Rethinking How Employers Address High-Cost Claims

AN EMPLOYER AND COALITION INITIATIVE

REFRESHED 2024 VERSION

Employer Coalition of Louisiana

A LOUISIANA HEALTH CARE QUALITY FORUM 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 emerged as one of the most significant financial threats to employer-sponsored healthcare. Over recent benefit years (2019-2022), nearly nine in 10 employers faced a stop-loss claim, making them a common occurrence. According to a 2023 survey by Willis Towers Watson, 94% of employers expect to face more high-cost claims in the next three years.

The frequency of these claims has increased, with Sun Life reporting that the number of million-dollar-plus claims rose by 39.9% from 2019 to 2022. While $100,000 remains a common threshold for high-cost claims, the landscape has shifted dramatically. In 2022, the average cost of a high-cost claim reached $421,000, a 4.4% increase from the previous year. The rise of gene therapies and advanced treatments has pushed some claims into the multi-million-dollar range, with the highest reported claim in 2022 reaching $6.9 million.

The complexity of managing these claims has grown exponentially. The latest Pulse of the Purchaser report by the National Alliance of Healthcare Purchaser Coalitions (National Alliance) found that over four out of five (84%) employers identify high-cost claims as a significant threat, along with drug and hospital prices. The need for comprehensive, sustainable strategies to address high-cost claims has never been more pressing. Equipping employers with knowledge and potential actions enables them to address diverse challenges head-on and may be the only way to mitigate growing concerns.

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 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.

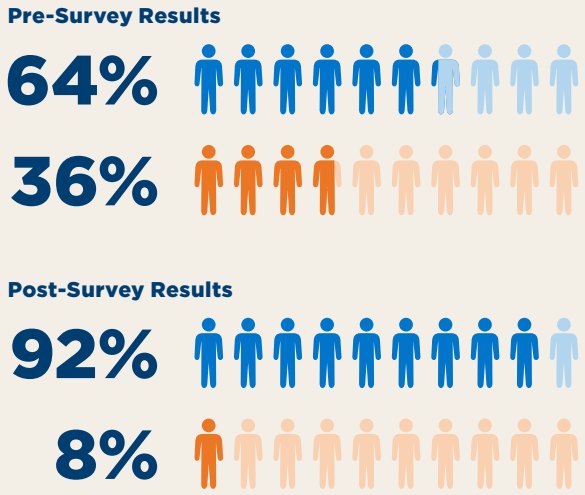
Following the kick-off meeting, the National Alliance conducted a pre-survey to assess how participants currently manage high-cost claims. This was followed by four regional breakout meetings involving more than 50 employers convened through the Alabama Employer Health Consortium, Dallas Fort-Worth Business 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 costs without compromising patient care and outcomes.

Building on the findings from Phase 1, the National Alliance kicked off Phase 2 in the spring of 2024. This initiative expanded the scope from Phase 1 to include more in-depth analyses, interactive workshops, and collaboration sessions with employers. These efforts involved more than 50 employers convened through five coalitions— Florida Alliance for Healthcare Value,

Greater Cincinnati Employers Group on Health, Houston Business Coalition on Health, Nevada Business Group on Health, and North Carolina Business Coalition on Health—alongside participants from other regions, through virtual sessions.

The interactive in-person workshops utilized the action steps set out in the National Alliance High-Cost Claims Workbook and included discussion of how to tackle complex claim drivers, particularly in the areas of cell and gene therapy, cancer, and specialty drugs. The workshops were designed to be hands-on and engaging. They included structured exercises, data-focused discussions, and employer-driven roundtable sessions. Employers were encouraged to bring their own data to examine challenges firsthand, which allowed them to identify key cost drivers and develop tailored action strategies. The comprehensive approach taken during Phase 2 had a significant impact, with employers' confidence in their ability to manage high-cost claims increasing by 28% from the pre-survey to the post-survey. This growth demonstrates the initiative's success in providing employers with essential resources and strategies for effective high-cost claim management.

Surveys conducted before and after the workshops reflect a significant improvement in employer confidence, with only 64% being somewhat confident and 36% not confident, to 92% and 8%, respectively.



These efforts have resulted in several key takeaways, highlighting effective practices and areas for continued focus.

Key Themes

Drivers of High-Cost Claims

- Nearly 8 in 10 employers consider high-cost claims, drug prices, and hospital prices a significant threat to affordability for employees and their families.
- **The top conditions for million-dollar-plus claims** are cancer, neonatal events, cardiovascular conditions, and sepsis.
- More than half of employers in this initiative describe $100,000 (or $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.
- Employers are seeing a rise in high-cost claims for younger plan members. This is consistent with findings from the pre-survey.
- Increasing mental health claims often coexist with other chronic conditions.
- 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.
- The highest priority areas for employers over the next couple of years, according to 2024 Pulse of the Purchaser results, include:
  - Reducing the risk of neonatal ICU claims (e.g., managed maternity, fertility benefits), 55%
  - Enhanced screening/early detection, 45%
  - Site of care redirection (e.g., home, infusion center, physician's office), 40%

Data Utilization

- Obtaining data is becoming easier for some, but interpreting and using it continues to pose challenges.
- Transparency and comprehensive reporting from data partners need improvement.
- Detailed data analysis and data warehouses for tracking claims and predictive analytics are important in managing high-cost claims.

Member Engagement

- Personalized engagement strategies are needed to improve compliance and outcomes.

Adoption of Non-Traditional Payment Models

- More employers are exploring innovative approaches to medical plan management (e.g. TPA, reference-based pricing, etc.) to manage costs.
- Transparent PBMs are gaining more market share than ever before. In fact, 12% of employers report they are currently using a transparent PBM for their primary contract, and 52% of employers are considering changing their PBM in the next 1–3 years.

High-Level Recommendations

Data Analysis: Identify high-cost claims drivers through detailed data analysis of associated costs, recognizing past trends may not predict future outcomes.

Prevention Strategies: Implement actions to prevent and mitigate common, preventable high-cost claims such as neonatal care, chronic conditions, and hospital readmissions.

Case Management: Strengthen case management programs and involve case managers to monitor patient progress and ensure treatment plan compliance.

Proactive Identification: Develop strategies to identify and manage employees' coexisting conditions that could lead to high-cost claims.

Stakeholder Collaboration: Encourage cooperation between healthcare providers, TPAs, PBMs, and employers for coordinated care.

> *"We need to work together—employers, healthcare providers, and other constituents—to address the egregious costs effectively."*
>
> —EMPLOYER WORKSHOP PARTICIPANT

Claims Review: Assess medical and pharmacy claims for appropriateness, focusing on drug mix and cost-effectiveness.

Early Intervention: Identify and intervene early. Use predictive models or clinical and utilization patterns to flag issues before they escalate. Promote the use of care managers who will advocate for high-value patient care long before high-cost medical bills appear.

Treatment Evaluation: 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.

Long-Term Planning: Build infrastructure to support long-term strategies, partnering with vendors experienced in high-cost-claims mitigation strategies.

