



Chairperson's Corner

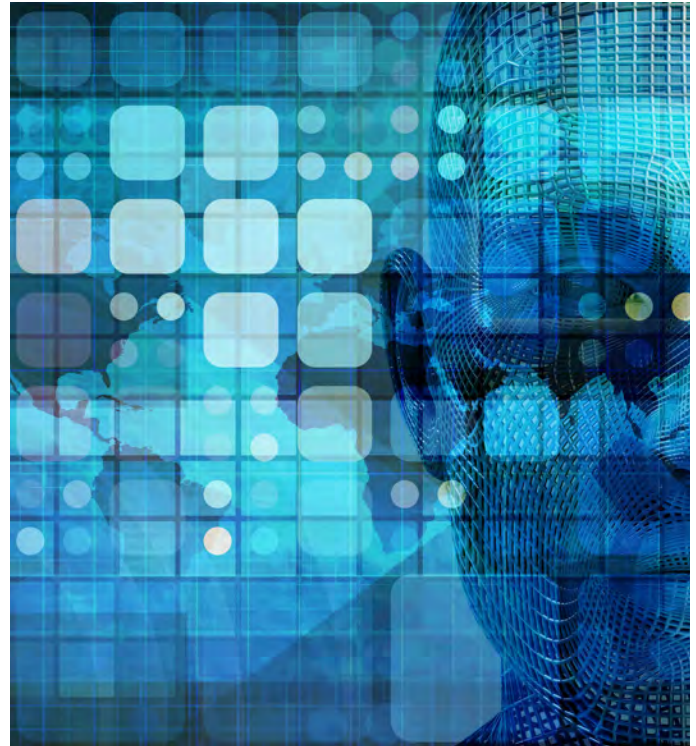
By Joan Barrett

Life is what happens to you while you're busy making other plans.
—John Lennon

I have used this quote from John Lennon frequently, but never as frequently as in 2020. I remember New Year's Eve, waiting for the ball to drop and planning so many fun family trips and celebrations. Then came COVID-19. Suddenly, trips were canceled and celebrations became more subdued. I cannot complain, however. My family and I are safe, happy and closer than ever. We were very lucky. Many of my friends have lost loved ones. My heart goes out to each and every one.

In January, the future also looked bright for the Health Section Council. We had quite the agenda planned for 2020, including the release of several strategic initiatives, podcasts, webinars, several issues of *Health Watch* and, of course, our signature event, the Health Meeting. Then came COVID. Thanks to the leadership of our chair, Jackie Lee, and with the support of our staff partner, Joe Wurzburger, and the section specialist, Dee Berger, the Health Section Council was able to meet the challenge of educating our members on the latest COVID information and the impact to our daily work quickly and effectively. In just a couple of weeks following the shutdown, we were able to provide two free webinars and three podcasts on COVID to our members. Since the initial rush following the shutdown, we have been able to produce two additional COVID podcasts and the health track for the SOA Virtual COVID Symposium. Of course, no discussion of our COVID efforts would be complete without a hat tip to the Society of Actuaries' health research actuary, Achilles Natsis, whose COVID updates and COVID model have been so valuable to all of us.

Needless to say, we did have to change our plans. I was very disappointed that we could not hold the Health Meeting in person. I always enjoy the Health Meeting. It gives me a chance to see old friends and to meet new ones. This year was especially hard because I really enjoy downtown Chicago. On the positive



side, more people than usual were able to attend the virtual sessions, and we received very positive feedback on the format and sessions. With this feedback in mind, we are looking into hybrid alternatives for next year.

Our remaining plans were delayed but not canceled. Some of the 2020 highlights so far:

- On March 23, 2020, the 10th anniversary of the Affordable Care Act (ACA), the Health Section Council released our strategic initiative, [The ACA@10](#). This initiative featured a data-driven research project, "50 States, 50 Stories," by Hans Leida, Lindsey Kotecki and Paul Houchens of Milliman. As the name implies, the report demonstrated that the success of the ACA varied by state. Other key features of the ACA were discussed in articles by Kurt Wrobel, Greg Fann, Dave Dillon, Ryan Mueller and others.
- In April, we released our [Value-Based Care](#) strategic initiative. More and more we are seeing reimbursement methodologies rewarding providers who provide value-based care. This initiative provides a framework for actuaries as they incorporate this important concept into

their day-to-day work. This effort was led by Jay Hazelrigs and Kelsey Stevens.

