Prior to the Affordable Care Act (ACA), most health plans had lifetime if not also annual dollar limits. Removal of those limits was of small notice—relative to all other legislated changes—as a truly catastrophic claimant of $1 million or more was a relatively rare occurrence. Providers, especially hospital systems, knew this common limitation as well and rarely billed beyond those amounts. According to the Kaiser Family Foundation’s 2009 Employer Health Benefits Survey, on the eve of ACA, 59% of covered workers had such limits, often at $1 million or $2 million.

Medical stop-loss, the insurance—or reinsurance—for a self-funded medical plan in the event of catastrophic claimants, typically contained a lifetime maximum reimbursement as well, often $1 million or $2 million, aligned with the health plan. Unlimited coverage was rare, if even possible to obtain. This dynamic was particularly acute across reinsurance markets, as coverage for unlimited liability of all types tightened after the 9/11 terrorist attacks.

ACA Removal of Annual and Lifetime Limits

Passage of ACA in 2010 instituted a graduated removal of annual dollar limits and an immediate removal of lifetime limits on nearly all health plans, both individual and group, beginning with plan years after September 20, 2010. Those plans remaining grandfathered were permitted an-
annual limits on essential health benefits over a three-year period, beginning with $750,000 for plan years starting after September 20, 2010, $1.25 million the following year and $2 million the final year. No annual limits were permitted by January 1, 2014.

Among the various cost impacts of ACA, this removal of annual and lifetime limits was not an area of much initial concern. According to a PricewaterhouseCoopers (PwC) study prepared in March 2009, “the aggregate cost increase for all companies with lifetime limits would be 0.4% to 0.6%.”

**Stop-Loss Impacts**

Medical stop-loss is not governed by ACA, as it’s not health insurance. It insures (or reinsures) a self-funded medical plan, not an individual. However, per ACA, stop-loss was now tasked with covering health plans subject to unlimited liability. Faced with a newfound increase in coverage demand, stop-loss underwriters, via the broader reinsurance markets, were more receptive to providing unlimited maximums.

While actuarial impact initially may have loaded perhaps 1% in costs, pricing for stop-loss required payment of fixed reinsurance ceding fees—as much as $1 to $2 per covered employee per month—as the stop-loss carrier itself obtained external reinsurance from accepting carriers to cover the unlimited aspect. On common stop-loss deductibles with monthly premium of $35 or more, the impact was slight. However, on high deductibles of $500,000 or more, with stop-loss premiums of $5 to $7, it was a significant rate load of 20% or more. Over time the market settled, and unlimited stop-loss coverage has become nearly universal, growing from only 10% of all stop-loss plans in 2010 to 99% in 2014, according to the annual Aegis Risk Medical Stop Loss Premium Survey (Aegis Risk Survey). Stop-loss and its underwriters responded to the ACA requirements impacting its underlying coverage. The initial ceding expense has also faded.

**A Surprising (or Not) Turn**

As plan sponsors took note to modify their health plans and communications, announcing the removal of annual and lifetime limits, others were noticing, too—notably, health care providers, led by hospitals, settings for the most critical and costly episodes of care. In evolving review of the initial post-ACA claims experience in 2011 and 2012, the lead actuary of one stop-loss carrier shares that it seems as if health systems were initially cautious—even suppressing overall trend. However, that soon ended, almost as if “all bets were off.”

Specialty drug providers were noticing as well. No longer did patients with Factor VIII hemophilia (most commonly the medical condition that may have tested prior plan limits) have to transition to Medicaid or other coverage after exhausting an employer’s coverage. Reimbursement could now continue unabated. In fact, the 2009 PwC study estimating less than a 1% increase in aggregate costs was funded by the National Hemophilia Foundation. It estimated the removal of limits would save Medicaid “more than $11 billion over the next ten years,” with much of that absorbed by employer-sponsored coverage.

Where providers previously hoped to maintain reimbursement with a new payer (once the initial coverage had exhausted), coverage now remained with the same employer plan. No longer was there a need for a medical provider to make a benefit verification call with an insurer (or request copies of a patient’s health plan summary plan document) and identify any maximum reimbursement limitations before proceeding on a costly course of treatment. Long-stay newborns in the neonatal intensive care unit no longer transferred to Medicaid after benefits exhaustion. Carte blanche seemed to be the new expense policy.

