

**STOP-LOSS**

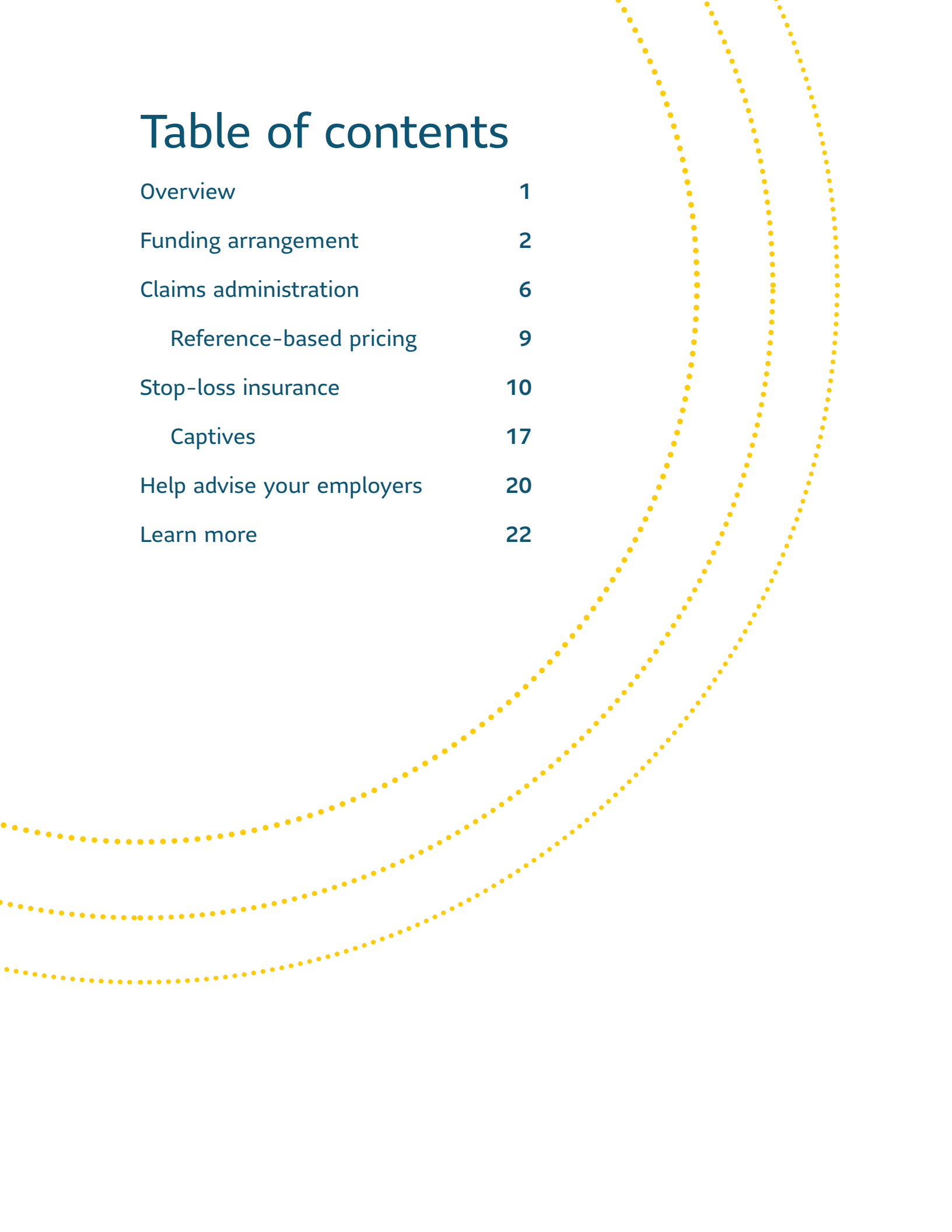
Broker guidance

# Self-funded playbook

A more detailed,  
broker-specific look into  
our self-funded playbook

# Table of contents

Overview	1
Funding arrangement	2
Claims administration	6
Reference-based pricing	9
Stop-loss insurance	10
Captives	17
Help advise your employers	20
Learn more	22



# OVERVIEW

Want some self-funding guidance? Whether your clients are already self-funded or are considering becoming self-funded, it's important for them to consider all the options, so they can make the right play for their business. In this playbook, you'll find insights and tips that you can use immediately to support them on this journey.

When it comes to self-funding, there are three key decision points:

**1. Funding arrangement** – how will an employer pay for health insurance benefits for its employees? To answer, an employer needs to first determine its benefits strategy and financial goals. Understanding its risk tolerance, size, and cash-flow needs will help the employer decide if it should be fully insured, self-funded with stop-loss insurance, or self-funded without stop-loss insurance.

**2. Claims administrator** – selecting a claims administrator determines the provider network or networks available to the employer and its health plan members. In addition, the claims administrator and their approach can have a significant impact on the success of the self-funded strategy and the benefits experience of the health plan members.

**3. Stop-loss insurance** – for many employers, the risk associated with a self-funded health plan is managed through stop-loss insurance. To choose the right stop-loss carrier and protection level, the employer needs to consider its own financial profile (including risk tolerance), its claims experience, and the potential carrier's attributes and product options.

Once the key decisions have been made, it is time to create an action plan. If the employer chooses to self-fund, it now has the flexibility to design a health plan to suit its business and can strategize about cash-flow management and stop-loss coverage. In addition, the broker, administrator, and stop-loss carrier can team up to help the employer contain costs and improve patient outcomes.

**Note:** Each employer may have different professionals who advise them on stop-loss insurance and self-funding. These professionals can include benefits advisors, brokers, consultants, and producers. In this document, we will use the term "broker" for simplicity.

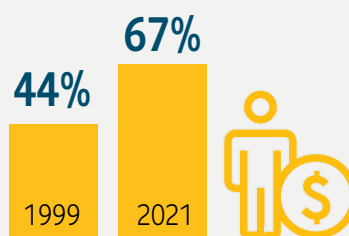
## Use this playbook to help clients:

- Learn more about what things to consider when deciding whether to self-fund.
- Expand their knowledge about how to make self-funding more effective for their business.
- Create an action plan for self-funding with next steps.

## Did you know?

Many U.S. employees are already covered by a self-funded medical plan. Sun Life expects that number to continue to rise.

The Affordable Care Act has increased employers' interest in self-funded medical plans.



The percentage of U.S. employees covered under self-funded medical plans.

Source: Number of employees covered under a partially or completely self-funded medical plan according to Kaiser/HRET's Survey of Employer Sponsored Health Benefits, 1999–2020.

# KEY DECISION #1: FUNDING ARRANGEMENT

## Tips for your employers

- Help them consider the advantages and responsibilities of self-funding.
- Give them guidance on determining whether your company is a good candidate for self-funding.
- If they decide to self-fund, work with their chosen plan administrator to design the plan to suit the culture and financial goals of their business.

## Balancing the budget and the benefits

The cost of healthcare continues to rise every year. The Centers for Medicare and Medicaid services project an increase of 5.5% annually through 2028, when it would be around \$6 trillion dollars. These cost drivers include a lack of cost transparency, pharmacy costs skyrocketing, and increased medical costs overall.<sup>1</sup>

Employers are faced with having to make sacrifices between balancing the budget and attracting and retaining talented employees with a strong benefits plan. Amid rising costs, it is important for employers to think about both their short-term and their long-term healthcare strategy. Premiums for families have risen by 5% on average in the past year alone.<sup>2</sup> Since the COVID-19 pandemic hit the U.S. in early 2020, there has been an increased emphasis on both healthcare benefits and providing more options for voluntary benefits for employees to protect themselves. By providing more customized voluntary benefit options, employers can better support their employees

as the workforce changes.<sup>3</sup> Even with all of the changes 2020 has brought to the world – and to both health and voluntary benefits – one thing remains constant: employers continue to prioritize providing health benefits to their employees. The big question is whether they do so through a fully insured plan, or through a self-funded one.

## Types of funding arrangements

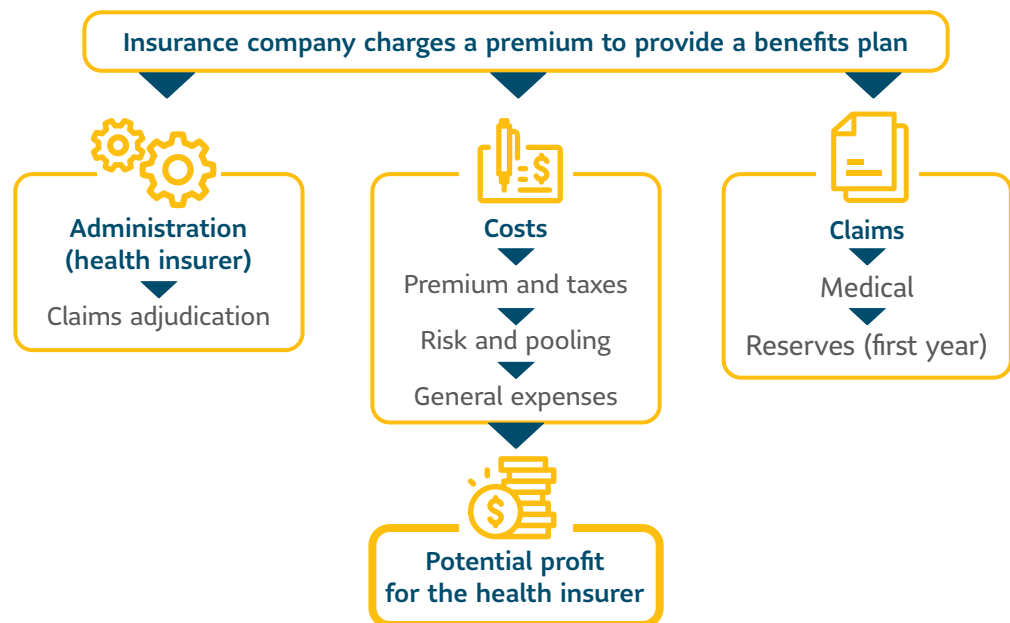
The employer, based on its benefits strategy and financial goals, determines how to fund health benefits for plan members. Employers are trying their best to provide affordable coverage to its employees, but the costs of future healthcare is unknown. Especially now, employers want to avoid disrupting their employees, obtain claims and benchmarking data, and have more control over their healthcare spending.

