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6 self-funding strategies to transform health plans

By Rob Gelb
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The United States already has one of the world's most expensive health systems – and with projections of 47% growth in U.S. health expenditures by 2028, it may feel like there's no end in sight.

The skyrocketing costs of care has many self-insured employers considering more affordable alternatives to traditional benefit plans and provider networks. NFP's 2022 U.S. Benefits Trend Report showed that most employers are ready and willing to implement new cost-containment measures, with almost two-thirds feeling a sense of real urgency to make a change.

The NFP report also shows roughly three-quarters of employers consider the following factors to be important when considering cost containment:

- Increasing employee access to quality providers
- Making costs more transparent
- Reducing out-of-pocket expenses for drug costs

But what do employers and benefits consultants need to drive better health outcomes and more positive member experiences while also managing spend? And how do they find the right solution that does it all? Here are six key aspects of a reimagined self-insured health plan that benefits everyone involved:

1. Seek deep data transparency

According to a 2019 study by health care scholars in the Journal of the American Medical Association, the annual cost of wasteful spending in health care has ranged from $760 billion to $935 billion in recent years, or nearly one-quarter of total health care spending. Most often, the member has no idea how or why this happens, even as they find themselves on the hook for many of these costs.

The primary issue plaguing the health care industry is a lack of transparency in data and how data is

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shared. Top-to-bottom data transparency, starting with clinical transparency, is the bedrock of a cost-effective health plan.

Transparency means information not just about cost and payment of health care services, but also detailed analyses of quality and utilization of care. When the plan, provider, payer and member are aligned with the data and everyone is on the same page at the beginning of the member's health journey, everything comes together. The member understands the treatment and care plan, the provider understands what and how they'll be paid, the plan understands exactly what's covered and where their best cost savings are derived, and the payer reaches a shared agreement on claim costs.

How do successful self-funded plans make this happen so everyone can access, share and leverage the right insights? By aggregating years of robust claims data from thousands of provider network cases with industry-leading sources of payment, cost and charge-based data sets, together with biometrics and clinical data.

Regulatory and technological advancements are improving employer visibility into the actual cost of care with supporting data analytics to forecast future expenses. That's a win-win for everyone and focuses on what's important: spending time on care, not administrative activities that drive health care spending sky-high for little ROI. Providers get paid faster, and members have a greater understanding of their health care choices, creating less anxiety that they're doing the right thing.

2. Deploy smart network design

According to an investigation by Kaiser Health News and NPR, more than 100 million Americans – including 41% of adults – are saddled with medical or dental bills they can't pay. A quarter of adults with health care debt owe more than $5,000, and about 1 in 5 said they'll probably never be able to pay it off.

Self-insured employers need provider networks tailored to meet their specific needs and those of their patient population, including low-cost to no-cost options. Members will get the right care at the right place and time through data-driven care navigation that provides guidance based on financial status as well as health needs. Many members don't realize or understand they may be eligible for free or low-cost care through the 501(r) charity care option, nor do they know they have access to Centers of Excellence with high-quality, pre-negotiated care bundles and surgical networks.

"Next-generation plan designs require simplifying the complexity of the health care ecosystem," the authors of the NFP report wrote. "Successful value-based structures empower the member through care navigation, helping to bridge the medical literacy gap by adding incentives that encourage prudent access, quality and cost decisions. The answer: Use data to work smarter."

When members receive direction of care that emphasizes keeping them in-network at the highest possible level of quality for the lowest cost, the results are lower stop-loss premiums, reduced plan spend and the removal of barriers to care. That means the employer and payer benefit as well.

3. Ensure the right price in the first place

Market-sensitive repricing is a powerful catalyst to help self-insured employers think about networks differently. This methodology delivers a fair cost of service while opening member access to a larger number of providers outside of traditional contracted networks.

Focus on taking a relational rather than transaction approach in aligning all parties involved and working with providers without the use of contracts. Market-sensitive repricing relies on a comprehensive range of data sources, including usual and customary rates, paid claims, high-performance networks, national benchmarks, and utilization data including the Medicare rate.

Medicare rates alone are not the answer, despite companies that deploy reference-based pricing (RBP), which sets provider reimbursements based solely on Medicare rates. That often causes friction. Health plans need a fully engaged partner to inform decisions based on numerous data points, rather than a singular benchmark. An agile, data-rich solution for pricing and reimbursement that reflects the local market will always come through as a more member-centric and frictionless choice.

The result of market-sensitive repricing is a fair, defensible reimbursement rate that delivers up to a 60% to 70% reduction from billed charges. Anything else leaves members vulnerable to surprise RBP-driven balance billing, shifts the cost burden to providers and patients, and adds to the complexity of healthcare.

4. Integrate comprehensive bill review

Erroneous, questionable billing and unnecessary charges associated with fraud, waste and abuse are running rampant in the industry. Some projections regarding the cost burden of payment errors or overpayments represent up to 7% to 10% of all health care spending in the next few years.

Self-insured plans need a complete bill review system with provider signoff, so most improper or incorrect claims won't see the light of day. In addition, a truly comprehensive solution will offer clear, defensible and plan-specific bill reviews that are integrated with negotiation and other offerings in networks and care. This is essential for end-to-end cost and claim management that ensures high capture rates for savings that prove to be 10% to 30% greater than contracted network discounts.

5. Empower true consumerism

Consumerism has become a big talking point in the health care industry, but choices continue to center primarily around the provider or plan. Members don't have the insights they need to make the right choices in such a complex system.

True consumerism is possible by personalizing the thought process about a member's unique needs and treating them like online shoppers, with a wealth of opportunity at their fingertips. With access to the right tools, such as a digital front door care, members engage one-on-one with care navigators and uncover the relevant health care information they need: provider lookups with cost and quality data, care management support, telehealth, remote patient monitoring options, access to their true out-of-pocket costs, and more.

Over time, members will rely on the digital front door – an app provided by their health plan – as their guide to the proper providers, setting and cost. When they engage with the app, they will see the benefits of improved coordination of care and take greater charge of their own health, leading to better health outcomes at lower costs.

Health care consumerism puts control in the hands of the members, giving them the data-driven ability to make the right decisions for themselves. For members, nothing drives a powerfully positive experience like having the control they want and deserve.

6. Use data differently on a reimagined platform

Spend management becomes possible by employing and leveraging a continuous loop of data and analytics across the life of a claim. The plan is empowered to engage early, align all parties involved, and navigate members to the most appropriate and cost-effective care.

A platform of fully integrated solutions then serves to bridge the divide between robust analytics, high-value provider networks, URAC-accredited care management, full-service claim management and assured payment integrity – while also providing deep data transparency that supports better decisions.

This includes incorporating data into risk analysis and stop-loss underwriting at the beginning of structuring a self-funded plan. True savings are achieved through the actions that come from deep analysis of claims data, especially those 15% of claims that drive 80% of the cost. Actively channeling those members to the least costly alternatives, such as 501(r) charity care and Centers of Excellence bundles, helps ensure you're paying the minimum for every claim by employing claim edits and prepayment bill review, or through innovative guaranteed programs that minimize plan risk.

When you put all these factors together, the result is a more effective and efficient health plan that engages members and leverages a comprehensive ecosystem of cost-containment solutions. Employers who deploy these six strategies will transform their self-insured plans and reduce the healthcare cost trajectory over time.

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