Annual
MARKET REPORT

2020

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
TMHCC1124 - 08/2020

CONTENTS

EXECUTIVE SUMMARY

2020

MESSAGE FROM OUR PRESIDENT

Our team at Tokio Marine HCC - Stop Loss Group (TMHCC) decided that we wanted to communicate a general overview of the stop loss market and what direction we believe it is headed, share data we have around claims and claim trends, and provide solutions to deal with new and old issues for the industry. We hope as you flip through these pages you will find this report informative and helpful.

We can all say that 2020 has been eventful. The impacts of COVID-19 are still developing, but we know the economic impact is real. Medical procedures overall experienced a slowdown with elective procedures and some non-elective procedures being delayed, but catastrophic claims still happen every day. As our medical community digests the deferred volumes along with normal demand, we expect to see a period of higher claims before we return to normal patterns. Unemployment growth was unprecedented and self-funded employers and plans continue to navigate the sudden shift. Relapse and future shutdowns remain a real possibility. Overall, this is a generational event that we must navigate together. Self-funded plans, our producers, TPAs and TMHCC have worked together very well so far and we are proud to be a small part of the solution.

As the year progresses, we know more change will come. Gene Therapy is no longer a horizon event; it is a growing industry that promises fundamental changes in how medicine will look in the future. Maintenance moving to cure is a very exciting development, but as with most groundbreaking developments, the costs are high. We must be prepared to deal with those costs for the betterment of patients and the plans that will be tasked with funding the treatments.

Overall, medical procedures and the resulting health benefit claims will continue to morph and evolve. Our understanding of the past patterns, combined with a vision for the future, allows us to chart a course for mutual success with our producers and policyholders. TMHCC prides itself on being a leader in the industry and we are constantly evolving our operations and capabilities to be recognized as a carrier of choice for your Medical Stop Loss and Organ Transplant needs.

We are pleased to give you this Annual Market Report, showcasing our efforts to keep you informed and to thank you for trusting us with your business. Thanks for taking the time to read through our report.

Jay Ritchie

President

TOKIO MARINE HCC

COVID-19 IMPACT

AT THE ONSET OF THE COVID-19 PANDEMIC,

TMHCC was prepared to seamlessly transition employees to a work-from-home environment, which enabled us to effectively avoid production losses and provide the necessary customer support required during uncertain times. In the days that followed, TMHCC knew our stop loss policyholders and their advisors were exploring ways of keeping plan participants safe and providing them with coverage options that may be outside their normal suite of benefits. We also explored these options and examined their consequences in light of their stop loss coverage, leading TMHCC to put out a notice that, effective immediately, TMHCC would honor the following actions that our policyholders decided to take in response to the virus.

SOME OF THE ACTIONS AND ELIGIBILITY REQUIREMENTS INCLUDED THE FOLLOWING:

1. Waiver of deductibles, co-pays and cost sharing on covered participants for COVID-19 testing.
2. Waiver of cost sharing for virtual visits or telemedicine allowed under the stop loss coverage.
3. Early refills of medication to ensure participants had a 30-day supply.
4. Determination of who is actively at work and covered under the plan was to be made by the employer, including determination for employees who have been furloughed or received reduced hours while still considered eligible for the purposes of plan coverage.
5. Allowed retroactive changes that kept the currently covered members on the plan for as long as employees were included in the census and the applicable stop loss COVID-19 and organ transplant premiums were paid.

TMHCC was also quick to address the Department of Labor Final Rule on Extensions and Timeframes with specific details regarding the Rule that required ERISA Plans to disregard the Outbreak Period when determining deadlines related to certain events outlined within the Rule. TMHCC views the Outbreak Period as an extension to normal timing requirements for those events.

TMHCC EFFECTIVELY IDENTIFIED AND ADDRESSED THE FOUR EXTENSIONS THAT COULD HAVE AN IMPACT ON POLICYHOLDERS' COVERAGE, INCLUDING:

