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Beware of Stop-Loss Coverage Gaps When Choosing a Self-Funded Major Medical Plan

Background

The Affordable Care Act requires "applicable large employers" to make broad-based offers of group health insurance coverage to substantially all their full-time employees—including, if the employer is a staffing firm, its temporary and contract employees—or face potential tax penalties.[1] Though technically referred as "employer shared responsibility rules," they are also referred to as "play-or-pay rules." By whatever name, these rules represent a major shift from prior law and practice.

Employers can satisfy the "play" requirement by offering minimum essential coverage (MEC) to at least 70% of their full-time employees (95% of employees after 2015). Plans can qualify as MEC by covering preventive and wellness services only (these are sometimes called "skinny" plans). While skinny MEC plans will protect the employer from the tax penalty imposed on employers that do not offer employees (and their dependents) the opportunity to enroll in minimum essential coverage, the employer will still be subject to tax penalties of $250 per month multiplied by the number of full-time employees who buy health insurance through a state exchange and receive government subsidies. To avoid penalties on employees getting subsidies, an employer must offer a plan that is affordable (i.e., the employee's share of the premium for single-only coverage does not exceed 9.5% of the employee's wages) and provides "minimum value." Guidance issued by the U.S. Internal Revenue Service last fall provides that, to be considered minimum value, health insurance plans commencing after the 2015 plan year must include inpatient hospital and physician services—i.e., they must be true major medical plans.

For a variety of historical reasons, most staffing firms have been unable to offer comprehensive major medical coverage to their temporary workers. The short-term and unpredictable nature of most temporary work, the low rates of employee participation in staffing firm health insurance plans, and the potential that those who do elect coverage will disproportionately be older or sicker (adverse selection), has left most staffing firms unable to find insurance carriers willing to underwrite such coverage at an affordable cost.[2] Other industries, such as restaurants, retail, and hospitality, face similar issues, but nowhere is the problem more severe than in the staffing industry.

The ACA insurance reform rules included provisions that modify traditional insurance underwriting practices to ensure that fully insured group coverage is widely available and accessible. In particular, the rules governing guaranteed issue and renewability were intended to sweep away barriers such as minimum participation or minimum employer contributions that have made covering temporary workers difficult or impossible. It has

1. An applicable large employer is an employer with 100 or more full-time and full-time equivalent employees (in 2015; 50 after 2015) on average business days in the prior calendar year.
2. Coverage is generally more widely available for information technology, health care, and other professional employees because they typically work for longer periods and are paid more, and thus are more likely to participate in the staffing firm's benefit plans.

not worked out that way in practice. With some exceptions, major group health insurance plan issuers have shunned the staffing market, imposed minimum participation or employer contribution requirements despite the ACA's rules, or quoted exorbitant premiums for fully insured major medical plans. As a result, staffing firms have been compelled to seek alternatives.

One alternative, at least for staffing firms that are adequately capitalized, is self-funded health care (also known as administrative services only), an arrangement through which an employer provides health insurance or disability benefits to employees with its own funds. The ACA has made it marginally more attractive for employers to utilize self-funded insurance. Self-funded plans are generally exempt from state insurance mandates (e.g., laws that require coverage of fertility treatments), so plan sponsors can exclude those benefits; they are not required to offer the ACA's 10 "essential health benefits";[3] they are exempt from state premium taxes that generally run from 2% to 3% of premium; and they are not subject to the ACA-imposed federal insurance provider tax that increases insurance premiums by an estimated 2.5% to 3.0%.

Several national and regional suppliers have developed self-funded arrangements consisting of administrative services, provider networks, and stop-loss coverage to protect against unusually large claims. Many of these arrangements are well constructed, and many of these suppliers are highly regarded. But there is often a significant lack of coordination between the general coverage terms of the underlying self-funded group health insurance plans (which are subject to the ACA's insurance market and other reforms) and the terms of the accompanying stop-loss coverage (which is not considered health insurance and therefore is not subject to the ACA). This gap in coverage could result in major unanticipated claims liability for the unwary staffing firm that adopts a self-funded arrangement.

