

WHITE PAPER
STOP LOSS INSURANCE, SELF FUNDING AND THE ACA

I. Introduction

Since the passage of the Patient Protection and Affordable Care Act of 2010¹ (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 everyone through a combination of premium tax credits, an individual mandate and health insurance market reforms, including guaranteed issue, adjusted community rating, and a prohibition on preexisting condition exclusions. 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 ACA², it will leave the older, sicker population to the fully insured, small employer group market. 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. These concerns must be balanced against concerns 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 or not 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. States do not regulate self-funded employer plans³ 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 Labor 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 U.S.

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.

Department of Labor (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 (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.

Many articles have been written discussing the potential for and consequences of small employer self-insurance in the post-ACA environment,⁴ however, at this point, the increase in small employer self-funding is not known. But there has been demonstrated interest in discussing self-funding in the small group market. One of the areas states are seeing evidence of this interest is in the stop loss insurance policies being developed for and specifically marketed to small employers.

This paper explores trends in stop loss insurance seen by state departments of insurance and the regulatory issues they raise. This paper also identifies 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 make sure 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. A self-funded employer may transfer some or all 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

⁴ See Appendix C for a bibliography of articles exploring the pros and cons of small employer self-insurance.

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

When the employer runs the entire program, the employer may face a number of issues. First, some employers have no expertise in estimating the cost of the program. The employer will need to estimate the cost for each employee and estimate the cost associated with changing any benefit. The employer may have little experience in processing medical claims or in creating mechanisms that control costs (like provider networks or in managing care for patients with complicated medical conditions). Even if the employer gains the skills necessary, the employer may lack economies of scale, which makes it very expensive for the employer. Finally, self-funding leaves the employer at significant risk for shock claims (high dollar but low frequency claims, such as an organ transplant) and high utilization (low dollar but unusually high frequency).

In response to these issues, some employers have sought out alternative arrangements. For example, an employer may hire a company to manage its health benefit program typically referred to as a third party administrator (TPA). TPAs (including insurers with ASO contracts) can provide a variety of services. They may assist the employer in designing the benefit package, estimating the costs associated with the entire program or in adding a particular benefit, as well as ensuring that the health plan complies with applicable federal law and notice requirements. TPAs may also provide cost management services, like access to provider networks and the ability to conduct sophisticated care management programs like large 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.

Employers can mitigate risk by using stop loss insurance. A stop loss insurance policy usually contains two components, a specific "attachment point" (or retention level) that protects against claim severity and 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

⁵ In the large group market, where community rating laws do not prohibit the practice, the issuer of a group insurance policy can also transfer risk back to the employer. An employer and an 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. These plans allow 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.

a high dollar claim or series of claims. Any costs exceeding the specific attachment point are covered by the 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 \$10,000 specific limit, and a \$150,000 aggregate limit. After meeting the limits, coverage is at 100%.

Scenario 1:

In January, February, and March, 50 employees have claims of \$3,000 or more

In June, one employee has back surgery costing \$200,000

The aggregate limit would be met by \$150,000 in claims. After that point, all covered claims would be paid by the stop loss insurer.

Scenario 2

In January, one employee has a premature baby costing \$1,000,000.

In June and July, two employees have back surgery costing \$150,000 each.

The rest of the employees have claims totaling \$50,000.

The stop loss insurer would be required to cover all costs of the premature baby exceeding the \$10,000 limit.

The stop loss insurer would cover the cost of each surgery over the \$10,000 limit.

The employer would not meet the aggregate limit of \$150,000 since the employer's liability was limited to \$80,000.

Stop-loss insurance does not, however, protect against 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 up front before the specific stop-loss coverage steps in for the remaining expense. If the plan reaches the aggregate attachment point at the end of September, the employer must pay the

year's entire aggregate retention 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. As part of the TPA agreement, the TPA may allow the claims account to go into deficit with agreement that the employer will fully fund the account over the course of the year. Sometimes these provisions are in the form of an addendum added to the stop loss policy and may be referred to as an advanced claim funding loan agreement.

III. Anatomy of a self-funded Health Plan combined with Stop Loss Insurance

An employer designing a self-funded plan with a TPA and stop loss insurance will have to make a number of important decisions in designing 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. 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. Employees covered under those health plans do not have the benefit of the regulatory oversight provided by state insurance departments that review and approve fully insured health plans. An employer that relies entirely on a TPA may not be aware that the health plan does not comply with the provisions of ERISA, HIPAA or the ACA that are applicable to self-funded health plans until there is a problem and a complaint is made. An employer may ultimately be held liable for a mistake made by the TPA in the design of the health plan.

