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## SPECIAL ARTICLE

## A Physicians' Agenda for Partnering With Employers and Insurers: Fresh Ideas

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### Abstract

We report the results of the second phase of a multiphase qualitative investigation of the ways physicians, employers, and insurers can work together more effectively to provide better ambulatory care to employees and their dependents. This article focuses on ways physicians can develop more useful relationships among these groups. We used a grounded theory approach to conduct 71 interviews from August 12, 2004, to December 27, 2005, with 25 practicing physicians in large and small groups, urban and rural areas, private and academic settings, and primary care and specialty practices; 33 hospital administrators, medical association executives, health insurance medical officers, and health policy analysts; and 13 senior executives of large and small companies. The study identifies 2 approaches to the structuring of ambulatory care that can lead to improved health care outcomes and value. In the first approach, direct contracting between physicians and employers transfers tasks previously performed by insurers to employers or other intermediaries who may be able to provide better service or lower cost. In the second approach, insurer-mediated relationships between physicians and employers are restructured, particularly in ways that improve information flow. Such relationships may strengthen physicians' ability to provide quality services while enabling patients to make more informed decisions about physician selection, treatments, and spending. We believe that broader use of these approaches may improve the quality and efficiency of ambulatory care for the large proportion of the population that has work-related health insurance. Although the findings are promising, our intent is not to claim broad external validity but rather to encourage greater experience with these approaches and more formal studies of their effectiveness.

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Although physicians work in the microsystems at the cutting edge of ambulatory care, employers and insurers play key roles in the mesosystems and macrosystems that provide the broader context for that care.<sup>1</sup> Employers pay for most private health care in the United States,<sup>2</sup> and insurers are the intermediaries between employers and physicians. The goals of each group are reasonable and compatible (Table 1); that is, each party wants health care to be more effective and efficient without jeopardizing its own financial interests.<sup>4,12</sup> However, in practice the groups often have adversarial or distant relationships.<sup>3,15,16,21,22</sup> Physicians are frustrated by insurers' reimbursement rates and cumbersome claims processing procedures, including referrals and authorizations.<sup>15,16</sup> Employers traditionally have permitted insurers to insulate them from physicians (Figure 1, A).

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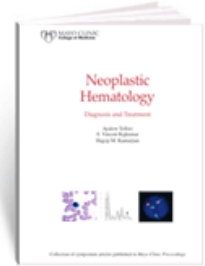
At first glance, the idea of collaborating directly with employers or insurers may seem unlikely or uncomfortable to many physicians, most of whom are consumed with the everyday task of delivering care<sup>23-25</sup> and have not been trained in business.<sup>26</sup> However, accepting the status quo seems even more unrealistic, especially for primary care physicians who face intense practice management and financial pressures<sup>6-11,25,27-29</sup> and have little capacity for investment in office-based quality improvement initiatives.<sup>3,12-14</sup> More fundamentally, improving quality in any part of the economy—including health care—requires involvement and leadership by the people who do the work.<sup>14</sup> In health care, physicians do much of this work and thus have an important opportunity, as well as some degree of obligation, to lead the way to better care.

The observations presented in this article are part of a multiphase project designed to explore ways in which physicians, employers, and insurers might restructure their working relationships to improve health care outcomes and value for employees and their dependents. In an earlier phase,<sup>30</sup> we focused on how employers can manage employee wellness and health care costs more proactively. In this phase, we have explored the collaborative actions that physicians can take.

**METHODS**

Our methods were designed to generate hypotheses about the ways physicians, employers, and insurers can restructure their relationships to improve the delivery of ambulatory care. We used grounded theory, an approach developed in sociological research in which the theory emerges from extensive study of the data and is then illustrated by representative examples of the data.<sup>31-34</sup> The researcher does not have a preconceived theoretical framework. Rather, the process begins with an open investigation of the problem area. Detailed notes are taken, coded, and analyzed. The new theory emerges as the data are compared with existing theory. The study sample is then expanded to include other examples that may indicate the boundaries of the theory. The data collection–analysis–theory development cycle continues iteratively until further searching no longer disconfirms the emerging theory. In our case, the approach identified ways health outcomes and value can be improved by replacing the often adversarial relationship among physicians, employers, and insurers with a cooperative relationship.