- The third strategic initiative released this year was the [Actuarial Perspectives on Prescription Drug Financing](#) led by Greg Warren. One of the few things Democrats, Republicans and independents all agree on these days is that the cost of prescription drugs is way too high. This strategic initiative provides some much-needed transparency into prescription drug financing. Greg and his team are currently developing a second round of articles.
- We have published five issues of *Health Watch*, thanks to our editors, Rick Pawelski and Casey Hammer, and to Julia Anderson Bauer, the former publications manager at SOA. These issues have covered a wide range of topics, including rural health care, quantile regression, vendor measurement and risk adjustment.
- We have provided over 50 webinars and virtual meeting sessions this year on topics ranging from machine learning to best practices for rate filings. This would not have been possible without the leadership of Kelsey Stevens and Deana Bell.
- Dave Dillon and Jackie Lee have done over 25 [podcasts](#) with topics ranging from gene therapy to interviews with industry leaders like Katie Keith, Dave Cutler and Larry Levitt.

We did delay release of the Managed Care 3.0 (MC3) strategic initiative. The term “Managed Care 3.0” refers to the fact that the first attempt to control health care costs, Managed Care 1.0, was very punitive in nature—restrictive language, limited benefits and so on. The second attempt, Managed Care 2.0, included more consumer-friendly features like disease management programs. Managed Care 3.0 is consumer-centric and focuses on the overall health of the consumer and the consumer experience. This strategic initiative, led by Sarah Osborne, will highlight innovations in the U.S. health care system that drive quality and efficiency so that other organizations can learn from them. There are two workstreams associated with MC3. The Technology workstream, led by Sudha Shenoy, will focus on how technology may promote efficiency in the health care system and how it may empower the consumer. The Case Studies workstream, led by Karen Shelton, will take an in-depth look at specific innovations.

We are just now launching two new, exciting strategic initiatives. The first will focus on social determinants of health (SDoH). There is increasing evidence that SDoH such as education, job status and income have a significant impact on modifiable health outcomes. The starting point for this effort will be the upcoming release of a research report on comparing measures of SDoH to assess the population risk. The authors of this report include Rachel Everhart of Milliman and Ashlee Cerda of Colorado



Managed Care Network. From there, we will be developing a framework for further analysis. This effort will be led by Jim Mange.

The second strategic initiative, Classroom for Actuarial Methods (CRAM), is being led by Geof Hileman. The goal will be to develop new ways to deliver content in a bite-size format, such as short videos or infographics. The initial focus will be on complex, technical topics like predictive analytics. Once the process is developed, however, other content may be delivered in these formats.

There is certainly a lot going on. So, how do you keep up? One place to start is the [Health Section](#) webpage. The landing page includes notices of upcoming webinars and recently released podcasts, research reports and strategic initiatives. The [Resources](#) page includes links to completed strategic initiatives, podcasts and research projects. Also, as the name implies, the newsletter tab will bring you to past and present issues of *Health Watch*. You may also want to refer to the [SOA Calendar](#) and the [Health Research](#) pages.

If you are looking for a community with similar interests as you, you may want to join a subgroup. We have several active subgroups, such as Medicaid and Public Health, that hold regular meetings with presentations and active discussions. To join a subgroup you just have to sign up for a [listserv](#). Another resource, [SOA Engage](#), provides a forum for exchanging ideas on a specific topic. In recent months, many members have been using this platform to exchange ideas on COVID.

I have to admit that the first thing I do every morning is to check Twitter and LinkedIn to see what is happening in the world. On Twitter you will want to follow specific people or organizations. Many of the people mentioned in this article are active on Twitter. I am [@JoanBarrettFSA](#). Please follow me and I will follow you back. On LinkedIn you can not only connect with an individual, but you can also join the [SOA Health Section subgroup](#). I really like the subgroup because many of the articles are from folks I am not currently connected with. We use the hashtag #soahealth for our tweets and posts.

Needless to say, everything we do is dependent on volunteers. I am a longtime volunteer and, I have to say, I have gotten much more out of volunteering than I have put in. Not only have I made many lifelong friends, but it has also made me a better actuary. If you are interested in volunteering, you can sign up using the SOA Volunteer Database. The database contains current positions we need to fill.