1. HIPAA Special Enrollments
2. COBRA
3. Receipt date of first dollar claims
4. External reviews

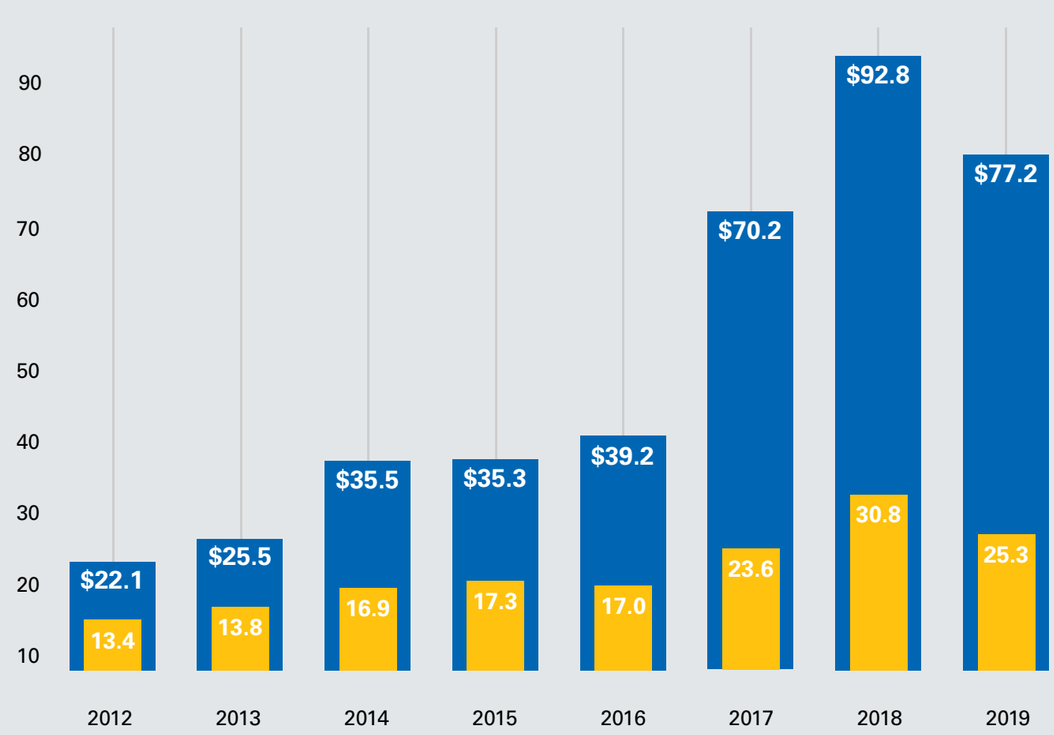
MILLION DOLLAR CLAIMS

In Excess Of $1,000,000 YTD Jan - Dec Over Specific Deductible

Beginning in 2014, provisions within the Affordable Care Act (ACA) required insurers to assume unlimited claim liability. As a result of the ACA, there was a significant increase in both frequency (number of claims) and severity (amount of individual claims) that exceeded $1 million.

While our block of business continues to grow in line with the entire stop loss industry, the **FREQUENCY AND SEVERITY OF CLAIMS IN EXCESS OF $1M CONTINUES TO OUTPACE OVERALL BLOCK GROWTH.**

The chart below reflects the growth from before the Affordable Care Act took effect and eliminated lifetime and annual maximums for self-funded plans.



EMERGING THERAPY SOLUTIONS (ETS)

– Best Practices In Cell And Gene Therapy

As costs continue to escalate at alarming rates for cell and gene therapies, TMHCC offers a solution to manage these high cost events. We have partnered with Emerging Therapy Solutions (ETS) for a best-in-class service to positively impact the plan and patient.

STEP DOWN DEDUCTIBLE

Through implementation of the suggested Plan Document language provided by ETS, TMHCC stop loss policyholders will receive a 10% reduction in the specific deductible for the patient receiving gene therapy via ETS's Programs of Excellence. The 10% step down deductible has a minimum of $15,000 and a maximum of $50,000, making the percentage more than 10% for groups with specific deductibles under $150,000.

THE 10% STEP DOWN DEDUCTIBLE HAS A MINIMUM DEDUCTION OF $15,000 AND A MAXIMUM OF $50,000 AS DEMONSTRATED IN THE FOLLOWING EXAMPLES:

Policyholders with a **$150,000 OR LESS SPECIFIC DEDUCTIBLE** would receive a
$15,000 reduction.

Policyholders with a **$500,000 OR GREATER SPECIFIC DEDUCTIBLE** would receive a
$50,000 reduction.

Policyholders with a **SPECIFIC DEDUCTIBLES BETWEEN THE TWO AMOUNTS** on the left will receive a
10% reduction.

FIVE WAYS ETS CAN ADD VALUE FOR CELL AND GENE THERAPIES:

1. Cell and Gene Therapy Utilization: ETS will proactively monitor the patient and direct each one to the right treatment at the right time.
2. Networking and Contracting: By using their POE, ETS clients have access to ETS rates for services delivered as part of the continuum of care.
3. Audit and Payment Accuracy: ETS will audit and re-price all claims for payment.
4. Personalized Pathway: Early patient identification allows ETS to maximize effect in both care management and quality of care throughout the specific treatment plan.
5. Direct to Manufacturer: Participating in the ETS buying group can potentially eliminate administrative waste associated with buy and bill, PBM rebates, warranty programs and 340B discounts.

GENE THERAPY TREATMENTS

	ZOLGENSMA	LUXTURNA	ROCTAVIAN* (HEMOPHILIA A)
	• Treats Spinal Muscular Atrophy in children under age 2 • FDA approval is broader in scope than clinical trials	• Treats inherited retinal disease gene mutation in the eyes	• Much about this treatment is unknown, but this therapy is expected to increase the claim costs of many individuals.
AVERAGE COST OF EPISODE	$2.3 MILLION	$965,000	$3.2 MILLION
AVERAGE COST OF THERAPY	$2.1 MILLION	$850,000	UNKNOWN: ASSUMPTION IS $3 MILLION
ESTIMATED SAVINGS USING ETS	$140,000	$67,000	$153,000

ETS utilizes a per case fee of $15,000 to $20,000 for current gene therapy treatments (or episodes of care). These fees are eligible under the stop loss policy; however, most will be paid directly to ETS by TMHCC.
*Roctavian is not yet approved and is not yet part of the ETS program.

