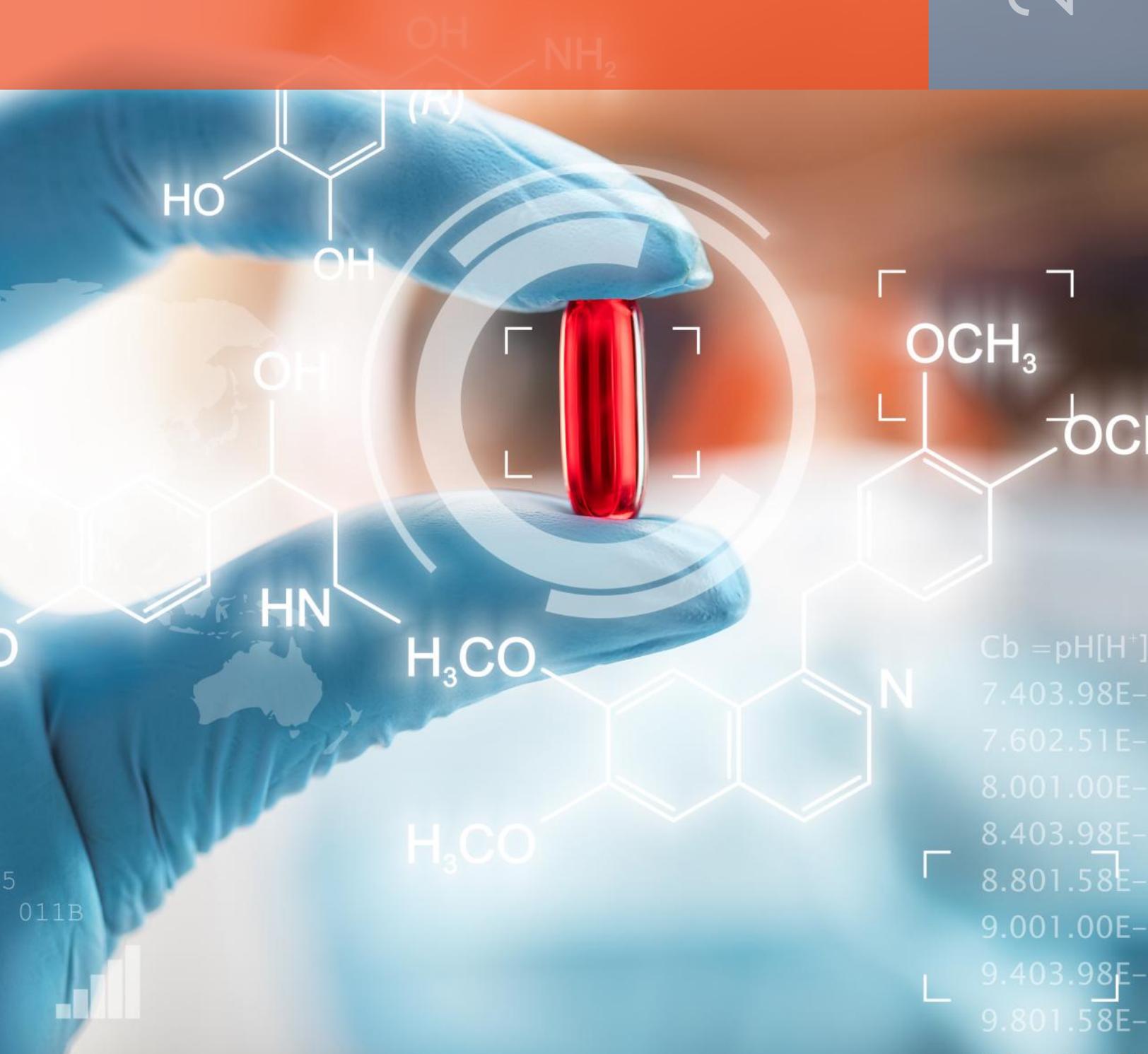


Heffernan Benefit Advisory Services

HEALTH CARE TREND REPORT

2018



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TABLE OF CONTENTS

4	Executive Summary
5	What is Trend?
6	Medical Trend Projections for 2019
7	Historic and National Medical Trends
8	Dental / Vision Trend Projections for 2019
9	Medical Plan Offerings and Enrollment
10	Prescription Drugs
12	Long-Term Strategies for Managing Care
	a. Voluntary Benefits
	b. Transparency Tools
	c. High Performance Networks
16	Convenience of Care
17	Conclusion

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



For almost a decade, Heffernan Insurance Brokers has been surveying the health, dental, and vision carriers in our key markets in order to ensure that our employer groups understand the driving factors that affect their renewals. Each year we strive not only to show what the projected trend increases are expected to be, but also to explain the factors influencing the trends and to guide employers in what to do to mitigate the increases. While employers have little control over the general marketplace, employers can manage costs with a strategic, multi-year approach.

