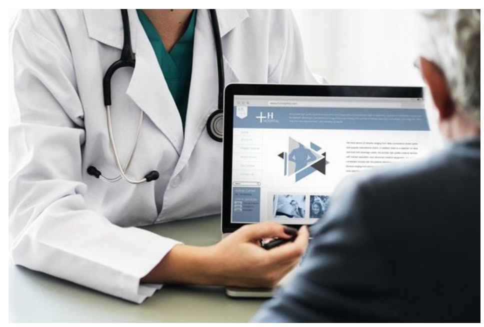
Here's How to Offer Competitive Benefits Without Sacrificing Salary

In a tightening labor market, employees expect (and receive) higher salaries and better benefits. Businesses must find innovative ways to stay competitive and attract top talent. This can be especially difficult for small business with limited financial resources. With a record number of Americans quitting their jobs -- up to 3.3 million in 2018 -- now is the time to act.

A new survey from the Association of International Certified Professional Accountants revealed 80 percent of workers would choose a lesser-paying job with good health benefits over a job with no benefits. But employers don’t have to choose between one or the other. A self-insured health plan can cut costs, provide access to value-based primary care and enable leaders to offer the attractive salaries and benefits that matter most to achieve a happy, healthy and productive workforce. Time and again, wise employers realize the best way to slash healthcare costs is to improve benefits.

Don’t worry about wellness programs.

Wellness programs seem to be trending. In recent years, employers have expanded their wellness offerings to include on-site fitness centers, free massages, exercise tracking devices and more. But these programs aren’t required for businesses to keep up with the competition. Wellness programs are an expensive add-on, costing employees approximately $100 to $150 per individual each year -- plus an average of $784 annually per employee in participation incentives.



Employers employers should do without this perk. Industry surveys suggest that fewer than one-quarter of employees take advantage of these programs. And of those who do, many already are healthy and therefore not in dire need of the services. Rather than investing additional money in a wellness program, employers should take a look at their existing health plans. Organizations can spend smarter by creating plans that provide high-quality, affordable care.

Improving benefits actually can lower costs.

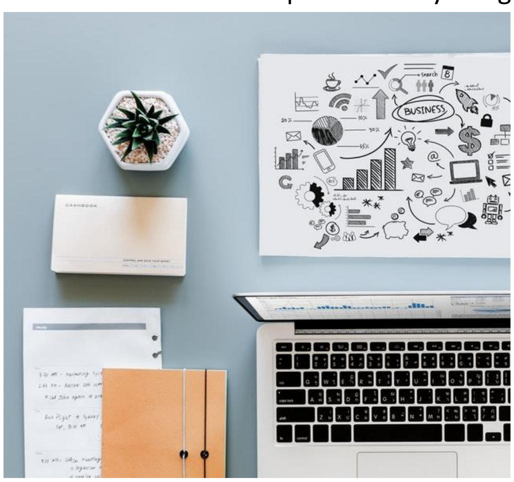
Becoming self-insured is the first step. This system runs counter to the popular fully insured model, in which employers and insurers split employee health costs. Self-insured plans require employers to pay for their employees' medical expenses with their own money. But who would do this? As it turns out, forgoing a fully insured plan allows employers to eliminate an insurer's profit margin and avoid annual rate increases.

Fully insured plans.

Former insurance executives have told me they make up to 10 times the margin on fully insured customers, compared to the margin on self-insured customers. It’s no wonder industry executives create compensation schemes that entice benefits brokers to keep employers fully insured as long as possible. In 2018, family premium rates rose 5 percent and singles’ rates rose 3 percent. Employers expect another 5-percent increase this year. And those figures are on the conservative side. I regularly hear of employers receiving rate increases of 20 percent and higher. It’s also easy to miss the fact that carriers are very adept at changing coverage, so an increase of “only” 5 percent actually can be quite a bit more, when increased copays and deductibles are factored in.

Self-insured plans.

Many employers fear that self-insured plans run more risk than fully insured ones. One employee’s emergency medical expense could eat up the sum total an employer had set aside for all of employees. This is why it’s so crucial to invest in stop-loss insurance -- coverage that kicks in after claims exceed a set amount. Claims can be processed by a high-value, transparent third-party administrator (TPA). The TPA charges a monthly fee to pay claims and perform other administrative functions for self-insured employers’ health plans.



A TPA can transform health benefits from a black-box line item that increases by double digits each year to a cost center employers can actively manage and control. The value is evident, with annual cost reductions of 10 to 25 percent. Our nonprofit, Health Rosetta, developed a simple calculator to help CFOs translate how getting healthcare costs under control can have a greater impact on earnings than a substantial increase in company sales.

Value-based options.

Some plans provide access to value-based primary care, which rewards health care providers for having positive patient outcomes. This option further slashes costs. Physicians focus on results, dedicating more time to discussing patient symptoms and treatment. This could lead to fewer unnecessary (and potentially harmful) tests and follow-up or referral appointments.

To further reduce costs, employees who already have established a relationship with a value-based primary-care physician could be encouraged to take advantage of telemedicine visits. Patients can address minor concerns via email, chat, phone, or video conference --- without a trip to the Urgent Care clinic. This gives people living with chronic conditions a chance to see the doctor before an acute condition worsens. This ready, low-cost access also also could help patients manage treatments so they don't deteriorate to the point of needing an expensive trip to the Emergency Room.

Communication is key.

Surveys and focus groups can help target worthwhile benefits by giving employees the opportunity to talk about the kinds of care they need most. For example, a business whose stable pool of employees primarily are done building their families may not take advantage of maternity coverage or adoption-related expense. An on-site physical therapist, however, could be a help if daily work responsibilities require strenuous activity (or, in contrast, sitting too much).

It’s not just about employees talking to employers, however. No health plan will work optimally unless employers make its details clear to employees via presentations, workshops or webinars for remote teams. Companies can create print materials and online portals or micro sites to provide "anywhere" access to plan information.

Human Resources professionals must take the time to learn the nuances of the plan so they can appropriately respond to employee concerns. Employees who receive clear information on the available options will require HR to spend less time fielding coverage questions or requiring a new doctor. Some mid-size and larger companies offer a benefits concierge. This position more than pays for itself by helping employees navigate their healthcare journey.

It can be a struggle for small businesses to keep up with increasing healthcare costs and compete against the salary/benefits packages that larger organizations can offer. However, they can boost their benefits offerings if costs decrease within care delivery -- eliminating widespread over-treatment such as improperly addressing back pain, for example. Working with a properly aligned benefits advisor is critical to help identify high-value health benefits. An experienced advisor even can help recommend interim steps for organizations that aren't yet ready to move wholly from a fully insured plan to a self-insured model.

Though they may take time and hard work to get off the ground, self-insured health plans that provide low-cost, value-based care are the secret to providing better benefits, saving money and running a successful small business.

Source: https://tinyurl.com/y83uu7jw