Cost-Saving Levers for Self-Insured Health Plans

Four tactics to control healthcare spending

amino

Healthcare utilization decreased in 2020 during the COVID-19 pandemic, yet healthcare remains the most expensive employee benefit for employers, and costs continue to rise for many. In fact, a 2021 survey from the Business Group on Health (BGH) projects an increase of anywhere between 5.3% and 6.1% in employer spend this year. That coverage comes at a cost of 8.2% of total compensation, according to the U.S. Bureau of Labor Statistics.

> **Including premiums and out-of-pocket costs for employees and dependents, the total cost of healthcare is estimated to be $14,769 per employee this year.**
>
> Large Employers' Health Care Strategy and Plan Design Survey, BGH

Employers can use a variety of tactics to drive savings for their healthcare plans. This eBook explores four common cost-saving tactics—**employee cost-sharing, adjusting network designs, preventing expensive healthcare episodes,** and **improving the use of existing healthcare offerings**—as well as the pros and cons of each.

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Tactic 1

Share costs with employees

Over the past 30 years, companies have responded to sustained healthcare cost pressures by adopting several significant changes to their employee benefits plans. In the ’70s and ’80s, for example, many employers moved away from indemnity plans toward health maintenance organizations (HMOs) and preferred provider organizations (PPOs). More recently, employers have adopted **high-deductible health plans** and **reference-based pricing** to share rising costs with employees.

High-deductible health plans

High-deductible health plans (HDHPs) require employees to take on greater cost-sharing responsibility up front before employers begin to pay for medical claims. HDHPs have grown in popularity over the past 10 years as a way to contain plan costs and put members in the driver's seat when it comes to shopping for care.

To help employees pay for more upfront out-of-pocket expenses, employers typically offer **health savings accounts (HSAs)** in conjunction with HDHPs.

An **HSA** is a pre-tax account created for or by employees covered under HDHPs to save and pay for qualified medical expenses. Contributions can be made by the employees, their employer, or both.

An HDHP/HSA combination gives employees a good target for healthcare spending because they know what their deductible and contribution amounts are, says Alex Shortridge, VP of Channel Partnerships at Amino. Since they know these fixed numbers, they have incentive to make efficient and intelligent choices about where to get care, choosing doctors and facilities that are higher quality and more cost-effective instead of defaulting to the most convenient options.

The IRS defines HDHPs as those with:

- **A minimum annual deductible of $1,400 for individual HDHP coverage (unchanged from 2020) and $2,800 for family HDHP coverage (unchanged from 2020).**
- **An out-of-pocket maximum limit (including items such as deductibles, copayments, and coinsurance, but not premiums) of $7,000 for individual HDHP coverage (up from $6,900 in 2020) and $14,000 for family HDHP coverage (up from $13,800 in 2020).**

The IRS defines HSA contribution limits as:

- **$3,600 for individuals with self-only HDHP coverage (up from $3,550 in 2020).**
- **$7,200 for individuals with family HDHP coverage (up from $7,100 in 2020).**

“The beauty of a pre-tax HSA is that you don’t have to fully use it every year. People can manage and protect their funds in a conscientious way.”

Alex Shortridge, Vice President, Channel Partnerships

Pros

+ HDHPs can lower your plan’s costs while still providing broad network coverage for employees.
+ HDHPs encourage plan members to take a more proactive role in managing their healthcare choices and spending because they’re footing more of the bill up front.
+ HSAs can help employees who don’t use much healthcare save up for future medical costs, since they’re able to roll over unused funds from year to year.
+ Funds contributed into employee HSAs are tax-free. If structured properly, the tax savings from HSA contributions combined with service cost savings from HDHPs can provide substantial value for both you and your employees.

Cons

- HDHPs and HSAs are often new to employees. Your team will need to invest more time and resources into ensuring that employees understand how they work so they get the most value out of them.
- Since employees are responsible for paying for care until their deductible is reached, HDHPs aren’t a great option for employees with chronic medical conditions or those who have dependents with above-average healthcare needs.
- While HDHP enrollment has been associated with lower healthcare spending, research suggests the savings are primarily due to decreased use of care and not because enrollees chose lower-cost providers, which can have negative impacts on long-term employee healthcare habits and outcomes.

