Segal Consulting

data

Practical Research on Public Sector Benefits

Fall 2016

Double-Digit Rx Benefit Cost Trends Projected for 2017

Lower Cost Trends Projected for Health Plans, but their Rates Significantly Outpace Inflation and Wage Increases

Health benefit plan cost trend rates for 2017 are projected to be similar to prior levels for most medical plan options. However, carved-out prescription drug benefit cost trends for active populations continue to increase at double-digit rates, according to forecasts compiled in the 2017 *Segal Health Plan Cost Trend Survey*, Segal Consulting's 20th annual survey of managed care organizations (MCOs), health insurers, pharmacy benefit managers (PBMs) and third-party administrators (TPAs).[1] Health plan cost increases continue to significantly outpace general inflation and average wage increases. (See page 13 for a description of the survey methodology and page 14 for a list of survey participants.)

What Is Trend?

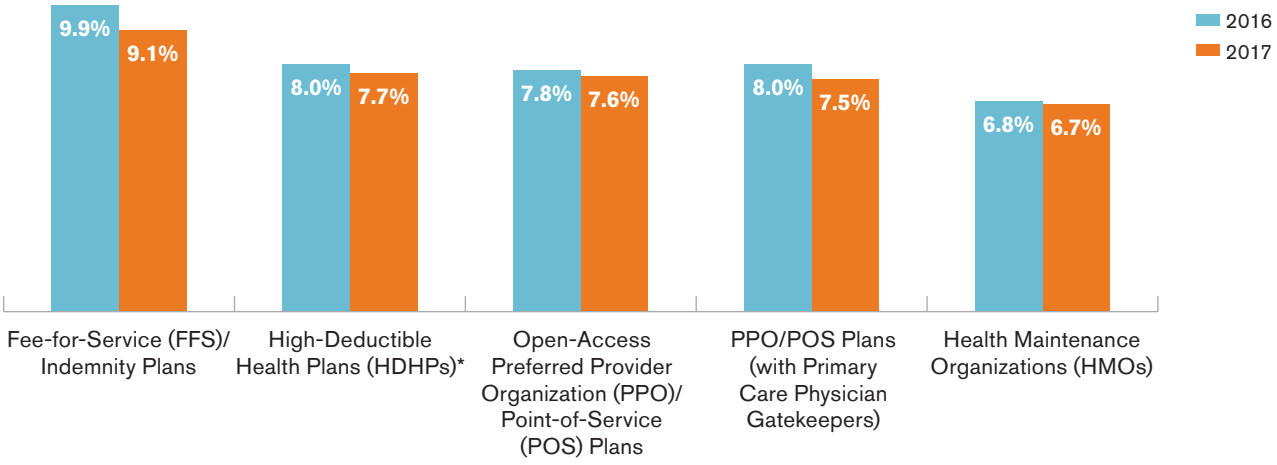
Trend is a forecast of per capita *claims cost increases* that takes into account various factors, including price inflation, utilization, government-mandated benefits, and new treatments, therapies and technology. Although there is usually a high correlation between a trend rate and the actual cost increase assessed by a carrier, trend and the net annual change in plan costs are *not* the same. Changes in the costs to plan sponsors can be significantly different from projected claims cost trends, reflecting such diverse factors as group demographics, changes in plan design, administrative fees, reinsurance premiums and changes in participant contributions.

[1] Trend forecasts are provided by the survey participants.

Medical Cost Trend Projections for Actives and Early Retirees Relatively Flat

For 2017, all medical cost trends for actives and retirees under age 65 are projected to be slightly lower — less than 1 percentage point — than 2016 projections.

Projected Medical Cost Trends for Actives and Retirees Under Age 65: 2016 and 2017



* 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, 2016

Observations Enrollment in HSA-qualified plans is growing, which suggests these plans may now be attracting participants who have higher medical risks compared to the early adopters of these plans. As a result, per-participant cost trends may be influenced by adverse selection between medical plan offerings. Sponsors of plans that cover lower-income workers should be aware that lower-income workers who switch to HSA-qualified plans are more likely than their higher-paid colleagues to avoid certain types of health care, according to new research by the Employee Benefit Research Institute (EBRI).[2] In contrast, HMO enrollment is relatively stable with longer histories of coverage, which perhaps minimizes the impact of adverse selection by new entrants.[3]

> "All medical cost trends for actives and retirees under age 65 are projected to be slightly lower."

