WHITE PAPER

STOP LOSS INSURANCE, SELF-FUNDING AND THE ACA

I. Introduction

Since the passage of the of premium tax credits, individual and employer mandates and health insurance market

ng guaranteed issue, a prohibition on preexisting condition exclusions, and adjusted community rating in the

nall group markets.

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One concern about the potential impact of the ACA is that if employers—particularly small employers, with younger, healthier employees—self-fund, thereby avoiding some of the requirements of the ACA, it will leave the TJ 0.154 Tw -22.578 -1.73

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stop loss policy. The aggregate coverage provides protection

claims and new enrollment. And, finally, the stop loss insurer ensures that the employer is reimbursed based on the policy. State insurance regulators have few concerns in the majority of cases where the policy language is clear, the claims are paid promptly and the employer is appropriately reimbursed for eligible losses. In other cases—for example, when policy language is ambiguous or the agent has not adequately explained the program—there may be significant regulatory concerns.

III. Anatomy of a Self-Funded Health Plan Combined with Stop Loss Insurance

An employer establishing a self-

be prepared to assume the risk of relapse to avoid a more costly premium increase. However, before taking that risk, the employer should first have the cash reserves to pay for a large claim incurred by that employee if a significant medical event occurs. The ACA prohibits self-funded employer health plans from discriminating based on health status or imposing annual or lifetime dollar limits on essential health benefits (EHBs).

Self-funded plans have a great deal of flexibility in plan design; however, the ACA has limited that flexibility somewhat. The ACA requires that certain benefits be covered, such as certain preventive benefits; it also prohibits annual and lifetime dollar limits, it limits employee cost-sharing and it places “minimum value” and affordability requirements on the health plan design. Still, an employer may wish to add or subtract benefits to accommodate its budget while still meeting the requirements of federal and/or state law, based on the needs of its employees. For the largest plans, almost any benefit can be added—for a price. Each benefit may be priced by the plan administrator based on how much it will raise the cost of the plan, both from a claims perspective and a stop loss insurance perspective. As employers get smaller, self-funded health plans (often designed by the TPA) tend to become more standardized.

Employers need to be aware that unless a stop loss insurance policy contains a provision or endorsement providing extended coverage, it reimburses the employer only for claims that were incurred and paid during the same policy year. To minimize gaps in coverage, the policy may include a “run-out” or “extended reporting” period, commonly referred to as “tail” coverage, which protects the employer against claims incurred during the policy year but

Stop loss insurance is sometimes referred to as a form of reinsurance, but a significant difference between stop loss insurance and reinsurance is the nature of the entity purchasing the coverage. Reinsurance covers a licensed insurer for its obligations under insurance policies, while stop loss insurance covers a self-funded employer for its obligations under a health benefit plan. However, for any given benefit plan, the actuarial risk—i.e., the usage of covered medical services by the plan participants during the plan year—is the same, regardless of whether the plan is fully insured or self-funded.

Many of the

The NAIC adopted the *Stop Loss Insurance Model Act* (#92) in 1995, and revised it in 1999, which set the following minimum attachment points, and gives the commissioner the authority to adjust them for inflation:

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In addition to the basic coverage for claims incurred and paid during the policy period, the contract should specify coverage, if any, for claims incurred but not paid during the policy period, including the length of the "run-out" reporting period, and should specify whether there is any coverage for claims incurred before the policy period. Employers should be aware of their liability for claims that are incurred during the policy period, but not covered under the terms of any "tail coverage" provided by the stop loss policy.

Stop loss policies are written with one-year terms. As a result, a stop loss policy's contract terms and price can vary from year to year, due to re-underwriting. In some cases, the stop loss insurer may even decline to renew or may cancel the policy, sometimes even mid-term. Because the policy is newly underwritten from year to year, when a stop loss insurer offers coverage to an employer whose employees have significant medical conditions, it may offer coverage at a much higher premium rate, with higher stop loss limits (both aggregate and specific), or may offer coverage with higher specific limits on some employees (known as a "laser specific").

Stop loss insurance

health plan fiduciary and are outside the scope of an insurance product whose primary purpose is to, in effect, “reinsure” a risk incurred by the health plan fiduciary, the employer.

Some stop loss insurance policy filings include provisions that add a managed care element with respect to the plan participants by offering financial incentives for using certain providers. This type of provision is typically part of the health plan, not part of the stop loss policy, and, depending on how the provision is worded, it might establish a direct relationship between the stop loss insurer and the individual plan participants that goes beyond the customary contract between the stop loss insurer and the employer. Rather than managing claims by capping the stop loss insurance benefits, and letting the plan sponsor handle benefit and network management, the stop loss insurer inserts itself into plan-management activities, even though stop loss policies expressly state that the stop loss insurer is *not* the plan fiduciary and that the beneficiaries of the plan have no legal recourse against the stop loss insurer.