**Types of Claimants**

Catastrophic claimants have many causes. (See Table I.) Frequency and overall cost will vary by dollar threshold (or stop-loss deductible), with less common but higher cost conditions such as congenital anomalies and hemophilia playing a larger role at higher thresholds of $500,000 or greater.

According to the 2014 Sun Life Stop-Loss Top Ten Catastrophic Claims Conditions (2010-2013) report from Sun Life Financial, cancer is the most frequent and costly stop-loss claim condition overall and highest for deductibles at and under $250,000. However, for deductibles $500,000 or greater, it is the sixth most frequent and eighth most costly. Most costly at that higher level is congestive heart failure, followed
health care strategies

by congenital anomalies, hemophilia/bleeding disorders and leukemia/lymphoma/multiple myeloma. Medical devices further contribute, particularly for congestive heart failure, where a left ventricular assist device (LVAD) may be implanted while the patient awaits a suitable heart donor. A lengthier wait will require multiple LVADs. On a frequency basis, the leading condition is congenital anomalies, most often represented by premature infants and live-born complications. In actuality, according to Sun Life, fully 71% of claimants at $1 million or more were dependent children, driven by newborns and Factor VIII hemophiliacs.

Likely to Increase

The occurrence of these catastrophic claimants shows no sign of abatement. Advances in medical care have improved mortality (e.g., survival rates of premature infants) but often with lengthy inpatient stays or costly maintenance. Several stop-loss underwriters have reported the observed frequency of $1 million or more claimants has at least doubled in recent years (Table II).

Prevalent reimbursement methodology for inpatient care also favors the provider; the definition of reasonable and customary expense is elusive. So-called outlier provisions often permit reimbursement of actual charges at more provider-favorable levels (e.g., 65% to 85% of billed charges) once claims exceed a stipulated level, often around $150,000. It is not apparent that most health plans are aggressively battling this expense borne by their self-funded customers—After all, it’s not the health plan’s risk. Greater use of referential pricing, such as Medicare “plus” (e.g., Medicare reimbursement plus an additional amount, such as 20%), in the context of the health plan’s provider contracting may offer greater plan sponsor value. Currently, providers are hesitant to pursue this reimbursement method.

**TABLE I**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Average</th>
<th>Median</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant Neoplasm</td>
<td>$41,245</td>
<td>$24,350</td>
<td>$1,704,810</td>
</tr>
<tr>
<td>Chronic/End-Stage Renal</td>
<td>$65,081</td>
<td>$59,132</td>
<td>$3,000,734</td>
</tr>
<tr>
<td>Leukemia/Lymphoma/Multiple Myeloma</td>
<td>$82,905</td>
<td>$45,468</td>
<td>$2,137,398</td>
</tr>
<tr>
<td>Congenital Anomalies</td>
<td>$92,645</td>
<td>$18,937</td>
<td>$2,556,925</td>
</tr>
<tr>
<td>Short Gestation and Low Birth Weight</td>
<td>$112,236</td>
<td>$26,476</td>
<td>$3,762,204</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>$92,878</td>
<td>$16,232</td>
<td>$2,265,552</td>
</tr>
</tbody>
</table>


**TABLE II**

<table>
<thead>
<tr>
<th>Stop-Loss Underwriter</th>
<th>Policy Years</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PartnerRe Health</td>
<td>2007-2012</td>
<td>“An increase of more than 350% (35% per year) in the frequency of claims above $1 million.” The average claimant remained constant at approximately $1.4 million.</td>
</tr>
<tr>
<td>HM Insurance Group</td>
<td>2010-2014</td>
<td>A tripling of claims incidence of $1 million or more, rising from 1.8 to 5.9 per 100,000 covered employees.</td>
</tr>
<tr>
<td>Sun Life Financial</td>
<td>2010-2013</td>
<td>“The number of claims that were individually $1 million or above rose by 1,000% (with a) sharp 144% increase in 2013 compared with the prior calendar year.”</td>
</tr>
</tbody>
</table>

*Sources: Various underwriters.*
A final driver to monitor is specialty pharmacy—particularly, evolving therapies that may be given the Food and Drug Administration’s recent Breakthrough Therapy designation. These are drugs and devices that are intended to treat serious or life-threatening conditions and have been offered expedited approval. All six of the initially approved therapies carried costly annual expense, ranging from $41,000 to $300,000. Many of these therapies are biotech-based for chronic or previously untreatable conditions. Often life-preserving, these therapies commonly require ongoing administration yet provide an otherwise “normal” existence for those for whom they are prescribed. As already seen with a Factor VIII hemophiliac, whose annual treatment expense often exceeds $1 million—if not $5 million or more in very rare instances—some of these uncommon but occurring conditions may each have an annual therapy costing in excess of several hundred thousand dollars.

