34TH ANNUAL ISCEBS
Employee Benefits
Symposium

A Rising Cost and Concern: Catastrophic Medical Claimants

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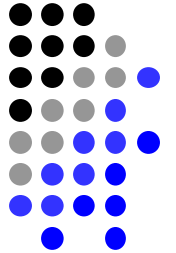
Three Key Takeaways Today

Awareness, Acknowledgment and Application



Awareness of the rising frequency of truly catastrophic medical claimants

- Greater than $750,000 if not $1 million…or more
- Common diagnoses—and those forthcoming
- Not a matter of if—but when

Acknowledgment of the risk—and its randomness

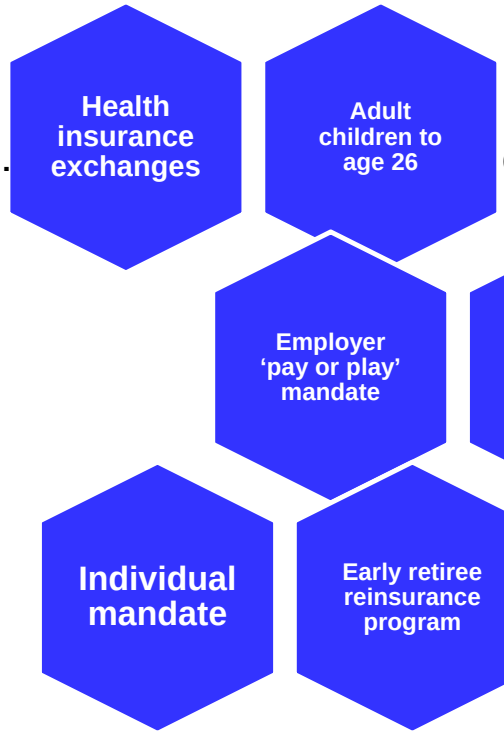
- Wellness has no real impact
- Market forces are against you
- No plan is too big to consider risk management (i.e. stop loss)

Application of evolving risk management strategies

- Actions, by size
- Laser-free stop loss coverage
- Plan mirroring, third-party claims review, dividend contracts
- What about captives?

The Patient Protection and Affordable Care Act
It Brought Many Changes

Historic legislation in 2010 instituted many now familiar issues. . .

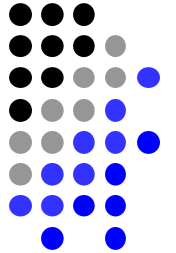


. . .many now well established. . .

. . .others already past.

All were requirements of health insurance—of which stop loss is not.

Removal of Dollar Limits Was Not a Key Concern
Even Though Many Plans Still Had One



On the eve of the ACA, most plans still had a lifetime dollar limit

- 59%, per Kaiser Family Foundation *2009 Employer Health Benefits Survey*
- Often at $1 million or $2 million

The actual occurrence of a $1 million claimant was very rare

- When it did, it most often was a Factor VIII hemophiliac—accumulated

The actuarial impact was projected to be slight

- According to a study by PricewaterhouseCoopers, “the aggregate cost increase for all companies with lifetime limits would be 0.4% to 0.6%”

A graduated roll-out of annual limits helped ease the transition

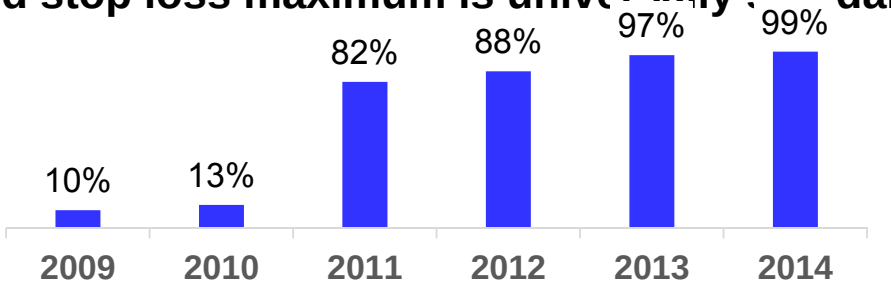
Plan Year	2011	2012	2013	2014
Limit	$750,000	$1.25 M	$2.0 M	None

