Medical Stop Loss – Recent Trends and Ongoing Catastrophic Claimant Impacts, incl. COVID-19, Specialty Drugs and Orphan Therapies

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AEGIS risk

Key Takeaways Today

- Share current stop loss benchmarks and costs
- Review COVID-19 impacts to stop loss
- Highlight catastrophic claimant dynamics
  - Rare disease & gene therapies – lifesaving, but costly
  - Demographics of the costliest claimants
- Discuss best stop loss practice and strategies
  - In advance and at time of claim
  - At your next renewal or placement

A Quick Primer–Two Types of Stop Loss

Specific (or Individual)

- Guards against the *volatility* of individual high-cost claimants
  - The common form of stop loss
  - Reimburses claims beyond a specified deductible – from under $50,000 to as high as $1+ million.
  - The contract stipulates covered claims based 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

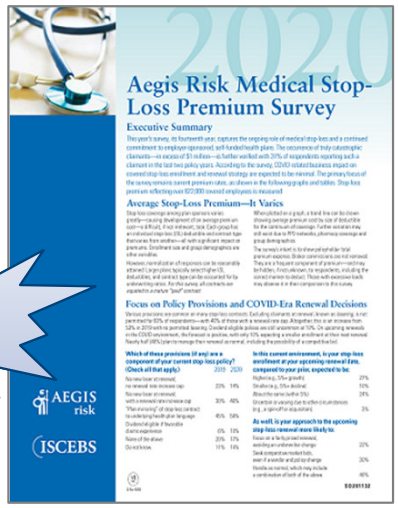
Aggregate

- Protects against *over-utilization* of the health plan
  - More common with smaller (<1,000 ees), risk-adverse employers
  - Reimburses if overall plan expense exceeds a threshold (e.g. 125% of expected)
  - Per covered claims basis
  - Premiums are less, as claims uncommon
  - Typically, it augments specific
    - No double indemnity or high claimant coverage

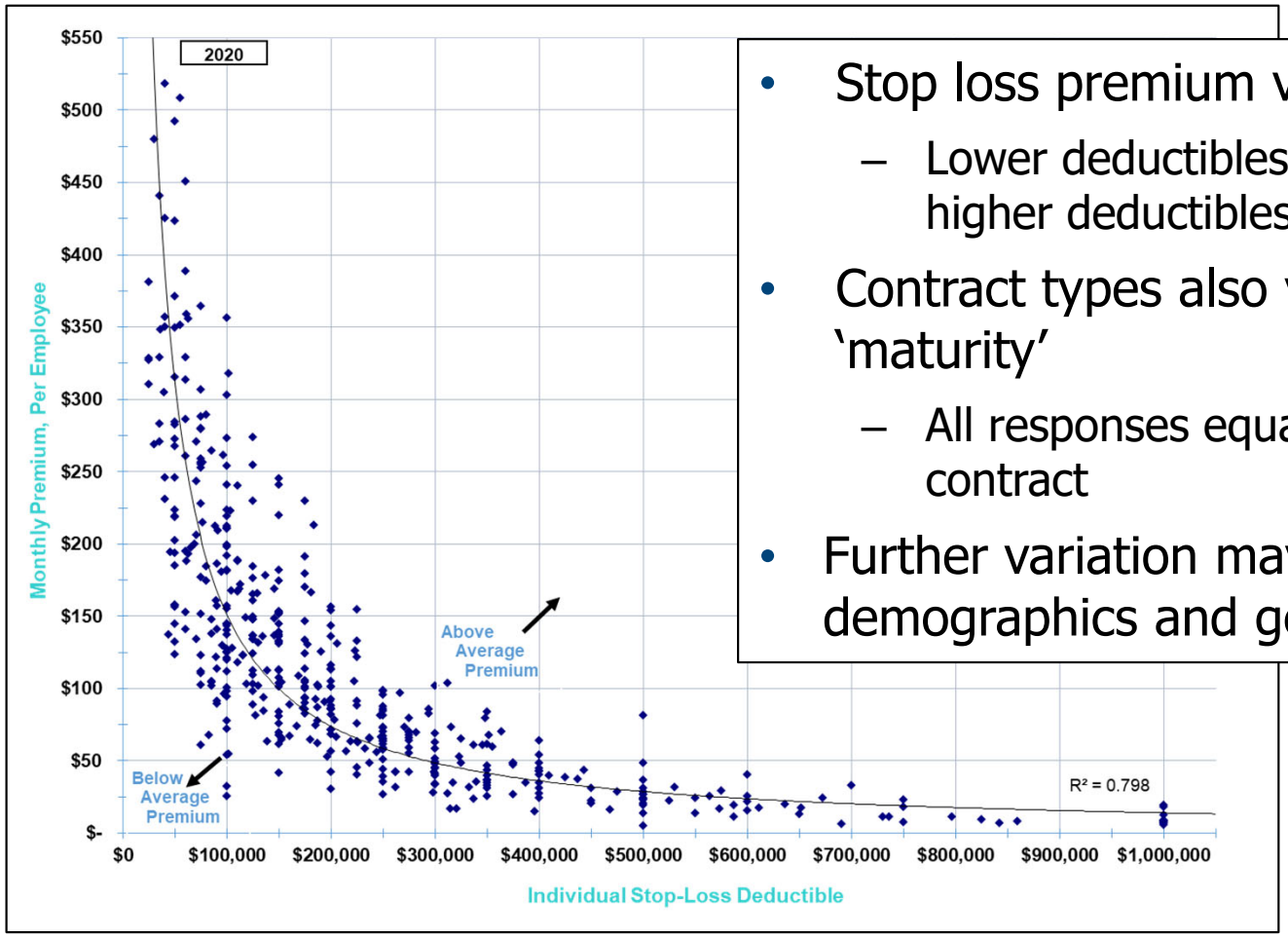
The 2020 *Medical Stop Loss Premium Survey* – Some Background