For the last 20 years, the norm has been for health care trends to outpace the general rate of inflation. The trend projections for 2019, while still high, are in general slightly lower than they were in 2018. The exceptions to the slight downturn in trend are the Consumer Driven Health Plans and Prescription Drugs.

The rising cost of prescription drugs is one of the main health care trends that is causing concern for employers. Each year the market is releasing an increasing number of specialty drugs that have a high price point, which can be cost prohibitive to both members and employers. For some of these specialty drugs, there are similar drugs at lower prices that can be offered as an alternative course of treatment; but for many, there are new drugs treating conditions for which there is no alternative. With so many new treatments in the pipeline, the good news is that the market is demanding more accountability for the prices of the new drugs, as well as introducing generic equivalents—where possible—much sooner to the marketplace.

The cost for care throughout the country for the different plan options can vary significantly. Ten years ago, for companies that have multiple locations in multiple states, employers would strive to offer uniform plans across all locations that would meet the majority of their employees' needs. Today, the focus has begun to shift to finding the best plans in each region. On the West Coast, Health Maintenance Organizations (HMOs) are much more prevalent than in other parts of the country and can provide a more-cost-effective plan option for employees. By shaping the benefit packages on a more regional level, employers are giving employees more options to find the plan that best suits their needs at the best price.

WHAT IS TREND?



There are many factors that influence a large employer group's renewal increase; but trend, which is defined as the change in health care costs, is the primary factor. Claims costs typically represent from 65 to 90% of the total health care premium. Therefore it is important to understand not only what trend is, but also what factors influence trend. The primary components of trend are:

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

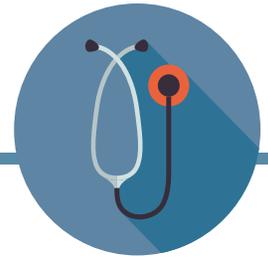
Health care trend is often looked at in two different ways: prospective health care trend and retrospective health care trend. Prospective health care trend is the prediction of where health care costs are expected to be in the future; whereas, retrospective health care trend is a measure of the actual change in health care costs experienced. Insurance companies will look at their own book of business and determine what they expect their future costs to be. These are the projections used in developing renewals. While it is important for an employer group to understand both outlooks of trend, 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 50 health, dental, and vision providers, asking them what trend factors that they will be using to determine their large group 2019 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.

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, Western Health Advantage

MEDICAL TREND PROJECTIONS FOR 2019



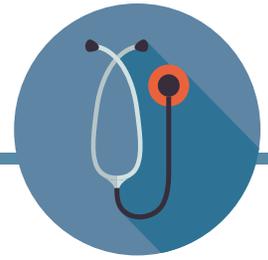
2019 MEDICAL PLAN SURVEY RESULTS

Plan Type	Northern California	Southern California	Northwest	New York	National
HMO w/RX	6.9%	7.1%	6.4%	8.8%	8.1%
PPO w/RX	9.4%	9.0%	8.0%	9.2%	9.3%
POS w/RX	8.2%	7.7%	6.4%	8.2%	8.4%
CDHP w/RX	8.6%	8.9%	6.5%	9.0%	9.1%
IND w/RX	11.4%	11.4%	8.7%	N/A	8.7%