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| <b>TABLE 1. COMMON SCENARIO: PHYSICIANS, INSURERS, AND EMPLOYERS AS ADVERSARIES</b>  |   |  |
|--|---|--|
| <b>The goals of physicians, insurers, and employers are reasonable and potentially compatible. Each party seeks to improve health care quality and reduce waste while protecting its financial interests ...</b> |   |  |
| <b>Physicians want to</b>  | <b>Insurers want to</b>   | <b>Employers want to</b>   |
| Spend more time with patients, less time resolving administrative hassles  | Minimize claims payouts   | Reduce growth in health care spending or, for some employers, cut back or eliminate health care spending |
| Regain autonomy in medical decision making   | Achieve an attractive profit                                    | Minimize management time invested in employee benefits issues  |
| Earn an attractive compensation  |   |  |
| <b>But strategies are uncoordinated and focus narrowly on individual goals. Too often, the strategies conflict with those of other parties ...</b>   |   |  |
| <b>Physicians' strategies include</b>  | <b>Insurers' strategies include</b>                             | <b>Employers' strategies include</b>   |
| Invest in administrative overhead to handle the complex claims reimbursement <sup>3</sup> process  | Negotiate lower reimbursement levels with physicians            | Focus health plan negotiations on cost and network size <sup>5</sup>                                     |
| Increase patient volume to compensate for lower reimbursement per patient <sup>3</sup>   | Require preauthorization to discourage unnecessary procedures   | Tighten eligibility requirements for participation in employer-based insurance <sup>5</sup>              |
| Emphasize delivering care through billable procedures  | Promote electronic claims filing to reduce administrative costs | Pass a portion of health care cost increases to employees <sup>6-11</sup>                                |
| Develop revenue streams from ancillary services <sup>3</sup>   | Enforce claims-filing requirements to minimize                  |  |

|  |   |  |
|--|---|--|
|  | inappropriate claims  |  |
| Sometimes reduce services to uninsured and high-risk patients <sup>4</sup>                                   |   |  |
| <b>As a result, quality, satisfaction, and efficiency gains have been hampered and mistrust prevails ...</b> |   |  |
| <b>Undesirable results for physicians</b>  | <b>Undesirable results for insurers</b>                           | <b>Undesirable results for employers</b>   |
| Declining levels of physician career satisfaction and morale <sup>3,12-14</sup>                              | Low trust by patients, physicians, and employers <sup>17-20</sup> | Escalating health care costs threaten to compete <sup>4</sup>                            |
| Limited investment in quality and productivity improvement initiatives <sup>15,16</sup>                      |   | Employees are dissatisfied with cost increases and health plan restrictions <sup>5</sup> |
|  |   | Medical care and disability costs from chronic disease increase                          |
|  |   | Take-up of health insurance benefits is reduced, particularly among lower paid workers   |

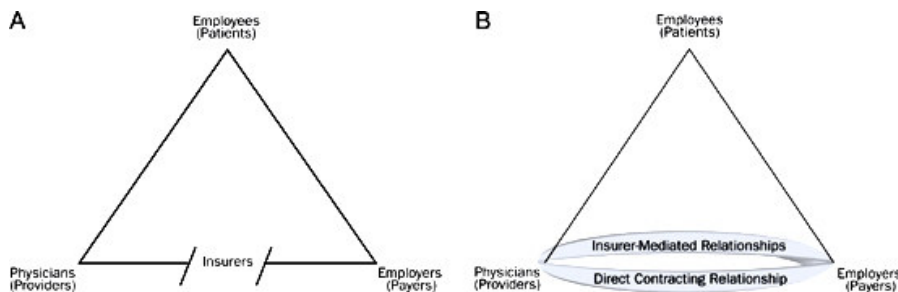


FIGURE 1. Models of physician-employer relationships. A, Existing model in which insurers insulate physicians and employers from each other. B, Proposed partnership model in which the relationships among physicians, employers, and intermediaries are focused on improving health care outcomes and lowering costs.

## PROJECT DESIGN

The study included 71 interviews conducted from August 12, 2004, to December 27, 2005. Our respondents included 25 practicing physicians in large and small groups, urban and rural areas, private and academic settings, and primary care and specialty practices. Another 33 respondents, two thirds of whom were physicians, included hospital administrators, medical association executives, health insurance medical officers, and health policy analysts. Employer interviews were conducted with 13 senior executives of large and small companies.

## DATA COLLECTION AND INTERPRETATION

We began by identifying participants (approximately one quarter of the total) who we believed would be knowledgeable about both clinical practice and business and would help us identify novel approaches to collaboration. The rest of the sample was then selected using the snowball sampling method in which interview participants referred us to others, an appropriate technique when the goal is hypothesis generation.<sup>35</sup> We conducted semistructured interviews of participants by telephone. Typically, 2 of the authors (L.L.B., A.M.M.) interviewed each participant for approximately 30 minutes, with one taking detailed notes. Interviewees frequently sent additional information as a follow-up to the interview.

Our first 17 interviews were with clinicians. Interview questions focused on the challenges physicians face in clinical practice and ways business might be able to help. We analyzed the interview transcripts, looking for novel ideas about how physicians could work with business in ways that could improve patient health, system

efficiency, and financial performance. We synthesized the emerging themes into a conceptual model of physician partnerships with employers and insurers. We refined the model during a second wave of interviews with 33 respondents, 28 of whom were physicians. Participants identified strengths and weaknesses of the draft model and proposed changes. Finally, we validated the feasibility of the revised model in a series of interviews with 21 business and insurance executives who could potentially partner with clinicians. We continued interviewing participants in each phase of the study until the marginal value of additional interviews was minimal.

