Rethinking How Employers Address High-Cost Claims

AN EMPLOYER AND COALITION INITIATIVE

National Alliance
of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

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Background, Key Issues, and Challenges in High-Cost Claims

High-cost claims have become the single fastest-growing healthcare cost for employers in the last decade and were identified as one of the "most significant threats to employer-sponsored healthcare" in a recent Pulse of the Purchaser survey. Since 2016, the number of health plan members with claims of $3 million or more has doubled, heightening sustainability concerns.

Although most employers define high-cost claims as those over $100,000, the elimination of annual and lifetime maximums through the Affordable Care Act has redefined what is possible. Consequently, plan sponsors increasingly experience high-cost claims in the millions of dollars for a single covered individual. Some plan sponsors have taken defensive but unsustainable action by either declining to cover certain treatments or by shifting costs.

The management of high-cost claims is diverse and complex and employers/purchasers are seeking to ways to best address a number of areas, many of which are identified in this report. Though market solutions exist in some areas, they have a tendency to be unevenly deployed. Equipping employers with knowledge and potential actions enables them to address diverse challenges head-on and may be the only way they can mitigate their growing concern.

> *"Networking with other employers through these activities has been highly valued. We can hear about others' challenges and have [a] dialogue on better approaches."*
>
> **—EMPLOYER PARTICIPANT**

Facts about high-cost claimants

JUST 1.2% OF ALL HEALTH PLAN MEMBERS ARE HIGH-COST CLAIMANTS

...but they make up 1/3 of total health care spending

29x

Average member cost

$122,382

Average annual cost

53% CHRONIC CONDITIONS

47% ACUTE CONDITIONS

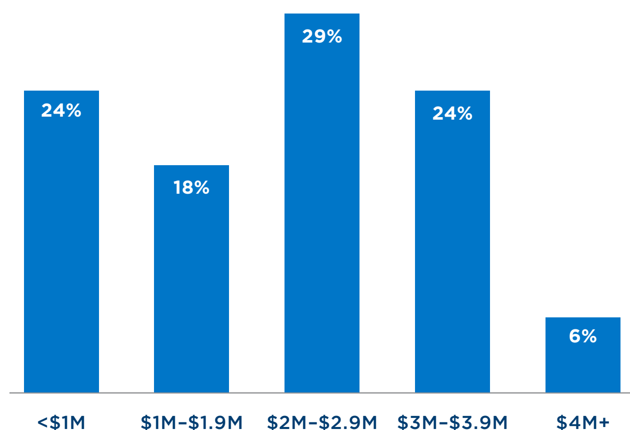
At the request of coalition members and employers across the country, the National Alliance developed its High-Cost Claims Initiative in 2022. The objective was to better understand the employer perspective on high-cost claims and provide a set of recommended strategies to effectively—and, when possible, proactively—address the challenges. In the summer of 2022, the National Alliance conducted a kick-off call with participating coalitions and employers to discuss key cost drivers such as cancer, prenatal/neonatal care, gene therapies, and specialty drugs.

Following the kick-off meeting, the National Alliance conducted a pre-survey to assess how participants currently manage high-cost claims. This was followed by four regional breakout meetings involving more than 50 employers convened through the Alabama Employer Health Consortium, Dallas Fort-Worth Business Group on Health, HealthCareTN, and Nevada Business Group on Health, complemented by a virtual meeting with all participants. This meeting combination enabled a deeper dive into high-cost claim topics and an open dialogue about approaches to help mitigate these costs without compromising patient care and outcomes. The discussions yielded the insights and takeaways summarized below.

Top Takeaways

- Nearly 8 in 10 employers consider drug prices, high-cost claims, and hospital prices a significant threat to the affordability of employer-provided health coverage for employees and their families. Some report high-cost claims have been "keeping them up at night."
- Almost half describe $100,000 as the lower limit for a high-cost claim. Some use $50,000 as a threshold to identify potential high-cost claims early.

What have been your largest high-cost claim in the past 3 years?



