Medical Stop Loss – Its Role for Self-Funded Employer Health Plans

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Three Key Takeaways Today
Awareness, Understanding and Actions

Awareness of current and evolving catastrophic claimants

- Greater than $1 million…or more – much more
- Inpatient, newborns, gene therapy. Coziness too?
- They're young

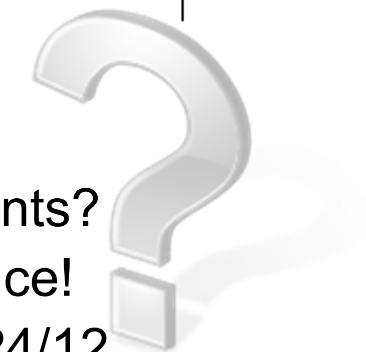
Understanding of stop loss and its key dynamics

- It's a risk – not a benefit
- Policy provisions
- Benchmarking (to the *Aegis Risk Medical Stop Loss Premium Survey*)
- Carve-outs, captives and distribution – what/when?

Actions for your next renewal, review or placement

- Plan mirroring, no-new-laser renewals with caps, dividends
- Sell your risk!
- Beware and manage your disclosure

Stop Loss
Common Questions, Curiosities and Concerns



"The thing I *__never get__* about stop loss is…"

- Why are renewals are so high?
- Why do we pay so much more in premium than reimbursements?
- How can the carrier 'laser' out bad claims? That's not insurance!
- What do all those numbers mean? You know, 12/12, 12/15, 24/12…

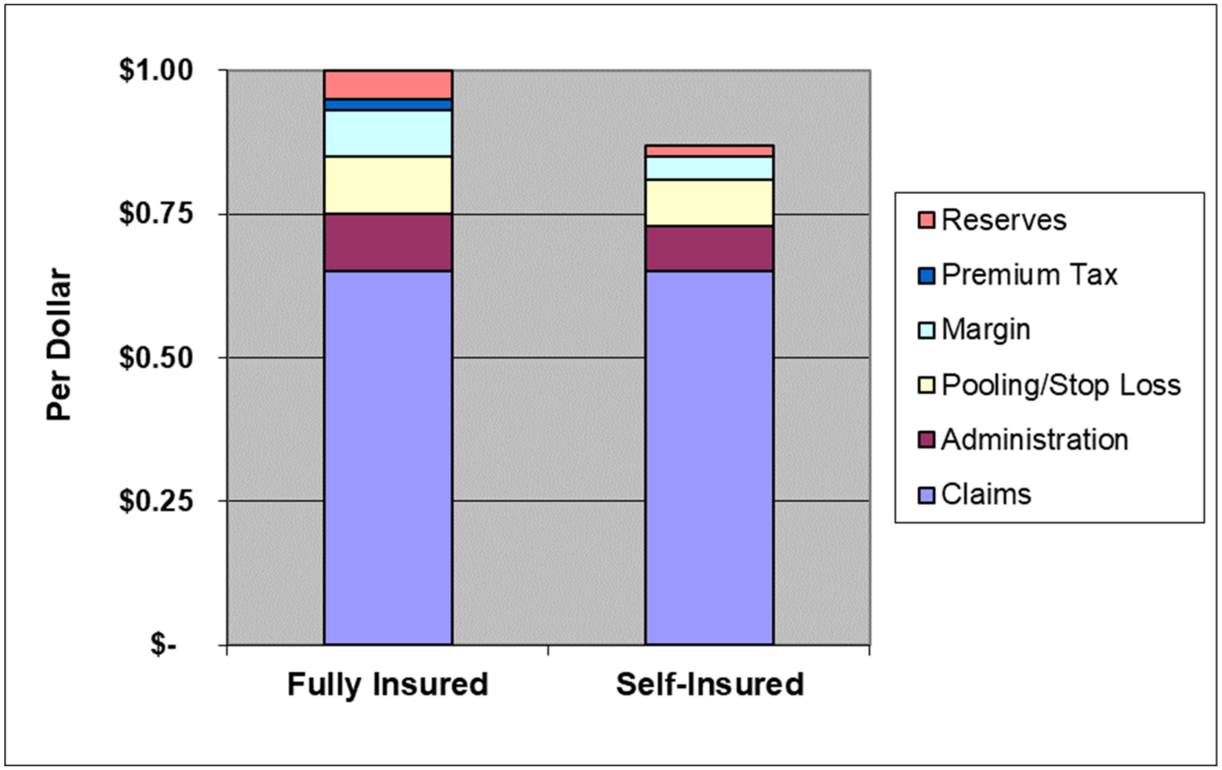
"The thing I *__wonder__* about stop loss is.."

