Protecting the Bottom Line

A Guide to Stop-Loss Insurance for Self-Funded Health Plans

By Zach Gerhardt

This book is dedicated to the Grand Canyon. Without you, I wouldn't be here.

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Introduction

I grew up between cornfields and a soybean field in rural Ohio. I first wanted to be a school librarian, a pizza man, and then an actor. For several years until my first semester in undergrad, I was certain that I would be teaching high school kids about World War II and the explorers who "discovered" the Americas. Like most, I fell backwards into the field of human resources and benefits. But it is only because of my unforeseen path that I can write this book to help you understand stop loss.

Employee benefits are terribly complicated and transitory. Major legislation changes the field every few years or even more often, regardless of which political party is in control. Whether it is the Affordable Care Act (ACA), which imposed different taxes on health plans and overhauled the private insurance market or the Further Appropriations Bill, which ended nearly all of the taxes created by the ACA, controversy goes beyond private insurance versus public. Employee benefits are regulated by a myriad of agencies that make it difficult for employers and health plans to navigate the ongoing changes and mandates: the Department of Justice, Health and Human Services, Internal Revenue Service, Equal Employment Opportunity Commission, Centers for Medicare & Medicaid Services, and more.

Outside of all the regulation is jargon that, like the stock market, makes health insurance seem complex on purpose. It's as if someone is hiding something by using these unique terms that aren't used anywhere else in our normal lives. When looking at net promoter scores, health insurance continuously scores in the 30's out of 100. This means that few understand how it works or how to use it. Terms get thrown around like EOB, out of network, second opinion,

prior authorization, 30-day supply, single-case agreement, and coinsurance. Most people don't know how insurance works unless they personally have an ongoing health condition or a loved one with issues that keep them in the healthcare system regularly.

What makes it more complicated is that the terms just mentioned apply only to what an individual deals with. There is a whole other layer of health insurance that most people are unaware of that comes with an additional set of confusion. That other layer is what the employer deals with.

My Professional Origins

After undergrad, I wanted to move into the field of human resources (HR) and took a job in an HR/benefits call center. It was in that job that I heard numerous stories of families who struggled to navigate the healthcare system and didn't understand their insurance benefits. I knew from that moment that benefits was the direction my life would point toward. After that, I spent several years quoting and negotiating benefit plans for small and midsize employers. Within those years, I gained a deep understanding and appreciation for stop loss.

I took the plunge to work toward my master's in health benefit design. It was a one-of-a-kind program constructed and led by industry professionals who are the pioneers in fixing the problems we see in our healthcare system. Now I consult with employers that have been purchased by private equity companies/funds to manage their benefit programs, mitigate financial exposure between transitions, and implement data-driven strategies that improve the financial health of the companies within the portfolios.

I fell into the benefits space by accident. Most HR professionals steer clear of benefits as it is complicated and they have enough on their plate in other areas. But I fell in love with it because there are so many ways to help people through benefits. When I was younger and my mom had a cold, I would make her toast and a bowl of cereal. I felt the need and wanted to take care of her, and I, along with many others, have a unique opportunity to take care of millions of people through benefits.

My method of helping is to work within the system and confines we have today and make impactful changes one step and employer at a time. Most people don't know this, but so much of insurance and healthcare is still controlled locally. While many people get their insurance directly through the government or the military, Kaiser Family Foundation reported that in 2022 nearly 58 percent of non-elderly Americans got their health insurance through their own or their spouse's employer. These employers, more often than not, are getting their own unique plans and paying for the coverage with their own revenue. While we still have private insurance and private healthcare, employers have the key opportunity to help their employees when they need it the most. The best way to help their employees is by using a self-funded health plan.

The employee will likely never know what that even means, but an employer providing a self- funded health plan can make more than toast and cereal for their employees and their families—they can change their lives for the better in so many ways.

What is this book about?

Self-funding is the superior method of insuring risk for employers and their employees. That said, there are many myths and mischaracterizations of self-funding that prevent employers and brokers from embracing the change that can actually help them. Over the years, the health insurance industry has moved like the two o'clock work hour. There have been major, rapid changes on the legal front, but the overall industry has been stagnant. Employers have been boxed into a system that hasn't given them an opportunity to make meaningful changes. Similarly, health insurance brokers have been reluctant to educate themselves and change, despite it being in the best interest of their clients. Self-funding requires more work and attention that many employers and brokers have avoided due to the complexity. Therefore, mostly sound bites of health insurance information are passed along. There are preconceived notions of self-funding having unlimited risk. Random anecdotes abound of employers not having a good experience.

