PwC Health Research Institute

Medical cost trend: Behind the numbers 2024

Increased pressure in healthcare

Heart of the matter: The cost of treating patients is on the rise

In 2022, inflation in the United States reached rates not seen since the 1980s.[1] With rising wages and expenses compounded by clinical workforce shortages, providers across the nation are fighting against declining profit margins. In turn, health plans are pressured to raise reimbursement levels in price negotiations with providers.

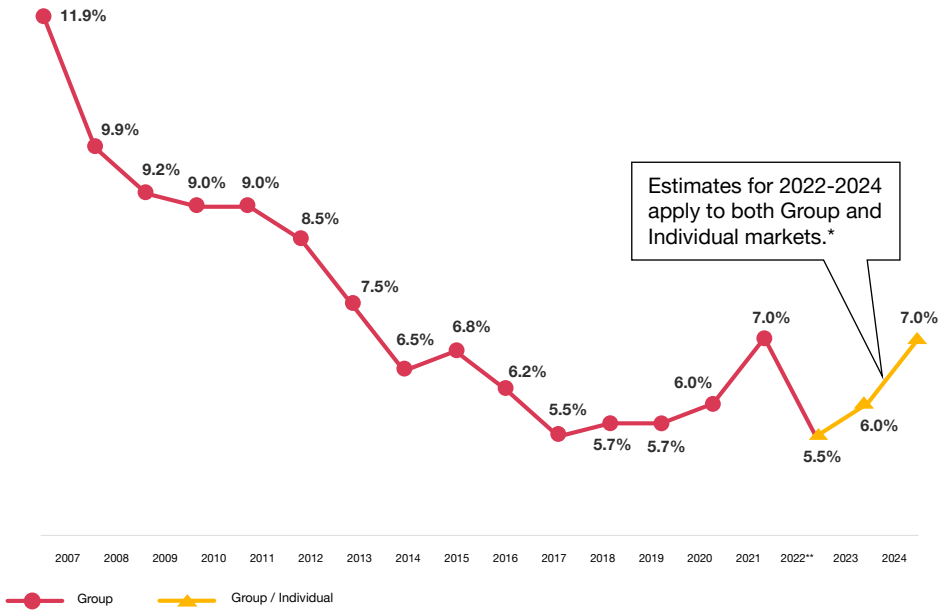
On May 11, 2023, the Public Health Emergency (PHE) officially ended, symbolizing a new stage in the pandemic. The past three years have seen not only a concerted effort to make available safe and effective COVID-19 diagnostics, therapies, and vaccines, but also shifts in how and where Americans gain access to care with an acceleration in technology and alternative sites of care. While some of these changes are temporary, others will likely persist into the post-pandemic world and become a different future.

PwC's Health Research Institute (HRI) surveyed and spoke with actuaries working at US health plans to generate an estimate of medical cost trend for the coming year. After considering various inflators and deflators of cost, HRI is projecting a 7.0% year-on-year medical cost trend in 2024 for both Individual and Group markets. This trend is higher than the projected medical cost trends in 2022 and 2023, which were 5.5% and 6.0%, respectively (see Figure 1). The higher medical cost trend in 2024 reflects health plans' modeling for inflationary unit cost impacts from their contracted healthcare providers, as well as persistent double-digit pharmacy trends driven by specialty drugs and the increasing use of the GLP-1 agonists for Type 2 Diabetes or weight loss. PwC updated its 2022 medical cost projection for the Group market to 5.5%, 1.0% down from the initial projection in 2022, primarily driven by a shift in sites of care from inpatient hospital settings to less costly alternatives such as outpatient and ambulatory surgical centers.

The inflationary impact is further exacerbated by continued clinical workforce shortages in 2023-24, prompting hospitals to increase salaries and consequently seek higher reimbursement from payers. On the pharmacy side, the introduction of new cell and gene therapies (11 approved in the past three years) is a key inflator expected to increase the median price of treatment going into 2024.

Although health plans reported some deflationary relief through shifts in site of care and the introduction of biosimilars, the overall impact is muted by the various inflators.

Figure 1: PwC Health Research Institute medical cost trends, 2009-2024
HRI projects medical cost trend to be 7.0% in 2024, up from 6.0% in 2023



Source: PwC Health Research Institute medical cost trends, 2009-2024

*For 2022-2024, medical cost trend was estimated separately for Group and Individual market based on the surveys and interviews conducted April–May 2023. HRI found no significant difference in the estimates for the two markets.

**The 5.5% medical cost trend for 2022 was revised from 6.5% originally projected in PwC Health Research Institute's "Medical Cost Trend: Behind the Numbers 2022" report, released in 2021. This revision reflects the average medical cost trend that was used for 2022 premium rate setting in 2021, shared with HRI during surveys and interviews.

See "About this research" for more details.

Inflators

Inflation and its ramifications across the healthcare landscape are the main factors driving spending in 2024.

- **Inflationary impacts on healthcare providers.** Hospitals and physicians are expected to seek higher rate increases (potentially also at a higher frequency) in contract negotiations. Workforce shortages and physician consolidation can further amplify the effect. Further, provider "burnout" and increased patient demand are expected to keep the pressure up on clinical workforces across the industry.
- **Increasing cost of pharmaceuticals.** Plans are experiencing inflationary pressure from the rising median price of new drugs, as well as the increasing price of existing drugs. Combined with the accelerated approvals of new cell and gene therapies, pharmacy trends are not expected to slow down in 2024.

Deflators

Some positive changes in the pharmaceutical market and care setting are expected to help counteract inflationary pressure, but their effect will be overshadowed by the inflators.

- **Biosimilars coming to market.** The prices of biosimilars are, on average, more than 50% lower than the reference products at the time of biosimilar launch. The launch of adalimumab biosimilars to Humira in 2023 is a new milestone in the market that is already driving significant savings.
- **Shift in site of care.** Plans reported a decrease in inpatient utilization as well as a shift towards outpatient care, allowing a two-pronged benefit to contain costs.

Recent reports of increases in outpatient utilization among Medicare plans was not commented on during the research period for this report.

Trends to watch

In addition to the inflators and deflators summarized in this report, there were several other factors reported by health plans as being impactful for trend development, but were not considered a significant trend bender as an inflator or deflator.

- **Total cost of care management.** Many health plans continued to invest in total cost of care management initiatives such as value-based care that helped maintain year over year trend. National health plans generally demonstrated better cost management and subsequently achieved lower cost trends. As these national plans continue to grow, they will have a deflator effect overall on medical cost trends.
- **COVID-19.** Impacts of changes in federal and state policies and the need for vaccines, testing and treatment vary, with the net effect likely being neutral. Health plans did not report a causal relationship between pent-up demand for care during the pandemic and utilization of care. The consensus among health plans is that inflationary pressures continuing in 2023 and going into 2024 will be driven by provider unit cost increases and pharmacy trends rather than a recovery in surgery utilization post-pandemic.
- **Health equity.** Health equity is a focus of every health plan. The impact of related efforts to improve population health in the long term has not yet factored into plans' cost of care models. Further, all plans are still working through CMS guidance on health equity.
- **Behavioral health.** While utilization of behavioral health grew during the pandemic and continues to grow, its cost remains relatively lower than other medical costs. Health plans did not account for behavioral health in their pricing and forecasting.
- **Centers for Medicare and Medicaid Services (CMS) Price Transparency Rule.** Health plans expect the impact of this rule on the 2024 trend will be neutral, given the immaturity of the data. In the long run, plans could see both upward and downward pressures.
- **Medicaid redetermination.** The impact is likely to be felt in the Individual market only, with magnitude and direction depending on the number of disenrollees who eventually purchase Individual plans and their risk profile.