- Measures current stop loss premium expense across the range of individual stop loss (ISL) deductibles and for aggregate stop loss
  - Also captures policy provisions, claim dynamics and risk strategies
  - Its 14th year and done in partnership with the ISCEBS
- Respondents include plan sponsors as well as other brokers/consultants and stop loss writers
  - 483 plan sponsors covering 822,000 employees
  - Nearly $430 million in annual premium
- *2021 Survey is now Open!* Respond at www.aegisrisk.com. Participants obtain in August.

2021 Now Open!

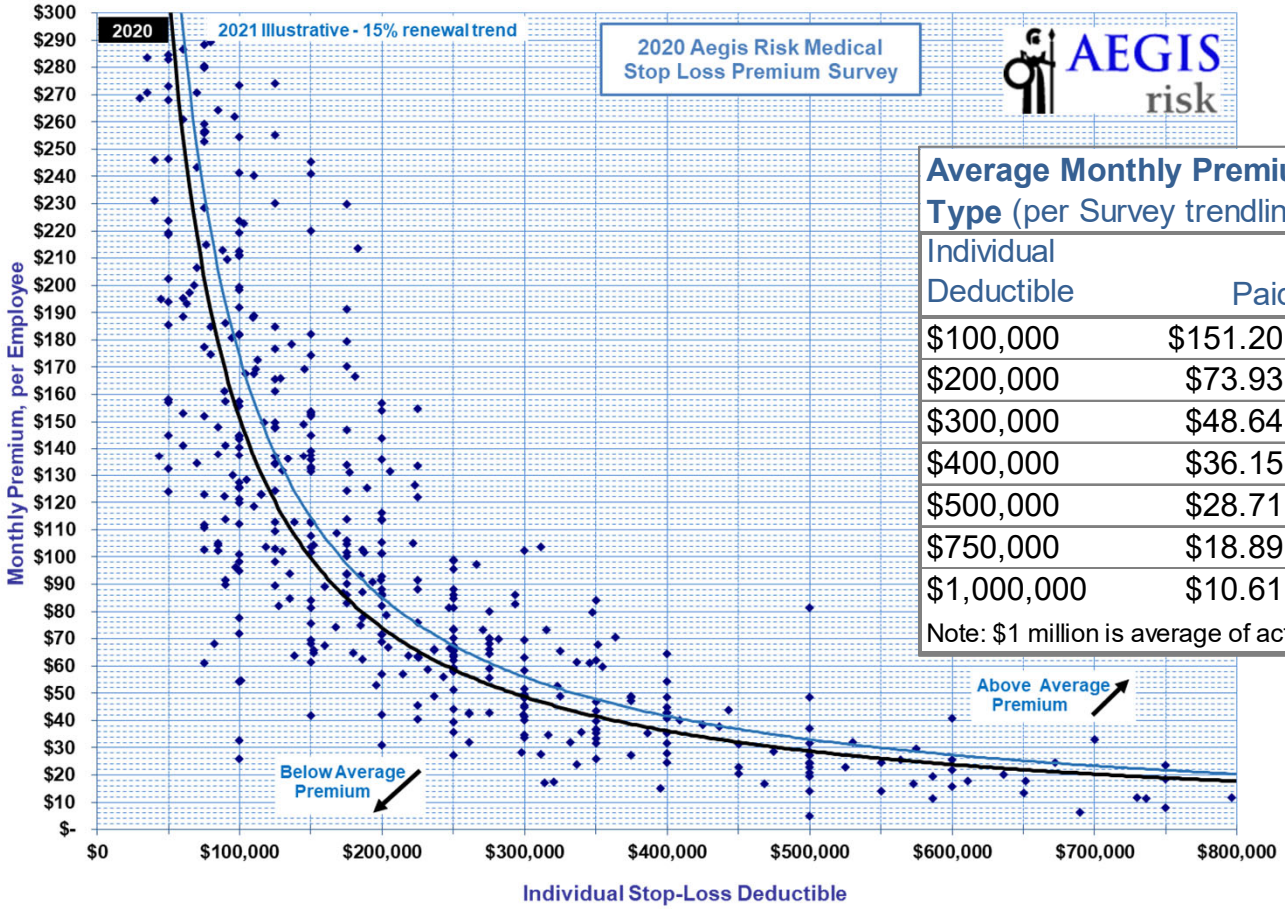


Avg. Premium, EE/Mo.–ISL by Deductible



- Stop loss premium varies greatly
  - Lower deductibles incur greater cost than higher deductibles
- Contract types also vary in their degree of 'maturity'
  - All responses equated to a mature "Paid" contract
- Further variation may still exist due to plan demographics and geographies

