2012 Segal Health Plan Cost Trend Survey

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Medical and Prescription Drug Plan Cost Trends Projected to Decline for 2012; Actual Rates for 2010 Lowest in 10 Years

For 2012, medical and prescription drug plan cost trend rates are projected to decline from 2011 levels, according to forecasts compiled in the 2012 *Segal Health Plan Cost Trend Survey*, the fifteenth annual survey of managed care organizations (MCOs), health insurers, pharmacy benefit managers (PBMs) and third party administrators (TPAs) by The Segal Company, the parent of Sibson Consulting.[1] (For a definition of trend, see the text box on page 2.)

The survey also asked questions about the Affordable Care Act.[2] In the short term, the Affordable Care Act is expected to add to plan sponsors' costs by a minimal amount.

In addition to compiling projected trend rates, the survey looks at historical trend rates. It appears that in 2010 (the most recent full year for which actual data is available), there were significant declines in actual trend rates from the previous year. *Actual trends for 2010 were the lowest reported in more than 10 years.* The survey also found a significant spread between actual and projected 2010 trends.

Trend Projections for 2012

Table 1 summarizes the key findings on trend projections for 2012 and compares them to projections for 2011. Notes about the projected cost trends for 2012 that are shown in Table 1 follow:

- All medical plan types are projected to experience lower cost trends for 2012. Projected managed care cost trends for 2012 range from 9.6 percent to 10.4 percent, compared to projections for 2011 that ranged from 10.2 percent to 11.7 percent. For example, projected cost trend rates for HDHPs and open-access PPOs/POS plans for

"All medical plan types are projected to experience lower cost trends for 2012."

Table 1: Projected Medical, Prescription Drug, Dental & Vision Trends: 2011 & 2012

	2011 Projected (without Rx)	2011 Projected (with Rx)[1]	**2012 Projected (without Rx)**	**2012 Projected (with Rx)[1]**
Medical (Actives & Retirees < Age 65)				
Fee-for-Service (FFS)/Indemnity Plans	12.7%	12.1%	**11.7%**	**10.9%**
High-Deductible Health Plans (HDHPs)[2]	11.7%	11.2%	**10.4%**	**9.8%**
Open-Access Preferred Provider Organizations (PPOs)/Point-of-Service (POS) Plans[3]	11.0%	10.7%	**10.0%**	**9.5%**
PPOs/POS Plans (with PCP Gatekeepers)	11.2%	10.8%	**10.4%**	**9.8%**
Health Maintenance Organizations (HMOs)	10.2%	10.0%	**9.6%**	**9.2%**
Medical (Retirees Age 65+)				
Medicare Advantage (MA)[4] HMOs	7.0%	7.4%	**6.6%**	**6.6%**
Prescription Drug (Rx) Carve-Out[5]				
Actives & Retirees < Age 65	9.2%		**7.2%**	
Retirees Age 65+	8.2%		**6.5%**	
Dental				
Scheduled Plans	4.8%		**4.1%**	
FFS/Indemnity Plans	6.6%		**4.2%**	
Dental Provider Organizations (DPOs)	5.5%		**3.8%**	
Dental Maintenance Organizations (DMOs)	4.2%		**4.4%**	
Vision				
Scheduled Plans	3.2%		**3.8%**	
Reasonable & Customary (R&C) Plans	3.5%		**3.9%**	

[1] Trend projections were derived by proportionally blending medical trends and freestanding prescription drug trends.

[2] HDHPs with an employee-directed, tax-advantaged health account — a health savings account (HSA) or a health reimbursement account (HRA) — are referred to as account-based health plans and are designed to encourage consumer engagement, resulting in more efficient use of health care services. HDHPs are defined as those plans where the deductible is at least the minimum health savings account (HSA) level required by the Internal Revenue Service ($1,200 single, $2,400 family in 2012).

[3] Open-access PPO/POS plans are those that do not require a primary care physician (PCP) gatekeeper referral for specialty services.

[4] MA plans, part of the Medicare program, can be private HMOs, FFS plans, PPOs or special-needs plans. Because enrollment is much higher in MA HMOs than in MA FFS or MA PPOs, this year's survey did not capture data for MA FFS or MA PPOs. The survey did collect information about projected trends for Medicare supplemental plans, commonly referred to as "Medigap" plans, which are projected to be 6.4 percent for 2012.

[5] Prescription drug carve-out data was captured for retail and mail-order delivery channels combined.

