2021 Annual Market Report

HCC Life Insurance Company Operating
as Tokio Marine HCC - Stop Loss Group

Tokio Marine HCC - Stop Loss Group
A member of the Tokio Marine HCC Group of Companies
TMHCC1152 – 08/2021

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2021

Message from The President & CEO

Tokio Marine HCC – Stop Loss Group is pleased to present our 2021 Annual Market Report. We received very positive feedback from last year's inaugural edition, and we hope that you find this year's version equally informative and thought-provoking.

The last year has truly been unprecedented. Rarely, do we get "new claims" where the disease itself is new and treatments must be created anew. The vast majority of medical claims are existing diagnosis' being managed with consistent improvements in treatments and outcomes. COVID-19 is indeed a new disease, and while we saw improvements in hospitalizations and postponed medical procedures by the spring and summer of 2021, the new Delta variant presents the possibility of another spike in COVID-19 cases. While we would expect to see less catastrophic cases than when the initial pandemic began, it is too early to predict with any degree of certainty. We continue to monitor the impact of COVID-19 and have shared some details in this report. Our goal is to keep you apprised of our findings so you can educate your clients and customers.

For the stop loss market, the past year has been very interesting. The trends in diagnosis frequency remains relatively unchanged, and while the top severity claim has been consistent, the movement in the rest of the top 10 reflects the changes we see in specialty drug costs. We also witnessed a tenth straight year of record numbers of life-saving transplants from deceased donors and expect this trend to continue. Our $million+ claims also continue to grow, with the number of cases per capita nearly doubling from 5 years earlier and our total claims spend more than tripling over that same time. Growth in cell and gene therapy solutions seemed to be delayed by 12 months with the delayed approval of Roctavian and the FDA focus on COVID-19. However, we see a very large pipeline for cell and gene therapy treatments developing in the next 12-24 months.

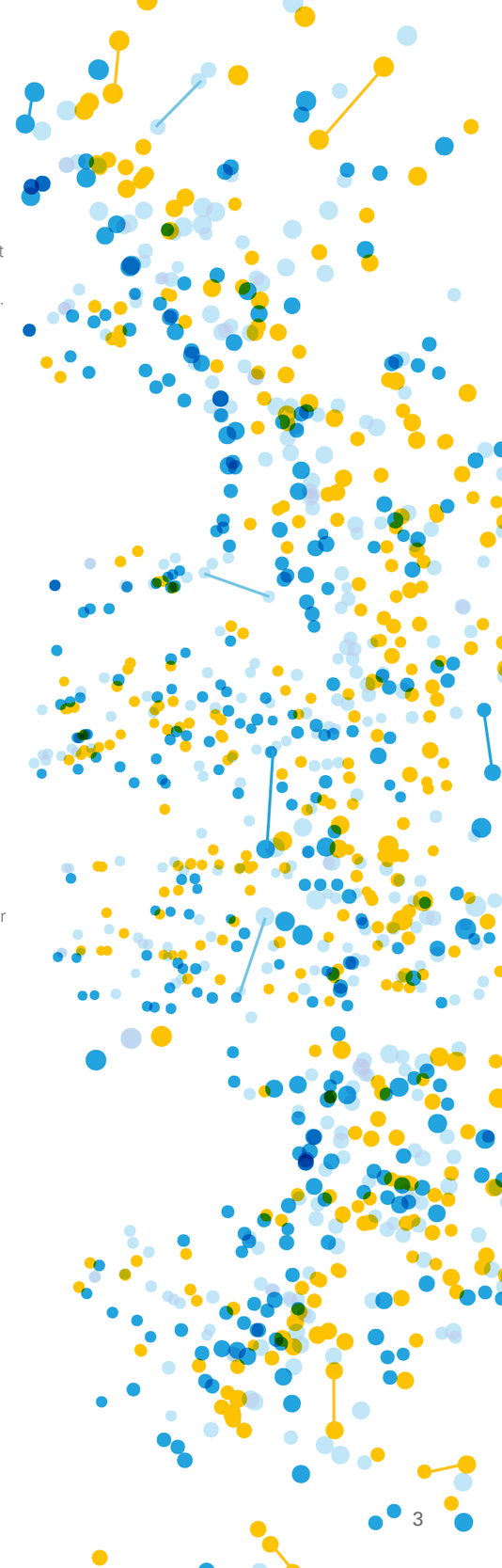
We have not limited this report to just claims and costs discussions. There are other factors that influence our market and we also want to share just some of those. Henkel v. Reliastar is a groundbreaking legal case concerning PBMs and fiduciary duty. The latest NAIC report shows the continued growth in the stop loss market with a flattening of the industry loss ratio. We invited our friends from the Self Insurance Institute of America (SIIA) to share their thoughts on state and federal legislative changes that matter to our industry.

We are pleased to offer this information and appreciate your interest in this report. If you have any questions as you read through the information that follows, please don't hesitate to contact our staff. Thank you for trusting us with you and your client's stop loss and organ transplant needs.