Key Realizations in Tackling High-Cost Claims

- You CAN impact high-cost claims.
- It is NOT a one-size-fits-all problem.
- You CAN start to move the needle significantly by tackling a handful of individual cases while determining broader strategies.
- Trust but verify!

> *"With the data transparency rules, it's finally our data, and it's our responsibility to manage it effectively."*
>
> —EMPLOYER WORKSHOP PARTICIPANT

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

Rethinking How We Mitigate *HIGH-COST CLAIMS*

The Problem: Few (if any) employers have the size, resources or focus to address rapidly escalating high-cost claims. ***Since 2016, the number of health plan members with claims $3M+ has doubled***, heightening sustainability concerns. Elimination of annual and lifetime maximums through the Affordable Care Act and the dysfunction of the reinsurance market has made this a top priority for every employer, purchaser and market.

High-Cost Claims Defined:
- Unpredictable/infrequent for individual employers
- Claims costing $50,000 or more per year
- Cost outliers that are frequently lasered (i.e., stop-loss insurance covers only the first year of claims, then will cover everything except that claim)
- Often for severe, debilitating disease conditions

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

Wellmark Blue@Work

"High-cost claims are the biggest threat to employer-sponsored healthcare coverage today. Only through collective employer action can these risks be mitigated."

Michael Thompson
National Alliance President & CEO

Strategies will vary based on duration of expenditures and quality or quantity of options

	Multiple Effective Options	*Limited Options*
Long-duration Treatment	Hemophilia Multiple sclerosis Multiple myeloma Autoimmune Cystic fibrosis End-stage renal disease (ESRD) Hereditary angioedema	Spinal muscular atrophy Metastatic cancers Duchenne muscular dystrophy Immune globulin (palliative) Congenital anomalies (lifelong)
Short-duration Treatment	Lymphoma Premature birth Spine surgeries Immune globulin (therapeutic) Inherited retinal dystrophy (RPE65)	Spinal muscular atrophy Neutrotrophic keratitis Transplant Congenital anomalies Idiopathic pulmonary fibrosis Sepsis Trauma and burns

National Alliance Offers Tools to Build the Bridge to Sustainability

- Mitigating High-cost Claims: A Closer Look at Hemophilia
- Employer Rx Value Report and Value Framework Infographic
- Hospital Payment Strategies: Setting Price & Quality Expectations

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

Be Proactive, not Reactive

Specific Saving Strategies for High-Cost Medical Drugs

Learn more: *Achieving Accountabilty & Predictibility on the Medical Side of Drug Benefits*

CLINICAL RIGOR
- Separation of dispensing/rebates from clinical functions
- Independent, expert clinical management
- Cost-effective step therapy, when appropriate
- Elimination of waste
- Same level of clinical rigor applied to to specialty drugs on medical side
- Longer term – increased specialization

COST-EFFECTIVE SOURCING
- Better align co-pay and patient assistance programs
- Unrestricted, competitive dispensing options and sources
- Site-of-care optimization for provider-administered drugs
- Longer term – collective management & stewardship

Contracting Strategies
- Deconflict PBM and medical carrier relationships (fiduciary compliant)
- Reduced/fixed markups for provider buy/bill drugs
- Outcomes-based drug pricing
  - Specialty generics filled in retail, not at specialty pharmacy
  - Payment amortization (pay-over-time)
  - Hospital at home/telehealth
  - Narrow networks
  - More timely and transparent reporting
  - Bill review/negotiation
- Longer term – population-based hybrid contracts

Plan Design Strategies
- All drug management under the pharmacy benefit
- Dose rounding protocols (for injectables)
- More rigorous utilization management for high-cost drugs
  - PA/pre-certification functions
  - Preferred drug lists/formularies
  - Quantity limits
  - Step therapy
  - Specialty carve out
  - Exclusions/coverage limitations
- Aligned financial incentives with plan participants
- Leverage secondary coverage when available (e.g., spouse employer, Medicaid or Medicare)
- Longer term - Steerage to improve quality, appropriateness, and reduce impact of middlemen

Integrate Core Pillars of Overall Risk and Cost Reduction

There is no one-size-fits-all approach to tackle the broad spectrum of high-cost claims; a combination of options is needed for each case

1 Prevention
- Genetic testing (pre- and postpartum)
- Education
- Risk factor identification
- Enhanced care/utilization management
- Plan design

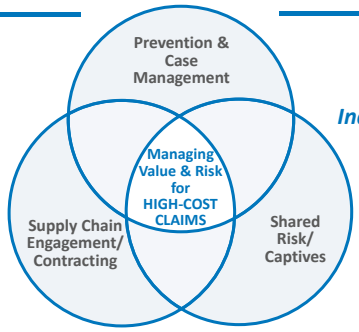
2 Optimal Care
- Right diagnosis & treatment
- Appropriate care goals
- Billing/coding accuracy; fraud/waste/abuse flags

Stop Loss | Short-term | Long-term | *Reduce Acquisition Cost* | *Cost Sharing Risk Shifting*

3 Collective Stewardship
- Diverse & evolving priority areas
- CAPTIVE development
- Population level cost/ROI evaluation
- Plan design alignment
- Innovative contracting
- Real-time data mining
- Forward focus

CONTINUOUSLY REEXAMINE PATIENT EDUCATION, INVOLVEMENT AND ACCOUNTABILITY TO ENSURE SUSTAINABLE PATIENT ENGAGEMENT

Longer-term Approach



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Data Transparency

In this initiative, employers were asked to bring their data for analysis. This request revealed a range of challenges employers face when attempting to acquire and analyze their healthcare data effectively (9% responded in the pre-survey that they were unable to get their data).

These obstacles include pushback or non-response from vendors when employers request data; difficulty securing contractual access to information from partners; and uncertainty about which data points to request and follow-up questions to ask.

Employers also struggle with identifying who should be responsible for consistent data analysis, determining the necessary internal resources for data synthesis (such as clinical expertise and auditing capabilities), and gaining access to data warehouses for issue stratification. Many employers also face resistance when digging deeper into data, hearing responses like, "No one else is asking for that. Why are you digging so deep?" These challenges highlight the complexities of data transparency in healthcare and underscore the need for strategies to overcome these barriers to effectively manage high-cost claims.

