

From: [Miller, Jeff](#)
To: [E-OHPSCA-STOPLOSS.EBSA](#)
Subject: Request for Information Regarding Stop Loss Insurance
Date: Thursday, May 17, 2012 2:37:07 PM

As an administrator of self-funded employee benefit plans I would like to offer my responses to your questions. (For your information I have been in the employee benefits field for 34 years, 30 of which have been working exclusively with the administration of self-funded health benefit plans.)

1. How common is the use of stop loss insurance in connection with self-insured arrangements? Does the usage vary (and, if so, how) based on the size of the underlying arrangement or based on other factors? In my experience, I have never worked with a plan that did not have stop loss insurance. Other than very large plans (perhaps 10,000 employees and higher) stop loss is a critical tool in protecting the plan from unforeseen catastrophic events. The employer's obligations as a plan fiduciary dictate that this protection is either provided or alternate funding is available should the unexpected happen. Absent this protection, one or two catastrophic claims - \$1,000,000 is no longer uncommon – could destroy a plan.

How many individuals, if known, are covered under stop loss insurance (either nationally or on a state-specific basis)? I do not know this figure.

What are the trends? Are past trends expected to be predictive of future trends? Self-funding has recently enjoyed new interest, mostly because employers are increasingly concerned about having the ability to rein in ever rising costs to provide health benefits to their employees. Self-funding offers them the ability to do so that traditional fully-insured plans do not, and their efforts at saving money drop right to the bottom line.

Is the Affordable Care Act expected to affect these trends (and, if so, how)? It is hard to know at this time. Only when fully implemented will we see how the markets react, and whether self-funding continues to be a helpful tool (I think it will be).

2. What are common attachment points for stop loss insurance policies, and what factors are used to determine these attachment points? To be sure we are speaking the same language, some clarification on terminology is in order. In my experience the term “attachment point” is usually used when referring to aggregate stop-loss coverage, and “deductible” is used for individual, or “specific” coverage, within the group plan stop loss contract. I believe you

are referring to the individual or “specific” deductible, so that is how I am addressing this question.

We have clients with specific stop-loss deductibles as low as \$15,000 and as high as \$125,000. (Note that the \$15,000 deductibles almost always include an aggregating feature. This means that rather than a straight \$15,000 deductible on each participant, the first claims in a contract year must exceed \$30,000, in aggregate, before any reimbursement is made by the stop-loss carrier. Thereafter each participant with claims in excess of \$15,000 will be eligible for reimbursement. It is important to note that this is NOT the same as aggregate coverage.)

What are common attachment points by employer size (e.g., for plans with fewer than 50, between 50 and 100, or between 100 and 250 employees, and how do these compare to attachment points used by larger plans)? This is a hard question to answer because it depends on several variables. A 50 life employer with good cash flow and relatively young employees might be receptive to taking on more risk (i.e. higher specific deductible) because they recognize the opportunity to save money by selecting a higher deductible and possess the assets necessary should a few larger claims hit them in a given plan year. A 200 life employer with a number of older employees might select a little lower deductible because their claims experience tells them they will see some larger claims over the course of the year and the lower deductible helps minimize their month-to-month cash-flow volatility. One of the benefits of self-funding is that it allows an employer to tailor the benefit plan to fit their particular situation.

What are the lowest attachment points that are available? What are the trends?
\$15,000 is the lowest we will work with, but \$20,000 is a much more common starting point. As medical costs continue to rise the increasing costs to the plan usually necessitate they implement higher stop-loss deductibles as a means to hold fixed cost inflation to a minimum. As such I would have to say the trend is towards higher deductibles – definitely not the other way around (seeing them decrease).

3. Are employee-level (“specific”) attachment points more common, or are group-level (“aggregate”) attachment points more common? By far specific attachment points are more common, mostly because many large plans only elect to purchase specific coverage to protect them from catastrophic individual claims. Larger employers usually have the assets to cover normal volatility for claims up to the specific deductible. (And if they don’t they purchase aggregate coverage.)