Speaking of volunteers, it is time to say good-bye and thank you to Jackie Lee, Rick Pawelski, Marilyn McGaffin and Geof Hileman as they roll off the council. I will miss your thoughtful comments, your tireless efforts, your smiles and, most of all, your sense of humor. You have done so much for the Health Section Council and the profession in the past few years. I am looking forward to seeing what is in store for you going forward.

I would also like to welcome our new members, Shereen Sayre, Kevin Francis, Shuaiqing Liu and Matt Kramer. I am really

looking forward to working with you. We have lots of plans for the next year. ■

If you are looking for a community with similar interests as you, you may want to join a subgroup.



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The ACA Underwriting Cycle

By Greg Fann

Earlier this year, I heard about a song collaboration between Ozzy Osbourne and Post Malone. I remember this only because I also heard a random but insightful observation regarding the collaboration. Everyone over 30 was asking, “Who is Post Malone?” Everyone under 30 was asking, “Who is Ozzy Osbourne?” That struck me as accurate, perhaps because it was personally, anecdotally true.

If there is a generational actuarial parallel, I suppose it’s—give me a minute, I’m literally making this up as I write—it’s about the research paper “The Decision Science Impact on the Underwriting Cycle,” with actuaries over 30 asking, “What is decision science?” and actuaries under 30 asking—you guessed it—“What is an underwriting cycle?”

The once pseudo-sacred underwriting cycle has fallen out of the common nomenclature at industry conferences and inside the walls of health insurance company buildings. But if you ask some of your seasoned associates about it, they will have some stories to share.

THE HEALTH INSURANCE UNDERWRITING CYCLE

Historically, health insurers were generally subject to an underwriting cycle of roughly six years. From the late 1960s to the early 1990s, market-level financial results in the insurance industry demonstrated a regular pattern of alternating periods of underwriting gains and losses. A repeating pattern of six-year cycles with three years of gains followed by three years of losses emerged. The basic theory of the underwriting cycle is that insurers cyclically adjust price levels in recognition of competing goals of growth and profitability. The common explanation is that as market profitability rises, insurers begin pricing more aggressively to gain market share, and competitors follow suit to protect their own market share. Lower prices ultimately lead to losses, prompting insurers to raise prices again to profitable levels. The entire cycle process lasts about six years, and then the cycle repeats itself.

I recall 1990s-era discussions with leading salespeople quizzing me about “where we were on the cycle” as they tried to understand and project the short-term competitive environment.



As insurers exit markets and fewer silver plans remain, premium subsidies increase and markets are more favorable to consumers.

As the cycle was never exactly six years, insurers' assessment of current conditions shaped aggressiveness of pricing decisions and other strategic deliberations. When discussed today, multiyear cyclical patterns are usually more related to broader financial management considerations, including surplus level optimization and regulatory risk-based capital concerns.

