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# EMPLOYER STOP LOSS INSURANCE CONSIDERATIONS

by Mark R. Troutman

**E**mployer stop loss is an insurance coverage offered to employers who self-fund their employee benefits program pursuant to an ERISA plan document. ERISA requires the plan to have a formal plan document that outlines the medical benefits and administrative protocols to be provided by the self-funded employer. This document essentially replaces a policy that would be issued by an insurance company and ultimately stops the transfer of risk. The self-insured employer becomes responsible for the risk associated with frequency and severity of utilization of employee benefits.

The benefit plan is typically administered by a third party administrator (TPA). The TPA will administer benefits according to the plan document in a non-discriminatory fashion and also arrange for managed care services such as case management utilization review, provider networks and disease management programs. The TPA needs to keep up-to-date on all the latest trends and technology associated with employee benefits (rules and regulations) in addition to complying with all regulatory requirements of operating a TPA.

Two coverages are provided to the employer to mitigate the impact of the medical risk they assumed when they chose to self insure the benefit plan. These are specific stop loss coverage and aggregate stop loss coverage. Specific stop loss coverage protects the employer against the severity of large losses per individual claimant. Aggregate stop loss coverage protects the employer against abnormal frequency of claims in total rather than abnormal severity of a single claim.

Employers choosing a specific deductible should consider expected severity and frequency of “large” claims for their size and for their risk tolerance. A typical employer’s capital resources are more limited than those of an insurance company and an HMO, and, therefore, they tend to have lower specific deductibles.

The typical aggregate stop loss coverage provides reimbursement to the employer when actual claims



(excluding those reimbursed by specific stop loss coverage) exceed 125 percent of the group’s expected claims. The aggregate protection may include additional coverages beyond medical care including dental, short term disability and vision and hearing. Aggregate benefits are typically capped with an annual maximum (e.g., \$1 million). Specific stop loss benefits are often capped at the maximum in the plan document and ranges from \$1 million up to \$5 million of paid reimbursements per covered person.

This aggregate protection is in contrast to most other medical excess policies or treaties, which normally do not have a component of aggregate protection.

Employer stop loss coverage usually provides reimbursement at 100 percent of all charges in excess of the chosen specific deductible. There are few, if any, internal limits.

Stop loss protection can be arranged on a variety of claim reimbursement bases. Claims eligible for specific stop loss reimbursement may be those incurred and paid within the 12 months of the policy year (referred to as 12/12), incurred within the policy year and paid within 15 months after the effective date of the policy (12/15), or even claims paid within the policy year with some run-in availability given termination from a previous carrier (15/12). Other options may be available upon request as well.

Additional “bells and whistles” may include the following product options:



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**Aggregating Specific Option**—The aggregating specific option is a product variation that may be attractive to an employer who is able to assume a fixed amount of additional risk beyond the stated individual's specific stop loss deductible. This fixed amount varies by employer group and is determined during the underwriting process. As with any variation from the normal employer stop loss product, the employer needs to understand the associated risks and rewards. In essence, the aggregating specific amount becomes an additional liability for which the employer is responsible before specific stop loss reimbursements will occur.

The aggregating specific option lowers the rate of the specific premium by creating an additional employer liability pool. This pool is a fixed dollar amount and is in addition to the employer's underlying specific deductible. Once an individual on the employer's plan reaches the underlying specific deductible, the employer will continue to be on the risk for the claims until the total additional employer liability pool has been exhausted.

Once an individual or a combination of individuals has met their specific deductibles and the dollars exceeding the deductibles have exhausted the additional pool, the employer's stop loss carrier reimburses the specific stop loss liabilities.

**Specific Advance Funding**—The specific advance funding option provides groups with cash flow assistance for specific stop loss claims. This specific advance option is requested in writing at time of quotation and is made a part of the policy via endorsement. Specific advance funding on specific stop loss claims is available to employers for covered expenses when the specific deductible is paid in full by the policyholder prior to any claims being considered for advance funding.

**Specific Terminal Liability**—The specific terminal liability option provides three months of paid claim run-out protection on the specific stop loss in the event the employer terminates their stop loss policy. The claims must be incurred prior to the end of the policy period to be considered eligible by the stop loss carrier.

The employer must select the specific terminal liability feature at the beginning of the first policy year.

**Aggregate Terminal Liability**—The aggregate terminal liability options provides three months of paid claim run-out protection on the aggregate in the event that the employer terminates their stop loss policy. The claims must be incurred prior to the end of the policy period to be considered eligible by the stop loss carrier. The employer must select the aggregate terminal liability feature at the beginning of the first policy year. In the event the employer terminates its policy with the stop loss carrier, the aggregate attachment point is adjusted upward by 25 percent, this 25 percent adjustment reflecting the additional 90 days of risk.

**Monthly Aggregate Accommodation**—The monthly aggregate accommodation is designed to assist smaller self-funded employers with cash flow during the policy period. Instead of reimbursing aggregate claims at the end of the policy year, this product feature will provide a monthly reimbursement in the event the year-to-date paid claims exceed the year-to-date aggregate attachment point. The employer is expected to reimburse the stop loss carrier if in the month subsequent to a monthly payout by the stop loss carrier, the employer's year-to-date paid claims dip below the year-to-date attachment point.

