2021 Medical Plan Cost Trends Similar to Pre-COVID-19 Levels

2021 *Segal Trend Survey* Finds Increase from 2020 Projections

Segal

Contents

1 Introduction

2 Key Findings

4 About the Survey

5 Medical Plan Trends and Cost Drivers

7 Prescription Drug Plan Trends and Cost Drivers

11 Dental Trends

12 Vision Trends

13 Medical Trends for Medicare-Eligible Retirees

14 Putting Trends in Context

18 Top Cost-Management Strategies in 2020

19 Medical Cost Management and Contracting Strategies

23 Pharmacy Benefit Cost Management and PBM Contracting Strategies

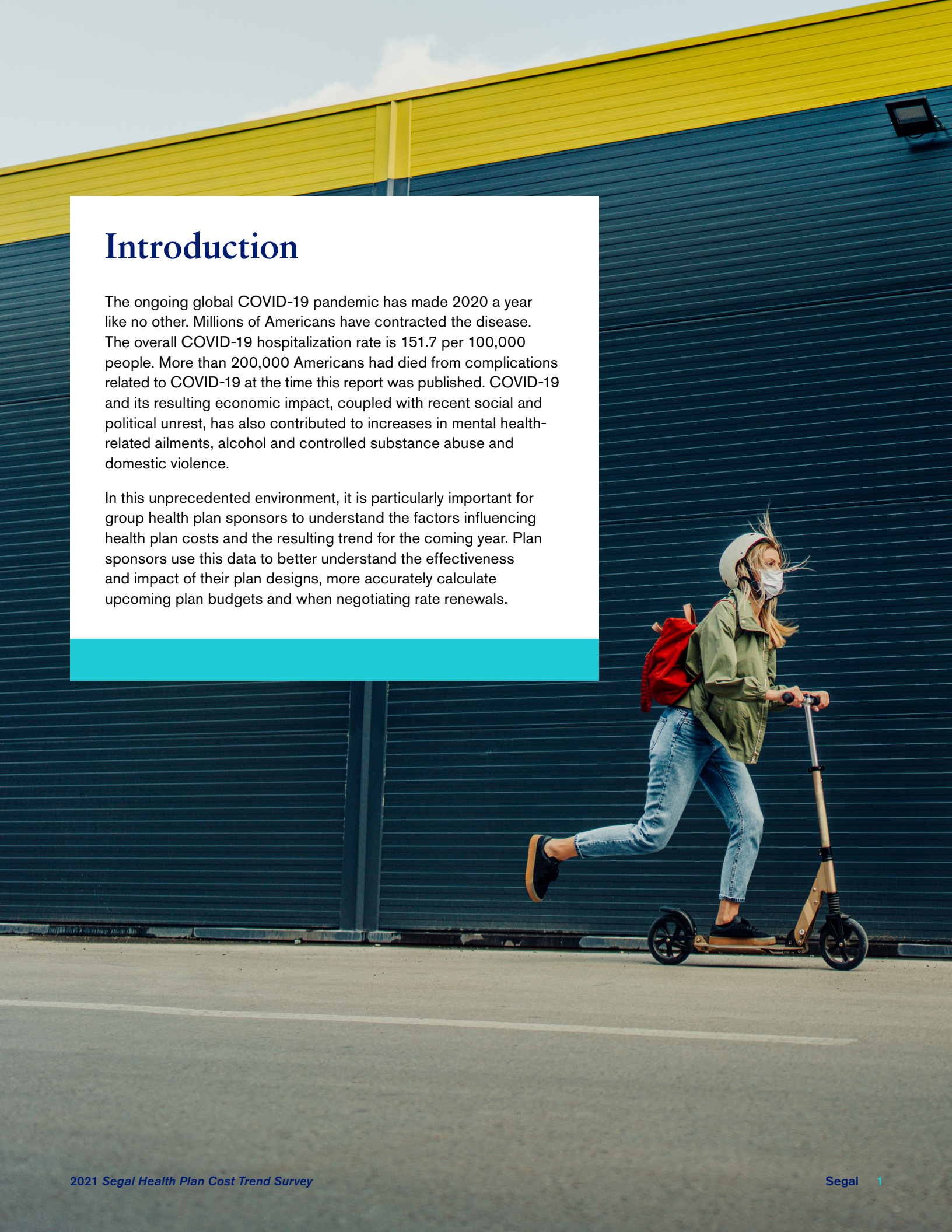
27 An Effective Strategy for Managing Costs

29 The Survey Respondents

Introduction

The ongoing global COVID-19 pandemic has made 2020 a year like no other. Millions of Americans have contracted the disease. The overall COVID-19 hospitalization rate is 151.7 per 100,000 people. More than 200,000 Americans had died from complications related to COVID-19 at the time this report was published. COVID-19 and its resulting economic impact, coupled with recent social and political unrest, has also contributed to increases in mental health-related ailments, alcohol and controlled substance abuse and domestic violence.

In this unprecedented environment, it is particularly important for group health plan sponsors to understand the factors influencing health plan costs and the resulting trend for the coming year. Plan sponsors use this data to better understand the effectiveness and impact of their plan designs, more accurately calculate upcoming plan budgets and when negotiating rate renewals.



Key Findings

Projected medical plan cost increases for 2021 are similar to projections for 2020. Contrast this finding with last year's survey, which reported a slowdown in medical trend projections.

Other key findings include:

- 2020 reductions in health plan costs as a result of pandemic-related suspension of non-essential care more than offset the cost to test and treat patients for COVID-19.
- Survey respondents project per-person cost trends for open-access PPO/POS plans to be 7.7 percent for 2021.
- The trend for outpatient prescription drugs is expected to be 7.3 percent for 2021.
- Double-digit specialty Rx cost trend, mostly driven by price increases and new specialty drugs, continues to be a challenge for plan sponsors.
- Provider price increases continue to be the primary driver for both medical and Rx trends.
- Trend projections for most dental coverages are lower for 2021.
- Vision trends are expected to decrease or stay the same.
- Medical trends for Medicare-eligible retirees are projected to increase.
- Health plan cost increases continue to significantly outpace general inflation and average wage increases.

Observations

COVID-19 has caused unexpected disruption in our healthcare system and strained the healthcare ecosystem. Healthcare providers, carriers and institutions will be looking for ways to offset anticipated financial losses. Plan sponsors hoping to avoid potential cost shifting must vigilantly monitor carrier policies and provider performance and pursue targeted cost-management strategies.

What Is Trend?

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

What factors influence trend?

Trend takes into account various factors, including:

- New treatment, therapies and technologies
- Provider cost shifting from reduced payment by Medicare and Medicaid
- Leveraging effect of fixed deductibles and copayments*
- Provider price increase
- Increased demand from increased health risks due to aging population or rise in obesity
- Greater emphasis on detection and diagnoses

Trend does not include the impact of PBM rebates.**

What is the relationship between trend and increases in a plan's costs?

Although there is usually a high correlation between a trend rate and the actual cost increase assessed by a carrier, trend and the net annual change in plan costs are not the same. A plan sponsor's costs can be significantly different from projected claims cost trends due to such diverse factors as:

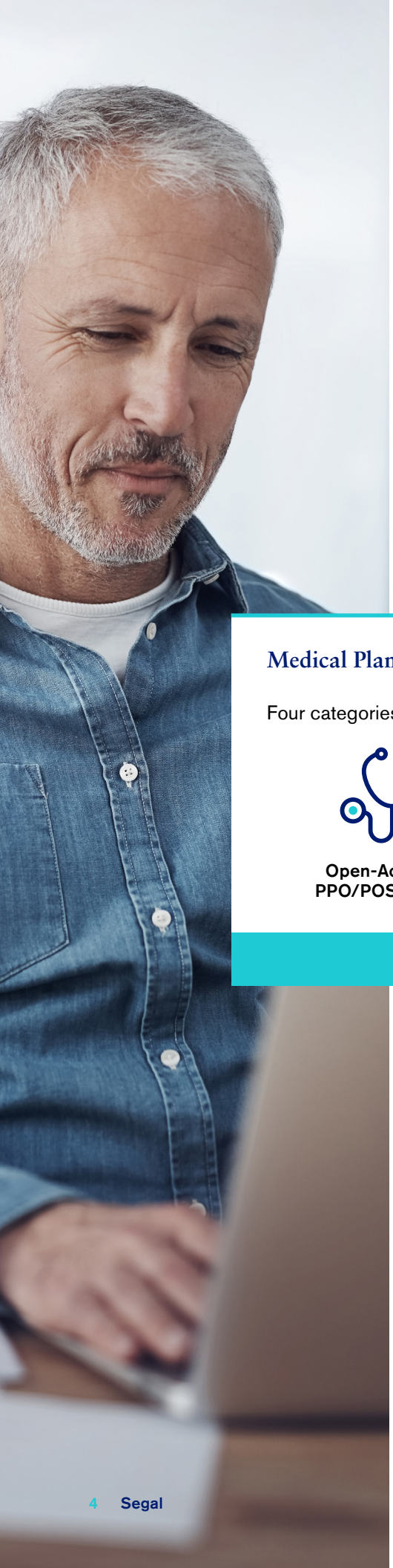
- Group demographics
- Regional market competition
- Changes in plan design
- Administrative fees
- Changes in participant contributions

How do plan sponsors use trend projections?