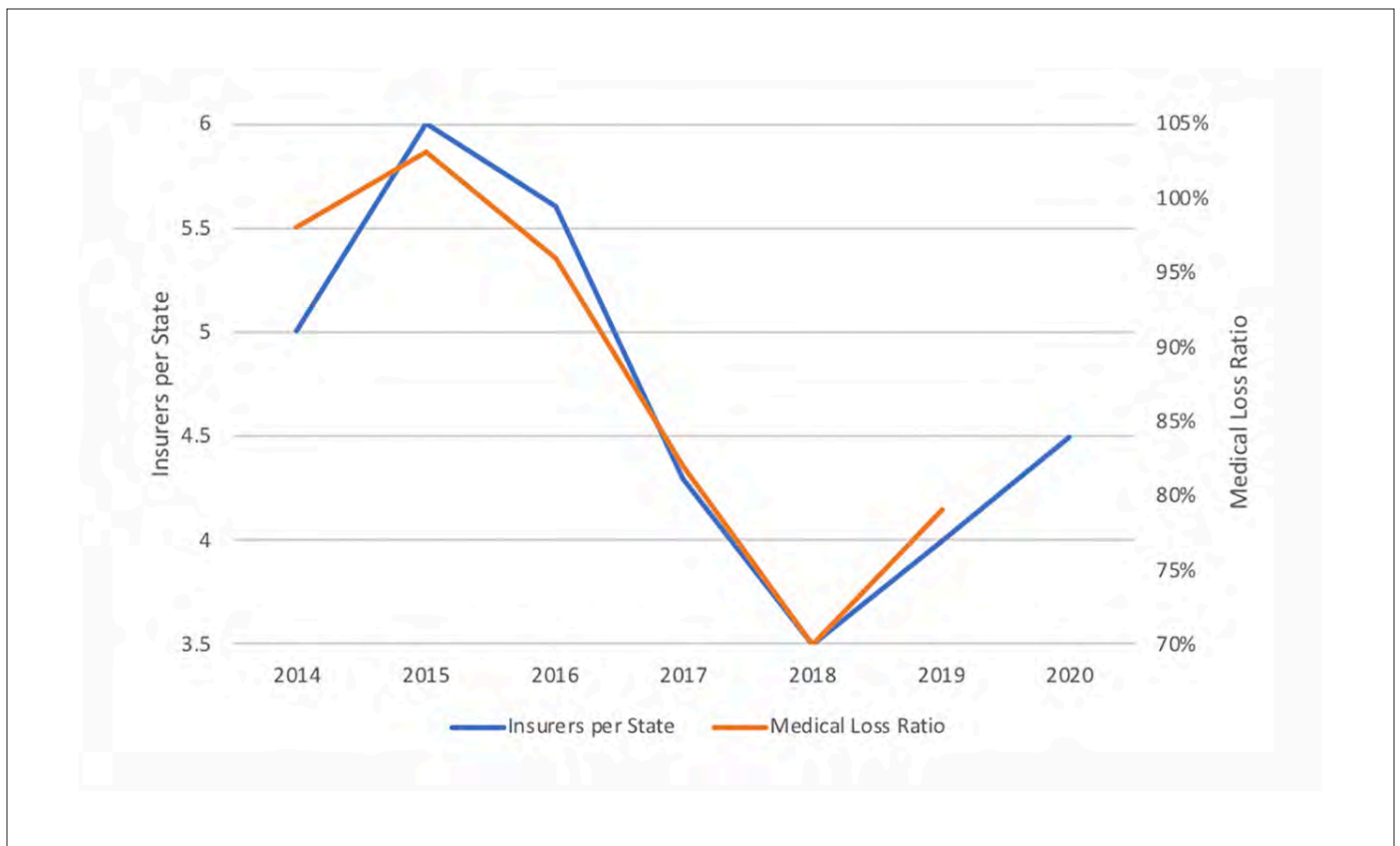
Although there is less evidence of recent annual patterns conforming to a cycle relative to prior years, the fundamental timing challenges of health insurance remain. Insurers develop premium rates for policies several years before they know how

underlying claims will materialize. Premiums are developed months before they take effect, sometimes earlier to allow for regulatory approval, and generally guaranteed on an annual basis. After the coverage period expires, it is usually about a year before all claims are paid. As future premiums are predicated on prior claim levels, there is a significant lag time to account for unexpected (either positive or negative) changes in health care costs. Accordingly, required pricing adjustments take time to recognize and implement, and periods of sustained gains or losses can last multiple years. Insurers test variations of reasonable scenarios to assure adequate capitalization to weather multiple years of material losses.

EARLY ACA PATTERNS

The Affordable Care Act (ACA) reset the individual market in 2014 with new rating rules and an income-based premium subsidy formula that changed the enrolled population. An early cyclical pattern, or at least a very strong correlation, has developed in the first six years. The Kaiser Family Foundation has compiled reports that demonstrate tight alignment of insurer participation and financial results (measured by nationwide medical loss ratios). Figure 1 displays historical annual results.

Figure 1
ACA Individual Market Competition and Financial Performance



Although this alignment should continue in 2020, it is too early to confidently determine longer-term patterns. There is reasonable causation here; correlation is not mere coincidence. Poor financial results through 2016 led to market exits through 2018; the better financial results, which were clearly apparent in 2018, drew insurers back to markets in 2019 and 2020, and perhaps 2021. The timing lag is suggestive of general accordance with a six-year pattern.

Like everything else in the ACA individual market, premium subsidy [dynamics](#) help explain results. Subsidies are calibrated based on the second-lowest-cost silver plan in each market. As insurers exit markets and fewer silver plans remain, premium subsidies increase and markets are more favorable to consumers.

[Conversely](#), “an increase in insurer participation alone creates a bias for compressed premium subsidies.” An increasing number of insurers in a marketplace also enhances the potential lionfish risk with a larger presence of low-cost plans; this [threat is understood](#) and “some savvy state exchanges have recognized this dynamic and deliberately and perhaps controversially avoided allowing low-cost plans on their platform.” Recent financial results have been strong and could entice more insurers; greater insurer attraction could cyclically lead to a crowded marketplace with the same recurring challenges.

