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Containing Healthcare Costs From an Employer's Perspective

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In recent years the employee benefits landscape in the United States has been transformed by the escalating costs of health care and other benefits, by changes in employment and benefits laws, and by new initiatives and options in health care benefits, particularly those set forth in the Affordable Care Act (ACA). As a result, employers should be exploring various ways to manage health coverage expense.

Business Case

Providing health benefits is an important tool for building a competitive workforce. For job seekers, the strength of an employer's benefits package may be nearly as valuable as salary. In fact, for a potential employee who has one or more dependents, benefits may be even more important than salary. Therefore, employers that want to hire the best, most productive employees must be prepared to pay the price in attractive, competitive health care benefits.

For many employers, however, the price of benefits is becoming increasingly unaffordable. Health care coverage is the largest employee-related expense for U.S. employers. According to the Bureau of Labor Statistics (BLS), private industry employer costs for insurance benefits averaged $2.59 per hour worked or 8.0 percent of total compensation. According to a 2016 SHRM Survey, employers spent an average of $8,669 per employee annually on health care coverage and 77% of organizations saw increases in their health care costs.

Health Coverage Cost Management Strategies

In recent years, employers have tried many ways to control the ever-rising costs of medical coverage for employees. Below are some steps that can produce cost savings relatively quickly:

- Offering consumer-directed health plans (e.g., health reimbursement arrangements, health savings accounts). Contribute to employee HSA per pay period as opposed to annually.
- Monitor Medical Plan Provider Network and Prescription Drug Discounts. *Discuss with your broker.*
- Establishing tiered health insurance plans.
- Offering a variety of preferred provider organization (PPO) plans, including those with high and low deductibles and co-pays. Offering a health maintenance organization (HMO) health plan. *Discuss with your broker.*
- Creating an organizational culture that promotes health and wellness and provide incentives or rewards related to health and wellness.
- Placing limits on, or increasing cost-sharing for, spousal health care coverage.
- Increasing the employee share contributed to the total costs of health care.
- Increasing the employee share contributed to the cost of brand name prescription drugs.

Those approaches are discussed in more detail below and demonstrate the many effective tools employers can use singly or in combination to help control their health coverage outlays.

Offering Consumer Directed Health Plans

Increasingly, employers' efforts to manage their health care costs are focused on getting employees to become better health care consumers. Health care consumerism refers to efforts to persuade employees to make healthful choices in daily living and providing tools and education to help ensure that when employees use health care, they are aware of its costs and have an incentive to reduce those costs when possible. Health care consumerism is tied to health plan design, incentives, an effective communication strategy and enabling plan participants to engage in healthful behaviors.

In many ways, efforts to move employees toward greater health care consumerism are similar to the efforts employers have made to persuade employees to save for retirement by using 401(k) and other defined-contribution plans. In health care as in retirement planning, more responsibility has been shifted to employees, and employers are using incentives to reward desired behavior. Just as employers can offer matching contributions to motivate employees to contribute to their 401(k) plans, employers are using incentives, such as contributions to a health savings account (HSA), to spur greater employee engagement in their health care decision-making.

The use of consumer-directed health plans (CDHPs), particularly high-deductible health plans (HDHPs), is significant in promoting health care consumerism. Studies indicate that employees enrolled in CDHPs are more likely than others to make sustainable, positive behavior changes leading to significant reductions in health plan spending year over year.

Consider making employer HSA contributions on a per pay period basis instead of annually. If an employee leaves the company on February 1st and the employer has the annual contribution to their HSA account in January, that employee is entitled to keep your entire contribution.

Monitor Medical Plan Provider Network and Prescription Drug Discounts

Groups of physicians, hospitals, and other health-care providers agree, through the jurisdictions insurance carrier or third-party administrator, to provide medical services to the organizations employees at discounted costs. Employers need to verify that these providers produce the best outcomes at the lowest price and to challenge

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their insurance carrier or third-party administrator to demonstrate that they have contracted with providers that produce quality outcomes. Periodically reviewing the provider network discounts that have been negotiated on the jurisdictions behalf will allow the jurisdiction to find the deepest discounts. Also, because there are many types of discounts for prescription drugs, plan sponsors need to make sure they understand what is available (e.g., discounts for generic drugs, brand-name drugs, and for retail and mail order transactions). The organization may also benefit from rebates provided by drug manufacturers. ***Make sure to discuss this with your broker.***

Establishing Tiered Health Insurance Plans

Given that the ACA requires employers to expand their health benefits programs to employees' adult children, some employers are looking for ways to share the increased costs of this requirement. Under the law, health plans that offer dependent coverage—as employer-sponsored plans routinely do—must allow participating employees' unmarried adult children to remain on their parents' plan until age 26. One way for employers to share the new requirement's cost is to charge health insurance premiums on a per-participant basis.

