EMPLOYER STRATEGIES TO REDUCE HEALTH CARE COSTS
Managing the rising cost of health care is a serious concern for companies of all sizes in the U.S. A recent study by the National Federation of Independent Business cited it as the No. 1 problem for employers. On average, employers are paying 34 percent more than they did five years ago, and employees contribute nearly 40 percent more.

Many employers fear health care reform will add even more to their costs. Large and midsize employers face costs related to compliance and small employers worry about costs added to the system that could ultimately increase their rates. Sixty-one percent of those surveyed expect their health care costs to increase due to health care reform, with 20 percent of those expecting to see a significant increase of 5 percent or more. Despite these fears, few employers (8 percent) are likely to drop coverage. Most intend to seek other ways to keep costs down. Ninety-two percent of employers plan to add or strengthen wellness programs as part of their long-term strategy to control costs related to health care reform.

The major factors adding costs to the system—an aging population, an epidemic of chronic conditions such as obesity and diabetes, and the cost of new technologies, treatments and medications—will continue well into the future. However, in this era of rapid change in health insurance and care delivery, there are innovative ways to drive down costs with smarter plan designs and cost-efficient benefit offerings.

Employers who succeed in controlling costs will have a competitive advantage because a lower percentage of their total compensation will be tied to active medical costs. Today, active medical expenses make up 11 percent of compensation. By 2018, it’s estimated that high-performing groups could see this number decrease slightly to 10.3 percent, while low-performing groups may face active medical costs that could be 17.4 percent of compensation.

Given the high stakes, employers are rethinking their plan options and emphasizing employee accountability in order to control costs.
Carriers and employers are making significant efforts to maintain quality care while minimizing costs through smarter plan designs and outside-the-box solutions.

**HYBRID PLANS**

New types of “hybrid” health plans are now available that are engineered (based on historical plan usage) to provide employees with up-front coverage for the most commonly utilized services—delivering just the right level of coverage and freeing employers and employees from shouldering the costs for benefits that aren’t typically used. The average consumer uses his or her primary care office, which often results in lab work or radiology services (e.g., X-rays, mammograms, colonoscopies). In this situation, the new type of hybrid plan would provide up-front first dollar coverage for these common services before deductibles or copays are incurred. For example, the plan pays $300 in first-dollar coverage for the primary care visit(s), as well as allocations for lab work and radiology. After the threshold is reached, the “deferred” deductible and copays kick-in. Thus, the hybrid plan provides members with up-front coverage for what they are going to use most under their plan, while still reducing overall costs through the use of deductibles and copays.

**CONSUMER-DRIVEN HEALTH PLANS**

While certainly not the answer for every employer, consumer driven health plans may help employers control costs while maintaining needed coverage for employees. Particularly when a high-deductible health plan (HDHP) is paired with a health savings account (HSA) or health reimbursement arrangement (HRA), premium relief can be obtained while supporting employee health care expenses through contributions to ancillary savings accounts. Towers Watson research shows that companies with at least 50 percent of employees enrolled in an HDHP with a savings option report that their total costs per employee were more than $1,000 lower than companies without an HDHP and savings option.²

**DEFINED CONTRIBUTION PLANS**

Defined contribution plans present another opportunity to control costs. A survey by Mercer in 2011 showed that 38 percent of U.S. employers were interested in some type of defined contribution model.³ These plans are based on a fixed employer contribution—the employer chooses how much to contribute on an annual basis. In turn, employees have the choice to select a plan (and other ancillary benefits) from a range of choices to create a customized benefits package that is tailored to their specific needs.
NARROWER NETWORKS

In the coming year, 25 percent of companies plan to encourage the use of high-performing, narrower networks through different levels of cost sharing. Narrow networks focus on quality and cost efficiency through exclusive-provider models. Some health plans offer tiered provider networks in which members pay more for broad access networks and less for high-performing networks. Benefit tiering helps support cost control—without sacrificing quality—through partnering with hospitals and physicians to provide the right care at the right place at the right cost.