MONITORING DEVELOPMENTS

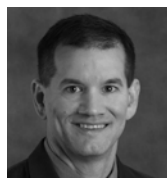
For the ACA’s [10th anniversary](#), a common actuarial refrain was “If you have seen one state ACA market, you have seen one state ACA market.” I have expanded that to “If you have seen one state ACA market in one year, you have seen one state ACA market in one year.” Although cumulative nationwide data is useful to interpret general conclusions, there are various underlying details at the [state](#) level.

Notably, states are at [different](#) stages of understanding ACA dynamics and reaching market equilibrium in terms of achieving appropriate metal level pricing relationships. After a partial response in 2018, market movement toward equilibrium [stagnated](#) in 2019 and 2020, with some rate filings explicitly referencing [risk adjustment](#) mitigation as a rationale.

Market equilibrium may be [accelerated](#) in 2021 by “emerging efforts from [consumer advocacy groups](#), states, and actuaries to strengthen compliance with ACA community rating rules and provide entitled tax credits to lower-income enrollees.” Markets will continue to improve and potentially attract more insurers during the transitional phase, which could last until [the end of this decade](#), according to the Congressional Budget Office. A gradual but steady market improvement could disrupt nationwide measures of an otherwise smoother pattern of results.

Will we see a new form of a six-year cycle in ACA markets? The same timing patterns of receiving data, analyzing results, filing premium rates and implementing new products remain, so a six-year pattern is a reasonable starting point. However, the new subsidy dynamics that reshaped markets in 2018 impact the timing course. The short history suggests a lagged response of insurer market entry as financial results improve. If financial results deteriorate, we may see insurer exits again. Complicating these matters is the unknown timing of various states to reach market equilibrium, as some are considering a faster pace through regulatory action in 2021.

At a minimum, stakeholders should recognize the correlation of profitability and insurer market participation. This is not merely traditional competitive dynamics. As insurers return to markets, competitive pricing does not provide subsidized consumers a better value. It only compresses premium subsidies and raises the net cost of consumers’ current coverage. This naturally results in enrollment losses, which leads to higher morbidity, financial losses and insurers exiting markets. Of course, this implies that premium subsidies are boosted again, and the ACA cycle begins to repeat; alternatively, the COVID-19 pandemic or other externalities may alter the natural cycle. We are either headed out on a new road with the ACA, or we are on a loop that will bring us back to the same place. ■



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Buying and Selling Employer Stop-loss Is Simple ... Or Is It?

By Dave Nelson, Keith Passwater and Luis Prieto

Any prudent organization that is obligated to cover health claims will consider the risk that those medical claims vastly exceed expectations. This is true for an employer self-funding employee health benefits, a health system contracted with two-way risk (e.g., accountable care organizations [ACOs]), and a small or midsize health insurance company. Without protection, these risk bearers can incur ruinous losses.

Interestingly, the forms of insurance sold to cover such large medical claims, although quite similar, sometimes go by different names depending on the buyer. The three main categories are as follows:

- **Employer stop-loss (ESL).** Self-funded employers who want protection against large unanticipated claims.
- **Provider excess (PXS).** At-risk health systems that have taken delegated risk from a public or private payer and desire protection against large unanticipated claims.
- **Medical excess/HMO reinsurance (HMO Re).** Health insurers (including HMOs) that desire protection against large unanticipated claims.

The concepts we discuss in this article apply to all three categories of large claim risk. They also apply somewhat to stop-loss sold through level-funded premium insurance policies (LFP), although LFP sold to employers with fewer than 50 employees is a topic for a separate article, which we might attempt to write if the 2020 golf season is shortened.



AGGREGATE STOP-LOSS

Aggregate stop-loss (agg) is, for many people, the most intuitive form of medical excess claim coverage. Agg policies reimburse the insured organization when total claims during a stated period, usually 12 months, exceed a stated threshold (also known as the agg attachment point). For technical reasons, the agg attachment point is derived as a percentage of expected underlying risk claims, with 120 percent and 125 percent being common attachment points. And, although the agg attachment point will be written in dollars in the policy coverage forms, writers of agg, buyers and their brokers frequently discuss a particular agg policy in terms of percent of expected claims, rather than a dollar amount.