Reference-based pricing

If you're looking for a plan design that will give you highly predictable costs, a **reference-based pricing (RBP)** strategy is worth considering. Instead of contracting with specific carriers and networks, a RBP program ties your payment rates to Medicare reimbursement rates—usually as a percentage of Medicare—so your costs stay consistent across providers. Plan members can get care with any doctor or facility they want, as long as the provider agrees to accept the per-service rates established by your organization.

RBP can replace traditional health plan offerings, or support carveouts for specific specialties or out-of-network bills.

"RBP is one of the neatest offerings that's come out in quite some time," says Shortridge. "It's really starting to gain traction because it allows employers to have predictable, consistent healthcare costs while still giving employees a lot of choice."

Because RBP is still a relatively new type of offering, many employers partner with a reference-based pricing vendor to manage provider outreach, member support, and claims settlements.

Pros

+ RBP can substantially reduce healthcare claims costs by setting a maximum payment amount that your plan will pay for every service.
+ Rather than having to find doctors or facilities within a predefined network, members can get care from any provider they want.
+ Members don't have to deal with traditional health plan artifacts like deductibles, out-of-pocket maximums, or coinsurance.

Cons

- Designing a RBP benefit is much more complex than offering a more standard health insurance offering, and often requires additional administrative overhead.
- Not all providers will accept RBP rates. Before members can get care, they'll need to understand whether or not a provider will accept your rates to avoid the risk of denied coverage or post-care balance billing.
- Cost savings from RBP may not outweigh the increased operational overhead required for your HR team to educate and support this type of plan.
- If RBP is your organization's only plan offering, it could hurt your competitiveness in the labor market if other companies are offering more traditional plans with richer benefits.
- You'll need to invest in a multipronged, proactive decision support system to help employees navigate their care options.

Tactic 2

Explore creative health plan designs

If you're willing to get creative, you can experiment with alternative plan designs to contain costs. These options involve a more nuanced approach to contracting, benefits, and cost structure than typical PPO or HMO plans, but they can drive cost efficiencies while still providing employees and dependents access to high-quality care options.

Let's explore a few options—**tiered networks, narrow networks, direct contracting, and centers of excellence**—that are gaining traction among self-insured employers.

Tiered networks

Tiered networks are similar to typical PPO plans, but divide providers into tiers based on the cost and quality of the care they offer.

"Tiering can be very effective," says Shortridge. "Your employees are happy because they have access to the services they need, and they have lots of options. And you're happy because you reward members for choices that save your plan money."

Tier 1 providers deliver the highest value of care (low cost, high quality). Employees have the lowest cost-sharing amounts with this smaller pool of preferred providers.

Tier 2 offers a larger network of providers and facilities. With this option, employees pay a higher cost-sharing amount.

Tier 3 has the widest pool of providers, services, and facilities, and includes out-of-network providers. Employees have the highest cost-sharing amounts.

Pros

+ Plan members have clear incentives to choose lower-cost, higher-quality providers within a broader network.
+ Unlike a narrow network, tiered networks still cover a broad pool of providers for people who don't mind paying extra to stick with existing doctors or facilities.

