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# OneDigital Cost Containment Playbook:

## 25 Strategies for Healthcare, Pharmacy & Workforce Optimization

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SECTION 1

# Introduction & Executive Summary

It is widely expected that 2023-24 will be a difficult period for American employers. After three years of wild economic fluctuations and more uncertainty on the horizon, business leaders across the country are worried about the financial resiliency of their organizations. One of the most concerning factors for employers to contend with is the seemingly endless rise of people-associated business costs, which can quickly overwhelm even the most financially responsible companies.

***The goal of this Playbook is to address these rising costs with an array of concrete and actionable cost containment policies that employers can use to save money on people-associated expenses.***

Crucially, the contents of this document have been limited to suggestions that do not negatively impact the employee experience. This means that "nuclear options" such as mass layoffs, pay cuts, and the reduction of core benefits are not covered here. While these practices are sometimes necessary and offer immediate cost savings, they also have lasting negative effects on morale and productivity and are generally inadvisable in the context of today's hyper-competitive job market.

This paper groups cost containment mechanisms into two main categories: **1. Healthcare & Pharmacy**, and **2. Workforce Optimization**. An executive summary of each of these sections is below:

## Healthcare & Pharmacy

While there are cost containment options available for organizations with fully insured health plans, organizations with a greater appetite for risk and experimentation should consider self-funding. This strategy opens the door to many effective cost containment tactics, such as the use of third-party administrators, the substitution of expensive brand-name medications with clinically effective alternatives, and a variety of carve-out options. Far from being a niche strategy, self-funding is open to many employers, regardless of size, industry, or workforce composition. Ideally, the greater level of financial risk that comes with self-funding will be outweighed by cost-saving rewards, and prudent employers are able to mitigate much of this risk with stop loss insurance and other instruments that are outlined in this paper.

## Workforce Optimization

Cost containment mechanisms in this space include potential administrative streamlining with PEOs, the use of benchmarking for vendor contracts, and strategic compensation planning. Employers may also move towards an audit of existing benefit offerings in order to uncover opportunities for the strategic pruning of expensive and underutilized benefits in favor of cost-effective alternatives that are more popular with employees. Businesses can also realize significant savings in recruiting, hiring, and onboarding costs by increasing retention and reducing turnover in their organizations. Retirement plan expenses can be reduced with changes in pricing structures and asset management models, as well as by leveraging the provisions of SECURE 2.0 legislation, which creates many savings opportunities for both businesses and individuals.

Many of the policies explored here are complex and may require multiple conversations with stakeholders and workforce experts to determine whether they are a good fit for your business. While this document is by no means a complete list of every option available to employers, our intention is to deliver a brief and high-level overview of the key options that leaders have available to them. Employers that adopt a strategic approach to cost containment will be well-positioned to weather rising healthcare costs, insulate themselves from economic downturns, and serve employee needs in an efficient and effective manner.

To get a better understanding of why people-associated expenses have been rising so much, proceed to the following section on cost drivers.

# Explaining Cost Drivers

*Why are people-associated costs increasing so dramatically?*

The forces that are causing people-associated business costs to rise can be boiled down to two main drivers: **1) post-covid macroeconomic trends**, and **2) the peculiar structure of the American healthcare industry**. Below, we've compiled brief explainers on each of these phenomena:

## POST-COVID ECONOMICS

During the covid-19 pandemic, governments around the world rapidly inflated their monetary supplies by creating large amounts of currency from thin air. They then distributed these enormous sums of new cash to millions of individuals and businesses in order to keep them afloat during the crisis. Because of this, the amount of money in circulation today is much higher than in 2019, even though the global economy has grown only modestly since then. This means that, proportionally speaking, **more money is now chasing fewer goods and services, which has caused prices everywhere to rise**.

America's Federal Reserve and other central banks have been working to "cool" this inflation by increasing interest rates, which has resulted in businesses and individuals paying higher borrowing costs when they take out loans. Unfortunately, this strategy has side effects: higher interest rates lead to less borrowing, less borrowing leads to less economic activity, and less economic activity often leads to an economic recession, which many experts now expect to occur in 2023 or 2024.

> ***Price inflation, higher borrowing costs, and a looming recession are quite enough to drive up costs for businesses all by themselves. However, employers have also been dealing with the effects of a historically competitive labor market, which makes the situation much worse.***

This combination of a down economy and hot job market is *very* unusual – typically, in times of economic turmoil, the demand for labor will decline, the unemployment rate will increase, and workers will do everything they can to keep their current jobs. However, 2021 and 2022 saw several uninterrupted quarters of record-breaking job openings, remarkably low unemployment, and extremely high turnover rates across nearly the entire economy.

On top of this, the labor force participation rate in the United States is currently at a sub-par 62.4%. This figure is a full point below its February 2020 value, which indicates that proportionally fewer people are participating in the workforce today than before the pandemic.[1] Employers are also affected by a decline in the size of the prime age working population (ages 15-64), which is shrinking in absolute terms due to unfavorable demographic trends.[2] [3] Based on the current data available to us, it is unlikely that these indicators of labor scarcity will improve at any point in the foreseeable future.

The United States labor force participation rate is currently at **62.4%**

This unfavorable environment has given employees and job-seekers significant leverage over the businesses that need to hire and retain them. **This has resulted in something of an arms race, with employers pressured to spend more on employee salaries and benefits in order to maintain a competitive edge in the War for Talent.** The inflation mentioned above has further exacerbated this issue, with employees maxing out their benefits and demanding higher wages to compensate for the rising cost of living.

While there have been some recent signs that this bizarre economic paradigm is beginning to ease up, employers should not bank on a return to pre-covid conditions anytime soon. The smart money says that people-related expenses will continue to rise in the years ahead, although probably not by as much as they did in 2022.

## EMPLOYER-SPONSORED HEALTH PLANS

There's a reason that Warren Buffett likes to describe medical costs as a "tapeworm in the American economy."[4] While expenditures associated with many kinds of employee benefits have risen in recent years, there is no denying that the cost of employer-provided health insurance is uniquely alarming.

As of 2022, **100 million** American adults held some amount of **medical debt**.[6]

It is widely understood that the United States has some of the most expensive care on Earth and what are arguably the worst health outcomes of any wealthy industrialized nation, which essentially means that Americans are paying more to get less.[5] Medical expenses are by far the leading cause of personal bankruptcy in the United States, with an estimated 100 million American adults holding some amount of medical debt in 2022.[6]

[1] *Civilian labor force participation rate. U.S. Bureau of Labor Statistics, January 2023.*
[2] *Want Another Perspective on the U.S. Labor Shortage? Talk to a Demographer. Population Reference Bureau, January 20, 2023.*
[3] *"Working age population." OECD iLibrary.*
[4] *Buffett on failed health care venture Haven: 'We were fighting a tapeworm in the American economy. And the tapeworm won'. Yahoo! Finance, May 1, 2021.*
[5] *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes. The Commonwealth Fund, January 31, 2023.*
[6] *Sick and struggling to pay, 100 million people in the U.S. live with medical debt. NPR, June 16, 2022.*

In addition to this, companies are struggling to cover the gargantuan cost of providing care to their employees: In a 2021 Kaiser Family Foundation Survey of business leaders, 9 out of 10 respondents agreed that the cost of providing healthcare to workers will become "unsustainable" at some point in the 2020s.[7]

The following statistics further highlight the severity of America's healthcare situation:

- The United States currently spends an estimated $4.3 trillion per year on healthcare[8], which is equal to the entire economy of Germany.
- At roughly $13,000 per person per year, American healthcare spending is roughly twice as high as that of other developed countries[9].
- This spending is projected to rise to $6.2 trillion by 2030, amounting to a ~50% increase in just the next seven years[10].
- Americans pay between two and four times as much for pharmaceuticals as citizens of similar countries, even when accounting for rebates and discounts[11].
- The United States accounts for almost half of all global pharmaceutical spending[12] despite making up only 4% of the world's population.

It is clear that the United States is careening towards a healthcare spending calamity, with businesses ultimately footing much of the bill. So how did things get to be this bad? It's an extremely complex topic, but here are three factors that go a long way toward explaining today's status quo:

### 1. Calculated Price Opacity

How often do you commit to paying for a service without knowing how much it's going to cost? If you're like most people, the answer is almost never.

**However, *healthcare does not function like a normal business,* and this type of price opacity is the industry standard.**

In the United States, healthcare services are provided via a deliberately convoluted system that is designed to permit arbitrary price inflation, allowing stakeholders throughout the healthcare supply chain to work together to mask the true price of drugs and medical services. This makes it difficult for both businesses and consumers to understand, predict, or audit their health expenses. Recent legislation has been enacted that attempts to

The United States spends an estimated **$4.3 trillion per year** on healthcare.[8]

American healthcare spending is roughly **2x** as high as other developed countries.[9]

Spending is projected to increase **~50%** in the next seven years[10].

[7] *Vast Majority of Large Employers Surveyed Say Broader Government Role Will Be Necessary to Control Health Costs and Provide Coverage, Survey Finds.* Kaiser Family Foundation, April 29, 2021.
[8] *Historical National Health Expenditure Accounts.* Centers for Medicare & Medicaid Services, December 15, 2022.
[9] "*How does health spending in the U.S. compare to other countries?*". Peterson-KFF Health System Tracker, February 9, 2023.
[10] *CMS Office of the Actuary Releases 2021-2030 Projections of National Health Expenditures.* Centers for Medicare & Medicaid Services, March 28, 2022.
[11] *U.S. Prices for Selected Brand Drugs Were Higher on Average than Prices in Australia, Canada, and France.* Government Accountability Office, March 29, 2021.
[12] *Global pharmaceutical sales from 2017 to 2021, by region.* Statista, July 27, 2022.

address this problem, but success has been limited and much ambiguity remains around pricing for healthcare services.

**2. High concentration of providers**

This type of unaccountable price-setting is made possible by the steady concentration of healthcare and insurance providers that has occurred in the United States over the past several decades. Endless consolidations, mergers, and vertical integration efforts have reduced consumer choice, discouraged innovation, and undercut the potential for competitive forces to lower prices. Today, healthcare is dominated by a small group of powerful conglomerates that are able to take advantage of what is essentially a captive market.

**3. Entrenched interests preventing reform**

The urgent problems of American healthcare are widely acknowledged throughout nearly all parts of society, and there are many possible reforms that could be implemented to improve the status quo. However, one shouldn't count on meaningful action any time soon. The healthcare-industrial complex is an entrenched system with powerful beneficiaries that have the means and the incentive to block changes that would be good for the general population but bad for their bottom line. Rising healthcare costs are a feature of the system, not a bug.

***The question remains, what are businesses to do about this intersection of an unfavorable economy and an unforgiving healthcare system?***

The rest of this paper will attempt to answer this question, but one crucial distinction between these two enormous cost drivers should be made here:

Post-covid macroeconomic trends are simply beyond the control of businesses. Policies detailed in the Workforce Optimization section of this document can help to mitigate the impacts of inflation, recession, and labor scarcity on businesses, but they cannot address the core issues that are causing costs to rise. These recommendations are more than a Band-Aid, but they are less than a cure.

However, healthcare and pharmaceutical spending is different.

***While the healthcare system may seem like an inflexible machine that cannot be challenged, the truth is that there are many actions employers can take to regain control of their health costs and avoid the worst elements of the status quo. This requires farsighted leadership and a certain appetite for risk, but the results are absolutely worthwhile.***

With that being said, readers are encouraged to keep an open mind while reviewing the options discussed here and pursue the policies that make the most sense to address the needs of their businesses and people. Employers who are interested in following these strategies should consider acting sooner rather than later, as costs will only continue to rise. Understanding and responding to these cost containment challenges today will be essential for employers' success in the years to come.

# Using the Cost Containment Playbook

The remainder of this playbook contains two types of entries: Strategic and Tactical.

Strategic entries, indicated by data and visuals in the right column, are intended to be read as miniature thinkpieces or explainers. Rather than focusing on the pros and cons of a single cost-containment policy, these entries cover multiple policies or broad topics that have wider business management ramifications. Examples of strategic entries include Health Insurance 101: Funding Models, Protection, and Control, Cost Containment for Specialty Drugs, and Retention as a Cost Containment Strategy.