- Am I paying too much in premium?
- Is my deductible too high or too low? Where are other employers my size?
- Is it or is it not covered by health care reform?

"The thing that *__scares__* me about stop loss is…"

- Changing carriers and having a claim fall between the cracks.
- Placing coverage with a carrier other than my plan administrator

Comparison of Funding Methods – Fully Insured vs. Self-Insured/Funded Medical



	Fully-Insured	Self-Insured
Advantages	Predictable, fixed expense.	Enjoy cash flow.
	Full risk transfer.	Plan design flexibility (no SMBs)
	'One-stop' plan management.	Control use of plan reserves.
Disadvantages	Premium tax.	Greater assumption of risk.
	Higher claims margins.	More active plan management.
	Follow state mandated benefits (SMB).	Need to develop rates.

The Role of Medical Stop Loss

A risk management tool for self-funded medical plans

- Allocates the cost of infrequent and sudden catastrophic claimants over each period
- In exchange for fixed monthly stop loss premium, it moderates the fluctuations in expense due to the volatility of claims
- Avoids budget deficits and related ‘catch-ups’
- Provides further protection from health care reform’s removal of individual lifetime maximums on the underlying health plan

…in summary, it’s a budgeting tool which protects self-funded plans from financial calamity – but easier said then done…

A Quick Primer–Two Types of Stop Loss

<u>Specific (or Individual)</u>

- Guards against the *volatility* of individual high-cost claimants
  - The common form of stop loss
  - Reimburses claims beyond a specified deductible – from under $50,000 to as high as $1+ million.
- The contract stipulates covered claims based on dates of incurral and/or payment (e.g. 12/15, paid)
- Reimburses expense for an individual contract year (i.e. it's not ongoing!)
- Premiums vary widely by deductible

<u>Aggregate</u>

- Protects against *over-utilization* of the health plan
  - More common with smaller (<1,000 ees), risk-adverse employers
  - Reimburses if overall plan expense exceeds a threshold (e.g. 125% of expected)
- Per covered claims basis
- Premiums are lower, as claims uncommon
- Typically, it augments specific
  - No double indemnity or high claimant coverage

$1M+ Claimants – Who Are They?

Congenital anomalies, blood disorders and neoplasms are common

- Not highly impacted by lifestyle and wellness initiatives – more random
- Gene therapies are evolving to treat some of these conditions (see further slide)

Other "million dollar" trends (source: Sun Life, *2023 Research Report*)

- They're increasing – up 15% in 2022 and 45% from 2019 through 2022
- From 2018 to 2021, 20% of their policyholders had a $1M+ claimant
- 70% were "first time" and 30% occurring multiple years