Source: *2022 National Alliance Employer Survey on High-Cost Claims*

> ***"We are a large company and should be addressing and even preventing high-cost claims like a smaller employer."***
>
> **—EMPLOYER PARTICIPANT**

- More than half the participating employers have experienced high-cost claims of $2–$4 million in the last few years.
- Employers are seeing a rise in high-cost claims for younger plan members, with $1 million+ claims disproportionately weighted toward this demographic. The top conditions for these claims include cancer, prenatal/neonatal care, and treatment for COVID-19/long COVID.
- Some employers are navigating high-cost claims *as they get them,* rather than *preventing* their occurrence, where possible, to mitigate their impact.
- Employers have historically been more reliant on third-party administrators (TPAs) and pharmacy benefit managers (PBMs) to manage high-cost claims. As costs have escalated, employers want to learn how best to hold service providers accountable for better management.
- As the number of high-cost claims has grown, so has interest in cost-sharing approaches that will keep costs lower for employees and families without compromising care.
- About 34% of employers set out-of-pocket maximums at $3,000 or below, while 42% have maximums of $3,000–$5,000. Almost 20% of employers have out-of-pocket maximums of $6,000 or more.
- Most employer strategies include a focus on managing complex cases (65%) and addressing the cost of specialty drugs (64%).
- Other strategies employers are deploying include using a specialty carve-out; implementing a patient-assistance program (PAP); case management (via

TPAs); reassessing stop-loss insurance; and accessing alternative, more affordable sources of medications (e.g., biosimilars).

- Employers noted that stop-loss insurance is expensive—and while some are concerned about whether to cover certain classes of claims, others have been "rolling the dice" by not incorporating stop-loss.
- The highest priority areas for employers over the next couple years include offering precision medicine for cancer treatment (45%); implementing centers of excellence (39%); negotiating and auditing hospital prices (34%); auditing intermediaries (30%); and mitigating costs and coverage of rare diseases (30%).

High-Level Recommendations

- Identify high-cost claims drivers by taking a deeper dive into data on associated costs (e.g., sites of care, high-cost medical drugs, medical devices, etc.), understanding the past is not necessarily a predictor of the future.
- Take actions to prevent the likelihood of, and mitigate the magnitude and seriousness of, common and often preventable high-cost claims (e.g., neonatal/multiple births, inadequately treated chronic conditions, poor care coordination for patients with complex conditions, and hospital readmissions).
- Identify and intervene early. Use predictive models or clinical and utilization patterns to identify issues as early as possible. Promote the use of care managers who will advocate for high-value patient care long before high-cost medical bills appear.
- Ensure high-cost therapies are warranted, asking for data to show efficacy and compare effectiveness to alternative treatments. Consider alternative sites of care when appropriate to manage costs.
- Build the infrastructure to support a long-term strategy. Work with vendor partners with experience in high-cost claims mitigation strategies.

"We have had our plan bring in their medical people and do a full case review of the HCC and determine how to best manage."

—EMPLOYER PARTICIPANT

What are Key Objectives for Managing High-Cost Claims?

A sampling of participant responses to the question of how they address access, quality, cost and affordability

Access and Prevention

- "Early intervention; proactive monitoring and creating a culture of health and preventive care; providing access to ACOs [accountable care organizations]/quality and value-based providers."
- "Analyz[ing] what led to the high-cost claim and determine if there's something that can be done to avoid similar cases from becoming high-cost claims in the future."
- "Early identification and resource support."
- "Promoting preventive and wellness [care] to catch potential high-cost disease with early intervention."

High-Quality Care

- "Ensuring our clinical management team is directing care appropriately to high-quality providers with proven outcomes."
- "Having plan participants receive the best care with the best outcomes at the lowest cost to ensure the plan is sustainable for all plan beneficiaries."
- "Steering patients to high-quality providers."

Cost Management and Affordability

- "Data and insight to tailor [employer] strategy to address high-cost claim drivers."
- "Working with the local health system to measure known high-cost situations."
- "Manage and better use taxpayer funds by decreasing claim costs for high-dollar claimants."
- "Optimize contracting rates and support from third-party vendors."

Insights, Lessons Learned, and Recommendations Across Key Areas

The balance of this report shows how these principles play out in four key areas of high-cost claims.

Click on the image to view the National Alliance high-cost claims infographic.

