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STRATEGIC MANAGEMENT OF HEALTH INSURANCE FOR COMPANIES: REDUCING COSTS AND MAXIMIZING COVERAGE

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ABSTRACT

This article aims to analyze the strategic management of corporate health insurance, focusing on cost reduction and expansion of the care coverage offered to employees. The research was conducted through a literature review, with a qualitative approach, based on authors who discuss expense control practices, rationalization of processes and integration of preventive measures in collective contracts. The data used were extracted from scientific articles, academic dissertations and institutional publications that deal with the theme from the perspectives of management accounting, human resources administration and supplementary health. The analysis of the materials revealed that the use of strategies such as preventive medicine, co-participation, home care, and medical auditing can generate significant impacts on the financial sustainability of the plans, as long as they are applied with planning, monitoring, and alignment with the epidemiological profile of employees. In addition, the importance of internal communication, integration between organizational sectors and the use of performance indicators as indispensable tools for the efficient management of benefits was highlighted. It was also observed that companies that adopt a systemic and strategic approach in the management of health plans obtain better results in terms of talent retention, organizational climate and productivity. It is concluded that the strategic management of corporate health insurance represents a competitive advantage when conducted in an integrated manner, based on concrete data and oriented towards the balance between the well-being of workers and the economic viability of the organization.

Keywords: Strategic management. Health insurance. Companies. Cost reduction. Supplementary health.

INTRODUCTION

The contemporary corporate environment is marked by challenges that require increasingly accurate decisions in the use of available resources, especially when it comes to supplementary health offered to employees. The contracting of corporate health insurance, in addition to representing a relevant attraction in the composition of the benefits package, has proved to be a tool for balancing well-being and economic sustainability, which requires companies to have refined strategies to ensure adequate coverage without compromising the financial viability of the organization. In this scenario, there is a need to develop a plan that combines quality of care with mechanisms that allow for intelligent control of expenses, especially in the face of escalating prices in medical and hospital services, which imposes strict control over their finances on organizations (Martins, 2009).

Several studies indicate that the development of a strategic model aimed at the administration of corporate health plans can generate significant results, both in terms of cost containment and in the improvement of internal satisfaction indicators, and it is essential to consider factors such as the epidemiological profile of the team, frequency of use of services, and alignment with preventive practices. Research shows that the introduction of actions aimed at preventive medicine, for example, is capable of significantly reducing the number of hospitalizations, repeated exams and unnecessary consultations, while promoting the engagement of employees in decisions related to their own health (Martins et al., 2013).

This rationalization, however, requires the development of specific metrics and the use of control tools that allow monitoring the effectiveness of the measures adopted, ensuring continuous monitoring of the variables involved in insurance administration. It is not only a matter of reducing expenses through cuts, but of understanding the flows and processes that generate inefficiencies, acting directly on them with corrective measures based on concrete evidence and well-structured management data (Costa, 2006).

The specialized literature points to the importance of integration between administrative, financial and human resources sectors in the design of a benefits policy that is both sustainable and effective, considering that the absence of well-defined criteria in the choice and management of operators can result in waste of resources, increased claims and wear and tear in internal relations. The development of a strategic model necessarily involves the identification of variables that directly affect costs, such as frequency of use, type of coverage contracted, profile of beneficiaries and co-participation structure (Oliveira and Leone, 2008).

Also, the measurement of the costs associated with benefits should be understood as part of the logic of investment in human capital, since employees who feel assisted in their basic needs tend to have better productivity rates, lower absenteeism rates, and greater commitment to the company's objectives. In this way, health insurance ceases to be an immutable fixed cost and becomes a strategic tool for people management (Martins, 2009).

The need for more efficient and personalized models is evidenced by authors who analyze the limitations of traditional plans, highlighting the importance of solutions adjusted to the profile of the internal public, especially in companies that deal with a diversity of age groups, different health conditions, and occupations with varying physical requirements. The use of mathematical models and simulations based on historical data has been a viable alternative for the redesign of plans and contracts, allowing scenarios to be predicted and decisions made with greater certainty (Oliveira and Leone, 2008).

