Sun Life Financial®

STOP-LOSS

Employer guidance

Self-funded playbook

Table of contents

Overview

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

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.

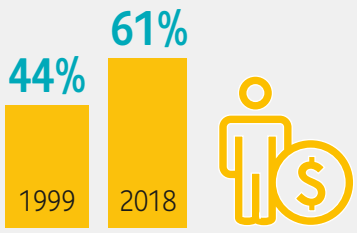
Note: Each employer may have different professionals who advise them on stop-loss insurance and self-funding. These professionals can include benefits advisors, brokers, consultants, and producers. In this document, we will use the term "broker" for simplicity.

Use this playbook to:

- Learn more about what things to consider when deciding whether to self-fund.
- Expand your knowledge about how to make self-funding more effective for your 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 percentage of U.S. employees covered under self-funded medical plans.

The Affordable Care Act has increased employers' interest in 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, 1999–2018.

Key decision #1: Funding arrangement

Tips for employers

- Consider the advantages and responsibilities of self-funding.
- Ask your broker for guidance on determining whether your company is a good candidate for self-funding.
- If you decide to self-fund, work with your broker and plan administrator to design your plan to suit the culture and financial goals of your business.

Balancing the budget and the benefits

Medical costs continue to rise. According to the American Medical Association, healthcare spending accounts for nearly 18% of the gross domestic product (GDP).[1] "Healthcare spending is way up. That's because prices are up for treatments, doctor visits and prescription drugs."[2]

In the face of rising medical costs, employers continue to grapple with balancing the budget and attracting and retaining talented employees with a strong benefits plan. But how employers are addressing that challenge is changing. Shifting costs from employer to employee is becoming more common, including requiring higher deductibles.[3] In addition, according to Eastbridge Consulting Group, employees are purchasing more voluntary products (the employee pays some or all of the cost) such as vision, critical illness and accident.[4] Despite these changes, employers continue to provide health benefits to employees, whether through a fully insured plan or a self-funded plan.

Types of funding arrangements

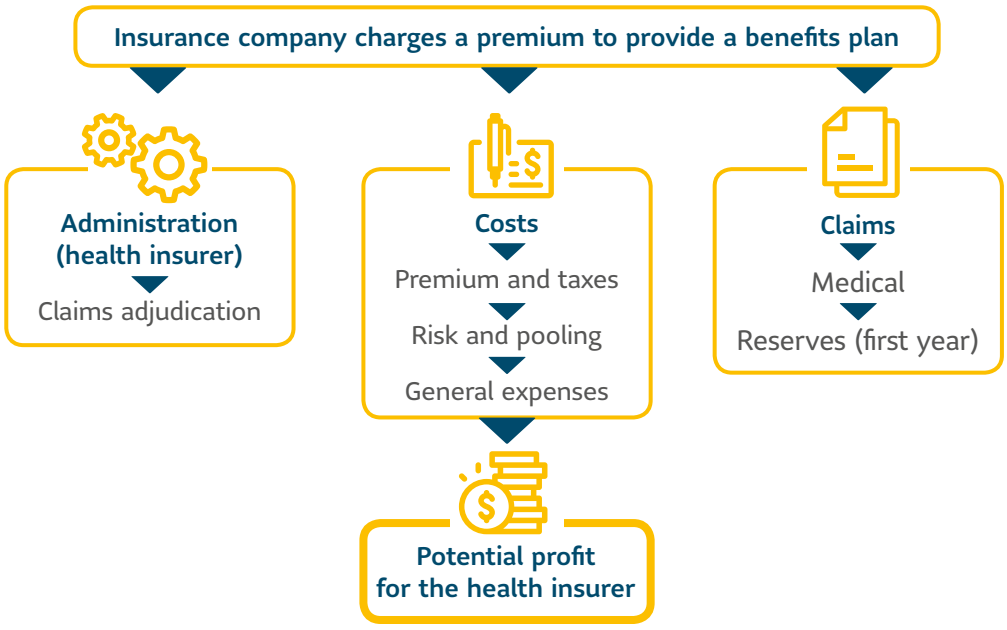
The employer, based on its benefits strategy and financial goals, determines how to fund health benefits for plan members. Employers are trying their best to provide affordable coverage to it's employees, but the costs of future healthcare is unknown. They want to avoid disrupting their employees, obtain claims and benchmarking data, and have more control over their healthcare spending.[6]