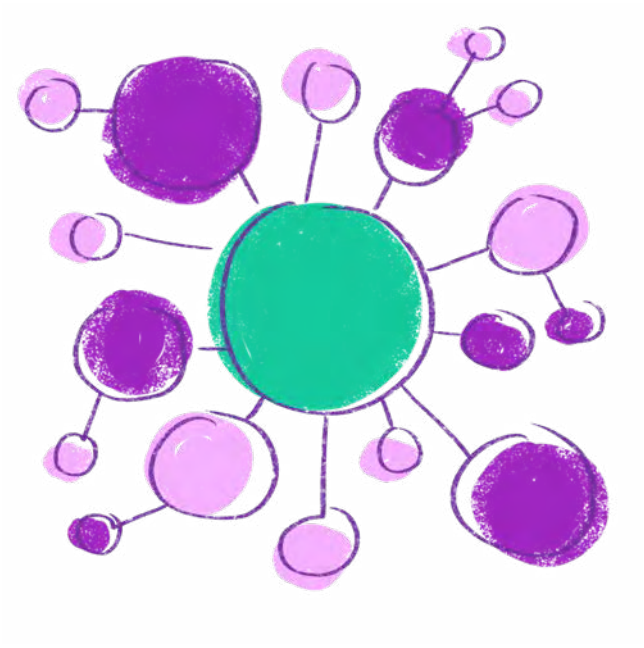
Cons

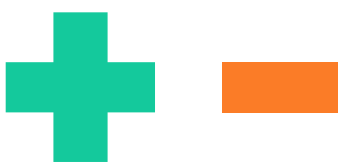
- When searching for care, employees must pay close attention to which tier a provider is in, which can complicate the decision-making process.
- Some geographic regions may not have enough providers or sufficient competitive dynamics to support tiered networks.

Narrow networks

While not strictly defined, **narrow networks** offer employees a more limited choice of doctors, clinics, and providers. In exchange for a higher volume of patients, doctors and clinics provide services at cost-effective rates in a more integrated fashion. This leads to cost savings for both members and employer health plans.

"The hope with narrow networks is that copays for employees are not as expensive, and they will use the plan," says Shortridge.





Pros

+ According to a study in Health Affairs, narrow networks can be significantly cheaper for employers because the carrier is able to negotiate more competitive rates with providers.
+ Employees benefit from lower copays and coinsurance, which can reduce their out-of-pocket costs.

Cons

- Narrow networks may not offer the broad access to doctors and facilities your employees are accustomed to. Narrow network plans often have 25% or fewer participating local physicians, compared to the approximately 70% found in broader PPO networks. This makes it even more important for members to check that a provider is in-network before getting care.
- If your employee base has specialty health needs or an existing care team they don't want to give up, a narrow network may not be the best option for them.
- Access to care may be more of a challenge for employees, especially for high-demand specialties like behavioral health or maternity care.

Direct contracting

Direct contracting is an agreement between an employer and a provider group or hospital system to provide care for plan members in a specific geographic area. Unlike a traditional payer arrangement where the carrier handles all the negotiations, your benefits team (and likely your broker/consultant) will determine reimbursement costs for specific services, prescriptions, and medical equipment.

Direct contracts can follow a traditional fee-for-service structure or employ alternative payment models such as pay-for-performance, shared savings, bundled payments, or global capitation.

"The value of direct contracting is that you control the spend," says Shortridge. "You're negotiating what the rates are. Knowing the specific costs of each provider can be very valuable to both your benefits team and your plan members because everyone knows what they're going to be paying for care in advance."

Pros

+ By eliminating carrier administrative overhead, your program can negotiate contracts with lower prices while reducing cost-sharing amounts for employees.
+ Having full visibility into care costs means your benefits team can more effectively predict annual claims spending.
+ You can align payments and incentives around care quality and outcomes in a way you can't with more standard plan designs.
+ Spending is easier to control as long as members get care with your preferred providers.

Cons

- Healthgram reports that company size and location are important factors in provider negotiations. Unless your organization can offer enough patient volume and exclusivity, direct contracting may not be an option.
- Direct contracting requires more legal and administrative oversight than a typical carrier agreement.
- You'll need to invest in additional education and resources like a provider directory or healthcare guidance solution to help members get care from your contracted network.

Centers of excellence

Centers of excellence (CoEs) are specialized programs within a healthcare center that provide concentrated clinical expertise and resources focused on a specific condition or care type. Unlike traditional hospital or specialty care settings, CoEs deliver comprehensive patient care in an interdisciplinary fashion.

To become a certified CoE, a healthcare institution must apply through the National Association for Continence. Once an institution is certified, it's inspected every three years to maintain CoE status.

Pros

- \+ CoEs provide advanced, specialized care for conditions that are often costly to treat and challenging to coordinate.
- \+ Employers can contract directly with CoEs, which provides additional flexibility on terms and costs.

