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The Tipping Point in Health Benefits—Three Strategies to Curb Unsustainable Health Benefit Cost

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ABSTRACT

The cost of employer-sponsored health benefits has reached the breaking point where any further increases will suppress wages to a point where employees will look elsewhere for employment. Three strategies hold promise for the breaking point to shift to a tipping point, bending the trend downward, or at least keeping it flat. Three strategies have emerged to break the dependence of employers with self-funded plans on carrier-provider negotiated network contracts. These strategies do not require traditional preferred provider organization networks and, thus, take leverage away from network purveyors. The three trends discussed in this article are: (1) technology-enabled health benefits; (2) direct contracting between employers and providers; and (3) reference-based pricing. These strategies can break this status quo and are not mutually exclusive. The result could be turning into a flat line of downward slope.

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Introduction

The cost of employer-sponsored health benefits has reached the breaking point where any further increases will suppress wages to a point where employees may look elsewhere for employment, in the opinion of this author.[1] In an era of nearly full employment, demand for skilled workers outweighs the available supply, forcing wages higher. Rising health benefit costs outpace general inflation, suppressing wage increases. The labor force is projected to grow at a slower rate in the next 10 years, placing more pressure on wages.[2] The term breaking point means that something has to give; the trajectory of the rising cost curve must begin to flatten out or move down if employers are to continue to offer rich, tax-advantaged health benefits. When the cost curve trajectory begins to stay flat, or move down on a sustained basis, the peak represents a tipping point. When employee benefit and financial advisors are more knowledgeable about these issues, they can educate their clients and respond to questions.

Following is a discussion of three strategies that hold promise for the breaking point to shift to a tipping point, bending the trend downward, or at least keeping it flat.

According to the National Business Group on Health (NBGH), the median annual cost of employer-sponsored health coverage is expected to reach $14,156 per employee in 2018.[3] This cost is the

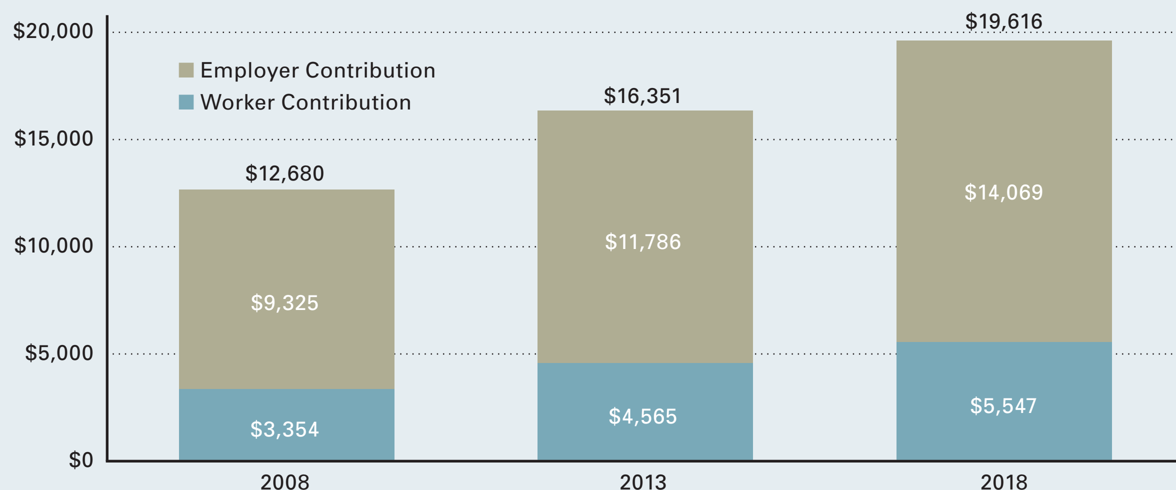
blended single/family total cost, including employer and employee contributions and out-of-pocket costs. Employers pay approximately 70 percent, on average. Furthermore, this cost is expected to increase another 6 percent in 2019.[4]

According to Barbara Gniewek, a health services principal at PwC, "Expensive new medical services and drugs and market consolidation are driving higher costs. It looks like costs are stabilizing, but they are still going up at a rate above inflation…they are still increasing at an uncontrolled level and are ultimately unsustainable."[5]