Cancer

With mortality rates improving considerably, cancer has been a top driver of high-cost claims for the past decade. In 2022, it was estimated that there would be more than 1.9 million new cancer cases in the US (more than 5,000 per day)—with the top diagnoses being cancers of the breast, prostate and lung. Cancer drugs are a leading area of personalized medicine, making up 11 of the top 20 high-cost injectable drugs in 2021.

The National Cancer Institute calculates the average cost of medical care and drugs tops $42,000 in the year following a cancer diagnosis.

Key Takeaways

- Cancer is arguably the most complex of all conditions, and employers have a mixed understanding of how to manage related care and costs.
- Employers are concerned about affordability but also about prevention, quality of care, and cancer-patient wellbeing.
- Innovation in cancer care and treatment has grown exponentially—as have related costs.
- A focus on navigation and case management supports patient, family and caregiver needs.
- Conducting pilot programs with health plans helps determine the best cancer care approaches.

Insights, Lessons Learned, and Recommendations

- Promote "getting back to basics" through the use of preventive screenings that can identify conditions in their earliest, most treatable stages, particularly if there is a family history of health risks. For some at high risk of inherited disease, genetic testing may be appropriate.
- Gather more data to help proactively manage risk by better addressing issues upstream:
  - Use a data warehouse to integrate data and identify issues sooner on both the medical and the pharmacy sides.
  - Review short- and long-term disability claims data to highlight potential issues before they become high-cost claims.
- Encourage benefits teams to collaborate with case managers to support patient navigation.
- Find a partner to help examine all the steps in managing care, especially for complex cancer cases; look at sites of care, end-of-life care, and survivorship.
- Make second opinions standard practice to avoid misdiagnoses and to address care-coordination requirements for complex cases.
- Ask health plans and other vendor partners to address access barriers; evaluate the unique support needs of members, especially those in underserved populations.
- Use centers of excellence to best support optimal patient care.
- Offer chronic disease prevention programs to patients and their families.

Start with the Basics

Is it the right diagnosis?

Some of the top high-cost claims exist because the wrong condition is being treated.

Are they using the right option?

Confirm appropriate site of care (e.g., centers of excellence, drug infusion centers).

Is the treatment appropriate?

In-home treatments can improve value and patient satisfaction—and save thousands.

Was billing/coding done right?

Investigate and confirm billing accuracy.

Prenatal/Neonatal Care

An estimated 380,000-plus babies are born prematurely each year in the US—more than 1 in 10 births—at a cost of more than $25.2 billion annually. Most high-cost neonatal intensive care (NICU) events involve premature infants with complications or micro-preemies (babies born before 26 weeks or who weigh less than 1 lb., 12 oz). Costs per infant can easily exceed $600,000; premature twins or triplets can multiply costs by up to 300%.

Key Takeaways

- Recognize that the cost of care for premature infants is an area of ongoing challenge due to limited prevention strategies.
- Offer managed fertility benefits and thoughtfully encourage their use to reduce the incidence of high-risk, high-cost multiple births.
- Identify opportunities to reduce costs without compromising care through strategies such as bundling maternity monitoring, NICU utilization and management, and case management.

A premature baby spends, on average, 25.4 days in a specialty care nursery at an average cost of $144,692. The costs associated with preterm birth add $26.2 billion to US healthcare costs each year.

Insights, Lessons Learned, and Recommendations

- Use a data warehouse to stratify issues; interpret/take action to address patterns that emerge; confirm vendor partners are effectively managing issues.
- Verify NICU patient cases to ensure the necessity of this high-level, high-cost care.
- Conduct claims reviews to catch NICU cases early; negotiate a case rate review where appropriate.
- Know in advance what health plans pay, understand their billing mechanisms, and identify inaccurate billing.
- Employ care management and billing reviews to manage costs for premature babies. (Some hospitals have reportedly billed egregious "outlier claims.")
- Audit hospital billing to confirm all charges are appropriate ("Don't let hospitals play 'catch me if you can,'" noted one participant).

Rare Disease and Gene Therapy

Multi-million-dollar gene therapies offer new hope to patients with rare and debilitating diseases, having the "potential to correct underlying genetic defects, offering a cure rather than simply managing symptoms." Current therapies include areas such as oncology, hemophilia, and heart disease contributing to employer concern about the cost of these drugs, estimated to reach approximately $30 billion a year in the US. It will be important for employers/purchasers to understand the benefits of these drugs and evaluate coverage issues to ensure appropriate access.