Cost trend assumptions are one element underwriters and actuaries use to project future plan sponsor costs. They can be used to set future premium rates or self-funded claim costs for budgeting purposes.

* This is a driver of net plan claim cost trends, not gross per capita claims cost increases.

** Rebates are discussed on page 8.



About the Survey

The 2021 *Segal Health Plan Cost Trend Survey* is Segal's 24th annual survey of managed care organizations (MCOs), health insurers, pharmacy benefit managers (PBMs) and third-party administrators (TPAs). Segal conducted the survey during the summer of 2020.

Respondents reported 2021 trend forecasts for medical, prescription drug, dental and vision coverage. In addition, the survey respondents reported actual allowed health cost trends for 2019 based on their group health plan experience.

Collectively, the survey respondents represent more than 80 percent of the commercially insured and self-insured market.

Medical Plans Covered in the Survey

Four categories of active and early retiree coverage are tracked in the survey:

Open-Access PPO/POS Plans

PPO/POS Plans with PCP gatekeepers

HMO Plans

HSA-Qualified HDHPs

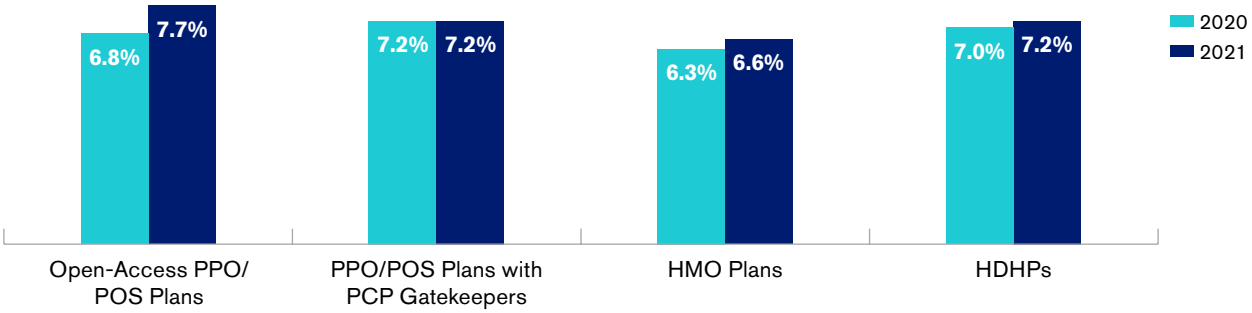
Higher Trends Projected for Most Medical Plan Types; Hospital and Physician Cost Drivers Differ

For 2021, survey respondents forecast higher trends than 2020 projections for three of the four plan types in the survey. The respondents estimate that COVID-19 will increase 2021 trend by 3.6 percentage points. Note, however, that plan sponsors are cautioned to recognize that these 2021 projections could significantly differ than their actuals, given the many unknowns related to the virus. For instance, the following factors may influence medical plan costs:

- The number of services that are postponed in 2020 and delivered in 2021
- The development of new tests, therapies and vaccines
- The rate of COVID-19 infection
- A new COVID-19 vaccine could lead to a faster return to pre-pandemic healthcare use
- Additional surges of the virus in 2020 and 2021
- Costs associated with disease progression for those with chronic conditions who delayed care during the pandemic
- Additional health complications resulting from COVID-19
- The overall health of the U.S. economy if high levels of underemployment or unemployment continue

Survey respondents estimate the net impact of the COVID-19 pandemic on 2020 medical plan costs to be a decrease of almost 4 percent. Respondents offer that pandemic-related suspension of non-essential treatment more than offset the added cost of COVID-19 testing and treatment.

Medical Trend Projections* for 2021 Are Higher Across Most Plan Types



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

Source: Segal, 2020

Leading drivers of medical trend

The survey examined components of trend and found two significant 2021 cost drivers:

- Hospital trend increases result from the prices of goods and services, rather than the surges in utilization of services; and
- Physician trend increases result from escalated utilization.

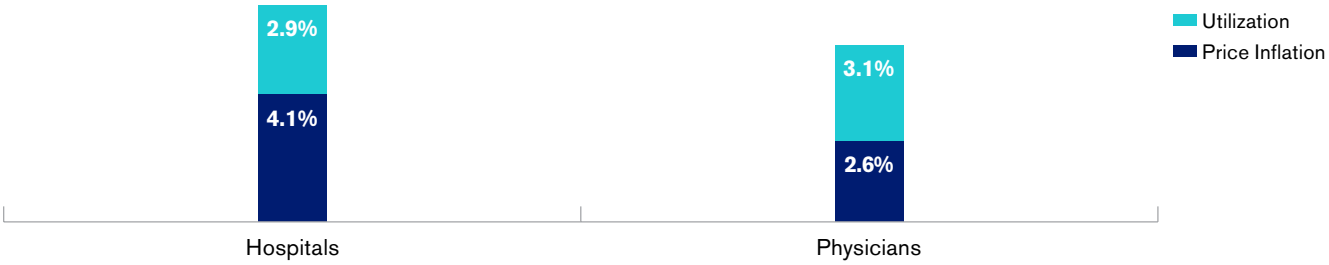
Hospital trend

The first leading cost driver related to hospital trend is consistent with more than a decade of our survey results. Despite grants authorized by the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act, most hospitals are experiencing revenue shortfalls. They may increase price of medical treatments and supplies to private health insurance carriers. Also, the growth in the uninsured population could lead to a large increase in Medicaid enrollment, as described in *Health Affairs*. Those changes could result in a shift of more costs to commercial, private payers that are already currently subsidizing costs.

Physician services

The second cost driver of medical trend relates to increased use of physician services. Forecasters may be predicting that there is pent-up demand for physician services that are becoming more accessible through advances in telemedicine. For instance, many physicians are finding that primary care visits can be effectively handled via telehealth. Additionally, MCOs are promoting and expanding access to telehealth services for sub-specialists, such as behavioral health therapy. As telehealth technology improves provider access, it is expected to continue increasing utilization of mental health services during the pandemic and beyond. Finally, some forecasted increases in utilization of physician services could be a result of medical complications from previously delayed treatment, due to limited physician access or virus transmission fears.

Hospital Price Inflation is the Largest Component of 2021 Projected Medical Trends*



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

Source: Segal, 2020

Questions? Contact Us.

Prescription Drug Plan Trend Continues to Increase Driven by Price Inflation

For 2021, cost trend for outpatient Rx plans is projected to be slightly higher than the 2020 projection. Outpatient Rx plans are typically administered by PBMs and represent brand-name drugs, generics, biosimilars and specialty drugs dispensed though retail, mail order and specialty management channels. Drugs administered in an inpatient facility or physician office setting are generally excluded because they are covered by a medical benefit program.

Projected trend for specialty drugs will increase by 11.5 percent. Although that rate is high, it is lower than the 2020 projection of 15.4 percent. In contrast, non-specialty growth is projected to be 2.8 percent.

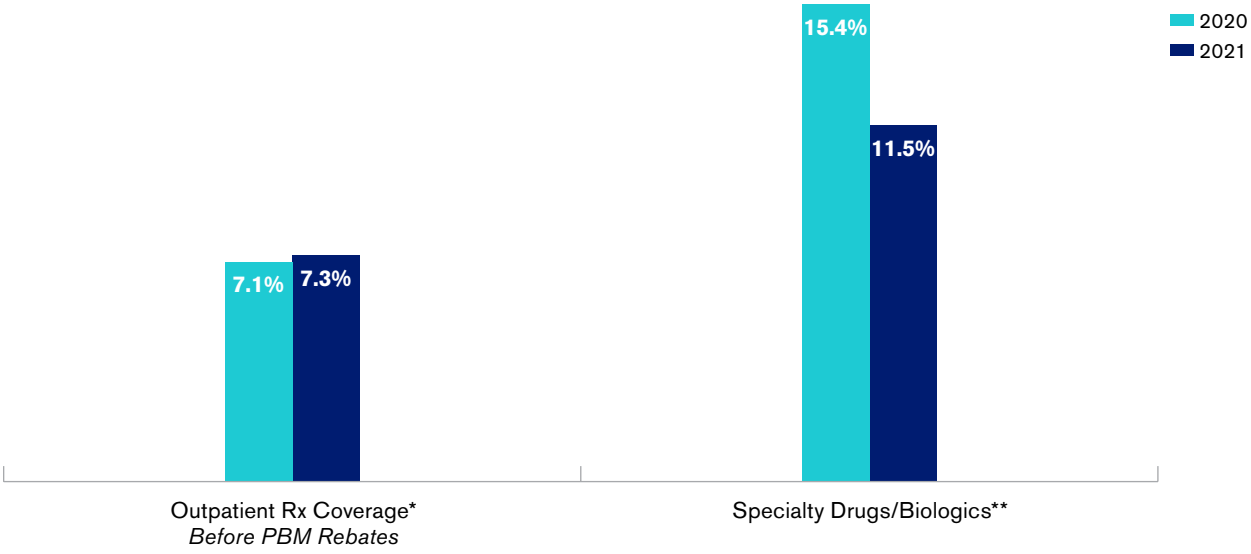
What Are Specialty Drugs?

