QBE Insurance

Accident & Health

2026 Market Report

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Tara Krauss
President of Accident & Health
QBE North America

As we share our sixth annual Accident & Health Market Report, I want to express my sincere appreciation for your continued trust and partnership. Our industry is experiencing meaningful change, driven by AI-enabled advances in healthcare, sustained inflation impacting provider costs, and claim trends that continue to elevate severity and challenge affordability. Through it all, our mission remains steadfast: to help you navigate risk, protect your organization, and promote the wellbeing of your employees.

Our 2026 report reflects the heightened importance of risk management as healthcare trends continue to evolve. We explore issues that matter most to you, from the impact of specialty drugs and advanced therapies to increased claim severity and the complexities of rising medical costs. Our team has examined the latest data and identified the key factors driving high cost claims and cost pressures.

As McKinsey's 'How the healthcare industry can weather ongoing challenges' notes, the reality is that fully insured membership has been steadily decreasing and overall market growth has leveled off. This shift underscores employers' strong desire for affordability and transparency in their healthcare spend. [1] Roughly **two-thirds of covered workers are now in self-funded plans** – up meaningfully from a decade ago. [2] Our report affirms the value of self-funding while emphasizing the need to deploy proactive, innovative strategies to anticipate and manage emerging risks.

We are committed to sharing actionable insights, practical strategies, and a clear perspective to help you prepare for what's ahead. QBE's deep expertise in claims, risk management, and cost containment is designed to empower your decision-making and safeguard your business. Above all, our goal is to continue being a reliable partner, and one that understands the risks and opportunities shaping today's market.

At the heart of expecting the unexpected, QBE is proud to be your trusted advisor, helping you navigate whatever the future may bring.

Tara Krauss

1. https://www.mckinsey.com/~/media/mckinsey/industries/healthcare%20systems%20and%20services/our%20insights/how%20the%20healthcare%20industry%20can%20weather%20ongoing%20challenges/how-the-healthcare-industry-can-weather-ongoing-challenges.pdf?shouldIndex=false
2. https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey.pdf

Executive summary

Healthcare trend acceleration is no longer theoretical, with its impact felt most acutely at the excess layer.

Over the past year, self-insured employers, insurers, and excess carriers have all experienced a marked shift in both the frequency and severity of high cost claims. Inpatient hospital stays exceeding historical norms, advanced cancer treatments requiring prolonged care, and the widespread adoption of specialty pharmaceuticals have fundamentally altered the risk profile of employer-sponsored health plans.

Our 2026 Accident & Health Market Report focuses on the sharp acceleration of healthcare trends, what has changed in the underlying delivery and financing of care, and how these changes are contributing to the escalation in excess loss experience. The uptick in excess cost trends is not due to any single disease (neoplasms and circulatory diseases remain the main contributors and in similar proportion to prior years), but rather an increase in underlying cost of care drivers impacting all conditions. Employers, as plan sponsors, are now confronting a convergence of longer inpatient stays, earlier use of high cost therapies, heightened level of care, and fewer opportunities for cost avoidance once catastrophic care begins. [1]

At the same time, **specialty pharmaceuticals have moved from an emerging risk to an unavoidable baseline cost**. High cost maintenance drugs, oncology biologics, and cell and gene therapies are now integrated throughout treatment pathways, increasingly introduced earlier in disease progression and applied to wider patient populations than initially expected. While some of these therapies can result in transformative clinical benefits, the associated financial impact, compounded by extended hospitalizations and complications, has created unprecedented pressure on self-funded plans and excess carriers alike. [1]

We examine:

- Where excess-level claims are concentrating today and why
- What employers, brokers, and excess carriers can and cannot control in the current environment
- How proactive plan design, vendor strategy, and risk financing decisions can meaningfully influence outcomes, even when underlying healthcare inflation remains elevated

Importantly, our report moves beyond trend identification to focus on key stakeholder responsibilities, as well as actionable steps that can be applied throughout the ecosystem. Employers cannot manage what they cannot see; brokers cannot advise without clarity on where risk is truly emerging; and carriers must balance protection, sustainability, and partnership in an increasingly volatile claims environment.

As healthcare costs continue to rise and treatment modalities grow more complex, medical stop loss insurance remains a critical stabilizing force. However, stop loss coverage alone is not enough. Like any insurance product, the product is intended for “unknown” risk. In recent years, market conditions have driven broader policy provisions and compressed premiums, shifting more known risk back onto self-funded plans and excess carriers. **Success in this market will be defined by how well stakeholders align around prevention, early intervention, disciplined cost management, and informed risk transfer strategies**. This report helps our customers navigate an increasingly complex healthcare system in which high cost claims have shifted from rare exceptions to expected events that must be proactively anticipated and managed.

1. QBE's 2025 Accident & Health Market Report

Captive insurance amplifies risk for the better

In an increasingly volatile medical stop loss market, captive insurance has emerged as a powerful amplifier, reinforcing underwriting discipline, aligning incentives, and advancing a more cohesive risk management strategy. For advisors, this shift reflects a broader reality: **employers are no longer satisfied with short-term pricing wins that fail to translate into long-term stability**. Captive insurance addresses this gap by creating a structure where employers, advisors, captive program managers, and insurers share accountability for outcomes, not just renewal negotiations. For advisors willing to lead with strategy and governance, captive insurance offers a powerful way to deliver stability, retention, and long-term value to employers.

Whether structured as a single-parent or a group, captives function as both an economic and behavioral amplifier. Captives are a strategic choice for policyholders with strong risk profiles and effective cost management practices. Organizations that proactively control expenses and confidently assume additional risk often realize exceptional long-term value and performance through captive arrangements. Captives allow participating employers to benefit directly from favorable experience, and this shared risk model encourages better decision making across plan designs, claims oversight, and vendor alignment.

Experience across established captive programs shows:

- **Higher retention** driven by transparency, efficiency, and long-term strategy
- **More favorable renewal action, on average,** driven by better performance
- **Reduced net costs** as policyholders earn back underwriting profits

QBE has over 20 years of experience underwriting captive insurance solutions in the medical stop loss market. Launched in 2023, our enhanced service model, **The QBE Captive Curve**, offers operational support, strategic guidance, and resiliency in today's captive insurance market. Examples of how QBE has and will support clients includes the following:

Single-parent captive owner:
QBE worked with the captive and its advisor on leveraging the client's existing P&C captive structure to support and fund medical stop loss risk.
Group captive program:
An agency with its own curated claims management solution model engaged with QBE to establish a group captive solution for their clients to realize additional cost efficiency for medical stop loss coverage.
Middle market employer:
Seeking relief from fully insured market volatility, an employer worked with QBE and its advisor to evaluate self-funding. QBE's sponsored captive program, **Agora**, provided a structured, scalable path to self-funding with enhanced control over risk and costs.

What distinguishes **The QBE Captive Curve** is the ability to evolve alongside clients and advisors. From the ease of accessible captive solutions, like Agora, to advanced single-parent and group captive structures, this service model is designed to support progression, not force it.

Cost saving strategies for Taft-Hartley trust funds

Taft-Hartley trust funds experience similar pressure from rising healthcare costs, broadly consistent with trends across large employer-based plans. Cost escalation is primarily driven by higher severity claims associated with chronic disease, increasing prescription drug spend, and utilization patterns tied to comprehensive benefit structures common in union-sponsored plans. [1,2]

Trustees and plan administrators are responding through a combination of plan design strategies and member engagement resources, with the goal of sustaining access and quality for their members. To meet their fiduciary obligations, employer and union trustees must work collaboratively to select cost effective vendor partners and rigorously monitor service performance to ensure alignment with the plan's long-term financial objectives. [3]

Value-based benefit strategies continue to gain traction. [4] Plans are steering participants to high-value providers through centers of excellence, tiered networks and expanding care management for high cost conditions and chronic disease. [5,6] A focused approach that fosters cost savings, access, added member benefits, and care can lead to positive outcomes as demonstrated by the proven successes of other organizations. [4,6] For example, adding a fertility management program can promote healthy pregnancies through member resources and advocacy, helping to mitigate the potential high costs associated with premature births. [7]

Plans are also investing in participant engagement and preventive care, including near-site clinics, wellness initiatives, chronic condition support, and education to promote appropriate utilization. Engagement remains a challenge due to system complexity, varying member interest, and geographically dispersed union populations. [2,5] Union populations have long reflected an older demographic profile, but that composition is changing. The influx of younger and more diverse members is reshaping the union workforce. [5] This new, younger population of workers is creating an opportunity for member engagement with digital tools. [2] As digital native workers become a larger share of the workforce, their openness to online education and cost management tools is reshaping how plans can engage members and influence long-term health outcomes.

QBE's clinical team proactively monitors claimants throughout the year to identify cost saving opportunities in coordination with our cost containment team.

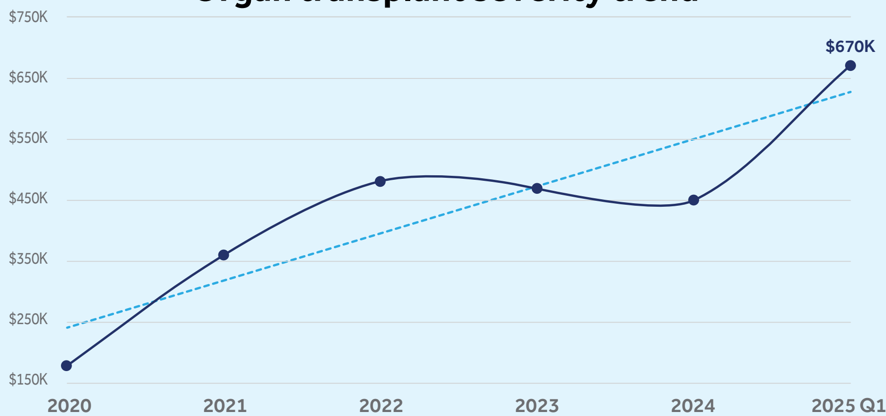
Through these efforts, in collaboration with consultants and administrators, QBE has delivered more than $16M in savings to clients over the past three years.

