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Practical Research for Multiemployer Plans

Fall 2018

Increases in Medical and Rx Costs Projected to Be Lower for 2019

Rx and Medical Costs Expected to Increase at Comparable Rates

Both medical and prescription drug (Rx) cost increases — trends — for actives and non-Medicare retirees are projected to be lower in 2019 than in previous years. Prescription drug trend is no longer at double digits and is now close to medical cost trend rates. Those are among the key findings of the 2019 *Segal Health Plan Cost Trend Survey*, Segal Consulting's 22nd annual survey of managed care organizations (MCOs), health insurers, pharmacy benefit managers (PBMs) and third-party administrators (TPAs).

Other key survey findings include:

- Medical plan trends are projected to be lower than 2018 projections.
- Actual medical *and* Rx trend results for 2017 were significantly lower than carrier projections for 2017.
- Actual Rx plan cost trend for 2017 was the second lowest in the last 13 years.
- Price inflation continues to be the primary driver of overall medical and Rx cost trends.
- Network physician reimbursement rate increases are projected to increase by less than 2 percent for both primary care and specialists, below overall CPI rates.
- Rx cost-management strategies and improved vendor contracting are still plan sponsors' top priorities.

Despite the welcome slowdown in trend projections, it is important to keep in mind that health plan cost increases continue to significantly outpace general inflation and average wage increases. That pattern underscores the need for ongoing monitoring of performance to target cost-management efforts as precisely as possible.

What Is Trend?

Health plan cost trend is a forecast of allowed *increases in 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. However, trend does *not* take into account plan design changes.

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, changes in plan design, administrative fees and changes in participant contributions.

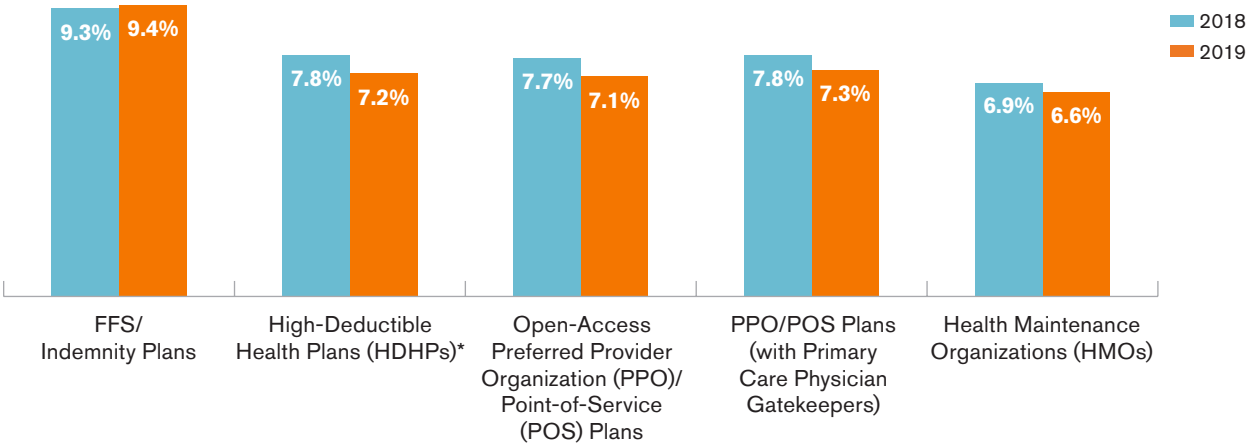
Health plan sponsors continue to advance programs and strategies to drive greater consumer engagement and provider accountability and transparency. As the industry moves towards value-based care,[1] plan sponsors and consumers require more information to comparison shop. These demands are pushing providers to justify costs and provide better value.

Most Medical Plan Trends for Active and Early Retiree Coverage Projected to Decrease Slightly

For 2019, almost all medical plan trends for both actives and retirees under age 65 are projected to be lower than 2018 projections. Fee-for-service (FFS)/indemnity plans are the exception.

Last year, medical plan trend projections increased slightly. That shift appears to have been temporary. Most medical trend projections are again decreasing slightly, following the pattern prior to 2018.

Projected Medical Trends for Actives and Retirees Show Little Difference Among Managed Plan Types



* This data is for HDHPs that meet minimum Internal Revenue Service amounts to qualify for health savings accounts (HSAs), a plan design that is increasingly referred to as an HSA-qualified plan.

Source: Segal Consulting, 2018

Observations Many plan sponsors have increased participants' cost sharing through higher coinsurance, deductibles and/or copayments. According to the Kaiser Family Foundation, between 2006 and 2016, deductibles rose 176 percent and coinsurance rose 67 percent.[2]

Not only do such changes help offset cost increases, they increase participants' accountability. For example, when participants in a well-designed plan are encouraged to become better consumers through incentives and tools to educate them, they seek higher-quality, lower-cost medical services and reduce unnecessary care. Also, the shift to value-based payment models continues to increase in popularity, which provides savings for both the participant and the plan sponsor.

[1] In contrast to a fee-for-service (FFS) approach, value-based models reward physicians and providers for helping participants improve their health. Reimbursement approaches to compensate providers include global capitation (fixed payment is made to entity who is responsible for providing all of the services that their patients need or may use, including not only primary physician and specialty care, but also hospital care, prescription drugs, and other services), shared savings (arrangement where providers keep a meaningful share of savings that arise if they are able to limit expenditures), bundled payments (lump-sum payment made for an episode of care which does not vary based on the number of services actually provided), reference pricing (a defined contribution approach, where a fixed amount is established for the cost of procedures, and members pay the price difference when selecting services that are higher than the referenced price) and pay-for-performance (which links payment increases for doctors and hospitals to measures of their quality and efficiency). Benefits include better outcomes through earlier intervention and higher quality, which result in a reduction in the total cost of care.

[2] Gary Claxton, Larry Levitt, Matthew Rae and Bradley Sawyer. "Increases in Cost-Sharing Payment Continue to Outpace Wage Growth." Kaiser Family Foundation, *Briefs*. Posted June 15, 2018.

