

Benefits Insights

5 Plan Design Tactics to Address Healthcare Spending



Healthcare costs continue to rise, placing sustained financial pressure on organizations of all sizes. In fact, PwC's annual medical trend report projects that the commercial healthcare cost trend is expected to rise to 9% in 2027, the highest figure in 17 years. While cost-sharing adjustments remain common, they are insufficient as a long-term strategy. Employers that achieve durable savings do so through deliberate plan design, structuring benefits in ways that reduce total cost while preserving the quality of care available to their workforce.

This article explores five plan design tactics for employers to consider to effectively address healthcare spending.

1. Centers of Excellence

Centers of excellence (COE) are high-volume, specialized facilities that have demonstrated superior clinical outcomes for specific procedures. Since these institutions perform a given procedure on a significant scale, they are often able to negotiate reduced facility rates while delivering fewer complications and shorter recovery times. Common services covered under COE arrangements include:

- Cardiac surgery and cardiovascular procedures
- Oncology and cancer treatment
- Orthopedic surgery, including joint replacement (e.g., hip and knee) and spine surgery
- Bariatric (weight-loss) surgery
- Organ transplants (e.g., kidney, liver, heart and lung)
- Fertility and reproductive health services
- Behavioral health and substance use treatment

For organizations with concentrated claims spending in surgical categories, COEs offer both improved clinical quality and lower total cost of care. When paired with a travel benefit that offsets transportation and lodging expenses, the model can be presented to plan members as a zero-cost or low-cost alternative to local facilities.

The primary implementation challenge is utilization. Members tend to default to familiar, geographically convenient providers. As such, effective COE programs invest in member education and ensure the associated travel benefit is substantial enough to shift behavior.

2. Direct Primary Care

Direct primary care (DPC) is a structural departure from the traditional fee-for-service model. Under a DPC arrangement, an employer pays a flat monthly fee, typically between \$50 and \$100 per enrolled member, in exchange for unlimited access to a primary care physician. The model eliminates claims processing for primary care visits entirely, reducing administrative friction and removing financial barriers to routine and preventive care.

Organizations whose workforce underutilizes preventive services, relies disproportionately on urgent care or accesses emergency departments for nonemergency situations are well-positioned to benefit from DPC. Improved access to primary care has meaningful downstream effects on chronic condition management and avoidable specialist referrals.

Industry benchmarks suggest that return on investment is generally realized over a 6- to 24-month horizon, making DPC a medium-term commitment. The model is most effective when layered with a high deductible health plan rather than deployed as a standalone benefit. COEs generally make more sense for larger organizations with local employees versus small businesses or employers with a remotely dispersed workforce.

3. Specialty Prescription Carve-out

Specialty drugs represented 54% of total U.S. drug spending in 2023, according to the IQVIA Institute for Human Data Science. However, specialty drugs (e.g., biologics, oncology therapies and gene therapies) account for a majority of total drug spending despite serving a relatively small patient population, underscoring their outsized impact on benefit budgets. This concentration of costs makes pharmacy benefit design one of the highest-leverage areas for employers.

A specialty carve-out separates high-cost specialty drugs from the rest of the pharmacy benefit and routes them to a dedicated vendor. The foundational decision is whether to maintain a bundled arrangement with the carrier's pharmacy benefit manager (PBM) or transition to an independent, pass-through PBM model. Pass-through contracts provide full transparency into ingredient costs and rebate flows, allowing the employer to capture manufacturer rebates directly rather than having them retained by the PBM. Instead of all prescriptions running through one PBM, specialty medications above a certain cost threshold are routed to a separate entity, often a specialty pharmacy or carve-out vendor, that negotiates its own contracts with manufacturers, manages rebates independently and applies utilization management specific to high-cost biologics and infusion drugs.

This approach adds a vendor relationship and some administrative complexity and can create friction if the carve-out conflicts with the main PBM's contract terms. However, for mid- to large self-funded employers, the savings potential usually outweighs the complexity. For smaller employers, a well-negotiated pass-through PBM contract may accomplish similar goals without the additional layer.

4. Reference-based Pricing

Reference-based pricing (RBP) is a strategy that employers with self-insured health plans can use to lower costs by capping plan payments for specific healthcare services. Unlike traditional strategies, which base payments on providers' billed charges, RBP uses a benchmark—or reference price—as a fixed payment amount. In general, a health plan with RBP will only pay the reference price for a specific healthcare service, regardless of who the provider is, where it is located or how much it charges. If a provider's charge exceeds the reference price, the covered individual is generally responsible for paying the difference out of pocket, since the plan's payment is capped at the established benchmark. As a reference price, plans with RBP often pay providers at a percentage above Medicare's payment for the same service (e.g., 140% of Medicare), based on what is reasonable for the local healthcare market. Other benchmarks may also be used, such as the provider's actual cost to deliver the service plus a fair profit margin. Most plans base their prices on Medicare-allowable costs, which are marked up to establish a profit margin. However, limits should apply only to “shoppable” services. These are services that allow an individual to take time to make a decision based on price and quality, such as imaging, lab tests or joint replacements. In all of these examples, there are lower-cost options that are typically the same quality as the more expensive alternatives.

Employers typically work with a third-party vendor to establish the best limit for a procedure. The vendor will help conduct market research and negotiate the most appropriate deals with providers. Finding a reliable vendor that works well with the company is crucial for negotiating the best prices for employees. RBP is most effective when applied to procedures with fluctuating costs. For instance, colonoscopies may range from \$400 to \$6,000, depending on the physician. In this case, an employer using RBP might set the spending limit to the median price of the procedure, based on market findings. If an employee uses a health facility that charges above the spending limit for a specific procedure, they will need to cover the difference out of pocket.

RBP represents a meaningful operational commitment and is not appropriate as an initial plan design change. However, for organizations that have established the necessary infrastructure, the potential for cost reduction is substantial.

5. High-performance Networks

High-performance networks direct members to a curated set of providers identified as delivering superior value, defined as a combination of clinical quality and cost efficiency. Cost-sharing is used to incentivize in-network utilization. For example, members who access designated providers face lower or no out-of-pocket costs, while those who seek care outside the network bear greater financial responsibility.

This approach is fairly straightforward to administer and doesn't require a self-funded plan structure or a new vendor relationship. However, its effectiveness is contingent on two factors: the quality of network construction and the magnitude of the incentive differential. A narrow network built solely around cost, without attention to quality, risks member dissatisfaction. Similarly, differentials that are too modest fail to meaningfully influence provider selection.

Conclusion

No single plan design tactic is sufficient on its own to make meaningful cuts. Organizations that achieve lasting reductions in healthcare spending typically do so by combining multiple strategies, prioritized based on their administrative readiness, claims profile and workforce demographics. However, there is a unifying principle across these highlighted approaches. Plan design deliberately aligned with how a workforce actually accesses care is more effective and equitable than cost-shifting alone.

Contact us for more resources.

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