The two most common employer funding arrangements are:

- 1. Fully insured:** Pay monthly premiums to a health insurance carrier, who manages the plan,

**With a fully insured health plan,** the health insurance carrier manages the plan, takes on the risk and pays covered members' healthcare costs.

## Fully insured health plan costs



1. 8 reasons healthcare costs continue to rise, Dec 2020. People Keep. <https://www.peoplekeep.com/blog/8-reasons-health-insurance-costs-continue-to-rise#>

2. Health Insurance Premiums are rising faster than wages of inflation. The Lively blog April 2020. <https://livelyme.com/blog/employer/how-fast-health-insurance-premiums-increasing/>

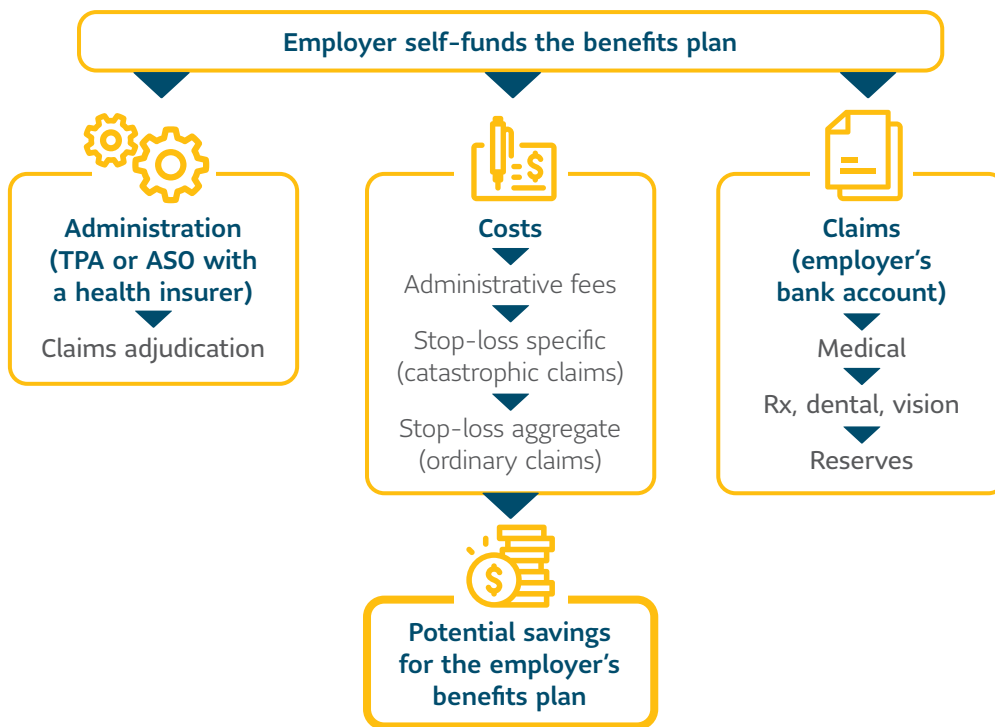
takes on the risk and pays covered members' healthcare costs. If any profit is realized after claims are paid, the carrier keeps it. A fully insured plan means that employees receive health benefits and the employer receives predictable monthly costs.

**2. Self-funded with stop-loss:** Pay the actual cost of claims, administration fees, and stop-loss insurance premiums. If claims costs are lower than expected, the health plan retains the savings. A self-funded plan means that the employees

receive health benefits and the employer (or a designated entity) assumes the financial responsibility for the health plan.

Stop-loss insurance protects the employer by limiting the risk associated with high-cost claims. It does not directly affect employees. Typically, only very large employers self-fund without mitigating the risk either with stop-loss or another method of protection. In fact, 70% of self-funded employers of companies with between 50 and 199 employees have stop-loss coverage.<sup>4</sup>

## Self-funded health plan costs



**With a self-funded health plan,** the employer pays the actual cost of claims, administration fees and stop-loss insurance premiums.

## Pursuing cost savings

A Sun Life survey of 44 brokers determined that cost savings is the primary reason employers consider self-funding. Specifically, according to brokers, employers look for savings through reduced fees, tax savings and control over benefits plan design.



3. What will voluntary benefits look like in 2021. Pr Newswire, Dec, 2020. <https://www.prnewswire.com/news-releases/what-voluntary-benefits-will-look-like-in-2021-301189487.html>

4. Content in this section is based on the Henry J. Kaiser Family Foundation, "2020 Employer Health Benefits Survey" <https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/>

# ADVANTAGES

## Employers talk about self-funding

“The goals really were to provide the best possible coverage at the lowest cost for employees.”

—Chief Financial Officer,  
15 years' experience,  
transportation  
industry, 500–1,999  
employees

## Why self-fund?

An employer has more flexibility and financial control with self-funding than it does by fully insuring. An employer that self-funds can design the health plan and cost-savings strategy according to its preferences. If an employer fully insures, it is limited to the health plan design options offered by a health insurer.

In addition, self-funding provides increased claims-data access, which allows the employer (or its broker or administrator) to make decisions to improve the health, wellness and productivity of its employees and help the bottom line through its ability to:

- Perform more in-depth utilization analysis and identify claim trends
- Refine its benefits plan design and options
- Tailor health management and improvement programs, such as case management, wellness programs, and employee incentives

Self-funded employers, more so than fully insured employers, have opportunities to save. Savings can come from lower taxes due to the different taxation laws. Self-funded employers also have the ability to design a health plan so it can produce savings. In addition, self-funded employers can use cost-containment strategies and programs, which may result in lower-than-expected claims amounts.<sup>5</sup>

## Lower taxes, anyone?

Self-funded medical plans tend to have lower taxes than fully insured ones. Why? Fewer taxes apply to self-funded plans. In addition, state premium taxes for self-funded plans are assessed against stop-loss insurance premiums instead of health insurance premiums. Stop-loss premiums are typically much less than health insurance premiums, so the self-funded employer gets a comparatively lower tax bill.



## How much can an employer save by self-funding?<sup>6</sup>

The Self-Insurance Educational Foundation shared the different ways that self-funded can lead to employer savings:

- Lower administration and insurer profit costs (typically 15–20% of plan premium for a fully insured plan)
- Lower premium taxes (only excess-loss coverage premium is taxable)
- Retained dollars from unspent claims funding

## Should businesses of a particular size self-fund?

The rising cost of health care combined with Affordable Care Act requirements has raised interest in self-funding. But self-funding is not for every business. In the past, very large companies typically self-funded and retained all of the risk; many large and midsize employers self-funded and retained some of the risk; and smaller employers tended to fully insure their health plans.

Regardless of employer size, every business needs to consider certain things when deciding to self-fund. When considering self-funding, there are a few key areas to evaluate:

- Benefits strategy and financial goals
- Risk tolerance
- Cash-flow needs
- Administration of the plan and access to the data
- Stop-loss and the appropriate levels<sup>7</sup>

So, the answer to “how small is too small to self-fund” really depends on the employer in question. By following the above recommendations and working with a knowledgeable broker, the employer—regardless of size—can determine if self-funding makes sense for its particular business.

5. WorldAtWork, Self-funded employers driving health care cost containment. Jan, 2020. <https://www.worldatwork.org/workspan/articles/self-funded-employers-driving-health-care-cost-containment>

6. Benefits Management Administrators, 2021. <https://bmatpa.com/2019/08/29/ways-to-save-through-self-funding/>

7. Self Funding Magazine, August 2020. <https://www.selffundingmagazine.com/article/decision-points-self-funded.html>

# RESPONSIBILITIES

## Costs associated with self-funding

When an employer self-funds, it must determine how much risk it's willing to take and if its cash flow can accommodate the new funding arrangement, including paying for claims, administration fees and stop-loss coverage. For more on claims administration and stop-loss, see pages 6 and 10. In addition, it's important to consider state and federal regulatory requirements.

## Regulatory requirements

Fully insured health plans, self-funded health plans and stop-loss insurance are all governed by a variety of laws. A host of federal laws apply to both fully insured and self-funded health plans. Additionally, every state has the ability to levy taxes, impose requirements, and regulate how fully insured health plans and stop-loss insurance are structured and sold. The easiest

way for self-funded employers to stay on top of federal and state requirements is to seek advice from experienced professionals, such as brokers and attorneys, who specialize in servicing self-funded clients.

## Weighing the self-funding decision

There are clear advantages and responsibilities to consider when deciding whether or not to self-fund. Self-funding isn't appropriate for every business, but it can be the right decision for many. Typically, an employer will depend on its broker to guide it through the process of funding arrangement evaluation and subsequent decisions. As their broker, you are a great resource to tap – and can advise them on self-funding and stop-loss coverage trends in different industries. You can also recommend ways to manage cash flow and the risk associated with high-cost claims.