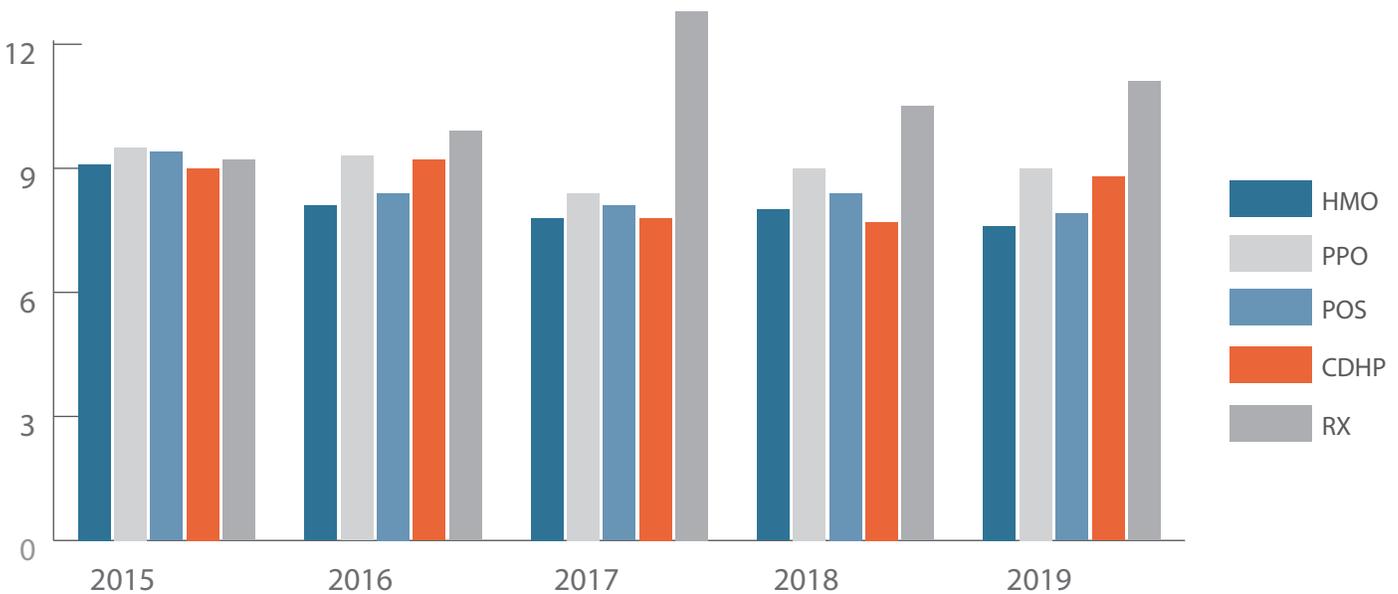
Summary of Medical Trend Results

- In prior years, Consumer Driven Health Plans (CDHPs) saw the lowest trend increases. In all regions, as well as nationally, CDHPs are trending higher than not only Health Maintenance Organizations (HMOs), but also higher than Point of Service Plans (POS). However, CDHPs are still trending lower than Preferred Provider Organizations (PPOs) in all marketplaces.
- With the exception of the Indemnity plan, the trend projection for PPO plans in almost all regions and nationally is the highest trending product. While the PPO is the product with the most market share nationally, in California HMOs have a larger share of the total enrolled population.
- Of all the regions represented, the Northwest is showing the lowest overall trends, followed by both California regions. The national trends and New York trends are significantly higher than the West Coast areas.
- Across all products and all regions, Prescription Drugs is an increasingly dominant driver of the trend. Five years ago, prescription drugs represented 10% of the overall medical spend. Today, with a few exceptions, most carriers are seeing prescription costs representing more than 15% of the total costs.
- In the California markets, the trend projections for 2019 are very similar to the trend projections for 2018. In the Northwest, the trends for almost all lines of coverage are lower than they were for 2018. This is also true for the National trend projections with the exception of CDHPs, for which the trend is almost a percent higher than it was in the prior year.

HISTORIC AND NATIONAL MEDICAL TRENDS



HISTORIC NATIONAL MEDICAL TREND



In our 2019 Medical Plan Survey results, we show the projected trend in each region for each product blending in the trend for prescription drugs. 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

- Overall, trend projections for 2019 are lower than they were for 2018. The exceptions to this are CDHPs and Prescription Drugs.
- The trend projection for CDHP for 2019 is 1.1% more than it was for 2018. Enrollment in CDHPs has also not increased in the last two years. While this plan is still often a low-cost alternative for many employees, it is not realizing as significant savings as it was a few years ago.
- HMOs are seeing a downward trend for 2019, but overall their trend has been relatively consistent over the last four years.
- Nationally, PPO plans have the highest enrollment rates—27% of employers only offer a PPO plan. The trend projections for these plans for 2019 remains the same as it was for 2018.