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 required notices. It governs the payment of claims. It specifies issues surrounding the funding of the account to pay claims. The document also covers run-in claims issues (claims incurred before the beginning of the contract year⁶ but not yet presented for payment) and run-out claims issues (claims incurred during the contract year but presented after the end of the year), and the transition process when the contract is renewed or terminated. It will also cover a myriad of other issues typically contained in insurance contracts.

⁶ Typically, the benefit plan, the TPA contract and the stop-loss policy all have the same one-year term, but there can be exceptions – for example, if the employer chooses to change its plan anniversary date.

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 will depend on how much risk the employer can afford to assume. 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. 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 pre-existing high cost medical conditions or other identified risk factors. For example, if an employee’s condition is in remission, the employer may 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.

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, limits employee cost sharing and places “minimum value” and affordability requirements on the health plan design. Still, an employer may wish to add or subtract benefits to accommodate a budget while still meeting the requirements of federal law, based on the needs of their employees. For the largest plans, almost any benefit can be added – for a price. Each benefit may be priced by the administrator based on how much it will raise the cost of the plan both from a claims perspective and stop loss insurance perspective. As employers get smaller, self-funded health plans (often designed by the TPA) tend to become more standardized.

For small employers, basic stop loss insurance reimburses the employer only for employee claims that the employer reports to the insurer during the policy year. The employer is only reimbursed for claims that were incurred and paid during the policy year. The policy may include “run-out” or “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 insurers to provide tail coverage, or at least to offer it on an optional basis. Insurers may also sell “run-in” or “nose” coverage, which protects against claims incurred during the prior policy year but paid during the current policy year.

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

IV. Regulating Stop Loss Insurance

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 – 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: 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—reinsurance and 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, and the only real 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. For any given benefit plan, the actuarial risk – the usage of covered medical services by the plan participants during the plan year, is the same 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, 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.

Stop loss can also be viewed as a form of liability (casualty) insurance. The difference here 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.⁷ 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.⁸ This distinction becomes critical when determining what 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, to take advantage of favorable

⁷ Although liability coverage is not strictly limited to tort liability, traditional contractual liability coverage still focuses on tort-like damages. It is typically triggered by cases where either the victim alleges a contractual duty or the tortfeasor alleges a duty to indemnify.

⁸ See 24-A M.R.S.A. § 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.”)

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, essential health benefit 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. The NAIC adopted the *Stop Loss Insurance Model Act* (Model #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 more than 50): at least 110% of expected claims;
- aggregate (groups of 50 or fewer): at least the greater of 120% of expected claims, \$4000 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 forms⁹ also should focus on protecting the interests of stop loss policyholders, and 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 “Anatomy of a Stop Loss Policy.” 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

⁹ Many states do not have the authority to review stop loss rates and some do not review or approve stop loss forms.

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 ERISA¹⁰. Fiduciaries can be personally liable if they fail to fulfill their fiduciary obligations under ERISA, and they are also 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 service providers (like a TPA), the employer is required to monitor the service provider periodically to assure 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. Because small employers lack credible and predictable 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 that mitigate the risk of high and low claims months by allowing claims accounts to include a temporary negative balance. This is essentially a loan from the TPA to the employer, and the contract should specify any repayment provisions including penalties and interest. Some stop loss insurance products marketed to small employers contain specific "advance funding" provisions, which may expose small employers to risk in the event they are unable to repay, especially if the repayment provisions are unduly punitive.
- Stop loss insurance policies typically cover 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, and for claims incurred outside the policy period. Employers should be aware of their liability for claims that are incurred, but not covered under the terms 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

¹⁰ See, Meeting Your Fiduciary Responsibilities, February 2012, Employee Benefits Security Administration, United States Department of Labor. www.dol.gov/ebsa/pdf/meetingyourfiduciaryresponsibilities.pdf

cases, the stop loss insurer may even decline to renew or may cancel the policy, sometime 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 (for example, employers with 51 to 100 employees) is not credible, or not fully credible, and some degree of actuarial judgment is needed to set a premium. In the case of a very small group (e.g. the 10 to 50 employees), 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”; e.g. 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, states generally do not regulate stop loss insurers in terms of the size of the employer policyholder, and some stop loss insurers, TPA’s and brokers may market to employers with as few as 10, or even 5, employees.