Jay Ritchie

President & CEO

TOKIO MARINE HCC



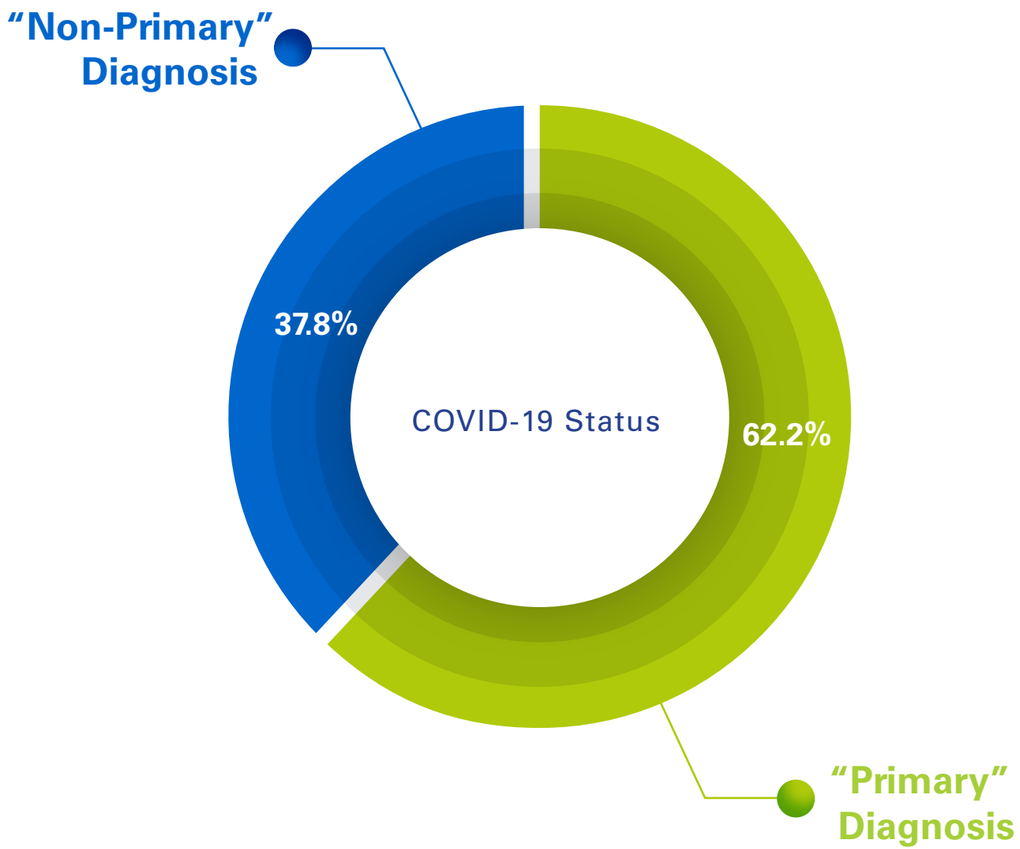
COVID-19's Impact on Claims

COVID-19 had a profound impact on claim submission activity in 2020. For some claim categories, the pandemic had an increasing effect, including:

- **Respiratory Disease**
- **Genitourinary Diseases**
- **Sepsis**

Conversely, COVID-19 had a dampening effect on other disease categories, likely a result of the reduction of normal activities, including:

- **Injuries/Poisoning**
- **Musculoskeletal/Connective Tissue**



Tokio Marine HCC – Stop Loss Group incurred over $100M in COVID-related claims, with the average claim being $165,403. As the chart above shows, 62% of those claims showed COVID-19 as the primary diagnosis, with the remaining 38% as being a secondary or later diagnosis.

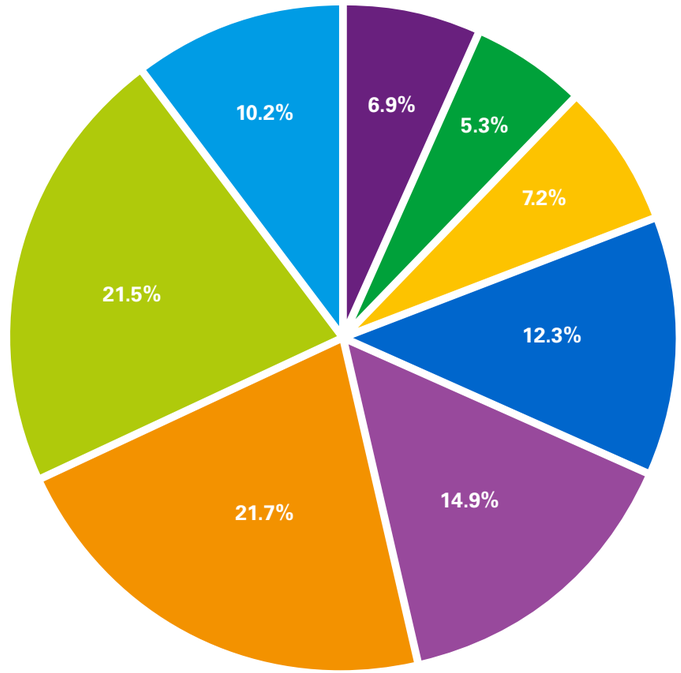
COVID Data through May 2021

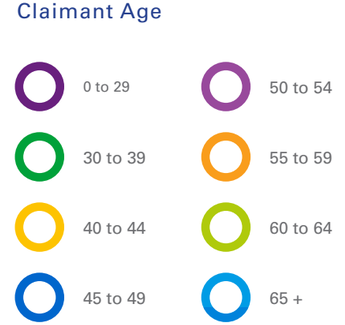
COVID-19 Reported Claims (through May 2021)

Number of Claims **617**

Average Claim Amount **$165,403**

= Total **$102,053,882**





Not surprisingly, nearly 2/3 of COVID-19 claims were for individuals age 50 or older.