This year, the scope of this report was broadened to include both small and large group ("Group")[2] and ACA marketplace ("Individual) plans.

The Individual market has seen significant growth from 12 million in enrollment in 2021 to 16.4 million in 2023. In addition to Individual market-focused plans, all major health plans in the group market also offer plans in the Individual marketplace, where competition has intensified in recent years. The impact of major factors driving medical cost is mostly felt in a similar way across the two markets. Meanwhile, there are distinct considerations that apply to one of the markets, most prominently Medicaid redetermination and network adequacy for the Individual market.

This report does not focus on trends in Medicare and Medicaid.

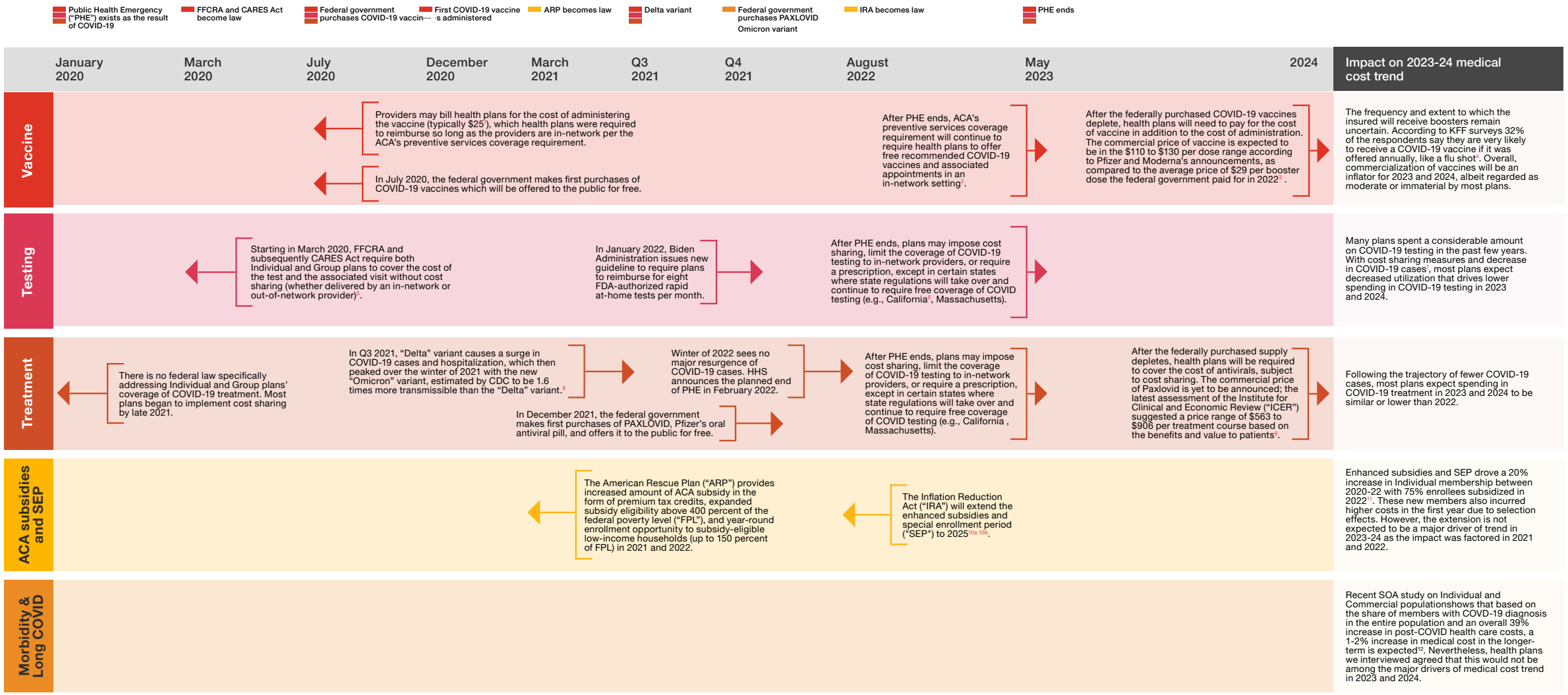
What is medical cost trend?

Medical cost trend is defined as the projected percentage increase in the cost to treat patients from one year to the next, assuming benefits remain the same. While medical cost trends can be defined in several ways, this report estimates the projected increase in per capita costs of medical services and prescription medications that affect insurers' Group and Individual plans. Insurance companies use the projection to calculate health plan premiums for the coming year. For example, a 5.0% trend means that a plan that costs $10,000 per member this year would cost $10,500 next year. The medical cost trend, or growth rate, is influenced primarily by:

- Changes in the price of medical products and services and prescription medications, known as unit cost inflation.
- Changes in the number or intensity of services used or changes in per capita utilization.

COVID-19 timeline:
From pandemic to present

On May 11, 2023, Public Health Emergency ("PHE") officially ended, symbolizing a new stage in our co-existence with the COVID-19 pandemic. The past three years have seen not only a concerted efforts to make available safe and effective COVID-19 diagnostics, therapies, and vaccines, but also shifts in how and where Americans gain access to care. While some of these changes are temporary, others will persist into the post-pandemic world and become the new-normal. The timeline below looks both past and ahead at the key events that impacted and will impact health plans' spending. Overall, our survey and interview indicated a consistent view among health plans that different factors as laid out below tend to cancel out and the net impact is expected to be neutral or immaterial as compared to other major inflators / deflators.