Cons

- – CoEs aren't available in every geographic region and may not be easily accessible to plan members who live outside a major city or suburb.
- – CoEs supplement rather than replace a traditional health plan, as they typically focus on a single clinical discipline instead of a broad suite of services.

Tactic 3

Prevent expensive health episodes

The most effective kind of healthcare is preventive care. That means providing employees with information on healthy habits, going to annual checkups, getting preventive screenings, and more.

“Preventive care is the most important part of ensuring that you and your employees don’t overspend,” says Shortridge.

Programs like **digital therapeutics, direct primary care, onsite or near-site clinics,** and **incentive programs** that support a healthy, physically active lifestyle can help employees be more productive and engaged at work while preventing serious health issues in the future.

Digital therapeutics

Technology-based solutions have a clinical impact on disease comparable to that of a drug. **Digital therapeutics,** also known as mobile health, use consumer-grade technologies (such as mobile devices, wearable sensors, data analytics, and behavioral science) to educate users on—and guide them to—healthy habits. These solutions can provide for a wide range of health needs, including chronic condition management, stress management, smoking cessation, and medication adherence.

Information is delivered online, via apps, or through smart medical devices in real time and at scale—critical for chronic disease management.

Pros

- These solutions are often easy to use once employees are initially onboarded and educated.
- They provide better care and more access options for employees in rural areas.
- For employees who may not be comfortable going into an office or clinic—or who simply prefer the ease of having an appointment from home—digital offerings provide a nice alternative to in-person visits.

Cons

- Without an ongoing engagement strategy, employees tend to forget they have access to digital services—or don't know they're available.
- It can be confusing to know when to use these additional digital services versus traditional health plan services.
- Not all employees have access to computers or reliable internet outside of work, which can lead to disparities in access.
- Some employees aren't comfortable sharing private health information digitally and prefer to see a provider face-to-face.

Direct primary care

Direct primary care (DPC) is a membership-based option for routine healthcare needs. DPC often runs on a subscription model where the employer pays a flat monthly fee per employee, and members pay predefined copays when they get care.

Typical services include comprehensive primary care, basic medication, lab tests, and follow-up visits in person, through email, over the phone, or by video call. Unlike many traditional primary care practices, DPC clinics incorporate digital services as part of their core offerings and provide more flexible, convenient access to care.

Pros

+ Because DPC works on a subscription model, providers spend less time wading through insurance paperwork and more time with patients.
+ DPC service costs are often very minimal for members, which can encourage people to get care more frequently.
+ Primary care practices offer a better patient experience (e.g., longer appointment blocks, more availability, more attentive staff) because they don't get paid per appointment as they would in a traditional fee-for-service model.
+ Many DPC clinics offer cost savings or performance guarantees to employers by managing preventive care and being able to divert patients away from expensive specialty or urgent care when they don't need it.

Cons

- Employees still need an insurance plan and prescription coverage to cover some types of healthcare services.
- Employees can still access primary care through a traditional plan network, so DPC may feel duplicative or confusing to some members.
- Employee utilization is a challenge, particularly for older patients who may have a preferred physician. The convenience and other perks of DPC may not persuade them to change doctors.

Onsite and near-site clinics

Onsite and near-site clinics are located at worksites or close by. These clinics can improve employee health and well-being because they're convenient and improve employee use of preventive screenings, immunizations, and services they might otherwise not get. Since employees have easy, regular access to healthcare, they may be less likely to take sick days or work while sick and spread illness to coworkers.

The National Association of Worksite Health Centers reports that 33% of U.S. employers with 5,000 employees or more currently offer onsite medical clinics, and 16% of companies with 500–4,999 employees provide onsite medical services. Another 8% say they plan to add a similar offering soon.

Pros

+ Onsite and near-site clinics reduce employee absenteeism by making access to care super convenient.
+ Onsite and near-site clinics can reduce the use of costly hospital ER and urgent care visits for non-emergency conditions.
+ Onsite and near-site clinics can help attract and retain employees who are concerned about health and wellness benefits.
+ Onsite and near-site clinics can reduce overall costs by delivering coordinated medical, pharmacy, and therapy services in one centralized location.