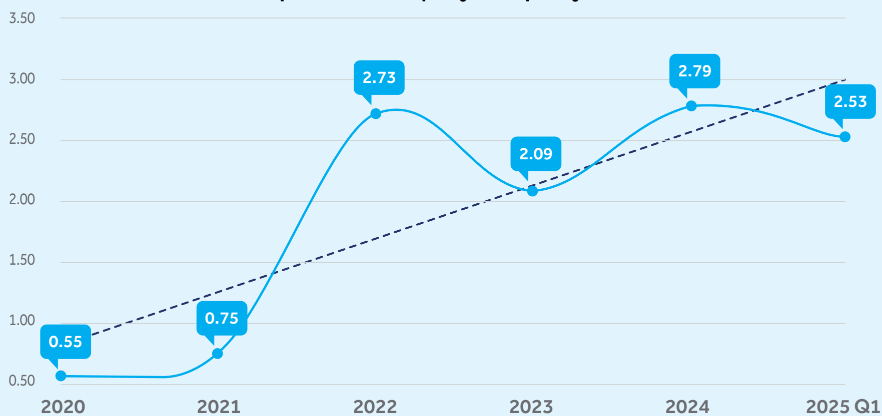
1. Kaiser Family Foundation (KFF) – 2025 Employer Health Benefits Survey https://www.kff.org/health-costs/2025-employer-health-benefits-survey/ [kff.org]
2. Cigna Healthcare – Capitalize on Taft Hartley Research https://www.cigna.com/static/www-cigna-com/docs/taft-hartley-fund-managers-needs.pdf [cigna.com]
3. U.S. Department of Labor – Meeting Your Fiduciary Responsibilities https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/meeting-your-fiduciary-responsibilities [dol.gov]
4. New England Journal of Medicine / VBID Literature – Value-Based Insurance Design https://www.ajmc.com/view/ad115_jun13_vbid [ajmc.com]
5. UnitedHealthcare – 6 Trends Shaping Taft Hartley Benefit Strategies https://www.uhc.com/agents-brokers/employer-sponsored-plans/news-strategies/trends-for-taft-hartley-2026 [uhc.com]
6. United Healthcare – How Value-based care continues to reshape health care How value-based care continues to reshape health care | Brokers | UnitedHealthcare
7. IFEBP Benefit Magazine Zeroing in on Women's Health July/Aug 2025-https://blog.ifebp.org/fertility-benefits-on-the-rise/

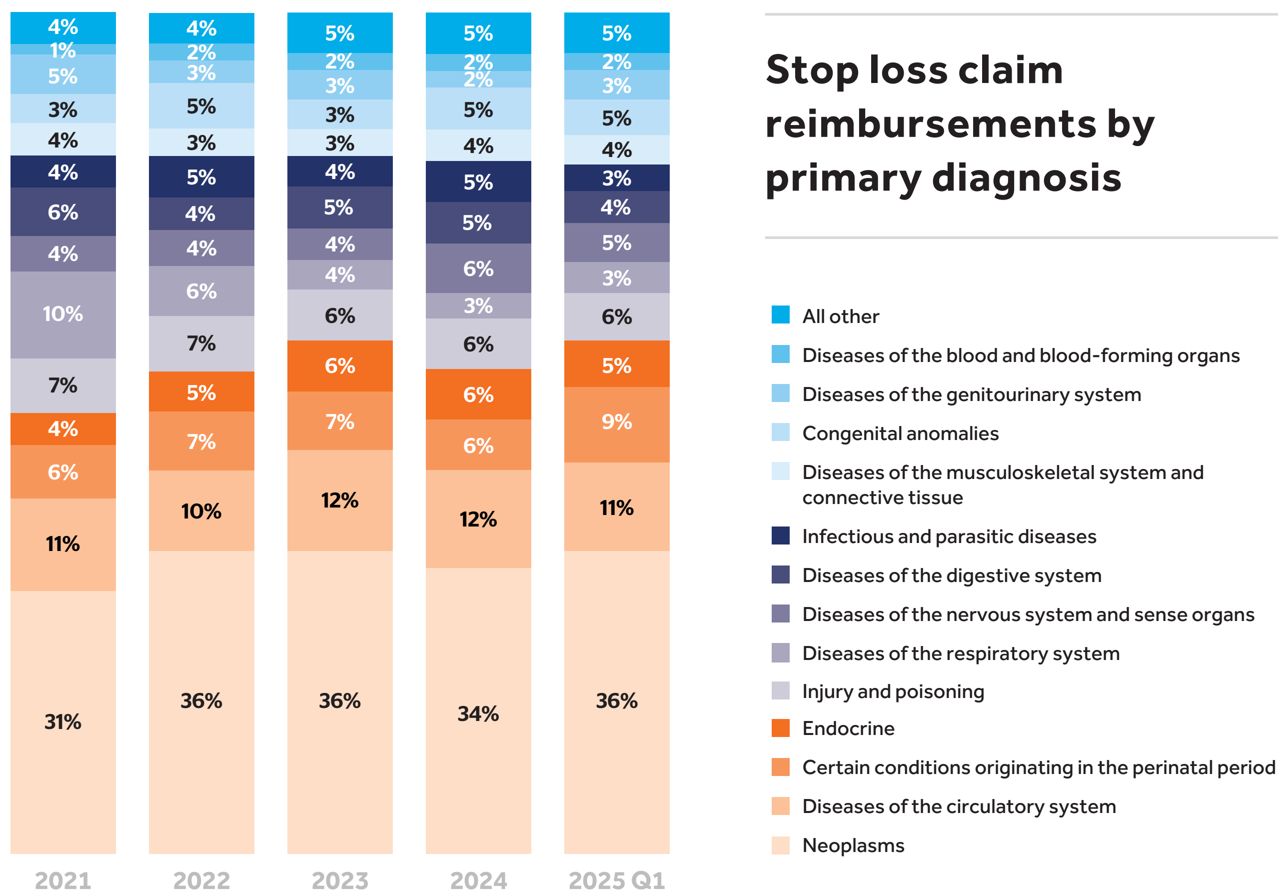
The high cost curve: organ transplant risk

Organ transplant risk continues to be driven by cost rather than by utilization. When adjusted for population, transplant claim frequency trends have remained stable over time, indicating that rising financial exposure is the result of increasing claim severity rather than increased use.

Severity has changed significantly. The average cost per transplant claim has risen steadily, driven by greater clinical complexity and longer hospital stays. While higher acuity hematopoietic stem cell transplants remain a key contributor, the broader trend reflects increasing intensity across individual cases. As a result, transplant risk today is shaped far more by rising costs than by changes in utilization.



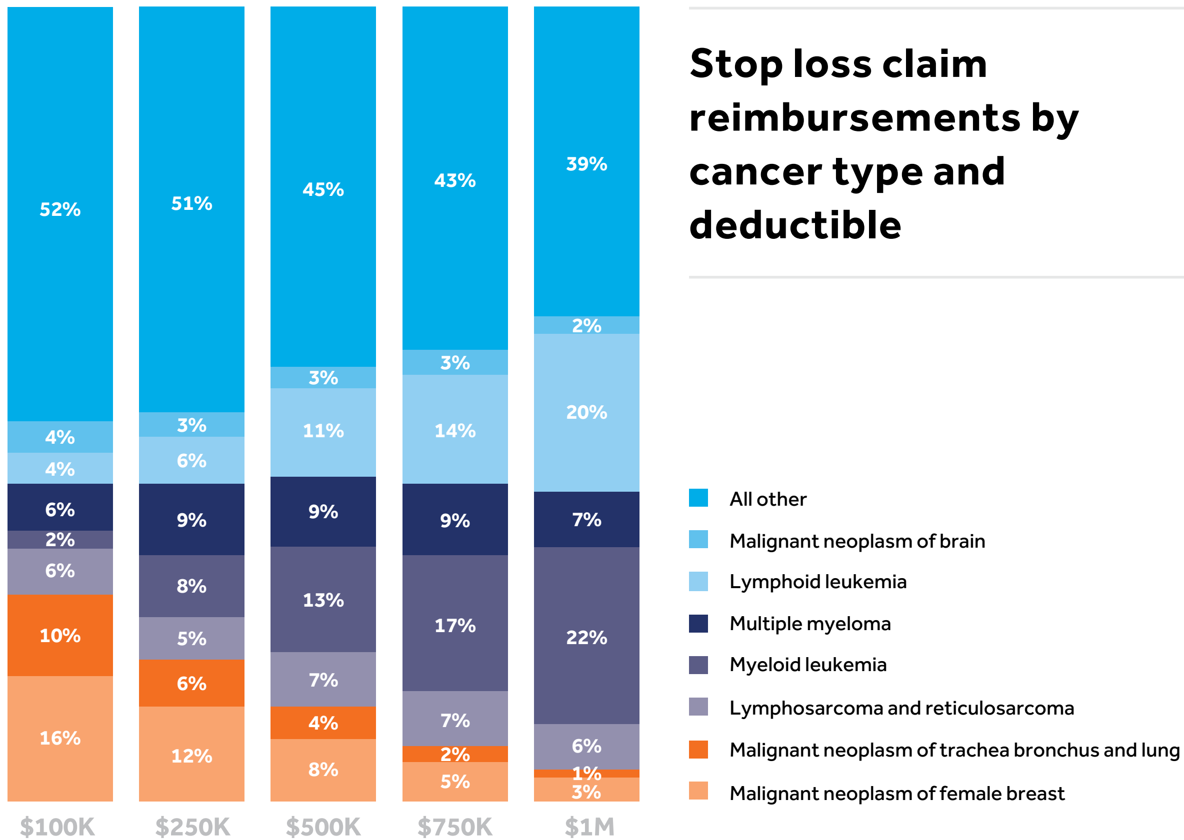




As reflected in the chart above, claim distribution by disease has remained stable over time. Neoplasms, circulatory, and birth-related conditions consistently represent the top three diagnoses across deductible levels.

- Neoplasms account for the highest share of claims, comprising between 31% and 36% of the total, and remain the leading diagnosis at all deductible levels, with a diminishing impact at higher thresholds.
- Diseases of the circulatory system represent the second largest category, contributing approximately 10% to 12% of total claims. It ranks as the second most common by frequency, accounting for approximately 11% to 13% across all deductible levels.
- Birth-related conditions account for about 6% to 9% of the total claims and, together with congenital anomalies, represent a growing share of overall claim costs at higher deductible levels.
- At deductibles of $500K and above, the claim mix is increasingly shaped by a small number of exceptionally high cost cases.