The National Supplementary Health Agency (ANS), by establishing minimum coverage standards and rules for adjustments, contributes to consumer protection, but at the same time imposes additional challenges on companies that need to maintain the quality of contracted services without exceeding their budgets. In view of this, it is essential that the management of the benefit goes beyond the simple hiring of operators, involving critical analysis of performance indicators, renegotiation of contracts and encouragement of preventive practices within the corporate environment (Costa et al., 2006).

Based on the evidence found in several studies, it is clear that the strategic approach to health insurance management must be connected to a broad vision of organizational sustainability, which recognizes the benefit not as an isolated expense, but as a factor of competitiveness and talent retention. Therefore, it is essential that business leaders take an active role in the constant review of these policies, adjusting them according to the reality of the company and the profile of its employees (Carpintéro, 1999).

By integrating concepts of managerial accounting and strategic cost management, the administration of health benefits now has more precise instruments for measuring results, enabling the adoption of indicators that help in more assertive decision-making and in medium and long-term planning, avoiding budget surprises and contractual imbalances (Costa, 2006).

The detailed analysis of the strategies applied by companies in the supplementary health sector points to concrete ways to build innovative solutions that combine economic efficiency and commitment to the well-being of workers, which is one of the most valued

differentials in the contemporary market, where competitiveness indices and financial challenges become increasingly relevant (Martins et al., 2013).

In view of this scenario, this article aims to analyze the strategic management of corporate health insurance from the perspective of reducing expenses and expanding coverage, based on data extracted from empirical and theoretical studies. To this end, models, practices and reflections on the relevance of this theme for organizational sustainability will be presented, especially in view of the requirements imposed by legislation and market transformations (Oliveira and Leone, 2008).

Based on the authors worked here, it seeks to contribute to the construction of knowledge applicable to the reality of Brazilian companies, especially medium and large ones, which face the challenge of offering care security to their employees without compromising their operational results, showing that a well-structured management can transform health insurance into a strategic asset (Costa, 2006).

Thus, it is hoped that the reflections proposed in this study will serve as a basis for managers, consultants and professionals in the corporate health area, encouraging the implementation of more effective models of benefits administration, focusing on the efficiency of expenses, the prevention of diseases and the valorization of human capital as a determining factor for organizational prosperity.

THEORETICAL FRAMEWORK

STRATEGIC MANAGEMENT OF HEALTH INSURANCE IN COMPANIES

The transformation of corporate requirements and the continuous search for competitive differentials have led organizations to position corporate health insurance as an integral part of the strategy of valuing human capital, especially because this benefit directly influences the motivation of employees, the talent retention rate and the perception of safety in the workplace. factors that impact not only individual well-being, but also collective productivity (Oliveira and Leone, 2008).

Given this scenario, the strategic management of health insurance needs to be understood not as an isolated cost, but as a planned investment that requires constant monitoring and periodic reassessment of contracts, coverage, and performance indicators, and it is necessary for the human resources sector to act in an integrated manner with the financial and administrative areas to ensure the sustainability of the plan over time (Costa, 2006).

In studies carried out with group medicine companies, it was observed that although there is conceptual mastery over costing tools, many institutions do not apply

methodologies that favor an in-depth analysis of the relationship between care expenditures and institutional return, which weakens the decision-making process and compromises the ability to negotiate with operators (Costa, 2006).

The absence of a well-structured model of benefits management can cause significant waste, either due to underutilization of contracted resources or due to misallocation of coverage in relation to the epidemiological profile of the beneficiaries, and it is essential to develop internal policies that prioritize the critical analysis of data and the use of quantitative and qualitative evaluation instruments (Martins, 2009).

The specialized literature suggests that the formulation of an effective corporate insurance policy depends on the clarity of organizational objectives, the definition of technical criteria for choosing operators and the implementation of actions aimed at health education, which promote the conscious use of services and prevent avoidable diseases, such as hypertension, diabetes and obesity (Martins et al., 2013).

