WHITE PAPER

STOP LOSS INSURANCE, SELF-FUNDING AND THE ACA

I. Introduction

Since the passage of the federal Patient Protection and Affordable Care Act of 2010[1] (ACA), there has been a lot of speculation about its potential impact. The goal of the law is to make affordable, quality health insurance available to all Americans through a combination of premium tax credits, individual and employer mandates and health insurance market reforms, including guaranteed issue, a prohibition on preexisting condition exclusions, and adjusted community rating in the individual and small group markets.[2]

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 older, sicker population to the fully insured, small employer group market. This concern is based on the differing underwriting standards. Because the small group market requires modified community rating and the self-funded market is allowed to reflect an employer's risk, it is assumed that self-funded plans will be attractive to low-risk groups; conversely, high-risk groups are expected to see better rates in the modified community-rated environment of a fully insured plan. For most states, the advent of modified community rating has widened that gap. Some have expressed the concern that if stop loss coverage is not adequately regulated, it can make the adverse selection problems worse by serving as a functionally equivalent product that competes directly with the community-rated small group market, but is allowed to underwrite and rate based on health status and claims experience. But small employers are facing higher and higher health insurance premiums every year, so the adverse selection concerns must be balanced against the fact that the rising costs of small employer health insurance will lead some small employers to exit the small group market entirely.

Predicting the effect of the ACA on employers' decisions regarding whether to self-fund is complicated by the lack of information about the prevalence of self-funding in the pre-ACA environment. There is little information about the number of employers that currently self-fund. The states do not regulate self-funded employer plans[3] and, consequently, have little information about them and the number of employers that self-fund.

In an effort to remedy this, Section 1253 of the ACA mandates that the Secretary of the U.S. Department of Labor (DOL) prepare aggregate annual reports with general information on self-funded group health plans (including plan type, number of participants, benefits offered, funding arrangements and benefit arrangements), as well as data from the financial filings of self-funded employers (including information on assets, liabilities, contributions, investments and expenses). The DOL engaged Deloitte Financial Advisory Services LLP to assist with this ACA mandate. Three years of reports have been completed. The 2013 report can be found at *www.dol.gov/ebsa/pdf/ACASelfFundedHealthPlansReport033113.pdf.*

The primary shortcoming of this data, however, is that it does not include small employers (i.e., employers with 100 or fewer employees) that pay for any portion of benefits from their general assets (rather than a segregated trust). These small employers are exempted from all filing requirements. This includes an unknown number of self-funded small employers.

[1] Public Law 111-148.
[2] See Appendix A for a discussion of the new ACA requirements on small employers as compared to self-funded plans.
[3] See Appendix B for a discussion of the relationship between state law, ERISA and stop loss insurance.

Many articles have been written discussing the potential for, and consequences of, small employer self-insurance in the post-ACA environment.[4] At this point, the increase in small employer self-funding is not known. However, there has been demonstrated interest in discussing self-funding in the small group market. One indication of this interest that the states are seeing is the development of stop loss insurance policies specifically designed to market to small employers.

This paper explores some of the policy provisions seen by state insurance departments and the regulatory issues they raise. This paper also identifies other issues about which state insurance departments need to be aware when regulating stop loss insurance policies. The insurance market is changing, and regulators need to keep abreast of what is happening in the marketplace and work together to ensure that small employers understand their obligations under any self-funded arrangement and that both the fully insured and self-funded markets operate in the interest of small employers and their employees.

II. How Does Self-Funding Work and Where Does Stop Loss Insurance Fit In?

Unlike the employer who purchases a fully insured plan from an insurance company, an employer who self-funds takes on all the responsibility and risk that a fully insured employer has transferred to the insurance company. A self-funded employer determines what benefits to offer, pays medical claims from employees and their families, and assumes all of the risk. Self-funding leaves the employer at significant risk for "shock claims" (i.e., high dollar but low frequency claims, such as an organ transplant) and high utilization claims (i.e., low dollar but unusually high frequency claims). A self-funded employer may transfer some of its risk of loss to a stop loss insurer by purchasing a stop loss insurance policy, but the employer remains ultimately responsible if the stop loss insurer fails to perform or denies a claim based on the terms of the stop loss contract, or if there are gaps in coverage or conflicts or inconsistencies between the stop loss policy as administered by the insurer and the employer's obligations under the self-funded benefit plan.[5]

Nearly all employers with self-funded plans, except for some of the largest employers, hire third-party administrators (TPAs) to administer their plans. TPAs—including insurers with "administrative services only" (ASO) contracts—can provide a variety of services. They usually assist the employer with designing the benefit package, estimating the costs associated with the entire program or adding a particular benefit, as well as ensuring that the health plan complies with applicable state and/or federal law and notice requirements. TPAs may also provide cost-management services, such as access to provider networks and the ability to conduct sophisticated care-management programs with the same economies of scale as insurers. Finally, a TPA will have staff available to help the employer deal with enrollment issues and process medical claims. For all these services, employers will pay a fee and provide the "checkbook"; i.e., the money necessary to pay the claims. However, a self-insured employer still bears ultimate accountability for the administration of the plan, so the employer must exercise due diligence in selecting a TPA.

Employers can mitigate risk by using stop loss insurance. A stop loss insurance policy usually contains two components: 1) a specific "attachment point" (or "retention level") that protects against claim severity; and 2) an aggregate attachment point that protects against claim frequency. The policy's specific coverage provides protection in the case of a single covered individual with a high-dollar claim or series of claims. Any costs exceeding the specific attachment point are covered by the

[4] See Appendix C for a bibliography of articles exploring the pros and cons of small employer self-insurance.
[5] Risk transfer can also operate in the other direction. In the large group market, a fully insured employer and its insurer may agree to a loss-sensitive rating plan, where the employer gets a surcharge or refund at the end of the year depending on claims experience. This type of plan allows the employer to assume some or all of the financial risks and rewards of self-insurance, while the employees have all the protections of a fully insured plan.

stop loss policy. The aggregate coverage provides protection against the cumulative impact of smaller claims that may never meet the threshold of a specific attachment point. Once the employer's total claims payments (not counting any claims paid by the specific coverage) reach the aggregate attachment point, the stop loss policy covers all remaining costs for the year (up to the policy limit, if any.) Except for very small employers, the aggregate attachment point will be significantly less than the sum of the specific attachment points.

