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Although we are only halfway through 2016, three trends have notably emerged and taken the front seat in the employee benefits world. With a presidential election to contend with in the latter half of the year — surely shaking things up a bit — it will be interesting to see if these trends continue to take root or fizzle out to make room for the next best thing. But until then, let's touch on the top three trends that have come to the forefront in the employee benefits industry.

1. Transparency/advocacy tools

Deductibles and employee out-of-pocket cost-sharing continue to rise as employers attempt to battle ever-rising medical insurance premiums. Additionally, more employers are moving to self-insured medical plans that shift the focus to controlling costs for employers themselves. Both of these factors highlight the need for employees to be able to access a high-quality outcome with lower cost providers and facilities. However, in order to do so, they must be armed with data and a means to point them in the right direction. Enter cost transparency and advocacy providers.

Healthcare is one of the only services where neither the buyer nor seller is aware of the cost involved in the transaction. But with cost transparency providers, these third party vendors or apps will arm the end-user with the actual cost of a plan (even factoring in how their specific plan will pay). Most of the good solutions are mobile-ready and can enable the user to make appointments or give driving directions with the click of a button. The industry leaders in this space include Castlight, Compass, Healthcare Blue Book, GoodRX, PokitDok and others.

Insurance carriers also are getting in the game. United Healthcare recently updated its Health4Me application in which UHC members are able to price out an entire claim episode end-to-end. For example, if you are looking to have ACL surgery on your knee, the app allows you to select the imaging center for the MRI, specialists for the consultation, the surgeon, facility and physical therapist for follow-up care. Users are given the option to select providers and see costs along the way. The app will also configure costs based on the medical plan the member is enrolled in, save the treatment plan and assist with scheduling.

The last piece of the puzzle is member advocacy. If you ask an HR person, they'll attest that much of their day is consumed with helping employees navigate a confusing Explanation of Benefits (EOB) or helping them access care if they are not successful in navigating their health plan. Most of these cost transparency vendors now include some component of patient advocacy. They can provide assistance in explaining or negotiating a disputed bill, help in finding doctors/specialists, coordinating a complicated treatment plan, or even scheduling an appointment. HR teams love this as it not only takes work off their desks but also reduces exposure to some uncomfortable HIPAA situations.

2. "Medicare Plus"/"Cost Plus" Pricing Arrangements

This concept isn't a new one, but it has been gaining steam and momentum. I will caution, however, that this approach is not for everyone and it takes an aggressive employer to go this route. As more employer groups have adopted this strategy, hospital and provider groups have begun to take notice and push back. Therefore, the future of these plans is still uncertain.

Here's how it works: Typically a self-insured employer will rent network access (say Cigna or Aetna) to give its employees access to their panel of doctors and facilities and also to benefit from the discounted rates that the network has negotiated with those providers. In a Cost Plus environment that self-funded plan sponsor will forego contracting with networks for hospitals and facilities. Although some will still contract with a smaller network for provider access, the hospital and affiliated facilities is where the lion's share of medical claims will occur.

Instead of paying a contracted or negotiated amount for a billed claim, the plan will pay based on what it views as a "reasonable amount." This can range from 125-300% of the allowable amount paid by Medicare. Believe it or not, these multiples of what Medicare pays are still lower than a typical discounted fee negotiated by a major network (Anthem, UHC, Aetna, Cigna, etc.).

The advantage of employing this tactic is found in significant savings realized by the plan sponsor, who pays much less for expensive procedures. This model focuses its cost based on a known price (filed Medicare charges) versus a carrier model of applying a percentage discount to billed charges. Traditionally, if a hospital wants to generate more revenue, they simply raise their billed charges and the carrier applies its discount to the higher amount. Medicare charges are a relatively fixed amount and are immune to such tactics.

The disadvantage of these programs is that they can create a lot of noise and resistance from employees and providers alike. An employer would need to field angry complaints about collections notices that get sent to employees' homes, be able to educate employees on how the program works, and be willing to engage legal support when needed. The best practice will be to marry a level of services for members that include patient advocacy, legal intervention, prospective pricing services and communication/education tools.

3. Telemedicine

Telemedicine has made quite a splash in the market and there has been widespread adoption from plan sponsors and insurance carriers alike. Whether it's Anthem's Live Health Online, United Healthcare's Virtual Visits or third-party providers such as MeMed or Teladoc, telemedicine is widespread and growing in popularity.

This technology allows for members to connect with a doctor — over a phone call or video conference via their mobile device — to diagnose (and prescribe medicine) for relatively simple conditions, such as a sinus infection or rash. These types of conditions are normally resolved with one visit and do not require follow-up care. Members love this approach to care for its convenience, and plan sponsors endorse it for the lower cost of delivering an office visit and reduced absenteeism from its workforce. In 2015 alone, the American Telemedicine Association reported 1.25 million telephonic/virtual visits.

Despite the growth in utilization and popularity, telemedicine has its challenges in the market. For example, Utah and Texas are pushing back and trying to strictly regulate telemedicine, making it more difficult to access in those states. As most insurance is regulated on a state-by-state basis, some states will only allow patients to speak with telemedicine providers physically located within their same state.

I see this trend taking hold and continuing forward with its uptake and popularity. The state insurance departments will likely work out their objections, the technology will get better and members will

embrace this new style of accessing care. I am sure that in the 1980s there were many that assumed people would never leave their favorite bank teller in favor of an ATM, but look where we are today.

While we still have half a year to determine whether these three trends will be the 2016 breakout stars of the employee benefits world, it is undeniable that they are gaining traction and are worth taking note of. Ultimately, the goal for most companies is to support optimal employee health at realistic costs, which translates to high productivity and engagement, and strong overall company performance. Whether these three trends succeed in doing that, only time will tell.