COVID Data through May 2021

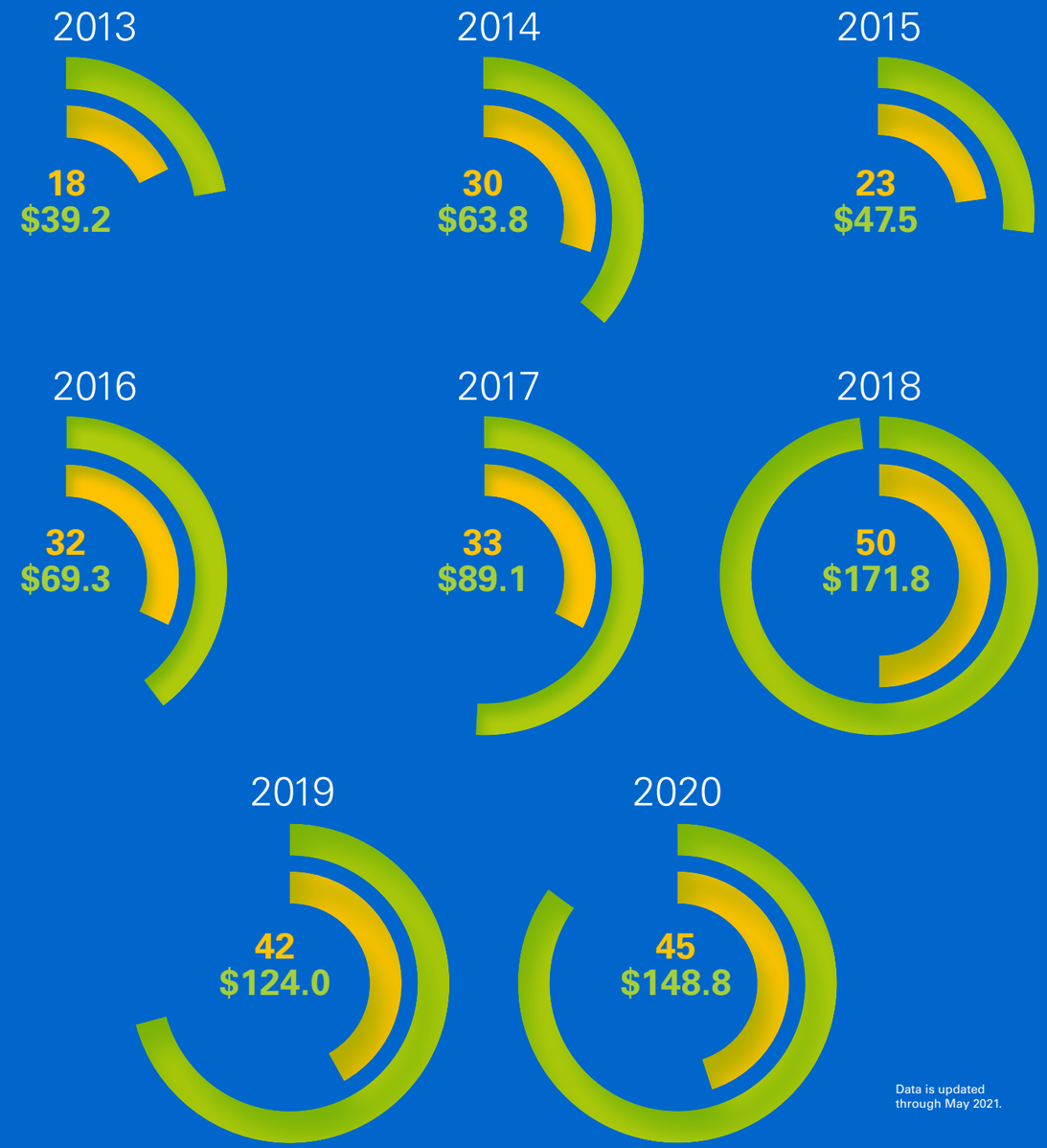
Million Dollar Claims

Incurred Claims in Excess of $1,000,000 Over Specific Deductible

Spurred primarily by the ACA's removal of annual and lifetime limits in 2014, TMHCC has seen significant growth in the number and amount of claims in excess of $1 million over the specific deductible.

Claims per 1,000,000 Employees

Incurred Amounts (in millions)

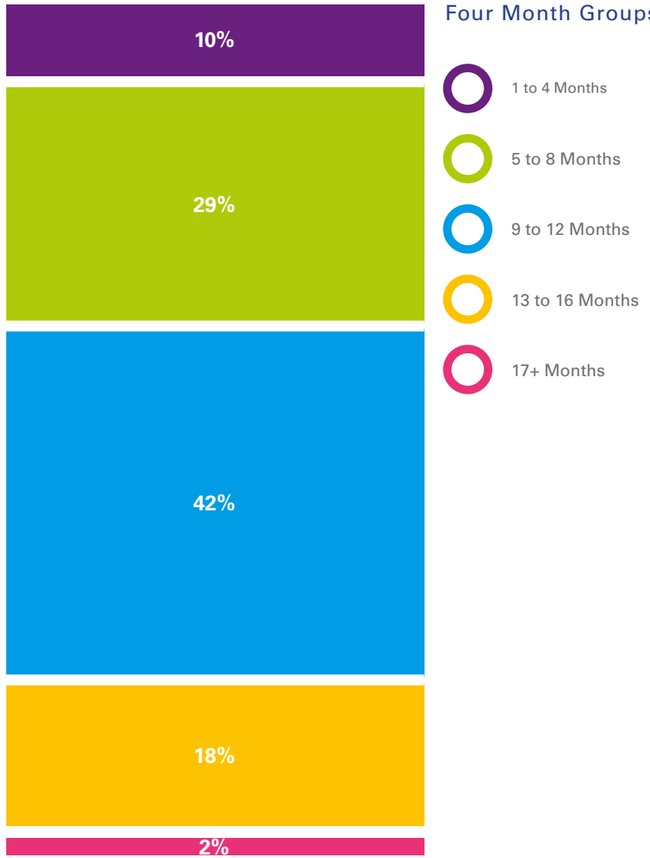


Data is updated through May 2021.