1. https://www.healthsystemtracker.org/chart-collection/where-do-americans-get-vaccines-and-how-much-does-it-cost-to-administer-them/
2. https://www.kff.org/womens-health-policy/fact-sheet/preventive-services-covered-by-private-health-plans/.
3. https://www.kff.org/coronavirus-covid-19/issue-brief/how-much-could-covid-19-vaccines-cost-the-u-s-after-commercialization/.
4. https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-march-2023/
5. https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-51.pdf
6. https://www.dmhc.ca.gov/Portals/0/Docs/DO/COVID-FactSheet2022.pdf
7. https://www.hhs.gov/about/news/2023/02/09/letter-us-governors-hhs-secretary-xavier-becerra-renewing-covid-19-public-health-emergency.html
8a. https://coronavirus.jhu.edu/region/united-states 8b. https://www.cdc.gov/museum/timeline/covid19.html
9. https://icer.org/news-insights/press-releases/icer-provides-update-on-value-based-pricing-of-paxlovid-as-an-outpatient-treatment-for-covid-19/
10a. https://www.healthinsurance.org/glossary/inflation-reduction-act/.
10b. https://www.kff.org/policy-watch/five-things-to-know-about-renewal-of-extra-affordable-care-act-subsidies-in-inflation-reduction-act/
11. https://www.kff.org/policy-watch/as-aca-marketplace-enrollment-reaches-record-high-fewer-are-buying-individual-market-coverage-elsewhere/
12. https://www.soa.org/resources/research-reports/2023/hcc-covid-effects-longterm/ The study does not publish the total cost of members with versus without COVID-19 diagnosis. Based solely on member count of 626,142 with COVID-19 diagnosis and total membership of 33.0 million over the three-year period, the impact on overall medical cost trend will be approximately 0.7%. However, the members with COVID-19 diagnosis includes high-risk groups and are likely to have higher overall cost than the rest of the population; thus the impact on overall medical cost trend shall be higher than 0.7%.*

Inflator:

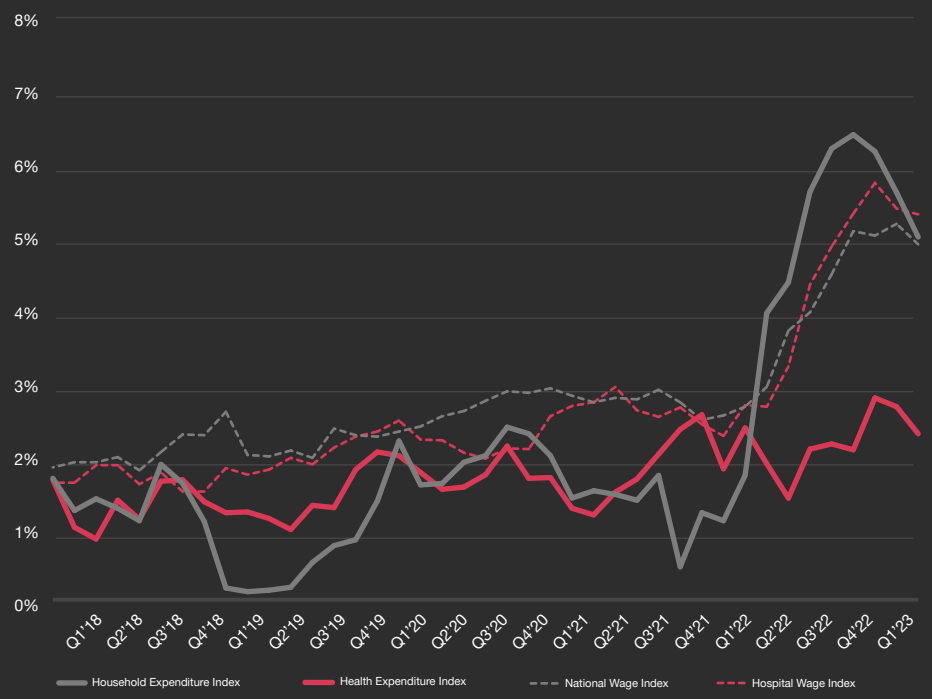
Inflationary impacts on healthcare providers

Inflation in the United States has reached rates not seen in decades. All health plans ranked inflationary impacts on providers among the top three inflators for 2024.

In 2022, while inflation was felt across the US economy, its impact on healthcare spending was dampened by existing annual or multiyear provider contracts. Figure 2 illustrates the lag between the household expenditure index, with a rise starting in the second quarter of 2021 and persisting at a high rate of 6.0% or more throughout 2022, and the health expenditure index, with a modest 2% to 3% increase. Generally, health expenditure inflation lags behind hospital wage inflation.

In a persisting high inflationary environment, hospitals and providers will ultimately be pushed to seek significant rate increases from payers. Many health plan actuaries said they are facing increasing inflationary pressure on unit cost in 2023 and 2024. Their ability to manage price increases during contract renewals will be a key factor in determining how the impact of inflation will materialize in the coming years.

Figure 2: Expenditure and Wage Indices year-over-year growth 2017-2022



Source: Bureau of Labor Statistics Consumer Price Index, PwC analysis

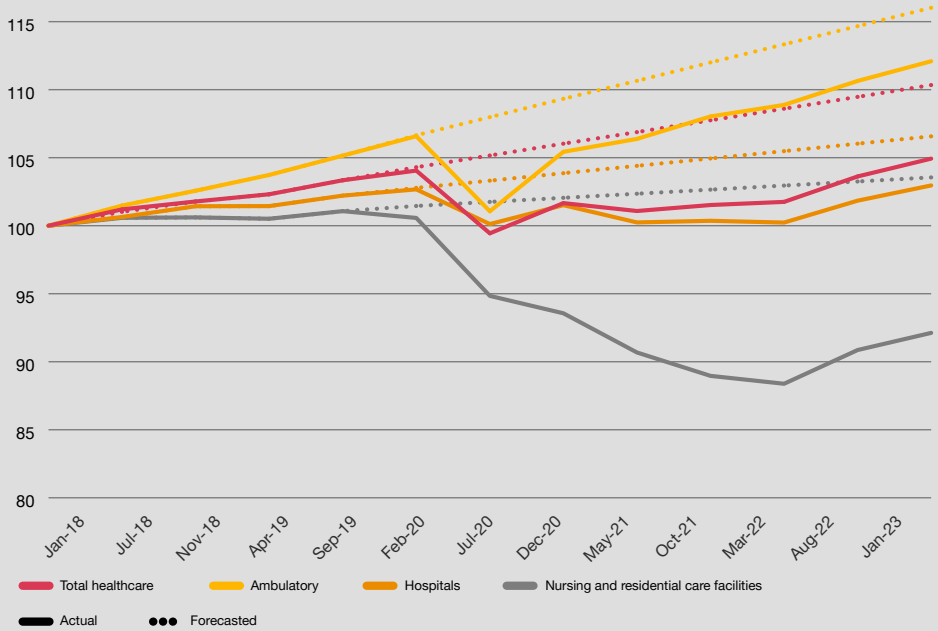
Clinical workforce shortages add to the contractual pressure from providers

Healthcare employment plummeted during the pandemic, leading hospitals to incur much higher labor costs. During the peak of the pandemic in 2021, hospitals experienced an estimated 16% increase in labor expenses per adjusted discharge compared to September 2019[3], not only due to paying higher wages but also from using temporary clinical staff through “traveler agencies” that can often charge high prices.

Though healthcare employment started to steadily recover in 2022, total employment still has not returned to pre-COVID levels, and a noticeable gap persists for the nursing/residential care facilities segment.

Several health plans expect no short-term resolution of the clinical staff shortage. Assuming the persistence of such shortages in 2024, hospitals will continue to be financially challenged and forced to seek higher reimbursement from payers. On the other hand, if healthcare employment levels return to a stable level in 2024, pent-up demand for care is likely to drive utilization up. In both cases, health plans can expect to face inflationary pressure in 2024.

Figure 3: Healthcare employment - actuals vs. pre-COVID forecast index 2017-2022*



Source: Bureau of Labor Statistics Employment Cost Index, PwC analysis
*Forecasted employment (dotted lines) is estimated by applying pre-COVID employment growth rates.