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[1] For information about the survey participants, see the text box on the last page of this report.

[2] The Affordable Care Act is the shorthand name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-48, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152.

"In 2012, prescription drug trends ... are forecast to be 7.2 percent for active participants and early retirees, a decline of 2 percentage points from 2011 projected trend rates."

2012 are forecast to be 1.3 percentage points and 1 percentage point lower, respectively, than 2011 projections. (The survey also found that 43 percent of respondents project trend rates for open-access PPOs/POS plans to be under 10 percent for 2012, which is almost double the percentage of respondents — 24 percent — that projected trend rates to be under 10 percent for 2008.)

- In 2012, prescription drug trends (for retail and mail order combined) are forecast to be 7.2 percent for active participants and early retirees, a decline of 2 percentage points from 2011 projected trend rates. (The percent of survey respondents reporting projected prescription drug trend ranges of less than 10 percent more than doubled over the last five surveys: 73 percent of respondents for 2012, up from 31 percent of respondents for 2008.)
- Trend rates for Medicare Advantage HMOs are expected to decrease to 6.6 percent from the 2011 forecasts of 7.0 percent. Medicare Advantage HMO trend rates are projected at 3.0 percentage points below HMO trends for active participants and early retirees. Factors influencing the 2012 trend projections for Medicare-eligible retirees include a reduction in Medicare payments for preventable readmissions.
- Trend rates for FFS dental indemnity plans and DPOs are expected to decrease significantly for 2012 compared to 2011, by 2.4 and 1.7 percentage points, respectively. However, trend rates for DMOs are expected to increase slightly.
- Trend rates for most vision plans are projected to increase slightly.

What is Trend?

Trend is a forecast of per capita *claims cost increases* that takes into account various factors, such as price inflation, utilization, government-mandated benefits, and new treatments, therapies and technology. 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. Changes in the costs to plan sponsors can be significantly different from projected claims cost trends, reflecting such diverse factors as group demographics, changes in plan design, administrative fees, reinsurance premiums and changes in participant contributions.

The survey also looked for regional variations in trend rates. Projected 2012 trend rates for PPOs and POS plans combined show regional variations. The lowest trend rates are expected in the South and Midwest regions: 8.8 and 8.9 percent, respectively. The highest trend rates are forecast for the West region at 10.8 percent, whereas the Northeast is forecast at 9.8 percent.

Impact of the Affordable Care Act on Costs

The Affordable Care Act introduced new rules and requirements for group health plans, including the following:

- Removal of annual and lifetime dollar limits,
- Expansion of adult dependent children to age 26,
- New fees applied to all plans for comparative effectiveness research,
- New taxes on insured policies and medical device makers that will be passed on in insured premiums,
- Covering a defined list of preventive services with no cost-sharing requirements when those services are provided in-network,
- Reduced waiting periods to a maximum of 90 days from the date of full-time employment, and
- Added administrative costs (*e.g.*, for special enrollment and new plan document disclosure).

Moreover, there is the possibility of some shift of provider ancillary fees to the claims base in order to better meet the Affordable Care Act's medical loss ratio (MLR) requirement, which requires insurers to spend at least 80 or 85 percent of premiums[3] on claims or quality improvement initiatives. This could result in more dollars being subject to higher trend rates.

These new rules have added to expected plan cost in the near term for some plan sponsors. Segal asked the survey respondents about the expected impact of changes introduced by the Affordable Care Act:

- Three-quarters (75 percent) of survey participants expect the extension of coverage to adult

"Three-quarters ... of survey participants expect the extension of coverage to adult dependents up to age 26 will contribute to an increase in *2011* plan costs."

[3] The 80-percent requirement applies to the individual and small-group market. The 85-percent requirement applies to the large-group market.

dependents up to age 26 will contribute to an increase in *2011* plan costs. However, as shown in Graph 1, almost three-quarters of respondents (71 percent) indicated the projected impact on plan cost was an increase of less than 1 percent.

- More than 80 percent of respondents do *not* expect the Affordable Care Act's MLR[4] requirement to result in a reduction in future premium increases for *2012*.

Trend Components

As was the case for the last several years, price inflation for services and supplies continues to be the biggest element of overall medical plan cost trends. In 2012, price inflation is expected to account for over 70 percent of hospital cost trends and 76 percent of prescription drug cost trends.

