be prepared and equipped to carefully assess and resolve the many business and legal issues that may drive the success or failure of the arrangement.

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ENDNOTES

- 1 The Patient Protection and Affordable Care Act (“PPACA”; P.L. 111–148, 124 Stat. 119), and its companion amendment, the Health Care and Education Reconciliation Act of 2010 (“HCEERA”; P.L. 111-152, 124 Stat. 1029),
- 2 Consolidated Omnibus Budget Reconciliation Act of 1986, as amended.

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