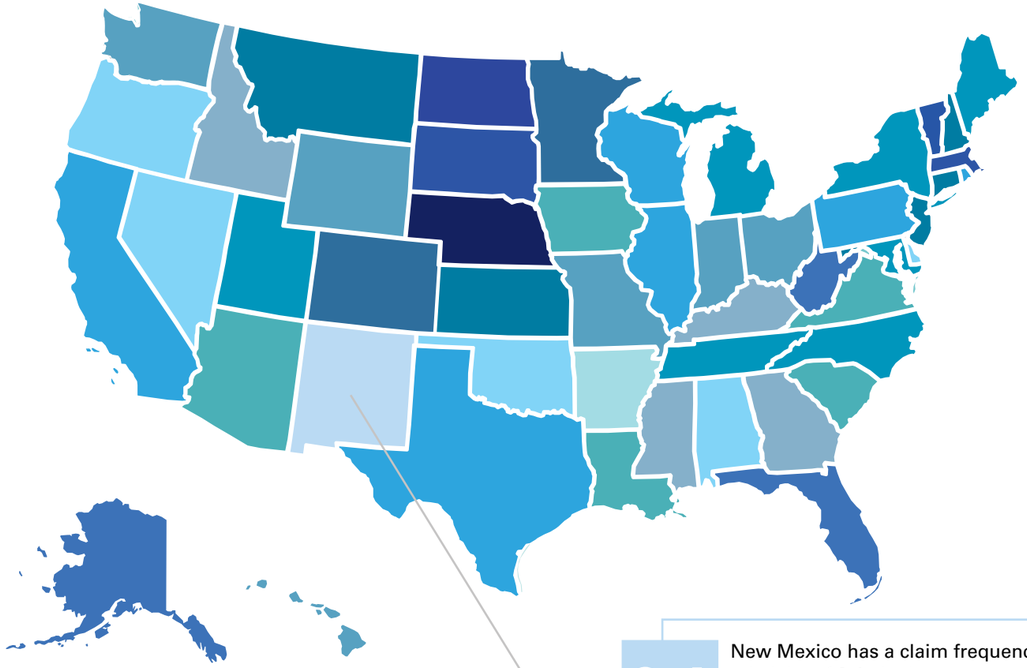
CLAIMS BY STATE

2016-2019

This data is influenced by the average specific deductible of the self-funded plan based on the state of domicile. The darker the color, the greater the frequency of claims. So with a frequency of 40% of the national average, New Mexico has the distinction of being the state with the lowest frequency of stop loss claims. At the other end of the spectrum is Nebraska, at 190% of the national average, followed by North Dakota (170%) and Vermont (160%).

2015-2019 CLAIM FREQUENCY RELATIVITY

0.4 1.0 1.9



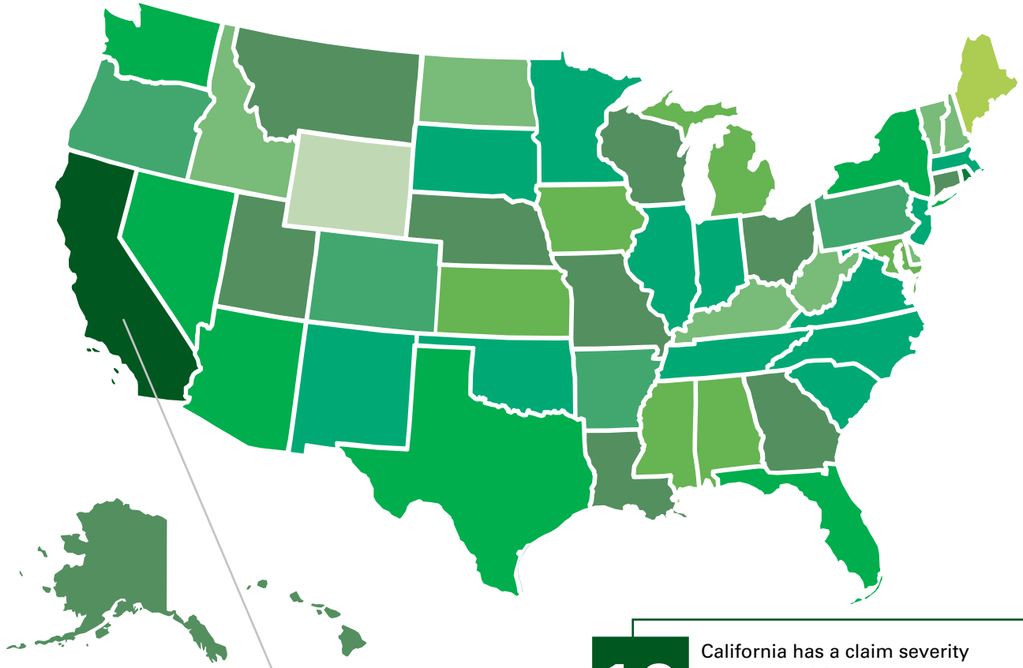
0.4 New Mexico has a claim frequency relativity of 0.4, the lowest across the country. This indicates that New Mexico has experienced a frequency of 40% of the national average.

