

What Are the Projected Health Plan Cost Trends for 2025?

Survey Finds Double-Digit Projected Rx Trends





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Introduction

The 2025 *Segal Health Plan Cost Trend Survey*, our 28th annual survey of managed care organizations, health insurers, PBMs and TPAs, shares respondents' 2025 trend projections for medical, prescription drug, dental and vision coverage. It also reports on drivers of cost increases and actual allowed health cost trends for 2023 based on respondents' group health plan experience.

We conducted the survey during the summer of 2024. Collectively, the [survey respondents](#) represent more than 80 percent of the commercially insured and self-insured market.

In addition, we present other data on historic trends, including from our health data warehouse, SHAPE (Segal's Health Analysis of Plan Experience) and note strategies plan sponsors can use to monitor and manage their cost trends over time.

It is vital for plan sponsors to monitor their actual health plan claims regularly to identify unanticipated cost drivers. Plan sponsors in industries facing tight labor market conditions may be reluctant to pass on cost increases to participants. Effective cost-management strategies can help maintain reasonable trends and avoid having to require participants to share the burden of higher costs.



Key Findings

For 2025, the highest projected rate of increase for all health benefit plan cost trends is for outpatient prescription drugs: 11.4 percent, up from the projection for 2024. Medical plan cost trends are projected to increase at median levels of 8 percent, which are higher than the prior year's forecast.

Other key 2025 trend projections include:

- Survey respondents project the per-person cost trend for open-access PPO/POS plans to be 7.9 percent.
- Specialty drug trend is projected to be 13.3 percent. Drivers of projected specialty drug trend are primarily due to utilization of new high-cost specialty drugs replacing lower-cost therapies. Trend attributable to utilization is forecast to be 7.8 percent, accounting for almost 60 percent of the specialty drug gross cost trend increase before rebates.
- Unit cost, including factors like price inflation, is still the primary driver for inpatient hospital trends.
- Plan sponsor focus has shifted dramatically to cost- and quality-management strategies related to prescription drugs and weight loss-treatments specifically, which now account for four of the top five cost-management strategies.
- Trend projections for dental provider organizations (DPO) are 4.5 percent.
- Projected vision trend is 3.0 percent for reasonable and customary (R&C) plans.
- While the projected medical trend for Medicare-eligible retirees with Medicare Advantage (MA) PPO plans is 4.9 percent, the projected Medicare Part D trend is 8.9 percent.





What Is Trend?

Health plan cost trend is the measure 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 considers various factors, including:

- New treatments, therapies and technologies
- Greater emphasis on detection and diagnoses
- Medical inflation, which impacts the cost of delivering care
- Provider consolidation
- Increased treatment burden due to the aging population and rise in obesity
- Social and economic factors, which can influence utilization or care decisions
- Regulatory changes (e.g., related to the No Surprises Act and the Inflation Reduction Act)
- 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
- Participation in disease-management programs and wellness initiatives
- Regional market competition
- Changes in plan design
- Administrative fees
- Changes in participant contributions
- Impact of contract renegotiations or vendor changes

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 allowed per capita claims cost increases.

** We discuss rebates on [page 8](#).



Projected Medical Plan Trends and Cost Drivers

Several factors are driving medical cost increases in 2025, including:

- **Medical price inflation.** In mid-2024, medical price inflation picked up and once again exceeded the growth of prices for non-medical goods and services. Inflationary pressure has led to higher contracting reimbursement rates.
- **Consolidation.** In addition to general economic inflation, greater industry consolidation of hospital and medical practices is driving rising healthcare prices. Private equity ownership in healthcare has also [grown](#) significantly and is associated with [increased spending](#) in acquired hospital and physician practices.
- **Workforce shortages.** Ongoing clinical workforce shortages are expected to contribute to financial challenges for hospitals, leading them to seek higher reimbursement rates from payers during contract negotiations.
- **Rising rates of chronic conditions.** The increasing prevalence and cost of managing chronic conditions contribute to overall healthcare spending, including conditions such as cancer, cardiovascular disease, diabetes, musculoskeletal conditions and obesity.
- **Demand for mental health and substance use disorder services.** Utilization continues to increase, partly due to expanded treatment options available to participants.
- **Higher-cost treatments due to advances in new treatments and technologies.** This includes gene therapy, advances in cancer care and transplant procedures. The gene therapy pipeline is dynamic and continues to expand with a focus on addressing a wide range of diseases and conditions.

Deflators of trend partially offsetting these increases include:

- Shifting of utilization to lower-cost sites for acute-care services
- More effective or lower-cost treatment alternatives
- Health navigation services that steer participants to high-quality, lower-cost providers
- Alternative payment contracting arrangements

Medical Plans Covered in the Survey

Three categories of active and early retiree coverage are tracked in the survey:



PPO/POS Plans

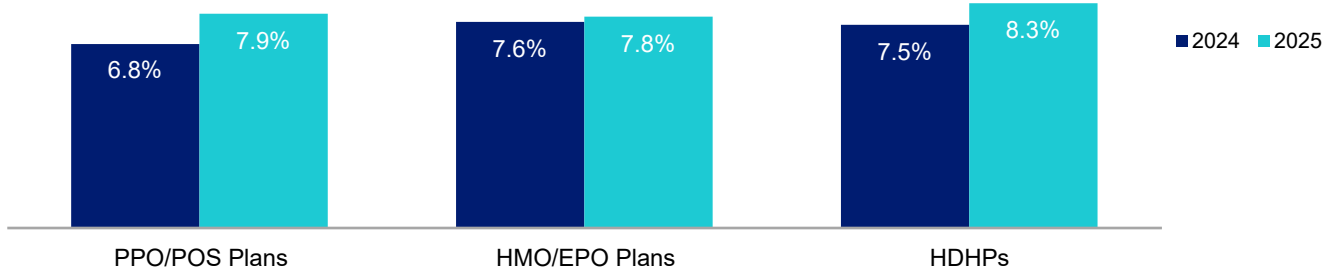


HMO/EPO Plans



HDHPs

Medical Trend Projections* for 2025 Are Higher than 2024 Projections.



* Projections are for actives and non-Medicare retirees and exclude prescription drugs.

Source: 2025 Segal Health Plan Cost Trend Survey

How the cost of provider services is driving projected medical trends

Medical trends are driven by price increases across site of setting.

Hospital Price Inflation Is a Much Larger Driver than Physician Services of 2025 Projected Medical Trends



*"Hospital services" includes inpatient and outpatient hospital services combined.

Source: 2025 Segal Health Plan Cost Trend Survey

Projected Prescription Drug Plan Trends and Cost Drivers

Rx plan cost trend forecasts continue to exceed other health benefit cost trends. Projected cost trend for outpatient Rx plans for 2025 is 11.4 percent. Outpatient prescription drug coverage, which is typically administered by PBMs, include generics, brand-name drugs, biosimilars and specialty drugs dispensed through retail, mail-order and specialty-management pharmacy channels. Generally, there's an exclusion for drugs administered in a facility or physician office setting because of coverage through a medical plan.

Outpatient Rx cost increase is being driven by the following factors:

- **Drug product price inflation with many drug prices rising faster than inflation.** New product launches are expected to have notably higher prices in response to price controls set forth by the Inflation Reduction Act. With the implementation of the Inflation Reduction Act and its rebate provisions for Medicare, there may be increased attention on rebates in the commercial market as well. Drug manufacturers are required to pay rebates to Medicare if they raise prices for certain drugs faster than the rate of inflation. Manufacturers and payers may look to adjust their rebate strategies, including increasing launch price for new drugs, in response to the changing landscape.
- **Changing drug mix.** More effective and expensive new drug therapies than previous treatments and expanded use of existing products, such as diabetes and obesity drug treatments with the Glucagon-like peptide-1 (GLP-1) receptor agonist mechanism. These have dramatically increased utilization and continue to be a top cost for plans providing this coverage.
- **Relentless direct-to-consumer advertising.** It increases demand for drug treatments, as studies, like this one by the [Johns Hopkins Bloomberg School of Public Health](#), have found.
- **Drug supply shortages in several classes, including cancer, ADHD and GLP-1s.** The [FDA](#) currently lists over 100 medications in shortage. Drug supply shortage can result in increase in price of available drugs, the use of an alternative with possibly more side effects, more costly treatment and delays in treatment, compromising patient care.
- **Specialty drugs/biologics, accounting for over half of drug spending.** Given the lack of a standard definition for specialty drugs, PBMs often re-classify drugs so they can steer prescriptions that would trigger exclusivity provisions requiring use of the PBM's affiliated specialty pharmacy. Exclusive-distribution contracts artificially restrict competition and increase pharmaceutical companies' ability to increase pricing.