A Focused Illustration–Common Deductibles

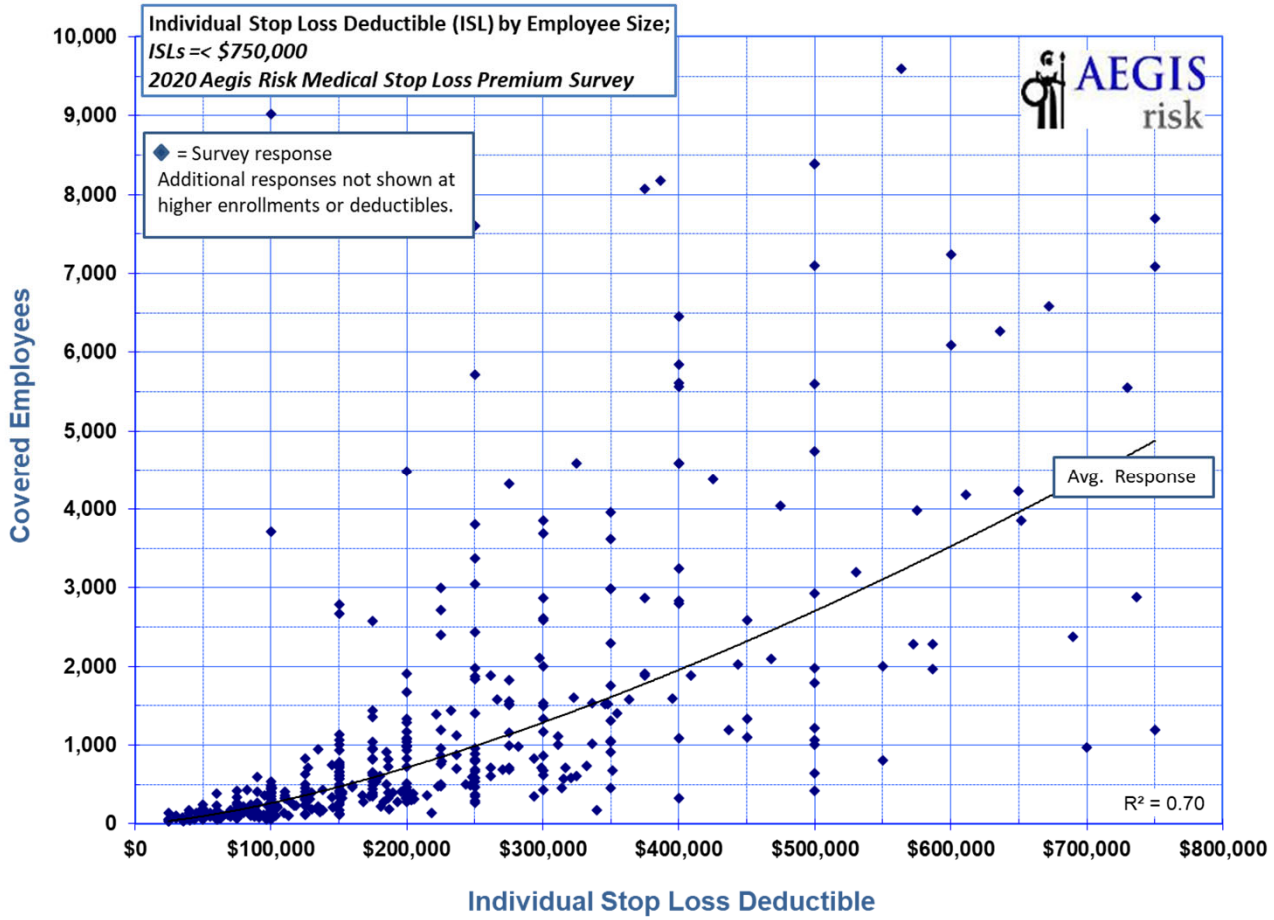


Average Monthly Premium: by Deductible & Contract Type (per Survey trendline, unless noted)

Individual Deductible	Paid	12/15	15/12	12/12
$100,000	$151.20	$148.24	$145.38	$120.00
$200,000	$73.93	$72.48	$71.09	$58.67
$300,000	$48.64	$47.69	$46.77	$38.60
$400,000	$36.15	$35.44	$34.76	$28.69
$500,000	$28.71	$28.15	$27.61	$22.79
$750,000	$18.89	$18.52	$18.16	$14.99
$1,000,000	$10.61	$10.40	$10.20	$8.42

Note: $1 million is average of actual responses; n = 10

ISL Deductible–By Employee Size



- Shows continuum of ISL deductible by number of covered employees
  - Larger go larger
- A benchmark, but individual risk tolerance is any plan's ultimate guide
- Additional responses lie outside this graph