This graph shows the average claim cost for each state against the national average. The darker the state, the higher the claim costs. Because this data is heavily influenced by the cost of health care in each state, it should come as no surprise that California is the highest cost state at 180% of the national average.

THE LOWEST COST STATES are West Virginia, Maine and Wyoming.

2015-2019 CLAIM SEVERITY RELATIVITY

0.5 1.0 1.8



1.8 California has a claim severity relativity of 1.8, indicating that the state's average claim amount is 80% higher than the national average.

TOP 10 DIAGNOSIS CATEGORIES

By Frequency 2016 - 2019

CANCERS - MALIGNANT NEOPLASM have been the most frequent diagnosis category in every year of our study, followed by CARDIOVASCULAR DISEASES AND MUSCULOSKELETAL/CONNECTIVE TISSUE conditions. Notable trends include a steady growth in CANCERS - LEUKEMIA/LYMPHOMA/MULTIPLE MYELOMA, as they have risen to the #4 most frequent diagnosis for stop loss claims. Overall, the distribution by diagnosis category has remained very consistent since 2016.

Ranked by number of claims per 10,000 Employees.

2016

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

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/ Multiple Myeloma
7	Digestive Diseases
8	Endocrine/Metabolic Diseases
9	Crohn's/Ulcerative Colitis
10	Perinatal/Neonatal

2018

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

2019

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

TOP 10 DIAGNOSIS CATEGORIES

By Severity 2016 - 2019

With the exception of Burns and Corrosion, which was the highest costing Diagnostic Category in three of the four years of our study, the other Diagnosis Categories tend to move around on the list.

What is remarkable about the new entrants to the list, such as Spinal Muscular Atrophy in 2017 and Hemolytic-Uremic Syndrome disease in 2018, is that their inclusion was spurred by high cost drugs—Spinraza and Soliris, respectively—entering the marketplace specifically for treatment of those diagnoses. While transplants have continued to rise in both frequency and severity, they have been outpaced by other categories in recent years. They remain a category of concern, as seen by their rise in 2019. We believe Hemophilia A will enter into this list in 2020 and 2021 due to FDA approval of Roctavian.

TMHCC uses this information to target its Cost Containment programs towards these Disease Categories. These programs include our fully insured Organ Transplant product, and our Cell & Gene Therapy Solution through our partnership with Emerging Therapy Solutions (each of which are discussed in more detail on other pages of this Report).

Ranked by number of claims per 10,000 Employees.

2016

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

2017

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

DIAGNOSIS GROUP

Total Cost

Cancers - Malignant Neoplasm, Cardiovascular Diseases and Cancers - Leukemia/Lymphoma/Multiple Myeloma have consistently been the top three diagnoses in terms of overall stop loss claims, representing about 40% of all stop loss claims. Certain categories such as Chronic Kidney Disease/Dialysis are showing a decreasing percentage of total claims over time, associated with a decrease in the average cost of treatment. Categories like Musculoskeletal/Connective Tissue have decreased due to the cost of treatment holding steady, while other categories, such as Perinatal/Neonatal, have rapidly increased over time, resulting in a change in distribution of total costs. Overall, these Top 10 diagnosis groups account for over 70% of our claim spend each year.

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

Rank By Year 2015-2019

TOTAL % OF COSTS	1	2	3	4	5	6	7	8	9	10
2015	21.0%	9.3%	8.3%	6.6%	5.0%	4.6%	5.5%	3.3%	4.1%	4.3%
2016	21.3%	10.2%	8.2%	8.0%	5.6%	5.9%	4.7%	4.0%	3.6%	2.9%
2017	21.1%	11.0%	8.4%	6.9%	5.6%	5.7%	4.2%	4.2%	3.9%	2.4%
2018	22.1%	10.0%	9.0%	6.0%	6.4%	5.9%	3.5%	4.0%	3.9%	2.8%
2019	23.9%	9.6%	10.4%	7.0%	4.7%	4.4%	3.1%	4.0%	3.9%	3.8%

TRENDS IN TRANSPLANTS

10.7% INCREASE IN NUMBER OF DECEASED DONORS

NEARLY **11,900** DECEASED DONORS IN 2019
9TH CONSECUTIVE RECORD-BREAKING YEAR

ALMOST **40,000** TRANSPLANTS

ALMOST **7,400** LIVING DONOR TRANSPLANTS
(NEW RECORD)

8.7% INCREASE IN TRANSPLANTS IN 2019
7TH YEAR OF INCREASE IN TRANSPLANTS

Hospital lengths of stay have been fairly stable (since 2017 report)

Wait times have increased slightly

Billed charges continue to rise

Emerging innovations and issues include organs from donors infected with hepatitis C and treating a marginal organ to make it suitable for transplantation