The case-management theme continues in stop loss policy provisions that permits certain plan-management fees to count as eligible expenses under the stop loss policy. Such fees include:

Reasonable hourly fees for case-management services provided by a nurse case manager retained by the plan sponsor or the TPA.

Fees for hospital bill audit services.

Fees for access to “non-directed” provider networks (which was an undefined term in the policy form).

Fees or costs associated with negotiating out-of-network bills.

One policy form with fee reimbursement provisions states that such fees can be considered eligible for stop loss reimbursement if the plan sponsor demonstrates to the stop loss insurer that the fees generated savings to the self-funded health plan. Stop loss reimbursement for such fees is limited by applying a percentage allowable, and a dollar maximum, per plan enrollee per hospital stay. These provisions might indicate that the stop loss insurer is actually simply footing the bill for case management and out-of-network claim negotiation and is engaging in plan fiduciary activities without acknowledging fiduciary responsibilities.

State insurance departments may consider the extent to which these and other types of innovative policy provisions might create a relationship between the stop loss insurer and the health plan beneficiaries that goes beyond the relationship between the stop loss insurer and the employer. If the stop loss coverage is no longer functioning as third-party coverage, state policymakers and insurance regulators need to consider how best to address the issues raised, including whether such provisions are appropriate in a stop loss insurance policy at all, whether they need to be explicitly disclosed to the employer and whether plan participants should be entitled to insurance law protections commensurate with the insurer’s involvement in the benefit-payment process. These types of policy provisions must be carefully studied and appropriately regulated in order to ensure that they do not adversely affect the interests of policyholders, employees and their dependent,Th

policy provisions. If the small employer is unable to manage the risks posed by these provisions, and is thereafter unable to meets its obligations with respect to the health benefit plan, there is the potential for substantial harm to individuals and the public. **The provisions listed below were found in a few stop loss policies that were reviewed. The drafters of this white**

employers, these TPAs are designing the health plan, preparing the summary plan descriptions (SPDs) and legally required notices, processing the claims (including making medical necessity decisions) and collecting all of the various required payments from the employer. Sometimes, it appears that the stop loss insurer is directing the TPA's activities to a greater extent than the employer is.

- The language in the stop loss policy makes it clear that the employer is the fiduciary for the health plan and is

Many stop loss insurance policies have **strict provisions requiring immediate and anticipatory reporting of any possible, or even suspected, large claims.** Employers are expected to submit "proof of loss" forms to the stop loss insurer "within 30 days" of the date the employer "becomes aware of the existence of facts which would reasonably suggest the possibility that the expenses covered under the health plan will be incurred which are equal to or exceed 50% of the specific deductible." Failure to meet this requirement, which forces employers to report claims before they have even been incurred, may result in the rescission of the terms of the stop loss insurance policy.

- In addition, most stop loss insurance policies reviewed in this sample required immediate reporting of medical conditions that developed or worsened for existing employees, new employees and their dependents. Failure to report (even before claims were incurred) could result in rescission of the stop loss insurance coverage.
- Many employers may not have this information available to them until after claims have been submitted, particularly concerning dependents.

All stop loss insurance policies require immediate notification of any new risk. That notification will then trigger various actions, up to and including mid-term rate increases, retroactive rate increases and policy cancellation. Some policies even include detailed lists of conditions that must be reported, even if they are only suspected and no claim has been incurred. All policies include provisions that trigger re-underwriting and rate increases if the employee census changes by more than a specified percentage; e.g., 10% or 20%.

- Employers are legally prohibited from discriminating on the basis of health status, but stop loss insurers are not, and many of the policies have provisions that will trigger immediate, or even retroactive, increased premium when the stop loss insurer receives greater-than-expected claims.

Reasons (other than nonpayment of premium) for termination by the stop loss insurer prior to the policy anniversary date:

- Some stop loss policies permit termination without cause by the insurer at any time with 30 days' notice. Some states have laws prohibiting such clauses, but stop loss policies are not subject to the standard form review procedures in many states. The employer is at serious risk if the stop loss insurer is not committed to the risk for the same time period as the employer, especially if the employer has already borrowed money from the stop loss insurer to finance its share of the claims. This is particularly problematic in the case of aggregate coverage, which becomes illusory if the insurer can cancel the policy if it sees the aggregate attachment point approaching.
- Failing to meet "participation" requirements by keeping a specified number of employees (e.g., more than 10, or 51 or 200) in the plan.
- Failure by the employer to pay a claim within 30 days from the employer's claim fund or to report (within 30 days) the possibility of claims triggering a payment from the stop loss policy.
- Underfunding of the employer's claim account.
- Change in the TPA.