Example:

An employer with 100 employees buys stop loss coverage with a $25,000 specific retention level and a $1 million aggregate retention level. After reaching the aggregate retention level, the employer is covered at 100%.

Scenario 1:

In January, one employee has a premature baby, with covered expenses costing $1.5 million. The specific retention level is met in this scenario; therefore, the employer is responsible for the amount up to the specific retention level ($25,000). The stop loss insurer is responsible for the amount above the specific retention level ($1.475 million). All expenses for that one employee for the remainder of the year will be reimbursed by the stop loss insurer. Only the amount the employer is responsible for ($25,000) counts toward the $1 million aggregate retention level. In this scenario, the employer has not reached the aggregate retention level.

Scenario 2:

In the plan year, 10 employees have incurred large claims in excess of $25,000. The employer is responsible for the amounts up to the specific retention level (10 x $25,000 = $250,000) and the stop loss insurer is responsible for the remaining expenses above the specific retention level for each of those 10 employees. Forty more employees have incurred claims averaging $15,000 each. The employer is responsible for these amounts (40 x $15,000 = $600,000), as they are below the specific retention level. The remaining 50 employees have incurred claims averaging $5,000 each. The employer is also responsible for these claims (5 x $5,000 = $250,000), as they are below the specific retention level. The total expenses paid by the employer ($1.1 million) exceed the aggregate retention level. In this scenario, the employer is reimbursed $100,000 under the aggregate retention level coverage.

An additional risk faced by self-funded plans is timing risk. A fully insured employer does not have this risk; the employer pays a fixed premium every month, established at the beginning of the policy term. A self-funded employer, by contrast, needs to pay claims when they are incurred, and the timing is beyond the employer's control. If an employee has a catastrophic medical expense in January, the employer must pay the entire specific retention upfront before the specific stop loss coverage steps in for the remaining expense. If the plan reaches the aggregate retention level at the end of September, the employer must pay the year's entire aggregate retention level in the first nine months. The unpredictable cash flow of a self-funded plan, even with stop loss insurance, cannot be budgeted with confidence, especially by small employers, and accelerated claims liabilities could result in significant financial hardship. Therefore, some stop loss policies contain clauses or endorsements that may be referred to as an "aggregate monthly accommodation" or an "advance funding loan agreement."

It is important to acknowledge the role of agents, TPAs and stop loss insurers in designing these arrangements for employers. In most cases, these policies work seamlessly because of the successful working relationship between all parties. The agent works directly with the client to ensure that the benefits package meets their expectations, and the client fully understands the cost implications of moving to a self-funded arrangement. The TPA works to ensure that the policy language is clear to the employer and the employees, and that proper guidelines and procedures are in place to deal with issues such as

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-funded plan will have to make a number of important decisions about the design of the plan. The contract between the TPA and the employer must detail the services provided by the TPA. The employer must determine how much risk to insure with a stop loss policy and select a stop loss insurer. The employer must also determine the benefits to be covered by the self-funded plan. A smaller employer often relies on a TPA to advise on what benefits and protections for employees are required by federal law and to ensure the health plan is fully compliant with applicable laws and/or regulations. Employees covered under these types of health plans do not have the benefit of the regulatory oversight provided by state insurance departments that review and approve fully insured health plans. The DOL does not conduct any prior review of self-funded health plans for compliance before they commence operation. If the health plan does not comply with the provisions of the federal Employee Retirement Income Security Act (ERISA), the Health Insurance Portability and Accountability Act (HIPAA) or the ACA that are applicable to self-funded health plans, an employer that relies entirely on a TPA may not be aware that there is a problem until a complaint is made or the plan is selected for a random audit. If the TPA or other contractor has made a mistake, the employer may be held responsible. The best way for an employer to avoid issues with its plan is to work with a well-informed agent that only works with a high-quality TPA. A good TPA will work with an agent to ensure that the employer does not face any surprises and stays fully informed on all pertinent issues.

The TPA contract must address a number of day-to-day operational issues. For example, the TPA contract must determine who creates and distributes the summary plan description and any other plan documents and/or required notices. The contract governs the payment of claims, and it specifies issues surrounding the funding of the account to pay claims. The document also covers run-out claims issues (i.e., claims incurred during the contract year but presented after the end of the year), run-in claims issues (i.e., claims incurred before the beginning of the contract year[6] but not yet presented for payment), and the transition process when the contract is renewed or terminated. It will also cover myriad other issues typically contained in insurance contracts.

The specific and aggregate attachment points of the stop loss insurance policy determine how much risk the business retains and how much risk is transferred to the insurer. How much the employer is willing to pay for lower attachment points, to the extent permitted by state and/or federal law, will depend on how much risk the employer can afford to assume and what attachment points the state insurance regulator will allow. The stop loss policy is subject to underwriting—both at the initial point of sale and upon renewal—so the insurer will examine the employer's claims history, and may offer coverage at an increased rate or refuse to offer coverage to that employer group if there is adverse or incomplete information. In some cases, either as a condition of offering coverage at all or in return for a lower premium rate, stop loss insurers will offer a "laser specific" attachment point, meaning a higher attachment point for one or more individuals with preexisting high cost medical conditions or other identified risk factors. For example, if an employee's condition is in remission, the employer may

[7] *See, e.g.,* 24-A Me. Rev. Stat. Ann. § 707(3) ("An insurer other than a casualty insurer may transact employee benefit excess insurance only if that insurer is authorized to insure the class of risk assumed by the underlying benefit plan").

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 not reported or paid during the policy year. The run-out period is a specified extended reporting period for claims incurred during the policy year but not submitted or paid until the after the end of the policy year. A few states require stop loss insurers to provide tail coverage, or at least to offer it on an optional basis. Stop loss insurers may also sell "run-in" or "nose" coverage, which protects against self-insured claims incurred during the prior policy year but paid during the current policy year. Group health insurance policies provide coverage on an occurrence basis, so nose coverage is not needed if the prior plan year was fully insured.

