

2016

Health Care  
Trend Report



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## Definitions:

- Health Maintenance Organization (HMO) – plans that require a Primary Care Physician (PCP) gatekeeper referral for specialty services
- Preferred Provider Organization (PPO) – benefits paid at a specific level if patient seeks care for a preferred provider network, these plans do not require a PCP referral
- Point-of-Service (POS) – plans that require a PCP referral on the first tier, and offer a PPO type structure on the second and third tiers
- Consumer Directed Health Plans (CDHP) – plans that have high deductibles, tax-advantaged, designed to encourage consumer engagement
- Dental HMO (DHMO) – a dental plan wherein a set group of dentists provides broad and affordable dental care at a low monthly premium
- Dental PPO - benefits paid at a specific level if patient seeks care through a preferred dental provider network
- Dental Indemnity – also known as traditional plan, services are paid on a fee for service basis, individuals can visit any dentist

# EXECUTIVE SUMMARY



Over the last few years, health care cost increases have remained at a fairly stable, manageable level. In fact, the prospective trend for 2017 is lower than it has been for the last five years. Despite the optimistic projections for 2017, health care trend still significantly outpaces the rate of inflation. Employers have been able to control costs through plan design changes and cost shifting to employees, but this strategy is not sustainable in the long run.

There have been significant developments in the health care industry in the last couple of years that have the potential to reshape the cost of health care. Among these developments are technological advances that provide consumers better access to quality care and information to make cost effective health care decisions. Another development is the change in how carriers and employers access, and pay for, care by creating specialized networks that integrate total care for an individual, offer centers of excellence, and encourage value rather than volume of care.

Whether it is because overall health care costs have been stable, a reluctance to make a drastic change due to unknown political climates in the near future, or the fear of departing from what has traditionally worked, many of the cost saving strategies that have the potential to mitigate health care costs in the future are not being widely adopted. Plan design changes alone cannot bring the health care trend back to a sustainable level, especially considering the rate at which pharmacy costs are escalating due to new specialty drugs.

With the increased pressure of the Excise Tax looming in 2020, it is important for employers to understand not only what may affect their renewals in 2017, but also to look at a multi-year strategy to manage rising health care costs. Heffernan's twelfth annual Health Care Trend Report shows what carriers are projecting their health care costs to be for medical, dental, and vision in 2017. In this report, we explore what is helping to drive these costs and what strategies are most commonly being explored to bend the health care curve.

# WHAT IS TREND?



**T**rend is defined as the change in health care costs. There are many factors that affect or influence trend but the primary components are:

**Price Inflation** - The average increase in the cost of goods and services such as medical supplies, equipment, staffing, etc.

**Utilization** - The usage of medical care and services.

**Deductible Leveraging** - The cost added to a health plan as a result of increases to the cost of services while benefits, such as copays and deductibles, remain constant.

For example:

*Year One: A \$3,000 claim with a \$500 deductible costs the carrier \$2,500.*

*Year Two: The same \$3,000 claim trended at 10% now costs \$3,300. With a \$500 deductible, this claim now costs \$2,800 which represents a 12% increase.*

**Technological Advancements** – The change in cost due to new procedures or equipment replacing older ones.

Health care trend is often looked at in two different ways, prospective health care trend and retrospective health care trend. Prospective health care trend is the prediction of trend whereas retrospective health care trend is a measure of the actual change in health care costs experienced. It is important for an employer group to understand both outlooks of trend, but when predicting what types of renewal increases that an employer might be facing, the prospective health care trend is a better indicator of an upcoming renewal.

Heffernan's annual trend report surveys more than fifty (50) health, dental, and vision providers asking them what trend factors they will use to determine their 2017 renewals. An employer group's actual renewal increase may differ from the regional or national trend predictions due to plan design differences, demographics, the size of the group, regional cost variations, and health care taxes. However, it is important to understand the prospective trend for 2017 because the projected cost of claims has the biggest influence on an employer group's renewal increase.