Hospital, private equity and other physician consolidation amplifies the inflationary pressure

Recent physician practice acquisition activities, including actions by hospitals, private equity firms and insurers amplify the inflationary pressure during contract renewals. Studies find that such acquisitions accelerated during the COVID-19 pandemic, and over the three-year period starting from 2019, the percentage of physicians employed by hospitals or corporate entities increased by 62% to 74% (Figure 4).[4] Specifically, private equity activities in the healthcare services sector set record highs in 2020-2022.[5] The ongoing consolidation of physician groups is expected to compound the inflationary pressure on medical cost in the near term.[6] In the long term, many consolidated physician groups aim to enter value-based care and thus lower total cost of care.

Individual market can be most impacted

We note potentially a higher impact of inflation on the Individual market due to network configuration. Compared to the Group market, more Individual plans utilize a narrow network to lower consumer premiums. Plans typically negotiate more favorable rates with select providers through membership steerage. These lower rates are expected to command a higher increase on a percentage basis to compensate for inflation, compared to the higher rates in the wide network plans that dominate the Group market.

Implications

Health plans and payviders: Confront affordability and disrupt costs. Health plans will encounter greater unit cost increase pressure from providers, which can play out for several years to come. Health plans should rethink their strategies as affordability is key to winning in the Individual and Group market. Value-based care, targeted care management, versatile in-house data analytics and harnessing the power of AI technology can help plans aggressively counteract the forces of inflation.

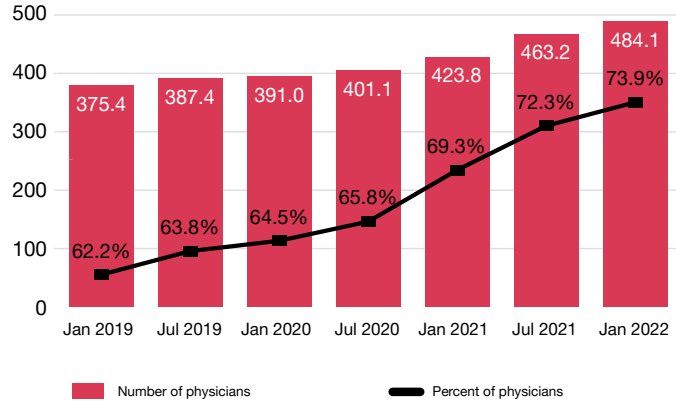
Providers: Solve systemic clinical workforce shortages, which have led to significant margin losses and, in some cases, even hospital closures. Providers should be proactive in attracting healthcare talent and doing more with less while also moving quickly to leverage technology such as AI to ease the workforce strain.

Employers: Because of continued talent concerns, employers are generally not expected to increase employee cost sharing. Instead, there will be an increased emphasis on network strategies, including the use of narrow/high-performing networks, centers of excellence to target high-cost claims (particularly cancer and orthopedic cases), plan designs that steer patients to lower-cost providers, and a renewed attempt at finding effective navigation tools.

Inflation and clinical workforce shortages will continue to exert pressure on healthcare.

Source: PwC Medical cost trend: Behind the Numbers 2024

Figure 4: Number and percentage of U.S physicians employed by hospitals or corporate entitites 2019-21



Source: Physician Advocacy Institute report on COVID-19's impact on acquisitions of physician practices and physician employment 2019-2021

Inflator:

Increasing cost of pharmaceuticals

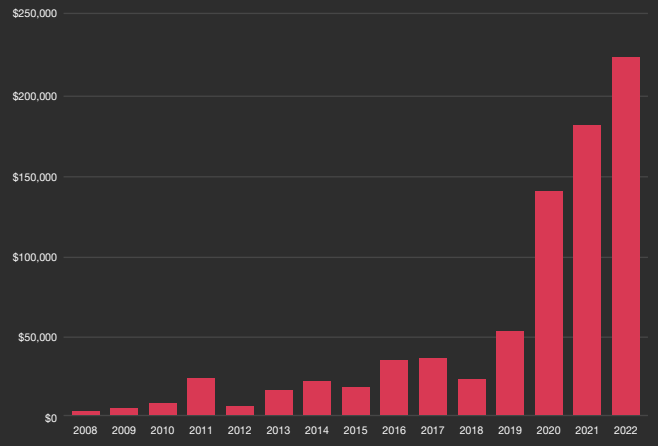
The new pharmaceutical pipeline is anticipated to be a strong headwind to any medical cost trend improvement. The median annual price for new drugs being approved by the U.S. Food and Drug Administration's (FDA) Center for Drug Evaluation and Research (CDER) increased from $180,000 in 2021 to $222,000 in 2022, implying double-digit annual growth in price.[7] This underlines a historical trend that led to median launch prices increasing from ~$2,000 per year in 2008 (37% annualized growth).[8] This surge in price is driven by a concurrent increase in the approval of high-cost drugs. The proportion of approved drugs priced at $150,000 per year or more was 9% in 2008-13 but increased to 47% in 2020-21.

Pharmaceutical manufacturer pricing is expected to be in the high single or double digits from 2023-2024. New drugs typically exist in the market for 15 years on average without competition from generic drugs, along with general increases in drug prices over time. Multiple insurers report that the trend used for pricing 2023 plans was lower than actual experience, driven by higher-than-expected pharmacy trends for both brand and specialty drugs. Plans also reported facing consistently increasing average wholesale price (AWP) over the last two years and do not anticipate this trend to flip.

This inflation is compounded by drug shortages and supply chain issues. In a report to Congress from the Office of the Assistant Secretary for Planning and Evaluation (ASPE), an analysis of the data showed a 16.6% increase in the price of drugs in shortage, driven mostly by an increase in the price of generics (14.6%).[9]

The largest increase in the number of drugs experiencing an increase in price was in 2021-22, and 2022 observed the largest historical increase in the average price (Figure 6).[10]

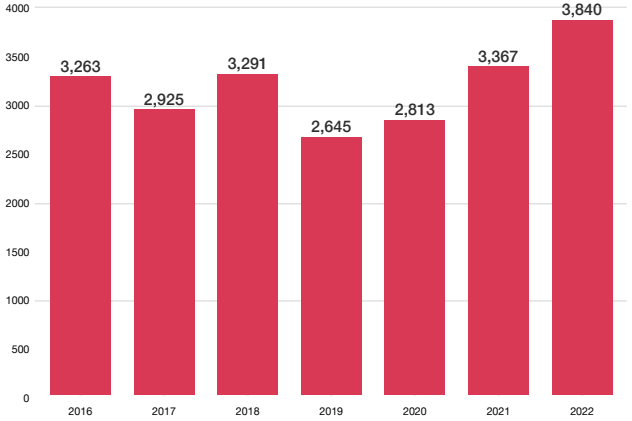
Figure 5: Median price of newly marketed drugs 2008-2022



Source: Trends in Prescription Drug Launch Prices, 2008-2021; Reuters survey[8]

Figure 6: Number of drugs with price increases per year and average dollar price changes per year 2016-2022 (January and July only)

Number of drugs with price increase per year



Average dollar price change per year

Source: Price Increases for Prescription Drugs, 2016-2022[10]
*Based on January and July price increases only; the research finds that these months historically account for most of the increases that occur each year.

