MEDICAL STOP-LOSS APPROACHES AN INFLECTION POINT

Reinsurance Retrenchment, Rising Claim Severity, and the Return of Pricing Discipline

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The medical stop-loss (MSL) market appears to be entering a period of meaningful and sustained rate firming, driven by a convergence of deteriorating underwriting performance, rising claim severity, and tightening reinsurance capacity. After more than two decades of persistent competition, several structural pressures are beginning to materially alter pricing dynamics and underwriting behavior across the sector.

Earlier this year, two major reinsurers announced their immediate exit from the medical stop-loss market, while another signaled plans to materially reduce a sizable block of unprofitable business. Industry estimates suggest these actions could remove more than $1.5 billion of effective reinsurance capacity from the market. At the same time, several leading carriers have reported significant underwriting losses and have begun implementing portfolio remediation initiatives.

The medical stop-loss market has been one of the fastest growing segments of the health insurance industry over the past fifteen years. Since implementation of the Affordable Care Act (ACA), annual premium volume has expanded from approximately $8 billion in 2010 to an estimated $40 billion by the end of 2025.

Despite that growth, underwriting performance has steadily deteriorated. Industry-wide gross loss ratios have trended upward for much of the past decade, reaching nearly 86% in 2024, the most recently reported underwriting period. Importantly, these figures reflect gross rather than net loss ratios. Given typical acquisition, administrative, and operational expense loads within the sector, current results suggest that many carriers may be operating at or near unprofitable combined ratios in this line.

Although some carriers initiated corrective pricing and underwriting actions during 2025, early market indications suggest overall results have continued to deteriorate and the industry-wide loss ratio will exceed 90% when the full-year data is released later this year.

The reduction in available reinsurance capacity is expected to reinforce pricing discipline throughout the market. Direct-writing carriers and managing general underwriters (MGUs) are likely to face tighter underwriting parameters, increased facultative review requirements, and higher reinsurance costs on excess treaties. Those additional risk charges will ultimately flow through to employer pricing.

As underwriting profitability becomes a greater priority, carriers are expected to pursue more selective risk selection, stricter renewal underwriting, tighter contract terms, and heightened claims scrutiny. Delegated underwriting authorities for MGUs may also narrow materially as reinsurers seek greater control over risk selection and claims exposure.

A MARKET DEFINED BY PROLONGED COMPETITION

The medical stop-loss market has remained intensely competitive for decades. The last broadly recognized hard market occurred more than twenty-five years ago, around the turn of the millennium. Since then, sustained competition has compressed pricing and gradually eroded underwriting margins across portions of the industry.

Competitive pressures have consistently driven demand for broader contract provisions, restrictive rate caps, and increasingly aggressive pricing, even as underlying medical costs and catastrophic claim severity continued to rise.

While carriers generally seek to price business at actuarially sound levels, prevailing market conditions have often constrained pricing flexibility. As a result, underwriters have frequently been forced to balance pricing adequacy against competitive positioning and retention objectives.

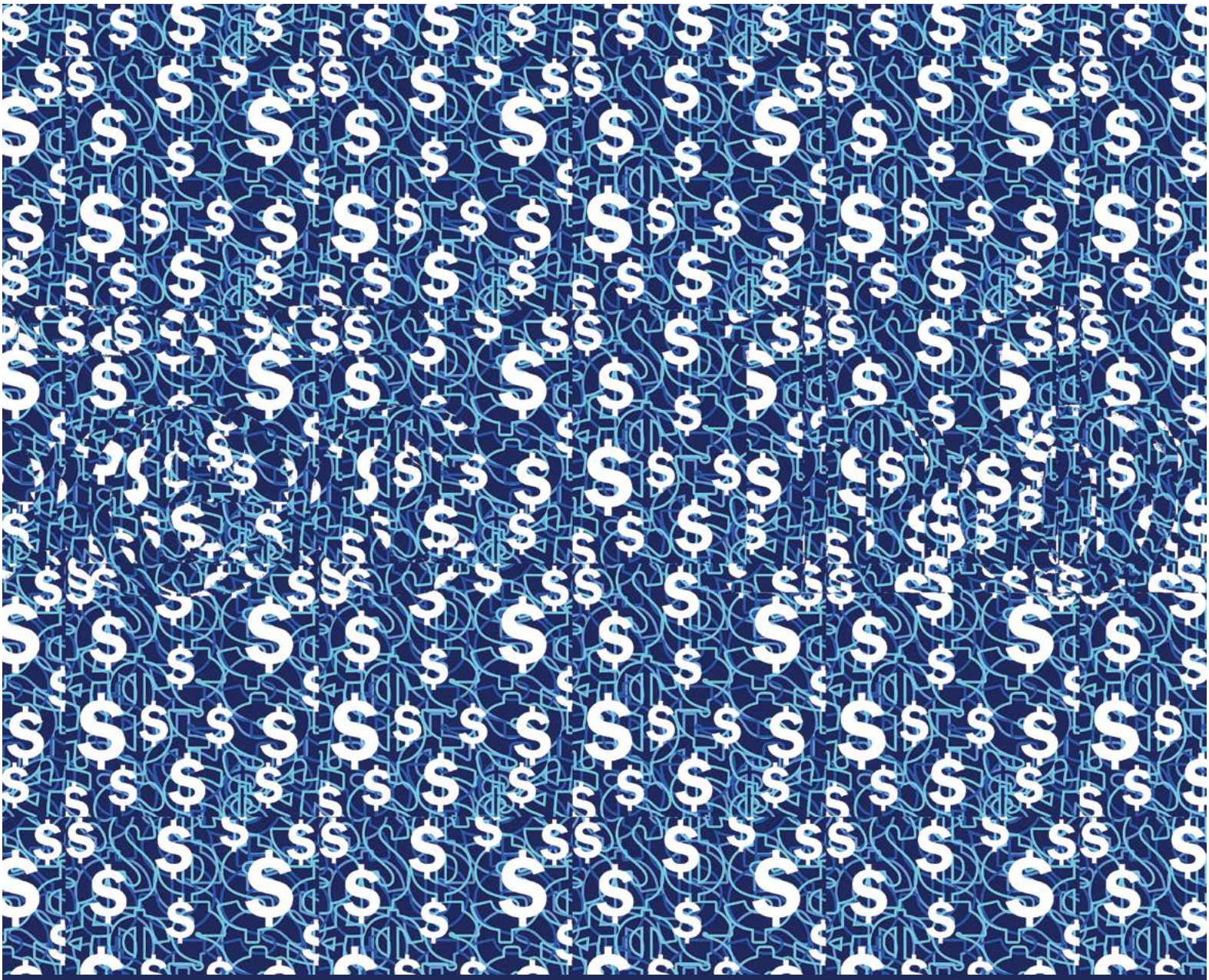
Premium Growth vs. Underwriting Performance (2015–2024)