Stop Loss Carriers Took Notice Though
It Uncapped a Previously Capped Liability

Prior to the passage of the ACA, unlimited stop loss maximums were rare

- Only reported by 10% of all stop loss plans in 2009 (*Aegis Risk Medical Stop Loss Premium Survey*)
- Like all forms of reinsurance in the post 9/11 markets, unlimited maximums were also difficult to write and/or obtain
- The newfound demand—and exposure—started to loosen the capacity

An unlimited stop loss maximum is universally standard now

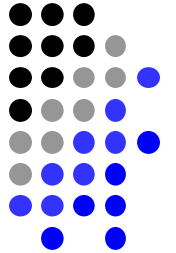


Source: 2009—2014 *Aegis Risk Medical Stop Loss Premium Survey*

The stop loss market responded to ACA's impact on the underlying risk

Providers Took Notice As Well

Perhaps Cautiously at First, But Hurriedly After



A long-established and/or anticipated billing maximum was no more

- No longer did hospitals have to "tap the brakes" as costly care approached $1 million

For the few patients who did exhaust employer benefits, a move to Medicaid was no longer necessary

- Many with chronic, ongoing maintenance costs
- The removal of limits was estimated to save Medicaid "more than $11 billion over the next 10 years" (PwC, 2009)

Specialty drug developers (and their investors) were provided a limitless runway to fund therapies—both current and in the proposed pipeline

- Potentially costing $100,000s per year

What's Been the Impact?
High Claimants Are Higher and More Frequent

Per various stop loss underwriters:

Stop Loss Underwriter	Policy Years	Observation
PartnerRe Health	2007–2012	"An increase of more than 350% (35% per year) in the frequency of claims above $1 million."
HM Insurance Group	2010–2014	More than a tripling of claims incidence of $1 million or more, rising from 1.8 to 5.9 per 100,000 covered employees
Sun Life Financial	2010–2013	"The number of claims that were individually $1 million or above rose by 1,000% (with a) sharp 144% increase in 2013 compared to the prior calendar year."

Who Are These Claimants?

Wellness May Not Have Much Impact

High catastrophic claimants are less impacted by lifestyle and wellness

- Disease, congenital anomalies, and neoplasms are most prevalent
- Frequency varies at higher deductible levels

	Frequency at Deductible Level		Max. Reimb.
Condition	**Overall**	**>$500,000**	
Malignant neoplasm	19.8%	5.8%	$1,704,810
Chronic/ESRD	5.9%	7.4%	$3,000,734
Leukemia, lymphoma	4.5%	7.9%	$2,137,398
Spinal	4.1%	<3.0%	Not provided
Heart disease	2.3%	6.3%	$2,265,552
Congenital anomalies	2.2%	14.2%	$2,556,925
Diseases of blood, blood-forming organs	<1.5%	8.9%	Not provided

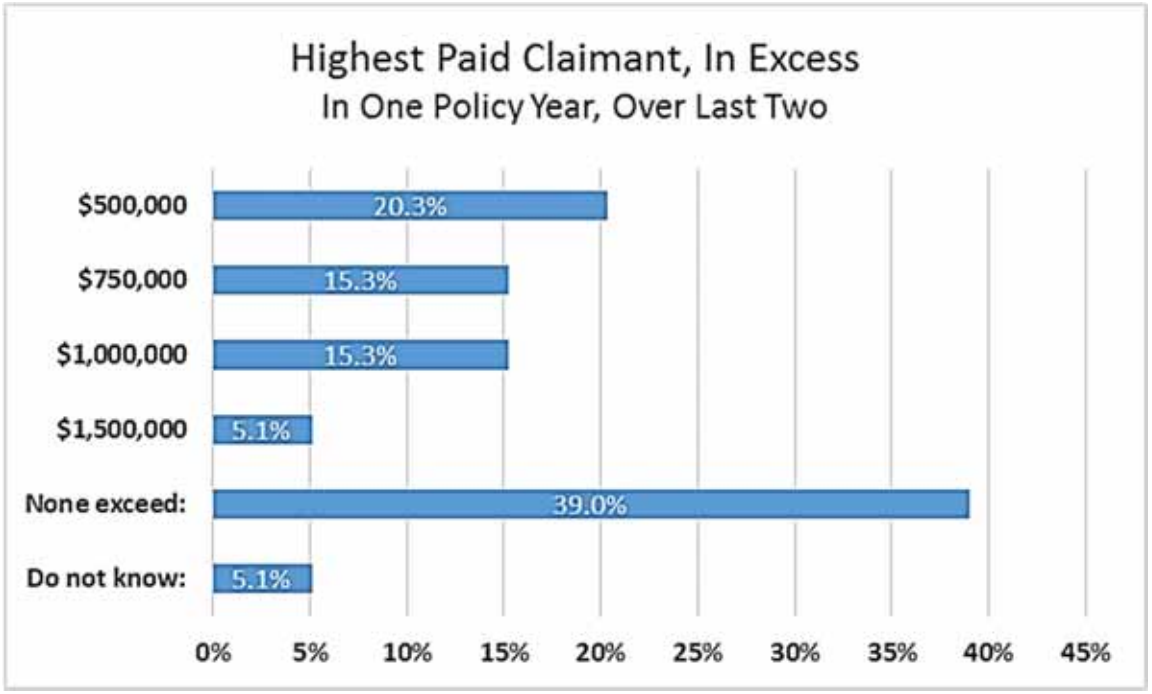
Source: *2014 Sun Life Stop Loss Report*