Stop Loss Claims by Duration

Average Month of First Reported Claim from Policy Effective Date

Many of our producers ask for "early locks" of 120 days or more for their clients' stop loss coverage, most often spurred by their clients' budgeting process. However, as the graph below illustrates, on over 60% of our policies, Tokio Marine HCC – Stop Loss Group does not even see the first claim until the ninth month of the policy year or later, making it very difficult to predict how the most recent experience year will turn out. Underwriters therefore must use caution given this risk uncertainty, which often results in higher rates for the policyholder. We therefore encourage our producers to allow for more time for experience to develop before requesting a firm quote, whenever possible.



Cell and Gene Therapy Treatments

Costs continue to escalate at alarming rates for cell and gene therapies. Tokio Marine HCC – Stop Loss Group (TMHCC) offers a solution to manage these high-cost events. TMHCC has partnered with Emerging Therapy Solutions® (ETS) for a best-in-class service to positively impact the plan and patient.

What is the difference between cell therapy and gene therapy? Cell Therapy is defined as the transfer of live cells into a patient to lessen or cure a disease. The cells may originate from the patient or a donor. **Gene Therapy** involves replacing a missing or mutated gene in the targeted cell to treat or cure a disease. This new gene can then help correct the missing functionality.

Zolgensma® (Gene) | zolgensma.com

Treats spinal muscular atrophy in children under age 2 with biallelic mutations of SMN1 gene

Cost of Therapy*	Estimated Cost of Treatment	Total Cost Estimate	Average Expected Savings from Billed Charges†	ETS Estimated Average Savings Over Traditional Network‡
$2,125,000	$236,000	$2,361,000	$670,000	$267,000

Luxturna® for both eyes (Gene) | luxturna.com

Treats biallelic RPE65 mutation associated retinal dystrophy

Cost of Therapy*	Estimated Cost of Treatment	Total Cost Estimate	Average Expected Savings from Billed Charges†	ETS Estimated Average Savings Over Traditional Network‡
$850,000	$94,000	$944,000	$245,000	$98,000

Breyanzi® (Cell) | breyanzi.com

Treats adult patients with r/r (relapsed or refractory) large B-cell lymphoma including diffuse large B-cell lymphoma (DLBCL) & r/r follicular lymphoma

Cost of Therapy*	Estimated Cost of Treatment	Total Cost Estimate	Average Expected Savings from Billed Charges†	ETS Estimated Average Savings Over Traditional Network‡
$410,300	$428,000	$838,000	$452,000	$126,000

Kymriah® for Acute Lymphoblastic Leukemia (Cell) | kymriah.com

Treats patients up to age 25 with r/r acute lymphoblastic leukemia

Cost of Therapy*	Estimated Cost of Treatment	Total Cost Estimate	Average Expected Savings from Billed Charges†	ETS Estimated Average Savings Over Traditional Network‡
$475,000	$309,000	$784,000	$429,000	$120,000

Kymriah(R) for Large B-Cell Lymphoma (Cell) | kymriah.com

Treats adult patients with r/r large B-cell lymphoma including diffuse large B-cell lymphoma (DLBCL)

Cost of Therapy*	Estimated Cost of Treatment	Total Cost Estimate	Average Expected Savings from Billed Charges†	ETS Estimated Average Savings Over Traditional Network‡
$373,000	$309,000	$682,000	$515,000	$143,000

Tecartus™ (Cell) | tecartus.com

Treats adult patients with r/r mantle cell lymphoma

Cost of Therapy*	Estimated Cost of Treatment	Total Cost Estimate	Average Expected Savings from Billed Charges†	ETS Estimated Average Savings Over Traditional Network‡
$399,000	$424,000	$797,000	$496,000	$138,000

Yescarta® (Cell) | yescarta.com

Treats adult patients with r/r large B-cell lymphoma including diffuse large B-cell lymphoma (DLBCL) and r/r follicular lymphoma

Cost of Therapy*	Estimated Cost of Treatment	Total Cost Estimate	Average Expected Savings from Billed Charges†	ETS Estimated Average Savings Over Traditional Network‡
$399,000	$439,000	$812,000	$443,000	$124,000

Abecma® (Cell) | abecma.com

Treats adult patients with r/r multiple myeloma

Cost of Therapy*	Estimated Cost of Treatment	Total Cost Estimate	Average Expected Savings from Billed Charges†	ETS Estimated Average Savings Over Traditional Network‡
$419,500	$560,000	$979,500	$669,000	$186,000

*Cost of therapy is based on current known cost from publicly available information. NOTE: For full indications and label information, please visit manufacturer websites.

**Luxturna is priced per eye at a cost of $425,000 per eye. Not all individuals may have retinal cells viable to have both eyes treated. If both eyes are treated, the therapy is not administered at the same time.

†Average expected savings from billed charges: ETS has provided these estimates of average savings based on internal data, experience and calculations. These numbers are estimates only and are not a guarantee of savings. Actual individual case savings will vary widely depending on location and other factors. Note that savings over billed charges can range greatly from $350,000 to over $2M for certain Cell Therapy cases.

‡ETS estimated average savings over traditional network: ETS has provided these estimates of average savings based on internal data, experience and calculations. These numbers are estimates only and are not a guarantee of savings. Actual individual case savings will vary widely depending on location and other factors.

Trends in Transplants

2020
most lives ever saved by deceased donors

6%
increase in deceased donors over 2019

More than
33,000 life-saving transplants
from deceased donors

10th
record year in a row for deceased donation

More than
12,500
deceased donors in 2020

2020 donors deceased and living
18,316

2020 total transplants
39,035
solid organs

More than
5,700 living donor transplants

The reduction in living donors in 2020 was a significant drop from 2019, due to the impact of COVID-19.

Since June of 2020, living donor transplants have occurred at rates more similar to pre-pandemic activity.