The two most common employer funding arrangements are:

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

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

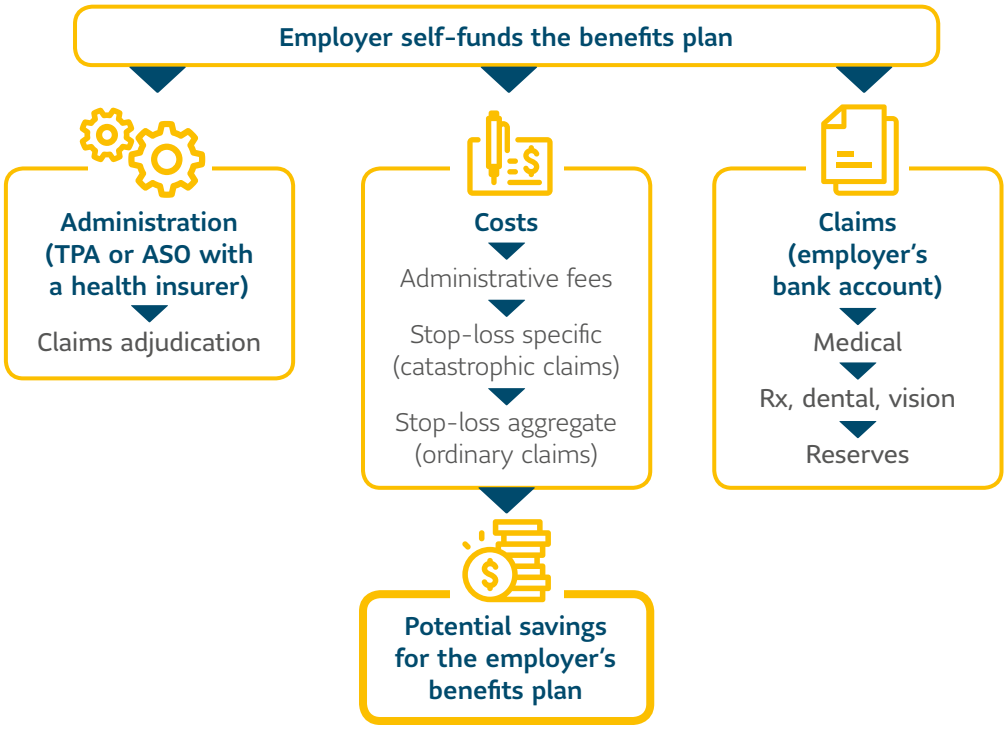


1. American Medical Association, 3 reasons why health care spending is so high. 2018.https://www.ama-assn.org/practice-management/economics/3-reasons-why-health-care-spending-so-high
2. Lemer, Keith. Hidden reasons your health care costs are skyrocketing. CNBC. March, 3, 2018. https://www.cnbc.com/2018/03/22/hidden-reasons-your-health-care-costs-are-skyrocketing.html
3. Kaiser Family Foundation, 2018 Employer Health Benefits Annual Survey.

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, 89% of self-funded employers of companies with between 50 and 199 employees have stop-loss coverage.[5]

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 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.[6]

4. Eastbridge Consulting Group. Voluntary sales are up just under seven percent for the second year in a row, according to Eastbridge's annual sales study. Globe News Wire. May 30th, 2018. https://globenewswire.com/news-release/2018/05/30/1514074/0/en/Voluntary-sales-are-up-just-under-seven-percent-for-the-second-year-in-a-row-according-to-Eastbridge-s-annual-sales-study.html

5. Content in this section is based on the Henry J. Kaiser Family Foundation, "2018 Employer Health Benefits Survey" https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/

6. Sun Life survey conducted by Chadwick Martin Bailey. Employer Insights research study. The blind study included decision-makers for companies that have between 50 and 999 employees and offer medical benefits to all their full-time employees. 2016.

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.[7]

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?[8]

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. A 2018 *Employee Benefit News* article written by Nathan Solheim shared a list of things to consider:

- Additional compliance responsibility
- Risk tolerance
- Ability to deal with volatility
- Level of knowledge about how to administer the plan and analyze data
- Stop-loss and the appropriate levels[9]

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.