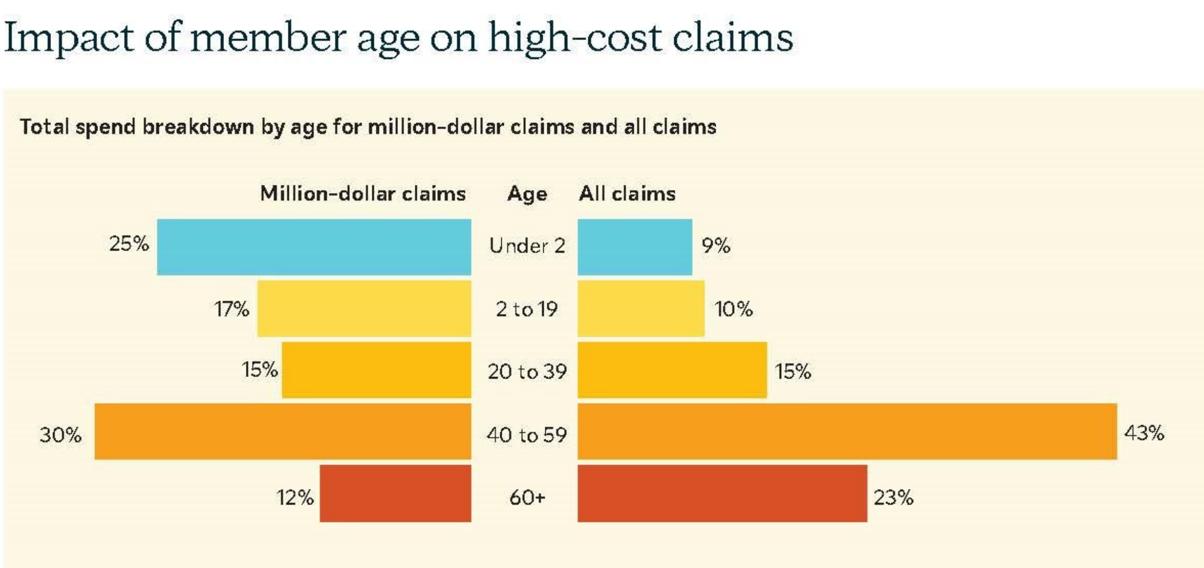
Beware lengthy inpatient stays as well

- Non-profit Children's Hospitals are particularly keen to significant bills
- PPO provider contracts greatly favor the provider over plan sponsor, with prompt payment provisions and non-review of already adjudicated claims.
- A straight 80.00% of billed charges isn't uncommon, being "outlier"
- Amongst some ASOs– a seemingly too cozy relationship between provider & payor

$1M+ Claimants – They're Younger

Driven by newborn and congenital conditions:

- Members under two are 25% of $1M+ claims vs. 9% of all claims
- Comparatively, over age 60 is 12% of $1M+ but 23% of all claims
- Top driver varies by age: neoplasm for 2 to 19; hemophilia for 20 to 39; leukemia for 40-59 and cardiovascular for 60 and over



