Rising costs continue to be a significant concern for employers, especially for their group medical and Rx benefit plans. According to new data from the International Foundation of Employee Benefit Plans (IFEBP), for the second time in as many years, employers are projecting a 7% rise in healthcare costs. The primary reasons, according to employer responses on the IFEBP 2024 Cost Trend pulse survey, are utilization due to chronic health conditions, catastrophic claims, specialty/costly prescription drugs, cell and gene therapy and medical provider costs.

“Employers are realizing that decades of delegation of oversight in their healthcare spend is not working,” states Heidi Cottle, SVP of Cost Containment Strategies. “The continued escalation of medical/Rx costs is not sustainable. With the advent of price transparency, employers are beginning to expect greater cost and quality accountability in the market for both the provider of healthcare services and the payers (such as carriers and third-party administrators).”
Further fueling this increase are ongoing inflation, supply chain challenges and labor shortages, which have a profound effect on healthcare providers and manufacturers of prescription drugs. This becomes readily apparent when examining the financial stability of hospitals and health systems.

According to a 2023 study by the American Hospital Association, sustained and significant increases in the costs required to care for patients and communities are putting the financial stability of the entire system at risk. After two years of battling COVID-19, health systems experienced a 17.5% increase in overall hospital expenses between 2019 and 2022, primarily due to the macro effects of inflation.²

Coupled with a decrease in the demand for profitable elective procedures and signs that cost barriers are driving delayed preventive and necessary medical care, it is likely that healthcare conglomerates will have little choice but to pass even more costs on to employers in the coming year.

Inflation similarly affects the operational costs of manufacturing medications. With increases in the costs of energy and transportation, along with disruptions in the supply chain, pharmaceutical companies are facing their own struggles. Despite the notion that drug manufacturers are typically immune from market pressures, rising expenses due to inflation affect their bottom line the same as any other organization. As a result of increased expenses, pharmaceutical companies will also likely continue to raise drug prices to protect their margins — even the already costly blockbusters such as Ozempic, Wegovy and Humira.

**Figure 1:**

49% of employers plan to increase medical/Rx budget at renewal

**Figure 2:**

21% plan to increase benefit budget by 10%+

**Figure 3:**

80% of employers find it very or extremely important to control Rx spend in designing Rx benefits
As every major stakeholder in the US healthcare system seems to struggle with inflation, employers are clamoring for strategies to manage these mounting costs while limiting disruption so their benefit offerings can remain attractive to workers. With great interest in identifying insurance plan strategies that can optimize the value of pharmacy benefits while accounting for high-priced drug therapies, employers would be wise to partner with experienced employee benefits advisors who can provide customized solutions to tame rising prescription drug costs. Fortunately, employers can also take proactive steps to curb healthcare cost increases while protecting their workforce and bottom line. Employers can optimize their spend with a medical strategy that utilizes advanced data analytics (paired with AI and machine learning capabilities) while advancing a value-based cost-containment strategy.

Figure 4: Of employers **do not use** a pharmacy consultant

31%

Figure 5: Of employers **are concerned** about **increasing pharmacy costs**

76%

Figure 6: Biggest Cost Drivers in Prescription Drug Spend

<table>
<thead>
<tr>
<th>Cost Driver</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auto-immune specialty medications</td>
<td>48%</td>
</tr>
<tr>
<td>Oncology medications</td>
<td>42%</td>
</tr>
<tr>
<td>GLP-1 diabetes/weight loss medications</td>
<td>39%</td>
</tr>
<tr>
<td>Ultra-rare gene therapies</td>
<td>30%</td>
</tr>
<tr>
<td>No visibility in pharmacy cost drivers</td>
<td>11%</td>
</tr>
</tbody>
</table>
Medical/Rx Planning

Strategic Foundations

When developing a comprehensive medical/Rx strategy, the following key elements will provide a firm foundation for plan design:

- **Develop a fiduciary evaluation and selection process for the medical/Rx plan.**
  ERISA, bolstered by the Consolidated Appropriations Act (CAA), requires a plan sponsor to adopt a formalized process of evaluation and selection for their employer-sponsored group health plans.

- **Ensure data analytics drives strategy and design.**
  To maximize value, employers must identify specific ways to apply advanced analytics to improve cost management, health outcomes and overall population management.

- **Utilize transparency – introducing cost, quality accountability and trend drivers.**
  Legislative advancements, including the CAA, have triggered market opportunities for cost transparency and opened the door for the creation and development of new market solutions.

- **Minimize disruption through a multiyear cost containment strategy and design.**
  To achieve optimal long-term outcomes, pair incremental, sustainable plan participant engagement measures with plan performance measurement through advanced data analytics.

- **Evaluate funding options.**
  There are two primary funding methods for medical/Rx plans: fully-insured and self-insured. However, there are a multitude of options within those funding methods which should be evaluated.

- **Adopt value-based benefit design.**
  Support clinical best practices by providing non-discriminatory incentives for members to adopt practices which lead to better health while addressing the overuse and underuse of healthcare services.

In each of these areas, there are many opportunities to optimize your medical/Rx strategy in ways that support employees and the bottom line.
Building from Strategy

After laying the groundwork on some of the key drivers of rising healthcare costs and potential high-level strategies to alleviate them, employers can take critical considerations into account around plan design. By leveraging data analytics, introducing greater transparency and accountability measures, and adopting value-based designs, plan sponsors can put conceptual strategies into actual practice. Delving into innovative plan models, targeted pharmacy management programs, and ensuring fiduciary responsibilities are met, the design process cements the creation of actionable steps to optimize benefits strategies.

Develop a Fiduciary Evaluation and Selection Process for the Medical/Rx Plan

BACKGROUND
ERISA and the CAA require a plan sponsor to adopt a formalized evaluation and selection process for their employer-sponsored group health plans. Working with an outside team for support keeping up with these requirements can be helpful. For example, NFP’s Compliance department provides a client toolkit for a comprehensive overview of requirements.

IMPLEMENTATION
The following steps are a good faith guideline. However, the guideline does not constitute legal advice. An employer should seek internal legal counsel for further guidance.

Step 1: Develop an internal Medical/Rx Plan Committee

Step 2: Evaluate the medical/Rx plan data claims analytics to determine a multiyear cost containment strategy and design. The data will define key utilization trends, better-performing networks throughout the US, and claims-specific areas where cost savings opportunities can be balanced against potential disruption to plan participants and access to quality care.

Note: The Dept of Health and Human Services (HHS) CAA FAQ release on February 23, 2023, makes clear requirements of the payers and their required release of data. Combining the transparency data with the claims data from this step establishes a plan sponsor’s current “unit cost of care” baseline. Medical procedural costs of care fluctuate considerably depending on geographic location.

Step 3: Develop a price transparency policy to include cost and quality accountability measures. Possible policy measures could include:

1. Network cost evaluation: Claims repricing analysis to determine the most cost-effective network.
2. Network quality evaluation: Perform network evaluation of in-network provider quality scoring. Depending on employer size, DEIB/social determinants of health can also be included in the evaluation process.
3. Evaluation of self-service tools required by CAA.

Step 4: Develop a methodology for evaluating your medical/Rx administrative service providers and funding methods.

Step 5: Define what “value” means to your organization. Develop value-based designs to support and incentivize the defined organizational value.

Figure 7: 76% of employers report that it is either very or extremely important to establish a best practice fiduciary policy and practice in 2024.
**Ensure Data Analytics Drives Strategy and Design**

**BACKGROUND**

Providing employee benefits is an expensive proposition, and the one-size-fits-all approach to designing a medical/Rx plan has proven to be ineffective. Following compensation, healthcare expenses are the second largest line item on an organization’s P&L statement.