Year	Total Premium ($B)	Loss Ratio
2015	14.2	75.5%
2016	15.6	79.3%
2017	17.3	78.6%
2018	20.3	79.6%
2019	23.8	82.2%
2020	25.8	80.5%
2021	27.8	83.6%
2022	30.2	84.6%
2023	35.3	80.0%
2024	40.0	85.7%

Source: NAIC Accident and Health Policy Experience Report.

While 2023 reflected temporary moderation in reported loss ratios, preliminary market indications suggest deterioration resumed during 2024 and into 2025.

Market concentration has also increased materially. In 2010, the top twenty-five carriers controlled approximately 70% of the market. Today, the top ten carriers control a similar share of a substantially larger market. Consequently, the underwriting performance of a relatively small group of carriers now exerts disproportionate influence over broader market conditions.



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DRIVERS OF CONTINUED MARKET DETERIORATION

Medical stop-loss coverage is specifically designed to protect self-funded employers from catastrophic claims exposure. However, the continued escalation in both the frequency and severity of high-cost claims is creating substantial underwriting pressure.

The primary drivers of catastrophic claims have remained relatively consistent in recent years. Oncology, cardiovascular disease, musculoskeletal conditions, injectable drugs, and infusion-based therapies continue to represent a significant portion of high-cost claims activity. Additional pressure has emerged from delayed diagnoses, worsening comorbidities, and increased disease severity following the COVID-19 pandemic.

One of the industry's most significant emerging concerns is the rapid development of cell and gene therapies (CGTs). While many of these treatments offer potentially transformative or curative outcomes, their long-term financial impact remains uncertain. Individual therapies are increasingly expected to cost from several hundred thousand dollars to multiple millions per treatment.

The actuarial challenge is compounded by limited longitudinal claims data and uncertainty regarding long-term durability, recurrence risk, and future treatment protocols. As a result, carriers and reinsurers are increasingly pricing for the inevitability of these claims through higher rates, targeted surcharges, tighter underwriting, and more restrictive contract provisions.

SPECIALTY PHARMACEUTICALS AND PBM DYNAMICS

Outside of provider and hospital system charges, specialty pharmaceuticals remain among the most significant contributors to rising healthcare costs.

Prescription drug distribution is largely controlled by pharmacy benefit managers (PBMs), which operate within a highly complex and often opaque pricing structure involving rebates, spread pricing, administrative fees, and manufacturer contracting arrangements. Limited transparency throughout the supply chain continues to contribute to elevated drug costs.

Specialty pharmaceuticals, many of which are used to treat chronic, rare, or life-threatening conditions, now represent a rapidly expanding share of total healthcare expenditures. Compounding the issue is the absence of a universally accepted regulatory definition for what constitutes a "specialty" drug. In many cases, classifications are effectively determined by manufacturers or PBMs rather than through consistent regulatory standards.

Annual treatment costs for specialty pharmaceuticals can range from several thousand dollars to multiple millions per patient. Although newer PBM models and biosimilar strategies may improve cost efficiency, specialty pharmaceuticals are expected to remain a significant driver of medical trend and stop-loss claim severity.