The survey also examined 2012 medical trends by service type. Table 2 compares that data to similar data collected last year. Hospital cost trends are forecast to exceed all other elements of medical benefit services. Consistent with forecasts for 2011, price inflation is projected to remain relatively high for hospital services.

[4] MLR stands for "medical loss ratio," a requirement that is described in the text on page 2.

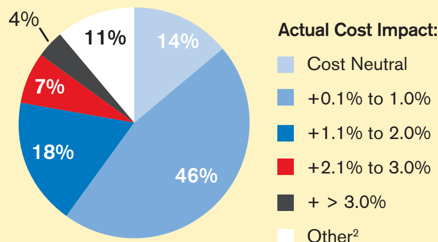
Long-Term Impact of the Affordable Care Act on Group Health Plan Costs

The long-term impact of the Affordable Care Act on plan sponsors' future health benefit plan cost trends is unclear. The following are among the key questions that cannot yet be answered:

- **Will the reduction in uncompensated care reduce subsidies paid by private sector payers and help to lower future private plan cost increases?**
- **Will the state insurance Exchanges and federal premium subsidies for low-income individuals have an impact on employees' choices and, as a result, employer-sponsored plan designs, cost-sharing levels and funding levels?**
- **Will new insurance reforms translate into more stable premiums in the long term?**
- **Will the state Exchanges, the new, simplified insurance markets, and the automation and standardization of data processes improve administrative efficiency?**
- **How will the federal focus on safety and quality, like penalizing hospitals for preventable hospital-acquired infections and preventable readmissions, affect patient care and plan sponsors' costs?**
- **How will plan sponsors be able to use the expanded quality performance data that will be collected by the federal government to negotiate with insurance companies, managed care organizations and physician and hospital networks?**
- **How will the investment in wellness benefits, community clinics and comparative-effectiveness research affect health plan utilization patterns and, ultimately, costs?**
- **Will the advent of accountable care organizations (ACOs),* medical homes and new payment models, like episodes of care, change the way that providers and insurers share risk? And, how will this affect plan sponsors' cost base and ability to assess networks?**
- **Will the cuts in Medicare mandates by health reform reduce payments to providers, fuel cost shifting to private payers and widen the gap of trends observed between plans for actives/early retirees and plans for Medicare-eligible retirees?**
- **How will the Bundled Payments for Care Improvement Initiative, which is intended to improve care for patients while they are in the hospital and after they are discharged, give doctors and hospitals new incentives to coordinate care, improve the quality of care and save money for Medicare?**

* ACOs are networks of doctors and hospitals that agree to share responsibility for providing health care services. Medicare will provide incentives for ACO providers to provide quality care at a lower cost.

Graph 1: Average Cost Impact on 2011 Plan Trend for Plans Extending Coverage to Dependent Adult Children[1]



[1] This data reflects responses from 28 of the health insurers, HMOs and TPAs that participated in the survey.
[2] "Other" includes decreases and increases that are greater than zero, but less than 0.1%.

Table 2: Components of 2011 & 2012 Projected Trends for Hospital and Physician Services and 2012 Projected Trends for Rx

Trend Component	Hospitals[1]		Physicians[1]		Rx	
	2011 Survey	2012 Survey	2011 Survey	2012 Survey	2011 Survey[2]	2012 Survey
Price Inflation	8.5%	7.2%	3.1%	4.6%	N/A	5.5%
Utilization	2.8%	2.6%	4.5%	3.7%	N/A	2.5%
Total Trend[3]	**12.0%**	**10.1%**	**8.2%**	**8.7%**	**N/A**	**7.2%**

[1] Hospital and physician trends are for open-access PPOs.
[2] For 2011, there was not enough valid data to publish the breakout of components for prescription drug trend.
[3] The components do not add up to the totals because there are other components of trend not illustrated, reflecting such factors as impact of cost-shifting, technology changes and drug mix. Also, not all participants provided a breakdown of trend by component.

Price inflation for physician services is expected to increase in 2012 by 1.5 percentage points, while utilization trends are forecast to decrease by 0.8 percentage points.

Generic drug utilization rates continue to rise as major brand-name drug patents expire. However, manufacturers' ongoing focus on the development and marketing of biotechnology or specialty drugs is a growing segment of brand-name drug costs. The 2012 trend rate for specialty/biotech drugs is expected to be 15.5 percent, representing a 1.9 percentage-point drop from the 2011 trend rate (17.4 percent). Specialty drug trend is forecast to be nearly double the aggregate prescription drug trend. It will continue to drive up aggregate prescription drug trend rates because, as new specialty drugs are released and existing drugs continue to gain new therapeutic uses, specialty drug costs and utilization are expected to rise. Plan sponsors will observe variances in specialty/biotech trend rates based on their participant populations.