Stop loss claim reimbursements by cancer type and deductible



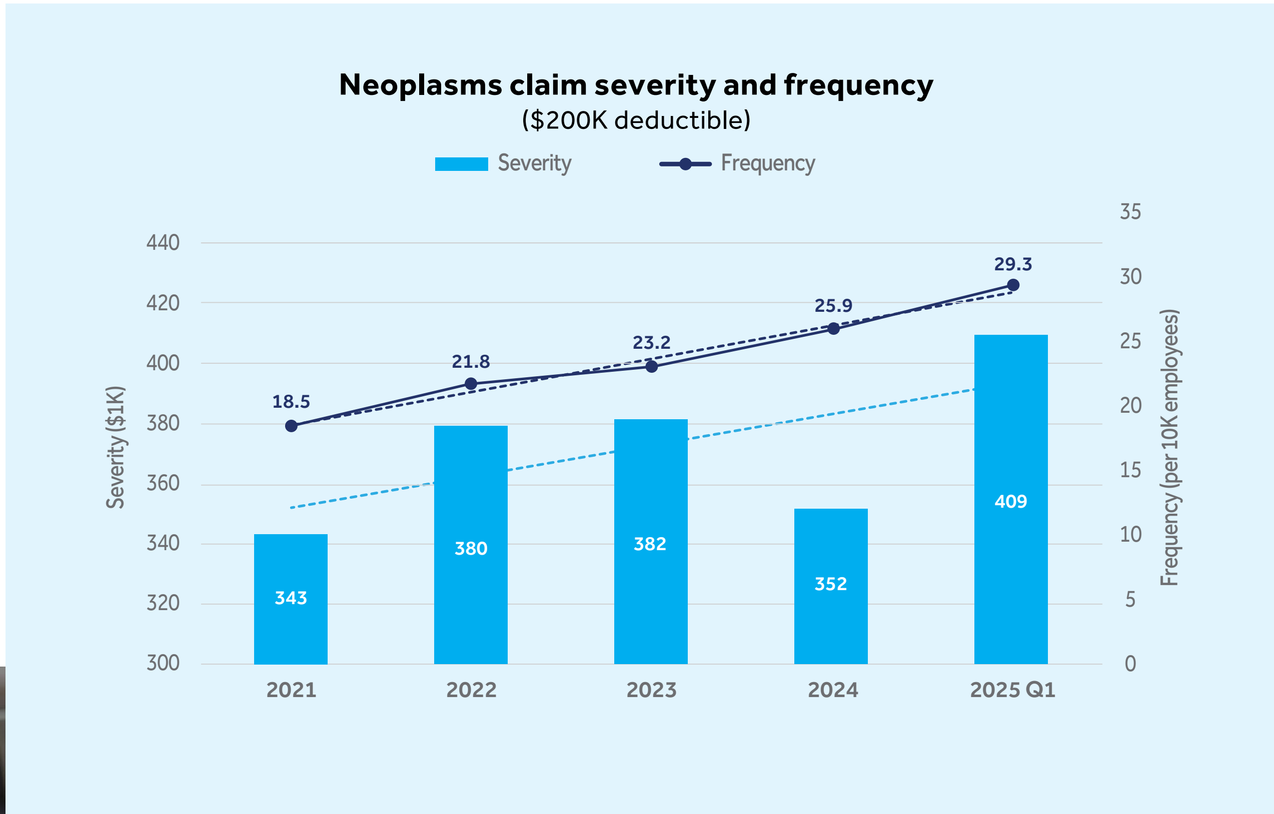
**Stop loss claims (2021 to Q1 2025) include both medical and drug claims based on the member's primary diagnosis (inclusive of comorbidities).*

As detailed above, the prevalence of different types of cancer claims varies by deductible level. For example:

- Female breast cancer accounts for 16% of cancer-related claims with a $100K deductible, decreasing to 8% and 3% at the $500K and $1M deductible respectively.
- Similarly, lung cancer accounts for 10% of cancer-related claims at a $100K deductible dropping to 4% and 1% at the $500K and $1M deductible respectively.
- Conversely, lymphoid leukemia and myeloid leukemia each account for less than 5% at a $100K deductible, doubling to over 10% at a $500K deductible, and exceeding 20% of cancer claims at a $1M deductible.

Neoplasms claim frequency and average ground-up claim size ($200K deductible)

Both frequency and ground-up severity indicated significant upward trends at the $200K deductible. Severity is up 12% from the average of prior years, while frequency is up nearly 30%.



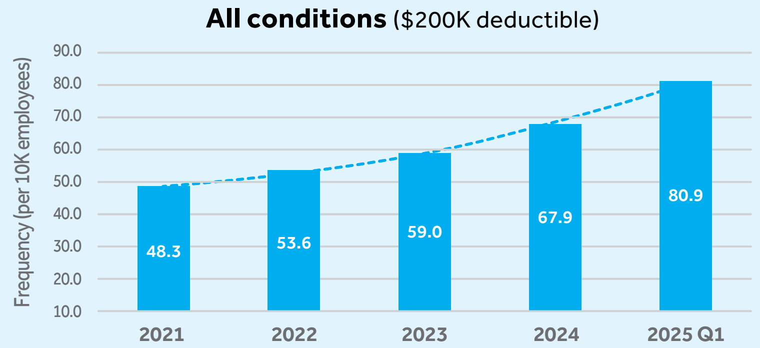
From diagnosis to demand: a market analysis of neoplasms

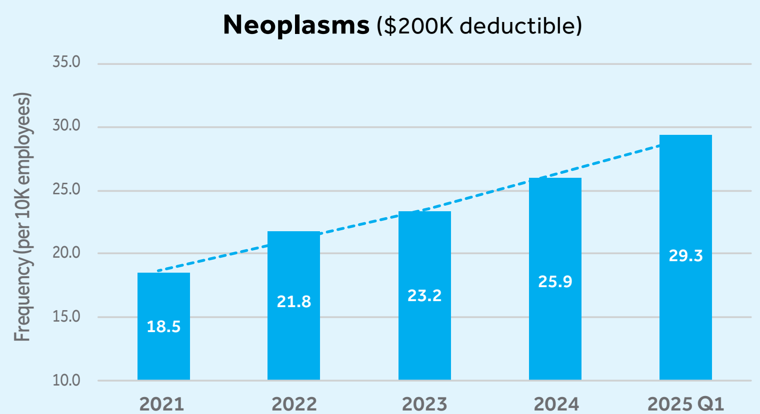
Neoplasms remain a primary driver of high-cost, hard-to-predict claims. While disease mix has remained relatively stable, the **cost profile of cancer care has shifted materially**. Earlier use of specialty oncology drugs, including immunotherapies, and cellular therapies, combined with longer and more complex treatment courses, has increased cumulative spend per claimant and significantly elevated severity once cancer care escalates.

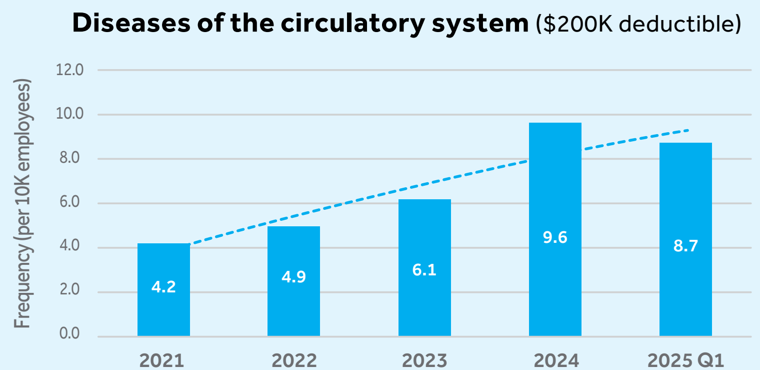
The financial impact of this shift is most evident in our largest individual claims. **QBE's highest claim to date exceeded $7M**, driven by complex oncology care progressing to transplant and advanced cellular therapy. What was once a single high cost event has evolved into a cascade of multi-million-dollar treatments, with each layer significantly amplifying claim severity.

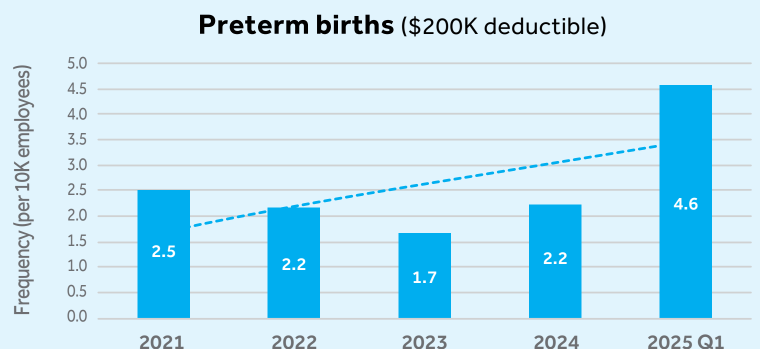
Claim frequency for members exceeding $200K in annual claims (per 10K employees)

Claim frequency across all conditions has increased steadily in prior years by approximately 10%-15% annually. The most recent year reflects nearly a 20% increase from the prior year, driven primarily by neoplasms, birth-related claims, and circulatory diseases. Notably, birth-related claim frequency more than doubled from 2024 to 2025.









Blood cancers: a disproportionate driver of high severity claims

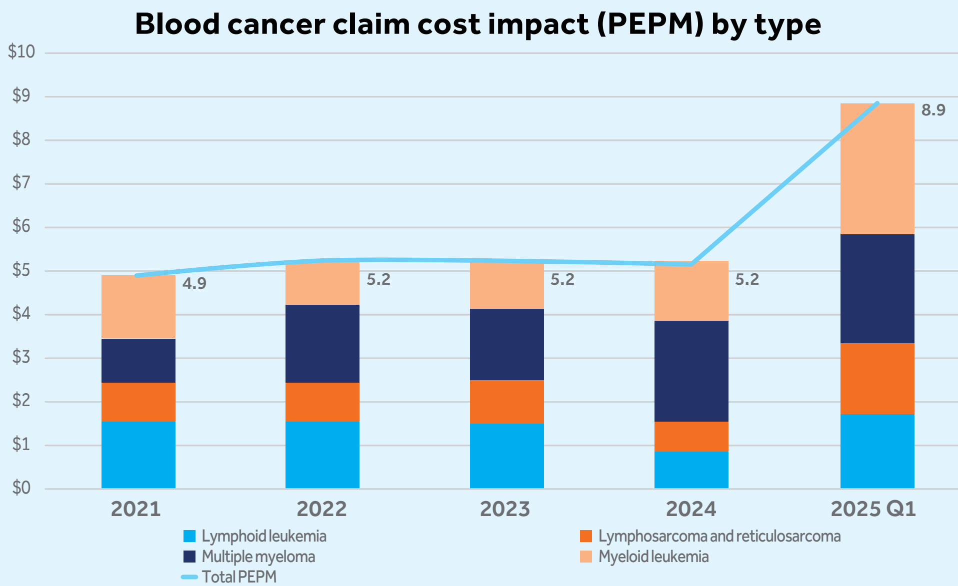
Deductible	$100K	$200K	$250K	$500K	$750K	$1M
2021	23%	34%	33%	53%	53%	66%
2022	24%	27%	28%	40%	43%	51%
2023	18%	25%	27%	40%	43%	49%
2024	10%	25%	26%	28%	29%	30%
2025 Q1	17%	28%	29%	42%	55%	62%
All years	18%	27%	28%	39%	47%	54%

- Within the broader neoplasm category, hematologic malignancies represent a disproportionate share of the highest-severity oncology claims. These conditions increasingly reflect a transition from episodic treatment to long-term disease management, characterized by substantial upfront and ongoing costs.
- As deductible levels increase, hematologic malignancies make up a significantly larger portion of total neoplasm claims, underscoring their outsized impact on jumbo claim exposure.
- Across all years, blood cancer claims represent a growing share of neoplasm claims as individual specific deductibles rise, **representing more than half of neoplasm claims at the $1M deductible level**. This pattern reflects the intensive, multiphase nature of blood cancer treatment, including transplant-related care, immune-based therapies, and extended inpatient utilization.
- Cost-of-care projections from QBE's risk management nursing team highlight the extreme variability and severity of these claims, with expected costs ranging from approximately **$110K to more than $2.5M**. Variability is driven by cancer subtype and stage, molecular and genetic markers, site of care, provider network, and treatment pathway selection, including the use of advanced cellular and gene-based therapies.