Highest Paid Claimant, In Excess

2015 Aegis Risk Medical Stop Loss Premium Survey

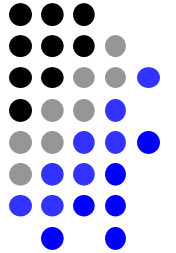
When surveyed on the last two policy years:

- 56% incurred a policy year claimant in excess of at least $500,000
- 36% of at least $750,000
- 20% in excess of $1 million. . . and 5% in excess of $1.5 million



What's the Prognosis?

…Don't Plan on It Slowing Down. It's Business.



While overall trend has moderated, catastrophic trend has not

- Rising frequency of multiple newborns (often w. fertility treatment)
- Use of latest—and pricier—technologies in ICU care management
- More chronic conditions, including non-traditional ones such as cancer

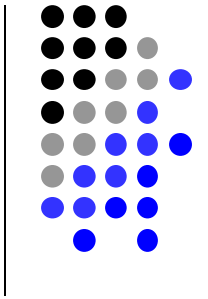
Many PPO/Health System reimbursement contracts turn more favorable for higher cost patients

- "Outlier" provisions often kick-in, reverting to a higher reimbursement %
- Evidence that ASOs are less vigilant on self-funded—it's not their risk!

Evolving reimbursement approaches need to incent provider efficiency

- Pay providers in a way that rewards cost savings and quality and away from paying a fee for each service
  - Reference-based pricing (e.g. Medicare + x %)
  - "Bundling" entire episode, including post-acute services (e.g. neonates)

The Specialty Pharmacy Industry
Funded by…Your Health Plan



THE WALL STREET JOURNAL.

Alexion-Synageva Deal Shows Lure of Rare-Disease Drugs

Price tag of $8.4 billion is double target's market cap

Updated May 6, 2015 6:58 p.m. ET

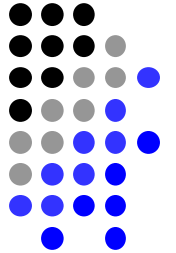
Specialty expense expected to multiply as more therapies hit market

- Most will be moderate cost for routine conditions, but highly specialized therapies for rare or specific *type* of diagnoses are envisioned ('orphans')
- Life-saving treatments—but at a significant and ongoing cost as formerly fatal diagnoses become 'chronic' conditions (e.g. cancer)

Creates an "accumulation" risk of future years' liabilities

- e.g. A 17 yr. old Factor VIII at $850K/yr and four years of future coverage
  - Approximate $3M of unreserved liability—in the *active* plan. Beware the CFO!
- Existing stop loss underwriting often 'lasers' or excludes such claimants after the initial year—or fully recoups it with premium increase
- Hybrid stop loss with a disability-like reserve rate component? Stay tuned.

Application
How Can We Protect Our Plan?