Costs continue to increase each year for employers, with corresponding increases in paycheck contributions and out-of-pocket costs for their employees and covered family members (Figure 1). Costs have increased by 5 percent or more for each of the last 5 years according to the NBGH.[6] Employers pay more than double the cost paid by the federal and state governments, through Medicare and Medicaid, for the same services. Commercial carriers, who sell networks of hospitals, doctors, and medical services to employers, pay significantly higher prices for common medical services than Medicare fee-for-service (FFS) and Medicare Advantage (MA) plans, according to a report from the Congressional Budget Office (CBO).[7]

One of the most common approaches to rising health benefit costs is to pass these costs onto employees and their covered family members. Cost-shifting takes many forms, from increases in the share of costs paid by the employee, through payroll deductions—as well as increased deductibles, coinsurance, copayments, and other out-of-pocket costs. Many employers have introduced consumer-driven approaches to health benefits through high-deductible health plans (HDHPs) and health savings accounts

FIGURE 1
Average Annual Worker and Employer Premium Contributions and Total Premiums for Family Coverage, 2008, 2013, and 2018



Note: Since 2008, the average family premium has increased 55%, and the average worker contribution toward the premium has increased 65%.

Source: KFF Employer Health Benefits Survey, 2018. *Kaiser/HRET Survey of Employer-Sponsored Health Benefits,* 2008 and 2013; accessed at: https://www.kff.org/report-section/2018-employer-health-benefits-survey-summary-of-findings/.

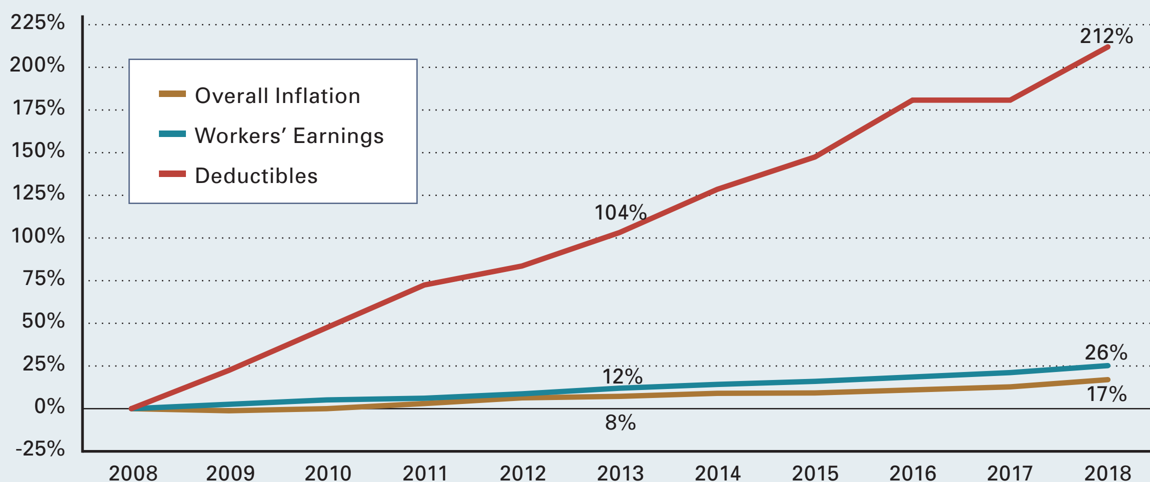
(HSAs) or health reimbursement accounts (HRAs). A full discussion of these strategies is outside of the scope of this article, but it is sufficient to say that consumer-driven strategies have not changed the trajectory of costs and are often confusing and burdensome to participants.[8]

According to the Kaiser Family Foundation president and CEO, Drew Altman, "Health costs don't rise in a vacuum. As long as out-of-pocket costs for deductibles, drugs, surprise bills, and more continue to outpace wage growth, people will be frustrated by their medical bills and see health costs as huge pocketbook and political issues."[9]

One poignant example of this member frustration is the increase in deductibles that participants pay before the plan kicks in to pay benefits. Since 2008, general annual deductibles have risen 212 percent, eight times faster than the rate of increase in employee wages. Stated another way, health care eats wages (Figure 2).