It is important to highlight that the National Supplementary Health Agency (ANS), by imposing rules on operators, established a scenario in which cost predictability has become more difficult, making proactive management the only way to avoid budget surprises and financial imbalances, which makes it essential to master contractual variables and the practice of periodic renegotiation based on concrete data (Martins, 2009).

Research indicates that the application of preventive measures and health promotion programs in the workplace substantially reduce the demand for emergency care and hospitalizations, in addition to improving the engagement rates of professionals in organizational activities, demonstrating that health insurance should not be interpreted only as medical care, but as a mechanism for institutional strengthening (Gonçalves et al., 2005).

The elaboration of collective agreements with co-participation, for example, has been shown to be effective in redistributing responsibilities between employers and employees, as it allows plan users to be more aware of the use of services and, at the same time, contributes to the containment of unnecessary expenses, without compromising the quality of care (Martins, 2009).

When the concept of strategic management is incorporated into corporate health plans, it is possible to adopt planning tools such as SWOT analysis, the Balanced Scorecard and activity-based costing, all of which are capable of providing technical support for decision-making, increasing the ability of organizational leaders to intervene directly in the improvement of care efficiency indicators (Costa, 2006).

Choosing an operator that is appropriate to the company's profile is also a fundamental step in the strategic process, since the variation in coverage, accredited network, response time and technical support can directly interfere with the beneficiary's experience, and it is necessary to compare not only prices, but historical results in terms of claims and customer satisfaction (Martins et al., 2013).

The use of performance indicators in the monitoring of the plan is another aspect pointed out in the literature as essential for the sustainability of contracts, as it allows the company to identify patterns of use, seasonality of services, areas with greater consumption of resources and possible waste, enabling contractual adjustments that maintain financial balance without compromising care (Costa, 2006).

The crossing between clinical information and financial data has been one of the most effective strategies in the integrated management of health insurance, as it enables the development of predictive models capable of anticipating risk situations, allowing the company to act preventively through vaccination campaigns, periodic examinations and home care in long-term cases (Martins, 2009).

In addition, authors point out that companies that invest in the governance of health plans obtain greater control over the rates of absenteeism, work accidents, and sick leave due to chronic diseases, which reinforces the need to develop corporate health programs aligned with the organization's strategic objectives, promoting a healthier and more financially viable work environment (Oliveira and Leone, 2008).

The strategic approach must also consider the impacts of employee health on productivity and operational results, and it is undeniable that the state of health influences professional performance, the capacity for innovation and the quality of deliveries, which reinforces the thesis that a well-managed health plan represents a competitive advantage in the current market (Costa, 2006).

Thus, it is observed that the management of health insurance in companies is not limited to the benefits area, but involves a systemic view that includes financial planning, organizational culture and relationship with stakeholders, and it is necessary that managers are trained to interpret data, plan actions and negotiate solutions that ensure both the care of the employee and the financial health of the institution.

STRATEGIES FOR REDUCING COSTS IN OPERATORS

The growing demand for health services, combined with the advancement of medical technologies and the aging of the economically active population, has pressured health plan operators to seek alternatives to maintain their economic viability, making it necessary

to resort to management models that integrate budget control and quality of care, which implies reviewing traditional practices and adopting strategies based on evidence and analysis of operational data to ensure balance between cost and result (Martins et al., 2013).

One of the measures that has shown high potential for impact is the investment in preventive medicine, especially tertiary medicine, with emphasis on home care, known as home care, which provides continuity of treatment in a family environment and at a lower cost compared to hospital admissions, resulting in a reduction in daily rates, the use of oxygen and the release of beds. without compromising the effectiveness of patient care (Martins, 2009).

The use of management methodologies such as *Kaizen* and *Just in Time* has also been incorporated by operators seeking to maximize the efficiency of their internal processes, with the first focused on continuous improvement through the involvement of operational and administrative teams in identifying bottlenecks, and the second focused on reducing waste and optimizing the time and resources employed. especially in the flows of scheduling, authorization and payment of procedures (Martins et al., 2013).