To assess the appropriate use of cost containment and value-based designs requires the use of data analytics. Under current conditions, employers continue to broaden and refine their metrics management and advanced data analytics requirements to identify emerging trends, earlier. Early adopting employers rely upon their advanced data analytics systems as an integral part of their benefit strategy. “If you can’t measure it, you can’t manage it,” states Cottle.

By identifying emerging claims trends, gaps in care and necessary remediation to mitigate unexpected costs in their healthcare spend, these leaders can take proactive measures to optimize expenditures and health outcomes. Advanced data analytics systems are further able to monitor and validate the key performance indicators of adopted benefit strategies.

**IMPLEMENTATION**

Establishing an effective business case for the use of advanced data analytics requires:

1. Defining organizational priorities.
2. Establishing a baseline for measurement.
3. Determining reasonable goals based on clinical insights and ability to influence change.
4. Monitoring outcomes that validate performance of the established goals.

Done correctly, companies can leverage historical and current information to predict future trends and patterns with a high degree of accuracy, enabling organizational key performance indicators (KPIs) for both short and long-term forecasting.

As Cottle explains, “Data is a window into the art of the possible. Accurately interpreting the data turns the art of the possible into actionable insights.”

Generally speaking, advanced data analytics combines and extends prescriptive and predictive analytics as a broader business intelligence capability. Most data analytics platforms offer easy-to-understand visualization with supportive insights, and some platforms provide proposed actions for remediation used by a skilled advisor. It is important to note that all advanced data analytic platforms are not created equal. Those which support both data and clinical methodologies offer the broadest lens for employers to improve a plan participant’s access to quality healthcare services at the most optimal price.

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**In Focus**

**Data Analytics**

Essentially, data analytics is the science of analyzing raw data to make conclusions about information. According to Amazon Web Services, one of the biggest players in the big data analytics game, through the use of tools, technologies and processes, data analytics can convert raw data into actionable insights that can identify trends, solve problems, improve decision-making and foster business growth. In the world of employee benefits, where containing medical costs is paramount, data analytics can unlock transformative opportunities to optimize benefit spend through granular insights.

**Advanced Data Analytics**

Advanced data analytics is a data analysis methodology that uses predictive modeling, machine learning algorithms, deep learning, business process automation and other statistical methods to analyze information from a variety of data sources. It applies data science beyond the scope of traditional strategic business intelligence to predict patterns and estimate the likelihood of future events. Utilizing empirical data empowers the organize to introduce cost and quality accountability supported by value-based benefit incentives, performance standards and guarantees for healthcare providers and administrators of healthcare services.

**Predictive Analytics**

The process of using historical and current medical and pharmaceutical cost data (including financial projections), with standard actuarial science methodologies to predict what will likely happen in the future and make educated forecasts.

**Prescriptive Analytics**

The process of using data from a variety of sources, including statistics, machine learning, data mining and clinical outcomes to envision predictive outcomes and understand why they will happen.
Utilize Transparency – Introducing Cost, Quality Accountability and Trend Drivers

BACKGROUND
Over the past few years, various transparency laws have gone into effect that require hospitals and payers across the healthcare system to post their negotiated commercial prices, all as part of a larger effort to make medical costs less opaque. These legislative advancements have triggered market opportunities for cost transparency and opened the door for the creation and development of new market solutions.

One such opportunity gives employers the capacity to compare negotiated pricing across health systems, networks and regions all over the country. The potential for data-driven pricing transparency to help employers make more informed and strategic decisions around plan design and network strategy is promising. So is the ability to make these decisions while forecasting current and future healthcare costs. However, achieving these outcomes relies on sophisticated analytical tools.

IMPLEMENTATION
Introducing cost and quality accountability through transparency legislation adds opportunities for employers to adopt broader clinical risk management and enhanced pharmacy management strategies, including:

- **Network analysis:** Validate the best network based on plan participant access, cost and quality accountability factors.
- **Enhanced pharmacy management:** Engaged pharmacists and consultants focus on pharmacy benefit management and medical/Rx strategies to optimize employer cost savings. Additionally, this can include site of care management, guidance based on the social determinants of health and other pharmacy arrangement opportunities.
- **Clinical care navigation:** Consumer improvement in medical literacy is needed. To help participants access the appropriate care and providers according to their plan, a clinical guidance program should be established to bridge the literacy gap and ensure plan adherence.

With the right tools at their disposal, employers can now effectively analyze the negotiated pricing across various health systems and utilize that information to explore the variables related to healthcare, just as they would do with other significant expenditures. This allows employers to ascertain if they are currently getting the best unit cost and actively seek out providers whose cost and quality metrics fit their cost containment goals.

---

**Figure 8:**
Transparency in Healthcare Costs Creates More of an Opportunity to Educate Members

65% of employers see transparency as an opportunity*

18% of employers see transparency as a challenge*

* Among those aware of changes
Cost and quality accountability utilizes the following cost containment and clinical risk management “checklist” that covers the leading disease conditions, and can be used by employers to evaluate the performance of their medical/Rx plan:

**Cost and Quality Accountability Checklist**

<table>
<thead>
<tr>
<th>Evaluate effective cost of care: access to quality providers, management of emerging disease states and management of chronic diseases.</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Provider Network Analysis</td>
</tr>
<tr>
<td>✓ Pharmacy Transparency</td>
</tr>
<tr>
<td>✓ Clinical Care Navigation</td>
</tr>
<tr>
<td>✓ Advanced Primary Care</td>
</tr>
<tr>
<td>✓ Second Opinion Services</td>
</tr>
<tr>
<td>✓ Disease Prevention</td>
</tr>
<tr>
<td>✓ Behavioral Health</td>
</tr>
<tr>
<td>✓ Cancer Support</td>
</tr>
<tr>
<td>✓ Chronic Disease Management</td>
</tr>
<tr>
<td>✓ Diabetes Reversal</td>
</tr>
<tr>
<td>✓ Musculoskeletal Health</td>
</tr>
<tr>
<td>✓ Digestive Health</td>
</tr>
<tr>
<td>✓ End Stage Renal Disease (ESRD)/Dialysis</td>
</tr>
<tr>
<td>✓ Other Emerging Trends Specific to Your Population</td>
</tr>
</tbody>
</table>

Employers can now effectively analyze the negotiated pricing across various health systems with cost and quality metrics that fit their **cost containment goals**.
Minimize Disruption Through a Multiyear Cost-Containment Strategy and Design

BACKGROUND
We already know that medical/Rx benefits are a top priority in recruiting and retaining employees. However, influencing change is difficult. Fortunately, implementing positive change while minimizing plan participant disruption is possible through a multiyear cost containment strategy. This strategy requires two main elements, focusing both on the short- and long-term. First, establish short-term milestones with incremental and sustainable plan participant engagement measures. Second, to achieve optimal long-term outcomes, it’s essential to measure and monitor plan performance through advanced data analytics.

IMPLEMENTATION
To contain medical and pharmacy costs, employers need access to their claims data so they can identify areas where appropriate clinical influence can be supported. Employers can drive health improvement while containing costs through increased early detection, stronger utilization management programs, reduction in gaps in care, population health, addressing social determinants of health and adoption of value-based incentives in plan designs to encourage plan participant engagement.