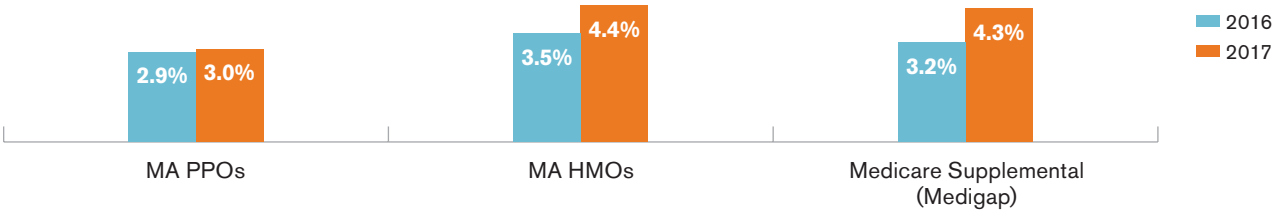
[2] The EBRI analysis, which looked at actual health claims of one large Midwestern employer by workers' income levels, found significant differences for the use of some health services, but not for others. For instance, switching to an HSA-eligible health plan caused a decline in (nonpreventive) outpatient office visits for workers at all income levels, but the decline was twice as large for workers and their dependents with incomes less than $50,000 as compared with those with incomes of at least $100,000. The decline in specialist visits accounted for most of the decline in outpatient office visits among the group of workers with less than $50,000 in income. Also, the HSA-eligible health plan was associated with a reduction in various preventive services by worker income. For example, lower-income workers reduced their use of influenza vaccinations more than higher-income workers. See EBRI's August 2016 *Issue Brief*.

[3] According to "National Health Expenditure Projections, 2015–25: Economy, Prices, and Aging Expected to Shape Spending and Enrollment," an article by Sean P. Keehan, John A. Poisal, Gigi A. Cuckler, Andrea M. Sisko, Sheila D. Smith, Andrew J. Madison, Devin A. Stone, Christian J. Wolfe and Joseph M. Lizonitz, which was published in the July 2016 issue of *Health Affairs*, nearly 25 percent of group health plans are estimated to be HDHPs in 2015, up from 20 percent in 2014.

Medical Trend Projections for Retirees Are Low but Rising

In contrast to medical trend projections for actives and retirees under age 65, projected medical trends for Medicare-eligible retirees are somewhat higher for 2017 compared to projections for 2016 — almost 1 percentage-point higher for Medicare Advantage (MA) HMOs.

Projected Medical Trends for Retirees Age 65 and Older: 2016 and 2017



Source: Segal Consulting, 2016

Observations The surge of Baby Boomers aging into the Medicare program helps lower the average cost per beneficiary for both Medicare and plan sponsors' supplemental coverage because 65-year-olds have noticeably lower health care costs than 75-year-olds. One of the forces putting pressure on plan sponsors' cost of coverage for Medicare-eligible retirees is rising prescription drug spending outpacing payments from the Centers for Medicare & Medicaid Services (CMS) under Part D to help subsidize these costs. In addition, increases in provider payments work to push up annual claim costs. The Affordable Care Act reformed the Medicare system to give providers incentives to improve the quality of care and reduce costs through such value-based purchasing initiatives as accountable care organizations (ACOs), primary care medical homes and bundled payments.[4] Results from these programs are mixed. For example, there is growing evidence that inpatient hospital (Medicare Part A) claims are declining, but outpatient claim costs continue to increase at rates above the consumer price index (CPI). Any savings in inpatient claims generally results in savings to CMS, not to group health plans that supplement Medicare for their retirees. Plan sponsors should evaluate their Medicare offerings and arrangements and develop strategies that include rewards for improvements in vendor performance, CMS subsidies, administration, coordination of care management[5] and costs.

> "Projected medical trends for Medicare-eligible retirees are somewhat higher for 2017 compared to projections for 2016."

[4] ACOs are networks of providers and suppliers that agree to be jointly accountable for managing the health of participating populations across the care continuum. Medical homes, which are sometimes referred to as Patient-Centered Medical Homes (PCMHs), focus an increased level of comprehensive health care resources on primary care and prevention for patients with chronic conditions. "Bundled payments" refer to the reimbursement of health care providers on the basis of "expected" costs for the multiple services a patient receives during a clinically defined episode of care. ACOs and other value-based provider initiatives are primarily found in MA HMOs.

[5] Care management is a promising team-based, patient-centered approach designed to assist patients and their support systems in managing medical conditions more effectively.