The popularity of HDHPs with health savings accounts (HSAs) continues to grow. Plan sponsors that adopt these strategies have access to improved plan participant decision support tools and may provide extensive preventive care treatment without losing tax advantages. As a result, these HDHPs are likely to be attractive to more plan participants in the future. An important issue when considering the use of HDHPs is whether they are affordable to all segments of the participant population. If the high deductible makes coverage too expensive, participants may forgo needed care. A study by the Employee Benefit Research Institute found that lower income workers were more likely to reduce their use of physician office visits and services not subject to the deductible, such as preventive screenings, not realizing they were covered in full.[3]

Consumers' need for price information to make better decisions about providers and services is driving demand for better price transparency. Online transparency tools, concierge services and education are becoming a more important part of an overall benefit program. With the price for elective non-emergency procedures varying greatly among providers, plan sponsors have been evaluating network charges by specific facility and specialty.

> "Although average annual cost trend rates continue to moderate, there are several actions that plan sponsors can take to further slow increases. For example, strategies that put pressure on high-cost outlier providers can yield future savings by lowering those providers' charges and/or reducing the number of plan participants that seek their care."

Ed Kaplan
Senior Vice President,
National Health Practice Leader

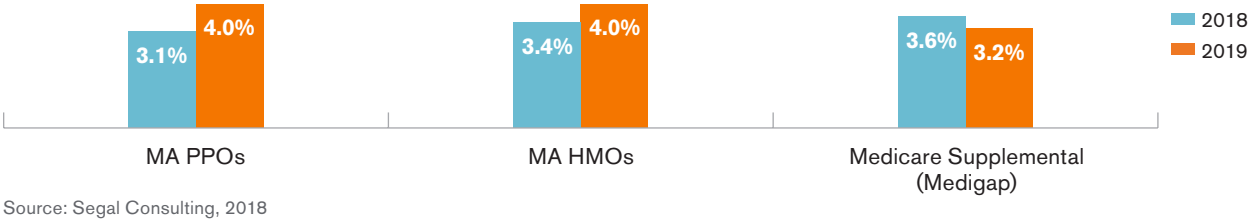
[3] Paul Fronstin and M. Christopher Roebuck. "The Impact of an HSA-Eligible Health Plan on Health Care Services Use and Spending by Worker Income." Employee Benefit Research Institute. August 2016: 14.

Slight Increase in Trend Projections for Some Medicare-Eligible Retirees

Medical trends for Medicare-eligible retirees in Medicare Advantage (MA) PPOs and HMOs are projected to increase slightly. That is a reversal from what last year's survey found: lower trend projections for both of those types of retiree health coverage.

However, the projected trend for Medicare supplemental (Medigap) coverage will continue to decrease for 2019.

Higher Projected Trends for Managed Medicare-Eligible Retiree Medical Coverage



Source: Segal Consulting, 2018

Observations Competition among insurers that offer MA plans continues to increase as thousands of baby boomers reach age 65 every day. One-third of Medicare-eligible individuals are enrolled in MA plans instead of traditional Medicare.[4]

> "We expect enrollment in MA plans to continue to increase because those plans have been shown to deliver savings while providing additional services, such as initiatives that promote wellness."

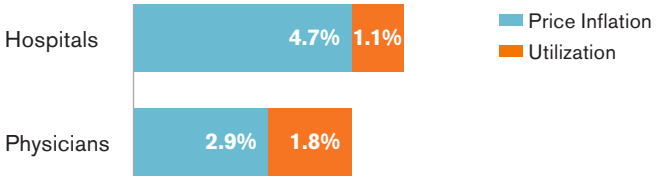
Richard Ward, FSA, MAAA, FCA
Senior Vice President,
Public Sector Health Practice Leader

[4] Medicare Advantage Fact Sheet. Kaiser Family Foundation. October 10, 2017.

Price Inflation Is the Leading Driver of Medical Trend

The leading driver of trend increases for 2019 continues to be price inflation for physician services and hospital services.

Price Inflation Is a Much Greater Component of 2019 Projected Medical Trends than Utilization*



* 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: Segal Consulting, 2018

Another factor influencing trends is the network-negotiated reimbursement rates paid to providers. This often varies by type of service. Network-negotiated reimbursement rates paid to providers differ from price inflation. Changes in provider reimbursement rates are the result of negotiations between provider groups and health care systems.

Hospitals Lead Projected Average Increases in Reimbursement Allowances

3.3%	2.1%	1.8%	1.7%	1.1%
Hospital/Facility*	Imaging/Diagnostic Services (outpatient)	Primary Care Provider	Specialist	Pathology/ Lab Services

* The projected average increase in reimbursement allowance for hospital/facility differs from the price inflation increase of 4.7 percent in the graph above because, as noted in the preceding text, the price inflation increase takes into account new treatments, therapies and technology.

Source: Segal Consulting, 2018

Observations The survey results suggest that network provider rate increases are expected to be modest in almost all categories of provider types. In particular, networks appear to be succeeding in keeping physician reimbursement rate increases to more modest levels. However, great variations in provider prices still exist within networks for the same procedures.

> "Plan sponsors should consider evaluating the potential savings associated with tiered or narrow-network strategies. Such networks exclude high-priced providers and steer patients to high-quality, lower-cost providers. For example, some network providers' contractual price for hip replacements may be nearly twice the average cost of network charges for peer network providers in the same market. The impact on access to care, as well as on the cost and quality of care, should be monitored."