Cons

- The IRS requires clinics to charge a fair market rate to employees with HSAs who want to use the clinic for more than first aid care.
- Operational and administrative costs and overhead can be substantial.
- Your organization takes on additional liability by providing medical care.

Incentive programs

Incentive programs are a great way to encourage health behaviors, decrease unnecessary spending, increase productivity, and raise morale among employees. Return on investment, according to Wellness Councils of America, is $3 for every $1 spent, though little has been published on incentives-based ROI alone.

These programs come in many forms, but as a general rule will fall under one of four types.

Participants must be enrolled in a company healthcare plan. As with the other programs, there must be alternatives available to employees who cannot meet the initial criteria.

When crafting an incentive program, it's important to research your options and evaluate how well each one aligns with your organization's goals. Your program should be thoughtful, compliant, relevant, and well-promoted. To be successful, you should consider your benefits program goals and whether your organizational culture will set you up for success.

Type 1: General educational or participatory programs

These are predominantly educational materials and non-mandatory classes related to health and wellness topics. They must be made available to everyone, not just employees who are eligible for your company's healthcare plans.

Examples include:

- Workplace posters showing the benefits of cutting back on sugar.
- Providing pamphlets outlining different types of stretching exercises.
- Lunch-and-learns to discuss health topics.

General education programs are flexible and can be very attractive to organizations with employees who enjoy a variety of reward opportunities for achieving specific outcomes.

Type 2: Health plan-related participatory programs

This type of program is open to all employees enrolled in their employer's health plans. Like Type 1 programs, Type 2 programs are participation-based, not outcome-based, and aren't mandatory. These programs are good for companies that want to incentivize preventive care activities covered by their health plans.

Type 2 programs can either be tied to a company health plan or can be a healthcare plan in and of itself.

Examples include:

- Programs that lower an employee's healthcare contributions based on participation in a cholesterol check.
- Waiving copayments for pregnant employees who get prenatal care.
- Offering premium holidays for employees who enroll in a tobacco-cessation program.

Programs must provide a reasonable alternative if an employee is unable to meet the original criteria for an incentive. For example, if an employee can't attend an in-person smoking cessation class, a reasonable alternative might be to instead have them watch a smoking cessation video.

Type 2 programs may involve medical care provided by a trained professional that's individualized to the participant. Medical care includes amounts paid for diagnostics, treatments, mitigations and preventions of disease, medical-related transportation, and payment for health insurance.

Examples of medical care include biometric screening, coaching by a trained nurse, flu shots, and counseling from a therapist.

Type 3: Health plan-related, activity-only programs

Type 3 programs provide rewards to participants based on the completion of certain health and wellness activities, regardless of health outcome (weight loss, lower blood sugar levels, etc.).

Examples include:

- Reduction in employee health plan contributions if the employee exercises at least three hours a week.
- Reduction in employee health plan contributions if the employee decreases sugar consumption.
- Rewarding an employee for sticking to a diet plan.

Employers must offer reasonable alternatives to employees with disabilities or other factors that prevent them from completing certain activities.

Type 4: Health plan-related, outcome-based programs

Type 4 programs provide rewards to employees based on certain program-specific outcomes. These programs include rewards such as a reduction in employee healthcare contributions for achieving a body mass index score of below 30 or quitting tobacco use. Type 4 programs often start with a health screening to establish a baseline so employees can track progress.

Participants must be enrolled in a company healthcare plan. As with the other programs, there must be alternatives available to employees who cannot meet the initial criteria.

Some Type 4 programs may include penalties for not meeting health standards, like requiring higher health plan contributions for employees who smoke or have a BMI of over 30.

Pros

+ Incentive programs can reduce sickness-related absenteeism.
+ Incentive programs can increase your ability to attract talent in a competitive hiring market.
+ Incentive programs can improve employees' self-management skills and help them achieve personal health and wellness goals.