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 viruses or 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 "highly similar" to another biologic medication (commonly known as the reference or innovator product), which is already licensed by the FDA.

Factors that offset increases include:

- Greater availability and adoption of biosimilars
- Patent expiration
- Utilization management (UM)
- Channel management

Increasingly, plan sponsors are also carving out specialty drugs out of the medical plan that can be administered in a physician's office or at home. Coverage of these drugs under outpatient Rx programs can achieve deeper discounts, provide access to rebates and reduce total health plan costs. Plans will need to consider both the potential savings opportunity and non-financial considerations (e.g., disruptive patient/provider experience) to determine appropriate drugs/classes to carve out.

Another factor offsetting trend is marketplace disruptors. Over the past few years, disruptors to traditional mail order pharmacies have offered competitive, transparent models. See Segal's [Q1 2024 Trends](#) for more on the evolving prescription drugs pricing landscape, including a discussion of the Mark Cuban Cost Plus Drug Company.

Prescription Drug Trend Is Projected to Reach Double Digits for Outpatient Rx Coverage with Specialty Drugs a Significant Driver



* Outpatient Rx trend is for all prescription drugs (non-specialty and specialty drugs combined) for employer-sponsored plans for actives and non-Medicare retirees.
** Specialty drug/biologics trend is for outpatient specialty coverage. This data is for all coverage of specialty drugs for actives and non-Medicare retirees.

Source: 2025 Segal Health Plan Cost Trend Survey





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.

Rebates

Prescription drug plan cost trends in our analysis exclude the impact of rebates. Rebates significantly impact drug prices for both specialty and non-specialty drugs. Survey participants that reported the impact of prescription drug rebates had an average spread between gross and net trends of 3.2 percentage points. The median rebates paid to plan sponsors represented 33 percent of projected prescription drug allowed costs in 2025. However, the range of rebate allocation for prescription drugs can vary dramatically based on a plan sponsor's PBM and drug formulary adopted.

The presence and magnitude of drug rebates on brand-name drugs in competitive therapeutic classes have become major elements of pharmacy benefit contracting. They are a substantial component of evaluating plan costs. However, drug rebate programs may promote use of high-cost brand drugs, through formulary placement, even when lower-cost generic equivalents are often available. PBMs may also be receiving additional rebates, also known as incentive rebates, from drug manufacturers to that are tied to market share or other sales targets and reclassifying the additional rebates to other areas, such as administrative, clinical or data management. Some PBMs have established separate, affiliated entities referred to as group purchasing organizations (GPOs) or rebate aggregators. While PBM GPOs were formed to provide greater bargaining leverage on behalf of plan sponsors, they have imposed new fees on drug manufacturers through these arrangements. These rebate aggregators are not contractually obligated to share these new fees with plan sponsors.

Specific impact of rebates on prescription drug trends for commercial plans in 2025 will depend on various factors, including market dynamics, policy changes and individual PBM strategies. This includes rebate contract language that PBMs are using due to the Humira® biosimilars that have come to market. Plan sponsors should evaluate rebates and ask how their PBM is managing the formulary to the lowest net cost. Efforts in Congress to ban rebates have made little progress. The secret world of rebates prevents plan sponsors from making full head-to-head price comparisons. Until we can see drug-specific rebates by individual drug, plan sponsors will be unable to make fully informed plan coverage decisions for their prescription drug plans.

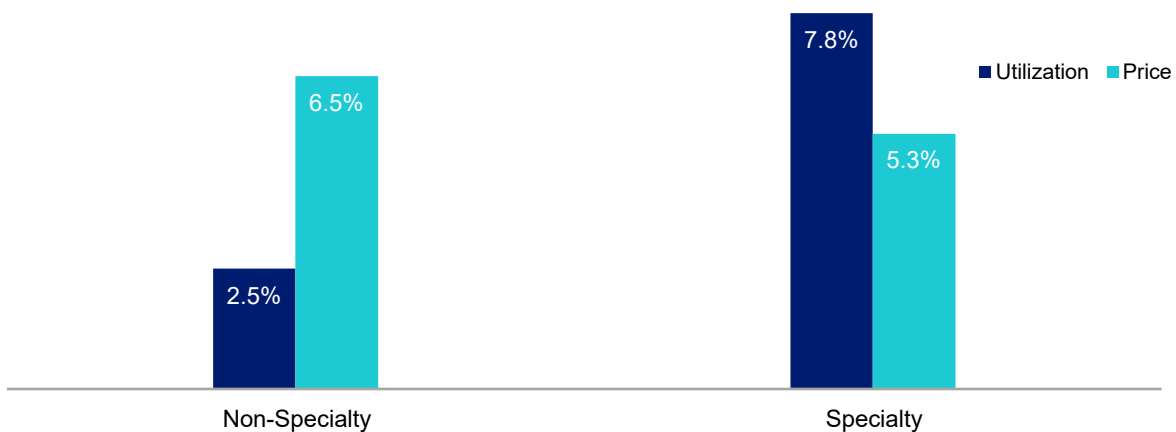
The leading driver of Rx trend is drug mix

The leading driver of overall projected Rx trend is drug mix, including higher-cost, single-sourced brand drugs and shifts to higher-cost treatments. The pipeline of costly new therapies, both specialty and non-specialty medications, replacing lower-cost therapies plays a major role. Non-specialty drug utilization has remained relatively modest at levels of 2.5 percent, whereas specialty drug utilization is forecast to increase 7.8 percent in 2025.

Non-specialty drugs saw growth in new costly therapies, including for diabetes and anti-obesity drugs as well as for prevalent disease conditions, such as migraines and skin disorders. GLP-1 medications are currently recommended or approved for both type 2 diabetics with atherosclerotic cardiovascular disease (ASCVD) and in individuals who are obese or overweight with comorbidities and a history of CVD to reduce the risk of severe CV events. Studies are underway to expand these CV-risk-reduction indications to non-weight loss versions of GLP-1 medications, which could increase utilization further. Over the past several years, the percentage of plan spending on GLP-1s has increased faster than the drugs with largest per-member per-month (PMPM) increase.

Utilization of high-cost new specialty drugs replacing lower-cost therapies is a primary driver of projected specialty drug trend. Utilization changes account for over 60 percent of the gross cost trend increase before rebates. While price increases of existing specialty drugs are also a driver of trend, growth in utilization is being fueled by newly launched drugs, expanded indications of high-cost drugs and reclassification of non-specialty drugs into the specialty class. Reclassification of drugs as specialty by PBMs can be utilized to steer specialty prescriptions to PBM-affiliated pharmacies and may result in a change to rebates based on contract. However, the number of biosimilars entering the market is expected to offset some of the rising specialty costs. In the PBM space, there is a lot of movement towards driving to the Humira biosimilars.

Specialty Drug Trend Driven by Utilization of High-Cost New Drugs Replacing Low-Cost Therapies*



* This data is for actives and non-Medicare retirees. The components do not add up to totals because there are other components of trend not illustrated, reflecting such factors as the impact of mandates, 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 7](#).