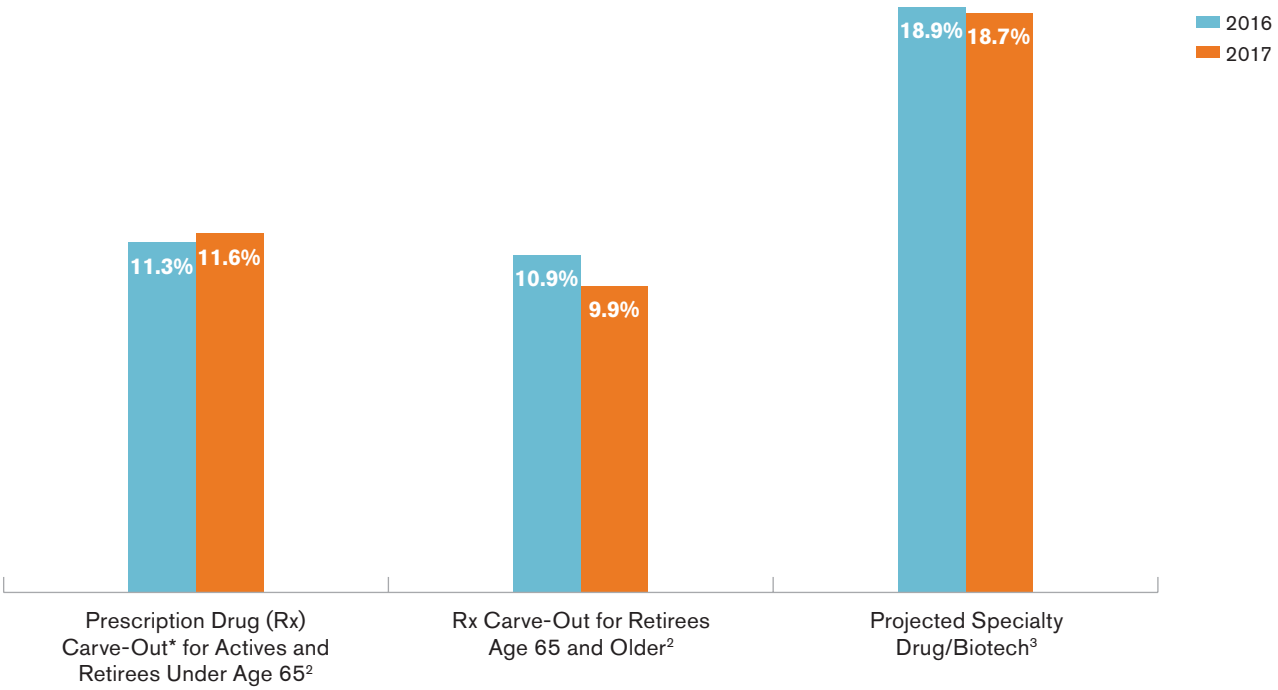
Prescription Drug Trend Projections Are High, Approaching 20 Percent for Specialty Drugs

Prescription drug trend for actives and early retirees is once again projected to be in the double digits. Moreover, it is expected to be higher than the 2016 projection. For Medicare-eligible retirees, prescription drug trend is also projected to be high, but lower than the 2016 projection.

The primary drivers of Rx benefit cost trends are cost price increases for brand-name non-specialty drugs and specialty medications, for which there is greater use. The projected specialty drug/biotech trend rate for 2017 is an exceptionally high 18.7 percent.

While typically less than 1 percent of all medications are specialty drugs, survey respondents indicated those drugs now account for 35 percent of total projected prescription drug cost trends for 2017. That is a 10-percentage point increase from only two years earlier when specialty drugs accounted for 25 percent of total projected prescription drug cost trends for 2015.

Projected Prescription Drug Trends: 2016 and 2017[1]



[1] These results do not include the impact of rebates from PBMs.

[2] This data is for all prescription drugs (non-specialty and specialty drugs combined).

[3] This data is for all coverage of specialty drugs and both age groups.

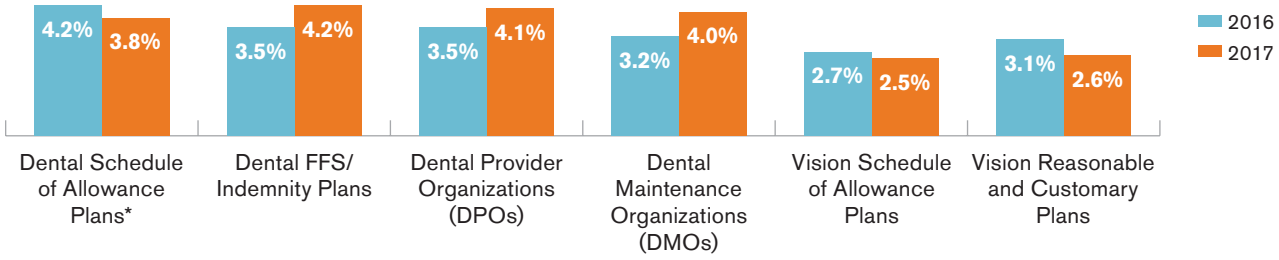
Source: Segal Consulting, 2016

Observations Given the increasing number of pharmaceutical products now available for conditions that require the use of specialty medications, plan sponsors should implement strategies to manage patients who use these drugs and target their costs. This can include utilization-management controls that were traditionally only available in the non-specialty drug market; formulary or preferred step-therapy; tiered copayment structure; and split fill and network management, including more aggressive specialty drug contracting terms that maximize client and patient value.

Trend Projections for Dental and Vision Coverage Are Much Lower than Trend Projections for Other Health Coverage

Trends for dental coverage are expected to be higher for 2017 compared to 2016 projections — except for dental schedule of allowance plans. The trend rate for both vision schedule of allowance plans and vision reasonable and customary plans are projected to decrease for 2017.

