

data

Practical Research for Employers

Fall 2019

Medical and Rx Cost Increases Are Leveling Off

Double-Digit Specialty Rx Trend Is Still Projected for 2020

Those are among the key findings of the *2020 Segal Health Plan Cost Trend Survey*, a survey of managed care organizations (MCOs), health insurers, pharmacy benefit managers (PBMs) and third-party administrators (TPAs) that collectively represent more than 80 percent of the commercially insured and self-insured market. The survey was conducted by The Segal Group of which Sibson Consulting is a member.

Other key survey findings include:

- Survey respondents project most medical and prescription drug (Rx) plan cost trends to be 7 percent for 2020.
- Price increase continues to be the primary driver for medical and Rx trends.
- Double-digit specialty Rx cost trend, mostly driven by price increases and new specialty drugs, continues to haunt plan sponsors.
- Reimbursement rates for hospital networks are projected to increase at a higher rate than physician claims.
- Plan cost trends continue to outpace both inflation and wage growth by a factor of more than two.
- Actual medical and Rx trends for 2018 were significantly lower than what survey respondents projected for that year.
- Greater health care cost and quality transparency is the top cost-management strategy for plan sponsors.

What Is Trend?

Health plan cost trend is a forecast of *increases in* allowed *per capita claims cost*. Allowed per capita claims cost is eligible billed charges (before participant cost sharing) less provider discounts.

What Factors Influence Trend?

Trend takes into account various factors, including price inflation, utilization, government-mandated benefits and new treatments, therapies and technology.

What Is the Relationship Between Trend and Increases in a Plan's Costs?

Although there is usually a high correlation between a *trend rate* and the *actual cost increase* assessed by a carrier, trend and the net annual change in plan costs are not the same. A plan sponsor's costs can be significantly different from projected claims cost trends due to such diverse factors as group demographics, regional market competition, changes in plan design, administrative fees and changes in participant contributions.

In addition to presenting the survey findings, this report looks ahead at the dynamics driving change in health and benefits. It also provides valuable insights into cost-management and contracting strategies for pharmacy and medical benefits.

Each plan sponsor has a unique set of goals, but all share the common objective of managing cost increases. Sibson advocates a three-pronged approach to the complexity of health care cost management that encompasses plan design management, vendor management and population health management.

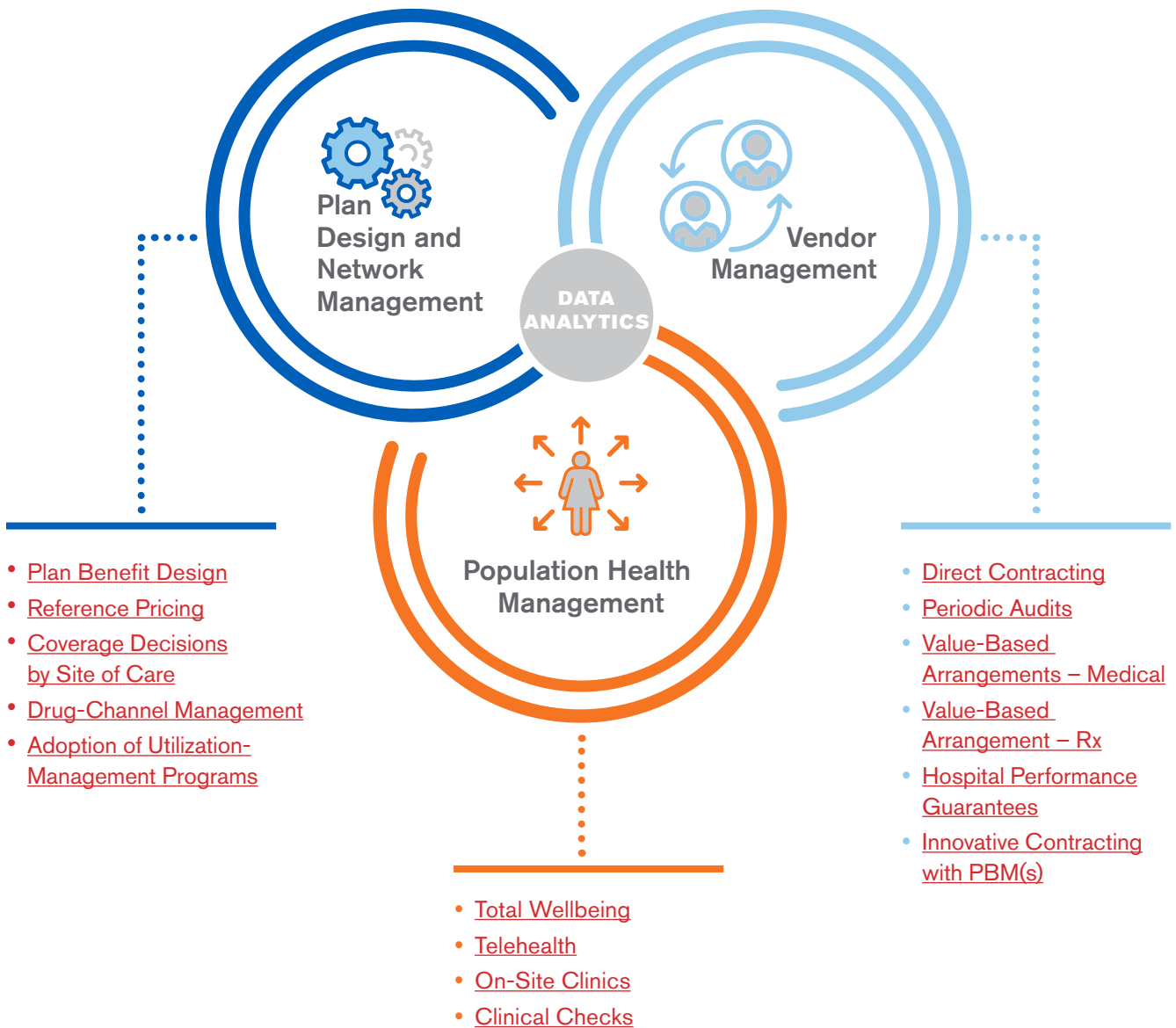


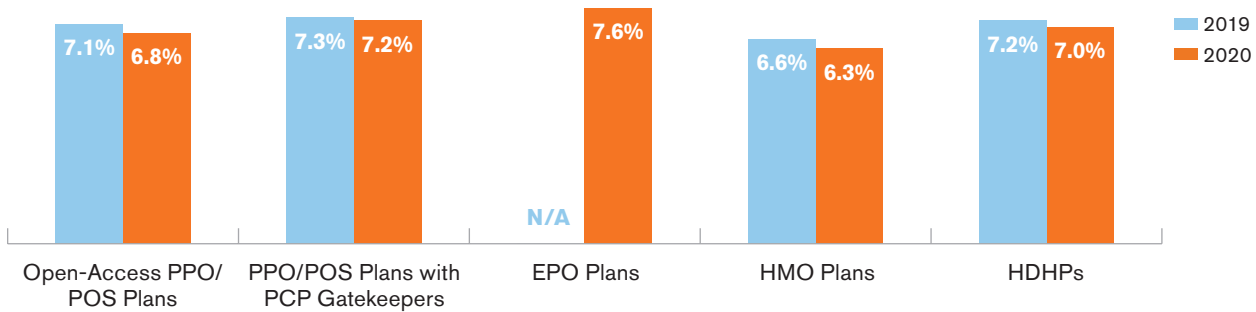
Table of Contents

- 2020 Projected Medical Plan Trends Slightly Lower than 2019 Projections [4](#)
 - Medical Plans Explained [4](#)
- Leading Drivers of Medical Trend [5](#)
- Projected Trend for Specialty Rx Is Double the Rate of Trend for Outpatient Rx [6](#)
 - Specialty Rx, Outpatient Rx and Rx Rebates Explained [7](#)
- Both Price *and* Utilization Increases Are Driving Specialty Rx Trend [8](#)
- Projected Dental Trends Similar to Last Year [9](#)
- Projected Vision Trends Expected to Decrease Slightly or Stay the Same for 2020 [9](#)
- Disparate Trend Projections for Medicare-Eligible Retirees [10](#)
- Keep in Mind: Projected Trends Are Typically Higher than Actual Trends [11](#)
- Historical Survey Data on Selected Medical, Outpatient Rx and Dental Trends Shows Dramatic Changes [12](#)
- Health Plan Trend Rates Still Outpace Increases in Consumer Prices and Wages..... [13](#)
- The Top Cost-Management Strategies Have Changed [14](#)
- Pharmacy Benefit Cost Management and PBM Contracting Strategies..... [15](#)
- Medical Cost Management and Contracting Strategies [17](#)
 - How Value-Based Arrangements Compensate Providers [17](#)
 - How Plan Sponsors Are Addressing Health Behaviors [19](#)
- Looking Ahead: Dynamics Driving Change in Health and Benefits [20](#)
 - Gene Therapy..... [21](#)
 - Two Health Care Disruptors [22](#)
- Health Plan Sponsors Must Stay Vigilant and Proactive on Multiple Fronts [23](#)

2020 Projected Medical Plan Trends Slightly Lower than 2019 Projections

The graph below illustrates our findings about medical plan trends.