New cell and gene therapies

Inflationary impacts from new drugs go hand-in-hand with the introduction of new cell and gene therapies. Of the 29 gene therapies currently approved by the FDA, 11 have been approved since 2021. Another 30 are in late-stage development with the potential for future approval. However, the development of these therapies includes extensive costs that will be passed on to payers who are already navigating an uncertain post-pandemic utilization and cost dynamic.

Payers are responding by more thoroughly assessing the cost/benefit of therapies in their coverage decisions, contracting with manufacturers to tie reimbursement to real-world evidence, exploring alternative financing arrangements (including stop-loss policies), and enacting prior authorization and other controls to manage drug utilization.

Some key gene therapies on payers' radars include Hemgenix, which was approved by the FDA in November 2022 as a one-time treatment for patients with Hemophilia B and cost $3.5 million; and Roctavian for severe Hemophilia A, expected to be approved in 2023 following European approval in 2022. In the first half of this year, three additional gene therapies are expected to be approved, and they will likely be highly priced, putting increased pressure on the healthcare system.[11]

GLP-1 (Glucagon-like Peptide-1) Agonist drugs in diabetes and obesity

In the US alone, about 130 million adults may become eligible for GLP-1 agonist medications because of their weight and other health conditions.[12] The prohibitive cost (upwards of $10,000 a year), however, has kept utilization down. Ozempic, Novo's weekly GLP-1 shot for diabetes, went on sale in 2018, followed in 2021 by Wegovy, a higher dose of the same medication developed for obesity.

Eli Lilly's Mounjaro, approved for diabetes last year, has shown even more dramatic weight loss results through a large trial published last year and reinforced through another trial this year.[13] Lilly is filing for approval to treat obesity. Wegovy, which has approval as an obesity treatment, costs more than $17,000 a year — 40% more than Ozempic, which is the same drug in a smaller dose.[14]

At the moment, most health plans do not cover the use of GLP-1 agonists for nondiabetic treatment unless specifically approved as a prescription weight-loss drug, meaning a drug like Ozempic is not being covered for weight-loss use. However, the FDA has already set a precedent after approving Wegovy in 2021[15] and perhaps Lilly's Mounjaro in the future. Should the FDA approve all of these drugs for weight-loss, utilization can be expected to increase substantially going forward.

Figure 7: List of gene therapies to watch

Gene Therapy	Estimated Cost
Abecma™	$482,000 per suspension
Astiladrin*™	$160,000 - $260,000 per therapy
Breyanzi™	$471,000 per suspension
Carvykti™	$500,000 per suspension
Hemgenix™	$3,500,000 per dose
Omisrige™	$338,000
Rethymic™	$2,700,000 per implant
Skysona™	$3,000,000 per infusion (single use)
Vyjuvek™	$25,000 per vial
Zynteglo™	$2,800,000 per infusion (single use)

Source: PwC analysis
*Forthcoming in 2H 2023

Implications

Health plans and payviders: Track new pipeline and related costs closely for accurate modeling

Payers are anticipating the new pharmaceutical pipeline will increasingly drive the medical cost trend. Plans have begun modeling double-digit pharmacy trends into their cost projection models to avoid underestimating overall cost trend heading into 2024 and beyond. The recent growth in the number of approved gene therapies is expected to drive cost to a historic high as consumers shift to alternative medicines. Adding to this, as the scope of physician prescriptions widens to allow GLP-1 agonist drugs to be prescribed for weight loss, plans will have a new challenge in 2024. Formulary management will be a key consideration for health plans.

Pharmaceutical manufacturers: Adjusting to regulations, removal of Medicaid rebate cap, and other impacts while navigating continued public pressures

Pharmaceutical manufacturers face pricing and Gross-to-Net impacts from regulatory changes, such as the Inflation Reduction Act (IRA) and the removal of the cap on Medicaid rebates based on average manufacturer price (AMP) in 2024. Pressure continues to be applied from potential federal and state government legislation, increased PBM/payer utilization management and competitive RFPs, patient copay and assistance program dynamics, and other key trends. Manufacturers will face continued challenges as they balance optimally enabling patients access to their therapies while continuing to invest in R&D and innovation.

Deflator:

Biosimilars coming to market

The FDA defines biosimilars as a biological product that is “highly similar” to and has “no clinically meaningful differences” from an existing FDA-approved reference product.[16] The adoption of biosimilars to specialty drugs has substantial potential to manage rising drug costs.

Research finds that, on average, biosimilar sales prices are more than 50% lower than the reference product’s price was at the time of the biosimilar launch, and similarly, the sales price of brand biologics competing with biosimilars fell on average 25% since the biosimilar launch.[17]

This year, there is a new milestone in the biosimilar market — the arrival of the first biosimilar to a major specialty drug — adalimumab biosimilars to Humira™. In 2022, the revenue from this blockbuster drug totaled more than $18 billion in the US.[18] In January 2023, Amgen launched its adalimumab biosimilar, Amgevita™, and to date, the FDA has approved nine adalimumab biosimilars and most others are likely launching within a year following Amgevita™. [19]

As a reference point for the potential savings, Amgevita™ was launched with two price points, one 55% below Humira™’s list price and the other 5% below, the latter likely coming with larger rebates to the payers[20] and plan sponsors. Health plan actuaries also reported manufacturers offering larger rebates for their flagship drugs to retain market share.

Overall, the biosimilar market continues to accelerate. Figure 7 shows biosimilars to 15 reference biologics in the pipeline for 2023-25, as compared with only two approved by the FDA in 2020-22. Moreover, heightened regulatory interest and support have been reflected in a comprehensive plan for addressing high drug costs published by the US Department of Health and Human Services (HHS) earlier in 2021, which calls out “promote biosimilars and generics” in one of the three guiding principles.[21]

Many health plans are watching biosimilar trends and conducting assessments to understand their impact. For 2024, the savings from biosimilars are expected to have a relatively moderate impact on the overall medical cost trend (two health plans cited expected impacts close to -0.5%), given biologics with existing biosimilars make up a small portion of the overall medical cost. Nevertheless, 65% of health plans surveyed ranked biosimilars coming to market among their top three deflators, and many have hopes of more savings to come.