Key Takeaways

- Employers are concerned about the extraordinarily high cost of gene therapy and the suggested one-time payments for these drugs.
- The "front-loading" of the cost of these drugs is currently causing an excessive burden for employers. Front-loading may be necessary to accelerate the administration of a particular drug that requires high levels immediately to maximize its clinical effects.
- For ongoing therapy, the costs raise concerns about claim lasering (see sidebar, below).
- Employers noted that many carriers are reducing coverage for rare diseases, and some are even adding conditional waivers (e.g., for hemophilia) to limit access and affordability.
- Employers need education; many are not sure what strategies are best.

Insights, Lessons Learned, and Recommendations

- Confirm that switching to high-cost gene therapy is medically warranted and evidence-based; ask for data showing efficacy.
- There are different ways carriers approach paying for these drugs—warranty, amortization, or even using a per member per month (PMPM) fee. Understand the true cost of these options; exercise caution when relying on stop-loss insurance.
- Manage the medical benefit for sites of care, additional care programs, and medical device charges.
- Integrate pharmacy and medical data down to the member level to better understand high-cost issues.
- Determine which programs are in place for managing drug spending; consider how to manage coverage in the medical benefit, including sites of care and treatment eligibility.

Beware of Stop-Loss Lasers

A "laser," or individual deductible, in stop-loss insurance is an exclusion or limitation placed on a specific plan member's individual stop-loss threshold. Even though an employer may have purchased stop-loss coverage as protection against excessively high claims, stop-loss underwriters have the right to laser a claimant, specifically one with a serious, ongoing, expensive medical condition. The laser puts the cost back on the employer—and it's becoming increasingly common in response to the elimination of lifetime maximums, advances in medical technology, and the development of high-cost specialty medical drugs.

In the US, a disease is considered rare if it affects fewer than 200,000 Americans. According to the National Institutes of Health, there are approximately 7,000 rare diseases, affecting 25–30 million Americans or one in 10 people.

Specialty Drugs

Specialty drugs account for roughly 40% of outpatient prescription revenues—and an even greater share of payers' net prescription costs. They remain the key driver of prescription revenues for the PBM industry. Both biologic and traditional specialty drugs may face increasing competition from biosimilar and generic versions.

Key Takeaways

- Employers are concerned about the ongoing cost increases for specialty drugs.
- Some employers are managing high-cost claims for specialty drugs by limiting them on the formulary.
- Others are implementing employee assistance programs for drugs over $5,000.
- Employers are carefully monitoring the medical benefit to flag claims that should be filed through the pharmacy benefit (e.g., infusions).

Insights, Lessons Learned, and Recommendations

- Make second opinions standard to confirm the diagnosis and reduce inappropriate care.
- Review pharmacy claims run through the medical benefit.
- Make sure patient care follows the "six rights": Right patient, right drug, right price, right time, right dose, and right setting.
- Consider short-term strategies to help reduce overall drug costs (e.g., limiting coverage for six months to determine adherence levels).
- Evaluate whether rebate strategies are limiting, or conflicting with, the adoption/implementation of biosimilars.

Cost ranges and medical vs. Rx spend

Condition/Disease/Disorder	Average cost	Highest cost	% Medical versus Rx
Hemophilia/Bleeding	$334.0K	$6.22M	16%
Newborn/Infant Care	$318.0K	$3.51M	99%
Leukemia, Lymphoma, Multiple Myeloma	$258.3K	$4.83M	69%
COVID-19	$231.3K	$1.75M	98%
Congenital Anomaly (structural)	$197.1K	$5.43M	97%
Transplant	$184.8K	$2.53M	93%
Sepsis	$179.6K	$2.21M	96%
Malnutrition	$178.1K	$3.20M	30%
Malignant Neoplasm	$170.4K	$2.09M	68%
Cerebrovascular	$153.3K	$2.71M	97%
Immune System	$120.9K	$1.94M	30%
Urinary/Renal	$114.1K	$2.24M	91%
Cardiovascular	$102.2K	$2.45M	95%
Blood and Blood-forming Organs	$99.2K	$2.66M	63%
Respiratory	$80.8K	$4.04M	83%
Gastrointestinal/Abdominal	$76.3K	$1.38M	72%
Orthopedics	$75.8K	$1.97M	81%
Neurological	$75.2K	$3.42M	74%
Mental and Behavioral Health	$68.3K	$1.04M	85%
Physician Treatment	$23.4K	$1.20M	76%