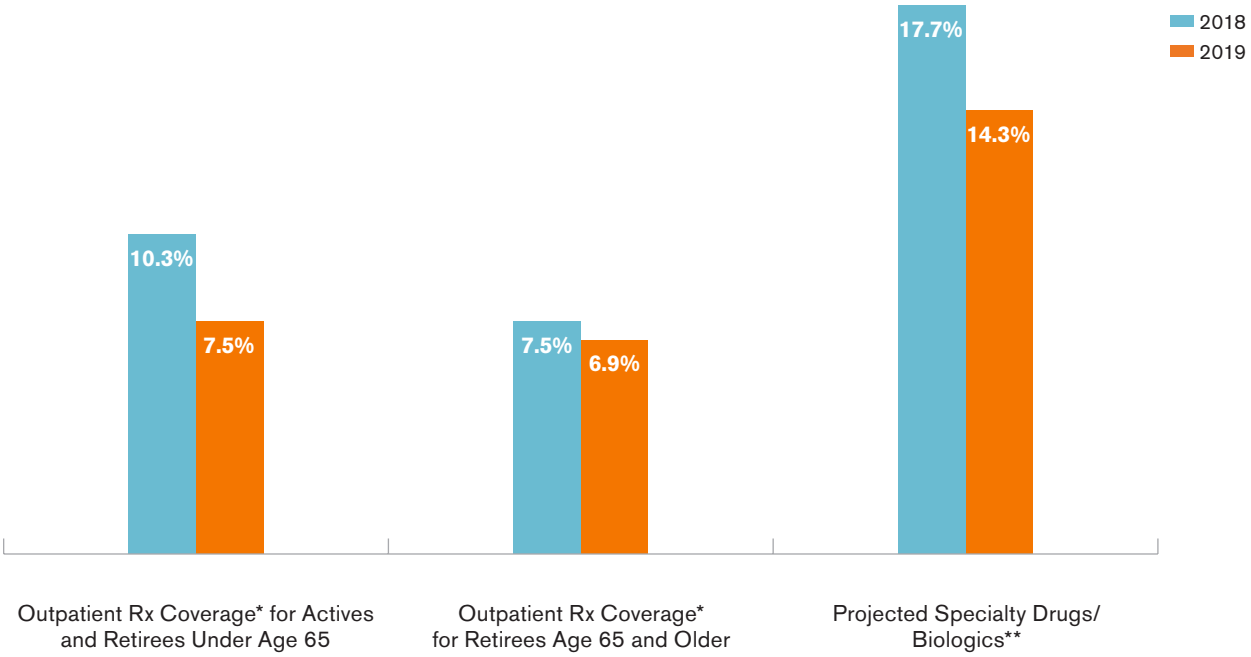
Chris Calvert
Senior Vice President,
Corporate Health Practice Leader

Rx Plan Trend Projections Decrease to Levels Similar to Medical Plan Trend Projections

Cost trends for all prescription drug plans are projected to slow dramatically. Projected trends for Rx coverage are no longer in the double digits. Moreover, they are at similar levels to trend projections for medical benefits.

However, specialty drugs are trending at a double-digit rate. That pattern is significant and concerning because specialty drugs now account for 35 percent of total pharmacy spending.[5]

Prescription Drug Trends Projected to Be Less Severe*



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

** This data is for all coverage of specialty drugs and both age groups.

Source: Segal Consulting, 2018

Prescription drug trend is primarily driven by price increase, with utilization rates remaining flat. (Drivers of Rx trend are discussed in the next section. See page 9.)

Rebates now account for a substantial portion of the drug pricing equation. In 2017, for those survey participants that reported prescription drug trend gross and net of rebates, the average trend before rebates was 6 percent. After taking rebates into consideration, trend was 1 percent. Clearly, rebate offsets now earned by plan sponsors and passed through by PBMs are helping to dramatically lower net plan cost trends.

[5] Segal Consulting SHAPE data, 2018

Observations The year-over-year drop in pharmacy benefit cost trend increases is the largest we have observed in several years. A lack of blockbuster drugs for common conditions entering the market is a factor contributing to the slowdown. As the federal government, plan sponsors and consumers continue to apply pressure to lower drug prices, scrutiny of the pharmaceutical manufacturing industry has intensified. Plan sponsors and their PBMs have adopted more aggressive strategies to impose purchasing discipline on patients, including use of step therapy, prior authorization, quantity limits, custom and PBM standard formularies (which include exclusions) and other utilization management techniques. These are designed to eliminate low-value, higher-priced drug options and lower plan spending.

Also in 2018, UnitedHealth Group, Humana and CVS Health accounted for over half (55 percent) of all Part D (PDP and MA-PD) enrollees in 2018.[6] The Medicare marketplace will change with the proposed acquisition of Express Scripts by Cigna, and Aetna by CVS. The closing of the "donut hole"[7] for 2019 and the changing marketplace should serve as catalysts for plan sponsors to re-evaluate any Medicare Supplemental retiree plans they may have.

Finally, the pharmaceutical manufacturing industry is also being criticized for its rebate practices and a lack of price transparency. State legislators are enacting laws intended to reduce drug pricing and provide more transparency. For example, California requires a drug manufacturer to give a 60-day advance notice to purchasers (including state plans, PBMs and insurers) if the wholesale acquisition cost (WAC) of certain drugs will increase by more than 16 percent over the prior two years and to explain the reason for the increase.[8] In May 2018, the Department of Health and Human Services (HHS) released the American Patients First Blueprint to Lower Drug Prices, which has a range of ideas designed to lower drug prices, reduce out-of-pocket costs and increase competition. In response, manufacturers Pfizer and Novartis, among others, indicated they would not raise prices on certain products for the rest of 2018. Merck also announced a drop in prices for several brand-name products. In July 2018, the Food and Drug Administration (FDA) announced it would work with HHS to consider importing sole-source, off-patent drugs from other countries under narrow conditions. The FDA also announced initiatives to enable a path to competition for biologics from biosimilars (generics of expensive drugs, produced by living cells and organisms).

> "Drug rebates are often used to offset premiums for participants. Rebates can vary significantly and there is little transparency on these arrangements between PBMs and manufacturers. Plan sponsors should consider negotiating contracts that credit 100 percent of rebates and other sources of manufacturer and PBM revenue, like administration fees, earned on behalf of plan participants."

Nick Taylor, RPh
Vice President,
National Pharmacy Practice Leader — Consulting Services

[6] "Medicare Part D in 2018: The Latest on Enrollment, Premiums, and Cost Sharing." *Issue Brief.* Kaiser Family Foundation. May 17, 2018.

[7] The donut hole refers to the coverage gap in Medicare Part D, the period during which there is no Part D coverage until Medicare beneficiaries reach an out-of-pocket threshold.

[8] In December 2017, PhRMA filed a lawsuit challenging the implementation of this law.

Price Inflation Is the Leading Driver of Rx Trend

Price is the leading driver of Rx trend, driven by specialty drugs. As noted earlier in the report (on page 7), specialty drugs are trending at a rate of 14.3 percent and represent 35 percent of overall pharmacy benefit spending.

Price Inflation Is a Much Greater Component of Projected Rx Trend than Utilization*

* 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 prescription drug plan cost survey results found on page 7.

Source: Segal Consulting, 2018

Observations Generic drugs represent approximately 85 percent of prescriptions for many prescription drug plans, and account for one-third of all dollars spent on Rx. This high generic dispensing rate drives savings for plan sponsors as generic drugs offer significant cost savings over brand name medications.