Medical Trends Projections* for 2020 Are Similar Across All Plan Types



* Projections are for actives and early retirees and exclude Rx.

Source: Sibson Consulting, 2019

Medical Plans Explained

The survey collected trend projections for four categories of active and early retiree coverage that we have tracked for many years:



Open-access preferred provider organization (PPO)/point-of-service (POS) plans



PPO/POS plans with primary care physician (PCP) gatekeepers



Health maintenance organization (HMO) plans



High-deductible health plans (HDHPs) that meet minimum Internal Revenue Service amounts to qualify for health savings accounts (HSAs)

In addition, for the first time, the survey requested trend projections for exclusive provider organization (EPO) plans. An EPO plan is a hybrid of an HMO plan and a PPO plan. Similar to an HMO plan, if a participant seeks out-of-network care, generally there is no coverage (except in an emergency). EPO plans do not require referrals to specialists, similar to PPO plans. However, EPO networks are narrower.

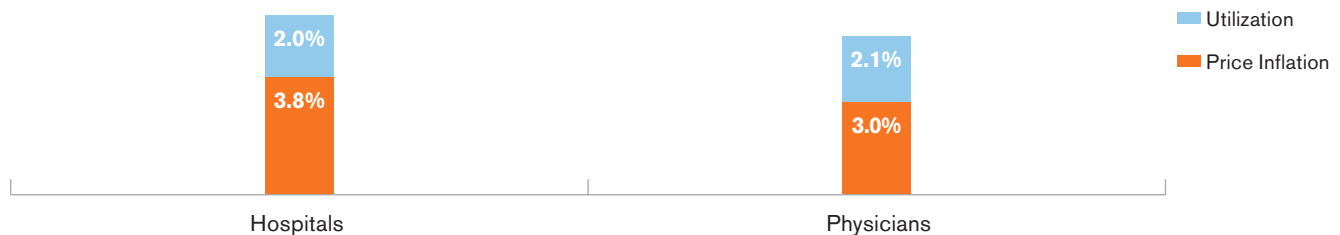
Leading Drivers of Medical Trend

The survey examined components of trend and found:

- The leading driver of trend increases for 2020 is price inflation of goods and services, not the utilization of services, which is consistent with more than a decade of our survey results.
- For hospitals, price inflation is forecast to increase by nearly two times the rate of utilization of services.

Although forecasters predict a modest increase in utilization of hospital and physician services, Sibson's analysis of the claims experience of large plan sponsors indicates a substantial number of plan sponsors are seeing flat or declining utilization rates for these services.¹

Price Inflation is the Largest Component of 2020 Projected Medical Trends*



* Hospital and physician trends are for open-access PPOs for actives and retirees under age 65. The components do not add up to totals because there are other components of trend not illustrated, reflecting such factors as the impact of cost shifting and technology changes. Not all survey respondents provided a breakdown of trend by component.

Source: Sibson Consulting, 2019

Another factor influencing trends is the network-negotiated reimbursement rates paid to providers. Changes in provider reimbursement rates are the result of negotiations between provider groups and health care systems. This often varies by type of service, as illustrated below. Reimbursement rates are projected to be higher for hospital networks than for physicians.

Projected Average Increases in Reimbursement Allowances Highest for Hospitals



* The projected average increase in reimbursement allowance for hospital/facility differs from the price inflation increase of 3.8 percent in the bar graph above because the price inflation increase takes into account new treatments, therapies and technology.

Source: Sibson Consulting, 2019

¹ This analysis is based on data from SHAPE (Segal Health Analysis of Plan Experience), Segal's data warehouse.

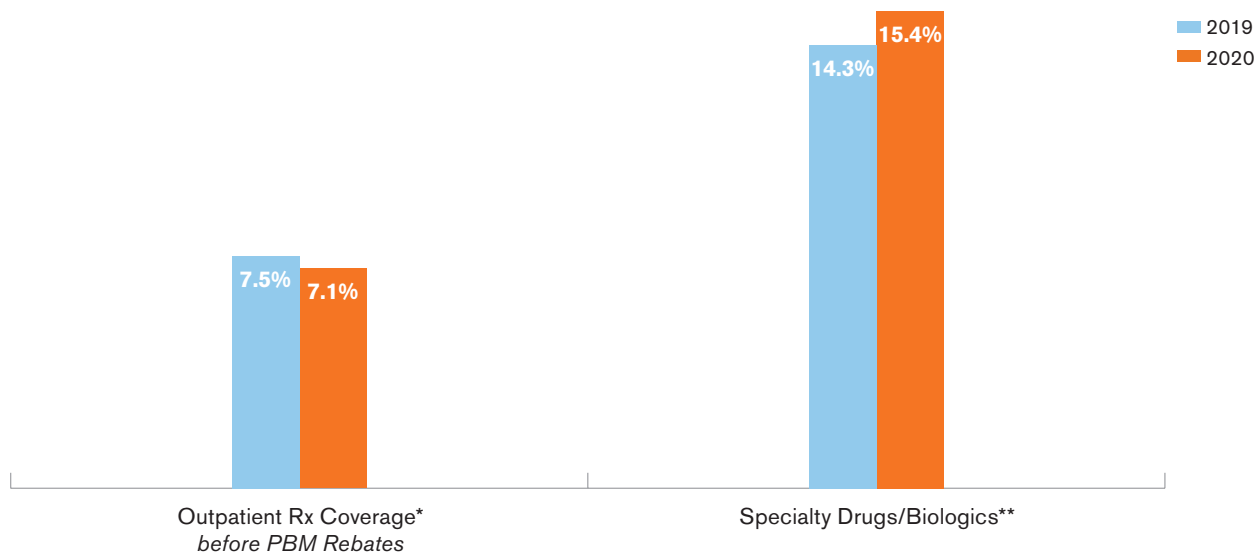
Projected Trend for Specialty Rx Is Double the Rate of Trend for Outpatient Rx

For 2020, cost trend projections for outpatient Rx plans (non-specialty and specialty drugs combined) are projected to be lower than 2019 projections. However, projected trend for specialty drugs will increase by more than 15 percent — more than double the projection for outpatient Rx coverage.

That pattern is cause for concern because while specialty drugs only represent 2.2 percent of all Rx claims,² for some plan sponsors, they account for 50 percent of total Rx spending.³

Factors driving specialty drug trend include price increases of existing specialty drugs, the high cost of new specialty drugs being introduced that are replacing lower-cost therapies, and the slow introduction of biosimilars⁴ into the marketplace. The slow adoption rates for biosimilar drugs are driven by several factors, including physician resistance, anti-competitive tactics taken by drug manufacturers and restrictive distribution contracts that limit supply chain options. Such issues create unique barriers that limit normal market competition forces that could help lower overall prices of specialty drugs.

Outpatient Prescription Drug Trends Projected to Be Less Severe, Even as the Trend for Specialty Drugs Is Projected to Accelerate



* Outpatient Rx trend is for all prescription drugs (non-specialty and specialty drugs combined) for employer sponsored plans for actives and retirees under age 65.

** Specialty drug/biologics trend is for outpatient specialty coverage. This data is for all coverage of specialty drugs for participants of all ages.

Source: Sibson Consulting, 2019

² IQVIA. "Medicine Use and Spending in the U.S.: A Review of 2017 and Outlook to 2022." *Institute Report*. April 19, 2018.

³ Prime Therapeutics, "The Inevitable Increase in Specialty Growth." *Prime Insights*. November 14, 2017.

⁴ A biosimilar is a biologic that is "similar" to another biologic medication (commonly known as the reference or innovator product), which is already licensed by the FDA. Biologic drugs are derived from living organisms and are significantly more challenging to develop and manufacture, resulting in their higher cost.

Rebates account for a substantial portion of the drug price equation. For those survey participants that reported prescription drug trend gross and net of rebates, the average impact of rebates was a 1.5 percent reduction in Rx trend. The presence and magnitude of drug rebates on brand-name drugs have become a major element of pharmacy benefit contracting for most plan sponsors. They are a substantial source of plan cost savings, as plan sponsors demand 100 percent pass back of all manufacturer rebates, which are typically used to offset claim costs.

Specialty Rx, Outpatient Rx and Rx Rebates Explained

Specialty drugs are generally high-cost drugs or those that require special handling. Trend results captured in the study only include outpatient specialty drugs. Outpatient Rx plans are typically administered by PBMs and represent brand-name drugs, generics, biosimilars and specialty drugs dispensed through retail, mail order and specialty management channels. Drugs administered in an inpatient facility or physician office setting are excluded because they are covered by a medical benefit program.

Rebates are payments made by drug manufacturers to PBMs and/or health plan sponsors for utilization of certain brand-name drugs. Most PBMs pass through all or a portion of Rx rebates to health plan sponsors.