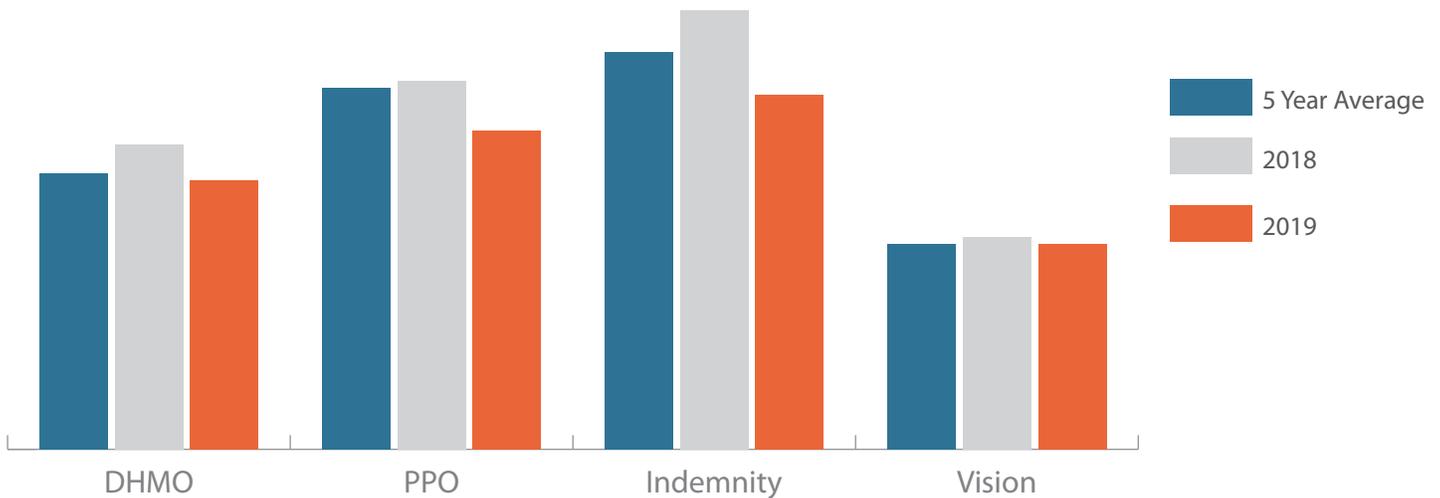
DENTAL AND VISION TREND PROJECTIONS FOR 2019



2018 DENTAL AND VISION SURVEY RESULTS

	2015	2016	2017	2018	2019
DHMO	3.6%	4.0%	3.6%	4.3%	3.8%
PPO	5.5%	5.2%	5.3%	5.2%	4.5%
Indemnity	6.4%	5.1%	5.4%	6.2%	5.0%
Vision	2.9%	3.0%	2.9%	3.0%	2.9%

2018 & 2019 DENTAL AND VISION TREND COMPARED TO FIVE-YEAR AVERAGE



Summary of Dental and Vision Trend Results

- Over the last five years, the vision trend has remained very consistent with no more than a 0.1% variance.
- The most popular dental product, the dental PPO, is projecting a 4.5% trend for 2019. This is more than a half percent lower than both the trend projection for 2018 and the five-year average.
- The trend for dental HMO plans is also significantly lower than it was in 2018. However, the trend projection for 2019 is more in line with the trend for the last five years.
- Across all dental products, the trend projections for 2019 are lower than they were for 2018. This is also true for the indemnity plans.
- Of the three types of dental plans typically offered, dental PPO plans represent 70% of the enrolled population, with dental HMOs representing 21% and indemnity plans only 9% of enrolled members. The distribution between employer-sponsored plans and voluntary plans (where the employee pays 100% of the premium) are fairly equally divided at 50% across all products.

MEDICAL PLAN OFFERINGS AND ENROLLMENT



Over the last 10 years, there have been some significant changes in the plans that employers are offering their employees. While the selection of plans offered vary by employer size, employer type, and the geographic locations of the employers, there are some consistent enrollment plan offering trends across all companies.

Health Maintenance Organizations (HMOs)

Twenty years ago, HMOs were widely offered as the low-cost option in an employee's benefits package. In 2007, 39% of employers offered an HMO plan, but in 2017 only 29% of employers offered this plan option.¹ In the early 2000s, 24% of members were enrolled in an HMO plan, whereas today only 14% of members are enrolled.² Due to provider contracting changes, HMOs have become more expensive and enrollment has decreased. HMO plans are most popular on the West Coast where regional carriers have been able to better manage costs and keep the price more competitive versus PPO plans. Over the last couple of years, HMO enrollment has held steady at 14%, as the cost difference between HMO and PPO plans has narrowed.²

Preferred Provider Organizations (PPOs)

For the last 20 years, PPOs have been the most popular plan offering. In 2007, 93% of employer groups offered a PPO plan; this number has only declined to 85% in 2017.¹ Twenty-six percent of employers offer a PPO plan as the only benefit plan available to employees. However, while most employers include a PPO as a plan offering, enrollment in PPO plans has been affected by the introduction of Consumer Driven Health Plans (CDHPs), which have become the most inexpensive plan option. In 2001, 69% of members were enrolled in PPO plans; this number has dropped to 58% in 2017.²