Projected Dental and Vision Trends: 2016 and 2017



* 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, 2016

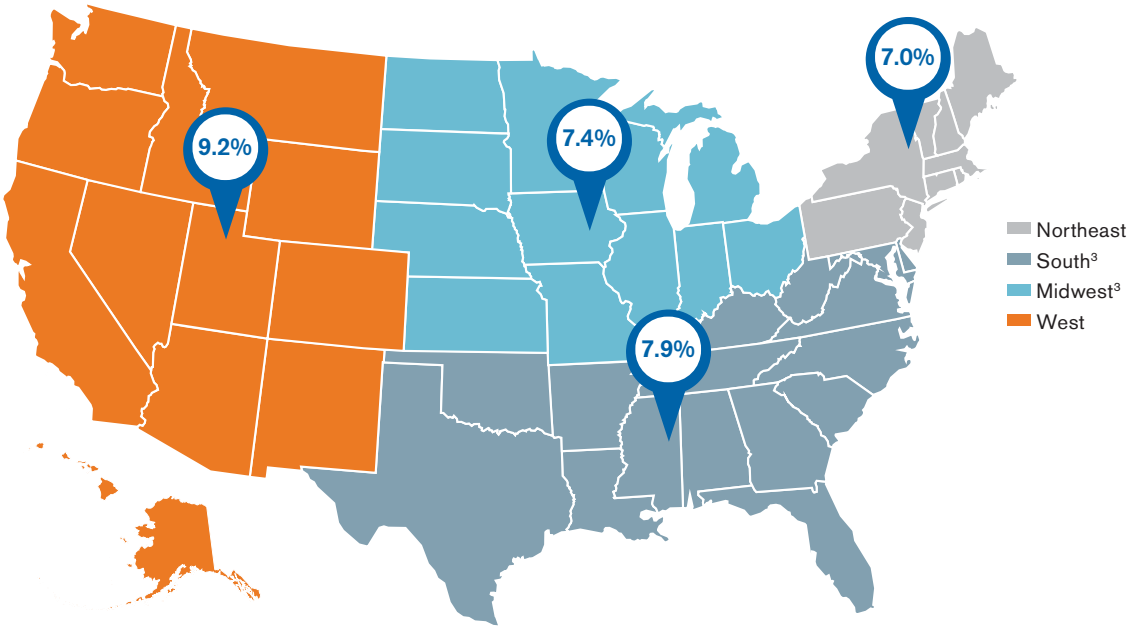
Observations Although projected trend rates for dental coverage are much lower than for medical and prescription drug coverage and dental coverage represents only about 10 percent of total health care costs, plan sponsors may want to consider taking advantage of opportunities to save money on their dental coverage. Dental Provider Organizations (DPOs) now offer substantial network-pricing discounts, which can expand the value of plan sponsors' dental benefits by 25 percent to 33 percent without increasing plan costs. Network access to contracted network dentists has improved dramatically in the last decade making a DPO a more viable option for plan sponsors that have not yet explored adding a DPO plan option to their benefit package. Recent new competition among vision network providers to gain market share may warrant a new look at vision provider networks.

> "Dental Provider Organizations (DPOs) now offer substantial network-pricing discounts, which can expand the value of plan sponsors' dental benefits by 25 percent to 33 percent without increasing plan costs."

Cost Trend Projections Vary by Region

The survey looked for regional variations in cost trend rates. The table below presents the results of that analysis for all PPO/POS plans, the most prevalent type of medical coverage.

Projected 2017 Medical Cost Trends for PPO/POS Plans[1] for Actives and Retirees Under Age 65 by Region[2]



[1] This analysis includes both open-access PPO/POS plans and PPO/POS plans with primary care physician gatekeepers.

[2] This analysis is based on the U.S. Census Bureau's regions.

[3] The results for this region are based on a limited sample size and, therefore, may not be representative of the region.

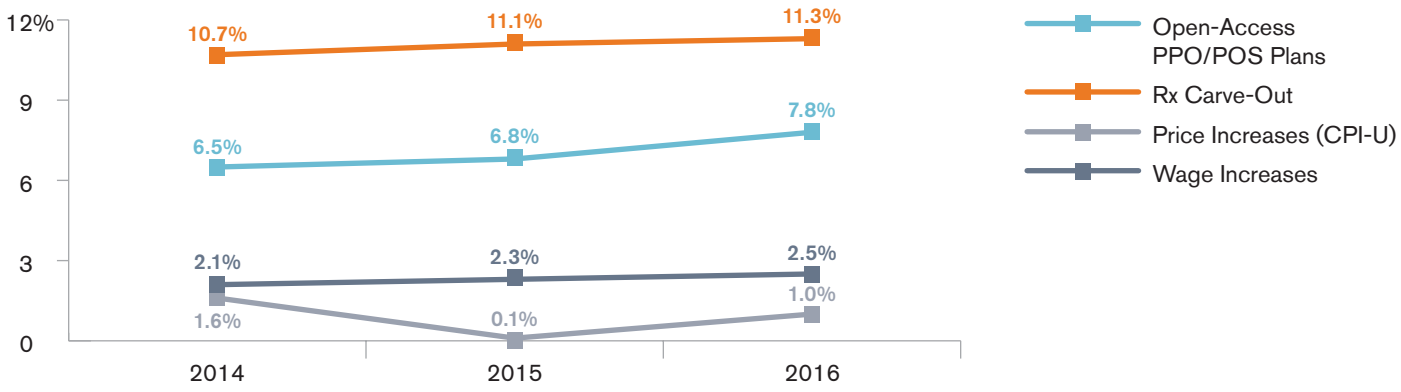
Source: Segal Consulting, 2016

Observations Regional competition among both health insurers and health care provider systems may play a role in health provider reimbursement rate changes and cost trends. As a result, the number of competitors with material market share in the Northeast, for example, may be helping to keep provider reimbursement fee increases to less severe levels. Several mergers of major insurers have been announced in the past year, including Aetna's proposed merger with Humana, and the Anthem-Cigna deal. While the U.S. antitrust regulators may block these deals, future consolidation could alter the competitive landscape of national managed care provider networks.

