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COMMENTARY

The Role of Employers in Addressing Quality Variation in Employer-Sponsored Health Insurance

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Employers fund more than $1 trillion of the U.S. health care ecosystem, and nearly half of Americans receive health insurance through an employer. Despite the high per capita costs of employer-sponsored insurance, it is plagued by widespread quality variation. Employers have a timely opportunity to catalyze health care improvements, not just for their own members, but systemwide. New data assets are increasingly available to understand — in robust and clinically relevant ways — the quality of care that clinicians provide. These data allow people to identify high-quality providers, clinicians to receive meaningful and actionable feedback, and employers and health plans to curate higher-quality networks and referrals. Employer-sponsored health care should be an investment into the overall well-being of employees and their families; as purchasers, employers are in a unique position to set a new quality standard for the U.S. health care system.

Employer-sponsored insurance is the most common source of coverage for Americans, insuring approximately 180 million people and accounting for more than $1 trillion dollars in health care spending annually.[1,2] The high costs paid by employers and employees alike are well documented: The average annual premium for family coverage in 2022 rose to $22,463, with the worker contributing $6,106 per year for that coverage. This represented an increase of 20% over the previous 5 years and 43% over the previous 10 years.[3] What is less clear is the value that American employers and their employees and their families receive from the U.S. health care system. As purchasers that fund much of the health care ecosystem, employers have a meaningful opportunity to catalyze system change. Here, we describe instances of low-quality care in employer-sponsored

insurance, outline opportunities for employers to drive quality improvements, and highlight examples from innovative employers and employer groups.

Employer-Sponsored Clinical Data Show Quality Gaps

Given their substantial investments into health coverage, it is reasonable for employers to assume that individuals covered through sponsored health plans are receiving consistent, high-quality care. In 2022, Morgan Health(a business unit of JPMorgan Chase established to improve quality, affordability, and equity for its own health plan members and more broadly in employer-sponsored insurance) commissioned the University of Chicago's NORC research group to conduct a comprehensive analysis of health care outcomes and disparities specifically within the population with employer-sponsored insurance in the United States.[4] The analysis identified clear opportunities within employer-sponsored insurance to improve access to care, implement effective chronic condition management, and address health disparities.

For example, delayed diabetes diagnosis can result in numerous health complications including coronary artery disease, neuropathy, and stroke.[5] The Morgan Health–NORC analysis found that 10.2% of adults with employer-sponsored insurance are diabetic — of whom 1 in 5 are undiagnosed, meaning that their HbA1c is greater than or equal to 6.5%, even though they have not been informed by a doctor that they have the condition and are not taking medication. After adjusting for age and sex, the prevalence of undiagnosed diabetes in U.S. adults with employer-sponsored insurance varies significantly by race: The prevalence is 3.3 percentage points higher in Black members, 3.4 percentage points higher in Asian members, and 3.3 percentage points higher in Hispanic members compared to white members.[4]

Likewise, providing regular mammograms to women at risk for breast cancer is a well-established, noninvasive method to reduce the risk of death from breast cancer.[6] Even though the cost of regular mammograms are covered by most employer-sponsored insurance plans, the overall rate of women over 40 who report having received mammography in the past 2 years is 74.4%.[4] This varies significantly by family income level: after adjusting for age and sex, women with household incomes <$50,000 are 10.7 percentage points less likely to have regular preventive breast cancer screenings compared to women with household incomes >$150,000.[4] Along with similar examples, these findings indicate that there are significant care gaps, even among a privately insured population.

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Variation in Provider Quality Affects Health Outcomes

Variation in provider quality is one important source of poor health outcomes, missed opportunities for life-saving treatment, and unnecessary utilization.[7] Historically, physician-level variation —

which manifests across the spectrum of clinical practice including diagnoses, clinical processes, and treatment plans — has been difficult to measure, in part because data to measure quality has been siloed by payer. Without multi-payer quality data, it is challenging to address physician quality in employer-sponsored insurance and identify high-quality providers.

However, new data assets and approaches are increasingly available to evaluate provider quality in robust, clinically relevant ways. For example, Embold Health — a Nashville, Tennessee–based, privately held analytics company — brings together medical and pharmaceutical claims data across more than 150 million lives (including approximately 110 million commercially insured members) with scientifically rigorous analytics to assess physicians on evidence-based guidelines. Transparent provider-level measurements create new opportunities for employers to improve the health care their members receive.