Policy Provisions–Findings

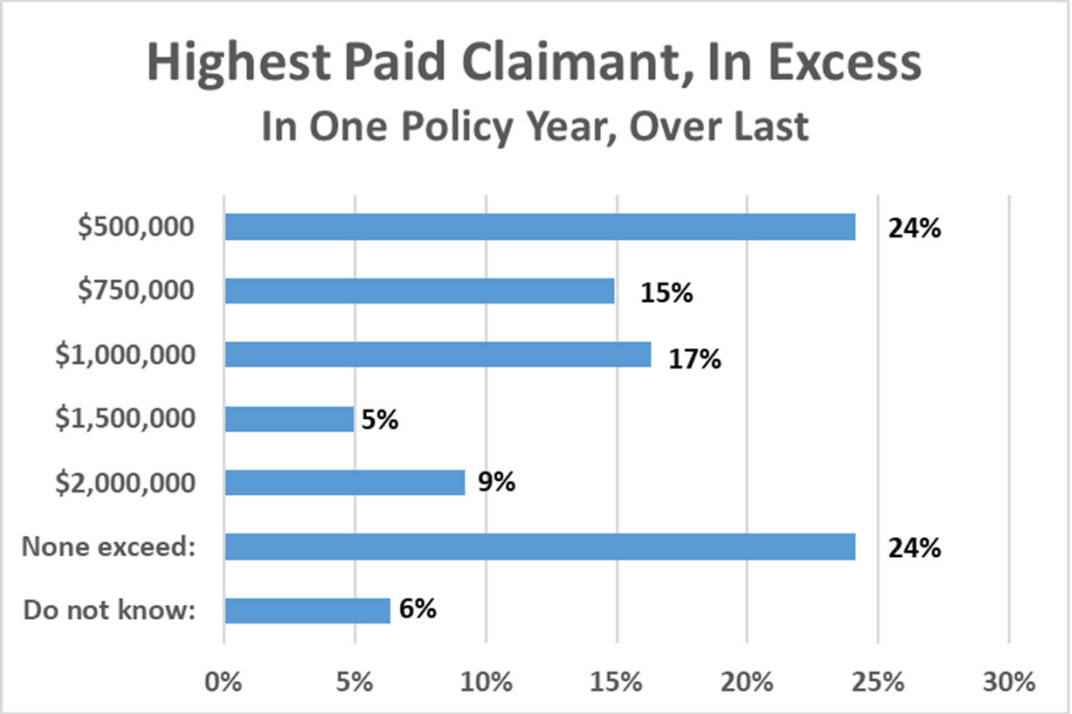
Which of these provisions (if any) are a component of your current stop loss policy? (check all that apply)

	2019	2020
No New Laser at Renewal; no renewal rate increase cap	23%	14%
No New Laser at Renewal; with a renewal rate increase cap	30%	46%
"Plan mirroring" of stop loss contract to underlying health plan language	45%	59%
Dividend eligible if favorable claims experience	6%	10%
None of the above	20%	17%
Do not know	11%	14%

- No new laser (e.g. an excluded claimant) with a renewal rate cap is becoming more prominent (46%, up from 30%)
- Plan mirroring, whereby stop loss follows the underlying plan document, is found in most plans now (59%)
- Dividend eligible policies are still uncommon, but rising, at 10%
- Survey further confirms that 98% cover pharmacy as well

Catastrophic Claimants–Prevalence

- Inquired on their last two policy years, 70% of respondents incurred a claimant greater than $500,000
  - Up from 64% in 2019
- Claimants in excess of $1 million are reported by 31%
  - 9% of those in excess of $2 million



COVID-19 on Stop Loss–What Impact?

- For Sun Life, approximately 1% of 2020 stop loss claimants were COVID-19 (~100 members), with an average cost of $340,000
- Most claims related to COVID-19 are not exceeding the stop loss deductible
  - Still, severe cases with lengthy inpatient stays or comorbidities have charges exceeding $150,000 if not much higher – claimant below in excess of $500,000

DIAGNOSIS:
COVID 19-VIRAL PNEUMONIA

COMORBIDITIES:
ACUTE RESPIRATORY FAILURE, CYTOKINE RELEASE SYNDROME, ACUTE EMBOLISM FATTY LIVER, ENCEPHALOPATHY DUE TO VIRUS, SEIZURE LIKE ACTIVITY, WEAKNESS ACQUIRED IN ICU, CRITICAL ILLNESS MYOPATHY, PYURIA, LEUKOPENIA, THROMBOCYTOPENIA, TRACHEOBRONCHITIS, HYPERTENSION, HYPERLIPIDEMIA, ASYSTOLE EPISODE 12/28

- Reduction in elective surgeries likely depressed surgical complications and sepsis claimants
- Uncertain is the potential uptick in 2021 as those elective services return …and if long-term health implications lurk for those recovered from COVID

$1M+ Claimants–Who Are They?