Figure 9:
The survey identifies key strategic levers being considered by employers. However, the design for implementation requires the use of data analytics to support the business case for adoption.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>62%</strong></td>
<td><strong>61%</strong></td>
<td><strong>60%</strong></td>
</tr>
<tr>
<td>Of employers are very/extremely willing to consider non-valued benefit programs.</td>
<td>Of employers are very/extremely willing to consider personalization of benefits.</td>
<td>Of employers are very/extremely willing to consider “high performance” providers.</td>
</tr>
<tr>
<td>This can be achieved through well written employee surveys, with supportive data analytics.</td>
<td>With four generations in the workplace this is important for effective recruiting and retention of key employees.</td>
<td>Utilizing advanced data analytics with the new transparency data sets (i.e., hospitals’ and payers’ posted costs for procedures) offers employers insight into negotiated costs with the various carriers/payers/third-party administrators. The initial data demonstrates that cost and quality are not synonymous. High-quality providers, based on industry acceptable clinical standards, are consistently the most optimal choice for cost.</td>
</tr>
</tbody>
</table>
According to McKinsey, a wide range of organizations are contributing to systematic changes that improve the quality of care and outcomes while better controlling costs. McKinsey further reports that following private capital over the pandemic, investment in value-based care companies increased more than fourfold from 2019 to 2021 and, given the current momentum, could result in $1 trillion in enterprise value as the landscape matures.7

- **Evaluate administrative needs:** Understand the requirements to establish fiduciary evaluation and selection process.
- **Analyze financial targets:** This includes evaluating the medical/Rx funding options.
- **Mitigate risk:** Ensure proper compliance practices, protocols and oversight are in place.
- **Establish qualitative and quantitative metrics for evaluation:** Establish reasonable and achievable goals. Utilize the cost and

### Figure 10: Areas of Cost Containment

<table>
<thead>
<tr>
<th>Area</th>
<th>Not all willing to consider</th>
<th>Slightly willing</th>
<th>Moderately willing</th>
<th>Very willing</th>
<th>Extremely willing to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce Rx cost effective programs</td>
<td>3%</td>
<td>9%</td>
<td>21%</td>
<td>39%</td>
<td>28%</td>
</tr>
<tr>
<td>Introduce high-performance networks with better quality outcomes</td>
<td>2%</td>
<td>10%</td>
<td>28%</td>
<td>35%</td>
<td>36%</td>
</tr>
<tr>
<td>through transparency tools</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce benefit costs by identifying non-valued benefit programs</td>
<td>2%</td>
<td>9%</td>
<td>27%</td>
<td>36%</td>
<td>26%</td>
</tr>
<tr>
<td>Improve personalization in benefits</td>
<td>3%</td>
<td>10%</td>
<td>26%</td>
<td>36%</td>
<td>25%</td>
</tr>
<tr>
<td>to manage the unique geneational differences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhance benefit programs through responsible use of AI capabilities</td>
<td>4%</td>
<td>13%</td>
<td>26%</td>
<td>33%</td>
<td>24%</td>
</tr>
<tr>
<td>Improve data-driven analytics</td>
<td>3%</td>
<td>10%</td>
<td>24%</td>
<td>38%</td>
<td>25%</td>
</tr>
</tbody>
</table>
quality accountability “checklist” to establish performance standards and guarantees for your selected medical/Rx vendors.

- **Monitor and manage qualitative and quantitative metrics:** Establish data analytics (advanced data analytics) to evaluate performance of the metrics. Integrate data analytics in the ongoing emerging claims utilization trends, disease management adherence, gaps in care, DEIB/social determinants of health, and wellness incentive programs tied to risk modifications.
- **Consider HR matters:** Do you adopt a “crawl,” “walk” or “run” approach to minimize disruption and align with business goals?

### Evaluate Funding Options

**BACKGROUND**

For employers to consider emerging trends and other innovative options, an annual evaluation of funding methods is required. A trusted advisor can assist through risk management, advanced data analytics, price transparency, actuarial and other plan design tools to support an organization’s business objectives. Through this process you can identify and exploit advantages in a carved-out pharmacy plan with access to claims and audit rights ensuring service performance guarantees.

NFP’s survey found that the vast majority of covered workers in mid-size and larger organizations are enrolled in a self-insured plan, while smaller firms are less likely to be self-insured. The Kaiser Permanente annual national report supports the NFP survey results, showing that smaller firms are more likely to be fully-insured. Their results showed that 58% of firms with 3 to 49 employees are fully-insured, 52% of those with 50 to 199 employees are, and 55% of small firms overall are.  

Being self-insured or fully-insured are the two primary funding methods for medical/Rx plans. However, there are a multitude of options within those funding methods which should be evaluated. The funding method an organization decides on for its employer-sponsored medical/Rx plan determines the level of risk/reward and value-based plan design levers which can and cannot be used. Your advisor can assist you with evaluating all appropriate options.

### IMPLEMENTATION

The different funding models each have their own mechanisms to allocate risk and financially cover medical/Rx expenses and, as such, create different relationships and responsibilities between employers and insurers depending on which entity takes on the most risk. In general, due to the nature of state filing requirements for insurers, fully insured options are limited to the plans filed with the state department of insurance. In some states there may be a limited risk-sharing fully insured option, but most states preclude this type of funding. Self-insured plans are federally qualified ERISA plans, and as such are not subject to most state mandates. There are advantages and disadvantages to the funding options available. Your advisor can provide broader evaluative insight into the options which are best aligned with your organization’s objectives. The following provides a broad level explanation of key funding options available in the industry.

The Affordable Care Act, enacted in 2010, aimed to usher in new measures, including certain mandates and affordability rules, meant to address rising costs (particularly for employees). Even carriers utilized narrow networks of providers to bring cost containment to the market. The latest alternative health plans are a modern cost-containment initiative aimed at providing high-quality care through a patient-centered approach, evidence-based practices, and appropriate, coordinated care. These plans strive to create a transparent cost environment before healthcare procedures are performed, thus helping individuals avoid unexpected costs.

There are several emerging plans which appear on a broad continuum of services in the US. For example, Coupe

---

**Figure 11:**
Prevalence of Self-Funded Plan Model

<table>
<thead>
<tr>
<th>Firm Size</th>
<th>% of Covered Workers in a Self-Funded Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>200-999</td>
<td>61%</td>
</tr>
<tr>
<td>1,000 - 4,999</td>
<td>81%</td>
</tr>
<tr>
<td>5,000 or more</td>
<td>93%</td>
</tr>
</tbody>
</table>
In Focus

Fully Insured

A group health plan in which the employer or association purchases health insurance from a commercial insurer. The employer pays premiums to the insurer in trade for the insurer taking on the financial risk associated with providing coverage and administering the plan. The primary benefits of a fully insured plan are financial predictability, cost stability, less administrative burden and lower risk. However, they can be far more expensive, given that the employer needs to cover the insurer’s profit margin, overhead, taxes and fees, and they are far less flexible in terms of plan design, network and rates. Atop this there are compliance issues and costs in play given that fully-insured plans are subject to state and federal regulations.

Self-Insured

A group health plan in which the employer takes on the risk involved with providing coverage instead of purchasing coverage from an insurance company. The employer pays for enrollees’ medical/Rx care directly to the providers. This is most commonly supported by an external administrator. The plan can be administered by the employer, but an administrative services only agreement with a carrier or an independent third-party administrator is often used.

Level Funded

Visibility into the actual cost of care through transparency laws has prompted the development of alternative funded plan designs, which allows small and mid-sized employers the opportunity to participate in a smaller percentage of the funding risk, while also having the opportunity to share in the savings.

Most level-funded plans are self-insured plans and, therefore, are not subject to state regulations. For many small or mid-sized employers, level-funded plans are a good entry point into the benefits of self-insured funding. With lower-level stop-loss coverage mitigating risk exposure by limiting financial liability coupled with set monthly payments, these plans incentivize employers to control costs. Given that the plan’s maximum annual liability is prepaid over the course of the calendar year, plan administrators use these premiums to pay claims as they occur. If at the end of the year claims exceed the prepayments, the administrator files a stop-loss claim; if claims are lower than the prepayments, the employer receives the excess funds.