As shown in the chart below, a closer look at blood cancer claims by type reveals that both their frequency and cost fluctuate from year to year. Overall claim frequency began rising in 2024, primarily driven by multiple myeloma and myeloid leukemia, and remained elevated through 2025. While average reimbursement per claim remained relatively stable through 2024, costs increased sharply in 2025, particularly for leukemias, reflecting more complex, high-intensity cases. **When frequency and severity are viewed together, claim cost per employee per month (PEPM) rose significantly in 2025, increasing by more than 70% overall, with the steepest growth seen in myeloid leukemia**. These results highlight the inherent volatility of blood cancer claims, where shifts toward higher severity cases can quickly translate into meaningful increases in plan cost and pressure at higher deductible and individual specific deductible levels.

In hematologic malignancies, care has evolved from episodic interventions to ongoing disease management, marked by substantial initial and continuing costs driven by multi-drug induction regimens and maintenance therapies. Stem cell transplantation and CAR-T therapies are being utilized earlier in treatment plans. When disease relapses or becomes refractory, patients may progress to high-volatility treatments, such as off-label combination regimens, CAR-T therapy, or bispecific T-cell engagers, resulting in substantial single-claim exposures that require close underwriting oversight.

Multiple myeloma highlights this trend. Although it represents approximately 2% of all cancer diagnoses, it accounts for roughly 10% of hematologic malignancies and is frequently diagnosed at an advanced stage, resulting in immediate and ongoing systemic therapy.



PEPM shown in dollars per employee per month

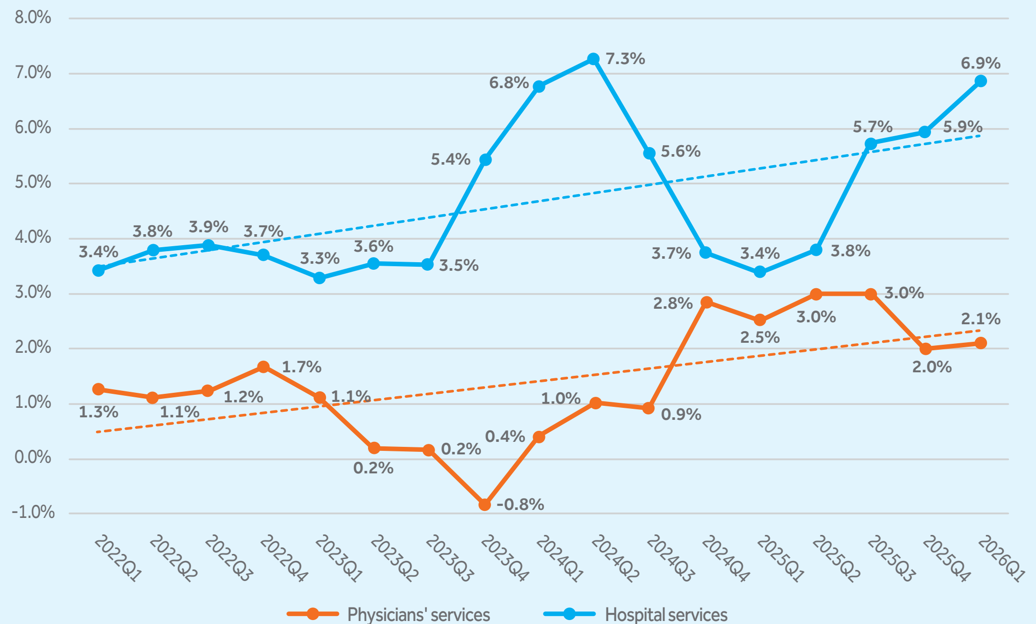
Hospital services vs. Physicians' services Consumer Price Index (CPI)

- Hospital services CPI is consistently higher and more volatile than the Physicians' services CPI across several years.
- Hospital care represents one of the largest single-sources of healthcare spending and is a dominant driver of claim cost and severity, particularly as services consolidate within hospital systems.

- As displayed in the chart below, the latest four quarters exhibit meaningful acceleration. This reiterates the importance of stop loss coverage, and both employers and carriers should diligently monitor evolving trends.

- Physicians' services CPI reflects a moderate increase, likely influenced by Medicare payment reductions to physicians implemented by the Centers for Medicare & Medicaid Services (CMS). However, employers and carriers should remain attentive to the possibility of future cost shifting to commercial populations.

- Several factors have contributed to the difference in CPIs for Hospital and Physicians' services including:
  - Renegotiated hospital-payer contracts post-pandemic resulting in material changes to reimbursement rates
  - Elevated hospital overhead costs, including labor
  - CMS Medicare payment cuts to physicians



https://www.bls.gov/cpi/tables/supplemental-files/home.htm

Hospital spending accounted for 40% of the growth in national health spending between 2022 and 2024, a far larger share than any other health spending category

Distribution of the growth in national health spending by type of good or service, 2022-2024. Total national health spending grew from $4.6T in 2022 to $5.3T in 2024.

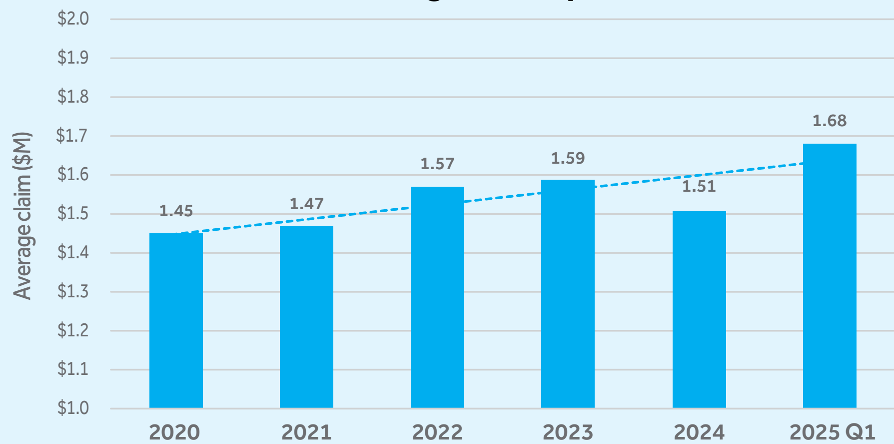
	Share of growth, 2022-2024	Growth
Hospital care	40%	$277B
Physician and clinical services	22%	$153B
Retail prescription drugs	11%	$76B
Other professional services	5%	$38B
Home health care	5%	$31B
Nursing care and CCRCs	5%	$31B
Dental services	3%	$22B
Government administration	2%	$13B
Non-medical insurance expenditures	2%	$12B
Government public health activities	-7%	$-51B
All other	13%	$90B

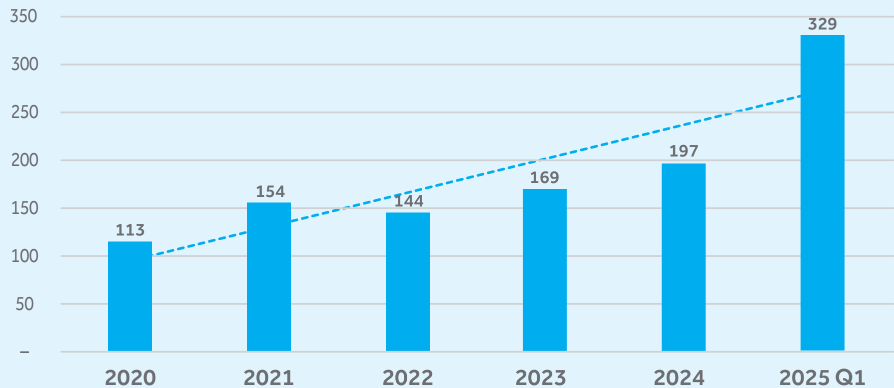
Note: "All other" includes spending on residential care facilities, ambulance providers, care delivered in non-traditional settings, and certain Medicaid waiver programs for home or community care, as well as retail medical products, investment in non-commercial research, and spending on medical structures and equipment. "Non-medical insurance expenditures" includes the net cost of private insurance, or the difference between premiums incurred and spending on benefits. "Government administration" includes all administrative costs of federal health insurance programs such as Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). "Nursing care and CCRCs" includes spending on nursing facilities and continuing care retirement communities (CCRCs).

Hospital Spending Accounted for 40% of the Growth in National Health Spending Between 2022 and 2024 | KFF

Million-dollar claims (ground-up) study:

- After a pause in 2022, claims have surged from 2023 through 2025.
- Claim frequency has tripled over the past five years, highlighting the growing importance of medical stop loss insurance for employers.
- Consistent with our time study, the highest cost claims each year stemmed from neoplasms, premature births with related congenital anomalies, and circulatory conditions.
- Claims exceeding $1M for neoplasms more than doubled in frequency in 2025 Q1.
- The 2025 severity trend is 10% higher than the average of prior years.