Sun Life, *2023 Research Report*

It's a Risk – Mind the Coverage and Process

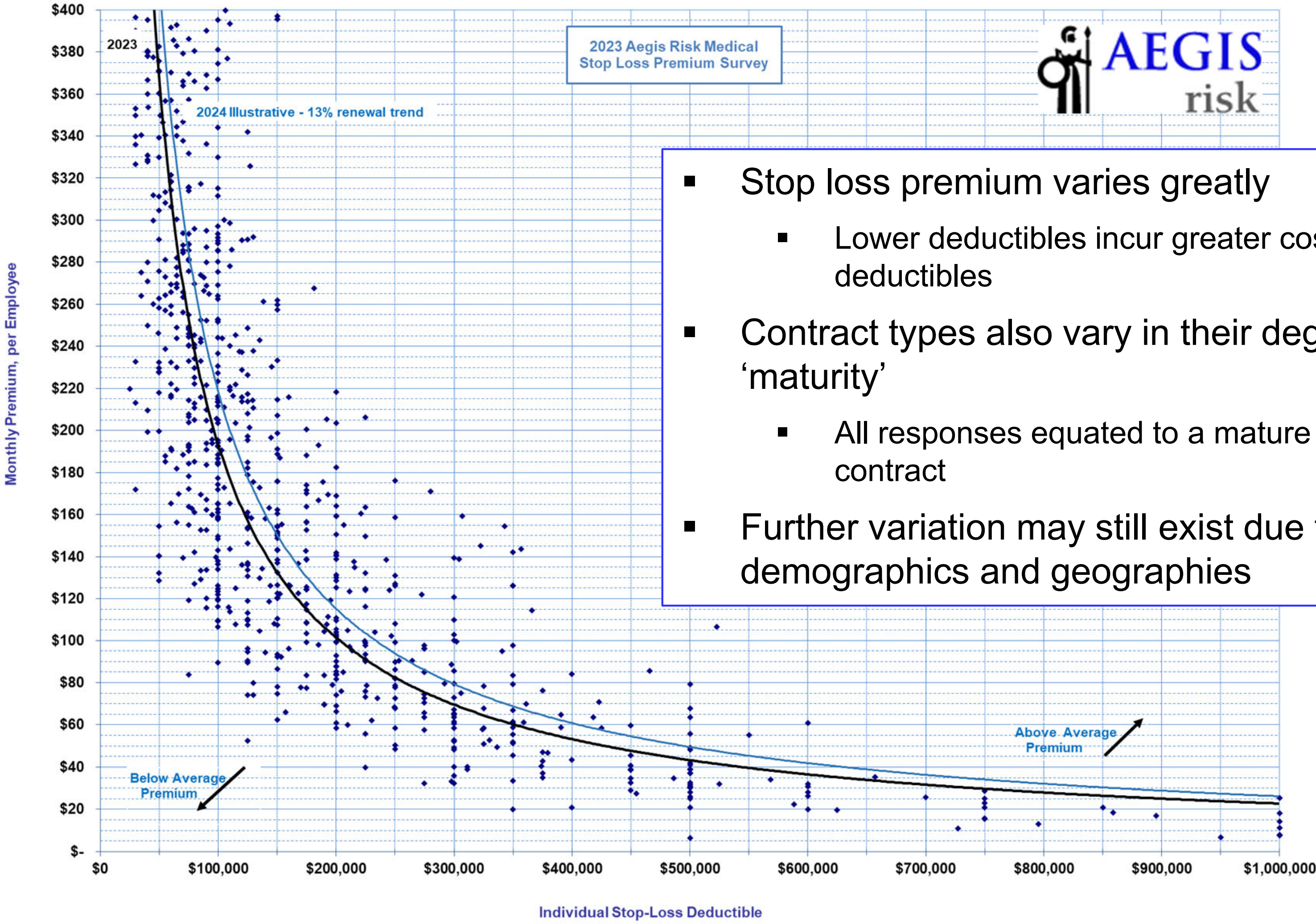
Stop loss is not an <u>employee</u> benefit. It covers the <u>plan sponsor</u>.

- Your plan is self-funded – and therefore the entity at risk
  - (…and your ASO/TPA pays providers per "prompt payment" requirements – and incurs absolutely no risk)
- Plan documents (e.g. SPD) largely define what is covered – as stop loss reinsures against plan authorized expense
- Ideally with <u>no</u> conflict to parallel language within the stop loss policy
  - Such as "usual and customary", "experimental", "covered participants"
  - Plan mirroring can avoid such conflict and coverage disputes