Health, Dental, and Vision Plans that HIB Surveyed Include:

Aetna, AIG, Ameritas, Anthem Blue Cross, Assurant, Atlantis Health Plan, Best Life and Health, Blue Cross Blue Shield of Missouri, Blue Shield of California, Cigna, Coventry Health Care of Missouri, Dearborn National, Delta Dental, EmblemHealth, Empire Blue Cross, EyeMed, Guardian, Health Net of California, Health Net of Oregon, Humana, Kaiser Permanente, Kaiser Foundation Health Plan of Oregon, Lincoln, Medical Eye Services, MetLife, Moda Health, Mutual of Omaha, PacificSource Health Plans, Premier Access, Principal, Providence, Regence Blue Cross, Reliance, Standard, Sun Life Financial, Superior Vision, Sutter Health Plus, United Concordia, United Healthcare, Unum, VSP

# MEDICAL TREND PROJECTIONS FOR 2017



## 2017 MEDICAL PLAN SURVEY RESULTS

Plan Type	Northern California	Southern California	Northwest	New York	National
HMO w/Rx	6.7%	7.0%	7.2%	10.4%	8.7%
PPO w/Rx	8.6%	8.8%	8.5%	10.7%	9.1%
POS w/Rx	7.9%	8.1%	8.2%	10.7%	8.9%
CDHP w/Rx	8.0%	8.2%	7.2%	11.0%	8.6%

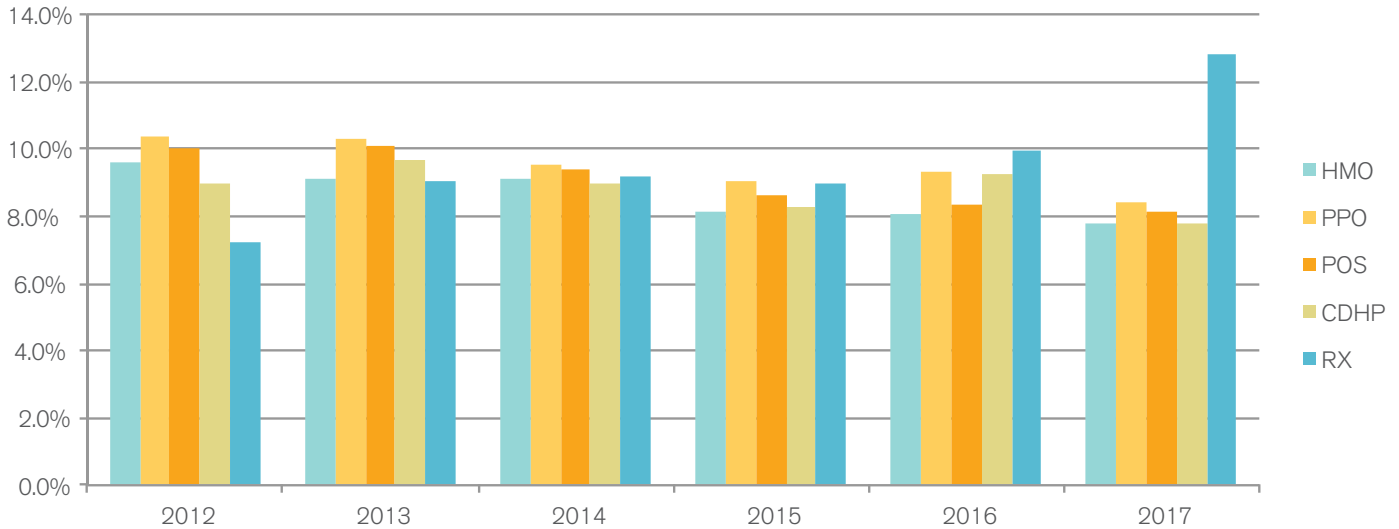
### Summary of Medical Trend Results

- In all regional market areas the plan type with the lowest trend projection for 2017 is the HMO plan. The HMO trend projections for both California regions are more than half a percent lower than the trend projections for 2016. While the HMO trend in the Northwest region has remained fairly consistent to the prior year, the HMO trend projection for New York is more than 2% higher than in 2016.
- The PPO trend projection for 2017 both nationally and in all regions except for New York is lower than the PPO trend projection for the prior year. In California, the PPO trend projection is almost 0.5% lower than the trend for 2016; whereas in New York the trend projection for the PPO is more than 1% higher than in the prior year. Nationally, PPO trend is 0.3% lower.
- In prior years, the POS trend projections have mirrored the movement of the HMO, which has decreased. In 2017, in all regions as well as nationally, the POS trend projection is higher than the trend for 2016.
- While nationally the 2017 trend projection for CDHP plans is the lowest trending plan type, in all of the regional trend projections, except the Northwest, the HMO plan is trending below the CDHP plan. However, trends for the CDHP plan are on average more than 0.5% lower than the trend projections for the CDHP plan in 2016.
- Overall, the trend projections for 2017 are lower than the trend projections for 2016.