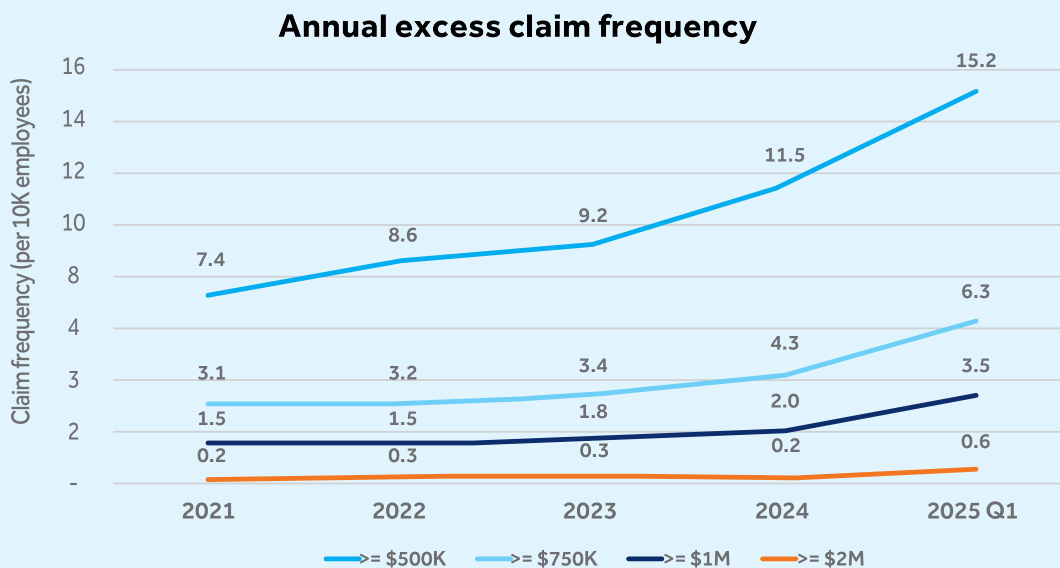
Jumbo claim frequency is expanding across all severity levels

Jumbo claim frequency increased materially from 2024 to 2025 across all claim size thresholds, signaling a broad-based shift rather than isolated volatility. Claims exceeding $500K, $750K, $1M, and $2M all demonstrated higher frequency, indicating that elevated claim activity is extending deeper into the severity spectrum and occurring more often than in prior years.

The increase was driven by a concentrated set of high severity clinical conditions. **Neoplasms were the dominant contributor**, accounting for nearly 50% of the period-over-period PEPM increase for most jumbo claim size categories. At the highest threshold (≥$2M), neoplasms represented approximately 20% of the PEPM increase, underscoring the persistent impact of advanced and prolonged cancer care.

Other conditions that contributed meaningfully to the upward trend include **birth-related conditions, congenital anomalies, diseases of the circulatory system, and diseases of the nervous system and sense organs**. Collectively, these drivers reflect rising clinical complexity and intensity rather than one-time shocks.

> The simultaneous rise in frequency across all jumbo thresholds reinforces that high-dollar claims are becoming a more routine part of plan experience, increasing pressure on affordability and challenging historical assumptions about the predictability of extreme claims.



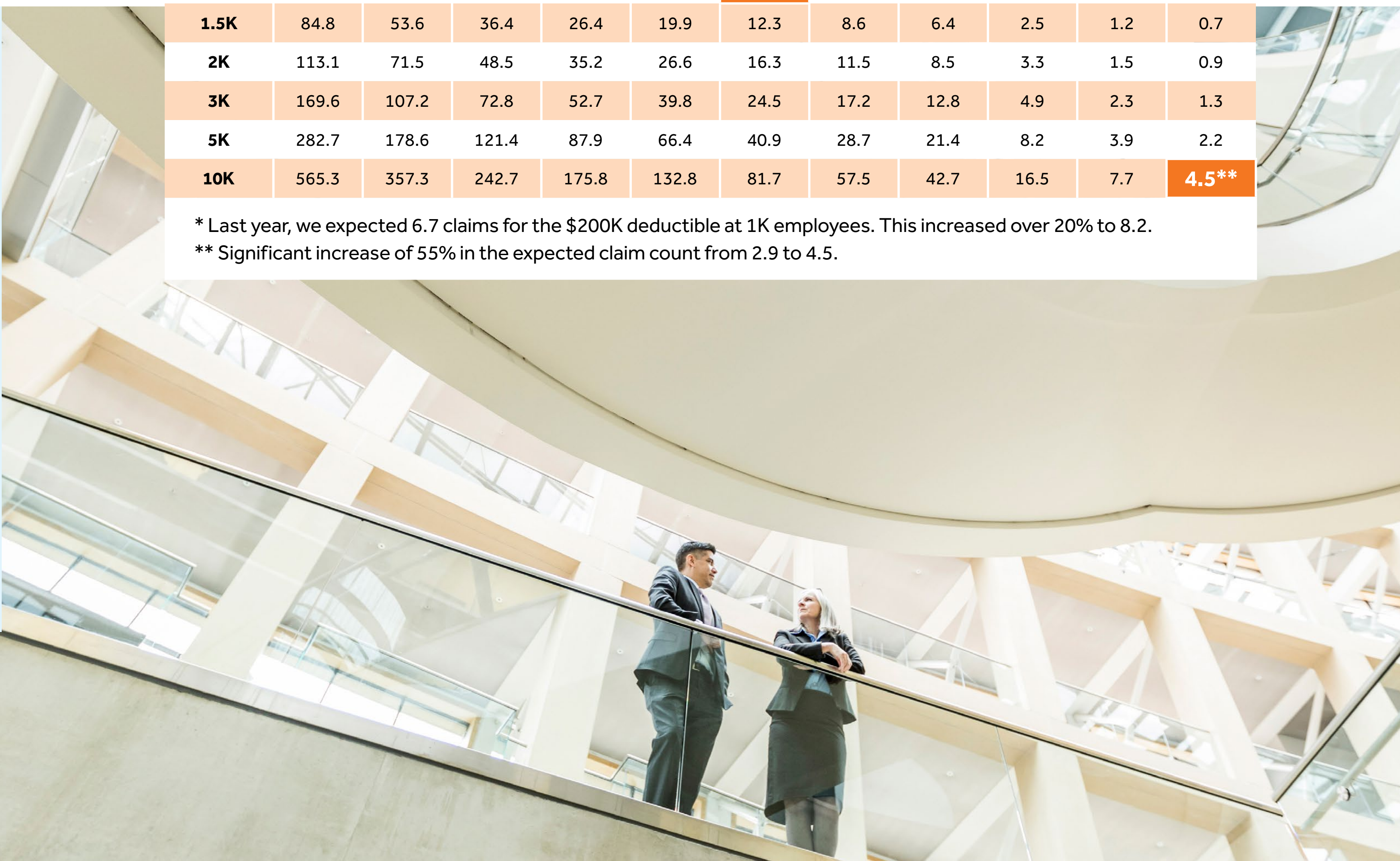
Expected claim counts at various specific deductibles based on group size

The table below provides an insightful benchmark for the expected excess loss claim count by size and deductible, based on a blend of QBE and industry experience. There are notable increases in the expected claim counts compared to our prior year report. The severity and frequency of neoplasms and premature births with related congenital anomalies largely contributes to this. When selecting a deductible, employers should evaluate group size, their overall risk tolerance, and their financial capacity to absorb claim volatility.

Employee count/ Deductible level	$50K	$75K	$100K	$125K	$150K	$200K	$250K	$300K	$500K	$750K	$1M
50	2.8	1.8	1.2	0.9	0.7	0.4	0.3	0.2	0.1	0.0	0.0
100	5.7	3.6	2.4	1.8	1.3	0.8	0.6	0.4	0.2	0.1	0.0
250	14.1	8.9	6.1	4.4	3.3	2.0	1.4	1.1	0.4	0.2	0.1
500	28.3	17.9	12.1	8.8	6.6	4.1	2.9	2.1	0.8	0.4	0.2
750	42.4	26.8	18.2	13.2	10.0	6.1	4.3	3.2	1.2	0.6	0.3
1K	56.5	35.7	24.3	17.6	13.3	**8.2***	5.7	4.3	1.6	0.8	0.4
1.5K	84.8	53.6	36.4	26.4	19.9	12.3	8.6	6.4	2.5	1.2	0.7
2K	113.1	71.5	48.5	35.2	26.6	16.3	11.5	8.5	3.3	1.5	0.9
3K	169.6	107.2	72.8	52.7	39.8	24.5	17.2	12.8	4.9	2.3	1.3
5K	282.7	178.6	121.4	87.9	66.4	40.9	28.7	21.4	8.2	3.9	2.2
10K	565.3	357.3	242.7	175.8	132.8	81.7	57.5	42.7	16.5	7.7	**4.5****

* Last year, we expected 6.7 claims for the $200K deductible at 1K employees. This increased over 20% to 8.2.

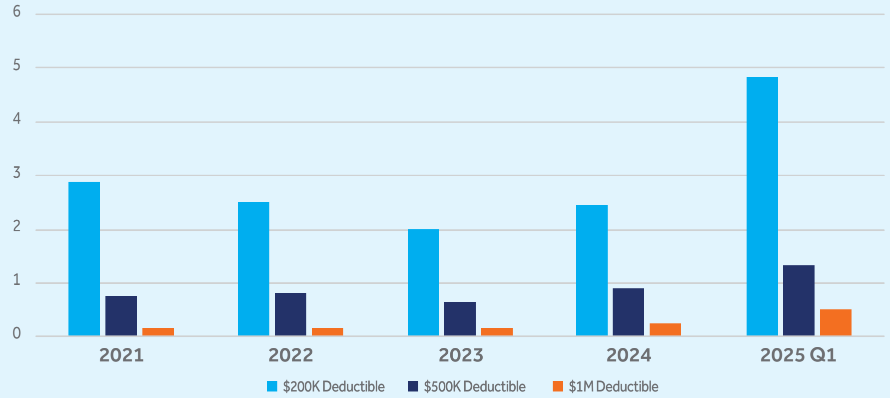
** Significant increase of 55% in the expected claim count from 2.9 to 4.5.

