MSL Captives

Adverse Risk Selection: No New Lasers, Rate Caps, & Captives

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Lasers are commonly used in the medical stop loss (MSL) industry to manage the cost of known high-cost conditions. Participants in the plan with known high-cost conditions have increased specific deductibles applied against them that are equal to the anticipated cost of treatment. This removes those known high costs from the MSL program and leaves them with the employer and their self-funded plan. The argument is that insurance is not an effective mechanism for paying for known events. (It's the equivalent of buying homeowners insurance when your house is on fire.)

While insurance may not be an effective mechanism for covering known high-cost conditions, employers remain concerned they'll buy stop loss only to see the costs from high-cost claimants be transferred back through the use of lasers in future years. This has led to a market practice in which employers and their brokers seek a No New Laser (NNL) provision in stop loss policies. This is usually matched with a rate cap provision so the additional cost – brought on by the inability to laser a high-cost claimant – isn't simply passed on to the employer through higher premiums (or, at the very least, the rate cap ensures the ability to raise premiums is limited). Rate caps can be anywhere from 30 to 50%+.

Today, requests for NNLs and rate caps have become standard in many RFPs, without much thought as to whether this is a good strategy for every situation.

The Case Against NNLs & Rate Caps

Why wouldn't you want to avoid having a laser imposed in a future year? Or limit a premium increase? Wouldn't these actions transfer the risk of a future high-cost condition to the stop loss insurer from the employer? Isn't this the exact type of situation in which you'd want to buy insurance?

Still, even within traditional stop loss policies, this strategy is flawed for several reasons:

- **No guaranteed renewal:** The major problem with trying to transfer the risk of a future high-cost claimant to the stop loss insurer through an NNL and rate cap provision is the insurance contract is not a multi-year contract. Instead, it's typically a 12-month contract, and, unless there's a guarantee to renew, the insurer is therefore not committed to the NNL and rate cap provision over a protracted period. Put another way, the NNL and rate cap are the parameters for renewal, (i.e., "We will only renew if you don't have a new high-cost condition or your experience doesn't warrant more than the rate cap increase"). If an employer does experience new high-cost events and the stop loss is a volatile line of coverage, being nonrenewed won't be helpful in providing stability to the stop loss program.
- **Other policy provisions:** A laser isn't the only way for an insurer to protect against the cost of a known or potential high-cost claimant. The use of an aggregating specific deductible (or of exclusions) could be applied without breaching the NNL provision.
- **Increased premiums & overall cost:** An NNL provision is paid through premiums. It will typically cost an additional 10 to 15% of premium just to include the provision. And that's without knowing whether you'll ever benefit from it. Should you have a high-cost claimant that would normally warrant a laser, the additional cost will be passed on through further premium increases. Paying for known costs through insurance increases the cost of care, as insurance

premiums include administrative expenses and insurer profit. Claims are only likely to account for 70 to 80 cents of every premium dollar, so paying for care through premiums will increase those costs by at least 25%. The rate cap is intended to limit the impact of this, but someone has to pay. As such, the cost of the known high-cost claimant is socialized across all policyholders, thereby increasing everyone's premiums. The amount of the rate cap becomes the "buffer" necessary to absorb costs that can't be passed on with lasers. The rate cap may be exactly what you would expect for a rate increase for the following year. (The impact of this socialization of lasers in a captive situation is discussed in more detail later in this article.)

- **Continued upward spiral in premiums:** A second impact of absorbing NNLs via increased premiums is that premiums rarely, if ever, come down. The laser should be a temporary policy condition to address a specific condition and claimant. Once the condition is treated or the claimant is no longer on the plan, the laser goes away. Reducing premiums may not be as responsive a strategy and could result in a continually elevated cost of care.

How This Impacts Captives

The NNL and rate cap provision is particularly challenging for captives. The captive is a risk-sharing pool in which there needs to be a high level of trust regarding how the shared risk is managed among members. Risk sharing is necessary for the captive to qualify as an insurance company for tax purposes, but there's some flexibility in how the captive is operated, particularly around who gets distributions and when.

A major advantage of a captive is the ability to get premium returns through distributions. It's a particularly effective financial tool to recapture investments in cost containment that may not be fully incorporated into premium rates. When employers join a captive, they go from insurance buyers to owners, and, with that change, there's a shift in focus toward limiting claims made against the captive.