7. The Rough Notes Company, Inc, "Stop-Loss insurer Sun Life provides a wide range of backup services,"http://roughnotes.com/self-funded-health-plans-put-employer-control/, March 28, 2018

8. Self-Insurance Educational Foundation., "Employers: Specific advantages of self-insurance," http://www.siefonline.org/employers.php

9. Employee Benefits News, "Small employers flock to self-funding," https://www.benefitnews.com/news/small-employers-flocking-to-self-funding, May 2nd, 2018

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. A broker is a great resource to tap – and can advise on self-funding and stop-loss coverage trends in different industries. He or she can also recommend ways to manage cash flow and the risk associated with high-cost claims.

	State laws	Federal laws
Fully insured health plan	● State laws apply • Health insurance premium taxes • Health insurance requirements	● Federal laws apply • ACA is just one example
Self-funded health plan	◑ Some state laws apply, but usually not subject to health insurance requirements	● Federal laws apply • Some ACA-related taxes and fees • ERISA
Stop-loss insurance	● State laws apply • Certain taxes and fees • Stop-loss requirements	○ Federal laws do not apply

Chart key

- ● Laws apply
- ◑ Some laws apply
- ○ Laws do not apply

Key decision #2: Claims administration

Tips for employers

- Consider the networks, service, data, vendors and programs that your business needs. Choose the claims administrator that meets those needs.
- Ask your broker for guidance on choosing a claims administrator—including ensuring that it follows best-practice claims processes—and review its performance regularly.

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.[10]

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.[11]

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

- Hospitals
- Outpatient clinics
- Physicians' offices

What should you 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?

10. 2018 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.
11. All information according to the 2018 Sun Life Stop-Loss Research Report "High-cost claims and injectable drug trends," which covers four years of catastrophic claims that Sun Life paid.

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

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."

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.

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. CNBC has reported on these rising drug prices in a variety of articles. Particularly in this featured article exploring the number of drugs whose prices increased in the early part of 2019. Drugmakers kicked off 2019 with U.S. price increases on more than 250 prescription medicines by January 2. That total has almost doubled, with pharmaceutical companies hiking prices on nearly 490 drugs by January 10.[12] Reuters has also has been documenting the rising prices of drugs by various companies, sharing that one company, "raised list prices [in 2019] on more than 50 drugs, and more than half of those by 9.5 percent."[13]

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.

12. CNBC. J&J raises U.S, prices on around two dozen drugs. January 11, 2019. https://www.cnbc.com/2019/01/11/jj-raises-us-prices-on-around-two-dozen-drugs.html

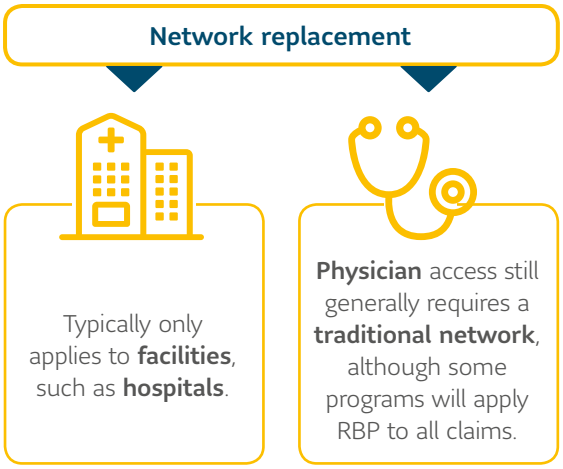
13. Erman, Michael. "Drug companies greet 2019 with U.S. price hikes" Reuters.com. January 2, 2019. https://www.reuters.com/article/us-usa-drugpricing/drug-companies-greet-2019-with-u-s-price-hikes-idUSKCN1OW1GA.