Implications

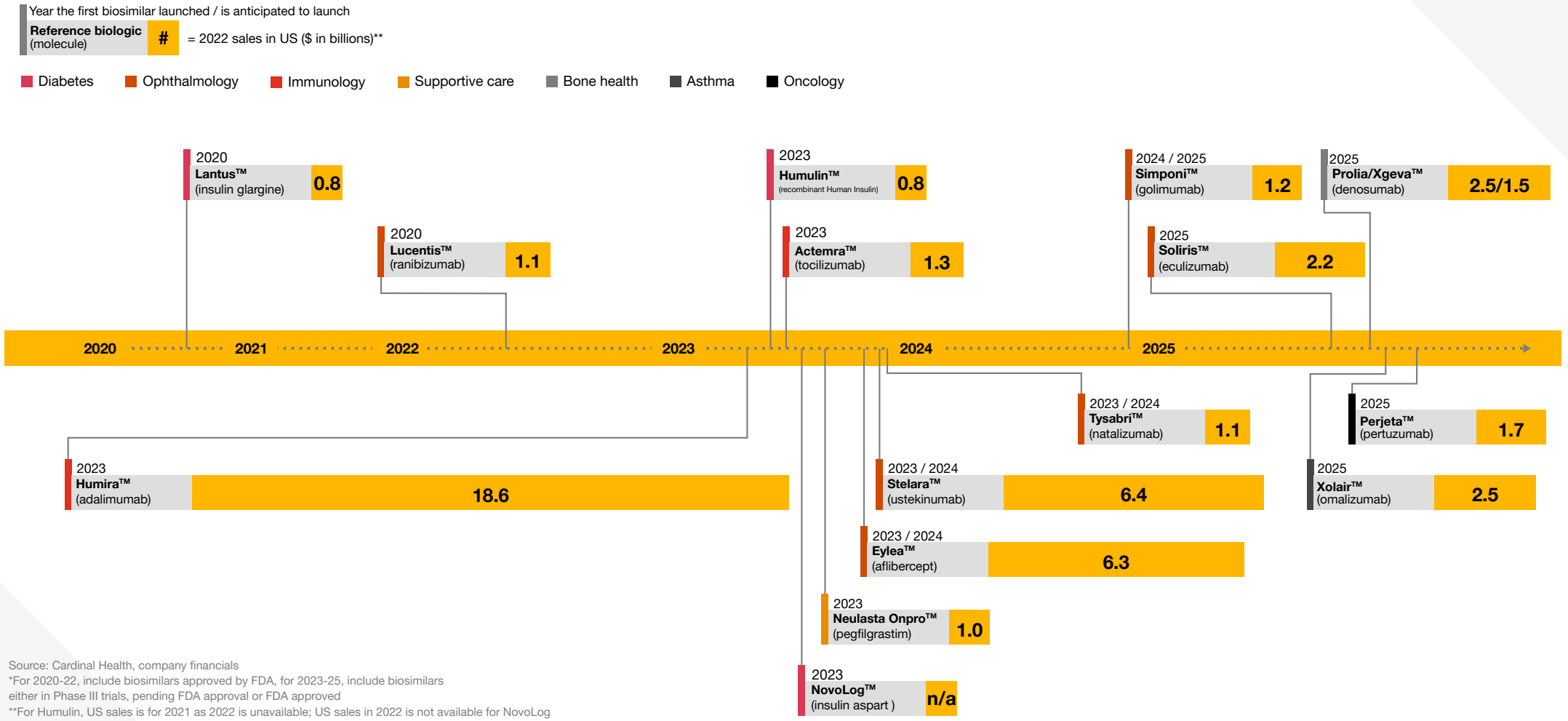
Health plans and payviders: Evaluate options to integrate biosimilars into pharmacy benefits

The idea that biosimilars offer lower-cost alternatives to biologics is simple, but the actual implementation can be complex. For health plans, the first step is likely to be working closely with pharmacy benefit managers to understand which biologic/biosimilar(s) is the most cost-efficient — sometimes staying with the existing biologics might be as cost-efficient as switching to biosimilars through competition-driven larger rebates. Next, health plans may explore alternative cost sharing design and utilization management tools, such as prior authorization that can be leveraged to incentivize members towards more cost-efficient options. An important consideration is the impact on member experience should the plans change existing benefit terms. Additionally, plans should consider potential increased utilization if the price of previously expensive drugs becomes more accessible. All the various factors need to be weighed and each health plan may make a different decision depending on its unique priority and membership characteristics.

Pharmaceutical manufacturers

While biosimilars have grown and carved out a space on the medical benefit side, particularly within physician-administered drugs in oncology, biosimilar market maturity within the pharmacy benefits space is just beginning. The entry of Lantus biosimilars last year and Humira™ this year have provided the first and largest tests of biosimilar penetration on the pharmacy benefit, with growing tests throughout 2023 (January Amgevita™ launch, multiple launches in July). Despite the uncertainty, there are some early strategies and implications emerging. First, manufacturers have launched with both high and low wholesale acquisition cost versions to appeal to different market segments, a trend that shows no sign of stopping with the Coherus + Mark Cuban Cost Plus Drugs recent announcement. Second, biosimilar entry in some cases replaces the innovator on the formulary and in other cases is disadvantaged / excluded vs. the innovator. Every entry has come at the expense of the innovator’s Gross-to-Net. Payers/PBMs are leveraging biosimilar entry to lower the cost of these drugs, and at times the entire class/therapeutic area. The industry will keep watching for any future regulatory/legislative actions that impact the biosimilar market as many players appear to remain committed to near and long-term growth of the biosimilar market.

Figure 8: Historical and anticipated future biosimilar launches 2020-25*



Source: Cardinal Health, company financials
*For 2020-22, include biosimilars approved by FDA, for 2023-25, include biosimilars either in Phase III trials, pending FDA approval or FDA approved
**For Humulin, US sales is for 2021 as 2022 is unavailable; US sales in 2022 is not available for NovoLog

Deflator:

Shift in site of care

The pandemic revolutionized the dynamics of the US healthcare system by rapidly shifting the site of care from more expensive inpatient hospitals to less expensive outpatient. While this trend started before the pandemic with cataracts and cosmetic surgery in the 2000s, it accelerated toward the end of the pandemic when employment in ambulatory care settings recovered the fastest.

As a result, lower-cost freestanding and non-acute sites were able to absorb a large portion of the demand for these healthcare services that were previously only available through inpatient settings.

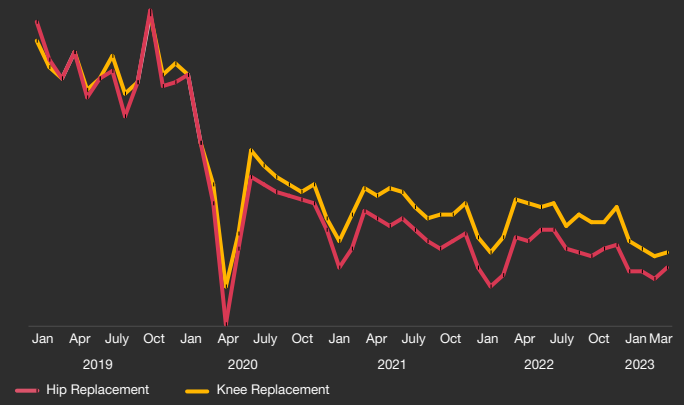
With the increased demand for outpatient surgeries, home-based services and virtual care, the healthcare delivery system has reached a new phase. Plans are factoring in higher utilization of less expensive in-person settings and virtual care going forward when pricing their 2023 plans and beyond.

Non-acute sites have lower costs for plans, which in turn is expected to decrease the share of revenue received by inpatient hospitals. With lower-cost in-person settings and virtual delivery setting the path going forward, the overall cost of care is expected to decline,[22] helping plans offset the trend inflators.