Efforts to remove financial barrier to living donors

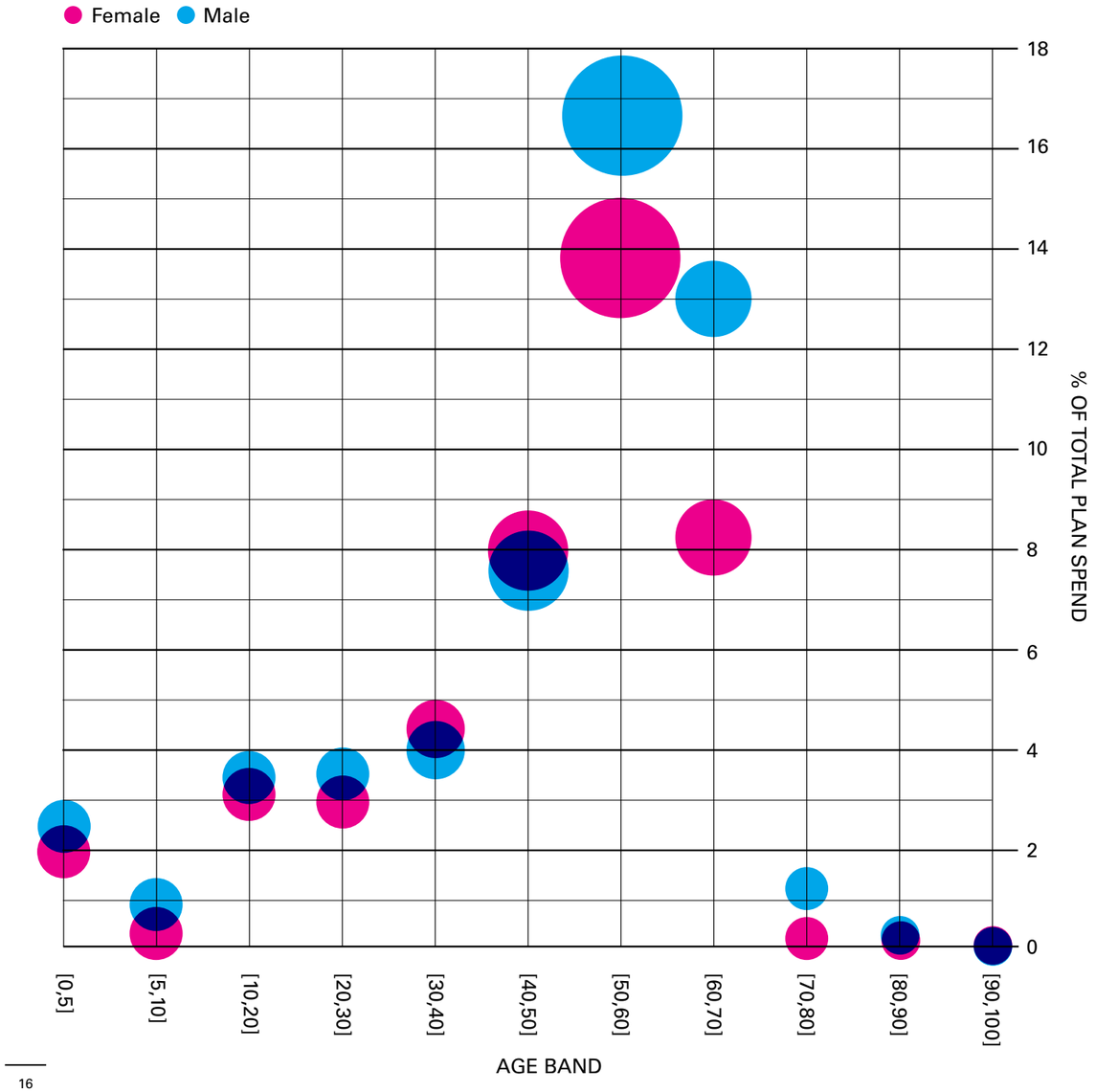
Source: UNOS.org – 2019 data:
Source: 2020 U.S. organ and tissue transplant: Cost estimates, discussion and emerging issues (Milliman Research Report)

