How healthy is your health plan?

A seven-point checkup for evaluating affordability, access and quality

Take our 7 point checkup

CENTIVO®

Employers invest a great deal of time and money into their health plan offerings.

They want to keep employees healthy and happy by providing quality care at a cost that makes sense for all involved.

At the same time, workers are viewing benefits options as a more important piece of their overall compensation package.

Amid today's "great resignation," salary is not the only key to attracting and retaining talent: a study by Fractl found that nearly nine out of 10 employees weighing a high-paying job against a lower-paying role with quality health benefits would choose the lesser salary.

As Mercer recently pointed out, in today's environment of record-breaking inflation and widespread labor shortages, employers face a tough balancing act: managing rising healthcare costs while making smart decisions about how to attract and retain the workers they need. Rather than cost-shifting, **most employers are prioritizing attractive benefits.**

So, how does your current health plan stack up?

And where should you consider making changes? What exactly does a "healthy" health plan look like?

We see it as a balance of what employees want and need for their physical and emotional health and financial wellness, and your smart investment in terms of quality, access and affordability.

Let's take the pulse of your current plan with this

How healthy is your health plan?

Take the seven-point checkup

		Horrible	Meh	Decent	Great
1	**Affordable to use:** Can employees afford to use your health plan? Do deductibles, copays and price uncertainty deter them from getting needed care?	○	○	○	○
2	**Focused on prevention:** Does your plan leverage preventive care and embrace primary care as a tool for centralizing overall health and wellness?	○	○	○	○
3	**Quality care:** Do employees have in-network access to trusted providers with proven outcomes?	○	○	○	○
4	**Easy to understand:** Do your employees understand their health plan and how it works? Are they taking advantage of plan options and going to the right places for the right level of care?	○	○	○	○
5	**Socially aware:** Does the plan meet the needs of all enrolled employees in terms of costs, provider access, health equity and other potential barriers to care?	○	○	○	○
6	**Accessible for all:** Is it easy for your employees to access covered care despite work commitments, family requirements or geographic restrictions?	○	○	○	○
7	**Aligned with the company budget:** Does your health plan meet the fiscal demands of your company? Are you doing the best by your employees for your health plan dollars?	○	○	○	○

Clear

Print your responses and share your assessment at your next planning meeting.

Looking back, moving forward

To understand where you are, it's important to know where you've been. So, let's start with a brief look back at how health plans evolved to where they are today.

Early days

The first iteration of employer-sponsored hospitalization plans started about 100 years ago by an executive at Baylor University Hospital.

To help make healthcare more affordable during the Great Depression, the Baylor Plan provided Dallas school teachers access to the hospital's medical services for just 50 cents per month, with no additional charges for up to 21 days of hospital care.

This first "health co-op," which evolved into Blue Cross and Blue Shield, made it possible for teachers and other modest-wage earners to avoid bankruptcy simply for needing medical services.

Evolving

Even as early health plans grew across the country, people were already avoiding care due to cost concerns.

But during World War II and beyond, as the need for factory and other industry workers burgeoned amid a government freeze on wages and bonuses, growth and improvements in benefits became an alluring, tax-free incentive to attract employees.

Today

As healthcare costs maintained a steady uptick, health plan types and options evolved over decades to manage, control and shift costs.

About two-thirds of the increase in per-person healthcare spending in the last five years is due to rising prices rather than changes in utilization.

Healthcare service pricing, an aging population, the relentless rise in chronic diseases and ballooning drug costs have left us with a sick and struggling system, with half of American adults saying they have difficulty affording healthcare costs.

Symptoms of an ailing system ⊕

Looking back, moving forward

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Symptoms of an ailing system

Unpaid medical bills are the **single largest** form of past due debt.

Read more »

Nearly a third of Americans say they've recently **skipped medical** care due to concerns about cost.

Read more »

America **spends 50% less on primary care** than any developed country. Yet it's the one area we know delivers actual cost savings with better results.

Read more »

2021 Centivo Healthcare and Financial Sacrifices Survey

Instant download

Read more about the significant financial and mental toll medical costs inflict even on insured employees — and how you can better position your plan to support your workforce.

Now that you've had your checkup, let's dive deeper into what's causing your symptoms.

We'll explore possible issues and potential fixes, with plenty of options to update and upgrade your plan offering.

1 Affordable to use

Can your employees actually afford to use your health plan?

Inflation and soaring medical costs have set an unsustainable, unhealthy stage for American workers. No question, health insurance helps working Americans access needed care. But depending on the health plan design, using that insurance can come at a price that makes healthcare flatly unaffordable.