Specialty brand prescriptions continue to dominate the price increases for most plan sponsors. New specialty drugs to treat conditions such as cancer, multiple sclerosis, HIV and genetic disorders contribute to this cost increase. There are limited opportunities to substitute generic in therapeutic classes dominated by single-source specialty brand drugs. Restrictive drug utilization management programs may not be applicable. Plan sponsors should evaluate more comprehensive disease management and site of care options, such as limiting the delivery of certain prescriptions to only the best priced supplier options.

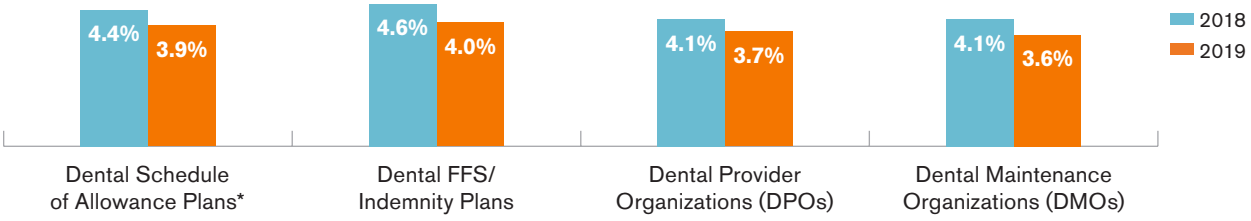
> "Managing specialty medications can be very complex. We recommend plan sponsors develop a strategy that targets the use of those drugs in both the pharmacy benefit and the medical benefit."

Eileen Pincay, RPh
Vice President,
National Pharmacy Practice Leader – Clinical Services

Dental Trends Projected Lower, but Vision Trends Projected Higher

Projected trends for dental coverage are expected to be lower for 2019 compared to 2018 projections.

Dental Coverage Trend Projections Expected to Be Lower in 2019



* 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: Segal Consulting, 2018

In contrast, the trend rates for both types of visions plans are projected to increase for 2019.

Vision Coverage Trend Projections Expected to Increase in 2019

Source: Segal Consulting, 2018

Observations Studies suggest that good dental hygiene can reduce the risk of other serious health care conditions. Plans that spent more on preventive care spent less on major restorative claims.[9] Given those positive results of preventive dental care, plan sponsors should seek ways to increase utilization in this category. Millennials, who became the largest generation in the U.S. labor force in 2016, are the least likely to visit a dentist for preventive care. According to a study by the American Dental Association, only 30 percent of millennials visited the dentist in the last year.[10]

Vision is also a benefit that can improve the overall health of participants. Vision exams can help uncover such chronic health conditions as diabetes, cardiovascular disease and hypertension. The increase in vision trends could be related to plan sponsors' emphasis on wellness and adherence to diabetic exams. Another factor could be vision problems associated with increased exposure to technology.

Plan sponsors that have not modernized their dental and vision programs should re-evaluate their dental and vision benefit offerings. Changes in technology and practices may have created gaps in older policies. A vision benefit can help improve productivity by addressing symptoms associated with increased exposure to technology devices such as smartphones and digital screens. Revising dental benefits to enhance coverage for cleanings and exams should increase participants' preventive care habits and ultimately reduce future utilization rates of higher-cost restorative procedures. Incentivizing the use of in-network providers by enhancing in-network benefits could also increase the value of the plan to participants while lowering costs.

> "Carefully crafted, custom participant communications that are designed for delivery via mobile device can play a key role helping individuals make smart health care choices. For example, to reach recalcitrant millennials about the importance of regular dental visits, use the formats that are most likely to get their attention: text messages and YouTube-length videos."

Randolph B. Carter
Senior Vice President,
National Communications Practice Leader

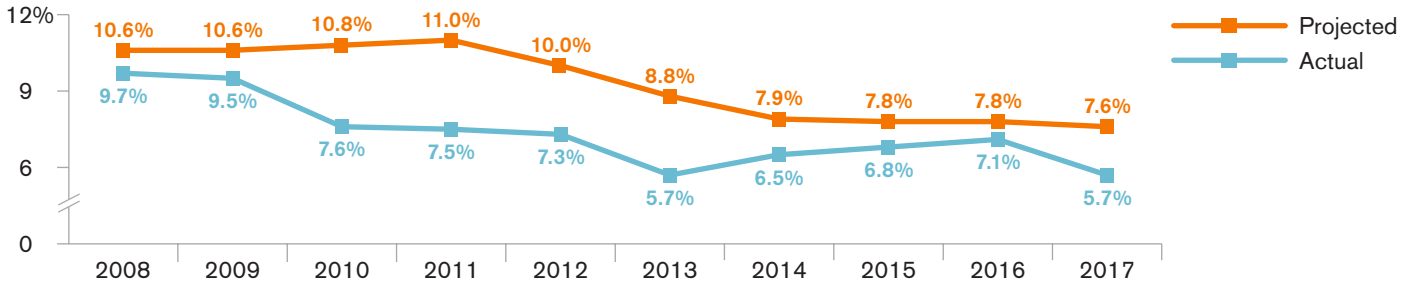
[9] Dental Benefits: A Bridge to Oral Health & Wellness. Guardian Workplace Benefits Study℠, 5th Annual. The Guardian Life Insurance Company of America, 2017.

[10] Oral Health and Well-Being in the United States. American Dental Association. 2015: 6.

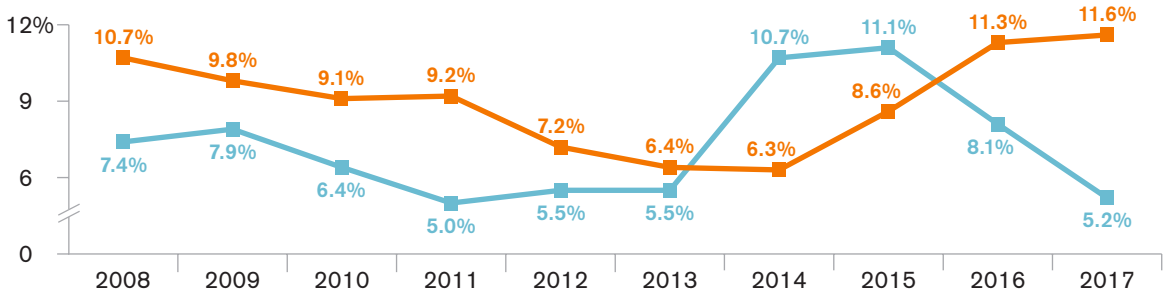
Keep in Mind: Projected Trends Are Typically Higher than Actual Trends

To assess the accuracy of trend projections, Segal compared 2017 projected trends for medical, prescription drug benefit and dental plans to the actual average trends for 2017 (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 10 surveys for three types of coverage for actives and retirees under age 65.