As an example, if a large employer buying ESL has 500 covered employees and dependents with an expected claim cost of \$400 per person per month, the agg attachment point might be 120 percent of $500 \times 12 \times \$400$, or \$2.88 million (M) over one year. Effectively, the ESL customer pays the claims up to the expected value ($\$2.4M = 500 \times 12 \times \400) *plus* a deductible for claims between expected claims and the agg attachment point ($\$0.48M = 20\% \times \$2.4M$). As a result, agg claims rarely occur, which is reflected in the relatively modest pricing. In fact, when an underwriter has a case that experiences an agg claim, the level of scrutiny that follows reinforces the desire to never have another agg claim. Given the infrequent payout associated with an agg policy, the bulk of this article examines the specific stop-loss product as described next.

Table 1
ESL Buyer's Average Results

Specific Stop-loss Attachment Point	Typical Annual Premium	Chance of Gain	Average Annual Top 10 Gains out of 100 Trials
\$75,000	\$213,681	28%	\$357,819
\$150,000	\$110,893	22%	\$279,107

SPECIFIC STOP-LOSS

In contrast to agg stop-loss, specific stop-loss (or spec) covers high claims on an individual in a covered group of patients (or members, as health insurance beneficiaries are termed). So, a spec policy might state that any claims on an individual in a year in excess of \$100,000 (the spec attachment point) are covered by stop-loss. Spec attachments are available in a very wide range. As a result, spec rates range from less than a dollar per member per month (pmpm) to \$200-plus pmpm based on the spec attachment, as well as other factors, including area, case size, provider network, and plan provision. We discuss these factors in the paragraphs that follow.

Specific Stop-loss Value Varies by Business Type

We have done considerable Monte Carlo modeling (see [Appendix](#)), which shows that spec purchasers pay more in premium than they receive in claims 70 to 80 percent of the time. But most at-risk organizations are still prudent to buy stop-loss to protect financial results. So, we recommend choosing an attachment point that is at the high end of the organization's risk tolerance. In fact, buying the right amount of spec is, in many ways, more important than getting the lowest price. To that point, population size is a critical variable in choosing the right spec attachment point:

At small population/case/group sizes (under 150 covered lives), stop-loss coverage expenses are typically quite high. But small groups need to buy this coverage, since our modeling suggests that the chance of a few large claims generating high losses is significant. If the prospective stop-loss ESL buyer has adequate retained earnings and management is comfortable with some annual earnings fluctuations, they can save money long term if they choose what might be considered higher attachment points at their size (between \$50,000 and \$200,000).

- **At very large case sizes (over 100,000 members), stop-loss expenses are lower as a percentage of stop-loss premium, but the chances of the group's claims being dramatically higher than average are low.** For that reason, very large groups should usually pick a spec attachment above \$1M (or go without coverage).
- **In between, groups would probably benefit from some of the modeling shown in the [Appendix](#).** Absent case-

specific modeling, it is good to remember that stop-loss premiums usually exceed stop-loss claims. Therefore, customers should choose a higher attachment point if some earnings fluctuation is tolerable.

Some brokers use 5 percent of expected plan cost as a conservative spec target and 10 percent as a more aggressive spec target. Assuming \$5,000 per member and 2 members per employee, a firm with 150 employees generates \$1.5M in expected cost. Using this rule of thumb, a conservative spec attachment would be \$75,000 and a more aggressive spec attachment would be \$150,000.

Our modeling suggests that a 150-employee (300-member) ESL buyer would generate the average results presented in Table 1.

The 5 to 10 percent rule of thumb seems to generate a good starting point when determining a reasonable attachment point, since the exceptional covered claim is large (see annual top 10 gains in Table 1) in relation to the premium. And if the employer can stand the loss that may happen at the higher attachment point, they can benefit from a known reduction in premium of similar average size (roughly \$100,000 in the example shown).

Spec Price Varies by Coverage

Spec coverage and operational features have significant impacts on stop-loss prices. Coverage features like run-in and run-out provisions and aggregating specific coverage can each generate 20 percent price impacts (see [full Appendix](#) for a summary of pricing differentials).

Run-in and Run-out Provisions

Customers need to read the fine print when choosing so-called run-in and run-out provisions. What will happen if a claim occurs during the policy's first effective dates but is not billed until the second policy year? Without proper planning, customers could be left with no coverage for some large claims.

