PROTECTING YOUR SCHOOL FROM CATASTROPHIC MEDICAL CLAIMS

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TODAY'S PRESENTATION

- Background information
  - What is stop loss insurance?
  - Why purchase stop loss insurance?
  - Who purchases stop loss insurance?
  - Types of stop loss insurance
  - Typical policy features
- Stop loss attachment points
- Prescription drug stop loss
- Changing vendors – pitfalls
- Stop loss examples/stories

BACKGROUND INFORMATION

WHAT IS STOP LOSS INSURANCE?

- Stop loss insurance is an insurance product that protects against catastrophic or unexpected losses in excess of a specified threshold
- Stop loss insurance is NOT medical insurance

WHY PURCHASE STOP LOSS INSURANCE?

- The decision to purchase stop loss insurance (and at what level) is based on an organization's risk tolerance
- Medical and prescription drug claims are volatile – costs can vary substantially from one year to the next
- Changes in medical technology and practice offer life-altering (or saving) improvements – sometimes at staggering cost
- The sponsor of a health plan bears the claim risk – the risk that claims exceed contributions
- Stop loss insurance is intended to provide protection for plan sponsors from events that are catastrophic in nature

WHO PURCHASES STOP LOSS INSURANCE?

- Self-funded plan sponsors (standalone school districts)
- School district health trusts (both pooled-risk and segregated-risk)
- Fully-insured school districts (portion of premium is a "pooling" expense)
- Insurers
- Reinsurers (from a "retrocessionaire")

TYPES OF STOP LOSS INSURANCE

- Specific stop loss
  - Caps losses on a single individual
  - Protects against catastrophic losses on a single individual
- Aggregate reinsurance
  - Caps losses on ALL individuals
  - Protects against catastrophic losses on the entire plan cost
  - Generally must have specific reinsurance to have aggregate reinsurance (aggregate covers losses up to the specific attachment point)

TYPICAL STOP LOSS POLICY FEATURES

- Attachment point
  - The attachment point is the point at which stop loss protection "attaches" – when claims cede to the reinsurer
  - For specific stop loss, this is typically a fixed deductible amount – ex: $300,000
  - For aggregate stop loss, this is less transparent
    - Typically determined as a percentage of expected cost: 115% to 125%, depending on the policy
    - Aggregate coverage would reinsure losses in excess of, for example, 125% of expected costs

TYPICAL STOP LOSS POLICY FEATURES

- Covered Claims Basis (EXTREMELY important)
  - The covered claims basis determines which claims are eligible for stop loss coverage during the contract period
  - Typically expressed as XX/YY, where XX is the months during which the eligible claims must be incurred and YY are the months in which eligible claims must be paid

TYPICAL STOP LOSS POLICY FEATURES

- Covered Claims Basis – Examples (assume the contract year is calendar year 2017)
  - 24/12: Claims incurred in 2016 and 2017, paid during 2017
    - Sometimes referred to as a "paid" policy
  - 12/15: Claims incurred during 2017, paid by 3/31/2018
  - 12/24: Claims incurred during 2017, paid by 12/31/2018
  - 12/12: Claims incurred during 2017, paid during 2017
- Understanding the contract basis is extremely important to avoid having catastrophic claims fall into "gaps" in stop loss coverage

TYPICAL STOP LOSS POLICY FEATURES

- Maximum Benefits
  - Stop loss insurance is not health insurance – not subject to ACA limits
  - Should ensure that policies do not have benefit maximums – especially since health plans are no longer permitted to have annual/lifetime maximums
  - Aggregate reinsurance typically contains a maximum benefit (generally $1M) – this is very important to assessing whether or not aggregate coverage is worth purchasing

TYPICAL STOP LOSS POLICY FEATURES

- Aggregating Specific Deductibles
  - Common feature used to reduce premiums while still having a relatively low attachment point
  - An aggregating specific deductible is like layering a second deductible on top of the attachment point
  - Could be a fixed-dollar amount, or a percentage of premium
  - Often priced very favorably

AGGREGATING SPECIFIC DEDUCTIBLE

$150,000 Attachment Point

No Aggregating Specific Deductible

- 3 Claimants
  - $200,000
  - $250,000
  - $300,000
- Stop loss reimbursement:
  - $50,000+$100,000+$150,000 = $300,000

