



2015 Segal Health Plan Cost Trend Survey

Expect More Variation in Health Benefit Cost Trends for 2015

Health benefit plan cost trend rates for 2015 are forecast to drop slightly for some coverage, but to increase substantially for prescription drug coverage, according to data compiled in the 2015 *Segal Health Plan Cost Trend Survey*, Segal's eighteenth annual survey of managed care organizations (MCOs), health insurers, pharmacy benefit managers (PBMs) and third-party administrators (TPAs). Trend is the forecast of annual gross per capita claims cost increases.¹ The survey captured data on trend projections for the following types of medical coverage for active participants and retirees under age 65: fee-for-service (FFS)/indemnity plans, high-deductible health plans (HDHPs), open-access preferred provider organizations (PPOs)/point-of-service (POS) plans, PPOs/POS Plans (with PCP gatekeepers) and health maintenance organizations (HMOs). In addition, the survey compiled data on trend projections for various types of medical coverage for Medicare-eligible retirees, prescription drug carve-out, dental and vision.

This report presents the survey results, including components of trend, in graphs and tables with observations on key findings. To assess the accuracy of projections, trend projections are compared to actual data. Actual trends for 2013 (the most recent full year for which actual data is available), were the lowest reported in more than 12 years for

managed care plans (HMOs and PPOs/POS plans). The report also compares trend data to increases in the consumer price index for all urban consumers (CPI-U) and wages. It concludes with Segal's commentary on top health care cost-management strategies.

Benefit Trend Projections for 2015

Health benefit trends for actives and retirees under age 65 are forecast to vary widely by type of coverage for 2015, as shown in Graph 1, which compares those projections to 2014 projections:

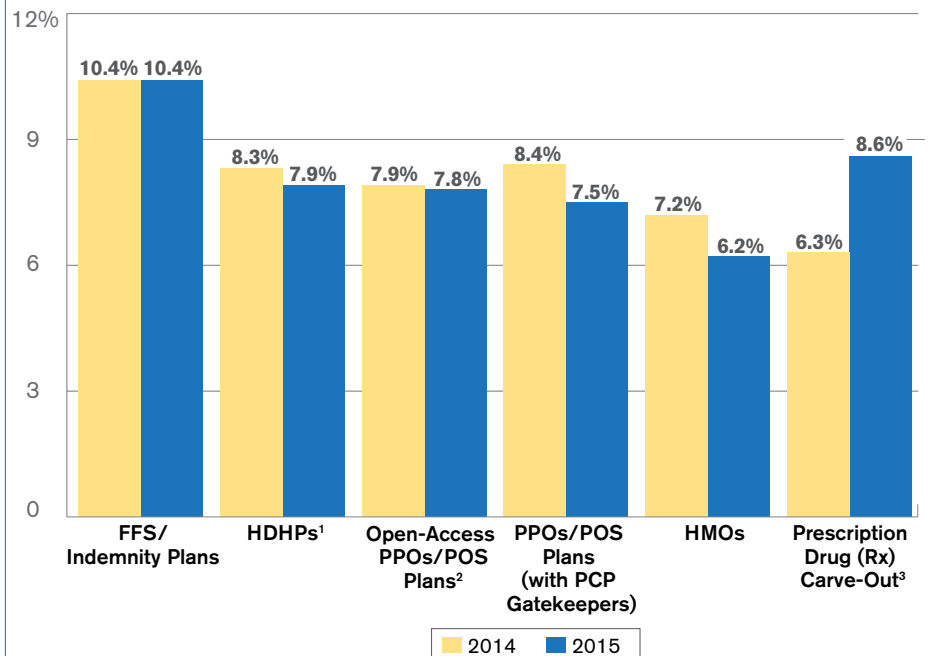
- Medical trends are projected to range from a low of 6.2 percent for HMOs

to a high of 10.4 percent for fee-for-service coverage.

- More closely managed medical plans, like HMOs and PPOs/POS plans with primary care gatekeeper models, are forecast to see a 1 percentage-point drop from 2014 projections.
- The increase in the cost of prescription drug carve-out coverage is expected to jump to nearly 9 percent.

