Demystifying Medical Stop Loss Lasers

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Introduction

There are known knowns. These are things we know that we know. There are known unknowns. That is to say, there are things that we know we don't know. But there are also unknown unknowns. There are things we don't know we don't know.

- Donald Rumsfeld

One of the basic principles of any alternative risk program is being able to assume predictable (known segments of risk while transferring more unpredictable (unknown) risks to insurers. The underlying premise is that a known or "expected" risk can be budgeted and held more efficiently as retained risk by the employer rather than transferring it, redundantly, to an insurer at a higher-cost fixed premium.

Many things become controversial when they are not fully understood. Medical stop loss lasering has always been a provocative topic; however, for most self-funded employers it is a long-accepted practice within the self-funded structure. The concept of stop loss lasering tends to become more controversial as the size of the self-funded employer becomes smaller. The Affordable Care Act (ACA) has fueled an expansion of selffunding, with much of this market growth coming from employers with less than 250 employees. Considered "small" by self-funding standards, many employers in this size category do not have the financial agility to comfortably absorb a significant stop loss laser.

What is lasering?

Within self-funded medical programs, individuals having serious, ongoing medical conditions that are likely to incur large expenses related to those conditions are "known" risks. Such risks are frequently isolated by a stop loss carrier to receive a higher specific deductible in relation to the rest of the insured population.

Isolating specific individuals for a higher stop loss deductible is known as "lasering" and has always been a common practice in the medical stop loss industry.

Here is an over-simplified illustration: Assume that a 250-life employer group has a $100,000 specific stop loss deductible. An individual in the group is currently being treated for cancer with an expected treatment cost of $500,000 during the plan year. Medical stop loss coverage with a $100,000 specific deductible is issued to the employer for each covered individual, except for the cancer patient who will be "lasered" with a $500,000 specific deductible. In short, a laser is a direct reflection of an underwriterís estimation of what a specific ongoing medical condition will cost.

What's known is known (except when it isn't)

Medical stop loss is actually a form of excess of loss coverage rather than primary coverage. The intent of excess coverage is to protect against larger, more unpredictable risks, whereas primary coverage secures the ground-up working layers of risk. In theory, when a known condition can be identified, thus becoming expected, placing a higher specific deductible on the anticipated financial liability is a prudent expectation of a stop loss carrier by a self-funded employer. The practice of lasering aligns with the self-funding principal of retaining known (or expected) risk and only purchasing insurance for unknown (unpredictable) risk.

It is also important to understand that medical stop loss is not a "pooled" product. This means that large claims are not spread across a multitude of other insureds within the insurance carrierís coverage portfolio

What's known is known (except when it isn't) continued

as they typically would be under primary (fully-insured) coverage. Large losses are charged directly to each employerís self-funded plan without any pooling-related credits to offset it. It is worth noting that some medical stop loss group captives will seek to absorb lasers by spreading them across all group captive members on a pooled basis. This is more common within the large "open-market" group captive programs that specifically target smaller employers. These programs, if large enough, can be effective in enhancing the stability of self-funding to some smaller employers.

During the underwriting process, it is not uncommon for underwriters to calculate the Net Known Loss Ratio. This is a simple analysis whereby the underwriter determines the expected annual cost of all known (ongoing) claims that are likely to penetrate the specific deductible. The expected annual (collected Net) premium is then divided by the sum total of the expected large claims to determine the Net Known Loss Ratio. This analysis assists the underwriter in determining both the need for individual lasers and validating the most appropriate balance between the account's specific deductible and required annual premium to help ensure profitability. It can also help underwriters justify the waiver of some marginal lasers if the expected penetration of specific deductibles is relatively minor in relation to the overall account premium.