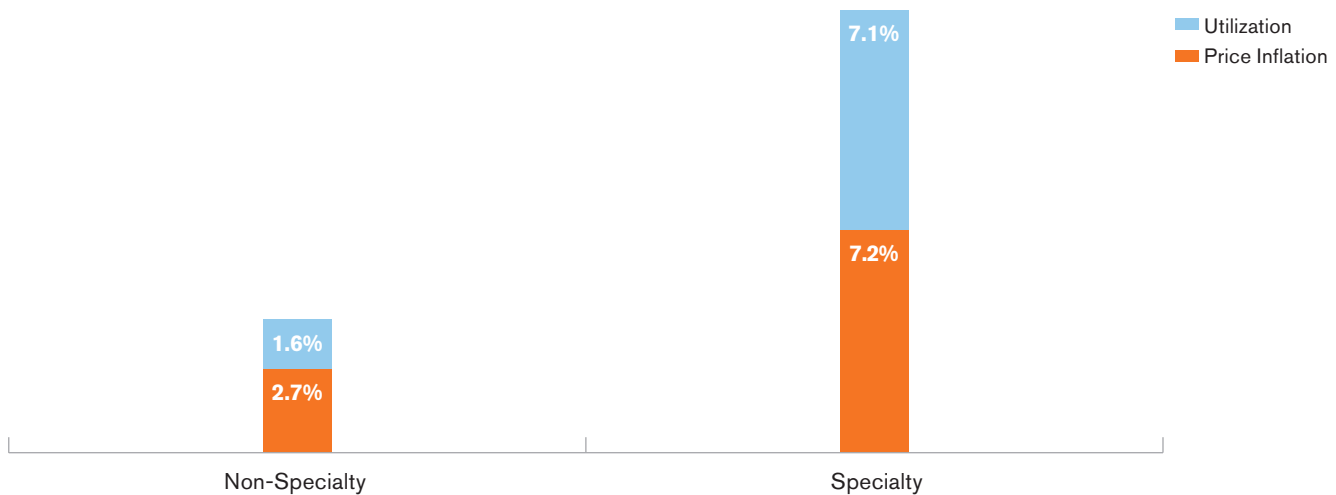


Both Price *and* Utilization Increases Are Driving Specialty Rx Trend

Similar to medical trend, the leading driver of outpatient Rx trend is also price inflation with specialty Rx being a major factor. Price inflation and utilization are almost equal components of the projected trend for specialty Rx trend.

According to a study by the journal *Health Affairs*, the rising cost of brand-name drugs is attributable to existing drug price inflation, whereas the rising cost of generics and specialty drugs are driven mostly by new products into the marketplace.⁵ Offsetting the impact of the rising cost of brand-name drugs will be the number of brands with an expiring patent. The IQVIA Institute for Human Data Science predicts the impact of patent expiration will increase steadily over the next five years and peak in 2023, resulting in lower spending on brand-name drugs.⁶

Price Inflation Is the Leading Driver of Rx Trend with Specialty Rx a Major Factor*



* The components do not add up to totals because there are other components of trend not illustrated, reflecting such factors as the impact of cost shifting, technology changes and drug mix. Not all survey respondents provided a breakdown of trend by component, which may produce results that vary from the overall Rx plan cost survey results found on page 6.

Source: Sibson Consulting, 2019

⁵ Inmaculada Hernandez, Chester B. Good, David M. Cutler, Walid F. Gellad, Natasha Parekh and William H. Shrank, "[The Contribution of New Product Entry Versus Existing Product Inflation in The Rising Costs of Drugs.](#)" *Health Affairs*. January 2019.

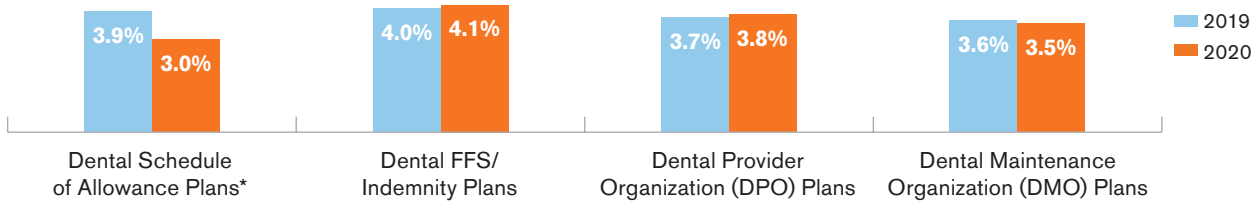
⁶ IQVIA, "[Medicine Use and Spending in the U.S.: A Review of 2017 and Outlook to 2022.](#)" *Institute Report*. April 19, 2018.

Projected Dental Trends Similar to Last Year

Projected trends for dental coverage are expected to be similar for 2020 for most plans except for dental fee-for-service (FFS)/indemnity plans.

Dental coverage, which has remained relatively unchanged for decades, is one of the most used and valued benefits. As a result of plan participant interest and changes in dentistry, opportunities exist for plan sponsors to improve, modernize and communicate their dental benefits. For example, coverage of dental implants is becoming more common.

Trend Projections for Most Dental Coverage Similar for 2020



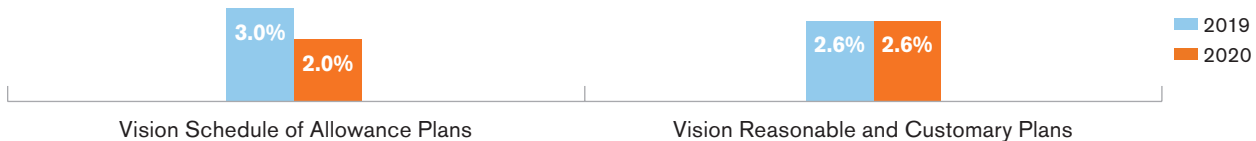
* A schedule of allowance plan is a plan with a list of covered services with a fixed-dollar amount that represents the total obligation of the plan with respect to payment for services, but does not necessarily represent the provider's entire fee for the service.

Source: Sibson Consulting, 2019

Projected Vision Trends Expected to Decrease Slightly or Stay the Same for 2020

Vision is a benefit that can improve the overall health of plan participants. Increasingly, plan sponsors are emphasizing wellness including adherence to diabetes eye exams. Identification of emerging chronic conditions such as diabetes, hypertension and cardiovascular disease are often detected through vision exams, particularly for participants who forgo routine or preventive medical services. Plan sponsors should reevaluate their vision offering and communicate the value of this benefit to their participants.

Trend Projections for Vision Schedule Plans Lower for 2020



Source: Sibson Consulting, 2019

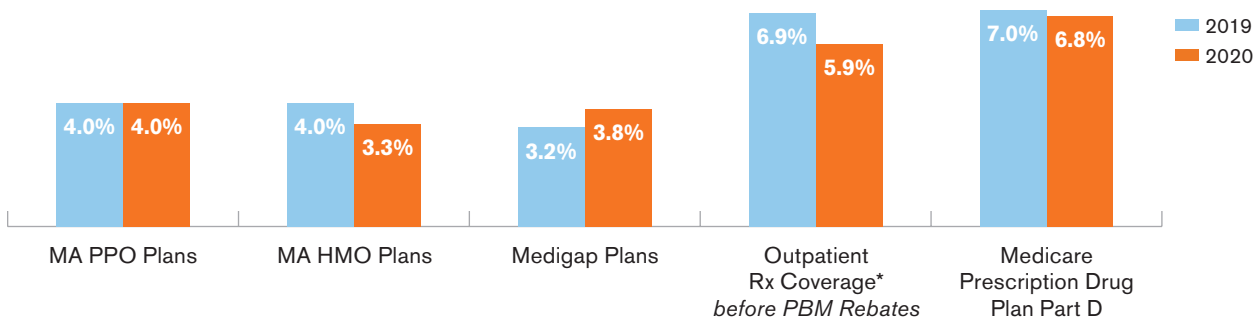
Disparate Trend Projections for Medicare-Eligible Retirees

Medicare-eligible retirees generally fall into one of three categories, each of which show unique cost trends: Medicare Advantage (MA) PPO plans; MA HMO plans; and Medicare supplemental coverage known as Medigap. The trend projections for each of these groups are considerably lower than trends for active and early retirees. Among other things, the survey found:

- No change in trend is projected for Medicare Advantage (MA) PPO plans.
- Projected trend for MA HMO plans will decrease for 2020.
- In contrast, medical trend for unmanaged Medicare supplemental coverage is projected to increase in 2020.

The projections for MA plans are good news given the growing participation and popularity of that coverage. Enrollment in MA plans has doubled over the past decade, with 34 percent of Medicare beneficiaries enrolled in 2019, according to the Kaiser Family Foundation.⁷ As thousands of baby boomers reach age 65 every day, the risk of the population is healthier. Additionally, as the number of retirees grows along with their participation in MA plans, more providers are offering MA plans.⁸ To differentiate themselves from the incumbents, expect providers to leverage technology, lower costs and provide more benefits. We expect enrollment in MA plans to continue to increase because those plans have shown to deliver savings while providing additional services, such as initiatives that promote wellness. Consequently, this market will become more competitive in the coming years.

Projected Trends for Medicare-Eligible Retirees Steady, Lower or Higher, Depending on Coverage



* Outpatient Rx trend is for all prescription drugs (non-specialty and specialty drugs combined). See page 6 for specialty drug trend projections.