### State laws



### Federal laws

### Chart key

#### Fully insured health plan

- |  |   |
|--|---|
| <ul style="list-style-type: none"><li>● State laws apply<ul style="list-style-type: none"><li>• Health insurance premium taxes</li><li>• Health insurance requirements</li></ul></li></ul> | <ul style="list-style-type: none"><li>● Federal laws apply<ul style="list-style-type: none"><li>• ACA is just one example</li></ul></li></ul> |
|--|---|

- Laws apply
- ◐ Some laws apply
- Laws do not apply

#### Self-funded health plan

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li>◐ Some state laws apply, but usually not subject to health insurance requirements</li></ul> | <ul style="list-style-type: none"><li>● Federal laws apply<ul style="list-style-type: none"><li>• Some ACA-related taxes and fees</li><li>• ERISA</li></ul></li></ul> |
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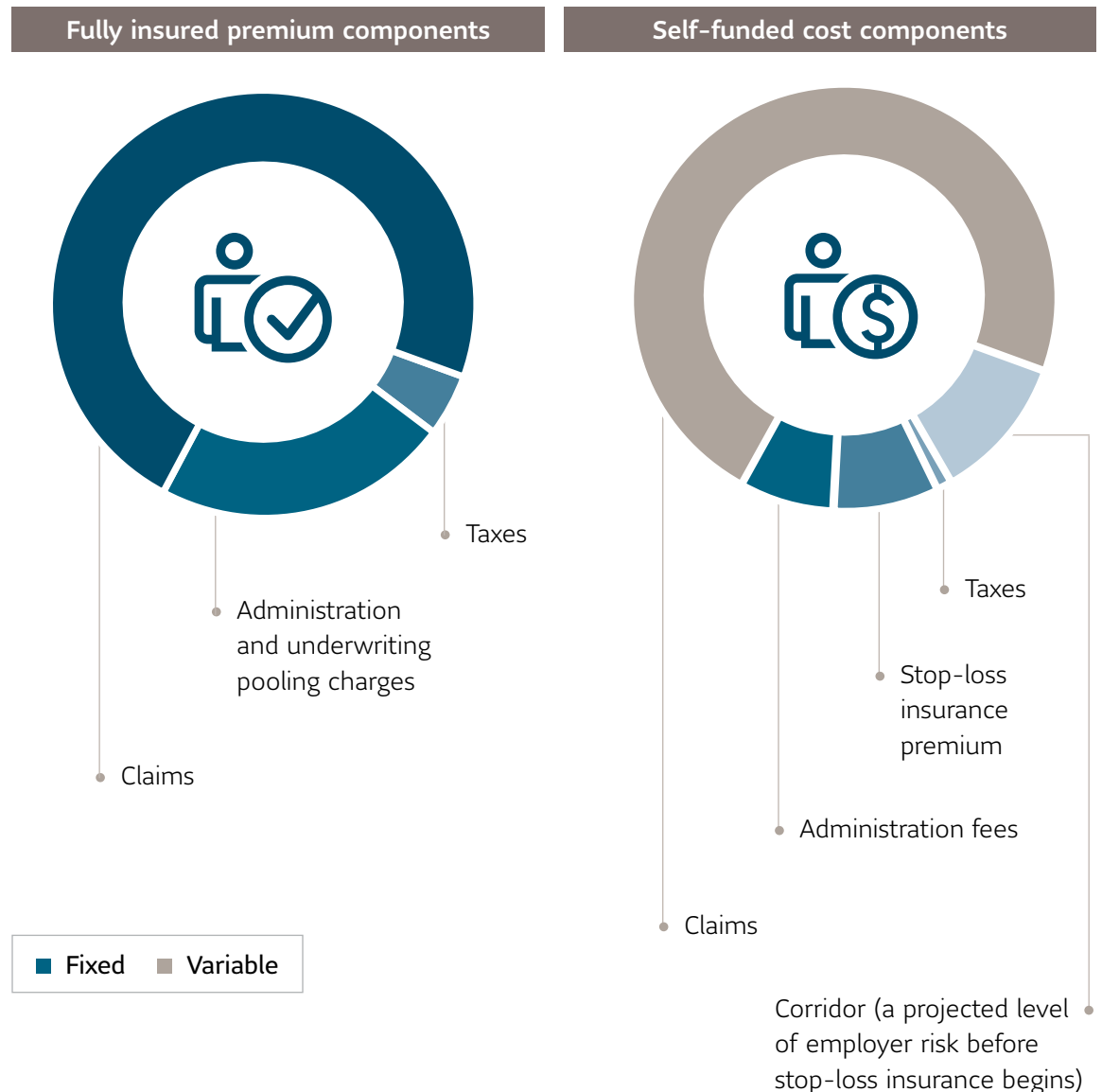
#### Stop-loss insurance

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li>● State laws apply<ul style="list-style-type: none"><li>• Certain taxes and fees</li><li>• Stop-loss requirements</li></ul></li></ul> | <ul style="list-style-type: none"><li>○ Federal laws do not apply</li></ul> |
|---|---|

### What goes into premium costs?

There is a lot to think about when deciding what type of funding arrangement will work best. But the primary driver is often cost, and the ability to control it. As you can see in the image below, fully-insured plans and self-funded plans often have similar claims costs — because the claims themselves don't change for the employer population — but self-funded plans have less admin fees and taxes. In the fully insured plan,

claims costs are baked into the premium which is larger because it is all claims, not just stop-loss claims. Employers in a fully-insured arrangement are paying taxes on the entire premium, where self-funded employers pay taxes and fees on a smaller stop-loss premium amount. Although there are still premiums for stop-loss coverage, employers can save if their claims are better than expected.





## KEY DECISION #2: CLAIMS ADMINISTRATION

### What types of claims administrators are there?

When an employer self-funds, it needs a claims administrator. Typically, it hires another company to administer claims. For most employers, claims administration comes down to two choices:

#### 1. Administrative services only (ASO) plan

With an ASO plan, which is provided by health insurance carriers, the employer is typically offered access to proprietary provider networks (which can frequently offer national reach), a standard service model, and set cost-containment programs. The ASO method is sometimes referred to as a “bundled” approach.

ASO plans can work well for employers that are comfortable with the standard set of cost-containment programs and vendor choices. Employers that work with ASO plans report that fewer exchanges make a health insurance carrier feel less risky.<sup>8</sup>

#### 2. Third party administrator (TPA) plan

With a TPA plan, employers receive access to local and regional provider networks (and some may also provide a national network), a personalized service model and customization options for plan design, cost-containment programs, and best-fit vendors.

An advantage of the TPA approach is that it supports choosing separate vendors for different

services (sometimes called the “unbundled” approach, whereby different partners are selected based on their area of expertise). For example, an employer might select a particular pharmacy benefits manager (PBM) or wellness vendor based on their preferred service model or business goals and seek to integrate those services with their medical claim administration.

### Creating the medical plan document

First, claims administrators typically send the employer a template medical plan document. Then, the employer, broker and claims administrator work together to create the plan document. The medical plan document governs many areas, such as the benefits offered and how claims are administered.

### Who sends in claims?

Administrators see every medical claim. For instance, a claim might come from a routine doctor’s office visit. Over the past few years, the conditions resulting in the most claims were two different types of cancer, and chronic/end stage renal (kidneys) disease.<sup>9</sup>

Here are the common types of entities that send in claims to the claims administrator for payment:

- Hospitals
- Outpatient clinics
- Physicians’ offices

### Tips to share with your employer clients

- Consider the networks, service, data, vendors and programs that their business needs. Help them choose the claims administrator that meets those needs.
- Provide guidance on choosing a claims administrator—including ensuring that it follows best-practice claims processes—and review its performance regularly.

### What should employers ask a claims administrator?

- **Administration**—how are they administering claims? What type of planning does auto-adjudication involve?
- **Cost-containment tools**—are they available to you and aligned for success?
- **Reporting**—is on-demand, detailed reporting regularly available and flexible?



8. Employer Voice-of-the-customer Research Study conducted by Conifer Research and sponsored by Sun Life. This blind study included in-depth interviews with benefits managers and executives from self-funded employers ranging in size 50 to 8,000 employees.

9. All information according to the Sun Life 2020 High-cost claims and injectable drug trends report, which covers four years of high-cost claims that Sun Life paid.

## The dual broker/administrator role

Some claims administrators are also licensed to advise and sell stop-loss insurance to employers. These professionals are referred to as “broker/administrators.”

## How are claims processed?

Claims can be processed through a variety of methods. In auto-adjudication, a system provides claims analysis and decisions based on criteria developed from the underlying plan document. If a claim is complex, manual adjudication may also be performed to support case management and the use of additional services such as cost containment.

Common claims analysis factors include:

- **Diagnosis codes:** The International Statistical Classification of Diseases and Related Health Problems (ICD-10) identifies medical conditions
- **Service codes:** The Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) identifies medical procedures and services
- **Billed charges:** The initial amount that a healthcare provider (such as a hospital) charges
- **Negotiated discount:** The amount that the charge is reduced by based on negotiations
- **Paid charges:** The amount paid to the healthcare provider (such as a hospital) after discounts were applied

## Claims best practices

The claims administrator needs to adjudicate claims according to the medical plan document. The employer should ask the prospective administrator to explain how it manages claims costs.

