# What Are the Projected 2023 Health Plan Cost Trends?

## Survey Finds Uptick in Most Trends with Outpatient Rx at Nearly 10%


Segal

# Contents

# Introduction

Medical plan cost increases for 2023 are returning to pre-pandemic levels, despite significant fluctuations as deferred care rebounded and COVID-19 variants peaked. While it's anticipated that previously observed spikes related to COVID-19 should moderate over time, the long-term impact on health plan costs of new variants, treatments and long COVID is difficult to predict. The full impact of delayed or deferred care is still unknown. One evident shift from the pandemic has been the greater adoption of virtual care/telehealthcare, with significant increases observed in those with mental health-related disorders being newly diagnosed and treated virtually. The shift appears to be permanent, although the long-term impact on health plan costs trends has yet to be properly quantified.

It is difficult to accurately forecast the impact of the dynamic changes in the healthcare delivery system fueled by the inflationary environment, provider group consolidation, digital advances and changes in the regulatory landscape. With the myriad of external influences that will touch health benefit programs, it's important for plan sponsors to monitor actual health claim results more regularly to spot sudden changes in costs patterns. These drivers will influence trends over the next few years. Effective cost-management strategies can help mitigate the influences of the continuously changing health plan economic environment.

The 2023 *Segal Health Plan Cost Trend Survey* shares trend forecasts for 2023 and techniques that can be used by plan sponsors to monitor and manage cost trends over time.

# Key Findings

The latest annual *Segal Health Plan Cost Trend Survey* found projected annual cost trend for outpatient prescription drugs is expected to be approaching double-digit levels, the highest rate observed since 2015.

Other key findings about 2023 trend projections include:

- Survey respondents project per-person cost trends for open-access PPO/POS plans to be 7.4 percent.
- Double-digit specialty Rx cost trend, mostly driven by price increases and new-to-market 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 hospital, physician and Rx trends.
- Trend projections for most dental coverages are expected to reach 4 percent, driven by inflation across the U.S.
- Projected vision trend is 2 percent for reasonable and customary (R&C) plans.
- Medical trend projections for Medicare-eligible retirees are similar to pre-pandemic levels, with Medicare Advantage (MA) PPO and MA HMO plans forecast to be 4.2 percent.

In addition to presenting trend projections, the report evaluates actual trends. While actual 2020 trends were negative for medical and dental for the first time since Segal has tracked trends, due to deferred and eliminated care from the pandemic lockdowns, 2021 trends experienced a spike in the opposite direction. The survey also evaluates how COVID-19, telehealth services and the No Surprises Act are expected to impact cost trends in 2023.

## Observations

The COVID-19 pandemic has significantly altered healthcare trend patterns during the last few years. Spending on medical expenses in the United States during 2020 decreased for the first time in recorded history. The decrease was driven by deferred or eliminated care, including elective procedures, routine care and cancer screenings. This mainly impacted outpatient hospital and physician services. Industry efforts to promote telehealth helped mitigate the disruption in physician services. Outpatient hospital services have since rebounded as in-person elective procedures resumed. Physician services have also mostly rebounded as participants become more comfortable with in-person care. Telehealth visits remain a popular option for participants and utilization of telehealth has mostly stabilized well above pre-pandemic levels.

In addition to the rebound of healthcare services, other external forces may be catalysts for higher healthcare trends and/or lower quality of care in the near term. These external forces include, but are not limited to, the following:

- The current high-inflation environment pushing up wage increases for the healthcare industry
- Provider burnout and increased patient demand
- Cost shifting to private payers to make up reduced revenue from a growing enrollment in Medicare and Medicaid
- Provider group consolidation demanding higher reimbursement amounts in select geographic service areas for specialties with already limited supplies of network contract providers

## 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 treatments, therapies and technologies
- Greater emphasis on detection and diagnoses
- Social and economic factors, which can influence utilization or care decisions
- Medical inflation, which impacts the cost of delivering care
- Provider price increases
- Increased treatment burden due to the aging population and rise in obesity
- Provider cost shifting from reduced payment by Medicare and Medicaid
- Erosion effect of fixed-dollar deductibles and copayments*

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. Trend projections can also be used to challenge vendor rate renewals.

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

** We discuss rebates on page 11.

# About the Survey

The 2023 *Segal Health Plan Cost Trend Survey* is our 26th annual survey of managed care organizations, health insurers, PBMs and TPAs. We conducted the survey during the summer of 2022.

Respondents reported 2023 trend forecasts for medical, prescription drug, dental and vision coverage. In addition, the survey respondents reported actual allowed health cost trends for 2021 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**

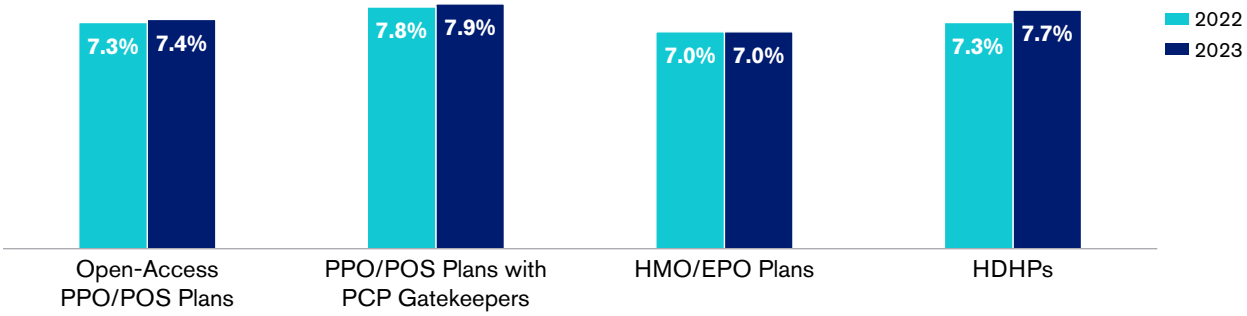
**HMO/EPO Plans**


**HSA-Qualified HDHPs**

# Medical Plan Trend and Cost Drivers

Several factors, including inflationary pressures, healthcare worker staffing challenges, provider consolidation, impact of delayed treatment, pent-up demand and new treatments and technology are pointing to higher medical trend projections during the next few years. As illustrated in the graph, for 2023, the projected trend for HMO/EPO plans is the same as the 2022 projection. For all other medical plan types, the projected trend for 2023 is slightly higher than for 2022.

### Medical Trend Projections* for 2023 Are Expected to Be Similar to Pre-Pandemic Levels, Despite Prior Year Fluctuations




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

Source: Segal, 2022

## Leading drivers of medical trend

The survey examined components of 2023 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 both hospital and physician trend increases.
- Utilization of services has been driving trend increases since February 2021, according to information from SHAPE, Segal's health data warehouse. Ther survey respondents noted that utilization appears to be leveling off in 2023.