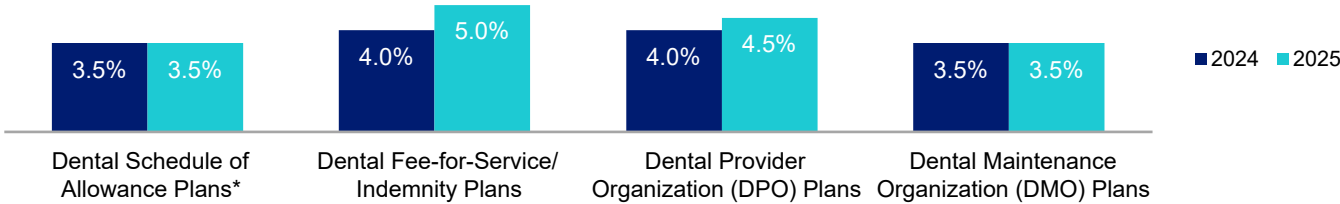
Source: 2025 Segal Health Plan Cost Trend Survey



Projected Dental Trends

Projected dental trends are slightly higher for 2025 than they were for 2024. Factors behind the increases include increasing cost of dental materials and equipment, lab and labor costs. There is also growing prevalence of oral and dental disorders and advancements in dental treatments contributing to the number of visits. Some advances in dentistry have promise for reducing cost, including using artificial intelligence (AI) for more efficient and accurate diagnosis, treatment and follow-up care.

2025 Trend Projections for Dental Coverages Are Slightly Higher than 2024 Levels for Fee-for-Service/ Indemnity Plans and DPO Plans and Are Unchanged for Scheduled and DMO Plans



* 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: 2025 Segal Health Plan Cost Trend Survey

Projected Vision Trends

Projected cost trend for R&C vision plans are 0.2 of a percentage point higher than the 2024 projection. The projected cost trend for vision schedule of allowance plans is unchanged.

A [study](#) from The Harris Poll and XP Health found that 95 percent of people say vision benefits are valuable, but half never use them to meet their care needs. Vision benefits can facilitate early intervention of medical-related issues and help save on medical claim costs.

Innovative approaches to vision benefit plans are evolving to meet the diverse needs of employees. Many vision policies now include coverage of smart glasses, which offer vision correction along with digital capabilities, and advanced contact lenses, which adjust to light conditions.

Vision insurance plans are also becoming more customizable, allowing individuals to choose coverage that aligns with their specific needs, such as more frequent eye exams or higher allowances for eyewear.

2025 Trend Projection for Vision R&C Plans Fairly Consistent with 2024 Projection

■ 2024 ■ 2025



Source: 2025 Segal Health Plan Cost Trend Survey





Projected Medical Trends for Medicare-Eligible Retirees

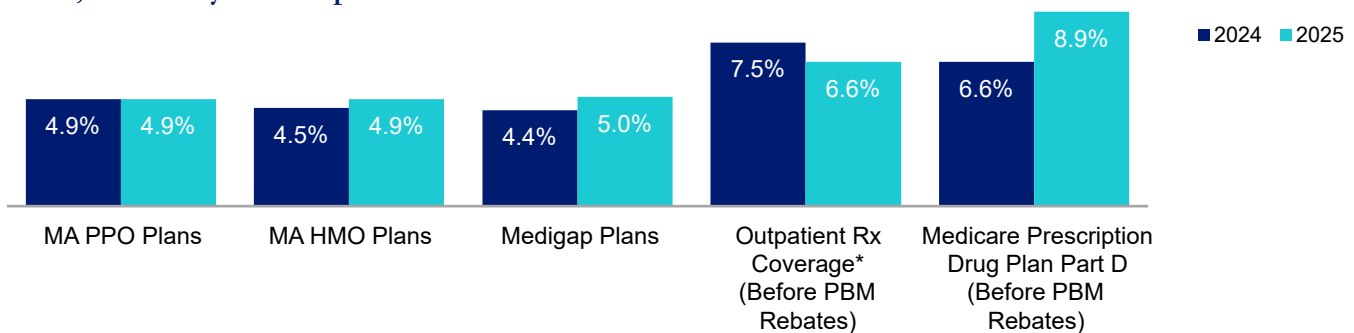
The 2025 projected Medicare Part D cost trend for Medicare-eligible retirees is significantly higher than the 2024 projection. For Medicare Advantage (MA) HMO plans and medigap plans, the cost trend projections are slightly higher. The projected trend for MA PPO plans is unchanged. However, recent Medicare Advantage prescription drug plan renewals from insurers are coming in at alarmingly high rates for group plan sponsors, well above survey projections for 2025. These early rate renewals suggest the Medicare Advantage market is going through substantial changes as a result of changes in payments by Centers for Medicare & Medicaid Services (CMS).

The Inflation Reduction Act enacted significant changes to the Medicare prescription drug program. While some changes took effect in 2023 and 2024, the majority are effective in 2025. The law makes significant changes to Medicare coverage: Medicare will negotiate prices for certain prescription drugs, Medicare will receive inflation rebates from manufacturers, the Part D design changes significantly and there is additional coverage for vaccines and insulin. For additional information on what's changing and the impact on Employer Group Waiver Plans (EGWPs) and plans that take advantage of the Retiree Drug Subsidy (RDS), see our [February 20, 2024 insight](#) and [March 19, 2024](#) webinar recording.

The economics between Medicare Advantage Prescription Drug Plans, EGWPs, the RDS and traditional Medicare continue to evolve. Plan sponsors will need to take a close look to ensure that they know about the Inflation Reduction Act changes and are offering the most cost-effective benefit to plan retirees.

Manufacturers taking revenue reductions under Medicare will likely find ways to make up for revenue. This could come in the form of raising pricing on product lines for commercial employer-sponsored health plans or turning off rebates.

2025 Projected Medicare Part D Trend for Medicare-Eligible Retirees Significantly Higher than 2024, Driven by IRA Impact



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

Source: 2025 Segal Health Plan Cost Trend Survey

Putting Trend Projections in Context

It is always important to put projections into proper context. It is difficult to anticipate the impact of macroeconomic issues, such as inflation, staffing shortages, wage pressure and the regulatory landscape. 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 on 2025 cost trend projections to their benefit programs.

Rx cost trends in 2023 were impacted by growing demand for GLP-1 drugs used for diabetes and obesity

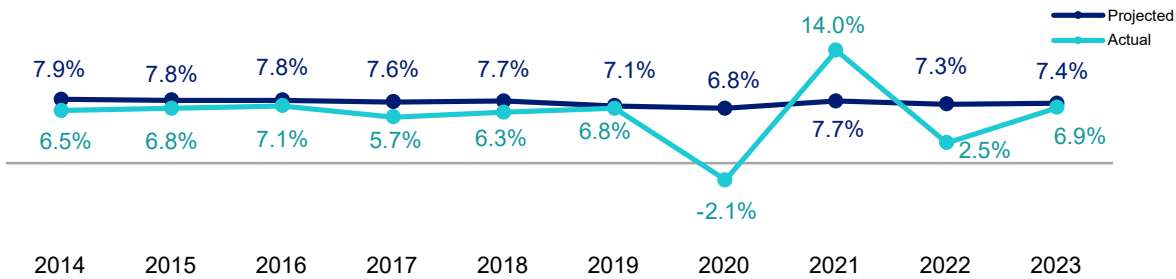
To assess the accuracy of trend projections, we compared 2023 projected trends for medical, Rx and dental plans to the actual average trends for 2023 (the most recent period for which actual data is available), as reported by the survey respondents.



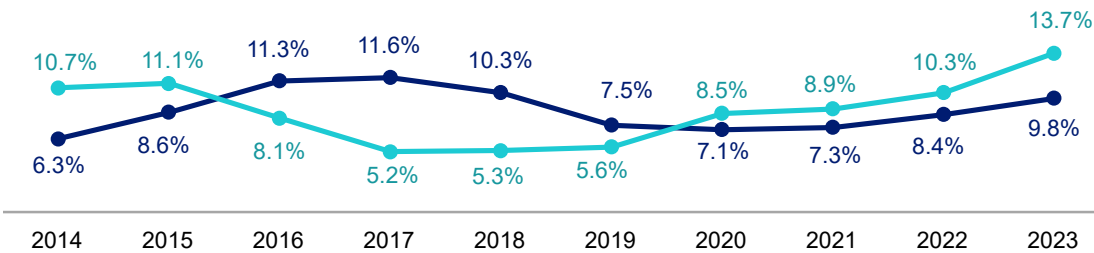
The graphs below illustrate comparative data from our last 10 surveys for three types of coverage for actives and non-Medicare retirees. While COVID-19 played a huge role in the variability of cost trends beginning in 2020, 2023 trends are back to typical levels.