Cost Trend Rates Continue to Outpace Increases in Prices and Wages

For many plan sponsors, the increase in medical plan cost trends can be more than three times the rate of increase in wages.

Comparison of Selected Cost Trend Rates (2014–2015 Actual and 2016 Projected) to Price and Wage Increases for Actives and Retirees Under Age 65



Sources: Segal Consulting, 2016 (cost trend rates) and Bureau of Labor Statistics CPI-U through July 31, 2016 from Consumer Price Index — July 2016 and wage increases from Table B-3. Average hourly earnings of all employees on private nonfarm payrolls, seasonally adjusted.

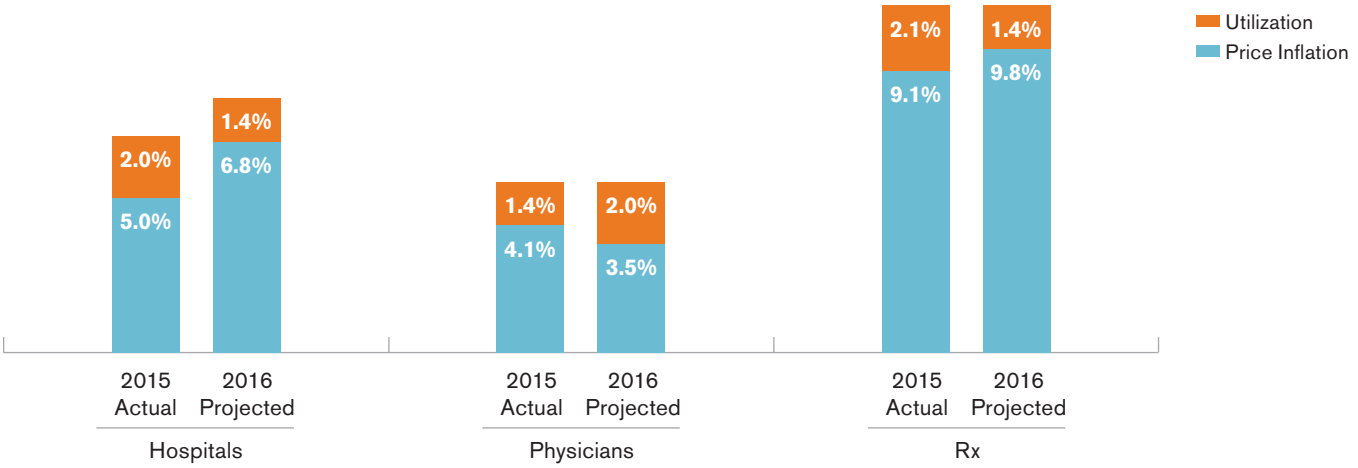
Observations Health care cost increases continue to outpace general inflation by almost eight times. Plan sponsors should consider implementing vendor performance guarantees that cap average network provider increases to overall CPI plus a margin, such as 1 percent or 2 percent. The goal for network providers should be to maintain network price increases to levels that are linking to overall CPI and to find ways to manage and avoid complications from disease that ultimately reduced claim costs.

> "For many plan sponsors, the increase in medical plan cost trends can be more than three times the rate of increase in wages."

Price Inflation Has Been the Leading Driver of Cost Trend

Price inflation for hospital services and prescription drugs are still the leading drivers of plan cost trend increases for 2016.

Components of 2015 Actual and 2016 Projected Cost Trends for Hospital Services, Physician Services and Prescription Drugs for Actives and Retirees Under Age 65*



* Hospital and physician cost trends are for open-access PPOs. The components do not add up to totals because there are other components of cost 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 cost trend by component, which may produce results that vary from the overall prescription drug plan cost survey results found on page 4.

Source: Segal Consulting, 2016

Observations Increases in the average wholesale prices of brand-name (and, in some cases, generic) drugs continue to have an impact on prescription drug price inflation. The recent price hike for drugs like EpiPen and Glumetza, which is used to treat type 2 diabetes, is a dramatic example of drug manufacturer pricing that requires attention from plan sponsors. Strategies include not covering these high-cost drugs or removing them from formularies where other therapy options are available, covering alternative drugs that are more cost effective and are clinically appropriate, and even lobbying policymakers into action.