**RESULTS**

The need for change was frequently and forcefully expressed by many respondents. An infectious disease specialist noted, “The biggest pressure I have as a doctor is to deal with insurance to get paid for what we do. Seeing patients is a piece of cake.” The director of benefits of a medium-sized employer said, “I wouldn’t consider us partners with our insurer. Every year we have the battle of premiums and administrative fees. It’s not much of a partnership.” (See [Table 2](#) for additional responses.)

Two broad opportunities for physicians to establish more productive partnerships emerged from the data ([Figure 1, B](#)). The first is for physicians to bypass insurers and contract directly with employers to provide health care services to employees and dependents. The second is for physicians to establish more productive and extensive relationships with insurers that, in turn, can strengthen insurers’ relationships with employers.

**DIRECT CONTRACTING BETWEEN PHYSICIANS AND EMPLOYERS**

Direct contracting is a promising model for improved physician-employer relationships ([Figure 2](#)). The medical director of a large employer that uses direct contracting said, “Medical groups loved the idea of direct contracting with us. No one turned us down. They had never before had a chance to talk to employers. The chance to work directly with an employer was appealing. We had them over and described where we were trying to go. We asked them to participate when we developed guidelines. We sent our drafts over for comment. We went out of our way to pay promptly.”

In a direct contracting relationship, the physician collaborates with an employer to provide health services to employees and dependents, either on company premises or at the physician’s office. We found that large medical groups, small groups, and solo practitioners were participating in direct contracting relationships. Employers appeared to favor physicians with board certification, an uncluttered history of malpractice litigation and complaints, and the ability to build interpersonal relationships with patients. Participating employers are typically self-insured firms with more than 200 employees, rather than smaller firms that purchase health coverage through an insurer.

Direct contracting relationships often consist initially of agreements between employers and primary care physicians; specialist relationships may be added later. Compensation is typically fee for service, and employers commit to prompt reimbursement. Physicians usually work with the employer’s medical director to establish clinical guidelines and patient satisfaction goals. Agreements typically stipulate that the physician is responsible for directing care and provide for noninterference by the employer. [Figure 2](#) lists common responsibilities of employees and physicians.

Employees and their dependents typically have a financial incentive to use company-contracted physicians but have the flexibility to seek care elsewhere. In some firms, employees choose on a visit-by-visit basis; in others, employees choose annually among health plans, with one option being lower-cost company-contracted physicians.

| <b>TABLE 2. ILLUSTRATIVE INFORMANT STATEMENTS</b>   |
|---|
| <b>The Need for Change</b>  |
| “There are differing reimbursement rules among insurers. That is an issue. I think it is a nightmare for physicians.”— <i>Chief medical officer of a health insurer</i>   |
| “The amount of resources we dedicate to getting paid is embarrassing. To the extent that business as the payer can be empathetic may create interesting solutions.”— <i>Hospital chief executive</i>  |
| “The growing image of health insurers is that they will do everything in their power to deny claims. Employers are fighting costs. Employees are angry with costs. Physicians feel no one appreciates them. It’s a dysfunctional family.”— <i>Chairman of a medium-sized employer</i> |
| “The only entity that truly cares about health care costs is the employer.”— <i>Internist</i>   |
| “As the CFO [chief financial officer] of a privately held company, nothing bothers me more than how I am  |

going to provide health care for my employees for the next 10 years.”—*Chief financial officer of a medium-sized employer*

“You will frequently hear physicians rant and rave about those lousy insurance companies and if you then ask them when they last actually sat down with someone from the insurance company to discuss specific issues, concerns, or strategies, their response is frequently, ‘Well, I’ve never actually done that.’”—*Internist*

“Don’t trash me, the employer. I, the employer, am not the enemy. I want what you want: healthy people. Why argue with the people who are employing half the population? Why not work with us?”—*Chief medical officer of a large employer*

#### **Promise of Direct Contracting Between Physicians and Employers**

“I believe solutions to this dilemma of spiraling costs will be found at the community level, not at the federal level.”—*Surgeon and chief medical officer of a multispecialty clinic*

“I could get excited about going into a workplace and talking to people about taking responsibility for their own health, how to deal with stress effectively, how to eat better. I see people who have stress issues and complain about their workplace environment.”—*Family physician*

“The thing that appeals to me the most is the direct pay model because I think it has a better potential to work. The key is to understand employees and to really identify what they want. The secret to improving their participation is education *and* incentives. Incentivize employees to do the things that are beneficial to their long-term health. And the employer is in a position to do that.”—*Internist and medical director of a large group practice*

“A company just came into our area adding 400 new employees. This is a prime opportunity for a large multispecialty practice to reach out and offer high-risk disease management, safety and injury management with aggressive care of injuries such that employees feel good about the care. This could be packaged as a recruiting tool for workers. For the physician it provides a more stable base income.”—*Registered nurse and hospital system quality improvement executive*

“We’ve studied how you put a complete EMR [electronic medical record] and decision-support system in a doctor’s office. The doctor does the “I” of the ROI [return on investment] and the payer gets the “R.” EMRs would reduce the amount payers fund by 15%. So why not have employers pay for EMRs in return for gain sharing?”—*Chief information officer of a hospital system*

