

# What Are the Projected 2022 Health Plan Cost Trends?

Latest Segal Survey Finds Most Are Similar to Pre-Pandemic Levels



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***Segal Health Plan Cost Trend Survey***  
**25 Years: 1996–2021**

# Introduction

Several uncertainties and risks persist as we near the end of the second year of the global pandemic. Even with the protections of vaccines that reduce the likelihood of hospitalizations and mortality, the Delta variant is creating new concerns and economic burdens. COVID-19 can result in prolonged illness and persistent symptoms, but much is still unknown about its long-term effects. There are also challenges in responding to the pandemic-triggered behavioral health crises, including increases in mental health-related ailments, alcohol and controlled substance abuse and domestic violence.

In this rapidly changing environment, it is particularly important for plan sponsors to understand the factors influencing health plan costs and the expected cost trends for the coming year. Plan sponsors hoping to avoid excessive cost increases must continuously monitor the emerging areas of cost pressures, the regulatory landscape, provider performance and claims experience so they can pursue targeted and effective cost-management strategies.

This report presents the results of the 2022 *Segal Health Plan Cost Trend Survey*. We also discuss various techniques to manage costs, including our recommended three-pronged approach.





## Key Findings

The latest annual *Segal Health Plan Cost Trend Survey* found projected medical plan cost increases for 2022 are similar to pre-pandemic increases.

Other key findings about 2022 trend projections include:

- Survey respondents project per-person cost trends for open-access PPO/POS plans to be 7.3 percent.
- The projected annual cost trend for outpatient prescription drugs is 8.4 percent.
- Double-digit specialty Rx cost trend, mostly driven by price increases and new specialty drugs, continues to be a major driver of Rx cost trends and a challenge for plan sponsors.
- Provider price increases are still the primary driver for both hospital and Rx trends.
- Utilization is the primary driver of trend for physician services.
- Trend projections for most dental coverages are expected to return to pre-pandemic levels.
- Projected vision trends are less than 2 percent.
- Medical trend projections for Medicare-eligible retirees are similar to pre-pandemic levels with projected Medicare Advantage (MA) PPO and MA HMO plans at 4.8 percent.

In addition to presenting trend projections, the report also evaluates actual historic trends. For the first time in the 25 years that Segal has conducted this survey, actual 2020 trends were negative for medical and dental due to deferred and eliminated care.

## Observations

COVID-19 has caused unexpected disruption in our healthcare system. Healthcare utilization was at historic lows as people chose to postpone and even eliminate care. In contrast, utilization of digital health services exploded over the past year and transformed the delivery of some healthcare. The COVID-19 pandemic has also influenced patterns of emergency room use, urgent care use and retail clinic use that may outlast the pandemic.

In addition, plan sponsors are dealing with issues related to vaccines, incentives to increase workforce vaccination rates, return-to-work strategies and greater variation in paid claim amounts from month to month and quarter to quarter. These added variables create increased challenges for accurate forecasting of health benefit expenses for many plan sponsors. Tracking claim-cost expenses more frequently and studying detailed utilization patterns can help plan sponsors effectively respond to increased plan cost volatility that may continue into 2022.



## 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. The 2022-projected increase over the prior year assumes removal of the impact of COVID-19 on claims costs.

### 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 increases
- Increased demand from increased health risks due to aging population or rise in obesity
- Greater emphasis on detection and diagnoses

For our reporting purposes, 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
- Impact of contract renegotiations, improvements or vendor changes
- Changes in plan design
- Administrative fees
- Changes in participant contributions

### How do plan sponsors use trend projections?

Cost trend assumptions are one element that underwriters and actuaries use to project future costs for plan sponsors. Those assumptions can help 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.

\*\* We discuss rebates on [page 9](#).





## About the Survey

The 2022 *Segal Health Plan Cost Trend Survey* is our 25<sup>th</sup> annual survey of managed care organizations, health insurers, PBMs and TPAs. We conducted the survey during the summer of 2021.

Respondents reported 2022 trend forecasts for medical, prescription drug, dental and vision coverage. In addition, the survey respondents reported actual allowed health cost trends for 2020 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

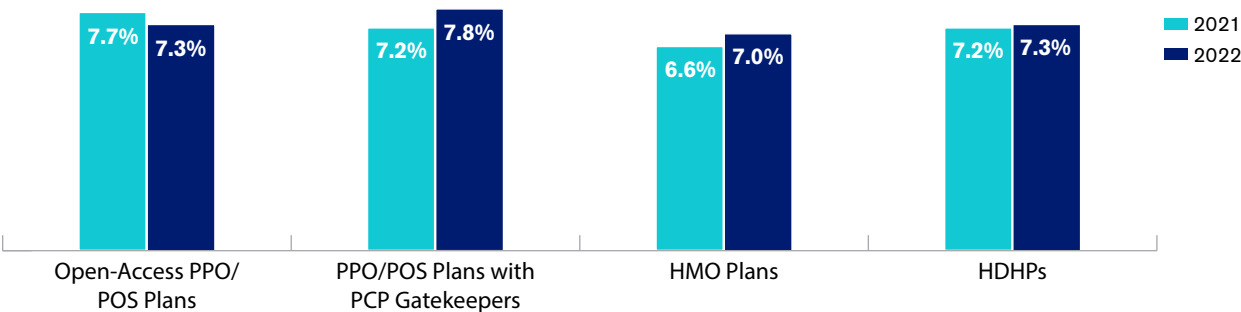


HSA-Qualified HDHPs

# Medical Plan Trend and Cost Drivers

While survey respondents acknowledge uncertainties related to the pandemic, they are assuming COVID-19 will have minimal effect on their 2022 costs. Most healthcare services have rebounded. Adjustments for testing, treatment, vaccination and vaccination booster costs have plateaued for most plan sponsors, with the impact of COVID-19 long-haulers still unknown. As illustrated in the graph, for 2022, the projected trend for open-access PPO/POS plans is slightly lower than the 2021 projection. For all other medical plan types, the projected trend for 2022 is slightly higher than for 2021.

## Medical Trend Projections\* for 2022 Are Expected to Be Similar to Pre-Pandemic Levels



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

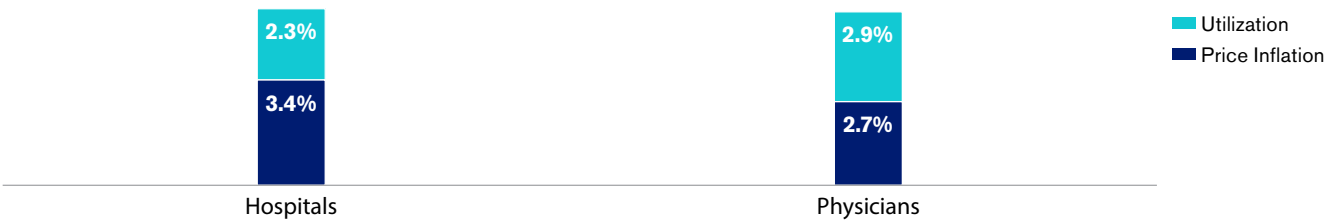
Source: Segal, 2021

## Leading drivers of medical trend

The survey examined components of 2022 trend projections and found two significant cost drivers:

- The prices of goods and services are a more significant factor than higher utilization of services in hospital trend increases.
- Greater utilization is driving physician trend increases.