# MEDICAL TREND PROJECTIONS FOR 2017



## HISTORIC NATIONAL MEDICAL TREND



In our 2017 Medical Plan Survey results, we show the projected trend in each region for each product blended with the trend for prescription drugs (RX). However, when we look at the historic national medical trend we are looking at the national trend projections for each type of plan with the RX trend as a separate component.

### Summary of National Medical Trend Results

- While 2016 trend projections saw an increase from 2015 across all products, the national trend projection for 2017 is lower for all products except for the RX. In 2016, RX costs were projected to increase 9.9%, whereas in 2017 RX costs are projected to increase 12.8%.
- The trend projection for CDHP plans shows the greatest downward change of all the products. The trend projection for 2017 is 1.4% lower than the trend projection for the prior year. In 2016, the CDHP plan saw an increased trend estimate from the prior year; the low trend projection for 2017 is likely a correction for over-projections from the prior year.
- Despite lower trend projections for 2017 for all medical plans, these trends are being offset by the 3% change in the RX trend. Not only are the costs of prescription drugs rising, but they are also becoming a larger component of the overall medical trend, having a double impact on the medical trend projections for 2017.

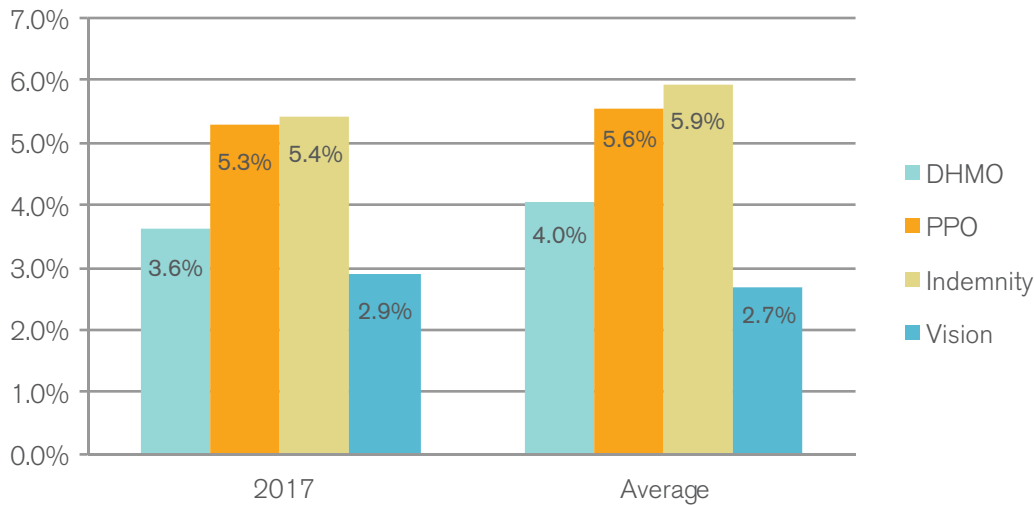
# DENTAL AND VISION TREND PROJECTIONS FOR 2017



## DENTAL AND VISION SURVEY RESULTS

Plan Type	2012	2013	2014	2015	2016	2017
DMO	4.7%	4.2%	3.6%	4.2%	4.0%	3.6%
PPO	6.1%	5.8%	5.5%	5.5%	5.2%	5.3%
Indemnity	7.2%	6.2%	6.4%	5.4%	5.1%	5.4%
Vision	2.6%	2.6%	2.9%	2.2%	3.0%	2.9%