In addition to the reorganization of processes, it has been observed that the structuring of co-participation systems can contribute significantly to the control of the frequency of use of services, since the beneficiary starts to share part of the costs of exams, consultations and procedures, which encourages a more conscious and rational use of the plan, while relieving unnecessary care and reducing accident rates. favoring the stability of contracts (Martins, 2009).

Another widely discussed practice is the use of medical auditing, both preventive and concurrent and retrospective, as a tool for technical and financial evaluation of the services provided, enabling the identification of non-conformities, undue charges, duplications and deviations from clinical conduct that artificially increase costs, in addition to allowing the correction of procedures and the reinforcement of the training of professionals involved in accredited networks (Costa et al., 2006).

The negotiation of contracts based on service packages and referenced networks has also been an alternative adopted by operators and contracting companies, as it allows greater financial predictability, control over the quality of providers and the development of sustainable partnerships in the long term, as opposed to the traditional model of free choice, which, although more flexible for the user, tends to generate greater expenses for the system as a whole (Martins, 2009).

In this sense, the integration of information and intelligence systems in health becomes essential to monitor clinical and financial indicators, facilitating the preparation of reports, the monitoring of goals and the crossing of epidemiological data with economic variables, which allows for more precise interventions and policies more adjusted to the profile of users, promoting a more effective and results-oriented management (Carpintéro, 1999).

The rationalization of the processes of purchase and storage of hospital materials, medicines and supplies is another sensitive point in the cost structure of operators, and it is common to implement tracking and logistics control systems that avoid losses, stock expirations and misuse of resources, strategies that are often associated with quality certifications and the standardization of care protocols (Costa, 2006).

For such strategies to be effective, it is essential to align the executive board, operational managers, and health professionals involved, as the fragmentation of information and the absence of shared goals limit the ability to generate concrete changes, requiring the creation of internal committees, periodic evaluation meetings, and investment in the continuing education of the leaders responsible for conducting the initiatives (Martins et al., 2013).

Therefore, cost reduction in health plan operators should not be understood as a simple reduction in expenses, but rather as a structured process, guided by diagnoses and coordinated actions, which seek to transform the current care model into a more sustainable, ethical and efficient proposal, capable of meeting market demands without compromising the health of the beneficiaries or the financial soundness of the institutions involved (Martins, 2009).

EXPANSION OF COVERAGE AND QUALITY OF CARE

The expansion of coverage in corporate health plans involves more than the simple inclusion of procedures in the contract, as it requires an in-depth analysis of the needs of the population served, the epidemiological profile of employees, and the organizational objectives that guide the benefits policy, and it is essential that this expansion is aligned with an evidence-based care model. focusing on comprehensive care and valuing preventive health as a strategy to contain risks and promote the functional longevity of professionals (Martins, 2009).

It is necessary to understand that the quality of the care provided is not limited to the existence of a broad accredited network, but is directly related to the problem-solving capacity of the services, the response time of the operators, the humanization in dealing

with the beneficiary and the effectiveness of the clinical protocols adopted, and it is relevant that the companies periodically monitor these indicators, in order to assess whether the contracted services satisfactorily meet the expectations and needs of its staff (Martins et al., 2013).

One of the main guidelines to ensure the effectiveness of expanded coverage is the implementation of primary health care programs in the corporate environment, with multidisciplinary teams focused on the continuous monitoring of frequent clinical conditions, such as hypertension, diabetes, respiratory diseases, and mental health, which not only reduces the number of emergency care, but significantly improves the perception of care by employees. creating bonds of trust between user and system (Gonçalves et al., 2005).

In this process of care restructuring, the insertion of information and communication technologies, such as integrated electronic medical records and telemedicine, has proven to be a decisive factor for the expansion of quality coverage, as it enables remote access to qualified professionals, shortens distances between patients and providers, and reduces operational costs with transportation, displacement, and unnecessary hospitalizations. optimizing the available resources and promoting a more intelligent management of care (Martins, 2009).