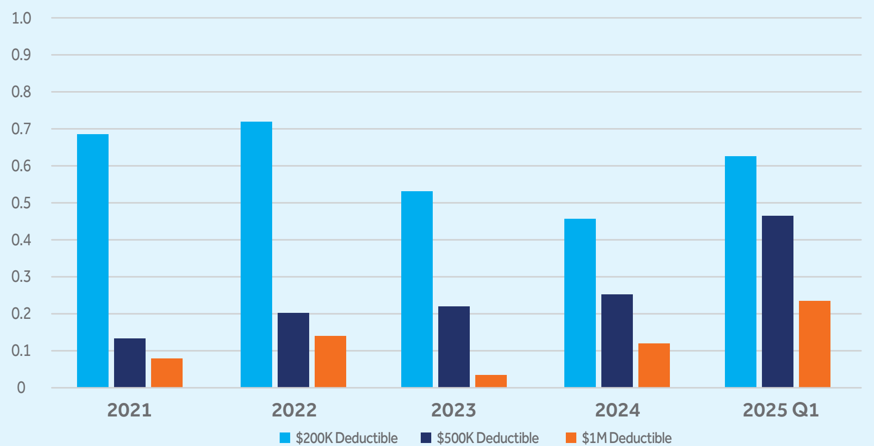


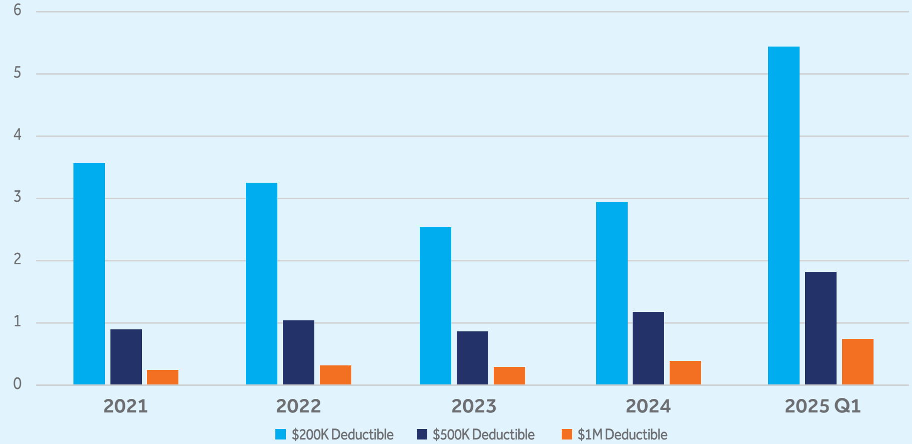
Preterm birth related claims

A materially higher claim frequency is observed in 2025 across all deductible levels.

- A significant increase in claim frequency has been observed for preterm births across all deductible levels, along with congenital anomalies related to preterm birth.
- Third Party Administrator (TPA) payments for costly pediatric claims ranged from **$10.6K to $5.6M**, underscoring both variability and the potential for high severity linked to congenital conditions.







Pediatrics: high severity claims driven by congenital and advanced therapies

Pediatric care represents a smaller share of overall healthcare utilization, yet pediatric claimants represent a disproportionately large share of high-severity claims. **In QBE's 2025 claims experience, pediatric claimants made up six of the 10 highest-cost claims.**

Pediatric claim severity is commonly driven by:

- Congenital anomalies and complex neonatal care
- Pediatric hematologic cancers
- Rare genetic and metabolic conditions

Treatment costs are frequently associated with:

- Cell and gene therapies
- Prolonged and repeated hospitalizations
- Intensive neonatal care
- Complex surgical interventions

Four of the top six pediatric claims were associated with extensive hospitalizations following birth, driven by cardiac defects, respiratory failure, congenital conditions, and sepsis.

While advances in pediatric and neonatal care have significantly improved outcomes and survival rates, they often extend care trajectories into adolescence and adulthood, resulting in higher long-term claim severity.

67% of pediatric claims were driven by extensive hospitalizations following birth.

Emerging clinical advances

One in 10 births occur preterm annually. Improved neonatal survival can translate into higher long-term claim severity and affordability pressure. [1,2]

AI-driven tools are being studied to improve prediction of complications among preterm infants and to support earlier clinical intervention – an example of innovation to improve the outcomes while increasing the intensity and cost of care over time. [3,4]

Gene therapy has similarly contributed to high severity pediatric claims. One claimant treated with Elevidys for Duchenne muscular dystrophy incurred approximately $3.4M in paid claims, reflecting both the clinical promise and the financial impact of gene therapy.

> About one in 33 babies in the United States is born with a birth defect each year, and the risk is more than twice as high among preterm infants. [2]

1. https://www.who.int/news-room/fact-sheets/detail/preterm-birth#:~:text=Key%20facts,the%20age%20of%205%20years.
2. https://www.cdc.gov/birth-defects/about/index.html
3. https://med.stanford.edu/news/all-news/2026/01/ai-prematurity-complications.html
4. https://www.tandfonline.com/doi/10.1080/14767058.2025.2532099?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed#abstract

Why diagnosis alone no longer predicts claim severity

Predicting ongoing claim risk has become increasingly complex as clinical pathways diverge earlier and more dramatically within a given diagnosis. Factors such as age, disease stage and progression, provider network access, site of care, and treatment plan contribute to cost volatility.

This volatility is further compounded when diagnosis or prognosis information is limited at the point of underwriting the risk. Claims can evolve so rapidly that a claimant showing minimal claims activity at initial review can become a catastrophic claim during final underwriting. Emerging therapies and access to advanced care, such as cell and gene therapies, can materially alter both cost trajectory and duration of claims.

The result is an inherent uncertainty in the potential outcomes of modern medical treatment. **The expanding cost range underscores how difficult it can be to forecast severity and financial exposure using diagnosis alone, reinforcing the importance of detailed, ongoing clinical updates and proactive risk management as claims mature**.

Below is a range of cost predictions that illustrate the variability based on claimant age, disease stage and progression, provider network access, site of care, and the specific treatment plan selected over time.

Across the cancer exhibit below, the lower end of the cost ranges generally reflect scenarios where care is predictable, well-coordinated, and financially managed early in the treatment pathway. The upper end of the ranges more often reflects **highly complex care that is not financially managed in a timely or coordinated manner**, including extended inpatient stays, evolving complications, and escalation to advanced therapies. Once treatment progresses into prolonged or repeated hospitalizations, opportunities for site of care optimization, pricing intervention, and single-case negotiations become more limited, resulting in materially higher total claim costs.

Cancer: non-solid tumor	Potential annual cost range
Acute lymphoblastic leukemia	$270K – $2.0M
Acute myeloid leukemia	$225K – $1.1M
B-cell lymphoma	$190K – $700K
Chronic myeloid leukemia	$75K – $785K
Diffuse b-cell lymphoma	$260K – $950K
Hodgkin’s lymphoma	$255K – $1.0 M
Mantle cell lymphoma	$190K – $650K
Multiple myeloma	$335K – $2.5M
Non-Hodgkin’s lymphoma	$145K – $1.4M

Cancer: solid tumor	Potential annual cost range
Bladder cancer	$250K – $1.1M
Breast cancer	$100K – $1.7M
Colorectal cancer	$130K – $1.1M
Endometrial/Uterine cancer	$100K – $1.4M
Kidney cancer	$160K – $1.4M
Lung cancer	$170K – $1.4M
Melanoma	$130K – $950K

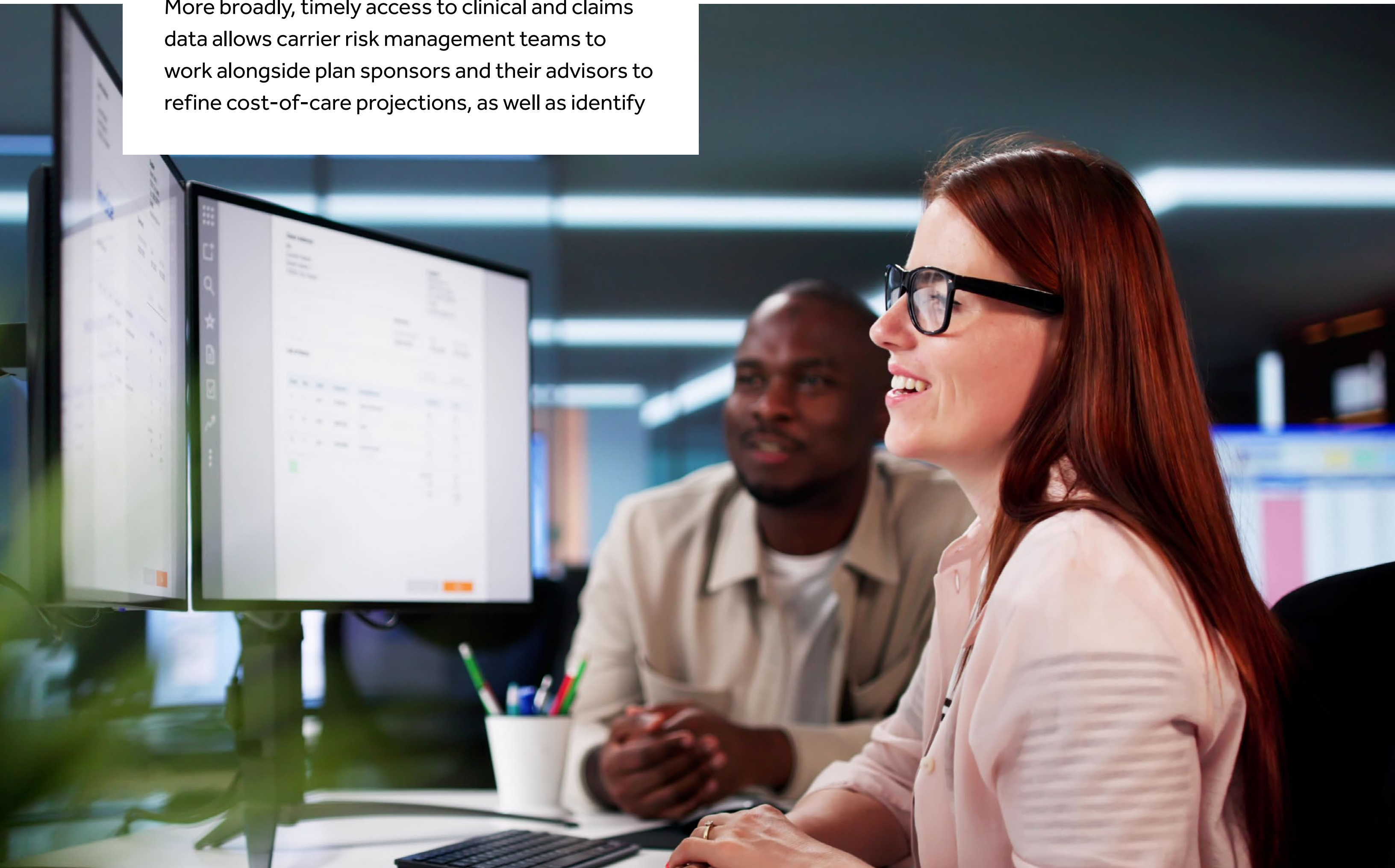
A collaborative approach to managing high cost claims

Effective claim management increasingly depends on strong employer-carrier partnerships. As claim severity rises, timely collaboration and information sharing between plan sponsors, administrators, and carriers plays a critical role in protecting plan affordability and improving financial outcomes.