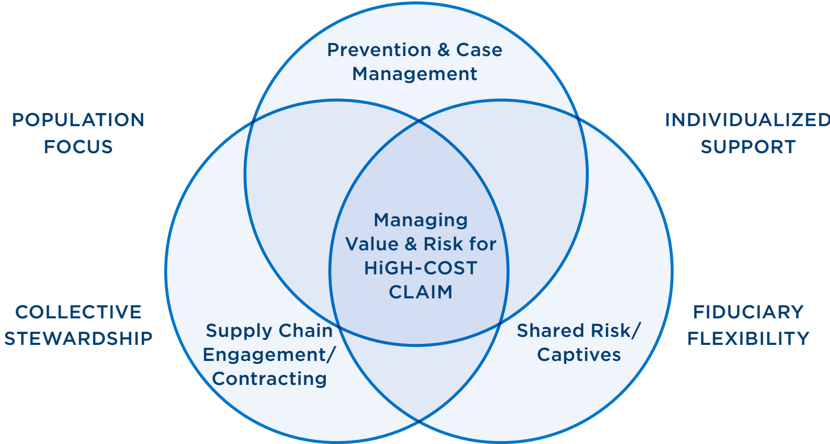
Source: Sun Life 2022 High-cost claims and injectable drug trends analysis

Wrap-Up and Future Plans

Starting in April 2023, the National Alliance began developing next steps informed by the groundwork described in this guidebook. Case studies and a playbook for HR and benefits professionals, from beginners to experts, will summarize best practices and lessons learned.

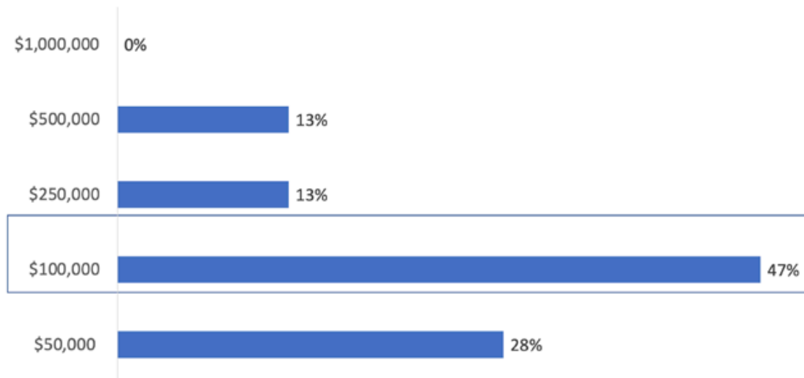
A combination of approaches may best facilitate improvements in prevention and case management engagement, and in contracting across the supply chain to achieve more effective mitigation of high-cost claim risk.

Longer-term Approach

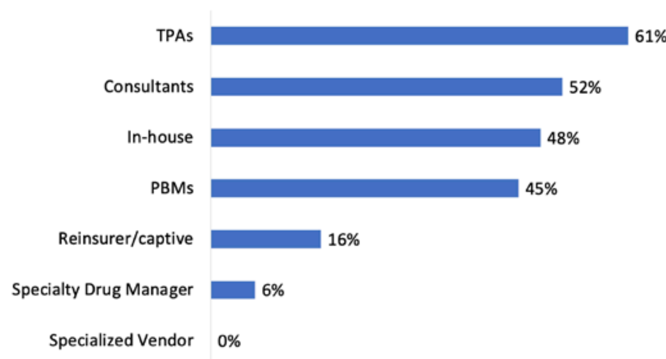


Appendix: Pre- and Post-Survey Highlights

What is an employer's minimum threshold for high-cost claims?



How employers are currently managing high-cost claims in benefit plans?