- Congenital anomalies, blood disorders and neoplasms are common
  - Not highly impacted by lifestyle and wellness initiatives – more random
- Other "million dollar" claimant trends (source: Sun Life, *2021 Research Report*)
  - They're young: members under age two are only about 6% of total stop loss claims, but 26% of claims over $1M and 43% of claimants over $3M
  - Congenital anomalies was leading diagnosis for claimants under age two
  - Hemophilia was the leading claim condition between the ages of 20 and 39

Medical Condition	Highest Claimant (Sun Life, 2020)
Congenital anomalies (present at birth)	$4.6M
Hemophilia/Bleeding disorders	$4.9M
Malignant neoplasm	$6.3M
COVID-19	$3.0M

Self-Insured? A Swim with Sharks

- Very sizeable health claimants now lurk
  - Over $2M if not $5M in a plan year
  - Member impact aside, these are organizationally impactful (e.g. quarterly financials and earnings)
- Creates a financial risk previously not envisioned for a self-insured, active employee health plan
  - Ensure your CFO is aware
  - Confirm adequate risk protection
  - Verify health plan programs and processes are in place

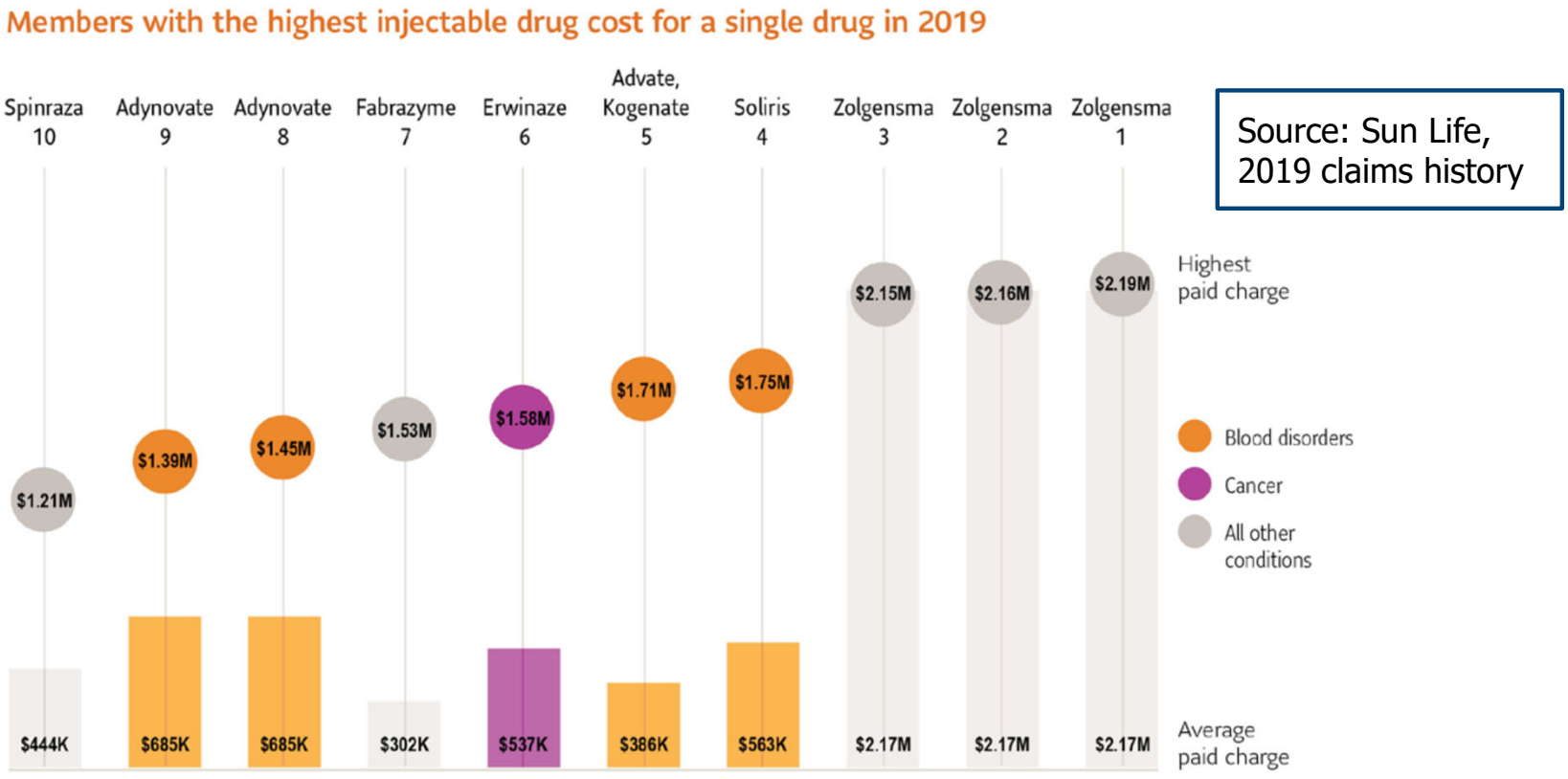
Rare Disease and Orphans–Lifesaving, but Costly

