healthcare coverage contribution an employer made for a single worker's family in 2016 reached $12,865 (see Figure 1), an amount that does not include the indirect costs due to loss of productivity, absenteeism, and increased workers' compensation.

For individuals, employers, and health plans alike, U.S. healthcare spending is rising at an unsustainable trajectory, necessitating action to bring costs under control. In response, the industry is designing payment models that focus healthcare spending away from acute care to prevention, early intervention, and health maintenance. Central to this transition is the role of fundamental healthcare services, such as clinical laboratory testing, given its role in improving diagnosis, treatment, and health management.[9]

Likewise, tiered networks work for clinical lab services, creating more affordable testing options for members and reducing the cost of care. Figure 4 illustrates the power of directing members to the most cost-effective lab to reduce total cost to the health plan, employer, and member.

Figure 4. Sample member out-of-pocket costs based on the average negotiated payment for in-network labs and average charges for out-of-network labs by site of service.

	I -Ne I de e de Lab	I -Ne H a Lab	O - f-Ne I de e de Lab
B M P	$	$	$
L P	$	$	$
P S	$	$	$

Source: Anthem Blue Cross. Saving Your Patients Money with In-Network Referrals. https://www11.anthem.com/ca/provider/f0/s0/t0/pw_e194232.pdf?refer=provider. Example based on a member who has met his or her annual deductible.

Still, careful design of tiered networks is important for maintaining high levels of member satisfaction. A 2015 survey found that almost one-third of privately insured adult patients had received a surprise medical bill in the previous two years.[15] This can happen in many situations, including when a physician knowingly or inadvertently sends a member's test to a non-preferred lab. When the test is performed and the health plan processes the claim based on the member's benefits plan, the member may be left holding a large bill—a major source of member dissatisfaction. Thus, it is important to educate members on the cost and quality-related benefits of utilizing the preferred lab and drive compliance with compelling incentives, convenient locations, and easy-to-access information.

Health plan benefit design change strategies for appropriate lab spending

A key approach to lowering healthcare costs focuses on covering preventive care, wellness visits, and cost-effective health management treatments such as medications to control blood pressure or diabetes, thereby reducing the likelihood that members will need more expensive medical procedures in the future. Evolving health coverage models are contributing to this goal. In partnership with or independent of tiered networks as described in the previous section, tiered benefit design options can help financially incent positive health behaviors by offering a lower or no copay for using certain in-network labs, shifting members to more cost-effective lab settings. Benefit design changes can then be implemented at the health plan level or plan sponsor level for large, self-insured employers. Benefit design changes may include value-based insurance design (V-BID), steerage programs, convenience and access improvements, and the creation of greater price transparency.

Value-based insurance design (V-BID) programs aim to increase healthcare quality and decrease costs by using incentives to promote cost-efficient services and consumer choices. To incentivize members to make use of these benefits, health plans typically have no or low copays for ordered lab tests and other high-value services for certain conditions to remove the concern for out-of-pocket costs. The American College of Physicians (ACP) recommended the implementation of V-BID to counteract consumer cost-sharing, particularly deductibles, that may cause patients to forgo or delay care, including medically necessary services.[16] Likewise, plans may use high cost-sharing models to discourage services considered to be of uncertain value or that are avoidable, unnecessary, or repetitive. Health plans apply evidence-based data to identify high-quality, low-cost providers and services that can lower overall costs.

Increases in Medicare beneficiary cost-sharing have been shown to adversely affect vulnerable beneficiaries, contributing to poor clinical outcomes, and, in some instances, increasing Medicare expenditures.[17,18,19] Recognizing this correlation, the Centers for Medicare and Medicaid Services launched the Medicare Advantage Value-Based Insurance Design (MA V-BID) Model Test to pilot cost-sharing reduction strategies that encourage the use of high-value clinical services and providers. Nine Medicare Advantage plans in three states were selected to enroll beneficiaries with specified chronic conditions in 2017. Thus far, expert interviews and quantitative modeling reveal that V-BID programs, which reduce consumer cost-sharing for the targeted chronic conditions, are a viable and cost-effective solution for the Medicare program. Moreover, the alignment of consumer engagement initiatives with ongoing provider-facing, value-based payment initiatives is a critical step to

improve quality of care, enhance patient experience, and contain cost growth.[20] In 2018, the model test will expand to three additional states and will include two additional clinical conditions.

UnitedHealthcare began a V-BID program in 2009 with the objective of more effectively managing their diabetic and pre-diabetic members to control the escalating costs of insuring this population.[21] According to UnitedHealthcare data, treating pre-diabetic patients costs $5,000, while the average annual cost of diagnosed diabetics with complications, such as heart disease or kidney failure, can be as high as $30,000.[22] The Diabetes Health Plan, a first-of-its-kind program, rewarded diabetic and pre-diabetic members for adhering to medically-proven steps to manage their condition, including regular blood sugar checks, routine exams, preventive screenings, and wellness coaching. The benefit incentives included diabetes-related supplies and prescription drugs at no charge, lower copayments for related doctor visits, and a voluntary lab screening model to help members determine if they had undiagnosed diabetes or suffered from prediabetic conditions. The UnitedHealthcare Diabetes Health Plan projected a savings of $500 a year per member.

E[illegible]

Another approach to promoting use of cost-effective lab services and driving savings for employers is a lab steerage program that wraps around a standard benefits plan. In partnership with a commercial lab services provider, and typically used on outpatient lab services, employers and their covered employees and dependents can receive savings (through contractual pricing) to routine lab tests including, but not limited to, blood tests (e.g., cholesterol, complete blood count), urine tests (e.g., urinalysis), cytology and pathology (e.g., pap smears and biopsies), and cultures (e.g., throat culture). The program encourages employees to take a more active role in their healthcare and promotes the use of standalone commercial labs versus other higher-priced, in-network labs. Services are also available to help educate providers on this program—either at the request of the member or employer.

E[illegible]

Regardless of the strategies implemented, member engagement is key to a health plan's or employer's overall efforts to manage lab spend. Ensuring members use in-network providers, for lab or other types of services,

contacting the SmartShopper hotline, members can find out how much a physician-recommended test or procedure costs at various in-network facilities. If the member elects a cost-effective option, he or she can qualify for a cash reward ranging from $25 to $500. Of the 39 services currently included in the program, lab/blood work is the most commonly used. Year-to-date claims data from June 2017 shows that 3,034 members have received 1,699 lab tests. Of those, 121 members consulted SmartShopper, resulting in a savings of $27,550 for the health plan. If all lab work had been compliant with the program, the health plan could have saved an additional $398,250[26] (see Figure 5).

Figure 5. Top five services with incurred claims by volume and potential savings to the health plan.

In a separate study designed by Cigna and one of their employer customers, Safeway, Inc.,[27] a RBP model was applied to lab services, such as a lipid or comprehensive metabolic panel, as part of their current benefits plan. The study evaluated 492 procedural codes for lab tests from January 2010 through December 2011. Study and control groups were Safeway employees and their covered dependents enrolled in a Cigna health plan. The study group received information from their employer about a set RBP and was provided with access to a free online shopping tool that displayed information about the cost, location, and type of lab services in their geographic area. The control group had no access to the RBP benefit, did not receive information about RBP from their employer, and did Lang (en15 (.1 (l)5 (o access t)11 (o ne online lab shop)0.2 (ping t)10 (oor)-10 .,)50 ( )]TJETEMC /Span ⁄Lang (en-US)/MCID