### Hospital Price Inflation Is the Largest Component of 2023 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, 2022

## Hospital services

Hospital price increases continue to be a leading cost driver of trend. Shortages among nurses and the provider workforce have resulted in wage increases, as many health systems had to pay contract agencies or travelers who commanded higher rates to fill vacancies. This ongoing wage pressure on hospital system operating costs, coupled with increased supply costs, naturally results in increases to the prices of services. It will take some time for the market to feel the full effect of these pressures due to the timing of provider re-contracting in commercial plans.

The pandemic has also accelerated the rise in outpatient care, including use of telehealth, urgent care and in-home care. As hospital revenue decreased, these systems have been forced to shift market share by acquiring outpatient facilities and physician practices. Additionally, reimbursement models are incentivizing providers to improve primary care delivery and shift care away from inpatient settings.

Separately, it has now been two years since the Hospital Price Transparency rule took effect, requiring hospitals to disclose their standard charges for a set of services in a publicly accessible and machine-readable format. While transparency is intended to help consumers identify lower-cost providers, the Semi-Annual Hospital Price Transparency Compliance Report indicated that only 16 percent of hospitals are fully complying with the rule. Furthermore, prior research suggests patients tend not to use these tools when they are available.

Over time, the landscape will evolve. We expect that high-cost outlier hospitals will face pressure to bring pricing down to market levels or risk being removed from the insurers' broad networks. We also expect that there will be less cost variation among providers over time.

Plan sponsors can use this survey data as a benchmark and negotiate prices, ultimately reducing cost trend.

## Physician services

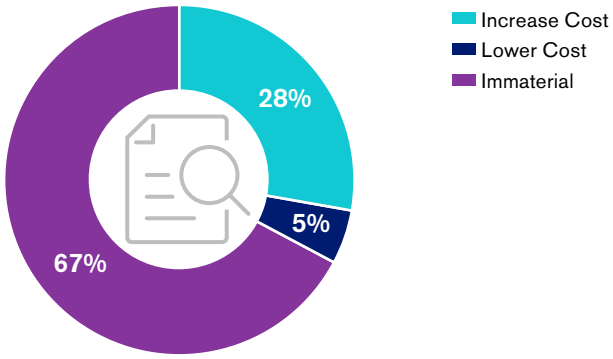
The second cost driver of medical plan cost trend in the past year was utilization of physician services. Pent-up demand and increased disease severity due to postponement of care contributed to physician utilization trends. Physician services have mostly rebounded as participants become more comfortable with in-person care. Telehealth remains, leading to a net increase in utilization for office visits and mental health for most plans. However, physician reimbursement rate increases have been relatively modest compared to recent overall CPI rates. This may reflect the success of PPO/POS networks' ability to hold the line on network provider negotiations.

## Projected impact of the No Surprises Act

Early data indicates the No Surprises Act is having its intended effect of lowering out-of-network charges for plan participants. However, a final rule governing how arbitrators are instructed to decide payment disputes could result in higher costs than anticipated. According to the U.S. Department of Labor Fact Sheet, under the final rule, certified Independent Dispute Resolution (IDR) entities must consider the Qualified Payment Amount (QPA) and then must consider all additional permissible information submitted by each party to determine which offer best reflects the appropriate out-of-network rate. There is also a higher volume of cases in IDR than originally forecasted.

While survey participants indicated the No Surprises Act will be immaterial to overall medical cost trend increases in 2023, 28 percent forecast increased costs.

### Most Respondents Forecast No Surprises Act to Have Immaterial Impact on Medical Cost Trend in 2023



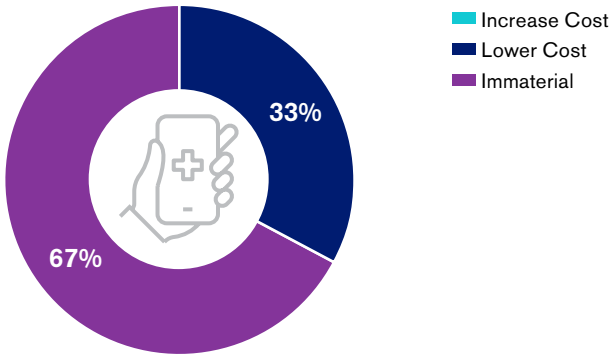

Source: Segal, 2022

## Projected impact of telehealth services

COVID-19 certainly helped accelerate the adoption of telehealth. Mental health has seen the most significant increase in telehealth utilization. According to a report from IQVIA, telehealth remains at over 20 percent of all diagnosis visits in mental health, offering a meaningful role in the delivery of care. Continued use in this area could help increase mental health diagnoses and increase patient access to providers.

While telehealth for primary care has dropped as people return to in-person visits, it has been widely adopted and is likely here to stay.

### Most Respondents Forecast Telehealth Services to Have Immaterial Impact on Medical Cost Trend in 2023

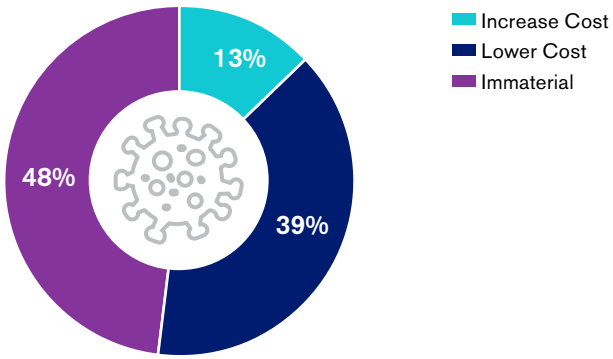



Source: Segal, 2022

## Projected impact of COVID-19

Expenses related to COVID-19 are expected to continue, but will moderate over time. Costs for treatment will likely decrease during the transition from pandemic to endemic. However, testing and vaccination costs will likely persist during the next few years, especially as the Biden administration shifts payment of vaccines to the commercial market. Nearly half of respondents indicated COVID-19 will be immaterial in 2023.

### Most Respondents Forecast Impact of COVID-19 to Be Either Immaterial or Have a Downward Effect in 2023




Source: Segal, 2022

## Plan sponsors' experience may differ from the projections

Healthcare prices are a key driver of cost increases and are highly variable based on several dynamic influences. We caution plan sponsors to recognize that the 2023 projections could significantly differ from their actual results, given the continuous disruption in the healthcare system and marketplace influences.

For instance, the following factors may influence medical plan costs:

- Delayed care that may go away altogether
- Delayed care that results in worsening of health condition or disease progression for those with chronic conditions, which could increase patients' cost of care
- Lost revenue and inflationary pressures that result in providers taking an aggressive approach to negotiations during contract renewals with network managers
- Value-based reimbursement contracting that lowers costs and improve quality
- Additional surges due to other COVID-19 variants and the cost of hospitalization among unvaccinated or higher-risk participants
- The development of new tests, therapies and vaccines
- Health complications resulting from COVID-19 long-haulers
- Transition of care to lower-cost settings, moving from inpatient to outpatient care
- Cost to comply with the No Surprises Act, including directly negotiating with providers and the outcomes of the 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 2023, the projected cost trend for outpatient Rx plans is approaching almost 10 percent. Outpatient prescription drug coverage, which is typically administered by PBMs, include brand-name drugs, generics, biosimilars and specialty drugs dispensed though retail, mail-order and specialty-management pharmacy 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.

