



FIELDING CATASTROPHIC CURVEBALLS

With large claims on the rise, data-driven solutions take center stage

Written By Bruce Shutan

The state of catastrophic claims management has become worrisome across the self-insured community, but data-driven solutions are helping shore up that sinking landscape.

Industry research suggests that huge claims are clearly on the rise. There was a 45% increase in \$1 million claims, a 55% increase in \$2 million claims and a whopping 292% increase in \$5 million claims just last year, according to Guy Carpenter and Oliver Wyman's second annual joint stop-loss market update.

A recent report by the A&H Group, a member of the Tokio Marine HCC group of companies, mirrored those findings. It noted, for example, that the frequency of stop-loss claims above \$2 million is now up as much as 1,251% since January 2014, when the Affordable Care Act removed the cap on health benefit payments. Self-insured employers were roughly 13.5 times as likely to receive a claim at that level last year as in 2013.

These headwinds, of course, make it challenging for stop-loss insurance carriers and medical stop-loss captives to rein in catastrophic claims. "Insurers are responding with higher rates and stricter terms, all while the industry adapts to new AI capabilities," according to Jay Ritchie, president and CEO of Tokio Marine HCC – A&H Group.

Keeping stop-loss insurance renewal rates manageable is often a struggle, and in some cases, carriers choose not to re-bid at all when an employer's population experiences a high volume of catastrophic claims, which usually are north of \$500,000.

Experts say members who drove most claims in one year may not be a factor the following year, while those who were not significant cost drivers in the past year may become major claimants in the upcoming year. By relying too heavily on last year's high-cost members, carriers risk missing opportunities to price competitively or preserve margin.



Scott Byrne

A MOVING TARGET

The sheer amount of \$1 million-plus claims today is not close to what they were within the industry even just five or 10 years ago, notes Scott Byrne, president of Blackwell Captive Solutions. "A lot of that has to do with advances in medicine – groundbreaking new treatments that are great from a societal standpoint," he says.

But paying these enormous bills has become unsustainable for many employer groups, producing a compounding effect. On the fully insured side, Byrne says groups are "constantly paying for sins of the past" through significant rate increases, and we're seeing that same kind of claim activity in the self-insured world."

This vicious cycle actually can be a moving target because large claims tend to clear up for different reasons, including high-cost claimants finally receiving appropriate treatment or finding new coverage through a spouse's plan or individual coverage health reimbursement arrangement.

Whatever approach is pursued to get a better handle on claims, self-insured health plans need to manage them from both a clinical and cost perspective. Bruce Roffe, president and CEO of HHC Group and a licensed pharmacist, notes that the former is about determining usual, customary and reasonable fees for hospitalization, while the latter addresses whether the services that are being provided are experimental or investigational in scope and the therapy being administered follows appropriate protocols.

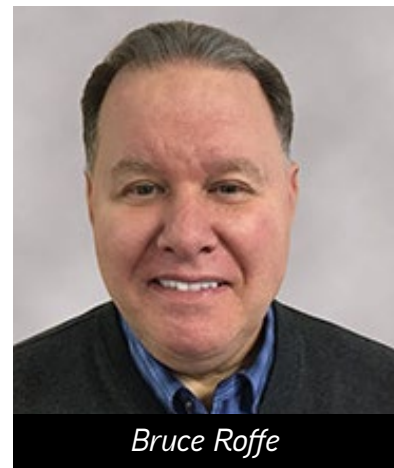
In the pharma area where he has expertise, an example of that would involve step therapy. Mindful that drugs are a huge chunk of healthcare costs and will only continue to escalate, he believes we're at the cusp of a revolution in terms of drug therapy and the types of genetically engineered drugs that are being created.

On the cost side, he says reinsurers aren't necessarily bound by PPO discounts and that Medicare serves as the best benchmark to negotiate affordable rates. Depending on the diagnosis-related group, Medicare will develop an arithmetic and geometric mean length of stay to calculate reimbursement rates.

As part of this dual approach through which clinical and cost-containment measures are simultaneously considered, it's invariably all about mining employee data. "We're as much a computer company as we are a service company," Roffe notes.

UNPACKING SURPRISE CLAIMS

When examining catastrophic claims, industry sleuths are always working to uncover – and head off – the element of surprise. Ali Panjwani, founder and CEO of Merit Medicine, describes upside-down loss ratios as the single biggest proponent of surprise claimants, explaining how the process unfolds when underwriting and pricing the risk of a self-insured group.



Bruce Roffe

Consider, for instance, that very little information is typically available for carriers in the request for proposal (RFP), with a generally limited turnaround time for responding. It's an even tighter window for ultra-small level-funding business. That RFP likely includes a census file of some demographic information and a large claims report that only covers a sky-high spend threshold that's usually half of the policy's spec deductible. And with healthcare information known for only about 2% to 5% of the group's overall enrollment, he says, "there may be very high-cost claimants who just fell under the radar because they never got captured in one large claims report."