By way of example, our team identified a member undergoing repeated immunotherapy whose per-treatment cost had nearly tripled, from approximately $7K to $20K, despite no change in provider, drug dosage, or treatment frequency. Through targeted review and engagement, **QBE addressed the escalation, resulting in $51K in plan savings**.

More broadly, timely access to clinical and claims data allows carrier risk management teams to work alongside plan sponsors and their advisors to refine cost-of-care projections, as well as identify emerging risks to address claim escalation while maintaining optimal care outcomes. Early case identification and alignment on appropriate clinical pathways, such as directing care to in-network centers of excellence, can materially influence outcomes.

For high cost oncology treatments and cellular therapies, proactive utilization management and pricing strategies, including site of care optimization, prior authorization, and single-case agreements, can meaningfully reduce allowed amounts and help prevent avoidable cost escalation. By leveraging shared data, clinical expertise, and aligned incentives, employer–carrier partnerships play a critical role in balancing access to innovative, high-quality care for members while protecting the financial stability of employer-sponsored health plans.



Specialty pharmaceuticals cost acceleration: limited populations, outsized impact

Specialty prescription drugs are a rapidly growing driver of plan spend. While used by a small number of members, these claims account for a disproportionate share of total spend due to high unit costs, and more importantly, increasingly long treatment duration. Many of today's most expensive therapies are designed for long-term or lifelong use, with expanding indications that broaden the eligible population. Once treatment begins, discontinuation is rare, leading to costs that persist across multiple plan years.

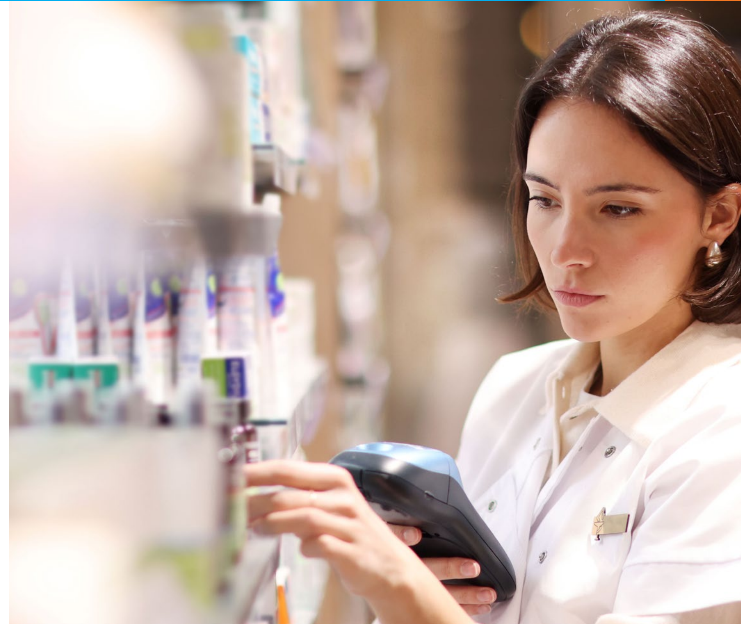
A small number of specialty drugs can generate millions of dollars in annual expenses, including rare disease therapies that pose catastrophic single-member exposure risks. As a result, **specialty pharmaceuticals are evolving into a long-tail liability embedded within the covered population, rather than a variable or episodic expense**.

The following exhibits highlight a **representative sample of high cost specialty and oncology drugs** and their **expected average cost amounts**, based on QBE's claims experience. These examples are **illustrative rather than exhaustive**, intended to demonstrate the magnitude and variability of drug-related exposure that self-funded health plans may encounter. Even within this limited set, **expected claim amounts vary widely by therapy**, reflecting differences in clinical indication, treatment duration, delivery method, and utilization patterns. Collectively, these examples underscore how a relatively **small number of specialty prescriptions, often affecting very few members, can materially influence overall claim severity and volatility**.

For commonly prescribed specialty drugs with more predictable utilization, cost variation tends to be narrower, as illustrated in the graphic below.

Indefinite therapy has become the standard rather than the exception. Many specialty medications used to treat autoimmune, oncology, and genetic conditions now serve as long-term maintenance therapies, resulting in persistent, multi-year exposure.

Specialty drug	Typical indication	Average expected annual cost (observed on QBE portfolio)
Humira	Psoriatic arthritis, Plaque psoriasis, Crohn's, Ulcerative colitis	$150K
Keytruda	Lung cancer, Melanoma, Head and neck cancer	$350K
Kisqali	Breast cancer	$230K
Opdivo	Lung cancer, Melanoma, Renal cell carcinoma	$395K
Revlimid	Multiple myeloma	$220K
Rinvoq	Rheumatoid arthritis, Psoriatic arthritis, Crohn's, Ulcerative colitis	$90K
Skyrizi	Psoriatic arthritis, Plaque psoriasis, Crohn's, Ulcerative colitis	$140K
Stelara	Psoriatic arthritis, Plaque psoriasis, Crohn's, Ulcerative colitis	$250K
Trikafta	Cystic fibrosis	$360K
Verzenio	Breast cancer	$215K



In contrast, **less common therapies, particularly oncology, enzyme replacement, and rare disease treatments, pose substantial financial risk**. Single member claims can surpass several hundred thousand dollars within relatively short time frames.

Importantly, opportunities for direct savings on **drug acquisition costs are limited**. When cost management potential does exist, it is more often driven by **care delivery decisions, most notably site of care, rather than changes to the medication regimen**. As specialty utilization continues to grow, understanding these dynamics is increasingly critical to anticipating plan exposure and managing high-severity claims.

Range of high-severity specialty drug exposure across QBE's portfolio

Specialty drug	Typical indication	Route	Risk profile	Average expected annual cost
Bylvay	Progressive familial intrahepatic cholestasis, Alagille syndrome	Oral	Lifelong therapy; pediatric onset; costs escalate with age	$1.3M – $2.3M
Cerezyme	Gaucher disease (enzyme replacement therapy)	IV infusion	Multi-decade duration	$1.7M
Hemlibra	Hemophilia A prophylaxis	Subcutaneous	Preventive therapy; long-term maintenance	$910K – $1.9M
Krystexxa	Refractory chronic gout	IV infusion	Smaller population but extreme per-member severity	$780K – $1.7M
Miplyffa	Niemann-Pick disease type C	Oral	Lifelong therapy; often combined therapy recommended	$1.5M
Nexviazyme	Pompe disease (enzyme replacement)	IV infusion	Chronic ERT; progressive disease; no discontinuation	$2.1M
Soliris	Atypical hemolytic uremic syndrome, Paroxysmal nocturnal hemoglobinuria, Myasthenia gravis, Neuromyelitis optica spectrum disorder	IV infusion	Multiple indications; partial biosimilar presence	$735K – $1.5M
Strensiq	Hypophosphatasia (enzyme deficiency)	Subcutaneous	Lifelong therapy; early diagnosis increases duration risk	$1.9 – $2.1M

What changed in 2025: severity, pricing, and affordability

Claim severity accelerated in 2025 not because different conditions emerged, but because of changes in how high acuity care is documented and reimbursed. Neoplasms, circulatory system disorders, and birth-related and congenital conditions remain the primary drivers of excess claims. The key change was the magnitude of the financial impact once those claims escalated.

Two dynamics converged in 2025. First, clinical complexity is being captured more comprehensively during extended inpatient stays. Longer admissions, evolving complications, and intensive supportive care are now documented with greater precision, particularly for oncology, blood cancers, neonatal care, and advanced cardiac cases. While this reflects more complete acuity capture, not increased prevalence, it has elevated the reimbursement severity profile of individual claims.

Second, provider reimbursement structures have materially changed. Recent contracting renewals have raised inpatient rates across many health systems, driven by sustained labor pressure, rising operating costs, and delayed post-pandemic negotiations. Once claims cross into high acuity inpatient care, reimbursement flows through higher contracted unit prices than in prior years.

The interaction of these forces has elevated per claim severity, narrowed the gap between large and catastrophic claims, and reduced predictability for employer-sponsored health plans. Even when utilization patterns remain stable, affordability pressures have intensified, as identical clinical pathways now lead to significantly higher financial exposure once severity escalates.

For employers, the implications are clear: in 2025, severity risk was increasingly determined by how care was documented and priced, rather than by how often care occurred.

Claim trends continue to rise across the healthcare industry, pushing loss ratios higher throughout the market. Insurers in the Affordable Care Act (ACA) Marketplace increased premiums by an average of 20% this year, with many raising rates by 30% or more, as shown in the chart below. [1] From our perspective, projected general medical cost trends are in the high single to low double digit range. Across both the individual and group markets, the same factors continue to drive medical cost trends: prescription drug and specialty medication spending, inflation and labor costs, and rising behavioral health expenses.

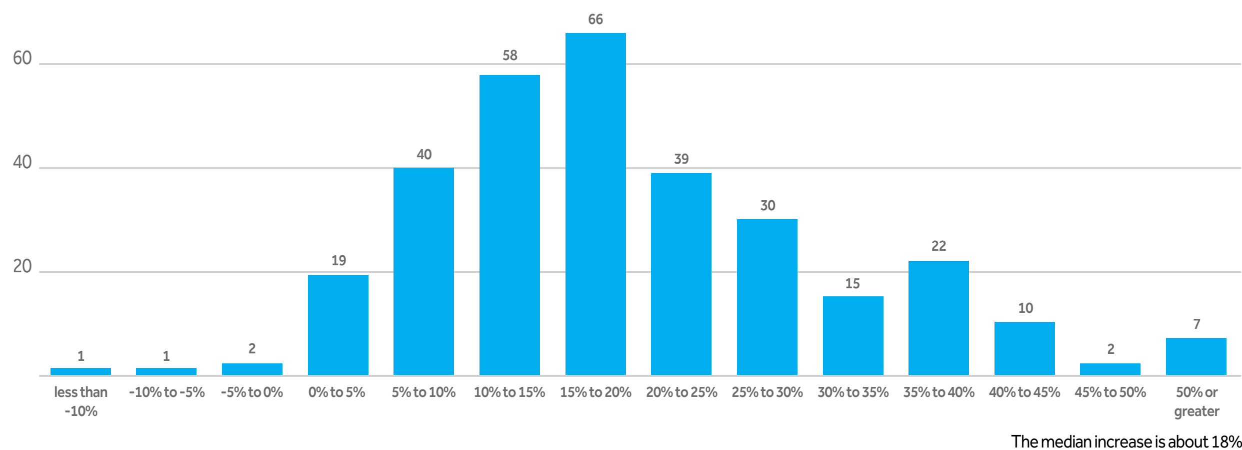
In 2025, overall pharmaceutical expenditures in the U.S grew 12.7% compared to 2024, for a total of $915.2B. [3] Newly developed drugs for common conditions, like nervous system disorders, are also likely to increase in use. While rapid progress in medical technology and therapeutics is significantly improving survival rates and quality of life, the associated cost trajectory continues to outpace overall medical inflation, shifting innovation from a clinical breakthrough to a growing financial pressure point for health plans.