Plans have noted a material difference in the 2022 and 2023 expected trends as compared to actual experience when factoring in the uptick in utilization in less expensive in-person settings.

Figure 9: Shift in primary hip / knee replacement to Outpatient

National Volume Changes - Inpatient



National Volume Changes - Outpatient

Source: Strata National Patient and Procedure Volume Tracker

Implications

Health plans and payviders: Model trend impact from shifting site of care and associated reduction in costs

The pandemic decreased inpatient utilization over the last two years — which has helped control the cost of care while also shifting care towards outpatient, allowing plans to reap the benefits from both aspects.

As inpatient surgery trends continue to decline every year, health plans do not know yet how much lower they will go and what their models will look like. There is enough evidence to support a deflationary impact on trend until inpatient utilization in general and surgery utilization, in particular, recovers to pre-pandemic levels, if at all.

Providers: Incentivize shift of care to gain a share in profits

Providers also have an important role to play. They can work with plans to establish ownership models that share financial gains and incentivize physicians to accelerate the shift to outpatient care. This will help ease the pressure on inpatient settings whose capacity has been the slowest to recover across the country driven by an acute lack of skilled labor.

It's important to note, however, that not all care can be shifted to ambulatory service settings and may not be appropriate for frail patients, for instance, or those with complex comorbidities. There needs to be clear criteria for defining use cases and when patients can safely be shifted to less costly in-person settings.

Recent reports of increased outpatient utilization among Medicare plans was not commented on by health plans during the research period for this report.

Employers: Encourage telemedicine for primary care and behavioral health

Through plan design changes and adding new third-party telemedicine vendors, employers will likely continue to encourage the use of telemedicine. Virtual visits for behavioral health have exploded in recent years, allowing for increased flexibility in addressing the pressing need for mental health treatment, especially to address significantly increased anxiety and depression issues among adolescent patients. Virtual primary care visits are expected to increase in the coming years as well.

Trends to watch

Not all trends are new or clear inflators or deflators of the medical cost, but they are important influencers to watch. These are the areas that we will be following over the next year to track and forecast medical cost trend.

Continued efforts to manage total cost of care

To confront the ever-rising costs, health plans have continued to execute and innovate.

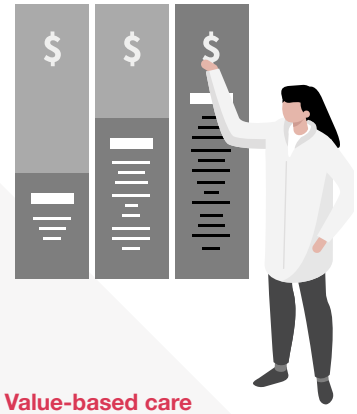
Value-based care, which better aligns incentives across payers and providers, has gained ground in recent years — analyses show that around 60% of health care payments in 2020 included some form of quality and value component, up from 38% in 2015.[23] For some plans, value-based care has proven to be a cost deflator. Meanwhile, long-standing efforts such as payment integrity and care management have continued to evolve with more sophisticated approaches and more advanced digital intelligence.

None of these cost strategies is new to the healthcare industry. National plans tend to lead in this sphere, given the high return on investment through scale. Meanwhile, more regional plans have been catching up — one plan actuary cited achieving a negative medical cost trend in 2022 by launching refocused cost of care programs. Any plan that has not made similar investments will likely to need to do so soon to keep up with the market.

Overall, the largest players in the market reported a greater impact of cost of care initiatives on trend than smaller plans. Some regional players, however, reported large one-time deflators as they catch up in the implementation of these programs. As National plans acquire smaller regional plans, this category is expected to be a deflator for medical cost trend. In the meantime, for plans that are mature in managing total cost of care, the effects of such efforts have become part of the year-over-year baseline, not explicitly a deflator but helping to keep the trend at the same level.

The COVID hangover

Impacts of changes in federal and state policies and the need for vaccines, testing and treatment vary, with the net effect likely being neutral. Health plans did not report a causal relationship between pent-up demand for care during the pandemic and utilization of care. The consensus among health plans is that inflationary pressures continuing in 2023 and going into 2024 will be driven by provider unit cost increases and pharmacy trends rather than a recovery in surgery utilization post-pandemic.



Value-based care

Move along the pathway to value from fee-for-service to shared savings and capitation arrangements

Payment integrity

Intelligent and automated process both pre- and post-payment to reduce duplication, errors and fraud or abuse with minimal provider abrasion

Utilization management

Fast but informed decisions that ensure appropriateness and drive overall value of care

Care management

Target at the right member at the right time, broaden sources of value from both medical cost and revenue sides

Advanced data analytics

Accessible to all functions, help Identify new opportunities and support existing business cases

Preventive Care & Wellness Programs

Improve both member experience and health outcomes

Behavioral health

While utilization of behavioral health grew during the pandemic and continues to grow, its cost remains relatively lower than other medical costs. Most health plans are not accounting for behavioral health in their pricing and forecasting.

During the COVID-19 pandemic, behavioral health (BH) and mental health/substance abuse services (MH/SA) saw a significant and consistent uptick in utilization. Outpatient visits related to this category trended upward in double digits year over year, reaching a new level of utilization. Omitting care for COVID-19, behavioral health visit volume was 16.8% above pre-pandemic levels in the first quarter of 2022.[24] Although the increase has slowed, health plans do not anticipate usage to go back down to pre-pandemic levels.

This large increase has been sustained across all types of BH services, whether it be in-person or telehealth and virtual care. When it comes to BH, plans reported a significant push from their consumer base for telehealth services during the pandemic that has continued since, growing from 32% pre-pandemic to 60% of all BH visits in the first quarter of 2022.[25] The growing focus on access to care improvement further motivated the use of telehealth services. An America's Health Insurance Plans (AHIP) survey covering 95 million lives showed that the number of in-network BH providers increased by an average of 48% in three years among commercial health plans, and that all plans provided coverage for telehealth services specifically for BH.[26] This trend to improve access will continue to be a hot topic as provider networks credentialled to provide these services grow and expand.

A related concern in this category is fraud, waste and abuse. A common example has been out-of-state behavioral health facilities that are covered by health plans to allow access to care but have limited, if any, oversight on the cost, quality and quantity of services being rendered. Striking the balance between network adequacy and fraud, waste and abuse will be a challenge for health plans going forward.

In most cases, while the dollars associated with these services are growing, they are still low and do not materially impact the trend development compared to other inflators. Additionally, recent studies have shown that promoting outpatient behavioral health (OPBHT) as a part of a population health strategy can help improve overall medical spending. Results indicate that healthcare costs for patient groups with OPBHT use were 10%-15% lower compared to those without OPBHT visits.[27] These findings support the cost-effectiveness of OPBHT utilization, which can act as a deflator on overall medical cost trend in the long term.