“I like the idea of a direct pay model. My staff could be half the size if we didn’t have to work so hard to get reimbursed by insurance companies.”—*Otolaryngologist*

“I like getting rid of the middleman. I would love to be able to have the discussion with business to tell them the stupid things we are dealing with.”—*Family physician*

“Several of my patients wanted me to be their company physician. One particular patient asked me 3 times before I agreed to look into it. Now [as a physician practicing at a company clinic], I get dependable reimbursement for my time; convenience and cost-savings for my patients, who are generally more appreciative of my time and services than even the patients at my own practice; and new referrals by the patients into my nursing home and office practice.”—*Family physician with a 1 ½ -day per week direct contracting arrangement*

“It breaks my heart that direct contracting is so rare. Couple this with evidence-based care and we could solve this mess. I think the issue is it’s time and energy intensive. Most employers tell me they are in the cereal business or the widget business, not the medical business. I say, ‘Of course you’re in the medical business. You’re spending as much on medical care as you earn in profits.’”—*Physician and chief medical officer of an employer that uses direct contracting*

#### **Promise of Insurer-Mediated Relationships Between Physicians and Employers**

“Pay physicians to talk to patients. The rise in alternative medicine is because each of its branches involves touching people and connecting with them. If you come back to a high-touch system, you address the critical issues in people’s lives such as stress, diet, exercise, smoking and drinking.”—*Physician and chief medical officer of a health insurer*

|   |
|---|
| <p>"Your model is our model. We grew our hospital system just to get critical mass with insurers. We got big enough so they can't ignore us. We created a dialogue. We told them what we wanted and asked what they wanted."—<i>Physician and chief executive of a rural hospital system and physician group</i></p>  |
| <p>"Our partnership with the insurer is truly a collaborative effort. We meet weekly. We developed a model to rank things, determine how we'll get paid and what the pot of money will be. We have set aside to an impressive degree all the old crap."—<i>Physician and chief executive of a large oncology practice</i></p>   |
| <p>"We have learned that if you don't have a relationship and if you don't work collaboratively on projects you lose communication. Administrative hassles and claims are resolved more easily when there is a relationship in place. The whole negotiation goes easier because you start from a place of mutual understanding."—<i>Physician and medical director of a health insurer</i></p>  |
| <p>"Insurance companies don't do a good job of cementing relationships with employers. They could provide meaningful reports—reports showing where the dollars are being spent, benchmarking expenses compared to similar employers, looking at the overall health of a firm's employees, and assessing plan design in terms of the company's objectives."—<i>Chief executive officer of an independent physicians' association</i></p>                   |
| <p>"Our members get services from people we don't employ. How do you make sure your customers get excellent service if you don't directly control it? We've concluded that partnering is more effective than hitting people over the head with a stick."—<i>Physician and vice-president of a health insurer</i></p>  |
| <p>"We recognize that medicine in the future will require us to measure performance and improve on it, rather than say we do a pretty good job and leave it there."—<i>Physician and associate medical director of a large multispecialty practice</i></p>  |
| <p><b>Words of Caution</b></p>  |
| <p>"Change happens when the pain of the status quo exceeds the perceived pain of change and we're not at that point yet. Health plans are doing well."—<i>Manager of health care programming for a large employer</i></p>   |
| <p>"In talking to employers, I've found that, while they may be in pain, it is very difficult to get them to do anything around health care other than tweaking the co-pay. The CEO [chief executive officer] may send you to the VP [vice president] of human resources who tends not to be a change agent. It's difficult to find the right people to listen."—<i>Internist interested in doing direct contracting</i></p>                              |
| <p>"For direct contracting, you need a special company with a special vision, a company that has run out of other options."—<i>Principal of an employee benefits consulting firm specializing in direct contracting</i></p>   |
| <p>"One of the great dilemmas we have is that people want unlimited access. In the direct pay model, you will highly limit choice. I don't think patients are going to buy it. Physicians will like the steady income stream from a long-term contract with an employer. It will simplify their lives. What's in it for the employee? Financial incentives? A vetted physician group?"—<i>Physician and chief medical officer of a health insurer</i></p> |
| <p>"I'm still leery of whether the direct model can work. You need to have the right doctors in the direct network. People are constantly disappointed to go through HMO [health maintenance organization] and PPO [preferred provider organization] lists and find that their doctors are not on the list of providers."—<i>Owner of a medium-sized employer</i></p>   |
| <p>"Companies considering direct contracting need to have a 3-year time horizon. The significant savings come in years 2 and 3. The focus on prevention often does not show a material return for 2 years."—<i>Principal of consulting firm that develops direct contracting relationships</i></p>  |
| <p>"The physician needs to have enough of the business's employees in the patient group to justify the internal administrative hurdles involved in setting up a payment system to a captive medical group."—<i>Physician and corporate medical director of a large employer</i></p>   |
| <p>"Adoption of EHR [electronic health record] and decision-support tools—the whole IT [information technology] piece— shouldn't be another prong in a multiprong paradigm, but should really be the central part of the model, the unifying part. IT is the cohesive bond. If that's not fixed it's silly to talk about these models."—<i>Physician and senior executive of a health insurer</i></p>   |

Direct contracting relationships have been initiated by physicians and by employers. Occasionally, the employer's human resources staff directly negotiates the contracts. Frequently, intermediaries facilitate the

administrative contacts between the physician and employer, performing functions traditionally handled by insurers. For example, an intermediary may develop the physician network by negotiating terms with participating physicians. Other intermediaries may administer benefits and claims and review utilization. These intermediaries do not assume risk or interpose clinical or fiscal policies. They are strictly administrative, which makes them fundamentally different from insurers.