Accuracy of 2012 Projections

To assess the accuracy of projections, Segal compared the average 2010 trend *forecasts* by national and regional insurers, MCOs, PBMs and TPAs for group medical, prescription drug benefit and dental plans to the *actual* average trend rates experienced by the health plans covered by those organizations for the same 12-month period, as reported by survey respondents. Comparing past projections to actual increases reveals that insurers and PBMs tend to make conservative projections for cost increases. Historically, forecasts are generally higher than the actual experience. The following are the most notable findings about the accuracy of trend projections based on the data shown in Table 3:

- For each type of health coverage surveyed in 2010, the projected trend rate was higher than the actual claim trend. For example, the 2010 actual claim trend rate for open-access PPO plans was 3.2 percentage points below the projection for that year.
- Even more dramatic differences are observed for Medicare Advantage HMOs, with actual trend rates in 2010 less than half the projected trend rates for the year (3.6 percent vs. 7.7 percent).
- Actual prescription drug trend rates continue to be lower than forecast. The differential between the 2010 projected and actual prescription drug trend is 2.7 percentage points. In 2009, that differential was 1.9 percentage points.

Moreover, actual trends for 2010 were the lowest reported in more than 10 years. Table 4 shows selected trends from the last 12 surveys

Table 3: Comparison of 2010 Projected Trends to 2010 Actual Trends

	Projected	Actual
Medical (Actives & Retirees < Age 65)	(without Rx)	
FFS/Indemnity Plans	13.3%	10.6%
HDHPs	11.9%	8.6%
Open-Access PPOs/ POS Plans	10.8%	7.6%
PPOs/POS Plans (with PCP Gatekeepers)	10.6%	8.3%
HMOs	10.2%	8.7%
Medical (Retirees Age 65+)	(without Rx)	
MA HMOs	7.7%	3.6%
Rx Carve-Out* (Actives & Retirees < Age 65)	9.1%	6.4%
Rx Carve-Out* (Retirees Age 65+)	9.1%	5.8%
Dental		
Scheduled Plans	5.6%	3.3%
FFS/Indemnity Plans	6.2%	3.4%
DPOs	5.5%	3.0%
DMOs	4.7%	4.4%
Vision		
Scheduled Plans	3.7%	2.4%
R&C Plans	4.1%	2.7%

* The 2010 survey captured prescription drug carve-out data for retail and mail-order delivery channels combined.

Table 4: Selected Medical, Rx Carve-Out & Dental Trends: 2001-2010 Actual and 2011 and 2012 Projected*

	PPOs (without Rx)	POS Plans (without Rx)	HMOs (without Rx)	MA HMOs (without Rx)	Rx	DPOs
2001 Actual	14.5%	12.8%	12.1%	13.0%	17.8%	5.7%
2002 Actual	13.9%	12.2%	12.8%	12.9%	18.4%	6.4%
2003 Actual	12.0%	11.5%	11.5%	10.0%	14.3%	6.5%
2004 Actual	10.9%	11.6%	11.5%	11.4%	13.3%	6.2%
2005 Actual	10.4%	11.1%	10.6%	8.4%	10.5%	5.0%
2006 Actual	9.6%	10.0%	10.2%	7.2%	9.5%	5.1%
2007 Actual	8.9%	9.5%	9.8%	7.0%	7.9%	5.0%
2008 Actual	9.7%	9.4%	9.7%	7.7%	7.4%	5.5%
2009 Actual	9.5%	9.7%	10.2%	4.0%	7.9%	4.7%
2010 Actual	7.6%	8.3%	8.7%	3.6%	6.4%	3.0%
2011 Projected	**11.0%**	**11.2%**	**10.2%**	**7.0%**	**9.2%**	**5.5%**
2012 Projected	**10.0%**	**10.4%**	**9.6%**	**6.6%**	**7.2%**	**3.8%**

* All trends are illustrated for actives and retirees under age 65, except for the MA Plans. (A graph comparing 10 years of survey data — 2011 and 2012 projected trends to actual trends for 2003 through 2010 — is available on the following page of Sibson Consulting's website: http://www.sibson.com/publications/surveysandstudies/2012trendsurveysupplement.pdf)

(actual trends for 2001-2010 and projected trends for 2011 and 2012).