This increase is being driven by the following factors:

- Drug product price inflation
- More effective and expensive new drug therapies than previous treatments, such as pre-exposure prophylaxis (PrEP) to treat HIV and obesity drug treatments with the GLP-1 mechanism, which was originally targeted for diabetes
- Specialty drugs/biologics, which have a higher projected double-digit trend for 2023 at a rate of 13.5 percent and now account for more than 55 percent of spending, driven by growth in autoimmune, oncology therapies and diabetes. In contrast, projected non-specialty trend is 3.2 percent.

Rx plan cost trends exceed all other health benefit cost trend estimates for 2023.

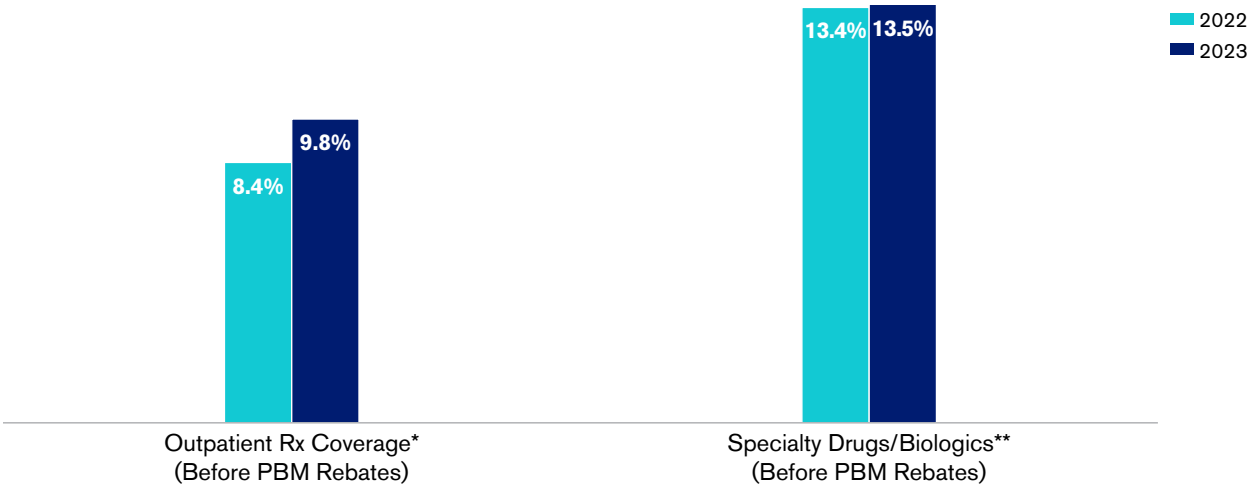
## What Are Specialty Drugs?

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

Most specialty drugs are biologics, which 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 FDA.

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




* 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.

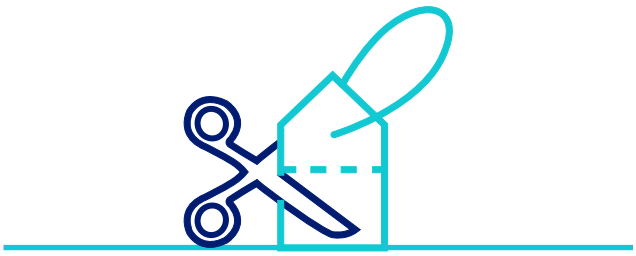
** Specialty drug/biologics trend is for outpatient specialty coverage. This data is for all coverage of specialty drugs for actives and retirees under age 65.

Source: Segal, 2022

## Rebates

Prescription drug plan cost trends in our analysis exclude rebates. Rebates account for a substantial portion of the drug price equation for both specialty and non-specialty drugs for most plan sponsors. Survey participants that reported the impact of prescription drug rebates noted the spread between gross and net trends was 2.6 percentage points. Rebates represent an average of 29 percent of projected prescription drug paid costs in 2023.

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 typically demand 100 percent pass-back of all manufacturer formulary rebates, which offsets 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

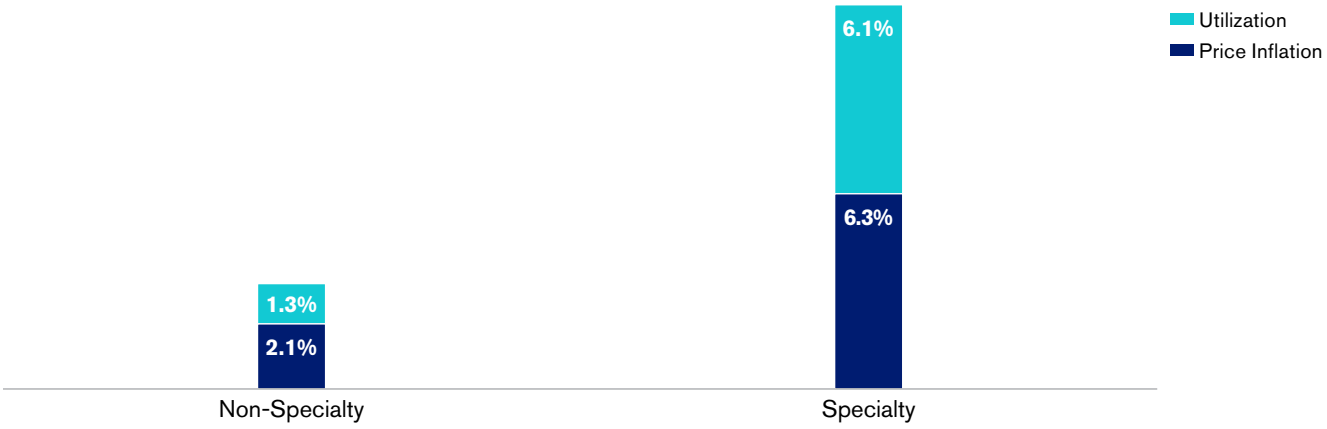
Similar to medical trend, the leading driver of overall projected Rx trend is price inflation. Specialty prescriptions play a major role. Non-specialty drug utilization has remained relatively modest, whereas specialty drug utilization is forecast to increase 6.1 percent in 2023.

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. Most pipeline drugs are specialty and/or orphan drugs, with more than 100 new oncology drugs. With precision medicine becoming more common, these are expected to be more narrowly prescribed. However, we expect the number of biosimilars entering the market to offset some of the rising specialty costs. Products such as ranibizumab (Lucentis®), adalimumab (Humira®) and ustekinumab (Stelara®) could face biosimilars.

Price inflation is also driving non-specialty drug costs.

The regulatory landscape could also have an impact on pharmacy price increases. With the expiration of American Rescue Plan subsidies, there could be an increase in vaccine costs as PBMs attempt to negotiate higher prices in the commercial market than what the government was paying. Additionally, while many provisions of the Inflation Reduction Act will not take effect for several years and are intended to produce savings under Medicare, the law could impact pricing terms for commercial prescription drug plans, including cost shifting of expected lost revenue from Medicare.