Typically, the only restrictions on policy termination will be the restrictions required by state law for commercial lines or casualty insurance policies in general; i.e., timely notice of cancellation or nonrenewal, and cancellation only for the specific grounds permitted by state law.

IV. Regulating Stop Loss Insurance

The states have taken different approaches to the regulation of stop loss insurance and it is important to understand how stop loss insurance functions from a regulatory perspective. Stop loss insurance is a "third-party" line of coverage. This means the claimant who has suffered the primary loss (i.e., the medical event) is **not** insured under the policy. This is the fundamental distinction between stop loss insurance and group health insurance. Stop loss insurance insures only the employer; therefore, the insurer has no direct contractual obligations to the plan participants. Plan participants rely on the employer, not the stop loss insurer, for benefit payments. Property insurance, by comparison, is "first-party" coverage; i.e., the claimant whose property has been stolen or damaged is the policyholder, and files a claim with his or her own insurance company.

While stop loss is a highly specialized line of insurance, it has much in common with the two most basic and ubiquitous types of third-party coverage: 1) reinsurance; and 2) liability insurance. The similarities and differences are instructive to regulators when they consider how best to regulate stop loss insurance.

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 distinguishing features of reinsurance regulation are based on the manner in which the ceding insurer and the underlying insurance transaction are regulated. In particular, reinsurers do not need to be licensed in the state where the ceding insurer is located, because the ceding insurer is already subject to comprehensive regulation, including oversight of its reinsurance program. Reinsurance is exempt from premium tax, because the underlying insurance transaction was already fully taxed at the "retail" level. These features do not apply to stop loss insurance.

The regulatory approach to reinsurance is based, in part, on the recognition that ceding insurers are relatively large and sophisticated business enterprises that do not need the same range of consumer protections as individuals who purchase insurance. Stop loss coverage, likewise, is a commercial, rather than a personal, line of insurance and should be regulated accordingly, although consideration should be given to the differing situations of small and large employers. While many small employer owners may be savvy businesspeople with access to large financial resources, others are not. It is the primary job of the regulator to be concerned with the least sophisticated insurance consumers, rather than the most sophisticated.

Stop loss coverage can also be viewed as a form of liability (casualty) insurance. The difference is that traditional liability insurance protects the policyholder against liability for harm to third-party claimants when the policyholder is in some way responsible for the harm. By contrast, an employer that has not established a self-funded health plan has no responsibility for employees' health care needs (except for work-related conditions that would be outside the scope of a health plan).

The two analogies lead to different conclusions as to which type of insurer should be authorized to write stop loss coverage. If stop loss insurance is treated like reinsurance, then it should be written by the same type of insurer that writes the underlying direct coverage, which would be a health insurer. On the other hand, if stop loss insurance is treated like liability insurance, then it should be written by a casualty insurer. Both types of companies participate in this market, and different states take different approaches. Some states treat it as a health insurance line, others as a casualty insurance line. Several states classify it as casualty insurance, but also authorize health insurers to write it.[7] This distinction becomes critical when determining which state insurance laws will apply.

While stop loss insurance provides essential protection for self-funded employers against large losses, it can also be used for a completely different reason; i.e., to take advantage of favorable regulatory treatment. A stop loss policy with low enough attachment points functions like a group health insurance policy with premiums being split between TPA fees, stop loss insurance and a fully funded claims account, but without being subject to the same regulatory requirements as health insurance. Additionally, even though the ACA has imposed some new requirements on self-funded health plans, many other provisions—including rating restrictions, EHB requirements and state-mandated benefit laws—do not apply.

Regulators have responded by establishing risk-transfer standards. Many states set thresholds for stop loss attachment points, with the goal of ensuring that employers buying this coverage retain enough risk that they remain truly self-funded.

[7] *See, e.g.,* 24-A Me. Rev. Stat. Ann. § 707(3) ("An insurer other than a casualty insurer may transact employee benefit excess insurance only if that insurer is authorized to insure the class of risk assumed by the underlying benefit plan").

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:

- Specific: At least $20,000.
- Aggregate (groups of 51 or more): At least 110% of expected claims.
- Aggregate (groups of 50 or fewer): At least the greater of 120% of expected claims, $4,000 times the number of group members or $20,000.

V. Rate and Form Review of Stop Loss Insurance

The regulation of stop loss insurance has, historically, in many states, been focused primarily or exclusively on prohibiting excessive risk transfer so that stop loss coverage is only sold to bona fide "self-funded" employers. However, because of the manner in which the stop loss insurance market has developed, and because of the types of provisions found in some stop loss policies, the review of stop loss rates and forms[8] also should focus on protecting the interests of stop loss policyholders, as well as the interests of health benefit plan members and others who might suffer collateral harm if the stop loss insurance has the potential to leave the self-funded employer unable to fulfill its fiduciary obligations.

Several aspects of the typical stop loss insurance policy are important to identify. Many of these aspects were mentioned in the previous section titled, "Anatomy of a Self-Funded Health Plan Combine with Stop Loss Insurance." Identifying these typical policy provisions is critical in assessing the financial exposure and risk of harm to a small employer, and, ultimately, to the member employees and dependents of the self-funded health plan. These aspects are also important in designing appropriate regulatory standards for the review of stop loss forms and rates.

- The self-funded employer remains legally responsible to pay the claims of its member employees and dependents. The employer is the plan fiduciary under ERISA.[9] Fiduciaries can be personally liable if they fail to fulfill their fiduciary obligations under ERISA, and they are liable if they know, or should have known, of any breach by a co-fiduciary. When a self-funded employer delegates some or all of its fiduciary responsibilities to a service provider (e.g., a TPA), the employer is required to monitor the service provider periodically to ensure that it is handling the plan's administration prudently.
- Both the timing and the amount of claims can vary significantly from month to month and year to year. And because, from an actuarial perspective, the smaller the group, the less predictable the claims experience, there can be significant cash flow issues for the small employer in months where the claims experience is significantly higher than average and employers are required to contribute additional funds to the claims account.
- Some policies include policy provisions, sometimes called "monthly aggregate accommodations," that mitigate the risk of high and low claims months by allowing claims accounts to include a temporary negative balance. The policy should clearly specify the repayment provisions, including any penalties and interest. Usually, the full amount of any advances must be repaid immediately if the contract is terminated, which could have a punitive impact. If claims advances are funded by an outside lender, they will be outside the scope of the insurance contract and should be reviewed carefully for hidden fees and charges.