Some stop loss insurance policies have rescission provisions. The ACA limits rescissions by health insurers, except in the case of fraud or intentional misrepresentation of a material fact. That provision does not apply to stop loss insurers. Many stop loss insurance policies allow for rescission on the basis of any mistake or misrepresentation, even if it was unintentional and made by only one employee or dependent. Any rescission leaves

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Most stop loss insurance policies contain explicit statements that the stop loss insurer is not the plan fiduciary, but the policy does not define what a "plan fiduciary" is.

Many stop loss insurance policies contain provisions that are generally not allowed under state law, such as venue restrictions (in favor of the insurer), attempts to limit the time frame for filing a lawsuit against the company in violation of state laws limiting waivers of statutes of limitations, and subrogation provisions that do not comply with state law. Regulators should review these provisions carefully to determine if they comply with applicable state laws and/or regulations.

VII. Regulatory Options to Protect Policyholders, Consumers and H

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9. Rate review. In the states where insurers are required to obtain the approval of the state insurance regulator prior to use of a stop loss rate, regulators may want to consider:
   a. Whether the rate is reasonable in relation to the benefits conferred, especially in the case of policy provisions that significantly limit the coverage of claims.
   b. Whether the rate is allowed to vary based on the claims submitted by the employer.
   c. How the rate is determined in cases where the employer's experience is not credible. For employers without credible experience, regulators should also carefully examine how the insurer calculates "expected claims" when determining compliance with minimum aggregate attachment point requirements.
10. Rate and form filing requirements; actuarial certification and memorandum. In order to keep abreast of developments in the stop loss insurance market for small employers, and in order to properly review the filed rate and form, state insurance regulators may wish to require that entities have information available for review on each employer, regardless of whether prior approval of the filing is required by law. For example:
    a. The number of policies issued to employers of certain group sizes.
    b. The SERFF tracking number for the policy form issued.
    c. The actuarial memorandum for each employer could include:
       i. The actuarial assumptions and methods used by the insurer in establishing attachment points for the policy issued to the employer, identified by group size.
       ii. The actuarial assumptions and methods used by the insurer to determine, with a reasonable degree of actuarial certainty, the expected claims of the employer.
    d. The actuarial memorandum for each employer (de-identified) could be accompanied by data for the stop loss insurer's experience with respect to the employer. Similar to requirements in place in Utah[14] and Rhode Island,[15] the following data could be included:
       i. Covered employee count and covered lives count at the beginning of the policy term.
       ii. Covered life exposure years and employee exposure period for the experience period.
       iii. Specific attachment point.
       iv. Expected claims in the absence of the stop loss insurance coverage.
       v. Expected claims under the specific attachment point.
       vi. Aggregate attachment point.
       vii. Earned premium.
       viii. Claims paid under the policy broken out by specific losses and aggregate losses.

This information would be available for the regulator to review on any market conduct examinations conducted on the stop loss insurer. Whether accompanying an actuarial memorandum or collected separately, data could help the states develop a sense of trends over time and monitor the performance and behavior of this market segment. Basic data collection on premiums and claims paid, possibly in categories related to group size, could provide the states with valuable information about the market. Colorado[16] and Missouri[17] have existing data-collection laws that could serve as models or as a springboard

[14] *See*, Utah R590-268-9.
[15] *See*, Rhode Island Annual Certification filing instructions for stop loss insurance.
[16] *See*, Colorado Revised Statute 10-16-119.
[17] 20 CSR 200-1.037.

for additional discussion. In Colorado, data is collected on premiums based on employer group size. However, no data is collected on claims paid, which could be an important part of understanding the market. In Missouri, both premiums and claims data are collected, but without regard to group size, leaving unanswered any questions as to the unique behavior of stop loss issued to smaller groups.

Other policy options might be to consider requiring guaranteed issue and community rating requirements in the small employer stop loss market similar to those that exist in the fully insured small group market. One plan considered by the U.S.

APPENDIX A

Counting employees. Federal rules establish a standard method to count employees. In the states where this federal counting method is used, some small employers will become large employers, and vice versa, resulting in winners and losers depending upon the demographic characteristics of the group.

Age rating curve. Federal rules establish a rate-development methodology that requires per-

APPENDIX B

ERISA and the Roles of State and Federal Regulation of Insurance

When discussing health insurance, most people tend to think of the fully insured health plans typically offered to individuals and small employers by insurance companies. But the truth is that the employer market is large and diverse, and f.

and/or regulations apply only to fully insured plans. In reality, ERISA applies to all employee benefit plans. Even if a plan is fully insured, certain features of the plan—such as the classification of eligible participants and the share of the premium that a participant pays for coverage—are established by the employer and are regulated under federal law by federal regulators. It is the group health insurance policy, not the fully insured plan itself, that is regulated by the states.

In general,[22] the line between federal and state authority is not based on the nature of the health plan, but on the nature of the regulated entity; i.e., the states can regulate insurers, but they cannov3n.003 6834gr.d-917(ate)-3eaC(en1)1-129(gr-17(ns)-12(no.001 To

APPENDIX C

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