Plan sponsors can put pressure on their health care provider networks to manage provider price inflation. In fact, Segal has helped clients secure price-inflation caps on network providers through contract negotiations during competitive bids so that the plans not only receive competitive network discounts today, but have guarantees that the increases in provider fees are reasonably tied to overall CPI.

Plan designs are an effective tool for affecting future utilization and plan costs. Plan sponsors can structure participant copayments to drive the right utilization and minimize visits to higher-cost settings when inappropriate. In essence, these "smart" plan designs create rational step-therapy-type incentives to reduce both participants' cost sharing and plan costs. Realigning copayments to set the right relative cost sharing across treatment settings can achieve significant savings for plans. For example, plan participants seeking care for non-emergency issues in the emergency room (ER), rather than a less expensive option, like lower-cost, urgent-care centers or office-based care, can be given an incentive to use lower-cost settings with lower copays. Conversely, participants can be required to pay their fair share if they go to ER settings for truly non-urgent care. Raising or eliminating out-of-pocket expense limits on out-of-network provider coverage may reduce the level of non-network provider use where cost and billing practices can be substantially higher than network costs.

Another factor influencing cost trends is the network-negotiated reimbursement rates paid to providers. This often varies by type of service as noted in the illustration below.

Projected Average Increase in Reimbursement Allowance by Type of Service

* The projected average increase in reimbursement allowance for hospital/facility differs from the price inflation increase of 5.0% in the graph on page 8 because it includes new treatments, therapies and technology.

Source: Segal Consulting, 2016

Observations Managed care networks' negotiated reimbursement rates differ by region, facility or specialists. Plan sponsors need to conduct a thorough analysis of a competing vendor's current provider pricing, network leasing fees, provider payment alternatives and network panels. Plan sponsors also can now consider limited or narrow provider networks offered by managed care organizations, which offer deeper pricing concessions, but could compromise participants' access to care. However, The Affordable Care Act is creating new minimal provider access standards by state, which may offer new protections to plan sponsors that would like to consider these narrow networks. Further, network evaluations should also include effective evaluation of medical management in addition to the impact of difference in network discounts.

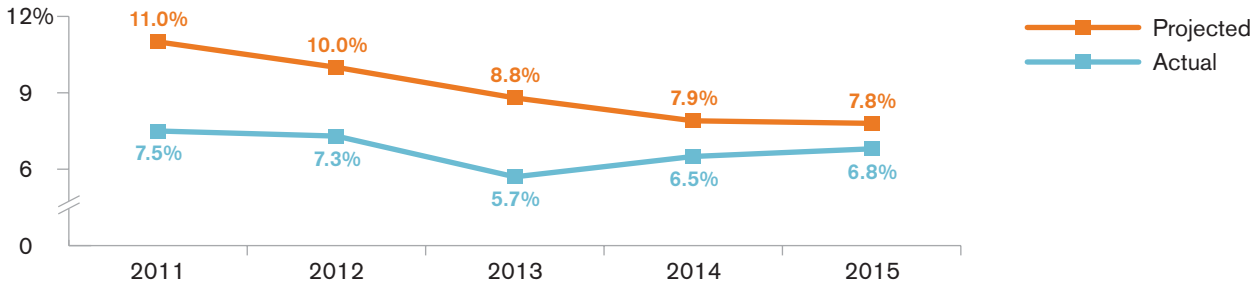
Our Analysis Finds Cost Trend Projections Are Typically Higher than Actual Experience

To assess the accuracy of cost trend projections, Segal compared the average 2015 cost of medical, prescription drug benefit and dental plans to the actual average cost trend rates experienced by the health plans covered by those organizations for the same 12-month period (the most recent full year for which actual data is available), as reported by the survey respondents. Consistent with the past four years, this year's findings support our observation that insurers tend to make conservative projections and confirm that cost trend projections have been generally higher than actual experience in most years.

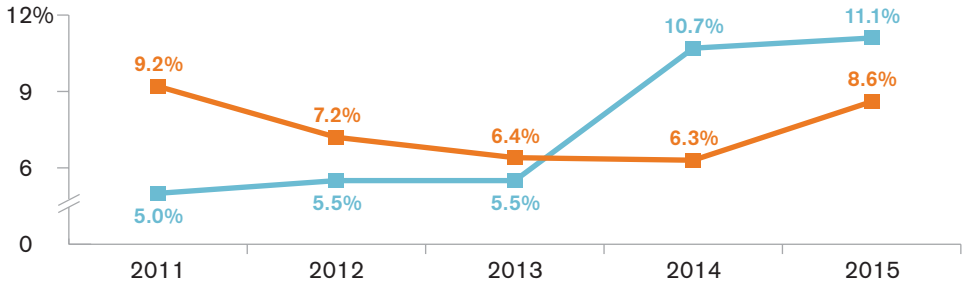
There is a notable exception: projections for pharmacy cost trend were understated substantially in 2014 and 2015. This is primarily attributable to the high costs of drugs for treating Hepatitis C and significant spending on compounded medications.

