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Employers Change Tactics to Curb Health-Insurance Costs

Instead of just passing on higher bills to workers, they are attacking some of the underlying causes

By Anna Wilde Mathews Dec. 2, 2018

Company leaders are grappling with how to deal with the rising cost of health insurance in ways that get beyond the longtime strategy of simply passing on more of the burden to workers.

"The CEOs of our clients are more involved in the health-care benefits program than I've seen in 25 years," says Jim Winkler, a senior vice president at consulting firm Aon PLC. "It's, 'What are we spending our money on, and does it make sense?' "

For years, employees' deductibles have risen rapidly, putting the average amount at $1,350 for a single worker, says the Kaiser Family Foundation. Employers have relied on the high-deductible plans, which force employees to pay more out of their pockets for care, to help rein in the cost of insurance. Even so, employer-provided family coverage this year cost $19,616 on average, and the total is almost certain to pass the $20,000 threshold in 2019.

Now there are signs that some companies are tapping the brakes on deductibles. A survey by the National Business Group on Health this year found that the share of employers planning to offer only high-deductible health plans was set to drop by 9 percentage points next year, to 30%. That came after increases each of the previous six years.

"We're seeing a really keen interest in moving away from high deductibles and coinsurance," says Forrest Burke, chief executive of national markets at UnitedHealthcare, the UnitedHealth Group Inc. unit that is the biggest U.S. health insurer. Employers are looking for ways to address the underlying factors that drive up costs, he says.

There are a number of strategies in play. Some organizations are bypassing insurers and negotiating deals with hospitals directly. A growing number are offering their own clinics. And some are launching new efforts to change how they pay for drugs, an area that has left many employers frustrated in the past.

Mr. Burke's company is working on efforts aimed at guiding patients to lower-cost, high-quality care, he says, including a tool that gives doctors more information about the places they might send patients for follow-up treatment.

Growing costs

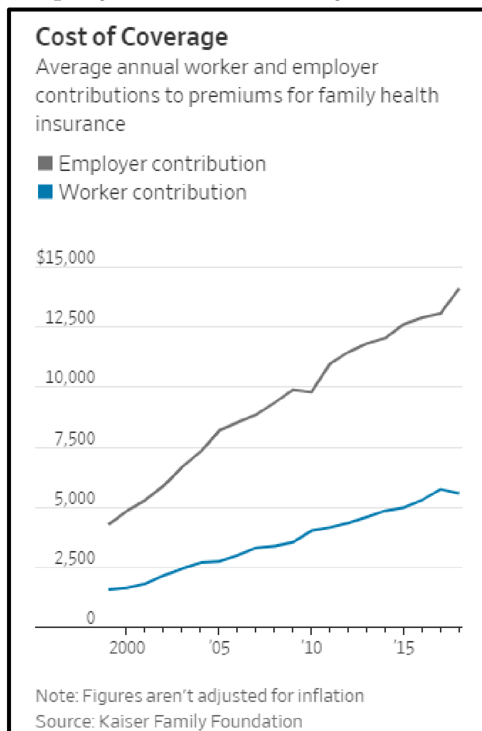
A report issued earlier this year by the nonprofit Health Care Cost Institute said that between 2012 and 2016, health-spending growth tracked in insurer claims from employer-sponsored

coverage was almost entirely due to price increases for services including emergency-room visits, surgical hospital admissions and administered drugs. Over the same period, "utilization of most health care services remained unchanged or declined."

"The bottom line is, Americans are using less health care and paying more for it every year," says Niall Brennan, chief executive of the institute.

A few employers are taking radical steps to change things.
Some "are just saying, 'This is ridiculous, I'm not going to do this anymore,' " says Brian Klepper, a consultant who works with employers on health issues.

The state treasurer of North Carolina, Dale R. Folwell, who oversees the state's employee health plan, next year wants to force hospitals and doctors to accept rates pegged to those paid by the federal Medicare program, which are set by the government and often lower than those paid by employers. That is very different from the current setup used by the state and nearly all employers, which involves payments negotiated by a health insurer.



