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Stop-loss symposium

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What's going on in the stop-loss insurance market?

Well, for starters, there's an increase in inquiries pertaining to aggregating specific deductibles. With ASD, there are two layers of deductible.

In exchange for the policyholder assuming an additional layer of claims, the stop-loss insurance premium is reduced. Stop-loss underwriters are using this provision to assist in mitigating premium rate increases. This provision also might be appropriate for employer groups that financially can afford to retain additional risk.

The first level, the individual deductible, acts in a similar manner as a standard individual stop-loss deductible, whereby individual claimants incur covered expenses which are applied to the individual deductible. However, instead of receiving reimbursement for claims in excess of the individual deductible, these covered expenses are applied toward the second level, the ASD. This second level of risk is the amount over and above the individual deductible that the policyholder, in this case the self-funded employer group, agrees to assume.

The policy provision provides an additional deductible to the purchasing employer group, since in addition to meeting an individual deductible (e.g., $100,000 per person), there will be an ASD amount that the employer might need to reach in order to obtain reimbursement from the stop-loss insurance policy. For example, an ASD might be $75,000, so before the stop-loss underwriter pays a claim above the $100,000 individual deductible, the employer will retain risk for a total of $75,000 above the deductible as an additional deductible before claims are reimbursable.

It should be noted that this provision is not new, but its frequency of use is much greater. In the late 1990s and early 2000s, reinsurers and stop-loss carriers might require their underwriting organizations, if using an outside entity such as a managing general underwriter, to send in cases with ASD for facultative review.

In today's stop-loss market, ASD options are more popular and part of the regular underwriting process. ASD options not only are offered in the self-funded employer stop-loss market, but also available in the HMO reinsurance, insurance company portfolio excess and the provider excess reinsurance market.

From a pricing perspective, it should be noted that the marketplace is giving full credit for the ASD to the premium as long as the relationship of the ASD to the premium is reasonable.

Trends

What other trends are in the market? Well, the industry is recognizing the need and implementing more standardization of disclosure forms, for one.

Disclosure forms are used by stop-loss underwriters to assess potential large claimants for the purposes of risk assessment, which might result in adjustments in premium rates or may be used for other underwriting purposes (e.g., lasering).

What is lasering? For the new business or renewal specific stop-loss quote, a stop-loss carrier might place a higher deductible on certain individuals or even exclude them from coverage. As an example, an anticipated claim such as a transplant might be excluded or have a higher deductible.

The market in general will consider lasering individuals when underwriting new business. However, upon renewal, insurance companies will not typically laser high-risk claimants unless coverage initially was sold on that basis and the need for the laser continues. There is a trend to look at lasering as an option for renewals by stop-loss carriers so that their rate quotes will be more competitive on a renewal (remember, a new company submitting a bid that is not the incumbent might use a laser to lower rates).

Disclosure

So just what are disclosure statements used for? In general, the documents are intended to help facilitate the sharing of health data information between self-insured entities/TPAs and stop-loss insurers/MGUs for the purpose of medical stop-loss underwriting. The underwriter obtains detailed information on known claimants so that they can make underwriting decisions for pricing (e.g., use of discretionary discounts, lasering of deductibles, etc.).

Some of the adverse results of disclosure statements are that they create additional opportunities to deny claims (e.g., the individual was not on the disclosure statement) and have resulted in litigious issues beyond just the denial of the claim (e.g., professional liability claims to the TPA, etc.).

Why have disclosure forms become more important in underwriting? With the continual pressure in the industry to have market level pricing, underwriters are using disclosure statements as a critical rating factor to identify an employer group's unique claims experience in addition to the review of demographics (e.g., age, sex, industry, etc.) that are part of the manual rating process.

The information on disclosure forms will assist an underwriter in identifying premium rating adjustments and/or identifying individuals within a group that might be adjusted for lasering, i.e., a different deductible or exclusion for a specific individual due to a catastrophic medical condition (e.g., transplant, cancer, etc.).

One unique item to the disclosure forms is the request for ICD-9 codes. Naturally, the ICD-9 codes may vary, so a wide range of codes may result in inclusion of more individuals on the list. Historically, ICD-9 codes were not consistently requested and this is an important focal point on the new forms.

The challenge with disclosure forms is that some third party administrators might not comply with the form. The reasons vary and may include a combination of items:

- The TPA does not want to create the extra reporting to accommodate this, beyond just providing 50 percent notifications, i.e., claims that reach 50 percent of the deductible. Many TPAs do not provide reporting for ICD-9 codes.
- The TPA may not be contractually required by employer groups in the TPA agreement, which typically gets negotiated prior to the selection of stop loss.
- Stop-loss carriers do not consistently enforce the provisions in this statement, so this becomes a balancing of whether missing information is critical as compared to "nice to have." All readers might agree that information is important to have, but there are differences in opinions on whether certain items are a "deal breaker."

The last point is important since stop-loss writers with an existing relationship with a TPA will over time develop a process of what they deem to be acceptable, resulting in a "preferred" TPA status from reporting purposes. The standard form helps develop a benchmark for reporting. However, consistent compliance by TPAs and enforcement of the form by underwriters may be challenging.

Are there any other noteworthy items on the disclosure form? The new forms do not request prognosis. The older industry forms included prognosis, but the reality is that most third party administrators will not give much detail on prognosis.

In addition, the standard form has three signature lines on the form: plan sponsor, claims administrator and agent/broker. The goal is to have all accountable or perceived accountable participants to take ownership in completing the form so that any pertinent information such as "known claimants;" be identified and disclosed to the stop-loss underwriter. A challenge is when a claimant becomes a "known claimant" and this is an evolving process and we will attempt to address it in future newsletters.

Sign-off

The three-signature process is not bulletproof since individual large claimants could still potentially slip through the cracks and not be included on a disclosure form. As an example, a TPA might not know of a large claimant until they are notified as such via claims submission or large case management. There also might be an inherent lag in reporting, since TPAs report off of their data warehouses, and there might be a lag from the time that reporting is available (e.g., 30-day lag), plus the lag as a result of the delay from the time the claim is received in the mailroom until the adjudication of the claim.

Similarly, an employer group and its agent/broker may be unaware of claimants, especially claimants that are covered dependents of employees, if the employee has not lost significant work time.

Other factors might be due to the size of the organization (employer group) with many locations so timing of information exchange within the organization may be delayed.

Stop-loss insurance underwriters try to mitigate this through more current disclosure statements, i.e., obtaining sign-off from the employer group and its vendor partners (TPA and broker) as close to the renewal effective date as possible. For example, if a group has a Jan. 1, effective date, then underwriters are targeting disclosure dates for after Nov. 15 or Dec. 1, which would be 30-45 days prior to the case effective date. Thirty to 45 days is a benchmark in the industry, but it is not necessarily applied consistently among all the stop-loss insurance underwriters.

What organizations have adopted the form? Over the past few years, the industry has moved toward a more standardized disclosure form. According to www.MyHealthGuide.com, roughly 20 companies, representing about 75 percent of the stop-loss market (assuming a self-funded market of $4 billion in premium), have adopted this form.

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