Consumer Driven Health Plans (CDHPs)

CDHPs are new to the benefits marketplace. With Health Reimbursement Accounts (HRAs) released in the early 2000s and Health Savings Account (HSAs) introduced in 2004, these tax-advantaged accounts were designed to shift some responsibility for claims costs to employees, encouraging members to become better, savvier consumers. Employers' interest in CDHPs has steadily increased over the last 10 years. In 2011, seven years after the HSA was introduced, 15% of employers offered a CDHP plan offering.¹ In 2017, 59% of employers offered CDHP plans. Enrollment in CDHPs has remained consistent around 28% for the last few years.²

PRESCRIPTION DRUGS



CDHPs have been the lowest-costing plan option for several years, but the high deductibles and out-of-pocket maximums have discouraged the overall enrollment from outpacing PPO plans.

% OF EMPLOYEES OFFERING EACH PLAN



Mercer, "National Survey of Employees Sponsored Plans, 2017".

% OF EMPLOYEES ENROLLING IN EACH PLAN



Employer Health Benefits, 2017 Annual Survey, The Kaiser Family Foundation and Health Research & Educational Trust.

PRESCRIPTION DRUGS

While prescription drug trend continues to outpace medical trend, the large trend spike in 2015 due to the introduction of the hepatitis C treatment has not been seen in the last few years. While the RX trend had been steadily decreasing since 2015, the trend projection for 2019 is higher than it was in prior years. There is still a lot of volatility in the prescription drug market as new and expensive drugs hit the market; lower-cost alternatives are being developed more quickly and cost-saving measures are being deployed more rapidly.³ Prescription drugs in 2001 represented 13.2% of total medical expenditures but have grown to 17.4% in 2018. This percentage accounts for prescriptions filled at a retail pharmacy. If you take into account prescriptions delivered to patients in hospitals or physician offices, the total prescription expenditure would likely be 20% of the total medical expenditure.³

Specialty drugs account for 40.82% of the total amount spent on pharmacy benefits, yet specialty drugs only treat about 1.0% of the people.⁴ Effectively managing the volatile cost of specialty drugs while providing cost-effective access to these potentially life-changing drugs is a challenge for most employer plans.

PRESCRIPTION DRUGS



There is no singular method that effective prescription drug managers (PBMs) employ to manage costs, but rather a number of programs together can lower trend increases. Some of the programs that are being employed are:

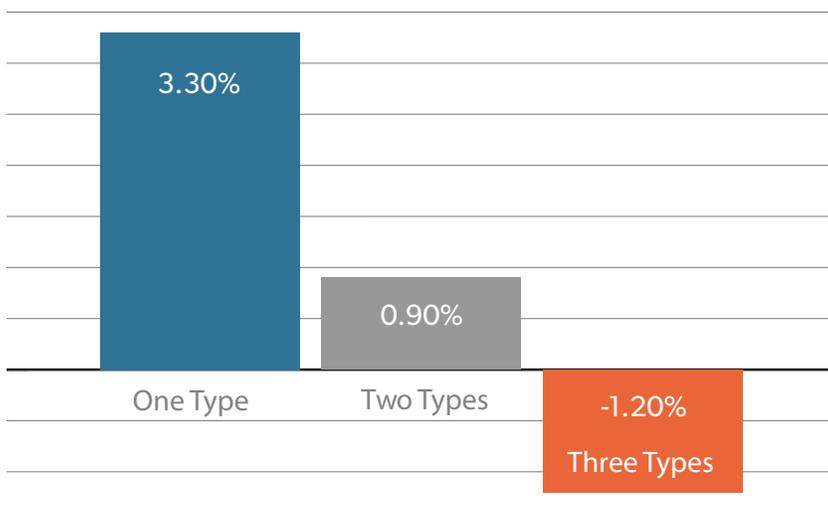
Requiring Pre-Authorization. The pre-authorization process will ensure that only members who meet the conditions for a course of treatment will receive the prescription.

Using a Closed Formulary. Plans that have a closed formulary may be able to maximize rebates by offering a limited number of prescriptions among the multiple drugs that are being offered to treat a certain medical condition.

Using a Limited Specialty Pharmacy Network. Limiting the number of specialty pharmacy networks may improve the discounts and rebates provided.

According to Express Scripts 2017 Drug Trend Report, plans that implemented three types of solutions saw their prescription drug trend decrease 1.2%.⁴

TREND FOR PLANS ADOPTING COST SAVING PROGRAMS



Express Scripts 2017 Drug Trend Report.