Specialty drugs are generally high-cost drugs or those that require special handling. They are often given by injection or infusion.

Biologics make up the majority of specialty drugs. Biologic drugs are derived from living organisms and are significantly more complex and more challenging to develop and manufacture compared to non-biologic drugs, resulting in their higher cost.

A biosimilar is a biologic drug that is "similar" to another biologic medication (commonly known as the reference or innovator product), which is already licensed by the Food and Drug Administration (FDA).

Prescription Drug Trends for Specialty Drugs Projected to Be Less Severe



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

** Specialty drug/biologics trend is for outpatient specialty coverage. This data is for all coverage of specialty drugs for actives and retirees under age 65.

Source: Segal, 2020

Rebates

Rebates account for a substantial portion of the drug price equation. For those survey participants that reported prescription drug trend gross and net of rebates, the average impact of rebates was a 3 percentage-point reduction in Rx trend. The presence and magnitude of drug rebates on brand-name drugs have become a major element of pharmacy benefit contracting for most plan sponsors. They are a substantial source of plan cost savings, as plan sponsors demand 100 percent pass back of all manufacturer rebates, which are typically used to offset claim costs.

In July and August 2020, the White House issued four executive orders aimed at lowering prescription drug costs, including one that directed HHS to complete rulemaking concerning elimination of rebates and requiring point-of-sale discounts for patients. How point-of-sale discounts could affect pricing will depend on how various parties, including the manufacturers and PBMs, respond to the new rule when it becomes effective. It is currently unclear when HHS will complete drafting these rules.

What Are Rebates?

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

Early refills and use of mail order services

Many plan sponsors observed a short-term 10 to 15 percent uptick in prescriptions in late March and April 2020, but saw a return to pre-pandemic utilization rates in May, according to data in SHAPE (Segal Health Analysis of Plan Experience), Segal's proprietary data warehouse. This experience was primarily driven by relaxation of early refill ("refill too soon") limits due to COVID-19. This relaxation allowed patients to refill certain prescriptions sooner than normally permitted by the PBM plan rules.

We have also seen a modest increase in pharmacy mail order and home delivery services as a result of the pandemic. Those services generally offer deeper discounts and, consequently, produce savings for some plans.

COVID-19 drugs

There have been more than 70 drugs studied for the treatment and prevention of infection of COVID-19. The majority of drugs are for hospital use for patients with moderate to severe disease. Drugs range from over-the-counter famotidine (PepcidAC) and vitamin D to anti-inflammatories, blood pressure medications, blood thinners, steroids and various anti-viral drugs. Therapies include currently approved and available drugs and drugs in development.

To date, the FDA has not licensed drug treatment specifically for COVID-19, although some drugs have been granted emergency authorization. Remdesivir was one of the first drug therapies to show efficacy, resulting in shorter hospital stays, reduced from an average of 15 to 11 days. The *New York Times* Coronavirus Drug and Treatment Tracker has a real-time list of promising treatments being tracked.

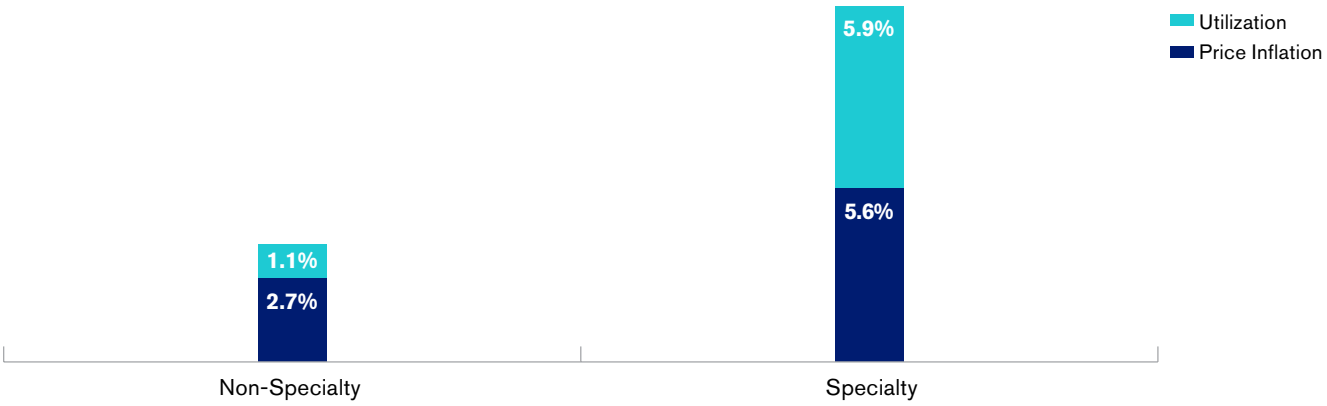
The leading driver of Rx trend is price inflation

Similar to medical trend, the leading driver of overall projected Rx trend is price inflation. Specialty prescriptions play is a major role. Non-specialty drug utilization has remained relatively flat, whereas specialty drug utilization has increased 5.9 percent.

Drivers of projected specialty drug trend include price increases of existing specialty drugs and the high cost of new specialty drugs being introduced that are replacing lower-cost therapies. Specialty drugs make up 40 percent of new products launched, including new drugs to treat cancer and rare or orphan diseases. Specialty drugs on the market are also obtaining approval for additional indications, increasing their base of covered members.

A factor reducing specialty drug trend includes the introduction of biosimilars into the marketplace. While biosimilars continue to be approved in the U.S. market, the launch of these products remains slow. Ultimately, biosimilars will play a pivotal role in reducing specialty costs. As discussed in a Segal white paper prepared for the ERISA Industry Committee (ERIC), biosimilars have the promise of being less expensive alternatives to their biologic brand-name counterparts, which represent the majority of specialty drug costs. There were 10 new biosimilars in 2019 and there have been two new biosimilar approvals in 2020 (as of August). Some PBMs are adding biosimilars as preferred products to their formularies, depending on contract negotiations. As biosimilars gain traction, specialty brand manufacturers are developing counterstrategies to maintain market share by matching the price of biosimilars and/or negotiating better rebate contracts to prevent patient switching.

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



* The components do not add up to totals because there are other components of trend not illustrated, reflecting such factors as the impact of cost shifting, technology changes and drug mix. Not all survey respondents provided a breakdown of trend by component, which may produce results that vary from the overall Rx plan cost survey results found on page 8.

Source: Segal, 2020

Dental Trends Projected to Decrease for 2021

COVID-19 has had a significant impact on dental spending for 2020. During the pandemic, most practices were either fully closed or only open to see emergency patients. Projected trends for dental coverage in 2021 are expected to follow suit and decline by approximately 1 percentage point for most plans.

As of mid-summer, dental practices started to reopen. Dental plans may incur new expenses to account for dental offices submitting claims for rising costs and increased standards associated with personal protective equipment, sterilization and infection control.

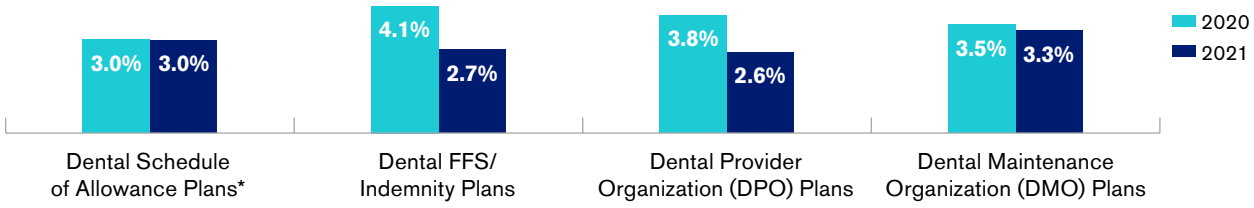
Dental telemedicine

In response to COVID-19, some dental providers launched virtual dental care. This allows patients to speak to a licensed dentist by video chat, eliminating the need to leave home. These virtual visits are designed to help address urgent dental situations such as pain, infection and swelling and facilitate prescribing of antibiotics and non-narcotic pain relievers.

Portable dental care

Another recent trend is portable dental care that is offered at the workplace through mobile dental units. This enables local dentists and hygienists to provide basic dental care to employees directly on site.

Trend Projections for Most Dental Coverages Lower for 2021



* 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, 2020

Vision Trends Projected to Decrease or Stay the Same for 2021

Vision plan cost trends remain low, hovering around 2 percent. Plan sponsors are increasingly emphasizing the role that vision and eye care plays in early warning of related medical issues. For instance, an eye exam can detect diabetes and hypertension, as well as diagnose sleep apneas and high cholesterol. It can also help determine if someone with high blood pressure is at risk of a stroke. Plan sponsors should consider reevaluating their vision offering and communicating the value of this benefit to their participants.

