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(1) How common is the use of stop-loss insurance in connection with self-insured arrangements?

Stop-loss is purchased by the employers who offer medical plans that self-funded to reduce the employer's share if the risk / exposure. Stop loss is not purchased by the plan. It is not a plan asset or feature.

Stop-loss insurance is recommended, and almost always purchased, for employers with fewer than 10,000 employees. Large employers will often purchase stop-loss coverage for highly catastrophic individual claims ($500,000 or more). Larger companies are often financially secure enough that they can absorb these catastrophic claims and, therefore, often choose to forego stop-loss insurance. Many mid-size employers purchase specific but not always aggregate.

How does usage vary based on the size of the underlying arrangement or other factors?

Usage is driven by claims, usually high dollar claims of individuals that result in the specific reinsurance level (attachment point) being met. An employer that is self-funded will have a complete analysis done at the outset and each year to determine where the attachment point should be and also they get a projection of the expected claims figures. The stop-loss is designed to reduce that exposure.

How many individuals are covered under stop-loss insurance?

The persons who participate in self-funded plans are not really covered by stop-loss; the employer is.

If you are interested in knowing the number of people who participate in self-funded plans, you may contact EBRI or use their website to glean that information at www.ebri.org. Stop-loss coverage is generally only reflected on Form 5500 if it is a plan asset which is rare, so

reviewing those filings will not provide a true picture of the prevalence of stop-loss coverage. You may be aware that the DOL recently reported to Congress on self-funded plans: http://www.dol.gov/ebsa/pdf/ACAReportToCongress041612.pdf

What are the trends?

Employers have a greater interest in self-funding their medical plans as insured plans premiums increase.

Employers have become more interested in customizing medical and other benefits to fit their long-term goals. Fully-insured plans have to be filed with the state departments of insurance and are somewhat limited as to modification. For example, self-funding allows an employer to customize their benefits to engage their employees to be more thoughtful as consumers in accessing health care and to be more consistent in living a healthier lifestyle. Both of these goals mirror those of the federal health reform law: more efficient spending of U.S. medical care dollars, and improved health of our citizens.

How is PPACA expected to affect these trends?

Additional fees and taxes for insured plans issuers are required by PPACA, which we anticipate fully-insured plan carriers will pass along in the form of higher premiums. This fact increases the interest in self-funding medical plans. However, the decision to self-fund should begin with a conversation about risk assumption and risk management. Larger employers are generally more able to absorb a risk, and so there is a connection between size and ability to self-fund, but that is not exactly a true correlation.

(2) What are common attachment points for stop loss insurance policies, and what factors are used to determine these attachment points? How do common attachment points vary by employer size? What are the lowest attachment points that are available?

You also could address these issues with organizations that study these issues such as EBRI.

Attachment points generally reflect risk tolerance – not size. Number of employee can be a proxy for risk tolerance, so you often hear employee populations cited in connection with stop-loss. A small medical practice may decide to self-fund up to a certain level of claims. A multi-state restaurant chain may decide not to self-fund a medical plan covering 3,000 employees due to risk.

In addition to risk tolerance, there are guidelines that reinsurers have regarding attachment levels they offer. The reinsurers want to make sure there is sufficient risk transfer. (As some would say, the carrier wants the employer to have "skin in the game.") As a result, a large group will be required to have a higher attachment point than a smaller one.

If the agencies are concerned that lower attachment points facilitate self-funding, and cause a resulting loss of participants in the fully-insured market that in turn may skew the expected impact of the law assumed by the original Congressional studies, then Congress should have given greater thought to stop-loss access, self-funding, and all related unintended consequences. The health reform law does not intend to regulate stop loss, nor does it. The states retain the authority to regulate stop loss.

Moreover, as a practical matter, stop-loss is fairly self-regulating in that if an employer should not self-fund due to the impact of the risk, the employer usually decides not to do so. Another such employer may continue down that path, and then rebound to the fully-insured market later when it realizes its risk intolerance. A return to fully-insured coverage should be significantly easier for employers in 2014 and beyond.