### 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 11.

Source: Segal, 2022

# Dental Trends

A recent study on the 2022 State of America's Oral Health and Wellness Report shows that preventive dental visits have still not returned to pre-pandemic levels.

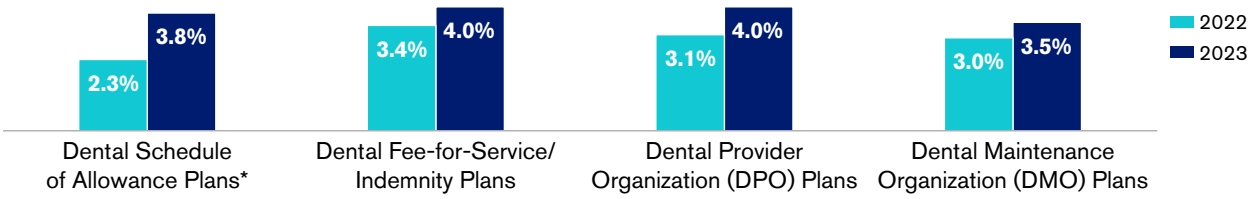
Inflationary pressures are impacting dental cost trends. Labor and supply cost increases directly affect dental practices. Additionally, fewer dentists are operating solo practices. As dental practices continue to consolidate, they have more leverage to negotiate higher reimbursement rates, contributing to price increases.

## Advances in dentistry

In response to COVID-19, teledentistry has become one of the most notable innovations. This is also a path for care for those who live in rural and urban settings. These virtual visits help address urgent dental situations, such as pain, infection and swelling and can even diagnose cavities with the advance of virtual technology.

Laser dentistry is another advancement in dentistry. This technology allows for minimally invasive oral surgery, reducing need for sutures and supporting faster healing with less risk of infection.

### Trend Projections for Most Dental Coverages Are 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, 2022

# Vision Trends

While vision plan cost trends for R&C plans increased by 0.3 percentage points over 2022, they remain low.

The vision care industry has accelerated its use of offering digital eye exams and online access to purchase frames and glasses. Increased competition for suppliers of eyewear is also putting downward pressure on prices.

While vision benefits are low cost, they provide high value and can improve employee productivity. Eye exams continue to play a role in the early warning of medical-related issues, such as detection of diabetes, hypertension, multiple sclerosis, STDs, Alzheimer's, tumors, thyroid disease, high cholesterol, brain tumors and certain cancers.

Plan sponsors should consider reevaluating their vision offering, exploring the new virtual landscape and communicating the value of this benefit to their participants. Some plan sponsors are offering vision discount benefits, rather than vision insurance. While these programs often require higher cost sharing from participants, they offer significant savings for services that may not be covered, such as Lasik surgery.

## Trend Projections for Vision R&C Plans Higher for 2023

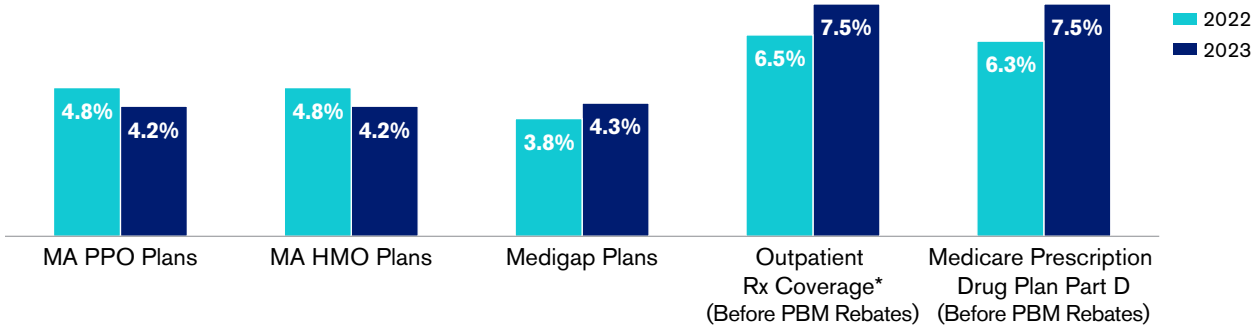

Source: Segal, 2022

# 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.

The pandemic has increased the shift towards in-home care due to the increased risk of infection for older populations. In response, most MA carriers have expanded access to at-home care for medical, behavioral health and palliative care, along with social services. Reimbursement structures should be aligned under home-based services to align with contracts in the market.

## Projected Medical Trends for Medicare-Eligible Retirees Similar to 2022




* Outpatient Rx trend is for all prescription drugs (non-specialty and specialty drugs combined) for employer-sponsored plans. See page 11 for specialty drug trend projections.

Source: Segal, 2022

# 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 healthcare cost inflation, broad economic effect (e.g., GDP, inflation and employment), health-status changes (due to aging in population, increased rate of obesity), new treatments and technology, provider group consolidation and cost shifting. 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.

## Medical cost trends in 2021 were driven by rebound of healthcare utilization

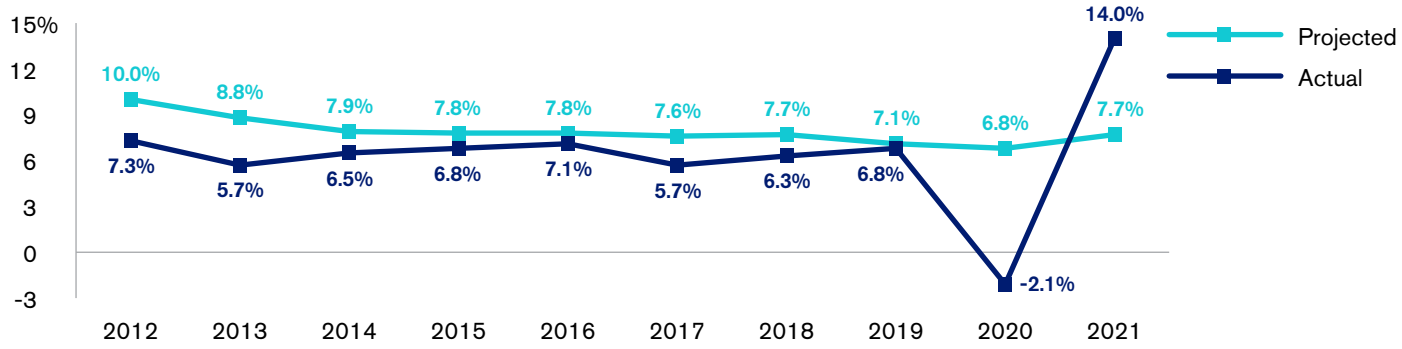
To assess the accuracy of trend projections, we compared 2021 projected trends for medical, Rx and dental plans to the actual average trends for 2021 (the most recent period for which actual data is available), as reported by the survey respondents.

Given the drop in healthcare expenses in 2020, many plans have experienced unusually high trends during 2021 when compared to the prior year.