Employers have always differentiated premiums based on types of coverage. What has changed is the detail involved in structuring premiums. Instead of offering family coverage with one premium no matter how many children are covered, employers are creating tiers of premium rates. A common four-tier strategy is:

- Employee only, generally called individual coverage.
- Employee plus one, which can mean employee plus a spouse, a partner or a child.
- Employee plus child or children without a spouse or a partner.
- Employee plus spouse or partner and child or children—often called family coverage.

Other options for employers include expanding tiers to require higher premiums for three or more children or having uncapped tiers under which the employee's premium is based on the number of individuals the employee enrolls in the employer's plan. Some employers limit the number of tiers to avoid making coverage too expensive for larger families.

Alternatively, to deal with the affordability of employees' premiums, employers are showing interest in basing premiums on employees' salaries by charging lower-wage earners less for health insurance.

Help Your Employees Stay Healthy

As much as 70 percent of health care spending can be attributed to behavioral and lifestyle choices; thus, employers are increasingly offering employees health improvement programs. Numerous studies have indicated that employers can contain or even reduce health care costs by implementing wellness programs.

Wellness benefits can take many forms, and they can be as simple or as complex as an organization desires. Some wellness benefits help employees deal with preventable and chronic conditions such as obesity, high glucose and elevated cholesterol. Other wellness benefits are incentive programs designed to motivate employees to complete certain health and wellness activities such as:

- Provide wellness resources and information.
- Send wellness tips and information to employees at least quarterly.
- Offer onsite seasonal flu vaccinations.
- Reimburses all or part of the cost of membership in a fitness center.
- Consider a diagnostic testing program that provides a reward for participation rather than for outcomes.
- Offer a program that reimburses employees for the cost of a smoking-cessation program without regard to whether the employee quits smoking.

Before implementing a particular wellness program or initiative, an organization should carefully consider the potential costs, advantages, levels of employee participation and legal concerns. For wellness programs to be effective, employees must know about and participate in the offerings. Fine-tuning an organization's benefits communication efforts can pay big dividends in getting employees involved in wellness initiatives.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), employers' group health plans are not permitted to discriminate against employees on the basis of health factors by varying premiums, but the law does allow employers to offer wellness programs and wellness incentives.

Shift Some of Cost to Employees

A 2016 United Benefit Advisors (UBA) health plan survey showed that families are bearing the brunt of the cost of health insurance. For an employee electing single coverage, the employer covers 71 percent of the monthly premium, but only 54 percent of a family premium. The survey also showed that employers are shifting costs to employees through increased out-of-network deductibles and emergency room co-pays. A major trend in managing employers' health care costs is having plan participants take on increasingly larger portions of the costs of their health care.

- Increase the deductibles and/or co-payments for medical services.
- Increase the costs of using out-of-network health providers rather than in-network providers.

Attaching a Surcharge to Spousal Coverage

Some employers have added "working-spouse" provisions to their health coverage plans. These provisions limit an employee's spouse's access to a plan when the spouse works for another employer that offers health insurance. Working-spouse provisions—also called "spousal carve-out" or "spousal exclusion" policies—generally take one of three forms:

A requirement that an employee's working spouse pay a premium surcharge for coverage through the employee's enrollment if the spouse's employer offers health insurance and the spouse has declined it.

A requirement that an employee's working spouse purchase health insurance through the spouse's employer's plan before also purchasing it through the employee's enrollment.

An outright exclusion of an employee's working spouse from coverage through the employee's enrollment if similar coverage is available from the spouse's employer. This approach is not commonly used.

Before adopting such rules, employers should determine if the savings from the requirements would at least offset the administrative costs and predict possible adverse employee reactions that the rules might entail. Employers must also be aware of the nuances of spousal exclusions, which can determine whether they are effective—and legal.