LONG-TERM STRATEGIES FOR MANAGING CARE



Over the last 10 years, one of the key long-term strategies in managing the high health care cost increases has been the focus on consumerism. Health care consumerism is the increased responsibility and awareness of the employees and members in consuming and purchasing health care. The concept of consumerism has led to the development of Consumer Driven Health Plans (CDHPs). The structure of these plans, by design, puts the purchasing power and decision making into the hands of the members by encouraging members to shop for the most-cost-effective providers. The two most common CDHP plans are Health Reimbursement Accounts (HRAs) and Health Savings Accounts (HSAs), with the latter being the most common. In the last couple of years, however, the growth of enrollment in CDHPs is not nearly as significant as it has been in the past.

83%
of employees
would be willing
to take a small
pay cut in order
to have a better
choice of benefits

While CDHPs have been effective at controlling costs and changing consumer behavior, these plans are not the only solution for employers to manage healthcare costs over the long term. In fact, many employers are committed to offering a variety of different benefits to meet the specific needs of their employees.

According to "MetLife's 16th Annual U.S. Employee Benefit Trends Study," 83% of employees would be willing to take a small pay cut (on average, 3.6%) in order to have a better choice of benefits from their employer. The same study also says that 73% of employees agree that "having benefits customized to meet my needs would increase my loyalty to my employer."⁵

However, CDHPs are still an important tool in controlling costs. Both nationally and in all of the regional market areas, CDHPs are the lowest-costing premiums out of the three main products offered (HMOs, PPOs, and CDHPs). But it is not enough to simply offer a CDHP; employers must also provide the tools that will make enrollment more attractive and help the employees to make the right financial decisions.

LONG-TERM STRATEGIES FOR MANAGING CARE

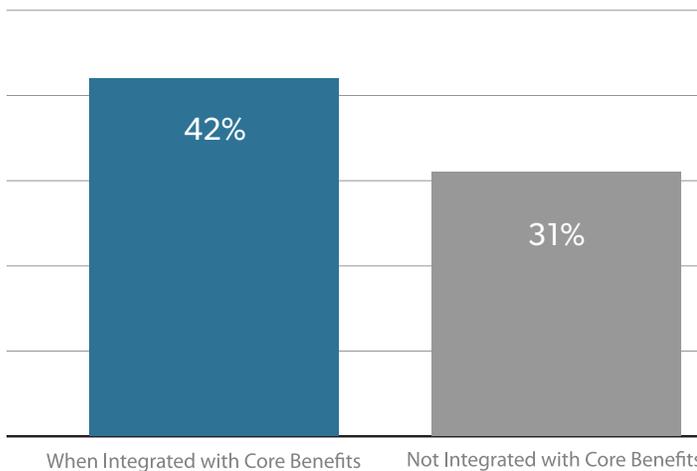


VOLUNTARY BENEFITS

With the double-digit trend increases at the beginning of the decade and the continued higher-than-inflation growth over the last few years, many employers have had to shift costs to their employees, increasing deductibles and out-of-pocket maximums. Voluntary benefits such as critical illness benefits, hospital indemnity plans, and cancer coverage plans patch gaps in coverage that the higher deductible plans have created. Because employees are choosing the voluntary benefits to meet their specific needs, the benefits have an increased perceived value, even when employees are paying for the additional benefits. The enrollment in voluntary plans will further increase if employers integrate the offering of voluntary benefits with the offering of their core benefits. Employers need to not only effectively communicate how these additional products can increase their coverage and eliminate benefit holes in the core benefits package, but also offer the voluntary benefits on the same platform and at the same time as the core benefits. Offering voluntary benefits at the same time as the core benefits allows employees to fully evaluate their coverage and helps to determine their overall out-of-pocket expenditures.

73%
agree that
having benefits
customized to
meet their needs
would increase
their loyalty to
their employer

LIKELIHOOD TO ENROLL IN VOLUNTARY BENEFITS



MetLife's 16th Annual US Employee Benefit Trends Study.

Other types of voluntary benefits such as pet insurance, legal assistance, identity protection, and financial wellness programs help to customize and round out an employee's overall benefits package. These voluntary products are often either unavailable on the individual market or the cost is prohibitive. Employees are willing to pay for these benefits that offer ease of enrollment, lower costs than individual plans, and reduce stress—which helps to create a culture of employee well-being that increases employee loyalty and satisfaction.