Segal also asked the survey participants to indicate the top five diagnostic categories that had the highest actual cost trends in 2010. The five, from highest to lowest, were heart disease, musculoskeletal, cancer, digestive disease and mental health conditions.

Accuracy of Projections Over Time

It should be noted that the accuracy of underwriter projections is subject to a natural lag in the underwriting cycle. In periods where costs are decelerating, forecasters will tend to overestimate trends. Similarly, when costs are accelerating, trend projections will generally be underestimated.

Accuracy of trend assumptions is best measured by comparing projected trend to actual trend over multiple years. Graphs 2 and 3 illustrate the significant but declining variances between trend forecasts versus actual trends experienced in 2006 through 2009. However, the variance in 2010 reversed that pattern, with actual trend coming in well below prior forecasts.

"Plan sponsors will need to continue to implement cost-management strategies that both mitigate increases and improve the overall health and well-being of their plan's population."

Commentary & Outlook

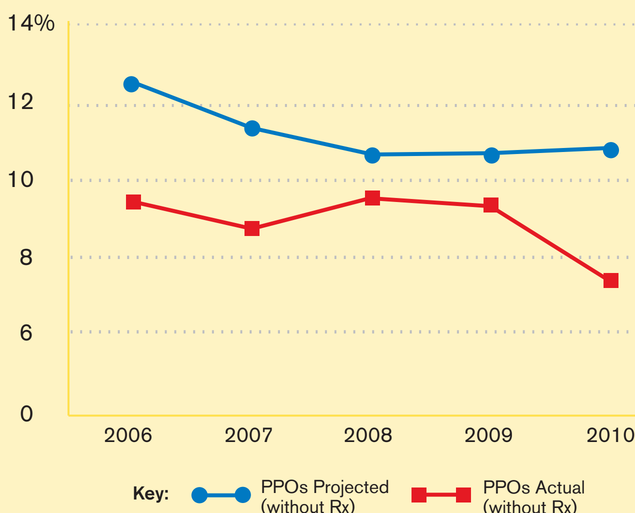
Health plan cost trends continue to move down, which is encouraging news for plan sponsors. High network utilization, stronger incentives to use more cost-effective treatments (*e.g.*, primary care providers, "physician extenders"[5] through clinics, generic drug use, outpatient imaging facilities, greater investment in wellness program engagement rates) and value-based designs[6] may be playing a role in keeping utilization rates relatively low. Some experts have suggested that the health care reform debate has created a temporary sentinel effect on health care providers to dampen price increases, contributing to the drop in trend rates. In addition, the weak economy may have also played a role in reducing utilization rates of medical treatments and services to the extent that consumers were cautious about their health care spending in light of higher health plan out-of-pocket expenses for participants. However, a reduction in utilization may be unwelcome as it could be an indication that some patients are forgoing or delaying necessary care, which could increase the frequency of more complex medical cases down the road, a development that would add to the size and volatility of a plan sponsor's future costs.

Although the rate of increase in health plan cost trends is slowing, it is important to keep in mind that those rates are still putting pressure on both private and public sector budgets. Consequently, plan sponsors will need to continue to implement cost-management strategies that both mitigate increases and improve the overall health and well-being of their

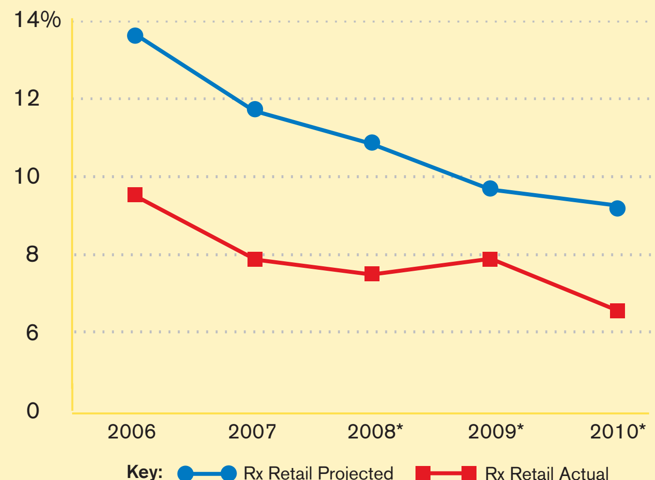
[5] Physician extenders are nurse practitioners and physician assistants.