(3) Are employee-level ("specific") attachment points more common, or are group-level ("aggregate") attachment points more common?

If both products are purchased, then both have attachment points. The products are somewhat separate. Specific stop-loss may be purchased on a standalone basis while aggregate stop-loss is not. It is strongly recommended that employer groups under 1,000 employees purchase both. It is more common for employers over 1,000 to purchase specific coverage only. Almost all but the most financially well-off employers purchase specific stop-loss to reduce their exposure. Aggregate insurance is not quite so common, and is called "sleep insurance," which means it enables the persons running a company to rest easy -- even if a huge number of employees have high dollar claims. Also, be aware that stop-loss coverage is not a complete umbrella covering the employer for all dollar amounts of incurred and paid claims. The coverage generally provides a corridor of claims cost (perhaps a million dollars) which is the most the policy will ever pay in a year. The employer bears the risk above that corridor. Each policy must be examined and mapped out so the purchaser knows exactly what the policy does and does not cover.

(4) How do insurers work with small employers to integrate stop loss insurance protection with self-insured group health plans?

The dialogue is similar for small employers as for larger ones – it is a matter of risk tolerance and risk management.

What kinds of options are generally made available?

That depends on the carrier.

Are policies customized to meet the needs of different employers?

Customization is not as likely with smaller policies as some products have certain fixed attachment points; if the state department of insurance is regulating the policy, then the state may set the rules.

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

Again, it is a matter of risk. Fixed costs and claims costs are the main cost factors.

Attachment points are determined by a reinsurance carrier's underwriter after reviewing typically 2-3 years of claims data, an overall disclosure of known risks by the employer, demographic information, and benefit design.

Do self-insured group health plans purchase stop loss insurance anticipating that they will purchase it every year?

Yes, though they may buy different policy types depending on their risks --- a different policy might be purchased to pay claims if the plan intends to switch funding types (i.e., if the employer wants to fully-insure its medical plan soon).

(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?

It depends on factors such as the claims and the level of the attachment point(s). Generally speaking, between 20% and 30% of all paid claims are generated by individual claims exceeding $50,000.

How much do the relative percentages vary for different attachment points?

That depends on the claims for that period and any known large claim risks.

What are the loss ratios associated with stop-loss insurance policies?

It depends on the claims for that period. Keep in mind that stop-loss carriers are not insuring medical claims – they are insuring an employer's risk. Some of the carriers providing stop-loss are insuring a variety of other risks, such as aviation losses. They are not medical insurers, though their underwriters are trained to calculate those risks, as they would when considering any losses. Employee benefits professionals generally do not believe stop-loss carriers incur the same level or type of non-claims expenses as traditional medical insurers; stop-loss is more of a "pure" insurance product, with pricing reflecting risk transfer.

(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?

Administrative costs are paid to either a third party administrator (TPA) or to a traditional insurance carrier that rents its provider network and provides administrative services only (ASO) to the employer. The charges include payment and adjudication of claims, rental of the provider network, disease management, administration of COBRA, large case management, and various other programs available on an optional basis.

Other policy related administrative costs are low, and relate to pricing the policy, examining any claims submitted, etc. The stop-loss carrier will not look at the same claims issues the same way as a typical carrier for a fully-insured plan; they do not adjudicate claims and consider appeals – all of that work is done by the plan administrator.

If your questions get to the heart of why employers self-fund, it is because they believe they can manage the risks better than a traditional insurance carrier. And in many cases, they can.

Congress apparently has sought to have more persons covered in the insurance carrier system, perhaps based on the belief of economies of scale and reduced fragmentation in the market if they could accomplish greater coverage of individuals, increased policy uniformity, and administrative consistency. However, the PPACA law was not drafted to achieve this result across the board. We can surmise that Congress was aware of self-funding and stop-loss, as we would with any other law, and that Congress chose not to regulate it. And, in the end, it really is not in need of regulation. The products have been market-driven, and while

there are pitfalls in not having as complete a stop-loss policy as is needed for the employer's own situation, employers continue to select the policies that best address their risks.