Here are some best practices to consider:



### Contain costs for high-dollar claims

**1. Develop** a systematic cost-containment approach toward high-dollar claims. Aspects to consider include understanding the medical plan document language and specifying how to apply it to claim adjudication, determining if the treatments are appropriate and medically necessary, and creating a price comparison protocol.

**2. Assess** if there are opportunities for cost containment for the services provided. Look at the providers of the services—they could be through the plan’s in-network preferred provider organization (PPO) or out-of-network (OON) providers. Are vendors available (through the claims administrator or stop-loss carrier) that can provide needed medical or specialty services that support improved patient outcomes at reduced or discounted rates? For example, if the medical condition is the need for a kidney transplant, the claims administrator or the stop-loss carrier might have access to a Centers of Excellence facility.

**3. Negotiate** with the OON provider and get a signed release showing that the provider accepts the negotiated charge in full and will not charge the claimant the difference (sometimes referred to as “balance-billing the claimant”). To determine the most appropriate payable charges, ask the administrator, stop-loss carrier or specialized service provider to conduct the negotiation.

Negotiation actions might include:

- Performing a medical bill review (pay special attention to billing and coding accuracy)
- Performing a diagnosis-related review if the diagnosis is in question
- Reviewing the medical plan document to determine if it contains UCR language about treatment costs
- Comparing the medical price to both the average wholesale price (which usually only applies to medications and durable medical equipment) and to Medicare Plus pricing

### Properly manage costs associated with dialysis treatments



Review the medical plan document language that relates to Medicare coverage for dialysis treatment. This language tells the administrator when the covered member may need to enroll in Medicare. The dialysis provider may or may not be in a PPO network. If it is not, there may be an opportunity for the administrator to negotiate costs.

If OON negotiation takes place on charges for services provided, it's important to get a signed release from the provider showing that the provider accepts the negotiated price in full and will not balance-bill the claimant. Administrators should review all cost-containment opportunities available through the PPO network, external vendors and stop-loss carrier. In addition, the administrator should investigate opportunities for rate reduction through vendor negotiation.

If possible, the administrator should also negotiate with the provider before treatments begin and get a signed release stating that the dialysis provider accepts the negotiated price in full and will not balance-bill the claimant. The administrator should develop a relationship with a knowledgeable dialysis consultant so there is always someone to ask for advice.

over 900 brand name and generic drugs saw price increases averaging at 6.8%.<sup>10</sup> The cost of healthcare is on the rise- but some areas, like drug prices, more than other. Drugs have increased in price by nearly 33% compared to other medical services at 17% since 2014.<sup>11</sup>

Another way to manage prescription costs is to find out how the Pharmacy Benefit Manager (PBM) handles both oral prescriptions and specialty prescriptions. Generally, specialty prescriptions require extra care in handling (keeping the medication at a certain temperature, for example) and are delivered in non-oral methods, such as intravenously. Ask the PBM to provide a regularly updated list of the medications it provides. This way, administrators will know if they can get the medication directly from the PBM, if the PBM works with a specialty Rx vendor that can provide it, or if it makes sense to ask the stop-loss carrier if it can provide access to a specialty Rx vendor that might be able to provide better pricing.



### Track higher-cost innovations

To stay on top of innovations, administrators can participate in a dialogue with cost-containment vendors and the stop-loss carrier to make use of all available resources. In addition, the administrator can connect with the broker to recommend changes in plan document language that relate to innovations.

Together, the team should keep close watch on emerging drugs, procedures and devices, as these are often high-priced. Administrators can get data from ClinicalTrials.gov, Drug Compendia, the stop-loss carrier and cost-containment vendors—such as those that provide specialty pharmacy plans.



### Focus on controlling prescription medication costs

Watch for specialty drugs used for chemotherapy, bleeding disorders, immunoglobulin therapy (also known as IVIg), and Hepatitis C. In addition, administrators need to watch generic drugs—spikes in cost can be quite high. The prices of generic drugs are on the rise – from January to July of 2020

10. GoodRx. August, 2020. <https://www.goodrx.com/blog/july-drug-price-hikes-2020/#:~:text=So%20far%20this%20July%2C%2067,1%20to%20June%2030%2C%202020>.

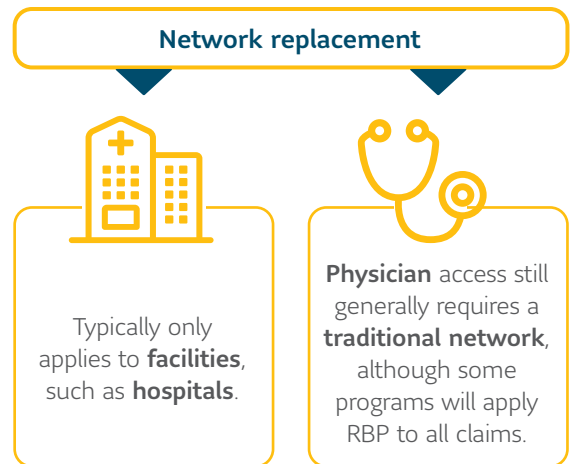
11. Minemyer, Paige. September 17, 2020. Here's how much fast drug prices are rising compared to other healthcare services. <https://www.fiercehealthcare.com/payer/here-s-how-much-faster-drug-prices-are-rising-compared-to-other-healthcare-services>

## Introduction to Reference-based pricing

Although it is not for everyone, Reference-based pricing (RBP) is a unique alternative designed to reduce costs by limiting the choice of facilities and networks, which results in charges that are closer to actual physician cost. This may be a smart choice for employers who:

- Are interested in exploring **alternative** forms of cost-containment
- Have an **engaged** group of employees, willing to actively help control medical costs
- Have employees located in areas with access to **multiple, competing hospitals**

Generally, RBP programs do not rely on contracts to define reimbursement with a provider, like the traditional network approach. Instead, the RBP program relies on a methodology to reimburse based on a fair market price for the service performed. This can create scenarios where members may be balance-billed (or asked to pay the difference), which is addressed as part of the program. The RBP program manager will tell the members how to best handle this situation.



**The goal of the RBP program is to pay claims at an amount closer to their actual cost, plus a fair and reasonable margin.**

## Reference-based pricing support services



Some RBP programs may confirm reimbursement or negotiate with the provider before services occur, while others may defend reimbursement or negotiate after a claim, if there has been an appeal.

# KEY DECISION #3: STOP-LOSS INSURANCE

## High-cost claims exposure

Once the employer has decided to self-fund and has selected a claims administrator, what's next? Remember, self-funding means that the employer is taking on risk because it is responsible for costs that are not always predictable. In simple terms, without protection against high-cost claims risk, the self-funded employer is vulnerable.

## How businesses respond to risk

Self-funded employers that want to cap exposure purchase stop-loss insurance. This type of employer takes on some – but not all – of the risk. The employer initially pays 100% of the medical claims but also buys stop-loss insurance. Stop-loss insurance mitigates the risk by providing reimbursement for large claims.

Self-funded employers that are comfortable with potentially high claim volatility may decide not to purchase stop-loss insurance. Typically, this happens with very large employers that have the financial strength to absorb unknown risk. The employer pays 100% of the medical claims.



### Self-funded with stop-loss

Pay claims, administrator fees, and stop-loss insurance carrier premiums

▼  
Capped maximum claims exposure



### Self-funded without stop-loss

Pay claims, administrator fees, but no premiums

▼  
Unknown and uncapped maximum exposure

## What can add up to over a billion dollars?



Sun Life reported that from 2016 to 2019, the top ten conditions represented over \$2.0 billion in stop-loss claim reimbursements, representing 50.6% of total reimbursements that Sun Life made.<sup>12</sup>

## Choosing stop-loss coverage

Stop-loss coverage helps the employer by mitigating a portion of the risk of self-funding. Stop-loss insurance “stops the losses” that can result due to high-cost claims. It does so by providing reimbursement to the self-funded employer for claims above a predetermined amount. Most of the self-funded community purchases stop-loss.

There are two main types of stop-loss coverage:

- **Specific:** Protection from large claims that occur for any one covered individual
- **Aggregate:** Protection from a situation in which the cost of all claims under the Specific deductible is higher than expected

Many employers purchase both products, though an employer can decide to purchase Specific stop-loss alone. But how can an employer figure out what products to buy and what coverage level (often referred to as a “deductible level”) makes sense for its business? To determine the stop-loss coverage types and deductible levels that fit best, the employer needs to decide what its risk tolerance is, analyze the health and demographics of its plan members, and develop a general understanding of projected claims costs for its group.

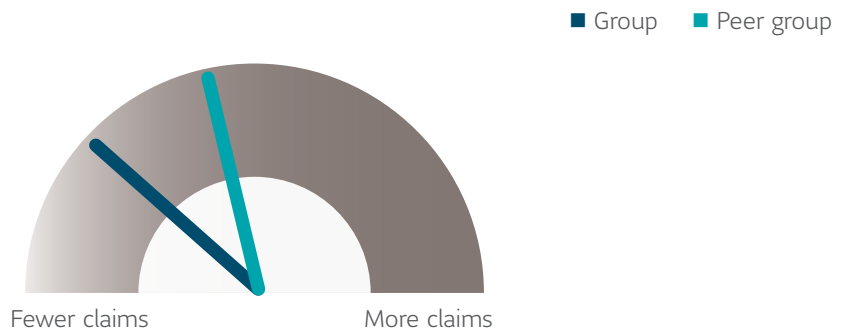
12. All information according to the Sun Life 2020 High-cost claims and injectable drug trends report, which covers four years of high-cost claims that Sun Life paid.