Also in this context, some companies have incorporated flexible service modalities into their benefit plan, such as reimbursement by free choice and the hiring of specific networks for certain specialties, providing greater freedom to the employee and increasing the perception of the value of the benefit, as long as these options are managed with technical criteria, with well-defined limits and strict monitoring of requests, in order to maintain the predictability of costs and avoid abuses (Costa et al., 2006).

Authors who study the quality of life in the business environment argue that health coverage should also cover psychological, nutritional and physical support services, integrating emotional and behavioral aspects into clinical care, as the integral health of the worker depends on the harmony between body and mind, and it is relevant to include in the scope of the plans actions such as weight loss programs, stress control, occupational therapy and food education, always anchored in realistic and evaluable goals (Gonçalves et al., 2005).

It is also important to consider that the expansion of coverage requires the company to be aware of the regulatory updates imposed by the ANS, which frequently changes the list of mandatory procedures, as well as changes in the demographic profile of its workforce, which may start to demand differentiated care with the aging of the team or with

the hiring of professionals with pre-existing chronic conditions, which requires continuous adjustments in the contract signed with the operator (Martins, 2009).

Care models based on lines of care and risk stratification also contribute to the balance between expanded coverage and financial sustainability, because by identifying population groups with greater clinical vulnerability, it is possible to direct efforts and resources to the points of greatest impact, concentrating actions on secondary and tertiary prevention, reducing adverse events and highly complex costs that compromise the plan's budget (Martins et al., 2013).

No less relevant is the role of internal communication in valuing the coverage offered, since many benefits available are underutilized due to lack of knowledge of employees or lack of adequate guidance on service flows and contractual rights, making it necessary for the company to promote educational campaigns, create efficient service channels and encourage the engagement of professionals in corporate health programs as co-authors of their own care journey (Costa, 2006).

Finally, the expansion of coverage and the search for quality care must go hand in hand, supported by clear metrics, periodic evaluation of indicators and a systemic view of occupational health, considering that the maintenance of a healthy workforce directly impacts the company's operating results, becoming a strategic investment with potential for both financial and social returns. consolidating the benefit as a sustainable management tool (Martins, 2009).

METHODOLOGY

The present investigation was developed through a qualitative approach, having as its central method the bibliographic review, which allows the systematization of knowledge already consolidated in the scientific literature about the strategic management of health insurance for companies, especially with regard to the reduction of expenses and the expansion of coverage. This type of study offers theoretical support for the construction of in-depth analyses, based on recognized academic sources, such as scientific articles, dissertations, institutional publications, and books by authors specialized in the subject (Martins, 2009).

The bibliographic review adopted follows the methodological principles recommended by Gil (2009), who understands this type of research as a way of exploring, interpreting and organizing existing knowledge on a given topic, enabling the researcher to understand the advances already made, identify gaps and suggest new approaches based on a critical and reasoned analysis of the material consulted.

To ensure the credibility and relevance of the content, sources published in recognized scientific vehicles were selected, with an emphasis on studies indexed in databases such as Scielo and Google Scholar.

The collection of bibliographic material was carried out through a survey on digital platforms and academic repositories, and the documents were selected based on thematic affinity with the central axes of the research: strategic management, cost control, expansion of care coverage and financial sustainability. The inclusion criteria considered the relevance of the content, the timeliness of the data and the authors' authority in the field investigated.

After the selection of the texts, the most relevant contents were read and filed, with subsequent organization of the information into thematic categories that guided the structure of the theoretical framework and subsidized the formulation of the analyses and interpretations developed throughout the work. This systematization allowed a panoramic and at the same time in-depth view of the challenges faced by companies in the management of corporate health insurance (Gonçalves et al., 2005).

Data analysis followed a descriptive and interpretative approach, focusing on the identification of convergences and divergences among the authors, as well as on the extraction of elements that could contribute to the formulation of a strategic model for health plan management aligned with the reduction of waste and the valorization of comprehensive care, respecting the particularities of each organizational context (Costa, 2006).