[6] Value-based designs encourage greater use of highest value treatments, settings and providers.

Graph 2: Comparison of Projected to Actual Trends for PPOs for Actives & Retirees under Age 65: 2006-2010



Graph 3: Comparison of Projected to Actual Trends for Retail Rx Carve-Out Coverage for Actives & Retirees under Age 65: 2006-2010



* Actual trend for 2008–2010 and projected trend for 2010 reflects retail and mail-order delivery channels combined.

"Although health plan cost trends for 2012 are projected to be lower than in recent years, plan sponsors must remain vigilant in their approach to containing health plan costs."

plan's population. Key areas of focus include the following proven strategies:

- Managing provider network reimbursement increases more tightly to obtain deeper discounts,
- Making effective investments in wellness and disease management, and exploring ways to encourage plan participants to make healthier lifestyle choices,
- Introducing comprehensive value-based designs that encourage greater use of clinics and physician extenders for minor episodes and the use of generic drugs and step therapy,
- Managing imaging/diagnostic technologies more tightly,
- Undertaking data mining that focuses on high-cost conditions and atypical utilization patterns,
- Using more aggressive hospital-admission management strategies that pay for quality outcomes, reduce readmission rates and channel patients to high-quality/high-value providers by specialty, and
- Conducting aggressive, data-driven renewal negotiations.

In addition, plan sponsors may want to introduce some of the following cost-management strategies that the Affordable Care Act will eventually be implementing systematically:

- Efforts to improve patient safety and quality that have major cost-saving potential (*e.g.*, reducing hospital acquired infections and preventable readmissions to hospitals),
- New, more efficient models of care, including advanced primary care practices (a.k.a. "Medical Homes"), and
- Adopting ACOs[7] and new payment models for episodes of care and primary care physician responsibility.

Although health plan cost trends for 2012 are projected to be lower than in recent years, plan sponsors must remain vigilant in their approach to containing health plan costs. Plan sponsors should continue to play an active role in balancing the needs of plan participants and the demands of the Affordable Care Act in order to moderate escalating health costs while providing financially sustainable, high-quality health care.

For assistance with health care cost management strategies, contact your Sibson consultant or the nearest Sibson office. A list of Sibson offices can be accessed from the second hyperlink in the red box below.

[7] ACOs are defined in the footnote of the large text box on page 3.

The Survey Participants

The 2012 *Segal Health Plan Cost Trend Survey* was conducted in May and June of 2011. Survey participants were asked to provide the trend factors they will be applying to historical claims to predict expected claims for 2012. Segal received more than 90 responses to the survey. The following 82 participants agreed to disclose their names: Aetna; Altius Health Plans; Amalgamated Life; Amerihealth of New Jersey; Anthem Blue Cross and Blue Shield, Anthem Blue Cross of California; Arkansas Blue Cross and Blue Shield; Blue Cross and Blue Shield of Alabama; Blue Cross and Blue Shield of Florida; Blue Cross and Blue Shield of Kansas; Blue Cross and Blue Shield of Michigan; Blue Cross & Blue Shield of Rhode Island; Blue Shield of California; BlueCross and BlueShield of Tennessee; Benecard; BeneCare Dental Plans; CareFirst BlueCross BlueShield and CareFirst Blue Shield, Inc.; Care-Plus Dental Plans, Inc.; Catalyst Rx; CDPHP; CIGNA; ConnectiCare, Inc.; CVS Caremark; Delta Dental Plan Association member companies in the following states: Alabama, Arizona, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, West Virginia, Wisconsin and Utah; Employers Dental Services; Excellus Health Plan, Inc.; Express Scripts, Inc.; Group Health Cooperative; Group Health Incorporated (GHI); Health Alliance Medical Plans; Health Net, Inc.; HealthTrans LLC; Horizon Blue Cross Blue Shield of New Jersey; Humana, Inc.; informedRx; an SXC Health Solutions, Inc. company; ING; Kaiser Foundation Health Plan; Medco Health Solutions, Inc.; Medica; Medical Excess, Inc.; Medical Mutual of Ohio; MedImpact HealthCare Systems, Inc.; MetLife; MVP Health Care; Nippon Life Insurance Company of America; Prescription Solutions, Inc.; Security Health Plan of Wisconsin, Inc.; The ODS Companies; Trustmark Group Insurance; UnitedHealthcare; and US Script.

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