Several forces propel such high employer and employee cost increases. A more detailed explanation can be found in a two-part series from this author published in this journal, entitled "The Health Care Benefit Crisis, Ten Years Later."[10] Most of these cost drivers result from misaligned incentives between the contractual parties to health care delivery. One of the most significant and uncontrollable misaligned incentives, driving high costs to employers, is the structure of network contracts. These contracts, often called preferred provider organizations (PPOs), are negotiated between large, managed-care organizations, or carriers, such as the BlueCross/BlueShield organizations (such as Anthem), United Healthcare, Cigna, and Aetna—collectively nicknamed BUCA, and hospital/physician provider systems. Both parties generate higher revenue as prices increase. While it may be obvious that doctors and hospitals generate higher revenue as prices increase, it may be less obvi-

FIGURE 2
Employee Deductibles Have Increased 10 Times More than Pay



Note: Average general annual deductibles are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

Source: KFF and KFF/HRET Employer Health Benefit Surveys. Consumer Price Index. U.S. City Average of Annual Inflation (April to April): Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April); accessed at: https://www.kff.org/health-costs/press-release/employer-sponsored-family-coverage-premiums-rise-5-percent-in-2018/.

ous that carriers also generate more revenue as prices increase. This is because their fully insured business counts premiums as gross revenue, and net revenue is often calibrated as a percentage of the total premium, capped only by regulated medical loss ratios (MLRs).

As a result, employers and health care consumers often feel stuck in the middle with minimal visibility and participation in a price negotiation—the results of which are their ultimate responsibility. The carrier networks and the health systems (hospitals and doctors) benefit from high and ever-increasing prices, but this model has reached the breaking point for many employers who are looking for new, sustainable strategies to tip this unsustainable trend in a new downward direction.

How has this unsustainable cost trend continued for decades? The answer again: Health care eats wages. Total employee compensation is a function of four components according to Willis Towers Watson:

- pay
- benefits
- work environment
- learning and development[11]

Work environment and learning and development are key aspects of company culture and are the transformational components of compensation. Pay and benefits, on the other hand, are transactional. As benefit costs have steadily increased, employee pay has stagnated. In the opinion of this author, these data points are correlated. Wages have lagged expectations in strong and weak labor markets. Despite some ups and downs over the past several decades, today's real average wage (that is, the wage after accounting for inflation) has about the same purchasing power that it did 40 years ago.[12]

According to author Dave Chase, "There are a number of tricks the industry plays on healthcare purchasers but none is more pervasive, yet easy to fix, than PPO networks. This has caused Americans to spend 30–50 percent (over $1 trillion per year) more than necessary."[13]

Three strategies have emerged to break the dependence of employers with self-funded plans on carrier/provider negotiated network contracts. These strategies do not require traditional PPO networks and, thus, take leverage away from network purveyors. The three trends discussed below are: (1) technology-enabled health benefits; (2) direct contracting between employers and providers, and (3) reference-based pricing (RBP).

Technology-Enabled Health Benefits

While technology has transformed medicine, health care benefits largely operate on antiquated systems. Doctors and nurses use laptops and tablets in patient rooms to record medical records and order prescriptions, sophisticated diagnostic equipment looks inside bodies to identify three-dimensional images of disease, surgeries are performed by robots, and wearables monitor sleep and heart rate. However, antiquated medical claim systems lie at the heart of how carriers process claims repriced under network contract terms. No standard format exists for such claims, and many are processed manually and arrive by mail.[14] The cost of insurance billing alone is estimated at over $471 billion annually, nearly 15 percent of health care spending.[15]

Employers, in an attempt to mitigate rising medical costs, have carved up their health benefits strategy. Large employers with self-funded health benefit plans commonly outsource prescription benefit managers (PBMs) to different vendors than their medical carriers. The carriers and PBMs are merging to gain market power and leverage over both providers and customers, helping them contain the profits lost by these carveouts. Following the lead of United Health Group and Catamaran, Aetna and CVS recently combined forces, as did Cigna and Express Scripts.[16]

In addition to PBMs, several other services are carved out from medical carriers including stop-loss insurance, disease management, second opinions, behavioral health, telemedicine, on-site clinics, transparency tools, and over 1,000 digital health solutions available on the market. The list of outsourced, carved-out, health benefits options is extensive. While

this best-in-class approach to medical benefits management may curb costs, a least for a time, it often erodes the member experience by creating confusion for plan participants, frustrated by a fragmented service offering, with multiple sources of information. This approach also requires additional management time and resources.