There are aggregate-only plans, but they are designed as a transitional tool for employers who want to migrate from fully insured to a traditional self-funded plan. These agg-only plans are usually implemented for just a year or two in order to obtain the claims data necessary for the employer to properly determine the risks inherent in their particular population, and where they should set their specific deductible. (And obtaining a group's claim data from a fully insured carrier is usually difficult if not impossible, hence the creation of a transitional method of self-funding.)

What are the trends? What are the common attachment points for employee-level and group-level policies? “Common” is not a word I would use because there are many variables involved, and the decision as to where to set the specific deductible has to take all of these things into consideration in order to determine what is best for a given employer. The “group-level”(aggregate) attachment point is mostly the result of an underwriter’s analysis of prior claims history, plus their estimate of future claims, medical trend, demographics, etc.

For instance, two groups, both with 250 employees, might have vastly different specific deductibles and aggregate attachment points simply because the number of employees is almost the least important piece of the puzzle. In self-funding one size definitely does not fit all (and that’s a good thing!).

4. How do insurers work with small employers to integrate stop loss insurance protection with self-insured group health plans? What kinds of options are generally made available? Insurance carriers try to respond to market needs and offer products to meet those needs. For instance, aggregate coverage is generally not settled until the end of the plan year, but many years ago carriers recognized this could be a cash-flow burden for some employers. So they started offering an “aggregate accommodation” where, for a small fee, they would refund the plan throughout the plan year if their aggregate claims exceed the accumulated attachment point. This financial tool enables the employer to have less month-to-month volatility, but if that’s not a concern for the employer then he can lower the plan’s fixed cost by not purchasing it.

Are policies customized to meet the needs of different employers? In my experience, no. Stop loss contract language is not usually up for negotiation, beyond the variables offered by the carrier.

How are the attachment points for a stop loss policy determined for an employer?

Again, attachment points are a function of many variables: The employer's claims experience, employee demographics, employer cash-flow and appetite for risk, to name a few.

Do self-insured group health plans purchase stop loss insurance anticipating that they will purchase it every year? This is almost universally a "yes".

5. For a given attachment point, what percentage of total medical costs incurred by the employees is typically paid for by the employer and what percentage is typically paid for by the stop loss insurance policy? How much do the relative percentages vary for different attachment points? Sorry, but these questions don't make any sense to me! Any answer would be totally based on the individual facts and circumstances of a given situation, and then only applicable to that incident. For instance, a plan with a \$50,000 specific deductible, with a \$500,000 claim would result in the carrier picking up 90% of the cost. But for patients who never reached the \$50,000 limit the employer would be 100% responsible for paying the charges and the carrier's loss would be Zero.

What are the loss ratios associated with stop loss insurance policies? You'll have to get that info from the carriers for their book of business, but on a per-employer basis it is irrelevant. If an employer buys a policy, and no claims exceed the stop loss deductible, everyone is happy. The employer was provided protection against a catastrophic incident, and the fact that none occurred doesn't negate the fact that they were able to sleep well knowing the protection was in place. The carrier receives a premium for providing this protection and, in this case, has funds available to help cover another risk that perhaps didn't pan out so well. On the other hand, if a \$500,000 claim was paid out by the carrier, but only \$75,000 in premiums were received by the plan, then their loss ratio, on that account, would be astronomical.
(Perhaps I'm missing the point of your question.)

6. What are the administrative costs to employers related to stop loss insurance purchased for the employers' self-insured group health plans? How do these costs compare to the administrative costs related to purchasing a health insurance policy from an issuer? There are no real administrative costs for an employer. The third party administrator (TPA) the employer hires to administer the claims for the plan almost always handles all communication/administration with a stop-loss carrier. Employers get more involved with the operation of the plan because as plan fiduciaries they are required to make prudent decisions, when called for. Other than that some employers don't wish to involve themselves or their staff beyond what is required. Others, however, have never had the data available to them showing how their plan dollars are being spent, and

take an active interest in plan design, wellness programs/disease management, etc. (This is always done with a careful eye towards the protection of confidential medical information, and unless absolutely necessary the information is de-identified to protect the patient's privacy.)