Tactical entries, indicated by keys, are laser-focused on individual cost containment policies and follow a consistent template. Examples of tactical entries include Non-Essential Drug Exclusion, Healthcare Navigation Services, and Professional Employer Organizations (PEOs). Most tactical entries include four metrics at the top of the page, which use a scale of one to four to provide a broad indication of the following:

**$**$$$ **Savings Potential:** The amount of money employers may be able to save by implementing a given policy.

**Change Management Difficulty:** The amount of difficulty that employers may face when implementing a given policy within their organization.

**Disruption to Employees:** How significant the impact of implementing a policy may be on the employee or plan member experience.

**Good Fit For:** Which types of organizations are most likely to benefit from implementing a policy.

The body of tactical entries are organized into the following sections:

- **What is it/are they?** This provides a high-level overview of the cost containment tactic in question.
- **How does it/do they work?** This discusses how a given tactic functions on a nuts-and-bolts level and provides additional context on how it can be adopted by employers.
- **How does it help control costs?** This zeroes in on the specific ways that a given tactic can work to save money for organizations that decide to implement it.
- **Key considerations for adopters:** This details potential issues or areas of concern that leaders should be cognizant of as they consider adopting a given tactic.

*Readers who are feeling intimidated by the volume of material in this document will be relieved to know that the 2023 Cost Containment Playbook is not necessarily intended to be read cover-to-cover.* The following entries contain information on a wide array of different subjects, some of which will naturally be more applicable than others. When considering the strategies and tactics detailed in the remainder of this document, readers should feel free to skip around, pursue the entries that seem the most relevant to the concerns of their organizations, and choose their own cost containment adventure.

SECTION 2

# Healthcare & Pharmacy

While there are cost containment options available for organizations with fully insured health plans, organizations with a greater appetite for risk and experimentation should consider self-funding. This strategy opens the door to many effective cost containment tactics, such as the use of third-party administrators, the substitution of expensive brand-name medications with clinically effective alternatives, and a variety of carve-out options. Far from being a niche strategy, self-funding is open to many employers, regardless of size, industry, or workforce composition. Ideally, the greater level of financial risk that comes with self-funding will be outweighed by cost-saving rewards, and prudent employers are able to mitigate much of this risk with stop loss insurance and other instruments that are outlined in this paper.

## UNDERSTANDING YOUR HEALTH PLAN OPTIONS

# Health Insurance 101: Funding Models, Protection, and Control

For most non-exempt, full-time workers in the United States, access to health insurance is an expected, non-negotiable condition of employment. Unfortunately, as mentioned in the Cost Drivers section of this document, the cost of health insurance and healthcare itself has exploded in recent years and is becoming increasingly unsustainable for employers everywhere.

However, plan sponsors are not helpless victims. If there's one thing that you should take away from this section, it's that you have the power to significantly lower the cost of your health plan as long as you are willing to think critically about the pros and cons of each funding model and adopt the one that is right for your organization.

You have the power to significantly ***lower the cost*** of your health plan as long as you are willing to adopt the one that is ***right for your organization***.

To understand how health plan costs can be reduced, we need to cover two topics: 1) The three primary funding models that employers can use to provide health insurance, and 2) The trade-off between protection and control that all employers face when selecting a health plan for their employee populations.

### FULLY FUNDED PLANS:

Fully funded plans are often the norm for mid-market size groups, though there has been an increase in employers looking for alternative funding arrangements in recent years due to rising costs. In a fully funded plan, employers outsource 100% of the financial risk associated with health claims to a third-party insurance provider, which offers protection in the event that claims utilization is higher than expected. Employers pay these providers a negotiated annual premium per enrolled employee, and employees access healthcare services at fixed rates within their provider's health network.

This option is attractive to employers because it presents the lowest amount of financial risk. In a year when employees submit a large number of expensive health claims, the cost for said claims will be assumed by the insurance provider rather than by the employer. While circumstances like these would likely lead to a sizeable premium increase the following year due to the high level of use, business owners can rest easy knowing that they are shielded from the direct cost of catastrophic health claims. However, the opposite can also occur: in a year where employees are largely healthy and claim costs are low, employers can wind up paying more to their insurance provider in premiums than their workforce used. When this happens, the insurance provider pockets the difference.

Another drawback of fully insured plans is their near-total lack of transparency and control. When employers decide to outsource financial risk, they are also outsourcing input over plan design, discretion over which medical providers and pharmacy networks to use, and information about how their health dollars are being spent. While fully funded plans are certainly the best option for some employers (particularly smaller ones), they can leave much to be desired.

Level-funded plans operate in a ***grey zone*** between the two mainstream plan models, with employers and insurance providers ***negotiating specific details***.

## LEVEL-FUNDED PLANS:

Although level-funded plans are technically a subcategory of self-funded plans, it is most helpful to think of them as a hybrid between the self-funded and fully funded models. Level-funded employers still assume the ultimate risk and responsibility for providing healthcare services to their employee populations, but are able to cooperate with insurance providers to mitigate this risk and share administrative duties.

Level-funded plans operate in a grey zone between the two mainstream plan models and are often heavily customized, with employers and insurance providers negotiating specific details and provisions. Generally speaking, employers in level-funded plans will pay their insurance provider a predetermined fee each month that is expected to cover all plan costs incurred during that period. This includes all healthcare claims, plan administration costs, and risk-mitigation policies such as stop loss insurance.

At the end of the plan year, the insurance provider will calculate the difference between the premiums they collected and the amount of money that was spent to cover the above items. If it is found that the amount of money spent was less than the premiums collected, the insurer will return some or all of these excess funds to the employer. If total annual expenses exceed the amount paid in premiums, the employer must pay the insurance provider to make up some or all of the difference. While the efficacy of this type of plan is highly dependent on the specific circumstances faced by an employer, it is often a good fit for those who are frustrated with the fully funded status quo but wary of assuming too much financial risk.

Funding your own health plan enables you to ***control your plan design***, and customize your offerings to suit your ***your employee population***.

## SELF-FUNDED PLANS:

In self-funded plans, the responsibilities associated with employee health claims are assumed by the employer, not a third-party provider. This means that the employer collects premiums from enrolled employees and assumes the managerial duties of a plan provider. When a covered employee or dependent goes to the emergency room, undergoes a surgical procedure, or begins taking a new medication, their employer is directly footing most of the bill.

Obviously, this model requires more from employers, both in terms of administrative involvement and the assumption of financial risk. In years when plan usage is high and claims are expensive, employers will have nobody to absorb costs for them and could find themselves faced with some large medical bills. However, this risk can be mitigated with things like stop loss insurance, carve-outs for particularly expensive procedures and drugs, and other policies that will be discussed later.

Assuming all the risk means ***reaping all the rewards***.

On the other hand, in years when plan usage is low and the employee population is mostly healthy, self-funded employers stand to save a great deal of money relative to those on a fully funded plan. Assuming all the risk means reaping all the rewards, and a growing number of employers are deciding that this dynamic is preferable to paying exorbitant premiums to insurance providers each year in exchange for an uncertain return. In addition to this, funding your own health plan enables you to control your plan design, customize your offerings to suit your employee population, and have near-complete visibility into your health spend, which enables you to find opportunities for efficiency gains.

## BUNDLED VS. UNBUNDLED:

When discussing cost containment strategies for health plans, it is useful to further subdivide self-funding into two subcategories. The first of these is typically referred to as a "bundled" model. In a bundled self-funded plan, all elements of the plan are administered by a single carrier. This means that the carrier provides all the same functions and services as they would in a fully insured plan while the plan sponsor covers the cost of health claims, carrier administrative fees, and stop premiums. For more specific information on this plan type, see the (Carrier ASO) section of this document.

It is beneficial to ***conceptualize each plan model*** as a trade-off between protection and control.

The second subcategory is an "unbundled" self-funded plan. In the unbundled model, different elements of the plan are administered by different parties, which enables plan sponsors to shop around and work with multiple partners instead of a single carrier. This means that the sponsor of an unbundled plan could use one company as a pharmacy benefit manager, a different company as a stop loss provider, and so on. For more specific information about carving-out particular plan components, please see the subsequent entries in this section on Third Party Administrators, Pharmacy Benefit Manager Carve-Outs, Carrier Administrative Services, and Stop-Loss Insurance.

## UNDERSTANDING THE TRADE-OFF BETWEEN PROTECTION AND CONTROL:

When weighing the pros and cons of different plan types, it is beneficial to conceptualize each plan model as existing within a continuum. This continuum is defined by a central trade-off between plan protection and plan control. Here, "protection" refers to protection from the financial risks that can result from higher-than-expected plan usage or catastrophic claims. High-protection levels tend to correlate to higher premium costs, more stable and predictable health expenditures, and less transparency into how an organization's health dollars are being spent.

"Control" refers to the ability of plan sponsors to customize their plan design according to the needs of their organization, determine what is covered and how, and pick which vendors they would like to work with. High-control plans tend to correlate to lower costs, a higher degree of financial risk (although this can be mitigated), and greater access to health spending information.

Figure A shows Fully Funded, Level-Funded, and both Bundled and Unbundled Self-Funded Plans organized along the continuum of Control and Protection:

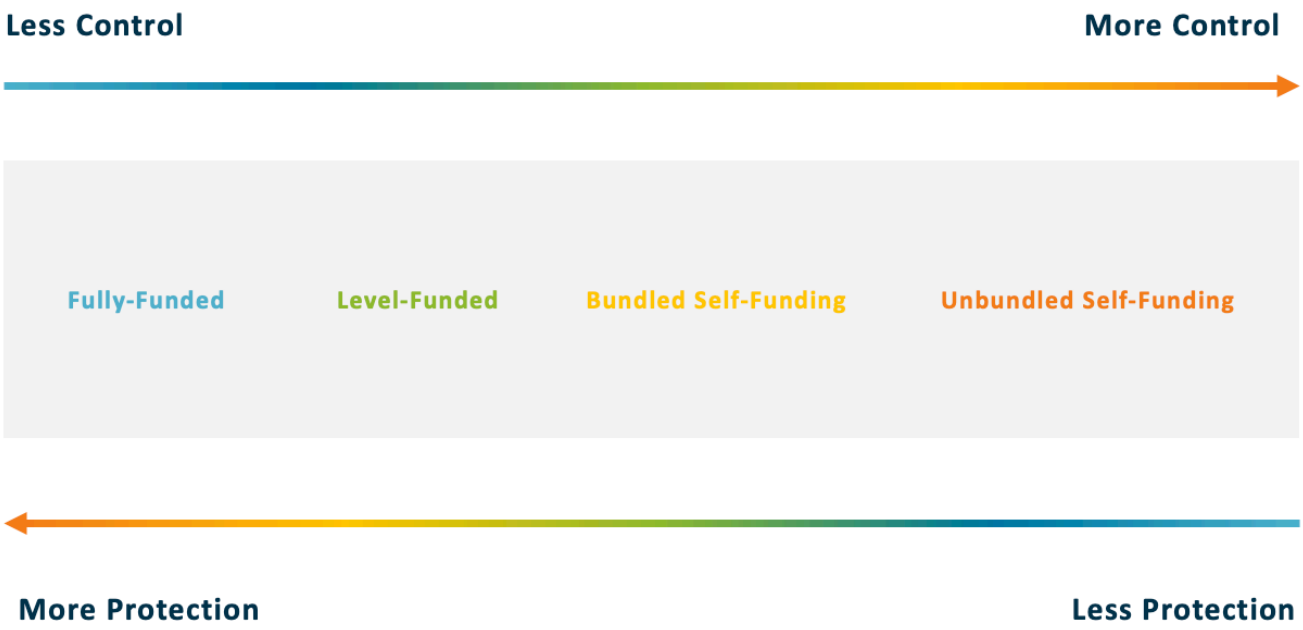


FIGURE A

***As you can see, these four plan models are not created equal.***

Fully funded plans offer employers total protection from price instability and catastrophic claims, but essentially no opportunities for input, customization, or control. Unbundled plans provide the greatest amount of control, the highest degree of customization, and the largest potential for savings. Level-Funded plans and Bundled Self-Funded plans lie somewhere in the middle, but generally skew in favor of prioritizing protection and stability over control and transparency.