### Determining stop-loss coverage

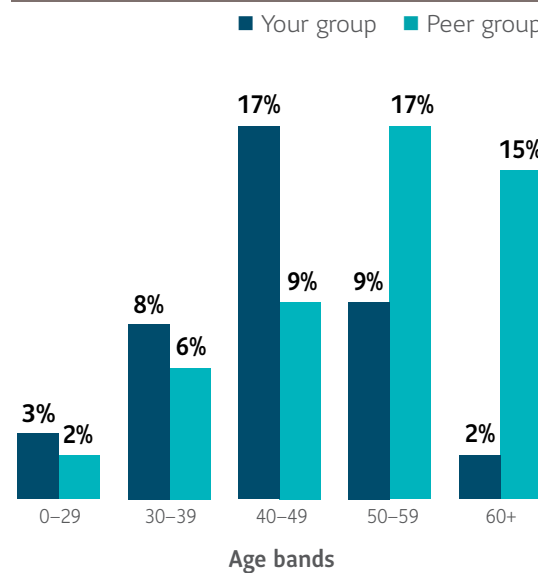
Using the employer's census data, it is possible to get a sense of how the demographics of the group could affect its stop-loss risk. Factors such as gender and age contribute to the group's overall risk profile and the likelihood of experiencing high-cost claims. Assessment of potential risk, along with other criteria such as stop-loss deductible level and contract type, can affect the cost of stop-loss coverage.

From a broader perspective, it can be helpful for an employer to understand how it compares to groups that are similar in terms of industry and size. Ask the broker to provide industry and marketplace benchmarks on associated stop-loss risks, stop-loss coverage, and deductible level options. Every employer is unique; if an employer knows how it compares to industry peers, it can make more informed coverage decisions.

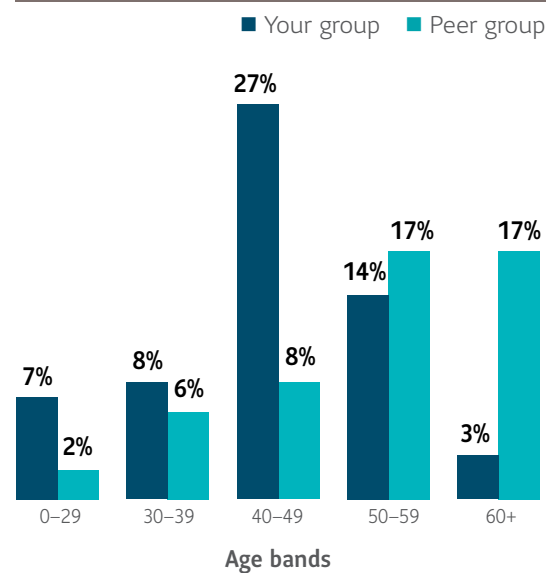
### Stop-loss risk profile



### Associated risk for women



### Associated risk for men



Source: The graphic is for educational purposes; it was created by Sun Life Stop-Loss Benchmark, which shows stop-loss deductible levels from stop-loss quote requests that Sun Life received from Sep 2015-Sep 2020, and provides hypothetical data for the "your group" statistics.

## How stop-loss works

Stop-loss provides reimbursements to the employer for eligible claims. The most common type of stop-loss is called "Specific stop-loss." It provides protection for the self-insured employer from large claims that occur for any one covered individual. Here's how it works:

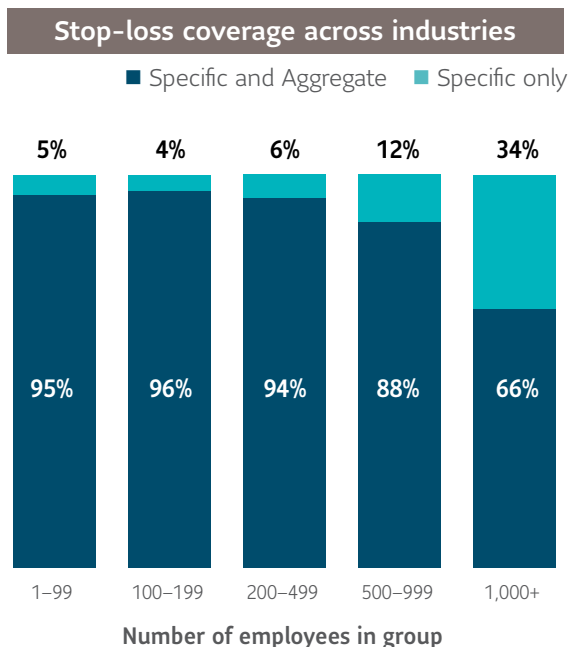


For example, if the stop-loss deductible is \$75,000 and the claim is \$1 million of eligible expenses, the employer pays the \$1 million claim. Then, the stop-loss carrier sends the employer a \$925,000 reimbursement.

## Popularity of different types of stop-loss coverage

This graph shows the distribution of Specific stop-loss compared to Aggregate stop-loss in the marketplace. In general, employers get both types of coverage. The smaller an employer is, the greater the chance that the coverage includes both Specific and Aggregate coverage. The larger an employer is, the greater the chance that employers will choose to get only Specific coverage.

For example, of employers with 99 or fewer employees, 5% had Specific coverage only, and 95% had both Specific and Aggregate coverage. For employers with over 1,000 employees, 34% had Specific-only coverage, and the remaining 66% chose a combination of Specific and Aggregate coverage.



Source: The graphic was created by Sun Life Stop-Loss Benchmark, which shows stop-loss deductible levels from stop-loss quote requests that Sun Life received from Sep 2015 to Sep 2020.

## Employers talk about self-funding

"It's good, every year we go and look at the medical plan from both a fully funded perspective and a self-funded perspective, and the fully funded plan always comes in at least a million dollars more a year than what we've experienced."

—Human Resources VP/Consultant 12 years experience, manufacturing industry 500–1,999 employees

## What should the stop-loss deductibles be?



As the broker, you or the employer should ask the stop-loss provider for benchmarks on stop-loss coverages and deductibles and for specific information about those benchmarks for employers in the same industry. This knowledge can aid both of you when making coverage and deductible decisions.

Based on an analysis of a variety of factors, the employer selects the deductible levels for stop-loss coverage. Those factors can include risk tolerance, industry, size, employee demographics, claims experience and typical medical costs in the employer's geographic location.

Deductible trends vary based on case size and industry. As you can see in the charts below, deductibles range from \$49,000 or below to over

\$500,000. As case size increases, so does the likelihood that a higher deductible level will be selected.

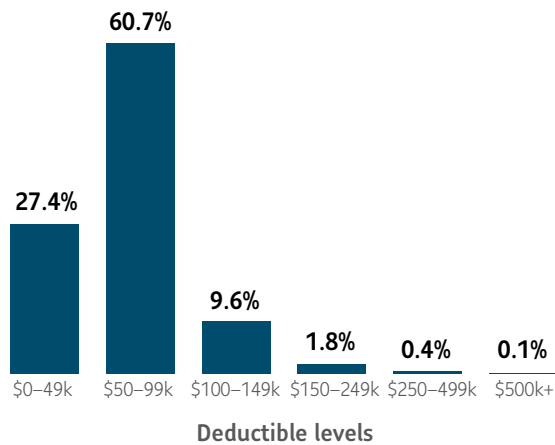
## Once the employer selects a deductible, should it always remain the same?



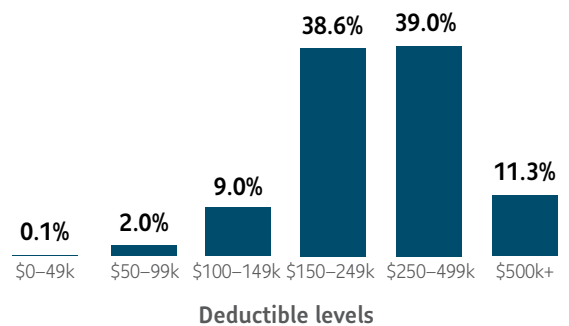
No. It's a good idea to analyze a set of factors every year, such as changes in risk tolerance, current industry coverage trends, a decrease or increase in staffing levels, employee demographics, claims experience, and typical medical costs in its geographic location. Based on that analysis, the employer can decide how to change the stop-loss deductibles. In fact, picking different deductibles year over year is common and can reduce stop-loss premium increases.

## Stop-loss deductible choices

### Employers with 100–199 employees



### Employers with 1,000+ employees

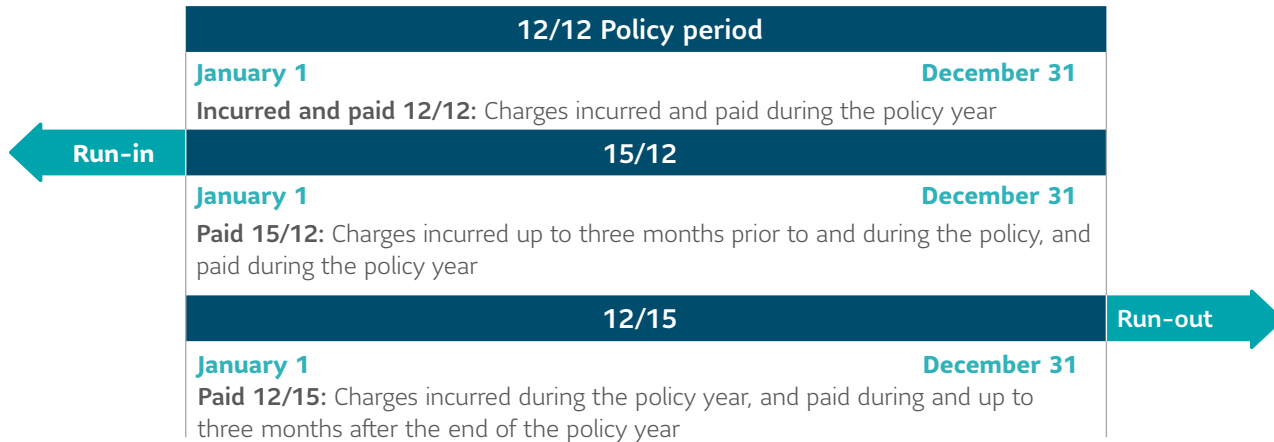


Source: This data is from Sun Life Stop-Loss Benchmark showing stop-loss deductible levels from stop-loss quote requests that Sun Life received from 2009 to May 2018 across a range of employer sizes and industries.