LONG-TERM STRATEGIES FOR MANAGING CARE



TRANSPARENCY TOOLS

With the rise in health consumerism, there has been a need to create tools to help employees make better health care decisions. Most insurance carriers throughout the country have developed transparency tools that allow the members to better understand the different costs associated not only with the different types of services, but also the different costs associated with different providers. When members are being charged high deductibles and coinsurance amounts, they need to be better aware of what the costs of the services will be in order to make the best care and financial decisions.

To give consumers more information with which to make better health care decisions, both the health insurance carriers as well as a growing number of outside vendors have developed estimators that evaluate the cost of care for different clinical treatments. Many of these tools also try to integrate performance or quality data into their cost-estimating tools. However, it is often hard for these tools to accurately predict the actual employee cost for treatment, especially if care changes during the course of the treatment. While it is important for consumers to understand the actual costs of the services that are being provided to them, most people are not proactive about their health care costs, and are either not using the tools provided to them or are not making their health care decisions based on the cost of the services. “Catalyst for Payment Reform, which advocates for health care price and quality transparency, estimates that just 2.0% of consumers overall use health plans’ cost-estimator tools”.⁶ This low rate of utilization of cost-estimator tools may be due to difficulty in obtaining credible pricing information, an unwillingness to disrupt existing physician relationships, or that consumers are attributing a higher perceived value to providers that are more expensive; but in the end, consumers are not price shopping.

Transparency tools alone do not seem to be enough to guide consumers or to ultimately lower health care costs. Over the last few years, there has been a recent rise in vendors who provide care advocacy services that in addition to helping consumers estimate and compare costs, also analyze treatment options, identify the most cost-effective treatment plans, coordinate with providers, and even sometimes offer logistical help such as transportation support. While CDHPs can lower utilization, which lowers costs, the growth of these care advocacy programs along with increased price transparency have the potential to have a significant impact in decreasing the medical trend.

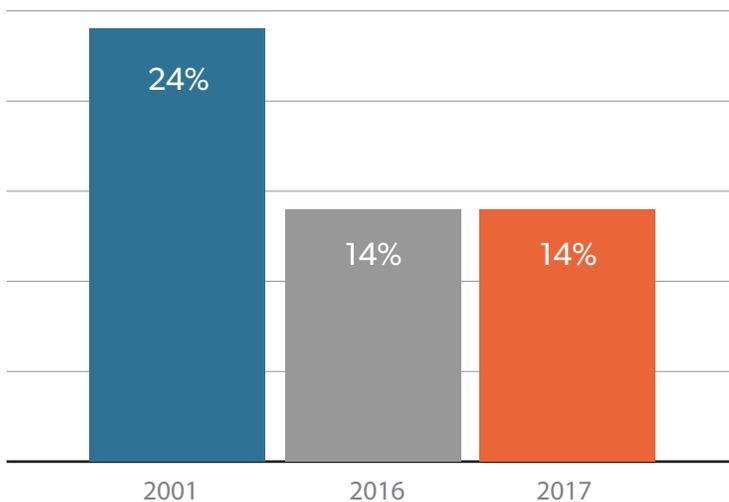
LONG-TERM STRATEGIES FOR MANAGING CARE



HIGH PERFORMANCE NETWORKS

Over the last 15 years, enrollment in Health Maintenance Organizations (HMOs) has steadily declined as Preferred Provider Organizations (PPOs) became more affordable. The introduction of Consumer Driven Health Plans (CDHPs) at an even lower price point has also greatly contributed to the decrease in HMO enrollment. According to the Kaiser Family Foundation and HRET “Employer Health Benefits Report for 2017,” enrollment in HMO plans was at 24% of those enrolled in 2001; whereas, enrollment in 2017 is only at 14% of those enrolled. However, since 2015 there has not been a change in HMO enrollment.² One of the key factors of HMO plans holding their enrollment has been the development of High Performance Networks.

HMO ENROLLMENT BY YEAR



In the early 2000s carriers would offer narrow network HMO options that would reduce the network of doctors and hospitals available to those providers with the lowest costing reimbursement rates. In the last couple of years, we have again seen these narrow network plans being offered to employees—except today’s narrow network plans are actually High Performance Network Plans. Rather than choosing the providers with only the lowest costs, health plans are creating narrow networks made up of providers with the highest quality at the lowest prices. The providers that are

selected for the High Performance Network Plans are those that are providing care that lowers the overall trend. Some of these providers are using outcome-based pricing where providers are reimbursed for the whole course of treatment instead of the specific procedures and treatments that are performed. The outcome-based pricing not only encourages less expensive care, but also increases the overall quality of the care. Consumers are responding to these new plan designs. “Among consumers that are willing to limit their provider choice, nearly all said they would do so if the providers were high quality.” PwC Health Research Institute⁷

There is not one plan design that can alone affect the medical trend. Offering employees a variety of plans from which to choose will encourage employees to become better consumers as they weigh the benefits, plan costs, and out-of-pocket costs among the many plans being offered.