$150,000 Attachment Point

$100,000 Agg. Specific Deductible

- 3 Claimants
  - $200,000
  - $250,000
  - $300,000
- Stop loss reimbursement:
  - $50,000+$100,000+$150,000 = $300,000
  - $300,000 - $100,000 = $200,000

SELECTING STOP LOSS COVERAGE

SELECTING STOP LOSS COVERAGE

- Choosing an attachment point
- Contract basis
- Evaluating aggregating specific deductibles
- Prescription drug coverage
- Aggregate coverage

CHOOSING AN ATTACHMENT POINT

- There is no "right" attachment point – this is a question of risk tolerance (and ability to absorb catastrophic losses)
- The higher the attachment point, the lower the premium (and the greater the risk to the plan sponsor)
- Typically, a "small" group will choose a low attachment point and a larger group will choose a higher attachment point
- Should look at multiple attachment point options and assess the premium savings relative to the risk
  - Example: what if moving from a $150,000 attachment point to $200,000 saves $300,000 in premium? Is this a "good" value?
    - What is the likelihood of claims between $150,000 and $200,000 being greater than $300,000?
    - Historical "look-back" analysis
    - Actuarial factors

CHOOSING AN ATTACHMENT POINT

- Over time, plan sponsors should anticipate increasing the attachment point or facing substantial increases in stop loss premiums
- Why: stop loss claims (and as a result, premiums) are subject to "trend leveraging"
- Example: A $300,000 attachment point and a $500,000 claim in 2016
  - Assume 10% medical trend – the claim (or similar claim) is expected to cost $550,000 in 2017.
  - Stop loss premium would increase by much more than trend
  - For the reinsurer
    - 2016 loss = $500,000 - $300,000 = $200,000
    - 2017 loss = $550,000 - $300,000 = $250,000
    - Increase: $250k/$200k -1 = 25% - much greater than 10% trend

CHOOSING AN ATTACHMENT POINT

- What if the deductible had increased with trend?
- Example: A $300,000 attachment point and a $500,000 claim in 2016
  - Assume 10% medical trend – the claim (or similar claim) is expected to cost $550,000 in 2017.
  - Assume attachment point increases 10% - $330,000
  - For the reinsurer
    - 2016 loss = $500,000 - $300,000 = $200,000
    - 2017 loss = $550,000 - $330,000 = $220,000
    - Increase: $220k/$200k -1 = 10%

CHOOSING A CONTRACT BASIS

- Again, there is no "right" contract basis – important to understand the risks of each type
- "Paid" basis (24/12): risk is that claims paid during 2 contract years will be subject to 2 attachment points
  - Example: The plan has a $200,000 specific attachment point. Joe has $300,000 paid in 2016 and $200,000 paid in 2017 for a surgery that occurred in December 2016. While the plan paid $500,000 for Joe, the plan would only receive $100,000 in reimbursement.

CHOOSING A CONTRACT BASIS

- "Incurred" basis (12/15 or 12/24): risk is that claims incurred near the end of a contract period may be paid when they are no longer eligible for reinsurance
  - Example: The plan has a $200,000 specific attachment point and a 12/15 contract basis. Premature triplets are born on Thanksgiving, and spend several months in the NICU. They are discharged from the NICU in April, and upon discharge an invoice is issued for $1M. This claim is not eligible for stop loss protection.
- "Incurred and paid" basis (12/12): typically only used in the first-year of self-funded program. In the subsequent year a 24/12 policy would be put in place.

CHOOSING A CONTRACT BASIS

- When changing vendors or coverage arrangements, it is essential to understand both contract bases
- Example: the 2016 policy is a 24/12 (paid) policy, and the district moves to a policy that is a 12/24 (incurred) policy with another vendor
  - There is a gap in coverage – claims incurred in 2016, paid in 2017 will not be covered by either policy
  - District would need to purchase "gap" coverage from a reinsurer, or run the risk of uncovered losses

EVALUATING AGGREGATING SPECIFIC DEDUCTIBLES

- An aggregating specific deductible reduces the premium in exchange for the plan sponsor having to pay a deductible before receiving reimbursement (see prior example)
- In theory, if the aggregating specific deductible reduced the premium on a dollar-for-dollar basis, it should always be elected
  - Example: $1.2M in premium, $200,000 aggregating specific reduces premium to $1M
    - If no losses occur, district would pay $1M in premium vs $1.2M – district gain
    - Worst case scenario – district receives stop loss reimbursements, less $200k – effectively pays $1.2M. The worst case is cost-neutral

EVALUATING AGGREGATING SPECIFIC DEDUCTIBLES

- Again in theory, an arrangement should never be so one-sided (but pricing errors do occur and may benefit the consumer)
- Typically an aggregating specific deductible will not create a dollar-for-dollar reduction. However, the district should assess the positive versus negative risk:
  - Example: if a $100,000 aggregating specific reduces premiums $80,000, the district stands to gain $80,000 at the risk of losing $20,000

SHOULD STOP LOSS COVER PRESCRIPTION DRUG?