Source: Sibson Consulting, 2019

⁷ Gretchen Jacobson, Meredith Freed, Anthony Damico and Tricia Neuman, "A Dozen Facts About Medicare Advantage in 2019." Kaiser Family Foundation. June 6, 2019.

⁸ CB Information Services, "A Simple Guide To Medicare Advantage And Why It's Taking Off Now." CB Insights. January 3, 2019.

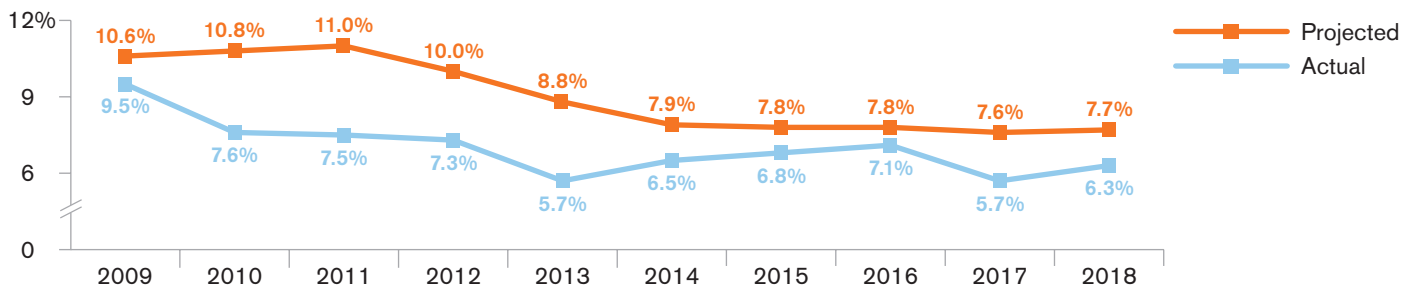
Keep in Mind: Projected Trends Are Typically Higher than Actual Trends

To assess the accuracy of trend projections, Sibson compared 2018 *projected* trends for medical, Rx and dental plans to the *actual* average trends for 2018 (the most recent full year for which actual data is available), as reported by the survey respondents. The graphs below illustrate comparative data from our last ten surveys for three types of coverage for actives and retirees under age 65.

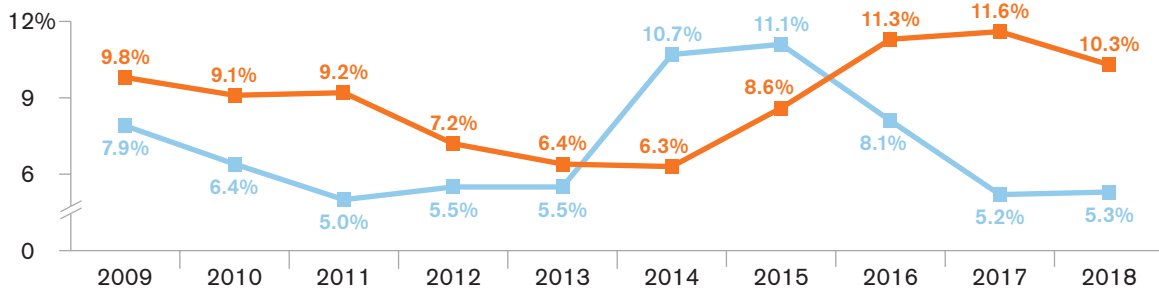
Some respondents forecasted trends to be several multiples of actual trend rates experienced for the same year. These conservative forecasts are particularly pronounced for Rx plans. For example, projected trend for 2018 was nearly double the actual trend for that year.

The accuracy of projections is subject to both underwriter's conservatism in predicting future events and a natural lag in the underwriting cycle. In periods where costs are decelerating, forecasters will tend to overestimate trends. Similarly, when costs are accelerating, trend projections will generally be underestimated for a period. This was evident in 2014 and 2015 when Rx trend forecasts were understated significantly, primarily due to the unforeseen high cost of drugs for treatment of Hepatitis C and significant spending on compound medications. **When considering trend projections, plan sponsors should take into account this historical pattern of projected trend to actual trends over multiple years.**

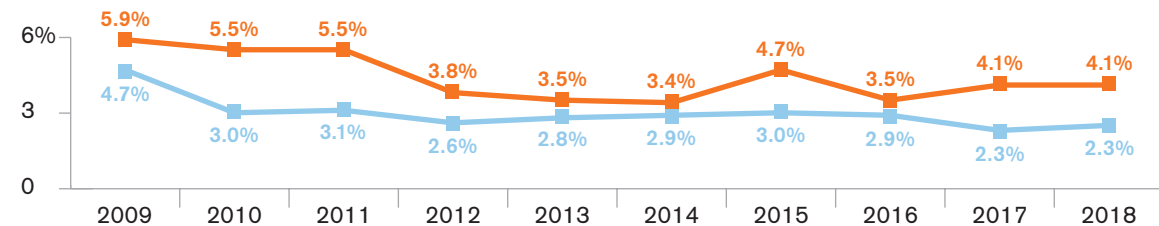
For Open-Access PPOs/POS Plans, Gap Between Projected and Actual Trends Narrows*



Projected Rx Trend Continues to Far Exceed Actual Trend**



Still a Significant Difference Between Projected and Actual Trends for Dental PPO Plans



* All medical trend results exclude Rx.

** This data reflects outpatient Rx trend for all prescription drugs (non-specialty and specialty drugs combined). These results do not include the impact of rebates from PBMs.

Source: Sibson Consulting, 2019

Historical Survey Data on Selected Medical, Outpatient Rx and Dental Trends Shows Dramatic Changes

Although projected Rx trends far outpace medical and dental trends, the gaps have generally been less dramatic for actual trends, as shown in the table below that presents data for the last 15 years. Trends are leveling off for medical and prescription drug plans. We expect this pattern to continue as plan sponsors fine-tune their cost-containment efforts.

Selected Medical,¹ Outpatient Rx² and Dental Trends: 2006–2018 Actual and 2019 and 2020 Projected³

	Year	Open-Access PPOs/POS Plans	PPOs/POS Plans with PCP Gatekeepers	HMOs	MA HMOs	Outpatient Rx	DPOs
Actual	2006	9.6%	10.0%	10.2%	7.2%	9.5%	5.1%
	2007	8.9%	9.5%	9.8%	7.0%	7.9%	5.0%
	2008	9.7%	9.4%	9.7%	7.7%	7.4%	5.5%
	2009	9.5%	9.7%	10.2%	4.0%	7.9%	4.7%
	2010	7.6%	8.3%	8.7%	3.6%	6.4%	3.0%
	2011	7.5%	7.8%	8.0%	4.5%	5.0%	3.1%
	2012	7.3%	8.4%	6.7%	3.0%	5.5%	2.6%
	2013	5.7%	6.7%	6.1%	3.1%	5.5%	2.8%
	2014	6.5%	7.6%	6.3%	1.9%	10.7%	2.9%
	2015	6.8%	6.9%	6.4%	4.2%	11.1%	3.0%
	2016	7.1%	7.4%	6.3%	5.3%	8.1%	2.9%
	2017	5.7%	5.8%	6.6%	1.8%	5.2%	2.3%
	2018	6.3%	6.1%	6.0%	4.1%	5.3%	2.5%
	Projected	2019	7.1%	7.3%	6.6%	4.0%	7.5%
2020		6.8%	7.2%	6.3%	3.3%	7.1%	3.8%

¹ Medical trends exclude prescription drug coverage.

² Prescription drug trend data for 2006–2007 only reflects retail. Data for 2008–2020 is for all prescription drugs (non-specialty and specialty combined). These results do not include the impact of rebates from PBMs.