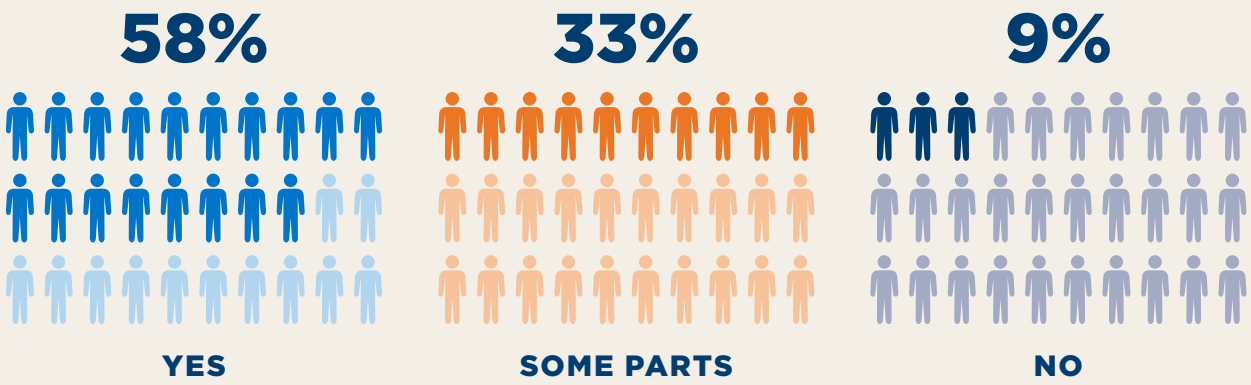
Getting Your Data: Starting with the Basics

Access to accurate and comprehensive data is the foundation for effectively managing high-cost claims. Without clear insights into claims, diagnoses, and treatment patterns, employers are left reacting to costs instead of proactively managing them. Below are basic requests:

- **Member ID:** A unique identifier that tracks claims across medical and pharmacy data, enabling a full view of individual care journeys and cost patterns.
- **Service Type:** Differentiates between inpatient, outpatient, and other service types, essential for identifying cost-driving categories.
- **Admission/Discharge Dates:** Key dates for monitoring the length of hospital stays, which help track the impact of hospital services on total costs.
- **Primary Diagnosis Code:** Identifies high-cost conditions and ensures appropriate treatment pathways, critical for managing chronic and serious/acute cases.
- **Rx Drug Name:** Provides visibility into high-cost specialty medications and their utilization, supporting formulary management and cost control.

Employer Access to High-Cost Claims Data

Pre-Survey Question: Were you able to access your high-cost claims data?



Key Takeaways

- **Data Access and Quality:** Access to high-quality, granular data is critical for managing high-cost claims proactively. Employers face challenges with data availability and transparency, often due to restrictive practices by vendors like PBMs and TPAs.

> *"Not knowing what we don't know is one of our biggest challenges."*
>
> —EMPLOYER WORKSHOP PARTICIPANT

- **Data-Driven Decision-Making:** Employers are encouraged to leverage new data transparency rules to manage claims more effectively and take ownership of the data analysis process to drive actionable insights.
- **Importance of Data Warehouses:** A centralized data warehouse allows for detailed claims analysis, enabling employers to spot trends and take early action on high-cost claims.

> *"We're constantly facing barriers to getting actionable data; without it, we're working in the dark."*
>
> —EMPLOYER WORKSHOP PARTICIPANT

- **Vendor Accountability:** Employers need to hold vendors accountable for timely data access and actionable reporting, which enable informed decisions on interventions and cost-containment strategies.
- **Complexity of Managing Data:** Employers express that while they recognize the need for data, navigating its complexity requires significant time and resources, highlighting the value of both data accessibility and interpretive support from experts.

> *"People are not a disease or a medication. We need to look at the whole situation and tailor our approach to the individual."*
>
> —EMPLOYER WORKSHOP PARTICIPANT

Insights and Recommendations

- Standardized data reporting across vendors facilitates seamless analysis and consistent tracking.
- Centralized data warehouses improve access to large, complex data sets and support trend-monitoring and predictive analytics.
- Securing contractual access to necessary data points ensures that information is always available when needed.
- Real-time data enables quicker responses to high-cost claims, especially in managing chronic and acute conditions.
- Setting clear expectations with vendors for data-sharing requirements ensures transparency and consistency in claims data. Because 90% of claims have errors — intentional or not — a third-party audit is recommended.
- Establishing partnerships with vendors committed to transparent data practices is essential for proactive high-cost claims management.

The Significant Impact of Sepsis

Sepsis is a top contributor to high-cost claims, with significant implications for both employee health and organizational healthcare expenses. Sepsis is the **number one killer of hospital inpatients** and a **top 10 driver** of high-cost claims. Sepsis claims rose dramatically during the COVID era due to co-infection, hospital-acquired infections, and delays in accessing care. Employers recognize that sepsis cases, whether community- or hospital-acquired, often lead to lengthy hospital stays and intensive care needs. Preventing sepsis and managing it effectively once it occurs can mitigate costs and improve outcomes for employees.

Key Takeaways

- Sepsis is one of the most frequent high-cost diagnoses and claims. Hospital-acquired sepsis is a significant cost driver that often is preventable.
- Many cases of sepsis, particularly those acquired in hospitals, can be avoided with improved infection control practices, early screening, and rapid response protocols.
- Delays in treatment are associated with increased mortality; each hour of delayed intervention can decrease survival by 7.6%. Employers see value in prevention and rapid treatment.

> ***"Sepsis was the most common diagnosis in the claims reviewed. We need to continue discussing how prevalent hospital-acquired sepsis is versus community-acquired and push to not pay for the former..."***
>
> **—FLORIDA ALLIANCE FOR HEALTHCARE VALUE**

Insights and Recommendations

- **Preventive Education and Awareness**
  Develop educational programs for employees about sepsis signs and symptoms, enabling early identification and timely medical help.
  - Implement sepsis awareness campaigns to promote quick responses to symptoms, which can drastically improve outcomes and reduce costs.
- **Hospital-Acquired Sepsis Prevention**
  - Encourage collaboration among healthcare providers to strengthen infection control measures, reducing the likelihood of hospital-acquired sepsis.
- **Data-Driven Sepsis Management**
  - Use claims data to identify patterns and trends in sepsis cases, which can help highlight high-risk areas, monitor outcomes, and shape preventive strategies.
  - Consider tracking sepsis cases to determine whether they are community- or hospital-acquired, promoting targeted interventions and vendor accountability.
- **Rapid Treatment Protocols:**
  - Advocate for sepsis screening protocols and rapid treatment in emergency departments and primary care settings to mitigate severity.
  - Work with hospitals to establish clear guidelines that prioritize timely sepsis intervention, reducing prolonged and costly hospital stays.

Cancer: A Top Contributer to High-Cost Claims

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.

Start with the Basics

- Is it the right diagnosis?
  - Some of the top high-cost claims occur 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.

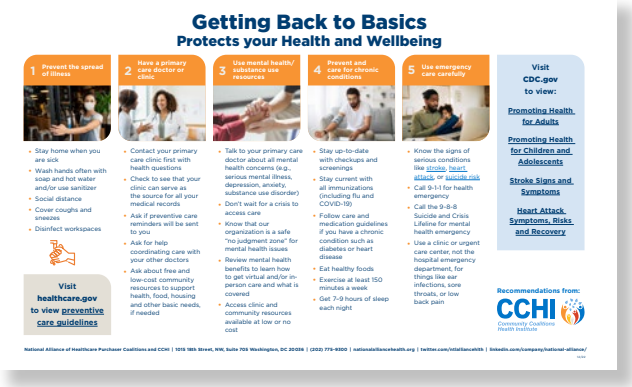
Key Takeaways

- 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 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

Preventive Care

- Promote "getting back to basics" through the use of preventive screenings for early detection, especially for those with family health risks.
- Consider genetic testing for high-risk individuals.