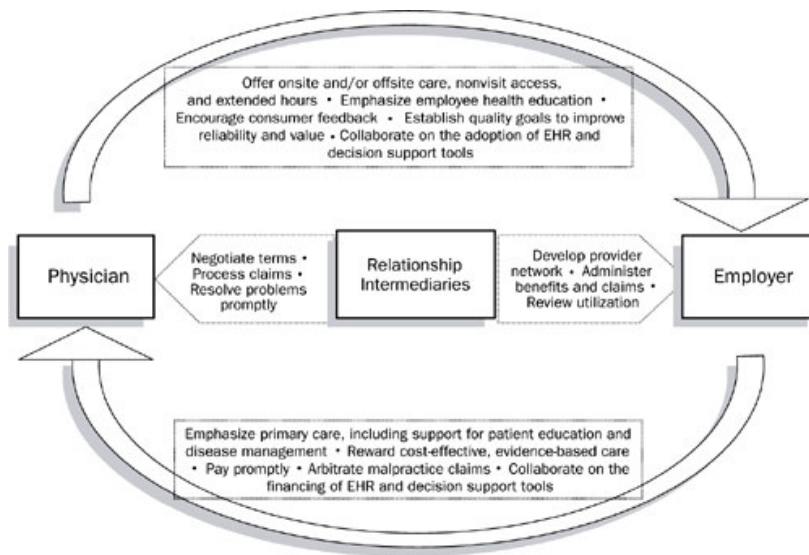


FIGURE 2. Direct contracting relationship between physician and employer. EHR=electronic health record.

The experience of Perdue Farms and physicians in rural Maryland and nearby states is illustrative. Perdue established direct contracting relationships with health care professionals in small and large practices to provide onsite and offsite care for Perdue's 45,000 employees and dependents. Perdue built onsite primary and specialty care clinics at its chicken processing plants. Employees and dependents receive longitudinal care for acute and chronic disease as well as preventive services. Employees are charged \$10 per visit, payable through payroll deduction. Employees complete health risk appraisals and receive personalized plans for health. Contracted physicians are supported by a single clinical laboratory. Primary care often assumes a central role in direct contracting, which is the case at Perdue. Since Perdue began contracting with physicians, primary care has increased from 6% of Perdue's physician spending to 30%. At their discretion, primary care physicians provide referrals to specialists.

Perdue reports an average annual health care inflation rate of 0.7% for 2002 to 2005, well below national trends.<sup>36</sup> Health care costs per employee, including costs of administering the plan, are approximately half the national average. Perdue attributes the savings to the direct contracting relationships that emphasize prevention and appropriate treatment of chronic conditions and reduce emergency department visits for employees with minor illnesses. Also, the onsite clinics are structured to encourage the use of evidence-based medicine and generic drugs.

Two of the programs we studied, the Perdue Farms direct contracting program and a similar program at Quad Graphics in Wisconsin, are fairly elaborate, but we also uncovered simpler direct contracting models. CareHere, a company in Nashville, Tenn, connects physicians with smaller employers who want to establish onsite primary care clinics at worksites with 100 or more employees. CareHere recruits physicians from the employer's health plan network, preferring physicians already popular with employees. Physicians we interviewed emphasized the dependable reimbursement, reduced administrative burden, and opportunity for referrals to their office practices. They perceived themselves as patient coaches rather than distrusted gatekeepers.<sup>37</sup> A board-certified family physician described his weekly 12 hours in an onsite clinic for county employees as, "A chance to get back to what medicine is all about. I spend my time taking care of patients—not filling out paperwork." Employers in the CareHere system are experiencing health care cost trends of 3%, approximately a third of national averages.<sup>36</sup> Drug costs are typically 7.5% lower in the first year and 15% lower in the second year of the direct contracting relationship.

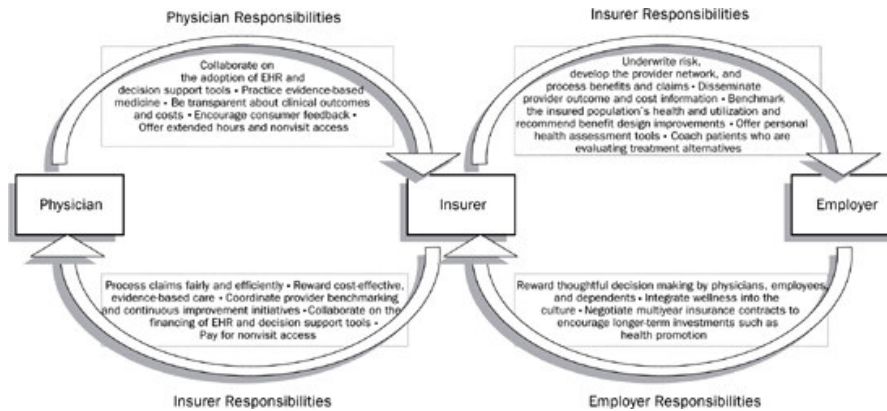


FIGURE 3. Insurer-mediated relationships between physicians and employers. EHR=electronic health record.