New specialty drugs coming to market and price increases of brand-name drugs are the main driving forces of prescription drug plan cost trends.

Graph 1: Projected Medical and Prescription Drug Trends for Actives and Retirees Under Age 65: 2014 and 2015



¹ HDHPs with an employee-directed, tax-advantaged health account — a health savings account (HSA) or a health reimbursement account (HRA) — are referred to as account-based health plans and are designed to encourage consumer engagement, resulting in more efficient use of health care services.

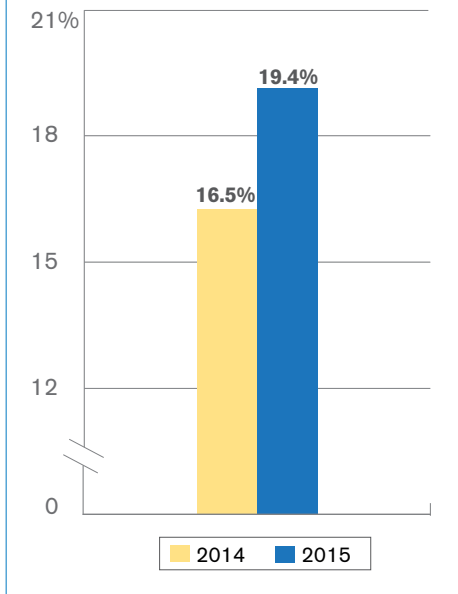
² Open-access PPO/POS plans are those that do not require a primary care physician (PCP) gatekeeper referral for specialty services.

³ Prescription drug carve-out data was captured for retail and mail-order delivery channels combined.

¹ For a more detailed description of trend, see the following online supplement: <http://www.segalco.com/publications/surveysandstudies/2015TSsupp1.pdf>. For information about the survey participants, see another online supplement: <http://www.segalco.com/publications/surveysandstudies/2015TSsupp2.pdf>.

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Graph 2: Projected Specialty Drug/Biotech Trend: 2014 and 2015



Typically, less than 1 percent of all prescriptions are specialty drug medications,² yet survey respondents noted these drugs now account for more than 25 percent of total prescription drug cost trends. The projected specialty drug/biotech trend rate for 2015 is an exceptionally high 19.4 percent. See Graph 2 above.

Graph 3 compares 2015 projections for Medicare-eligible retiree coverage to 2014 projections. Notable findings follow:

- The trend for Medicare supplemental (Medigap) plans is expected to decline, while the trend for Medicare Advantage (MA) PPO plans will remain the same and the trend for Medicare Advantage HMOs is forecast to be higher.
- Prescription drug trend for retirees age 65 and older is expected to rise to 7.5 percent, more than twice the rate of retiree medical cost trends.

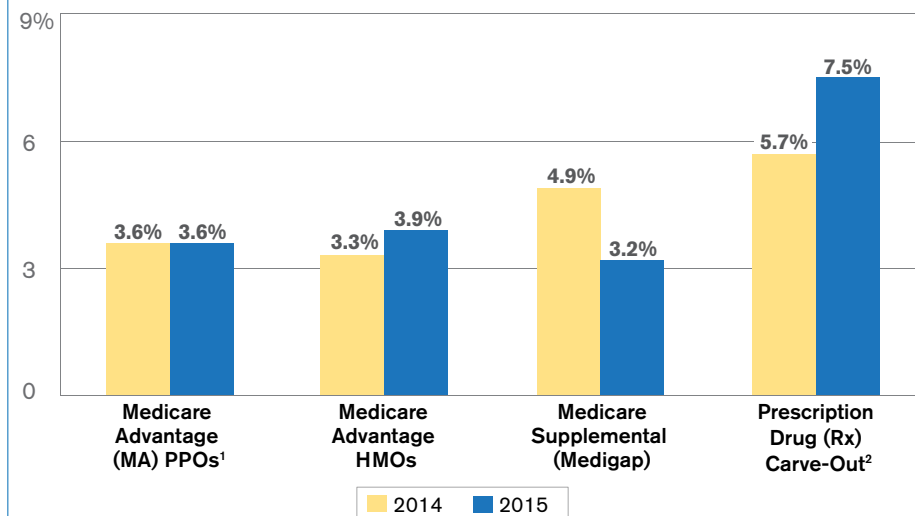
As shown in Graph 4, trends for dental coverage are expected to be either flat or higher for 2015 compared to 2014 projections, whereas trends for vision coverage are forecast to be lower. Notably:

- Dental plan trends are projected to increase to 4.7 percent for dental provider organizations (DPOs).