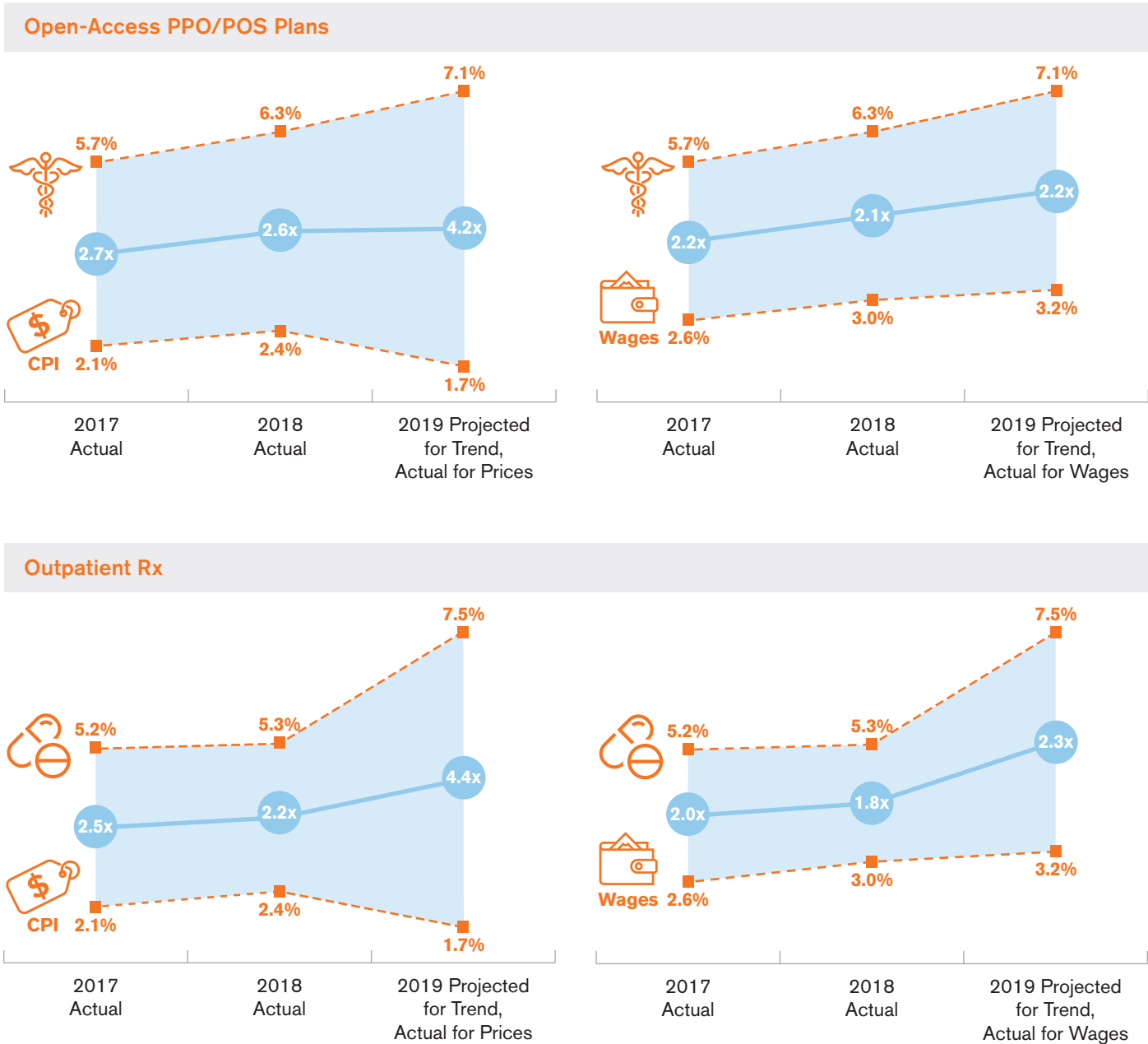
³ All trends are illustrated for actives and retirees under age 65, except for the MA HMOs. (Graphs comparing 15 years of survey data — 2006 through 2018 actual trends and 2019 and 2020 projected trends — and showing average actual annual trend by coverage type for the last five years are available [upon request](#).)

Source: Sibson Consulting, 2019

Health Plan Trend Rates Still Outpace Increases in Consumer Prices and Wages

PPO/POS plan costs continue to outpace overall inflation and wage growth by a factor of more than two. The higher the increase in health care cost trends, the harder it is for plan sponsors to contribute towards wage increases. Plan sponsors that actively manage their health plans and maintain low-cost increases are able to allocate more budget towards wages for their participants.

Comparison of Two Trend Rates to Price and Wage Increases



Sources: Sibson Consulting, 2019 (trend rates), Bureau of Labor Statistics Consumer Price Index for All Urban Consumers (CPI-U) from [Consumer Price Index – July 2019](#) and Bureau of Labor Statistics wage increases through July 2019 from [Table B-3. Average hourly earnings of all employees on private nonfarm payrolls, seasonally adjusted.](#)

Top Health Plan Cost-Management Strategies Have Changed

Plan sponsors continue to use various cost-management strategies to help mitigate increasing health plan costs. We asked survey participants to rank the cost-management strategies being utilized by group health plans in 2019. The chart below compares the top five strategies being used today to last year's ranking.

The use of transparency tools is at the top of the list for 2019. The White House issued an executive order to improve price and quality transparency of some health care services.⁹ This included a proposal that hospitals disclose their negotiated rates in a readable, consumer-friendly format. The need for consumer access to price and quality transparency to make better decisions about providers and services is still an ongoing concern for many plan sponsors and other consumers of healthcare. *The Wall Street Journal* recently reported that anti-competitive contracting between insurers and hospitals can drive higher spending. The article reported that some hospitals demand they be included in every plan, discourage use of lower-cost health provider rivals, mask prices from consumers, limit audits of claims, add extra fees and block efforts to exclude health care providers based on quality or cost.¹⁰

As participant consumerism of health care services continues to expand, accurate quality metrics and pricing data will help participants make smart health care choices. That said, even the best tools may have had mixed results driving behavior without proper communications, training and engagement. One study found offering enrollees access to a price transparency tool did not result in lower health care spending. Instead some plan sponsors see better results with health care advocacy and concierge service programs. Many of these programs offer more personalized services and leverage technology to help participants navigate their benefits and the health care delivery system to determine the right course of treatment, understand care options and identify high-quality, lower-cost providers. Plan sponsors considering health advocacy and concierge service programs should evaluate vendor service offerings, how they integrate with existing programs, analyze projected savings and explore vendor performance guarantees.

Use of Health Care Transparency Tools is the Most Used Strategy

2019 Top Five

2019 Top Five	2018 Top Five
1 Health care transparency tools	1 Specialty pharmacy management tools or techniques
2 Rx management for non-specialty drugs	2 Pharmacy management program
3 Rx management for specialty drugs	3 Lower-cost primary care access*
4 Telehealth/virtual care	4 Value-based contracting**
5 Value-based contracting	5 Opioid abuse prevention management

* Strategies include telemedicine, walk-in clinics and on-site clinics.

** These include accountable care organizations (ACOs), which are networks of providers and suppliers that agree to be jointly accountable for managing the health and cost of a defined group of participants across a predetermined set of health care services, and Patient-Centered Medical Homes (PCMHs), which focus an increased level of comprehensive health care resources on primary care and prevention for patients with chronic conditions.

Source: Sibson Consulting, 2018 & 2019

⁹ [Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First](#), whitehouse.gov. June 24, 2019

¹⁰ Anna Wilde Mathews, ["Behind Your Rising Health-Care Bills: Secret Hospital Deals That Squelch Competition."](#) *The Wall Street Journal*. September 19, 2018.

Pharmacy Benefit Cost Management and PBM Contracting Strategies

As noted on the previous page, both specialty and non-specialty Rx management made this year's top-five health plan cost-management list. Plan sponsors can use a variety of techniques to reduce these prescription drug costs, such as:

- **Innovative Contracting with Pharmacy Benefit Managers (PBMs)** — Holding PBMs contractually accountable to control costs is an effective Rx cost-management strategy. Contract terms could include unique specialty drug pricing guarantees, performance-based rebates, direct contracting with regional specialty pharmacies and adoption of value-based formularies.
- **Expanding Clinical Checks** — Amending plan terms to include clinical safeguards may prove to be an effective cost-management tool. The safeguards can include step therapy, targeted prior authorization for high-cost services and quantity-duration limits based on Food and Drug Administration (FDA) guidelines.
- **Plan Benefit Design** — Plan sponsors are using benefit design to increase the use of generics and lower-cost, brand-name drugs to help manage increases in Rx drug costs. Percentage copayments with out-of-pocket maximums continue to drive competition among therapy classes. Tiered designs, which place clinically effective, lower-cost drugs into lower tiers at lower cost sharing, also increasing in popularity by plan sponsors. In 2018, the Pharmacy Benefit Management Institute reported that 59 percent of those surveyed had a separate cost-sharing tier for specialty drugs.¹¹ A growing number of plan sponsors charging Rx coinsurance offer point-of-sale rebates that lower participants' out-of-pocket expenses. Self-insured plans gain a more favorable rebate cash flow because a portion of the rebate is paid to the employer when the drug is dispensed. However, these arrangements will sometimes increase plan sponsor costs if the PBMs charge for the time value of the rebate. Self-insured and insured plans also see a cost increase when the rebates are shared with the participant.
- **Auditing** — Plan sponsors should conduct periodic audits of their PBMs and carefully evaluate drug classification against contract terms and pricing guarantees. Some PBMs continue to apply complicated pricing re-classifications that can increase plan sponsor costs.
- **Drug-Channel Management** — Plan sponsors should assess whether the medical plan or pharmacy plan is the best purchasing channel for medications. A strategy that excludes certain drugs from coverage under one or the other may save the plan money. For instance, some pharmacy benefit plans cover all oral and self-injectable specialty medications, while chemotherapy is best covered by the medical benefit. Another strategy is to renegotiate pricing terms on specialty drugs administered under the medical benefit, leveraging the pharmacy benefit arrangement. Among other things, plan sponsors can use data analytics to model which channel will provide the better pricing for certain drugs.

¹¹ Pharmacy Benefit Management Institute, *2019 Trends in Specialty Drug Benefits*. 2019.