Note that this paper focuses on self-funded plans that involve employer exposure to catastrophic liability under major medical plans that cover inpatient hospital and physician services. Self-funded MEC plans that cover only preventive and wellness services do not expose employers to such liability and therefore are not the subject of this paper. Nor are self-funded "minimum value lite" plans that do not cover inpatient hospital or physician services.

Note also that the paper focuses on the potential claims risks associated with gaps in stop-loss coverage. It does not address the federal regulations and reporting rules applicable to self-funded plans.

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3. The 10 essential health benefits under the ACA are (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

Basics of Self-Funded Insurance and Stop-Loss Coverage

In a self-funded group health insurance plan, the employer retains the claims risk rather than shifting the risk to an insurance carrier. Stop-loss policies insure either the plan sponsor or the plan itself for claims above certain levels. Stop-loss carriers do not make direct payment to health care providers or covered individuals.

Stop-loss coverage is designed to protect self-funded employers against losses that exceed anticipated claims. Very large employers may be able to rely on the law of large numbers to predict claims—although even large firms can suffer significant unanticipated losses, especially if plan participation rates are low and a disproportionate number of older, sicker employees sign up for coverage. For smaller firms, there is a much greater risk that claims will exceed anticipated amounts.

While self-funded health insurance plans are regulated as "group health plans" under federal law, including the ACA, stop-loss coverage is regulated under state insurance laws as property and casualty insurance, not health insurance. As a result, stop-loss policies are not required to comply with the ACA or other federal laws governing group health plans.

For example, stop-loss policies may impose annual and lifetime limits, but group health plans may not. Thus, if a claim exceeds the stop-loss policy's annual and lifetime limits, the employer must pay the difference. The employer's exposure to such excess liability can rise exponentially in the case of high-cost claims to treat diseases such as hepatitis C, cancer, hemophilia, and rheumatoid arthritis that can cost tens of thousands of dollars per month to manage.

Stop-loss coverage generally comes in three forms:

- **Specific stop-loss insurance:** Specific stop-loss insurance protects the plan sponsor against a large claim on a *particular* participant or beneficiary. It limits the plan sponsor's liability to a predetermined dollar amount per person, per policy year e.g., a $20,000 deductible for a small employer (under 75 lives) and perhaps a $200,000 deductible for a larger employer (500 to 750 lives). The policy provides protection against claims exceeding this amount (referred to as the "specific deductible") in the case of a specific covered individual. Coverage above the specific deductible is generally unlimited.
- **Aggregate stop-loss insurance:** Aggregate stop-loss insurance protects the plan sponsor against *total* paid claims liability for claims that do not exceed the specific deductible. In this type of insurance, the attachment point (also sometimes referred to as the "retention level" or "aggregate deductible") is stated in terms of a percentage of total expected paid claims (e.g., 120% to 125%). The aggregate coverage provides protection against the cumulative effects of smaller claims that may never meet the threshold of a specific deductible point. Aggregate stop-loss insurance is particularly important in the case of smaller plans for cash flow purposes.

- **Monthly Aggregate Accommodation:** A monthly aggregate accommodation policy has no individual specific deductible. An aggregate attachment point for the entire year is determined and broken down into 12 monthly amounts. If claims in any one month exceed that month's attachment point, the stop-loss carrier prefunds the excess amount. That works as a bookkeeping credit against any month in which paid claims do not exceed the monthly attachment point. At the end of the year, if total paid claims exceed the attachment point (which may go up or down based on fluctuations in monthly employer census data), then the stop-loss carrier will have paid out all amounts due. If total paid claims do not exceed the attachment point, the stop-loss carrier owes nothing back to the employer. The result is that the employer knows what its total claim payment outlay will be for each month and for the year.

Claims Coverage—'Run-In' and 'Run-Out'

There also is the matter of what claims are covered and when. Coverage is generally based on the number of incurred months covered followed by the number of paid months covered. For example, policies may be quoted on a 12/12 basis. With this type of contract, only claims that are both incurred *and* paid during the 12-month policy year will be covered. This is not recommended because there is often a lag in the submitting and paying of claims due to provider billing or medical claim processing delays. In contrast, so-called "run-in" contracts cover some claims incurred *prior* to the policy effective date. For example, a 15/12 contract would cover claims incurred up to three months prior to the effective date. "Run-out" contracts are more common. For example, a 12/15 stop-loss policy with a Jan. 1, 2014, effective date would pay claims incurred and paid during calendar year 2014 (12 months) plus the first three months of 2015 (15 months). Contracts providing 12/18 coverage are also offered that provide additional coverage when compared with a shorter-term policy.