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

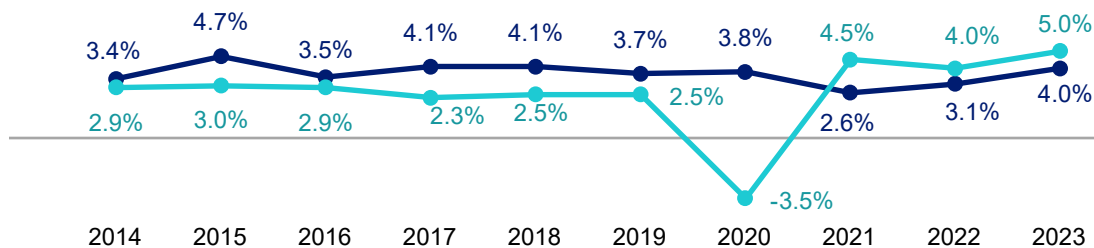
Historical Survey Data on Selected Medical Trends Shows Projected Trends Consistent with Pre-Pandemic Levels¹



Actual Rx Trends Reached Double-Digit Levels in Both 2022 and 2023, Far Exceeding Projected Trends for Those Years²



2023 Actual Dental PPO Plan Trend Higher than Both 2022 Actual and 2023 Projected



¹ All medical trend results exclude Rx.

² 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: 2016-2025 Segal Health Plan Cost Trend Survey

Historical Survey Data on Selected Medical¹ and Outpatient Rx² Trends Shows Projected Trends Consistent with Pre-Pandemic Levels of Actual Trends³

	Year	PPOs/POS Plans	HMO/EPO Plans	MA HMO Plans	Outpatient Rx Plans	DPO Plans
Actual	2011	7.5%	8.0%	4.5%	5.0%	3.1%
	2012	7.3%	6.7%	3.0%	5.5%	2.6%
	2013	5.7%	6.1%	3.1%	5.5%	2.8%
	2014	6.5%	6.3%	1.9%	10.7%	2.9%
	2015	6.8%	6.4%	4.2%	11.1%	3.0%
	2016	7.1%	6.3%	5.3%	8.1%	2.9%
	2017	5.7%	6.6%	1.8%	5.2%	2.3%
	2018	6.3%	6.0%	4.1%	5.3%	2.5%
	2019	6.8%	6.6%	2.2%	5.6%	2.5%
	2020	-2.1%	0.8%	-4.1%	8.5%	-3.5%
	2021	14.0%	13.3%	9.1%	8.9%	4.5%
	2022	2.5%	3.2%	3.0%	10.3%	4.0%
	2023	6.9%	6.8%	6.0%	13.7%	5.0%
Projected	2024	6.8%	7.6%	4.5%	9.9%	4.0%
	2025	7.9%	7.8%	4.9%	11.4%	4.5%

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 non-Medicare retirees, except for the MA HMOs. (Graphs comparing 15 years of survey data — 2011 through 2023 actual trends and 2024 and 2025 projected trends — and showing actual annual trend by coverage type for the last five years [are available.](#))

Source: 2013–2025 Segal Health Plan Cost Trend Survey

Top Health Plan Cost-Management Strategies in 2024

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 2024. The chart below compares the top five strategies being used today to last year's rankings. Only one strategy, adopt custom or narrow drug formulary, made both lists.

Four of the 2024 Top Five Health Plan Cost-Management Strategies Are Focused on Prescription Drugs

2024 Top Five

1 Implement strategies to address anti-diabetic GLP-1 medications (e.g., limits, step therapies, preauthorization)

2 Implement strategies to address anti-obesity medications for GLP-1 coverage (e.g., limits, step therapies, lifestyle modification, no coverage)

3 Control specialty drug mix through use of biosimilar strategies (e.g., lowest net cost, mandatory biosimilars for new patients)

4 Adopt custom or narrow drug formulary

5 Implement digital health coaching for behavioral health issues, diabetes, hypertension, etc.

2023 Top Five

1 Adopt a high-deductible health plan (HDHP)

2 Use healthcare navigator or health advocate service

3 Promote use of wellness program (e.g., offering financial incentives)

4 Adopt custom or narrow drug formulary

5 Implement virtual physical consultation for primary care

Source: 2024 & 2025 Segal Health Plan Cost Trend Survey

Given that the expected increase in prescription drug costs, particularly for GLP-1 medications, will significantly impact plan sponsors and their budgeting for 2025, it comes as no surprise that the top four strategies are focused on prescription drug cost management.

Based on our work with health plans, we know that various other Rx cost-management strategies, such as implementing pre-authorization, quantity limits, step therapy, reauthorization and lifestyle-modification approaches are being considered to reduce long-term cost implications and ensure the right medication reaches the patient at the right time for a positive response to therapy.

Ranked at number three is controlling specialty drug mix through use of biosimilar strategies. Several biosimilars to Humira biosimilars are now available, including interchangeable products. As manufactures get more aggressive in pricing to gain formulary placement, plan sponsors should evaluate lowest net cost options available from their PBM to ensure they are controlling costs.

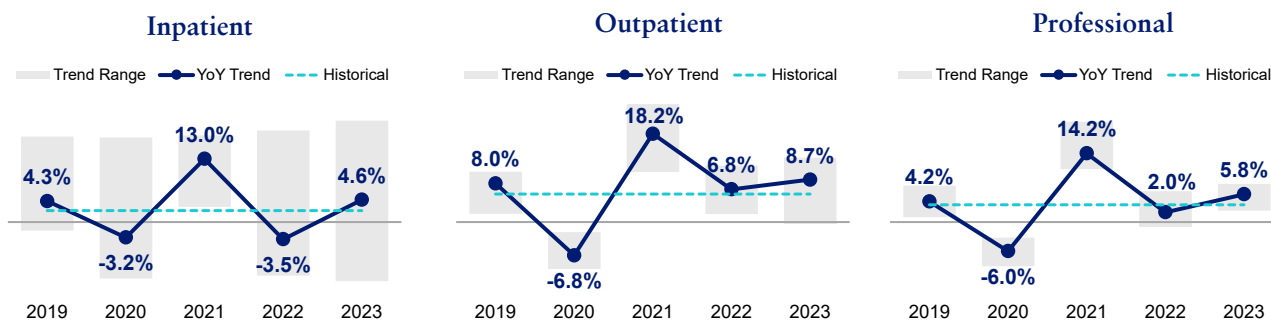
Insights into Actual Medical and Prescription Drug Trends

Segal's SHAPE data warehouse is a repository of detailed medical and prescription drug claims data that provides insights into the drivers of healthcare costs and the quality of care participants are receiving.

Actual medical trends by site of service

Segal's SHAPE data warehouse found medical trend was 6.0 percent in 2023 and primarily driven by outpatient hospital expenses for most plans.

Outpatient Care Is a Greater Driver of Medical Trend than Care Received at Other Sites



Source: Segal's SHAPE data warehouse, 2019–2023

As hospital price increases continue to be a leading cost driver of trend, several factors are playing a role in shifting care to outpatient sites:

- **Coverage choices made by the CMS.** CMS has been a primary driver of treatment shift by removing certain orthopedic and cardiac procedures from its inpatient-only list.
- **Surgical care.** Advances in technology have enabled some surgeries that are typically performed in an inpatient setting to be moved to an outpatient setting, including ambulatory surgery centers.
- **Lower-level sites of care for infusions.** Hospital-administered pharmaceutical treatments, particularly related to cancer treatments, are being directed to lower levels of care that are clinically appropriate, such as at outpatient facilities and physician offices.
- **Reimbursement changes.** Insurers continue to incentivize providers when they perform expensive outpatient care.
- **Home-based care.** Many hospitals and healthcare systems are providing services in patients' homes, where they can recover better and experience lower infection risks at a lower cost. There's also been a rise in home infusion therapy, due to patient demand, specialty drug availability and workforce shortages.