At renewal/placement, disclosure of known claimants is required

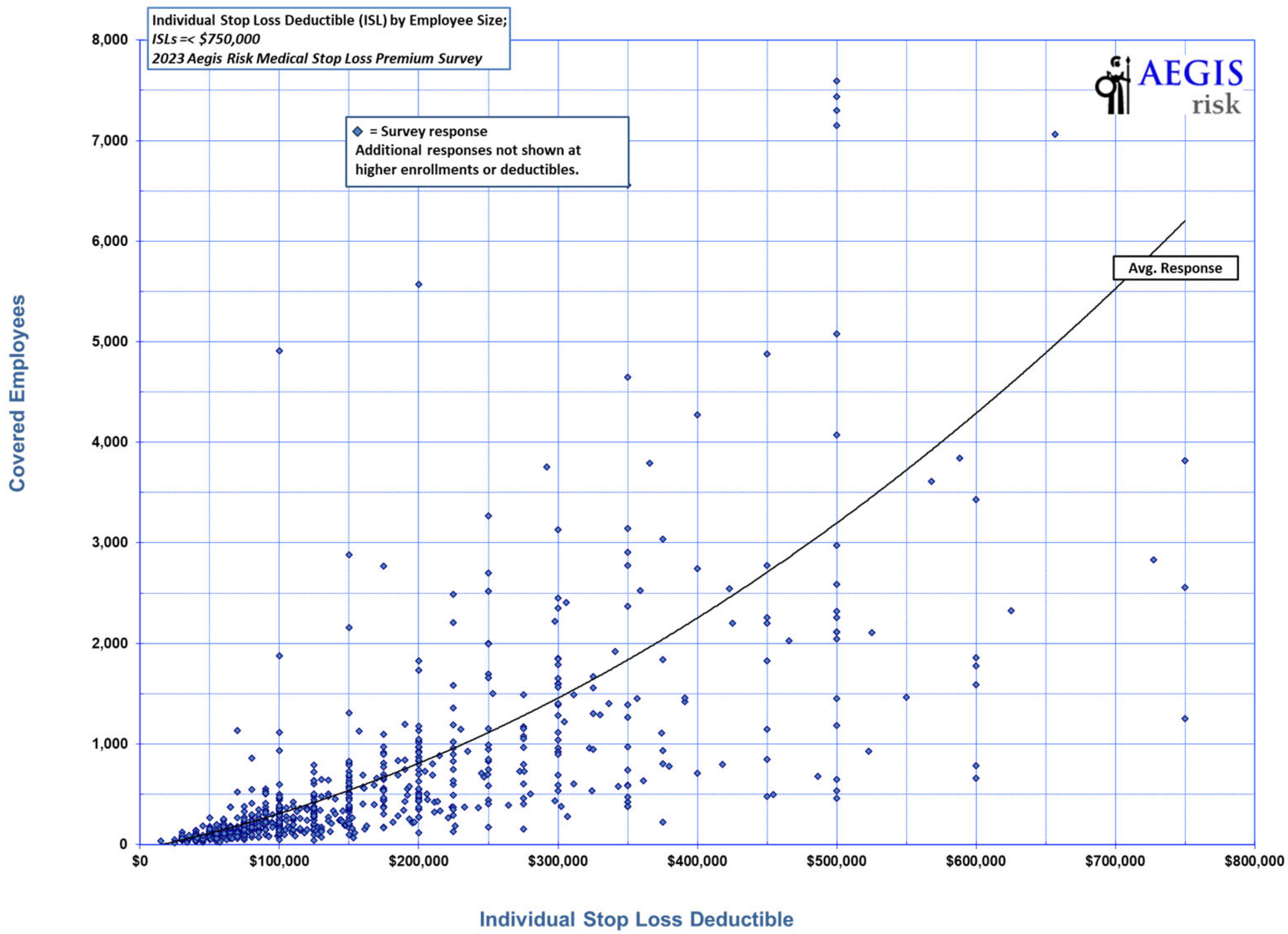
- Current stop loss reports (eg 50%) often accomplishes – with clinical notes
- If not disclosed – and should have, it's subject to exclusion. Blame follows.
- The presence of jumbo claimants ($1M+) and gene therapies further amplifies – as one claimant may be a multiple of annual premium.