Captive

A hybrid model combining elements of self-funding and lower-level pooled stop-loss insurance with other employers. The employer takes on some of the risk while placing a cap on volatility. The insurer calculates an expected monthly cost covering estimated claims, stop-loss premiums and fees which the employer covers as a set monthly payment.

Alternative Health Plans

Consumers expect better health outcomes, lower costs and a seamless continuum of care to assist them to make better informed decisions and participate in managing their health. Creating that experience is the objective of the new emerging alternative health plans.

Adopt Value-Based Benefit Designs

With targeted, non-discriminatory incentives and disincentives, value-based benefit designs can address one of the most pressing issues driving costs — the overuse and underuse of healthcare services.

Strategic benefits programs that employ the use of targeted incentives can address both underutilization and overutilization. Through plan design, healthcare cost-sharing arrangements can be established to avoid overuse of unnecessary or low-value care. Throughout this process, plan participants begin to understand, through appropriate incentives, other options which lead to...
the advancement of better-informed non-emergency healthcare decisions. To enhance participant engagement of value-based designs, employers are leveraging the new digital self-service tool required under the transparency law. The digital self-service tool gives participants visibility to the cost and quality of providers of their healthcare services in advance of non-emergency procedures.

In the US, we see rampant overuse of low-value or no-value care, which has been consistently identified as contributing to the high costs occurring in the US healthcare system. Conversely, the low intake of effective and affordable evidence-based care is just as problematic, given the expensive downstream effects on morbidity and mortality. Through thoughtful plan design, employers can address both problems.

The goal is to steer employees to seek out only useful and appropriate healthcare services from reputable, low-cost, high-quality providers. This encourages things like better engagement with chronic condition management while discouraging unnecessary tests and procedures. By aligning the right mix of plan components, employers can help educate employees on the proper use of health services to not only maximize their health outcomes but also optimize spending on care.

**FULLY INSURED – VALUE-BASED DESIGN**

Despite the industry’s investment in innovative value-based care companies, some fully insured health plan options haven’t really changed in decades. It is recommended that value-based fully insured solutions become a priority in the organization’s selection process. At an organization like Garner Health, which believes that fully insured employers have been denied access to innovative data-driven solutions for far too long, they’ve created a new plan design that allows employers to keep their existing medical carrier while incentivizing employees to see the highest quality doctors throughout their course of care. Based on claims records from over 180 million patients, their self-service pricing and quality tool gives employers and their employees greater visibility into cost and quality of service, all backed by a dedicated concierge team.

**Figure 12: Strategies to Offset Increasing Medical/Rx Costs**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Strategy Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>37%</td>
<td>Benefit modifications</td>
</tr>
<tr>
<td>32%</td>
<td>Value-based benefits to incent better health care behaviors</td>
</tr>
<tr>
<td>29%</td>
<td>Passing along any increase to plan participants</td>
</tr>
<tr>
<td>27%</td>
<td>Changing carriers, ASOs or TPAs</td>
</tr>
<tr>
<td>26%</td>
<td>Changing funding approach (e.g., fully-insured to level or self-funding, captive, etc.)</td>
</tr>
<tr>
<td>25%</td>
<td>High-performance clinical programs</td>
</tr>
</tbody>
</table>

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Generally speaking, fully insured employers have had little incentive to control their costs and lower their claims because the majority of the savings would go to the payer. However, with Garner’s innovative funding mechanism involving a self-funded health reimbursement arrangement designed to replace an existing HRA or HSA program, fully insured employers are given the opportunity to not only steer employees toward top-performing practitioners but finally share in the savings from more efficient and effective healthcare.

**LEVEL-FUNDED - VALUE-BASED DESIGN**

In the last few years, the popularity of level-funded plans as a subset of self-insured has grown. Many level-funded programs offer cost-effective maximum funding of liability. This allows the participating employer to limit their exposure but participate in savings based on lower claims usage. Depending on the payer or independent TPA offering the Level-Funded Option will determine the flexibility of value-based benefit designs that are offered.

**SELF-INSURED – VALUE-BASED DESIGN OPTIONS**

Although there are a number of self-insured organizations involved in value-based care, challenges remain in executing and scaling initiatives for many more. With recent evidence from Health Affairs demonstrating that unadjusted prices for common services in self-insured plans were typically (albeit slightly) higher than fully insured plans, it suggests that employers have not yet explored all the opportunities available to them to contain costs.14

When considering self-insured options, there is an array of administrative options, networks and value-based point solutions to evaluate prior to making a well-informed decision. Your advisor can support evaluation and consideration of the following options.

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### Self-Insured - Value Based Design Options

#### Administrators
- Payer, Administrative Services Only (ASO) (e.g., Aetna, BCBS plans, Cigna, UHC, regional payers)
- Payer, Third-party Administrators (TPAs) (e.g., Aetna/ Meritain, Anthem BCBS/Ameriben, UHC/UMR etc.)
- Independent, Third-party Administrators (TPAs)

#### Provider Networks
- Payer owned Networks – ASO Only
- Leased Payer Networks to Independent TPAs (e.g., Aetna, BCBS plans -Associations, varies by States, Cigna, UHC etc.)
- High Performance Networks – specifically designed by using a cost/quality scoring methodology. Alternative health plans use a form of high-performance provider cost/quality scoring.

#### Stop-Loss
- Payer – ASO with Integrated Stop-Loss
- Payer – ASO with Carve-out Stop-Loss
- Payer – TPA with Integrated Stop-Loss
- Payer – TPA with Carve-out Stop-Loss

#### Rx
- Payer – ASO with Integrate Rx
- Payer – ASO with Carve-out Rx.
- Payer – TPA with Integrated Rx
- Payer – TPA with Carve-out Rx
- Independent TPA – with Integrated Rx
- Independent TPA – with Carve-out Rx

#### Disease Management Point Solutions
- Payer – ASO, no integrated point solutions
- Payer – ASO, yes preferred point solutions
- Payer – TPA, no integrated point solutions
- Payer – TPA, yes preferred point solutions
- Independent TPA – employer selected point solutions
- Independent TPA – preferred point solutions
Employers can help educate employees to not only maximize their health outcomes but also optimize spending on care.

**DIRECT EMPLOYER CONTRACTING OF HEALTHCARE PROVIDER SERVICES**  
(E.G., COALITION, CONSORTIUM OR COMMUNITY-BASED HOSPITAL PLAN)  
Employers are beginning to consider all market solutions including aggregators who standardize contracts and pool lives for purchasing directly with providers. These aggregators are typically referred to as a coalition or consortium; some are community-based hospital plans. Employers’ objectives include a focus on a long-term strategy and design to overcome cost containment obstacles.

With access to new transparency data, the aggregators use the visibility into pricing structures to negotiate payer equity, monitor quality scores, and better facilitate value-based care. Furthermore, simply coordinating with groups of clinicians, hospitals and other healthcare providers to provide high-quality care is an excellent first step in any program design to incentivize employees and optimize health expenditures. For that matter, stronger partnerships between employers and providers can help lay the foundation for even more transformative change.