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 2014 to 2017, the top ten conditions represented over $1.5 billion in stop-loss claim reimbursements, representing 51.8% of total reimbursements that Sun Life made.[14]

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

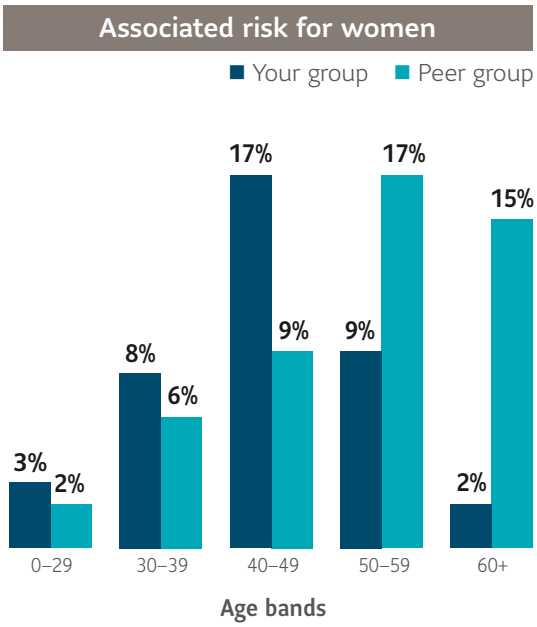
Many employers purchase both products, though an employer can decide to purchase Specific stop-loss alone. But how can an employer figure out what products to buy and what coverage level (often referred to as a "deductible level") makes sense for its business? To determine the stop-loss coverage types 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.

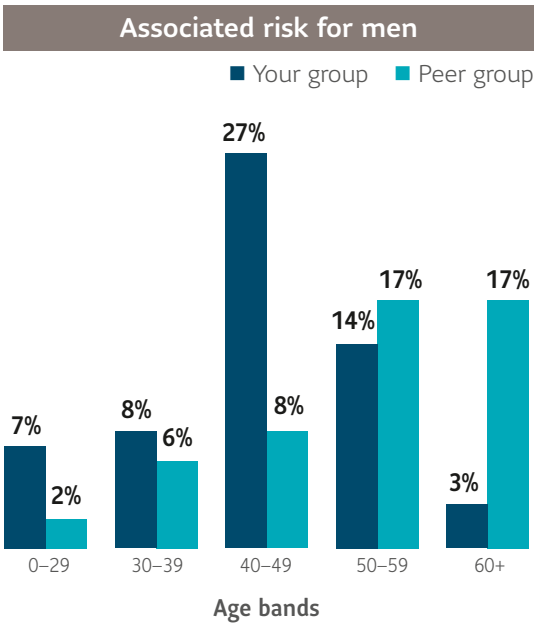
14. All information according to the 2018 Sun Life Stop-Loss Research Report "High-cost claims and injectable drug trends," which covers four years of catastrophic claims that Sun Life paid.

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.





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 2009 to May 2018, 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:

The self-funded employer (or "Plan") purchases stop-loss insurance from a carrier.

The employer pays all of the claims of members covered by the health plan.

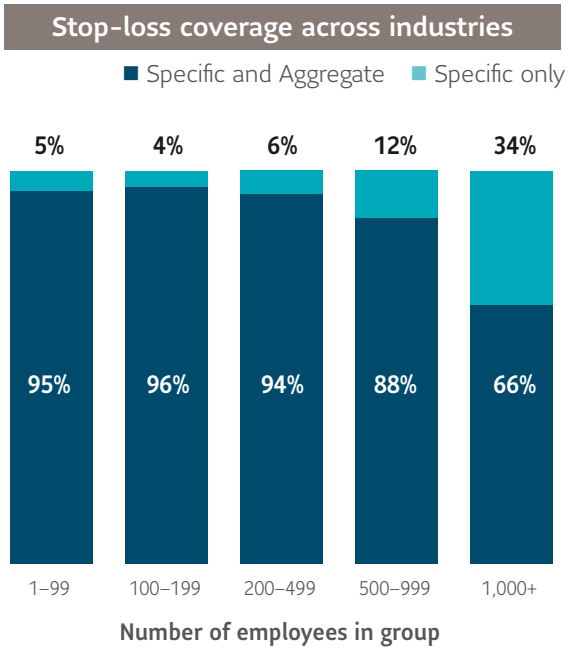
The stop-loss carrier sends the employer reimbursement dollars for claims costs above a pre-determined amount (referred to as the "individual" or "Specific" stop-loss deductible).

For example, if the stop-loss deductible is $50,000 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 $950,000 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 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 2009 to May 2018.

What should the stop-loss deductibles be?