- Orphan diseases affect small groups of patients – but diseases are numerous and many yet to have a regimen
- Aside from rare disease, costly treatments may also target cancer, hemophilia and genetic conditions
- Pharma is eagerly pursuing new regimens – it's their primary basis of future revenues (and stock price)


The Washington Post
BUSINESS
His parents signed away privacy rights for financial help to treat his life-threatening disease
Max's best hope costs $750,000

Format	Basis	Example - costs
Biologics	Living cells, organisms	Soliris – blood disorder, $550,000
Gene Therapy	Use of normal genes to correct faulty	Luxturna – blindness;$900K to $1.1M Zolgensma – spinal musc. atrophy; $2.1M
CAR-T	Cell-modification immunotherapy	Kymriah – cancer; $475K

Injectable Drugs–A High Dollar Driver



Source: Sun Life, 2019 claims history

Watchlist–Recent and Evolving Therapies

Disease	Therapy (FDA Approve)	Notes and costs
Hemophilia A	**Roctavian** (estd. '22/'23); others in late phase studies	1st Hemo gene therapy – FDA denied 8/20, but still in study. ~$2M - $3M 1x
Spinal Muscular Atrophy (SMA)	**Spinraza** (12/16), **Zolgensma** (3/20), **Evrysdi** (8/20)	~400 newborns each year, US. Varying therapies of ongoing ($400K/yr) or one-time (Zolgensma, $2.1M)
Cancer – CAR-T	**Tecartus** (7/20), **Kymriah** (8/17), **Breyanzi** (2/21), **Abecma** (3/21)	Therapy of $300K-$500K + ancillary/hospital $ ~ $1M total. May occur alongside stem cell transplant.
Hereditary Angioedema (HAE)	**Orladeyo** (12/20)	Daily, oral ~ $485K/yr vs. existing therapies (eg Cinryze) ~ $600K-$1.6M
Duchenne Muscular Dystrophy (DMD)	**Viltepso** (8/20)	Injection for ~8% w. the specific gene mutation of DMD;~ $750K/yr expense

Stop Loss Cover? Ensure Plan Authorized, Medically Necessary and Clinically Managed

- As with any stop loss reimbursement, it must be a plan authorized expense – medically necessary, with further evidence of a clinical review
  - As genetic testing or a specific clinical diagnosis required for dispensation, have that process in place
  - Seek stop loss policy "plan mirroring" to underlying health plan document, avoiding conflict in terms
  - Monitor the expansion of gene therapies and how both your medical plan and PBM authorize and cover – an "investigational" use may creep in and disqualify
  - Clarify plan language to address outcome-based payment models
- Ensure disease and care management vendors have genetic and rare disease capabilities
  - Member access to disease-specific management programs
  - In-network specialty pharmacy fulfillment

Beware Accumulation Risk–Large and Ongoing

- Many specialty and orphan claimants are ongoing – not "one and done" claim episodes, like traditional stop loss claimants
  - As already seen with Factor VIII hemophilia claimants of several $100,000s per year
  - Create sizeable, multi-year *accumulation* of plan liability – typically unreserved
- In example:
  - 17 year old Factor VIII dependent claimant
  - Annual regimen = $650,000
  - Liability, present value over the next 5 years ≈ $3 million
  - Typically unreserved – despite being a very predictable expense
- CFO reaction: What??!! How much?! How long!? Where's our hedge?
  - (stop loss is one answer)

Lasering–Isn't This Supposed to Be Insurance?