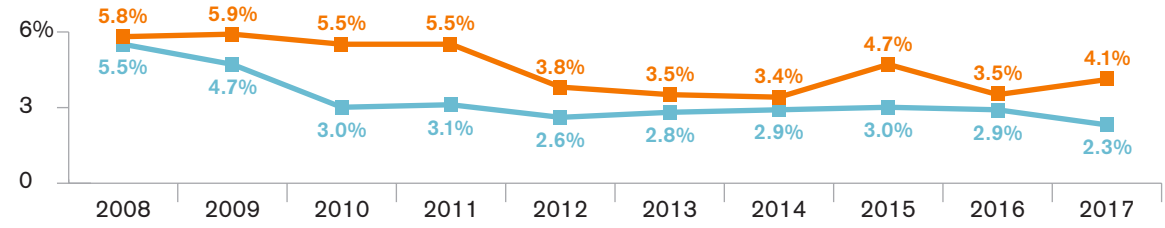
Gap Between Projected and Actual Trends for Open-Access PPOs/POS Plans, Which Had Been Closing Since 2014, Widened in 2017*



Projected Rx Trend, Which Had Been Rising Since 2014, Increased Slightly Between 2016 and 2017, While Actual Trend Was Dramatically Lower**



Projected and Actual Trends for Dental PPOs, Which Were Relatively Close for Many Years, Are Growing Further Apart



* 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: Segal Consulting, 2018

Observations Consistent with previous surveys, insurers tend to make conservative projections and actual trends are typically lower than levels forecasted. Actual Rx trend of 5.2 percent in 2017 was the lowest reported in more than five years. Plan sponsors should keep these patterns in mind when considering trend projections.

Some respondents provided projections that were several multiples higher than actual trend rates of their peers for the same time period. These overestimates skew projections towards higher trend rates.

After several years of declining increases in trend projections, the projections are leveling off. As the economy picks up and overall spending increases, we may start to see the beginning of a reversal of the pattern of downward trends. Historically, there is a correlation between a healthy economy (*e.g.*, strong growth in gross domestic product and low unemployment) and increased utilization of health services. All of the following factors will play a role in future health plan cost increases:

- The overall economic climate;
- Government policy;
- Health provider consolidation;
- The future supply of providers;
- Efforts to increase patient consumerism; and
- Greater investment in wellness and preventive care.

> "Actively managed health plans that use data to drive changes that specifically target problem areas can produce trend rates at levels 1 to 2 percentage points lower than the survey forecasts."

Eileen Flick
Senior Vice President,
Director of Health Technical Services

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

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.

Selected Medical,[1] Outpatient Rx[2] and Dental Trends: 2005–2017 Actual and 2018 and 2019 Projected[3]

	Year	Open-Access PPOs/POS Plans	PPOs/POS Plans with PCP Gatekeepers	HMOs	MA HMOs	Outpatient Rx	DPOs
Actual	2005	10.4%	11.1%	10.6%	8.4%	10.5%	5.0%
	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%
Projected	**2018**	**7.7%**	**7.8%**	**6.9%**	**3.4%**	**10.3%**	**4.1%**
	2019	**7.1%**	**7.3%**	**6.6%**	**4.0%**	**7.5%**	**3.7%**

[1] Medical trends exclude prescription drug coverage.

[2] Prescription drug trend data for 2005—2007 only reflects retail. Data for 2008–2019 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. (A graph comparing 15 years of survey data — 2005 through 2017 actual trends and 2018 and 2019 projected trends — is available as a supplement to this report.)

Source: Segal Consulting, 2018

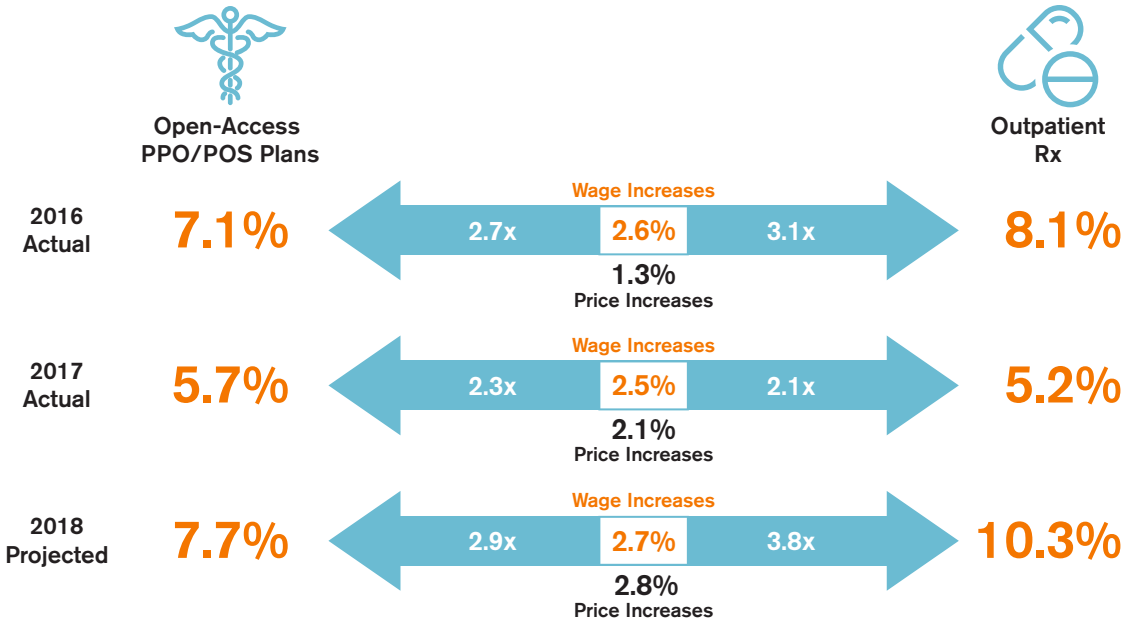
Observations There has been a general downward slope of actual trend from 2005 through 2017 across all categories. That pattern is attributable to efforts by plan sponsors to manage costs through such strategies as moving from fee-for-service to value-based delivery arrangements and restrictions on networks.