- Vision plan cost trend rates are projected to decline to just below 3 percent.

The survey looked for regional variations in trend rates. Projected 2015 trend rates for PPOs and POS plans combined show regional variations, with the lowest rate of 5.8 percent in the South

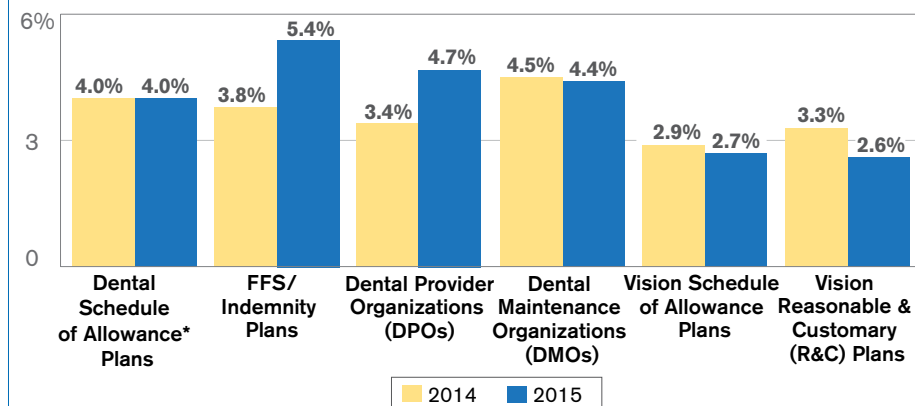
Graph 3: Projected Medical and Prescription Drug Trends for Retirees Age 65 and Older: 2014 and 2015



¹ The 2014 survey combined PPOs with FFS plans. The 2015 survey only captured data about PPOs, not FFS plans.

² Prescription drug carve-out data was captured for retail and mail-order delivery channels combined.

Graph 4: Projected Dental and Vision Trends: 2014 and 2015

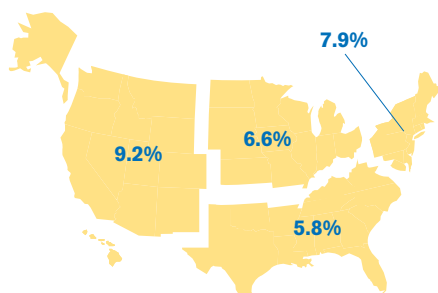


* A schedule of allowance plan is a plan with a list of covered services with a fixed-dollar amount that represents the total obligation of the plan with respect to payment for services, but does not necessarily represent the provider's entire fee for the service.

² 2013 Express Scripts Drug Trend Report: <http://lab.express-scripts.com/~media/7f14884da6ef434dbf30abd82dd7e655.ashx>

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Graph 5: Projected 2015 Medical Trends for PPOs/POS Plans for Actives and Retirees Under Age 65 by Region



and highest rate of 9.2 percent in the West, as shown in Graph 5 above.

For plans that offer narrow networks,³ survey participants were asked the average cost impact on 2015 plan trend relative to standard broad networks. Most reported no difference, as shown in Table 1. However, 38 percent indicated narrow network cost trends would average 3.8 percentage points lower than standard networks.

Affordable Care Act Mandates Adding to Health Plan Cost Trends

The Affordable Care Act imposes new mandates and taxes on most health plan sponsors and charges new fees

³ Narrow networks typically offer less than half of available providers in the network area.