'Lasering'

Lasering is the practice of applying a higher specific deductible for high-risk employees; it shifts a portion of the costs of insuring the sickest workers back to the plan sponsor. Employers may accept a laser in order to keep the overall stop-loss premium at a lower level. But employers can't pass on to employees the higher deductible costs associated with lasering because laws such as the Americans With Disabilities Act prohibit employers from firing employees or refusing them insurance coverage due to illness. It may be possible to purchase a "no-laser" stop-loss policy, but it will cost more.

Evaluating Stop-Loss Coverage

Employers must determine how much risk to insure with a stop-loss policy. To do so, they must first understand the nature of the risk they are assuming. Employers routinely rely on a third-party administrator (TPA), supplier, or promoter to ensure compliance with the benefit requirements and other protections for employees that are required by federal law. But the employer is ultimately liable for mistakes made by the TPA, supplier, or promoter. While service contract with the TPA or supplier should address day-to-day operational issues (e.g., who creates and distributes the summary plan description, other plan documents, and required notices; the terms of claims run-in and run-out, etc.), the scope of the stop-loss coverage is determined by the terms of the stop-loss policy. Thus, employers should pay particular attention to the terms of that policy.

Red Flags

These are examples of terms that ASA members have encountered in stop-loss policies. Some of these provisions are inconsistent with the ACA and other laws that apply to health insurance plans. Staffing firms should carefully review their stop-loss policies to determine whether they include one or more of these provisions, many of which could materially increase the staffing firm's claims risk. Staffing firms should discuss with their insurance representatives whether and to what extent such provisions can be deleted or modified to reduce the staffing firm's exposure—and what effect such changes would have on the cost of stop-loss coverage.

Actively at Work Provisions

Some stop-loss policies specifically exclude claims incurred by individuals who were not "actively at work" at the start of the stop-loss policy period—for example, if the employee was already in the hospital on the policy's effective date. Federal and state regulations generally prohibit actively at work provisions from being used to delay or deny eligibility under health insurance plans, but those prohibitions generally do not apply to the stop-loss coverage. Thus, an individual who is absent from work may qualify as a participant in a self-funded group health plan but not be covered under the stop-loss policy. In such cases, the plan sponsor (i.e., the employer) would be liable to pay the claim.

Maximum Reimbursements

Stop-loss policy terms labeled as, or referring to, "maximum reimbursements" are effectively lifetime or annual limits for aggregate—but normally not for specific—coverage, which cannot be imposed under the ACA. Similar terms include "specific excess loss benefit," "lifetime limit of liability" and "lifetime maximum." In each instance, once the limit is reached, the plan sponsor is liable. Lifetime limits rarely include "expenses incurred or paid in all prior periods." Thus, in the case of a chronic condition (e.g., cancer or AIDS) the plan sponsor's exposure may be amplified. Of course, an employer can change stop-loss carriers when the policy is up for renewal to one without such a feature and start the accumulation process anew.

Experimental or Investigational Claims

A stop-loss policy may decline to cover payments for treatment or services that are considered "experimental or investigational." The ACA generally requires group health plans to cover those services but only when they are part of a qualified clinical trial and the plan would cover that type of treatment if it were not experimental or investigational (e.g., prescription drug or radiation treatment).

Mental and Nervous Disorders

A stop-loss policy may carve out coverage for the treatment of "any illness or injury resulting from mental and nervous disorders or alcohol or drug abuse." But federal law (i.e., the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008) generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less-favorable benefit limitations on those benefits than on medical and surgical benefits. As noted before, however, insurers in the 50-employees-and-over-market, and all sizes of self-funded plans, are not required to offer MH/SUD coverage.