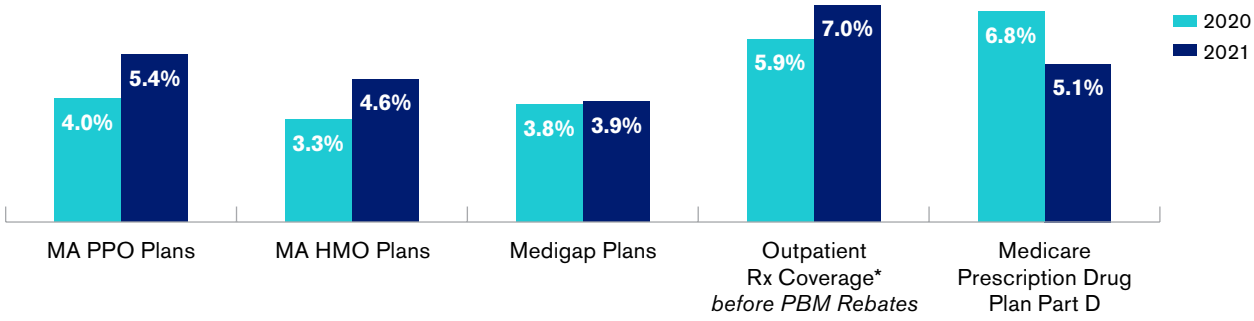
Trend Projections for Vision Reasonable and Customary Plans Lower for 2021

Source: Segal, 2020

Medical Trends for Medicare-Eligible Retirees Are Projected to Increase

Coverage for Medicare-eligible retirees generally falls into one of three categories: Medicare Advantage (MA) PPO plans; MA HMO plans; and Medicare supplemental insurance coverage known as Medigap. While trend projections for each of these coverage categories are expected to go up, those projections are considerably lower than trends for active and early retirees. Due to the increased risk of infection for older populations, some MA carriers are starting to expand access to at-home preventive care for cancer and diabetes management screening. Depending on the length of the pandemic, we may start to see additional at-home services.

Projected Medical Trends for Medicare-Eligible Retirees Increase for 2021



* Outpatient Rx trend is for all prescription drugs (non-specialty and specialty drugs combined). See page 8 for specialty drug trend projections.

Source: Segal, 2020

Putting Trends in Context

Plan sponsors that put trend projections in the proper context more successfully reap the benefits of the data. For example, trend projections are generally higher than actual costs. The data shows that actual costs appear to be leveling off for many medical, prescription drug and dental plans. That said, actuals continue to far outpace consumer prices and wages, which are a meaningful data comparison impacting millions of Americans. This section of the survey is intended to help plan sponsors better understand this context so they can more effectively apply the data to their benefit programs.

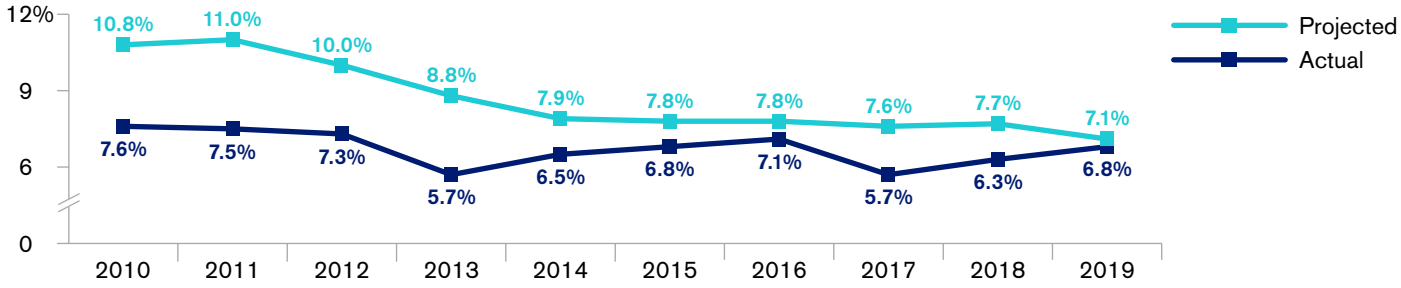
Projected trends are typically higher than actual trends

To assess the accuracy of trend projections, Segal compared 2019 projected trends for medical, Rx and dental plans to the *actual* average trends for 2019 (the most recent period for which actual data is available), as reported by the survey respondents. The graphs on the next page illustrate comparative data from our last 10 surveys for three types of coverage for actives and retirees under age 65. As the chart indicates, forecasters' recent projections have been closer to actual cost trend results for medical plans than for Rx plans or dental PPO plans.

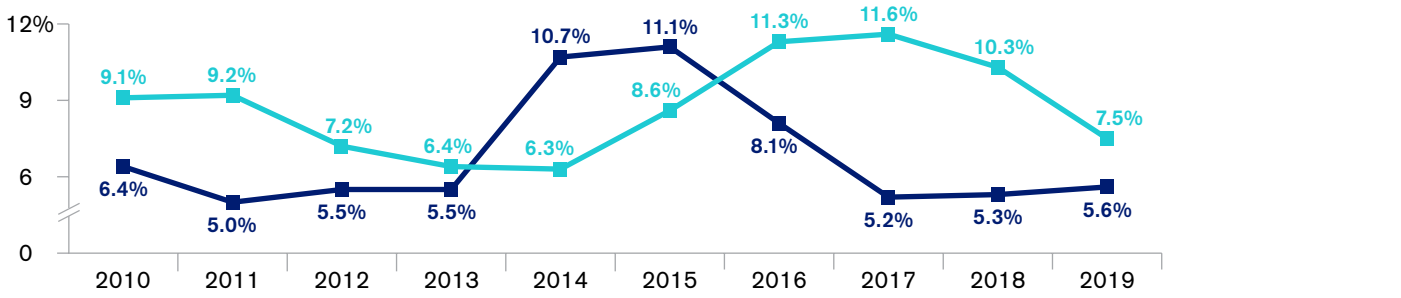
The accuracy of projections is subject to both underwriters' conservatism in predicting future events and a natural lag in the underwriting cycle. In periods where costs are decelerating, forecasters will tend to overestimate trends. Similarly, when costs are accelerating, trend projections will generally be underestimated for a period.

In the past, we saw evidence of this in 2014 and 2015 with prescription drug plans when forecasters significantly understated trend, primarily due to the unforeseen high cost of drugs for new treatments for Hepatitis C and significant spending on compound medications. The novel Coronavirus adds a new element of uncertainties in plan cost projections. **When considering trend projections, plan sponsors should take into account this historical pattern of projected trend to actual trends over multiple years.**

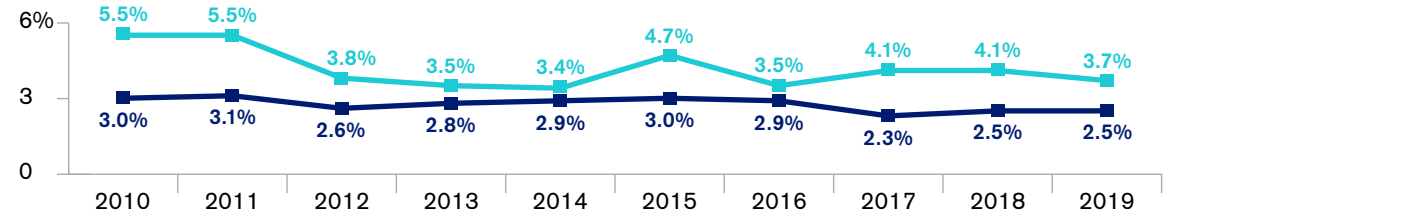
For Open-Access PPOs/POS Plans, Gap Between Projected and Actual Trends Narrows*



Projected Rx Trend Continues to Far Exceed Actual Trend**



Projected Dental PPO Plan Trends Exceeded Actual for the Past 10 Years



* 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, 2020

Historical survey data on selected medical, outpatient Rx and dental trends shows trend leveling

Actual trends are leveling off for medical and prescription drug plans. Plans sponsors that use aggressive cost-containment efforts are experiencing lower trend rates than projected levels.

