Self-Insured Employer Plans Offer Innovations that Lower Costs and Improve Employees' Health

Over 100 million people in the U.S., 65 percent of those with employer coverage, are covered through self-insured plans.[1] This means the employer, rather than a health insurer, pays health care providers — including doctors, hospitals, therapists, labs, and pharmacists — and bears primary financial risk for the cost of care for employees and their families. **Annual spending on health coverage by self-insured employers and their employees is about $800 billion**,[2] with the average family cost exceeding $22,000 and the average individual cost approaching $8,000.[3] After relatively low cost growth in the last five years,[4] employers are expecting larger cost increases in the future, and many aim to avoid shifting costs to employees in a tight labor market.[5]

Self-insured employer plans have grown in popularity over the last two decades; as recently as 1999, they covered fewer than half of those with employer coverage.[6] Because they are exempt from state premium taxes and many state laws and regulations, **self-insured plans give employers flexibility to design health benefits and incorporate innovative offerings and programs for their employees**. Employers who self-insure typically choose a health plan to serve as a third-party administrator to provide disease management and wellness programs, network management, claims processing, member enrollment, and regulatory compliance.

Limitations of Provider Discounts

Many employers select the health plan that offers the largest provider price discounts. This approach has limitations.

- Provider discounts keep the focus on the unit price of services, rather than their quality, appropriateness, and effectiveness.
- A broad, longer-term focus on helping employees use high-value services is a more effective way to reduce total cost of care.

Employers can partner with health plans that help reduce wasteful spending by increasing the use of preventive care, shifting avoidable emergency department visits to more effective settings, and reducing the length of hospital stays through better planning and post-acute care.

Focusing on Service Use, Rather than Price Per Service, Is the Most Effective Way to Reduce the Total Cost of Care Over Time

Total Cost of Care	=	Price Per Service	x	Service Use
Spending on health coverage by employers and their employees		Discounted prices do not eliminate hospitals' incentives to provide complex and costly services		Ensuring employees receive the right care in the right setting at the right price leads to better health outcomes, higher quality care, and greater savings

Leading health plans deliver a range of complex and innovative services that, when executed effectively, increase the quality of care delivered and improve the health of employees, while reducing the total cost of care and creating savings for employers and employees. Health plans accomplish these goals by:

- **Designing health benefits** to drive better outcomes and lower costs
- **Using advanced data analytics** to help employees make better-informed choices
- **Providing personalized clinical support** to facilitate high-quality care
- **Empowering patients** in their interactions with the health care system

Through these approaches, **UnitedHealthcare has achieved total cost of care that is 9.7% lower than market averages**, without always being the market leader in price discounts.[7]

Over the next decade, **self-insured employers and their employees will spend over $10 trillion on health coverage**.[8] Using an effective health plan to implement comprehensive solutions allows employers to manage costs and deliver value to their employees. If all self-insured employers ultimately implemented strategies to **reduce spending on health coverage by 5 percent**, employers and their employees would **save over $500 billion over 10 years**.

$10 trillion in spending by self-insured employers and employees x **Reduce spending on health coverage by 5%** = **$500 billion in savings** over 10 years

Designing Health Benefits

UnitedHealthcare (UHC) helps employers refine and manage their health benefits in order to drive better outcomes and lower costs over time. Based on their current health benefit selections, employers' benefits are benchmarked by the ability to incentivize employees to make more effective health care choices. **Employers can make their benefit plans more effective by increasing employee engagement through solutions that include benefit and network design, clinical and well-being resources, and payment protocols.** As employers assess their options and make their selections for each new plan year, UHC estimates potential annual savings for employers and employees.

Benefit design: For example, employers can choose to offer Surest, a cost-saving product design that simplifies the care experience for the employee. Surest achieves **high member satisfaction and savings** for employers and their employees by:

- No deductible or coinsurance
- Delivering a digital experience through a mobile application that allows the member to compare prices and treatment options before selecting a provider and making an appointment
- Helping members seek care within UnitedHealthcare's network of high-quality providers

Clinical and well-being resources: Many employers offer a one-size-fits-all case management program that is event driven – triggered, for example, when an employee has a hospital admission or receives a new diagnosis. These employers can **improve their employees' health outcomes and reduce avoidable spending** by adopting disease management and well-being programs that:

- Target specific conditions, identify employees' comorbidities, and work to reduce the risks of future hospital stays
- Proactively identify and engage high-risk employees before they develop chronic health conditions
- Encourage all employees to exercise, visit their primary care provider, and receive preventive care screenings