Figure B shows a Fully Funded plan in the leftmost column, a Bundled Self-Funded plan in the next column, and different iterations of Unbundled Self-Funded plans in the remaining three columns.

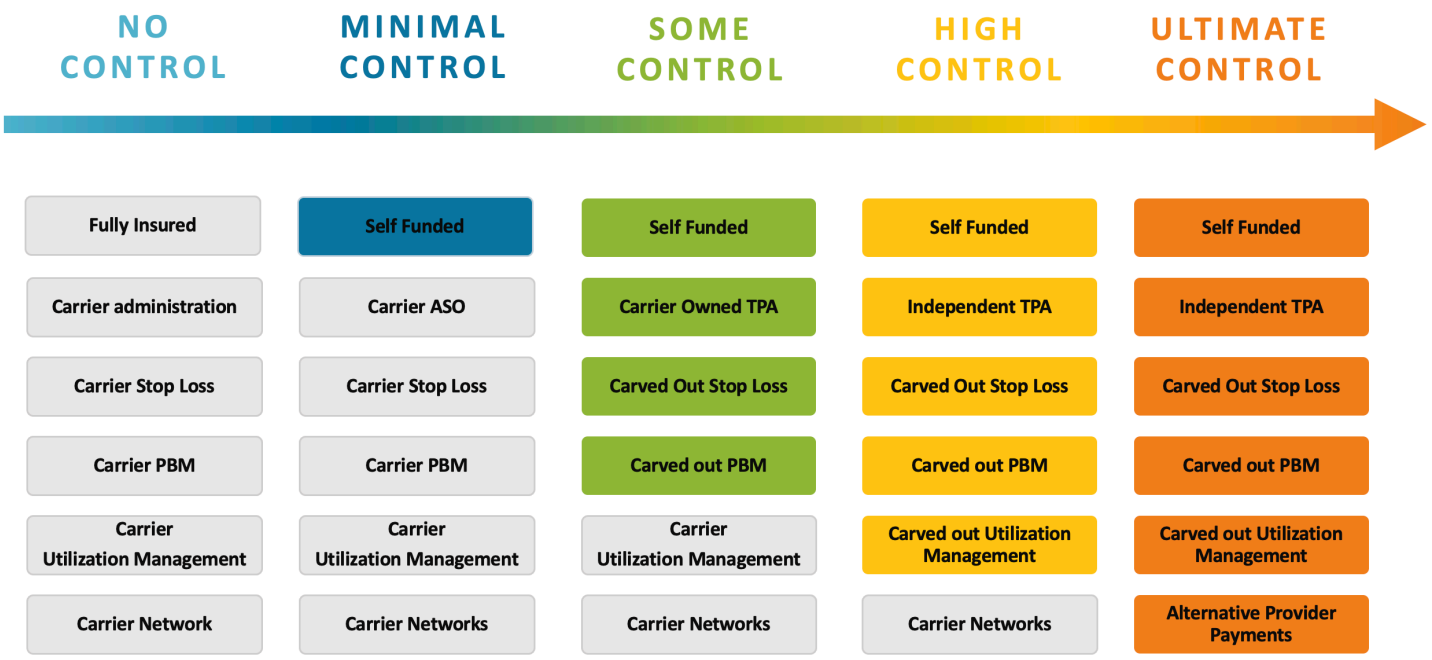


FIGURE B

Much of the remainder of this document is dedicated towards exploring the possibilities that come with Unbundled Self-Funded Plans. Employers who are considering a move in this direction should understand that there is a wealth of plan design options within this category that can enable them to customize the different components of their health plans and assume as much or little control as they would like.

# Cost Containment for Fully Insured Groups

A fully insured health plan can offer many advantages to employers relative to self-insurance, such as predictable month-over-month expenses, virtually no administrative burden, and reduced exposure to risk. However, fully insured health plans also restrict cost containment tools and strategies to whatever the carrier is able to offer and any internal policies that employers can implement within their organizations. Though cost containment options are more limited for those with fully insured plans, there are still multiple options for plan sponsors to consider:

1. **Participating Insurance Policies –** Some carriers offer a "participating fully insured policy." This type of fully insured contract is identical to traditional fully insured policy except that it includes a retrospective review, or settlement, a few months after the end of the policy. If the plan's claims were lower than anticipated, then the carrier will refund the plan sponsor a share of the savings. Typically, plan sponsors will receive up to 50% of said savings in the form of a dividend. The timing of this process usually requires the plan sponsor to confirm their renewal with the carrier to receive the dividend and they will usually forfeit their access to the dividend in the event of a carrier change. If the actual claims run higher than expected, then there is no additional risk to the plan sponsor. Plan sponsors will not owe any additional payments in this scenario, but may find themselves subjected to a significant premium increase on their next renewal.

2. **Tiered Network Plans –** Some carriers sort healthcare service providers into tiers based on reimbursement rates and quality metrics. Tier one providers are in-network, rated as providing high-quality care at a lower price point, and offer the fullest level of coverage. Tier two providers constitute the rest of the carrier's network and typically provide benefits that are 20-30% less rich than those in tier one. Tier three providers are those outside of the carrier's network and require either substantial cost sharing or no coverage at all. Socializing this information with plan participants can enable them to avoid waste and unnecessary claims costs.

3. **Value-Based Insurance Design –** Employers can craft internal policies that reduce practical and financial barriers for members to seek care and encourage plan participants to adopt healthier lifestyles. Some possibilities in this space include:
   **a.** The adoption of telemedicine solutions, which have dramatically expanded since the outbreak of the covid-19 pandemic and are able to be covered

Employers can craft internal policies that ***reduce practical and financial barriers*** for members to seek care and encourage plan participants to ***adopt healthier lifestyles***:

by employer health plans until at least December 31st, 2024. Telemedicine providers are often much more convenient and less costly than urgent care clinics or emergency rooms.

**b.** Providing plan options that cover the cost of preventative medicines and low-cost maintenance medications that help with managing chronic conditions and reduce the likelihood of health crises. This involves a modest short-term expenditure that can potentially result in medium-to-long-term savings.

**c.** Providing incentives for beneficial lifestyle improvements, such as subsidized gym memberships.

4. **The Elimination of Out-Of-Network Benefits –** This step can offer significant savings on premium costs without tremendous impact to employees, since most national networks capture over 95% of utilization. One policy option is for employers to create multiple plans: A "buy up" plan that offers out-of-network benefits and a "buy down" plan without out-of-network benefits that maximizes savings. In this scenario, employees who desire out-of-network coverage can still access it, albeit at a higher premium.

Employers can provide plan options that cover ***preventative medicines and maintenance medications*** that help to manage chronic conditions and ***reduce the likelihood of health crises***.

# Population Health Management (PHM): A Modernized Approach

According to the American Hospital Association,[2] population health management refers to the process of improving clinical health outcomes of a defined group of individuals through improved care coordination and patient engagement supported by appropriate financial and care models. These programs focus on policy offerings that help to keep members healthy, proactively address emerging health risks, and intelligently manage the care of patients with comorbidities.

***The idea is that healthier employees require fewer healthcare resources and employers that take a strategic interest in the welfare of their workforce may be rewarded with reduced plan costs.***

Effective PHM programs can help employers to contain health costs in the following ways:

- Reduced healthcare costs from avoidable complications. This is done by identifying and treating conditions quickly and effectively to slow progression of a disease.
- Improved health literacy resulting in lower-cost, higher-quality healthcare consumerism and decreased care redundancy.
- Early diagnosis and intervention (primary and secondary prevention) that reduces the risk of more costly and advanced conditions (tertiary prevention) and avoid higher-cost, catastrophic events.

Historically, PHM programs have identified health risks based on clinical diagnoses and prescription utilization. While some programs also take behavioral information into account, such as nicotine use, most PHM initiatives are based solely on the presence of disease and the physical health status of patients. However, this approach overlooks several categories of data that can have a large impact on patient health, including social determinants, mental health issues, financial wellness, and genetic predispositions. **Modern PHM program design places a greater emphasis on these previously-neglected indicators in order to develop more effective policies for improving a cohort's health.**

Employers who take this modernized approach may be surprised by how great the potential for savings is. Employees with physical or mental health problems are more likely to get injured at work, less likely to care if they perform poorly, and more susceptible to getting sick. They also might not be motivated to change lifestyle habits or practice self-care, which can cause a negative spiral that requires more expensive interventions down the road. Poor employee wellbeing costs employers in the form of absenteeism, heightened turnover, and reduced productivity. **In fact, Gallup estimates that employees missing work due to poor mental wellbeing costs the US economy $47.6 billion per year.**[1]

[1] "The Economic Cost of Poor Employee Mental Health." *Gallup, Inc., December 13, 2022.*
[2] "What is Population Health Management?" *American Hospital Association, 2023.*

The roundup below covers multiple initiatives employers can incorporate into modern PHM programs that focus on several interrelated wellbeing risk factors, not just physical health:

## ASSESS THE STATUS QUO AND CONSIDER POLICY INTERVENTIONS

Gather a wide variety of data points to measure the current state of workforce health and use these insights to determine which areas should be addressed for your population. This process should go beyond the obvious and include non-physical indicators of health.

- For example, if 401k usage is low that might mean employees are struggling with monetary stress and need help with financial wellbeing.
- Are workplace injuries increasing? This could stem from burnout or other mental issues that can be addressed with improved mental health benefits.
- Are employees taking short-term leave? This could be an indicator of external sources of stress that may be reduced with the implementation of a more flexible attendance policy.

Once areas for wellbeing improvement have been identified and policy interventions have been brainstormed, monitor the situation and survey employees for their perspectives. Continuously evaluate the impact of your PHM program by determining whether members are making use of your solutions, whether outcomes and behaviors are changing and whether employees perceive them to be beneficial. If executed effectively, these efforts may bear fruit in the form of reduced health risks and lower medical plan costs.

## PROVIDE HEALTH GUIDANCE AND ENCOURAGE PROACTIVE CARE

The impact of a healthy lifestyle and proactive health interventions cannot be overstated. **Rather than waiting until employees are visibly struggling and suffering, management should work to create a culture that encourages self-care, provides resources and encouragement for employees to make positive lifestyle decisions, and educates plan members on the best way to use existing health benefits to seek preventative care.**

Tie this into the section above by assessing employee demographics and considering areas where they might need support.

- Does a majority of your workforce live in low-income areas with little access to healthy food? Provide healthy eating options in the workplace or offer a

healthy food delivery service as a voluntary benefit.

- Are employees struggling to fill prescriptions? Consider waiving co-pays as a short-term investment that can prevent higher future costs.
- Are employees having trouble accessing and using their health benefits? A Healthcare Navigation Service can assist them in seeking out lower-cost providers and using their benefits efficiently. While these initiatives may not produce dramatic changes overnight, they can work to reduce wasteful spending, prevent costly catastrophic future claims, and decrease the likelihood of premium increases.

## IMPLEMENT TARGETED DISEASE MANAGEMENT PROGRAMS

Targeted Disease Management programs are aimed at reducing healthcare costs and improving the quality of life for members with chronic conditions. Approximately 90% of the country's annual healthcare spending is attributed to treating patients with chronic physical and mental ailments, which means that managing these diseases properly can result in large savings for employers.[2] **High blood pressure, diabetes, smoking, physical inactivity, and obesity are just a few of the risk factors and chronic conditions that cost American employers an estimated $36.4 billion a year due to employees missing work.**[3] Effectively managing these conditions can result in large savings for businesses and members.

While chronic conditions are largely a culprit of lifestyle behaviors, health status is highly influenced by social determinants of health and genetics. **Early detection and prevention is the most cost-effective strategy to avoid or delay the onset of chronic disease.**

With adherence to evidence-based recommendations such as check-ups, routine preventive exams, taking medication as prescribed, and lifestyle changes such as improved diet and exercise, patients can slow the progression of disease and, in some cases, entirely rid themselves of chronic conditions.