The employer or its broker 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 the broker and employer 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?

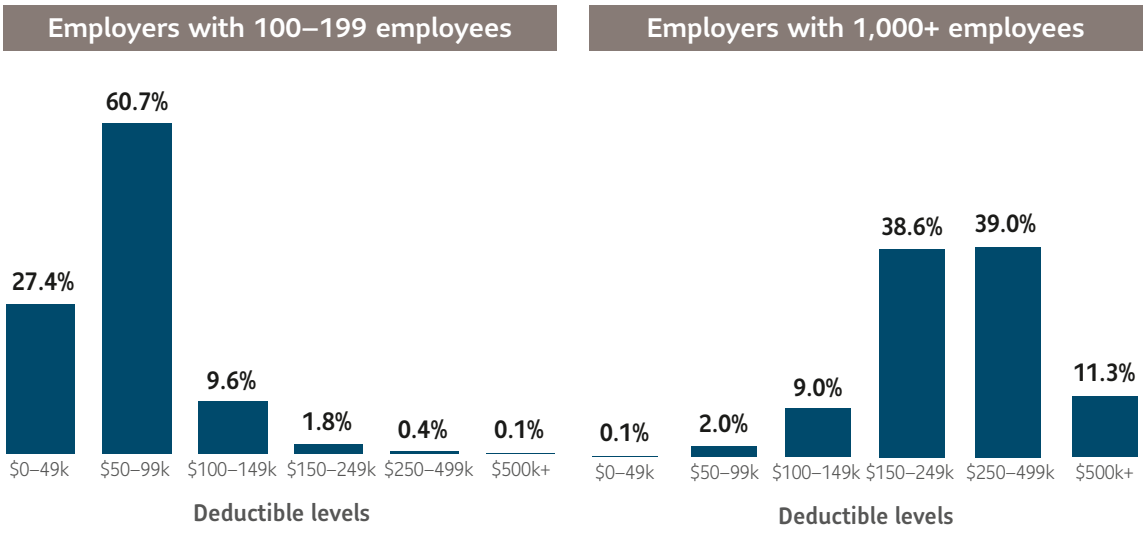
No. It's a good idea to analyze a set of factors every year, such as changes in risk tolerance, current industry coverage trends, a decrease or increase in staffing levels, employee demographics, claims experience, and typical medical costs in its geographic location. Based on that analysis, the employer 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.

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*

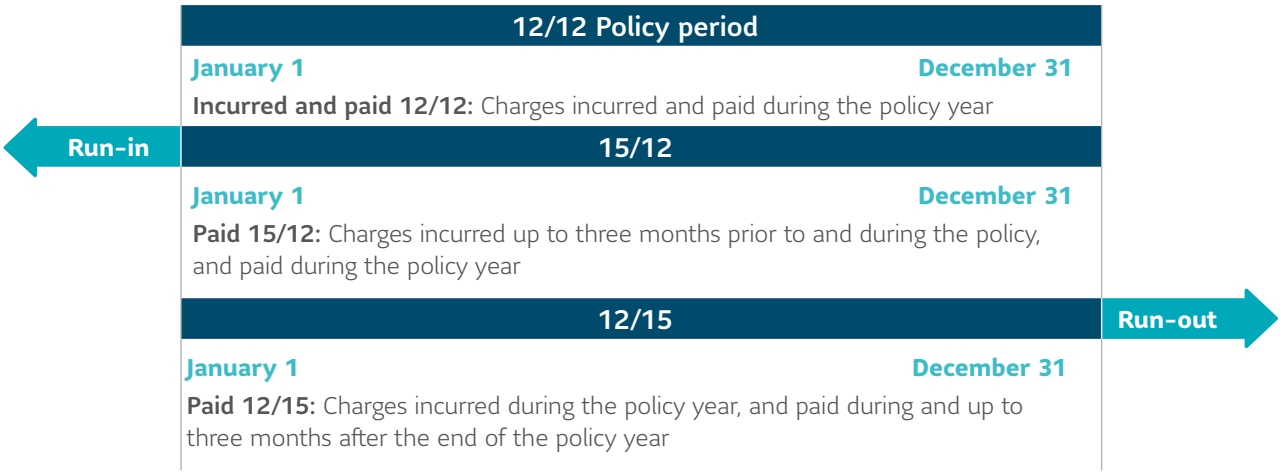
Stop-loss deductible choices



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 typically 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.