- Offer incentives for preventive care participation.
- Focus on crucial screenings and vaccinations, like HPV vaccines for cancer prevention.

Data-Driven Management

- Use data warehouses to integrate medical and pharmacy information for early issue identification.
- Review short- and long-term disability claims data to highlight potential issues before they become high-cost claims.

Care Coordination

- Encourage collaboration between benefits teams and case managers to support patient navigation.
- Explore potential partners to examine all care-management steps, especially for complex cancer

cases; consider sites of care, end-of-life care, and survivorship.

- Make second opinions standard to avoid misdiagnoses and to address care coordination requirements for complex cases.

Access and Support

- Ask health plans and other vendor partners to address access barriers and evaluate unique support needs, particularly for underserved populations.
- Utilize centers of excellence for optimal patient care.
- Offer chronic disease prevention programs to patients and families.

Top 20 high-cost claim conditions

Stop-loss claim reimbursements

2023 rank	4 Year rank	Condition/Disease/Disorder	2023 reimbursements	2020-2023 reimbursements
1	1	Malignant Neoplasm	$415.6M	$1.31B
2	2	Cardiovascular	$165.8M	$510.4M
5	3	Leukemia, Lymphoma, Multiple Myeloma	$96.2M	$461.2M
3	4	Newborn/Infant Care	$140.8M	$408.1M
4	5	Orthopedics/Musculoskeletal	$121.8M	$389.0M
7	6	Respiratory	$81.6M	$287.9M
9	7	Sepsis	$79.4M	$285.4M
6	8	Gastrointestinal	$87.0M	$273.8M
8	9	Neurological	$79.4M	$263.4M
12	10	Urinary/Renal	$55.7M	$224.1M
10	11	Physician Treatment*	$63.7M	$193.5M
11	12	Congenital Anomaly (structural)	$56.8M	$185.6M
29	13	COVID-19	$6.8M	$135.0M
13	14	Mental and Behavioral Health	$38.1M	$121.5M
15	15	Cerebrovascular	$29.8M	$110.5M
17	16	Hemophilia/Bleeding	$28.8M	$104.1M
16	17	Malnutrition	$29.6M	$98.9M
18	18	Transplant	$27.3M	$98.8M
14	19	Blood and Blood-Forming Organs	$33.2M	$94.7M
19	20	Immune System	$25.0M	$91.8M

Source: Sun Life 2024 High-cost claim and injectable drug trends analysis.

Prenatal/Neonatal Challenges

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 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, and NICU utilization management (including frequent level-of-care review).

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).

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.

Rare Disease and Gene Therapy

Multi-million-dollar gene therapies offer new hope to patients with rare and debilitating diseases, with 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 cost about $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 "frontloading" of the cost of these drugs—which occurs when drugs must be administered in immediate high doses to maximize clinical effect—is currently causing an excessive burden for employers.
- 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 which strategies are best.

Beware of Stop-Loss Lasers

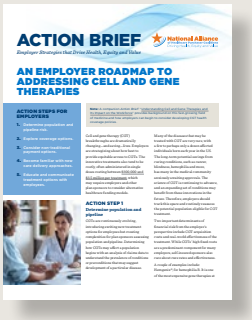
A "laser," or individual deductible, in stop-loss insurance is an exclusion or limitation placed on a specific plan member's individual stop-loss threshold. Even though an employer may have purchased stop-loss coverage as protection against excessively high claims, stop-loss underwriters have the right to laser a claimant, specifically one with a serious, ongoing, costly 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.

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. For employers with stop-loss coverage, coverage via the carrier may be the most cost effective.
- 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, e.g., pause/discontinuation of maintenance medications to assess effectiveness of gene therapy intervention.
- 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.

Understanding Cell and Gene Therapy and its Impact on the Workforce

This two-part Action Brief series covers the basics of the fast-growing field of life-changing, life-saving—and costly—cell and gene therapies (CGTs). Learn to navigate the challenges and strategize about how best to provide equitable, affordable access to CGTs. Click on the images to view:



Other Specialty Medications

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 available to confirm the diagnosis and reduce inappropriate care, particularly in the setting of experimental treatment protocols and/or when there is an inability to find an effective regimen.
- Review pharmacy claims that are run through the medical benefit.
- Make sure patient care follows the "six rights": Right patient, right drug, right price, right time, right dose, right setting.
- Consider short-term strategies to help reduce overall drug costs (e.g., limiting initial authorization to six months to determine effectiveness and adherence levels).
- Evaluate whether rebate strategies are limiting, or conflicting with, the adoption/implementation of biosimilars.
- Evaluate specialty medication usage and explore cost-effective alternatives.
- Implement site of care changes for drug infusions to reduce costs, such as moving from hospital to home infusion.
- Consider the feasibility of direct contracting with drug manufacturers to secure better pricing and reduce overall pharmaceutical costs.
- Evaluate the opportunity and cost of a J-code lockout policy to require fulfillment of certain specialty medications via the pharmacy benefit instead of the medical benefit to obtain optimal pricing and clinical oversight.

Cost ranges and medical vs. Rx spend

4 Year rank	Condition/Disease/Disorder	Average cost	Highest cost*	% Medical vs. Rx
4	Newborn/Infant Care	$470.8K	$11.5M	100%
16	Hemophilia/Bleeding	$286.2K	$1.5M	15%
12	Congenital Anomaly (structural)	$236.2K	$3.5M	95%
3	Leukemia, Lymphoma, Multiple Myeloma	$222.2K	$2.1M	66%
7	Sepsis	$219.7K	$3.0M	96%
1	Malignant Neoplasm	$213.3K	$2.7M	61%
18	Transplant	$170.6K	$7.4M	91%
17	Malnutrition	$166.8K	$2.5M	26%
15	Cerebrovascular	$165.7K	$1.8M	97%
19	Blood and Blood-Forming Organs	$152.6K	$3.7M	62%
2	Cardiovascular	$144.2K	$5.3M	94%
20	Immune System	$126.7K	$1.7M	29%
9	Neurological	$121.8K	$6.0M	75%
10	Urinary/Renal	$116.7K	$1.8M	87%
13	COVID-19	$115.8K	$1.7M	94%
5	Orthopedics/Muskuloskeletal	$102.5K	$3.3M	71%
6	Respiratory	$99.5K	$5.5M	82%
8	Gastrointestinal/Abdominal	$96.5K	$2.4M	65%
14	Mental and Behavioral Health	$81.2K	$2.2M	78%
11	Physician Treatment**	$42.7K	$8.0M	72%

Highest cost above $5M
% Medical Spend
% Rx Spend

*Based on highest cost claim attributed to this condition category.

**Physician treatment category contains physician-provided care, including injury aftercare, implant or prosthetic care, preventative and supportive care, health counseling and examination, and review of diagnostic results.

Note: Totals may not add up to 100% due to rounding.

Source: Sun Life book of business data including first-dollar claims and stop-loss reimbursements, 2023. Top 20 rank from four-year stop-loss reimbursements.