In addition, the concepts and practices used by health plan operators analyzed in case studies were considered, especially those that adopted methodologies such as preventive home medicine, co-participation, contracts with referenced networks and audit and control mechanisms, and these experiences were interpreted in the light of the principles of strategic management and indicator-based planning (Martins et al., 2013).

The theoretical nature of the research does not preclude its practical applicability, since the data and reflections presented can be used by business managers, consultants and health professionals to develop more effective corporate benefits policies, strengthening the commitment to the well-being of workers and the operational efficiency of organizations.

RESULTS AND DISCUSSION

The analysis of the studies examined during the literature review allows us to affirm that the strategic management of health insurance in companies goes beyond simple financial control, as it represents a tool for institutional strengthening when articulated in an

integrated manner with corporate objectives, which implies the adoption of practices such as preventive medicine, contractual reorganization and health education. measures that, when applied in a coordinated manner, promote a reduction in care costs without prejudice to the quality of the services provided (Martins et al., 2013).

The home care model, known as home care, has stood out among the most effective strategies identified, especially because it allows patients with stable conditions, but who require therapeutic continuity, to be treated outside the hospital environment, promoting not only a significant reduction in expenses with hospitalizations and supplies, but also a positive impact on the beneficiary's satisfaction. who finds more comfort and humanization in the care process (Martins, 2009).

The introduction of co-participation systems as an instrument to contain claims has been shown to be recurrent in documented experiences, being considered a viable alternative to redistribute responsibilities between employers and employees, since it encourages a more conscious use of the plan, avoids unnecessary consultations and allows greater financial predictability, as long as it is implemented with clear communication and reasonable limits (Costa, 2006).

Studies have also shown that companies that adopt continuous management methodologies, such as Kaizen, are able to map more accurately the operational bottlenecks that make the benefit more expensive, promoting small gradual but cumulative interventions, which have a direct impact on the efficiency of internal processes, especially in the area of authorizations, billing, and relationship with providers (Martins et al., 2013).

It was also found that many organizations neglect the monitoring stage of care indicators, limiting themselves to analyzing only total expenses, without considering variables such as epidemiological profile, seasonality of use, return rates and recurrence of tests, which hinders strategic planning and compromises the company's response capacity in the face of unexpected increases in the use of the plan (Costa, 2006).

The lack of integration between the sectors involved in the management of the benefit was also identified as a limiting factor, since, in several institutions analyzed, the responsibility for the health contract is restricted to HR, without dialogue with the areas of finance, legal and occupational medicine, which weakens control over the results and prevents a more effective performance in the negotiation with operators (Gonçalves et al., 2005).

The literature revealed that the simple choice of operators with lower monthly costs is not a guarantee of long-term savings, since cheaper plans, but with low resolution or limited networks, tend to generate rework, user dissatisfaction and increased lawsuits,

especially when employees do not have quick access to specialists or are subjected to denials of coverage (Martins, 2009).

On the other hand, operators that have the structure to offer primary care programs and integrated lines of care are able to keep users healthier and more engaged, which has repercussions on the reduction of sick leaves, the lower incidence of injuries and the stability of contracts, which is an indication that the quality of the plan's management is directly related to the company's economic and social results (Martins et al., 2013).

The analysis of dissertations and articles indicated that the use of medical audit tools, both at the time of authorization and in the analysis of medical records and invoices, is essential to avoid waste and fraud, and this is a practice that, although often seen as bureaucratic, can mean savings of thousands of reais per year, in addition to allowing the improvement of clinical and administrative protocols (Costa, 2006).

Another point widely debated was the relevance of the internal communication policy for the success of the corporate health plan, as many employees are unaware of the extent of the services available, the functioning of co-participation and the support channels, which leads to the underutilization of benefits and the creation of distorted perceptions about the plan, which can generate dissatisfaction even when the care is technically adequate (Gonçalves et al., 2005).

Authors also highlighted that the alignment between health insurance management and quality of life programs at work strengthens the organizational culture and contributes to the prevention of chronic diseases, especially when investing in actions such as workplace gymnastics, psychological care, educational campaigns and periodic assessment of occupational risks, initiatives that directly reflect on the reduction of sick leave and increased productivity (Martins, 2009).

