



By
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Thousands of health care claims reach or exceed \$1 million each year, and industry research and our own experience at RGA show the frequency of these large claims has increased eightfold since 2003. Meanwhile, the frequency of claims in excess of \$2 million has increased more than five times since 2005. Complex treatments, technological breakthroughs and high medical trends are a fact of life and, combined with regulations in the Patient Protection and Affordable Care Act phasing out annual and lifetime claim limits, create an environment where carriers and reinsurers are offering benefits

to make up a large percentage of the high claims and can quickly reach \$2 million or more. Spinal cord injuries and trauma are also significant, and multiple complications have a multiplier effect that can be staggering.

Long-term drug treatments for chronic conditions are also a concern. For example, costs for Factor VIII deficiency (Hemophilia A) with acquired inhibitor, can average \$750,000 per year. Treating Gaucher's disease, a metabolic disorder that can lead to neurological damage, may reach \$625,000 in charges per year. With these as the starting maintenance drug dosages—and with no claim

Million-Dollar Claims Grow More Frequent

Medical claim limits phase out under the new health care law as the size of individual claims continues to rise.

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for layers over \$10 million per year.

Increasing costs and regulatory changes are noteworthy but not unmanageable. Let's look at the reasons for this and ways of managing your exposure.

A persistently high medical trend is certainly one factor. Individual claims that were under \$500,000 a few years ago may now exceed \$1 million, and those in excess of \$1 million may now be well over \$2 million. While we haven't seen \$10 million claims yet, they are coming. Additionally, consumers are more aware of their treatment options and have higher expectations, even as there is a continuous stream of new and expensive technological advances.

Most catastrophic claims are acute in nature. Premature births, congenital anomalies, cancer and treatments such as transplants continue

limits—it is easy to see how these costs can add up, even if there are no further complications.

Until now, health plans could expect such claimants to "max out" their benefits and leave the plan. Under PPACA, this is no longer a possibility and has raised concern among insurers that providers might adopt a "blank check" mentality. It's worth noting, however, that the HMO industry has had unlimited benefit plans for many years with no discernible change in provider behavior in that market. While one can make a case for no significant deviation in the trends for large claims under health care reform, even small changes in provider behavior can have a leveraged effect on claims in higher layers.

While there is no way to eliminate large claims, you can reduce exposure via plan design features that steer patients and providers to appropriate care settings, or incenting the use of centers-of-excellence and contracted facilities, especially if you identify networks experienced in catastrophic claims. While all reinsurers offer financial relief on catastrophic claims, some offer services that help manage this risk before, during and after a claim is incurred.

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