Network design: Employers can opt into high-value networks that focus on quality and cost of participating providers. Compared to traditional broad networks, employers can **achieve higher savings and improve results** by:

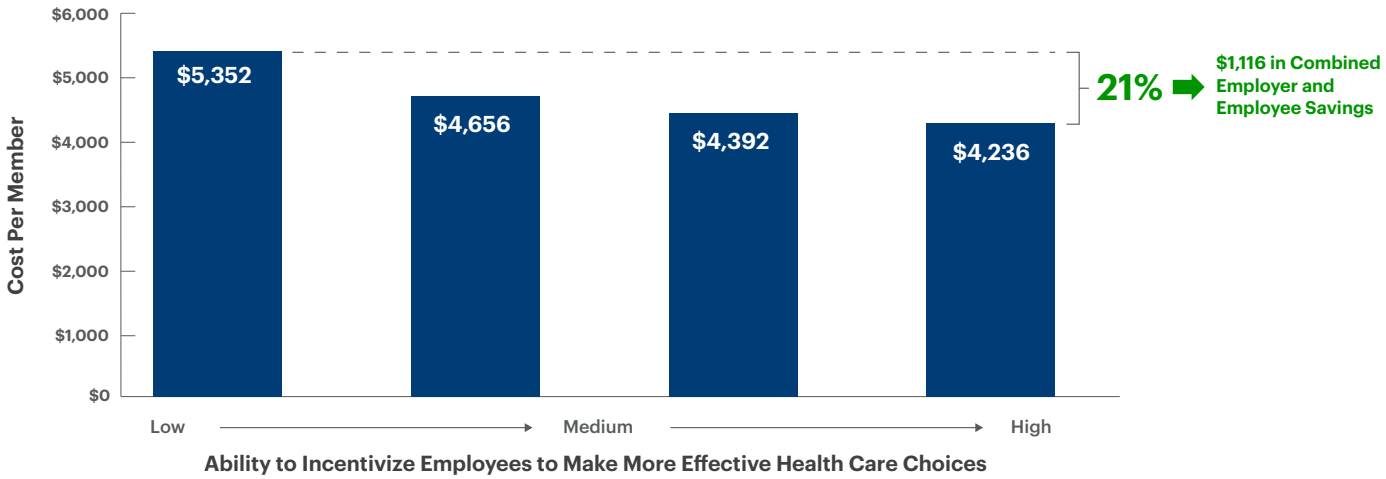
- Promoting providers with a proven track record of better patient outcomes
- Incorporating value-based payments that reward providers for delivering high-quality and cost-effective care
- Incentivizing employees to choose high-value sites of care and in-network providers

Payment protocols: Employers can opt into a range of payment integrity programs that help ensure only appropriate claims are paid. These programs reduce health care spending by **detecting, preventing, and recovering payments for fraudulent, wasteful, and abusive practices**. Specifically, these programs:

- Identify significant potential billing errors through manual reviews by professional auditors prior to claim payment
- Retrospectively review paid claims to validate that a correct payment was made based on medical records and billed codes
- Leverage artificial intelligence to identify abnormal billing patterns by providers

Clients who adopt benefit design solutions that encourage employee engagement saw average savings of up to **21 percent**.[9]

Average Annual Medical and Pharmacy Cost by Level of Employee Incentives, 2021



Using Advanced Data Analytics

UHC uses advanced data analytics to measure the ability of employees and their family members to make better-informed health care choices and take positive actions to improve their health. UHC's Health Activation Index (HAI) is an employee engagement score on a 0% to 100% scale that analyzes evidence-based decisions and underlying health care and demographic data for 15 million covered individuals each quarter to benchmark individuals against cohorts of similar people. **Individuals with higher HAI scores are more likely to have favorable health outcomes, better quality of care, and lower costs.**