CONVENIENCE OF CARE



Along with the desire for increased plan options, members are also looking for greater access to care. They are no longer willing to wait in long lines at doctors' offices or in emergency rooms. While Telehealth services have been offered for many years by employer plans, employees are finally starting to use these services that are available.⁸ From 2015 to 2016, telehealth in urban areas increased from 25% to over 45%, and from 35% to over 40% in rural areas. "Telehealth services allow patients to receive the treatment they need no matter where they live."⁸ For many employers, telehealth was originally a service that was provided to their employees at an additional cost for either the employer or the employee. Because of the increased demand for these services, many health plans are now building telehealth into their core benefits.

Another trend that shows this increased demand for convenience is the growth of the on-site clinics in both grocery store and pharmacy chains. These clinics provide immediate access to nurse practitioners and physician assistants for common, minor illnesses such as colds, flu, sprained muscles, and so on. Members no longer have to wait for days for appointments to their primary care doctors or bog down the emergency rooms for nonemergency complaints. Members not only have quick access to providers for these immediate ailments, but they can also get their prescriptions filled at the same time. This demand for convenient care has also created a growth of urgent cares across the country. According to the Urgent Care Association of America, the number of urgent care centers nationwide has increased from about 6,400 centers in 2014 to 7,639 centers in 2017.⁸ This is a growth of almost 20% in three years. Urgent care clinics, like the on-site clinics in grocery stores and pharmacies, offer same-day access to care and shorter wait times when accessing services. "Many consumers are seeking out care in settings outside of the traditional doctor's office; of those surveyed with employer-based insurance, 60 percent said they have received care in an urgent care center, 25 percent in a retail health clinic and 11 percent by video visit."⁷

The increased access to care provided by telehealth services, urgent care clinics, and retail clinics all increase member utilization, which can increase trend. However, this utilization of clinics encourages the quick treatment of illnesses, which can decrease the need for further treatment and is often more cost effective than a primary doctor's office. "FairHealth, a nonprofit that runs a national database of insurance claims, found that in 2016, the median charge for a 30-minute new patient visit cost \$294 in a doctor's office and \$242 in an urgent care clinic. A New York Times/Blue Cross Blue Shield survey found treating a middle ear infection cost about \$500 in the ER, compared with \$100 in an urgent care clinic."⁹ Furthermore, the use of these alternative methods of care alleviates some of the traffic from the traditional doctor's office, allowing physicians to have more time with patients with chronic or persistent illnesses.

The number of urgent care centers has increased by almost

20%

in three years

CONCLUSION



While projected trends are not as high as they have been in the past several years, they are still a key concern for employers. There is not a unique solution to controlling health care costs. However, by using a combination of methods for controlling costs, employers can realize savings that bend an employer's specific trend below that of the general marketplace. One particular trend in managing costs is the elimination of the one-size-fits-all benefits plan option. Employers can save money by partnering with providers and vendors in different regions that are taking measures to control costs. Employees are looking for more options in their benefits packages to find the right mix that works for them.

Prescription drug coverage remains a key component of the overall health care trend. The new drug therapies that are being developed, while expensive, do have the potential to treat conditions before they result in higher-costing medical or surgical care. However, these life-saving drugs come at a steep price, and employers are looking deeper at their pharmacy plans to make sure that their prescriptions are being properly managed. Formularies are getting stricter—and new programs are being developed and utilized that encourage mail order fulfillment, increase adherence to their prescription treatment, and make use of the rebates available to them. In order to keep costs down, employers have had to become savvier at managing their costs.

Throughout the country, there has been tremendous growth in urgent care facilities and minute clinics. These clinics that offer immediate treatment for minor, acute services are helping to eliminate the delays and long waits in the traditional doctors' offices, as well as offering care at an affordable, predictable price. While patients can't control the providers they access in the case of an emergency, members in general have a greater consciousness of the dollars they are spending when they do seek care. The health care marketplace has responded 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 inform individuals about their care. Ultimately, the health care industry needs to manage costs so that they are at a sustainable rate. However, the fact that trend increases have been relatively stable over the last few years is a hopeful indicator that the industry is moving in the right direction.

CONCLUSION



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