As these shifts occur, hospitals will look for ways to improve their bottom line. One avenue is through hybrid ER-urgent care facilities, where some hospitals are partnering with private equity-backed firms to combine emergency and urgent care. Through this model there is the ability to raise hospital profits by attracting patients, increasing diagnostic testing and referrals for specialists or inpatient care.

In addition to shifting care from hospital inpatient to outpatient, other site-of-service shifts include physician visits to urgent care centers, retail clinics or digital platforms. These other settings have expanded significantly in the past few years to serve the many patients who do not have a relationship with a primary care provider.

The [Hospital Price Transparency Rule](#) and [Transparency in Coverage Rule \(TiC\)](#) have had minimal impact on trends. There continue to be challenges accessing large volumes of data and issues related to data integrity. Additionally, consumer utilization of price transparency has been historically low, due the complexity of effectively using price data and the inconvenience to change behavior. While enhancements to hospital price transparency and TiC reporting requirements are expected to occur in the future, [states are beginning to impose their own price transparency requirements](#) on hospitals and insurers to improve transparency.

While the No Surprises Act is not anticipated to impact trend increases significantly in 2025, a [report](#) found most payment determinations were in favor of providers. While the median amount accepted by payers was typically the in-network rate (e.g., 100 percent of the qualifying payment amount), when providers won, it was 322 percent of the qualifying payment amount. Additionally, in the second quarter of 2023, four firms, backed by private equity, accounted for two-thirds of all cases. This current determination rate could result in higher in-network provider rate negotiations in the future.



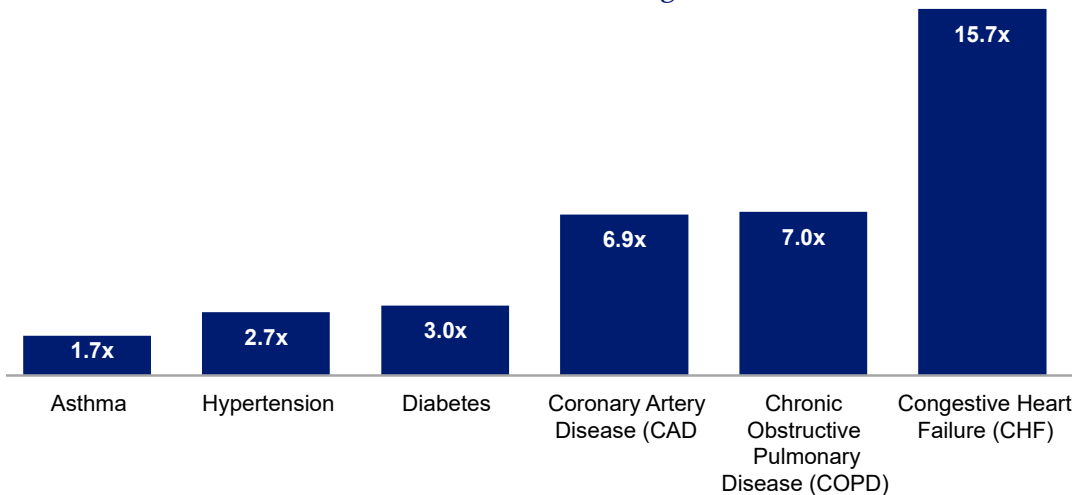


High-cost claimants

When reviewing trend, it's important to understand the potential impact of high-cost events (defined as individual claimants with \$100,000 or more in annual claim costs). According to Segal's SHAPE data warehouse, from 2019 to 2023, the top 1 percent of medical claims — high-cost claimants (HCCs) — have consistently represented approximately one-third of all medical expenses with one exception: 2020.

Over 70 percent of HCCs have one or more of the six chronic conditions noted in the graph. People with CHF are 15.7 times more likely to have an HCC than the general population.

Six Chronic Conditions Are Risk Factors for Being an HCC



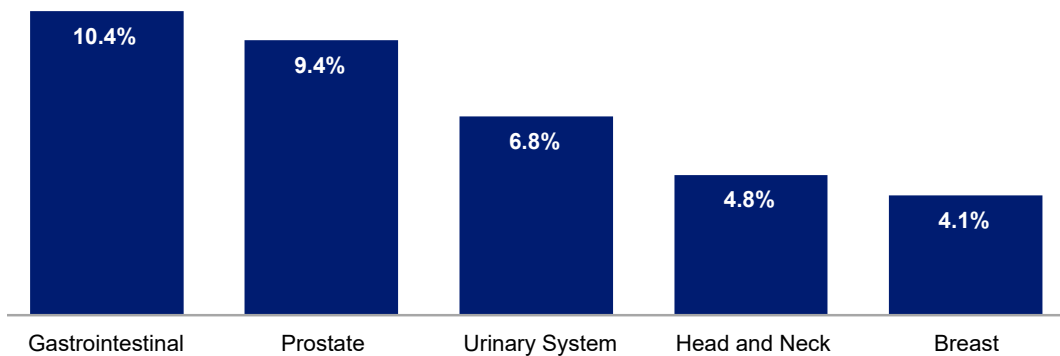
Source: Segal's SHAPE data warehouse

Several factors can contribute to high-cost events and could put upward pressure on spending, including an aging population, increased prevalence of chronic conditions, costly new technology and treatments such as gene therapies. Some of these factors may result in high cost in the near term, with the potential of creating longer-term savings. Consequently, effective strategies for predicting, preventing and managing HCCs have become increasingly important for plan sponsors.

Cancer care

For most plan sponsors, cancer is the number one disease category for healthcare cost spending. In 2023, increases in prescription drug costs related to cancer were five times more costly than that of medical treatment for cancer, driven by new therapies for advanced cancers and recent drug launches. Gastrointestinal cancers, linked to cigarette smoking, alcohol consumption, unhealthy diet and obesity were ranked the highest cost driver.

Five Cancer Types Are Driving Cancer-Related Costs



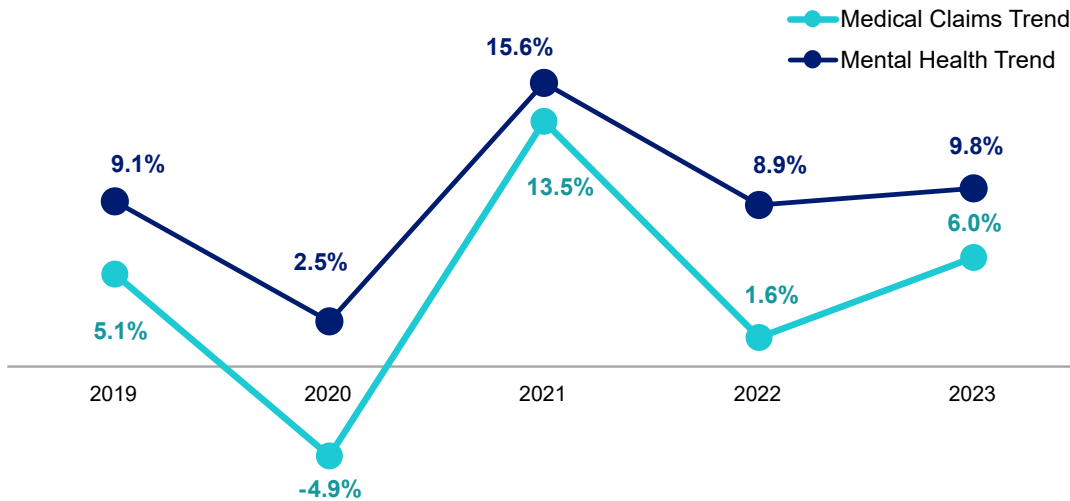
Source: Segal's SHAPE data warehouse, 2023