### INSURER-MEDIATED RELATIONSHIPS BETWEEN PHYSICIANS AND EMPLOYERS

In this model, insurers shift their missions from minimizing claims costs to improving health care value (Figure 3). The insurer-mediated model reassesses 2 sets of relationships: those between employers and insurers<sup>30</sup> and those between physicians and insurers, which we focus on herein. Our informants told us that participants in a fully evolved physician-insurer relationship will need to undertake most of the actions described on the left side of Figure 3.

During our investigations, we found examples in which physicians and insurers were able to improve quality and finances through collaboration. To illustrate, Premera Blue Cross in Washington State asked physicians to codevelop a quality scorecard, rather than imposing a reporting system. The initiative, which covered 13 clinics and 300,000 members in 2005, began in 2001 when Premera invited 6 large multispecialty medical groups to identify key quality and satisfaction indicators. A clinic medical director observed, "Premera was smart to let us build the scorecard. We can't use the 'they did this to us' excuse. And we set the bar higher than Premera might have." Contracts with some participating clinics are structured to provide financial rewards for improvements in performance over prior year results.

Such efforts were associated with documented improvement in the delivery of recommended care, particularly for low-scoring measures. For example, early results show substantial improvement among the 1200 diabetic patients with Premera health coverage seen at participating clinics: from 2003 to 2004, hemoglobin A level of less than 7% improved from 27.4% to 51.3% of patients; low-density lipoprotein cholesterol level of less than 100 mg/dL improved from 26.7% to 41.6% of patients; and systolic blood pressure less than 130 mm Hg improved from 25.9% to 38.6% of patients.<sup>38</sup>

The scorecard also gives physicians an early warning of undesired trends. For example, appropriate use of antibiotics for acute bronchitis, another low-scoring measure, improved 37.7% in 2003 and then declined 10.5% in 2004. Participating medical groups and Premera discussed reasons for the retrenchment (some physicians noted that the decline paralleled reduced media attention to the appropriate use of antibiotics<sup>39</sup>) and were then able to pay greater attention to appropriate practices. Premera is also developing desktop tools that allow physicians to see their monthly performance along with a list of their patients who are not receiving recommended care or not filling prescriptions, which enables physicians to follow up.

Insurers can facilitate cooperation among medical groups. A physician participating in Premera's quality scorecard program commented, "Doctors are competitive. If another clinic can do well at making sure congestive heart patients are on ACE [angiotensin-converting enzyme] inhibitors, then we can, too. There's an overwhelming willingness among the clinics to share their expertise so we can all get better." Cancer Care Northwest, an integrated multispecialty oncology practice in Spokane, Wash, created a program with Premera designed to improve quality, reduce waste, and improve practice finances by adopting evidence-based clinical pathways. It is now measuring adherence to the pathways, for example, tracking the percentage of breast cancer patients with sentinel lymph node sampling or appropriate axillary dissections. With Premera's encouragement, Cancer Care Northwest reached out to other local medical groups, and Spokane-area pulmonologists, surgeons, and medical and radiation oncologists are working together to develop joint clinical pathways for evaluating and treating lung cancer. The oncology group's chief executive observed, "I've been interested in quality for years but I didn't have the infrastructure or the time. In the ideal world, we should just do it, but in the real world, we

needed a partner who could structure payment programs to provide appropriate incentives.”

Insurer-physician collaborations require an appreciation of the strengths and limitations of each partner. Premera tailored a quality recognition program for small office practices, which typically lack the computer and staff infrastructure for quality reporting. The insurer reviews claims histories to recognize physicians who consistently follow national guidelines in, for example, cancer screenings or appropriate use of antibiotics.

**DISCUSSION**

Using business parlance, physicians, health insurers, and employers form the core of a distribution channel, defined as the set of interdependent organizations involved in the process of making a good or service available to the end user. However, when distribution channel relationships are dysfunctional, inefficiencies develop, and dissatisfaction is more likely.<sup>40</sup> In health care, abundant evidence has shown that the current distribution channel does not operate optimally. Patients report difficulty in obtaining access to care and to physician-level quality and price information. Physicians complain that claims processing, referrals, and authorizations are overly burdensome. Employers believe costs are too high, and physicians believe reimbursements are too low.