Self-funded plans of all sizes should give consideration to stop loss

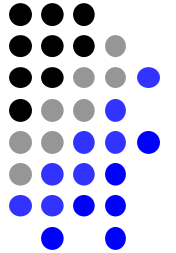
- If less than 10,000 employees and you don't have stop loss—get it!
  - The occurrence of a truly catastrophic in excess of $2M+ is real
  - Find the deductible that costs ≈ $500,000 per year in annual premium
- Those with existing coverage, aggressively manage
  - Review lasering approach and ability to 'plan mirror' (see following slides)
- If more than 10,000 employees—and no stop loss, conduct a review
  - Price a truly catastrophic specific deductible at $1M (about $5.60 PEPM, 2014)
  - Relatively low premium relative to actual risk will mirror other organizational coverage (go ask the Risk Manager)

If remain uncovered, "stress test" your plan—and check with Finance

- Model a $5M Factor VIII hemophilia claimant—recurring annually
- Ensure an adequate reserve in your rate funding, if able (e.g. 5%)
- Confirm that Finance understands the evolving claim risk and that your health plan has full, unlimited liability (better now then later)

Application

Lasering—Isn't This Supposed to be *Insurance*?

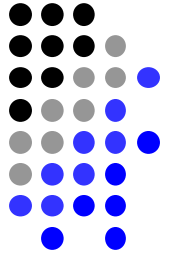


A cool term with not-so-cool effects

- Based on premise that insurance covers *unknown* and future risk, not *known* and existing
- A focused reduction or elimination of coverage for a specified claimant
  - A higher deductible
  - A full removal of a claimant from the policy
  - Reduced coverage in claims basis, typically run-in (e.g. 12/12 laser on a 15/12)
- A 'firm' proposal should clearly identify any laser, as should the final policy
- During a bid, confirm each carrier's "laser-free" philosophy—it varies
  - No new lasers at renewal: always offers a no-laser renewal; but if a large ongoing claim, it may renew quite high—forcing a renewal option with the laser
  - No-laser renewal rider: an ongoing premium load with renewal rate cap; e.g. a 7% to 9% rate load and rate cap not to exceed 45% to 55%
  - Be sure to separate green apples from red apples in your review—and show it
- If presented with a laser at renewal, seek options both with and without
  - Review and make the best choice; lasers may work favorably if claim 'ending'

Application

Evolving Stop Loss Strategies—Dividend Contracts



These stop loss policies are gaining in popularity

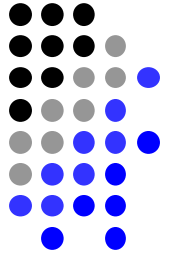
- Per a set or negotiated formula, a percentage of the paid plan premium is refunded if certain claim to premium loss ratios are achieved.
- They typically require two to three years of continual coverage prior to payment
- Underwriters enjoy that multi-year commitment from a policyholder
- Favorable claims history may offer as much as a 5 to 10% premium refund

An effective way to "claw back" extra premium during periods of strong claims experience

- A key to success is negotiating a competitive target loss ratio (e.g. 65% or more)

Application

Plan Mirroring; Third Party Claims Review



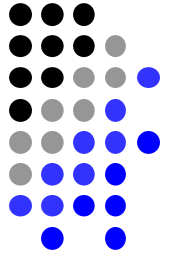
Large and sizeable claims (e.g. >$1M) increase the potential for conflict between your health plan language and stop loss contract

- You want stop loss to reimburse what the health plan has properly 'paid'
- Potential conflict is most often centered on "usual, customary and reasonable" (UCR) charges or plan member eligibility
- However, what is deemed UCR may vary on higher claimants
- 'Plan Mirroring' stop loss amendments minimize, if not erase, difference by "clamping on" to the health plan document and/or medical decisions

Third-party claim review organizations may obtain additional savings

- An external party to assess UCR and/or medical necessity
- Used by many stop loss carriers on their TPA risks to aggressively manage provider reimbursement
- Evolving opportunity for employers to insert post-TPA/ASO adjudication
- Lower net claim = lower hits to stop loss = lower premium

Application
It's Your Health Plan Data—Manage Your TPA/ASO



Some ASOs are taking an aggressive posture on reporting

- Case management and prognosis notes are "proprietary. . . work product"
- "not available for review or release to clients and/or their vendors."
- "By providing..the stop loss carrier could. . . hold (us) liable for. . . decisions"

This disconnect does not support placement and renewal of stop loss

- Naïve to believe stop loss should be written "blind" and also at 'low' rate
  - What an underwriter doesn't know often raises the rate even higher
- Identify any disconnect between ASO/TPA and stop loss—be assertive!

'Seamless' placement of stop loss with the ASO has its easy appeal, but externally placed coverage offers attributes as well

- Transparency on high claimants due to monthly reporting
- A sentinel effect on your highest claimants for claims and care accuracy

Application
What About Captives?