Employers Beware: Alternative Funding Programs Require Careful Review to Avoid Negative Consequences

As healthcare costs increase, employers and other plan sponsors continue to explore strategies to better manage pharmaceutical costs. Given that prescription drug spending accounts for 18% of all healthcare spending, such strategies focus on the specialty medications that account for a significant share of that spending. One approach is the use of alternative funding programs (AFPs). AFPs have been gaining traction with employers by marketing strategies that shift the entire financial burden of high-cost specialty medications away from the employer, primarily by directing covered employees to manufacturers' patient assistance programs (PAPs). This practice comes with risks. Click on the image to view:


ACTION BRIEF

National Alliance

Employer Strategies that Drive Health, Equity and Value

EMPLOYERS BEWARE

ALTERNATIVE FUNDING PROGRAMS REQUIRE CAREFUL REVIEW TO AVOID NEGATIVE CONSEQUENCES

Wrap Up and Future Plans

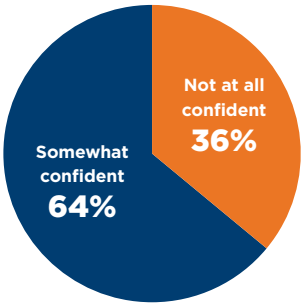
Over the past year, the National Alliance has partnered with employers nationwide to tackle high-cost claims, culminating in the creation of a comprehensive High-Cost Claims Playbook. This playbook, informed by collaborative workshops and employer feedback, provides action steps for managing complex and costly healthcare needs. Employers who participated in the workshops reported valuable, practical takeaways, with increased confidence and preparedness for addressing high-cost claims. This initial success underscores both the effectiveness of shared learning and the importance of continuing to engage in collaborative problem-solving as new challenges emerge.

Pre- and Post-Survey Results

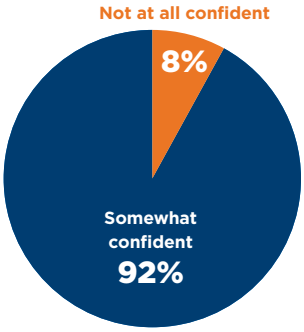
The surveys conducted before and after the workshops reflect a significant improvement in employer confidence and preparedness:

- **Confidence Growth:** Employer confidence in managing high-cost claims increased from 34% "Very Confident" in the pre-survey to over 92% post-survey. This growth underscores the value of actionable strategies and the importance of data in guiding decision-making.

Pre-Survey Confidence



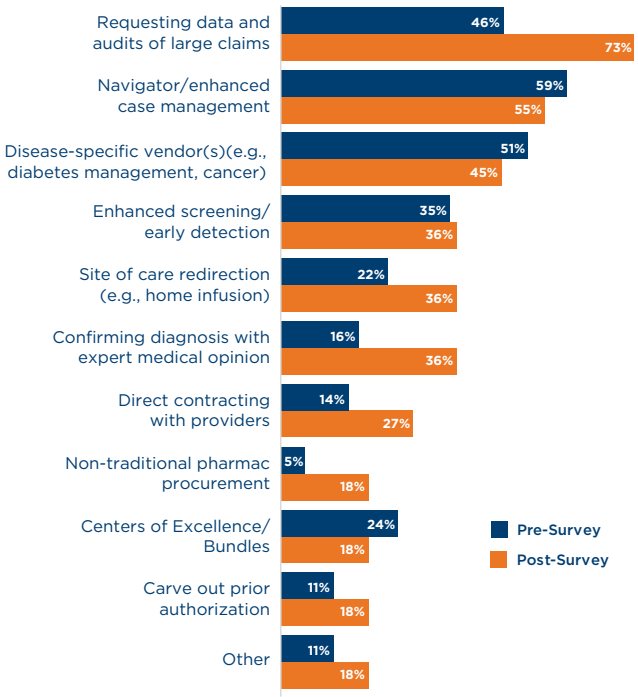
Post-Survey Confidence



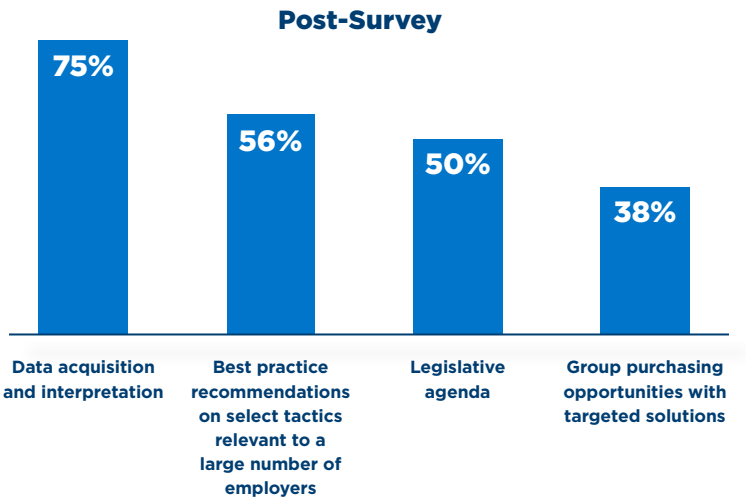
- **Strategy Adoption:** Employers noted marked increases in strategy adoption across critical areas, including **direct provider contracting, carve-out prior authorizations,** and **non-traditional pharmacy procurement.** These results reflect an elevated commitment to addressing high-cost claims at multiple levels.

Employer Strategies Currently Doing

pre vs. post survey



- **Employer Needs:** Employers noted the greatest need for data acquisition and interpretation. The National Alliance remains focused on continuing efforts to help employers acquire and understand their data. Additionally, employers noted a continued desire for best practices and recommendations.



As seen from employer needs post-survey results, data access remains a cornerstone of effective high-cost claims management. Throughout the project, employers repeatedly emphasized that having transparent, detailed, and timely data enables more accurate tracking and targeted interventions, customized to member and organizational needs. Moving forward, the National Alliance is dedicated to helping employers secure and understand this data to empower proactive and informed decision-making.