PLAN SPEND

By Age/Gender

Treaty years 2015-2019

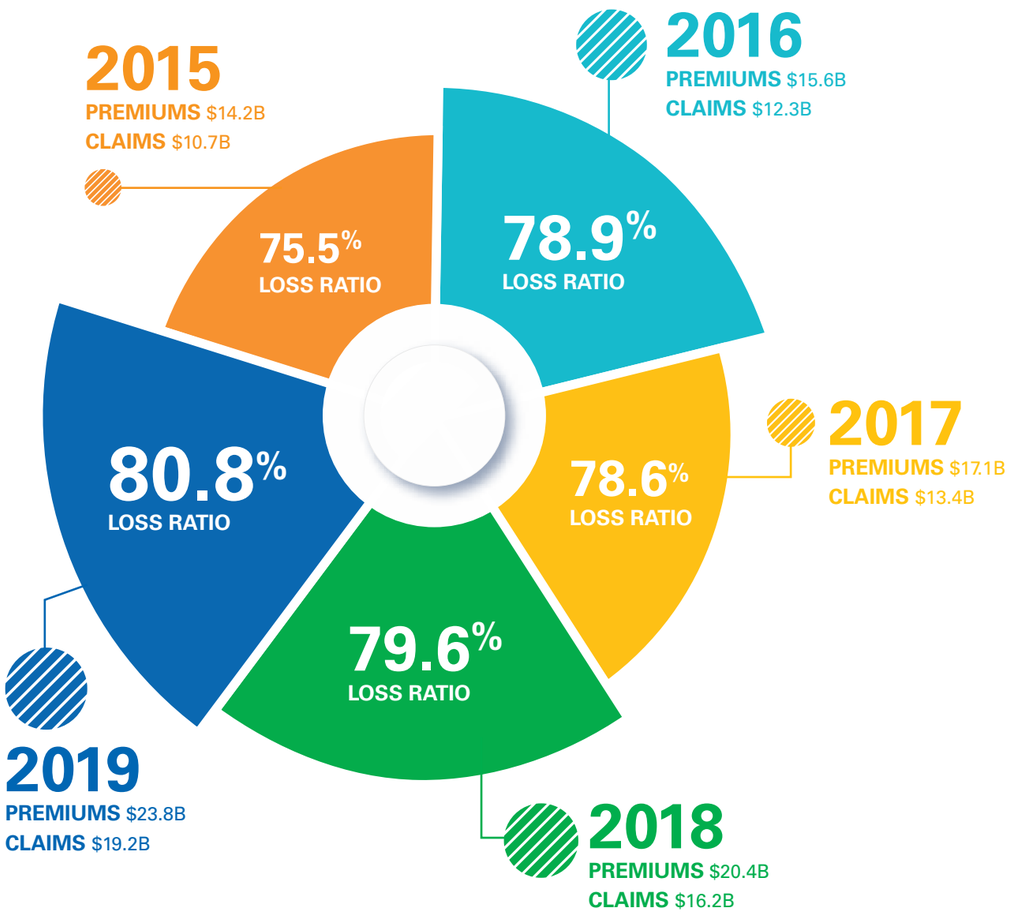
Babies ages 0-5 show a higher percentage of Plan Spend than children ages 5-10. This is due to the costs of high severity claims in neonatal care. Beyond age 10, average Plan Spend remains relatively consistent through age 30. Then we see a correlation between increases in age and increases in percentage of Plan Spend until the age of 65. The drop in overall percentage of Plan Spend in ages 70+ can be linked to Medicare and retirement.



NAIC STOP LOSS INDUSTRY DATA

Earned Premiums And Incurred Claims By Calendar Year

From 2015 through 2019
PREMIUMS INCREASED BY **67.2%** but **CLAIMS INCREASED** **79.0%**



Information is from line C2 from the Accident and Health Policy Experience Exhibit for Years 2015 through 2019. Data Source: National Association of Insurance Commissioners, by permission. The NAIC does not endorse any analysis or conclusions based upon the use of its data.

TOP INDUSTRIES

By Specific Deductible And By Employee Size

Over TMHCC's 45 years, we continue to have a robust block of business in all industries.

SERVICES, MEMBERSHIP ORGANIZATIONS

$288,400
average deductible

1,083
average # of employees

INDUSTRIES WITHIN SERVICES, MEMBERSHIP ORGANIZATIONS have the highest average deductible.

INDUSTRY	AVERAGE NUMBER OF EMPLOYEES	AVERAGE DEDUCTIBLE
Agriculture, Forestry, Fishing	367	$84,800
Construction	309	$96,100
Finance, Insurance, Real Estate	636	$132,500
Manufacturing	491	$122,400
Mining	407	$158,000
Public Administration	858	$155,000
Services (except Health, Edu., MEWA)	536	$118,000
Services, Educational	1,150	$185,400
Services, Health (except Hospitals)	354	$96,100
Services, Health, Hospital	1,853	$240,400
Services, Membership Organizations	1,083	$288,400
Trade, Retail	584	$125,400
Trade, Wholesale	408	$101,900
Transportation & Public Utilities	564	$123,800

INDUSTRIES WITHIN SERVICES, HEALTH, HOSPITAL have the second highest average deductible.

$240,400
average deductible

1,853
average # of employees

INDUSTRIES WITHIN SERVICES, EDUCATIONAL have the third highest average deductible.

$185,400
average deductible

1,150
average # of employees

Tokio Marine HCC Stop Loss Group
Industry Information with experience through August 31, 2019
Treaty Years from 2016 to 2019

UNDERSTANDING

The Laser Option

Lasering is often a misunderstood tool in the medical stop loss insurance industry, however it is often the most financially prudent option for employers when considering an acceptable insurance arrangement. Lasers appeal to some groups while others elect to increase the premium rates to cover the laser liability, because it allows them to budget monthly cash flow. While TMHCC gives you the option to choose, below are some reasons why you may want to consider the laser option for your client.