Charges in Excess of 'Usual and Customary'
Most health insurance plans take advantage of preferred provider only (PPO) networks where provider claims are subject to payment based on an agreed schedule. Stop-loss carriers will treat those payments as payable under the stop-loss contract. Outside of claims through a PPO, most plans limit claims payments or reimbursement to "usual and customary charges" (UCR). This describes the amount an insurance carrier or TPA decides to use as the starting point in the payment for a service. UCR is most often defined to mean the "amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service." In each case, it is important to ensure that the health insurance plan's definition agrees with the stop-loss policy. This takes on added significance in the case of out-of-network services. But even with in-network services, there is no assurance that the stop-loss carrier will agree to the negotiated rate.

Midyear Changes in Premium Rates and Underwriting Factors
Most stop-loss carriers reserve the right to change premiums or stop-loss calculation factors if the participation rate goes above or below the number upon which the original premium and stop-loss factors were set. The difference in census that most often invokes such a change is a monthly variation in enrollment of 10%. Such provisions are obviously designed to mitigate the stop-loss carrier's risk, not that of the employer. Of course, there are instances—such as a merger, acquisition, or other corporate restructuring—in which a midyear change is justified.

Right to Terminate
Stop-loss policies universally include early termination rights—e.g., for nonpayment of premiums. Many stop-loss insurers also reserve the right to terminate based on inadequate participation, which is often a sign of adverse selection that can negatively affect the economics of the arrangement. The ACA bars insurance carriers and health insurance plan issuers from imposing minimum participation requirements on initial issuance of a group health plan. Such requirements may, however, be applied on renewal in the small-group fully insured market (fewer than 50 employee lives) other than during the annual open enrollment period from Nov. 15 to Dec. 15 of each year. The ACA does not prohibit a self-funded plan from requiring a minimum participation level.

Right of Rescission
"Rescission" in the group health plan context means the retroactive cancellation of a health insurance policy. Before the ACA took effect, insurance companies would sometimes retroactively cancel a policy in its entirety if the policyholder made a mistake on his or her initial application. While this was largely a problem in the individual market, the ACA prohibits rescission in both group and individual markets and by self-funded plans—except in cases of fraud or intentional misrepresentation of material fact. But the ACA prohibition does not apply to stop-loss insurers, and many stop-loss policies allow rescission based on any mistake or misrepresentation, even if unintentional, and even if the mistake involved only one employee or an employee's dependent. Some carriers do not retain the right to rescind the entire policy but may reserve the right to offer adjustments to the premium or other terms of the policy if there has been a misrepresentation of material fact by the employer or an employee as a part of the underwriting or claim process. Because rescission materially increases risk, employers should be aware of rescission provisions and their potential effect on the solvency of a self-funded health insurance plan.

Costs
The cost of a self-funded arrangement is not always apparent from the stop-loss policy itself. Stop-loss premiums are only a part of the story. The real cost also includes TPA fees and related costs, monthly claim fund contributions (the employer's portion of the claims payment), and, when appropriate, repayment of stop-loss "advance funding." Staffing firms must understand all of the components of the fees being charged.

Choice of Law and Venue Restrictions
Stop-loss insurance policies often include provisions—for example, specifying where lawsuits can be brought against the insurer, limiting when such suits can be filed, and subrogation provisions—that conflict with state law. Other provisions can leave the plan sponsor exposed even in the case of a valid claim. For example, they may impose a shorter period for submission of claims than the plan allows.

Conclusion

Staffing firms considering self-funded insurance should be aware of all of the provisions discussed in this paper. They should pay particular attention to certain specific provisions and try to negotiate changes to these terms to reduce the costs and risk that the staffing firm will face: whether the stop-loss policy imposes annual dollar limits; whether claims will be denied if submitted outside a narrow time window; whether the policy excludes claims for certain services such as prescription drugs or mental health care; whether the policy includes rescission provisions; whether the policy includes rate increase triggers; and whether the policy imposes charges or fees in addition to the stop-loss premium.

Ideally, employers choosing self-funded insurance should be able to purchase stop-loss coverage that conforms with the ACA. In most cases, however, this is an unrealistic expectation. But efforts should be made to avoid the more egregious problems described in this paper, even if the cost of the stop-loss coverage increases as a result. At the very least, employers should be aware that self-funding with stop-loss coverage can potentially result in significant risks that must be carefully assessed and, to the extent possible, avoided or mitigated.