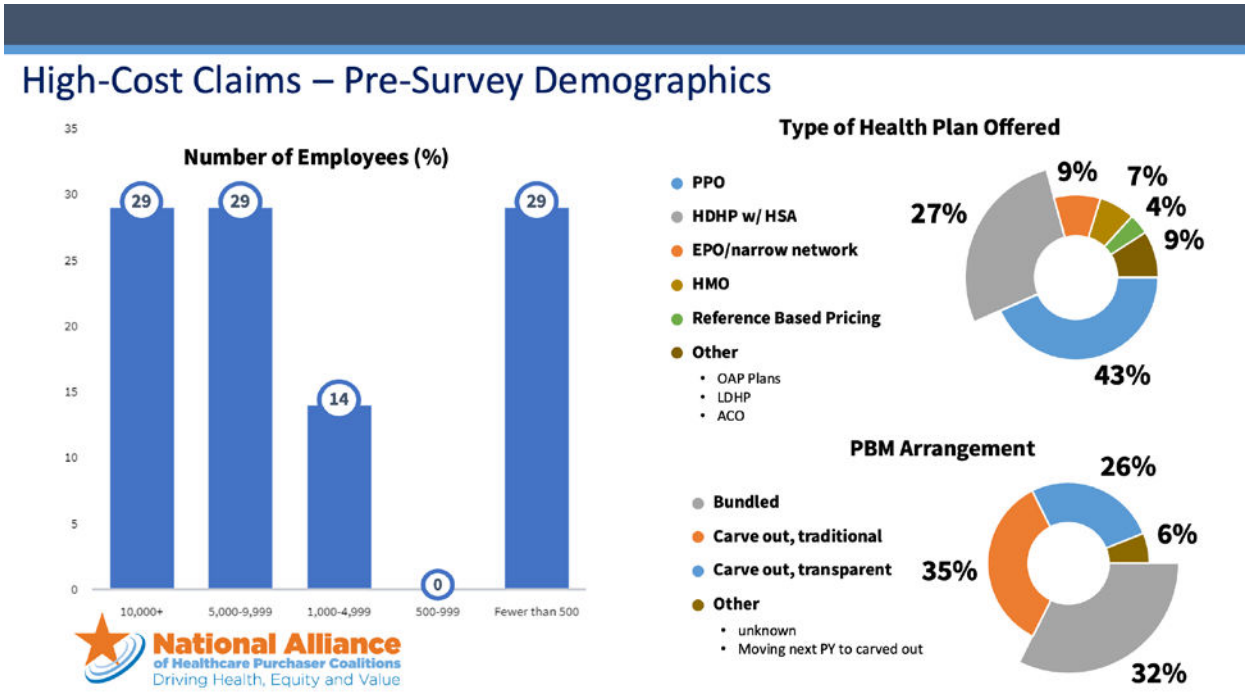
Future efforts will focus on **continuing to help employers dive into their data and fostering continued collaboration.** We plan to support employer workgroups and coalitions that allow members to share insights, access resources, and develop innovative strategies to address the evolving landscape.

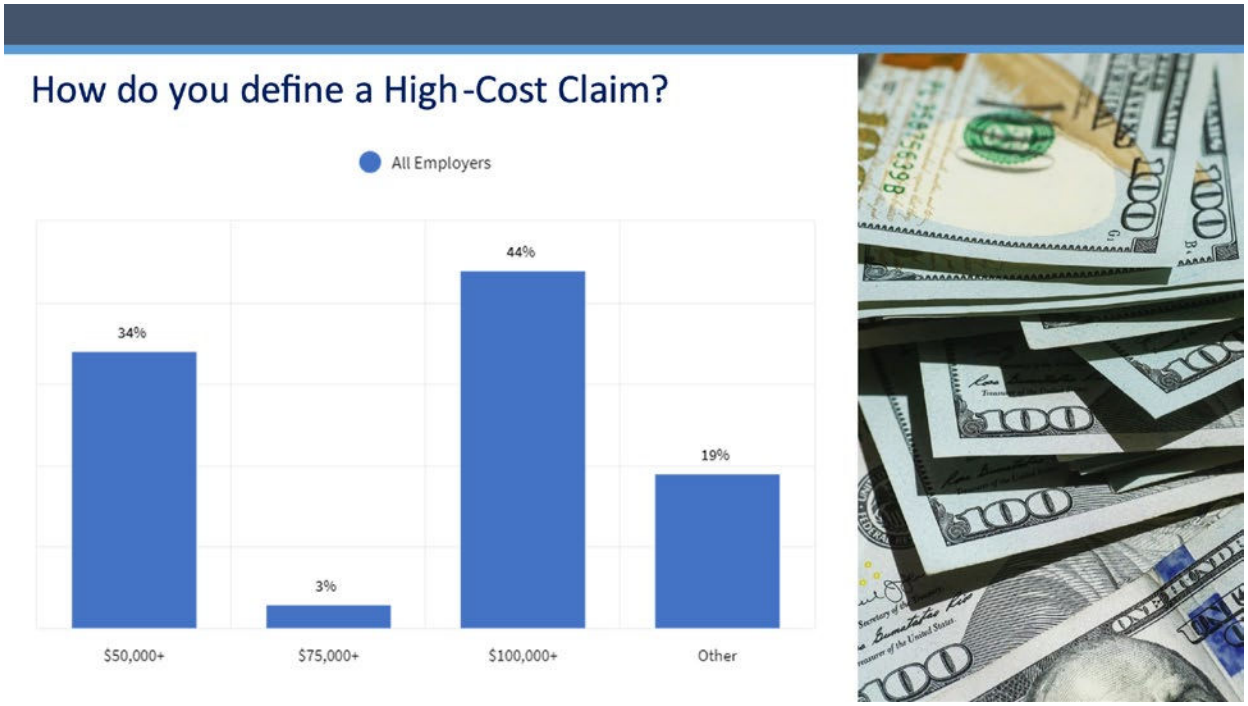
Next Steps and Building on Success

The successes of this initiative have laid a strong foundation, and the National Alliance will continue to build on these accomplishments. Advancing solutions that help employers gain control over high-cost claims, emphasizing data transparency, strategic interventions, and ongoing improvement in prevention and care management practices all are on the agenda.

Appendix

The following images are from the National Alliance Pulse of the Purchaser Survey. To view full results, click here.





High-Cost Claims by the Numbers

94%

Employers are self-funded

68%

Employers have stop-loss coverage

36%

36% of employers are not at all confident in their ability to manage current/future High-Cost Claims

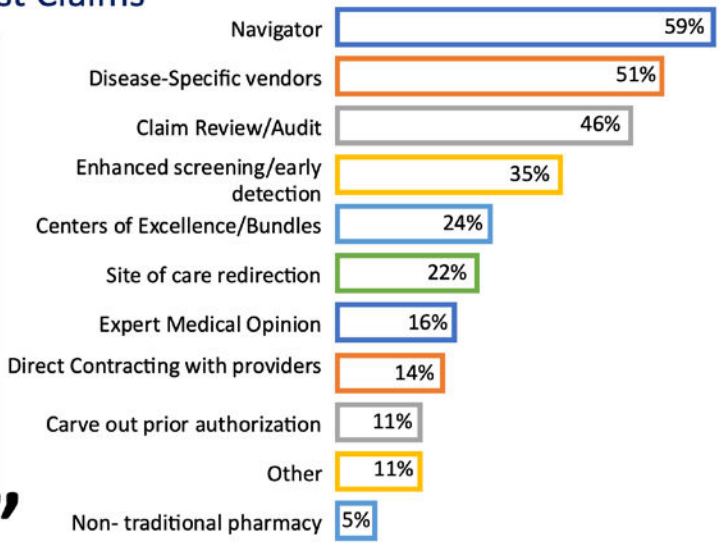
64%

64% of employers are somewhat confident in their ability to manage current/future High-Cost Claims

Strategies to Address High-Cost Claims

How satisfied are you with your strategies?