Mental health services

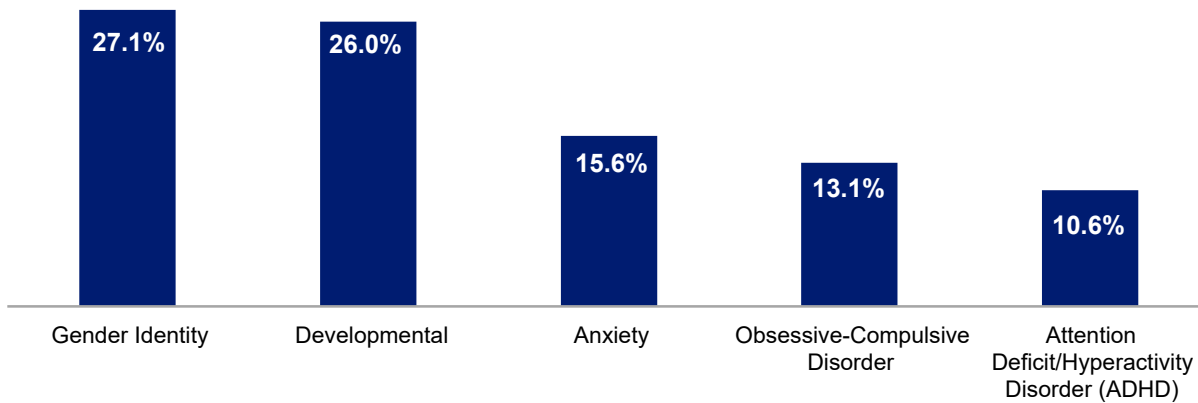
According to Segal's SHAPE data warehouse, mental health trend is increasing faster than general medical trend. That increase is being driven by utilization, as stigmas for treatment lessen, behavioral health networks improve and treatment infrastructure expands. Additionally, the impact of mental health co-occurring with other conditions can increase costs, especially for HHCs.

Treatment of Mental Health — the Largest Cost Driver During the Pandemic (Aside from COVID-19), When the Percent of Participants Seeking Mental Health Treatment Increased — Was Still a Major Cost Driver in 2023



Source: Segal's SHAPE data warehouse, 2019—2023

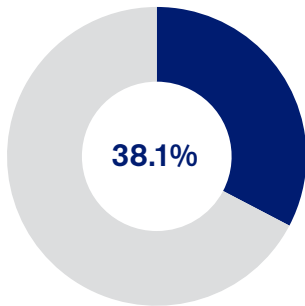
Five Conditions Are the Main Drivers of Mental Health Cost Trends



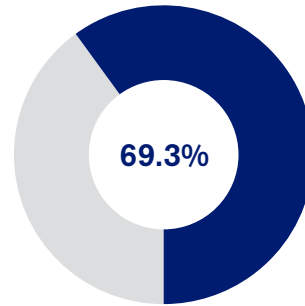
Source: Segal's SHAPE data warehouse, 2019—2023



Percent of All Mental Health-Related Visits Done Virtually



Percent of All Virtual Visits that Are Related to Mental Health

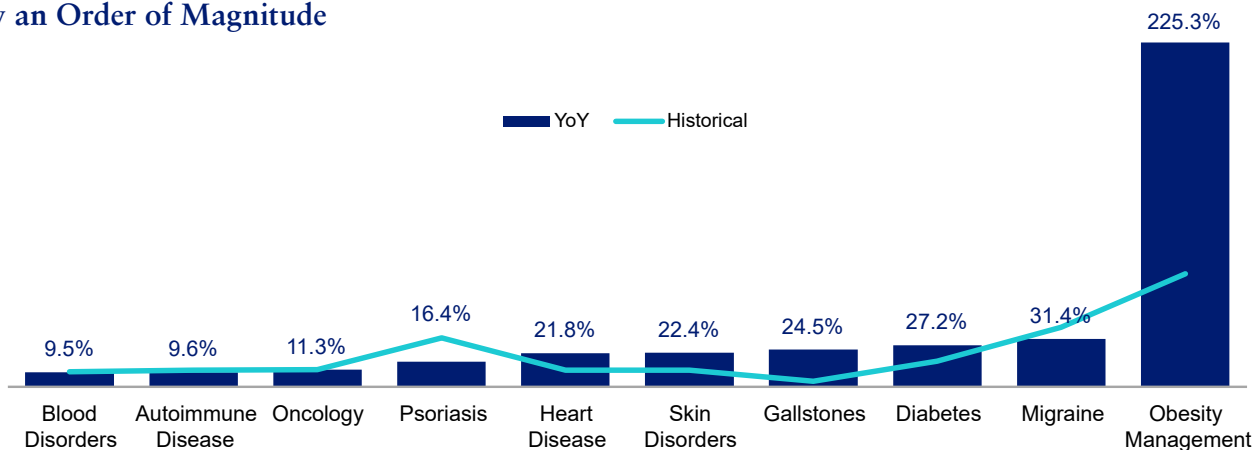


Source: Segal's SHAPE data warehouse, 2019–2023

Obesity management is the top driver of medical trend

Obesity management had the highest trend of all disease classes, with an increase in PMPMs of 225.3 percent in 2023 for plans that cover this disease indication. Migraine medications have the second highest year-over-year trend rates. When setting prescription drug trend rates, it is important to understand which disease classes are driving trend and the underlying prevalence of each disease within a plan sponsor's population.

Obesity Management Leads the Top 10 List of Medical Conditions Driving Medical Trend by an Order of Magnitude

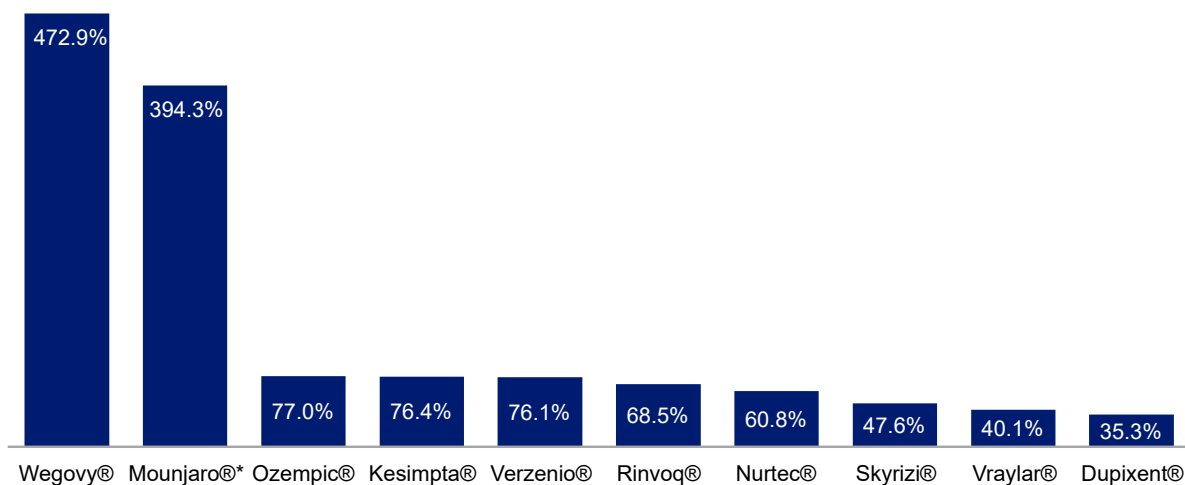


Source: Segal's SHAPE data warehouse, 2019–2023

Primary drivers of prescription drug trend

The top drugs driving trend are all GLP-1s (Wegovy®, Mounjaro®, Ozempic®). Wegovy®, which was approved in 2021 for obesity management and was the first drug to enter the market in this class since 2014, experienced the highest year-over-year trend rate of 472.9 percent.

Drugs for Treating Diabetes and Weight Loss Are the Main Drivers of Rx Trend



* Mounjaro was FDA-approved in May 2022.