1. Examining health plan data, such as medical and prescription claims, in order to determine the most prevalent threats to workforce health. This information should be reported in an aggregate format and stratified based on risk severity and projected cost savings. In addition to this, biometric screening results should be used if available through employer-sponsored health screenings. This typically includes blood glucose assessments, BMI measurements, blood pressure readings, and lipid testing.

Approximately **90%** of the country's annual healthcare spending is attributed to treating patients with ***chronic physical and mental ailments***.[2]

[2] "Commentary on Chronic Disease Prevention in 2022." *National Association of Chronic Disease Directors, April 18, 2022.*
[3] "Workplace Health Promotion." *Centers for Disease Control and Prevention.*

2. Identify any programs available to help manage chronic conditions and mitigate risk factors through the medical and pharmacy carriers or local community providers such as hospitals and health centers. It is also possible to select a third-party vendor solution with expertise to address the top chronic conditions within your workforce.

3. Develop a custom engagement and communication strategy to effectively reach high risk members and encourage them to participate in the appropriate disease management programs. Buy-in and consistent participation is required for these programs to be effective, it is critical to ensure that plan members are aware of their options and understand that their employer can act as a disease management partner.

Ultimately, PHM is not something that is done to a population, but the summation of individual behaviors driven by thoughts, feelings, and overall mental health. The key to truly minimizing health risks (and costs) associated with your workforce is to drive proactive communications and employee education to improve utilization and eliminate wasteful healthcare spending. Whether employees are with you for six months or sixteen years, you can partner with your people to implement any of the tactics discussed in the following sections to change the way your workforce consumes care and yield hard-dollar savings.

The key to minimizing ***workforce health risks & costs*** is to drive proactive communications and employee education to improve utilization and ***eliminate wasteful healthcare spending***.

## ADMINISTRATION & PLAN DESIGN

# Third Party Administrators (TPAs)

Self-funded plans require an entity known as a Third Party Administrator (TPA). The role of a TPA is to coordinate with plan vendors and partners, process pharmacy and medical claims, and ensure that the plan is managed properly. The mission of a TPA is to function as a plan hub that replicates the seamless experience of a fully insured plan.

The role of a TPA is to ***coordinate with plan vendors and partners***, **process pharmacy and medical claims**, and ***ensure that the plan is managed properly***.

### WHY CONSIDER A THIRD PARTY ADMINISTRATOR?

An employer typically contracts a TPA when they are contemplating a move to a self-insured program or are looking to evolve their current self-insured program from a bundled to an unbundled model. Unbundled plans that are coordinated and managed by TPAs offer many potential upsides to plan sponsors, including the following:

- Greater control over plan design and benefit coverage options.
- Greater access to utilization data and price transparency.
- Reduced prescription drug claims via a PBM carve-out.
- Access to different network models, including reference-based pricing. programs.
- Greater flexibility in integrating with point solutions rather than defaulting to a single carrier program (disease management programs, analytical platforms, healthcare navigation services, etc.).

In other words, employers may find the highest degree of control and flexibility by working with a TPA in an unbundled plan. This model offers unparalleled opportunities to build a cost-effective plan that is customized to the needs of an organization and employee population, albeit with a certain degree of increased risk and managerial responsibilities.

### HOW TO SELECT A THIRD PARTY ADMINISTRATOR:

There's a wealth of TPA options out there for plan sponsors to pick from. Oftentimes, it is advisable to begin by searching within your existing network. If you are migrating from a Fully insured plan or a bundled self-insured plan, it's likely that your carrier owns a TPA. Using your carrier's TPA minimizes disruption to members and generally makes change management easier as you transition to an unbundled self-insured plan.

Alternatively, plan sponsors can consider independent TPA organizations that are able to "rent" the use of a mainstream national health network, although it should be noted that using a TPA that is not affiliated with a major carrier will likely entail a greater amount of member disruption. To mitigate this issue, it may be advisable

Employers may find the highest degree of ***control and flexibility*** by working with a TPA in an unbundled plan.

to perform a network disruption analysis. This type of analysis is conducted by identifying all providers that are currently being utilized and asking the prospect carrier to indicate whether said providers are in or out of network. Generally speaking, disruption levels are lowest when transitioning from one national network to another.

Aside from change management concerns, plan sponsors who are deciding between multiple TPA options should consider factors such as analytical platforms and technical capabilities, the ability to integrate with PBMs and other service providers, and the ability to provide data and insights around spending that can be leveraged for further plan optimizations. In addition to this, it is prudent to ensure that TPA candidates can support potential future changes, such as switching to a captive or transitioning to reference-based pricing.

Plan sponsors deciding between multiple TPA options should consider factors such as ***analytical platforms and technical capabilities***, and the ability to provide ***data and insights*** for further plan optimizations.

## HOW TO MITIGATE IMPACT TO EMPLOYEES:

Though moving to an unbundled self-insured plan often entails many changes for the employer, it does not necessarily need to be disruptive to employees and their covered dependents.

It's worth remembering that the bulk of employees tend to enter their open enrollment period with three primary questions:

1. Did my carrier or network change and will that impact my care team?
2. Did the quality of my health benefit get worse?
3. Did the amount of money that I pay for health insurance increase?

Employers can answer these questions and mitigate concerns by taking the following actions:

- Conducting a provider disruption analysis, as mentioned above.
- Making plan design decisions that mirror previously existing benefits, maintain existing coverage, and refrain from increasing premium contributions.
- Running a pharmacy formulary disruption analysis: This type of analysis assesses the impact that switching to a new pharmacy benefit manager may have on plan participants. It typically involves pulling a list of currently utilized drugs and asking the proposed pharmacy benefit manager to indicate how their policies and formulary would affect coverage. In many cases, they will agree to maintain existing coverage of ineligible drugs on a temporary basis in order to allow members to work with their healthcare providers to find a clinically effective alternative.
- Creating and executing an effective communication plan that anticipates employee concerns and provides clear information on things such as new ID cards, any changes in coverage, and a list of new providers with instructions on how to contact customer service.

Moving to an unbundled self-insured plan does not necessarily need to be ***disruptive to employees***.

# Carrier Administrative Services Only (ASO)

**Savings Potential:** $$$$

**Change Management Difficulty:**

**Disruption to Employees:**

**Good fit for:**
Almost any larger group open to accepting a moderate amount of risk.

## WHAT IS IT?

Administrative Services Only (ASO) is a funding approach for healthcare. An ASO is typically a subsidiary of a health insurance company with a limited option for provider networks from the parent insurer. Simply put, ASO is a "one stop shop" solution for going self-funded where a plan sponsor purchases all plan services in one channel with a limited suite of provider options. In addition to this, most independent Third Party Administrators offer multiple health networks that plan sponsors can choose from. While ASOs do not offer the same level of customization as unbundled self-funded plans, they are a good option for risk-averse employers who are frustrated with fully funded plans.

## HOW DOES IT WORK?

The transition from a fully insured plan to an ASO plan is generally smooth, with members experiencing no disruption in their healthcare experience. Because all parties and providers are operating on the same network, the employer and employee experience should be just as seamless as in a fully funded plan. In an ASO plan, the employer only pays fixed costs for administrative services and stop loss insurance. Instead of paying non-refundable premiums, employers with ASO plans cover the cost of healthcare on a rolling basis, paying for claims if and when they occur. ASO carriers are also able to provide plan sponsors with plan usage data, giving employers with ASO plans greater insights into their spending.

## HOW DOES IT HELP CONTROL COSTS?

Employers with ASO plans are often able to realize instant savings through the removal of premium taxes and carrier profits. In addition to this, employers who were previously stuck with exceptionally high premium rates due to past periods of high claim volumes will benefit from abandoning the premium structure altogether and bringing their spending in line with their current level of plan usage. In addition to this, because ASO is a form of self-funding, plan sponsors will be able to access and implement savings strategies that are typically used by carriers to contain their internal costs. Programs for utilization management, disease management, prescription management, and others can now be employed to save money for the plan sponsor rather than the plan carrier.

## KEY CONSIDERATIONS FOR ADOPTERS:

It should be noted that plan sponsors who were previously on HMOs or other "limited" network plans will not be able to save as much as employers who are transitioning from a conventional fully funded plan. Employers who are considering a move to an ASO plan should understand that their health spending will now be directly tied to plan usage, with monthly payment amounts varying according to whatever claims happen to arise at a given time. Because of this, adopters should ensure that they have enough liquid assets to cover an unexpected period of high utilization or the confluence of multiple large claims. Employers with ASO plans should generally adjust themselves to the realities of a more uneven and less predictable health spend. While many organizations stand to realize aggregate cost savings from switching to these plans, they must assess whether these savings are worth a larger amount of risk and volatility.

# Reference-Based Pricing

**Savings Potential:** $$$$

**Change Management Difficulty:** 

**Disruption to Employees:** 

**Good fit for:**
Businesses looking for immediate health plan savings opportunities, even with significant employee disruption.

## WHAT IS IT?

Reference-Based Pricing (RBP) is an alternative network option that allows members to go to any provider at a fraction of the price of traditional carrier networks. RBP Plans are unique in that there is no network of participating providers or facilities — members are free to seek care from any provider or facility they want. RBP plans allow employers to cap the amount paid for specific services by their health plan by referencing Medicare pricing as a baseline.

## HOW DOES IT WORK?

RBP plans are offered by many entities, including both major carriers and smaller "boutique" providers. Unlike most health plans, RBP plans do not use a predetermined fee-for-service model with a network of preferred vendors. Instead, Medicare pricing is used as a baseline for the prevailing cost of medical services in the marketplace, and medical charges are paid as a percentage of what Medicare enrollees would pay for the same service (for example, an RBP plan may pay 120% of Medicare price for a biopsy at a dermatology practice).

## HOW DOES IT HELP CONTROL COSTS?

- Plan payments for claims are typically less than traditional network plans, which can lead to savings of 20-30%.
- As a result of setting price caps for certain procedures, overall costs for the employer can be significantly lowered.
- This results in reduced premiums, deductibles, and coinsurance costs for plan members.

## KEY CONSIDERATIONS FOR ADOPTERS:

- The absence of a preferred provider network means members may have access to a greater variety of providers and facilities than they would under more conventional health plans. However, this access is not guaranteed – while any medical provider *can* agree to see a patient and reimburse them according to their plan's reference-based pricing policies, there is no contractual obligation for them to do so. Some medical providers and facilities may be unfamiliar with reference-based pricing and require an explanation before determining how they react.
- Due to the complexity of these plans, careful planning and member education is necessary for successful adoption and utilization. This cost containment tactic requires a heavy lift for both employers and employees.
- Routine auditing should take place to ensure that reference-based claims are being processed correctly.

- If an employer sets a benchmarked limit on how much they will spend on a certain type of care and an employee receives said care at a higher price, said employee may be charged for the difference in cost (this is called "balance billing"). This is especially concerning in the context of emergency situations where employees may not be able to properly evaluate their options.
- Because of this, employers looking to implement this strategy should find a vendor with a track record in managing RBP plans and a known focus on member advocacy. It is advisable to plan ahead, establish safeguards, and consider ways to support employees who have received a balance bill.

# Healthcare Navigation Services

**Savings Potential:** $$$$

**Change Management Difficulty:** 

**Disruption to Employees:** 

**Good fit for:**
This can benefit almost any group with significant health plan usage and expenditures.

## WHAT ARE THEY?

Healthcare Navigation Services are third-party service providers that work with plan participants to effectively access healthcare services. These services work to guide employees and covered dependents through their healthcare journeys and have a vested interest in achieving both positive health outcomes and reduced healthcare costs.

## WHAT DO THEY DO?

Healthcare Navigation Services advocate for *patients* rather than for insurers, hospitals, pharmacies, or other entities within the healthcare system. Healthcare Navigation Services act as a liaison between plan participants and these entities, providing a concierge-style feel and helping employees to understand their benefits, find the right providers for their needs, and access health services in the most efficient and effective manner possible. Some solutions solely focus on care coordination and advocacy, while the more comprehensive options include clinical support features to assist patients in selecting treatment options. These services can be offered virtually, powered by AI through an app, or through live, one-on-one coaching.

## HOW DO THEY HELP CONTROL COSTS?

Employers should consider contracting a Healthcare Navigation Service provider because these services are able to uncover hard dollar, measurable savings for the employer and offer care, convenience, and support for employees. These services also assist in gaining more value out of existing programs and resources by educating employees about the company sponsored benefits available to them.