Millions of insured Americans with employer-sponsored health plans face sky-high deductibles and bank-breaking out-of-pocket costs. Many are **"functionally uninsured"** — meaning "on paper" they have coverage, but in actuality they lack the financial ability to use it.

As healthcare costs steadily increase, employers must face this reality as they consider passing it along by raising premiums, deductibles, coinsurance and/or out-of-pocket maximums.

As evidenced in a recent survey by West Health and Gallup, 38% of American adults — about 98 million people — are trading off necessities to pay for medical costs: delaying or avoiding care or medications, cutting back on driving and utilities, skipping meals or borrowing money to pay medical bills. And they found workers were cutting back whether their annual salaries were under $50K or close to $200K.

Turns out, skipping or delaying care doesn't save costs for anyone in the long run. About 94% of large employers anticipate an increase in medical services due to delayed healthcare, according to a survey by the Business Group on Health.

At the core of the affordability crisis are high-deductible health plans (HDHPs). At first glance, these plans sound attractive for their lower premiums. And, for workers who can afford to stash funds away each paycheck, a health savings account (HSA) is a tax-saving tool to prepare to pay for care. Unfortunately, one-third of Americans can't afford to contribute to one. Plus, HDHPs have been found to actually make patients sicker: A survey of more than 700 providers by the National Opinion Research Center at the University of Chicago found that 80% had patients who denied or deferred care due to cost and 79% specifically named high deductibles as the primary barrier.

In 2020, more than

2 in 5

working-age adults were **inadequately insured.**

Commonwealth Fund survey

1 Affordable to use

Your plan prescription

If your costs are rising at the expense of your employees' health, wealth and productivity, it's time to take a hard look at what's driving the high prices in your plan and think outside the traditional benefits box for relief. For instance:

Ensure the plan is the best fiscal fit for your company. If not, a different funding option could give you more flexibility to offer employee savings — on average, an employer can save 4% to 12% per year with a self-funded health plan.

Include a low or no-deductible plan that encourages needed care. According to a recent Mercer poll, 41% of employers are currently providing a medical plan option with a low (or no) deductible and an additional 11% are considering it for 2023.

Give your employees incentives to seek preventive care and avoid more expensive care later on. Consider making all primary care visits free, which is not only less expensive than urgent and emergency visits but helps your employees avoid issues arising from delayed care.

2 Quality care

Can your employees access trusted providers with proven outcomes?

You want the best quality care for your employees, at a cost that makes sense for your business. So how does your current plan stack up? And what exactly is "quality" care, anyway?

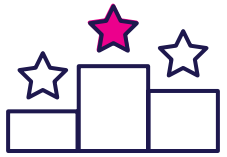
Quality is defined by the National Academy of Medicine as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. There are hundreds of measurable outcomes. Some of the top categories, according to the Centers for Medicare & Medicaid Services (CMS), include safety and effectiveness of care, readmissions, patient experience and timeliness.

That said, healthcare quality varies greatly across providers, hospitals and health systems. And worse, this quality differential is often unrelated to cost. One way to address this gap is by focusing on value-based care.

Value-based healthcare is a model in which providers, including hospitals and physicians, are paid based on quality and patient health outcomes. This is very different from traditional fee-for-service medicine, where doctors and hospitals bill for every service regardless of the results. With value-based care, providers are rewarded for doing the right thing — improving health, preventing chronic disease and helping patients make better choices.

One key to the success of value-based care is doctors and hospitals working together in a coordinated, integrated way. Patients can easily become lost in the healthcare system. Follow up care can be difficult. But care coordination means sharing information among all participants concerned with a patient's care to achieve safer and more effective outcomes.

Collectively, employers are the largest purchaser of healthcare in the United States, providing benefits for over 153 million people. With this scope comes the opportunity to improve quality and reduce cost in the system by partnering with health plans focused on value-based care where quality is rewarded.



Almost **41%** of healthcare payments made in 2020 were **tied in some way to value or quality of care.**

Health Care Payment Learning & Action Network (LAN)

2 Quality care

Your plan prescription

Making value-based care a foundation of your benefit structure can have a positive impact not only on your employees' wallets and health, but also their overall productivity and morale.

Employers can directly contract with providers practicing value-based care, monitor their results and focus on continuous quality improvement. But that's not realistic for employers with limited expertise in healthcare delivery and resources.

Partner with a health plan that incorporates value-based care in its design. Health plans may focus on a subset of the network, working with providers who may have accountable care organizations (ACOs), do population health, care coordination and care management.