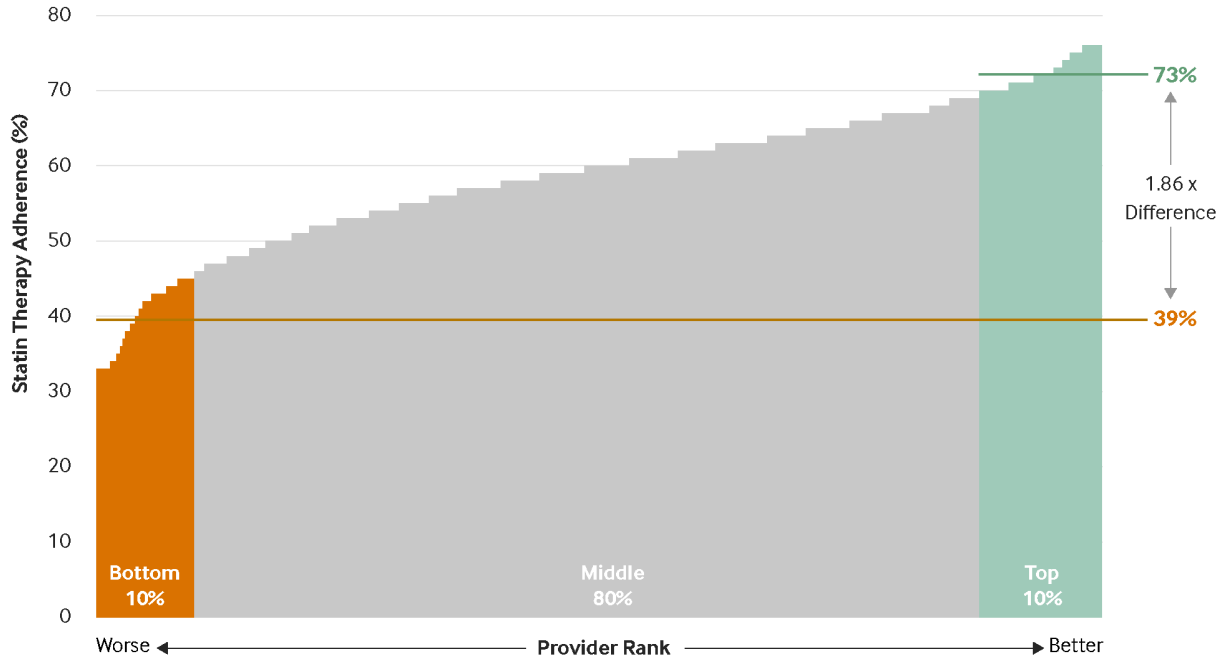
These data show that across the system, different physicians exhibit varied patterns of clinical decisions even among similar groups of patients, with major implications for patient care.[7] For example, for nearly a decade, clinical practice guidelines recommended statin therapy for patients with coronary artery disease because adherence to statin medications is associated with lower risk of heart attack, stroke, and death,[8,9] Nonetheless, there remains marked variation across physicians in the proportion of their patients with coronary disease who adhered to guideline-recommended statin therapy.

Figure 1 leverages Embold Health data analysis to demonstrate the extent of physician-level variation after controlling for differences in patient characteristics. The analysis assesses provider performance on clinical evidence-based measures using commercial-predominant claims data, in particular, adherence to statin therapy among members with stable coronary artery disease. While Medicaid and Medicare data were also included to improve the size of the sample and reliability of the measures, no meaningful differences were detected when the sample was reduced only to commercial patients. In a sample of 809 cardiologists in Ohio, among the top 10% of providers, an average of 73% of their patients are taking these life-saving medications regularly. However, among the bottom 10% of providers, about half as many patients receive the benefits of statin adherence (39%).

FIGURE 1

Adherence to Statin Therapy Among Members with Stable Coronary Artery Disease

Individual provider performance among 809 cardiologists in Ohio on the rate of adherence to statin therapy with chronic coronary artery disease (controlling for patient characteristics) is represented by the height of the bar, with the 90th percentile designated in green at right and the 10th percentile in orange at left. The data cover a period from January 2018 through December 2021, and represent 5,095,529 commercially insured patients, 885,575 covered by Medicare, and 1,114,419 covered by Medicaid.