- Ultimately a cost-benefit decision
- Historically, prescription drug expenses were rarely catastrophic on their own – typically medical expenses had to be included to reach the attachment point
- Modern drugs have proven very expensive, but on their own nearly all treatments would fall below most attachment points
- However, some rare courses of drug therapy are extraordinarily expensive – sometimes in excess of $100,000/month – **and ongoing in nature** (i.e. not short-term but maintenance)

SHOULD STOP LOSS COVER PRESCRIPTION DRUG?

- The problem with catastrophic ongoing costs – the reinsurer will factor these in at renewal
- In the initial year of therapy, the plan is likely to benefit from reinsurance protection
- However, at renewal, the reinsurer is very likely to exclude the individual from coverage or substantially increase the premium to cover the known expense of the high-cost drug
- This is an extremely difficult – and risky – proposition of self-funding created by the expense of some modern drug therapy treatments. Ongoing, known expenses will not be willingly absorbed by a reinsurer, and could devastate a district's finances.

SHOULD MY PLAN HAVE AGGREGATE COVERAGE?

- Aggregate coverage – a.k.a. "sleep insurance" – gives plan sponsors comfort that their total costs will not exceed a predetermined level (ex: 125% of expected)
- Important to consider the maximum payout – if the aggregate coverage has a $1M limit, it is not providing a true cap on costs
- Aggregate coverage is less valuable the larger a group becomes
  - The likelihood of claims exceeding the aggregate attachment point is lower, since a large group experiences less variance in claims than a smaller group
  - The $1M benefit limit is less significant to a large group as well in terms of overall protection

SHOULD MY PLAN HAVE AGGREGATE COVERAGE?

- Aggregate coverage should be carefully evaluated as to whether or not it truly provides value to the plan sponsor
- Many aggregate polices are poorly priced, preying on a sponsor's risk aversion and costing far more in premium than is delivered in value

CHANGING VENDORS - PITFALLS

THE RFP/RENEWAL PROCESS

- Typically illustrative stop loss rates are available 90-120 days prior to renewal
- However, FINAL rates often are not presented until 45 days prior to renewal (or are conservative if presented earlier)
- Because reinsurance can change quickly – the birth of premature children, patients becoming approved for transplant, etc. – reinsurers want to reserve as much time as possible to adjust their proposals for emerging costs
- Important to begin the bid process early – may not be able to wait on a renewal to begin shopping for quotes

THE PROBLEM OF KNOWN HIGH COSTS

- As discussed earlier, it is highly unlikely that any reinsurer is going to ignore or accept known/expected high costs without making adjustment
- One option is to pay a higher premium that "bakes-in" the cost of paying these claims
- Another option, often perceived negatively, is "lasering" – excluding individuals from coverage or giving these individuals higher attachment points
- "Lasering" is not inherently bad – if the claims are included in the premium, the reinsurer is likely to add margin (profit, retention) to those costs. If lasered, the sponsor may only have to pay the claims – which may be a lower cost than including the costs in the premiums
- This highlights the value of having rate caps on renewal increases

THE IMPORTANCE OF DISCLOSURE

- When changing vendors (or upon renewal), the stop loss carrier often requires employers to disclose any known emerging claim events
- This paperwork may be complex, and require assistance from an advisor or insurer to complete
- The paperwork is important, as a failure to disclose a known risk may result in the plan having no coverage and unreimbursed catastrophic expenses

AVOID (OR UNDERSTAND AND ACCEPT) GAPS IN COVERAGE

- As previously covered, gaps in coverage can occur when changing contract bases
- Employers should ensure continuity of coverage through the purchase of gap coverage, or at a minimum understand and retain the risk of uninsured losses

STOP LOSS EXAMPLES AND STORIES

THANK YOU FOR YOUR TIME AND ATTENTION

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