**DIRECT EMPLOYER CONTRACTING FOR ADVANCED PRIMARY CARE, DIRECT PRIMARY CARE, ACCOUNTABILITY CARE ORGANIZATION AND OTHER HIGH-PERFORMANCE PROVIDER SERVICES**  
Along the value-based care continuum, which is an option outside of the health plan, is the opportunity for employers to directly contract with advanced primary care, direct primary care (DPC) or accountable care organization (ACO) for better access to primary care services and other high-performance provider services. Some early adopting employer examples:

**Example 1: Accountable Care Organization (ACO)**  
Although ACOs are primarily used in Medicare arrangements, some private plans have contracted with ACOs to create an affordable, outcome-oriented benefit. Employers like Intel, Micron Technology and Boeing have been pioneers in this space.15

**Example 2: Center of Excellence (COE) Programs**  
As many benefits teams may recall, early center of excellence programs by Lowe’s and Walmart, among others, targeted high-cost interventions and partnered directly with healthcare entities utilizing bundled pricing to optimize costs and outcomes.16

**Example 3: Integrated Independent Third-Party Administrators**  
Unlike traditional models where employers contract with carrier/payers, independent TPAs are expanding their services to includes direct to provider contracting model(s), allowing employers to partner directly with disease management point solutions, ACOs and other advanced primary care, as well as other high-performance providers to design value-based care solutions. This alignment between providers, patients and the employer incentivizes better health outcomes and lower costs. It also aligns clinical processes and financial incentives between stakeholders (e.g., employees receive premium reductions for participating in condition management programs) as well as eliminating administrative barriers.
Navigating direct provider negotiations is a time and resource-intensive process and for benefits departments with limited bandwidth, overhauling contracting models would be a formidable endeavor. With so many employers relying on their broker or the plan itself for strategic guidance, leveraging experienced consultants or advisors to facilitate these discussions can keep the focus on value-driven outcomes, and the methods in place to minimize disruption. As most employers continue to remain dependent on their plan for healthcare delivery, the exploration of alternative solutions, such as direct contracting, has yet to reach its full potential.

POINT SOLUTIONS
For many years now, employers have been inundated with a seemingly never-ending array of novel point solutions designed to address chronic health conditions, gaps, inefficiencies or a specific component contributing to rising benefit costs. Although the vendors of these products have been successful in raising awareness of solutions that deliver positive outcomes outside of the health plan, emerging trends show that many fragmented, one-off offerings are actually hindering employers’ capacity to align benefits, well-being programs and healthcare partners under a single strategy focused on overall population health. In addition, point solution programs pose unique compliance challenges, including implementing and coordinating point solution program compliance requirements in conjunction with the major medical plan.

Rather than implementing additional disjointed point solutions, employers are increasingly seeking integration strategies that consolidate disparate vendors and create a seamless experience for their workforce, allowing for a holistic view of data and a more strategic approach to workforce health and cost management.

Integrated platforms can mitigate these risks by streamlining administration, coordination, data aggregation and providing a unified experience. Furthermore, rethinking point solution offerings can help identify and prioritize those solutions that are beneficial, relevant and in line with your value-based care offering and those that are causing your efforts to become brackish.

In Focus
Point Solution Fatigue
A condition that occurs when HR professionals become overwhelmed managing the multiple vendors behind an organization’s total benefits program.

The concept of “point solution fatigue” has developed over the last few years, the effects of which are felt by not only members but HR teams as well. Fragmented point solutions pose administrative, tracking, cost and branding risks. Juggling multiple vendors strains resources and hinders holistic measurement. Vetting and integrating disparate tools increase expenses. Without cohesion, it undermines program branding and engagement.
Pharmacy Benefits

Carving Out Opportunity

Along with optimized funding structures for the medical plan, employers are looking for strategies that can maximize the impact of pharmacy benefits to further control overall costs. There are two main ways self-insured employers can go about this: carving in or carving out their pharmacy benefits.

According to the Centers for Disease Control and Prevention, 6 in 10 adults in the US have a chronic disease with 4 in 10 suffering from two or more. As heart disease, cancer and diabetes are the leading causes of death and disability in the United States and leading drivers of the country’s $4.1 trillion in annual healthcare costs, employers have a vested interest in managing costs resulting from employee chronic conditions. With growing year-over-year pharmacy spend, especially due to specialty medications like Humira and the rising popularity of GLP-1 medications, the need for pharmacy strategies aimed at optimizing overall prescription drug costs is becoming increasingly urgent.

Deciding to carve-in or carve-out the pharmacy benefit is contingent on the funding structure for the medical plan. Pharmacy carve-in is typically applied to the fully-insured funding model, whereas carve-out strategies are more common with the self-insured funding model. When weighing the potential to maximize the impact of pharmacy benefits through either strategy, employers should carefully weigh the pros and cons of each. Serious attention should be given to evaluating current pharmacy plan costs, integrating with medical management, accessing data and rebates, reducing administrative complexity, offering plan design flexibility, and leveraging pricing. Timing and potential disruption should also be taken into account as plan changes of this magnitude require significant resources to strategically administer.

Figure 13: Types of Pharmacy Arrangements Deployed
Comparison: Carve-In vs. Carve-Out

When a pharmacy carve-in strategy is used, the pharmacy benefits are folded in with the medical benefits to provide integrated, comprehensive coverage through a single insurer. The health plan will then either administer the program itself or subcontract a PBM to administer and manage the program. The primary advantages of carving-in pharmacy with medical are evident in the coordinated and streamlined services as well as integrated claims data which helps to better identify cost-saving opportunities.

With a carve-out strategy, the pharmacy benefits are separated from the medical benefits and managed outside of the health plan. This typically occurs within a self-insured funding structure and results in the employer contracting directly with a PBM. Carve-outs occur on two levels of the medical insurance business: payer level and plan level. In plan-level carve-out situations, the insurance provider, employer or sponsor assigns some benefit to a third-party contractor.

By carving out pharmacy plans, employers have the flexibility to shop around and design a benefit plan that best meets the needs of participants at a lower price. Additionally, the ability to have a flexible plan design allows employer groups to react swiftly to industry changes and adjust their plans for maximum value.

Figure 14: Comparison: Carve-In vs. Carve-Out

<table>
<thead>
<tr>
<th>Carve-In</th>
<th>Carve-Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract for medical and pharmacy is with one vendor, which can simplify administration and management</td>
<td>Flexible plan design and clinical programs that can help reduce costs</td>
</tr>
<tr>
<td>Potential for better coordination of care between medical and pharmacy benefits</td>
<td>Standard language in the PBM contract allows for increased transparency</td>
</tr>
<tr>
<td>Easier coordination with stop-loss insurance</td>
<td>Access to pharmacy claims data</td>
</tr>
<tr>
<td>Less flexibility with plan design</td>
<td>Audit rights include: claims audit and operational assessment</td>
</tr>
<tr>
<td>Combined medical and pharmacy contract allows for limited transparency and audit rights</td>
<td>Limited access to claims data experience to see if you are “winning” or “losing” under the fully insured mode</td>
</tr>
<tr>
<td>Limited audit rights, if any</td>
<td>The contract typically includes penalty fees if the employer wants to change to a carve-in in the future</td>
</tr>
</tbody>
</table>

Carve-out pharmacy plans often involve direct contact with clinical experts who provide perspective and insight on patient health and plan design. Proactive clinical experts are largely responsible for patient well-being and plan success.

Lastly, carved-out pharmacy plans provide oversight to employer groups. They offer employer groups a greater understanding of their pharmacy spend and the ability to negotiate better deals based on informed decisions. Audit rights, claims data, clear definitions, discount and rebate guarantees, and market checks are strong elements of a pharmacy benefit carve-out.

In Focus

Carve-In
A management strategy in which the employer contracts directly with the medical plan vendor for medical and pharmacy benefits.