[8] Many states do not have the authority to review stop loss rates and some do not review or approve stop loss forms.
[9] See, "Meeting Your Fiduciary Responsibilities," February 2012, Employee Benefits Security Administration, U.S. Department of Labor; *www.dol.gov/ebsa/pdf/meetingyourfiduciaryresponsibilities.pdf.*

- 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 premiums are developed based on an actuary's determination of the expected losses of the self-funded group. In the case of a large self-funded group, the experience of the group is generally credible, and premium development proceeds in a manner similar to an insured large group. The experience of a smaller group (e.g., employers with 51 to 100 employees) is not fully credible, and some degree of actuarial judgment is needed to set a premium. In the case of a very small group, a credible estimate of expected losses may not be realistic. In these circumstances, an actuary may be unable to determine, with a reasonable degree of actuarial certainty, the "expected claims" of the small employer, and, therefore, may be unable certify that the policy is in compliance with regulatory standards regarding establishing minimum specific or aggregate attachment points with reference to "expected claims." In this case, for example, the actuary may be unable to provide an actuarial certification that the annual aggregate attachment point is no lower than 120% of expected claims.

All of the above factors increase the financial risk and uncertainty to the small employer. However, most states do not limit the size of employers that may buy stop loss insurance, and some stop loss insurers, TPAs and brokers may market to employers with as few as 10, or even five, employees.

VI. Additional Stop Loss Insurance Policy Provisions that Merit Regulatory Consideration

In addition to the common policy provisions discussed above, state insurance regulators have seen other provisions in stop loss policy forms addressing a variety of additional issues. The provisions discussed below are not intended as a representative sample of "typical" policy provisions. Some are relatively common, but others are highly unusual. Some were approved by the regulators who reviewed them, while others were rejected—but all of them have been found in regulatory form filings. This means that, in the states that do not review stop loss forms, even the disapproved provisions might be in policy forms that are currently available in the marketplace.

One area of concern is related to provisions that are typically found in health insurance plans, such as medical necessity determinations, "usual, customary and reasonable" (UCR) determinations, experimental/investigational determinations, case-management requirements and mandated provider networks. Because there is no fully insured health plan present, some states might treat these arrangements as being outside the scope of state regulatory authority. However, some states will disapprove these provisions in stop loss insurance policy forms on the grounds that these determinations must be made by the

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 dependents, health care providers and the market for fully regulated health insurance products.

Samples of provisions found in stop loss insurance products reviewed by the drafters of this paper are detailed below. This was not an exhaustive review of available stop loss insurance products. However, even in this small sample, the policies reviewed were often significantly different from each other. The provisions described below were found in some policies, but not all, which demonstrates the fact that stop loss insurance products are not uniform and contain many variations. Some of these provisions may represent a significant risk to small employers, who may not have the resources to manage the complexities of some of these policies, or the financial resources to withstand the additional risk imposed by some stop loss

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 paper do not assert that these provisions are found in every stop loss policy nor that any one policy includes all these provisions.**

- **Run out periods vary.** Some insurers offered run-out periods as short as three months.
  - Some claims can take as long as 18 months to "run out" for reasons including mandatory internal and external appeal process, which all self-funded employers must offer as a result of the ACA. The claims that are externally appealed are often the most expensive and, if the claim takes longer than three (or six or 12) months after the end of the policy period to resolve, the employer may be solely responsible for those costs.
  - Some stop loss insurers do not acknowledge that decisions of independent review organizations (IROs) in the external review process are binding on them. In fact, some policies expressly state that the stop loss insurer has the final say regarding which claims it will acknowledge and pay, which is the exact opposite of the "follow the fortunes" clause in a typical reinsurance contract. External review is binding on the employer, leaving the employer with no recourse if the IRO orders payment but the stop loss insurer is allowed to deny reimbursement.
  - On the other hand, at least one policy reviewed expressly acknowledged that decisions of IROs would be binding on them and that the tail may be extended in that case.
- **Some stop loss insurance policies do not include a standard benefit package, and some benefits, such as prescription drugs,** may not be covered unless the employer opts into the coverage. Small employers should be made aware of these types of exclusions before they purchase a stop loss policy
  - Other exclusions, though rare, included broad stop loss exclusions for certain types of mental illness. Employer health plans are required to follow ACA provisions and federal mental health parity laws and may be responsible for paying these claims even if the stop loss insurer excludes coverage.
  - Some stop loss policies have additional deductibles for transplants, or for individuals who have been identified as an "exceptional" risk.
- **Some stop loss insurance policies specifically exclude claims incurred by individuals who are "not actively at work" at the start of the stop loss policy period;** for instance, if the employee was already in the hospital. Federal regulations prohibit health plans from excluding claims from individuals who fall into this category. However, most applicable state and federal limitations on this exclusion may not apply to stop loss coverage.
- **Self-funded employer plans, like fully insured plans, may not apply lifetime or annual dollar limits to EHBs, and self-funded employers are also subject to employee maximum out-of-pocket limits**. Before the ACA, any annual limits in stop loss policies were typically designed with matching limits in the employer's plan. Despite the prohibition on annual limits in the underlying plan, some stop loss policies currently on file still include ***maximum annual benefits (per employee) of $1 million per family or potentially less.*** While many stop loss policies that do not contain these types of limits, those that do may put the employer at risk.
- **Some stop loss insurers require employers to use a specific TPA; usually, the stop loss insurer owns that TPA or has a special business relationship with the TPA.** Often, and especially in the case of products targeting small

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 legally responsible for all plan decisions in the event that a legal action is taken against the plan—even though the employer likely had no knowledge and no actual control over the claims decision or the plan design resulting in the litigation.
  - Some stop loss policies have additional language stating that the stop loss insurer is never legally responsible for decisions made by the TPA.