- Not satisfied, I know there is more that can be done.
- My lack of satisfaction is with understanding how the claims are being calculated, what criteria is being used to determine the claims and how stop loss insurance is calculated.
- ... I'm disgusted at how much is being passed along to the plans regarding facility fees and medical devices. HCA charges an outrageous amount for implanted devices. I'd love to delve more into this because our large cost claimants have been largely due to the extreme markup on medical devices
- We are not satisfied with the current strategies we have in place to mitigate high-cost claims.
- We feel there is more that can be done at the level of care management.
- At the starting line



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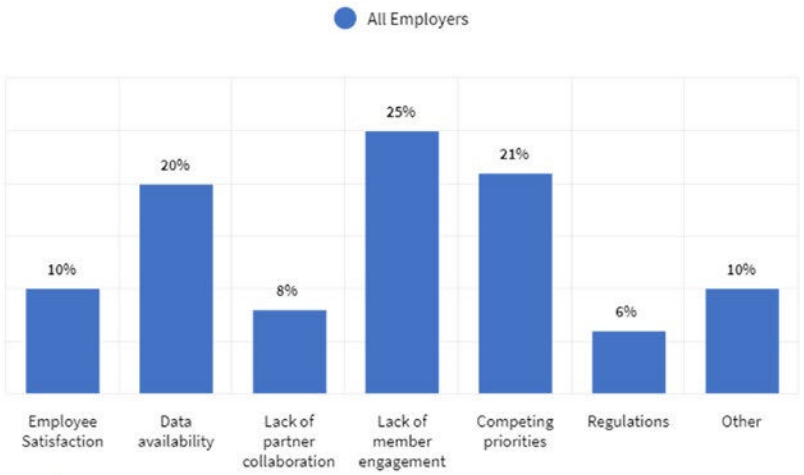
Other: Disease-specific programs through medical and Rx TPAs, such as Diabetes management, Blue Distinction Centers, etc.; On si te medical clinic free for employees and their covered dependents 16+ to use; bundling stop loss w/ TPA so TPA has skin in the g ame

Barriers encountered while trying to address HCCs



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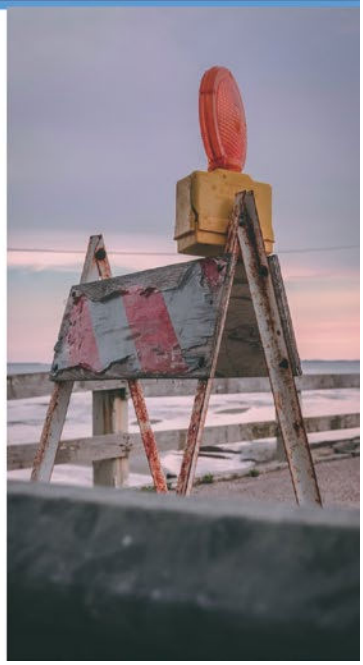
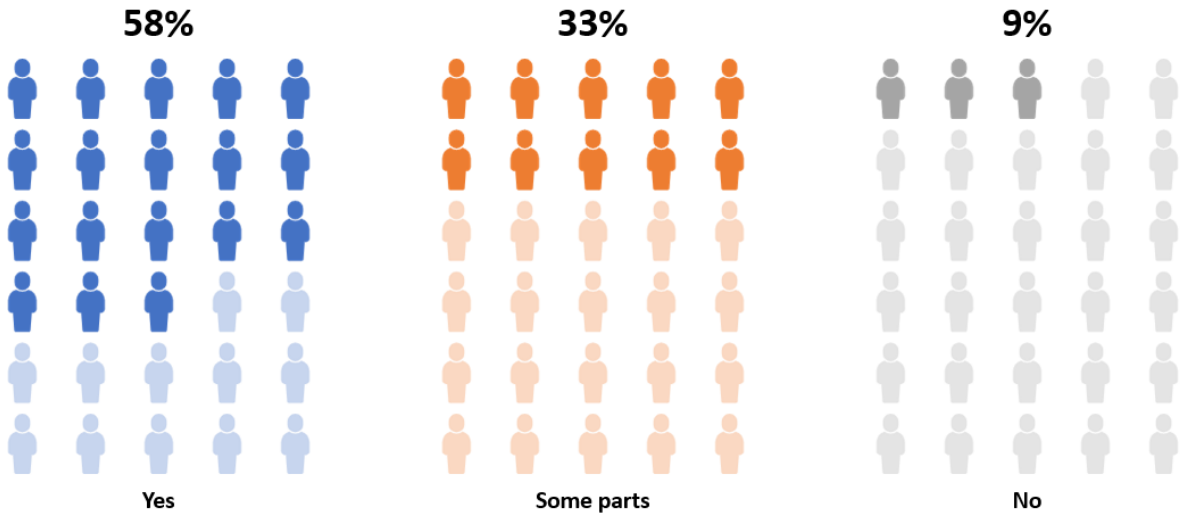


Employer Access to High-Cost Claims Data

Pre-Survey Question: Were you able to access your high-cost claims data?



Conditions that make up your largest HCC spend

	Clinical Conditions
Cancer	23%
Cardiovascular	15%
Immune conditions	13%
Diabetes/Kidney Disease	10%
Genetic conditions	9%
Musculoskeletal	9%
Infections	6%
Neonates	5%
Rare disease	2%
Trauma/burns	1%
Mental/behavioral health	1%
Other	6%

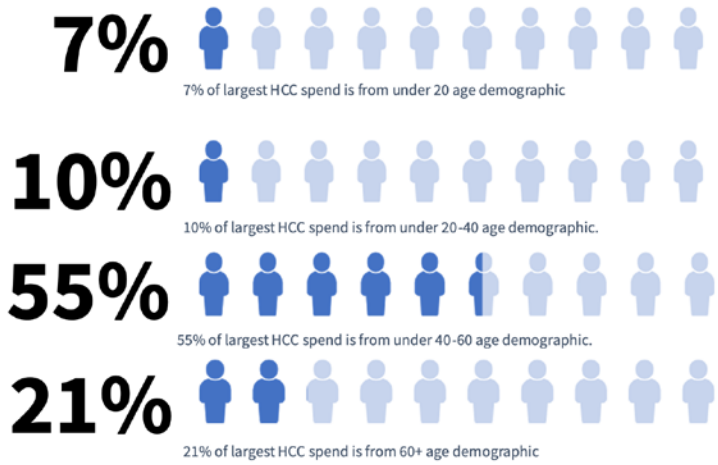
Other Conditions: Transplant; Neonatal; skin and subcutaneous tissue (1), ne system (2), digestive system (3); High Risk Pregnancy; Autism/Cerebral Palsy