2023 Aegis Risk Medical Stop Loss Premium Survey – Avg. Premium, per EE/Month – Specific by Deductible



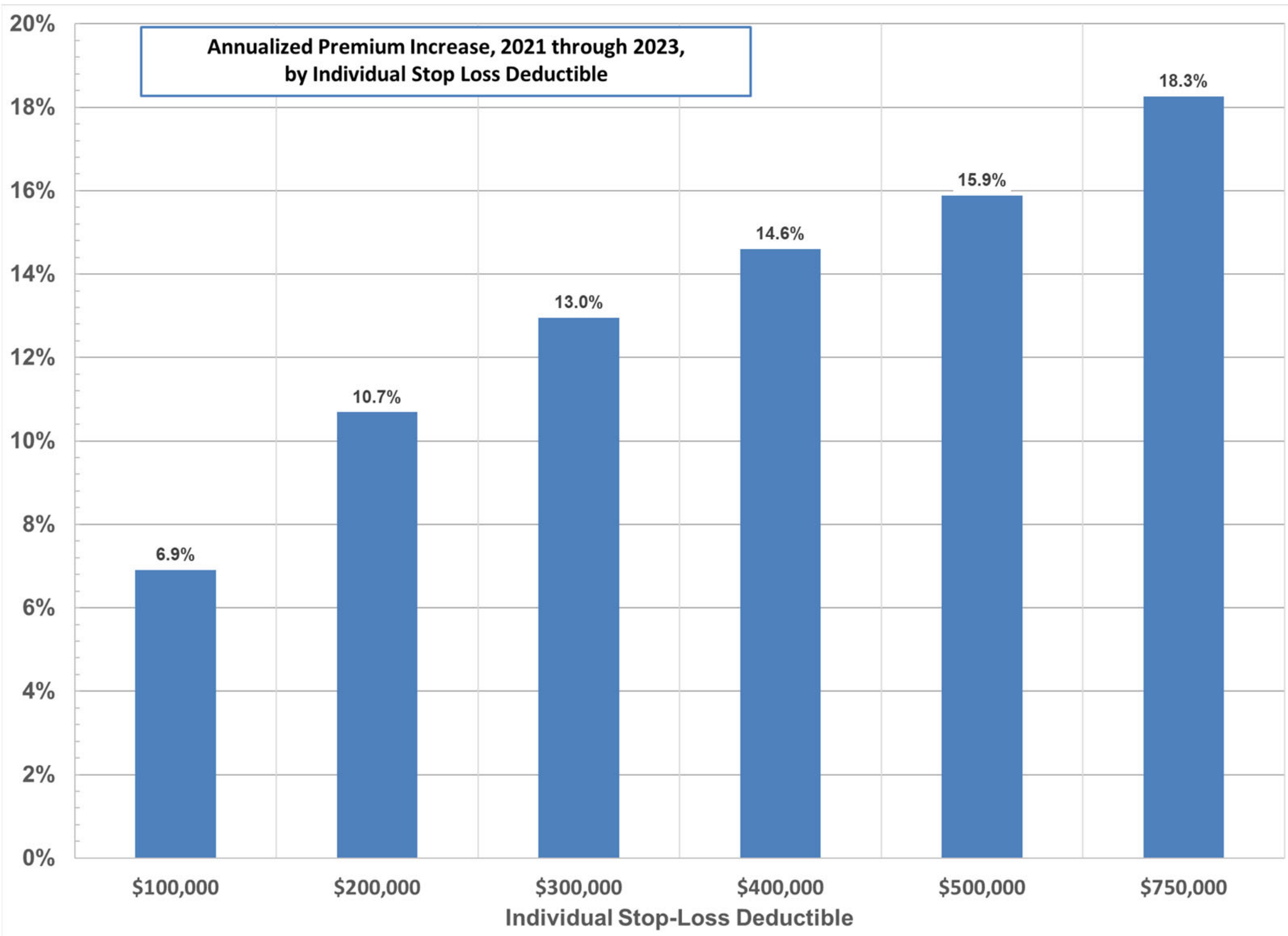
- Stop loss premium varies greatly
  - Lower deductibles incur greater cost than higher deductibles
- Contract types also vary in their degree of ‘maturity’
  - All responses equated to a mature “Paid” contract
- Further variation may still exist due to plan demographics and geographies

2023 Aegis Risk Medical Stop Loss Premium Survey – Specific by Employee Size



Appendix: Leveraged Trend

Tragically, it's real – and gets higher the deductible



<u>Example:</u>

Year one

Claimant:	$400,000
<u>Less:</u>	<u>$300,000 specific</u>
Net reimb.	$100,000

Year two (5% trend)

Claimant:	$420,000
<u>Less:</u>	<u>$300,000 specific</u>
Net reimb.	$120,000

Annual trend: 20%

Lasering – Isn’t This Supposed to Be Insurance?