Comparison of Projected to Actual Cost Trends: 2011–2015

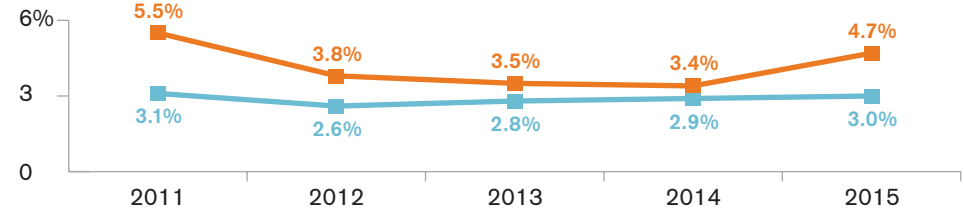
Open-Access PPO/POS Plans for Actives and Retirees Under Age 65[1]



Rx[2] Carve-Out Coverage for Actives and Retirees Under Age 65



Dental PPOs



[1] All medical trend results exclude Rx.

[2] This data reflects retail and mail-order delivery channels combined.

Source: Segal Consulting, 2016

Observations An assessment of the accuracy of cost trend assumptions should be based on a comparison of projected cost trend to actual cost trend over multiple years. For example, difference between projected to actual cost trend over the past 15 years showed an average differential of 1.6 percentage points down for open-access PPO/POS plans and 2.2 percentage points up for prescription drug carve-out coverage.

The table below shows selected cost trends for 15 years (actual cost trends for 2003–2015 and projected cost trends for 2016 and 2017). Between 2013 and 2014, actual prescription drug cost trend nearly doubled from 5.5 percent to 10.7 percent, primarily because of the launch of new specialty drug options and brand-name drug price inflation. This was the largest single-year increase in actual prescription drug cost trend ever reported by the *Segal Health Plan Cost Trend Survey*.

Selected Medical,[1] Rx Carve-Out[2] and Dental Cost Trends: 2003–2015 Actual and 2016 and 2017 Projected[3]

Year	PPOs	POS Plans	HMOs	MA HMOs	Rx	DPOs
2003 Actual	12.0%	11.5%	11.5%	10.0%	14.3%	6.5%
2004 Actual	10.9%	11.6%	11.5%	11.4%	13.3%	6.2%
2005 Actual	10.4%	11.1%	10.6%	8.4%	10.5%	5.0%
2006 Actual	9.6%	10.0%	10.2%	7.2%	9.5%	5.1%
2007 Actual	8.9%	9.5%	9.8%	7.0%	7.9%	5.0%
2008 Actual	9.7%	9.4%	9.7%	7.7%	7.4%	5.5%
2009 Actual	9.5%	9.7%	10.2%	4.0%	7.9%	4.7%
2010 Actual	7.6%	8.3%	8.7%	3.6%	6.4%	3.0%
2011 Actual	7.5%	7.8%	8.0%	4.5%	5.0%	3.1%
2012 Actual	7.3%	8.4%	6.7%	3.0%	5.5%	2.6%
2013 Actual	5.7%	6.7%	6.1%	3.1%	5.5%	2.8%
2014 Actual	6.5%	7.6%	6.3%	1.9%	10.7%	2.9%
2015 Actual	6.8%	6.9%	6.4%	4.2%	11.1%	3.0%
2016 Projected	**7.8%**	**8.0%**	**6.8%**	**3.5%**	**11.3%**	**3.5%**
2017 Projected	**7.6%**	**7.5%**	**6.7%**	**4.4%**	**11.6%**	**4.1%**

[1] Medical cost trends exclude prescription drug coverage.

[2] Prescription drug cost trend data for 2003—2007 only reflects retail. For 2008–2017, prescription drug retail and mail-order delivery channels are combined.

[3] All cost trends are illustrated for actives and retirees under age 65, except for the MA HMOs. (A graph comparing 15 years of survey data — 2003 through 2015 actual cost trends and 2016 and 2017 projected cost trends — is available as a supplement to this report.)

Source: Segal Consulting, 2016

A Range of Cost-Management Strategies Are Being Used

As health plan cost trends continue to increase, plan sponsors continue to use various cost-management strategies. Survey participants were asked to rank the top cost-management strategies implemented by group health plans in 2016. Each strategy was rated from 5 (frequently applied) to 1 (not being applied). Here are the top five based on averages of these ratings, which are shown in parentheses:

1. Using specialty pharmacy management (4.4);

2. Intensifying pharmacy management program (4.3);

3. Contracting with value-based providers, including accountable care organizations (ACOs) and Patient-Centered Medical Homes (PCMHs) (3.8);

4. Adding low-cost primary care access through strategies such as telemedicine, walk-in clinics and on-site clinics (3.5); and

5. Increasing financial incentives in wellness design (3.3).

Other cost-management strategies implemented in 2016 include high-deductible health plans (HDHPs) (3.3); narrow, limited or restricted provider networks (2.7); Medicare Employer Group Waiver Plans (EGWPs) (2.4); a defined contribution approach with or without use of a private Exchange (2.1); and reference-based pricing for specific medical procedures, such as hip or knee replacement (1.3).