(7) Is stop-loss insurance more prevalent in certain industries or sectors?

Not really, except as to their ability to assume and manage risks.

Are there any minimum employee participation requirements for a small employer to be offered stop loss insurance?

You will need to consider the products' details.

(8) What types of entities issue stop-loss insurance?

Stop-loss is issued by reinsurers, some of which deal in other types of reinsurance and insurance, while other reinsurance issuers are purely or almost purely medical reinsurers, such as national medical carriers that also offer fully-insured medical insurance products. Reinsurers often purchase reinsurance themselves, creating several layers of risk transfer as a result of prudent business decisions (not to be confused with a securitization of the risk).

How many small entities issue stop-loss insurance policies?

You might ask the insurance regulators and/or reinsurers. It is not a matter of reinsurer size – it is presumably a matter of finances and capacity.

(9) Do stop-loss issuers increase fees for groups below a certain size or exclude those groups? If so, how?

Stop-loss carriers can charge more to cover a particular risk or may deny / refuse to insure a certain risk, as can any carrier. Each stop-loss insurer does a detailed analysis of their business on an overall basis to determine which industries require a load or surcharge, and which they might exclude, based on historically poor performance. Some of the more common industries considered "high risk" include coal mining, long haul trucking, and certain specific populations based on extraction. If the premiums and/or fees are higher, then that is a factor that enters into the analysis of fixed costs and also into the comparison between insured vs. self-funded with stop-loss.

(10) How do stop-loss insurers evaluate the plans seeking coverage, and how is this evaluation reflected in the coverage or premiums offered?

Specific stop-loss is mostly a pooled product. While adverse experience may have a negative effect on renewals, the rates are mostly based on book or manual rates. Some

insurers will give credibility to the group's specific stop-loss experience. Aggregate stop-loss is based almost entirely on a group's claims experience. Carriers also may be concerned about whether specific persons' medical conditions are continuing or resolved. The carriers often have the ability to laser certain employees due to continued expected high claims.

Does the profile of the plan have an effect on the attachment points available?

If, by the profile of the plan, you mean demographics of a particular group, for many groups there may be no effect on the attachment points available, but age and gender may affect claims and risk patterns, for example, which can affect costs somewhat.

(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, or best practices with regard to stop-loss insurance? Do such proposals focus on attachment points, size of the group, percent of total claims paid by the stop-loss insurer, or other criteria?

You should address these questions specifically to stop-loss carriers and / or state departments of insurance; it is hoped you receive input from those parties. Some state-level attempts were made in the 1990s to address and regulate these issues, namely attachment points as an indication of risk transfer. The market is somewhat self-regulating as reinsurers compete to provide coverage that reflects employers' needs.

(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?

The availability of stop-loss affects whether a plan will be insured or self-funded, **not** whether small employers will offer the coverage. If fully-insured products are too expensive, an employer may consider self-funding or at least get a quote for negotiations sake. You also should know that the market for both types of insurance varies geographically. Where managed care is strong, and the carriers or MCOs do a good job, such as Kaiser, then it is often more attractive to all size employers to stay in the fully-insured market. Where the carriers' products are too pricy and claims costs are high, smaller employers will be interested in self-funding. As employers change their approaches to funding, traditional and stop-loss markets adjust pricing, features, and other aspects of coverage.

(13) What impact does the use of stop-loss insurance by self-insured small employers have on the small group fully-insured market?

Stop loss has an impact on the ability of the smaller employers to self-fund, as the ability to shift the risk allows them to retain more of the risk rather than shifting it all to an insurance carrier. You should not consider the "answer" to this type of situation to be greater regulation of the stop-loss market. The stop-loss market and the ability of employers to self-fund have the potential in many cases to affect the pricing of fully-insured medical insurance carriers and to "keep them honest."