- Laser: a claimant excluded from stop loss, at placement or renewal
  - Based on premise that insurance covers unknown risk, not that already known
  - Typically via higher deductible, restrictive claims basis or outright exclusion
- Best practice to have a No New Laser (NNL) with Renewal Rate Cap
  - Ensures that evolving claimants remain covered – as “no new” lasers
  - Alongside a renewal rate cap, perhaps 40% to 50% or higher
  - Which can be a very strong deal. Lacking, the renewal could be 100% or worse
- But NNL in perpetuity is becoming more challenging
  - Many writers now limit to a ‘one year forward’ NNL, reserving the right to laser in the subsequent renewal
  - Others still indicate in perpetuity, but closely review the policy for material changes to cancel
- Be ready: taking a laser and self-funding the claimant may be more necessary and cost-effective going forward – “a new fixed cost of the plan”

Gene Therapy – Is Stop Loss Ready to Cover?

One claimant being a multiple of annual policy premium is highly variable, difficult to competitively price, and alters the risk profile

- In response, underwriters are more strictly managing disclosure at placement to avoid walking into a $3M claim (e.g. Roctavian)
  - At the resulting and potential liability of the self-funded policyholder
- Still, stronger underwriters have properly added the impact of these claimants into their book-of-business and forward pricing

As with any stop loss reimbursement, it must be a plan authorized expense – medically necessary, with evidence of a clinical review

- As genetic testing and/or clinical diagnosis required, have that process
- Clarify plan language to address outcome-based payment models
- Ensure PBM and disease/care management vendors have genetic and rare disease capabilities

Carve-Outs, Captives and Distribution – Observations

The procurement of medical stop loss continues to evolve

- Gene therapy stop loss carve-outs offer fixed pricing for specified therapies
  - Initial offerings at a PMPM basis – e.g. $0.99 per member per month
  - Removes the risk from underlying stop loss – but often requires use of the a related PBM (e.g. Optum, CIGNA)
  - Some plan sponsors may not want to tie PBM to such selection
  - Beware required disclosure if gene therapy risk is later put back into stop loss
- Stop loss captive opportunities continue to dazzle potential buyers
  - Sensible for smaller plans to obtain coverage – often in a group collective
  - A trickier solution to traditional stop loss for most other, established groups. Stop loss pricing remains competitive; requires a one year commitment.
- Remember the Sentinel Effect of external stop loss
- Everyone wants in – it's a big ticket item! (but remains tricky to place)
  - Consultant/broker "panels", wholesalers…commission opportunities

Actions for Your Next Stop Loss Renewal or Placement – Policy Provisions

- Seek a No New Laser policy (and underwriter) with a competitive renewal rate cap of no greater than 50%
  - Larger enrollment, higher dollar premium policies can go even lower
- Confirm or pursue “plan mirroring” amendments
  - Ensures consistency between covered, eligible expenses per your health plan documents and your stop loss policy
  - Minimizes, if not erases, conflict by “clamping on” to the health doc
- Investigate a dividend contract
  - An effective way to “claw back” premium when favorable claims
  - May offer as much as 5 to 10% premium refund in favorable years
- Periodically index your ISL deductible to underlying trend at renewal
  - In example, 5% trend on \$300,000 ISL = \$315,000 at next year
  - Unchanged, it incurs greater, leveraged percent of plan costs over time (see exhibit in Appendix)