A second benefit is stability. The volatility that's naturally seen in stop loss can be spread across a pool of employers to smooth this unpredictability out from year to year. Group captives must establish a balance between the stabilizing effect of the group and a rewarding of those group members with favorable claims experience.

Including NNL and rate cap provisions in a captive creates two main problems:

1. **Uneven contributions to the risk in the pool:** The employer with the high-cost claimant is protected while the cost of the high-cost condition is socialized by the other members of the captive through increased premiums. This is like ordering a wagyu steak and expecting to split the bill evenly when everyone else in your party orders burgers. It doesn't do much to keep the group together, even if you've promised the group you'll pick up the cost of your wagyu steak at some point in the future.
2. **Impact on distributions:** Some captive programs are managed to break even rather than for distributions. It's argued this creates a more tax-efficient structure (since premiums can be deducted), but distributions will likely be taxed. These kinds of captives also offer NNLs and rate caps. The profit in these programs – from the cost-containment

efforts and the good performance of most members – is effectively being used to pay for the cost of the NNL and rate cap provision. This creates a double whammy in which the good-performing members aren't receiving distributions and they're also seeing rate increases to absorb NNLs. While all captives differ in how they're structured and how they run, it's quite common for distributions to be made only to those members with surplus (i.e., premiums paid to the captive, less claims). In such cases, those with deficits do not receive distributions. In this way, the good-performing members are rewarded, and the poor-performing members are not. But by using surplus to fund high-cost claimants and limit rate increases, the poor-performing members are being rewarded at the expense of the good. This creates a situation of adverse risk selection. Over time, the good-performing members will leave, and the experience within the captive will increasingly deteriorate.

Unfortunately, the people who benefit most from this approach are the providers and even the stop loss insurers and reinsurers. When absorbing known high-cost claimants into a premium, you see an increase in demand and in pricing for the stop loss insurance product. Providers who are usually paid in relation to volume (of premium or employees) are the ones who benefit.

This can quite easily become a situation in which the captive is run for the benefit of the providers or the sponsors rather than for the benefit of the members. It then becomes a critical governance issue to ensure the members are actively engaged and have some control over the actions of the providers of the program.

And yet there are many examples of group captives (P&C and benefits) that have failed at this due to abuse or to misaligned interests among the sponsors or providers to the program.

What to Look for in a Captive Program

Treat captives offering NNLs and rate caps with caution. As a buyer, these provisions may seem like good benefits (and they've become a fairly standard ask from brokers), but as an owner of the captive, accepting NNLs on another member's program may be less appealing. Ask how the captive is going to finance the ultimate cost of such provisions.

Understand the captive's distribution philosophy. Is it trying to generate a profit and recapture premium, or is it trying to underwrite to break even? If it's underwriting to break even, how are funds generated from improved cost containment used if they're not returned to the members? How are distributions calculated, and who is eligible to receive them? When are distributions made? In addition to setting expectations on what distributions might be available, these processes will impact the amount of collateral needed. For example, if underwriting years are not closed out for 12 months after the end of the treaty year, there will be a stacking of collateral over two years.

Managing High-Cost Claimants & Conditions

NNLs and rate caps are insurance jargon used to address employees with serious medical conditions. Employers have taken on a responsibility to provide care to these employees through their self-funded health plan. But instead of trying to transfer responsibility to pay for the employer's obligations, shouldn't we be focused on what's being done to ensure the affected employees or beneficiaries receive the care they need at an appropriate price? With good case management, many of these cases can be overseen with the right care at a lower cost than projected.

Lasers can also play a role in cost containment and in reducing the total cost of care. Keeping the cost out of premiums provides a more efficient way of paying for care. There's also some uncertainty around how cases will develop. Imposing a conditional laser rather than including the projected cost (plus expenses) into a premium provides a structure where maximum costs are known, while actual costs could be significantly lower.

A TPA might find a lower-cost and higher-efficacy solution or treatment. The member might leave the plan, take another job, etc. In the event of a specialty prescription, the drug could be sourced internationally or approved under a patient assistance program. Lasers, especially conditional lasers, encourage the group and TPA to find lower-cost alternatives, as the liability is entirely with the employer. This reduces the employer's cost of care and, in a captive situation, provides protection to the other members of the captive.

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