	Year	Open-Access PPOs/POS Plans	PPO/POS Plans with PCP Gatekeepers	HMO Plans	MA HMO Plans	Outpatient Rx Plans	DPO Plans
Actual	2007	8.9%	9.5%	9.8%	7.0%	7.9%	5.0%
	2008	9.7%	9.4%	9.7%	7.7%	7.4%	5.5%
	2009	9.5%	9.7%	10.2%	4.0%	7.9%	4.7%
	2010	7.6%	8.3%	8.7%	3.6%	6.4%	3.0%
	2011	7.5%	7.8%	8.0%	4.5%	5.0%	3.1%
	2012	7.3%	8.4%	6.7%	3.0%	5.5%	2.6%
	2013	5.7%	6.7%	6.1%	3.1%	5.5%	2.8%
	2014	6.5%	7.6%	6.3%	1.9%	10.7%	2.9%
	2015	6.8%	6.9%	6.4%	4.2%	11.1%	3.0%
	2016	7.1%	7.4%	6.3%	5.3%	8.1%	2.9%
	2017	5.7%	5.8%	6.6%	1.8%	5.2%	2.3%
	2018	6.3%	6.1%	6.0%	4.1%	5.3%	2.5%
	2019	6.8%	6.8%	6.6%	2.2%	5.6%	2.5%
Projected	**2020**	**6.8%**	**7.2%**	**6.3%**	**3.3%**	**7.1%**	**3.8%**
	2021	**7.7%**	**7.2%**	**6.6%**	**4.6%**	**7.3%**	**2.6%**

[1] Medical trends exclude prescription drug coverage.

[2] Prescription drug trend data for 2007 only reflects retail. Data for 2008–2021 is for all prescription drugs (non-specialty and specialty combined). These results do not include the impact of rebates from PBMs.

[3] All trends are illustrated for actives and retirees under age 65, except for the MA HMOs. (Graphs comparing 15 years of survey data — 2007 through 2019 actual trends and 2020 and 2021 projected trends — and showing average actual annual trend by coverage type for the last five years are available.)

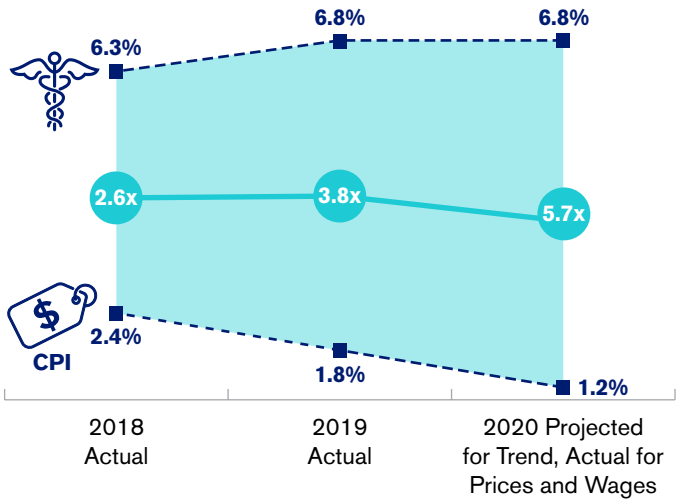
Source: Segal, 2020

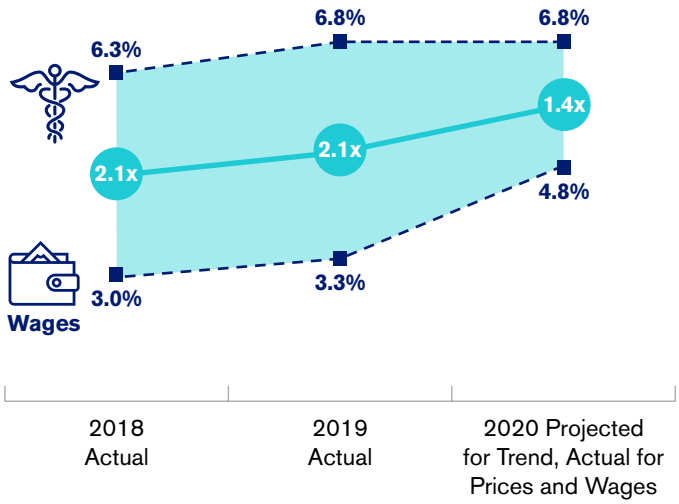
Health plan trend rates still outpace increases in consumer prices and wages

PPO/POS and prescription drug plan costs continue to significantly outpace overall inflation and wage growth. High increases in health plan cost trends compete with limited dollars that could be used for other forms of compensation. Plan sponsors that actively manage their health plans and maintain low-cost increases are able to allocate more budget towards compensation or other benefits and programs for their participants.

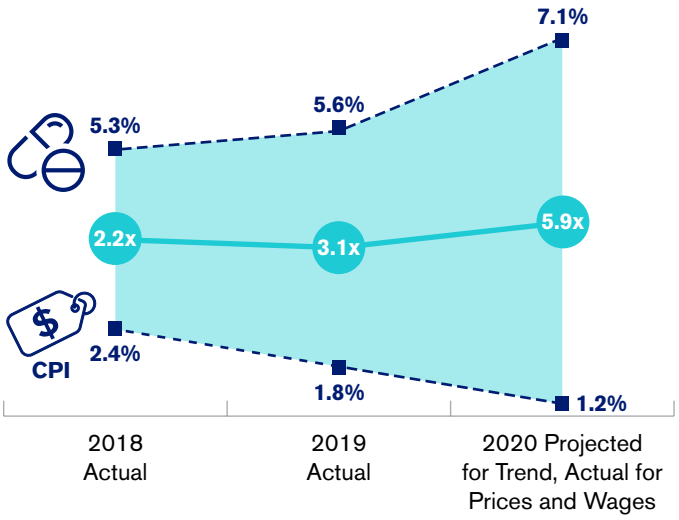
Comparison of Two Trend Rates to Wage and Price Increases

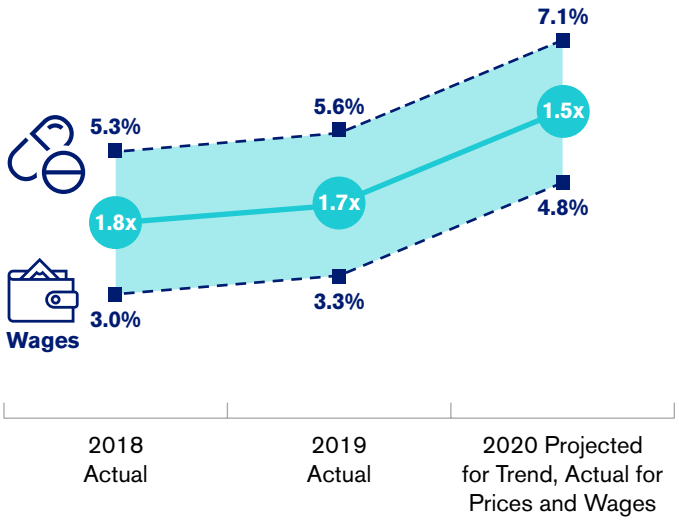
Open-Access PPO/POS Plans





Outpatient Rx Plans





Sources: Segal Consulting, 2020 (trend rates), Bureau of Labor Statistics Consumer Price Index for All Urban Consumers (CPI-U) from Consumer Price Index – July 2020 and Bureau of Labor Statistics wage increases through July 2020 from Table B-3. Average hourly earnings of all employees on private nonfarm payrolls, seasonally adjusted.

Top Health Plan Cost-Management Strategies in 2020

Plan sponsors continue to use various cost-management strategies to help mitigate increasing health plan costs. We asked survey participants to rank the top strategies being used by group health plans in 2020. The chart below compares the top five strategies being used today to last year's ranking.

2020 Top Five	2019 Top Five
1 Waiving cost sharing for treatment related to COVID-19*	1 Using healthcare transparency tools
2 Using of healthcare transparency tools	2 Expanding Rx management for non-specialty drugs
3 Implementing telehealth for behavioral health support services or enhanced virtual therapy sessions	3 Expanding Rx management for specialty drugs
4 Including high-deductible health plan options	4 Implementing telehealth/virtual care
5 Expanding pharmacy management programs	5 Using value-based contracting**

* Although not necessarily a cost-management strategy, the top strategy used in 2020 was waiving cost sharing for treatment related to COVID-19

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

Source: Segal, 2019 & 2020

Questions? Contact Us.

Medical Cost Management and Contracting Strategies

Plan sponsors are using various cost-management strategies to help mitigate significant increases in their health plan costs while maintaining high-quality standards and access to healthcare goods and services. This section presents an overview of key strategies plan sponsors may consider as part of medical cost management for 2021 and beyond.

Enhanced behavioral health

For medical plans, implementing telehealth for behavioral health support services or enhanced virtual therapy sessions made this year's top-five health plan cost-management list. Many participants are navigating self-quarantine, work disruption, makeshift work-from-home environments and increased financial stress. Caregiving duties such as helping school-age children and older or sick individuals add to stress and exhaustion. The high rates of furloughed workers, unemployment, social distancing and remote working has led to uptick in mental health needs.

With advances in technology, the vendor market for behavioral health benefits, which previously suffered from limited access to quality providers, has expanded in scope. Point solutions that focus on targeted or specific conditions have been emerging as alternatives to traditional direct vendor offerings. These solutions have increased the number of vendors in the behavioral health space that can supplement a plan's network with expanded access to a larger pool of quality therapists than may otherwise be available using online therapy.