The first emerging trend for consideration is for employers to hire concierge vendors, or switch to a technology-enabled, third-party administrator (TPA), who integrates disparate programs and provides meaningful support to participants in a centralized platform. These strategies aim to increase engagement in health programs, and the integration can lessen the time and effort required of employers. New entrants to the market offer higher levels of service to members in a measurable, more effective way.

Employers are increasingly concerned about the poor member experiences that have become commonplace with legacy carriers. When employees and their covered dependents are confused and frustrated with their health plan, their satisfaction with the employer erodes as well. Fortunately, a tool to measure employee satisfaction with various vendors, called the net promoter score (NPS), has become a standard measure of customer satisfaction across most industries. The NPS was developed by Frederick Reichheld and was published in the *Harvard Business Review* in 2003.[17] NPS uses an index ranging from -100 to +100 to measure how consumers are willing to recommend a company's product or service to others.

The average NPS of the health insurance industry is below 20 according to publicly available information, with some as low as -5.[18]

In contrast, the NPS rankings of concierge vendors, like Accolade and Quantum, or a technology-enabled TPA (also known as a workforce health management system), such as Collective Health, have scores between 70 and 75. Concierge vendors, like Accolade and Quantum, do not administer the health plan but serve as a middleman between the employer and health plan, and other vendor-led programs, to improve integration, engagement, and member experience. In contrast, technology-enabled TPAs replace the health plan by adjudicating claims and providing all of the services of a carrier or TPA, while also providing concierge service and integration with other programs.

When employers move their health benefits administration to platforms that use modern technology that integrates with multiple health solutions in one place, it changes the status quo from carrier-based approaches with a poor track record of managing costs and poor member experience, to solutions that reduce cost while improving the member experience. While concierge vendors help to break the status quo, technology-enabled TPAs go further to mitigate the grip that carriers have on employers. Based on finding from Capgemini, digital TPAs are delivering value compared to traditional TPAs in the following ways:

1. Digital customer engagement—Eighty percent of consumer engagement in the insurance industry occurs through traditional paper and voice-based channels, and that's not likely to change soon. However, digital TPAs let plan members interact with a company's customer service center using the digital channels of their choice, enabling members to start their customer journey on one channel and complete it on another—providing flexibility and responsiveness across a broad range of demographics. With digital TPAs, over 60 percent of interactions take place through digital channels, delivering more data and analytics that provide a much greater view and inform product decisions across the business.
2. Quicker product launches—Although traditional TPAs mimic the often inefficient process used by insurance companies to launch new products, digital TPAs can launch new products within 90–120 days. This allows companies to benefit from an agile and "lite" implementation process to experiment with product design.
3. A reduced-paper environment—With digital

customer interactions delivering information via interactive voice response (IVR), text message, email, and customer portals, digital TPAs focus on further eliminating paper through automating document, payment, and e-statement processing, leveraging artificial intelligence (AI) to route transactions to a specialized team. Using less paper holds the promise to deliver faster, more objective data collection, increased portability for data consistent with member privacy rights, and potentially reduces risk of error—all of which translates to better experiences and better insights.

4. More insights, fewer reports—Digital TPAs invest significantly to create useful insights and analytical models which benchmark and enhance their administration platforms. This promises to lead to enhanced decision-making for employers regarding health benefit strategy.
5. Platform ecosystem versus administration system—Digital TPAs invest significantly in building out their platform ecosystems to integrate plug and play, third-party or proprietary applications. These integrations take place in a highly automated environment to drive efficiencies and increase productivity by 3–5 times, according to Capgemini.[19]

Direct Contracting between Employers and Providers

The second trend for employers with self-funded plans, particularly large employers with at least 1,000 employees in a market, is directly contracting with a local health system rather than purchasing a network from a carrier.

Employers with large, local populations, defined as 1,000 or more enrolled employees, have significant clout with local health systems and can negotiate with the highest quality hospital systems in their areas to achieve the most favorable unit cost (rates), along with quality and cost-containment guarantees.