VI. Additional Stop Loss Insurance Policy Provisions that merit regulatory consideration

Stop loss insurance policies sometimes include provisions that are typically found in health insurance plans, such as medical necessity determinations, UCR determinations, experimental/investigational determinations, case management requirements and mandated provider networks. Because there is no fully insured health plan present, these arrangements may not be subject to any state regulatory standards. 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 “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 establishes a direct relationship between the stop loss insurer and the employer’s member employees and dependents 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 care 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 (policy does not define what non-directed networks are);
- Fees or costs associated with negotiating out of network bills.

The policy 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.

States insurance departments may consider the extent to which these and other types of innovative policy provisions might create a direct 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 and health care providers.

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. A review of current stop loss policies being submitted to state insurance departments for approval revealed the following provisions. If the small employer is unable to manage the risks posed by these provisions, and is thereafter unable to meet 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.**

- **Run out periods vary.** Some insurers offered run out periods as short as 3 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.
 - Some stop loss insurers do not acknowledge that decisions of Independent Review Organizations (IROs) in the external appeal 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. The claims that are externally appealed are often the most expensive and if the claim takes longer

than 3 (or 6 or 12) months after the end of the policy period to resolve, the employer may be solely responsible for those costs.

- 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 excluded claims incurred by individuals who were “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 essential health benefits, and self-funded employers are also subject to employee maximum out of pocket limits. Some stop loss policies currently on file include **maximum annual benefits (per employee) of \$1,000,000 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 small employers to use a specific third party administrator—usually the stop loss insurer owns that third party administrator (TPA) or has a special business relationship with that TPA.** Often, and especially in the case of products targeting small employers, these TPA’s are designing the health

plan, preparing the Summary Plan Descriptions (SPD's) 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 very 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 they are 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 who 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.** However, some insurance departments will not approve such medical necessity language. Therefore, other policies are more subtle in their approach, such 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. Medical necessity provisions that do not align with the health plan can leave employers exposed to great risk, and all employers should be particularly aware of these provisions and the possible consequences to the solvency of the self-funded health plan, and therefore the employer;
 - Some stop loss policies specifically state that no matter how the employer (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 IRO's decisions regarding which claims should be paid and for how much.

- Some stop loss insurers insert their own definition of “experimental and investigational” and clinical trials 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 “usual, reasonable and customary charge (UCR).” That definition may conflict with the UCR definition in the health plan.
- Some stop loss insurance policies have very **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) towards 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 very **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 nullification 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 nullification 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 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 his 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;
 - Insolvency of the employer's claim fund; or
 - 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 their dependent. Any rescission leaves an employer exposed to great risk, and all employers should be aware of all rescission provisions and the impact on the solvency of their self-funded health plan.

- **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, even 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—for small employers, this is often divided into 12 equal monthly installments; and 4) there is usually also the potential (for small employers) of repayment of “advance funding.”
 - Advance funding 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. Of course, there are additional financing costs associated with borrowing this money.
 - Before an employer can easily compare the cost of self-funding against the cost of private health insurance, he/she 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.
- **No rate guarantees.** Most 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 very difficult, especially for a small employer.
 - Some stop loss insurance policies charge a “provisional premium rate.” The premium is then adjusted 6 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 very 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 who is then left on the hook for claims that it did not anticipate paying, as well as immediate repayment of advancement funding received.
- **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 timeframe for filing a lawsuit against the company in violation of state laws on 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 state law.

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 American 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. States 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 laws and 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-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:

- Creation by the state regulator of a guide that details the issues a small employer will need to address in choosing to provide a self-funded health insurance plan.
 - Requiring uniform disclosure forms that ensure small employers receive 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 (limitations on coverage, “monthly accommodations”, and terminal liability funding).
 - 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, and the meaning of those terms, (ii) whether a “terminal liability” option is available, and 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.
 - Require 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 has an annual dollar limit on coverage, or (ii) if a claim will be denied if submitted outside a narrow window of time, the stop loss policy excludes certain categories of benefit claims, such as prescription drugs or mental health claims, rescission provisions, rate increase triggers and (iii) the cost of fees that are in addition to the stop loss premium.
 - 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 (Model No. #92) sets minimum attachment point requirements, which states should review to determine whether they are appropriate to market conditions in their states.