## Hospital Price Inflation is the Largest Component of 2022 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, new mandates and technology changes. Not all survey respondents provided a breakdown of trend by component.

Source: Segal, 2021

## Hospital services

For more than a decade, hospital price increases have been a leading cost driver of trend. Consolidation and mergers of regional hospitals have given these larger hospital systems new bargaining power to increase their prices well beyond overall inflation rates. Additionally, the growth in enrollment in Medicaid and Medicare, which offer lower reimbursement rates to hospitals, have put pressure on hospitals to replace lost income by raising their rates to private payers.

Separately, transparency advocates are pushing for more access to pricing. New Transparency Rules go into effect this year. On January 1, 2021, a Department of Health and Human Services regulation took effect that requires hospitals to disclose their standard charges for a set of services in a publicly accessible and machine-readable format.

While transparency will help consumers identify lower-cost providers, the reliability of the data suggests consumers need to be cautious. A [2021 Advisory Board study](#) of 50 hospitals found that 52 percent of hospitals posted a machine-readable file, but only 14 percent posted all required elements. Additionally, there is little guidance on how to post the information, and some price information is difficult to locate. Furthermore, while hospitals are required to report negotiated rates, they are not required to report other information that would make cost comparisons more meaningful, such as data on patient satisfaction, quality ratings and outcomes. Machine-readable formats are not consistent to allow comparisons adjusting for patient risk, market share and the underlying payment method, such as value-based payment risk-sharing arrangements. Consequently, it is likely that it will take years for plan sponsors to take advantage of the newly published pricing data to negotiate better terms with hospitals or create more cost-efficient hospital networks.

As the landscape continues to evolve, plan sponsors can use this data as a benchmark. It is expected to place downward pressure on prices, ultimately reducing cost trend.





## Physician services

The second cost driver of medical plan cost trend is utilization of physician services. The pandemic has rapidly changed the landscape of digital health technology. According to Segal's [SHAPE database](#), virtual visits increased dramatically from 2019 to 2020, from 4.1 to 899.9 per 1,000. During year-to-date 2021, the rate is 1,031 per 1,000. While telehealth is here to stay, some anticipate higher utilization will be an addition to in-person visits, not a replacement for them.

Additionally, telehealth interactions are transactional and lack continuity of care. Proponents of telehealth have long argued that remote monitoring and check-ups could replace from 50 to 70 percent of visits to the doctor's office. Virtual primary care, which uses video visits for remote monitoring of patients, is the next evolution of care. It has the potential to enhance patient care by enabling comprehensive care through ongoing relationships with a provider virtually, at a lower cost.

## Plan sponsors' experience may differ from the projections

However, we caution plan sponsors to recognize that the 2022 projections could significantly differ from their actual results, given the continuous disruption in the healthcare system and many unknowns related to the virus and variants. For instance, the following factors may influence medical plan costs:

- Delayed care that may go away altogether
- The development of new tests, therapies and vaccines
- Transition of care to lower-cost settings, such as telehealth and telebehavioral health
- The cost of hospitalization among unvaccinated participants who are at higher risk for COVID-19
- Additional surges of the virus related to the Delta and other variants
- Regional differences in vaccine accessibility and uptake
- Temporary postponements of elective care due to hospital capacity issues, primarily in regions with lower vaccination rates
- Additional health complications resulting from COVID-19 long-haulers
- Costs associated with disease progression for those with chronic conditions and undiagnosed cancer who delayed care during the pandemic
- Higher utilization of telehealth that persists and adds to rather than replaces in-person visits
- Pressure from providers seeking to recoup lost income to increased reimbursements
- Cost to comply with the No Surprises Act, including directly negotiating with providers and the outcomes of Independent Dispute Resolution (IDR) process, when applicable
- Cost to comply with other government mandates, including the Transparency Rules
- Expensive new gene-therapy treatments for rare conditions

# Prescription Drug Plan Trends and Cost Drivers

For 2022, the projected cost trend for outpatient Rx plans is higher than the 2021 projection.

PBMs typically administer outpatient Rx plans. They include brand-name drugs, generics, biosimilars and specialty drugs dispensed through retail, mail-order and specialty-management channels. Generally, there's an exclusion for drugs administered in an inpatient facility or physician office setting because a medical benefit program covers those drugs.

The main driver is the cost of specialty drugs/biologics, which have a higher projected double-digit trend for 2022 than for 2021: 13.4 percent, up from 11.5 percent. Specialty drugs now account for 53 percent of spending, driven by growth in autoimmune and oncology therapies, according to a [report from IQVIA](#). In contrast, projected non-specialty trend is 4.6 percent.

## What Are Specialty Drugs?

Specialty drugs are generally high-cost drugs or those that require special handling. Often, they're given by injection or infusion.

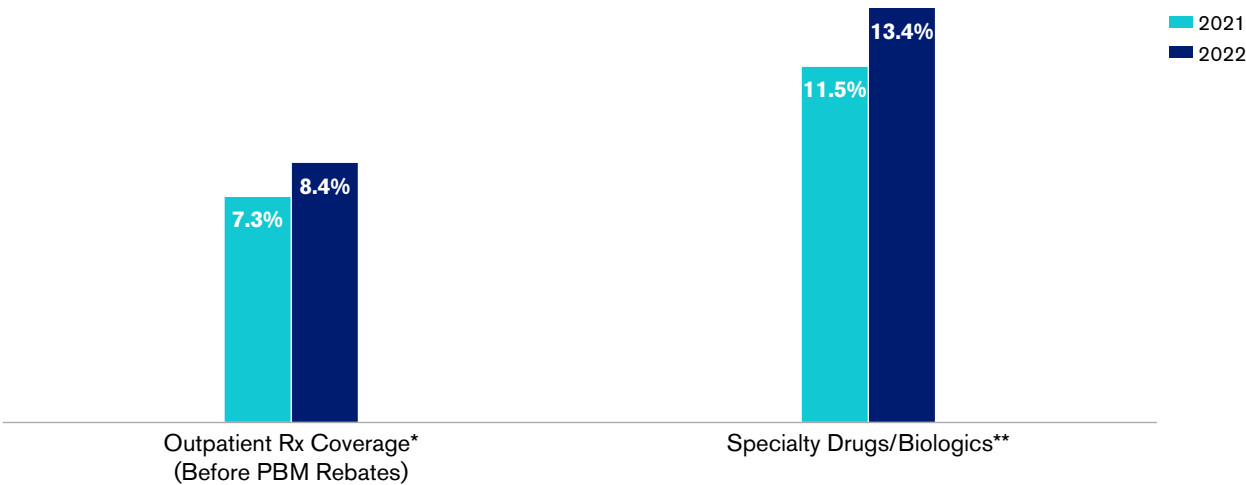
Biologics make up the majority of specialty drugs. Biologic drugs are derived from living organisms and are significantly more complex and challenging to develop and manufacture compared to non-biologic drugs, resulting in their higher cost.