Those mystery claimants can rise in risk in the following year and significantly affect the loss ratio for a particular group. On the flip side, he notes that the risk of many of the large claimants could plummet the following year because of surgery, disease-modifying therapy with better efficacy or other factors.

Panjwani notes that carriers and managing general underwriters, without advanced tooling or advanced data sets, will scour the group for high-cost claimants and judge how risky it is based on the proportionality of those claims relative to the size of that group. The proverbial \$64,000 question is, will that risk persist in the following year?



Ali Panjwani

COMBING DATA AT A GRANULAR LEVEL

Since what happened in the past 12 months isn't always predictive of what's going to happen in the next 12 months, the ideal approach is to examine each individual member separately. "This is why advanced technology with AI proprietary access to data to acquire and make



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sense of that kind of granular data can serve both quantitative and qualitative insights back to you in a way where you can make very quick and accurate decisions about that group from a pricing and underwriting perspective. That will lead to healthier books of business and healthier loss ratios," according to Panjwani.

He recalls a recent case in which there wasn't much information available from the previous year in underwriting the risk of a particular group that seemed fairly healthy. His firm's software, however, flagged a diagnosis that occurred just before that timeline in which the health plan member did not follow the recommended treatment path. "That imposes a layer of risk that the carrier is inheriting," he says, noting that such neglect can lead to adverse and costly outcomes.

Making a predictive inference for risk on a group based on present conditions, comorbidity, or high-cost drugs reveals only part of the story. Members who haven't been diagnosed with a condition and aren't yet on a disease-modifying therapy could end up being surprise claimants for the coming year.

"The only way you can get ahead of that and predict those things before you underwrite that risk and price the group is if you have the granular data around," Panjwani explains. Possible scenarios could involve, say, knowing a member has been to a series of specialists over the past eight months due to losing his or her eyesight, or being hospitalized a year earlier with a comorbidity and having an adverse reaction to a particular drug.

NO NEW LASER RATE CAP PROVISION

One increasingly popular but imperfect strategy for managing large claimants is the no new laser rate cap provision. Byrne recalls a case involving a roughly 2,000-employee school district facing renewal with about a half-dozen large claimants in active treatment, which would have driven a 55% rate increase.

While the group's captive participation agreement included this provision, lasers were not forced on the client. Instead, they were presented as an alternative solution to mitigate the steep increase. The school district chose to accept the lasers, which, along with a slight increase to the specific deductible, reduced the renewal increase to the mid-teens. This approach allowed the group to fund high-cost claims as they occurred rather than baking them into the premium.

Ultimately, the lasers never took effect: one claimant sadly passed away, and another gained coverage under a spouse's plan. The danger of this approach is that "you're going down the same path as the fully insured side of the business," he cautions. "You're pricing those claims into next year's premium."

In a group captive setting, friction would be unavoidable because Byrne says a rate increase wouldn't adequately cover an expected high-cost claim from one member and spreading additional liability across the entire group would unfairly penalize those that had a strong underwriting year.

Another point he makes is that if a captive layer is filled with known liabilities and claims that have already been accounted for, it will reduce the chance of a successful underwriting year, with surplus dollars being distributed back to those members that are running well.

AI can be particularly helpful on the front end for underwriting an account by identifying cases where self-funding may not make sense, he believes. One example would be in a relatively small population with fairly significant claims activity or drugs being prescribed. Others would be to evaluate employers for membership in a group captive, as well as claims review and the data mining process.

Blackwell Captive Solutions uses a data analytics tool for renewals called Springbuk to better anticipate potential large claims that may arise in future years but also builds into a medical stop-loss captive risk management and certain point solutions, such as centers of excellence.

Panjwani recommends working with a data partner whose pre-built relationships will result in unencumbered access to all of a plan's demographic and healthcare data dating back several years for the most accurate view of where risks in a group will arise. "We usually will go back three or four years to be able to understand if someone, say, was diagnosed with Crohn's disease 18 months ago, and then hasn't been taking care of it over the last 12 months," he says. "That changes the risk profile of that person in the next 12 months."

If an accurate projection of risk is baked in upfront when a group is being priced or renewed, those risks materialize and the loss ratios are healthy, then he says it's going to be predictable and stable year over year across all parties. That means better data and better insights will always win in the long term.

The overarching goal, of course, is to avoid even having a catastrophic claim in the first place. "It really starts in having a good case management utilization review company following those patients and making sure that they're staying in the hospital only for as long as they've been approved to stay," notes Roffe, who also suggests offering an employee wellness program.■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 35 years.

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