Here are some examples of how Healthcare Navigation Services help to contain costs:

- Changing places of service – for example, sending a member to a free-standing surgery center for a colonoscopy instead of an outpatient hospital.
- Avoiding unnecessary care and looking for inexpensive equivalents to costly treatments and prescriptions.
- Educating employees on their benefits, reminding them to stick to treatment plans, and encouraging them to access routine and preventative care, which lowers the likelihood of negative long-term health outcomes and associated expenses.
- Reducing absenteeism and increasing productivity by alleviating stress and worry for employees who are experiencing medical issues.

## KEY CONSIDERATIONS FOR ADOPTERS:

- As with any other service provided by a third-party vendor, employers should be thoughtful about the likely return on investment when considering Healthcare Navigation Services. For some, the price of contracting a Healthcare Navigation Service provider may be greater than the savings that said service provides, especially in years when plan usage is low.

# Medicare & COBRA Education

Medicare is a federally funded entitlement program that provides health insurance to senior citizens. All Americans become eligible to sign up for Medicare three months before their 65th birthday, and Americans with certain medical conditions are eligible at even earlier ages. In some cases, Medicare may be a better fit for eligible employees than their company-provided health insurance. However, some employees may not be aware of Medicare or may not be aware that they are eligible for it.

In some cases, Medicare may be a ***better fit*** for eligible employees than their ***company-provided*** insurance.

While employers are forbidden from providing incentives for employees to move off of their plan and onto Medicare, it is perfectly legal and ethical for employers to provide information and educational resources to employees about this topic. Employees who are aware of their options may voluntarily choose to switch to Medicare due to reasons of lower costs or superior coverage. Situations like this can be a win-win, with better health outcomes for employees and reduced costs for employers.

Educating employees about their options can be as simple as providing written materials about Medicare eligibility or having a dedicated Medicare expert speak to employees. These resources can be provided either at open enrollment or on a referral basis to employees as they approach age 65. Ensuring that employees have access to this type of information empowers them to make an informed choice that may also be better for their physical and financial wellbeing. It costs employers nothing to refer employees to a Medicare expert, and employees will be grateful to have a source of accurate and unbiased information.

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law that allows some workers who become ineligible for their existing employer-provided health insurance to stay on their group's health plan for a limited period of time. This is most frequently used in situations of involuntary job loss, but eligibility can also stem from reduction in hours worked, transitioning to a new job, or other qualifying life events.

It costs employers **$0** to refer employees to a Medicare expert.

In a similar vein to the Medicare discussion above, employees who are eligible for COBRA may not be aware of all of their options and could choose to elect COBRA coverage without considering alternatives. Though employers are obligated by law to provide notice of COBRA eligibility to qualifying plan members and are forbidden from providing incentives for them to decline COBRA, it is permissible to provide information and resources about other health coverage options.

Employees usually assume their employer-sponsored plan is better than what they might be able to get elsewhere, but this may not actually be the case. Purchasing coverage from state healthcare exchanges may be a better option for some COBRA-eligible employees because involuntary job loss can possibly qualify them for income-based subsidies that they were not previously eligible for.

In most cases, it is advisable for employers to provide educational resources about state healthcare exchanges, Medicare and Medicaid, and the potential of migrating to their spouse's health plan. Many people don't know where to learn about these options, and employers who provide this type of information may find fewer people electing COBRA, which can help to contain plan costs.

It is advisable for employers to provide ***educational resources*** about state healthcare exchanges, Medicare and Medicaid, and the potential of ***migrating to their spouse's health plan***.

## RISK MITIGATION PROGRAMS

# Group Captives

**Savings Potential:** $$$$

**Change Management Difficulty:**

**Disruption to Employees:**

**Good fit for:**
Small to mid-size businesses that are frustrated with the lack of transparency, flexibility, and control in most "off the shelf" health plans.

### WHAT ARE THEY?

A Group Captive is a strategic and financial arrangement between a group of like-minded employers to pool risk, leverage economies of scale, and create their own high-performing health plan.

### WHAT DO THEY DO?

Group Captives are a financial strategy that gives participating employers a high degree of transparency, flexibility, and control over health costs and plan design. Member employers pool their resources, cooperate to manage risk, and share in the rewards of increased flexibility, transparency, and choice. By participating in this arrangement, member employers can reimagine the value of their health plan and potentially achieve greater price stability than would be possible alone.

### HOW DO THEY HELP CONTROL COSTS?

Employers must be self-insured in order to participate in a Group Captive. This eliminates some insurance carrier and state mandated costs like carrier risk charges, state premium taxes, state mandates, etc. Also, it is important for participating employers to implement value-based plans and networks and/or risk management programs that engage employees, manage risk, and reduce costs. Examples include Consumer-Based Health Plans, value-based networks or alternative network options, member advocacy platforms, wellbeing programs, and more. These actions generally result in lower claim costs, resulting in improved cost and claim trends over time. When the group captive performs well, employers have the potential to get cash back. With sustained cost reductions and savings, member employers can re-invest these dollars back into their most important asset, employees.

### KEY CONSIDERATIONS FOR ADOPTERS:

- If the employer is already self-insured, their burden is very low for moving into a Group Captive. For fully insured groups transitioning to self-funding, there are some transitional items that need to be managed before joining a Group Captive. In most cases, the burden is communicating the change from a traditional carrier to a third-party administrator, which is most optimal to utilize in a group captive.
- Employee disruption is very low and most won't know they are in a group captive. The main burden for employees is working through any carrier or third-party administrator (TPA) change.
- Willingness to collaborate with other like-minded employers to optimize the health plans for employees and your company
- Are you willing to move to self-funding with a TPA and carve out your PBM?

# Stop Loss Insurance

**Savings Potential:** $$$$

**Change Management Difficulty:** 

**Disruption to Employees:** 

**Good fit for:** Almost any self-funded group.

## WHAT IS IT?

Stop loss insurance is a policy that can be purchased by businesses to protect themselves from the financial risk of catastrophic plan claims or cost overrides.

## WHAT DOES IT DO?

With a stop loss policy in place, policy-holding companies are protected against high-dollar claims from individual participants or many claims from several covered participants. It should be noted that stop loss insurance is provided on a reimbursement basis, meaning that companies still must have the short-term liquidity necessary to cover large claims prior to receiving payments from their provider.

## HOW DOES IT HELP CONTROL COSTS?

Once considered a rarity, million-dollar claims have become more common and have jumped 49% over the last four years alone[1]. With stop loss coverage in place, an organization is protected from any health plan losses that go over a set employee deductible limit. For smaller companies, this limit can be as low as $10,000. Stop loss insurance coverage provides companies with valuable financial protection that can mean the difference between business success and bankruptcy in the event of a major illness or injury. By outsourcing the inherent financial risk of health plans, these policies enable businesses to remain financially solvent in the event of large claims and provide insurance to all eligible employees at a reasonable cost.

## KEY CONSIDERATIONS FOR ADOPTERS:

- Like all insurance products, there is an element of risk associated with stop loss. In years when claims are low and members are generally healthy, it is unlikely that stop loss policies will be triggered, which means that the money paid to a stop loss carrier is "lost". However, in years when claims are high and members experience significant health issues, stop loss carriers may provide reimbursements that are much greater than the amount paid in premiums.
- Employers considering stop loss insurance should evaluate the existing deductible limits on their health plan and ensure that potential stop loss policies align with their plan agreement documents.
- Claims reimbursement does not automatically occur and will need to be requested. Most claims are processed and paid in less than 7 business days.

[1] "*2022 Sun Life Stop-Loss Research Report: High-cost claims and injectable drug trends analysis.*" *Sun Life, June 22, 2022.*

# Dialysis Cost Mitigation

**Savings Potential:** $$$$$

**Change Management Difficulty:**

**Disruption to Employees:**

**Good fit for:**
Any self-funded group that has one or more members with a diagnosed kidney-related condition.

## WHAT IS IT?

Dialysis cost mitigation programs are arrangements between employers and third-party providers that work to reduce the human and financial costs of kidney disease, End-Stage Renal Disease (ESRD), and other related conditions. These services are only available to those with self-funded health plans.

## WHAT DOES IT DO?

Kidney disease and ESRD are devastating health conditions that can act as enormous cost drivers for medical plans. According to the National Kidney Foundation, up to 37 million Americans have some form of chronic kidney disease, with about 90% being unaware of their diminished kidney function[1].

Dialysis cost mitigation programs work to manage the risk associated with these conditions in four key ways:

1. Identifying hidden risks for kidney disease by analyzing claims data and employee demographics.
2. Facilitating early clinical intervention for policyholders who are determined to be at high risk for kidney disease.
3. Providing healthcare navigation services for those who have kidney disease or are at high risk for developing kidney disease – the goal is to steer them towards lower-cost, high-quality treatment options and prevent them from becoming an emergent claim (meaning a patient with a life-threatening condition that requires immediate medical attention).
4. Implementing dialysis re-pricing programs to reduce the catastrophic claim costs for members.

## HOW DOES IT HELP CONTROL COSTS?

- Dialysis cost mitigation programs work with dialysis providers to help policyholders access high-quality and cost-effective care for kidney conditions.
- Intervention programs enable at-risk employees to receive care earlier, which leads to better health outcomes and curbs overall costs for both patients and plan sponsors.
- These programs steer affected employees away from unnecessary emergent visits, which are responsible for a large fraction of excessive claim costs.
- These programs partner with stop loss carriers to prevent financial hardship resulting from large claims.

[1] "Estimated Glomerular Filtration Rate (eGFR)." *National Kidney Foundation.*

## KEY CONSIDERATIONS FOR ADOPTERS:

- It is best to implement dialysis cost mitigation programs early, when the risk of diagnosis is minimal or nonexistent. If a group already has an emergent claim, the program is not as beneficial to the company or claimant due to most of the cost savings coming from steerage prior to emergent admission.
- There may be a lag in claim payment processing due to the risk management now being carved-out to a third-party vendor. After dialysis-related claims are received, TPAs need time to review, analyze, and act on them. While eligible claims will be paid, these administrative steps may not be immediate.

# Transplant Carve-Outs

**Savings Potential:** $$$$

**Change Management Difficulty:**

**Disruption to Employees:**

**Good fit for:**
Self-Funded groups that do not currently have a member currently in need of a transplant.

## WHAT ARE THEY?

Transplant carve-outs are insurance policies that allow health plan sponsors to manage the financial risk associated with organ transplant claims.

## WHAT DO THEY DO?

With organ transplants becoming more commonplace and more expensive, these policies can help employers to mitigate both the severity and frequency of catastrophic claims stemming from this type of procedure. Transplant carve-out policies are a proactive way to isolate and manage financial risk while providing policyholders with high-quality care.

## HOW DO THEY HELP CONTROL COSTS?

Having a transplant carve-out plan in place alleviates the financial burden brought about by high transplant costs. A transplant carve-out product not only covers the actual transplant, but also pre-op and post-op expenses, including travel and lodging, outpatient treatment, home health needs, and some out-of-network expenses. Because transplant procedures are often isolated for higher specific deductibles by stop loss carriers, removing transplant risks via a carve-out can help to reduce stop loss premiums and keep costs predictable.

## KEY CONSIDERATIONS FOR ADOPTERS:

- For some plan sponsors, the administrative costs of a transplant carve-out may outweigh the benefits. As with any type of insurance, it is possible that groups who purchase a transplant policy will not have a claim arise for many years, resulting in premiums being paid but no services being rendered in exchange.
- Groups with any potential transplant claimants at the time of marketing will be declined for coverage by most providers. The decision on whether to pursue a transplant carve-out policy depends on the plan sponsor's cost-benefit analysis and appetite for risk.
- Transplant carve-outs generally do not offer complete coverage for out-of-network expenses, with 80% coverage being more typical. For this reason, transplant recipients should be encouraged to seek in-network care.