In case studies carried out with medium and large companies, it was possible to observe that those that adopted a strategic approach to insurance, involving data analysis, claims targets and technical monitoring, presented greater contractual stability, were able to negotiate better conditions with operators and maintained the quality of care, even in adverse economic scenarios (Martins et al., 2013).

The construction of a culture of co-responsibility, in which the employee actively participates in the maintenance of his or her health and understands the impact of his or her choices on the cost of the benefit, is pointed out as essential for the health plan to be sustainable in the medium and long term, and it is necessary for companies to encourage the protagonism of beneficiaries through educational programs and prevention incentives (Costa, 2006).

The integration between financial and clinical data has also proven to be a powerful resource in benefit management, allowing managers to identify patterns, project scenarios, and implement preventive actions with greater precision, which includes, for example, early interventions in cases of poorly controlled chronic diseases, as well as the reduction of duplicate or inadequately requested tests (Martins, 2009).

Thus, the results indicate that the strategic management of corporate health insurance should be treated as a continuous process, which requires technical knowledge, analytical capacity and sensitivity to deal with human and economic variables, making it possible to achieve a balance between financial sustainability and comprehensive care, as long as there is planning, monitoring and commitment of leaders with a systemic view of health at work.

FINAL CONSIDERATIONS

The strategic management of health insurance for companies has proved to be a complex, dynamic and absolutely necessary field in the contemporary corporate context. More than an additional benefit, the health plan represents an essential mechanism for the promotion of the well-being of employees and for the preservation of the productive capacity of organizations, requiring an approach that goes beyond the mere control of expenses and achieves the construction of a responsible and financially sustainable care policy.

Throughout this study, it was possible to understand that cost reduction and expansion of care coverage are not mutually exclusive objectives, as long as they are accompanied by planning, technical knowledge and permanent data analysis. Companies that apply well-structured strategies and promote alignment between internal sectors tend to obtain better results not only in economic terms, but also in strengthening relationships with employees.

The practices identified throughout the research demonstrate that the integration between preventive medicine, co-participation, quality of life programs and management by indicators contributes significantly to the financial stability of contracts, while promoting the engagement of users in maintaining their health. The replacement of the reactive model by a preventive logic stands out as a watershed in the administration of health benefits.

The conscious choice of operators, clarity in the contracts signed and the use of auditing tools are resources that help build effective governance over the health plan, reducing waste, optimizing the services offered and raising the level of satisfaction of the

professionals served. This governance, when well applied, also strengthens the company's institutional image and contributes to talent retention.

The critical analysis of the results obtained by companies that invest in active management reveals that the return on this investment is not limited to the financial field, as it directly impacts the organizational culture, the motivation of the teams and the perception of appreciation of human capital, promoting a healthier, more ethical and balanced corporate environment.

In this sense, it was evident that the success of health insurance management depends on the continuous commitment to the review of the practices adopted, the search for innovation and the monitoring of indicators that signal the paths to be followed. The rigidity of standardized models gives way to adaptive flexibility, respecting the particularities of each company and the profile of its employees.

Internal communication proved to be essential to ensure the understanding and proper use of the resources offered, reinforcing that clear, accessible and up-to-date information is a central element for the conscious use of the benefit. When employees understand the objectives and limits of the health plan, they start to act in a more participatory and collaborative way.

The articulation between strategic areas, such as human resources, finance, and occupational health, favors a more integrated and effective management, especially when accompanied by evidence-based decision-making processes. Interdisciplinarity, in this context, strengthens the company's ability to respond quickly to the challenges that arise with changes in the economic scenario and in the regulation of the sector.

Finally, it is concluded that the strategic management of corporate health insurance is a practice that requires technical preparation, institutional sensitivity and a look to the future. When conducted in a structured and coherent manner, this management is capable of transforming the health plan into a competitive differential, promoting not only savings, but also well-being, trust, and sustainable long-term results.

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