Altogether, this creates a risk dynamic previously not envisioned by self-funded medical plan sponsors (if not stop-loss carriers)—claimants both catastrophic and ongoing, also known as accumulation risk. An alert chief financial officer (CFO) instantly sees this as an unfunded future liability, over multiple periods, valued in the millions and tied to one participant in the self-funded employer medical plan. This was never foreseen several years ago.

For example, a therapy at $850,000 per year for the next four years, at a 4% discount rate, presently is valued at $3.1 million (almost certainly unfunded, too). It can be argued that the employee to whom the claim is tied, likely through a covered dependent, is by default one of the organization’s most highly compensated employees.

To avoid both this risk and its impact—if not the risk of the chief executive officer (CEO) pointing toward “distressed babies” as a drain on overall benefits expense, as AOL’s CEO infamously proclaimed in February 2014 to explain a 401(k) cutback to employees—the CFO likely will ask, “What’s my hedge?”

**Risk Management**

In light of this rising occurrence, what is the recommendation for employer-provided health plans to obtain this hedge or risk protection? It varies, particularly by employer size.

Most plans with 5,000 or fewer covered employees likely have stop-loss already. If not, it’s simple—Obtain it! At an illustrative $10,000 total health plan cost per covered employee, a 5,000-life employer incurs $50 million in annual medical plan expense. A single $1.5 million claimant is 3% of budgeted cost—or, potentially, the difference between meeting a budgeted increase of 4% and missing it at 7%. For this employer, the market average for annual premium for stop-loss with a $500,000 specific deductible is about $800,000, according to the 2014 Aegis Risk Survey. It would reimburse $1 million on the $1.5 million claimant, and likely a few hundred thousand further on other eligible claimants, and keep the plan at budget—and the finance department undisturbed.

Larger groups, if not already covered, should consider stop-loss. Increasingly, employers with 10,000 or more covered employees are giving it further consideration, if just to remove a fully uncapped liability from their possible expense. In the shadow of the removal of lifetime maximums and these ongoing claim dynamics, many finance executives may not realize that an uncapped liability exists in the self-funded health plan. Such a liability often is prohibited elsewhere in the organization, and identifying and containing organizational risks and liability is the core objective of the risk manager.

Stop-loss deductibles of $1 million or more are also increasingly quoted on larger employers. Frequency of claim at that deductible, according to several stop-loss carriers, is approaching 0.6 per 10,000 covered employees—or greater than in any given year for an employer at that size. According to the 2014 Aegis Risk Survey, 23% of respondents reported a $1 million or greater claimant in the last two policy periods—up from 14% in 2013. Further, included in the 23% were 9% of respondents that reported a claimant was in excess of $1.5 million (see the figure).

The market premium for stop-loss with a $1 million specific deductible is approximately $5.60 per employee per month, or $672,000 annually for a 10,000-employee plan sponsor, according to the Aegis Risk Survey. Based on a per capita health plan cost of $10,000 per covered employee, this is 0.67% of
total plan expense of $100 million—a sizable line item but a small expense to anticipate and budget for the likely occurrence of a $1 million or more claimant. Its value further is underlined by its protection against the truly unpredictable occurrence of a $4 million or $5 million claimant. Nearly all major stop-loss underwriters report at least one such claimant each calendar year. They’re typically in network and fully managed as well, not a runaway non-network claim.

For plan sponsors with more than 10,000 covered employees, stop-loss still may not appeal. Financially and statistically, their ability to withstand the impact of catastrophic claimants is stronger than for smaller plan sponsors. However, additional reserve and margin for self-funded budget rates is advised.

### Coverage Strategy and Considerations

As the primary and established means of protection from catastrophic claimants, stop-loss remains a valued and effective risk management tool. However, the rising occurrence of truly catastrophic claimants raises several coverage strategies and considerations.