Source: UNOS.org – 2020 data

Top 10

Diagnosis Categories by Frequency 2017-2020

Cancers – Malignant Neoplasms continue to be the most frequent diagnosis category, followed by Cardiovascular Diseases and Musculoskeletal/Connective Tissue conditions. It is noteworthy that the only new disease category that entered the top 10 in 2020 were Respiratory Diseases, undoubted driven by the COVID-19 pandemic.

2017

1. Cancers - Malignant Neoplasm
2. Musculoskeletal/ Connective Tissue
3. Cardiovascular Diseases
4. Injury/Poisoning/ External Causes
5. Nervous System Diseases
6. Cancers - Leukemia/ Lymphoma/Multi Myeloma
7. Digestive Diseases
8. Endocrine/ Metabolic Diseases
9. Crohn's/ Ulcerative Colitis
10. Mental/Behavioral Disorders

2018

1. Cancers - Malignant Neoplasm
2. Cardiovascular Diseases
3. Musculoskeletal/ Connective Tissue
4. Injury/Poisoning/ External Causes
5. Cancers - Leukemia/ Lymphoma/Multi Myeloma
6. Nervous System Diseases
7. Digestive Diseases
8. Endocrine/ Metabolic Diseases
9. Respiratory Diseases
10. Perinatal/Neonatal

2019

1. Cancers - Malignant Neoplasm
2. Musculoskeletal/ Connective Tissue
3. Cardiovascular Diseases
4. Cancers - Leukemia/ Lymphoma/Multi Myeloma
5. Nervous System Diseases
6. Injury/Poisoning/ External Causes
7. Digestive Diseases
8. Crohn's/ Ulcerative Colitis
9. Endocrine/ Metabolic Diseases
10. Sepsis

2020

1. Cancers - Malignant Neoplasm
2. Cardiovascular Diseases
3. Musculoskeletal/ Connective Tissue
4. Cancers - Leukemia/ Lymphoma/Multi Myeloma
5. Nervous System Diseases
6. Injury/Poisoning/ External Causes
7. Respiratory Diseases
8. Digestive Diseases
9. Crohn's/ Ulcerative Colitis
10. Endocrine/ Metabolic Diseases

Ranked by number of claims per 1M Employees. Data through March 2021.

Top 10

Diagnosis Categories by Severity 2017-2020

Burns and Corrosions once again tops the list as the most expensive diagnostic claim category, as it has for the prior three years. Eight of the 10 diagnosis categories are the same for each of the four years, including Transplants, Hemophilia/Bleeding Disorders and diagnoses associated with premature births. Some of the annual high cost diagnoses, such as Spinal Muscular Atrophy and Hemolytic-Uremic Syndrome, are driven by specialty prescription drugs and gene therapies targeted at those specific diseases.

2017

1. Burns and Corrosion
2. HAE/Defects of Complement System
3. Spinal Muscular Atrophy
4. Hemophilia/ Bleeding Disorder
5. Transplants
6. Perinatal/Neonatal
7. Congenital/Chromosomal Abnormalities
8. Cancers - Leukemia/ Lymphoma/Multi Myeloma
9. Chronic Kidney Disease/Dialysis
10. Blood Diseases/ Immune Disorders

2018

1. Burns and Corrosion
2. HAE/Defects of Complement System
3. Hemolytic-Uremic Syndrome
4. Perinatal/Neonatal
5. Hemophilia/ Bleeding Disorder
6. Spinal Muscular Atrophy
7. Transplants
8. Cancers - Leukemia/ Lymphoma/Multi Myeloma
9. Congenital/Chromosomal Abnormalities
10. Blood Diseases/ Immune Disorders

2019

1. Burns and Corrosion
2. Transplants
3. Spinal Muscular Atrophy
4. HAE/Defects of Complement System
5. Hemophilia/ Bleeding Disorder
6. Cancers - Leukemia/ Lymphoma/Multi Myeloma
7. Perinatal/Neonatal
8. Chemo/i/Radiation
9. Chronic Kidney Disease/Dialysis
10. Congenital/Chromosomal Abnormalities

2020

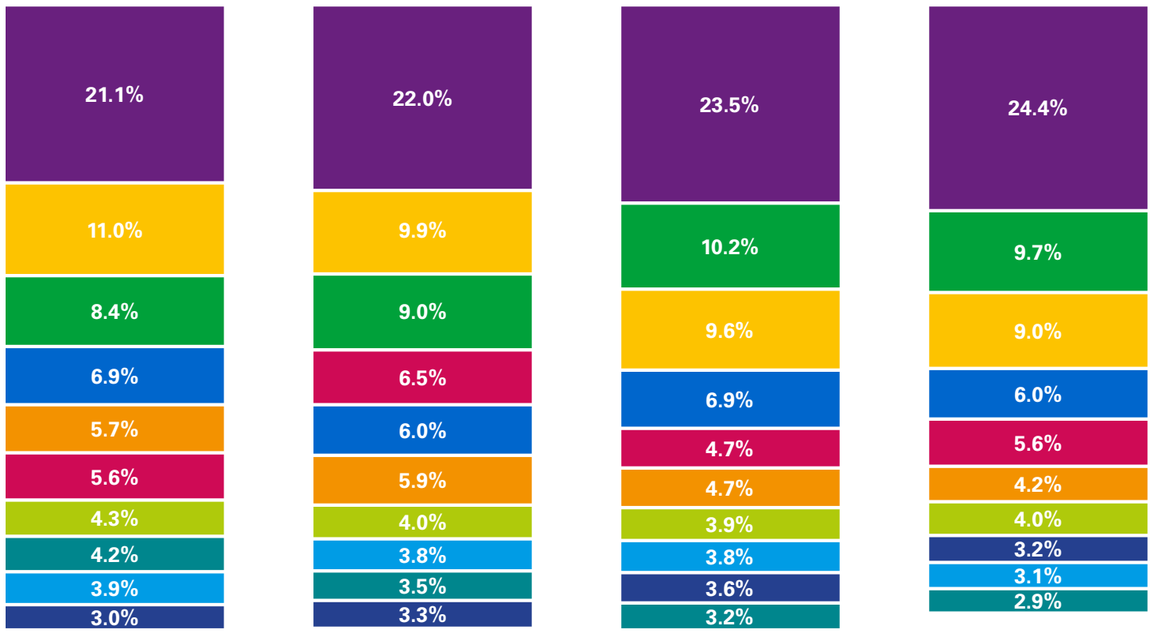
1. Burns and Corrosion
2. Spinal Muscular Atrophy
3. Hemolytic-Uremic Syndrome
4. HAE/Defects of Complement System
5. Transplants
6. Perinatal/Neonatal
7. Cancers - Leukemia/ Lymphoma/Multi Myeloma
8. Congenital/Chromosomal Abnormalities
9. Chemo/Immunotherapy/ Radiation
10. Hemophilia/ Bleeding Disorder