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).



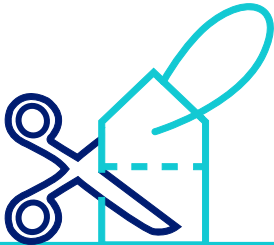
# Projected Prescription Drug Trend for Specialty Drugs Is Considerably Higher than the Projected Trend for Overall Outpatient Rx Coverage

Rx plan cost trends exceed all other health benefit cost trend estimates for 2022.



\* 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, 2021



## Rebates

Prescription drug plan cost trends exclude rebates. Rebates account for a substantial portion of the drug price equation. For the survey participants that reported prescription drug trend gross and net of rebates, the average impact of rebates was a 2.4 percentage-point reduction in Rx trend.

The presence and magnitude of drug rebates on brand-name drugs have become major elements 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 formulary rebates, which, typically, offset claim costs.

## What Are Rebates?

Generally, rebates are payments made by drug manufacturers to PBMs and/or health plan sponsors for preferred formulary placement of certain brand-name drugs. However, other forms of drug manufacturer payments exist, including price inflation rebates, fees for access to drug-utilization data, grants for clinical studies and other fees.

Drug manufacturers and PBMs control the definition of rebates and other incentive payments, which require plan sponsors to set contractual minimum-payment guarantees to ensure they receive payment streams that are predictable and auditable. Today, most PBMs pass through all or a portion of drug formulary rebates to health plan sponsors.

# 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 a major role. Non-specialty drug utilization has remained relatively flat or modest, whereas specialty drug utilization is forecasted to increase 8.1 percent in 2021.

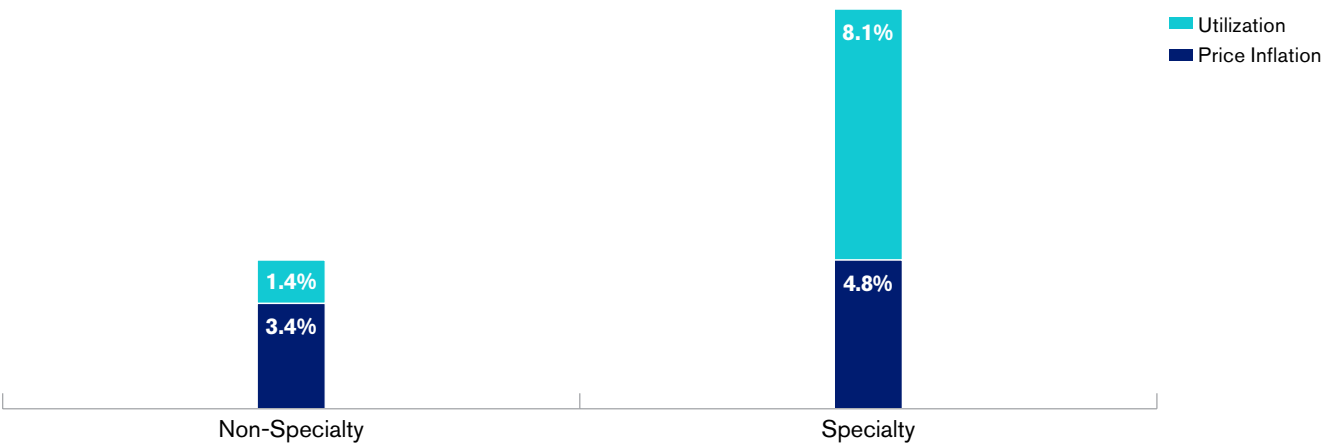
Drivers of projected specialty drug trend include price increases of existing specialty drugs and the high cost of new specialty drugs that are replacing lower-cost therapies. The majority of pipeline drugs are specialty and/or orphan drugs. However, we expect the number of biosimilars entering the market to offset some of the rising specialty costs. Specialty drugs on the market are also obtaining approval for additional indications, which will drive utilization and, therefore, overall cost up in the coming years. Examples include autoimmune drugs (such as Humira®), with initial indication for rheumatoid arthritis and extended approval for treatment of psoriasis, ulcerative colitis, Crohn's disease and atopic dermatitis.

While biosimilar utilization is not as high, biosimilars volume has increased 60 percent over the past two years, according to [IQVIA](#). Some PBMs are adding biosimilars as preferred products to their formularies. As biosimilars gain traction, specialty brand-name manufacturers are developing counterstrategies to maintain market share by matching the price of biosimilars and/or negotiating better rebate contracts to prevent patient switching. Because of the higher costs to develop and distribute new biosimilars, the potential savings are not as great as the substitution of low-cost generic equivalent drugs.

Plan sponsors are expanding the use of narrow formularies, copayment assistance programs and more comprehensive clinical care-management rules that are showing substantial cost savings.

Price inflation is also driving non-specialty drug costs. The Transparency Rule may contribute to decreasing trend over the long term because it makes it easier for consumers to shop for the price of healthcare services. See our [insight](#) on delayed enforcement related to transparency requirements for Rx reporting.

## 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 9](#).

Source: Segal, 2021





## Dental Trends

COVID-19 had a significant impact on dental spending for 2020. During the pandemic, most dental practices were either fully closed or only open to see emergency patients. As dental practices reopened, they incurred new expenses to account for increased standards associated with personal protective equipment, sterilization and infection control.

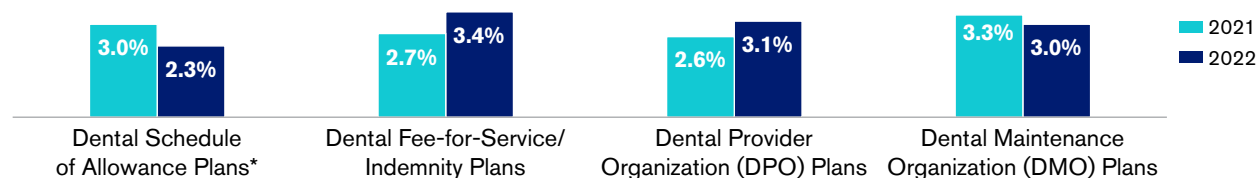
Due to the economic impact on revenue, dental practices continue to consolidate. That may lead to greater negotiation power and higher reimbursement rates in some communities. However, survey data as well as review of Segal SHAPE dental claim experience suggest a return to pre-pandemic annual rates of dental cost trends.

### Advances in dentistry

In response to COVID-19, some dental providers launched virtual dental care. This is also a path for care in rural and urban settings. These virtual visits help address urgent dental situations, such as pain, infection and swelling, as well as facilitate prescribing of antibiotics and non-narcotic pain relievers.

There are a number of advances to improve patient care. Market innovations include the use of artificial intelligence to interpret x-rays or data from smart toothbrushes and other smart oral home care devices.