#### Lasering

Like all forms of insurance, stop-loss is designed to cover unknown and future risk, not known and existing risk. At the inception of coverage, when existing claims history must be disclosed, it is possible for an existing and known claimant to be excluded from coverage, or lasered. Such coverage may often be at a higher deductible, a more limited contract term or, occasionally, fully excluded. While it seems unjust, absent lasering, the expected reimbursement would otherwise be fully included in the premium.

What is less fortunate is when an ongoing claimant is lasered by the existing underwriter at renewal. Being subject to similar lasering by any competitive underwriter quoted in possible replacement, the ongoing claimant—and the possible accumulation risk mentioned earlier—is transferred back to the self-funded medical plan. So much for insurance.

Many underwriters offer a laser-free renewal approach, promising not to exclude existing claimants at renewal. Still, this approach may permit a sizable renewal increase (75% or greater) as the renewal loads the expected reimbursement. A request by the policyholder for a laser to lower the requested rate increase often follows. Given options, the plan sponsor may roll the dice and elect the laser, in hopes the claimant quiets.

A stronger protection is sometimes described as laser-free with a renewal rate cap, often around 45% to 50%. What may initially be seen as an onerous ability to rate a sizable increase will prove its value if an ongoing Factor VIII hemophilia claimant, or similar expense, occurs within a plan. These offers typically are required to be selected at contract inception and are subject to

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**FIGURE**

**Highest Paid Claimant, in Excess in One Policy Year, Over Last Two**

(Source: 2014 Aegis Risk Medical Stop Loss Premium Survey.)
Dividend Contracts

These stop-loss policies are gaining in popularity. Per a set or negotiated formula, a percentage of the paid premium is refunded if certain claim-to-premium loss ratios are achieved. They typically require two to three years of continual coverage prior to payment, and underwriters enjoy that multiyear commitment from a policyholder. Favorable claims history may offer as much as a 5% to 10% premium refund. With stop-loss ratios often in the 55% to 65% range (common to most catastrophic coverages, as they save for the "rainy day"), this is an effective way to "claw back" extra premium during periods of strong claims experience. Negotiating an equitable, if not aggressive, target-loss ratio is key.

A Role for Captives?

An ever-present buzzword of many brokers and consultants, captives—while proper in certain conditions—are not vehicles well-suited for coverage against truly catastrophic claimants. This is primarily because the infrequent but severe nature of catastrophic claimants may exhaust funding and reserves with just one claimant. More predictable and less severe benefit risks (e.g., life, disability) may be a stronger fit for a benefits captive. Furthermore, stop-loss pricing remains "soft" as capital (i.e., investors seeking strong returns) seeks to enter the reinsurance market for its favorable returns. A well-negotiated premium rate may undercut the financial argument for a supposedly more cost-efficient captive. A broader organizational directive to diversify an existing captive, perhaps on property and casualty risks, may otherwise support this pursuit.

Include Pharmacy

While fully 91% of plans report pharmacy coverage on their stop-loss, according to the Aegis Risk Survey, the few holdouts often omit it due to a pharmacy carve-out situation and elect to keep stop-loss solely on medical—often with a carrier tied to or owned by the administrative-services-only (ASO) company/third-party administrator (TPA). With the specter of rising specialty pharmacy costs, this no longer is advised. Pharmacy benefit managers can support stop-loss reporting, and an effective benefits manager or consultant can match claimants with the medical reports and submit reimbursement. Pharmacy should not be left uncovered.

Aggressively Manage ASO or TPA

Financial management of high-cost claimants has multiple components, all dependent on proper reporting from a health plan administrator, be it a smaller TPA or a national health plan such as Blue Cross, UnitedHealthcare, Cigna or Aetna, also referred to as a BUCA. Components include monthly updates on evolving high claimants to any external stop-loss carrier, claims disclosure support at renewal and clinical updates on existing claimants to anticipate future expense and budget accurately. Traditional TPAs typically are effective at reporting necessary claim information, and most stop-loss carriers continue to prefer TPAs.