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

Health plan cost trends continue to outpace wage increases and overall consumer price inflation. However, the gap is closing.

In 2016, the actual trend for open-access PPO/POS plans was nearly three times the average wage increase. In contrast, in 2017 the gap had narrowed to slightly more than two times.

Comparison of Two Trend Rates to Wage and Price Increases



Sources: Segal Consulting, 2018 (trend rates), Bureau of Labor Statistics CPI-U from Consumer Price Index – June 2018, and Bureau of Labor Statistics wage increases through June 2018 from Table B-3. Average hourly earnings of all employees on private nonfarm payrolls, seasonally adjusted.

Observations Rising health plan costs may be a factor in dampening wage increases. Specifically, the higher the increase in health care cost trends, the harder it becomes to increase wages.

> "A growing number of plan sponsors are able to keep their health plan cost increases to low single-digits, year after year, by actively managing their health plans. That discipline and successful cost containment allows them to increase wages."

Megan Kelly, CEBS
Senior Vice President,
Multiemployer Health Practice Leader

Rx Cost-Management Continues to Top the List of Strategies Plan Sponsors Are Using

Plan sponsors continue to use various cost-management strategies to grapple with ever-escalating health plan costs. We asked the survey participants to rank the cost-management strategies implemented by group health plans in 2018.

Prescription Drug Cost Management Continues to Be Plan Sponsors' Highest Priority Strategy

2018 Top Five	2017 Top Five
1 Using specialty pharmacy management tools or techniques	1 Using specialty pharmacy management tools or techniques
2 Intensifying pharmacy management program	2 Intensifying pharmacy management program
3 Adding low-cost primary care access*	3 Contracting with value-based providers**
4 Contracting with value-based providers**	4 Increasing financial incentives in wellness design
5 Opioid abuse prevention management	5 Adopting an HDHP

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

** These include 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: Segal Consulting, 2017 & 2018

Other cost-management strategies implemented in 2018 include:

- Use of a health care transparency tool;
- Adopting a high-deductible health plan;
- Increasing financial incentives in wellness design;
- Use of centers of excellence for non-transplant surgeries (*e.g.*, a high-performance network for hip, knee, cardiac and bariatric surgery);
- Use of a narrow or limited provider network;
- Adopting a custom or narrow network drug formulary;
- Use of health care navigator or health advocate service;
- Introducing a defined contribution approach with or without use of a private Exchange;
- Direct contracting with a hospital or provider system; and
- Providing coverage to Medicare-eligible retirees through Employer Group Waiver Plans (EGWPs).[11]

[11] EGWPs are custom group-sponsored plans to provide supplemental coverage for retirees beyond the standard benefits typically offered by Medicare Advantage plans for Medicare-eligible retirees.

Observations As the survey suggests, plan sponsors are using a wide range of cost-management strategies. The fact that three of the top five strategies focus on prescription drugs is not surprising given that Rx trends outpace medical trends. It is also notable that increasing financial incentives for wellness fell out of the top five strategies in 2018. Many plan sponsors are looking to more creative ways to engage participants in wellness, and broadening their view of wellness to a more holistic well-being perspective.

With the cost of treating opioid addiction ranging from approximately $10,000 to $20,000 per patient,[12] and the thousands of opioid overdoses in America, it is also not surprising that opioid abuse prevention management is one of the top five strategies being used in 2018. In response to the ongoing opioid epidemic and national attention, there has been a decline in the number of opioid prescriptions across all major disease categories. The CDC published guidelines for prescribing opioids. Many states have already enacted the opioid first fill limit laws. In addition, many plans through their PBM have embraced opioid management strategies from these guidelines, including limiting supply (*e.g.*, first fill limit of seven days for acute pain), limiting quantity (*e.g.*, for the treatment experienced, providing a maximum dosing per day as recommended by CDC), requiring step therapy by redirecting new patients who initially received long-acting opioids to short-acting opioids, and integrating a prescription drug monitoring program (*e.g.*, which helps physicians identify patients who are obtaining opioids from multiple doctors). Some plans have also implemented an enhanced fraud and abuse type of program through their PBMs which identifies patients going to multiple pharmacies and/or multiple physicians. All of these strategies should be reviewed to assure that they are consistent with the Mental Health Parity and Addiction Equity Act (MHPAEA).

> "The impact of these strategies is a reduction in the number of prescriptions and could also be a contributing factor in the lower projected trend for 2019. Medical cost trend reduction can also be achieved over an extended time horizon as acute opioid utilizers are prevented from becoming long-term users."
>
> **Sadhna Paralkar, MD**
> Senior Vice President,
> National Health Practice

[12] Noam Y. Kirson, PhD; Lauren M. Scarpati, PhD; Caroline J. Enloe, BS; Aliya P. Dincer, BS; Howard G. Birnbaum, PhD; and Tracy J. Mayne, PhD. "The Economic Burden of Opioid Abuse: Updated Findings." *Journal of Managed Care & Specialty Pharmacy*, Vol. 23, No. 4 (April 2017).

Where to Focus Cost-Management Efforts

Plan sponsors are demanding that networks identify and remove wasteful and overpriced providers. They are also embracing new methods of provider incentives. Value-based payment models that reward quality and efficiency are gaining momentum as cost-saving alternatives to fee-for-service care. Two-thirds of payment models are based on value-based arrangements. A national survey of 120 payers[13] found that value-based care is bending the health care cost curve, reducing unnecessary medical costs by an average of 5.6 percent while improving care quality and patient engagement.