## 2017 DENTAL AND VISION TREND COMPARED TO SIX YEAR AVERAGE



## Summary of Dental and Vision Trend Results

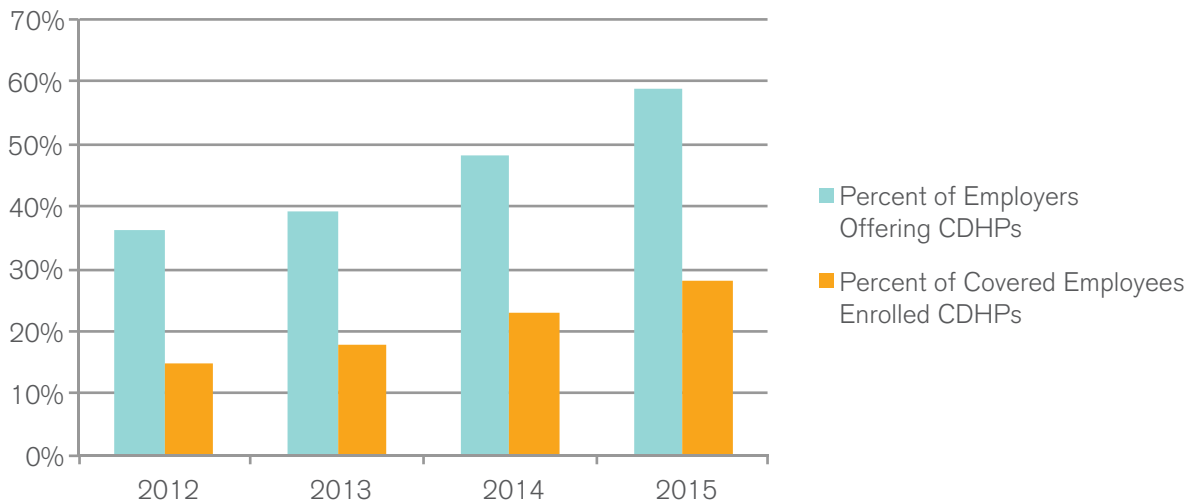
- The dental trend projections for almost all dental products, with the exception of the dental HMO product, are marginally higher than the trend projections for the prior year.
- Looking at the average trend projection for all dental products over the last six years, the trends for 2017 are projected to be lower across all dental products.
- In 2016, vision was projected to be significantly higher than in the prior year. In 2017 this trend projection while still high is 0.1% lower than in 2016.
- In contrast to the dental, the 2017 vision projection is 0.2% higher than the average of the last 6 years.



## Consumerism

In 2015 and 2016, there was considerable growth in consumer driven health plans (CDHPs). CDHPs are high deductible health plans tied to a tax-advantaged Health Savings Account (HSA) or Health Reimbursement account (HRA). Not only are more employers offering CDHP plans, but also more employees are enrolling in these plans.

### RISE IN CONSUMER DRIVEN HEALTH PLANS



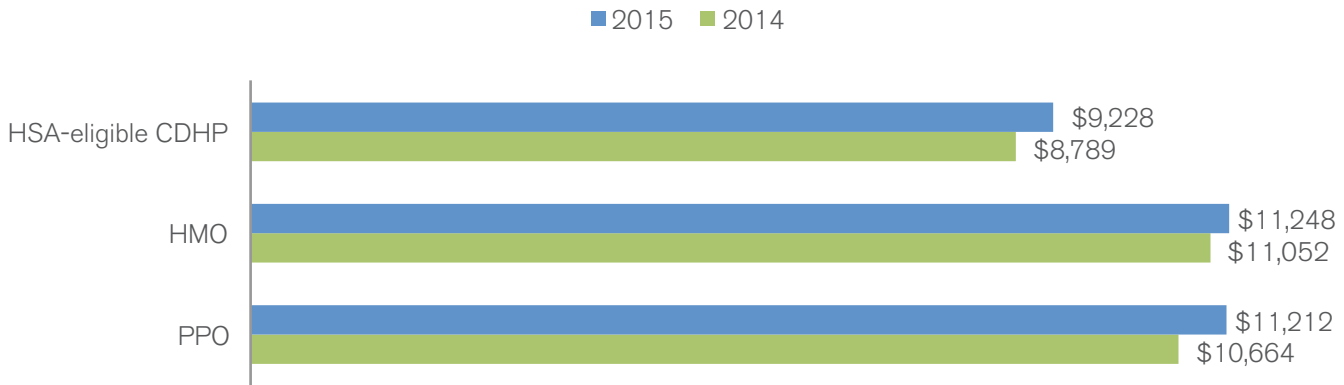
*\*National Survey of Employer-Sponsored Health Plans: 2015 Survey Report*

Many attribute the rise in consumer driven health plans to the looming Excise Tax. The Excise Tax, also known as the Cadillac Tax, was originally scheduled to go into effect in 2018 but in December 2015 the effective date was delayed until 2020. The Excise Tax charges a 40% tax on plans that exceed the annual premium thresholds. In order to avoid this potentially high tax, many employers have tried to lower their medical spend by offering CDHP plans that cost on average about 18% less than traditional PPO plans.