Changing Prescription Drug Benefits

Prescription drug benefits are fast becoming a larger, more complex and integral component of an employer's total approach to managing health care costs. Pharmacy benefit costs have increased at an alarming rate rising from 20 percent of an organization's overall health care spending in

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the early 2000s to 30 percent in 2016. To manage all drug costs, employers plan to use a variety of tactics, such as requiring:

- Prior authorization before filling a prescription.
- Quantity limits.
- Step therapy, requiring less expensive drugs to be tried first.
- Having the member pay the difference between generic and brand prices.
- Closed formulary excluding certain brand name drugs.
- Integrated medical and pharmacy data for more effective cost management.
- Mandatory mail order for maintenance medications.
- Four-tier or higher pharmacy plan design.
- No co-pay for select generic medications.

Additional Options

Additional options that have potential for significant savings in employers' health care costs include:

- Auditing family-member eligibility and other aspects of the plan.
- Including telemedicine access.
- Self-funding the health plan.

Telemedicine

Virtual doctor visits are a trending health care savings strategy. Telemedicine, in which individuals contact a health care provider through videoconferencing or phone to obtain a diagnosis and treatment, was offered by nearly one quarter of employers in 2016. This arrangement is often less expensive than an office visit and more convenient to individuals who are seeking care after hours or who cannot easily go to a doctor's office. Major health insurance carriers are more frequently offering telemedicine, or employers can contract directly with third-party vendors that provide this type of service. Employee education and communication are necessary for making effective use of telemedicine benefits with employers often promoting the convenience factor to working parents or traveling employees. See Telemedicine: An Emerging Health Care Trend and The Doctor Is In—On Skype.

Self-funding the Health Plan

Concerns that implementation of the ACA would drive up employers' health insurance costs prompted greater interest in self-funding. In a traditionally insured plan, an insurance company assumes the risk, controls the plan's administration, establishes reserve capital levels and manages other major decisions concerning the health care coverage provided to employees and dependents. Under a self-funded arrangement—also called self-insured—the employer assumes the liability and risks of providing health coverage in exchange for more control over the plan's administration and funding. Self-funded plans are most prevalent among organizations with 500 or more employees, although self-funding can work for smaller companies also.

With self-funding, an employer takes the money it would otherwise pay to an insurer and establishes a special bank account to pay for claims. A broker or benefits consultant is hired to develop a customized medical plan for the group. A third-party administrator (TPA) is hired to receive and manage claims, and the employer authorizes the TPA to draw money from the bank account to pay claims. Typically, the TPA arranges to have preferred PPO networks, wellness programs and other managed care elements in place. The TPA issues employee ID cards, too, and thus from the outside the employees appear to have traditional medical insurance.

Self-funded plans are governed by the Employee Retirement Income Security Act (ERISA) and are attractive to employers because of the greater level of flexibility that comes with being able to tailor the plan to their needs. Although employers take on additional financial risk, they are able to limit total risk through the purchase of a stop-loss policy, and they benefit from the increased cost savings typical of the self-funded model.

Communications

Effective communication to employees is critical for success when rolling out health care cost-control measures. In communicating about health care benefits, employers should consider the following recommendations:

Communicate early and repeat the message often. Even though open enrollment is an important time for employers to educate employees about cost-conscious health benefits choices, health care communications experts recommend that organizations provide ongoing communication activities rather than concentrate only on open enrollment season. More employers now believe they need to engage employees continually in health consumerism because the results it can produce derive from day-to-day decisions.

Communicate in a variety of media. Use both traditional and electronic methods. Traditional methods include open enrollment, payroll-stuffers, posters, and a table outside a break area where people explain the program and one-on-one benefits counseling. Electronic methods include intranet communications, e-mail, and mobile-device and social-media access to health benefits information.

Provide employees with tools to help them make cost-effective health care benefit choices. These choices include selecting appropriate health plan options, treatments and providers based on available cost and quality information. With cost information at their fingertips, employees are able to make more insightful decisions about their health care and the care for their families. They can learn to balance cost, convenience and quality in a manner that meets their budgets. That process can lower the overall cost of health care for both employees and employers.

Encourage employees to evaluate how they and their family members used health care in the previous 12 months. Suggest that they consider how much they spent out-of-pocket on deductibles, flat-dollar co-payments, and percentage-of-cost co-insurance and review the number of doctor visits and the cost of ongoing medications. Employees who have an HSA or an HRA should determine what remaining balance they might be able to apply to the subsequent year's expenses.

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