Direct contracting lets employers improve the effectiveness of population health programs and reduce medical-plan costs through unit-cost reduction and risk-sharing arrangements. For example, General Motors entered into an arrangement with Henry Ford Health System in Detroit. By doing a direct deal, “We are able to specifically focus on the conditions in the GM population and what we want to improve on,” said Sheila Savageau, U.S. health care leader for GM. For health care providers, such contracts can guarantee a patient volume without the need to bet their entire businesses on performing well under new quality requirements and payment models.[20]

Other employers including Walmart, Boeing, Intel, and Walt Disney have negotiated direct deals with hospitals/health systems.[21] These health systems gain market share through employer plan design that limits the use of competing health systems. This concentrated level of revenue from large employers allows the health system to tailor services and access, including on-site clinics, preferred scheduling, care management, and wellness services.

Self-insured employers who contract directly with local health care providers, with the help of digital TPAs who assemble and manage all the essential components, may be able to lock in favorable pricing for health services and to lessen the burden on employees to comparison shop and navigate a broad ocean of providers.[22]

Of the three main parties to a health benefit contract, employers, carriers, and providers, employers have the most leverage to fundamentally challenge the status quo. According to Rajaie Batniji, MD, PhD, and cofounder of Collective Health, “It’s fundamentally up to employers to drive the creation of an employer-driven health care economy, which means it’s up to employers to ensure that we’re creating a real market in health care, and we don’t have one today.”[23]

Reference-Based Pricing

The third strategy to break the status quo and avoid the breaking point of health benefit cost is ref-

erence-based pricing (RBP). RBP does not involve a traditional insurance carrier or provider network negotiating covered services for the plan. With RBP, employers set a fixed limit on the amount a plan will pay for certain health care services.

The fixed limit is often based on a percentage, or multiplier, of what Medicare would pay the provider. The question then becomes whether the health care provider will accept these payments, which can be much less than what traditional insurance carrier networks would pay.[24]

Example

Let's say that a participant needs a certain kind of surgery, and a hospital would expect to be paid $2,500 for it, even if some insurance carriers may have contracted to pay less. The Medicare rate is $500, and the reference-based pricing plan's fixed limit is 200 percent of the Medicare price, which comes out to $1,000.[25]

While RBP lowers plan costs, it can be controversial, because members can be caught between the actions of the plan and health care providers. If the provider does not accept the referenced price, the patient may receive a balance bill for the full cost of services. Because of this, employers who use RPB as a strategy attempt to settle negotiations quickly and to provide member support to covered participants when charges are pending to reduce member anxiety over unpaid hospital bills.

While RBP can be controversial, the strategy is gaining traction with certain state governments. For instance, North Carolina and Montana are moving to RBP approaches for their state employees. Montana has 30,000 plan members. North Carolina has 727,000 teachers, state workers, retirees, and their dependents on its plan.[26] These states set the prices their plans pay as a percentage of Medicare rates. The Carolina employee plan is expected to save $300 million per year.[27]

Conclusion

If employers continue to rely on carrier-based networks to manage the cost of their employee health plans, they can expect to see costs increase each year by rates significantly higher than inflation. Three employer strategies can break this status quo. Leveraging technology, direct contracting, and RBP each hold promise for self-funded employers and are not mutually exclusive. For instance, technology-enabled TPAs can administer direct contracts and RBP strategies with a keen focus on member satisfaction.

While RBP has been implemented mostly by smaller employers and direct contracting by larger employers, technology can make these disruptive strategies available for self-funded employers of all sizes. For smaller (fewer than 1,000 employees) employers to adopt direct contracting, they may either look for opportunities to band with other employers in their market to participate in direct contracts or leverage direct-contracting products developed by technology-enabled administrators. For larger (1,000 employees or more) employers to leverage RBP, they need to partner with firms that significantly mitigate balance billing concerns through proactive, high-touch member services and legal advocacy. As the gap closes for employers with these strategies, the rising trajectory of health benefit cost could reach a tipping point, turning into a flat line of downward slope, a welcome reprieve for employers who would rather pay employees higher pay, offer an improved work environment, and offer richer learning and development opportunities—the other components of total compensation. If we hit a tipping point, employers can gain a competitive advantage in a global market. ■

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