## PHARMACEUTICAL COST CONTAINMENT

# Carving-Out Your Pharmacy Benefit Manager (PBM)

**Savings Potential:** $$$$

**Change Management Difficulty:**

**Disruption to Employees:**

**Good fit for:**
Businesses with 100+ employees who are self-funded or considering self-funding.

### WHAT IS IT?

A Pharmacy Benefit Manager (PBM) is a third-party administrator of prescription drug benefits. PBMs were created to be the healthcare system's pharmaceutical middlemen, helping people access affordable and effective medications and treatments. PBMs create formularies, negotiate rebates with manufacturers, process claims, create pharmacy networks, review drug utilization, and can even manage mail-order specialty pharmacies.

Employers have two options to manage pharmacy benefits — either "carved in" or "bundled" as part of their medical benefits or "carved out" and managed outside of the medical plan. Carving-out or unbundling is available for businesses who self-insure and requires an employer to work directly with their PBM to administer and manage pharmacy benefits.

### HOW DOES IT WORK?

There are many advantages to carving out pharmacy benefits, with the primary one being increased transparency of cost drivers which will be discussed in the following sections of the Pharmacy Cost Containment Strategies section. By taking a crawl-walk-run strategy, employers have the option to decide how much risk they are willing to absorb to gain efficiencies and control in the long run.

### HOW DOES IT HELP CONTROL COSTS?

For far too long pharmacy hasn't been at the forefront of benefits conversations, but with rebates, specialty spend, and drug waste showing no signs of stopping, controlling pharmacy spending is one of the best options employers have to reduce their overall costs.

Prescription drugs are the fastest-growing cost category for the majority of health plans and are only forecasted to continue this upward trend. Pharmacy costs that recently constituted a mere 15% of plan expenses are now generally 20% or more, and factors such as the ballooning prices of specialty medications threaten to bump that up to 25% or 30% in the near future. Fortunately, once pharmacy benefits are carved out, there are many strategic options that can be negotiated with the PBM to obtain better contracts and maximize savings.

From the start, most organizations that carve-out their PBM can expect to realize savings of 15-30% on pharmacy spending. This is due to factors such as those summarized below:

- Full control over everything from selecting a preferred pharmacy benefits partner to pharmacy network, stop loss carrier, and more.

- Improved pharmacy contract visibility.
- Auditing rights and greater opportunities to make use of discounts and rebates.
- A deeper understanding of plan performance from a clinical perspective, which enables better health outcomes and more efficient drug utilization.
- Access to data on drug claims and specialty medication spending that enables the development of customized cost mitigation policies.

## KEY CONSIDERATIONS FOR ADOPTERS:

- Switching to a new PBM has the potential to disrupt the treatment of members who are taking prescription medications that are not supported by the new PBM's formulary.
  - This can be mitigated by proactive communication between the employer, affected plan members, and their doctors, as well as by negotiated agreements that enable the PBM to temporarily cover said prescriptions until a viable and effective alternative can be determined.
- Carving out a PBM will necessitate deeper involvement and additional administrative duties for the employer.
- To mitigate the potential for increased financial risk, it is advisable for plan sponsors to conduct pharmacy benefit reviews and create long-term plans that anticipate potential change management issues.

For more information on PBMs and other related topics, visit our Pharmacy Benefits blog.

# Non-Essential Drug Exclusion

**Savings Potential:** $$$$

**Change Management Difficulty:** 

**Disruption to Employees:** 

**Good fit for:** Self-funded groups with flexible PBMs.

## WHAT IS IT?

Non-essential drug exclusion is a method of reducing wasteful pharmacy spending by restricting coverage of medicines that are high in cost but low in clinical value. Plan members are still able to access alternatives to these medicines that are less expensive and equally effective.

## HOW DOES IT WORK?

Employers with self-funded plans that do not use one of the "big three" Pharmacy Benefit Managers (CVS Caremark, Express Scripts, and Optum Rx) are frequently able to work with their Pharmacy Benefit Manager to create a list of non-essential medicines to exclude from coverage. These medications may include brand-name drugs that have generic alternatives, drugs that are priced differently depending on their formulation (tablet vs. capsule vs. inhalant, etc.), and pricey pharmaceuticals that are nothing more than a combination of multiple over-the-counter drugs.

## HOW DOES IT HELP CONTROL COSTS?

Wasteful pharmacy spending is estimated to represent 3-12% of all claims.[1] By eliminating this waste, plan sponsors are able to save money and pass those savings to members in the form of lower premiums and smaller out-of-pocket costs. Specific examples of preventable waste are outlined below:

- Metformin is a generic medication for type 2 diabetes. The brand-name equivalent, Glucophage, costs nearly thirteen times more than metformin. These medications are chemically identical to each other, so excluding coverage for Glucophage saves money without impacting the health of plan members.
- Fluoxetine is the active ingredient in the antidepressant Prozac. A 20 mg tablet of fluoxetine is four times as expensive as an equivalent dose in capsule form. Because there is no therapeutic difference between these formulations, it is advisable to exclude coverage for the tablet version.
- Vimovo is a pain relief drug that is commonly prescribed for arthritis at a cost of $2,600 per prescription. However, Vimovo is nothing more than a combination of Nexium and Aleve, two over-the-counter medications with a combined cost of about $24. Excluding medications like these can help employers to quickly eliminate many thousands of dollars in wasteful spending that would otherwise have gone straight to drug manufacturers.

[1] "*Reducing Wasteful Spending in Employers' Pharmacy Benefit Plans.*" *The Commonwealth Fund, August 30, 2019.*

### Weight Loss Drug Exclusion

Many employers and pharmacy benefit managers are currently grappling with the discovery that some medications for type 2 diabetes, namely the drug Ozempic (Semaglutide), can cause significant weight loss. This secondary effect of Ozempic has gotten a lot of notice, with some commentators suggesting that it be prescribed as a weight loss aid for obese patients.

Obesity is a preventable condition that is a contributing factor to many leading causes of death in the United States, and high obesity rates are a significant contributing factor to rising health care costs and worsening health outcomes. However, excluding Ozempic and other weight loss drugs from coverage has been the industry standard due to a lack of long-term effectiveness and burdensome side effects. Ultimately, research by reputable institutions such as the Institute for Clinical and Economic Review and the U.S. Preventive Services Task Force indicates that the use of Ozempic and similar medications for weight loss is clinically dubious and is less-cost effective than behavior-based intervention or existing generic alternatives.

## KEY CONSIDERATIONS FOR ADOPTERS:

- The ability of plan sponsors to exclude non-essential drugs is contingent on the willingness of pharmacy benefit managers to cooperate. Oftentimes, it is beneficial to include third-party pharmacy consultants in talks with pharmacy benefits managers in order to make a more authoritative case for specific exclusion requests.
- There is the potential for slight member disruption due to exclusion of certain high-cost medications. However, through a coverage exception process driven by the physician, a member may still access their non-essential medication of choice if it is determined to be medically necessary.

# Specialty Drug Cost Containment

Specialty drugs are a class of prescription medications that are typically used to treat complex health conditions. The cost of specialty drugs has skyrocketed in recent years, presenting a significant financial burden to pharmacy plan sponsors and members. According to the Department of Health and Human Services, spending on specialty drugs totaled $301 billion in 2021, representing a 43% jump since 2016 and half of all prescription drug spending in the United States.[1] Employers with unbundled self-funded health plans may be able to leverage the following strategies to contain the cost of specialty medications:

Spending on specialty drugs totaled **$301 billion** in 2021, representing a **43% jump** since 2016 and half of all prescription drug spending in the United States.[1]

## BIOSIMILARS:

- **Definition:** Many specialty drugs are biologics, meaning that they are derived from living organisms such as yeasts, bacteria, and animal cells. Insulin, which is used by millions to manage diabetes, is one of the most well-known biologic medicines. Biologics often come with hefty price tags due to the complexity of their design and manufacturer patent exclusivity. A biosimilar drug is a biologic medication that has no clinically meaningful difference from FDA-approved biologics. Biosimilars are administered the same way and have the same strength, dosage form, and potential side effects as their biologic equivalents.
- **How biosimilars help to control costs:** The 2022 U.S. Generic and Biosimilar Medicines Savings Report, published by the Association for Accessible Medicines, found that the U.S. healthcare system saved over $7 billion in 2021 by substituting expensive brand-name biologics with less expensive biosimilars.[2] The FDA has been approving greater numbers of biosimilars in recent years, which should put negative pressure on market prices and provide increased opportunities for patients and plan sponsors to save money on biologic specialty prescriptions.
- **How plan sponsors can implement:** By working with a flexible pharmacy benefit manager that is following market trends and placing the biosimilar in a favorable formulary position.

## ALTERNATE FUNDING:

- **Definition:** In many cases, third party organizations are able to provide alternate funding solutions for patients who are taking costly specialty medications. These alternate funding sources can take the form of various endowments, manufacturer coupons, private and public foundations, and

[1] "Trends in Prescription Drug Spending, 2016-2021." *ASPE Office of Science & Data Policy. September 2022.*
[2] "Report: 2022 U.S. Generic and Biosimilar Medicines Savings Report." *Association for Accessible Medicines, September 2022.*

municipal, county, or state-level programs. These alternate funding sources can often be directly applied to the cost of specialty medications, saving money for both plan sponsors and members.

- **How alternate funding helps to control costs:** Alternate funding programs help control costs by finding assistance that either fully or partially covers the cost of the specialty medication. Today, 100% payment coverage is available for ~80% of all specialty patients.
- **How plan sponsors can implement:** The availability of such programs is highly dependent on the circumstances of a specific patient's case. Not all pharmacy benefit managers or third party administrators will be able to assist with securing alternate funding sources. In many cases, it is advisable to work with a team of qualified pharmacy consultants in order to assess whether somebody is a good candidate for alternative funding and connect them to the proper resources.

It is advisable to work with a team of ***qualified pharmacy consultants*** in order to assess whether somebody is a good candidate for alternative funding and ***connect them to the proper resources***.

## UTILIZATION MANAGEMENT TECHNIQUES (PRIOR AUTHORIZATION/STEP THERAPY):

- **Definition:** Utilization management techniques are used to determine whether a prescribed pharmaceutical product will be covered by a pharmacy benefit manager before the prescription is actually dispensed. These are put in place in order to control costs, ensure safety, and determine the appropriateness of different therapies.
- **How Utilization Management Techniques help to control costs:** The two most common Utilization Management Techniques are prior authorization and step therapy. Prior authorization is a health plan cost-control process that requires physicians and other health care professionals to obtain advance approval from a pharmacy benefit manager before a specific medication is covered for a patient. Prior Authorizations allow the pharmacy benefit manager to evaluate whether the requested medication is medically necessary instead of utilizing a covered alternative. Similarly, step therapy is a program that requires patients to try a lower cost prescription drug that treats a given condition first before "stepping up" to a more expensive alternative.
- **How plan sponsors can implement:** ·Most pharmacy benefit managers have UMTs in place automatically, but certain pharmacy benefit managers are better at enacting these policies than others. It's important that plan sponsors select a pharmacy benefit manager that aggressively executes their prior authorization and step therapy requirements in order to seek out opportunities for savings.

Utilization management techniques are put in place in order to ***control costs, ensure safety, and determine*** the appropriateness of different therapies.

## SECTION 3

# Workforce Optimization

Cost containment mechanisms in this space include potential administrative streamlining with PEOs, the use of benchmarking for vendor contracts, and strategic compensation planning. Employers may also move towards an audit of existing benefit offerings in order to uncover opportunities for the strategic pruning of expensive and underutilized benefits in favor of cost-effective alternatives that are more popular with employees. Businesses can also realize significant savings in recruiting, hiring, and onboarding costs by increasing retention and reducing turnover in their organizations. Retirement plan expenses can be reduced with changes in pricing structures and asset management models, as well as by leveraging the provisions of SECURE 2.0 legislation, which creates many savings opportunities for both businesses and individuals.

# Moneyball for Employee Benefits

You don't need to be a baseball fan to appreciate the messaging behind *Moneyball*. Both the 2011 film and the 2003 book of the same name focus on one core theme: the intelligent management of scarce resources in order to win an unfair game. Despite having a miniscule budget, the Oakland Athletics changed baseball forever by discarding outdated assumptions about player worth, using data-driven decision making to secure undervalued talent, and dramatically outperforming expectations in the 2002 MLB season.