Plan sponsors can play a role in evaluating the rapidly expanding marketplace and support mental well-being, which helps maintain health, productivity and the morale of plan participants. This may require revisiting integration of behavioral health benefits, including employee assistance programs, with physical health benefits, including wellness.

Total well-being

The wellness marketplace is complex and rapidly expanding with a range of point solutions competing with traditional carrier offerings aimed at targeting care for specific employee health conditions. COVID-19 was also a catalyst for accelerating some of the change, with most vendor stakeholders adopting platforms to support or expand virtual care. COVID-19 has also amplified the need to assess the impact of social determinants of health during the COVID-19 pandemic, specifically underscoring the associations between health outcomes and racial and economic inequalities.

We have seen many developments that indicate the evolution of well-being to a largely virtual platform. There have been a number of recent mergers. Teladoc and Livongo merged to expand digital health and chronic disease diabetes management. Omada acquired Physera to add musculoskeletal care as part of its digital health services. Many of these organizations are shifting their focus from acute care to managing chronic care. The RAND Corporation reports that 60 percent of American adults have at least one chronic disease and that 90 percent of healthcare spending is attributable to these individuals.

Many chronic diseases are preventable and/or manageable with the adoption of a healthy lifestyle. Healthy habits, including good nutrition and frequent physical activity, are the first steps in protecting health and staying well. Promoting these and other beneficial activities is the foundation of any total well-being campaign or wellness program.

In addition, plan sponsors are recognizing the many other influencers of health status that are not typically part of a health plan — a feeling of purpose, stress as a caregiver, financial worries and many more. Race and income are also determinants of health outcomes. There are solutions for each of these, and plan sponsors should focus not only on health plan design, but take a broader view of ways to improve the health status of their participants.

Plan sponsors can address the social determinants that influence poor health outcomes among their workforce through efforts that ameliorate transportation, housing and food instabilities that participants may be experiencing during the pandemic. Additionally, plan sponsors should carefully review access to care by neighborhood when making network and plan design decisions. Access to care within a geographic area can vary greatly and often aligns with the social determinants.

Plan sponsors should continue to focus on strategies that keep people healthy and engaged. Increasingly, plan sponsors are recognizing that being truly healthy extends beyond physical activity and optimal nutrition. Some plan sponsors are taking a broader view of wellness to encompass total well-being, including support of social, emotional and financial health.

New network strategies

Typically, broad networks provide employees with a choice of providers and do not offer the deepest discounts over other marketplace options. Plan sponsors are using alternative network strategies to reduce cost and improve quality over traditional broad provider networks:

- Tiered networks divide a network into two groups. The preferred tier has lower cost sharing, deeper discounts and higher-quality providers. In a narrow network, a plan sponsor directs its participants to use a more limited provider network where costs are lower or discounts are even deeper.
- A center of excellence is a strategy used to encourage participants seeking care for select procedures, such as a transplant or cancer treatments, to receive care by a specialized team with high concentration of expertise and resources. These centers help to deliver care in a comprehensive, interdisciplinary fashion. Plan sponsors that implement these programs typically see both reduced costs as well as improved outcomes.

To achieve deeper discounts, a growing number of plan sponsors are considering these newer strategies:

- Contracting directly with hospitals, clinics and other specialized providers
- Negotiating direct-contracting pricing for prescription drugs
- Increasing access to services by adding other options, such as on-site clinics, retail clinics or other point solutions to improve the quality of care, outcomes and long-term cost for their group health coverage
- Eliminating out-of-network coverage entirely to address management of cost from out-of-network providers that submit excessive charges

Value-based arrangements

Fee-for-service arrangements reward providers for volume, not value. According to a study published in *JAMA*, about 25 percent of U.S. healthcare spending annually is waste, resulting from unnecessary or inefficient care. There is a wide range of pricing variation within the same service areas, without evidence of superior outcomes.

Plan sponsors are increasingly considering cost-saving alternatives thorough value-based arrangements. In contrast to a fee-for-service approach, value-based models reward physicians and providers for helping participants improve their health.

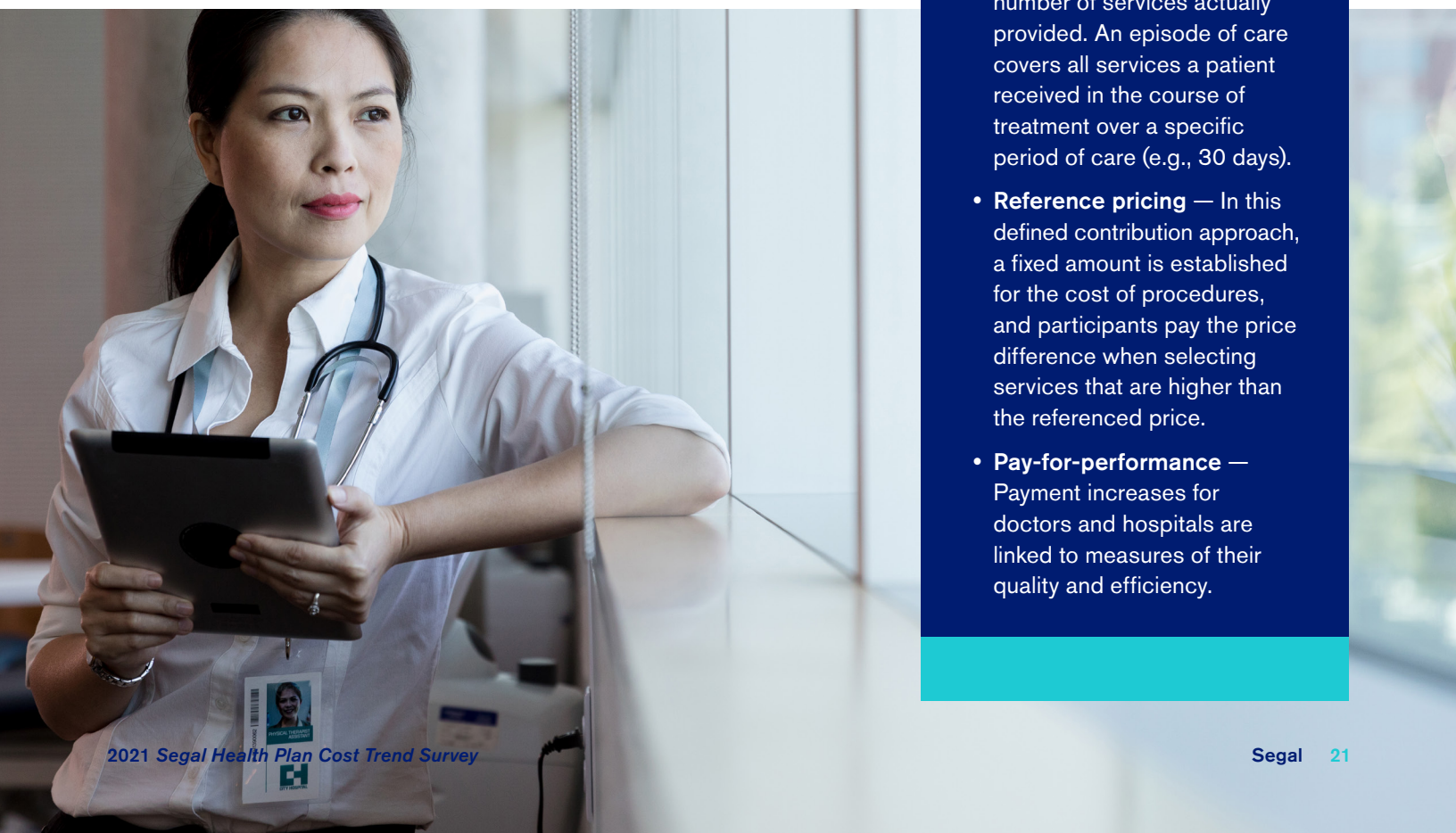
Benefits include better outcomes through earlier intervention and higher-quality care. This results in a reduction in the total cost of care over fee-for-service arrangements. Plan sponsors should work with their vendors to evaluate value-based reimbursement contracting offered through the delivery service models available in their plan. Examples include accountable care organizations, PCMHs and centers of excellence. Many of these arrangements raise compliance issues so they should be reviewed to ensure they comply with applicable regulations.

Plan sponsors should keep in mind that carefully crafted, custom communications can play an important role in ensuring the success of cost-management strategies.

How Value-Based Arrangements Compensate Providers

These are examples of reimbursement approaches:

- **Global capitation** – Fixed payment is made to an entity that is responsible for providing all of the services that their patients need or may use. This can include not only primary physician and specialty care, but also hospital care, prescription drugs, and other services.
- **Shared savings** — In this arrangement, providers keep a meaningful share of savings that arise if they are able to limit expenditures.
- **Bundled payments** — These are lump-sum payments made for an episode of care which do not vary based on the number of services actually provided. An episode of care covers all services a patient received in the course of treatment over a specific period of care (e.g., 30 days).
- **Reference pricing** — In this defined contribution approach, a fixed amount is established for the cost of procedures, and participants pay the price difference when selecting services that are higher than the referenced price.
- **Pay-for-performance** — Payment increases for doctors and hospitals are linked to measures of their quality and efficiency.



