Providing both good and affordable health care benefits to employees may be getting more difficult—but it’s not impossible. Some options available to plan sponsors for controlling costs can also result in better care.

Both proponents and detractors of the Patient Protection and Affordable Care Act (ACA) are cautiously looking at ways to optimize value—providing the best possible health and welfare benefits at the lowest possible cost. The challenge is complicated but, for plan sponsors with the right information and a clearly defined strategy, not insurmountable.

Delivering participant value requires more than cost-containment strategies that simply cut benefits. It requires programs that provide better quality and more cost-effective care. According to a recent International Foundation of Employee Benefit Plans survey, plan sponsors remain committed to providing health insurance coverage. But with continually rising health care costs, some plan sponsors are looking into strategies like giving participants incentives to use high-performance networks or retiree exchanges that were unthinkable not long ago.

However, the outlook is not necessarily dire. Plan sponsors have options to achieve better quality and cost-effectiveness for participants and plan sponsors. They should thoughtfully review the ideas presented here and determine which programs make the most sense for their situation, keeping in mind that the best way to manage cost and quality is through a combination of programs and initiatives.

Effectively managing costs and participant value can be approached through these six categories:

1. Administration
2. Benefits
3. Eligibility
4. Networks
5. Programs
6. Provider payments.

Administration

Administrative cost-containment strategies focus primarily on completing a series of audits. Audits are a cost-effective tool to find savings. Plan sponsors should consider the following audits:

by | Dee Shaw
Delivering Participant Value in an ACA World

**Medical Claim Payment**

This postpayment audit can determine whether claim payments were accurate by reviewing for duplicate payments, input errors, coordination of benefits, cost-sharing provisions, eligibility and usual and customary charges. Audits can also readjust claims in accordance with the plan of benefits, required authorizations and third-party liability.

**Pharmacy Claim Payments**

This audit reviews and monitors how the pharmacy benefit manager (PBM) is performing compared with contractual terms. The use of pharmacy audits is growing due to the sophistication of the pricing and contractual terms of pharmaceutical programs, plus the savings returned due to audit results.

**Large Case Management**

This audit considers best practices in large case management, which relates to managing the health care of participants with high-cost medical conditions. Large case management reviews are receiving increased attention due to the ACA requirement to remove annual and lifetime benefit maximums. Implementing large case management best practices helps members with high-cost medical
health care cost containment

conditions by coordinating care with a focus on improving the quality of care (often at lower costs for the participant and/or plan sponsor).

**Dependent Eligibility**

This audit validates the eligibility status of dependents through the verification of birth certificates, adoption papers and marriage/divorce records. According to the audit firm HMS, “4%-6% of covered dependents are actually ineligible for coverage.” This is significant, and these audits are receiving increased attention because of potential savings on claim payments and ACA fees, which are paid on a per person basis.

**Out-of-Network (OON) Negotiation Service and Claim-Editing Software**

The services and vendors for these two programs often go hand in hand. OON negotiation services work to negotiate with OON providers prior to payment of the claim. The vendor typically receives a contingent payment based on a percentage of savings, which generally is defined as the difference between the billed and negotiated amount.

Claim-editing software looks for duplicate payments, unbundling of billing codes and input errors. The program runs on a real-time basis before any payments are made. Claim-editing programs differ from medical claim audits, which are retrospective reviews of claims.

**Stop-Loss**

By providing a list of all cost-containment and medical management programs to a stop-loss vendor, a plan can show the work being done to manage costs. Stop-loss vendors have exhibited a willingness to drop renewal increases or to offer better rates when advised of current or planned programs that support cost savings.

**Benefits**

**High-Deductible Health Plan (HDHP) and Cost/Quality Transparency**

Plan sponsors are beginning to understand the vast cost and quality variation that exists in health care. HDHPs are designed to mitigate the effects of poor quality and high-cost care by encouraging consumers to make value-conscious, informed decisions. These plans have the potential to generate real savings; however, the ability to capture savings is highly dependent on plan design, consumer engagement and incentives.

To make informed decisions, consumers must have easy access to cost and quality information. There has been a recent rise in the use of cost and quality transparency tools for members’ use. Medical carriers offer many of these tools. HDHPs are gaining popularity in the single employer plan environment, but adoption among multiemployer plans is less common.

**Value-Based Benefit Design**

Value-based benefit plans are designed to both remove barriers to high-value health services and encourage care from the most cost-effective service providers. An example is offering plan participants a lower copay for procedures performed at outpatient facilities (compared with a hospital that may offer the same service but at a higher cost). Another example is offering an incentive to use a center of excellence (COE). Facilities earn the COE designation when they have met certain cost and quality outcomes.