I will clear the slate and reset the base levels to zero. You will learn how self-funding is achievable for any company from the ground up. I will address any concerns of uncapped risk or horror stories. I will address what components are important to know and discuss the ins and outs of stop-loss to help employers limit their financial liability. There are right ways to self-fund a health plan and wrong ways to do it. If you are looking to "'fix" healthcare, then self-funding health insurance is the first step in your quest. I will help you understand stop loss and its role in getting your self-funded health plan set up correctly to be sustainable for years to come.

The Takeaway

This book is primarily designed for individuals who deal with benefits in their work, like HR staff and CFOs, but the book can also be a great tool for new brokers, insurance-carrier reps, and self-funded vendor reps. A better-educated industry will help us improve the state of healthcare nationally. After reading, you should feel confident enough to join the discussion on how to improve employer-sponsored health plans and therefore improve the health and wellbeing of Americans. By being part of the discussion, you will be able to be part of the solution. Self-funding is key to the system we have in place today. Whether you are in favor of a public system or a private system for the future, self-funded health plans are the best existing method of helping employers continue to offer benefits, improve their employees' health and wellbeing, and create long-term financial sustainability.

On completion, you will be able to debunk the myths and misunderstanding around self- funding by comprehending stop-loss insurance and the role it plays in helping employers and self-funded plans. Additionally, you will be able to address ways that more employers can transition to a self-funded health plan and take control of their costs.

No one will disagree that our healthcare system is riddled with issues, but after you read this, I hope that you will feel more comfortable understanding stop loss and how it can be used to help. Due to the complexity of benefits and insurance, there will be areas that aren't explored heavily or at all. That said, we are here to discuss stop loss and self-funded health plans in great depth. With all of that said, I intend for this book to provide a real service for you and many others.

Chapter 1 – Understanding Health Plans and Claim Funding

Insurance, self-insured, stop loss, TPAs, captives, consortiums—language like this tends to be confusing if you aren't in some way part of the benefits industry. So imagine this book functions as your *Schoolhouse Rock!* introduction to stop-loss insurance, without the song. To best understand stop loss, however, you first need to understand health plans and their funding models.

There are two types of employer-sponsored health plans: fully insured and self-insured. You may hear them also be called fully funded or self-funded. Most people think all health plans are fully insured due to their lack of knowledge of how the health insurance system works. To set the record straight, most people who get their health insurance from their employer or spouse's employer are actually on a self-insured health plan (65 percent in 2022 according to Kaiser Family Foundation). The key difference between the two funding arrangements is who is responsible for paying the medical or prescription claims when the employee incurs it. Consumers aren't aware of the actual cost of healthcare most of the time. They may have a copay of $300 to go to the emergency room, but the plan pays the remaining $1,000+. In a fully insured health plan, the health insurance company is responsible for paying the claims. In a self-insured health plan, the employer who sponsors the health plan is responsible for paying the claims.

Fully insured plans are most popular among small employers—think organizations with fewer than 100 employees on their health plan. Generally, the smaller the employer, the more likely they are to be fully insured. Nevertheless, I've seen companies of two be self-insured

and companies of 1,300 be fully insured. The decision comes down to the employer and what sort of risk they are willing to take on.

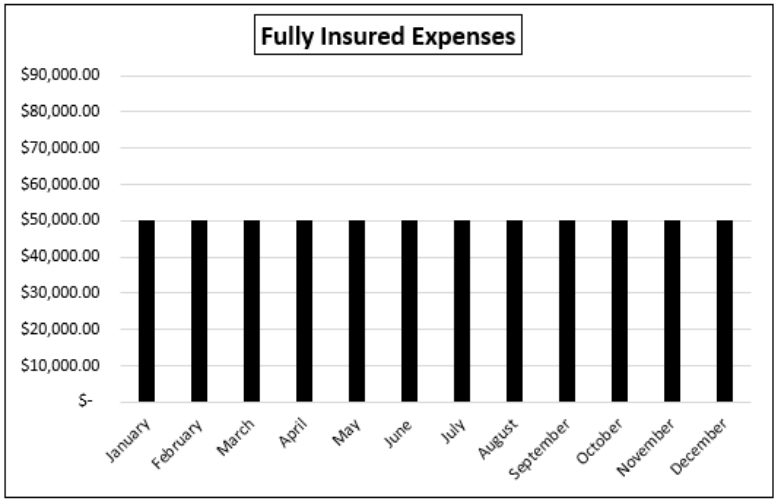

Figure A

Fully insured plans (Figure A) are simple because each month is fairly predictable. Regardless of how healthy or sick employees are, the employer's rates are fixed across a 12-month period. The employer is provided premiums from the insurance carrier for each election tier (employee only, employee and spouse, etc.) and generally does not face any variable costs.