Carve-Out
A management strategy in which the employer contracts with a specialist firm or pharmacy benefits management (PBM) vendor to administer some or parts of its pharmacy benefits program.
Rx Cost Control through Claims Data

Carving out pharmacy grants plan sponsors access to Rx claims data, which is key to any Rx strategy. Data provides insight into what is currently taking place within the Rx plan as well as emerging trends that can inform cost-containment tactics. By analyzing quantitative information on drug spend, employers can get a snapshot of the root causes of their highest expenditures and uncover opportunities to better manage those costs through solutions such as therapeutic alternatives, identification of inappropriate utilization of high-cost specialty medications, auditing for waste and non-adherence, or identifying members who could benefit from care management programs.

Once a plan sponsor carves out pharmacy, they also gain access to a team of experts who can help analyze their claim data and identify real-time solutions to inform planning and strategy. Improving the accuracy of forecasting can help prevent overspending on prescription drugs. By involving pharmacy consultants in monitoring the current status of GLP-1 drugs, upcoming major changes in biopharmaceuticals and the future wave of gene therapies, that team can be better positioned to offer proactive advice to plan sponsors on how to mitigate the costs of pipeline drugs before they impact the market.

Balancing GLP-1 Drug Demand

The high costs of GLP-1 drugs, which average $1,200 to $1,400 per month, are giving employers pause. Indicated for Type II diabetes, obesity, and overweight, drugs like Ozempic and Wegovy are skyrocketing in popularity due to their effectiveness in weight loss. Because they also lower blood sugar levels and have been shown to lower blood pressure, improve fatty liver disease, and reduce the risk of heart disease and kidney disease, it could be argued that this class of drugs is the most popular in America today.22

Despite the long list of increased health risks that accompany diabetes, obesity, and overweight, such as heart disease and cancer, many companies are wrestling with whether to cover these weight loss medications in their sponsored benefits health plans. With obesity affecting 42% of US adults (projected to reach 50% by 2030),23 the demand for these weight loss drugs has complicated efforts to manage rising healthcare costs. The path toward health is often associated with weight loss, and it’s hard to ignore the potential impact these drugs can have. Coupled with a reported 44% of obese individuals who would change jobs to gain coverage for GLP-1 treatments,24 employers will have to devote serious time and effort to balancing costs for these new therapies and providing access for those who will benefit most from them, but there appears to be growing interest in expanding coverage for these new drugs. As more and more workers are asking employers for covered access to them, balancing employee demand with financially responsible benefits spending is challenging.

Given employee demand as well as the effectiveness of these drugs, plan sponsors are re-examining their coverage options. As off-label prescriptions proliferate, it makes fiscal sense for employers to proactively manage this booming class of drugs.
As the GLP-1 drug class is relatively new and there are no long-term studies, many employers are examining the impact of diabetes, obesity, and overweight on their health spend and their employee’s health and well-being. Treating these conditions with GLP-1 agonists is an expensive proposition, and the mishandling of these new drugs could add to those costs. In the meantime, employers should look for enhanced prescribing requirements and utilization management to ensure the appropriate use of these drugs. Furthermore, they should examine the intersection of their most costly diagnoses and identify whether their true underlying cause is, indeed, obesity.

By pinpointing those areas that are driving costs upward, employers can begin to define what success looks like. For some organizations, success may lie in keeping year-over-year increases below medical trend. For others, success may be defined by achieving greater flexibility and control by going self-funded. For pharmacy plans, in a self-funded environment, it could mean carving in or carving out PBM services from the plan to achieve optimal savings. Given that consulting pharmacists provide valuable insights into reasonable plan design modifications based on current utilization patterns and identifiable opportunities, they offer employer groups a greater understanding of their pharmacy spends and the ability to negotiate better deals based on informed decisions. Regardless of the exact definition, setting clear markers of success around cost and plan optimization is essential to the design of multiyear strategies.

*Respondents were asked to select all that apply.
SOURCE: IFEBP 2023 Pulse Survey

**Figure 15:**
Cost-Control Mechanisms in Place for GLP-1 Drugs for Weight Loss (IFEBP) *

- **79%** Utilization Management
- **32%** Step Therapy
- **16%** Eligibility Requirements
- **14%** None
- **5%** Annual Maximum
- **4%** Lifetime Maximum

*Respondents were asked to select all that apply.
SOURCE: IFEBP 2023 Pulse Survey
Managing Biosimilar Momentum

Most specialty medications are large-molecule biologics that come at a high cost. Controlling spending on these medications is fundamental to any Rx plan design.

In January of 2023, California biotech Amgen released its drug Amjevita, the first biosimilar to Humira — the best-selling drug in the history of pharmaceuticals. Humira is an injectable tumor necrosis factor blocker indicated for the treatment of rheumatoid arthritis and several other autoimmune conditions such as Crohn’s Disease and psoriasis. The release of this first biosimilar was significant as it put an end to Humira $200 billion rein of unopposed revenue.

Biosimilars are just what they sound like — in comparison to biologics they are similar. In fact, there is no significant clinical difference between a biosimilar and a name-brand biologic. So, when a branded biologic drug loses its exclusivity, a biosimilar, if approved, is immediately launched, offering patients a lower-cost alternative. According to drugs.com, there were 44 approved biosimilars as of November 2023, with more than 100 more under development.

All this comes as great news for employers given that by one estimate, plan sponsors see an average annual cost of $38,000 at the member level to cover specialty drugs and typically speaking, specialty prescription costs account for 50% or more of an employer’s total drug spend.

As of the time of writing, there are now nine FDA-approved biosimilars for Humira, with three more pending approval. As use of these biosimilars increases, it is projected that there will be a significant financial impact in 2024 or 2025. As more patents expire and the exclusivity period ends for other specialty drugs, there will be more cost savings opportunities for pharmacy.

In 2021, McKinsey declared that an inflection point for biosimilars had arrived. This insight was based on the substantial growth of the biosimilars market, opportunistic regulatory environments, and the pharma companies themselves continuing to innovate with new products. Much like generic medications, the current and future success of the biosimilar market is partly contingent on the fact that they can offer their medications at a lower price in comparison to their costlier name-brand biologics. While these lower-priced products proliferate and patient access increases, the clock continues to tick on patent exclusivity for incredibly expensive, big-selling drugs.

Most famous among these expirations was AbbVie’s exclusive patent over Humira in 2023, which now faces competition from several new biosimilars. Other therapies from Johnson & Johnson, Takeda, AstraZeneca, Roche and other organizations are also on the precipice of facing biosimilar competition. As more of these therapies reach market, plan sponsors will need to review coverage and reimbursement strategies. As a projected $76 billion in projected savings is on the immediate horizon, employers will further need to ensure minimal disruption for employees as they evaluate different scenarios to maximize cost-savings with these new biosimilars.
Preparing for the Rise of Gene Therapy

Gene therapy is a cutting-edge tool that modifies or manipulates gene expression to treat genetic diseases.

Unfortunately, with unbelievably high costs attributed to handling and controlling the cells or viral vectors to produce them, they are, by far, the most expensive therapy on the market. As a result, the rise of gene therapy treatments could eventually threaten the funding system for the US healthcare system as average costs per dose range from $1 to $2 million dollars. As of mid-2023, the FDA has approved 12 gene therapies for conditions such as hemophilia B, beta-thalassemia, and retinol dystrophy, among other predominantly rare conditions. This may seem like a small number, but considering that the first gene therapy was only approved in 2017, it’s clear that pharmaceutical companies are working diligently to bring more of these therapies to market. Although they treat extremely low prevalence conditions, the probability that every employer will eventually be impacted grows with each new approval. For example, with research ongoing, it is thought that these therapies may one day evolve to treat other inherited disorders, such as cystic fibrosis or sickle-cell anemia, in the future.