Client Story: Addressing Over-Budget Health Plan Expenses

A large client came to Segal with an urgent challenge: its health plan expenses were over budget by about $10 million.

Segal assisted in the identification of four overriding strategic objectives: cost management, participant engagement, efficiency for the plan covering active participants and efficiency for the plan covering retirees.

To achieve those objectives, we proposed a multi-year strategic plan that involved close collaboration with vendors. The core of the strategy was to educate them and other stakeholders on the need for change and arrive at a consensus for what should change. The result was net annual actual trend of 2 percent from 2015 through 2019.

First, we recommended these measures:

- Financial incentives for participants to use a preferred health system (offering advantageous pricing) for most services, which has resulting in annual savings equivalent to 3 percent of medical spending
- Enhanced travel benefits for medical care with a concierge approach, which saved $500,000 in the first year
- Renegotiation of existing PBM contract, which improved pricing guarantees by 5 percent
- Developed longer-term employer financial commitment in conjunction with adoption of 5 percent annual trend target for plan expenses

Subsequently, we helped the plan sponsor to address Rx costs through:

- Modified participant cost structure that improved incentives to promote generic and preferred brand utilization
- Introduction of a program to access specialty drug manufacturer coupons to benefit the plan and the participants
- Procurement of carved-out PBM services, which resulted in annual savings of 15 percent for the active plan
- Implementation of an Employer Group Waiver Program for the retiree plan, which yielded savings of about $30 million in the first year

Additionally, we helped modernize the plan's options and overall cost structure.

Questions? Contact Us.

Pharmacy Benefit Cost Management and PBM Contracting Strategies

As noted in the list on page 18, expanding pharmacy management programs made this year's top-five health plan cost-management list. Plan sponsors can use a variety of techniques to expand pharmacy management programs to reduce Rx costs.

Innovative contracting with PBMs

PBM contracting can include complex exclusions and terms that are counterproductive for plan sponsors. New contracting approaches that simplify terms and reduce the holes in pricing guarantees can substantially improve plan sponsor financials by better holding PBMs contractually accountable to control costs. PBM contract terms should be consistently monitored and reviewed.

Converting rebates to per-member, per-month guarantees eliminates the impact of complex PBM definitions and exclusions. Direct contracting with regional specialty pharmacies or hospital pharmacies can improve terms. Demanding price inflation trend guarantees separately for brand and generic drugs can add a new layer of protections against excessive price increases by some manufacturers. Plan sponsors that push for better contracting are seeing lower cost increases for their pharmacy benefits.

Adoption of narrow and value-based formularies

There is a movement by PBMs to offer lower gross cost drug formularies without compromising clinical quality. Typically, narrow-based formularies are heavy in generic use and provide minimal rebates. Additionally, outcome-based or value-based contracts are a method of controlling costs for specialty drugs. Outcome-based contracts offer plan sponsors rebates and discounts tied to specified health outcomes.

Promotion of biosimilars

Greater use of biosimilars presents an opportunity to reduce specialty drug spending. While current awareness and utilization is low, there is growing interest in and greater access to these emerging drugs. There are several opportunities for plan sponsors to potentially lower specialty drug cost by including biosimilars in plan design strategies, creative PBM contracting and promotion of biosimilar education.

Plan sponsors can work with their PBMs or pharmacy advisers to promote biosimilars through communication and education about drug options with plan participants and providers. Plan design and step-therapy rules can also promote biosimilar use over higher-cost biologic originator product. Plan sponsors should review contract terms with their PBMs to ensure their terms are competitive for these emerging drug therapies. These strategies are discussed in more detail in a white paper Segal prepared for ERIC.

Coupons and specialty copayment-assistance programs

Brand-name drug manufacturers commonly offer coupons to patients, processed by retail pharmacies, primarily for non-specialty brand-name drugs. This marketing tactic was designed to increase use of certain brand-name drugs by reducing participant copayments for these high-cost medications. Manufacturers may also get tax deductions for funding these copayment assistance programs.

For non-specialty drugs, these couponed drugs (many of which are "me-too" drugs) should be non-preferred or excluded from formularies as there are lower cost formulary alternatives available. For specialty drugs, there are also manufacturer coupons (patient copayment assistance) available to patients. However, most patients are unaware of the copayment assistance or choose not to complete the registration process required to enroll. For plans with relatively modest copayments for brand-name drugs, these programs offer little value.

PBMs began offering copayment-assistance programs to help plan sponsors take advantage of these funds as well as generate additional fees from managing these programs. Some plans have developed "in-house" processes to help participants access/enroll with drug manufacturers for coupons. However, it is time-consuming for staff, and most plans do not have the capacity to take on the work of identifying which drugs have coupons available and submitting participant enrollment forms.

Over the last several years, vendors have been taking advantage of the copayment-assistance programs for specialty drugs offered by manufacturers to bring savings to plans by accessing non-needs-based funds. (Non-needs based programs include private coupon programs set up by Pharmaceutical Research and Manufacturers of America, not eligible to those covered by Medicare, and manufacturer-sponsored programs for branded pharmaceutical specialty products which are directed at the commercially insured population.) As a result, PBMs are advocating specialty copayment assistance programs, which yield savings for plan sponsors and their participants.

Plan sponsors evaluating these specialty copayment-assistance programs should consider the potential implications they present, including:

- Impact on generic dispensing strategy
- Restricted use of a PBM's exclusive specialty vendor
- Evaluation of PBM service and administration fees
- Issues in tracking the out-of-pocket maximum for participants
- Ensuring drugs that are included as part of the program are rebate compliant
- Understanding that the list of affected medications may be subject to change and programs may be discontinued
- Evaluation of compliance considerations

Strategies for specialty management

Commons strategies to lower specialty drug costs include channel management medical carve-out strategies to assess whether the medical plan or pharmacy plan is the best purchasing channel for medications. A strategy that excludes certain drugs from coverage under one or the other may save the plan money. For instance, some pharmacy benefit plans cover all oral and self-injectable specialty medications, while chemotherapy is best covered by the medical benefit.

Another strategy is expanding clinical treatment protocol or therapy management. Amending plan terms to include clinical safeguards may prove to be an effective cost-management tool. The safeguards can include step therapy, targeted prior authorization for high-cost drugs and quantity-duration limits based on FDA guidelines.

Other strategies include:

- Step therapy and prior authorization
- Split fill, formulary or preferred step management
- Network management
- Helping participants access coupons directly
- Plan design changes

Plan benefit design

Plan sponsors are using benefit design to increase the use of generics and lower-cost, brand-name drugs to help manage increases in Rx drug costs. Percentage copayments with out-of-pocket maximums engage consumers in drug choices and better drive competition in pricing among drug manufacturers. Keeping generic drug cost sharing low drives high levels of generic drug use and savings for both the plan sponsor and plan participants. Greater use of deeply discounted retail 90-day-supply options are gaining in popularity and can yield plan cost savings. Tiered designs, which place clinically effective, lower-cost drugs into lower tiers at lower cost sharing, are also increasing in popularity among plan sponsors.

Client Story: A Successful Rx Cost-Management Strategy and Improved Transparency

With outpatient prescription drug costs outpacing general inflation rates, a plan sponsor reached out to Segal for a strategy to rein in that expense, which was consuming an ever-larger portion of benefit dollars. The plan sponsor also sought a more transparent and competitive prescription drug acquisition cost process and contracting from its PBM. We introduced initiatives that helped to reduce the plan sponsor's pharmaceutical costs by approximately 10 percent the first year the contracts took effect.

Working with the plan sponsor's benefits professionals, Segal evaluated detailed pharmacy benefit claims data to find ways to improve purchasing power and lower the gross cost to the plan sponsor and its participants. We isolated the pharmacy benefit plan cost trend influences and current discounted pricing being applied to covered medications.

Adopting an innovative approach to managing Rx costs, Segal helped the plan sponsor negotiate and set up one of the first direct pharmacy contracts with a health system. To improve the pricing of specialty drugs, which represent a growing contributor to overall pharmacy benefit cost increases, Segal also worked with the plan sponsor to develop and apply new PBM bid-pricing requirements and tactics. We helped negotiate aggressive minimum guarantees for specialty drugs based on a current acquisition cost plus administrative fees contracts for multiple specialty pharmacy entities. Using detail pharmacy claims data, we helped to secure pricing improvements that could be independently verified. Understanding the growing margins on specialty brand drugs, we helped to negotiate improved minimum pricing discounts that resulted in substantial savings to the plan sponsor and long-term pricing transparency by drug and specialty pharmacy.

Questions? Contact Us.

An Effective Strategy for Managing Costs

The impact of the COVID-19 pandemic and its long-term effect on the U.S. population and the health of the economy is still unknown. The current health environment is a moving target that requires continuous monitoring.