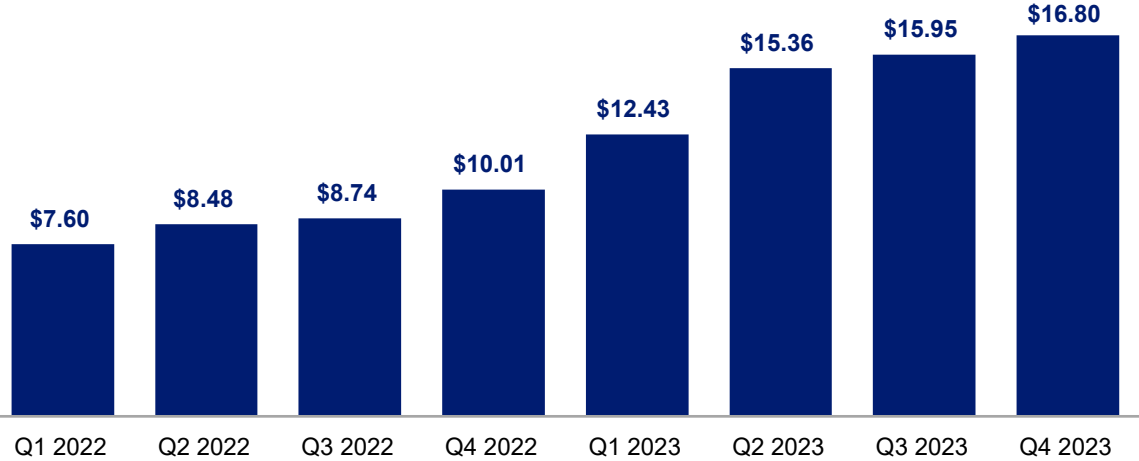
Source: Segal's SHAPE data warehouse, 2022–2023

GLP-1 medications and weight loss

Diabetes and obesity therapies have seen a significant cost increase, driven by GLP-1s used for both treatment of diabetes and obesity due to their efficacy in promoting significant weight loss. The market for GLP-1s continues to expand, with several medications currently approved for diabetes and weight loss. There are also a number of [oral weight loss drugs using similar or different hormones in the pipeline](#). Dosing convenience can greatly improve patient compliance, with companies developing once-monthly injections and oral formulations.

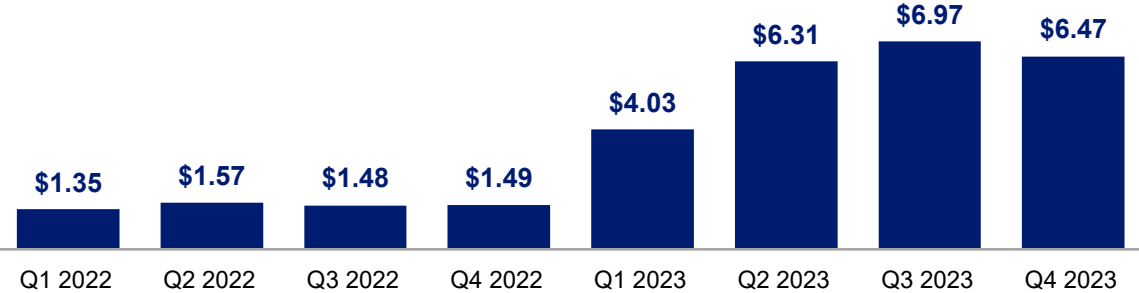
Wegovy, originally approved as an anti-obesity treatment, obtained FDA approval in March 2024 for cardiovascular risk reduction in individuals with obesity or who were overweight as well and now is covered under Medicare due to the approval of this new indication. (Medicare does not currently cover Wegovy and other medications when used specifically for obesity.) This expanded indication paves the way for commercial payers who are considering coverage. Manufacturers are performing studies for similar cardiovascular risk reduction unrelated to obesity, which could further increase the number of eligible patients. Recent trials and off-label use suggest benefits in areas such as chronic kidney disease, alcohol use disorder, neurological disorders (Alzheimer's disease, dementia and Parkinson's disease) and polycystic ovary syndrome.

The Gross Allowed Cost PMPM for Anti-Diabetic GLP-1s (e.g., Mounjaro, Ozempic and Rybelus) Increased 125% from the First Quarter of 2022 to the Fourth Quarter of 2023



Source: Segal's SHAPE data warehouse, 2022–2023

The Gross Allowed Cost PMPM for Anti-Obesity GLP-1s (e.g., Saxenda and Wegovy), Increased Almost Four Times from the Fourth Quarter of 2022 to the Fourth Quarter of 2023*



* ZepboundT[®], the anti-obesity version of Mounjaro, is not included in these figures because it was not approved until late 2023.

Source: Segal's SHAPE data warehouse, 2022–2023



An Effective Approach to Managing Costs

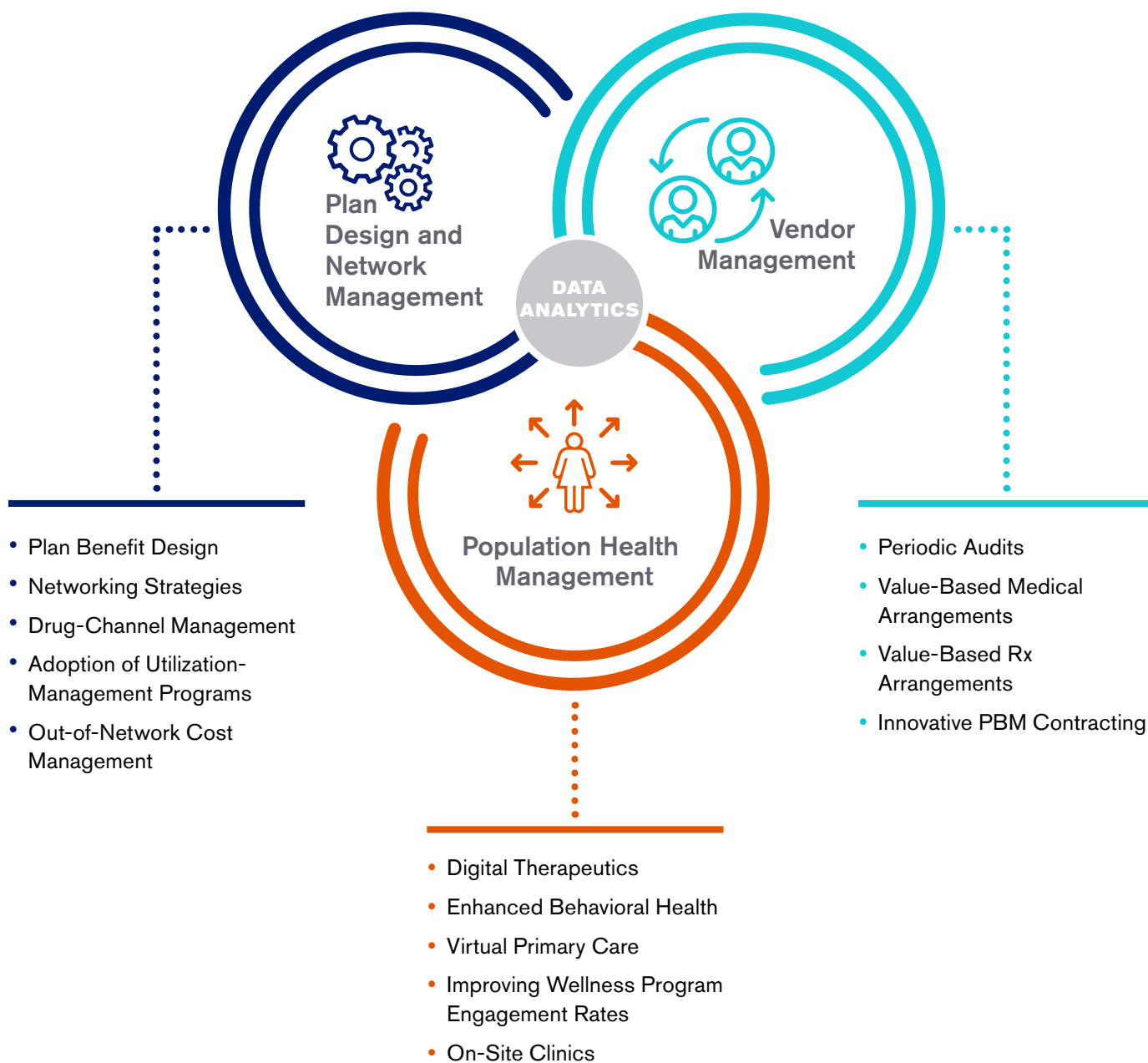
Cost trends for medical plans are increasing, with projected outpatient pharmacy benefit cost trends now in the double digits. The inflationary environment has imposed significant burdens for plans in maintaining competitive benefits and the regulatory landscape continues to create uncertainty. Contracting terms are becoming more complex, with restrictions and hidden provisions that can impact costs. As care treatments evolve and advance, plan sponsors are challenged with understanding potential cost impact and coverage considerations.