Average TPA Paid per claimant. Data through March 2021.

Diagnosis Categories by Total Cost

Cancers – including Malignant Neoplasms and Leukemia/ Lymphoma/Multiple Myeloma – continue to be the most costly overall diagnostic conditions, annually representing 30-35% of total TMHCC stop loss claims spend. Cardiovascular Diseases and Musculoskeletal/Connective Tissue Conditions, along with Cancer, account for about half of the total cost of stop loss claims.

- Cancers - Malignant Neoplasm
- Cancers - Leukemia/ Lymphoma/Multi Myeloma
- Cardiovascular Diseases
- Musculoskeletal/ Connective Tissue
- Perinatal/Neonatal
- Injury/Poisoning/ External Causes
- Nervous System Diseases
- Digestive Diseases
- Endocrine/ Metabolic Diseases
- Chronic Kidney Disease/Dialysis

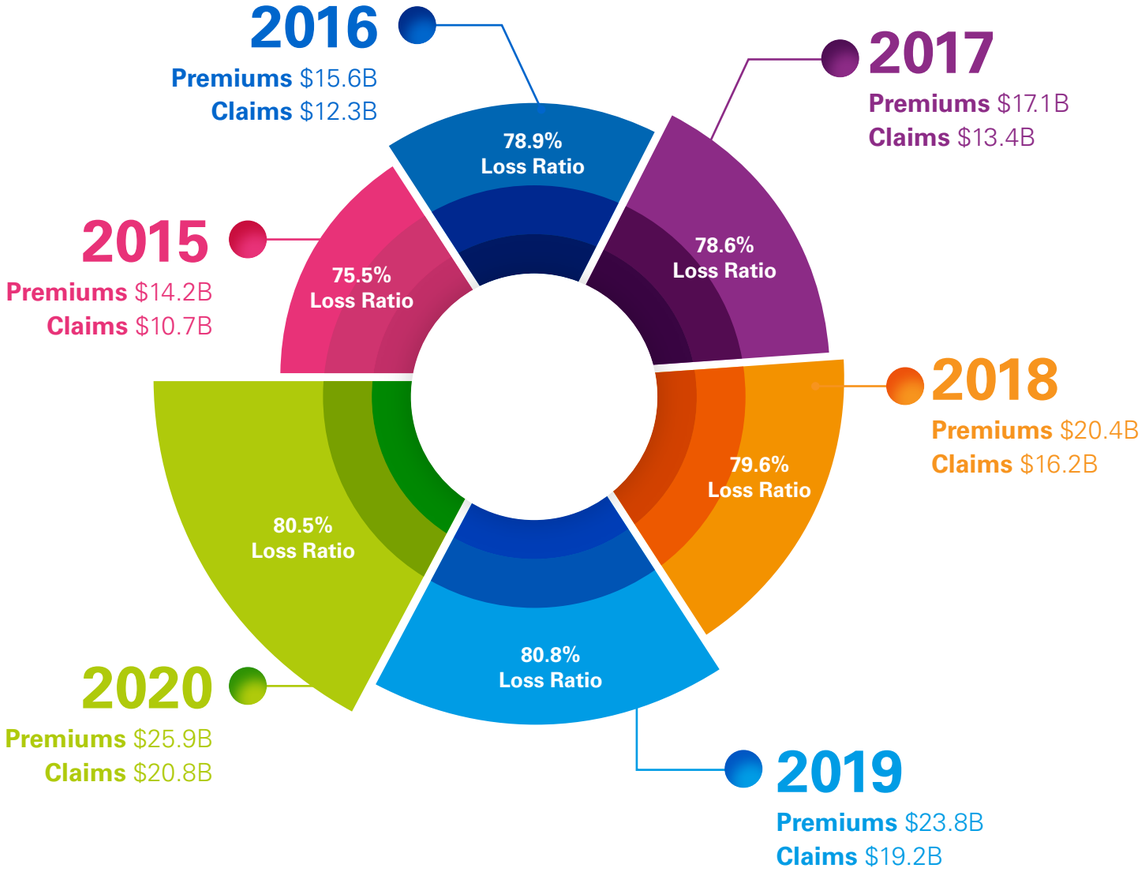


Ranked based on 2019 and 2020 percentages.

NAIC Stop Loss Industry Data

Earned Premiums and Incurred Claims by Calendar Year

From 2015 through 2020, premiums increased by 82% but claims increased by 94%



Custom Benchmarking and Proposal

One of our primary goals is to provide you with the tools and reference materials necessary to assist you and your clients in making stop loss coverage decisions. TMHCC generates custom benchmarking data and automatically includes it with all new business and renewal proposals. Below is a sample of one of the pages from our Custom Benchmarking and Proposal report.