Ask your health plan about their value-based options. Give your employees the level of quality care they deserve: a value-based network with a core focus on primary care, screening and prevention.

3 Easy to understand

How well do your employees understand how their plan works — and are they going to the right places for the right level of care?

Since healthcare benefits are one of the top spends for employers, it makes sense to do everything you can to ensure employees understand their choices and options. But uncertainty and misunderstanding about health benefits can lead to stress during open enrollment and the wrong plan choice for an employee's needs — and budget — when they don't know what they don't know:

- About 54% don't know the full scope of what their current health insurance offers them.
- More than 75% of Americans with health insurance can't define "coinsurance" and nearly half can't explain "copayment" and "deductible."
- 44% said they're uncomfortable asking HR representatives questions about health insurance enrollment. Instead, 47% ask their friends and family about what health insurance plan they should sign up for during open enrollment.

According to Justworks' Health Insurance Knowledge Snapshot, over half of employed Americans don't feel they are getting the most out of the health insurance options available to them. And 49% of employees feel pressure to select the most expensive health insurance option to ensure they have the coverage they need. Even game-show champions are confused about the terminology.

For employees who are basically happy with their health plans — despite not clearly understanding them — that bliss can be short-lived if their plan includes a high deductible or expensive copays that eat into a family's savings. And that can happen with just one unexpected medical expense.

Plan designs with a high deductible can be attractive for their lower monthly premium and "opportunity" for consumers to engage in managing their healthcare costs. But with so much confusion around the terminology, many don't realize they have to pay high out-of-pocket costs before health coverage kicks in. And despite their plans' intent, most Americans who have HDHPs aren't saving for medical expenses, shopping around for better prices, talking to their doctors about prices or making other smart consumer moves.

96%
of Americans **overestimate their understanding** of health insurance concepts.

Policygenius survey of 2,000 American health insurance consumers

3 Easy to understand

Your plan prescription

Offering an easy-to-use plan design with clearly defined deductibles (if any) and predictable copays can empower employees to make informed choices, both at open enrollment and throughout the plan duration.

Make sure employees understand how health plan options really work, so they don't waste money on an expensive plan or choose a cheap alternative that won't meet their needs (or worse, put them in debt).

At open enrollment, be sure to communicate the total costs of care and not just how much is coming out of their paycheck each month.

Stay in touch during the year, so employees don't forego valuable plan features or inadvertently see out-of-network providers, putting their physical and financial health at risk.

4 Focused on prevention

Does your plan value preventive care and a primary care-centered partnership?

The evidence is clear and growing: robust access to primary care means better outcomes and fewer disparities among patients, as well as overall lower costs. Yet, according to a Kaiser Family Foundation study, one quarter of all adults and nearly half of adults under 30 do not have a primary care doctor. And the stats are worse among minority groups. That means it's likely that many of your employees don't have a PCP to call their own.

A good relationship and lasting connection with a primary care doctor is important for maintaining and managing health. Employees and HR leaders alike agree on the importance of primary care:

- 80% of employees and 89% of HR leaders say it's important to see a primary care provider on a regular basis.
- On average, 80% of employees and over 90% of HR leaders say that in addition to routine care, primary care providers should play a significant role in coordinating specialist care and hospitalization, offering advice on health promotion and disease prevention and providing mental health care.

Despite its association with better health, however, fewer Americans are getting primary care than ever before, according to Harvard Medical School researchers. This dip could be due, in part, to high deductibles and copays. And with fewer providers and fragmented care, patients are missing out on that first-line advocacy that's possible with a long-time primary care relationship.

A California study of insured patients found that increased primary care spending could avoid

25k acute hospital stays + **89k** ER visits,

saving $2.4 billion in a single year.

California Health Care Foundation report

4 Focused on prevention

Your plan prescription

Encourage all your employees to set up a primary care relationship. Without a primary care doctor to know and trust, getting care can be a prohibitive, expensive maze that's easier to avoid than access.

Offer a plan that puts primary care at the center, guides employees through the system and gets them to the right provider at the right time.

Invest in primary care for a better patient experience, fewer hospital and emergency room visits and a lower total cost of care.

In the Centivo primary care-centered plan model, PCP visits increased 12% while ER visits were down 25%.

5 Socially aware

Does the plan meet the needs of all enrolled employees?

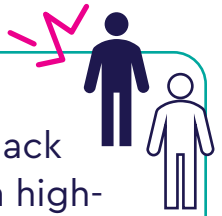
No question, offering your workers health insurance can increase access to care. But depending on the health plan design, using that insurance can come at too high a price. Right now, a significant number of workers feel their benefits are inaccessible, unaffordable and fail to meet their real-life needs. Especially vulnerable within the system: racial and ethnic minority communities, who are at a higher risk for chronic, manageable health conditions but are less likely to seek out or receive consistent care.