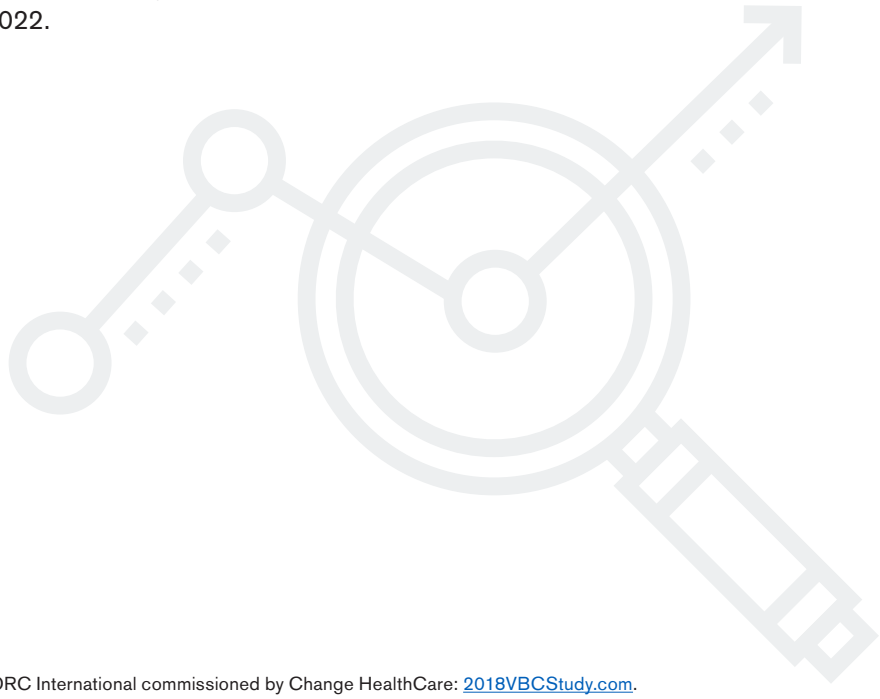
Shared savings,[14] bundled payments for episodes of care, reference-based pricing and other alternative value-based payment approaches can help mitigate price inflation. For example, using a bundled-payment approach, providers are reimbursed a set rate for all services involved in an episode and are accountable for the quality of care and outcomes. Value-based payment models may be better suited for focused procedures as opposed to all services.

For example, using reference-based pricing with specific surgical costs can address one of the largest components of health care spending. Plan sponsors should evaluate the feasibility of carving out elective non-emergency surgery benefits to a network that offers high-quality, low-cost options. Typically, these arrangements include high-performance surgical providers with pre-negotiated bundled rates for a set list of elective surgeries (*e.g.*, knee replacement).

For participants, this benefit will help lower costs and provide a high-quality care coordination experience. Participants incur less of a financial burden as deductibles and coinsurance are typically waived. The higher-quality surgeries also result in fewer complications and lower readmission rates.

Plan sponsors can save 30 to 50 percent per surgery versus a traditional network. When considering this arrangement, take into account plan design incentives (*e.g.*, covering travel expenses for participants in rural areas), network access, communications, regulatory requirements, performance guarantees and financial measurements.

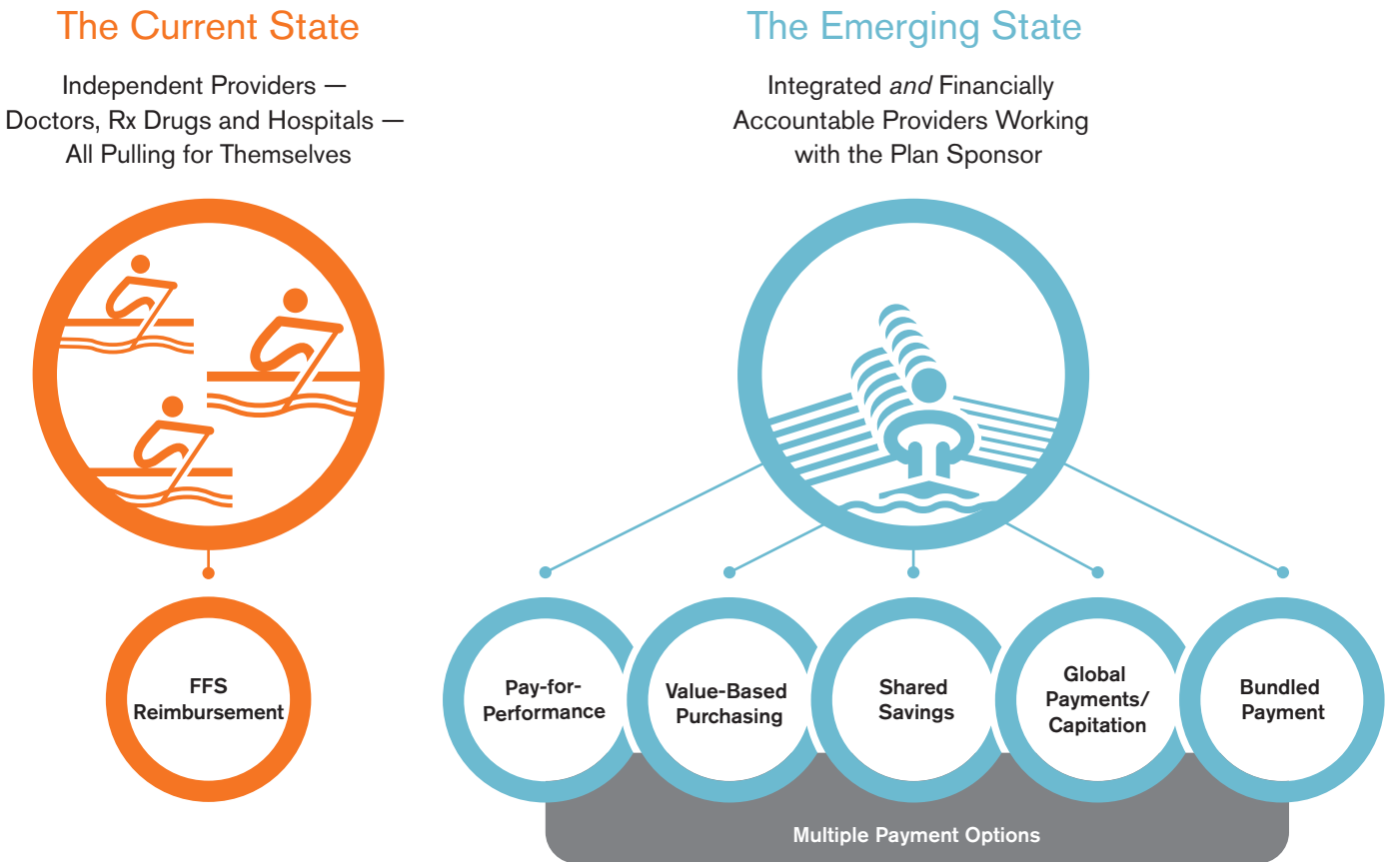
Plan sponsors still need to watch what Congress does about the Affordable Care Act's 40 percent excise tax and plan accordingly. That "Cadillac Tax" on high-cost health plans above a certain threshold is still scheduled to take effect in 2022.