Health plan sponsors need to continue to take an active role in understanding industry trends and closely manage their health benefit programs. One cannot manage what cannot be measured. As such, plan sponsors should consider drawing on their own data better understand underlying drivers of cost to make well-informed decisions about which strategies and services produce the most value, especially given their limited resources. A data-driven strategy provides answers to key questions and gives plan sponsors the information needed to focus their cost-management strategies and align them with the changing environment. It also can be used to evaluate the success of the initiatives they implement and make refinements to maximize program efficiencies and outcomes.

Whether it's improving contracts, revising plan designs or modernizing prevention and clinical programs, plan sponsors should continue to look at strategies that give them the most benefit value for the dollars they spend.

We recommend Segal's proven balanced, three-pronged approach to effective healthcare cost management. It involves managing plan design/networks, vendors and population health, with data analytics being central to supporting each of those cost-management strategies.

Our Approach to Effective Healthcare Cost Management



Overview of Strategies for Managing Medical and Pharmacy Benefit Costs in 2025 and Beyond

Achieving the goal of delivering cost-effective health coverage to plan participants with optimal outcomes is increasingly challenging due to the many influences driving costs discussed in this report. We continue to observe that plan sponsors using aggressive cost-management strategies have lower plan cost trend rates than projected average levels. To manage healthcare cost increases, sponsors need a multifaceted approach. This section presents an overview of strategies for managing medical and Rx costs plan sponsors may wish to consider for 2025 and beyond.

Medical cost-management strategies

Strategies like these can help plan sponsors manage their medical plan costs while striving to maintain or improve the quality of care provided to participants:

- **Network management.** This encompasses a wide range of approaches, including tiers, narrow networks, centers of excellence, direct contracting, value-based-care models, digital health coaching, out-of-network care — and more.
- **Cancer-prevention and early detection.** Components include education, screening, accurate diagnosis, treatment and support.
- **Enhance high-cost claims management.** Start with your data. Early identification of risk factors associated with a future high-cost event allows for proactive interventions and care-management strategies to be implemented, such as a comprehensive wellness program to help participants get engaged in their health and prevent the onset of chronic conditions. For those who do develop chronic conditions, implement and monitor case management. Consider or evaluate a stop-loss policy.
- **Address mental health/substance use disorders (MH/SUDs).** Conditions, such as depression and anxiety disorders, correlate with serious medical conditions. Incorporating mental health factors into predicting health outcomes can help plan sponsors improve interventions.
- **Take steps to eliminate fraud, waste and abuse.** Monitor claims through data analytics. Additionally, the use of predictive modeling and machine learning can help identify new patterns of irregular activity and automatically generate alerts. Perform routine vendor audits. Work with your insurer's special investigation units.

Pharmacy benefit cost-management strategies

Delivering cost-effective prescription drug coverage to plan participants is increasingly challenging due to the dynamic nature of the market. Plan sponsors are implementing a combination of approaches to manage rising prescription drug costs, including these:

- **Target high-cost generics and guide participants to the lowest-cost drugs.** In some cases, brand drugs are less expensive than generics.
- **Contracting strategies.** Leverage rebates to the fullest extent with PBMs or health plans. Negotiate strong provider contracts to reduce costs and ensure consistent pricing and review them periodically.
- **Benefit plan redesign.** Regularly evaluate and adjust plan design to align with the plan's clinical and economic goals.
- **Formulary optimization.** Revise formularies to focus on drugs with better clinical and economic value.
- **Clinical management.** Implement prior authorization, quantity limits and/or step therapy for high-cost therapies that have multiple therapy options available.
- **When considering covering GLP-1s to treat obesity, have a comprehensive approach to obesity management.** Consider customized programs that includes a range of options for weight loss (e.g., lifestyle weight loss program and bariatric surgery, as well as GLP-1s). Implement accountability check-ins with patients and require them to be in a behavioral health management program to ensure they will continue a healthy lifestyle.
- **Incentivize use of biosimilars.** This can be accomplished through a tiered plan design, updated formularies, use of prior authorization, step therapy, \$0 cost-sharing, capping reimbursement based on the lowest-cost biosimilar and/or excluding coverage for the originator drug. When developing a strategy to incentivize biosimilar utilization, it is very important to understand the potential rebate impact.



The Survey Respondents

Approximately 70 health insurance providers and other healthcare management organizations participated in the survey. As a group, the survey respondents represent 80 percent of the commercially insured and self-insured market.

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

Medical Plans



- 43 PPO/POS plans
- 35 HDHPs
- 44 HMO/EPO plans

Rx Plans



- 58 Outpatient Rx drug plans

Dental Plans



- 37 DPO plans
- 19 Dental fee-for-service/indemnity plans
- 18 DMO plans
- 15 Dental schedule of allowance plans

Vision Plans



- 22 Vision schedule of allowance plans
- 15 Vision reasonable and customary plans

The following respondents agreed to be identified by name:

Aetna	Highmark Blue Shield of Central Pennsylvania
Ameritas Life Insurance Corp.	Highmark Blue Cross Blue Shield of Delaware
Arkansas Blue Cross Blue Shield	Highmark Blue Shield of Northeast New York
BeneCare Dental Plans	Highmark Blue Cross Blue Shield of Northeast Pennsylvania
BeneCard PBF	Highmark Blue Cross Blue Shield of Western New York
Blue Cross Blue Shield of Arizona	Highmark Blue Cross Blue Shield of Western Pennsylvania
Blue Cross Blue Shield of Illinois	Highmark Blue Cross Blue Shield of West Virginia
Blue Cross Blue Shield of Kansas City	Horizon Blue Cross Blue Shield of NJ
Blue Cross Blue Shield of Massachusetts	Independence Blue Cross
Blue Cross Blue Shield of Michigan	Kaiser Foundation Health Plan, Inc.
Blue Cross Blue Shield of Montana	Medical Mutual of Ohio
Blue Cross Blue Shield of New Mexico	MedImpact Healthcare Systems, Inc.
Blue Cross Blue Shield of North Carolina	Metropolitan Life Insurance Company
Blue Cross Blue Shield of Oklahoma	Navitus Health Solutions LLC
Blue Cross Blue Shield of Texas	OptumRx
Blue Shield of California	Point32Health
Brighton Health Plan Solutions, LLC dba MagnaCare	Premera Blue Cross Blue Shield of Alaska
Capital Blue Cross	Premera Blue Cross Washington
Capital District Physicians' Health Plan, Inc.	ProAct Rx
Cigna	Sav-Rx Prescription Services
ConnectiCare	Trustmark Companies
CVS Health	United Concordia Dental
Elevance Health	UnitedHealthcare
EmblemHealth	Vision Service Plan (VSP)
Express Scripts	Voya Financial
Group Vision Service	Wellmark Blue Cross and Blue Shield Iowa
Guardian Life Insurance	Wellmark Blue Cross and Blue Shield of South Dakota
Health Net of California, Inc.	

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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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