Table 1: Average Cost Impact on 2015 Plan Trend for Narrow Networks Relative to Standard Broad Networks

Rank	Percent of Responses	Trend Rate Impact
No Difference	63%	0.0%
Lower	38%	3.8%
Higher	0%	Not Applicable

to them, all of which are adding to cost trends. Segal asked the survey respondents specifically about what the expected cost increase would be to comply with the Affordable Care Act's out-of-pocket maximum requirement for 2015, which applies to non-grandfathered plans. That requirement is expected to add an average cost increase of about 1 percent to medical plans and 1.5 percent to prescription drug carve-out plans.

Components of 2015 Medical Trends

The survey also examined 2015 projected medical trends by service type. Similar to prior-year projections, price inflation remains the largest component for hospital services and brand-name medications.

The survey respondents predict a nearly 3.5 percent increase in utilization of hospital and physician services, up slightly from prior projections. Prescription drug utilization rates (the number of prescriptions filled per enrollee) are forecast to increase by 2.5 percent. However, for many "mature" groups (those with stable enrollment), Segal continues to see relatively unchanged inpatient admission and prescription drug utilization rates.

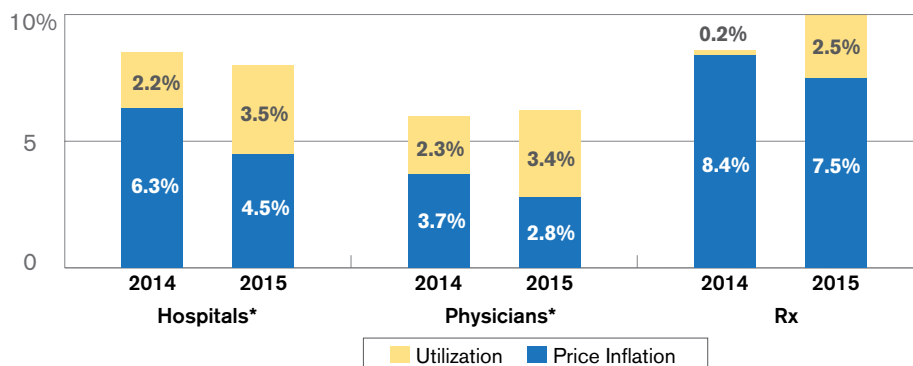
Accuracy of Trend Projections

To assess the accuracy of trend projections, Segal compared the average 2013 trend forecasts by national and regional insurers, MCOs, PBMs and TPAs for group medical, prescription drug benefit and dental plans to the actual average 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 previous survey findings, this year's findings support our observation that insurers and PBMs tend to make conservative projections and confirm that trend projections have been generally higher than actual experience in most years.

"Trend projections have been generally higher than actual experience in most years."

It should be noted that the accuracy of projections is subject to both underwriters' 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

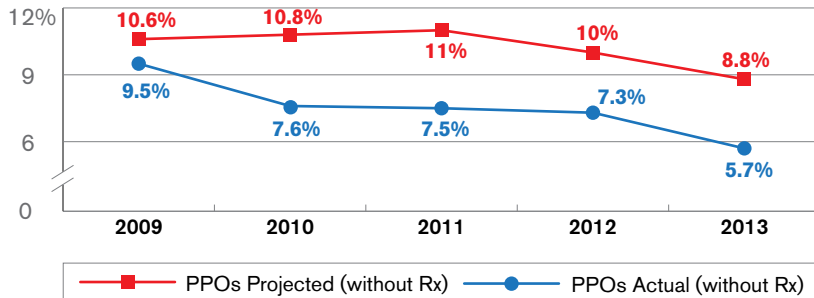
Graph 6: Components of 2014 and 2015 Projected Trends for Hospital Services, Physician Services and Prescription Drugs for Actives and Retirees Under Age 65