Custom Benchmarking Data

DG Manufacturing Group

Tokio Marine HCC – Stop Loss Group is one of the largest direct writers of Stop Loss in the country. With our experience, we have created one of the industry's largest databases of Stop Loss statistics. In an effort to help you make an informed decision, we are including benchmarking metrics for your consideration.

		DG Manufacturing Group	Employee Size 125 to 149	Industry Manufacturing	State Alabama
Average Number of Employees		132	136	502	386
Average Age of Employees		51	46	47	45
Male/Female Employee Split		70/30	65/35	74/26	65/35
Average Specific Deductible*		$80,000	$75,000	$130,000	$95,000
Expected Number of Stop Loss Claims		2.9			
Probability of Having an Organ Transplant	In 1 Year	8%			
	In 5 Years	35%			

*Current specific deductible for DG Manufacturing Group is shown.

Medical Stop Loss - - **Leveraged Trend**

As plans budget for the next fiscal year, medical cost inflation is undoubtedly a critical element of the planning process. New medical technologies, rising provider charges, and specialty pharmaceutical costs continue to cause health coverage expenses to rise faster than general inflation. Medical inflation, along with deductible erosion, are the two factors that create leveraged trend, and unfortunately, medical stop loss insurance is not immune to these forces.

How does leveraged trend affect stop loss rates?

Suppose a self-funded plan has a $100,000 specific stop loss deductible. In year one, an employee has $250,000 in claims. The first $100,000 of the claims is paid by the self-funded plan. The remaining $150,000 is reimbursed by the medical stop loss policy.

Assume the following year's medical trend is 10%. For a similar claim, the employee's claim amount would increase from $250,000 to $275,000. But if the plan's specific deductible remains at $100,000, then the self-funded plan would still pay the first $100,000 of the claims, but the medical stop loss policy now reimburses the remaining $175,000 in claims – a 17% "leveraged trend" increase from the preceding year. **In other words, 10% medical inflation turns into 17% stop loss coverage inflation.**

What can self-funded plans do to help manage the impact of leveraged trend?

Many self-funded employers find that increasing their specific deductible to match the annual trend expectations helps mitigate the cost impact of leveraged trend on their stop loss policies.

Raising your specific deductible could mean lower overall costs.

Each plan should be evaluated based on the size and risk tolerance of the employer. Plans should weigh the cost of the claims to be paid out of the plan against the cost of premiums for coverage of the medical stop loss claims.

YEAR 1
$250,000 - Total Claims
$100,000 Specific Deductible

YEAR 2
$275,000 - Total Claims
$100,000 Specific Deductible

10%
medical inflation turns into
17%
stop loss coverage inflation.

Legal Cases to Watch

Ramifications of the Pharmacy Benefit Manager (PBM) Case

While ERISA preempts state laws that affect ERISA plans (except those that affect insurance), SCOTUS ruled that PBMs aren't ERISA plans. More importantly, states can regulate ERISA indirectly when it is only costs that are being regulated Self-insured ERISA plans may be required to participate in surprise billing mediations. States are looking at out-of-network billing and are, at present, allowing a self-insured plan to opt-in to the mediation. This ruling suggests that states may be able to freely regulate service providers to ERISA plans (since that only affects costs), not benefit choices.

HENKEL V. RELIASTAR CASE

The Henkel v. Reliastar case involves a very expensive drug which the PBM, Express Scripts, approved as medically necessary. The U.S. federal court in Connecticut has recently denied Express Scripts' Motion for Summary Judgment, indicating questions of fact remain.

The court indicated that there remains questions of fact concerning the approval of millions of dollars in drug costs without clear evidence (no lab results) of medical necessity. In addition, the court noted that, at one point, the participant was using 66 vials a day, a number well over what was recommended on the label.

Legislative Update

Political Environment: Process & Procedure

With control of the U.S. Senate tied at 50-50 and a slim 9-seat majority in the House, this new political environment has created a unique and challenging path for policy change in general, and health care reform specifically. However, the House and Senate will attempt to work together to pass health care changes through the reconciliation process, which allows Congress to push through a limited legislative package through a simple majority vote. Changes such as expanding Medicare, drug pricing reform, and a Medicare-like public option, would fit into such a process.

Healthcare Price Transparency

In addition to surprise billing, Federal agencies have also issued the Transparency in Coverage Rule. With incremental effective dates ranging from 2022-2024, the final rule requires self-insured plans, as well as fully-insured group and individual market plans, to disclose information related to cost-sharing information, negotiated in-network rates, and payments to out-of-network providers.

Implementation of the surprise billing and the transparency in coverage rule simultaneously will be complicated. While the Federal agencies will likely be providing surprise billing guidance through a series of Interim Final Rules, Self-Insurance Institute of America, Inc. (SIIA) has requested a streamlined implementation approach that includes safe harbors and a more appropriate compliance timeline.

SIIA Legislative & Political Overview

The 2020 election drastically changed the political and policy landscape being faced by the self-insurance industry. The Self-Insurance Institute of America, Inc. (SIIA) and its dedicated government relations team has continued to educate, engage, and advocate on self-insurance and stop-loss issues on the state and federal levels, in addition to fostering policies that leverage industry growth and innovation. SIIA continues to focus on healthcare transparency and cost, drug pricing, and the need for increased data availability.

Surprise Medical Billing Protections

The recently enacted No Surprises Act includes new Federal requirements beginning in January 2022 that protect patients from balance bills and set rules for how much an insurance carrier/self-insured health plan will pay a medical provider in certain out-of-network situations. These surprise billing protections cover out-of-network emergency situations and air ambulance, in addition to when a patient is provided care at an in-network facility by an out-of-network provider without the patient's consent.