- **Some stop loss insurers will immediately terminate the coverage if the employer changes TPAs**. If the stop loss insurer owns or has a close business relationship with the TPA, then it is may be the stop loss insurer that is managing the claims decisions. Employers should be aware that they are the fiduciary for the plan and, legally, they are ultimately liable for claims decisions made by the TPA.
- **Many stop loss insurance policies preserve the right of the stop loss insurer to make decisions about claims payment that may be different from those made by the health plan fiduciary or its TPA. Some policies declare that the stop loss insurer will make its own medical necessity determination, separate from that made by the health plan.** Because some state insurance departments will not approve such medical necessity language, other policies are more subtle in their approach by including such statements as: the stop loss insurer controls the TPA; the stop loss insurance policy claims the right to physically examine any claimant (including autopsy); and the stop loss insurer requires the plan members to use certain networks or "centers of excellence," especially for transplants. All employers buying stop loss insurance should pay particular attention to medical necessity provisions that do not align with the health plan. Any such gaps in coverage leave employers exposed to great risk, with potential consequences that could, in the worst case, include bankruptcy.
  - Some stop loss policies specifically state that no matter how the employer (i.e., the health plan fiduciary), and presumably, any external review organization, interprets the plan's benefits, the stop loss insurer is free to interpret it differently. In other words, the stop loss insurer is not bound by the plan's or the external review organization's decisions regarding which claims should be paid and for how much.
  - Some stop loss insurers insert their own definitions of "experimental and investigational" and "clinical trial" in the policy language. Some provisions even exclude coverage for certain "routine claims" for covered persons in a certain types of clinical trials. The ACA requires self-funded health plans to cover "routine costs" for patients in a clinical trial for a life-threatening disease.
  - Some stop loss insurance policies include a definition of a UCR charge. That definition may conflict with the UCR definition in the health plan.
- Some stop loss insurance policies have **strict provisions requiring prompt payment of claims by the employer.** In one example, the stop loss insurer would not credit claims payments made by the employer (from the employer's claim fund) toward the employer's specific or aggregate retention if the claim payment was not made within 30 days of receiving adequate proof of loss.

- 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

an employer exposed to great risk, and all employers should be aware of all rescission provisions and the potential impact on the employer's solvency.

- **The cost of these arrangements is not always immediately apparent from the policy itself.** The cost of these plans involves at least three, and often four, separate parts: 1) the TPA fee and related costs; 2) the stop loss premium itself (which is generally subject to change, in some cases, retroactively—usually there is no rate guarantee, even for the plan year); 3) the monthly claim fund contribution, which is the employer's portion of the claims payment—especially for small employers, this is often divided into 12 equal monthly installments; and 4) the potential of repayment of advance funding, or, if the policy does not have an advance funding provision, the risk that additional contributions to the claim fund will be necessary to pay claims that exceed the fund balance.
    - Advance funding[10] was an optional component of all plans reviewed. Employers without a sufficiently deep pocket may need to "borrow" money from the stop loss insurer so that they can pay their share of large claims incurred early in the year, before the employer's claim fund contributions have accumulated. Even if there are no explicit financing costs specified in the contract, they will be built into the premium, and possibly into provisions allowing the insurer to keep the "float" on any positive claim fund balance.
    - Before employers can easily compare the cost of self-funding against the cost of private health insurance, they would have to have a clear and accurate picture of all the cost components of self-funding. There is no law requiring these costs to be made transparent to employers and no rate-stabilization laws for stop loss insurance. Like most commercial lines of insurance, stop loss premiums in most states are subject to little or no rate review.
- **No rate guarantees.** Many stop loss insurance policies state that premiums can increase at any time, or even retroactively, during the policy year when additional, unforeseen risk occurs, making financial planning difficult, especially for a small employer.
    - Some stop loss insurance policies charge a "provisional premium rate." The premium is then adjusted six months after the end of the policy period to reflect actual claims paid. The adjusted premium is a variable percentage of the claims paid by the stop loss insurer.
    - The concept of an "unforeseen risk" is problematic. The risk of plan participants developing medical problems during the year is precisely the risk the employer might reasonably believe it is insuring against when it buys a stop loss policy.
- **Advance funding arrangements have strict repayment provisions.** Policy terms require that repayment of advance funding take precedence over every other type of debt, including claims payment. Failure to make prompt payments on advance funding will result in termination of the stop loss insurance policy. If the policy is terminated for any other reason, repayment of advance funding is required immediately. The policy language does not describe the interest that may be owed on advance funding options. Early termination or rescission of the stop loss insurance policies for the reasons stated above could result in financial disaster for a small employer that is then left on the hook for claims that it did not anticipate paying, in addition to immediate repayment of any advancement funding received.

[10] Different stop loss policies use different terms, such as "advance funding," "advance funding loan agreements" and "monthly aggregate accommodation riders."

- **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 Health Care Providers

A wide range of options are available to regulators to address concerns in a stop loss insurance policy issued in connection with a self-funded health benefit plan. Which regulatory options, if any, are suitable for a particular state will depend on many factors, including, but not limited to, the following:

A. The U.S. insurance regulatory system is a state-based system, with an umbrella of uniform, national standards, coupled with significant discretion for each state to tailor its regulatory policies to the unique needs and environment of the state. A regulatory approach that is suitable in one state may not be feasible or effective in another state.

B. The legal authority to regulate stop loss insurance varies widely from state to state.[11] State insurance departments may not impose insurance regulations on self-funded employers. In some states, the regulatory agency is obligated to disapprove a policy form or rate if the agency determines it is not in compliance with applicable state laws and/or regulations, and is not in the public interest or "deceptively affects the risk purported to be assumed." In other states, a more limited review standard is in effect, but the agency may have the authority to adopt regulations establishing minimum standards for stop loss insurance. In some states, insurance departments may be able to address concerns through complaint or market conduct examination procedures that reference general insurer obligations in the Unfair Trade Practices Act or the Claims Settlement Act. Other states may determine that the potential for harm to the public is more prevalent in the case of small employers, whether the term is defined as 50, 100 or 200 employees.