LASERING ADVANTAGES

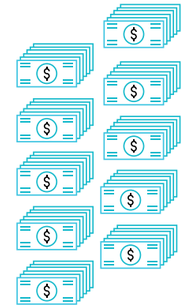
1. Lasers help keep the premium low. If the lasered individual never experiences the anticipated higher medical costs, then the plan saves money.

2. The employer avoids the add-on costs associated with premium tax, commissions and home office expenses that are loaded into the gross premium. The additional gross premium may, in some instances, equal or exceed the additional deductible for the covered person.

3. Lasering provides an alternative for the stop loss insurer to offer coverage. Without the laser option, the insurer may decline to offer coverage.

Sample Calculation

STOP LOSS (NO LASER OPTION)



EXPECTED STOP LOSS CLAIMS: $800,000

EXPENSES, TAXES, COMMISSIONS (20% OF EXPECTED PREMIUMS): $200,000

TOTAL STOP LOSS PREMIUM: $1,000,000

STOP LOSS (WITH $300,000 TRANSPLANT LASER)

EXPECTED STOP LOSS CLAIMS: $500,000

EXPENSES, TAXES, COMMISSIONS (20% OF EXPECTED PREMIUMS): $125,000

TOTAL STOP LOSS PREMIUM: $625,000

SAVINGS FROM LASER OPTION (IF TRANSPLANT OCCURS) $75,000

SAVINGS FROM LASER OPTION (IF TRANSPLANT DOES NOT OCCUR) $375,000

LEGAL CASE TO WATCH

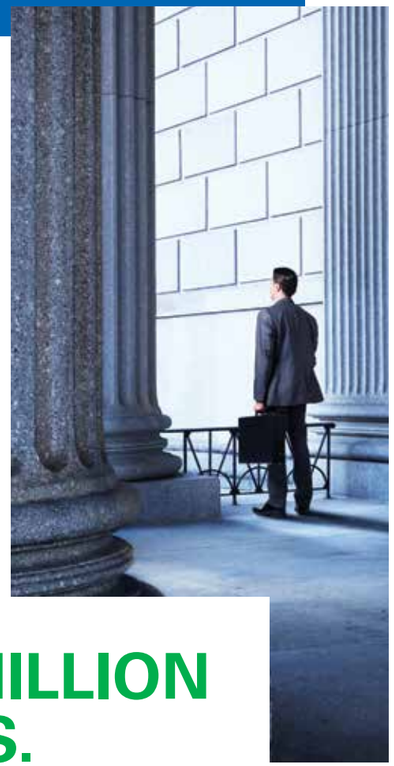
Recently, a group of physicians, unaffiliated with a large group health plan's PPO, brought suit in the federal district court in New Jersey against the carrier alleging:

1. Misrepresenting that a contract or agreement exists between the Plaintiffs and the carrier for hidden networks allowing for discounted pricing;

2. Conspiring with its vendors to submit fraudulent savings to ERISA self-insured health plans earning extra fees;

3. Using conflicting Explanation of Benefits (EOBs) to patients and providers, showing saving to the former and amounts due to the latter, leaving patients with outstanding balances;

4. Allowing the vendor to negotiate minimal payments to nonparticipating providers or paying low reimbursements if the discount is refused.



THE PHYSICIANS ALLEGE OVER 50 MILLION DOLLARS IN DAMAGES.

Some of these allegations could contain a kernel of truth. Large carriers often pay the PPO discounted amount first, then negotiate a reduced payment, allowing an additional fee to the plan for the purported savings. In addition, outside vendors often try to negotiate a reduced rate with nonparticipating providers. There is nothing wrong with this practice, but using hidden networks or paying below Usual, Reasonable and Customary can expose participants or plans to costly appeals or litigation.

The use of EOBs that contain conflicting statements to the provider and the participant is a recipe for disaster. To inform a participant that the Plan saved the member hundreds or thousands of dollars and then reporting to the provider that the same amount can be balance billed to the participant will cause untold trouble to the provider, carrier and Plan Sponsor. Hopefully, this activity is rare or there is a program error in producing the benefit statements.

If these plaintiffs are successful, one can expect a flood of litigation by both Plans and providers against the largest carriers administering these plans.

(Advanced Gynecology and Laparoscopy of North Jersey.et. al. v. Cigna Health and Life Insurance; Case Number: 2:19-cv-22234 in the United States District Court for the District of New Jersey,12/31/19)

SIIA Legislative & Political Overview – Tokio Marine HCC - Stop Loss Group Market Update

UPDATE

Heading into the 2020 election, healthcare continues to be center stage in Washington, and on the campaign trail, as policymakers now focus on COVID-19 specifically, and more generally on the cost of care. In the long-term, candidates and policymakers will continue to debate the future of employer-based care and a single-payer system.