However, in recent years, the ASOs—typically a BUCA—have obtained greater market share. At the same time, they have become less supportive of adequate high-claimant reporting, often hiding behind cloaks of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy requirement or, even more brazenly, the idea that health plan information is a proprietary work product of their exclusive keeping. Conveniently, they may not be willing to release necessary high-claimant detail to underwrite stop-loss (which is permitted by HIPAA for "health plan operations") but will readily quote stop-loss coverage of their own—often in a vacuum of competition, as only they have the data.

Plan sponsors should be aggressive with their claims administrator and seek acknowledgment of the necessity to report on high-claimant details. If stop-loss is placed with an external carrier, monthly reporting will be necessary, and all administrators have a standard reporting package. But plan sponsors should beware unreasonable fees. Reporting should cost no more than $0.20 to $0.30 per employee per month, regardless of size. Higher expense often is an effort...
to prevent a competitive stop-loss option from displacing the ASO’s own option.

**The Sentinel Effect**

Individual claimants costing several hundreds of thousands of dollars, if not $1 million or more, are not average claims. Individually, they may equal the average expense of 200 or more similarly covered participants. With drivers discussed earlier, including aggressive provider billing, costly inpatient stays, transplants and ongoing drug therapies, there are many areas for possible abuse and billing errors. Alternative or stronger reimbursement deals may be identified as well. An external stop-loss carrier offers this oversight. With their existence based solely on catastrophic claimants and as the ultimate payer of such expense, most external stop-loss carriers have extraordinarily strong transplant and specialty pharmacy networks and deals. Those features may overlap the underlying health plans but are always accessible to drive stronger clinical and financial results. An additional review of the previously adjudicated claim may reveal areas for savings due to duplicate charges or identifying more efficient reimbursement structures. Two sets of eyes often beat just one.

**Seek a Strong Advisor**

Catastrophic medical claimants—and stop-loss itself—may occur in an employee benefits environment, but it’s more accurately a property and casualty risk, not an employee benefit. The risk is financial and relatively infrequent but has high exposure. One claimant is potentially one or more times the size of the annual stop-loss policy premium—a dynamic never found with, say, dental benefits. Underwriting and placement is a careful process, requiring integration with any expiring coverage and assurance that any known risks are properly disclosed and accounted for. Self-funded plan sponsors need to be vigilant. As evidence of the complexity of stop-loss placement, several of the larger benefits consulting and outsourcing firms now require client “hold harmless” agreements at the onset of a stop-loss placement, absolving themselves from any coverage gaps that may result due to errors and omissions in the process.

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**A Conversion Back to Fully Insured?**

The dynamic of catastrophic claimants is unlikely to fuel renewed interest in fully insured health plan funding for presently self-funded employers. For most, save the smallest (or fewer than 500 covered employees), the long-established evidence that self-funding reduces overall cost is unchanged. Among several variables are the additional premium tax as well as the more conservative claims margin inherent in fully insured rates. Stop-loss is still present in fully insured rates but labeled as a *pooling charge*. Furthermore, health care claim dynamics are unaffected by a plan sponsor’s funding mechanism. Finally, stop-loss is “full insurance” for the catastrophic claims component of a self-funded health plan. Its use, argued here for a wider range of plan sponsors, has always leveraged full insurance at the proper risk point for a self-funded health plan.

As appropriate, plan sponsors should seek medical stop-loss protection and further ensure it covers the plan in the event of the accumulated risk of an ongoing claimant. Laser-free renewal coverage should be strongly considered, and a dividend contract may offer further value.
The evolution of private exchange models and their acceptance by some—but hardly many—may reflect a reluctance to be tied to such risk. But initial adopters of that approach seem to state an ability to fund a fixed employer contribution and exit much of the overall administrative need instead of potential risk.

**In Summary**

ACA removed all annual and lifetime limits by 2014. While initially a benefits issue, it was apparent to health care providers that billing limits were also no longer a concern. The health plans try to manage catastrophic expense, but their tasks are many and it requires plan sponsor vigilance as well. The drivers don't seem to be fading, but increasing. As appropriate, plan sponsors should seek medical stop-loss protection and further ensure it covers the plan in the event of the accumulated risk of an ongoing claimant. Laser-free renewal coverage should be strongly considered, and a dividend contract may offer further value. Plan sponsors should aggressively manage their TPA or ASO and request a vigilant approach from their stop-loss carrier as well. Finally, an experienced and knowledgeable advisor always helps.

**Endnotes**


**References**


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