A self-insured plan, on the other hand, comes with key differences that will be discussed at length throughout this book. In simple terms, an employer with a self-insured health plan (Figure B) pays both fixed and variable costs each month. The variable costs are the claims that are incurred by the employees and their dependents. Since claims can range from procedures like an x-ray to gallbladder surgery, and frequencies of 2 or 20, the health plan will see claims fluctuate month to month. While fully

insured plans can also incur fluctuating claims, the employer never experiences the variation in cost because fully insured plans hand off all risk to the insurance carrier. The insurance carrier takes the risk that the claims won't exceed yearly expectations but also reaps the reward if claims run less than projected.

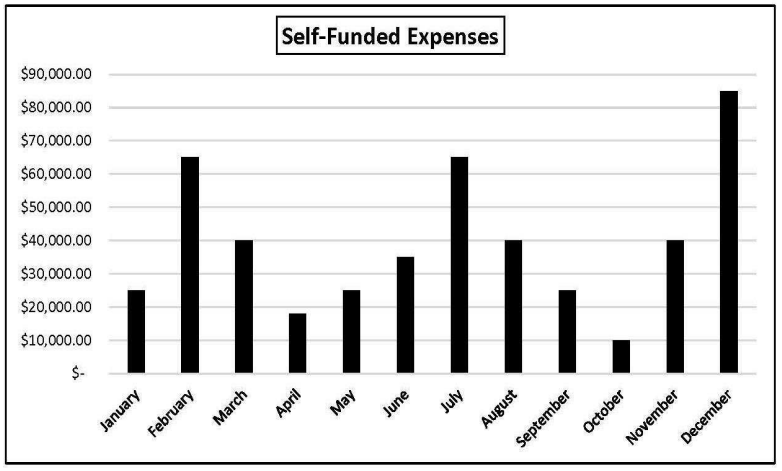

Figure B

To sum things up so far, a fully insured plan is 100 percent fixed costs. Whereas it is commonly accepted within the industry that in most traditional self-insured health plans, approximately 60–70 percent of each dollar spent will be variable claims that fluctuate, leaving about 30–40 percent for fixed costs to help keep the employer financially protected and the plan operating.

Clearly, there are positives and negatives to both fully insured plans and self-insured plans. However, as a company grows, I'd argue it makes less financial sense to let another entity take on the risk for your claims, due to a variety of factors. One of the main reasons employers make the switch to being self-insured is to have more control over

their costs. Because roughly 70 percent of health plan costs are variable in a self-insured arrangement, employers can put strategies in place to reduce claim exposure over time. Whether such strategies are as simple as biometric screenings or as complex as reference-based pricing, self-insured employers can see and feel the impact of their strategies. There is a paternalistic instinct common among self-insured employers to take care of the employees so that they can keep high-cost medical claims as low as possible, thus reducing costs associated with their health plans. An employer may not be able to control a car accident that puts one of their employees in the hospital, but they may be able to help a diabetic adhere to a care plan created by their doctor through wellness plans or disease management programs. You see fewer employers in a fully insured plan as invested in keeping their plan members as healthy as possible because their costs are set in stone for at least a year. These employers then lack the control and the data insights to impact their premiums year over year. More critically, they lack any incentive to control costs in real time.

Components of a self-funded health plan

So far, we've primarily talked about the variable claim costs in self-insured plans; however, there are two other *fixed* costs to consider when selecting self-insured plans: administration and stop loss.

Almost all self-funded health plans have an administrator who acts on behalf of the health plan and processes claims from providers. Employees often assume the administrator *is* the insurance company. They see the administrator's name on the ID card and that is who they call if they run

into issues like being denied a claim or needing prior authorization for a procedure. The administrator is, therefore, connected to all pieces of a health plan—once the healthcare provider submits the claim, the administrator first works with the network (if there is one) to see what discount/cost share should be applied and then talks with the employee to explain payment and coverage. While there are several more tasks that administrators perform, for our purposes it's important to remember they are connected to nearly every step of the health plan.

The insurance industry often refers to administrators as Third-Party Administrators (TPAs) and Administrative Services Only (ASO). Despite both administering self-funded health plans, TPAs tend to represent an unbundled health plan not owned by a large commercial insurance company. Conversely, ASOs tend to represent a self-insured health plan bundled with a commercial carrier. With a TPA, you may have 3–20 vendors providing different medical and pharmaceutical services. In ASO, you have one company providing all types of services. The best way I can explain this difference in administration is to imagine Apple and Android phones. Apple is ASO. They make the hardware, the software, and the operating system for their products. It's all bundled together. If you want it serviced, you have to go to an Apple store. An Android phone is TPA, meaning it's as customizable as the consumer wants it to be. There are positives and negatives to both providers, but some consumers don't mind the extra work of having to coordinate among the different vendors in an Android in exchange for getting the features and tools they want in a phone. Apple gives you less customization but is relatively simple and widely accepted.

Whether the employer is working with a TPA for administration or with an ASO, the administrator's primary