From our interview data, we developed a conceptual model (Figure 1, B) with 2 approaches for improving the delivery of outpatient medical care: direct contracting between physicians and employers (Figure 2) and restructured relationships between insurers and employers and between insurers and physicians (Figure 3). Our model should be considered a prospective model that conveys what could be. Although both approaches are now being used successfully, they have yet to spread widely. Measuring the extent and sustainability of their potential benefits requires more time and much more research. We hope that presenting these ideas at this early stage will stimulate that research while encouraging physicians, employers, and insurers who are dissatisfied with the status quo to consider these options.

Our findings suggest that direct contracting between physicians and employers has the potential to offer more appropriate reimbursement to physicians, reimbursement that rewards adherence to evidence-based medicine and quality results and ultimately may lead to less costly health care. Participants cited improved access to primary care, more consistent care for chronic diseases, an emphasis on preventive health and early detection of disease, and lower unnecessary emergency department use among the salient benefits of direct contracting. The assessment is consistent with the emerging literature that associates improved access to primary care with reduced illness and disease, rationalized access to specialty care, reduced socioeconomic and geographic disparity, reduced emergency department use, and lower costs.<sup>29,41-50</sup> Direct contracting participants also suggested practice innovation may be sparked by the opportunity for physicians and employers to communicate directly. Physicians may be able to reduce staff expenses for billing and collection.

The direct contracting model best fits self-insured employers with 200 or more employees who assume the financial risk of health care costs and use third-party administrators to process benefits and claims. Approximately 50% of all US employees are enrolled in self-insured companies’ plans.<sup>51</sup> Because these employers retain financial responsibility for health care costs, there is no need to carve out the direct contracting relationship for actuarial calculations. The concept holds less financial appeal for smaller, fully insured employers, who would absorb the cost of direct contracting services in addition to health insurance premiums.

Direct contracting should work best in organizations that have earned the trust of employees. Employees need assurance of a firewall between the physician and the company’s operating management, given the highly personal nature of health care and the potential for divided loyalties of physicians who work directly for their employer. Indeed, some staff physicians hired by large companies to offer onsite medical care and manage workers’ compensation programs report pressure to minimize corporate expenses rather than provide high-quality care.<sup>52,53</sup> The relationship between physician and employer cannot dominate the physician’s ethical and legal duty to the patient and achieve sustainable success.<sup>54</sup> We restrict the application of our direct contracting model to physicians and employers who are both committed to putting the patient first. Nonetheless, because the potential for divided loyalties exists, we favor direct contracting models in which patients retain the choice between company-contracted physicians and other physicians.

| <b>TABLE 3. UNCOMMON SCENARIO: PHYSICIANS, INSURERS, AND EMPLOYERS AS PARTNERS</b>  |  |  |
|---|--|--|
| <b>Physicians, insurers, and employers engaged in progressive partnerships will be more likely to adopt goals and behaviors related to the larger goals of improved health care outcomes and efficiency ...</b> |  |  |
| <b>Physicians will tend to push to</b>  | <b>Insurers will tend to push to</b>           | <b>Employers will tend to push to</b>                            |
| Provide evidence-based care   | Improve the health of the entire insured group | Observe improved efficiency, effectiveness, and safety of health |

|  |  |  |
|--|--|--|
|  |  | care services for employees and dependents                               |
| Improve practice productivity  | Assure quality of services paid for  | Stabilize health care cost increases                                     |
| Earn an attractive compensation  | Minimize inappropriate claims payouts  |  |
|  | Achieve an attractive profit   |  |
| <b>The partners align incentives to encourage coordinated strategies ...</b>   |  |  |
| <b>Physicians are more likely to</b>   | <b>Insurers are more likely to</b>   | <b>Employers are more likely to</b>                                      |
| Invest in electronic health records  | Track physician performance initially measuring adherence to preferred processes and eventually measuring outcomes | Encourage and educate employees to make thoughtful health care decisions |
| Invest in evidence-based decision-support systems  | Recognize high-performing physicians with meaningful, timely rewards   | Offer personal health assessments and identify appropriate interventions |
| Be transparent with outcomes and cost information  | Disseminate physician outcome and cost information to employers and patients                                       | Integrate wellness into the company culture                              |
| Invest more in patient education and counseling  | Coach patients who are evaluating treatment alternatives   | Emphasize prevention   |
| Offer extended hours and nonvisit access   |  | Demand and reward quality from health care physicians                    |
| <b>As a result, the health care system is strengthened and channel members are rewarded for strong performance ...</b> |  |  |
| <b>Physicians are more likely to achieve</b>   | <b>Insurers are more likely to achieve</b>   | <b>Employers are more likely to achieve</b>                              |
| Safer, more effective, patient-centered care delivered in a timely, efficient, and equitable manner                    | Better decision making by patients   | Reduced incidence of lifestyle diseases                                  |
|  | Continuous improvement among physicians  | Reduced regional variation in care                                       |
|  | Improved reputations   | Improved employee productivity and job satisfaction                      |

Although the direct contracting model is promising in certain situations, we believe insurers will continue to mediate most relationships between physicians and employers. Insurers underwrite risk, a critical requirement of smaller employers. Moreover, many employers and physicians will be reluctant to invest the time required to establish direct contracting relationships. In addition, some employees may prefer access to noncontracted physicians or need such access when they require highly specialized care or are traveling.