### Trend Projections for Most Dental Coverages Similar to Pre-Pandemic Levels



\* 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, 2021

# Vision Trends

While vision plan cost trends for reasonable and customary plans increased by 1 percentage point over 2021, they remain low. The vision care industry has accelerated its use of offering digital eye exams and online access to purchase of frames and glasses. AI technology can analyze a consumer's face and help with fit of frames. Vision and eye care continue to play a role in the early warning of related medical issues, such as detection of diabetes and hypertension. Increased competition for suppliers of eyewear are also putting downward pressure on prices.

Plan sponsors should consider reevaluating their vision offering, exploring the new virtual landscape and communicating the value of this benefit to their participants.

## Trend Projections for Vision Reasonable and Customary Plans Higher for 2022



Source: Segal, 2021





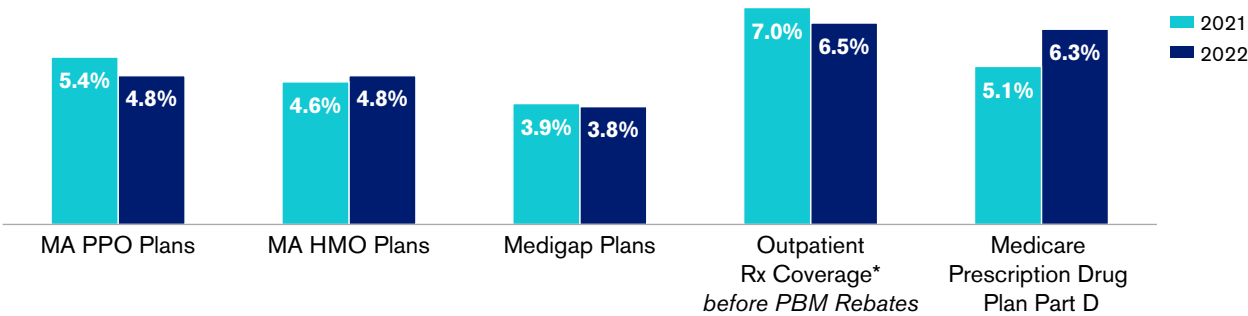


# Medical Trends for Medicare-Eligible Retirees

Coverage for Medicare-eligible retirees generally falls into one of three categories: MA PPO plans, MA HMO plans and Medicare supplemental insurance coverage known as Medigap. While trend projections for each of these coverage categories are comparable to pre-pandemic levels, 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 have expanded access to at-home care for medical, behavioral health and palliative care, along with social services. MA carriers are working collaboratively with patients and providers to ensure high-risk seniors receive support to manage their care on an ongoing basis. The Medicare market continues to show highly stable plan cost trends.

## Projected Medical Trends for Medicare-Eligible Retirees Similar to 2021



\* Outpatient Rx trend is for all prescription drugs (non-specialty and specialty drugs combined) for employer-sponsored plans. See [page 9](#) for specialty drug trend projections.

Source: Segal, 2021



## Putting Trend Projections in Context

Plan sponsors that put trend projections in the proper context more successfully reap the benefits of the data. It is difficult to anticipate the impact of the dynamic changes in the healthcare delivery system fueled by provider group consolidation, changes in the covered landscape and digital advances. As a result, trend projections are generally higher than actual costs. This section of the survey helps plan sponsors to understand this context better so they can more effectively apply the data to their benefit programs.

### **Before the pandemic, the survey respondents predicted positive plan cost trends for 2020, but actual trends came in negative for most plans**

To assess the accuracy of trend projections, we compared 2020 *projected* trends for medical, Rx and dental plans to the *actual* average trends for 2020 (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.

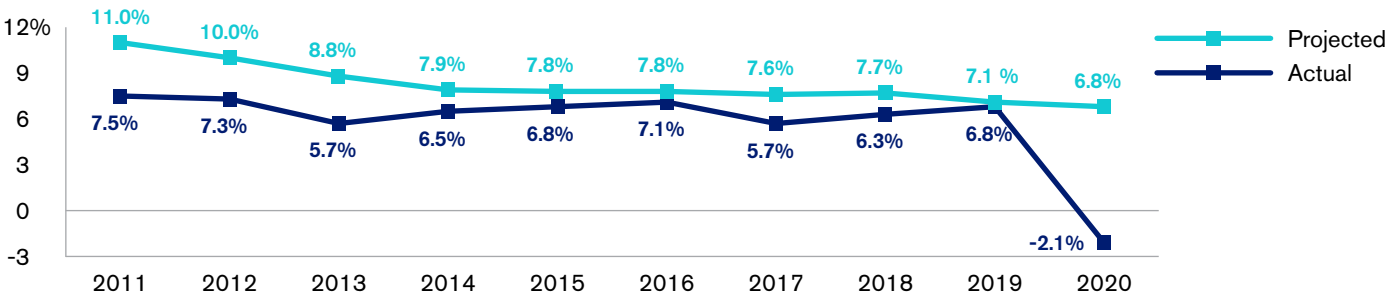
The accuracy of projections is subject to both underwriters' conservatism in predicting future events and a natural lag in the underwriting cycle. The pandemic added significant uncertainties in plan cost projections and forecasters did not anticipate the magnitude of impact for 2020. For the first time, medical and dental trends were negative due to deferred or cancelled care.



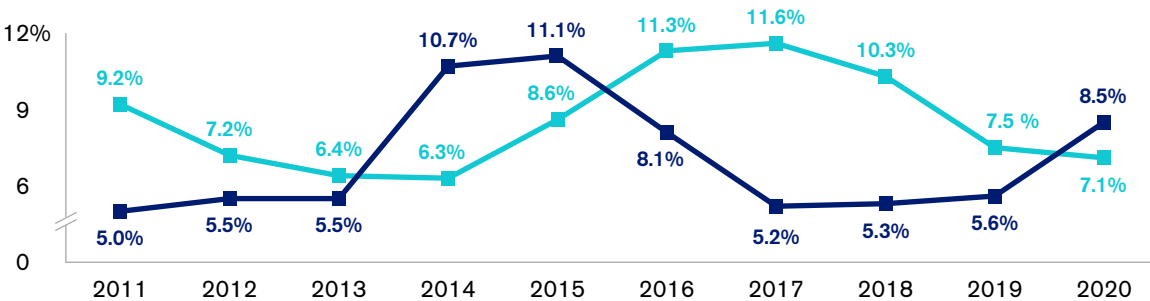
For prescription drugs, however, actual trends were not negative. Drivers of those trends were high-cost specialty drugs, drug price inflation and increased utilization of both mail-order pharmacies and drugs to treat behavioral health conditions.