- **Site of Care** — Because some specialty drugs require administration by a health care professional, it may be important to confirm that participants are using the most cost-effective and high-quality health care facility. For instance, hospital outpatient settings are widely recognized as expensive settings for injectable products. For this reason, it may be important to direct patients to more convenient and less costly sites of care, such as doctor's offices or labs.
- **Promotion of Biosimilars** — Greater use of biosimilars (the alternative to costlier biologic drugs, which are generally injected) presents an opportunity to reduce Rx spending. While current awareness and utilization is low, there is growing interest in and access to these emerging drugs. Plan sponsors can ask their PBMs to promote biosimilars through communication of education about drug options with plan participants and providers. Plan design and step-therapy rules can also promote biosimilar use over higher-cost biologic drugs. Plan sponsors should review contract terms with their PBMs to ensure terms are competitive for these emerging drug therapies.
- **Value-Based Pricing** — As plans pay more for the cost of expensive drug therapies, there is a movement by PBMs to offer outcome-based or value-based contracts as a method of controlling costs for specialty drugs. Outcome-based contracts offer plan sponsors rebates and discounts tied to specified health outcomes. For example, oncology medications are typically approved to treat multiple types of cancer and the costs may not be justified given the low success rate for specific cancers. Outcome metrics that can tie a portion of reimbursement to clinical outcomes will help avoid use of less effective drugs. Plan sponsors can negotiate with their PBMs to include performance- or outcome-based guarantees in their contracts.



Medical Cost Management and Contracting Strategies

For medical plans, value-based contracting made this year's top five health plan cost-management list. These arrangements provide cost-saving alternatives to fee-for-service care by rewarding for quality and efficiency of care. Other key strategies for plan sponsors to consider in 2020 include the following:

- **Value-Based Arrangements** — Prices have increased significantly in many markets and there is a lot of pricing variation. A recent RAND report shows that in some states the price in inpatient and outpatient facilities can vary from 300 percent to 700 percent of Medicare.¹² Plan sponsors are increasingly considering cost-saving alternatives through value-based arrangements. In contrast to a fee-for-service approach, value-based models reward physicians and providers for helping participants improve their health. Benefits include better outcomes through earlier intervention and higher quality, which result in a reduction in the total cost of care over fee-for-service arrangements.
- **Bundle Payment Arrangement** — In the shift away from fee-for-service payments to value-based reimbursement, one of the fastest-growing payment models is compensation for episodes of care. An episode of care covers all the services a patient received in the course of treatment over a specific period of care (e.g., 30 days, 60 days). Under bundled payment arrangement, a single negotiated payment is made to a provider for an episode of care. That gives providers an incentive to eliminate unnecessary services, improve coordination of care and achieve better outcomes. Plan sponsors can implement episodes of care contracts using several models. One is to use a Center of Excellence with a single facility. Another is to create a network strategy with multiple facilities and physician groups that encourages providers to continuously improve the outcome of care for the episode they deliver.
- **Site of Care** — One option is to steer participants to custom or narrow networks that have lower-cost options for procedures that can be performed in alternative sites of care. For example, Ambulatory Surgery Centers (ASCs) offer a high-quality, low-cost option for many hospital-based surgical procedures. Surgeries performed at ASCs offer significant benefits over surgeries performed in hospital inpatient settings. Plan sponsors and consumers save an estimated \$37.8 billion annually by using ASCs.¹³ Also, the average infection rates for ASCs are one per 1,000, compared to 20 per 1,000 at hospital facilities nationally and procedures performed at ASCs take 31.8 fewer minutes, on average, than those performed at hospitals, according to a study conducted by *Health Affairs*.¹⁴ Other site-of-care steerage options include outpatient radiology, lab, pathology and some specialty medications. Steering participants to lower-cost, high-quality networks through plan incentives or communications could achieve cost savings and improved outcomes for plan sponsors, participants and dependents.

¹² Chapin White and Christopher Whaley, "[Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely](#)," RAND. 2019.

¹³ Ambulatory Surgery Center Association (ASCA), Healthcare Bluebook and HealthSmart, "[Commercial Insurance Cost Savings in Ambulatory Surgery Centers](#)." 2016.

¹⁴ Elizabeth L. Munnich and Stephen T. Parente, "[Procedures Take Less Time at Ambulatory Surgery Centers, Keeping Costs Down And Ability to Meet Demand Up](#)," *Health Affairs*. May 2014.

How Value-Based Arrangements Compensate Providers

These are examples of reimbursement approaches:

- **Global Capitation** — Fixed payment is made to an entity that is responsible for providing all of the services that their patients need or may use. This can include including not only primary physician and specialty care, but also hospital care, prescription drugs, and other services.
- **Shared Savings** — In this arrangement, providers keep a meaningful share of savings that arise if they are able to limit expenditures.
- **Bundled Payments** — These are lump-sum payments made for an episode of care which do not vary based on the number of services actually provided (as discussed further in the adjacent "Bundled Payment Arrangement" bullet).
- **Reference Pricing** — In this defined contribution approach, a fixed amount is established for the cost of procedures, and participants pay the price difference when selecting services that are higher than the referenced price.
- **Pay-for-Performance** — Payment increases for doctors and hospitals are linked to measures of their quality and efficiency.

- **Reference Pricing** — Hospital consolidation and the lack of price and quality transparency does not provide incentive to change the system and hold providers accountable. To create a more efficient system, consumers must be more actively engaged in the decision making process. Plan sponsors can use Medicare or a best-in-class network facility price as a reference to set plan reimbursement. They are also considering benefit carve-outs, with specific services in a narrow or custom network with a reference pricing benefit design.
- **Direct Contracting** — To achieve deeper discounts, a growing number of plan sponsors are contracting directly with hospitals, clinics and other specialized providers, such as centers of excellence. In addition to medical coverage, some plan sponsors are also negotiating direct-contracting pricing of Rx.
- **Telehealth** — Telehealth, including virtual care, a more focused strategy on high-cost claims, has been growing rapidly in the past few years as an option for plans to improve access to care and offer lower-cost alternatives for patients seeking care for acute conditions that are not emergencies. One development that has received a lot of attention recently is the expansion of telehealth to support mental health. According to the National Health and Nutrition Examination Survey, 80 percent of adults with depression reported at least some difficulty with work, home and social activities due to their depression.¹⁵ Major depression is a common and treatable mental disorder. Fifty-six percent of plan sponsors will begin offering tele-behavioral health services in 2018 as a solution (more than double from the prior year).¹⁶ This platform offers an online alternative to the traditional face-to-face office appointment and is expected to become more common. Tele-behavioral health can help improve access to care by offering a larger pool of therapists in a geographic region than may otherwise be available (especially in rural areas).
- **On-site Clinics** — More than half (56 percent) of large employers have at least one on-site clinic.¹⁷ Plan sponsors are implementing on-site clinics as a way to provide a true Patient-Centered Medical Home to their participants. The clinics can provide preventive/primary services, disease management, health risk assessments and on-site pharmacy. When designed and incented correctly, plan-sponsored clinics can help the plan gain better control of primary care, help direct care to quality providers and can work very well as a wellness hub. This strategy moves a portion of care away from the fee-for-service reimbursement arrangements, which can be inflationary. Plan sponsors should conduct a feasibility study, revise the plan design to give participants a financial incentive to use the clinic and set up performance guarantees if they are interested in setting up an on-site clinic.
- **Total Wellbeing** — Plan sponsors continue to focus on strategies that keep people healthy and engaged. Increasingly, plan sponsors are recognizing that being truly healthy extends beyond physical activity and optimal nutrition. Some plan sponsors are taking a broader view of wellness to encompass total wellbeing, including support of challenges, such as stress relief, family caregiver financial insecurity and mental health challenges.

¹⁵ Debra J. Brody, M.P.H., Laura A. Pratt, Ph.D. and Jeffrey P. Hughes, M.P.H., "[Prevalence of Depression Among Adults Aged 20 and Older: United States, 2013-2016](#)." NCHS Data Brief. Centers for Disease Control and Prevention. February 2018.

¹⁶ National Business Group on Health (NGBH), "[2018 Trends to Watch](#)." Accessed August 8, 2019. (Telehealth is not one of the NGBH's 2019 Trends to Watch.)

¹⁷ National Business Group on Health, [The Large Employers' Health Care Strategy and Plan Design Survey](#). 2019.

Plan sponsors should keep in mind that carefully crafted, custom communications can play an important role in ensuring the success of cost-management strategies. The case studies below describe how two plan sponsors made the most of their communications about health benefits and, as a result, were able to successfully manage their health costs.



How Plan Sponsors Are Addressing Health Behaviors

Plan sponsors are investing a lot of energy in educating participants and their families about how to use transparency and decision-support tools and engage appropriately with the health care system. Two case studies illustrate successful efforts to change health behaviors:

1

A large university system partnered with its medical plan to provide a suite of consumer-friendly tools via mobile devices: a price transparency app, a health plan participant dashboard and a prescription drug app. Knowing that it would be difficult to get participants and their family members to use the tool, the university launched a campaign with a time-sensitive contest. The “Get Connected” campaign asked people to download and sign up for the three apps. The reward was entry into a contest for a free trip. With robust multi-channel promotion, about 40 percent of participants got connected, creating a foundation for ongoing engagement with the health tools.