Our findings suggest that the health care system will be better served by physician-insurer interactions characterized by open communications and cooperation, thus facilitating the pooling of resources to better understand and care for patients. Although insurers will continue to manage risk, they can add value by focusing less on managing costs and more on managing information in ways that help physicians, patients, and employers make better decisions about care. Insurers can help employers reward innovative physicians who achieve superior clinical outcomes, adopt proven medical practices, and satisfy patients. We believe the distrust that physicians, employers, and patients harbor for insurers<sup>15,16,55</sup> could help motivate these changes. Insurers

hold substantial power in the current structure. Organizational research suggests that industries are likely to lose social power if it is misused; for example, government regulation may restrict the options of offending parties.<sup>54</sup> Finally, we note that many insurers we interviewed espouse the values articulated in our model, but few physicians or employers had seen evidence of insurers' intentions. This finding further suggests to us the value of physicians reaching out to insurers.

Our study has several limitations. One is the relatively small number of informants. The hypothesis-generating rather than hypothesis-testing study purpose mitigates this limitation to a degree. Moreover, we continued interviewing participants in each phase of the study until the marginal value of additional interviews was minimal. Another limitation is that the resulting models do not encompass the large number of patients without employer-sponsored health insurance. With employer-sponsored health insurance covering only 63% of the population,<sup>56</sup> the approaches discussed herein can make important contributions but are not comprehensive solutions. Most importantly, our study's research design can identify interesting and promising ideas, but it cannot provide the information needed to decide with confidence the generalizability or the sustained merit of the ideas.

Third-party payers, driven largely by commercial and political pressures, are so deeply entrenched in the US health care system that their role in the current dysfunctional delivery system seems somehow natural or inevitable. However, the results of this study suggest that it is possible to shift the relationships among physicians, insurers, and employers to create a more efficient and effective ambulatory care delivery system (Table 3). Physicians, especially those in smaller practices and in primary care, generally have less bargaining power than insurers or large employers in the current system.<sup>21</sup> The 2 approaches discussed in this article can help elevate physicians' relative influence. A 2-physician practice that takes care of numerous employees in an organization will certainly have influence with that employer. Physicians who can document superior health outcomes and reduced waste have a better opportunity to influence an insurer. Table 4 indicates some initial steps physicians can take to develop these relationships. An argument can even be made that physicians are uniquely equipped to catalyze the development of better medical care delivery systems. As one of our respondents stated,

| <b>TABLE 4. GETTING STARTED IN BUILDING PARTNERSHIPS WITH INSURERS AND EMPLOYERS</b>  |   |
|---|---|
| <b>All relationships start with communication. Physicians can foster partnerships by establishing dialogues with employers and insurers that begin with an examination of mutual goals and evolve into well-defined programs. Not all employers and insurers will be willing to partner with physicians, but some will. These are steps physicians can take to get started.</b>   |   |
| <p><b>Building Relationships With Employers</b></p> <ol style="list-style-type: none"> <li>1. Make a presentation to local business groups on the opportunity to improve health care quality and efficiency. Focus on ways to improve employee health status and the value of employers' health care spending.</li> <li>2. Build personal relationships with the chief executive officer of local employers through one-on-one visits. Ask about the firm's top health care concerns, perhaps as measured by claims costs. Offer to advise the company on how to address the concerns.</li> <li>3. Inform local employers, business organizations, and health care purchasing coalitions that you are open to contracting directly, if there are no provisions in your managed care agreements specifically prohibiting you from approaching employers directly.</li> <li>4. Design a safety and injury management program that employees feel good about and that gets employees back to work quickly.</li> <li>5. Ask large local employers to appoint company representatives you can contact to resolve back-to-work issues for injured employees.</li> <li>6. Offer to set up an after-hours walk-in clinic as an alternative to the emergency department for employees with minor illnesses or injuries.</li> </ol> | <p><b>Building Relationships With Insurers</b></p> <ol style="list-style-type: none"> <li>1. Meet the health plan's chief medical officer or regional medical director. Explore the visions each of you have for medical care and ways you can work together to further mutual goals.</li> <li>2. Ask the director of pharmacy how you can collaborate to reduce pharmaceutical spending in a way that would benefit patients.</li> <li>3. Express a willingness to collaborate on the deployment of clinical information technology.</li> <li>4. Ask the quality director how you can collaborate to deliver evidence-based care.</li> <li>5. Request a meeting with the network provider to discuss inconsistencies and/or slowness in claims payments and work out an improvement plan.</li> <li>6. Be persistent. Demonstrate that you want to be at the table to share ideas. Come with solutions, not just complaints.</li> </ol> |

Physicians must lead change in health care. They better understand the health care system and better

understand what constitutes value. They are better able to lead other physicians. They understand patients' needs. And they understand physicians' fiduciary responsibility to patients as well as responsibility to the population. Ultimately, this is all about changing culture and physicians can best do that.

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