This theme will likely resonate with leaders in the employee benefits space who have been torn between the conflicting demands of a stuttering economy and red-hot labor market. On the one hand, many organizational budgets are either shrinking or being hollowed out by inflation. On the other hand, employee benefits are expensive and play a critical role in both recruitment and retention. How can employers make the most of a relatively weak hand to keep costs low and employee satisfaction high?

How can employers make the most of a relatively weak hand ***to keep costs low*** and ***employee satisfaction high***?

Here, we present a broad roadmap that employers can use to apply the *Moneyball* framework to their benefits strategy. By following these steps, it is our hope that you will be able to maximize the value of your dollars, optimize your benefit package for the needs of your employee population, and discontinue inefficient offerings in favor of less expensive and more popular alternatives:

1. **Review benefits utilization data and measure this against costs**
   Employers should evaluate the cost of the benefits offered relative to employee utilization. Benefits with high utilization and low costs are more likely to be delivering value to your employees, while benefits with low utilization and higher costs might merit a closer look.

2. **Account for employee socioeconomic and demographic information**
   Consider the life circumstances of your employee population and evaluate the ways in which these influence their benefits needs. What issues are people like them most likely to face? What sorts of services would improve their quality of life the most? Map your conclusions to potential offerings that you do not currently provide.

3. **Survey existing employees for their benefits preferences**
   Employers should consider soliciting employee input and involve them in the policymaking process. Gather their thoughts on current benefit offerings, ask

Consider the ***life circumstances*** of your employee population and evaluate the ways in which these ***influence their benefits needs***.

them what new offerings they would like to see, and give them a voice on what types of benefits should be prioritized. Involving employees in your benefits optimization initiative is an excellent way to secure buy-in, ensure that future offerings are tailored to their desires, and reduce the risk of making decisions that will be perceived as management "taking things away."

4. **Benchmark benefit offerings against competitors**
   Are competitors in your industry offering something valuable that you do not? What benefits would make your company compelling to talented jobseekers in the roles that you need to hire for? Incorporating this information will allow you to tailor your offerings for not only the employees you have today, but the employees that you want to onboard tomorrow.

5. **Pull these threads together and find opportunities for strategic pruning**
   The first step towards optimizing your offerings is identifying benefits that are not currently providing a good return on investment. These benefits may be underutilized, undesired, or more costly than the value they provide to your employee population. Strategically pruning these low-ROI offerings and replacing them with data-driven alternatives that are better aligned with the needs and preferences of your workforce can be an effective way to control costs while better serving your employees. If eliminating some offerings entirely is a bridge too far, consider converting them into voluntary benefits, which will save your organization money while still allowing employees to access said benefits at a discounted rate.

The first step towards ***optimizing your offerings*** is identifying benefits that may be ***underutilized, undesired, or more costly than the value*** they provide to your employees.

# The Importance of Benchmarking

## WHAT IS BENCHMARKING?

Benchmarking is the process of comparing an organization's benefits, performance, and outcomes against those of similar industries, size, and demographics. Benchmarking can be used to evaluate the competitiveness and effectiveness of an employer's benefit programs, such as health insurance, retirement plans, or other employee benefits.

## WHY IS IT IMPORTANT?

1. **Attracting and retaining top talent:**
   Employees today expect competitive benefits packages. By evaluating the benefits offered by other companies in the same industry or region, employers can ensure that their benefits are on par with or better than their competitors.
2. **Controlling costs:**
   By comparing their benefits against industry averages, companies can identify areas where they may be overspending or where they may be experiencing higher utilization rates than their peers, allowing them to make data-driven decisions on how to adjust their benefits programs to be more cost-effective.
3. **Improving engagement and productivity:**
   When employees feel that their employer values their health and wellbeing, they are more likely to be engaged in their work and less likely to seek employment elsewhere. By providing valuable information that can be leveraged to achieve these positive outcomes, benchmarking helps to improve benefit offerings, boost employee wellbeing, and improve retention and productivity.
4. **Making informed decisions about overall benefits strategy:**
   By analyzing data on what benefits are most important to employees, how benefits are being used, and what benefits are costing the company, employers can make strategic decisions on how to allocate resources and adjust their benefits package to best meet the needs of their business and employee population.

By evaluating the benefits ***offered by other companies*** in the same industry or region, employers can ensure that ***their benefits are on par with or better*** than their competitors.

## HOW DOES IT HELP CONTROL COSTS?

In some instances, employers may find that they are overpaying for services and discover opportunities for savings via vendor management and consolidation, changes in plan design, and benefits optimization. Benchmarking reports can be used to contextualize expenses and make comparisons within the following

categories, as well as many others:

- Administrative claims and costs
- Ancillary/Voluntary Benefits
- Benefit Levels/Employee Contribution
- Compensation and Total Rewards
- Employee Population Demographics
- Employer-Type (Industry and Market Segment)
- Funding Arrangements: Alternative Funding, Self-Funding, Captive, etc.
  Managed Care Platforms (HMO, ACO, PPO, POS, etc.)
- Pharmacy
- Retirement Plans
- Risk/Property & Casualty

Benchmarking provides employers with ***insights that enable them to assess their benefits program*** relative to those of similar companies.

## SUMMARY

Benchmarking provides employers with insights that enable them to assess their benefits program relative to those of similar companies. In the same way that retailers consider competitors' rates when setting prices for their products, benchmarking enables the comparison of an organization's spending to external data in order to understand this spending within the context of the wider market. This enables leaders to identify organizational shortcomings and make decisions that improve the overall health, productivity, and competitiveness of their business.

For these reasons, those who do not already use benchmarking should consider adopting it as a tool for both cost containment and organizational competitiveness. Working with a qualified benchmarking partner, monitoring competitor and marketplace trends, and using these insights to influence both tactical and strategic planning is an effective way to ensure that key decisionmakers are always armed with the data they need to make the right call.

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## RETIREMENT PLAN OPTIMIZATIONS

# Retirement Plan Pricing Models: Per Participant vs. Asset-Based

### WHAT ARE THEY?

Employer-sponsored retirement plans are typically priced in one of two ways:

1. A fixed annual fee for every plan participant
2. An asset-based plan structure that charges a collective fee for management of the entire plan (this is often called a Variable Asset Charge, or VAC)

### HOW DO THEY WORK?

Per-participant plan pricing is very straightforward. If a company with 100 employees participating in its retirement plan benefit agrees on a $75 annual fee per participant, the company will pay $7,500 for that year's plan management and recordkeeping costs. If the same company goes on a hiring binge and has 200 participants in the following year, the company will then pay $15,000.

The fee structure of VAC plans is based on the collective monetary value of the assets in a company's retirement plan. For example, a company with an employer-sponsored retirement plan that has assets totaling $10 million and a plan management fee of 0.15% would pay $15,000, regardless of the number of plan participants. If the value of those assets grows to $11 million in the following year, the company would then pay $16,500.

### HOW DO THEY HELP CONTROL COSTS?

Each of these pricing models has different pros and cons, and it is up to employers to crunch the numbers and decide which option is most cost-effective for their employee population. The per-participant model is often advantageous for employers with low or stable headcounts, highly compensated employees who tend to save a lot, or plans with assets that are rapidly growing in value. On the other hand, VAC plans are generally a good fit for employers that sponsor plans with low average account balances, plans with conservative investment compositions that appreciate in value slowly, or plans with rapidly growing headcounts.

### KEY CONSIDERATIONS FOR ADOPTERS:

Employers who are weighing these two options should consider factors such as historic plan usage data, average plan account balances, employee demographics, future changes to headcount, and market trends that affect asset valuation. Plan sponsors who take the time to assess these variables, map them to both plan models, and consult with trusted plan advisors may be able to save a substantial amount of money.

*Investment advice offered through OneDigital Investment Advisors LLC, an SEC-registered investment adviser and wholly owned subsidiary of OneDigital.*

Each of these pricing models has ***different pros and cons***, and it is up to employers to crunch the numbers and ***decide which option is most cost-effective*** for their employee population.

# Retirement Plan Management Styles: Active, Passive, & Hybrid

## WHAT ARE THEY?

Employer-sponsored retirement plans are typically priced in one of two ways:

1. Active management, which involves frequent and direct intervention by one or more human investment managers
2. Passive investment management, in which plans are put "on autopilot" with little personal intervention by human investment managers
3. Hybrid management, a more recent approach that tries to combine elements of active and passive management

Benchmarking provides employers with ***insights that enable them to assess their benefits program*** relative to those of similar companies.

## HOW DO THEY WORK?

- In actively managed investments, an Investment Portfolio Manager or team of managers personally curate portfolios with the aim of yielding higher returns for clients. Plans managed in this manner generally involve more buying and selling of positions as the managing party attempts to add value, mitigate risk, and outperform the market.
- Passively managed plans tend to be set up with the goal of adhering to a predetermined allocation of investments. The original investment composition is typically designed to mirror a portion of the market at large, and specific assets are not bought and sold as often as in actively managed plans.
- Plans managed under a hybrid model use a mixture of both passive and active investments in an attempt to deliver an optimized portfolio that incorporates the strengths of both investment styles. This type of approach is gaining in popularity but still less common than the two mainstream models.

## HOW DO THEY HELP CONTROL COSTS?

Generally speaking, plan pricing directly corresponds to the degree of effort and involvement from the plan's managing party. Actively managed plans cost the most, as they require more frequent intervention and curation than the other two plan models. Passively managed plans tend to be inexpensive due to the lower level of attention required from plan managers. Hybrid plans fall somewhere between these two extremes, with prices depending on specific asset compositions. Employers who are looking for cost-saving opportunities should consider switching to plans with a higher ratio of passively managed assets.

Plan pricing ***directly corresponds*** to the ***degree of effort and involvement*** from the plan's managing party.

## KEY CONSIDERATIONS FOR ADOPTERS:

The major variable to consider when deciding between the three models of plan management is the relationship between cost and performance. While no guarantees can ever be made about the performance of a specific plan, conventional wisdom says that actively managed assets attempt to garner higher returns or mitigate risk to a greater degree than passively managed assets. Because of this, employers who are considering a move towards passive management should weigh the value of any savings against the potential of lower yields. To select the plan management model that is the best fit for their needs, plan sponsors should articulate their plan goals and priorities, conduct a thorough analysis of multiple investment managers, and try to strike a balance between high plan performance and low management costs.

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To select the plan management model that is ***the best fit for their needs***, plan sponsors should try to ***strike a balance*** between **high plan performance** ***low management costs***.

# Retirement Plan Investing: SECURE 2.0 & Non-Qualified Contributions

"SECURE 2.0" is the name given to a package of retirement plan reforms signed into law in December 2022. This legislation contains over 90 different provisions that will take effect between 2023 and 2027. The roundup below summarizes three of the most significant SECURE 2.0 provisions from a cost-containment perspective and also contains a brief overview of non-qualified retirement plan contributions, which existed prior to the law's passage.

"SECURE 2.0" contains over **90** ***different provisions*** that will take effect between 2023 and 2027.

## SMALL BALANCE THRESHOLD INCREASING TO $7,000

- Takes effect in 2024
- Applies to all employers
- Small balances attributable to terminated employees can drag a plan's average account balance down, which is a key pricing metric for many recordkeepers. Retirement plan providers should consider increasing to the new threshold included in the Secure 2.0 legislation.
- By increasing the small balance threshold, employers will likely be able to eliminate small accounts which are increasing organization and participants fees.
- Some providers also charge "per account" fees which would also be reduced further by increasing the threshold.

## PART-TIME EMPLOYEE PLAN PARTICIPATION

- Takes effect in 2025
- Applies to employers with part-time/seasonal staff that have worked between 500-999 hours for three consecutive years
- This new provision will mandate that employers include these long-term part-time employees in company-sponsored retirement plans but will allow them to be excluded from employer matching.
- This provision may be helpful for employers looking to expand benefits but keep costs in check, as it enables them to provide a retirement benefit to a new subset of their population without the financial burden of an employer match.

Retirement plan providers should consider ***increasing to the new threshold*** included in the Secure 2.0 legislation.