7. Is stop loss insurance more prevalent in certain industries or sectors? Are there any minimum employee participation requirements for a small employer to be offered stop loss insurance? *In my experience self-funding is utilized by all industries. Minimum number of employees is usually 25 and up, although I have heard of plans with as little as 15 employees successfully using self-funding.*

8. What types of entities issue stop loss insurance? How many small entities¹¹ issue stop loss insurance policies? *Usually insurance carriers issue stop-loss policies. Some do so directly, while others issue them through managing general underwriters (MGUs). Although a MGU might be quite small in some cases that fact is irrelevant – the carrier is what is important. How one defines “small” is probably different depending on how many people you ask.*

9. Do stop loss issuers increase fees for groups below a certain size or exclude those groups? If so, how? *I wouldn't say they increase fees (premiums) for small groups. Premiums are based on claims experience and the size of the specific stop loss deductible. Some carriers might have a “sweet spot” as to the size of accounts they like to write, and some don't want to write very small groups. If there is a market for stop-loss, regardless of size, and it makes business sense, there are usually carriers willing to service it.*

10. How do stop loss insurers evaluate the plans seeking coverage and how is this evaluation reflected in the coverage or premiums offered? Does the profile of the plan have an effect on the attachment points available? *Stop-loss carriers primarily look at the demographics of the employee population (age, sex), where the plan and participants are located, claims experience for the last year or two (more if available), size of specific deductible and plan design (what are the deductible and coinsurance levels, office visit copays, drug plan copays, etc., etc.).*

11. How do States regulate stop loss insurance? In States that are regulating this insurance, what are the licensing processes and standards? Have States proposed laws, regulations, attachment points, size of the group, percent of total claims paid by the stop loss insurer, or other criteria? What are the issues States face in regulating stop loss insurance? Varies by state, but they are usually licensed as insurance companies. Stop-loss carriers can probably better address this issue.

12. What effect does the availability of stop loss insurance with various attachment points and other particular provisions have on small employers' decisions to offer

insurance to employees? In my opinion, whether an employer decides to offer insurance to employees, whether fully-insured or self-funded, is directly tied to the cost of offering these benefits. Self-funding can provide a vehicle for doing so, and is usually cheaper than a fully insured plan (over a 3-5 year period). But if costs get too high, no matter how they are funded, the employer may have to cease providing benefits.

13. What impact does the use of stop loss insurance by self-insured small employers have on the small group fully insured market? Well no doubt fully insured carriers will tell you it erodes their business, but as I see it that only encourages a fully-insured carrier to dig deeper and get more competitive in order to retain that business. If an employer is able to continue providing health benefits because they have obtained more control of how their plan is designed, and it better fits the needs of their individual employee population, that seems like a beneficial thing to me.

I hope these responses prove helpful but if you have any questions please feel free to contact me.

Sincerely,

Jeff Miller

Vice President

HUB International Benefit Administrators, a division of HUB International Southeast

176 McSwain Drive

PO Box 21308

Columbia, SC 29221

Direct: (803) 739-6125

Toll Free: (877) 840-0936

Fax: (803) 796-8505

jeff.miller@hubinternational.com

www.hubinternational.com

This communication (and any information or material transmitted with this communication) is confidential and has been prepared for the intended recipient's exclusive use. This communication may also contain Protected Health Information as defined by federal law and subject to protections required by law. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to protect the information after its stated need has been fulfilled. If you are not the intended recipient, any review, retransmission, conversion to hard copy, copying, circulation, publication, dissemination, distribution, reproduction or other use of this communication, information or material is strictly prohibited and may be illegal. If you received this communication in error, please notify us immediately by telephone or by return email, and delete this communication, information and material from any computer, disk drive, diskette or other storage device or media.