Strategies for deflecting lasers:

Most stop loss carriers can offer No New Laser (NNL) contract options. These options are typically written on new (as opposed to renewal) accounts to the stop loss carrier. At the inception of a new contract, the stop loss carrier may establish initial lasers. However, upon renewal the carrier will not add any new lasers to existing insureds within the plan. The NNL contract will also typically come with a renewal rate cap which specifies the maximum rate increase that can be charged upon renewal. The premium rate load for a NNL contract option will range from 5% to 15% with rate cap maximums ranging anywhere from 40% to nearly 100%. Generally, a 10% load for a 50% rate cap is considered to be fairly standard. It is important to note that NNL provisions are rarely written as "evergreen" commitments and are normally valid only for a one year policy contract period.

Many lasers are attributable to issues such as cancers, kidney failure, premature births, severe injuries, and conditions requiring organ transplants or conditions requiring high cost specialty pharmaceuticals. Having a network of recognized Centers of Excellence (COE's) that specialize in these types of conditions as part of the plan requirements should be helpful in negotiating lasers with underwriters. At the very least, COE's will be helpful in mitigating the ultimate cost of claims incurred within the self-funded plan and paid by the employer.

Some carriers are willing to offer "conditional lasers" in which the higher (lasered) deductible is only applied if the individual has treatment for the specified condition during the contract period. For example, an individual covered by a plan with a $100,000 specific deductible has been identified as a candidate for an organ transplant which has an expected cost of $500,000. A $500,000 laser would be applied to the individual in the event the transplant occurred during the policy period. If the transplant were not necessary, this individual would only be subject to the same $100,000 specific deductible as is in place for the rest of the group.

A few stop loss carriers also offer stand-alone organ transplant "carve-out" coverage which provides firstdollar coverage for transplants. Since this coverage effectively removes the transplant exposure of the selffunded plan, the need for lasers attributable to transplants is effectively nullified. This coverage is economically priced, and premiums can be efficiently offset through corresponding rate discounts provided by stop loss carriers.

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Strategies for deflecting lasers: continued

The use of captives can also be effective in absorbing stop loss lasers. Single-parent captives can retain the "soft cost" of lasers as increased retention or transition this cost to an appropriate premium charge for increased insurance provided by the captive to cover the laser. As mentioned earlier, some group captives will seek to reduce or absorb lasers by pooling them across all group captive members.

Each of these options has proven to be fairly effective for reducing or eliminating an employer's susceptibility to increased self-funded retention in the form of lasers.

Conclusion

Lasers will always be a part of most self-funded plans, especially as the cost of large, potentially catastrophic claims continues to increase. Since ACA, the cost of large claims has increased dramatically. Many claims that used to cost $100,000 or $200,000 are now regularly eclipsing $500,000 or more, and the frequency of $1M+ claims has risen to unsettling levels. With the growth and increased frequency of large claims, it is safe to assume that the application of lasers by stop loss carriers will also continue to increase. As mentioned earlier, employer perspectives of the theoretical and practical applications of lasering continue to differ according to the employerís size and financial agility. That said, being mindful of lasering considerations in structuring a self-insured program and the various strategies which can be employed to mitigate the impact of lasering can be of great benefit.

About the Author

Phillip C. Giles, CEBS has more than 30 years of Accident and Health and Property and Casualty alternative risk experience and leads business development initiatives for MSL Captive Solutions.

In 2019, Phil was named Reinsurance Specialist of the Year by Cayman Captive Magazine. In 2017, Phil was presented with the Captive Professional of the Year recognition at the U.S. Captive Awards. He has been named to Captive Review's "Power 50" listing of most influential individuals in the worldwide captive insurance industry and is a regular content contributor to several industry publications.

About MSL Captive Solutions, Inc.

MSL Captive Solutions is the industry's only platform devoted exclusively to the development of comprehensive (re)insurance solutions for group and single-parent medical stop loss captives.

MSL Captive Solutions provides consultative underwriting support to some of the industry's leading stop loss carriers and operates independently to work with all qualified brokers, consultants, and captive managers.

For more information visit www.mslcaptives.com.