2

A prominent high-tech company that had recently launched a near-site clinic, telemedicine and a health care concierge wanted to help participants and their families access all of these providers and get to the right type of care at the right time. A multi-channel campaign called “Your Health Care Game Plan” promoted the various resources and helped employees choose where to go for different scenarios. The information was presented in an infographic and online content, including how to differentiate between the near-site clinic, urgent care and the emergency room. The result of a campaign was a significant decrease in emergency room use and an increase in visits to the near-site clinic and telemedicine.

The keys to success with these efforts? Strategic communication with simple and fun messages.

Looking Ahead: Dynamics Driving Change in Health and Benefits

Plan sponsors should watch for these dynamics driving change in health benefits plans in 2020 and beyond.

 <p>Emerging technologies to assist in diagnosis & treatment</p>	 <p>18% GDP Almost \$4 trillion (attracts private equity investors)</p>	 <p>Declining health: rise in chronic conditions and increase in obesity</p>	 <p>The Opioid Epidemic continues to present treatment challenges</p>
 <p>Enhanced behavioral health benefits may help moderate medical cost trends</p>	 <p>Vast array of "point solutions"</p>	 <p>New delivery models (Amazon, Berkshire Hathaway & JP Morgan joint venture called Haven)</p>	 <p>Health insurer/ PBM consolidations</p>
 <p>Increased participant out-of-pocket costs — affordability crisis</p>	 <p>Digital health continues to expand to improve treatment and benefit navigation</p>	 <p>Hospital/physician group vertical & horizontal mergers</p>	 <p>Increased pressure from regulators</p>

These marketplace influences have direct and indirect implications for future health plan spending. Plan sponsors should be aware of significant dynamics as they develop strategies to address health plan cost increases and seek greater value from their benefit programs.

- Hospital Consolidation** — Hospital care is the largest single component of health care spending in the U.S., accounting for more than \$1 trillion annually.¹⁸ Hospital consolidations also drive health care cost increases. According to an analysis of hospital mergers in 25 metropolitan areas, the overall price of a hospital stay increased as much as 54 percent after the mergers.¹⁹ This result isn't a surprise. Mergers typically result in less market competition, leading to higher prices. To mitigate this financial impact, plan sponsors should consider how they select and design their hospital networks, including using centers of excellence and higher-value facilities.

¹⁸ Centers for Medicare & Medicaid Services, "[National Health Expenditures 2017 Highlights CMS.](#)"

¹⁹ Reed Abelson, "[When Hospitals Merge to Save Money, Patients Often Pay More.](#)" *The New York Times*. November 14, 2018.

- **Gene Therapy** — The number of Investigational New Drug Applications in cell and gene therapies have significantly increased over the past year. The FDA recently approved \$2.1 million Zolgensma® gene therapy to treat an inherited condition called spinal muscular atrophy.²⁰ The treatment targets a defective gene that weakens a child's muscles so dramatically that they become unable to move, and eventually unable to swallow or breathe. Gene therapy, which holds great promise to deliver new breakthrough treatments and even cures, will likely come with severely high price tags that could add to plan cost trends.
- **Greater Use of Artificial Intelligence (AI)** — AI can be used to diagnose or predict medical conditions, as well as identify fraud, waste and abuse in health care plans. Some plans are using AI to enhance their communications and engagement. For example, rather than overwhelming participants with all communications, AI can identify those patients who may have emerging needs for procedures or surgeries. This technology can improve the ability for targeted outreach and direct participants to higher-quality, cost-effective providers, resulting in potential cost savings.
- **Digital Health** — One of the fastest growing areas is the development of applications (apps) and devices to facilitate health improvement. More than 318,000 health apps are now available, with 200+ added daily.²¹ Some apps track exercise and weight loss. Others manage biometric measures for chronic conditions, such as diabetes. Plan sponsors will need to identify and prioritize which applications can be leveraged to impact the health and wellbeing of their population.
- **Regulatory Outlook** — The fiscal pressures on both federal and state budgets, as well as an outcry from individual consumers who pay increased out-of-pocket expenses, will continue to drive new health care laws and regulations. President Trump has issued several executive orders on health care since taking office, although several initiatives, such as Association Health Plans, have been overturned in litigation. Most regulatory activity has concerned Medicare or Medicaid, but the Administration has also encouraged price transparency, particularly with respect to Rx. The Administration has also announced interest in cutting down on paperwork, including proposing to eliminate Section 1557 antidiscrimination notices and modifying electronic distribution rules.
- **Drug Importation** — On July 31, 2019, the U.S. Department of Health and Human Services (HHS) and the FDA released a "Safe Importation Action Plan," outlining steps they will take to allow the importation of Rx at some point in the future.²² While no rules have been published at this time, the plan would consider allowing approval of state government demonstration projects to import drugs from Canada, as well as importation of generic drugs sold in other countries.

Gene Therapy

Gene therapy replaces a gene that causes a medical problem with one that does not, adds genes to help the body fight or treat disease or turns off genes that cause medical problems. Initially, plan sponsors should determine whether they will cover this novel therapy. Absent clear language excluding them, it is likely that they would be covered by the terms of most plans because they have been FDA-approved, they are no longer experimental and they will be considered medically necessary for a rare subset of patients. While the number of people needing these therapies is small, the costs are extremely high.

A plan sponsor that wishes to exclude coverage should consult with legal counsel and compliance experts to draft an appropriate plan language. For plan sponsors that decide to cover these gene therapies, there are several implementation concerns that should be addressed, including whether to cover it under the medical or pharmacy benefits, prior authorization, network provider access issues, travel benefits and stop-loss coverage.

²⁰ The FDA approved Zolgensma® on May 26, 2019.

- **ER Visits and Surprise Medical Bills** — Another trend catching the eye of plan sponsors is the cost of ER visits and surprise billing. According to a report released by the Health Care Cost Institute, the average cost of an ER visit increased 176 percent between 2008 and 2017.²³ President Trump has called upon Congress to take action on “surprise” medical bills, and several congressional committees have held hearings on the issue. Surprise medical bills are sent to patients either by out-of-network hospitals for emergency room care or by out-of-network professionals providing services at in-network facilities. These bills reflect the charges remaining after the individual's health plan has paid its share, in a practice known as “balance billing.” The bills would protect patients from balance billing, and require providers to accept payment, but there is disagreement on whether a benchmark rate would be used or providers would have the right to arbitrate disputes with health plans.
- **Health Care Disruptors** — A number of health care disruptors are changing the landscape of the supply chain. Most disruptors are focused on innovative changes to the delivery service model with the goal of lowering the cost of care. Two examples are described below.

Two Health Care Disruptors

Uber and Lyft have moved into the health sector, partnering with benefits companies to transport employees to medical appointments. Benefits company Grand Rounds recently announced a **transportation partnership** with Uber to provide free transportation to drive employees to high-quality, lower-cost physicians. Self-insured plans may want to use medical transportation services to encourage care coordination and remove barriers to accessing care. Eventually, lower-cost alternatives to medical transportation services should bring down the cost of ambulance services.

Amazon is **disrupting the supply chain** by selling medical supplies directly to hospitals, thereby cutting out group purchasing organizations who typically negotiate discounts on behalf of hospitals and other facilities. Summit Pacific Medical Center reportedly said Amazon lowered their shipping cost and streamlined hospital operations.* Amazon's effort is still in their infancy, however, as it addresses concerns such as the ability to track and trace products.**

* Alex Kacik, “[Amazon primed to streamline healthcare supply chain.](#)” *Modern Healthcare*. September 29, 2018.

** Tatiana Darie, “[Amazon's Push in Health-Care Supply Chain Has Faded, UBS Says.](#)” Bloomberg. July 8, 2019.

²¹ “[The Growing Value of Digital Health: Evidence and Impact on Human Health and the Healthcare System.](#)” Institute Report. IQVIA, November 7, 2017.