**When considering trend projections, plan sponsors should take into account this historical pattern of projected trend to actual trends over multiple years.**

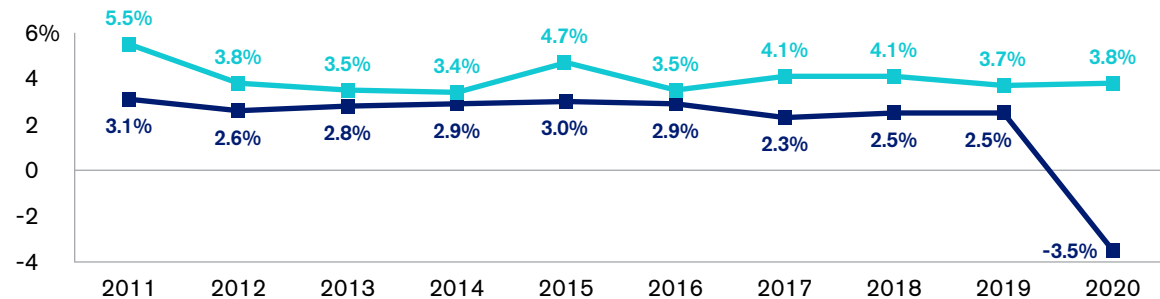
**For Open-Access PPOs/POS Plans, Actual Trend in 2020 Was Negative Due to Deferred and Eliminated Care\***



**Projected Rx Trend Compared to Actual Trend Mixed over 10 Years\*\***



**Actual Dental PPO Plan Actual Trends Negative for First Time in 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, 2021

## Historical survey data on selected medical, outpatient Rx and dental trends shows forecasted trend back to pre-pandemic levels

While it is uncertain whether the pandemic will have a longer-term impact in the future, most forecasters are reporting trends that are mostly in line with pre-pandemic cost trend estimates. In some cases, trend projections for 2022 are slightly higher than in previous plan years.

We continue to observe a subset of plan sponsors that use aggressive cost-containment efforts and strategies to offset cost trends. Those sponsors have lower plan cost trend rates than projected average levels.

### Selected Medical,<sup>1</sup> Outpatient Rx<sup>2</sup> and Dental Trends: 2008–2020 Actual and 2021 and 2022 Projected<sup>3</sup>

	Year	Open-Access PPOs/POS Plans	PPO/POS Plans with PCP Gatekeepers	HMO Plans	MA HMO Plans	Outpatient Rx Plans	DPO Plans
Actual	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%
	2020	-2.1%	1.5%	0.8%	-4.1%	8.5%	-3.5%
Projected	2021	7.7%	7.2%	6.6%	4.6%	7.3%	2.6%
	2022	7.3%	7.8%	7.0%	4.8%	8.4%	3.1%

<sup>1</sup> Medical trends exclude prescription drug coverage.

<sup>2</sup> Prescription drugs trends combine non-specialty and specialty drugs. These results do not include the impact of rebates from PBMs.

<sup>3</sup> All trends are illustrated for actives and retirees under age 65, except for the MA HMOs. (Graphs comparing 15 years of survey data — 2008 through 2020 actual trends and 2021 and 2022 projected trends — and showing average actual annual trend by coverage type for the last five years [are available](#).)

Source: Segal, 2021

# Top Health Plan Cost-Management Strategies in 2021

Plan sponsors continue to implement various cost-management strategies to help mitigate increasing health plan costs while maintaining high-quality standards and access to healthcare goods and services.

We asked survey participants to rank the top strategies group health plans are using in 2021. The chart below compares the top-five strategies being used today to last year's ranking.

2021 Top Five	2020 Top Five
<b>1</b> Adopting a high-deductible health plan	<b>1</b> Waiving cost sharing for treatment related to COVID-19*
<b>2</b> Expanding pharmacy management programs (i.e., prior authorization or step therapy)	<b>2</b> Using healthcare transparency tools
<b>3</b> Using healthcare transparency tools	<b>3</b> Implementing telehealth for behavioral health support services or enhanced virtual therapy sessions
<b>4</b> Implementing chronic-condition management and digital health coaching for diabetes, hypertension and weight management	<b>4</b> Including high-deductible health plan options
<b>5</b> Implementing virtual counseling for behavioral health issues	<b>5</b> Expanding pharmacy management programs

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

Source: Segal, 2020 & 2021

As noted in the table above, plan sponsors are using a number of different cost-management strategies in 2021. Adopting a high-deductible health plan (HDHP), the top strategy, with health savings accounts (HSAs), coupled with healthcare transparency (ranked number three) has helped plan participants make more conscientious decisions about healthcare services by identifying lower-cost, higher-quality providers.

It's not surprising that expanding pharmacy management programs is ranked within the top-three strategies given the current levels of Rx projected trends. For most plan sponsors, COVID-19 has fueled a transformation in digital therapeutics, which explains why virtual behavioral health ranks among this year's top-five strategies.



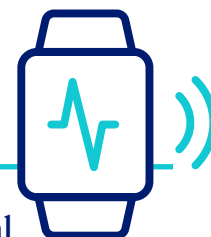
## Medical Cost Management

This section presents an overview of key strategies plan sponsors may wish to consider as part of their medical cost management for 2022 and beyond.

### Digital therapeutics

There continues to be an evolution of well-being solutions offered through digital therapeutics platforms. Solutions that focus on targeted or specific conditions have been emerging as alternatives to traditional direct vendor offerings, and aim to bridge gaps in current plan offerings. The marketplace has many products covering several disease conditions, including (but not limited to) diabetes, hypertension, behavioral health, cardiovascular, musculoskeletal, obesity, cancer, sleep disorders and digestive health.

Digital therapeutics offer plan sponsors a number of advantages. Virtual care can reach a wider audience to address access needs of a population, helping to cover shortages in primary care and (potentially) all specialties. Data from wearables on vital signs can lead to customized messaging, with the potential to achieve desirable behavioral changes via real-time virtual health coaching. To reduce the risk of lifestyle-related diseases and achieve better outcomes, health and wellness plans are increasingly focusing on prevention through behavior-change practices. Patient engagement tends to be higher through these types of solutions. As treatments and protocols evolve, digital therapeutics can quickly incorporate them into their workflows, sharing new medical knowledge and therapies. Virtual health is a core component in helping consumers proactively improve or maintain overall well-being.



### What Are Digital Therapeutics?

Digital therapeutics, also known as virtual therapeutics, use the patient's smartphones, tablets and computers to help manage their health conditions virtually. They aim to deliver favorable clinical outcomes by addressing several aspects of health, including social determinants, such as access to primary care, access to quality care and health literacy. Digital therapeutics also address factors that can have an impact on a patient's health, such as lack of transportation.



Plan sponsors considering digital therapeutics for their benefit programs should develop a strategy for evaluating these offerings. This starts with establishing specific goals, such as improving participants' experience, increasing access to care and achieving specific health outcomes. Using data mining, plan sponsors should draw on their claims data to make informed decisions based on the top cost drivers and the conditions prevalent within their population.

It is also important to understand what solutions currently exist in a health plan's ecosystem. Many vendors, including PBMs, offer turnkey partnerships. Plan sponsors should explore the feasibility of funding digital therapeutics by credits or vendor allowances. After selecting a vendor, it's important to develop strong communications and tailored to the participants. Meaningful plan incentives can also help drive participation. It's also important to monitor and evaluate program outcomes over time. Plan sponsors may want this done independently, rather than solely through vendor ROI reporting.