To solve coverage problems, several options are available. Essentially customers need to create some overlap between the old and new contract years to cover any claims incurred in the few months surrounding the contract change date. This is especially true if the customer is switching insurance carriers.

Samples of common contract coverage periods follow¹:

Table 2
Example of Aggregating Specific

Claimant	Total Claim Amount	Specific Stop-loss Attachment Point	Amount in Excess of Attachment Point	Application of Aggregate Specific Deductible	Stop-loss Coverage Reimbursement
#1	\$250,000	(\$200,000)	\$50,000	(\$50,000)	\$0
#2	\$255,000	(\$200,000)	\$55,000	(\$10,000)	\$45,000
#3	\$235,000	(\$200,000)	\$35,000	\$0	\$35,000
Total	\$740,000	(\$600,000)	\$140,000	(\$60,000)	\$80,000

- 12/12 is the lowest-priced option.** Claims are covered only when the services are incurred and the claims are processed within the policy year. This is a common contract length for the first year when an ESL buyer moves from fully insured to self-funding. A terminal liability option (TLO) is sometimes sold alongside 12/12 coverage. TLO coverage allows the ESL buyer to purchase “run-out” coverage later in the year.
- 12/15 or run-out policy.** With this form, claims are covered when services are incurred within the policy year and paid within three months after the end of the policy year. Other common run-out periods are six months for a 12/18 policy and 12 months for a 12/24 policy. ESL buyers pay an additional premium for any of these run-out options.
- 24/12 or run-in policy.** Claims are covered when services are incurred 12 months before the policy start date. Typically, a company that bought 12/12 in the first year buys 24/12 in the second year to make sure they don’t end up with a coverage gap. Not surprisingly, this feature costs more than the others described here.

Aggregating Specific Coverage

As mentioned previously, an aggregating specific feature can also impact premiums significantly. Customers can lower their premium by 20 percent or more if they accept additional risk when a claim or claims exceed the spec attachment point. With aggregating specific, the amount exceeding the spec attachment point is first applied to the aggregating specific deductible before the stop-loss carrier pays claims. The concept is analogous to a medical plan in which a copay applies first and then a deductible applies.

Table 2 illustrates the concept. Assuming three claimants and a spec attachment point of \$200,000, an aggregating specific deductible of \$60,000 would function as shown in Table 2.

Typically, the cost of the spec coverage is lowered dollar for dollar by the size of the aggregating specific deductible. This works well for the carrier if the group is large enough (over 250 members) and the spec attachment point is low enough

(below \$200,000) that enough claims will exceed the spec attachment point.

Stop-loss writers can learn quite a bit about the viability of a dollar-for-dollar premium reduction by modeling expected claims. In the full [Appendix](#) to this note, we show two examples. In the first example, we model a 251-member (126-employee) group with a spec attachment point of \$50,000. Here the stop-loss carrier can offer a dollar-for-dollar premium reduction, since it is likely that the aggregating specific deductible will be recouped from two or three claims, commission reductions and premium tax reductions. In the second example, a 150-member (75-employee) group with a spec attachment point of \$100,000, the expected number of claims is too low to support a dollar-for-dollar premium reduction. The buyer, however, may still have some interest in aggregating specific if the seller offers a premium reduction that is greater than the expected aggregate claims charge (see full [Appendix](#) for the math on this point).

Specific Stop-loss Price Varies by Operational Features

Operational features like underwriting and lasers, network payment rates, large case claims management and expense and profit margins can generate 10 to 30 percent price impacts. In fact, stop-loss carriers typically need to be proficient in two or three of these areas to have a competitive product.

Underwriting and Lasers

Individuals having serious ongoing medical conditions present material **known** risks that impact stop-loss rating of the risk. Stop-loss insured groups with fewer than 1,000 lives are frequently assigned higher spec attachment points for these higher-risk people. Isolating particular high-risk individuals for a higher stop-loss attachment point is known as **lasering** and is a common practice.

Spec buyers need to be aware of lasers in current and future years. Often it is reasonable to request a rate that guarantees no new lasers with a maximum rate increase in the next year. Of note, one alternative to a laser is loading the spec premium to accommodate the higher risk.

Network Payment Rates

Provider payment rates can vary tremendously by carrier. To demonstrate the impact of these differences on stop-loss rates, let’s consider the impact of differences on a spec attachment point of \$200,000.