## MEDICAL PLAN COST PER EMPLOYEE, BY PLAN TYPE



*\*National Survey of Employer-Sponsored Health Plans: 2015 Survey Report*

In order for the cost savings from Consumer Driven Health Plans to be realized, employers need to provide employees with the information and tools to make effective health care decisions. As their name implies, CDHP plans encourage individuals to become better health care consumers. This means that insureds need to have the tools to compare prices of different providers, have shopping choices when faced with non-emergency treatment options, and have resources or advocates to rely on for help when larger, acute medical issues arise.

### Tools to Help Encourage Consumerism

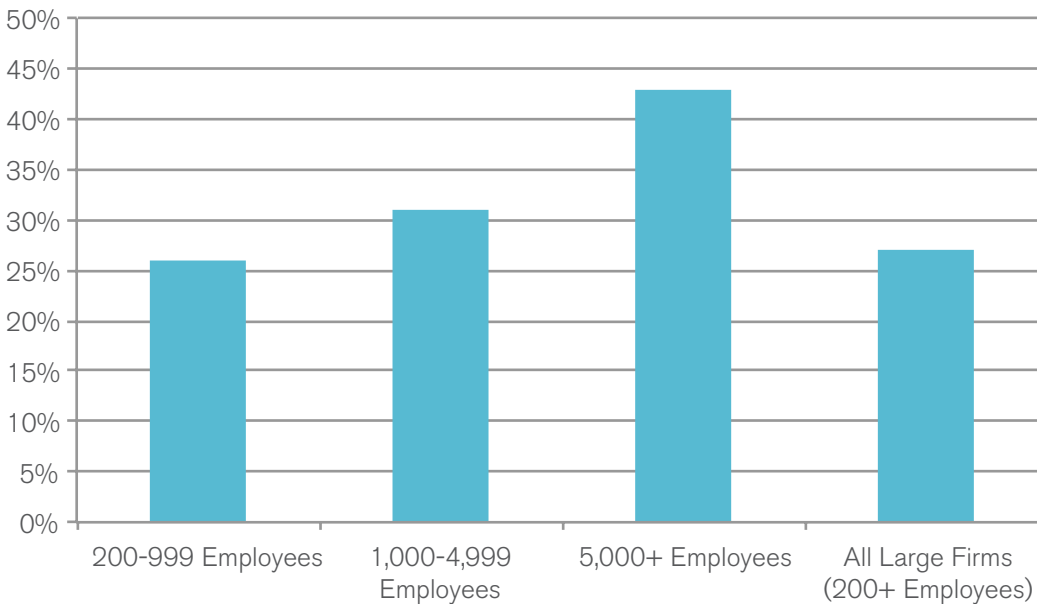
Providing employees with a high deductible, tax-saving plan is not enough to realize the cost savings of these lower premium plans. In addition to getting more employees to enroll in these plans, employees also need to be educated on how to get real value from their plans. Many of the methods that are gaining popularity among employers use technology. There is an increasing number of applications for smart phones that allow an individual to learn more about medical procedures, better understand the costs associated with such procedures, and find the best providers at the best price. Many companies also use the services of health advocates who not only help make appointments, but also guide consumers in finding the right doctor and hospital for their medical needs.

In the last few years there has been a significant rise in the number of telemedicine services offered by employers. In 2013 only 28% of employers offered telemedicine services in contrast to current day where approximately 46% of employers offer telemedicine services. This number is expected to rise to 90% by 2018. (Willis Towers Watson). As more employers increase their plans' deductibles and convert to CDHPs, an office visit to a primary care doctor or a specialist will cost the employees more out of their pocket. Adding a telemedicine option to an employer's plan could be a cost-effective alternative. However, employees are still not using these services to their full potential, less than 10% of employees use telemedicine services.