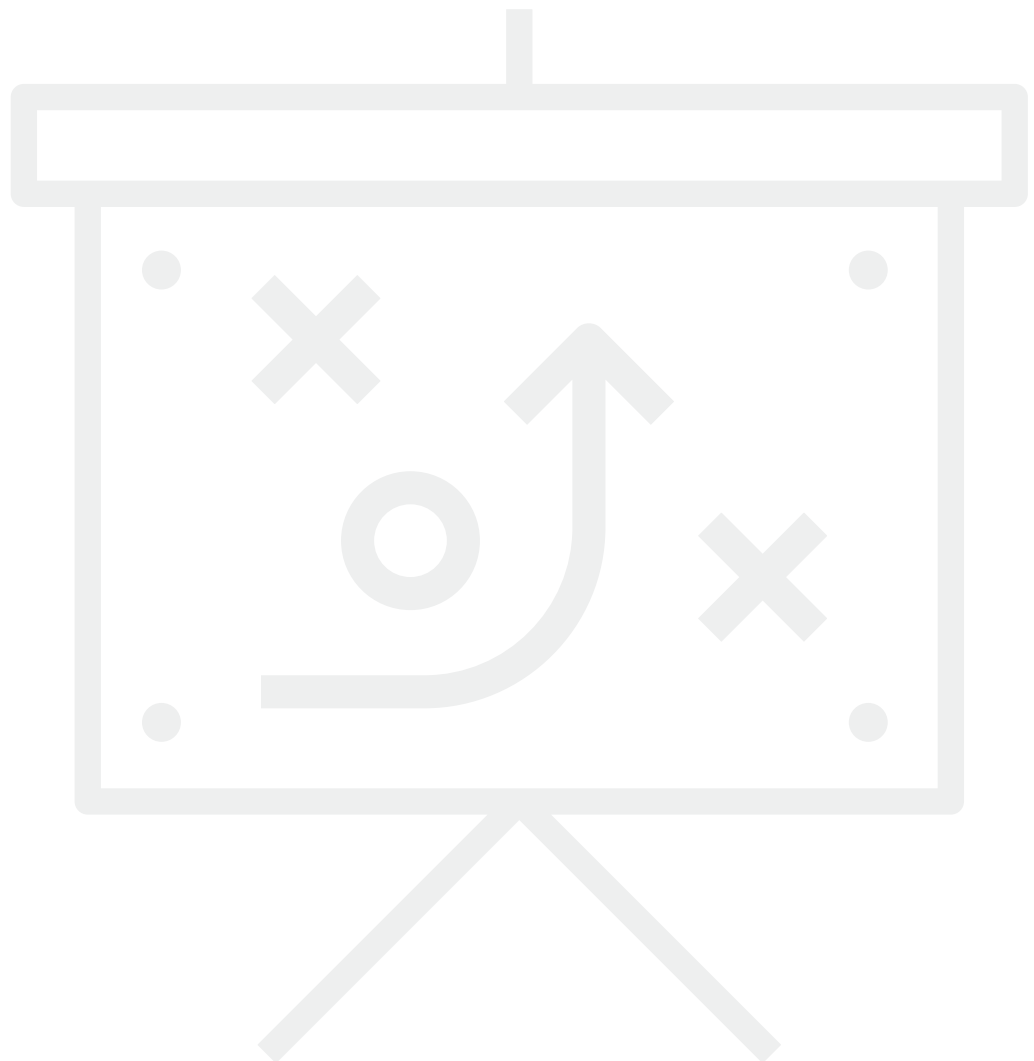
²² The “[Safe Importation Action Plan](#)” was released on July 31, 2019. For a summary, see Sibson's August 1, 2019 web post, “[Federal Agencies Announce Action Plan on Importation of Prescription Drugs.](#)”

²³ John Hargraves and Kevin Kennedy, “[10 Years of Emergency Room Spending for the Commercially Insured.](#)” Health Care Cost Institute. 2019.

Health Plan Sponsors Must Stay Vigilant and Proactive on Multiple Fronts

Plan sponsors continue to deal with providing affordable and valuable health benefits to their workforce as a key business strategy. As the complexity of the marketplace continues to evolve, plan sponsors should continue to explore all avenues that may produce cost savings and develop strategies to improve outcomes for participants and mitigate price increases.

By targeting strategies that address aggressive vendor contracting, measurable population health improvement and smart plan design, plan sponsors can continue to offer high-value benefits while bringing down their plan cost trends. This is a period of extraordinary cost-management experimentation and innovation. Some health care vendors are promoting solutions or services that may be more focused on generating revenue than providing solutions that produce measurable results or improve participant experience. As a result, plan sponsors should proceed cautiously and draw on their data to make well-informed decisions about which strategies and services to select that produce the most value for their limited resources.



About the Survey

During the summer of 2019, Sibson surveyed MCOs, health insurers, PBMs and TPAs about health plan cost trend. More than 100 health insurance providers participated in the survey. They reported 2020 trend forecasts for medical, prescription drug, dental and vision coverage. In addition, the survey respondents reported actual allowed health cost trends for 2018 based on their group health plan experience.

A count of respondents by coverage category follows. As a group, the survey respondents represent 80 percent of the commercially insured and self-insured market.

Medical Plans



- 43** Open-Access PPO/POS Plans
- 38** HDHPs
- 38** HMO Plans
- 28** PPOs/POS Plans with PCP Gatekeepers
- 19** EPO Plans

Rx Plans



- 35** Outpatient Rx Plans

Dental Plans



- 64** DPO Plans
- 59** Dental FFS/Indemnity Plans
- 31** DMO Plans
- 21** Dental Schedule of Allowance Plans

Vision Plans



- 22** Vision Schedule of Allowance Plans
- 16** Vision Reasonable and Customary Plans

The following respondents agreed to be identified by name:

Aetna	Delta Dental of Delaware	Health Net, Inc.
AmeriHealth New Jersey	Delta Dental of Idaho	Highmark Blue Cross Blue Shield
Ameritas Life Insurance Corp.	Delta Dental of Indiana	Highmark Blue Cross Blue Shield of Delaware
Anthem, Inc.	Delta Dental of Iowa	Highmark Blue Cross Blue Shield of West Virginia
Benecard PBF	Delta Dental of Massachusetts	Highmark Blue Shield
BeneCare Dental Plans	Delta Dental of Michigan	Humana, Inc.
Blue Cross Blue Shield of Alabama	Delta Dental of Missouri	Independence Blue Cross
Blue Cross Blue Shield of Arizona	Delta Dental of New Mexico	Kaiser Foundation Health Plan, Inc.
Blue Cross Blue Shield of Illinois	Delta Dental of New York	MagnaCare
Blue Cross Blue Shield of Michigan	Delta Dental of North Carolina	Medical Mutual of Ohio
Blue Cross Blue Shield of Minnesota	Delta Dental of Ohio	Moda Health Plan
Blue Cross Blue Shield of Montana	Delta Dental of Oklahoma	OptumRx
Blue Cross Blue Shield of Nebraska	Delta Dental of Oregon	Metropolitan Life Insurance Company
Blue Cross Blue Shield of New Mexico	Delta Dental of Pennsylvania	Navitus Health Solutions
Blue Cross Blue Shield of Oklahoma	Delta Dental of Tennessee	Premera Blue Cross
BlueCross BlueShield of Tennessee	Delta Dental of the District of Columbia	Prime Therapeutics LLC
Blue Cross Blue Shield of Texas	Delta Dental of Virginia	Starmark
Blue Cross North Carolina	Delta Dental of West Virginia	Sun Life Financial
Blue Shield of California	Delta Dental of Wisconsin	Superior Vision
Capital BlueCross	Emblem Health	Tufts Health Plan
Care Plus Dental Plans	EnvisionRx Options	United Concordia Companies Inc.
Cigna	Envolve Pharmacy Solutions	UnitedHealthcare
ConnectiCare, Inc.	Express Scripts, Inc.	Voya Financial
CVS Health	Group Vision Service	Wellmark BCBS of South Dakota
Delta Dental Insurance Company (DDIC)	Guardian Life Insurance Company of America	Wellmark Blue Cross and Blue Shield Iowa
Delta Dental of Arizona	Harvard Pilgrim Health Care	
Delta Dental of California	Hawaii Dental Service	
Delta Dental of Colorado	Health Alliance Medical Plans	

Questions? Contact Us.

If you have questions about medical cost-management strategies or about the 2020 *Segal Health Plan Cost Trend Survey*, contact your Sibson consultant or one of the following Health Practice leaders:



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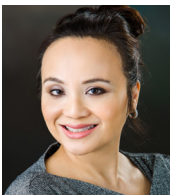
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Sibson's Health Benefits Consulting Services



Today's benefits environment demands a comprehensive approach to formulating health plan design strategies that leverage innovative approaches as well as the power of data analysis, modeling and benchmarking.

Our professionals can help your organization plan, design and strategize by providing:



Plan Design and Analysis — Are you providing high-quality, cost-effective health care to your plan participants? Sibson's health professionals can help plan sponsors with the design and redesign of health benefit plans, including medical, dental, prescription drug, vision, behavioral health, short- and long-term disability, life, accidental death and dismemberment, and flexible benefits.



Strategies for Improving Workforce Wellbeing — Are you offering benefits, which may include voluntary benefits, to promote wellbeing? Such offerings include stress management, caregiver benefits, paid leave and student debt relief as well as other financial advice.



Cost and Utilization Modeling — Has your plan modeled plan sponsor expenses, or calculated the out-of-pocket cost of plan changes to participants? Sibson's consultants can help you evaluate the financial impact of plan design modifications, predict future utilization patterns and estimate changes in claims costs.



Financial Monitoring — Does your plan have the proper budgeting tools in place to ensure long-term financial stability? Sibson can assist in reviewing or developing your plan's reserve policy and analyzing the impact of proposed plan design changes on future expenses.



Service Provider and Insurer Competitive Bidding — When was the last time you put your plan out for a competitive bid? Sibson brings industry-leading expertise and innovative contracting to secure highly competitive pricing and service terms for our clients.



Data Mining and Analysis — Are you getting the information you need to make important plan design decisions? Sibson can provide data-mining services — such as exploring emerging population health-risk factors that impact utilization and uncovering potential fraud and abusive provider practices — to help you better manage future health care expenses.



Benchmarking — Have you compared your policies and initiatives to what other employers are offering? Sibson provides benchmark assessments that provide a unique and invaluable understanding of how benefit programs compare to others.

Our communications consultants work closely with our health consultants to develop creative communications campaigns that capture the attention of participants and their families to support desired behavior.