5 Best Practices

How employers can save money with best-in-class health plan design

One of the best ways to control your health costs and trends is through your plan design. That's why a self-funded environment provides an advantage for employers, says Mark Haegele, regional vice president of sales at HealthLink.

"There's more to plan design flexibility, and you can take ownership over the plan design to change participant behavior," Haegele says.

How does pay for performance work?

This term is broadly used throughout health care, but for plan design it means properly aligned incentives and paying for the performance of members and health care providers.

A provider might be reimbursed, based on how it performs according to metrics. If a primary care provider treats a member, it's hard to quantify if that member is receiving the appropriate levels of care unless you set up a performance metric and engage on it.

Not only can health care providers and hospitals be reimbursed for performance, it works for members, too. The plan design can reimburse members based on their commitment to seeking and ensuring they meet the minimum levels of care for an illness or their overall health. Is their blood pressure, cholesterol and body mass index in range? If they are in check, your employees and their dependents might get dollar credits toward their premium.

You can also measure upwards of 30 chronic conditions for the minimal levels of care associated with those conditions. If a member meets that treatment protocol, you can either 1) pay for those minimum levels of care or 2) ensure that member gets credit toward his or her premium.

What are benefit carve outs?

In a self-funded plan, you can provide preferred pricing and providers for certain services that are carved out of your normal benefits. This includes things like dialysis, cancer, certain elective surgeries, laboratory or high-cost imaging.

Very specific language can be incorporated to help manage these cost items. Not only are you putting a limit on it, you're also directing members to certain facilities.

How do member self audits help cut costs?

It has statistically been proven that when members get care, health care providers will make mistakes and bill for services that members didn't receive. There have even been extreme examples where somebody has his or her broken arm set and gets billed for a hip replacement. Because there's no mechanism to scrutinize these billings, mistakes often don't get caught.

You can set specific plan language, so that if members ask for a list bill from their hospital stay (whether it's in or outpatient), identify services that they didn't receive and then get them eliminated from the bill, the employer shares the savings with the member.

What does 'not to exceed' language mean?

This is true reference-based pricing, with a list of common health procedures and the maximum that the plan will pay.

For example, a health network might determine knee replacements in your region on average cost $15,000. It also finds five facilities within 20 miles that charge $9,000. So, your self-funded plan might state that it will provide members with knee replacements, not to exceed $10,000.

It steers behavior and forces the member to ask questions and have a dialog with the insurance company, third-party administration or network about the cost.

How can state mandate exclusions be incorporated into plan design?

Under a fully insured environment, insurance companies have to cover everything that the state mandates. For example, bariatric surgery and infertility treatment have to be covered in Illinois.

If you're self-funded, your plan design language can exclude state mandates. It highlights the fact that you have flexibility and control as a self-funded employer. You could even say: I'll cover 50 percent, instead of the state mandated 80 or 90 percent.

Plan design features in a self-funded plan allow you to exercise more control over your health care costs, which is something that many employers are looking for.