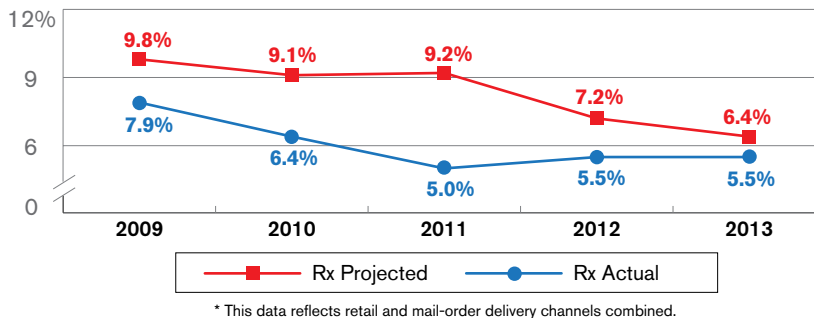
* Hospital and physician trends are for open-access PPOs. The components do not add up to totals because there are other components of trend not illustrated, reflecting such factors as the impact of cost shifting, technology changes and drug mix. Not all survey respondents provided a breakdown of trend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

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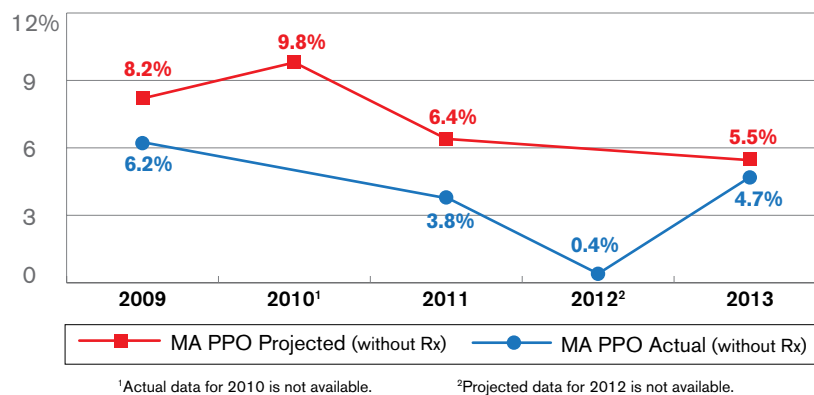
Graph 7: Comparison of Projected to Actual Trends for Open-Access PPOs/POS Plans for Actives and Retirees under Age 65: 2009–2013



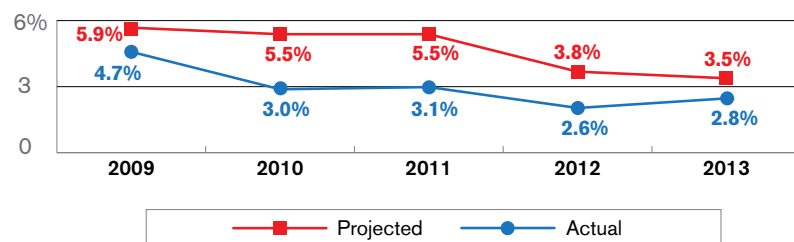
Graph 8: Comparison of Projected to Actual Trends for Rx* Carve-Out Coverage for Actives and Retirees under Age 65: 2009–2013



Graph 9: Comparison of Projected to Actual Trends for MA PPOs: 2009–2013



Graph 10: Comparison of Projected to Actual Trends for Dental PPOs: 2009–2013



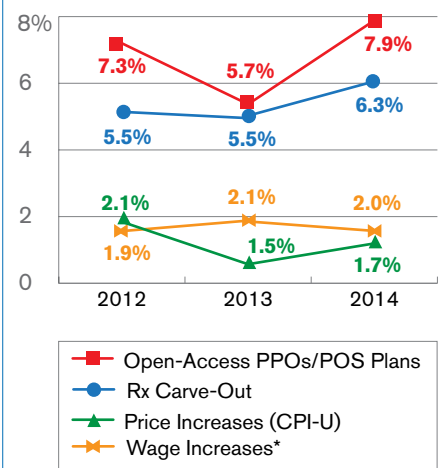
will generally be underestimated for a period. Also, actual historic results may reflect changes to plan design taken by plan sponsors year to year, while forecasted trends are based on the same level of benefits. Consequently, accuracy of trend assumptions is best measured by comparing projected trend to actual trend over multiple years. Graphs 7–10 compare projected trends to actual trends for five years.

Table 2 on the next page shows selected trends for 13 years (actual trends for 2003–2013 and projected trends for 2014 and 2015). Actual trends for 2013 for managed care plans were the lowest reported in more than 12 years.