## PERCENTAGE OF FIRMS WHOSE PLAN WITH THE LARGEST ENROLLMENT COVERS TELEMEDICINE

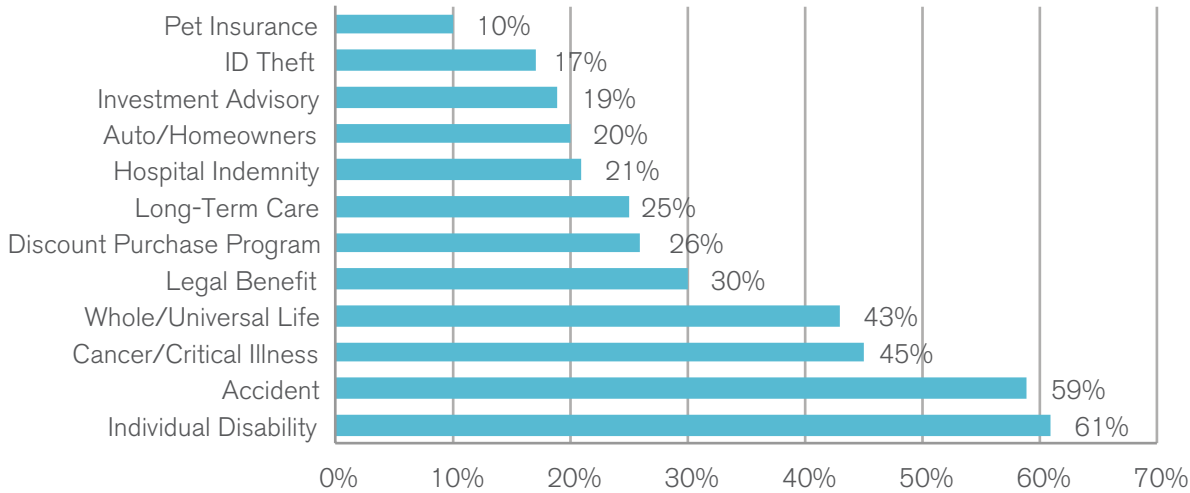


*\*The Kaiser Family Foundation and Health Research & Educational Trust Employer Health Benefits 2015 Annual Survey*

Voluntary benefits have always been part of a well-rounded employee benefit portfolio. However, with the increase in high deductible plans and employees having to pay more for their benefits, there has been increased demand for a broader spectrum of voluntary benefits. By increasing the suite of voluntary options available to their employees, employers can supplement benefit offerings by enabling employees to choose how to round out their benefit packages at the price and risk levels that make sense for them and their families. These new voluntary benefits packages include more than the supplementary life insurance and critical care benefits typically offered in the past; they also include a range of options from pet insurance, legal aid, financial planning, as well as supplemental hospital insurance.



## VOLUNTARY INSURANCE BENEFITS OFFERED

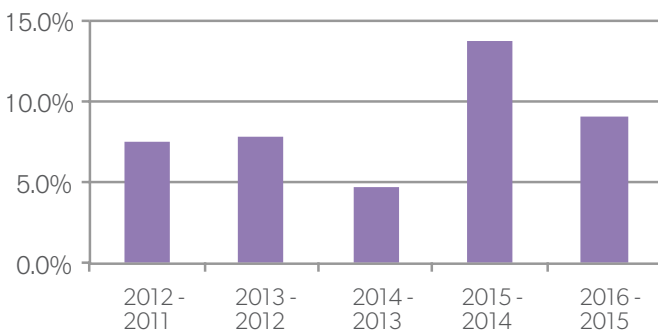


\*National Survey of Employer-Sponsored Health Plans: 2015 Survey Report

## Rising Cost of Prescription Drugs

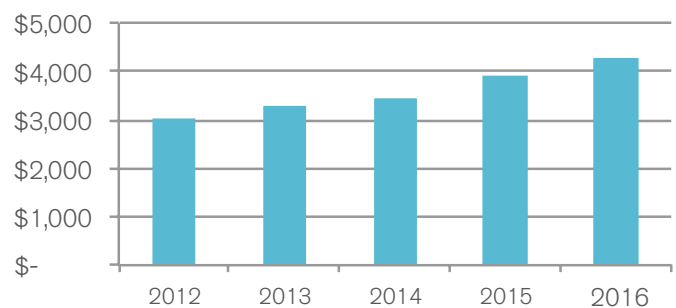
In the last couple of years, prescription drugs have been an increasingly large component of the overall medical spend. For several years prescription drug trend remained relatively flat at 5%; in 2015 and again in 2016 the nationwide prescription drug trend jumped to 8% (Milliman Medical Index). The market has always seen new patented drugs offered at a high price, yet these new drugs were offset by other drugs coming off of patent and becoming available in generic form. In the last two years, the number of drugs coming off patent has not been sufficient to stabilize the rise in cost due to new specialty drugs.