Captives. Have you heard? They're *groovy*, man.

- A lot of talk; some growth; still a lot of uncertainty
- A captive works best for predictable risks
  - In benefits, think life/disability; organizationally, there are many such risks
- Stop loss is highly volatile with infrequent, but high exposure (i.e. claims)

Where most sensible, there's often another variable

- An existing P/C captive seeks 'outside' risks to maintain its tax status
- A "small" group transitioning to self-funding is unable to find stop loss
  - Pool with others and gain a 'cell' within an existing captive 'condo', providing a lower captive deductible (e.g. $50K) before higher stop loss (e.g. $250K) level
  - <u>But</u>, your low claims may be offset by the high claims of others in the condo

Oh. . . and stop loss and reinsurance pricing remains 'soft'

- Establishing a captive structure is not cheap ($750K+)

With All That Said. . .

. . . your Questions, Confusions and Concerns?

For those that exist—please ask!

AEGIS risk

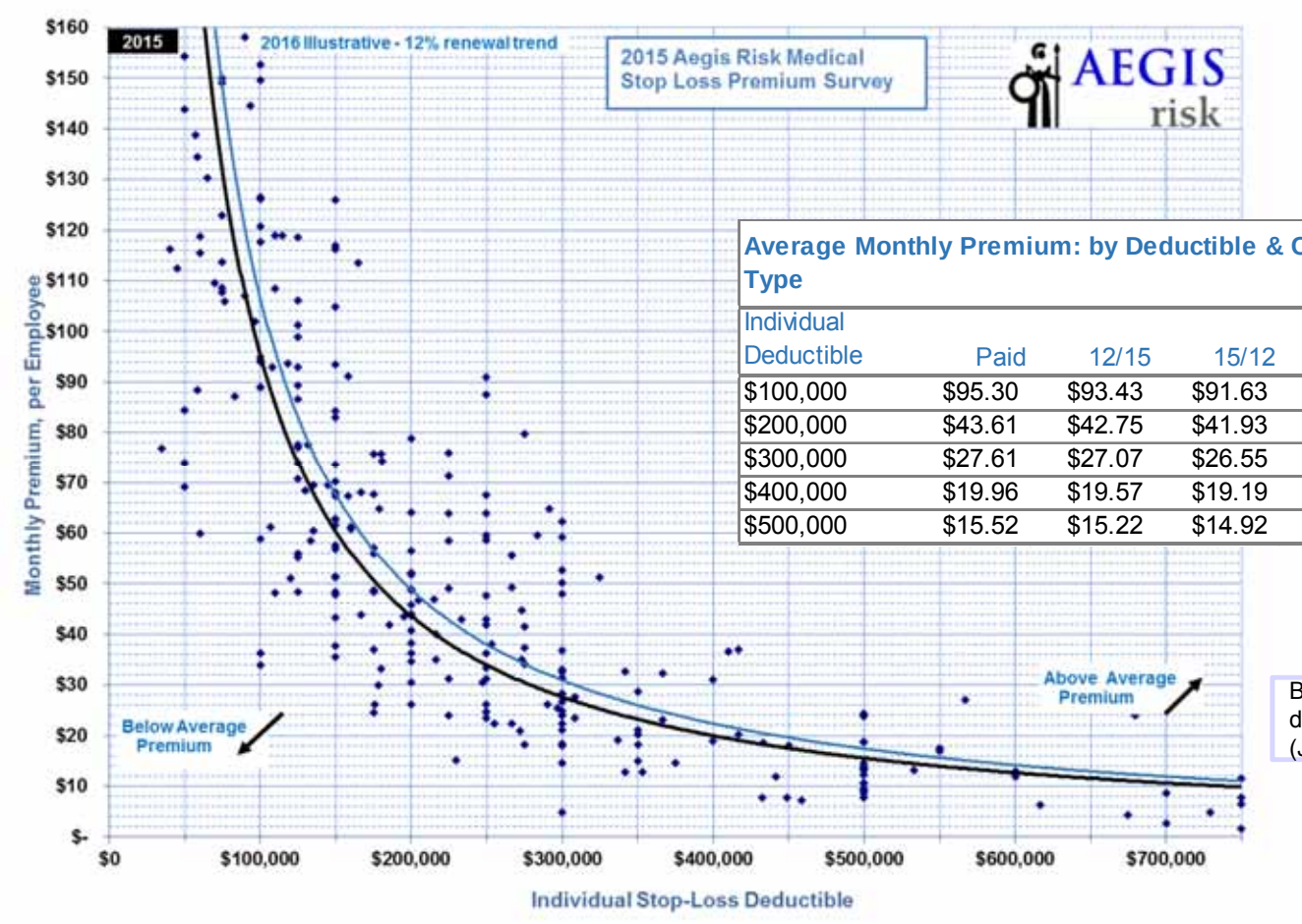
Medical Stop Loss Premium Survey

2015

The survey results were included in your Symposium briefcase. Additional copies are on our sponsor display table. Feel free to leave a business card for notification of the 2016 survey.

. Conducted in conjunction with the ISCEBS.

Appendix: How Much Does Stop Loss Cost?
2015 Aegis Risk Medical Stop Loss Premium Survey