## Common stop-loss contract types

Employers can choose from a variety of stop-loss contracts to meet their needs.



### What should the stop-loss contract period be?

Next, employers need to set the contract period. The stop-loss policy period itself is usually 12 months. The contract period determines which claims are covered under stop-loss. Stop-loss carriers provide a variety of options in order to serve a particular employer's preference. The graphic above shows a few examples. A run-in contract might be offered to add stop-loss coverage for claims incurred before the beginning of stop-loss policy period. A run-out contract extends stop-loss coverage for claims paid after the end of the stop-loss policy period.

In addition, a carrier might also offer a "paid contract," which covers claims that are actually paid during a 12-month timeframe. The incurred period, for a paid contract, expands to the beginning of the active policy relationship with the carrier. Brokers should analyze what's available from the stop-loss carrier and advise the employer on what will work best.

### Options to investigate

To increase the strength of coverage, it's a good idea for employers to consider available options. Carriers may provide additional products and services that can improve cash flow, manage costs and better align the stop-loss coverage with the underlying medical plan document.

On behalf of your employer client, you should explore these stop-loss features with the stop-loss carrier:

- **Advance Funding**, which improves cash flow by allowing the employer to receive funds before it has to pay for eligible claims
- **Aggregating Specific deductible**, which lowers stop-loss premiums in exchange for the employer retaining more risk
- **Claims Experience Refund**, which returns a portion of stop-loss premium when claims run lower than expected
- **Mirroring**, which aligns the medical plan document with the stop-loss policy to help guard against coverage gaps
- **Monthly Aggregate Accommodation option**, which provides for earlier reimbursement when non-catastrophic first-dollar claims exceed projected monthly levels
- **No new lasers (a higher deductible for a particular plan member) at renewal option**, which can make it easier for employers to manage potential high-cost, high-risk claims
- **Renewal rate cap**, which can help create more predictable renewals and support longer-term budget planning

## Tips for your employer clients

- As high-cost claims risks are not always predictable, it's prudent to use stop-loss insurance to protect against risk exposure.
- Get benchmarking data that compares their business's demographics and claims experience to industry peers and the marketplace at large to help inform their stop-loss coverage and deductible decisions.
- Provide them with a few choices of stop-loss carriers and to explain the advantages of each.

## Who provides stop-loss?

An employer can get stop-loss from a health insurer or a stop-loss carrier. Some employers choose to get stop-loss coverage from the same company that administers their medical claims. Other companies prefer to work with an independent stop-loss provider.



### 1. Bundled with a national ASO carrier

This approach means that the company (typically, a health insurer) that administers the self-funded health plan (sometimes referred to as administrative services only or ASO) also provides the stop-loss insurance.

The ASO claim administrator adjudicates all claims including first-dollar claims (which are claims that occur before the stop-loss deductible is breached) and claims that are eligible for reimbursement under the stop-loss policy.

Using this approach, there is a proprietary network provider (which can frequently offer national reach) and the administration is centralized, but programs and services can be limited to a predetermined set of options.



### 2. Unbundled with a direct carrier

Using the direct carrier approach means that one company administers the self-funded health plan, and a separate company provides the stop-loss coverage. Claims are administrated either by a third-party administrator (TPA) or through an ASO plan provided by a health insurer.

A separate stop-loss carrier can provide more flexibility to the employer when it comes to stop-loss coverage options. For example, a stop-loss carrier can provide one stop-loss policy that

## Key decision-makers



Who's making the decision on what type of stop-loss insurance to buy? Human resources directors, chief financial officers, risk managers and other senior executives.<sup>13</sup>

covers multiple administrators. In addition, it can leverage its specialized knowledge of how to make stop-loss most effective for the employer. When this type of plan is in place, the employer can choose among the "plug and play" specialty services—such as enhanced cost-containment programs—according to its needs.

Highly effective stop-loss carriers are adept at working well with all the stakeholders (brokers, administrators, cost-containment vendors, pharmacy benefits managers and others) so administration is seamless for employers. Direct carriers can provide increased employer flexibility and dependable claim reimbursement, especially when they have extensive experience with a particular claim administrator.

## Seamless experience

How can an employer ensure that it gets a seamless reimbursement experience from the stop-loss carrier? Both stop-loss approaches—bundled and unbundled—can provide a seamless experience. Help your clients investigate the typical reimbursement experiences associated with potential stop-loss carriers.

<sup>13</sup>. Employer Voice-of-the-customer Research Study conducted by Conifer Research and sponsored by Sun Life. This blind study included in-depth interviews with benefits managers and executives from self-funded employers ranging in size 50 to 8,000 employees.

## Selecting a stop-loss carrier

To help your clients evaluate stop-loss carrier candidates, look for these key attributes.

### Strength and stability



- Strong financial ratings from independent agencies
- Impressive experience in the industry to handle challenges
- Ability to reimburse the largest claims fast
- Autonomous underwriting decision-making without reliance on a reinsurer's approval
- Leadership based on expertise and client insights

### Insights and innovation



- Commitment to the stop-loss industry and to providing educational opportunities
- Access to cost-containment services and consulting that help support the employer's self-funding and benefits strategies
- Self-funding best practices and customized benchmarking data to guide your self-funded strategy
- Innovative approaches to new employer needs and legislative requirements

### Health advocacy and care navigation



- High-touch, personal service model based on each member's needs, goals, and preferences
- In-depth knowledge of the healthcare system to connect members to local, in-network providers
- Fast, seamless, objective process to get expert guidance, quickly for any health concern
- Knowledge and expertise that leads to improved health outcomes, better member experiences and potential cost savings
- Robust benefits that focus on the care of individuals keep employees happy, healthy, loyal and return to work faster

Once an employer selects potential stop-loss carriers, they will need to provide information to the carriers so they can underwrite the coverage. Typically, that includes providing:

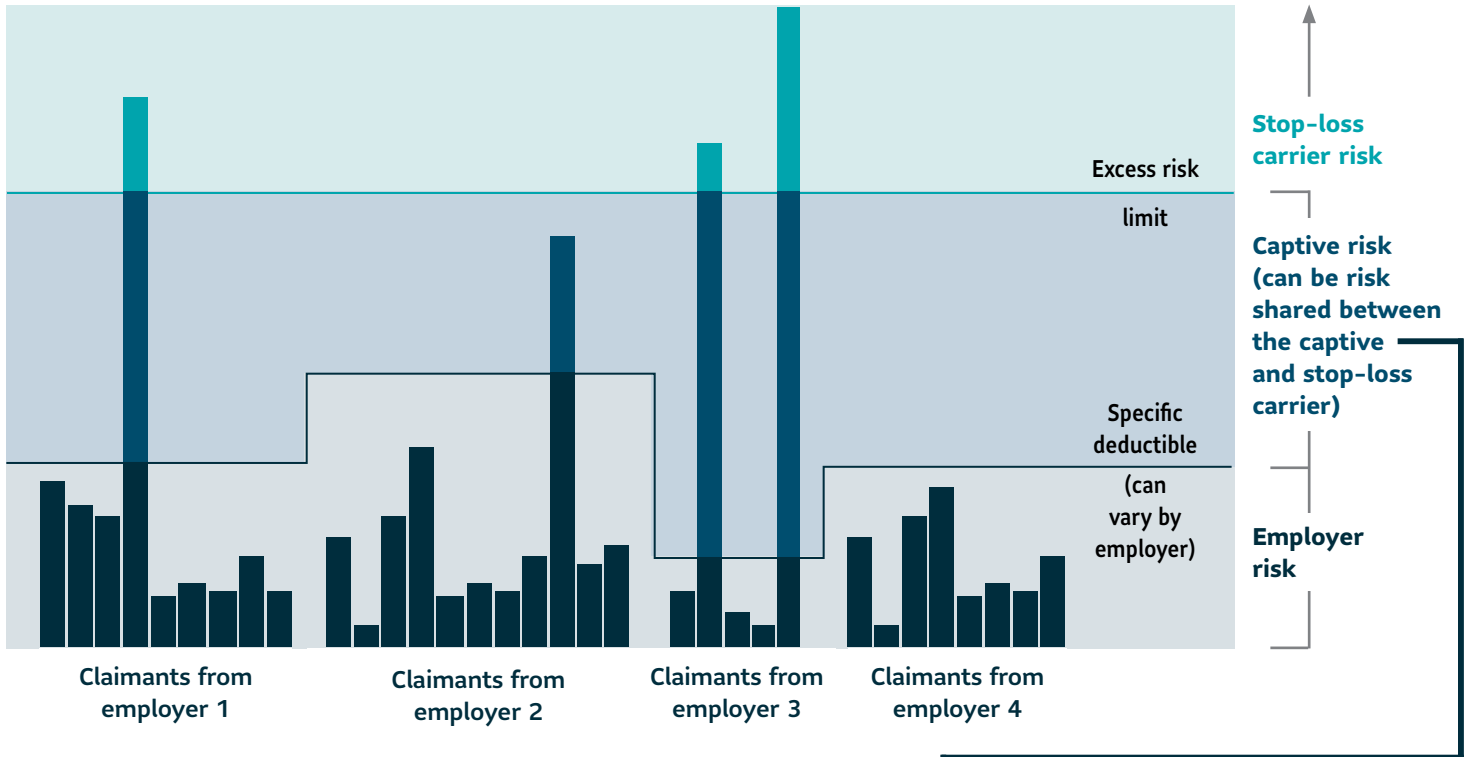
- A complete census
- At least two years of claims history
- The current/proposed medical plan document
- A list of plan changes in the last two years
- The current/proposed claims administrator and network
- Broker commission percentage
- Policy requirements, the desired Specific and/or Aggregate stop-loss deductible(s), and the policy basis (timeframe of when claims are incurred and paid)

## Employers talk about self-funding

"One size definitely does not fit all, and you have to find what makes sense for your organization."