C. While it is important to consider the potential harm these products might cause, without proper regulation, to employers, plan participants and competition in the marketplace, it is also important to consider the costs of regulation, both the transactional costs of compliance and the loss of flexibility to meet employer needs, if employers' choices are unnecessarily restricted.

D. After considering how these factors apply in particular circumstances of their state, regulators might consider one or more of the following policy options adopted or considered by various states.

1. Disclosure. A small employer is unlikely to have a human resources manager or other designated employee whose job it is to manage the health plan and understand commercial insurance products. Because stop loss insurance products are not generally required to conform to state or federal health insurance law, including the ACA, there may be exposure to additional risk in some stop loss insurance products that is not immediately apparent. Small employers may benefit from education on, or disclosure of, the risk they are assuming in "self-

[11] New York prohibits the sale of stop loss insurance to groups with 50 or fewer workers (NY Ins. Law 3231, 4317). Delaware prohibits the sale of stop loss insurance to groups of 15 or fewer (Del. Code Ann. 18-7218(e)). North Carolina's small group health insurance law requires stop loss coverage sold to self-funding small employer groups of 25 or fewer employees to comply with rating, underwriting and any other applicable standards (NCGS 58-50-130(a)).

funding" a health plan, as well as protections that they should be looking for when they shop for a stop loss insurance policy. Approaches to disclosure that can be considered include the following:

a. Creation of a guide or model bulletin that details the issues a stop loss insurance policy purchaser should consider.

b. Requiring uniform disclosure forms, including uniform key terms and definitions, that ensure stop loss policy purchasers receive and understand all necessary information. A small employer stop loss regulation adopted in Utah includes a uniform stop loss application by the employer, a disclosure form with some uniform information, as well as policy-specific information relating to provisions where clear disclosure may be necessary (e.g., limitations on coverage, "monthly accommodations" and terminal liability funding).

c. Requiring, suggesting or offering training and continuing education credits for insurance producers involved in the sale of stop loss insurance policies to small employer groups.

d. Requiring specific contract disclosures for key issues. A Vermont regulation requires disclosure of: (i) whether claims are paid on a "run-in," "paid" or "run-out" basis, along with the meaning of those terms; (ii) whether a "terminal liability" option is available, along with a clear description of the option; and (iii) a required notice concerning whether the policy restricts covered claims to those that are both incurred and paid during the policy period.

e. Requiring prominent, first-page disclosure of terms that subject the small employer to additional risks. For example, the regulator may decide that an employer, especially a small employer, needs to know: (i) if the stop loss policy has an annual dollar limit on coverage; (ii) if a claim will be denied if it is submitted outside a narrow window of time; (iii) if the stop loss policy excludes certain categories of benefit claims, such as prescription drugs or mental health claims; (iv) if the policy includes rescission provisions or rate increase triggers; or (v) the cost of fees that are in addition to the stop loss premium.

f. Require disclosure of de-identified claims information. This disclosure allows small employers to shop for other stop loss coverage.

2. Risk transfer. The NAIC *Stop Loss Insurance Model Act* (#92) sets minimum attachment point requirements,[12] which state insurance regulators should review to determine whether they are appropriate to market conditions in their states.[13]

3. Minimum policy standards. In some situations where the state insurance regulator determines that disclosure alone does not adequately address certain risks, some specific minimum policy standards could be adopted to protect employers and help ensure a level playing field for all insurers. Areas that some states might choose to address through minimum standards include:

   a. "Lasering"; i.e., assigning different attachment points or deductibles, or denying coverage altogether, for an employee or dependent based on the health status of that individual.

   b. Annual dollar limitations on coverage.

[12] States may want to review the Milliman NAIC Report, Statistical Modeling and Analysis of Stop-Loss Insurance for Use in NAIC Model Act, May 24, 2012, *2012 NAIC Proceedings*, Vol. II, pp.7–294.

[13] U.S. Department of Labor, Employee Benefits Security Administration, Guidance on State Regulation of Stop Loss Insurance, Technical Release 2014-01, references NAIC Model #92 when it reiterates the states' authority to regulate stop loss insurance.

c. Provisions allowing the stop loss insurer to deny coverage for claims the employer is legally obligated to pay.
d. Early termination of the policy at the discretion of the stop loss insurer, or for grounds that would not be considered "good cause" under state laws applicable to other commercial lines insurance.
e. Provisions allowing mid-term rate increases.
f. Rescissions for reasons other than fraud or intentional material misrepresentation.
g. Misleading or deceptive terms and conditions.
h. Prohibiting employee recourse to the stop loss insurer in connection with a covered but unpaid claim in excess of stop loss attachment points.
i. Any other limitations on coverage that a state regulator may consider to be unfair, deceptive, or contrary to the public interest.

4. Form disapproval. State insurance regulators may need to seek additional authority through legislation or rules in order to disapprove provisions they consider to be inappropriate. However, most state insurance departments already have broad authority to disapprove any policy provision that is misleading, deceptive or misrepresents the risk purported to be assumed.
5. Functional Analysis. State insurance regulators should determine whether the provisions in the contract are consistent with stop loss insurance as third-party liability coverage. (See the previous section titled, "Regulating Stop Loss Insurance.") The states might view stop loss insurance policy provisions that create a direct relationship between the stop loss insurer and the plan beneficiaries because of the insertion of "case management" requirements into a stop loss policy more suitable to health insurance than to stop loss insurance. For example:
   a. Provisions that require the policyholder to use the stop loss insurer, or a TPA affiliated with the stop loss insurer, for case-management functions.
   b. Provisions that confer on the stop loss insurer the authority to make its own determinations regarding medical necessity, UCR and other utilization-review matters.
   c. Any other provisions that, in effect, substitute the judgment of the stop loss insurer for the judgment of the employer in connection with the administration of the health benefit plan and the payment of claims.
6. However, third-party coverage does not necessarily mean plan participants have no rights at all, but rather, that the nature of their rights is different and more limited because they have no contractual relationship with the insurer. For example, reinsurance treaties and liability insurance policies provide that the obligation to pay claims is not extinguished by the insolvency of the ceding insurer or liability policyholder. The states might wish to consider whether similar protections would be appropriate for stop loss insurance.
7. Fair claims practices. Existing state laws prohibiting unfair claims settlement practices, including the prompt payment of claims when liability is clear, may be applicable to the stop loss insurer's payment of the employer's health claim obligations.
8. Utilization review statutes. Some state laws apply their utilization review statutes to TPAs and possibly to stop loss insurers also, regardless of whether the benefit plans is insured.