Trend Rates Compared to Increases in Prices and Wages

Medical health plan cost trends continue to outpace the CPI-U and wage growth by a margin of at least three to one. See Graph 11. For many plan sponsors, the increase in medical plan cost trends can be more than four times the rate of increase in wages.

Graph 11: Comparison of Selected Trend Rates (2012–2013 Actual and 2014 Projected) to Price and Wage Increases



* Bureau of Labor Statistics (BLS) – Table B-3. Average hourly earnings of all employees on private nonfarm payrolls, seasonally adjusted: <http://www.bls.gov/news.release/empsit.t19.htm>

Cost-Management Strategies

Survey participants were asked to indicate the top cost-management strategies implemented in 2014. The text box at the bottom of this page lists the common strategies implemented for medical and prescription drug plans, respectively.

Commentary & Outlook

The improving economy continues to play a significant role in the spending and utilization of health care. Additionally, the impact of the Affordable Care Act is also beginning to take effect. Not only has the law failed to provide significant cost relief for plan sponsors, it has had the opposite effect as a result of new mandates, taxes and fees. Several studies estimate the increase in health costs to range between 1 and 4 percent, depending on the year.⁴

Sponsors of large group plans must stay focused on exploring health plan strategies that produce high-value medical benefits with stable cost trends, even as the health benefits landscape changes around them due to the Affordable Care Act. Some of these strategies include:

➤ **Setting Appropriate Cost Sharing**

The level of cost sharing influences plan utilization and overall costs. The relative relationship between treatment copayments for different treatment options and settings is a critical element of creating a highly efficient plan design. For example, the right copayment differences for lower-cost settings, such as tele-medicine, walk-in clinics and urgent care, can play a role in reducing

Table 2: Selected Medical,¹ Rx Carve-Out and Dental Trends: 2003–2013 Actual and 2014 and 2015 Projected²

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 Projected	7.9%	8.4%	7.2%	3.3%	6.3%	3.4%
2015 Projected	7.8%	7.5%	6.2%	3.9%	8.6%	4.7%

¹ Medical trends exclude prescription drug coverage.

² All trends are illustrated for actives and retirees under age 65, except for the MA Plans. (A graph comparing 13 years of survey data — 2014 and 2015 projected trends to actual trends for 2003 through 2013 — is available on the following webpage: <http://www.segalco.com/publications/surveysandstudies/2015TSsupp3.pdf>).

Top Medical Plan and Prescription Drug Plan Cost-Management Strategies Implemented in 2014

Medical Plan Strategies

- Expand Use of Low-Cost Primary-Care Access (Telehealth, Walk-In Clinics, Worksite Clinics)
- Reference-Based Pricing¹
- Follow the Medicare Hospital Readmissions Reduction Program to Reduce Hospital Readmissions
- Value-Based Contracting, including:
 - Accountable Care Organizations (ACOs)²
 - Patient-Centered Medical Homes (PCMHs)³
 - Use of Narrow/Tiered Networks⁴
- Defined Contribution Approaches with or without the Use of Private Exchanges
- Continued Focus on Wellness

Prescription Drug Plan Strategies

- Medication Therapy Management Program
- RetroDUR Program⁵
- EGWP⁶ Implementation
- Formulary Management
- Prior Authorization
- Step Therapy
- Physician Dispensing and Pharmacy Network Management
- Specialty Pharmaceutical Management

⁴ See *2014 Employer-Sponsored Health Care: ACA Impact* (https://www.ifebp.org/pdf/research/ACASurvey_2014.PDF); *Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans* (<http://www.ahipcoverage.com/wp-content/uploads/2011/11/Insurer-Fees-report-final.pdf>); *Impact of the Health Insurance "Annual Fee" Tax* (http://americanactionforum.org/uploads/files/research/Impact_of_the_Health_Insurance_Tax.pdf); and *The Cost of the Affordable Care Act to Large Employers* (http://www.americanhealthpolicy.org/content/documents/resources/2014_ACA_Cost_Study.pdf).

¹ Reference-based pricing involves designs where a plan sets a maximum price for covering the cost of a particular service to steer patients away from higher-priced providers who have no evidence of providing higher-quality services.