—Head of Benefits, legal industry, 2,000+ employees

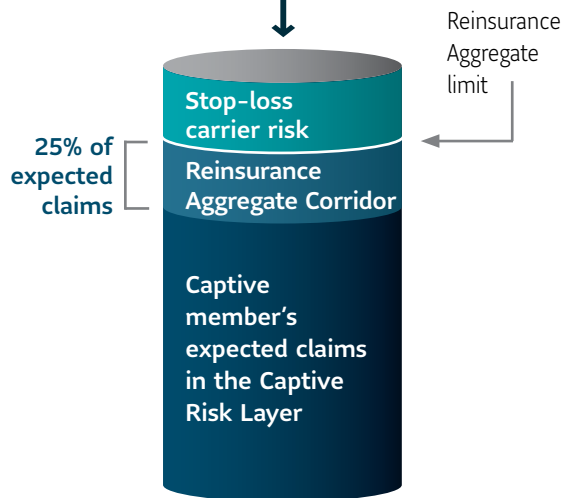
## Understanding stop-loss captive solutions



Interest in group stop-loss captives is on the rise. For employers that may think they are too small to self-fund, captives can be a great option to consider. Below is information to determine if a captive solution may be a good fit for your business.

### What is a stop-loss captive?

A stop-loss captive is an insurance entity formed and managed by like-minded employers looking to increase control of their employee health benefit programs to reduce overall cost. Specifically, group stop-loss captives allow small employers to gain negotiating power of a larger company by sharing a layer of risk. This results in more predictable claims experience, while stabilizing the overall cost of providing healthcare insurance to employees on a long-term basis. As with traditional stop-loss, the shared layer of risk in a stop-loss captive is capped by an Excess Limit and a Reinsurance Aggregate.



### Who may be a good fit for a stop-loss captive solution?

Small employers, typically with 50–250 employees but possibly up to 500, are potentially a good fit for a captive solution. Choosing a captive solution can also be an effective way for a fully insured employer to transition to self-funding.

### Why choose a stop-loss captive?

Employers select a stop-loss captive to pool and share their risk and to reduce their claims volatility, which can ease the transition to self-funding. For instance, when an unexpected high-cost claim occurs, a group captive can absorb the shock and its impact is shared among the pool of employers. More specifically, a stop-loss captive can choose to absorb some of the risks, which may be covered by traditional medical stop-loss policies, such as certain individuals with large, ongoing medical conditions.

On the other hand, when employee claims are at or below the expected level, the employer members share the profit that would normally have gone back to the insurance carrier. This is one of the key drivers and benefits of self-funding.

### What are the different types and structures of stop-loss captives?

There are a few types of stop-loss captives and structures to consider.

Within the group captive category, two types of captives exist: heterogeneous and homogeneous. With the heterogeneous category, employers from many different industries come together to form a collective captive. Generally, this type

of captive acquires more participants and can quickly achieve an appropriate spread of risk. In contrast, in a homogeneous group captive, employers from the same or similar industries come together to form a captive arrangement. In this case, employer membership can be smaller; however, their underlying risks and underwriting profiles can be quite similar.

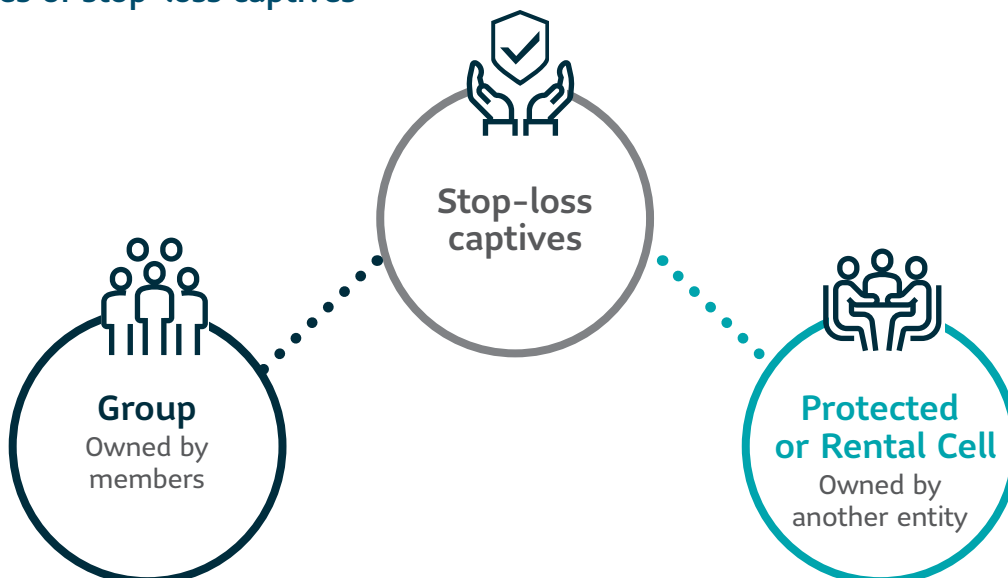
Stop-loss captives generally have two structures: protected or rental cell and group captives. A group captive is owned by its member participants who insure their risk through the captive arrangement. A protected or rental cell captive is owned by parties unrelated to the member participants who insure their risk through the captive arrangement.

The protected or rental cell captive may appeal to small employers that want the benefits of participating in a captive arrangement without the responsibility of ownership, governance or management. However, their ability to select service providers for their program (in other words, stop-loss carrier, broker, TPA, etc.) may be limited. With a group captive, participants own the management of the program and have more flexibility in selecting service providers.

### Employers that choose a captive solution typically:

- Focus on health management and cost-containment within their benefit plans.
- Are willing to join like-minded employers.
- Value peer-to-peer collaboration.
- Are open to trying something new.