Cons

- Incentive programs are highly regulated, requiring close coordination with your compliance team and broker-consultant.
- Incentive programs can take years to have a measurable impact on your population's health. External factors can also contribute to long-term health changes that may slow progress.
- According to several studies, the cost-effectiveness of incentive programs varies widely.
- It's hard to prove ROI for some programs, depending on the incentivized behavior.

Tactic 4

Improve the use of existing healthcare offerings

Your benefits team invests time, resources, and effort into your insurance plans and other healthcare programs. But if your employees ignore these resources, or use them ineffectively, you won't realize the cost savings potential of your investments.

Education and consistent communication are key to ongoing employee engagement with healthcare programs. But sometimes, communication isn't enough—your employees need additional support to navigate their options and make smart choices about where to get care. That's where healthcare navigation resources like **advocacy services** and **healthcare guidance solutions** can help.

Advocacy services

Advocacy services provide human-to-human, synchronous healthcare support. Employees can call, direct message, or text for advice on a variety of healthcare-related topics such as benefits, billing, provider recommendations, clinical second opinions, or general healthcare questions. Depending on the nature of their question, the service will route employees to the appropriate subject matter expert to provide assistance.

"Advocacy services can get employees involved in their healthcare programs, because they're talking to somebody who can steer them in the right direction," says Shortridge. "Once they're using something, they're less likely to stop using it."

Pros

+ The human, personal interaction of advocacy services can help employees rediscover relevant healthcare services and actually use them.
+ Advocacy services can take pressure off your HR/benefits teams to field every healthcare question for your team.
+ Advocacy services can support a wide range of questions on healthcare issues, from clinical to billing to provider recommendations.

Cons

- Because advocacy services are human powered, they tend to be more expensive than digital solutions.
- These services often require the member to pick up a phone during predefined support hours, which some employees may not want to do.
- Advocacy recommendations are based on individual experience and expertise, not a standardized set of data or learnings, which can lead to inconsistent results.

Healthcare guidance solutions

Healthcare guidance solutions use data models and personalized inputs to guide users to cost-effective care options for their health needs. These solutions are typically self-service, digital, and available to all members of an employer's self-insured plans. Some solutions are standalone, while others integrate with benefits administration or HRIS platforms as part of a centralized benefits ecosystem.

Pros

+ These solutions provide personalized guidance on where to get care based on the member's plan coverage, benefits, demographics, and search terms.

+ They can be accessed 24 hours a day to inform care choices, providing added convenience for members.

+ Guidance solutions are often less expensive than advocacy services.

+ Guidance solutions are easy to use and provide value whether members have routine health needs or more complex conditions to manage.

Cons

- Some employees may feel more comfortable talking to a person about their healthcare needs than using technology to get recommendations.

- Many people are used to turning to their carrier directory or Google to look for care. Guidance solutions require ongoing education and engagement to ensure employees remember the service is there when they need it.

Summary

Every benefits program is different. As you explore cost-savings tactics, consider which approaches best align with your employee's health needs and preferences as well as your program goals and budget. The right changes and additions to your program can help you contain healthcare costs while still providing generous, competitive benefits to your employees.

No matter which cost-saving levers you use, one rule of thumb persists: The more you educate employees about the health plans and benefits available to them, the more likely they are to use them—and use them effectively.

"An important part of any kind of medical care is educating your employees on what's available," says Shortridge. "You don't want them to enroll in something and then forget about it. You need to make sure they understand what care options are available and how to use them."

People are naturally resistant to change, and they need repeated exposure to new ideas to buy in and take action. Introducing new offerings during open enrollment is a good start, but ongoing communication is key to driving long-term adoption. Ultimately, this consistent adoption and utilization is what will save money for your benefits program and your employees over time.

Looking to increase engagement with your healthcare plans, sponsored benefits programs, and incentive programs?

Amino Guidance is the smartest, easiest way for plan members to find and book care. Our platform uses data to recommend the most cost-effective, high-quality, relevant care options for each member's health needs and benefits, saving your program time and money.

Request a demo

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