Health equity

Health equity is a focus area for health plans, although the impact of population health efforts was not factored into their medical cost trend. A broad array of factors within and beyond the healthcare system — including social, economic, and environmental factors —drive disparities in health and healthcare. Recent years have seen increasing attention and resources invested to address such disparities. On the regulatory side, the CMS published its Framework for Health Equity 2022-2032, stating its "unwavering commitment to advancing health equity" and, in practice, introduced new policies with reference to health equity to Medicare (ACO REACH benchmark adjustment)[28] and the individual marketplace (network adequacy).[29] Health equity is an important topic among health plans.

Network adequacy is a measure to ensure more equal access to care in the rural areas. On the Individual market, in the 2023 Final Rule[30] CMS set forth that it will resume its network adequacy review, which was paused in 2018, evaluating Qualified Health Plans (QHPs) for compliance with quantitative standards based on time and distance standards starting plan year (PY) 2023. As mentioned before, narrow networks are common in the Individual market. Many health plans can become noncompliant with their current network configuration — as of August 2022, CMS identified 243 out 375 issuers that were not in compliance with network adequacy standards as part of the agency's certification review of QHPs for PY 2023, either out of errors in completing the paperwork or actual noncompliance.[31] To stay compliant, many plans need to rapidly broaden their networks and contract with more providers, which will highly likely drive the unit cost up.

Setting network adequacy aside, for 2024, all of the health plans regarded health equity as having a neutral or low impact on the medical cost trend. At this stage, most plans are gathering data and forming necessary analyses to come up with actionable plans to address the disparities in health and health care and have not factored health equity into their cost of care models with respect to shifts in near-term utilization pattern changes nor long-term population health impact.

Centers for Medicare and Medicaid (CMS) Health Plan and Hospital Price Transparency Rule

Starting January 1, 2021, hospitals have been required by CMS to provide clear, accessible pricing information online, including a comprehensive machine-readable file listing gross charges, discounted cash prices and charges negotiated between the hospital and third-party payers for all the items and services provided. In July 2022, the rule was extended to include both plans and Issuers as well.[32]

In theory, the implementation of the Price Transparency Rule would expand visibility into unit prices and have wide implications for all stakeholders, including both hospitals and payers. On the one hand, hospitals could analyze the price transparency data to identify services where their charges are low relative to the market, or payers that are more generous in their reimbursements for competitor hospitals, and demand greater price increases for these services or with these payers in future contract negotiations. On the other hand, payers could similarly leverage price transparency data to improve their contracted prices as related to high-cost services or hospitals.[33]

Nevertheless, in the short term, the utility of price transparency data could be limited given several practical issues. Data accuracy is one concern. One plan reported that it found that the prices published by the hospitals could not be reconciled with the contracted prices per their own database. In addition, published in various formats, machine-readable files require data analytics efforts to be transformed and merged into a meaningful dataset.

Overall, 75% of the plans surveyed deemed the impact of the Price Transparency Rule on 2024 medical cost trend to be neutral or immaterial mainly given the immaturity of the data. In the long run, plans could see both upward and downward pressures during the contract negotiation (for example, price increases demanded by low-paid providers and price control on high-cost providers). The extent to which more transparency will shift the balance of power in negotiations, which currently favor providers and payers with higher market share and in less competitive markets, remains to be seen.

Medicaid redetermination

In response to the public health crisis, Congress passed the Families First Coronavirus Response Act in 2020, which prohibits state Medicaid agencies from disenrolling people unless they specifically request it. The Kaiser Family Foundation reported that, as a result, enrollment in Medicaid and Children's Health Insurance Program (CHIP) has grown by 21.9 million to nearly 93.0 million from February 2020 to January 2023.[34] This continuous enrollment provision ended on March 31, 2023, after which states have 12 months to initiate redeterminations of Medicaid and CHIP eligibility for all enrollees and two additional months (14 months total) to complete all pending actions.

The HHS projects the unwinding of the continuous enrollment provision to result in 15 million people losing Medicaid/CHIP coverage.[35] Specifically, among the disenrolled, 6.8 million are still eligible for Medicaid/CHIP but lost coverage due to administrative churning (they will not qualify for ACA subsidies[36]). For the remaining 8.2 million who are no longer Medicaid/CHIP eligible, HHS estimates 3.6 million to obtain employer-sponsored insurance (ESI), 2.7 million to qualify for ACA premium tax credits (PTC), including 1.7 million also eligible for zero-premium Individual plans under the provisions of the ARP and IRA. A separate study by the Urban Institute estimates 18 million people losing Medicaid/CHIP coverage, of which 2.5 million will be eligible for PTCs.[37]

A consensus among health plans is that the impact of Medicaid redetermination is likely to be felt predominantly in the Individual market. Disenrollees who obtain employer-sponsored insurance can either be previously double-covered by Medicaid/CHIP and ESI or obtain ESI through new employment as unemployment recovers back to the pre-pandemic level. It is uncertain how many will eventually be covered by small or Large Group plans, but these new members are not expected to significantly alter the risk pool of Group plans. On the Individual side, among the 2 million to 3 million disenrollees who become eligible for PTCs, not all of them will enroll in Individual plans. Many health plans expect a selection effect in which those who choose to enroll in Individual plans tend to have higher risk. Nevertheless, per the HHS projection, the Medicaid/CHIP disenrollees are much younger than the existing Individual market population and thus potentially lower risk.[38] Overall, the net impact of Medicaid redetermination could be an inflator or deflator, as believed by most health plans, and 80% of the plans indicated the impact to be neutral or low on the 2024 medical cost trend.

Between 2.5 to 2.7 million members disenrolled from Medicaid/CHIP are estimated to qualify for ACA subsidies.

About this research

Each year, PwC's Health Research Institute (HRI) projects the growth of employer medical costs in the coming year and identifies the leading trend drivers. Health insurance companies use the medical cost trend to help set premiums by estimating what this year's health plan will cost next year. In turn, employers use the information to make adjustments to benefit plan design to help offset health insurance cost increases. The report identifies and explains what it refers to as "inflators" and "deflators" to describe why and how the healthcare spending growth rate is affected.

This forward-looking report is based on the best available information through June 2023. HRI conducted 21 surveys and 12 interviews from April through May 2023 with health plan actuaries whose companies cover nearly 100 million employer-sponsored large and small group members and 10 million ACA marketplace members. Participants were asked about their trend experience for 2022, and trend estimates for 2023-24, and the factors driving those trends.

Results from the surveys and interviews were aggregated using a weighted average approach based on the number of self-reported lives in the survey. Results for Group and Individual trend were not aggregated for any purposes or results during this process.

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Endnotes for figures

Slide 1/Main Trend Chart:
Source: PwC Health Research Institute medical cost trends, 2009-2024

Slide 2/Medical Inflation/ wages:
Source: Bureau of Labor Statistics Consumer Price Index, PwC Analysis

Slide 3/Employment:
Source: Bureau of Labor Statistics Employment Cost Index, PwC Analysis

Slide COVID Timeline Chart (numbers can be tracked to boxes in the COVID Timeline chart in slide):

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Slide 4/Physician acquisitions:
Source: Physician Advocacy Institute report on COVID-19's impact on acquisitions of physician practices and physician employment 2019-2021
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Slide 5/Median price of newly marketed drugs:
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