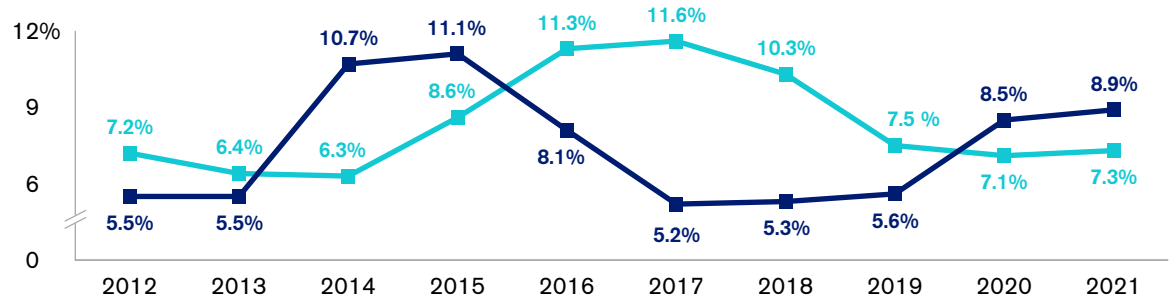
The graphs below illustrate comparative data from our last 10 surveys for three types of coverage for actives and retirees under age 65. As the chart indicates, forecasters' recent projections have not anticipated the magnitude of rebound of healthcare utilization for medical plans.

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

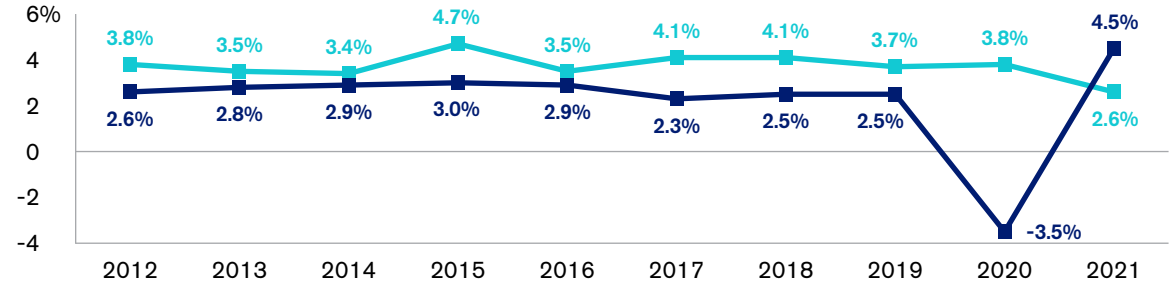
## For Open-Access PPOs/POS Plans, Actual Trend in 2021 Was Driven by Rebound in Utilization from Deferred Care*




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




## 2021 Actual Dental PPO Plan Trends at Pre-Pandemic Levels




* 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, 2022

## Historical survey data on selected medical, outpatient Rx and dental trends shows forecasted trends higher than pre-pandemic levels

Inflationary pressures and increased utilization are expected to drive healthcare trends up during the next few years, whereas staffing challenges and delayed care could lead to impact in the quality of care and worsen outcomes. Additionally, the impact of long COVID is still unknown and could impact healthcare trends over time.

We continue to observe that plan sponsors using aggressive cost-management strategies have lower plan cost trend rates than projected average levels.

### Selected Medical,[1] Outpatient Rx[2] and Dental Trends: 2009–2021 Actual and 2022 and 2023 Projected[3]

| | Year | Open-Access PPOs/POS Plans | PPO/POS Plans with PCP Gatekeepers | HMO/EPO Plans | MA HMO Plans | Outpatient Rx Plans | DPO Plans |
|---|---|---|---|---|---|---|---|
| Actual | 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% |
| | 2021 | 14.0% | 12.0% | 13.3% | 9.1% | 8.9% | 4.5% |
| Projected | **2022** | **7.3%** | **7.8%** | **7.0%** | **4.8%** | **8.4%** | **3.1%** |
| | **2023** | **7.4%** | **7.9%** | **7.0%** | **4.2%** | **9.8%** | **4.0%** |

[1] Medical trends exclude prescription drug coverage.

[2] Prescription drugs trends combine non-specialty and specialty drugs. 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 — 2009 through 2021 actual trends and 2022 and 2023 projected trends — and showing average actual annual trend by coverage type for the last five years are available.)

Source: Segal, 2022

# Top Health Plan Cost-Management Strategies in 2022

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 2022. The chart below compares the top five strategies being used today to last year's rankings.

| 2022 Top Five | 2021 Top Five |
|---|---|
| 1 Use of healthcare transparency tools | 1 Adopting an HDHP |
| 2 Implement virtual counseling for behavioral health issues | 2 Expanding pharmacy management programs (i.e., prior authorization or step therapy) |
| 3 Implementing chronic-condition management and digital health coaching for diabetes, hypertension and weight management | 3 Using healthcare transparency tools |
| 4 Implement virtual physical consultation for primary care | 4 Implementing chronic-condition management and digital health coaching for diabetes, hypertension and weight management |
| 5 Implement cost-management negotiation service for out-of-network services | 5 Implementing virtual counseling for behavioral health issues |

Source: Segal, 2021 & 2022

As noted in the table above, the need for using effective healthcare transparency tools was identified as a top priority this year. Under the No Surprises Act, effective January 1, 2023, plans are required to offer price comparison information to participants online and via phone support to enable cost comparison across participating providers in a specific geographic region for specific items or services. See Segal's insight, "Transparency Laws Timeline and No Surprise Medical Billing." Many vendors offer digital healthcare guide platforms that go beyond the transparency regulations to help participants get the most out of their healthcare benefits, including patient advocacy services such as identifying quality providers, providing personalized health recommendations, steerage to preferred provider options and scheduling appointments.

Virtual care for behavioral health, chronic-condition management, including digital health coaching, and primary care are ranked two through four. Virtual care gained momentum during the pandemic. Previously, there was resistance from both the provider community and from patients. Patient concerns about privacy and data security, as well as provider concerns about the quality of care, continuity of care and losses in revenue were factors. Worries of contagion during the pandemic overrode these concerns and accelerated acceptance of virtual care. See Segal's insight, "The Current and Future State of Digital Health," which discusses virtual services in the market.

# Medical Cost Management

Achieving the goal of delivering cost-effective medical coverage to plan participants is increasingly challenging due to dynamics that drive costs. To manage healthcare cost increases, sponsors' efforts to improve their vendor/network contracts, adjust plan designs that reduce wasteful spending and improve their covered population's health through effective clinical programs remain the focus. This section discusses a few key strategies plan sponsors may wish to consider as part of their medical cost management for 2023 and beyond.