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. Congress was called "Affordable Benefit Choices for Employers," or "ACE" plans. That proposal would have codified the *AMS v. Bartlett* decision, a Fourth Circuit decision ruling that ERISA prohibited the states from classifying low attachment-point stop loss insurance as "health insurance," but would have added additional regulatory requirements on very small self-funded plans (down to five lives).

VIII. Conclusion

Since the passage of the ACA, health insurers, regulators, employers and insurance consumers have all been working to understand the changes in the insurance marketplace. State insurance regulators are charged with the regulation of insurance, including stop loss insurance. This paper explores some of the stop loss policy provisions observed by state insurance departments and highlights some of the regulatory issues that state insurance departments should consider. Regulators must be aware of what is happening in this rapidly evolving marketplace and work together to ensure that employer policyholders, especially employers with fewer resources, understand their obligations if they choose to self-fund their employee health plan in combination with the purchase of stop loss insurance. Stop loss insurance products vary significantly in the protections offered and vary according to the laws of the state where the stop loss policy is issued. Employers need to understand how to choose a stop loss product that offers the best protections. Certainly, insurance producers and the insurers themselves will assist employers in understanding these products. However, state insurance regulators have a legal duty to protect consumers, and this issue presents an important opportunity to educate employers seeking information. In addition, state insurance department staff involved in all parts of regulation should be aware of how stop loss insurance interacts with self-funded health plans, how the public may be affected and which existing state insurance laws may apply to stop loss insurance products.

APPENDIX A

The ACA and the Small Group Market

The ACA makes various changes to the insurance market that impact small group market plans, and the concern has been that some of these changes will lead to higher premiums. For small businesses that are particularly sensitive to variability in revenue and expenses, a substantial increase in health benefit expenses is difficult to absorb. For some small employers faced with a significant increase in health insurance premiums, there are three options: (1) reducing operational expenses or investments, if possible; (2) dropping coverage, and thereby permitting employees to access federal subsidies on a health benefit exchange; or (3) exploring the possibilities of self-insurance.

Of particular note, the small group market is subject to disruption whenever regulatory requirements—including, but not limited to, mandated benefits—cause an increase in premium to the employer. The ACA impact may include cost increases due to the requirement to cover EHBs and changes in rating regulations, such as moving from rate bands to adjusted community rating. In 2016, there will be another major change to the market, when the threshold separating "small" groups from "large" groups is raised from 50 employees to 100 employees.

Depending on the state, changes to comply with EHB and federal rating regulations may or may not lead to significant changes in benefits and/or rates. When rate increases occur, employers look at the options available, including self-insuring, with the idea that controlling the benefit will lead to a lower-cost plan. Small employer experience is more volatile because their experience is not credible, and, for that reason, responsible employers seek stop loss insurance to cover the unexpected claims cost. Balancing against the potential cost-savings and expanded coverage from some employers moving to self-funded arrangements is the concern that self-funded employer health plans are most attractive to the lowest-risk groups. As a result, there is some concern with adverse selection in the fully insured marketplace. But these concerns also applied to President Barack Obama's transition relief guidance that allow insurers to continue to offer existing plans to existing customers (called "grandmother" plans) through 2017, including large group plans purchased by employers with 51 to 100 employees.

Health insurance rates have increased due primarily to the age band compression, elimination of composite rating, some enrichment of benefits (i.e., EHBs) and the elimination of underwriting. Healthier, younger groups are likely to pay more and older, less healthy groups often pay less under the new regulations.

With the exception of grandfathered and "transitional" plans, new rating rules will apply to plans offered in small group markets. Section 2701 of the ACA eliminates all rating factors other than age, geography, tobacco use and whether the coverage is for an individual or a family. With regard to age, the rate is not allowed to vary by more than 3 to 1. For tobacco use, the rate is not allowed to vary by more than 1.5 to 1.

Some of the specific provisions in the ACA impacting the small group market include:

- Community rating. Rates in the small group market may not vary by more than a 3:1 ratio, and variations based on tobacco use of members is limited to an additional 1.5:1 ratio. Many states already limited rate variations pre-ACA, but often allowed greater rate variation than the ACA allows.
- Medical underwriting. Rates may not vary because of the health status of the group, nor may groups be denied a plan for health-related reasons (this is known as the "guaranteed issue" principle). HIPAA requires guaranteed availability for small employers, but some states have "rating band" laws allowing small groups to be rated on the health status of the employees in that group.

- 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-member build-up using year-to-year rate factors. For those states and insurers that used a different rate development methodology, there are rating winners and losers. Small businesses are likely to see a greater incidence of rating winners and losers, because small group census tends to magnify the effect of rating rule changes.
- EHBs and cost-sharing limitations. In the states where insurers were permitted to offer plans with fewer services and higher cost-sharing than are now permitted by the ACA, higher premiums will be necessary to support a broader scope of services, and to support lower out-of-pocket costs and deductibles. However, this depends on the plans that were common in that state's marketplace. In many states, the ACA's maximum out-of-pocket requirements are the same or even higher than the limits in plans that were marketed in 2013.
- Federal taxes and fees. The ACA imposes several new taxes and fees health insurers, including a health insurance provider fee, a reinsurance fee and a Patient-Centered Outcomes Research Institute (PCORI) fee. Insurers have no way to recover the cost of those taxes and fees except to include them in premiums. The reinsurance fee also applies to self-funded plans.
- In 2016, ACA laws and regulations require a change in the definition of "small group" from 50 or fewer employees to 100 or fewer employees. This change will impact groups of 51–100 employees in different ways: those groups with favorable demographics relative to the small group risk pool will see an increase in premium; those groups with unfavorable demographics relative to the small group rating pool may see a decrease in premium, or at least a lower annual premium increase. Employers in this 51–100 employee range may also have greater financial resources with which to consider the self-insurance option.