## Greater access and incentives to use urgent care and retail clinics

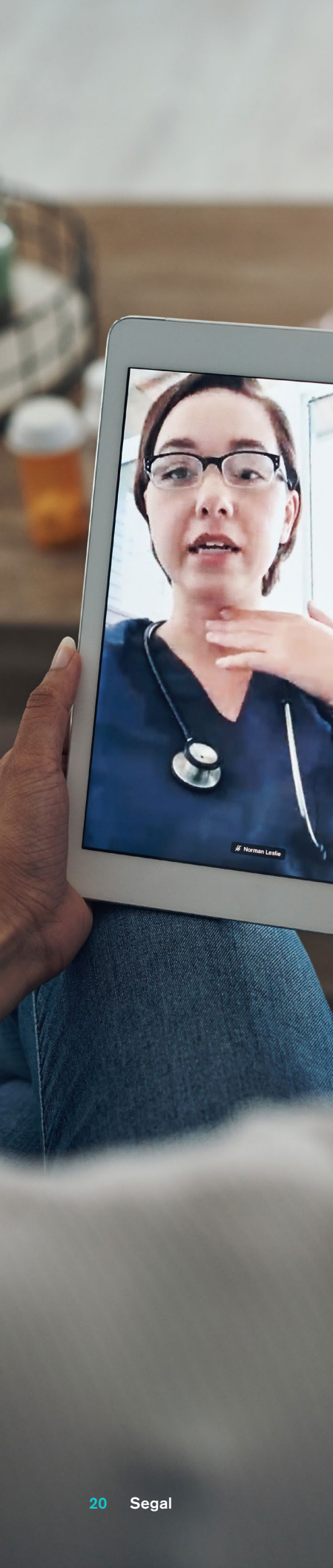
Investment in community-based urgent care facilities and retail clinics continues to show growth. Plan design incentives that lower copayments for using these facilities and improved participant education to raise awareness of these service options have redirected patients away from hospital emergency rooms. Lower costs, shorter wait times and expanded hours have resulted in greater utilization and savings to plan sponsors. The average cost of an ER visit can be close to \$1,900 while a visit to an urgent care facility is closer to \$165 and a retail visit costs \$70.

## Enhanced behavioral health

Access to traditional behavioral healthcare is often a major barrier to people getting the treatment they need in a timely fashion. A shocking statistic reported by [BenefitsPro](#) showed less than half of the counties in the U.S. have a licensed mental health professional.

The increasing availability of virtual behavioral health resources makes it possible to fill the gaps. Implementing virtual counseling for behavioral health issues continues to be a priority for plan sponsors. Virtual mental health can support employee assistance program (EAP) visits as well as behavioral health visits to licensed psychiatrists, psychologists, counselors and social workers. It can also support other therapies, including psychotherapy, cognitive behavioral therapy and dialectical behavioral therapy. Telebehavioral health was gaining popularity even before COVID-19, with providers helping with mental health diagnosis, stress, anxiety, sadness, work pressures, grief, trauma and relationship or family concerns.

While increasingly popular, new digital telebehavioral health technology solutions should only augment, not replace, evidence-based care. The best approach to addressing the mental health needs of a population is a multi-faceted behavioral health program. Apps and virtual counseling are not a replacement for coverage of mental health and addiction treatment, but rather can be a valuable complement to care by providing education, easy access, timely feedback, mood monitoring and mindfulness exercises.



Plan sponsors should carefully vet digital behavioral healthcare programs. When evaluating digital behavioral health, plan sponsors should assess adequate access to evidence-based, medically appropriate care, as well as compliance with applicable laws and regulations. Plan sponsors should look for vendors to offer performance guarantees for getting appointments within a reasonable time and having an adequate number of provider specialists. Measures of success should include improved productivity, active and sustained participant engagement, reduction in symptoms, sustained effect of the intervention and reduced costs on clinically validated measures.

## Virtual primary care

Virtual primary care providers can refill prescriptions, conduct wellness screenings, order lab tests, create care plans for lifestyle changes and manage chronic conditions. Patient data collected at home through wearable devices and sent to a doctor online enhance virtual visits. These include fitness trackers, blood-pressure monitors, pulse oximeters, smart thermometer and self-examination kits. Technology has evolved to facilitate remote monitoring through devices that enable examination of ear, eyes, skin, lungs, heart, throat and temperature. A number of insurers have “virtual-first” primary care solutions, including Teladoc, MDLIVE, Amwell, DoctorOnDemand, Kaiser and Amazon Care.

Virtual primary care solutions should include best-practice plan design and clinical protocols using evidence-based medicine. They should incorporate patient privacy and security protection. Plan sponsors evaluating virtual primary care options should ask insurers what conditions they are able to prevent, manage and treat. As these solutions become mature, plan sponsors should evaluate results of virtual primary care to determine if patient care improves outcomes and what savings are achieved.

## The No Surprises Act and Transparency Rule

The No Surprises Act, which goes into effect in 2022, will add new protections for plan participants who have emergency out-of-network claim events. The new law will reduce out-of-pocket expenses for these patients. The [Congressional Budget Office estimates](#) that the new law will also lower employer plan cost by half to 1 percentage point by lowering the impact of excessive billed out-of-network provider charges. The [interim final rule](#) that was released on September 30, 2021 provides details on how the IDR process will work.

## Enhancing high-cost patient case management

With healthcare costs driven by a relatively small number of high-need individuals, it makes sense to focus on high-cost claimants to reign in healthcare expenses. With the rise in high-cost specialty drug use and evolution of treatment through gene therapy, the health industry has witnessed heightened exposure to catastrophic claims for both insured and self-insured employer-sponsored health plans. Managing high-cost participants by intensive case management and prescription drug management is one way to stay on top of such claims.

Intensive case management can help to:

- Reduce the likelihood of a patient receiving duplicative or low-value services in low-quality settings.
- Make sure a support structure is in place to help patients seek care.
- Negotiate costs for services, such as outpatient rehabilitation and home healthcare.
- Provide high-quality care options to participants for their particular conditions, such as centers of excellence.
- Refer patients to a second expert medical opinion to ensure they receive the right care at the right time in the right setting.

Intensive prescription drug management can help to:

- Put in place tighter prescription management and formulary controls.
- Make available programs like prior authorization or drug-tiering.
- Decide which channel (medical plan or PBM) is most cost-effective for delivery of specific medications.

Plan sponsors should closely examine their high-cost claims expense and consider appropriate stop-loss coverage. Stop-loss coverage, in combination with a robust clinical-services program, from simple reporting to comprehensive clinical review and engagement, can also help plan sponsors address the rising number of high-cost participants.





# Pharmacy Benefit Cost Management

To reduce Rx costs, plan sponsors can use a variety of techniques to expand their pharmacy benefit management programs.

## PBM contract review

With the complex dynamics between drug manufacturers and PBMs, plan sponsors should consistently monitor and review their prescription drug plan contract terms. The maze of pricing terms continue to get more complex as definitions of incentives, discounts, rebates and fees change. Contract reviews can be part of an annual market check, a renewal or an RFP.