Value-based benefit designs can also be used to promote wellness activities. Plans can offer incentives for completion of a specific activity such as a health risk assessment, biometric testing and adherence to medication or chronic condition management.

---

**Education**

**25th Annual Health Benefits Conference & Expo**

January 25-27, 2016, Clearwater Beach, Florida

Visit hbce.com for more information.

**Trustees and Administrators Institutes**

February 15-17, 2016, Lake Buena Vista (Orlando), Florida

Visit www.ifebp.org/trusteesadministrators for more information.

**Specialty Drug Costs: What’s an Employer to Do?**


**From the Bookstore**

**Self-Funding Health Benefit Plans**


Visit www.ifebp.org/SelfFunding for more details.
**Outpatient Preauthorization**

Plans may want to expand preauthorization to include a targeted list of outpatient procedures, including surgical procedures and diagnostic imaging. Many health care procedures have shifted to outpatient treatment; however, the costs for these procedures vary and can be expensive.

With preauthorizations in place, case managers would receive early identification and be able to intervene quickly to coordinate care. The case manager's goal is to have the patient receive high-quality, cost-effective care and ensure that the treatment is necessary.

**Private Insurance Exchanges—Retirees and Actives**

Private insurance exchanges often are viewed as outsourcing health benefits or as a defined contribution approach for health coverage whereby a plan sponsor contributes a set dollar amount for an employee to purchase coverage. If the employee chooses coverage that costs more than the plan sponsor contribution, he or she is responsible for the difference. Third parties such as brokers, consultants or carriers have developed privately run insurance exchanges and set up coverage offerings. Often, the plan sponsor subsidizes premium costs.

Exchange options, including privately run exchanges, may provide opportunities for the more cost-effective redesign of both Medicare-eligible and early retiree medical programs. Coverage for early retirees in the public exchange marketplace may be less costly than privately sponsored coverage for both the retiree and the plan sponsor due to age-related underwriting restrictions for these plans.

Medicare exchanges are increasingly popular for Medicare-eligible retirees and may also be less expensive for retirees and the plan. Exchanges give Medicare-eligible and early retirees the opportunity to select plans that are best suited to their health care needs and financial situation.

**Retiree-Only Plans**

Plan sponsors that offer retiree coverage may want to consider offering a “retiree-only” plan. These plans are separate from active plans in terms of documentation, funding, benefits, accounting, reporting, disclosure and administration. Plan sponsors are adopting retiree-only plans to take advantage of exemptions from certain ACA requirements; this can provide opportunities for savings if plan designs are adjusted to exclude the required changes.

**Eligibility**

**Requirements for Eligibility**

Whether or not changes are made, it is worth considering a review of the plan's requirements for benefit eligibility. With options now available through public exchanges, many low-paid employees may qualify for subsidies on a public exchange that could potentially offer cost-effective options for both the member and the plan.

Reviewing eligibility requirements is especially important for retiree medical eligibility. Plan sponsors are revisiting age and service requirements for retiree coverage.

**Spouse or Dependent Contributions**

Reviewing spouse or dependent contributions for benefit coverage, especially when the dependent has other coverage available, is a recent trend.

**Networks**

**High-Quality, Narrow Provider Networks**

These networks include providers that are selected based on efficiency and quality. Medical carriers developed these networks and have reported significant cost and quality gains, such as improved patient outcomes, fewer hospital admissions, fewer unnecessary emergency room visits, lower readmission rates and progress in diabetes treatment.

**Specialty Networks**

Other types of networks to consider:

- **Preferred provider organization (PPO) wrap networks,** which are used as a second tier to fill in gaps from a primary network to receive discounts for what would have been considered out-of-network, higher cost services
- **End-stage renal disease (ESRD) networks,** which accept negotiated rates for dialysis treatments and do not balance bill participants.

**Programs**

**Decision Support, Second Opinion and Patient Advocacy**

Decision support is a collaborative process between a patient and his or her provider or an outside professional service to make health care decisions together. These decisions take into account the best scientific evidence available as well as the patient's values and preferences.
Second opinion is a process of seeking another doctor’s opinion about a diagnosis or treatment options. It either confirms the initial diagnosis or treatment plan by the primary physician or offers an alternative diagnosis and treatment approach.

Patient advocacy is a specialized service that covers patient representation and the support and education of patients.

Technology
Private equity and venture capital firms are making significant investments in new technologies to help eliminate inefficiencies in health care. For example, mobile applications, social communities and online games are being developed to improve wellness. Members are engaged via mobile devices including personal trackers, biometric tracking, diaries and journals. Social media is also being used to encourage healthy behaviors through the use of peer competition and communication.