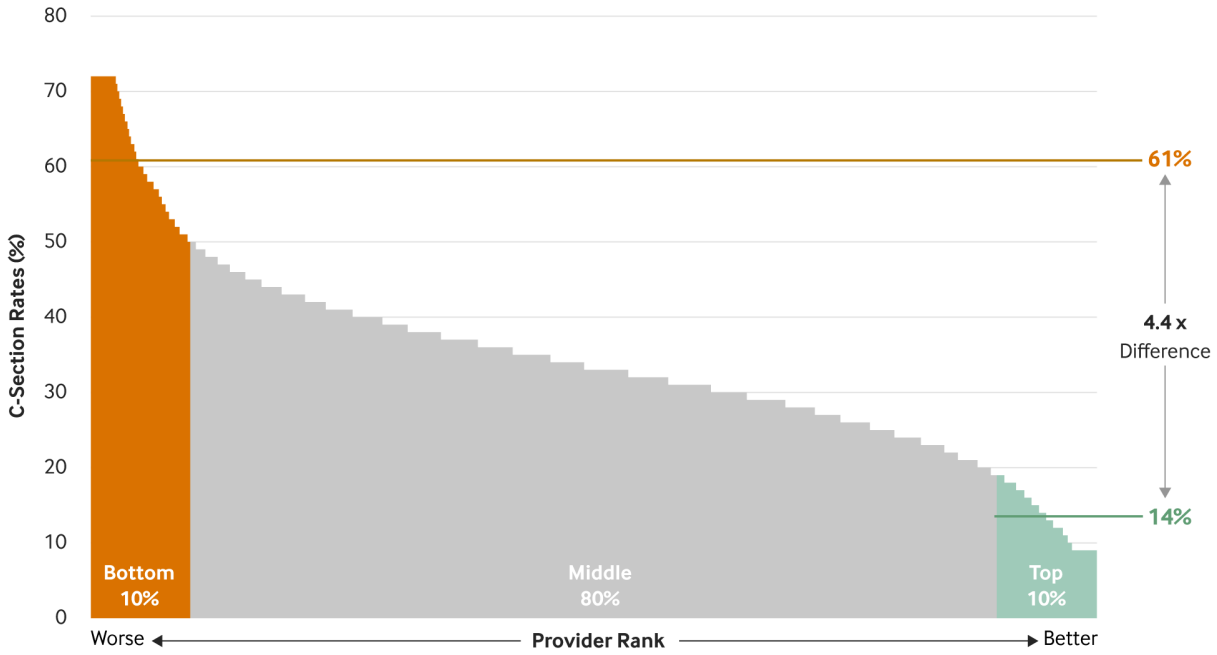
Source: Embold Health analysis of commercial-predominant longitudinal closed claims data comprising 7.1 million members in Ohio.

Similarly, expert clinical organizations established the risks of inappropriate cesarean delivery (C-section). According to the American College of Obstetrics and Gynecology, "for most pregnancies, which are low-risk, cesarean delivery appears to pose greater risk of maternal morbidity and mortality than vaginal delivery."[10] Despite this, Figure 2 demonstrates that among 3,121 obstetricians in Texas, after controlling for patient-level characteristics, instance of a woman with uncomplicated pregnancy undergoing a C-section ranges from 14% for 10th percentile to 61% for the 90th percentile, depending on which obstetrician delivers the baby.

FIGURE 2

C-section Rates Among Women with Uncomplicated Delivery

Individual provider performance among 3,121 obstetricians in Texas (controlling for patient characteristics) is represented by the height of the bar, with the 90th percentile designated in green at right and the 10th percentile in orange at left. The data cover a period from January 2018 through December 2021, and represent 12,303,670 commercially insured patients, 784,356 covered by Medicare, and 6,413,513 covered by Medicaid.



Source: Embold Health analysis of commercial-predominant longitudinal closed claims data comprising 19.5 million members in Texas.

While employers may seek to provide access to high-quality care for their employees, in many cases today, neither employers nor individuals covered by employer-sponsored insurance reliably know which physicians are *orange* (low-performing) and which are*green* (high-performing) per Figure 1 and Figure 2.[11] Making provider-level quality data trustworthy requires providers to participate in the process of measure development and iteration. The performance measures should be directly actionable with changes in provider behavior, such that if a provider improves on a measure, this improvement should clearly and directly create value for employers and the health plan members.[12]

Opportunities to Improve Quality and Health Outcomes in the Commercial Market

When it comes to improving quality for individuals and families with employer-sponsored insurance, employers have a critical role to play. One way in which employers can foster broader quality improvement is to create an information ecosystem that allows members and providers to access and act on provider quality information. This serves three distinct purposes: First, it

helps better inform employees' choices about the physicians they might choose for specific needs; second, it creates an environment where physicians receive feedback regarding where they are performing well and how they can improve; and third, it gives employers the basis to curate higher-quality networks and steer their employees to high-quality clinicians.