Review of PBM contract terms can ensure financial terms are competitive in the market. PBM contracting can include complex price guarantee exclusions and terms that are counterproductive for plan sponsors. It's prudent to ensure that financial and non-financial terms agreed to during an RFP are in place. A review can identify the need to update language to fix outdated plan provisions and help plan sponsors keep pace with current marketplace dynamics. A contract review can also confirm plan sponsor audit rights are appropriate. Some PBMs continue to apply complicated pricing re-classifications that can increase plan sponsor costs.

PBM rebates now make up a significant portion of pharmacy benefit expenditures for a typical plan sponsor. These rebates can account for 25 percent of paid claims for the plan sponsors and can help to offset plan cost trends. Plans must actively manage their rebate contracts to make sure these rebates continue to keep pace with prescription drug claim cost trends.

Contract reviews can reduce costs without negatively affecting participants. Plan sponsors can achieve prescription drug costs savings ranging from 3 to 5 percent with a market check to double-digit savings with a full RFP.



## Strategies for specialty management

For the typical plan sponsor, specialty drugs now account for approximately half of total drug therapy costs. In addition, new products and therapies continue to enter the marketplace with price tags that can be substantially more than the existing therapies with little additional efficacy. As a result, a focused approach that combines securing best pricing and rigorous clinical analysis will produce the greatest cost management. For example, exclusive contracting with a specialty pharmacy can increase specialty drug discounts and rebates.

Expanding clinical treatment protocol or therapy management produces results for a growing number of plan sponsors. Amending plan terms to include clinical safeguards may prove to be an effective cost-management tool that reduces wasteful spending. The safeguards can include step therapy, targeted prior authorization for high-cost drugs, developing rules to cover or not cover new-to-market drugs and quantity-duration limits based on FDA guidelines.

Other strategies include:

- Review and renegotiate contracting for pricing of provider-administered drug therapy under the medical plan.
- Customize network pharmacy and introduce incentives for participants to use it, including through targeted retail maintenance pricing.
- Integrate and leverage funding from specialty drug copayment assistance programs.
- Introduce outcome-based pricing or inflation-protection caps.
- Change the plan design to reduce wasteful drug utilization.
- Add incentives to maximize the use of generic, over-the-counter and lower-cost brand-name drugs.
- Install support services during transitions in settings/care for patients and family members to reduce the risk of errors during transitions.

## Promotion of biosimilars

Biosimilars have the promise of being less expensive alternatives to their biologic brand-name counterparts, which represent the majority of specialty drug costs and are a leading driver of overall rising prescription drug cost trends. Although biosimilars have existed in the U.S. for several years, biosimilar uptake remains slow due to barriers that include lack of understanding by both patient and physician, contracting concerns and no interchangeability (in contrast to the generic version of a brand counterpart). The ERISA Industry Committee (ERIC) established an initiative to better understand biosimilars' potential to lower specialty drug costs. In 2020, ERIC reached out to us to learn about different strategies that plans can implement to increase adoption of biosimilars. There are several opportunities to reduce specialty spend, as discussed in a [white paper we prepared for ERIC](#). They include:

- Plan design — Establish plan design strategies and step-therapy rules to promote biosimilar use over higher-cost biologic originator product.
- Creative PBM contracting — Review contract terms with their PBMs to ensure their terms are competitive for these emerging drug therapies.
- Promotion of biosimilar education — Work with PBMs or pharmacy advisers to promote biosimilars through communication and education about drug options with plan participants and providers.

## Coupons and specialty copayment-assistance programs

Historically, brand-name drug manufacturers offered coupons to patients, which were processed by retail pharmacies, circumventing the PBM. This manufacturer marketing tactic aims to increase the use of brand-name drugs by decreasing the patient's cost burden for high-cost brand drugs as opposed to having the patient take a lower-cost product.

This practice raised cost issues for plan sponsors. In some cases, the manufacturer's coupon for a brand-name drug may make the copayment for that drug even cheaper than the copayment for a generic equivalent, resulting in a higher cost for the plan sponsor.

For non-specialty drugs, coupons may exist for several brand-name drugs that treat the same condition and are generally applied outside of the PBM control of plan copayments. Consequently, it's impractical to attempt to exclude all drugs with coupons from formularies. Fortunately, for many non-specialty drug therapies, multiple sources of drug therapies are available. Installing step-therapy rules for some drug treatments that require the use of lower-cost generic drugs where they are clinically equivalent may help reduce the increased use of higher-cost brand-name drugs that offer coupons.

For specialty drugs, there are also manufacturer coupons (patient copayment assistance) available to patients. Specialty drugs tend to have less generic drug options that are available. As a result, it may make sense for plans for plans with higher brand copayments or HDHPs to help plan participants to take advantage of the copayment assistance programs for high-cost specialty drugs.

PBMs can now underwrite plan designs that maximize copayment assistance to plans with higher levels of participant cost sharing, while still creating a program that results in low or zero copayments for participants. Plan sponsors can obtain pharmacy plan savings by aggressively renegotiating renewals with PBMs or by conducting full RFPs.



Copayment assistance generally requires the patient to enroll or register to obtain funding and agree to share their data with aggregate-level clinical studies. Some PBMs now offer programs to manage the registration process for eligible plan participants on behalf of the plan sponsor.

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 not-for-profit foundations or the Pharmaceutical Research and Manufacturers of America, which are not eligible to those covered by Medicare, and manufacturer-sponsored programs for branded pharmaceutical specialty products directed at the commercially insured population.) PBMs began offering specialty copayment-assistance programs to help plan sponsors take advantage of brand-name drug manufacturer's coupons as well as to generate additional fees from managing these programs.

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

- The impact on generic dispensing strategy
- Restricted use of a PBM's exclusive specialty vendor
- Evaluation of PBM service and administration fees
- Plan design and 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 legal requirements and compliance considerations, including updating plan documents appropriately
- Developing member communications strategies to properly educate plan participants

## Help may be coming from the federal government

The Biden Administration has announced its intention to lower prescription drug prices. One approach would be to let the federal government negotiate with drug makers and make those prices available to commercial plans.