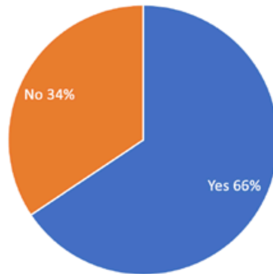


Level of stop-loss coverage

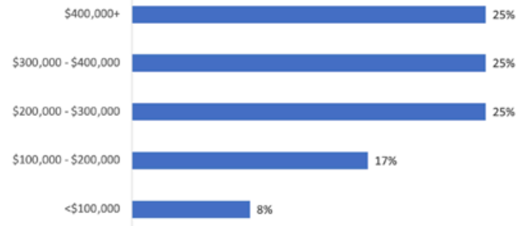
Pre-Survey Highlights

High–Cost Claims Strategy

Do you currently carry stop loss coverage for high-cost claims?



For the 66% carrying stop loss coverage:
At what level?

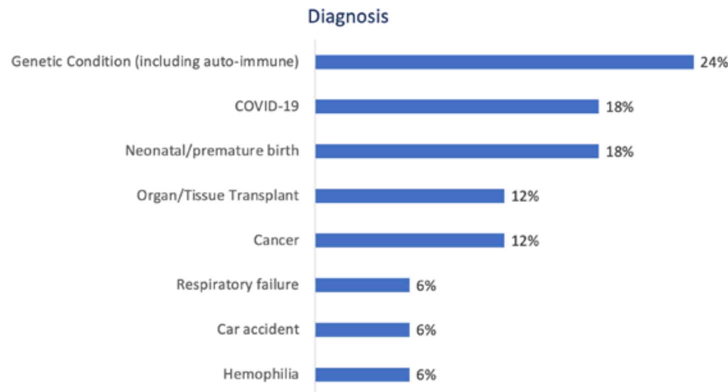


Condition for largest high-cost claim

Pre-Survey Highlights

High–Cost Claims Strategy

What has been your largest high-cost claim in the past 3 years?



Strategies employers are currently using to mitigate high-cost claims

Pre-Survey Highlights

High–Cost Claims Strategy

Strategies deployed in mitigating the cost

- Specialty Carve-out
- Implemented PAP
- Access 340B pricing
- Case management (via TPA)
- Stop loss
- Alternative, more affordable source of medication
- Audit and negotiations

Areas of concern in mitigating the cost

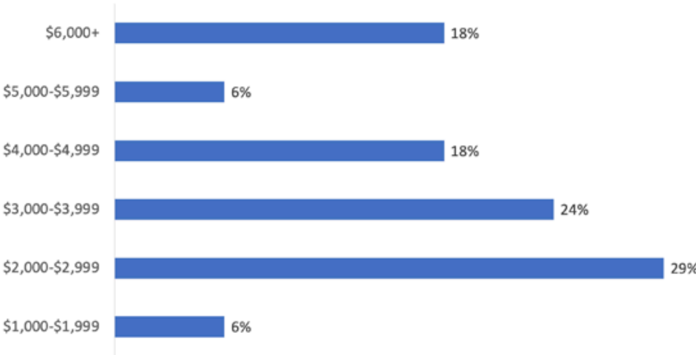
- Balancing Access to quality care with the costs while protecting all beneficiaries and the plan
- PAP not guaranteed, may be temporary assistance
- Potential for injury
- Organization of information in an action-oriented way
- Was there an alternative?
- RX therapies (Specialty Drugs)
- No SOP
- Site of care, medication sourcing, aftercare

Out-of-pocket maximum

Pre-Survey Highlights

High–Cost Claims Strategy

What is your Out-of-Pocket maximum for your most common plan?

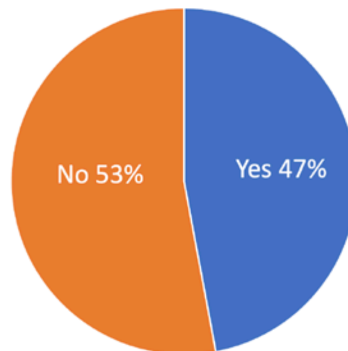


Deploying a copay maximizer strategy

Pre-Survey Highlights

High–Cost Claims Strategy

Do you deploy a copay maximizer strategy?



The National Alliance also conducted a brief employer post-survey. Below are the areas respondents say they will review or consider as a result of the roundtables.