Secondary/co-morbid conditions that make up your largest HCC spend

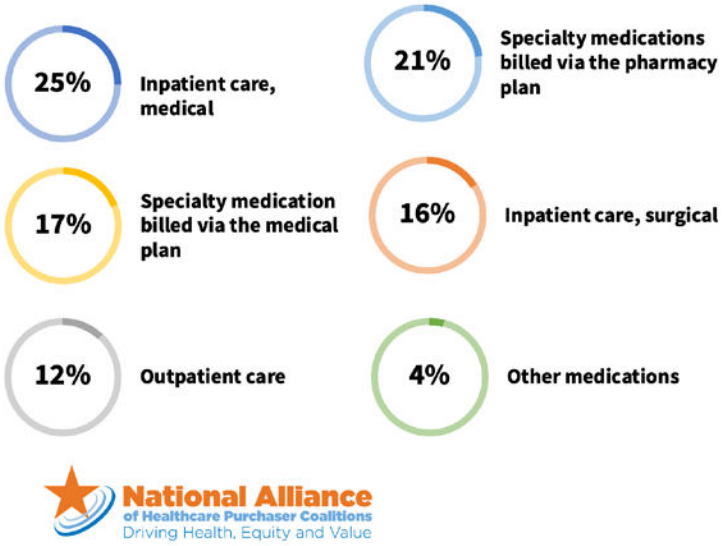
	Secondary Co/morbid Conditions
Cardiometabolic	**37%**
Obesity	**35%**
Mental/behavioral health	**10%**
Infections	**10%**
Other	**10%**

Other Secondary/co-morbid conditions: Complex GI conditions; Secondary tumors; Transplants and preemies; 57% of our HCC's have a mental health diagnosis. Number of members presenting with MH issues are going to continue to increase due to de -stigmatization of MH. We have partnered with a local MH resiliency group for first responders, and implemented a MH leave program for employee's who present with life threatening MH issues/emergencies.

Age demographics that make up your largest HCC spend



Type of care having the greatest impact



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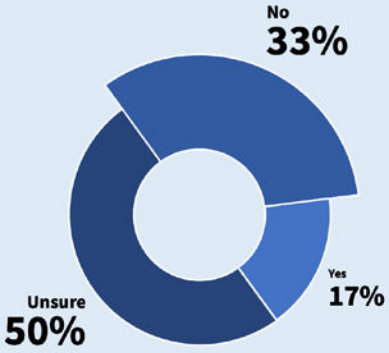
Are there certain providers contributing to disproportionate spend?



Concerns about future HCCs

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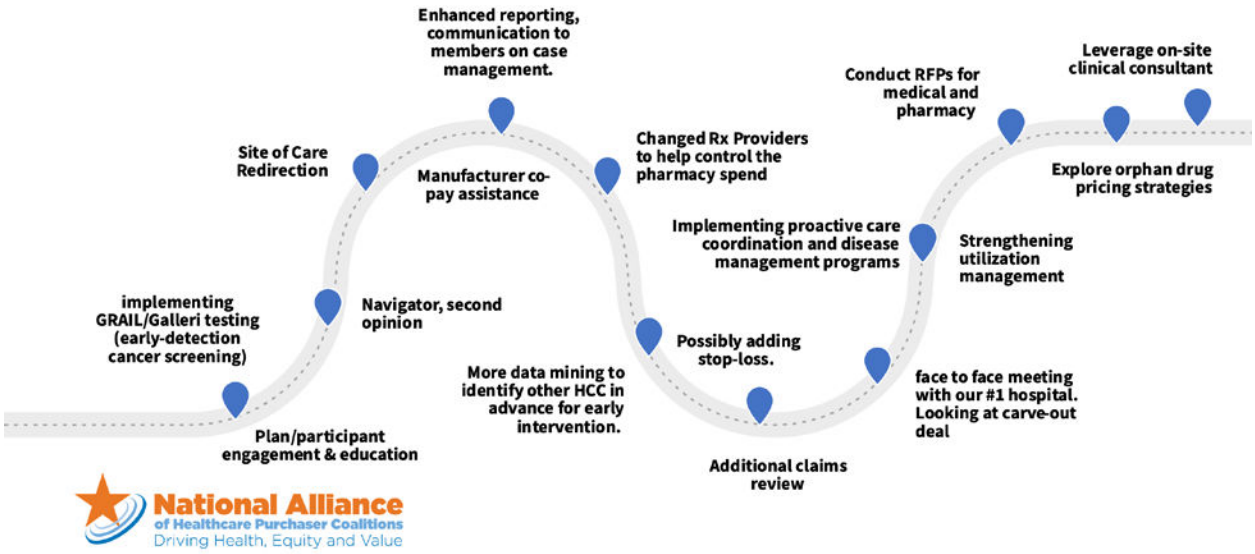
HCC interventions on your 2024/25 roadmap



About the National Alliance and Participating Coalitions

National Alliance of Healthcare Purchaser Coalitions

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 over 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 Phase 1

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 dollars. 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 its member organizations and their employees, and the bottom line.

Dallas-Fort Worth Business Group on Health

Coalition Contact: Marianne Fazen, PhD, 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: Phil Belcher, CEO

HealthCareTN brings stakeholders together across the state of Tennessee to improve the health of the communities they serve. The coalition is a leader and catalyst in creating market solutions, improving the cost and quality of healthcare, and pioneering local market changes by innovating and implementing new strategies in the evolving 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.

Participating Coalitions Phase 2

Florida Alliance for Healthcare Value

Coalition Contact: Karen van Caulil, PhD, President and CEO

The Florida Alliance for Healthcare Value (formerly Florida Health Care Coalition) is a statewide organization representing public and private sector employer/healthcare purchasers. Established in 1984, it strives to make Florida a world-class leader in healthcare quality and affordability through collaboration, innovation, transparency, and action. The Alliance represents more than 80 employers and works to promote health and drive down the cost of care while improving its quality.

Greater Cincinnati Employers Group on Health

Coalition Contact: Jeff Walton, Executive Director

The Greater Cincinnati Employers Group on Health (GCEGH) is a nonprofit organization founded in 2021 to enhance healthcare quality and value for employers in the Greater Cincinnati area. It focuses on promoting value-based care, improving mental health services, and increasing price transparency. Members benefit from access to healthcare data, networking opportunities, and resources for best practices in employee health management. GCEGH aims to leverage employer collaboration to drive meaningful improvements in the local healthcare system for businesses and their employees.

Houston Business Coalition on Health

Coalition Contact: Chris Skisak, PhD

The Houston Business Coalition on Health (HBCH) is a nonprofit organization that has been serving employers in the Houston area for over 12 years. HBCH provides employers with access to resources and expertise aimed at improving healthcare benefits and employee wellbeing. The coalition focuses on innovative approaches to healthcare delivery, leveraging collective employer influence to enhance health outcomes and cost-effectiveness. Members include various organizations that value collaboration and shared knowledge in navigating the complexities of healthcare.

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.

North Carolina Business Coalition on Health

Coalition Contact: Jon Rankin, Executive Director

The North Carolina Business Coalition on Health (NCBCH) is a statewide organization uniting HR and benefit professionals from various employers to improve healthcare delivery in North Carolina. NCBCH advocates for better healthcare quality and cost management while providing resources, education, and networking opportunities for its members. The coalition serves as the employer voice in the state and collaborates with key healthcare stakeholders to promote innovation and collective influence.

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For over 30 years, the National Alliance has united business healthcare coalitions and their employer/purchaser members to achieve high-quality care that improves patient experience, health equity, and outcomes at lower costs. Its members represent private and public sector, nonprofit, and labor union organizations that provide health benefits for more than 45 million Americans and spend over $400 billion annually. To learn more, visit nationalalliancehealth.org and connect on LinkedIn.