What Is Going On With Aggregate Coverage?

Ever wonder why two carriers have different aggregate factors? In some cases, the difference can be significant, which elicits an employer/broker's reaction of, "Wow, great numbers!" no matter how much lower they are versus others. This article is intended to help explain why this may be occurring, as well as the potential for unintentional or unforeseen consequences for the employer group if the aggregate is rated too low.

First, why do unusually low aggregate attachment points matter? If self-funded, an employer sets aside funds to cover eligible medical expenses, which can be a significant percentage of their overall company revenue. Year after year, an employer makes projections using their current costs for healthcare to budget for their future anticipated costs. They use the aggregate factors as their funding guideline. If the employer's annual healthcare funding has significant swings, this financial roller coaster can create a financial shortfall if waiting for monthly aggregate accommodation or worse, if they need to wait until the end of the plan year for an aggregate reimbursement. This monthly (or annual) aggregate reimbursement issue can affect any employer who is cash flow sensitive, for whatever reason, and can ultimately impact their ability to operate their day-to-day operations. Aggregate reimbursements have been more frequent due to unsustainable aggregate factors.

Why is this particular aggregate so low? This is a question that needs to be asked more often. Experience reports, which are used to price aggregate coverage, typically reflect medical and pharmaceutical claims with various payment terms. The most common are "incurred" claims, "incurred and paid" claims, and "paid" claims with various run-in or run-out limits. These are typically expressed in two time periods: the incurred time period (first 12 months); and the paid time period (second 12 months). A "12/12" would mean "incurred in 12 months" and "paid in 12 months." This would be considered an immature claims period with a lag period of 1.5 to 2 months at the beginning of the period. Remember, a claim cannot be paid the same month it is incurred. A "24/12" would be considered a mature claims period and include incurred claims going back 12 months plus the current 12 months (thus the first 24) and then a 12-month paid period (the second 12). Again, the claims on 24/12 would be considered mature paid claims with no lag. The claims costs differential (increase factor aka load) between an immature 12-month period to a mature 12-month is approximately +13% to +16%. For a shorter claims period, the load becomes greater to mature the claims, e.g., for a 9-month period, approximately +18% to +22%.

An experienced underwriter can recognize immature claims on a claim report and manually "mature" the claims or, based on their pricing system, indicate in their pricing system that the claims need to be matured. Sometimes the reports are confusing, sometimes the underwriter is inexperienced and doesn't recognize the immature claims pattern, or some underwriters may assume their pricing system will automatically make the adjustment.

I have noticed an increased trend in the marketplace where no lag adjustments are being used on 12/12, 12/15, 12/18, or 12/24 contracts in the most current incomplete year. When claims are not lagged or matured, then the average claims cost are not accounting for 30-60 days of claims lag and is underpriced. Even groups on a 12/12 contract need to have the claims matured when entering into the pricing system since the system will automatically adjust for the 12/12. If only 12/12 claims are entered, the system will further reduce, thus reducing 12/12 claims by another 12/12 contract adjustment. This unintentional underpricing of the aggregate. This may impact the employers claim fund evaluation at the next renewal due to the increased likelihood of an aggregate breach. When this unfortunate event occurs, underwriting pricing history has shown that an employer will likely experience a minimum of a +45% increase in their aggregate claims funding, which also translates to an unexpected increase in their overall business expenses.

Our industry needs to do more self-policing if we are to maintain the integrity of stop loss as a viable self-funded product, especially considering the escalating medical and pharmaceutical costs. This begins with brokers/agents, TPAs, and finally, stop-loss carriers. As the old adage goes, if aggregate numbers "look too good to be true," they probably are, and additional questions should be asked. The days of aggregate coverage being considered simply as "sleep insurance" are gone, but a sense of sanity is still needed. The number of aggregate claims has skyrocketed over the last 2 to 3 years along with aggregate claim amounts. Also, the number of employer groups needing monthly accommodation advances to keep their self-funded plan afloat has tripled. This is then followed by a +50% or so aggregate factor renewal increase and a resurgence of groups considering a move back to fully insured. Cost predictability is needed by small to mid-size employers and this requires credible aggregate pricing. Competitive pricing helps us all, but unsustainable aggregate factors in relation to paid claims is becoming a weak link in our challenge to remain a viable market to the small to mid-level employer market.

Deborah Dore is a senior underwriter at USBenefits Insurance Services. For more information, contact www.usbstoploss.com.

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