## Competitive bidding yields favorable results

Given the current competitive forces among medical provider networks to increase membership, plan sponsors can secure improved pricing terms by putting their contracts out for competitive bidding every three to five years. This will ensure they are able to capture the best market pricing terms and market changes in key regions that may offer more network coverage to plan participants as networks evolve. The medical provider network changes over time as major networks acquire smaller regional networks, recruit new providers and lose providers over contract disputes. Consequently, medical PPO networks can experience fluctuations in network pricing by region or provider type in just a few years. The market is not static and can fluctuate over time within an area. With the consolidation of hospital systems in recent years, competing medical networks may align with different regional hospital systems. Additionally, many carriers are offering new technologies and capabilities that can improve the patient experience. Administrative fees charged by networks have also been declining in recent years. Bids can produce substantial savings in the administrative fees paid by plan sponsors that have older contracts. A marketplace analysis will ensure plan sponsors are achieving the best solution for their participants with optimal financial terms.

## Enhancing high-cost patient case management and managing risk

With healthcare costs driven by a relatively small number of high-need individuals, it makes sense to manage risk of high-cost claimants to reign in healthcare expenses. According to a recent study from the Business Group on Health, cancer has overtaken musculoskeletal conditions as the top healthcare cost driver, with plan sponsors observing more late-stage cancers. With the rise in high-cost specialty drugs use and evolution of treatment through gene therapy, the health industry has witnessed a growing number of claims exceeding $1 million annually for both insured and self-insured employer-sponsored health plans.

A growing number of therapies can exceed $1 million annually in Rx paid claims for a single individual, such as Carbaglu®, Myalept®, Ravicti® and Zokinvy® (according to Segal's SHAPE), which underscores the value of stop-loss policies that cover these treatments.

High-cost claimants with $100,000+ paid annual claims over the last two years accounted for less than 1% of all claimants but 28% of total medical plan claim expenses, based on data from SHAPE.

Managing high-cost participants by intensive case management and prescription drug management is a 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 care services that are medically unnecessary and provide no health benefits.
- Require networks to report claim totals more regularly for known high-amount claimants.
- Demand audits of claim charges from providers for catastrophic cases before payments are made to providers for reasonableness and appropriateness.
- 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 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.
- Assess pricing discounts and rebates for high-cost therapies. Negotiate best-in-market pricing.
- Make programs like prior authorization or drug-tiering available.
- Decide whether the medical or PBM channel is most cost-effective for delivery of specific medications.
- Review plan documents for plan exclusions and coverage determinations periodically.

Plan sponsors should closely examine their high-cost claims expense and consider appropriate stop-loss coverage. As the number and value of high-amount healthcare claims continues to grow, stop-loss coverage, in combination with a robust clinical-services program, provides plan sponsors important asset protection and cost predictability, particularly for self-funded plans, smaller groups and those with modest cash reserves. For those plan sponsors that already have stop-loss coverage, the rapid rate of change in newly approved medical technology and procedures may require a close inspection of the coverage language offered by each stop-loss insurer.

## Implement cost-management negotiation service for out-of-network services

Out-of-network provider reimbursement can be an obstacle to effective healthcare cost management. Use of out-of-network services also increased participants' out-of-pocket costs. Through balance billing, participants can be responsible for uncovered costs for claims not addressed by the No Surprises Act. The No Surprises Act's creation of a benchmark payment rate equal to the median in-network rate for similar services to prevent excessive billing practices for out-of-network emergency services is estimated to impact 25–35 percent of out-of-network claims. This leaves up to 75 percent of out-of-network claims that could still be subject to excessive charges. Effective out-of-network cost-management strategies include setting benchmark schedules for out-of-network reimbursement and negotiating directly with healthcare providers to maximize savings for plan sponsors and prevent balance billing for participants.

## Expansion of patient clinical tools and design to achieve best outcomes

Plan sponsors should continue to focus on strategies that keep people healthy, reduce the risk of high-amount claims and improve patient outcomes, including:

- **Value-based contracting** — There is a wide range of price variation under fee-for-service arrangements within the same geographic area without evidence of improved outcomes. Fee-for-service arrangements reward for volume, not value. Plan sponsors are increasingly considering cost-savings alternatives through value-based arrangements. These payment models provide better efficiencies by holding providers accountable for the quality of care, managing the use of healthcare resources to reduce inappropriate care, rewarding the best-performing providers and encouraging participants to be knowledgeable healthcare purchasers. Advanced primary care is among one of the newer models. Advanced primary care is designed to improve patient outcomes and reduce total cost of care by promoting strong patient-provider relationships, referral management, care coordination and integrated health coaching. Virtual care options are also an integral part of this model to support convenient access to care to promote health and improved outcomes.

- **Site of care** — Steering participants to custom or narrow networks that have lower-cost options for procedures that can be performed in alternative sites of care (e.g., ambulatory surgery centers, at-home acute care or free-standing lab) can offer significant savings to both plan sponsors and participants. Plan sponsors should continue to look at reimbursement models that incentivize the use of lower-cost provider settings, where appropriate.

- **Integrated digital health** — Point solutions typically address only a small portion of the needs of an overall participant population and cannot integrate with other solutions and platforms. Today, it is not unusual for plan sponsors to have as many as 10 different non-integrative point solutions or apps to address various patient needs, which contributes to patient confusion and vendor fatigue. We expect this situation will prompt plan sponsors to look for integrated solutions from their current health provider network and PBM carriers to replace multiple, separate contracts. To better serve plan sponsors and their participants, as the market matures, the digital therapeutics industry may transition toward a more integrated approach and offer broader platform with multiple solutions. It's also possible that, with the exception of a few large contenders, most of these solutions become part of large plan offerings.

- **Reduce readmission** — Inpatient hospital admissions typically account for the largest expense component of most health plans. Plan sponsors can hold their carriers accountable for reducing readmission rates. Improper discharge planning, poor office management, treatment compliance and social determinants of health/health literacy all play a role in these numbers. Steps to reduce readmission rates can include:

  - Contract with discharge support services. This is often provided by carriers or with specialty third-party vendors that monitor and support patients during discharge. Such services should entail timely outreach services that address patient follow-up needs and help secure the proper patient support.

  - Potentially remove poor-performing network hospitals with excessive high levels of readmission rates.

  - Leverage participant communications tools (via website or mobile applications) that participants can access to get more information.

  - Enforce and make sure carriers use predictive criteria for readmissions. There are known risk factors that result in readmission, including clinical factors (e.g., use of high-risk medication, polypharmacy, more than six chronic conditions or specific conditions, such as uncontrolled diabetes, heart failure, stroke, cancer or depression) and demographic and logistic factors, including prior hospitalization, poor health literacy, lower socioeconomic status and discharge against medical advice.


# Pharmacy Benefit Cost Management

Achieving the goal of delivering cost-effective prescription drug coverage to plan participants is increasingly challenging because there are numerous cost drivers. To get more mileage from prescription drug benefits, plan sponsors need to pay close attention to each of the following: plan design, PBM contracting and clinical controls.

## Effective plan design

Effective plan design strategies offer low-cost sharing for lower-cost generic drug therapies and higher cost sharing for more costly brand drugs, where interchangeable or lower-cost alternative therapies exist. Such designs will drive an increase in generic drug dispensing rates that maximize savings for both the plan and the patient, as well as create greater incentives for patients and their prescribers to find the best-value formulary drug therapies for their conditions. In addition, caps on out-of-pocket spending should be set to avoid excessive cost burdens to plan participants.