When employers provide their members transparent quality data on provider performance, they simplify the patient process of identifying and choosing high-quality doctors. Employers can integrate evidence-based provider quality into a member's provider selection process in multiple ways, including through enhanced provider search guides. In contrast to the current methods that many members currently rely on to choose their providers (including word of mouth and non-vetted publicly sourced satisfaction scores), having access to provider quality data enables employees and their families to compare providers in a meaningful and comprehensive way.[11]

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Accelerating a systemwide shift to high-quality care also requires the engagement and action of the provider community. Even though employers do not often interface directly with health care providers, employers can shift their health plans toward accountable care models, where physicians manage cost and quality across the spectrum of care delivered to their patient panels. Within these arrangements, provider quality data can be leveraged to both improve a provider's own clinical practices and to facilitate high-quality specialty referrals.[13]

Finally, employers can promote high-quality care delivery through network design and steerage. Traditionally, large, self-insured employers rely on carriers to curate provider network. However, the carriers' focus on quality of care in network design may be constrained by market consolidation and demand for broad networks. Employers can increase the likelihood that members receive care from high-quality providers by incorporating provider quality into network design or incentivizing members to choose the high-quality providers through low out-of-pocket payments. Employers can also deploy tools that leverage physician quality assessments to match or steer members to high-quality providers. By shifting member volume to high-quality providers, employers instill greater motivation for providers to shift toward evidence-based clinical decisions and improve their own quality.

Establishing Quality as a Central Goal for Employers

Leading employers understand that health care is an investment in the overall well-being of employees and their families. For many employers, this investment takes shape through wellness campaigns and targeted point solutions, while for others it is formalized into annual targets of engagement and clinical improvements. For example, the JPMorgan Chase Morgan Health team

Table 1. JPMorgan Chase's Morgan Health 5-Year Impact Framework

Objective	5-Year Outcome Goals for Employees and Families	Sample 5-year Outcome Metrics	Sample Progress Metrics
Quality	• Improve access to primary care • Increase continuity of care and care coordination • Promote effective management of conditions (including mental health, maternal health, and chronic conditions)	• Number of large metropolitan areas offered access to programs that improve quality of care (e.g., advanced primary care management) • Number of interventions identified through JPMC pilot programs that significantly improve the quality of care for JPMC U.S. health plan members	• Patient-reported outcomes on health care services delayed or avoided due to scheduling difficulties and long wait times • Continuity of care in primary care and specialists measured using medical claims data • Quality management measures specific to the condition. For example, HEDIS measures: oMental health: depression screening and follow-up for adolescents and adults oMaternal health: timeliness of prenatal care and postpartum care oCardiovascular disease: 80% statin adherence for patients with cardiovascular disease oDiabetes: HbA1c control (<8.0%), blood pressure control (<140/90 mm Hg)
Affordability	• Design and promote accountable care structures that incentivize provider groups to manage the total cost of care • Increase pricing transparency, minimize surprise large bills • Increase the number of affordable care options (e.g., reasonably priced insulin, low-cost narrow networks with advanced primary care support)	• Number of large metropolitan areas offered more affordable cost options for health care that do not compromise care quality • Number of JPMC U.S. health plan members who are offered lower-cost health care options that do not compromise quality	• Patient-reported outcomes on difficulty paying health care bills • Patient-reported outcomes on health care services avoided due to high costs or cost uncertainty • Number of new solutions that reduce the burden of preventive and maintenance care (e.g., low co-pays for insulin, lower-cost virtual care alternatives, etc.)
Equity	• Identify and quantify health care disparities within the JPMC U.S. health plan and more broadly across ESI • Design and implement interventions to minimize differences in care • Socialize learnings on health disparities in ESI broadly to other employers and health care providers	• Number of Morgan Health publications that promote greater understanding of health disparities in ESI with aligned solutions • Number of interventions identified through JPMC pilot programs that significantly reduce disparities in health care access or outcomes	• Number of JPMC vendors collecting and leveraging diversity data such as race, sexual orientation, and income to understand and address health disparities • Size of health disparities in quality management (example measures above) measured through adjusted differences (comparing the best- to worst-performing subgroups) and variance