² ACOs, which have mainly been developed for the Medicare population, are networks of providers and suppliers that agree to be jointly accountable for managing the health of participating populations across the care continuum.

³ PCMHs focus on an increased level of comprehensive health care resources on primary care and prevention for patients with chronic conditions.

⁴ Tiered networks require lower cost sharing if participants use high-quality, preferred providers within a network.

⁵ RetroDUR stands for retrospective drug utilization review.

⁶ EGWP is an abbreviation of Employer Group Waiver Plan.

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emergency department visits for minor illnesses. Reintroducing percentage copayments for some services (e.g., prescription drugs, rehabilitative services and elective surgery) can encourage participants to be thoughtful health care consumers. Having an incentive to reduce out-of-pocket costs, where treatment options exist, will create more engaged plan participants and will reduce non-essential treatments and increase the use of lower-cost alternatives.

- **Selecting the “Right” Network Providers** Managed care networks have competitive advantages (deep discounts) in different regions. Some plan sponsors are evaluating the potential savings associated with narrow network strategies that steer patients to higher-quality, lower cost providers. Substantial migration to shared-savings provider reimbursements shows promise with respect to long-term cost savings.
- **Emphasizing Prevention, Wellness, Early Detection and Improved Health Consumer Literacy** The amount of excess health care spending that is the result of preventable behaviors and lifestyle has been well-documented in the consulting and academic community. Smoking, obesity, stress, lack of physical activity, and poor eating habits contribute to a significant percentage of our national health spending. When plan sponsors design, incent and support the proper wellness and health literacy programs, they experience long-term reductions in hospitalization, emergency room visits, advanced complications of disease and rates of chronic diseases with comorbidities.

- **Considering a Reference-Based Allowance Approach** Many plan designs are reviewing the feasibility of implementing reference-based pricing for particular procedures

(e.g., a knee replacement). The goal is to negotiate cost-effective arrangements with high-quality providers.

- **Considering a Defined Contribution (DC) Approach** The elimination of pre-existing exclusions and guaranteed issue underwriting and the maturation of private health Exchanges has created new coverage opportunities for plan sponsors to consider. While a DC approach is sometimes used as a way to simply cut benefits, in some situations, employers and plan sponsors can create more economically sustainable health benefit strategies by converting to a defined contribution funding strategy and outsourcing medical coverage to the private health Exchanges.⁵ This approach may be even more compelling for covered retirees and has become more widely adopted for sponsors of plans with large retiree populations.
- **Resetting Eligibility Rules** In light of individual coverage available through the public Marketplaces, some plan sponsors are considering eliminating coverage for working spouses or charging for each covered dependent. This approach may most attractive in industries where incomes tend to be lower because spouses may be able to obtain heavily subsidized coverage through the public Marketplaces.

The Affordable Care Act’s pay-or-play design for providing health coverage to full-time employees creates a complicated set of new options for plan sponsors. Segal expects large self-funded health plan sponsors to continue to provide higher-value, responsive health care

⁵ According to a study by the National Business Group on Health, while 3 percent of employers will move workers into the private health Exchanges next year, 35 percent say they are considering doing so for 2016. See the press release, “U.S. Employers Changing Health Benefit Plans to Control Rising Costs, Comply with ACA, National Business Group on Health Survey Finds”: <https://www.businessgrouphealth.org/pressroom/pressRelease.cfm?ID=234>

benefits to participants as they can provide these benefits at lower long-term costs than will be found in the public Marketplaces and private Exchanges over the long term. Removing or avoiding the cost of commissions, taxes and insurer profits is one obvious advantage that these larger plans will continue to enjoy. The ability to understand what their unique participant population demands in terms of coverage, choice and service will allow these plan sponsors to focus on strategies that are most appropriate. Plan sponsors can take steps to remove excess waste and fees in vendor contracts; to identify providers that produce the best value; and to choose levers and incentives to help promote healthy participant behavior. The combination of these strategies will produce meaningful dividends to plan sponsors and allow them to maintain control over providing high-value medical benefits that are well received by current and future employees.



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