Effective prescription drug plan designs address these questions:

- What is the appropriate balance of coverage for prescription drug benefits?
- How much should plan participants pay for their medications?
- What incentives should be used to reduce waste and excessive utilization?
- Has the plan removed high-cost, “me too” brand drugs that are just repackaged over-the-counter products, combination medications or multiple source brand drugs that offer generic equivalent options?
- Are the costs to participants resulting in underuse of needed drug therapies that stave off complications of disease and high-cost hospital events, or worse?

The answers depend on many factors, including the income levels of the workforce, the plan sponsor's industry and budgetary constraints.

These five strategies are among the best practices for managing the cost of prescription drug coverage:

1. **Keep copayments low for generic drugs.** Having no deductibles and low-fixed dollar copayments for most generic drugs is an effective and attractive solution. Since ample competition still exists for generic drugs, annual generic drug price inflation is modest and is not driving much of plan cost increases. A copayment of less than $10 for a 30-day supply of generic drugs will be affordable for most plan participants and will mean cost certainty to the participants who account for 85–90 percent of total prescriptions dispensed throughout the year. To ensure participants pay less for the roughly 20 percent of generic prescriptions that have a very low cost, the PBM contract should include this language: "the lesser of discounted price or the plan participant copayment will be applied for all eligible claims."

2. **Set a coinsurance for brand drugs (with per-prescription caps for formulary brand drugs).** Applying a percent coinsurance with maximum per Rx and an annual out-of-pocket maximum for Rx benefits provides adequate participant coverage and drives competition among therapeutic equivalent brand options which in turn, generated higher rebates and savings for plan sponsors. A typical annual Rx benefit maximum is set at around 20 percent of the medical plan out-of-pocket dollar maximum, if separate maximums are applied. Moving to percentage coinsurance keeps pace with price inflation and doesn't erode in value over time as fixed-dollar copayments do.

3. **Implement exclusive mail-order and retail 90-day maintenance network choices with higher guaranteed discounts.** Exclusive contracting with the PBM's mail-order facilities and/or a subset of retail chains to fill maintenance medications can generate deeper pricing discounts. Create incentives for participants to use these deeper-discounted settings by offering lower cost sharing for a 90-day supply compared to the same three 30-day retail supply prescriptions.

4. **Leverage specialty drug copayment assistance program dollars by modifying specialty drug tier copayments to take advantage of these savings.** This strategy will help offset some of the cost burden created by the high-cost specialty drug class. If using an outside vendor, confirm that the vendor can work with the plan's PBM and that the program will not negatively affect rebates in the current PBM contract.

5. **Apply comprehensive prior authorization, step therapy and quantity-limit rules for high-cost therapies that have multiple therapy options for patients.** For many therapy treatment classes, the presence of multiple drug options allows patients and plans to lower costs by trying proven and effective lower-cost options first, if the plan establishes the right clinical protocols.

## PBM contract review

Price setting for pharmaceuticals is a complicated process. It's important to recognize that the actual "sales price" of a prescription drug varies dramatically by buyer and, on average, is somewhere between 50 percent to 55 percent of the actual "list price of drug." The actual production costs to produce a drug may be only 15 percent of the typical revenue earned by a manufacturer.

As a result, there is a lot of room for drug manufacturers to create complex pricing schemes and incentives to improve their market share while still enjoying high profit margins. Of course, drug companies will need revenue to cover more than production, distribution and marketing costs, as well as costs to recoup research and development.

The large gaps between revenue and costs means there's an opportunity for plan sponsors to negotiate better pricing. Plan sponsors need to recognize their buying power. By understanding the best prices available in the market and the true breakeven operating expenses of PBMs and retail pharmacies, plan sponsors can trade market share for better pricing in contracts and cut out much of excess margins retained by the intermediaries (e.g., PBMs, retail pharmacies and mail-order pharmacies).

Consider these PBM contract RFP must-haves:

- Pass through retail pharmacy minimum ingredient cost guarantees.
- Pass through 100 percent of all manufacturer rebate revenue earned on claims with minimum guarantees.
- Forbid the PBM to include offset language for each pricing guarantee element.
- Require consistent and auditable definitions of brand drugs, generic drugs and specialty drugs.
- Limit pricing guarantee exclusions to only a few drug categories to have valid reasons for being excluded.
- Set rebate guarantees on fixed and unmanipulated metrics (e.g., fixed PMPM rebate guarantees and minimum rebate per all brand Rx dispensed or minimum rebates as a percent of actual brand average wholesale pricing for the plan).
- Consider applying rebate values as a claim adjustment at the point of sale/purchase.
- Pay direct and transparent PBM administrative fees (i.e., move away from no-fee model to better match fees to PBM administrative costs and remove the PBM incentive to hide revenue sources received from manufacturers).

- Exceed 40 percent of average wholesale pricing for that plan for brand ingredient cost discounts and rebates for mail order, retail maintenance and specialty drugs. Not all therapy classes will approach these levels, but on a composite basis, we have negotiated PBM contracts that are achieving close to 50 percent off average wholesale pricing after accounting for discounts and rebates.
- Demand generic drug discount guarantee minimums at 85 percent of AWP or higher.
- Consider custom generic maximum charge lists per year as an alternative to percentage discounts off average wholesale pricing.
- Request an acquisition-cost-plus-fee contract with the PBM, if the plan is very large.
- Direct contract with specialty pharmacies as an alternative to the PBM-exclusive pharmacy.
- Determine how biosimilar drugs will be positioned within the formulary and represented in the contract.

Applying more rigor to a PBM contract and RFPs can result in substantial annual savings to the plan and the plan participants — without compromising benefit value. Contract reviews can be part of an annual market check, a renewal or an RFP.

## Applying effective clinical controls

Prescription drug benefits involve more than cost.

There is tremendous value in a strong PBM partner that provides meaningful clinical support to your plan participants. Knowledgeable and responsive clinical staff can help guide you to programs or strategies that improve patient quality of life.

Not all PBMs are the same. Plan sponsors should test the PBM's clinical systems and staff and only use the programs that will work for the plan. In some cases, utilization management programs, like prior authorization and step therapy, are useful tools to produce plan cost savings. In other cases, clinical programs that support participants who have complex needs and conditions may not save on the prescription drug claim costs but can avoid costly medical plan claims and complications. Turning on the right clinical programs can make a difference in patients' quality of life and appropriate physician prescribing.

An expert review of the PBM clinical program offerings is an essential step to creating programs that avoid needless burdens and inconveniences to your plan participants as well as providing worthwhile value to your plan.