Increasingly, employers have diversity, equity and inclusion (DE&I) in mind when it comes to benefits. Three in four employers share concern about inequities in their company's health and well-being initiatives, according to the Business Group on Health. Fortunately, a smart health plan design can offer a more inclusive benefit and ease some of the financial barriers that affect low-income families, many of whom are racial or ethnic minorities.

A few ways you can address DE&I in your plan design and meet employees where they are:

- Structuring plans that feature no or low deductibles and clearly defined copays. High-deductible health plans have been shown to have greater consequences for racial/ethnic minorities.
- Encouraging or ensuring primary care participation provides a built-in navigator through the complex maze of healthcare and better coordinate appropriate care.
- Incorporating virtual care offers promise in terms of closing inequity gaps and increasing access to underserved communities, especially for primary care and behavioral health. It removes travel and mobility limitations, both shown to be critical social determinants of health.

A 2021 Deloitte report makes it clear: Persistent health inequities stand in the way of affordability, health and well-being for the entire healthcare system. Addressing them head on can help businesses improve health outcomes and reduce healthcare spending by addressing the drivers of health, removing biases and inefficiencies in care and enabling data and technology to help monitor, diagnose and deliver care.



22.8% of Black cancer survivors on high-deductible plans **skipped medication to save money**, while **8%** of white cancer survivors with high-deductible plans did the same.

Additionally, **14.9%** of Black patients on high-deductible plans **couldn't afford to see a specialist**, vs. **6.2%** of white patients.

JAMA 2020

Click here for your plan prescription

5 Socially aware

Your plan prescription

Employers like you can have an impact on the ability for underserved employees to live healthier lives. Certain plan designs, like high-deductible health plan models, can fuel health disparities and discourage preventive and chronic care. Consider alternatives and/or better education around the true cost of high-deductible health plans.

Highlight the importance of a primary care-centered plan. A provider who knows a plan member's history can help them navigate and coordinate needed services based on their unique needs.

Push for better integration of behavioral health into primary care. Many people from racial and ethnic minority groups face additional obstacles in accessing needed mental health services.

Explore virtual primary care's promise in terms of closing inequity gaps and increasing access to underserved communities. It removes travel and mobility limitations, both shown to be critical social determinants of health.

6 Accessible for all

Does your plan make it easy for employees to get the care they need, wherever they are?

There are a lot of reasons your employees may not see a PCP or get preventive care, especially when they are feeling well. They don't have a regular doctor, they can't take time off from work, appointments are too far away, physically or chronologically. But what happens when your employees suddenly need care?

Especially during the COVID-19 pandemic, the solution was to see doctors online. In fact, in 34 percent of households in 2021, telehealth was the only option for seeing a provider. Quickly, what began as an after-hours, episodic approach to telemedicine evolved into a burgeoning era of barrier-breaking care enablement.

For instance, a McKinsey & Company study touted the potential for telehealth to increase access to necessary care in areas with shortages such as behavioral health, improve the patient experience and improve health outcomes. And virtual care can reduce unnecessary ER and urgent care visits by 19%.

Today, there's a new era of virtual care — virtual primary care. The movement shifts the concept of off-hours or urgent online visits to that of a virtual yet consistent care team that replaces the traditional in-office primary care relationship.

For employees who don't have the time, access or mobility to get to a primary care provider — or if they are among the 25–30% of American adults who simply don't have a primary care doctor — virtual primary care offers:

- Flexible scheduling to fit work and family commitments
- No travel involved, decreasing absences and expenses while eliminating any transportation and distance barriers
- Reduced wait times for visits — and no physical waiting room
- Fewer gaps in care, especially for managing chronic conditions

Other benefits of the virtual doctor-patient relationship include the potential for more personal, less rushed visits and an effective solution for provider shortages or medical deserts.

To influence quality of care, **84%** of employers believe integrating virtual health and in-person care delivery is **essential and the most important action** their partners can take.

Business Group on Health. 2023 Large Employers' Health Care Strategy and Plan Design Survey. August 2022

6 Accessible for all

Your plan prescription

While telehealth options are great add-ons, they are meant for episodic care. To truly break down the barriers on equity and access, consider adding virtual primary care physicians to your provider network.

Start thinking about incorporating virtual primary care into your health plans now: A study by Wheel showed that 63% of clinicians believe virtual primary care will surpass in-person care within five years.