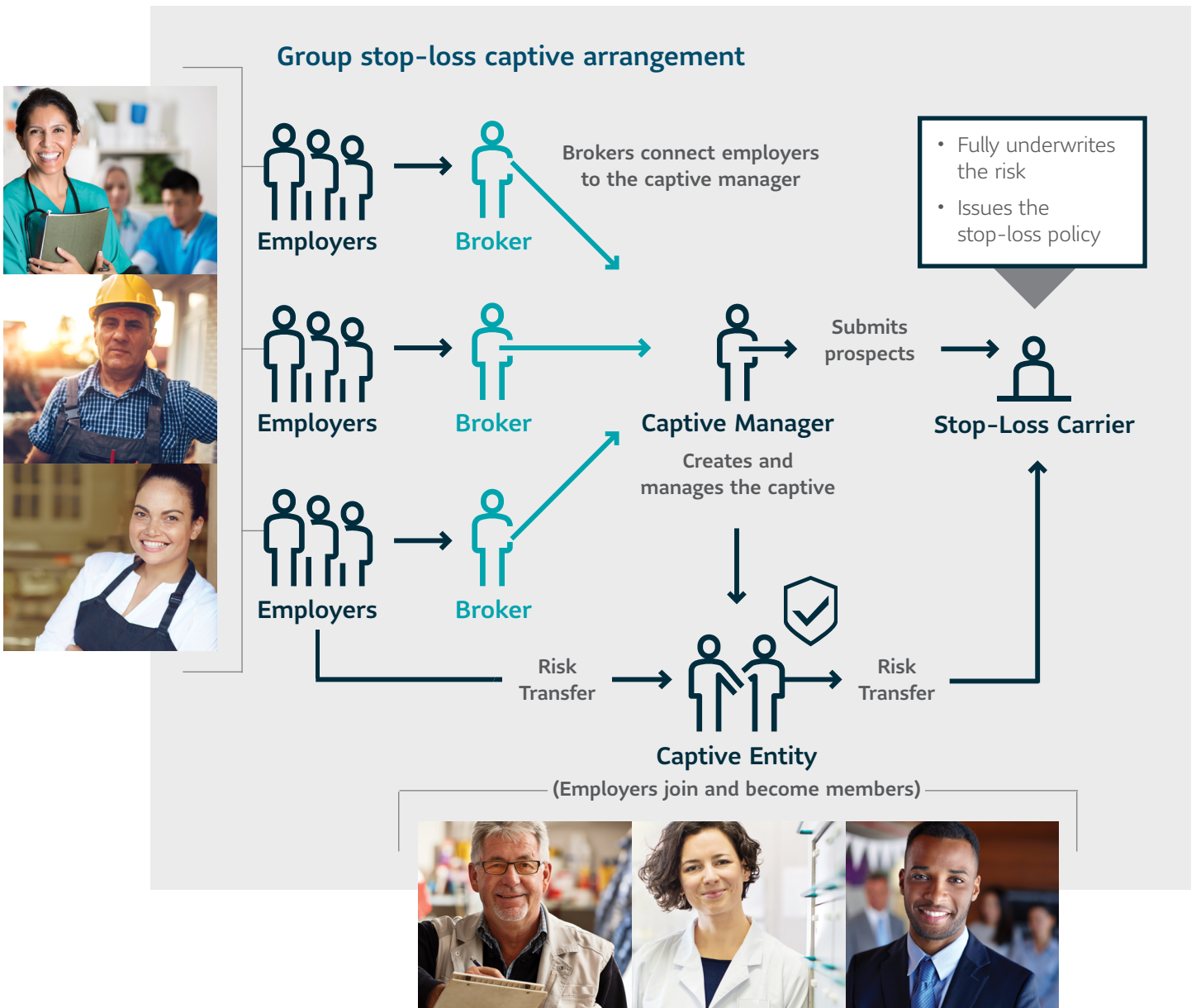
### Types of stop-loss captives



### How do the companies work together in a group stop-loss captive arrangement?

Within a group stop-loss captive arrangement, each employer member sponsors a unique plan that benefits its employees and their dependents. Each member has its own stop-loss policy. For example, your employer client may be sharing about 20% of their total healthcare dollars with like-minded employers, but all of them will have their own stop-loss coverage.

Financially, the captive is a licensed insurance company and needs capital to operate. Participating employer members become equity owners in the company and will receive equity in return for their capital. If the claims exceed the premium, capital is used to pay the claims. On the other hand, if the premium exceeds the claims, the profit is distributed evenly to the participating employer members.



# HELP ADVISE YOUR EMPLOYERS

To plot the way forward, consider creating an action plan. It can be a formal written document or simply a list of items to discuss. The broker, claims administrator and stop-loss carrier can work together to meet the employer’s needs.

## Funding arrangement

Action	Steps	Include
Evaluate if self-funding makes sense for the particular business	<ul style="list-style-type: none"> <li>Determine the business’s benefits strategy and financial goals. Understanding their risk tolerance and cash-flow needs will help the employer decide if it should be fully insured, self-funded with stop-loss insurance, or self-funded without stop-loss insurance. Provide counsel to your employer clients alongside their chosen plan administrator.</li> </ul>	<input type="checkbox"/>

Once they’ve decided to become self-funded, the next few pages have elements to consider when creating a self-funded plan.

## Claims administration

Action	Steps	Include
Finalize the medical plan document	<ul style="list-style-type: none"> <li>Provide guidance alongside their claims administrator, make their plan document follows all applicable laws and describes the benefits the employer is offering to the covered plan members.</li> </ul>	<input type="checkbox"/>
	<ul style="list-style-type: none"> <li>Confirm with the claims administrator that they can administer the plan document.</li> </ul>	<input type="checkbox"/>
Perform an annual plan document review	<ul style="list-style-type: none"> <li>Review the plan document every year. A variety of factors can necessitate amendments to the plan document. Examples include new federal or state regulations, changes in the business, new benefits, or an interest in adding new cost-containment language to the plan document.</li> </ul>	<input type="checkbox"/>
Select or change the claims administrator	<ul style="list-style-type: none"> <li>Consider what type of networks, service, data, vendors and programs their business needs. Choose the claims administrator that meets those needs—typically either an administration services only (ASO) plan through a health insurance company, or a third party administrator (TPA) plan.</li> </ul>	<input type="checkbox"/>
	<ul style="list-style-type: none"> <li>Check to see if the selected claims administrator uses claims best practices such as giving high-dollar claims special attention, properly managing costs associated with dialysis treatments, focusing on controlling prescription medication costs, and tracking higher-cost innovations.</li> </ul>	<input type="checkbox"/>
Apply data analytics	<ul style="list-style-type: none"> <li>Provide your employer clients with marketplace and industry benchmarks—this information can provide key insights to help make plan design and coverage choices.</li> </ul>	<input type="checkbox"/>
	<ul style="list-style-type: none"> <li>Provide additional guidance based on predictive modeling, which can help reduce healthcare risks and costs for the both the covered employee population as a whole and for individual covered employees.</li> </ul>	<input type="checkbox"/>

## Strategic teamwork

“Today, employers are looking for more robust and effective management of escalating medical and prescription drug claim costs. This presents a significant opportunity for employers, brokers, administrators and stop-loss carriers to collaborate to build self-funded plan options that meet those needs.”

—Michael Hoefler,  
Sun Life Stop-Loss  
Vice President

## Stop-loss insurance

Action	Steps	Include
Select stop-loss coverage and deductibles	<ul style="list-style-type: none"> <li>Analyze a set of factors such as changes in federal and state laws, current industry coverage trends, the employer’s risk tolerance, a decrease or increase in staffing levels, employee demographics, claims experience, and typical medical costs in its current or new geographic location. Based on that analysis, the employer can decide how to change the stop-loss deductibles, modify the policy basis, or add or remove certain features or services.</li> <li>Investigate options to tailor stop-loss coverage to meet the needs of the particular employer.</li> </ul>	<input type="checkbox"/>  <input type="checkbox"/>
Perform an annual stop-loss review	<ul style="list-style-type: none"> <li>Determine how to best adjust deductible levels and coverage selections using the factors listed above. One important consideration should be addressing ongoing high claims. Higher deductibles (sometimes called “lasers”) can be set for particular employees at high risk for higher-cost claims. Some employers are willing to accept the additional risk of a laser at the annual stop-loss renewal. Some employers don’t want to take on more risk at renewal. For those employers, ask the stop-loss carrier about an option that provides no new lasers at renewal with a renewal rate cap so upcoming costs are more predictable.</li> </ul>	<input type="checkbox"/>

## Cost containment

Action	Steps	Include										
Leverage resources	<ul style="list-style-type: none"> <li>Work with the claims administrator and stop-loss carrier to help determine when certain resources will be used. Stop-loss carriers and claims administrators both have resources to help contain costs and support better patient outcomes.</li> </ul> <p>For example, a claims administrator or stop-loss carrier might give access to specialized services or programs such as:</p> <table border="0"> <tr> <td>–Cancer Centers of Excellence facilities network</td> <td>–Organ and tissue transplants</td> </tr> <tr> <td>–Congenital heart disease Centers of Excellence facilities network</td> <td>–Out-of-network claim negotiation</td> </tr> <tr> <td>–Hospital bill audit</td> <td>–Specialty pharmacy distribution and services</td> </tr> <tr> <td>–Kidney dialysis</td> <td>–Utilization review and case management</td> </tr> <tr> <td>–Medical review</td> <td>–Ventricular assist devices</td> </tr> </table> <p>Some stop-loss carriers also have nurse consultants on staff who review claims data to identify cost savings and care optimization opportunities.</p>	–Cancer Centers of Excellence facilities network	–Organ and tissue transplants	–Congenital heart disease Centers of Excellence facilities network	–Out-of-network claim negotiation	–Hospital bill audit	–Specialty pharmacy distribution and services	–Kidney dialysis	–Utilization review and case management	–Medical review	–Ventricular assist devices	<input type="checkbox"/>
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–Medical review	–Ventricular assist devices											



## Cost containment (continued)

Action	Steps	Include
Share cost-containment best practices	<ul style="list-style-type: none"><li>The broker, the stop-loss carrier, and the administrator should share what works and look for ways to apply successful strategies more widely. These can be approaches that have been in use for years or new methods that are showing positive results.</li></ul>	<input type="checkbox"/>
Follow the plan document	<ul style="list-style-type: none"><li>Include clear cost-containment language and ensure that the claims administrator processes claims according to the plan document.</li></ul>	<input type="checkbox"/>
Review the hospital charges	<ul style="list-style-type: none"><li>Apply discounts and perform an accuracy review, so the employer pays the correct amount.</li></ul>	<input type="checkbox"/>
Explore wellness programs	<ul style="list-style-type: none"><li>Match programs to the particular employee population. However, it's wise to be realistic about savings goals and timeframes, and to understand that the impact of these programs may be difficult to measure. The impact of wellness programs can be difficult to measure. Recent research suggests that wellness programs should focus on fixing the problem of unhealthy behaviors to make an impact on healthcare costs.<sup>14</sup></li></ul>	<input type="checkbox"/>
Care navigation and health advocacy	<ul style="list-style-type: none"><li>Talk to your clients about the value of providing expert medical opinions, fast access, and personal advisor support for their employees. By supporting their employees in the moments that matter, it can result in better health outcomes for the member and cost-savings for the employer.</li></ul>	<input type="checkbox"/>

## LEARN MORE

### Additional stop-loss resources

[2022 High-cost claims and injectable drug trends report](#)

[Introduction to Gene Therapies](#)

[Clinical 360 overview and success stories](#)

[Stop-Loss Captives: a path to self-funding](#)

[Sample benchmark report](#)

[Unpacking unbundling](#)

14. Aldana, Steve. 2020. This is the impact of wellness programs on healthcare costs. <https://www.wellsteps.com/blog/2020/01/02/impact-wellness-programs-health-care-costs/>





*Thank you!*

To find out more about  
the solutions Sun Life offers  
self-funded employers ask your  
**Sun Life Stop-Loss Specialist.**



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