### ANNUAL RATE OF INCREASE IN PHARMACY COST



\*2016 Milliman Medical Index

### ANNUAL PHARMACY SPENDING GROWTH



# HEALTH CARE TRENDS

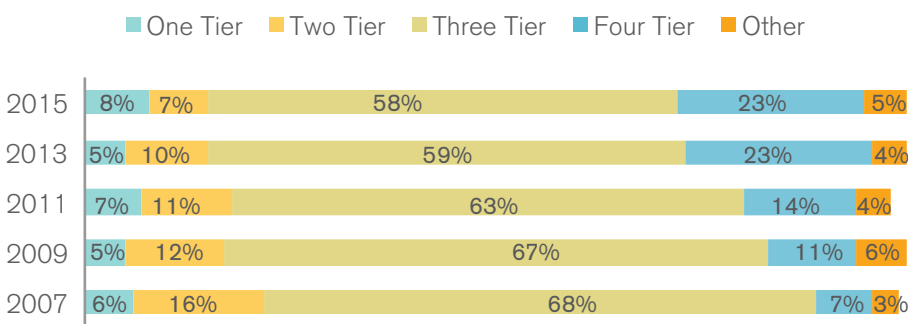


While there is not one standard definition of specialty drugs, specialty drugs are typically defined as drugs that are both costly to make and complex to manufacture. Historically, they have been prescribed to treat complex conditions such as cancer, HIV, and inflammatory diseases. Specialty drugs have a high cost per unit because in addition to being costly to manufacture there was a limited market for them. Typically specialty drugs were developed to treat a specific component of a disease or to treat rare conditions with very small populations. The specialty drugs hitting the market in the last few years were created to treat more complex diseases with large populations such as cancer, multiple sclerosis, and hepatitis C.

Because many of the specialty drugs on the market today have had significant success in treating and curing diseases that affect millions of people, future health care costs might be dramatically lowered by these specialty drug treatments. However, employers today are faced with having to manage the quickly escalating drug costs. According to the Milliman Medical Index, specialty drugs now represent 35% of total prescription drug costs and 6% of the total health care spend.

Some of the recommended strategies for controlling prescription costs are ensuring that plans have prior authorization and step therapy programs, limiting the network of specialty pharmacies, and identifying preferred treatments within disease categories. More employers are also adapting 4 or 5 tier prescription drug structures with special cost sharing for specialty, biotech or lifestyle drugs.

## WORKERS' COST SHARING FOR PRESCRIPTION DRUGS, US



\*California Health Care Almanac: June 2016

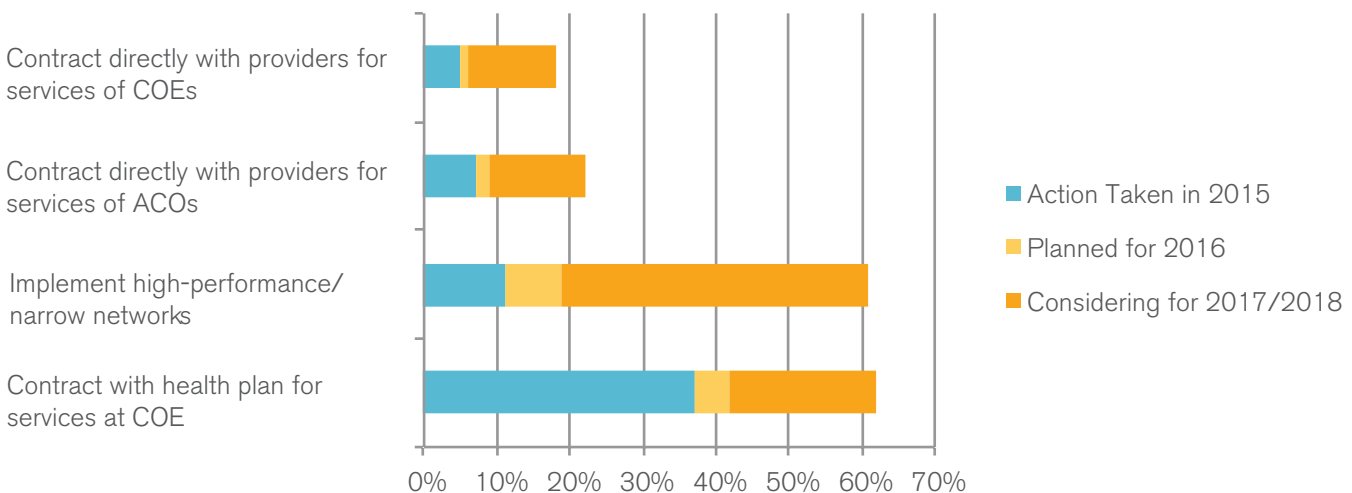


## Change in How Care is Provided

The overall price of health care in the last few years has remained fairly steady, between 4% to 6% (including benefit plan adjustments). This trend, while considerably lower than the double digit increases of the earlier part of the decade, is still not sustainable in the long run given that the consumer price index is increasing at a fraction of the health care trend. Furthermore, in 2020 the Excise Tax will go into effect, charging employers whose costs are above the designated cost thresholds with a considerable tax. In order to bend the cost curve, employers will need to do more to lower costs than simply adjusting their plan designs.