What employers are currently doing BUT plan to review and/or modify as a result of the roundtables:

- Review the option for a stop-gap, stop-loss amount and negotiate coverage.
- Review all high-cost claims over $95,000 ($25,000 subrogation).
- Review the efficacy of current patient navigation strategies.
- Evaluate plan design—as well as benefit education and advocacy.
- Assess the current case management approach.
- Conduct an RFP for PBM services to help with specialty drugs.
- Examine top claims with vendors.
- Proactively review the drug formulary; add a specialty medication carve-out program.
- Explore adding a chronic disease prevention program for prediabetes/diabetes.
- Explore whether a maternity-bundle-plus-fertility benefit could help reduce neonatal spending.

What employers are not doing BUT considering as a result of the roundtables:

- Taking a more hands-on approach with TPAs.
- Steering providers toward high-value care and hospitals.
- Reviewing biome and genetics-based programs.
- Requesting audits of large (especially stop-loss level) claims.
- Conducting J-code audits for drugs and alternate sourcing or administration.
- Exploring at-risk maternity management and bundling.
- Reviewing management of musculoskeletal claims.
- Examining the travel benefit to direct care to better, more cost-effective hospitals, which may be out of state.

About National Alliance & Participating Coalitions

National Alliance of Healthcare Purchaser Coalitions

Contacts: Margaret Rehayem, Vice President & Michael Thompson, President & CEO

As a nonprofit 501(c)(6), the National Alliance of Healthcare Purchaser Coalitions (National Alliance) is a membership organization of purchaser-aligned healthcare coalitions that seek to accelerate the nation's progress toward safe, efficient, equitable, high-quality healthcare. The National Alliance is developing activities to enhance education and improve healthcare delivery through several initiatives focused on key issues in the areas of delivery and payment reform, health policy, and total person health. For almost 30 years, the National Alliance has provided expertise and resources to its member coalitions, which represent private and public sector, nonprofit, and Taft-Hartley and union organizations that provide benefits for more than 45 million Americans spending over $400 billion annually. National Alliance member coalitions are committed to community health reform, including improvement in the value of healthcare provided through employer-sponsored health plans.

Participating Coalitions

Alabama Employers Health Consortium

Coalition Contact: Michael Howard, President & CEO

The Alabama Employer Health Consortium is an employer-led nonprofit organization that was established in 2018 by three cornerstone member companies: Regions Financial, Austal USA, and McWane, Inc. They are dedicated to improving the provision of healthcare benefits from the employer's perspective and provide important resources to private and public member employers to optimize the value of their healthcare dollar. Their overall goal is to shine a light on current health benefit trends and the governmental activities that affect employer members. AEHC also promotes quality and value for the benefit of their member companies, their employees, and the bottom line.

Dallas-Fort Worth Business Group on Health

Coalition Leader: Marianne Fazen, President & CEO

The Dallas-Fort Worth Business Group on Health (DFWBGH) is a coalition of Dallas and Fort Worth area employers committed to educating and empowering local employers and their employees to make informed healthcare-related decisions and to promoting healthcare quality, cost-effectiveness, transparency, and accountability in the community.

HealthcareTN

Coalition Contact: Gaye Fortner and Cristie Travis, co-CEOs

HealthCareTN brings stakeholders together across the state of Tennessee to improve the health of the communities they serve. They are a leader and catalyst in creating market solutions, passionate about improving the cost and quality of healthcare, and continue to pioneer local market changes by innovating and implementing new strategies in the emerging health benefits market.

Nevada Business Group on Health

Coalition Contact: Chris Syverson, CEO

Nevada Business Group on Health (NVBGH) is a partnership between public and private sectors formed to provide quality and cost-effective healthcare for the mutual benefit of employers, employees and families.

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The National Alliance of Healthcare Purchaser Coalitions (National Alliance) is the only nonprofit, purchaser-led organization with a national and regional structure dedicated to driving health and healthcare value across the country. Its members represent private and public sector, nonprofit, and Taft-Hartley organizations, and more than 45 million Americans spending over $300 billion annually on healthcare. Visit nationalalliancehealth.org, and connect with us on Twitter and LinkedIn. ©National Alliance of Healthcare Purchaser Coalitions. May be copied and distributed with attribution to the National Alliance.