The JPMorgan Chase Morgan Health team 5-year Impact Framework is organized under the objectives of improving quality, affordability, and equity for the JPMC health plan and across employer-sponsored insurance. The framework includes sample metrics and methods that JPMorgan Chase and other employers can use to track progress, including through clinical measures and patient-reported outcomes. Abbreviations: JPMC = JPMorgan Chase; ESI = employer-sponsored insurance; HEDIS = Healthcare Effectiveness Data and Information Set. Source: The authors

created a 5-year *Impact Framework* that outlines measurable objectives of improving quality, affordability, and equity. The outcome and process metrics displayed in Table 1 provide examples of how progress can be quantified and tracked over time and may be leveraged across employer-sponsored insurance more broadly.

Employers are establishing health care quality as a central goal in at least two ways: through transparency and through incorporating quality objectives into contracts. As purchasers, innovative employers are putting quality front and center in their health care benefits. Several large employers have launched initiatives to make it easier for their employees to identify and access quality providers who are showing the best outcomes and experiences for their patients. Two recent examples include Microsoft and Walmart.

Working with Embold Health, Microsoft deployed a digital provider search tool that helps members identify the highest-quality primary care and specialty providers that specifically meet the member's unique medical needs. Early results suggest that Microsoft employees who used this digital tool were, on average, more likely to switch to a higher-quality provider and more likely to choose higher-quality providers for any new care needs.

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Walmart also partnered with Embold to create a provider guide for associates that identifies local doctors who consistently deliver high-quality care to their patients. Going a step further, Walmart's medical plan covers a higher share of eligible costs when the associate chooses a preferred provider who has been shown to diagnose health conditions more accurately, recommend the right treatments, and whose patients report better outcomes. As with Microsoft, early results suggest that the combination of quality transparency and higher coverage reduced the rate that associates see underperforming providers and improved the overall quality of primary care and specialist providers that deliver care to Walmart associates and their families, based upon Embold's assessment of provider quality. Beyond steering members to higher-performing providers, both Microsoft and Walmart engaged their delivery system partners to improve the quality of care delivered in local communities by sharing data and collaborating to drive improvement in key clinical areas.

Another powerful lever available to employers to improve quality is including performance measures in their health care contracts. Large employers are familiar with annual contractual processes but can easily overlook the opportunity for these contracts to drive accountable care, in which plans and providers to take meaningful accountability for quality outcomes. Establishing accountable care contracts requires a longer time horizon and system investments into data integration, consensus on measurement, methodologies, and reporting, and communication to drive member engagement. However, innovative employers are demonstrating that it also offers an opportunity to drive system change for quality improvement.

In 2022, JPMorgan Chase partnered with two health care providers — apree health and Kaiser Permanente — that prioritize quality of care through their accountable care models. JPMorgan Chase takes a multiyear approach to contractually incentivize quality measurement and improvement over time: (1) data collection on social demographics and baselining of clinical quality measures, (2) population-wide quality improvements, and (3) closing of quality disparities across races, disability status, language barriers, and other subgroups. Quality objectives have included

reducing avoidable utilization and improving cardiovascular disease risks through preventive care. The resulting improvements to employees' health will be measured on a yearly basis.

Other employers also have prioritized quality improvements for their members through risk-based accountable care contracts. General Motors launched ConnectedCare in partnership with the Henry Ford Health System to incentivize both controlling total cost of care and improving 19 health quality measures. The contract was designed so that Henry Ford Health System can obtain full payment if the quality measures are met, even if they do not fully meet the financial total cost of care goal.[14,15] Unlike traditional benefits contracts that primarily prioritize cost management, this arrangement concretizes the employer's focus on quality and achieved system efficiencies through integrated data flows and lowering barriers to access care.

In addition to individual employer efforts, many employers have started committing to quality improvements through organizations such as the Purchaser Business Group on Health. This nonprofit organization provides guidance, policy expertise, and has leveraged its multi-employer scale to establish regional centers of excellence to improve health outcomes. They also released an advanced primary care measure set focused on measuring high-performing primary care for commercially insured groups.[16]

Looking Ahead

Employers are currently in a unique position to improve the quality of care for the millions of Americans with employer-sponsored insurance and to set a new standard for the U.S. health care system. Despite the high cost of employer-sponsored insurance, covered members continue to receive variable care that may fail to meet quality standards. By leveraging provider-level quality data in their operations and making these data accessible to their members, employers have a timely opportunity to take a leading role in creating a health system that consistently delivers high-quality care for employees and their families.

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