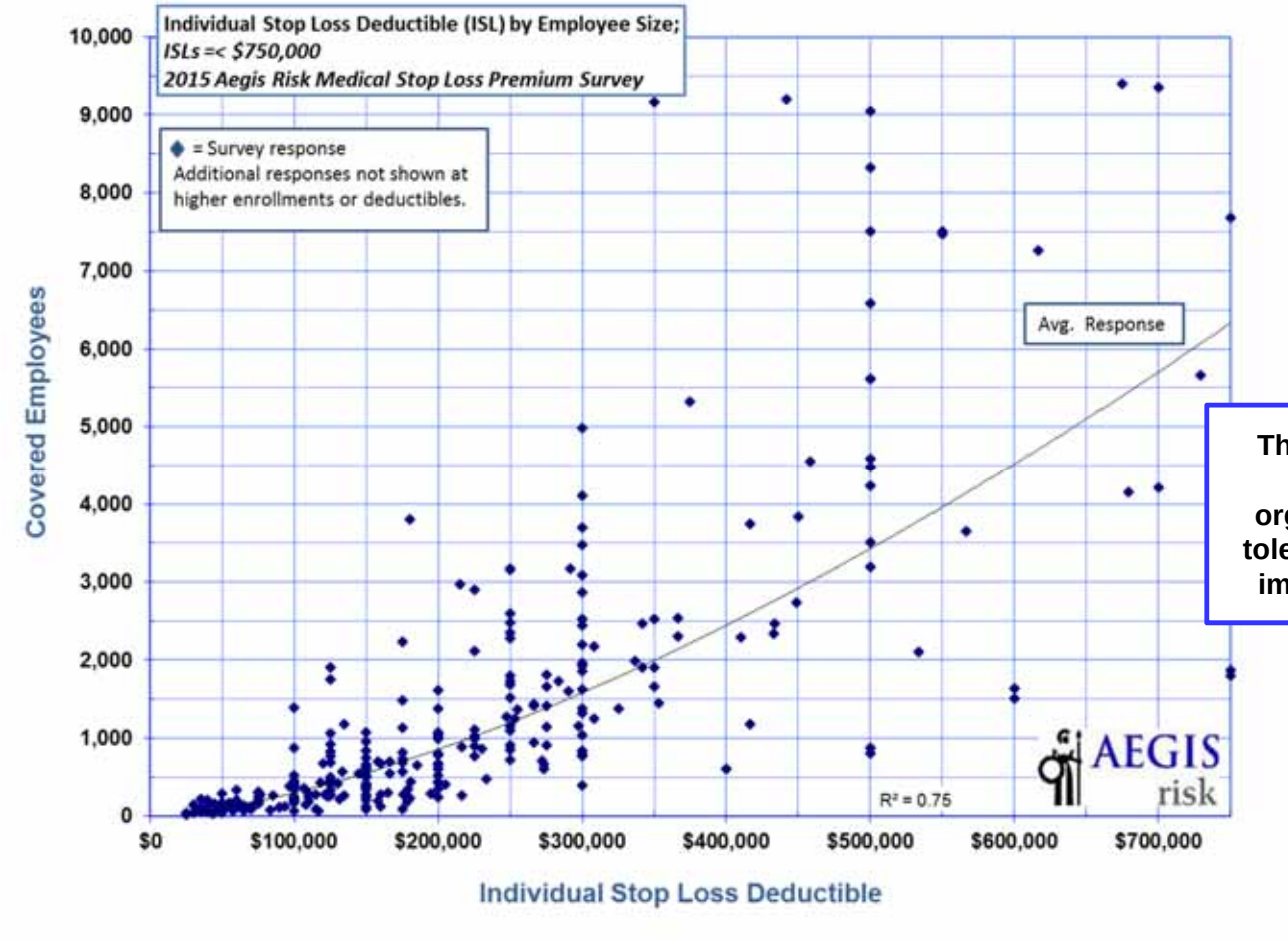


Average Monthly Premium: by Deductible & Contract Type

Individual Deductible	Paid	12/15	15/12	12/12
$100,000	$95.30	$93.43	$91.63	$75.63
$200,000	$43.61	$42.75	$41.93	$34.61
$300,000	$27.61	$27.07	$26.55	$21.91
$400,000	$19.96	$19.57	$19.19	$15.84
$500,000	$15.52	$15.22	$14.92	$12.32

Based on initial data; final may vary (July 2015)

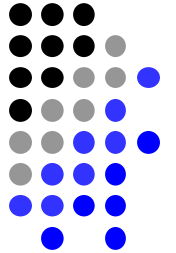
Appendix
What Size Deductible?



This shows market position – organizational risk-tolerance is the most important variable.

Appendix: Stop Loss Coverage

Two Types of Stop Loss: Specific and Aggregate



Specific (or Individual)

Guards against the volatility of individual high-cost claimants

- The common form of stop loss
- Reimburses claims beyond a specified deductible—as low as $50,000 to as high as $1+ million.
- The contract stipulates the covered claims basis on dates of incurral and/or payment (e.g. 12/15, paid)
- Reimburses expense for an individual contract year (i.e. it's not ongoing)
- Premiums vary widely by deductible

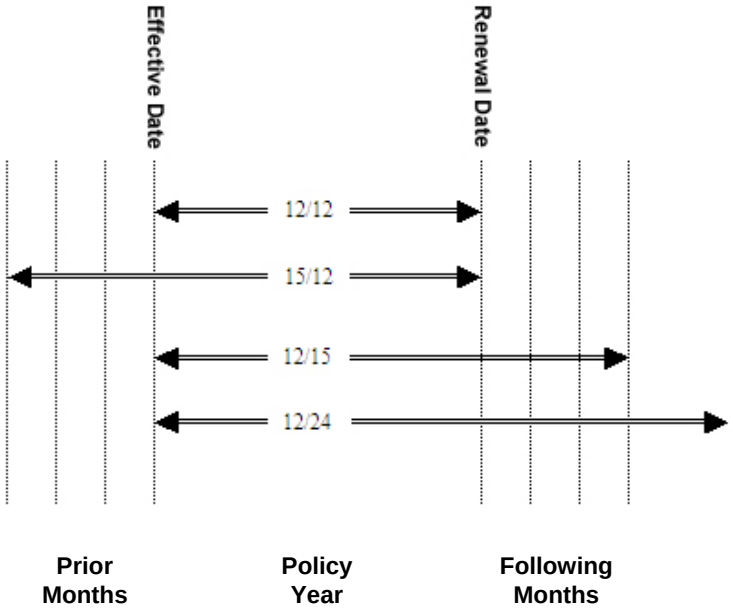
Aggregate

Protects against over-utilization of the entire health plan

- More common with smaller (<1,000 ees), risk-adverse employers
- Reimburses if overall plan expense exceeds a threshold (e.g. 125%)
  - Based on an expected claims rate per covered employee
- Per covered claims basis
- Premiums less, as claims uncommon
- Typically, it augments specific
  - No double indemnity

Appendix: Contract Types

What's with all those numbers?



. . . on renewal!!!

Usually refers to Incurred/Paid months:

- **12/12**: Incurred and paid within the 12-month contract period. Good initial coverage. Renew with a paid.
- **15/12**: . . . Covers claims incurred the prior 3 months (i.e. run-in). First year coverage. A longer run-in is advised, such as an 18/12. Renew with paid.
- **12/15**: Like a 12/12, but further covers claims paid in the following 3 months (i.e. run-out). Often renews with a 12/15.
- **12/24**: Longer run-out, with payment over 12 months. A 12/18 covers six months.
- **Paid**: Covers claims paid during the policy year, regardless of date incurred. The most comprehensive contract, typically on renewal/ongoing coverage. Not common at initial placement.