NO NEW LASER CONTRACTS AND RATE CAP COMPRESSION

No New Laser (NNL) contracts combined with restrictive rate cap provisions may represent one of the most significant contributors to underwriting deterioration in recent years.

A foundational principle of alternative risk financing is that predictable or manageable risk is often more efficiently retained by the employer than transferred to an insurer at commercial premium levels. When carriers are unable to appropriately isolate or price known high-risk claimants through lasers or other underwriting mechanisms, underwriting performance will inevitably deteriorate over time.

In many cases, carriers have offered broad NNL protections and restrictive renewal caps in order to remain competitive. That environment now appears to be changing. Underwriters are becoming increasingly selective in offering these provisions and are placing greater emphasis on employer risk management, claims oversight, and cost-containment capabilities.

Going forward, employers seeking broad renewal protections are likely to encounter stricter underwriting scrutiny, narrower eligibility standards, and increased expectations regarding plan management and clinical intervention strategies.

STRATEGIC IMPLICATIONS FOR SELF-FUNDED EMPLOYERS

As the market hardens, self-funded employers will likely need to adopt more disciplined and proactive approaches to managing catastrophic claim exposure and long-term healthcare cost trends.

Pharmacy Management

Prescription drugs and specialty pharmaceuticals remain one of the most significant drivers of medical cost inflation. As a general benchmark, pharmacy-related costs should typically account for no more than 25–30% of an employer's overall health plan spend; however, it is not uncommon for those costs to approach or even exceed 50% in plans utilizing inefficient or non-transparent PBM arrangements. Employers are placing increasing emphasis on PBM transparency, international and alternative sourcing strategies, biosimilar substitution, patient assistance programs, and more direct pass-through of manufacturer rebates. While these approaches may help mitigate pharmacy trend, broader structural pricing pressures in the pharmaceutical market are likely to persist.

Infusion Management

A meaningful portion of infusion therapy cost is driven by the site of care rather than the underlying drug. Shifting treatment from hospital outpatient departments to specialty infusion centers or home-based infusion models can produce significant reductions in overall claim severity and total plan cost.

Leverage alternative provider arrangements

Self-funded employers have significant flexibility to adopt more efficient provider payment and network strategies, including narrow networks, direct contracting, reference-based pricing, and cash-pay models. These approaches can be layered within traditional networks to preserve access and employee acceptance while improving cost efficiency. Selecting the optimal provider strategy is often one of the most impactful levers for reducing total plan cost—and by extension, stop-loss premiums.

Index specific deductibles to offset leveraged trend
Leveraged trend reflects the amplified effect of first-dollar medical inflation on stop-loss reimbursements. For example, a $100,000 claim under a $50,000 specific deductible produces a $50,000 reimbursement. If the same claim increases by 10% to $110,000, the stop-loss reimbursement rises to $60,000—a 20% increase on only a 10% increase in the underlying claim. This dynamic causes carrier exposure to grow faster than underlying medical inflation unless deductibles and premiums are regularly adjusted. Because the cost of expected claims rise annually, specific deductibles should be reviewed and indexed periodically.

Consider aggregating specific deductibles

In addition to selecting an appropriate specific deductible, an aggregating specific deductible can help moderate rate volatility. This structure adds a secondary layer of employer-retained risk above individual claim deductibles and is typically defined as a fixed annual threshold (e.g., $50,000 or $100,000). Once the aggregating specific threshold is met, the carrier begins reimbursing otherwise eligible claims, providing an additional mechanism for premium stabilization.

Captives

A longstanding principle in alternative risk is to transfer risk in soft markets and retain risk in hard markets. Group stop-loss captives have become one of the most significant growth mechanisms in self-funded healthcare, offering employers greater underwriting transparency, volatility control, and long-term financing stability. As the stop-loss market continues to harden, captives are likely to

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become increasingly relevant as a tool for high-quality self-funded employers seeking to manage volatility and improve long-term rate predictability.

LOOKING AHEAD

The medical stop-loss market is not experiencing a routine cyclical shift; it is undergoing structural recalibration. Years of pricing compression, increasing claim severity, and expanding coverage expectations have converged to require a rebalancing of risk and pricing.

In the near term, this will likely result in higher costs and tighter underwriting. Over the longer term, however, a more disciplined market, characterized by appropriate pricing, stronger risk selection, and better-aligned incentives, can improve sustainability across the self-funded ecosystem.

Success for carriers, brokers, and employers will depend on adapting to this environment with analytical discipline, strategic flexibility, and a willingness to reconsider long-standing assumptions about risk transfer and cost management. ■

Phil Giles is Chief Growth Officer for Skyward Accident & Health. He has more than 38 years of experience including senior leadership roles within the medical stop-loss and captive industry.
Phil has received multiple industry honors, including Captive International's U.S. Reinsurance Individual of the Year (2023) and Cayman Reinsurance Individual of the Year (2019 and 2021). He was also named Captive Professional of the Year at the 2017 U.S. Captive Awards and has been named to Captive Review's Power 50 listing of the most influential individuals in the worldwide captive industry.