Trends

Statistics and Strategies for Health Plan Sponsors

Fourth Quarter 2025

Key statistics

A growing number of conditions can **exceed $1 million** per patient annual treatment costs; particularly hemophilia A and B, as well as sickle cell disease, according to SHAPE, Segal's claims data warehouse.

Some therapies cost **over $3.5 million**, including Hemgenix® and Lenmeldy®, as noted in the *American Journal of Health-System Pharmacy*.

High-cost conditions with $100,000+ paid annual claims account for less than 1% of all claimants but almost **30% of total medical and prescription drug claim expenses**, based on data from SHAPE.

10 strategies to manage high-cost claims spending

As healthcare costs continue to rise amid economic uncertainty, high-cost claims (HCCs) remain one of the most significant drivers of financial strain for health plans. These claims — often stemming from complex conditions, specialty drugs and prolonged hospitalizations — can account for a disproportionate share of total spending, challenging even the most robust risk-management strategies. In today's environment of inflationary pressures, evolving care models and increasing demand for advanced therapies, mitigating the impact of these claims is no longer optional — it's essential for sustainability.

This issue of *Trends* explores the top 10 strategies health plan sponsors can deploy to effectively manage HCC spending without compromising quality of care:

1. **Start with data.** HCCs have different characteristics across populations, industries and geographic locations. The first step in managing HCCs is to start with a data-driven approach that can be customized depending on the plan's needs. This includes evaluating the underlying claims history and identifying the risk factors associated with unfavorable outcomes. Early identification of risk factors associated with a future high-cost event allows for proactive interventions and implementation of care management strategies, potentially leading to improved health outcomes and significant cost savings.
2. **Promote preventive cancer screenings.** Cancer is a common cause of HCCs. Over half of cancers experienced in most populations have screening guidelines depending on age and gender. Additionally, the recommendations are constantly evolving. Plan sponsors should educate and promote these screenings to plan participants regularly.
3. **Prevent and manage chronic diseases.** A comprehensive wellness program can help plan participants get engaged in their health and prevent onset of chronic conditions. For those who do develop chronic conditions, plans should have resources in place to help them manage their conditions effectively. These resources can be multifaceted and range from a point solution that specializes in certain conditions to providing benefits websites that summarize effective exercises and/or recipes relevant to each condition (e.g., keto-friendly recipes to manage diabetes). Communication of these resources is critical to engagement in health promotion.
4. **Implement and monitor case management.** Plans should discuss how HCC cases are identified and managed with the medical vendor. Vendors may need to lower identification thresholds and/or change how they conduct patient outreach depending on the population. An examination of the vendor's case identification, including predictive modeling and referrals, may be warranted. To improve outcomes, it's important to make sure the right support structure is in place to help patients

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seek care. Plan sponsors should also ensure referrals are consistent with plan terms and assess integration capabilities of the various vendors being utilized (e.g., benefits through various offerings, including point solutions, to prevent fragmentation). A clinical HCC review can identify opportunities to improve care management interventions as well as create the ideal benefit design to achieve better outcomes for managing cost.

5. **Implement proactive claim reviews.** Plan sponsors should implement a support structure for large claim reviews to detect the billing errors and abuses that can occur on very large, complex cases. Audit high-cost provider bills before they are paid.

6. **Choose the right stop-loss coverage.** Group health plans should assess their risk tolerance and ensure they have adequate protection against catastrophic claims, including those from high-cost conditions (e.g., burns, leukemia, premature births) and emerging therapies, such as specialty drugs, orphan drugs and gene therapies, which increasingly drive claims exceeding $1 million. Plans without stop-loss coverage should consider obtaining a stop-loss policy. Plans that have stop-loss coverage should regularly review the policy terms to address gaps caused by rapid medical advancements, including gene therapy, which can be carved out for stop-loss insurance. Also, plan sponsors may want to confirm proper coordination with third-party insurers to avoid paying claims that should be subrogated.

7. **Negotiate risk-sharing arrangements with current network providers.** Reduce financial exposure from catastrophic claims and high-cost therapies by aligning incentives with providers. Ask vendors to put their fees at risk for HCCs for amounts in excess of a given threshold (e.g., 1.5 x trend).

8. **Implement centers of excellence (COEs).** COEs encourage participants seeking care to use specialized treatment providers who have a high concentration of expertise and resources, leading to reduced costs and improved outcomes. Oncology care is emerging as an area where COEs excel. New, cutting-edge cancer care infusion treatments are very expensive, so precision matters. Experienced oncology teams avoid giving expensive treatments by trial and error, so the right care is delivered the first time.

9. **Pharmacy benefit optimization.** Specialty drugs are major drivers of HCCs. In addition to adopting cost-management strategies such as prior authorization, step therapy, biosimilar adoption and rebate negotiations, some plan sponsors are implementing site-of-care optimization between their medical vendor and their PBM.

10. **Out-of-network cost management.** Out-of-network care drives higher plan costs and exposes participants to balance billing for charges not fully covered by the No Surprises Act. While that law offers protections for certain services, unresolved disputes often move to the independent dispute resolution (IDR) process, which can be costly and time consuming. To reduce these risks, plan sponsors should set benchmark reimbursement schedules, use IDR strategically and ensure negotiation with providers to secure fair pricing and prevent participant balance billing.

Compliance reminder: Stay on top of ACA amounts

Get our handy summary chart, ACA Dollar Amounts and Percentages, which we updated in November 2025.

To discuss the implications for your plan of anything covered here, contact your Segal consultant or get in touch via our website, segalco.com.

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