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 ensure a level playing field for all insurers. Areas that some states might choose to address through minimum standards include:
- “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.
 - Annual dollar limitations on coverage.
 - Provisions allowing the stop loss insurer to deny coverage for claims the employer is legally obligated to pay.
 - 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.
 - Provisions allowing mid-term rate increases.
 - Rescissions for reasons other than fraud or intentional material misrepresentation.
 - Misleading or deceptive terms and conditions.
 - Prohibiting employee recourse to the stop loss insurer in connection with a covered but unpaid claim.
 - 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” some of these provisions. 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. Are the provisions in the contract consistent with stop loss insurance as third-party liability coverage? (See previous section “Regulating Stop Loss Insurance”) 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 “care 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 claims administration and care 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. 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 third party administrators and possibly to stop loss insurers also, whether or not the benefit plans is insured or not.
 9. Rate review. In states where insurers are required to obtain the approval of the state regulator prior to use of stop loss rate, a regulator may want to consider:
 - a. Whether the rate is reasonable in relation to the benefits conferred, especially in the case of policy provisions which significantly limit the coverage of claims;

- b. Whether or not the rate is allowed to vary based on the claims submitted by the employer; and
 - c. How the rate is determined in cases where the employer's experience is not credible, especially in determining aggregate attachment points which may be calculated based on expected claims.
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, a state may wish to require that entities have information available for review on each employer, whether or not 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, including the following data:
 - 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. One other policy option, which would likely require Congressional action, is to consider requiring similar guaranteed issue requirements on the small employer self-funded market as exist in the fully insured small group market. Congress considered a similar plan which was called “Affordable Benefit Choices for Employers” or ACE plans. The proposal codified the *AMS v. Bartlett* decision, but added additional regulatory requirements on very small self-funded plans (down to 5 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 departments of insurance and highlights some of the regulatory issues 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 small employers, 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 also vary according to the laws of the state where the stop loss policy is issued. 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 employees seeking information. In addition, 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

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, the options are limited to: (i) reducing operational expenses or investments, if possible, (ii) dropping coverage, and thereby permitting employees to access federal subsidies on a health benefits exchange, or (iii) 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 consumer employer. The ACA impact may include cost increases due to the requirement to cover essential health benefits (EHB) 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 not lead to significant changes in benefits or rates. When rate increases occur, the employer looks 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 since 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 Obama’s transition relief guidance that allow insurers to continue to offer existing plans to existing customers (called “grandmother” plans) through 2017

Health insurance rates have increased due primarily to the age band compression, elimination of composite rating, some enrichment of benefits (Essential Health Benefits 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 exception for grandfather and 2013 “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 family. With regards 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. States already limited rate variations pre-ACA, but broader ratios applied in many states, resulting in greater rate variation pre-ACA. **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 (the guaranteed issue principle). All states had guaranteed availability for small employers, but some group rating bands allowed 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 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 insurances 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.
- **Essential Health Benefits and cost sharing limitations.** In those states where insurances were permitted to offer plans with fewer services and higher cost sharing than are now required by the ACA, higher premiums will be necessary to support a broader scope of services, and to support lower out of pocket costs and deductible. However, this depends on the plans that were common in that state’s marketplace. Depending on what was being marketed, in many states, the max OOP requirements are the same or even higher than

2013 plans. Most states are allowing a variance from the \$ 2000/4000 deductible limitation.

- Federal taxes and fees. The Affordable Care Act imposes on insurance insurances an insurance fee, a risk corridor fee, and a PCORF fee. Insurers have no choice but to include the cost of those taxes and fees in premium. The risk corridor fee also applies to self-funded plans.
- In 2016, ACA laws and regulations require a change in the definition of “small group” from over 50 employees, to over 100 employees. In those states that have regulated the small group market, 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 the small employer to offer health benefits to its employees through a self-funded plan. The changing definition of the small group market in 2016 may create a new incentive for small groups between fifty one and one hundred lives.

APPENDIX B

ERISA and the Roles of State and Federal Regulation of Insurance

When we think of health insurance, in general, we 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 very 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.¹¹ 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. ERISA's "deemer clause" prohibits states from deeming a self-funded employer to be an insurer.¹² As a result, self-funded plans are subject only to federal requirements, which are much more limited than those established by state insurance laws. They reflect a philosophy that

¹¹ ERISA § 514(b)(2)(A), *codified at* 29 U.S.C. § 1144(b)(2)(A).

¹² 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.

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 insurance insurances, self-funded employers are not subject to any licensing or financial strength requirements or solvency monitoring.¹³ 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” – 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 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,¹⁴ 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: states can regulate insurance insurances, but cannot regulate employers. The Supreme Court explained this principle in one of the first cases construing the impact of the saving clause, *Metropolitan Life v. Massachusetts*,¹⁵ 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 § 514(b) (2) (A).” However, the Court held that the saving clause does not distinguish between

¹³ 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.

¹⁴ 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 MEWAs if the MEWA 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, states’ primary regulatory focus should be on the insurance carrier rather than on the benefit plan.

¹⁵ 471 U.S. 724 (1985).

“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 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.

APPENDIX C

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