Often you will hear it quoted that 20% of the population spends 80% of the health care dollars. Plan designs with high deductibles, tax savings accounts, and advanced technologies might encourage the 80% of the population that spends a moderate amount on health care to make wise health care decisions, but an employee that has already hit their out of pocket maximum has little incentive to control their costs. This has created a need for change in the way that health care is delivered.

In the marketplace today there are several strategies that are being employed that either change how benefits and medical expenses are being paid or how the services are delivered to patients. None of these new strategies have been widely adopted by employer groups, but each strategy has had some success in not only controlling costs, but also in shifting the mindset regarding health care.



\*2015 20th Annual Willis Towers Watson/National Business Group on Health Best Practices in Health Care Employer Survey



## Alternative Networks

Some providers are able to provide coverage at a rate that is lower than other provider networks. Offering a plan with a narrow network limits the choices and options for employees but can lower the cost of care. Many of the plans offered to individuals through the State Exchanges use narrow networks and many employers are following suit by offering a narrow network plan design in their benefit portfolio. However, for individuals that are currently being treated, if their provider is not in the limited network, then they cannot benefit from these plan designs.

Another emerging strategy that when partnered with a narrow network has been successful in controlling cost is the development of Centers of Excellence (COEs). Centers of Excellence specialize in specific, complex conditions that may require specialized care. Originally the Centers of Excellence were developed to treat transplants, but COEs now handle a wide variety of complex conditions. Because a patient's care is fully integrated, patients are not only treated holistically but provider costs are also lowered.

## Accountable Care Organizations

Accountable Care Organizations (ACOs) are groups of physicians, hospitals, and other health care providers that are incentivized by providing a value of service rather than a volume of service. Similar to the creation of Centers of Excellence, ACOs have a payment structure that is results based rather than volume based. Some large employers and a few insurance carriers are contracting directly with these ACOs to provide cost effective, quality care. While ACOs have shown to offer positive health outcomes at lower prices, this method of delivering services has not been widely adopted. Many employers plan to contract in the future, but haven't yet made the transition. While the marketplace recognizes that the current trend in health care costs is not sustainable, many employers are still reluctant to take the leap to some of these alternative payment strategies.

# CONCLUSION



Ten years ago, employers with populations in multiple regions or states would look to create a health care package for their employees that would offer the same suite of benefits and services. Because health care is so personal, an emerging trend is the localization of health care. In recent years, this focus of offering one comprehensive, consistent benefits package has shifted to a more localized approach. The needs of an employee in one location may not be the same as the needs of another. Employer strategies that adapt to the differences in different geographical areas will result in overall improved pricing and ultimately better care.

Despite the relative stability of costs in the last few years, new technologies and medical developments that can potentially save lives also come at a steep cost that is not sustainable in the long run without significant change. The health care marketplace has already started to respond to the need to control costs by changing the relationship between individuals and their health care providers, creating a climate of consumerism and developing technologies that not only improve care, but also better informs individuals about their care. Furthermore, employers have shifted to looking at an employee's overall well-being rather than just certain health aspects when developing their employees' benefits packages. All of these paradigm shifts are paving the way to a future where employees are better satisfied with their benefits and employers are able to more easily manage their costs.

## Sources:

1. *2015 High-Performance Insights: Best Practices in Health Care; National Business Group on Health, Willis Towers Watson.*
2. *2016 Milliman Medical Index.*
3. *National Survey of Employer-Sponsored Health Plans, 2015 Survey Report, Mercer.*
4. *The Future of Health, 2015 Aon Hewitt Health Care Survey.*
5. *California Health Care Almanac, California Employer Health Benefits: Workers Pay the Price, California Health Care Foundation, June 2016.*
6. *Employer Health Benefits 2015 Annual Survey, The Kaiser Family Foundation and Health Research and Educational Trust*



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