Actions for Your Next Stop Loss Renewal or Placement – Approach

- Be mindful of the role of Disclosure – all placements have it, even if there's not a signed disclosure agreement
  - It remains a key cause of Errors & Omissions for brokers & consultants
  - But it impacts the covered plan
- Sell your risk! (or ensure your advisor does)
  - If strong claimant history – show it off!
  - If effective purchasing or network discounts – say it! Can lower u/w factors.
- Benchmark to ensure effective coverage and purchasing
- As underlined by all of the above – leverage expertise
  - A competitive marketing isn't as many quotes as possible
  - It's much more a thoughtful, experienced review with underwriters that best match your plan, demographic and network

Three Key Takeaways Today – Revisited

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Awareness of current and evolving catastrophic claimants

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With All That Said…
..your Questions, Confusions and Concerns?

For those that exist – please ask!

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Medical Stop Loss Premium Survey
2023

Pick up a copy – or download below. Leave contact for notification on the 2024 Survey. Opens in June.

All respondents receive an immediate copy upon Survey release. Performed in conjunction with the ISCEBS.

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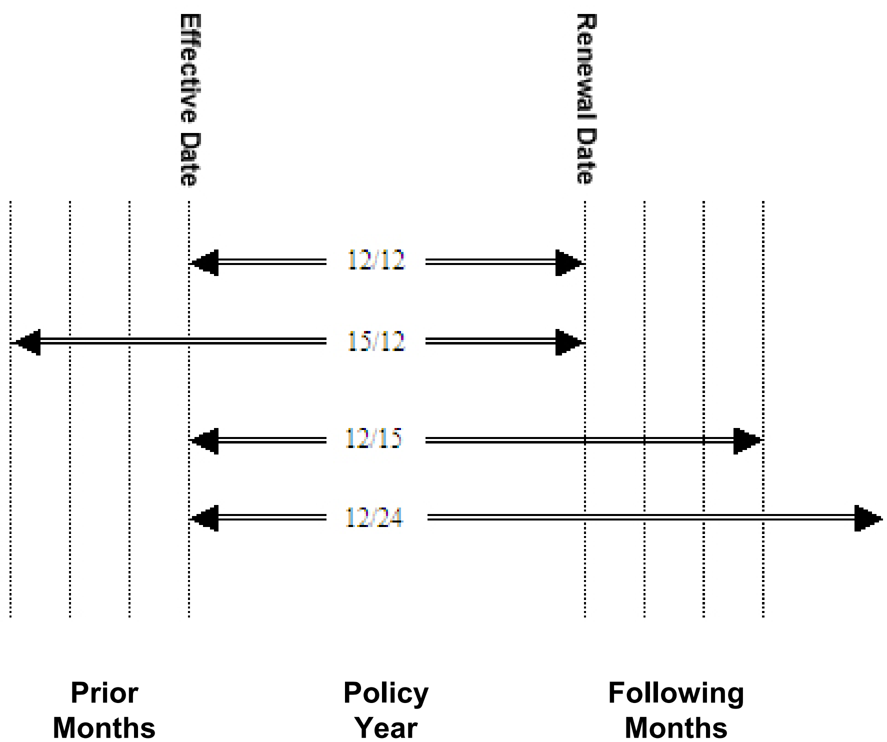
Appendix: Contract Types
What's with all those numbers?



MIND THE GAP

…on renewal!!!

Usually refers to Incurred / Paid months:

- **12/12**: incurred and paid within the 12-month contract period. Good initial coverage. Renew with a paid.
- **15/12**: …covers claims incurred the prior 3 months (i.e. run-in). First year coverage. A longer run-in is advised, such as an 18/12. Renew with paid.
- **12/15**: like a 12/12, but further covers claims paid in the following 3 months (i.e. run-out). Often renews with a 12/15.
- **12/24**: Longer run-out, with payment over 12 months. A 12/18 covers six months.
- **Paid**: Covers claims paid during the policy year, regardless of date incurred. The most comprehensive contract, typically on renewal/ongoing coverage. Not common at initial placement.