The Self-Insurance Institute of America, Inc. (SIIA) and its team in Washington has a continued advocacy presence, with a particular emphasis on ensuring that self-insurance and stop-loss issues have a strong voice as part of this debate. Over the course of the COVID-19 crisis, SIIA transitioned its in-person Hill activities to virtual meetings and hosted a series of virtual congressional town hall events with Members of Congress. Currently, SIIA's policy focus is centered on three critical areas, including ongoing self-insurance and stop-loss education, cost transparency and accountability, and data accessibility.

COVID-19: COSTS AND COVERAGE

With COVID-19 related costs and coverage among key issues being focused on in Congress, SIIA has been tracking legislative activity related to self-funding and stop-loss.

Of importance are several congressional coverage mandates that include no cost sharing requirements for employer plans, including self-funded plans, to retroactively covering COVID-19 testing and related visit charges, and vaccinations, when available. In the coming months, Congress is likely to also include no cost sharing requirements for COVID-19 treatment, including hospitalization charges. These are important changes to note as plan sponsors and administrators plan and deal with the ongoing and rapidly changing environment.

TRANSPARENCY & COST: SURPRISE BILLING

Over the course of the past year, SIIA has held hundreds of congressional meetings on the issue of surprise billing. While various proposals tackle the issues in different ways, Congress is looking to end the practice of balance billing patients for emergency services and instances in which patients go to in-network facilities that have out-of-network providers within them. That's where agreement ends and differences begin as to what a fair reimbursement may be. While a Senate proposal aims for a standard benchmark based on private sector in-network median rates by geography, House proposals are leaning towards a pure baseball style arbitration approach or a hybrid spanning benchmark and arbitration. SIIA continues to advocate for a fair benchmark reimbursement rate solution in Congress. Congressional leaders have now set a November deadline for passing a broader federal healthcare package, though efforts are underway in upcoming economic stimulus packages to prohibit surprise billing in COVID-19-related situations or more broadly. In addition, the Administration has placed a requirement on providers receiving federal funding that they not engage in balance billing/surprise billing practices. This issue, while just a portion of overall cost, points to a larger discussion occurring in Washington on the rise of health care costs and patient protection in general.

TRANSPARENCY & DATA ACCESSIBILITY: FEDERAL INSURANCE TRANSPARENCY RULE

Earlier this year, SIIA formally submitted comments to the Departments of Health and Human Services, Treasury and Labor in response to a proposed regulation that would require self-insured plans, along with fully-insured group and individual plans, to disclose information about cost sharing, negotiated in-network rates and historical out-of-network payments, among other things.

SIIA's comments focused on a number of key points in response, including the need for increased transparency of medical prices and cost-sharing information, the need for data access, the unique nature of self-funded plans and networks, and the cost and administrative burden of implementation. Recently, SIIA coordinated a call with SIIA members and the federal agencies to discuss data accessibility in more depth. A final rule is expected to be issued this fall.

STOP-LOSS AND RISK CORRIDOR PAYMENTS: RESPONSE TO COVID-19 HEALTH COSTS

As the House addressed COVID-19 needs in various economic stimulus packages, one proposal involves setting up risk corridor payments for both self-funded and fully-insured plans with higher than expected costs incurred during the 2020 and 2021 plan years. Specifically, the legislation passed by the House institutes a federal reimbursement payment to plans for healthcare costs exceeding 105% of the health claims incurred in the preceding year. Under the proposal, the 75% payment from the Feds will be reduced by amounts the plan receives from, for example, their private stop-loss policy. While this program looks to have been created to help those self-insured plans that do not have stop-loss or other reinsurance coverage, it likely creates a number of questions and potential concerns for those plans with stop-loss. While SIIA is supportive of a federal backstop for certain excessive COVID-19 healthcare costs, it has been working with Congress, in conjunction with carriers such as Tokio Marine HCC - Stop Loss Group, to revise this reinsurance payment to better accommodate the self-insured and stop-loss market, including rewarding employer plans who access stop-loss to mitigate such high risks.

AVOIDING NEW STATE PREMIUM TAXES: STATE INDIVIDUAL HEALTH INSURANCE REINSURANCE PROGRAMS

As health care costs continue to grow and individual health insurance markets continue to be less stable after the enactment of the Affordable Care Act (ACA), many states are looking to create, or have created, individual health insurance market reinsurance programs. These programs are funded with state revenue, generally insurance premium taxes, that qualify for matching federal funds and lower individual health insurance premiums from ten to twenty percent.

For self-insured plans utilizing stop-loss, the funding mechanism a state legislature chooses to use is important. Generally, most state reinsurance programs use state revenue that has little or no impact on self-insured plans. However, more states are looking at various revenue streams impacting self-funded plans and participants. For example, Maine's reinsurance program uses a TPA covered lives assessment of $2 per member per month and Louisiana has been looking at a TPA assessment to cover its reinsurance program.

WHAT TO EXPECT

Advocacy is a continual process as legislators and regulators make decisions that affect the availability and cost of stop-loss and self-insured benefits generally. 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. What the upcoming election will determine is the future of health care, whether protecting employer-based care, or a larger policy debate about single-payer and Medicare expansion. Voters, and the policymakers they elect, have a full agenda ahead in advancing health care priorities, while looking at cost and delivery.

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