Your Plan to Reduce Healthcare Spend by 20-50%

Controlling healthcare costs means understanding the core parts of your health insurance plan, and how to align those components with your goals.

Health Insurance Plan Components

Every health plan has four components regardless of whether it is fully insured or self-funded: (1) Network, (2) TPA, (3) PBM, and (4) stop-loss/pooling point. These components are defined below:

1. *Network*

A group of healthcare providers and facilities that have contracts in place that enable access to care for plan members.

2. *Third Party Administrator (TPA)*

Any company that processes insurance claims or other benefit plan details on behalf of another company. Companies typically outsource the administration or management of their benefits to other companies for a fee.

3. *Pharmacy Benefit Manager (PBM)*

An intermediary company ("middleman") that manages and controls drug pricing and claims. Supposedly, its role is to negotiate and lower drug prices between manufacturers and consumers. In reality, most PBMs operate with unverifiable pricing models and skims $$$ off the top of drug transactions, which makes drugs more expensive for plan members.

4. *Stop-loss*

An insurance product purchased by self-funded employers to protect against excessive or unpredictable losses to the company health plan. In fully insured plans, this concept is known as pooling.

Stage 1: Fully Insured Plans

Fully insured plans will bundle the four components of health insurance plans together. Consider an example of an employer's fully insured health plan administered by United Healthcare (UHC):

1) Network = UHC
2) TPA = UHC
3) PBM = Optum (Owned by UHC)
4) Stop-loss (pooling) = UHC

In this example, the components are not independent of one another. Therefore, UHC is not incentivized to lower your healthcare costs because the parts of your health plan are swapping **your** money between themselves.

Fully insured plans are suboptimal for many other reasons. They are legislatively set up to fail because the health insurer profits when your healthcare expenses go up. If you do come out ahead financially in a given year on medical expenses, UHC will simply raise your premiums next year to recoup their losses. Fully insured plans also give you the least amount of control of your claims data (since UHC manages the plan for you), which prevents you from making informed decisions that will lower your plan's costs.

Stage 2: Transitioning to Self-Funded

Transitioning your health plan from fully insured to self-funded is the most important step to taking back control of your healthcare costs.[1] If you have a fee-only benefits advisor guiding you, the transition to self-funded comes at no additional risk to the plan (same maximum liability as the fully insured plan). It also comes at no disruption to employee access to healthcare providers. Here's an example of what a self-funded health plan could look like:

1) Network = UHC
2) TPA = United Medical Resources (UMR, owned by UHC)
3) PBM = Optum (UHC)
4) Stop-loss = American Fidelity

The only real change to your plan components in Stage 2 is the underlying stop-loss insurance carrier. Now that you have a self-funded plan, you have the opportunity to reverse the trajectory of your company's healthcare spend.

[1] For an explanation of how and why this transition is done, see https://www.wincline.com/fully-insured-self-funded

Stage 2.5: Continuing to Make Progress

Thinking forward about your employee benefits requires gradually splitting up the four components of your health insurance plan so that each actor is incentivized to work on your behalf. With the continued guidance of a fee-only benefits advisor, you can begin to strategically "unbundle" each component from UHC. Employers move forward by first making the PBM independent:

1) Network = UHC
2) TPA = United Medical Resources (UMR, owned by UHC)
3) PBM = Drexi
4) Stop-loss = American Fidelity

Stage 3: Optimizing the Four Components

Then, employers need to fully "unbundle" the components by splitting up the network and TPA, which makes all parts of the plan completely independent:

1) Network = Cigna PPO
2) TPA = Aither Health
3) PBM = Drexi
4) Stop-loss = American Fidelity

This affords you transparency, allowing you to manage medical and pharmacy claims as well as ensure the right amount of stop-loss insurance coverage.

Stage 4: Eliminating the Network Entirely

Once self-funded employers have made each component of their health insurance plan independent, they have the option to eliminate their network entirely. Instead, they can leverage proven cost-saving payment methods like reference-based pricing (RBP)[2] and direct contracting.[3]

1) Network = None (use RBP and direct contracting in its place)
2) TPA = Aither Health
3) PBM = Drexi
4) Stop-loss = American Fidelity

[2] In a reference-based pricing model, the employer sets an amount based on the Medicare reimbursement rate (i.e., 130% or 150% of Medicare) that it is willing to pay for a claim. This allows employers to exert control over their healthcare costs without plan members being restricted by a PPO network. For a more in-depth explanation, see: https://wincline.com/reference-based-pricing/.

[3] Direct contracting simply refers to paying a healthcare provider directly for rendered services.