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Over the next ten years, health care spending in the United States is projected to increase at an annual rate of 5.4%. If these trends continue, total annual health care costs will reach \$6.2 trillion by the year 2028, according to a recent report by the Centers for Medicare & Medicaid Services (CMS). In response to the cost escalation, plan sponsors in corporate, multiemployer and public employer environments are looking for ways to limit the growth of their health care expenditures while continuing to provide high-quality coverage to their participants.

The 2020 *Employee Benefits Survey* from the International Foundation of Employee Benefit Plans provides benchmarking data on the methods that health care plan sponsors are using to control escalating costs, including administration/data analysis, cost sharing, plan design and utilization control initiatives.

Nearly all (98%) of the 752 organizations that responded to the survey offer health care benefits, most commonly through a preferred provider organization (PPO) (75%), a high-deductible health plan (HDHP) with a health savings account (HSA) (52%) or a health maintenance organization (HMO) (26%).

Administration/Data Analysis Initiatives

Respondents use a number of administrative and data analysis initiatives to target growing costs. Three in five (60%) responding organizations conduct health care claims utilization analyses, which include any number of initiatives used to control costs and eliminate both the over- and underuse of health care services. Less than one-half (43%) conduct health care claims audits to examine health provider records to determine whether services provided were necessary, properly administered and correctly

billed. In addition, more than one in four (27%) respondents use *predictive modeling*, which uses data analysis techniques to forecast health care spending trends and determine the likelihood of future spending.

Cost-Sharing Initiatives

Responding organizations employ a range of cost-sharing initiatives to target escalating costs. Particularly, tiered cost-sharing plans are commonly offered. *Tiered systems* classify health care providers into tiers using a combination of cost and quality metrics. Participants pay a higher price to use the higher cost or less efficient providers in plan networks. These types of plan designs provide an incentive for participants to choose the most efficient and/or high-quality providers while motivating providers to become more efficient and/or improve the quality of their care. Two-tiered cost-sharing arrangements are the most common (34%), but three (20%), four (19%), and even five or more (3%) tiers are often employed by responding organizations.

Plan Design/Program Initiatives

Survey respondents also incorporate several plan design initiatives to save costs and sustain coverage. About two in five (37%) use dependent eligibility audits to verify the eligibility of dependents—including spouses, children, stepchildren, disabled adult dependents and wards—enrolled in health plans. One in seven (14%) employs *spousal surcharges*, which reduce coverage available to a worker's spouse if the spouse has coverage through their own employer. About 5% of responding organizations go a step further and institute *spousal carve-outs*, in which spouses with coverage elsewhere are denied coverage. Similarly, about one in eight (12%) responding organiza-

tions uses opt-out incentives, typically a lump sum or monthly payout offered by an employer to workers who decline participation in a health care plan.

Purchasing/Provider Initiatives

Initiatives aimed at the purchase point of health care also are becoming more prevalent among responding organizations. More than four in five (80%) offer telemedicine services. *Telemedicine* refers to the use of technology to deliver health care services, usually for nonurgent situations or the management of chronic conditions. The number of responding organizations using these services saw a drastic uptick between 2016 and 2018, followed by another uptick between 2018 and 2020. Other International Foundation studies have attributed this most recent increase to the COVID-19 pandemic, when in-person medical appointments may have been unavailable or participants sought to avoid them.

One in three (37%) responding organizations has access to *centers of excellence*, which are programs within health care institutions that supply high concentrations of resources to specific medical areas to achieve comprehensive and targeted outcomes. A similar proportion (37%) of organizations provide price transparency or comparison tools, which allow plan participants to make more informed health care decisions. More than one in four (25%) responding organizations use health care advocates/navigators

to help workers traverse the complicated health care system, while more than one in seven (15%) plans contract directly with hospitals and doctors for health care services to obtain reduced prices. With direct contracting, employers may realize cost savings by bypassing insurers and other third parties. A similar proportion (13%) of responding organizations are members of health care coalitions or purchasing groups. These groups use their enhanced purchasing power to obtain medical services at a significant cost savings and are the most common in the multiemployer health plan sector.

Thirteen percent of responding organizations deploy any number of provider health care quality initiatives. About one in twelve (8%) respondents offers *narrow health networks*, which establish smaller groups of providers that participants can use in exchange for paying lower premiums. A small but stable proportion of responding organizations offer *medical travel/tourism services*—sending workers to other locations to obtain health care services, most commonly nonemergency surgeries. Travel can be to both domestic (5%) and international (5%) locations.

Utilization Control Initiatives

Responding organizations continue to offer cost-saving initiatives aimed at controlling the utilization rate of health care services. About seven in ten (67%) use *case management*, a care model that focuses on coordinating health



care services needed by patients. These services vary but can include checking for available benefits, negotiating provider fees, arranging for special services, coordinating referrals, coordinating claims among benefit plans and providing postcare followup.

About two in three (66%) plans use *prior authorization/utilization management*, which requires the participant to obtain authorization from a health plan or insurer for care prior to receiving the care. In these cases, failure to obtain prior authorization may result in a financial penalty to either the plan member or provider. More than three in five (61%) offer disease management initiatives, which are used to improve the health of participants with chronic conditions such as diabetes, cancer and heart disease. About three in five (56%) responding organizations offer

nurse advice lines that employ registered nurses to answer health care questions over the telephone. The service, which often includes counseling and patient education, guidance in obtaining services and referrals to service providers, is more frequently offered in corporate and public employer environments.

More than one in three (36%) responding organizations offer education materials, such as medical self-care guides, directly to health care consumers. About one in four (27%) responding organizations offers second-opinion services in their health plan. These services allow reviews of recommended medical procedures and allow organizations to look for more effective alternatives. Finally, more than one in six

(17%) have access to an on-site health care clinic, an offering more commonly found in larger organizations.

The 2020 *Employee Benefits Survey* reveals extensive benchmarking data from 752 organizations representing nearly 20 industries and ranging in size from fewer than 50 to more than 10,000 employees. Employers reported on a wide range of benefit offerings including retirement, health care, life insurance, survivor benefits, voluntary benefits, paid holidays, vacation, paid-time-off banks, disability benefits, paid and unpaid leaves of absence, work/life benefits, executive perquisites and more. International Foundation members and nonmembers may purchase and download the survey at www.ifebp.org/store/employee-benefits-survey.