Under the law, providers and insurers will have 30-days to come to an agreement on an appropriate payment amount based on the in-network median rate within a geographic area. If an agreement on that payment amount cannot be reached, each party can enter into a "baseball style" arbitration process that requires each party to submit their own best and final payment amount, which the arbiter will then use to pick one of the amounts. Importantly, the arbiter cannot take into account billed charges or government set rates like Medicare.

Implementation guidance will be determined through a series of federal rulemakings, the first of which was released in July 2021, setting out a number of statutory definitions, including providers and emergency services, reimbursement and payment amounts, geographic areas, and notice and consent requirements, among others. SIIA submitted a comprehensive set of comments and directly engaged with the Federal Departments, and is encouraged that this Interim Final Rule (IFR) includes specific recommendations from the SIIA comment letter that protect patients and lower the cost of healthcare.

Among other things, the Phase 1 IFR verifies SIIA's request that ERISA pre-empts state surprise billing laws, and clarifies that self-insured plans may voluntarily opt-in to state surprise billing protections. Also consistent with SIIA's request, the IFR permits a sponsor of a self-insured plan to allow the plan's TPA or service provider to determine the Qualifying Payment Amount (QPA) on behalf of the plan sponsor by calculating the median contracted rates for all of the self-insured plans administered by that TPA or provider, not just those rates charged by the particular plan sponsor. This will allow for improved information for smaller self-insured plans in the median contracted rate calculation.

SIIA continues to be heavily engaged with Federal agencies in advocating for self-insured plans and will be submitting recommendations ahead of the various rule phases expected throughout the remainder of the year.

Health Care Reform: Drug Pricing & Medicare Expansion

While many big-ticket health care reform options are likely off the table prior to the 2022 mid-term elections, there are several issues that could gain momentum through a reconciliation bill. The Administration and Congress are looking at changes to employer-based care and the ACA that may impact employer-based healthcare in general, and the self-insured industry specifically, including:

- Advancement of public option health proposals
- Medicare expansion
- ACA interpretive changes
- Insurance regulation and mandates

Already under reconciliation, Congress has expanded and increased the availability of ACA subsidies for low- and middle-income individuals and families purchasing an individual market plan. This allows any individual at any income level to access an even more generous premium subsidy than under current law, irrespective of whether this individual is offered an employer health plan that is considered an affordable/minimum value plan. Congress is planning to consider making these ACA subsidies permanent.

Through the budget reconciliation process, Congress is potentially considering lowering the Medicare eligibility age from 65 to 60, thus eroding the employer-based insurance firewall by allowing those individuals to enroll in Medicare and leave the employer insurance pool.

In addition, Congress continues to look at drug pricing reform, including changes to orphan drug exclusivity, Medicare negotiation for the top tier of high-cost drugs, and creating a price increase cap tied to inflation. The House has already passed changes to orphan drug exclusivity, making it easier for generic drugs to enter the market. In the absence of major drug reform, and understanding the increased cost for self-insured plans, SIIA has also formed the Drug Pricing Task Force that is currently finalizing a set of best practices across the industry to better understand and manage drug spend, which will be forthcoming later this year.

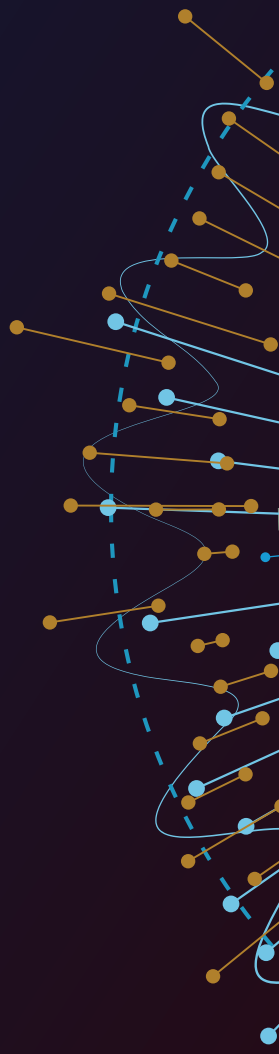
State Legislative & Regulatory Activities

State legislatures across the country have been considering a myriad of legislation in 2021 related to issues ranging from placing limits on small-group stop-loss insurance to imposing assessments on employer benefit plans, including self-insured plans, to pay for individual market reforms. Many of these assessments, such as those passed in New Hampshire, place a per member per month assessment on the plan to help pay for an expanded individual market. In some cases, states have also looked to expand the individual state insurance market into a "public option" proposal that would create a state-based health insurance plan for individuals and within the small group market, as has been considered in Connecticut, and passed recently in states such as Colorado and Nevada. In addition, a number of states such as Arkansas, North Dakota, and Texas have passed or have considered pharmacy benefit reforms for ERISA-covered plans, which would change the way self-insured plans manage pharmacy benefits in those states.

On the Horizon

Advocacy is a continual process as legislators and regulators make decisions that affect the availability and cost of stop-loss and self-insured benefits. Concerns arising from the increasing cost of health care, price and data transparency, and market access continue to drive legislative, and regulatory activities across the country. With the post-2020 political dynamic evolving, and the nation emerging from COVID related restrictions, healthcare remains one of the most important topics across the country.

With new price transparency rules going into effect, and the potential for further ACA and Medicare eligibility expansion, the future of health care and employer-sponsored care is an ever growing policy debate. In the meantime, self-insured plans, stop-loss carriers, and others are at the forefront of advancing cost, delivery, price transparency and the protection of employer-based health benefits.



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