[13] *Finding the Value: The State of Value-Based Care in 2018*. ORC International commissioned by Change HealthCare: 2018VBCStudy.com.

[13] As noted in footnote 1 on page 2, in shared-savings arrangements, providers keep a meaningful share of savings that arise if they are able to limit expenditures.

Organization of Health Care Delivery: The Movement Towards Value-Based Care



Source: Segal Consulting, 2017 & 2018

As the complexity of the industry continues to evolve, value-based contracting is emerging as an effective strategy to manage pharmacy price increases and improve the quality of care for participants. An example includes outcomes-based contracting, where reimbursement is tied to achieving a desired outcome. With diabetes, which is a therapy class that has experienced significant price increases, a manufacturer might be required to represent that A1C[14] levels will be lowered by a certain percentage for patients receiving diabetic drugs covered under an outcomes-based contract. If desired outcomes are not achieved the manufacturer would be responsible for paying a larger rebate. Federal rules concerning wellness programs need to be considered when designing these type of programs.

When considering these arrangements, plan sponsors should think about how they want to design their program, determine what metrics are needed to monitor drug performance, evaluate rebate structures to ensure they are aligned with drug performance, get access to data to measure appropriate clinical outcomes and evaluate the financial impact.

[14] A1C is a test that measures the level of blood glucose or blood sugar levels for the preceding two to three months to gauge how well a patient is managing their diabetes.

By targeting solutions and value-based strategies that address plan design, aggressive vendor contracting, best-value providers, participant decision-support tools and measurable population health improvement, plan sponsors can maintain control over providing high-value benefits that are well received by current and future participants.

Other effective strategies for managing the cost of Rx coverage include:

- Data mining to determine where to target cost-management efforts;
- Percentage coinsurance designs with copayment minimums;
- Comprehensive formulary management;
- Value-based performance guarantees;
- Targeted clinical drug management programs (*e.g.*, prior authorizations, step therapy and drug quantity limits);
- Incentives to use deeper discounted mail order or retail 90-day options;
- Custom contracting for specialty drugs; and
- Maximizing rebate dollars for the plan through contracting and formulary design.

About the Survey

During the summer of 2018, Segal surveyed MCOs, health insurers, PBMs and TPAs about health plan cost trend. More than 100 health insurance providers participated in the survey. They reported 2019 trend forecasts for medical, prescription drug, dental and vision coverage. In addition, the survey respondents reported actual allowed heath cost trends for 2017 based on their group health plan experience.

A count of respondents by coverage category follows.

Medical Plans

- 23 FFS/Indemnity Plans
- 32 HDHPs
- 36 Open-Access PPOs/POS Plans
- 29 PPOs/POS Plans with Primary Care Physician Gatekeepers
- 36 HMOs

Prescription Drugs

- 28 Prescription Drug Carve-Out Plans

Dental Plans

- 12 Dental Schedule of Allowance Plans
- 61 Dental FFS/Indemnity Plans
- 66 DPOs
- 33 DMOs

Vision Plans

- 17 Vision Schedule of Allowance Plans
- 13 Vision Reasonable and Customary Plans

The following respondents agreed to be identified by name:

Aetna

Amalgamated Life

American Health Care

AmeriHealth New Jersey

Ameritas Life Insurance Corp.

Anthem, Inc.

Benecard PBF

BeneCare Dental Plans

Blue Cross Blue Shield of Alabama

Blue Cross Blue Shield of Arizona

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Minnesota

Blue Cross Blue Shield of Nebraska

BlueCross BlueShield of Tennessee

Blue Shield of California

Capital BlueCross

Capital District Physicians' Health Plan Inc.

Care Plus Dental Plans

Cigna

ConnectiCare

CVS Health

Delta Dental Insurance Company (DDIC)

Delta Dental of Arizona

Delta Dental of California

Delta Dental of Colorado

Delta Dental of Delaware

Delta Dental of the District of Columbia

Delta Dental of Idaho

Delta Dental of Indiana

Delta Dental of Iowa

Delta Dental of Massachusetts

Delta Dental of Michigan

Delta Dental of Minnesota

Delta Dental of Nebraska

Delta Dental of New Jersey

Delta Dental of New Mexico

Delta Dental of New York

Delta Dental of North Carolina

Delta Dental of Ohio

Delta Dental of Oklahoma

Delta Dental of Pennsylvania

Delta Dental of South Dakota

Delta Dental of Tennessee

Delta Dental of Virginia

Delta Dental of Washington

Delta Dental of West Virginia

Delta Dental of Wisconsin

Delta Dental Plan of Maine

Delta Dental Plan of New Hampshire

Delta Dental Plan of Vermont

EnvisionRx Options

Express Scripts, Inc.

Group Vision Service

Guardian Life Insurance Company of America

Harvard Pilgrim Health Care

Hawaii Dental Service

Health Net, Inc.

HealthPartners

Highmark Blue Cross Blue Shield

Highmark Blue Cross Blue Shield of Delaware

Highmark Blue Cross Blue Shield of West Virginia

Highmark Blue Shield

Horizon Blue Cross Blue Shield of New Jersey

Humana

Independence Blue Cross

Kaiser Foundation Health Plan, Inc.

MagnaCare

Magellan Rx Management LLC

Medical Mutual of Ohio

MedImpact Healthcare Solutions

OptumRx

Metropolitan Life Insurance Company

Navitus Health Solutions

Prime Therapeutics LLC

Sun Life Financial

Tufts Health Plan

United Concordia Companies Inc.

UnitedHealthcare

Voya Financial

Wellmark BCBS of South Dakota

Wellmark Blue Cross and Blue Shield Iowa

WellDyneRx

Questions? Contact Us.

If you have questions about health care cost-management strategies or about the 2019 *Segal Health Plan Cost Trend Survey*, contact your Segal consultant or one of the following Health Practice leaders:

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Segal'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? Segal'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.
- ***Cost and Utilization Modeling*** Has your plan modeled plan sponsor expenses, or calculated participant out-of-pocket cost of plan changes? Segal's consultants can help you evaluate the financial impact of plan design modifications, predict future utilization patterns and estimate changes in claims costs.
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- ***Data Mining and Analysis*** Are you getting the information you need to make important plan design decisions? Segal 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 trustees better manage future health care expenses.
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