PHARMACY SOLUTIONS

The opportunity to manage pharmacy costs is significant, especially with newer strategies that focus on generics utilization. Employers are moving to benefit designs with drug formularies that encourage use of generics. They may even opt for generic-only riders, making a strategic shift from brand-name to generic drugs in order to combat rising costs. Employees enjoy greater generics coverage today than ever before due to the unprecedented number of brand-name drugs losing patent protection and entering the market in generic form.

Other solutions include incentivizing mail order fulfillment for drugs that treat chronic diseases. Nearly half of surveyed employers responded that they are implementing mail order programs for chronic disease drugs, and about one-quarter are restricting certain brand-name drugs or excluding them from their formularies when generic forms are available.

ALTERNATIVE FUNDING

Concerns about the rising costs of traditional, fully insured plans have also sparked interest in self-funding and retrospective funding arrangements. According to a 2011 survey, 28 percent of large employers and 8 percent of small employers were likely to switch from a fully insured to a self-funded plan within the next three years.

With alternative funding arrangements, the employer assumes greater degree of responsibility for claims than in a traditional fully insured plan in exchange for the potential to share in the rewards—cost savings—if the plan performs well. As a result, there’s great incentive for the employer to drive down costs through wellness programs in order to improve health outcomes. By implementing a strong wellness program within an alternative funding arrangement, the health and wellness of employees is enhanced, and a portion—or all—of the related cost savings may be returned to the plan annually.

THE RIGHT LEVEL OF CARE

One of the most overlooked strategies in cost control is simply to incentivize the right behaviors in regard to level of care, which can lead to enormous cost savings for employers and employees. Some insurers offer plans that use evidence-based medical information as the basis for plans with built-in incentives to guide members toward following medically proven practices, guidelines and treatments for their care.

For example, medical evidence shows that elective C-sections can lead to complications for babies and mothers. A health plan that encourages the right level of care would require the insured to pay more out-of-pocket for an elective C-section compared to a medically necessary C-section, sparing the employer and employee base as a whole the burden of supporting expenses that are not medically justified. The goal is to remove unnecessary costs and focus on the medical treatments and care with proven results and a sound medical basis in achieving health outcomes.
Implementing change to health benefits comes with challenges, namely preserving quality employee care and satisfaction with benefits, while working to change ingrained habits of utilization that aren’t aligned with informed cost-conscious behavior.

In the “old” HMO world, employees were often isolated from the costs associated with their use of provider services, which fostered the tendency to overutilize emergency medical care, even for relatively minor ailments that could be addressed more cost effectively through conventional channels. Today, faced with the imperative of holding the line against surging costs, employers and carriers need to educate and incentivize employees to use the medically appropriate level of service.

On the flip side, there are employees that may put off preventive care and screenings because they don’t fully understand their coverage and fear incurring costs—not understanding that preventive care is fully covered in their plans. In this situation, the employer and carrier need to more effectively educate the member on benefits to ensure they are fully leveraging preventive care for better health.

Education can be accomplished through a combination of face-to-face meetings, educational handouts and online tools. Ongoing communications are needed throughout the year—not just during open enrollment—to help keep employees informed of the ways they can get the care they need while being sensitive to costs.

In the Towers Watson survey, 21 percent of employers indicated they were looking to help members make more informed choices by adopting decision-making support tools next year.2 These web-based tools are typically provided by insurance carriers and can be conveniently accessed by employees from home or work. The tools are designed to assist plan members in making more informed and cost-conscious health care decisions while understanding and leveraging the full benefits that are available to them.

When employees have the tools to choose the appropriate level of care to meet their needs in a cost-effective manner, there is greater potential for savings. Employers may also find that employees are eager to adopt a more cost-effective health plan when they can connect the dots between the choices they make on a daily basis and their savings on health insurance. One study showed that employees are generally open to new solutions if there are financial savings in it for them—90 percent of employees surveyed would accept significant benefits changes at some level of savings to them.5

Finding a successful strategy for managing health care costs while providing quality care will require a coordinated effort on the part of carriers, providers, employers and employees. As innovative new plans and strategies emerge, employers should evaluate them to determine the fit for their organizations.

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5 Oliver Wyman Health & Life Sciences Practice 2012 Survey on Employer Health Benefit Plans and Preferences.
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