Given how rare the qualifying conditions are for gene therapies, as well as the limited types of treatments available, the current probability of this happening is extremely low. As more gene therapies come to market, though, the likelihood of such an event will correspondingly increase, which may require consideration of new payment models.

Indeed, the financial exposure for employers grows with the expansion of gene therapy. Preparing for it will require a multiyear, data-driven strategy to mitigate future risk. Current wisdom suggests that stop-loss insurance should protect employers in a fashion similar to biologics, and for the vast majority of employers, it will. However, for patients already identified by the carrier as high-risk because of diagnoses or medication usage, there are typically terms written in the contract that exclude coverage for these individuals. This could leave the employer exposed to the risk despite having purchased protection.

NFP has been working to develop opportunities with payment arrangements and stop-loss carriers to share and spread out the financial risks of gene therapy, but many employers have not mapped out their potential exposure scenarios as of yet.

In Focus

Gene Therapy

A technique that uses gene(s) to treat, prevent, or cure a disease or medical disorder. It often works by adding new copies of a gene that is broken, or by replacing a defective or missing gene in a patient’s cells with a healthy version of that gene.
In the coming years, employers should pay attention to the number of new gene therapies coming to market and strict attention to those whose use is indicated for more common conditions e.g., different types of cancer. They should also watch for increases in premiums and deductibles from stop-loss carriers for gene therapy, as well as changes to coverage levels and cost-sharing. Consulting with a trusted advisor may lead to a conversation about carving out financial responsibility for specific gene therapies from employer health plans, although the current availability of such plans is limited, and coverage typically only lasts one year.

With hundreds of potential new gene therapies in development, it is almost certain that alternative funding models involving the plan sponsor, stop-loss carrier, and pharmaceutical company will arise to better manage these new treatments. Right now, consultants are strategizing with larger insurers and PBMs to identify ways to mitigate the risk to self-insured plans. However, the effectiveness of these emerging partnerships and corresponding solutions remains uncertain due to the newness of strategy. Regardless, risk management strategies that leverage integration, data, and cross-sector partnerships will be the most prepared for future developments in gene therapies.

**Savings, Flexibility and Control**

Carve-out plans have a lot to offer employer groups, including customization, adaptability, insight and oversight. By carving out pharmacy plans, employers have the flexibility to shop around and design a benefit plan that best meets the needs of participants at a lower price. Additionally, the ability to have a flexible plan design allows employer groups to react swiftly to industry changes such as the impact GLP-1 drugs have recently had on plan design, and adjust their plans for maximum value.

Removing the pharmacy benefit from the medical benefit and allowing it to be managed outside of the health plan is one of the many positives of carve-out pharmacy. Typically resulting in significant employer savings, carving out pharmacy offers employers greater transparency, flexibility and control with plan design as well as access to rebates and utilization data. Ultimately, the increased leverage and insights of a pharmacy carve-out model enable more impactful management of out-of-control prescription costs.

Furthermore, carved-out pharmacy plans provide oversight to employer groups. They offer a greater understanding of pharmacy spend as well as the ability to negotiate better deals based on informed decisions. Lastly, audit rights, claims data, clear definitions, discount and rebate guarantees, and market checks are strong elements of a pharmacy benefit carve-out.

**Figure 16: Strategies for Controlling Prescription Drug Costs**

*Respondents were asked to select all that apply.*

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical management strategies</td>
<td>35%</td>
</tr>
<tr>
<td>W’ll need to pass some of these costs along to employees</td>
<td>34%</td>
</tr>
<tr>
<td>Formulary strategies</td>
<td>33%</td>
</tr>
<tr>
<td>Manufacturer assistance programs</td>
<td>31%</td>
</tr>
<tr>
<td>W’ll cover the cost increases</td>
<td>29%</td>
</tr>
<tr>
<td>Therapeutic exclusions</td>
<td>27%</td>
</tr>
<tr>
<td>Stop loss solutions</td>
<td>22%</td>
</tr>
<tr>
<td>I do not know how to control these costs</td>
<td>5%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>0%</td>
</tr>
</tbody>
</table>

*Respondents were asked to select all that apply.*
Self-insured plan sponsors who are interested in carving out pharmacy should be focused on finding the right fit for their organization. There are many things to consider in the evaluation, including per-member-per-month (PMPM) cost measures, step therapy, and prior authorization structures, along with denial rates and average costs for the top therapeutic classes of drugs. Formulary options, including standard and customized, are another important concern that must align with the financial and clinical goals of the organization. Although customizing formulary options can be a complex process, they do allow the plan sponsor some control over volatility by having the capacity to move drugs on and off the formulary. Additionally, plan sponsors should choose the right pricing model that suits their organization’s needs.

Lastly, the type of relationship the plan sponsor wants to have with the PBM should be taken into consideration. Based on the size of the group, intent of management, and understanding of utilization and clinical opportunities, employers may want to join a coalition, contract with a fiduciary, or take advantage of a transparent PBM. Regardless of choice, the PBM must align with the employer and their employees’ best interests.
Aligning PBM Relationships with Plan Goals

Coalition / Consortium Benefit Management

Pharmacy coalitions and consortiums can be categorized as group purchasing organizations that bring any number of employer groups and plan sponsors together to leverage their combined purchasing power and negotiate from a position of greater strength. Given that these coalitions can number anywhere from the thousands to millions of covered lives, they are able to secure more favorable pricing, rebates, and contract terms that any individual employer or health plan could achieve independently.

In addition, coalitions often offer preferred medication lists, patient assistance programs, and customized clinical programs. Plan sponsors should also expect access to custom reporting and detailed analytics to identify additional opportunities and financial and performance tracking.

Transparent PBM

Transparent pharmacy benefits empower purchasers with data-driven decision-making based on full visibility into factual drug information. This model places control in the hands of the purchaser, who, by leveraging their own financial, operational, contractual, and administrative data, can make optimal choices around pharmacy offerings. Transparency ensures members have relevant information for informed decisions, while clinical choices follow efficacy and real cost.

Ultimately, transparent pharmacy benefits should work entirely in the purchaser’s best interest. It encourages members of the plan to be better engaged in their therapy and can help patients make better choices and, in some instances, increase the likelihood of healthier outcomes.

Fiduciary PBM

Under a fiduciary pharmacy benefit, the partner is contractually obligated to act not only in the employer’s best interest but without any conflict of interest whatsoever. This means that the fiduciary PBM has no ownership stake in any pharmacy nor does it engage in so-called spread pricing, where they would charge the plan sponsor more for a therapy than they would pay the pharmacy. Furthermore, all rebates go to the plan sponsor, and the fiduciary receives no payment whatsoever from pharmaceutical manufacturers.

Eliminating conflict of interests comes at a cost, though — typically speaking, they will charge a significantly higher administrative fee as it is the sole source of their compensation. However, this allows the fiduciary to stay laser-focused on clinical management while securing the best price for medications.

Data Analytics and Trend Drivers

Given that data plays a significant role in identifying trend drivers in a pharmacy plan, there is huge potential for self-funded employers to implement design changes that lower costs and risks with little to no member disruption.
Bringing a level of transparency into the equation that is, quite frankly, overdue, data analytics puts employers in position to optimize their pharmacy benefit by examining plan performance and utilization, identifying financial and clinical risks, and forecasting costs and potential program impact.

Utilizing real-time data analytics in biosimilar management, gene therapy, and GLP-1 cost-containment can help initiate targeted interventions in key high-cost categories with precision and efficiency. Although biosimilars and gene and cell therapies are nothing short of miraculous, having even a single member of the plan file a claim for one of these therapies could be catastrophic. Therefore, self-insured employers need to consider a multi-faceted approach to pharmacy benefit design, one that involves plan design, clinical oversight, and stop-loss at the minimum.