Plan sponsors should evaluate their plan costs and use effective strategies that dovetail with their specific needs. This is a period of extraordinary cost-management uncertainty and change. Some healthcare vendors are promoting solutions or services that may be more focused on generating revenue than producing measurable results or improving participant experience.

Furthermore, the outcome of the presidential election could result in dramatic changes in the future. As a result, plan sponsors should proceed cautiously and draw on their data to make well-informed decisions about which strategies and services to select that produce the most value given their limited resources.

As the complexity of the healthcare marketplace evolves, plan sponsors should continue to explore all avenues that may produce cost savings and develop strategies to improve outcomes for participants and mitigate price increases. This begins with access to data, including detailed medical and pharmacy claims information. By evaluating data and targeting strategies that address aggressive vendor contracting, measurable population health improvement and smart plan design, plan sponsors can continue to offer high-value benefits while bringing down their plan cost trends.

Modeling COVID-19 Costs

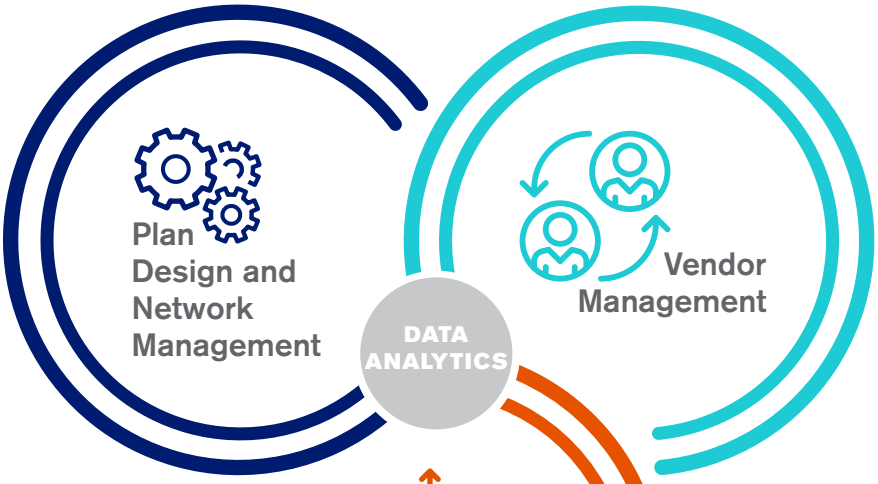
Segal has developed a model that forecasts the impact of COVID-19 on health plan costs. The model takes into account:

- The cost of testing
- The percentage of people being tested and, of those tested, the percentage who have the coronavirus
- The percentage of those with the virus who have no additional cost
- The cost of treatment
- The cost of hospital treatment
- Treatment distribution

The model covers both the direct cost for testing and treating COVID-19 patients that need hospitalization and the reduction in use of delayed or suspended non-essential services.

Segal recommends a balanced three-pronged approach to effective healthcare cost management. It involves managing plan design, vendors and population health.

Segal's Approach to Effective Healthcare Cost Management



- Plan benefit design
- Networking strategies
- Drug-channel management
- Adoption of utilization-management programs

- Periodic audits
- Value-based medical arrangements
- Value-based Rx arrangements
- Innovative PBM contracting

- Total well-being
- Enhanced behavioral health
- Telehealth
- On-site clinics

Questions? Contact Us.

The Survey Respondents

Seventy health insurance providers participated in the survey. A count of respondents and the estimated lives covered in the book of business reflected by coverage category follows. As a group, the survey respondents represent 80 percent of the commercially insured and self-insured market.

Medical Plans

		Covered Lives
40	Open-access PPO/POS plans	Nearly 100 million
32	HDHPs	
37	HMO plans	
25	PPOs/POS plans with PCP gatekeepers	

Rx Plans

57	Outpatient Rx drug plans	313 million

Dental Plans

31	DPO plans	1 million+
22	Dental FFS/Indemnity plans	
13	DMO plans	
17	Dental schedule of allowance plans	

Vision Plans

19	Vision schedule of allowance plans	1 million+
13	Vision reasonable and customary plans	

The following respondents agreed to be identified by name:

Aetna

Amalgamated Life Insurance Co

Anthem, Inc.

BeneCare Dental Plans

Blue Cross Blue Shield of Alabama

Blue Cross Blue Shield of Arizona

Blue Cross Blue Shield of Illinois

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Montana

Blue Cross Blue Shield of New Mexico

Blue Cross Blue Shield of Oklahoma

BlueCross BlueShield of Tennessee

Blue Cross Blue Shield of Texas

Blue Cross North Carolina

Blue Shield of California

Capital BlueCross

Capital District Physicians' Health Plan, Inc.

Cigna

ConnectiCare, Inc.

CVS Health

Emblem Health

EnvisionRx Options

Envolve Pharmacy Solutions

Express Scripts, Inc.

EyeMed Vision Care, LLC

Group Vision Service

Guardian Life Insurance Company of America

Harvard Pilgrim Health Care

Health Alliance Medical Plans

Health Net of California, Inc.

Health New England

Highmark Blue Cross Blue Shield of Western Pennsylvania

Highmark Blue Cross Blue Shield of Central Pennsylvania

Highmark Blue Cross Blue Shield of Delaware

Highmark Blue Cross Blue Shield of West Virginia

Horizon Blue Cross Blue Shield of New Jersey

Humana, Inc.

Independence Blue Cross

Kaiser Permanente

Medical Mutual of Ohio

Metropolitan Life Insurance Company

Navitus Health Solutions LLC

OptumRx

Premera Blue Cross

Prime Therapeutics LLC

Trustmark

Tufts Health Plan

United Concordia Companies, Inc.

UnitedHealthcare

Voya Financial

WellDyne

Wellmark BCBS of South Dakota

Wellmark Blue Cross and Blue Shield Iowa

Questions? Contact Us.

If you have questions about medical cost-management strategies or about the 2021 *Segal Health Plan Cost Trend Survey*, contact your Segal consultant or one of the following Health Practice leaders:

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Ms. Flick has special expertise in healthcare cost-management strategies, with an emphasis on healthcare informatics, pricing and plan design. She manages SHAPE, Segal's proprietary health data warehouse and the development of claims models for retiree health valuations, rate manuals for medical, prescription drug and dental programs and healthcare benchmark database systems.

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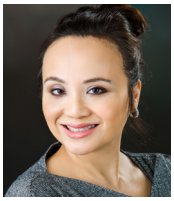
Dr. Paralkar, who is a licensed family practitioner with more than 20 years of experience in the healthcare industry, leads Segal's medical management consulting. She has specialized expertise in on-site clinics, disease management and wellness programs, medical management program design, healthcare informatics and network management strategies that improve health while containing costs.

To discuss strategies for managing your prescription drug benefit, contact the following leaders of our Pharmacy Benefit Practice:



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Ms. Pincay has more than over 20 years of experience in the pharmacy industry, serving in management, clinical and consulting roles. As the leader of clinical services for Segal's National Pharmacy Consulting Practice, she provides consulting services that incorporate advanced data analytics with the latest best-practice guidelines for clinical pharmacy. She has extensive expertise in PBM clinical programs, client management and plan design strategy. She also focuses on assisting clients with vendor selection and implementation, contract negotiation, formulary management and clinical program development.

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Mr. Taylor is a Vice President and leader of Segal's National Pharmacy Consulting Services. Nick has extensive experience in PBM operations, pharmacy pricing, account management and data analytics. Mr. Taylor provides consulting services that incorporate advanced data analytics with the latest best-practice guidelines for clinical pharmacy. He serves as an expert regarding prescription drug benefit design, cost-savings strategies, clinical management strategies, practice development and market trends.

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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.

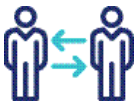
Our professionals can help your organization plan, design and strategize by providing:

Plan design and analysis — Are you providing high-quality, cost-effective healthcare 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.

Strategies for improving workforce wellness and well-being — To improve participants' and their families' physical health, are you offering wellness programs that focus on fitness, nutrition and weight management? Are you offering benefits, which may include voluntary benefits, to promote well-being? Such offerings include stress management, caregiver benefits, paid leave and student debt relief as well as other financial advice.

Cost and utilization modeling — Has your plan modeled plan sponsor expenses or calculated the out-of-pocket cost of plan changes to participants? 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 long-term financial stability? Segal can assist in reviewing or developing your plan's reserve policy and analyzing the impact of proposed plan design changes on future expenses.



Service provider and insurer competitive bidding — When was the last time you put your plan out for a competitive bid? Segal brings industry-leading expertise and innovative contracting to secure highly competitive pricing and service terms for our clients.

Data mining and analysis — Are you getting the information you need to make important plan design decisions? Segal can provide data-mining services through our proprietary warehouse, SHAPE — such as exploring emerging population health-risk factors that impact utilization and uncovering potential fraud and abusive provider practices — to help you better manage future healthcare expenses.

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

This publication is for informational purposes only and does not constitute legal, tax or investment advice. You are encouraged to discuss the issues raised here with your legal, tax and other advisors before determining how the issues apply to your specific situations.

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