Beyond high cost severity challenges, many health plans identify GLP-1 medications as a leading driver of rising expenses, expected to account for 0.5% – 1% of the estimated medical cost trend in 2026. [2]

The use of both inpatient and outpatient behavioral health services is also increasing rapidly. Claims for inpatient behavioral services were up nearly 80% from early 2023 to the end of 2024, with trend increases of 10 – 20% anticipated for 2026. The rise in popularity of virtual care for anxiety, developmental disorders and depressive disorders is cited by health plans as a driver of utilization.

Inflation continues to strain hospitals and care facilities. Higher wages and general operating expenses are prompting providers to seek higher reimbursement rates in contract negotiations. Rising inpatient stays and greater care severity further intensify these pressures. Inflation has not eased and is likely to remain elevated, leaving the question of whether plans or providers will ultimately bear these costs to be settled through contracting. [2]

Distribution of proposed 2026 rate changes among 312 ACA marketplace insurers



https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2026/#Distribution%20of%20proposed%20 2026%20rate%20changes%20among%20312%20ACA%20Marketplace%20insurers

Legislative actions to address rising healthcare cost pressures

Misaligned financial incentives within the system are at the root of today's healthcare cost challenges. Pharmacy Benefit Managers (PBMs), providers, and vendors are often compensated based on higher utilization and rising prices, rather than efficiency or improved patient outcomes. Consequently, cost management efforts tend to focus on mitigating the impact of rising costs instead of addressing their underlying causes.

This dynamic leaves employer plans and benefit consultants increasingly frustrated by the barriers that limit transparency and restrict access to their own data, undermining their ability to make informed decisions. Adding to these challenges, PBM affiliated Group Purchasing Organizations (GPOs) introduce new transparency concerns. While PBMs may promise "100% rebate passthrough," what qualifies as a rebate can vary based on contract definition. In some cases, payments from drug manufacturers are routed through affiliated entities and labeled as administrative or service fees rather than rebates. As such, contracts can appear compliant despite those dollars not being returned to the plan. With these concerns, continuing to escalate transparency is a high priority for the current administration.

Earlier this year, Congress proposed legislation that would require PBMs to disclose key payment practices to group health plans. These disclosures would include details on rebates, price concessions, and "spread pricing," as the gross and net costs of prescription drugs within the PBM's drug formulary, and whether covered drugs are dispensed through PBM-owned pharmacies, mail-order, or specialty programs. [4] Plans could request this information through a machine-readable file on either a quarterly or bi-annual basis. The proposal would also require PBMs to pass 100% of manufacturer rebates directly to the plan.

Further, the Department of Labor issued proposed regulations requiring PBMs to disclose up to eight types of compensation streams to a self-insured group health plan in accordance with the Employee Retirement Income Security Act (ERISA) Section 408(b)(2)(B) Compensation Disclosure requirements. The Self-Insurance Institute of America (SIIA) submitted comments supporting the Administration's work to expand disclosure on in-network negotiated rates and out-of-network allowed amounts on a public website, while emphasizing that the information must be usable and understandable in order for plan sponsors to meet their fiduciary duties. SIIA also recommended requiring an attestation of completeness and accuracy by an authorized representative and treating machine-readable file data as plan assets under ERISA. [5]

Legal developments further reinforce transparency efforts. An increasing number of cases argue that TPAs have a fiduciary duty to share plan data with self-insured employers, given that they are hired to manage the plan. Recent rulings suggest that courts are receptive to this view. While TPAs control the data, ownership ultimately resides with the employer. Although no court has ruled that withholding plan data breaches fiduciary duties specifically, courts have consistently recognized TPAs as ERISA fiduciaries when they control plan assets and exercise discretionary judgement. [6] **While litigation is not a primary strategy for employers, recent rulings send a clear message – employers have increased leverage to demand access to their own data as part of their fiduciary and plan oversight responsibilities**.

What employers can do to facilitate access to clear and accurate data

As the industry waits for greater transparency reform, experts note that employers should consider several options to address the pressure of rising costs.

Steps employers can take to manage cost acceleration

Contracting levers

- Reassess provider contracting strategies in response to sustained unit cost pressure.
- Consider value-based contracting and alternative payment models to improve predictability.

Transparency and data access

- Improve access to usable medical and pharmacy data to identify primary cost drivers.
- Use vendor accountability measures (i.e. performance reviews, audits, guarantee validation).

Predictive analytics

- Apply analytics to detect leading indicators: severity creep, inpatient intensity, and high cost claim emergence.
- Use signals to deploy early care management and targeted vendor actions.

Utilization management and payment integrity

- Strengthen utilization management for appropriateness and site of care optimization.
- Increase scrutiny of fraud, waste, and abuse to reduce avoidable spending.

Pharmacy management

- Intensify PBM oversight (i.e. rebates, spread pricing exposure, channel steering).
- Tighten specialty drug utilization controls for high-cost therapies that disproportionately drive overall cost trends.

Coverage strategy

- Re-evaluate pharmacy benefits considering sustained GLP-1 utilization and the expanding pipeline of high cost cellular therapies.

PBM transparency and efficiency

- Consider PBM solutions designed to improve visibility into pricing mechanics, reduce friction, and optimize net cost outcomes.

Utilization support

- Complement GLP-1 coverage with structured nutrition, behavior, and weight management programs to support appropriate use and long-term effectiveness.

Behavioral health integration

- Expand access to behavioral health and employee assistance programs' resources to address comorbid conditions that influence pharmacy utilization and overall cost trends.

Cost containment through alignment

- Apply pharmacy insights in coordination with clinical, utilization management, and employer engagement strategies to mitigate avoidable escalation.

Considerations when choosing plan administration

TPAs play a critical and central role in claim processing, compliance, and day-to-day plan operations. At the same time, the structure of an administrative arrangement can meaningfully influence an employer's ability to identify and respond to emerging trends within their covered population.

While TPAs manage the administrative functions of the plan, self-insured employers remain responsible for funding claims and safeguarding plan assets. In many arrangements, decision-making authority is delegated to the administrator, which can limit the employer's ability to influence outcomes on high-cost or complex claims. This separation is not inherently problematic; however, without appropriate contractual alignment, timely data access, and defined escalation pathways, it can constrain intervention precisely when early action matters most. Limited visibility can also result in missed recoveries or overpayments that remain the plan's financial responsibility.

As a result, the effectiveness of a self-funded plan depends heavily on selecting an administrative partner whose capabilities, transparency, and incentives align with the employer's fiduciary responsibilities. **Administrators that provide timely, usable data, support proactive claim management, and enable collaborative decision-making better position employers to monitor trends, pursue recoveries, and manage high-cost claims before severity escalates.**

Administrative alignment matters. Employers that work with administrators offering transparency, data access, and collaborative claim governance are better positioned to identify cost drivers and respond to emerging risk.

Where control and financial risk diverge: key structural considerations when choosing plan administration

Structural consideration	Why it matters to employers
Claims decision authority Claims discretion is delegated to the administrator, while the employer funds the claims.	Because discretion is delegated, the employer's ability to participate in or influence individual claim decisions may be limited.
Financial risk and operational alignment In many administrative models, financial responsibility remains with the employer while claims administration is delegated.	When financial risk and claims discretion reside with different parties, alignment depends on how incentives, reporting and escalation processes are structured.
Claims and cost data ownership Data access can vary widely by administrative model and agreement terms.	Limited data access can restrict transparency, independent analysis, and oversight, which are key components of an employer's fiduciary responsibility.
Recoveries and overpayments Under many administrative arrangements, recovery decisions may reside with the administrator unless otherwise specified.	Employers often assume recoveries are automatic. Unpursued or compromised recoveries remain the plan's financial loss.
Cost containment strategies Administrators typically operate under standardized protocols and internal guidelines.	These protocols can limit flexibility, particularly in high cost or high growth claim areas, where alternative or earlier intervention strategies could have the greatest impact.
Indemnification and accountability Administrative agreements often include broad indemnification provisions, while employers retain exposure related to plan design and claim exceptions.	This allocation of risk can influence accountability and may limit innovation and proactive, assertive cost control approaches.

1. https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2026/
2. https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html
3. https://pubmed.ncbi.nlm.nih.gov/42059345/
4. SIIA Newsletter on PBM proposed legislation
5. SIIA Newsletter on DOL clarification feedback
6. The TPA Transparency Campaign Is Just Beginning | Leader's Edge Magazine

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QBE North America's Accident & Health team delivers innovative, dependable solutions to our customers, including **Medical Stop Loss**, **Captive Medical Stop Loss** and **Organ Transplant** coverage, as well as **Taft-Hartley programs**. With deep expertise, advanced cost containment strategies, and a passion for service, we help our production partners and administrators protect their clients and grow their business. Through tailored offerings designed to safeguard plans and control costs, QBE empowers customers to self-fund their healthcare with confidence.

The QBE Accident & Health team is dedicated to helping employers thrive. If you'd like to review our findings, discuss further industry insights, or explore our range of insurance products and risk management solutions, please connect with us.

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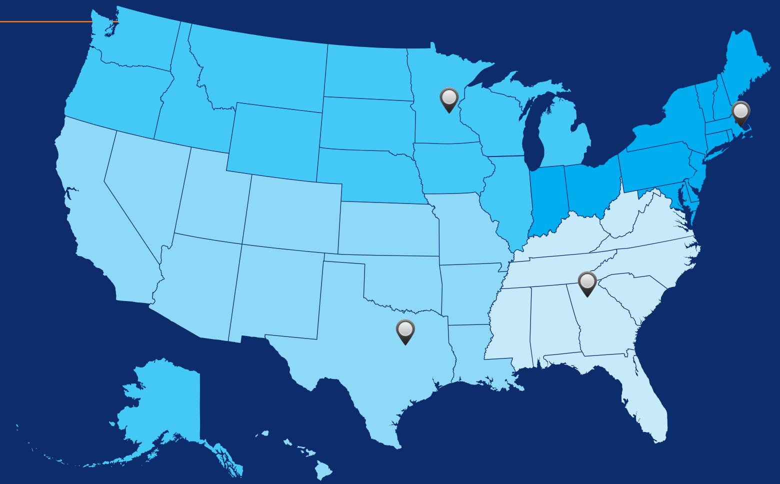

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