HEALTH CARE INFLATION

HOW HEALTH INSURERS ARE TRYING TO REIN IN COSTS

BUSINESSES CONTINUE to see higher increases in group health plan premiums due to medical cost inflation, higher utilization and rising drug prices.

As a result, many insurers are pursuing structural changes designed to control long-term costs while improving care quality and the member experience.

Interviews with health plan executives and recent industry reporting point to a common theme: reducing avoidable care, simplifying administration and investing earlier in health to prevent expensive problems later.

Employers and their staff can benefit from these strategies, which are increasingly being built into plan design, provider networks and care management programs that influence both premiums and employees' out-of-pocket costs.

Preventive and personalized care

A central focus for many insurers is expanding preventive care and making it easier for enrollees to engage with their providers. Executives at plans such as Humana and Highmark Wholecare, in a recent roundtable with the news website *Becker's Payer Issues* emphasized coordinated care models that connect primary care, specialists and support services for the patient.

These models rely on data and digital tools to identify care gaps early, such as missed screenings or unmanaged chronic conditions. Members may receive targeted reminders, care manager outreach or digital coaching to stay on track.

Cost containment

Many insurers are expanding value-based payment arrangements that reward providers for keeping patients healthy rather than paying for higher volumes of services. Under these arrangements, insurers and providers share data and align financial incentives around outcomes and the total cost of care.

Plans are also using predictive analytics and artificial intelligence to identify members at higher risk of complications and intervene earlier through care coordination, remote monitoring or alternative sites of care.

Administrative efficiency and transparency

Health plans are investing in modernized claims systems, real-time eligibility and claim validation and more streamlined prior authorization for routine or evidence-based care.

Some plans are reducing or reforming prior authorization requirements where data shows little value, while using technology to make remaining reviews faster and more predictable. Insurers are also working to improve transparency around costs and benefits, helping members better understand service costs and coverage before care is delivered.

For employers, lower administrative costs can help moderate premium growth and reduce HR workload tied to billing disputes and employee questions. Employees may benefit from fewer delays, clearer explanations of benefits and less confusion when accessing care.

What this means for employers and their staff

If these strategies are implemented successfully, both employers and employees stand to benefit through lower premium increases, less expensive claims costs and better health outcomes.

If you have questions about your coverage or our products, please reach out to me:

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