- In the first instance, the provider submits a claim of \$400,000 to carrier A, which applies its network rate and pays \$100,000 to cover the amount over the \$200,000 attachment point.
- In the second instance, the same provider submits the same claim of \$400,000 to carrier B, which applies its network rate and pays \$50,000 to cover the amount over the \$200,000 attachment point (Table 3).

Table 3
Comparing Network Payment Rates

	Carrier A	Carrier B
Claim	\$400,000	\$400,000
Provider discount	(\$100,000)	(\$150,000)
Net provider charge	\$300,000	\$250,000
Specific attachment point	(\$200,000)	(\$200,000)
Stop-loss claim	\$100,000	\$50,000

Not every claim will substantiate a 50 percent stop-loss claim differential, but one can see that provider payment rates (and particularly payments for high-cost outlier claims) can have a huge impact on stop-loss rates.

Large Case Management

Complexity and fragmentation of the medical system makes opportunities for improvement in the care possible—especially for complicated cases like transplants or services outside the carrier’s primary service area. Effective stop-loss carriers take steps to make sure that the right care is delivered at the right location at the right price. Most ESL, PXS and HMO Re stop-loss contracts require advance reporting of claims likely to exceed the spec attachment point. When stop-loss buyers comply, potentially costly care is identified early so that nurses and network management people can help patients and families understand what their options mean in terms of cost, quality, convenience and comfort.

Frequently, case management is performed by the stop-loss carrier’s third-party administrator (TPA) partner and is often governed by a preferred provider agreement that limits large case management activities. If case management is done well, stop-loss prices can be reduced materially (recall the earlier

example that shows how small differences in total costs can drive a big difference in amounts in excess of the attachment point).

Expense and Profit Margins

Expense and profit loads can be very significant in the sale of stop-loss because the coverage is risky and expenses can be quite high. Rates for a 100-life ESL group typically include fees for agents and underwriters, whereas stop-loss fees are infrequent on 1,000-plus employee groups where a benefits consultant is usually paid a flat fee. In addition, the TPA will often be compensated by the stop-loss carrier from the stop-loss premium. And at case sizes of less than 150 employees, it is often easier for the TPA to sell a higher stop-loss rate (bearing some TPA revenue) than a higher administrative services only (ASO) fee. Spec loads can vary from 35 percent on small case size to 20 percent on a larger case.

Timing

Our final note about the purchase of spec concerns timing. In the first year, customers often take less risk by choosing a lower attachment point as they switch from fully insured to self-funding. In future years, customers often buy down renewal increases by switching to a higher attachment point or agreeing to a separate aggregating specific deductible. Customers taking more risk at renewal makes sense for two reasons:

- in renewal years the customer has more experience with self-funding, and
- stop-loss renewal increases are often high on account of deductible leveraging.

Table 4 shows how a 5 percent overall trend can turn into a 15 percent stop-loss trend.

Table 4
Stop-loss Renewal Increases

	Year 1	Claims Trend	Year 2
Claim	\$400,000	5.0%	\$420,000
Provider discount	(\$100,000)	5.0%	(\$105,000)
Net provider charge	\$300,000	5.0%	\$315,000
Specific attachment point	(\$200,000)		(\$200,000)
Stop-loss claim	\$100,000	15.0%	\$115,000

CONCLUSION

Although it is somewhat difficult to generalize about the best way to purchase spec, it is safe to say that one should be aware

of the nuances of the product and pricing structures in the stop-loss market. Buyers wishing to purchase the optimal stop-loss insurance value for their organizations can often benefit from expert outside counsel to evaluate both their true risk needs and the competitor stop-loss offerings available.

APPENDIX

To accommodate *Health Watch* size limits, the Appendix to this paper is being made available at www.pascoadvisers.com/soa. The authors encourage readers to at least scan the Appendix as a way to understand the rationale for the observations made in this paper. In addition, the visualizations and tables in the Appendix help summarize the content in a succinct manner. This is especially helpful for students hoping to get a good feel for how stop-loss needs vary by case size and how an aggregating specific deductible impacts costs.

GRATITUDE

The authors wish to thank the following people for sharing their perspectives concerning stop-loss plan operation:

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- Mike Hierl, CPCU, CIC, executive vice president at Hierl: Powered by M3. ■



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ENDNOTE

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