## STUDENT LOAN-LINKED 401(K) CONTRIBUTIONS

- Takes effect in 2024
- Any business with employees who have student loans (both public and private) may make use of this provision.

- Secure 2.0 allows employers to implement a more cost-effective approach to helping employees with student loans.
- Instead of sending direct payments to student loan debt servicers, employers will be able to provide a "match" into the retirement plan for those participants making qualified student loan payments in lieu of 401(k) contributions.

Secure 2.0 allows employers to implement a more ***cost-effective approach*** to helping employees with student loans.

## KEY CONSIDERATIONS FOR ADOPTERS:

- Any employer can make use of this cost containment tactic, but it is especially applicable to growing companies looking to recruit or retain top talent.
- Consider contributing to Non-Qualified Plans in lieu of sign-on bonuses or salary increases. Employers using this provision have discretion in setting vesting schedules.
- Contributions can also be conditioned on company performance or financial incentives without diluting ownership by giving stock

For more information on Secure 2.0, watch The Change in Retirement: Why the Secure Act 2.0 Makes Retirement a Requirement.

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# Strategic Compensation Planning

It's no secret that compensation is one of the largest expense categories for most employers. This has been especially true over the past couple of years, with inflationary pressures and an acute labor shortage causing wages to rise across many sectors of the economy.

It is sometimes prudent to limit the amount of ***money allocated to such increases*** or even cancel them altogether during periods of distress.

Generally speaking, compensation is one of the last things that employers want to touch when they are trying to contain costs. However, strategic changes to compensation policies can sometimes be the lesser of two evils for companies that find themselves caught in difficult circumstances. While full-throated pay cuts are outside the scope of this paper due to their negative impact on the employee experience, the list below contains other compensation levers that employers can pull. These policies will likely be unpopular, but they represent real opportunities for savings that can help businesses to navigate unfavorable conditions in the short-to-medium term.

1. **Reduction/Suspension of Merit Increases**
   While merit increases to employee pay are generally advisable for reasons of retention, productivity, and morale, it is sometimes prudent to limit the amount of money allocated to such increases or even cancel them altogether during periods of distress. This option is arguably the least severe of any of the items on this list, as merit increases are not guaranteed by definition and suspending them is merely continuing the status quo rather than "taking something away". However, it is no secret that inflation has reduced the purchasing power of employee salaries, and a portion of your workforce may view the implementation of this policy as a de facto pay cut.

2. **Reduction/Suspension of Incentive Payments**
   A similar strategy may be applied to incentive-based payments that are contingent on employees meeting concrete goals, although this can be a bit dicey. For example, incentive payments that are unequivocally guaranteed in offer letters or other employment agreements will likely need to be honored. In addition to this some types of positions may have low base salaries and high performance-based payouts, meaning that limiting incentive pay could have a crippling effect on employee wellbeing (sales jobs are the most prominent example of this). For these reasons, employers should exercise discretion and weigh the pros and cons of such policies prior to implementation.

Limiting incentive pay could have a ***crippling effect*** on employee wellbeing.

### 3. Limitation of Overtime Pay

Lax overtime policies can quickly add up to a significant drain on a company's bottom line. If employees are not already required to obtain approval from management before incurring overtime, it may be prudent to implement stricter controls along these lines. Employers may also consider allocating a set budget for overtime expenditures per week or per month and working with frontline employees to ensure that this is adhered to. Please be advised that, generally speaking, employers are legally required to pay overtime once it is incurred, even if it was incurred in violation of an internal policy.

Employers may also consider allocating a ***set budget for overtime expenditures*** per week or per month and working with frontline employees to ***ensure that this is adhered to***.

### 4. Suspension/Reduction of Certain Reimbursements

Laws regarding the reimbursement of work-related employee expenses vary between different jurisdictions. In jurisdictions with lower levels of regulation, employers may be able to save money by instituting stricter reimbursement standards or even suspending reimbursements entirely. Temporarily reducing or suspending reimbursements for things such as car mileage, cell phone usage, meals, or internet for remote workers may be a good way to cut back on "nice-to-have" policies during fiscally challenging periods in a way that does not affect a company's core employer value proposition. In order to ensure that no laws or regulations are being violated, make sure to confer with your finance team before implementing policies such as these.

Before electing any of these compensation cost saving strategies, it is important that employers mitigate any associated risks. We suggest taking the following steps:

- Ensuring that no discrimination of a protected employee category is occurring
- Consulting with legal and financial counsel (where appropriate) to ensure the action is in accordance with local, state, and federal laws
- Clearly communicating the changes with employees, including what change is occurring, why it is occurring, who it impacts, and for how long

# Professional Employer Organizations (PEOs)

**Savings Potential:** $$$$

**Change Management Difficulty:** 

**Disruption to Employees:** 

**Good fit for:**
Smaller businesses with room for administrative streamlining.

## WHAT ARE THEY?

PEOs are third party organizations that enter into co-employment agreements with businesses and execute various administrative and compliance duties for their clients.

## WHAT DO THEY DO?

Once contracted, PEOs act as the employer of record and handle routine administrative duties on behalf of their clients. These duties typically include items such as payroll, hiring, onboarding, benefits administration, and worker's compensation. Employers who work with PEOs retain responsibility for day-to-day operations, the direct management of employees, and strategic planning and decision-making.

## HOW DOES IT HELP CONTROL COSTS?

PEOs can save employers money by leveraging economies of scale, consolidating various tasks and vendor relationships into a single efficient stream, and enabling HR and administrative employees to focus on higher-value activities. Because PEOs can pool the plan risks and administrative burdens of many different clients, they can put forward attractive pricing structures and plan designs that cost significantly less than what individual employers would be able to achieve on their own.

## KEY CONSIDERATIONS FOR ADOPTERS:

- While PEOs can certainly help employers to save money, their main selling point is the ability to streamline human capital management challenges with dedicated staff and technology platforms. This means that the best candidates for cost containment via PEOs are those who currently have inefficient or low-tech administrative processes.
- Just like any other business, it is possible for PEOs to go into bankruptcy or cease operations. Because of this, employers should ensure that their PEO has the necessary credentials, certifications, and memberships to protect their company in the event of a shutdown.

# Retention as a Cost Containment Strategy

In 2021 and 2022, roughly 100 million Americans quit their jobs.[1] Despite the present climate of economic uncertainty, turnover numbers from early 2023 seem to indicate that this trend will continue for the foreseeable future.

In 2021 and 2022, roughly **100 million** Americans quit their jobs.[1]

Employers have been grappling with two continuous years of record-high job openings, record-low unemployment, and a workforce participation rate that remains below its pre-pandemic level. Demographic changes are making this labor shortage even worse: Americans are having fewer children, over 10,000 baby boomers are hitting retirement age every day, and the population of working-age Americans has been in decline for almost two decades.[2] [3]

Savvy business leaders understand that this dearth of human capital is not going away anytime soon. They also understand that it represents an acute financial burden for their organizations. Most employers equate the cost of turnover with the cost of hiring a replacement, which is commonly quoted as 30-50% of salary. However, this figure grossly underestimates the true cost of replacing a seasoned performer with someone new. In professional roles, new hires can take months or years to reach the productivity and contribution levels of those they replace. Taking this into account, organizations like Gallup estimate that the actual cost of turnover is closer to 50-200% of salary[4].

The actual cost of turnover is estimated closer to **50%-200%** of salary.[4]

Things get even more expensive when a new employee winds up being a poor fit for their role. Research by Topgrading Inc. suggests that mis-hires cost a staggering 400-2,700% of salary depending on the level of the role and the amount of exposure it has to customers and other employees[5].

Because of all this, cultivating a high-retention atmosphere is one of the most surefire ways for employers to contain costs. However, there is a lot of misinformation and myth-making on this topic that has led well-meaning managers astray. For example, the simplest and most common step many leaders take to boost retention is also one of the least understood: they raise pay.

[1] "Job Openings and Labor Turnover Archived News Releases." U.S. Bureau of Labor Statistics.
[2] "Aging Readiness & Competitiveness (ARC), United States." American Association of Retired People.
[3] "Working age population." OECD iLibrary.
[4] "This Fixable Problem Costs U.S. Businesses $1 Trillion." Gallup Inc., March 13, 2019.
[5] "Calculate the True Impact Mis-Hires Have Had On Your Organization." Topgrading, Inc.

While below-market compensation has been shown to drive employees away, decades of research show that high pay alone does not prompt the type of extreme satisfaction that causes employees to stay with an organization long-term. What's worse, pay raises have little or no lasting impact on productivity or effectiveness. So what practices can employers cost-effectively implement that act as strong satisfiers? Consider these three:

1. **Elevate Clarity:** Articulate what the role is, what responsibilities it has, and how performance is measured. Ambiguity about these things causes stress and frustration.
2. **Connect to Purpose:** It is critical for employees to understand how their efforts contribute to a larger mission or goal and to make sure that this is compatible with their own "why".
3. **Focus on Growth:** This one is the most important. Provide the people you manage with a path forward in their professional lives and actively work to help them advance.

***High pay alone*** does not prompt the type of ***extreme satisfaction*** that causes employees to ***stay with an organization long-term***.

Retention is a natural byproduct of organizations getting these things right. This isn't a reluctant, I-guess-I'll-stay-another-year retention, but a true and enduring satisfaction and enthusiasm that boosts productivity and turns employees into brand ambassadors. Focusing on these three satisfiers, and especially on growth, is an effective strategy that secures real savings by way of preventing turnover.

So instead of advising managers to retain their people, insist that they grow their people. Instead of "if we pay, they'll stay", think "if they're not growing, they'll be going." When it comes to clarity, focus on what, how, how much, and why. Spell out exactly what great performance looks like, naming the skills and behaviors you are looking for. Create measurable goals and indicators, especially for non-sales roles that rarely experience such clarity.

Take the time to understand what makes each employee feel a sense of purpose. Encourage them to share their "why", not the company's why, and map their role and responsibilities to this. Pursue moments of intentionality and have clarifying conversations about what interests them and how they would like to see their role evolve and change.

***Take the time to understand*** what makes each employee ***feel a sense of purpose*** and map their role and responsibilities to this. .

Finally, don't assume that people know where and how they should grow. Collaborate with them on a growth plan, tie measurable development goals to it, and put these in writing. Once this is done, revisit the plan in your recurring check-ins and progress updates. Be relentless in your guidance and encouragement and prove to them that your organization cares about its people.

| Growth Practices | | Retention Practices | |
|---|---|---|---|
| Role and goal clarity | Free | Salary increases | 5-10% of salary |
| Mentorship or accountability buddies | Free | Higher variable comp or bonus | 5-25% of salary |
| Book clubs or lunch-and-learns | Free or low $ | Equity incentives | $$$$ |
| 3-6 months of professional coaching | $$$ | Promotions | $$$$ |
| Eliminate unfair or annoying policies | Free | Legal Action Against Departed Employees | $$$$ |

These practices not only work to contain recruiting and hiring costs, but also increase productivity and morale. Helping people grow is low-cost, high-impact, and rewarding in its own right. Development is about progress over perfection – if you can make everyone in the organization feel like they are growing, retention issues will begin to melt away.

SECTION 4

# Conclusion

With millions of workers under increasing financial strain and a rocky economic outlook for the foreseeable future, it is critical for leaders to make informed cost containment decisions that ensure the financial protection of their businesses and people. Employers will need to adapt to this difficult environment by building resilient organizations, insulating themselves from rising costs, and addressing continued labor challenges.

While these challenges may seem daunting, they also present an opportunity for employers to implement data-driven cost containment policies and position themselves for future growth and stability.

Though this resource has addressed many of the top cost containment policies that employers can consider, it is by no means a complete list of every option available. Many additional strategies exist that can help to control costs while retaining people, and we encourage you to keep an open mind and cast a wide net as you begin to build a plan for your organization.

As you consider the information presented here and begin to decide which cost containment tactics are best suited for your needs, connect with your OneDigital team for additional support. We're fierce advocates for our clients and committed to working tirelessly for those we serve, offering personalized guidance and support to help navigate the complexities of the modern business, workplace and financial landscape.

**Together, we can craft a customized strategy that empowers you to serve your employee population, insulate yourself from risk, and chart a sustainable path into an uncertain future.**

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