Whether a small business sees a financial benefit or a financial loss as a result of the ACA's regulatory changes depends upon the characteristics of the small business, and the state market rules applicable to small group insurance before 2014. Broadly, the ACA's regulatory changes may create financial incentives for many small employers to offer health benefits to their employees through self-funded plans. The changing definition of the small group market in 2016 may create a new incentive for small groups between 51 and 100 lives.

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 the majority of employers may use self-funded arrangements to finance health care for their employees. In short, employers can provide health benefits to their workers and their families in two ways, with very different financial and regulatory consequences:

- In a ***fully insured plan,*** the employer buys a group health insurance policy from a licensed insurer, the policy documents define the plan's benefits and the insurer assumes full responsibility for providing those benefits to all covered individuals.
- In a ***self-funded plan,*** often colloquially referred to as a ***"self-insured plan,"*** the employer is fully responsible both for defining the plan's benefits and for providing those benefits to covered individuals.

The legal framework for employee benefit plans is established by ERISA, which makes employee benefit plans subject to exclusive federal regulation and preempts state laws that relate to employee benefit plans. However, ERISA contains a "saving clause" that protects "any law of any State which regulates insurance" from preemption.[18] Because of the saving clause, both the terms of a fully insured plan and the insurer providing the coverage are subject to comprehensive regulation by the state insurance department. This includes rating and benefit standards for the insurance policy and regulatory supervision of the insurer's compliance and financial strength.

By contrast, self-funded employers and their benefit plans are exempt from state insurance regulation.[19] ERISA's "deemer clause" prohibits the states from deeming a self-funded employer to be an insurer.[20] As a result, self-funded plans are subject only to federal requirements, which are much more limited than those established by state insurance laws and/or regulations. They reflect a philosophy that self-funded employers are not in the business of insurance, and that benefit plans are voluntary programs that should not be discouraged through the imposition of extensive regulatory requirements. Unlike insurers, self-funded employers are not subject to any licensing or financial strength requirements or solvency monitoring.[21] Unlike insurance policies, self-funded benefit plans are subject to very few minimum coverage requirements, although some ACA requirements now apply to self-funded, as well as fully insured, plans. And by their nature, self-funded plans cannot be subject to rate regulation, because they have no "rates"; i.e., the cost of a self-funded plan is whatever it costs to provide and administer the benefits.

Because of the central role played by ERISA, self-funded plans are often referred to as "ERISA plans." This terminology makes sense for many purposes, but it suggests that ERISA applies only to self-funded plans, while state insurance laws

[18] ERISA § 514(b)(2)(A), *codified at* 29 U.S.C. § 1144(b)(2)(A).

[19] This exemption does not extend to stop loss insurance policies purchased by self-funded employers, which are subject to state insurance regulation. New federal guidance specifically references NAIC Model #92 when it reiterates the states' authority to regulate stop loss insurance. See, U.S. Department of Labor, Employee Benefits Security Administration, Guidance on State Regulation of Stop-Loss Insurance, Technical Release 2014-01,

[20] ERISA § 514(b)(2)(B), *codified at* 29 U.S.C. § 1144(b)(2)(B). By its terms, the deemer clause prohibits states from deeming an employee benefit plan to be an insurer, but ERISA was subsequently amended to permit states to apply licensing laws and most other state insurance laws if an employee benefit plan is a "multiple employer welfare arrangement" (MEWA). ERISA § 514(b)(6), *codified at* 29 U.S.C. § 1144(b)(6). MEWAs and other multiple-employer plans are outside the scope of this paper.

[21] By contrast, self-funded workers' compensation plans are not subject to ERISA. ERISA § 4(b)(3), *codified at* 29 U.S.C. § 1003(b)(3) Nearly all states that permit workers' compensation self-insurance require some form of licensure, either from the workers' compensation regulator or the insurance regulator, and impose financial requirements.

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 cannot regulate employers. The U.S. Supreme Court explained this principle in one of the first cases construing the impact of the saving clause, *Metropolitan Life v. Massachusetts*,[23] in which an insurance company had challenged a state law mandating coverage of mental health benefits, arguing that this law "is in reality a health law that merely operates on insurance contracts to accomplish its end, and that it is not the kind of traditional insurance law intended to be saved by Section 514(b)(2)(A)." However, the Court held that the saving clause does not distinguish between "traditional and innovative insurance laws." Although the Court had held two years earlier that a New York law requiring employers to provide pregnancy benefits was preempted, the Court held that the Massachusetts law was different because it applied to the insurer, not to the employer. Employers that did not want to pay for the benefits mandated by state law were not required to buy insurance on the state-regulated market. The Court acknowledged "that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not," but held that this was the line the U.S. Congress had drawn.

While an employee benefit plan's self-funded or fully insured status is obviously an important characteristic of the plan, it is important to understand that this is only one element of the plan design, and the operational details of either type of plan will vary from plan to plan. Both insurers and self-funded employers can delegate or outsource various aspects of plan administration, as long as they retain responsibility for their subcontractors' performance. Often, self-funded plans are administered by insurance companies, and their outward appearance is indistinguishable, to the untrained eye, from a fully insured plan. Plan beneficiaries are given an "insurance card" with the name and logo of a major national insurance company, and the only indication that the plan might be a self-funded plan is the statement on the back that "Benefits are administered by … Insurance Company or affiliate." When health care providers ask for "insurance information," they are looking for the name of the insurer or TPA that administers the plan. If the plan operates as designed, the providers have no direct contact with the self-funded employer.

[22] The exception proves the rule. When the employee benefit plan is a MEWA, ERISA does expressly draw a distinction between fully insured plans and plans that are not fully insured—and the distinction is that states have less regulatory authority over a MEWA if it is fully insured (ERISA § 514(b)(6)(A), *codified at* 29 U.S.C. § 1144(b)(6)(A)). The reason is precisely because when a plan is fully insured, the states' primary regulatory focus should be on the insurance carrier rather than on the benefit plan.

[23] 471 U.S. 724 (1985).

APPENDIX C

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