- Laser: a claimant excluded from stop loss, at placement or renewal
  - Based on premise that insurance covers unknown risk, not that already known
  - Typically via higher deductible, restrictive claims basis or outright exclusion
- Pursue/Price a No New Laser with Renewal Rate Cap contract
  - Better ensures that evolving claimants remain covered – as "no new" lasers
  - Typically offers a renewal rate cap, perhaps 45% or 50%
  - Which can be a very strong deal, as without, the renewal could be 100% or higher
  - Or the uncovered liability of the ongoing claim producing even higher plan expense
- With a strong No New Laser with Rate Cap contract, a plan is best protected from accumulation risk of an ongoing claimant
  - As once the claim occurs, it's 'known'. Other underwriters will likely laser it too.
  - But get it while you can – one year forward guarantee NNL is evolving

Other Renewal and Placement Strategies

- Confirm or pursue "plan mirroring" amendments
  - Ensures consistency between covered, eligible expenses per your health plan documents and your stop loss policy
  - Minimizes, if not erases, conflict by "clamping on" to the health doc
- Investigate a dividend contract
  - An effective way to "claw back" premium when favorable claims
  - May offer as much as 5 to 10% premium refund in favorable years
- Monitor carve-out gene therapy stop loss offerings
  - On a PEPM basis, coverage extended if selected therapies incurred
- Periodically index your ISL deductible to underlying trend at renewal
  - In example, 5% trend on $500,000 ISL = $525,000 at next year
  - Unchanged, it incurs greater, leveraged percent of plan costs over time

It's a Risk–Mind the Renewal Process

- Stop loss is not an employee benefit. It covers the plan sponsor.
- In that aspect, it's much more a property / casualty risk
  - With no member service function, focus is on policy and claims paying ability
- Like property/casualty, it behooves to sell the risk to the underwriter
  - The underwriters are a bit more the "pickers and choosers"
  - Share your information
- Be very mindful of the Disclosure process – even if it's "No Disclosure"
  - The process still requires disclosure of all known high claimants (e.g. claim reports)
  - If not disclosed – and should have – it's possibly not getting covered. Blame ensues.
  - The presence of jumbo claimants $1M and higher is further amplifying

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With All That Said…

Any questions – please ask!

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Appendix: Key Provisions and Processes

Provision/Process	Description	Recommended Strategies
Actively at Work	Coverage only for employees actively at work at onset of coverage – unless waived.	Seek waiver during final Disclosure and acceptance of risk – prior to effective date.
Experimental	Medical claims deemed experimental and not eligible for coverage.	Ensure agreement or deference to the underlying medical plan SPD.
Aggregating Specific Deductible	A separate plan-wide deductible requiring fulfillment before any individual deductibles.	Lowers premium, but an increase in the plan deductible is simpler & obtains same.
Reporting Requirements	Stipulated claim reports, often monthly, required by the stop loss carrier.	Ensure TPA/ASO provides both '50%' and claim detail reports. Ideally with no fees.
Change in TPA/ASO	Notification of a change in TPA to stop loss carrier.	Observe. The presence of an approved TPA is an underwriting element.
Coverage exclusions	Uncovered expenses (e.g. occupational related, above R&C, from criminal acts).	Ensure agreement or deference to the underlying medical plan SPD.
Pharmacy	Coverage of pharmacy expenses.	If elected, ensure reporting if not integrated with medical – many forget!
Lasers	Exclusion or placement of a higher deductible on select individuals.	Avoid, but balance their presence with potential reduction in premium.
Disclosure	Final process to a 'firm' proposal, where underwriter reviews known high claims.	A key process! Better claims data often means lower premium and no lasers.