In addition to the usual terms and conditions in a reinsurance and insurance contract, the following are specific items of note for employer stop loss coverage. Also, a coverage specimen is enclosed.

### ***Common Employer Stop Loss Insurance Policy Definitions and Considerations***

**Aggregate Benefit**—The amount that the company agrees to pay the contractholder after the end of the contract period for eligible claims paid by the contractholder as set forth in the schedule and pursuant to the terms, conditions and limitations of the contract.

**Aggregate Benefit**—The aggregate benefit for the contract period, or fraction thereof, is the total of

the eligible claim payments, on an incurred and/or paid basis as shown in the aggregate contract basis of the schedule:

- a. less the aggregate deductible
- b. less the amount of the claims paid by the contractholder in excess of the maximum eligible claim expense per person as shown in the schedule; and
- c. less amounts recovered from other sources;
- d. multiplied by the aggregate payable percentage.

Aggregate benefits are not payable until after the end of the paid basis shown in the aggregate contract basis of the schedule. If the contract should terminate prior to the end of the contract period, the company shall not be liable for aggregate benefits for expenses incurred or paid by the contractholder after the termination date.

In no event will the aggregate benefit exceed the maximum aggregate benefit shown in the schedule.

**Aggregate Contract Basis**—Identifies the dates during which employee benefit plan expenses must be incurred and must be paid to be considered eligible for reimbursement as aggregate benefits.

**Aggregate Deductible**—The sum of each aggregate deductible per month for each month during the contract period or fraction thereof.

**Employee Benefit Plan**—The formal plan of medical expense benefits, called the plan document, sponsored by the contractholder to provide coverage of plan participants and dependents.

**Incurred**—Refers to the date on which a covered medical service was rendered, the date disability benefit payments become due, or a covered medical purchase was made for a covered person under the employee benefit plan.

**Maximum Aggregate Benefit**—The amount set forth in the schedule as the maximum total aggregate benefit payable under the terms, conditions and limitations of the contract during the contract period.

**Maximum Eligible Claim Expense Per Person**—As it relates to aggregate coverage, means the maximum dollar value of claims paid on any covered person that can apply toward satisfaction of an aggregate deductible, or that can apply toward the calculation of the aggregate benefit for a contract period.

**Maximum Specific Benefit**—The amount set forth in the schedule that is the maximum total specific benefit payable under the terms, conditions and limitations of the contract during an agreement year that an individual is a covered person under the employee benefit plan. Covered expenses for any covered person are limited to the lifetime maximum benefit stated in the plan document.

**Paid**—Funds are actually disbursed by the contractholder or his agent. Payment of a claim is the unconditional and direct payment of a claim to a covered person or their health care providers. Payment will be deemed made on the date that both (1) the payor directly tenders payment by mailing (or otherwise delivering) a draft or check, and (2) the account upon which the payment is drawn contains, and continues to contain, sufficient funds to permit the check or draft to be honored.

Should the account upon which payment is drawn not contain sufficient funds to cover all outstanding checks and drafts on the account, then the company may consider, in its sole discretion, any particular checks or drafts as not having been paid, but only to the total amount representing the difference between the funds in the account and the total of outstanding checks and drafts.

**Plan Participant**—An employee, a dependent or any other person who is eligible and who is covered under the employee benefit plan. No plan participant may be covered by the contract prior to the date his or her coverage is effective under the employee benefit plan or after the date his or her coverage under the employee benefit plan ends.

**Specific Benefit**—The amount the company will pay to the contractholder for eligible claims paid by

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the contractholder over and above the contractholder's specific deductible per person, and pursuant to the terms, conditions and limitations of the contract.

**Specific Benefit**—The specific benefit with regard to each covered person is the total of the eligible claim payments, on an incurred and/or paid basis as shown in the specific contract basis of the schedule;

- less the specific deductible; and
- less amounts recovered from other sources;
- multiplied by the specific payable percentage.

**Specific Contract Basis**—Identifies the dates during which employee benefit plan expenses must be incurred and must be paid to be considered eligible for reimbursement as specific benefits.

**Specific Deductible**—The per covered person deductible as shown in the schedule at the end of this article.

The contractholder shall not be entitled to any specific benefit unless and until the contractholder has actually paid the full amount of the specific deductible as set forth in the schedule for the covered person(s) for which the specific benefit is sought. The

contractholder shall only be entitled to a specific benefit up to the amount actually paid by contractholder over and above the specific deductible.

**Responsibilities of the Contractholder's Designated Third Party Administrator**

Without waiving any of its rights under the contract, and without making the designated third party administrator a party to the contract, the company agrees to recognize the designated third party administrator as respects the normal administration of the contractholder's plan subject to the third party administrator being responsible on behalf of the contractholder for auditing, calculating and processing all claims eligible under the employee benefit plan within a reasonable period of time, preparing periodic reports as required by the company and maintaining and making available to the company at all times such information as the company may reasonably require for proof of payment of the claims(s) by the contractholder. \*

*Editor's Note: Specimen schedules can be found on the section Web site at: [www.soa.org/files/pdf/employer-stop-loss-ins.pdf](http://www.soa.org/files/pdf/employer-stop-loss-ins.pdf).*

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