Get to know the savings and improved outcomes possible with virtual primary care — and communicate the value of a virtual primary care provider to your employees.

Consider expanding your virtual benefits to other critical services like behavioral health and chronic disease management.

7 Aligned with the company budget

Is your health plan and funding strategy the right fit for your company?

Even while health benefit costs continue to rise at roughly 5% each year, many employers are leaning away from cost-shifting strategies to more employee-friendly approaches. The current war for talent has upped the ante for funding richer benefits. Yet, during these inflationary times, the company's bottom line makes this even more challenging.

It's a delicate balance to strike. So, what does the right plan look like for your company? Here are some aspects to consider:

- Your company size
- Preferred level of control over year-to-year investment
- Plan design and feature flexibility
- Actionable access to claims data

From a funding perspective, if you're facing increasing premiums and rising healthcare expenses, it could be time for a pivot from a traditional one-size-fits-all plan to a better funding fit. The funding option you choose — fully insured, self-funded or a shared arrangement — gives you varied elements of risk, control and customization.

It pays to explore your options. While 93% of benefits advisors and consultants surveyed said self-insured was in the best interest of their customer's long-term strategy, nearly half of the respondents said clients remained fully insured due to risk aversion or a misconception that they're too small. While self-funded plans put greater risk on your company, they offer more flexibility and data access — making the move to self-funding a growing trend for small and mid-size employers.

Another way to gain better control over costs (without sacrificing quality or access) is to dig deeper into what's driving your expenses. Does your health plan contract with high value providers for more effective outcomes? Does it prioritize primary care and enable accessibility to reduce unnecessary specialist or ER visits? At Centivo, we've found that by changing up plan design and shifting investments to the right types of care, companies can save between 14–27%, if not more.

Care redirection is a powerful way to influence costs in a self-funded plan. This all starts with the identifying the highest value providers and developing a preferred network around them. But it's also about encouraging your employees to use the right care at the right time to prevent unnecessary care downstream. This gets back to the importance of primary care.

By anchoring your plan on a primary care-centered model — or better yet, making all primary care free (as we advocate for here at Centivo) — you can promote the use of preventive care and discourage the use of urgent and emergent (aka more expensive) care. And the proof exists. On average, Centivo clients using our PCP-centered model saw primary care visits 12% above, and ER visits 25% below, Milliman benchmarks. That's a huge cost savings, not to mention a better use of care in general.

63% of covered workers, including 21% of covered workers in small firms and 82% in large firms, **are enrolled in self-funded plans.**

Kaiser 2021 Employer Health Benefits Survey

7 Aligned with the company budget

Your plan prescription

After payroll, health benefits are one of the top expenses in your budget. As such, they demand investigation and responsible stewardship.

Ask your health plan to validate the quality and value of the providers and health systems in their network. Take advantage of new price transparency rules to ensure your health plan is negotiating the best pricing without sacrificing quality or access.

Invest in primary care for better control of downstream (specialist, inpatient, ER) costs and a healthier workforce.

Ensure your funding structure is truly the best option for your company's needs.

Building a healthier health plan

A path forward

The objectives of today's employer-sponsored health plans are not far off from their Dallas beginnings. Ideally, a good plan enables workers to get quality, necessary care without the fear of draining their savings. They should make preventive care easily attainable so problems can be identified and treated early. Additionally, they should ensure specialist and proven innovative care is affordable, if needed.

With these considerations front-of-mind, **a healthy health plan can lead to better outcomes at a more affordable price and attract and motivate a vital, loyal workforce.**

65% of workers would give up bonuses, vacation time and flexible hours for better healthcare benefits

and expect employers to ensure they have access to best-in-class primary care providers.

One Medical study

Key features of a healthy health plan

1. Makes healthcare accessible and affordable for employees — and your business
2. Puts primary care at the center
3. Partners with proven quality providers
4. Enables and encourages effective healthcare decisions
5. Removes barriers to care for ALL employees
6. Embraces innovations to improve care outcomes, including virtual care
7. Makes financial sense for your business now and going forward

About Centivo

Centivo is an innovative health plan for self-funded employers on a mission to bring affordable, high-quality healthcare to the millions of working Americans who struggle to pay their medical bills. Anchored around a primary care based ACO model, Centivo saves employers 15 to 30 percent compared to traditional insurance carriers. Employees also realize significant savings through our free primary care (including virtual), predictable copay and no-deductible benefit plan design. Centivo works with employers ranging in size from 51 employees to Fortune 500 companies.

To learn more

about Centivo plans and how they can work for you and your employees, visit us at centivo.com or

Sign up for our next 20-minute live demo

Register now