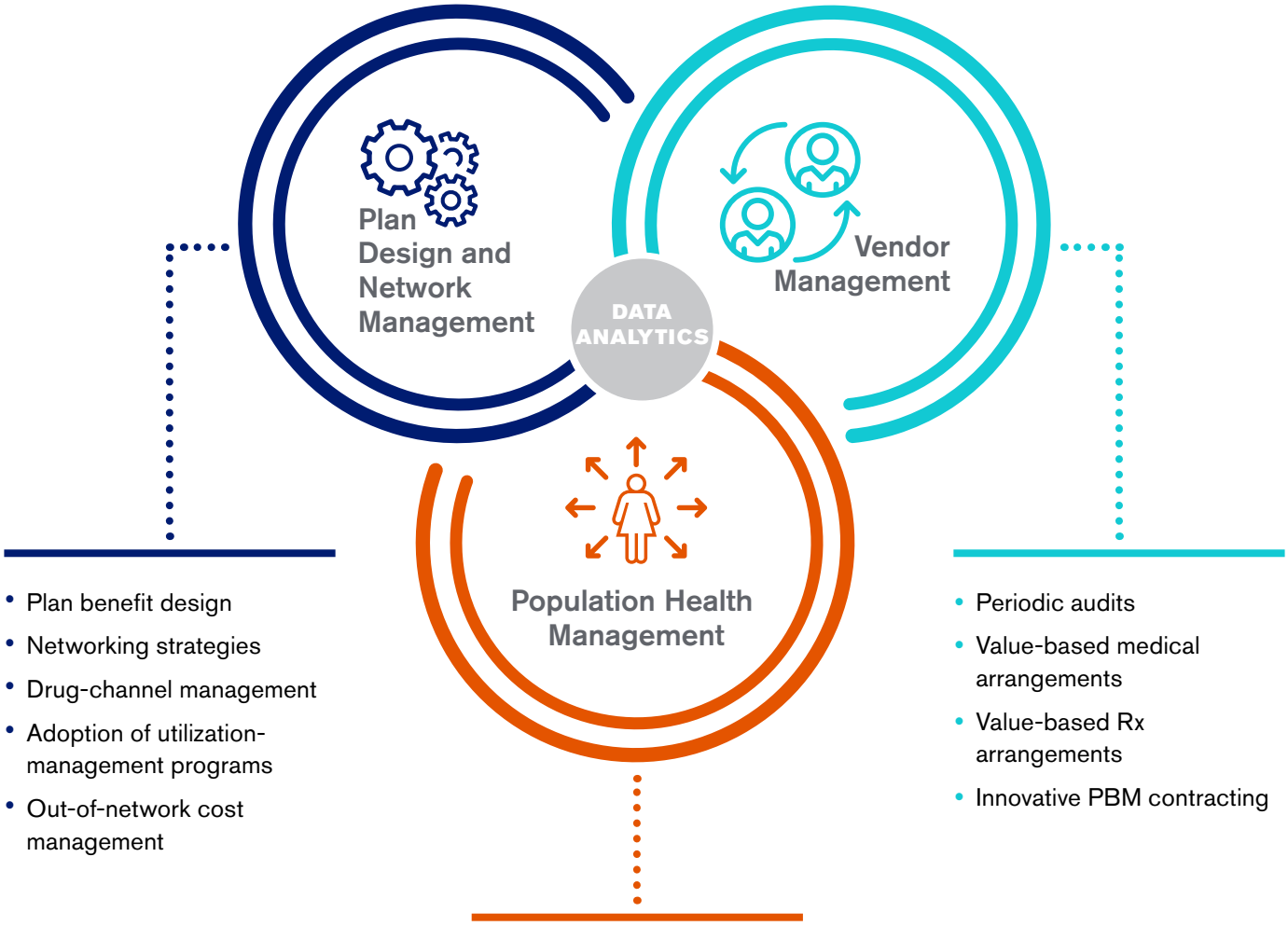
# An Effective Approach to Managing Costs

Cost trends for medical plans are ticking up, with outpatient pharmacy benefit cost trends approaching double digits. The regulatory landscape continues to change, and the inflationary environment has imposed significant burdens for plans in maintaining competitive benefits.

Health plan sponsors need to continue to take an active role in understanding industry trends and closely manage their health benefit programs. Plan sponsors should consider drawing on their own data to make well-informed decisions about which strategies and services produce the most value, especially given their limited resources. Whether it's improving contracts, revising plan designs or modernizing prevention and utilization management programs, plan sponsors should continue to look at strategies that give them the most benefit value for the dollars they spend.

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

## 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

| | |
|---|---|
| 42 | Open-access PPO/POS plans |
| 34 | HDHPs |
| 41 | HMO/EPO plans |
| 27 | PPO/POS plans with PCP gatekeepers |

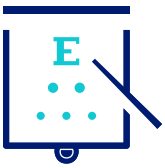
### Rx Plans

| | |
|---|---|
| 63 | Outpatient Rx drug plans |

### Dental Plans

| | |
|---|---|
| 36 | DPO plans |
| 20 | Dental Fee-for-Service/Indemnity plans |
| 14 | DMO plans |
| 14 | Dental schedule of allowance plans |

### Vision Plans




| | |
|---|---|
| 20 | Vision schedule of allowance plans |
| 12 | Vision reasonable and customary plans |

The following respondents agreed to be identified by name:

Aetna

Ameritas

Anthem, Inc.

Arkansas Blue Cross Blue Shield

BeneCard PBF

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 Kansas City

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Minnesota

Blue Cross Blue Shield of Montana

Blue Cross Blue Shield of New Mexico

Blue Cross Blue Shield of Oklahoma

Blue Cross Blue Shield of Texas

Blue Cross Blue Shield of North Carolina

Blue Shield of California

Capital Blue Cross

Capital District Physicians' Health Plan, Inc.

Cigna

ConnectiCare, Inc.

Elixir Solutions

Emblem Health

Express Scripts, Inc.

Group Vision Service

Guardian Life Insurance Company of America

Hawaii-Western Management Group

Health Alliance Medical Plans

Health Net of California, Inc.

Highmark Blue Shield of Central Pennsylvania

Highmark Blue Cross Blue Shield of Delaware

Highmark Shield of Northeast New York

Highmark Blue Cross Blue Shield of Western New York

Highmark Blue Cross Blue Shield of Western Pennsylvania

Highmark Blue Cross Blue Shield of West Virginia

Humana

Horizon Blue Cross Blue Shield of New Jersey

Independence Blue Cross

Kaiser Permanente

Medical Mutual of Ohio

MedImpact Healthcare Systems, Inc

Metropolitan Life Insurance Company

Navitus Health Solutions LLC

OptumRx., Inc

Point32Health

Premera Blue Cross

Prime Therapeutics LLC

Trustmark Companies

United Concordia Dental

UnitedHealthcare

Voya Financial

Wellmark Blue Cross and Blue Shield Iowa

Wellmark Blue Cross and Blue Shield of South Dakota

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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.

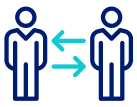
Our professionals can help your organization plan, design and strategize by providing:

**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, designed to promote well-being? Such offerings include stress management, caregiver benefits, paid leave and student debt relief as well as other financial advice. Do health benefits address the unique needs of a diverse workforce and workers living in underserved communities?

**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 and actuaries 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.

Our communications consultants work closely with our health consultants to develop communications campaigns that capture the attention of participants and their families to support desired behaviors.

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