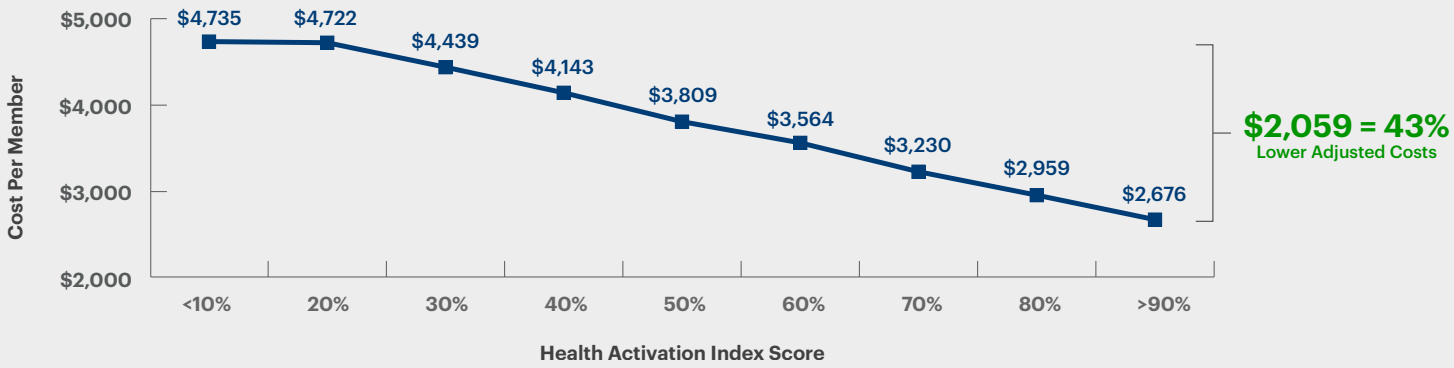
Individuals increase their HAI scores by:

- Receiving appropriate screenings, including for high cholesterol, diabetes, and colon, breast, and cervical cancer
- Engaging in condition-based disease management programs, wellness and coaching programs
- Using Centers of Excellence for cancer treatment, kidney disease, and select surgeries
- Selecting networks of high-quality providers

Increases in HAI scores are associated with generating health care savings for employers and employees, helping avoid unnecessary use of hospital services, improving health outcomes, and increasing productivity.[10]

Individuals with high HAI scores (>90%) have **43 percent lower costs** than similar individuals with low (<10%) HAI scores.[11]

Average Annual Medical Cost by Health Activation Index Score, 2021



High-risk individuals with HAI scores above 90% have **43 percent fewer hospital admissions** and **67 percent fewer emergency department visits** than similar individuals with HAI scores of 50%.[12]

Providing Personalized Clinical Support

Over 12 million patients in the U.S. receive a misdiagnosis each year.[13] As a result, as many as 160,000 patients die or suffer from a permanent injury, often as a result of unnecessary procedures or delayed treatment.[14] UHC offers timely second opinions from leading providers to **help patients ensure they have the correct diagnoses and a sound evidence-based treatment plan**. Through the 2nd.MD program, employees and their family members can:

- Meet virtually with a nurse, who will discuss their situation, collect the relevant medical records, and refer them for a follow-up consultation
- Meet virtually with a leading specialist with expertise in the patient's condition to review the patient's diagnosis and treatment plan and discuss next steps
- Receive a written summary of the consultation with recommendations

2nd.MD consultations have resulted in higher quality care for employees and lower costs for employers and employees:[15]

89%
of treatment plans improved following a consultation

32%
of patients received a corrected or improved diagnosis after a second opinion

Empowering Patients

UHC empowers patients by **providing information and advocacy services that help avoid unexpected out-of-network (OON) bills**, which remain a threat because the recently enacted federal No Surprises Act does not cover many OON services. Through the Naviguard program, UHC manages the medical bill resolution process with the goal of reducing the patient's financial obligation by having Naviguard's patient advisors:

- Educate and help patients to select in-network providers so they no longer receive balance bills
- Negotiate directly with OON providers on the patient's behalf
- Use reference-based pricing information to obtain the best pricing

Using Naviguard has achieved the following results for employers and their employees:[16]

Successfully negotiated **reductions for 78 percent of balance bills** that members receive from an OON provider

Realized average **savings of $2,400 per bill**, a 70 percent reduction from billed charges

Generated over **$4 billion in savings** over two years

Citations

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9 UnitedHealthcare (UHC) 2022 analysis of 2021 commercial claims from self-insured employers.
Costs are normalized for age, gender, geography, and categories of spend in increments of $150,000.
Costs include HRA spend, exclude HSA funding, and are not adjusted for COVID.

10 UHC 2019 analysis of 2018 commercial claims from self-insured employers.

11 UHC 2019 analysis of 2018 commercial claims from self-insured employers. 2018 allowed medical costs are risk adjusted for demographics, risk score, geographic region, and categories of spend. Costs are inflation adjusted to 2021 dollars by applying the increase in private health insurance spending using the National Health Expenditure data. (See 2022 Historical Table 5-6.)

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