Telemedicine is also on the rise. These programs supplement the participant’s primary care physician (PCP) relationship when the PCP is unavailable. In a recent Harris Poll, 64% of consumers reported a willingness to have a video visit with a doctor. In addition to being convenient, telemedicine visits generally cost less than emergency room or physician office visits.

Technology has become more prevalent in administrative tasks such as scheduling appointments, communicating reminders, requesting referrals and reviewing lab results.

Pharmacy Programs
A number of programs should be explored to assist with cost containment for both the plan and participants. This is especially true given that many professionals in the industry are projecting double-digit pharmacy cost increases in the near future. Examples of these programs include:

- Reducing/eliminating gaps in care that occur when patients don’t comply with prescribed treatment courses
- Step therapy, which is the practice of beginning medication for a medical condition with the most cost-effective drug therapy and progressing to other more costly or risky therapies only if necessary
- Waste reduction (for example, providing only a portion of an expensive prescription until patient tolerance is determined)
- Narcotics management
- Pharmacy medical management, including prior authorizations
- Formulary management, including generic drug incentives.

Provider Payments
New provider payment models attempt to align payer, provider and patient incentives. This shift is aimed toward promoting value-based care, which gives health care providers incentives to maintain a high quality of care rather than a high quantity of patients. These are not necessarily activities or programs a plan sponsor can initiate but are included here as informational. These tools are being employed in the market to address structural issues in providing quality, cost-effective care.

Prevalent models include accountable care organizations (ACOs), which are medical organizations that receive a set payment to provide medical services. The payment increases with improved outcomes and patient satisfaction. Another provider payment model is patient-centered medical homes, which receive payment to coordinate care for patients who have complex conditions or diseases.
Case Studies With Results

Two case studies show how certain plans have implemented some of the methods described above and achieved the desired outcomes.

Case Study #1: Medical Trend of 0% Over Five Years

A Taft-Hartley plan sponsor that implemented a number of the programs described above has had a medical cost trend of 0% over the past five years, which is far below average trend. For comparison, a plan with an 8% medical trend each year would expect to pay 47% higher medical costs after five years of increases.

To achieve this, the plan sponsor was very aggressive in cost-containment programs and took the following actions:

- Offered incentives to receive independent expert second opinions
- Directed plan participants to COEs
- Added direct contracting for routine physical examinations and a reduced rate from a local hospital
- Introduced a 24-hour nurse line, disease management programs and a gaps-in-care program with messaging to members and providers
- Conducted dependent and prescription drug audits
- Upgraded vision screening and retinal scan coverage for disease management
- Implemented claim prescreening for fraud, waste and abuse
- Provided its stop-loss provider with a list of all cost-containment programs to receive a premium reduction.

Case Study #2: Retiree Coverage Savings of Almost 50%

One plan sponsor that was committed to finding ways of reducing retiree health costs implemented a retiree-only plan for its early retirees and offered a private insurance exchange for Medicare-eligible retirees. The plan sponsor put these programs in place when the retiree health and welfare plan projections indicated a major financial shortfall.

The retiree-only plan saved money by taking advantage of the benefit exemptions under ACA:

- Out-of-pocket maximums higher than those allowed under ACA were maintained.
- Summaries of benefits and coverage (SBCs) were not needed.
- Claims appeal provisions changes, such as external review, were not required.

Medicare-eligible participants were moved from a defined benefit plan to a defined contribution plan for medical and pharmacy benefits, using a private health benefit exchange. Retirees were provided with a health reimbursement arrangement (HRA) to subsidize the cost of premiums on the exchange. The retirees were then able to select plans best suited to their health care needs, geography and financial situation. The plan has saved almost 50% of retiree expenses year over year as result of these changes.

Endnote


Dee Shaw is a senior consultant in the Los Angeles, California office of Horizon Actuarial Services, LLC. She has 30 years of experience in health care and benefit consulting management. Shaw helps clients nationwide manage health care costs and navigate the complexities of health care delivery and financing. She has advised Taft-Hartley, major, national and large groups in various aspects of health care management, including health plan design, HMO/POS, PPO and consumer-directed plan consulting, behavioral health benefit management and retiree medical plan consulting. Shaw previously was the health and group benefits practice leader for Watson Wyatt (now Towers Watson). She has also served as vice president of special accounts at Kaiser Permanente and was the regional director of commercial and large accounts at Health Net. Shaw holds a bachelor of science degree from the University of Iowa and is a graduate of the Advanced Leadership Program at the University of North Carolina Kenan-Flagler Business School.