The idea is drawing strong pushback from North Carolina hospitals, which say they have talked to state legislators about the issue.

In Utah, the independent agency that handles health coverage for state workers is offering to pay for workers to travel to Mexico to fill prescriptions for certain medications that are far cheaper south of the border. The employees who choose that option will also get $500 to keep for themselves each time they go to fill a three-month prescription, part of a larger program of "cash back" payments for choosing lower-cost health-care providers.

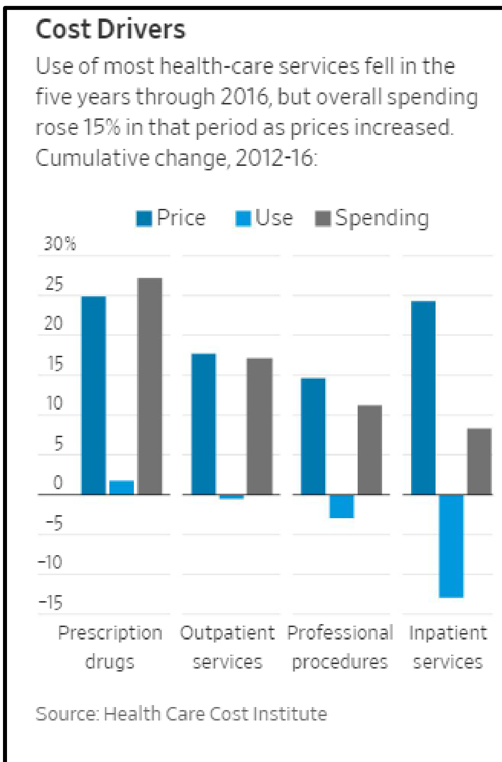
"There are some drugs where the only way we could find a lower-cost provider was to put them on a plane and send them to Tijuana," says R. Chet Loftis, managing director of PEHP Health and Benefits, the Utah agency.

The plan saves around 40% to 60% compared with getting the medications in the U.S. even with the cost of the cash-back payments and transportation factored in, he says.

A growing segment of employers are directly providing care for employees. Last year, according to a survey by Mercer, a unit of Marsh & McLennan Cos., a third of large employers had primary-care clinics at or near workplaces, up from 24% five years earlier.

Stuart Clark, chief executive of Premise Health, a major provider of clinics to employers, says one goal is to help companies "avoid that unit-cost treadmill everyone is on," where doctors often refer patients to high-cost services provided by hospital systems.

Other employers are taking less sweeping steps, but still aiming to get more deeply involved in how their workers get care and how it is paid for.



In August, General Motors Co. became the latest big company to announce it had cut its own deal directly with a hospital system. GM says that by negotiating its own terms, instead of using an insurance company's setup, it could offer a plan that cost employees less while also promising special customer-service perks and quality standards. Other employers trying this tack include Boeing Co. , Intel Corp. and Walt Disney Co.

Walmart Inc. years ago crafted limited direct contracts with hospital systems to perform particular types of procedures. Next year, the giant retailer will go further, requiring its employees to use certain hospitals for costly spine surgeries, in an effort to weed out unnecessary procedures and lower its health-care spending.

A deal for drugs

On the pharmaceutical side, the National Drug Purchasing Coalition, a group that includes PepsiCo Inc. and Exxon Mobil Corp. , in October unveiled a new deal with pharmacy-benefit manager Express Scripts Holding Co. that changes how they pay for drug coverage.

Under the new setup, the pharmacy-benefit manager is supposed to pass through all rebates and other payments from drug companies to employers. Express Scripts can get extra payment—or potentially have to give back some money—based on whether it hits goals for patient outcomes and financial savings. "The clients wanted alignment and accountability," says Stuart Piltch, a consultant who works with the employer coalition.

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