**Involving Pharmacists in Disease Management and Population Health**

Employer success in disease management should be measured by the effectiveness of interventions rather than the volume of services. An often-overlooked player in the design of effective disease management programs is the pharmacist. With expertise spanning medication management, preventive care, chronic disease support, and overall wellness, pharmacists contribute immense value to employers looking to contain costs and optimize benefits in their pharmacy spend.

Partnering with employers, pharmacists provide diversified clinical services, optimizing medication management to ensure appropriate therapy for the population while controlling costs. They can assist in the design of the pharmacy benefit and identify additional savings opportunities through evidence-based changes that optimize medication use without compromising quality of care. They can also assess the effectiveness of a current PBM contract, customize formularies, and provide guidance on specialty drug management and biosimilar strategies.

Involving a pharmacist in workplace disease management programs can also have a positive impact on healthcare costs. Pharmacists are knowledgeable when it comes to designing plans that influence employee behavior and can increase engagement with programs focused on lifestyle changes and medication adherence. With their expertise in motivational interviewing techniques, they can help fine-tune programs and further reduce population health risks. Their broad training allows them to work with the benefits and well-being team to encourage employee engagement through targeted interventions aimed at improving lifestyle factors that contribute to chronic conditions. As chronic conditions are the major cost driver for most employers, incentivizing healthy behaviors is a key strategy for preventing disease and reducing healthcare costs.

In a nutshell, pharmacists are there to identify and address employer needs. They not only review medication expenditures but can also conduct analyses of overall healthcare plan design and use of clinical programs to optimize medical and prescription-drug management.

*AI and machine learning have the potential to provide unprecedented visibility into cost drivers...as well as savings opportunities.*
The Next Step: Cost and Quality Accountability

Using the “Triple Aim” Approved Clinical Practice

Assessing, evaluating and evolving a medical/Rx plan can be a daunting undertaking. Defining realistic achievements as you start the process will help and suggests the need for an employer’s adaptation to a clinically acceptable process. A Triple Aim approach is one such guideline to establish quantitative and qualitative measures as you optimize your plan.

The Triple Aim was established by the Institute for Healthcare Improvement in 2008. Evaluating the effectiveness of a health plan through Triple Aim standards of care includes:

1. Improving the patient care experience for higher quality, safety and satisfaction.
2. Improving the health of populations by addressing social and environmental determinants of health access.
3. Reducing the per capita cost of healthcare.

Utilizing this initial assessment is an effective baseline for evaluating improvement. Depending on the employer size and funding methodology selected performance standards and guarantees can be applied as a component of a carrier/vendor/third-party administrators’ accountability. Some Advanced Data Analytics platforms provide cost and quality metrics within the data sets to support an employer’s accountability measures. Success markers should align with overall established goals and key performance indicators so that continuous improvements can be evaluated, and evolving strategies fine-tuned for maximum impact. Done correctly, plan sponsors should be able to identify those strategies that are working well, as well as any gaps or opportunities that require a shift in tactics.

All in all, faithfully monitoring outcomes through advanced data analytics ensures that multiyear cost-containment initiatives stay on track while providing valuable data to identify remediation areas and refine next steps. This may involve adjusting ineffective tactics, doubling down on successful interventions, or implementing additional plan design changes based on the data analysis. Ultimately, the remediation effort should work within the cost optimization framework and identify next steps to overcome challenges and deliver defined success metrics.

Harnessing Cost and Quality Accountability with Technology

The new healthcare transparency laws, paired with the development and use of advanced data analytics, have given employers the capacity to gain greater visibility and a deeper understanding of the minutiae that make up their medical/Rx expenses.

There are fixed expenses (e.g., administrative) which are approx-
imately 20% of total premium and variable expenses (e.g., claims), which are approximately 80% of total premium. The employer’s ability to influence plan designs depends on the organization’s selected funding strategies. For example, fully-insured, level funded or self-funded for the medical/Rx plans. By identifying areas which have favorable impact on claims costs, organizations can better control variable expenses.

This is paramount as variable expenses are about 80% of the premium spend and can be influenced with appropriate clinical intervention. Allowing the data to drive the areas of focus improves development of a better-informed strategy to optimize costs and work with clinical best practices for potential interventions.

Throughout this process, leveraging data to inform decisions at every stage is foundational to any successful cost optimization strategy. Advanced data analytics, including AI and machine learning, have the potential to provide unprecedented visibility into cost drivers and uncover actionable insights on wasteful spending as well as savings opportunities. These emerging tools can further project future trends and accurately model different plan design scenarios to predict their impact on overall spend. These can include innovative strategies such as the use of healthcare price transparency data to forecast current and future healthcare costs or examining alternative funding methods across the risk/reward continuum.

Ultimately, with surging healthcare costs, employers need strategies to rein in medical and pharmacy spending without disrupting benefits. Fortunately, by leveraging advanced data analytics, they can. Now is the time to strategize the best uses of price transparency and accountability measures, funding models and specialized pharmacy solutions, setting your company up for sustainable cost containment and a healthy workforce.

References

22. Cleveland Clinic. GLP-1 Agonists, my.clevelandclinic.org, 2023.
About the Data

The 2024 NFP US Benefits Trend Report draws on data from NFP’s US Employee Benefits Survey 2023 and NFP’s US Employer Benefits Survey 2023. Any other sources are as referenced throughout. For full information on the methodology for each NFP survey, contact marketing@nfp.com.
About the Experts

Kim Bell
Kim is executive vice president, head of Health and Benefits at NFP, where she directs the overall strategy and operations for NFP’s national employee benefits practice. With more than 30 years of experience in the employee benefits industry, Kim is an influential thought leader in the corporate benefits space. She graduated from Indiana University’s Kelley School of Business with a Bachelor of Science in finance and has a Master of Science degree in management from Indiana Wesleyan University. Kim also holds the Certified Employee Benefits Specialist® (CEBS) designation from the International Foundation of Employee Benefit Plans.

E. Heidi Cottle
Heidi is senior vice president, Cost Containment Strategies, collaborating with offices to develop strategies driven by data analytics, medical/clinical risk management programs and service/vendor assessments. With 30+ years of experience in the health and welfare market, Heidi has specialized insights on medical/Rx cost containment and emerging trends in traditional and non-traditional strategies. Heidi was also a finalist for the 2019 World Health Congress “Innovator of the Year” award, a reflection of her engagement in digital transformation efforts designed to enhance the client experience. Heidi holds over 30 health and welfare licenses, credentials and certifications in the US and its territories to support a holistic view of the market.
Nelly Rose

As vice president of Clinical Pharmacy, Nelly supports NFP’s Rx Solutions with clinical insights and new initiatives while also providing strategic analysis for drug trends and utilization. She works directly with members to support and educate on clinical programs and drug interventions. Nelly received her Doctor of Pharmacy degree from St. Louis College of Pharmacy.

Deb Smolensky

Deb is senior vice president, Well-Being and Engagement practice leader and #1 best-selling author of Brain On! In addition, Deb serves as a subject matter expert for the insurtech, fintech and digital health verticals of NFP Ventures. She consults with a variety of clients, including numerous Fortune 500 companies, to develop programs and practices that empower employees and leaders to lead healthy, productive lifestyles through innovative and highly engaging solutions. Deb holds a bachelor’s degree in accounting from Illinois State University as well as a multitude of certifications and designations in organizational health and productivity.
NFP is committed to sharing insights that help clients make informed decisions regarding their most significant challenges. By delivering ideas, expertise and perspective on opportunities in the marketplace, NFP is driving improvements to solutions that help clients meet their goals.

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