## An Effective Strategy for Managing Costs

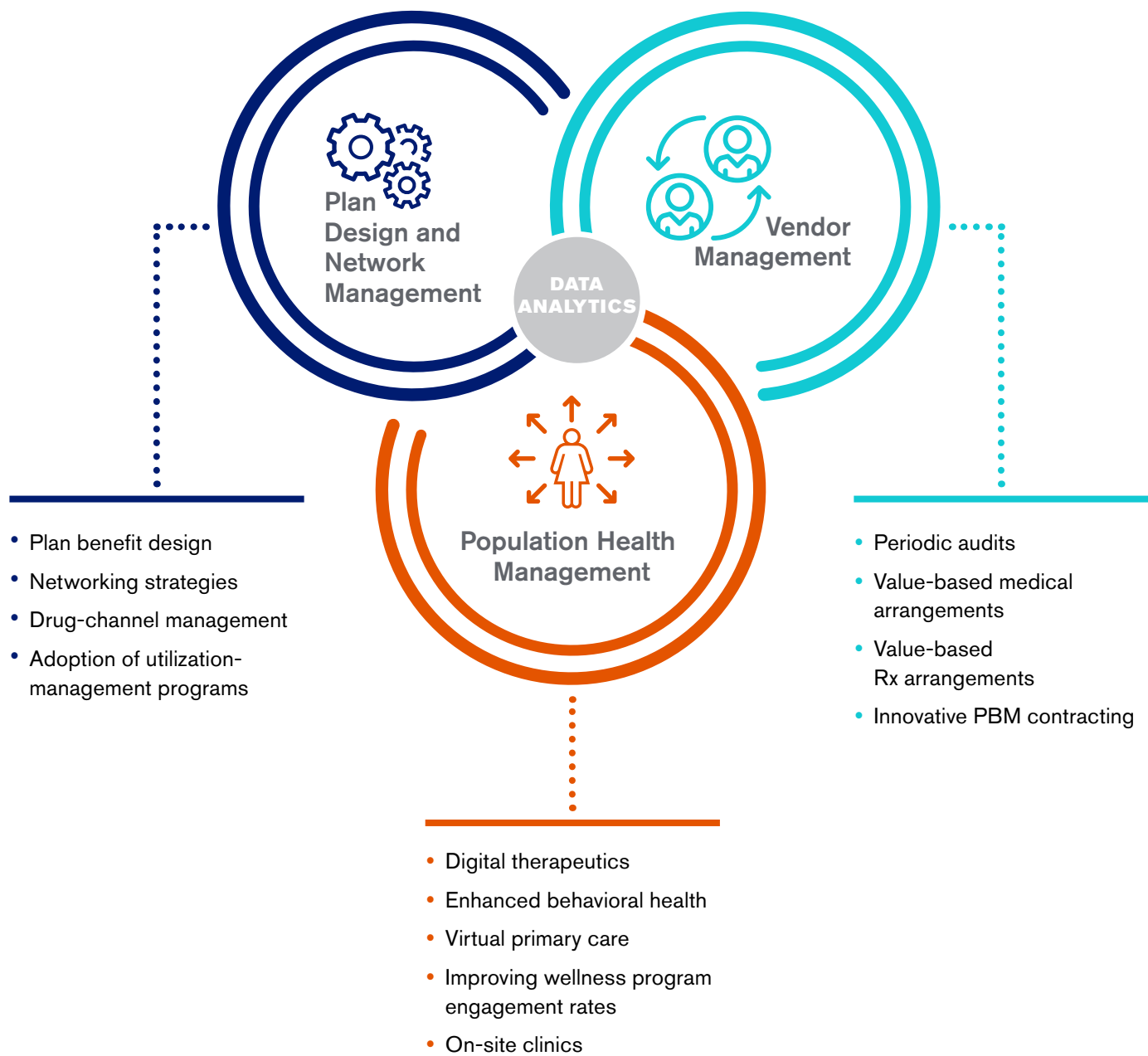
While COVID-19 pandemic and its long-term effect on the population and health service utilization is still unknown, most analysts believe services will return to pre-pandemic levels. Cost trends for medical plans appear to be ticking up slightly with pharmacy benefit cost trends approaching double-digit annual levels once again. The pandemic has accelerated the advancement of digital therapeutics and other innovations with the hope of lowering costs and improving access to care.

The regulatory landscape continues to change and impose significant administrative burdens for plans. While much of the focus is to provide more protection for consumers, this is a period of extraordinary cost-management uncertainty and change for plan sponsors. As a result, plan sponsors should proceed cautiously and draw on their data to make well-informed decisions about which strategies and services produce the most value given their limited resources. As new vendor services enter the market, many are promoting solutions or services that may focus more on generating revenue than producing measurable results or improving participant experience.

Plan sponsors can continue to offer high-value benefits while bringing down their plan cost trends using best practices that produce evidence of results and plan data to develop targeting strategies that address aggressive vendor contracting, measurable population health improvement and smart plan design.

We recommend a balanced three-pronged approach to effective healthcare cost management. It involves managing plan design, vendors and population health, as illustrated on the next page.

Our Approach to Effective Healthcare Cost Management





# The Survey Respondents

Almost 80 health insurance providers participated in the survey. As a group, the survey respondents represent 80 percent of the commercially insured and self-insured market.

The following chart shows a count of respondents by plan type.

## Medical Plans



43	Open-access PPO/POS plans
35	HDHPs
40	HMO plans
25	PPO/POS plans with PCP gatekeepers

## Rx Plans



61	Outpatient Rx drug plans
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## Dental Plans



33	DPO plans
23	Dental Fee-for-Service/Indemnity plans
16	DMO plans
17	Dental schedule of allowance plans

## Vision Plans



20	Vision schedule of allowance plans
13	Vision reasonable and customary plans

The following respondents agreed to be identified by name:

Aetna	Guardian Life Insurance Company of America
Amalgamated Employee Benefits Administrators, Inc.	Harvard Pilgrim Health Care
Amerihealth New Jersey	Health Alliance Medical Plans
Ameritas	Health Net of California, Inc.
Anthem, Inc.	Health New England, Inc.
Arkansas Blue Cross Blue Shield	Highmark Blue Cross Blue Shield of Western Pennsylvania
BeneCare Dental Plans & Affiliates	Highmark Blue Cross Blue Shield of Central Pennsylvania
Blue Cross Blue Shield of Alabama	Highmark Blue Cross Blue Shield of Delaware
Blue Cross Blue Shield of Arizona	Highmark Blue Cross Blue Shield of West Virginia
Blue Cross Blue Shield of Illinois	Humana – Group Medicare
Blue Cross Blue Shield of Kansas City	Independence Blue Cross
Blue Cross Blue Shield of Michigan	Kaiser Permanente
Blue Cross Blue Shield of Minnesota	Medical Mutual of Ohio
Blue Cross Blue Shield of Montana	MedImpact
Blue Cross Blue Shield of New Mexico	Metropolitan Life Insurance Company
Blue Cross Blue Shield of Oklahoma	Navitus Health Solutions LLC
BlueCross BlueShield of Tennessee	National Vision Administrators LLC
Blue Cross Blue Shield of Texas	OptumRx
Blue Cross North Carolina	Premiera Blue Cross
Blue Shield of California	Prime Therapeutics LLC
Capital District Physicians' Health Plan, Inc.	Sun Life Financial
Cigna	Trustmark
ConnectiCare, Inc.	Tufts Health Plan
CVS Health	United Concordia Companies, Inc.
Elixir Solutions	UnitedHealthcare
Emblem Health	Voya Financial
EmpiRx Health LLC	Wellmark Blue Cross and Blue Shield Iowa
Express Scripts, Inc.	Wellmark Blue Cross and Blue Shield of South Dakota
Group Vision Service	

## Questions? Contact Us.

If you have questions about medical cost-management strategies or about the *2022 Segal Health Plan Cost Trend Survey*, contact your Segal consultant or the author of this report:



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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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# 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.

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