Observations Plan sponsors will need to apply multiple management strategies to bring health cost trends down to more sustainable levels. Each plan sponsor has a unique set of goals and cost drivers. Segal's health benefit experts can present a range of solutions that are tailored to each client's needs. We present a plan sponsor with options and note the potential plan cost savings and the impact on plan participants. By targeting solutions and strategies that address plan design, aggressive vendor contracting and measurable population health improvement, we can help clients meet their health benefit objectives.

Refining Your Approach to Managing Costs

An ability to understand participant coverage needs, appropriate levels of choice, employee affordability and service preferences will allow plan sponsors to focus on design and strategies that are most appropriate for their population. Data analytics and predictive modeling can be used to help understand true drivers of costs and uncover substantial savings. Data-driven techniques are often used by high-performing plan sponsors to continuously assess their investments needed for more efficient and effective care without simply shifting costs to participants.

A concerted effort to explore what health care conditions drive the most cost, what providers and treatments produce the best value and what levers and incentives help change an individual's behavior to drive healthier lifestyles can reduce long-term claim cost trends. This will allow plan sponsors to maintain control over providing high-value medical benefits that are well received by current and future participants.

Methodology and the Survey Participants

During the summer of 2016, Segal surveyed managed care organizations (MCOs), health insurers, pharmacy benefit managers (PBMs) and third-party administrators (TPAs) using a detailed, two-page questionnaire. The survey captures average forecasted changes in health plans' per capita claims costs for medical, prescription drug, dental and vision coverage for 2017, before plan changes are taken into account. Cost trends for carve-out prescription drug plans do not reflect the impact of rebates from PBMs. In addition, the survey collected actual cost trends for 2015 based on respondents' group health plan experience.

Nearly 100 insurance providers participated in the 2017 *Segal Health Plan Cost Trend Survey*. A count of participants who submitted responses by coverage category follows.

Medical Plans	
Fee-for-Service (FFS)/Indemnity Plans	26
High-Deductible Health Plans (HDHPs)	42
Open-Access Preferred Provider Organization (PPO)/Point-of-Service (POS) Plans	27
PPO/POS Plans (with Primary Care Physician Gatekeepers)	37
Health Maintenance Organizations (HMOs)	37
Prescription Drug Carve-Out Plans	56
Dental Plans	
Dental Schedule of Allowance Plans	19
Dental FFS/Indemnity Plans	58
Dental Provider Organizations (DPOs)	65
Dental Maintenance Organizations (DMOs)	46
Vision Plans	
Vision Schedule of Allowance Plans	25
Vision Reasonable and Customary Plans	26

> "The survey captures average forecasted changes in health plans' per capita claims costs for medical, prescription drug, dental and vision coverage for 2017, before plan changes are taken into account."

The following respondents agreed to be identified by name:

Advantica
Aetna
Amalgamated Life
American Health Care
AmeriHealth New Jersey
Anthem, Inc.
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 North Carolina
Blue Cross of Idaho
Blue Shield of California
BlueCross BlueShield of Tennessee
Cambia Health Solutions
Capital BlueCross
Care Plus DentalPlans
CareFirst BlueCross BlueShield
Cigna
CVS Caremark
Davis Vision
Delta Dental Insurance Company (DDIC)
Delta Dental of Arizona
Delta Dental of Arkansas
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 Iowa
Delta Dental of Massachusetts
Delta Dental of Minnesota
Delta Dental of Missouri
Delta Dental of Nebraska
Delta Dental of New Jersey
Delta Dental of New York
Delta Dental of Pennsylvania
Delta Dental of South Dakota
Delta Dental of Virginia
Delta Dental of Washington
Delta Dental of West Virginia
Delta Dental Plan of Maine (part of Northeast Delta Dental affiliation)
Delta Dental Plan of New Hampshire (part of Northeast Delta Dental affiliation)
Delta Dental Plan of Vermont (part of Northeast Delta Dental affiliation)
EmblemHealth
Envision Pharmaceutical Services, LLC
Express Scripts, Inc.
Group Vision Service
Harvard Pilgrim Health Care
Health Alliance Medical Plans
Health Net, Inc.
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
Medica Health Plans
Medical Mutual
Metropolitan Life Insurance Company
National Vision Administrators, LLC
Navitus Health Solutions
Nippon Life Insurance Company
Optum Rx
Prime Therapeutics LLC
ProAct, Inc.
Sav-Rx Prescription Services
Starmark
Sun Life Financial
Tufts Health Plan
United Concordia Dental
UnitedHealthcare
Voya Financial
Wellmark BCBS of South Dakota
Wellmark Blue Cross and Blue Shield

Questions? Feedback? Contact Us.

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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 members? 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 member 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.
- ***Financial Monitoring*** Does your plan have the proper budgeting tools in place to ensure fund stability? Segal can assist in reviewing or developing your plan's reserve policy, analyzing the impact of proposed plan design changes on future expenses, and evaluating whether your fund is at risk for insolvency.
- ***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.
- ***Benchmarking*** Have you compared your policies and initiatives to other funds? Segal provides benchmark assessments that provide a unique and invaluable understanding of how benefit programs compare to others.

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