Ask the broker to 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
- **An 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

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 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.

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.[15]

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. Ask your broker to investigate the typical reimbursement experiences associated with potential stop-loss carriers.

Tips for employers

- As high-cost claims risks are not always predictable, it's prudent to use stop-loss insurance to protect against risk exposure.
- Ask your broker for benchmarking data that compare your business's demographics and claims experience to those of your industry peers and the marketplace at large to help inform the stop-loss coverage and deductible decisions.
- Ask your broker to provide a few choices of stop-loss carriers and to explain the advantages of each.

15. 2018 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.

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*

Selecting a stop-loss carrier

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

Strength

- High financial ratings from independent agencies
- Decades of experience so things are handled properly
- Ability to reimburse the largest claims
- Autonomous underwriting decision-making without reliance on a reinsurer's approval
- Leadership based on expertise and listening to the customer

Specialization

- Commitment to the stop-loss industry and to providing educational opportunities
- Knowledgeable sales, underwriting and service professionals who all specialize in stop-loss
- Seamless reimbursement experience with processes that help ensure claims-payment accuracy
- Nurse consultants who can help identify opportunities to improve patient outcomes and lower claims costs

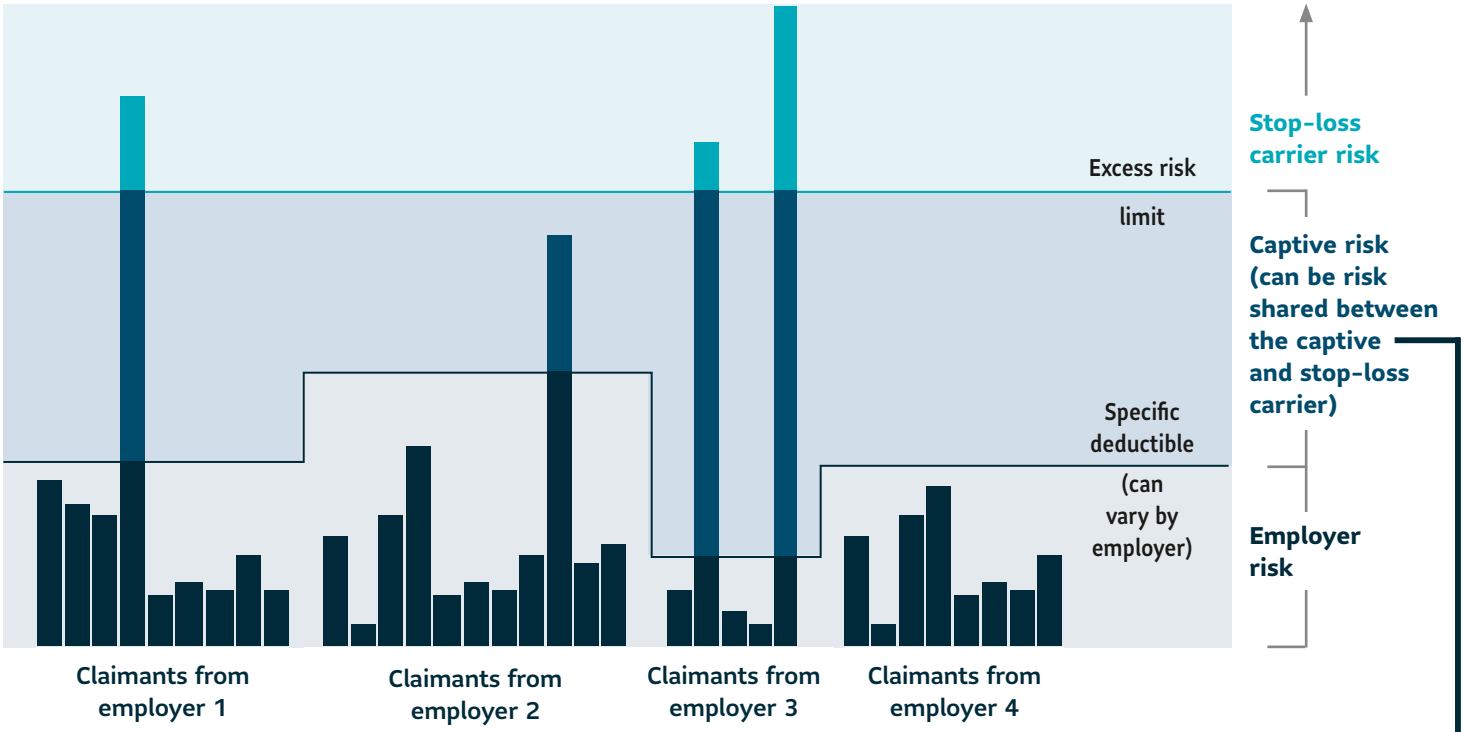
Solutions

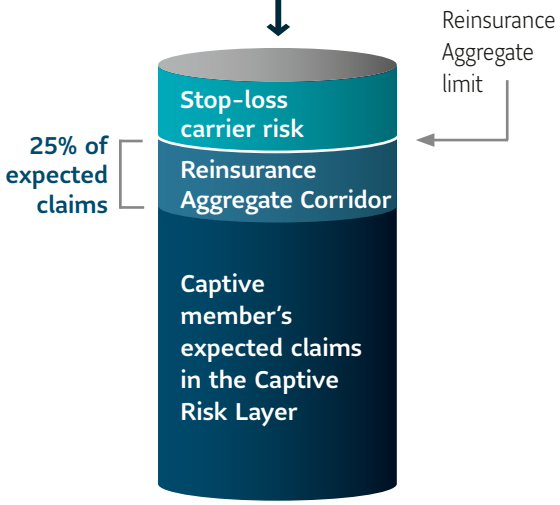
- Choice among a wide range of products so an employer can get what fits it's organization
- Innovative approaches to new employer needs or legislative requirements
- Convenient cash-flow options such as the carrier advancing funds to the employer to pay for claims or arranging to get claims data more quickly to speed up the reimbursement process
- Access to cost-containment services and consulting that help support the employer's self-funding and benefits strategies

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)

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.

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.

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, your 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 lasered 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?

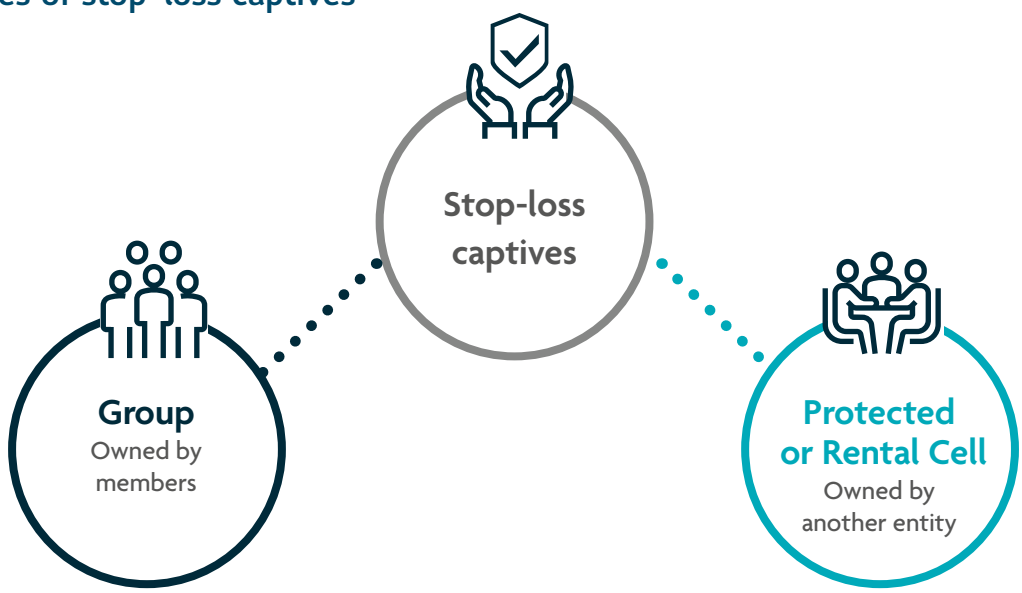
There are a few types of stop-loss captives and structures to consider.

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.

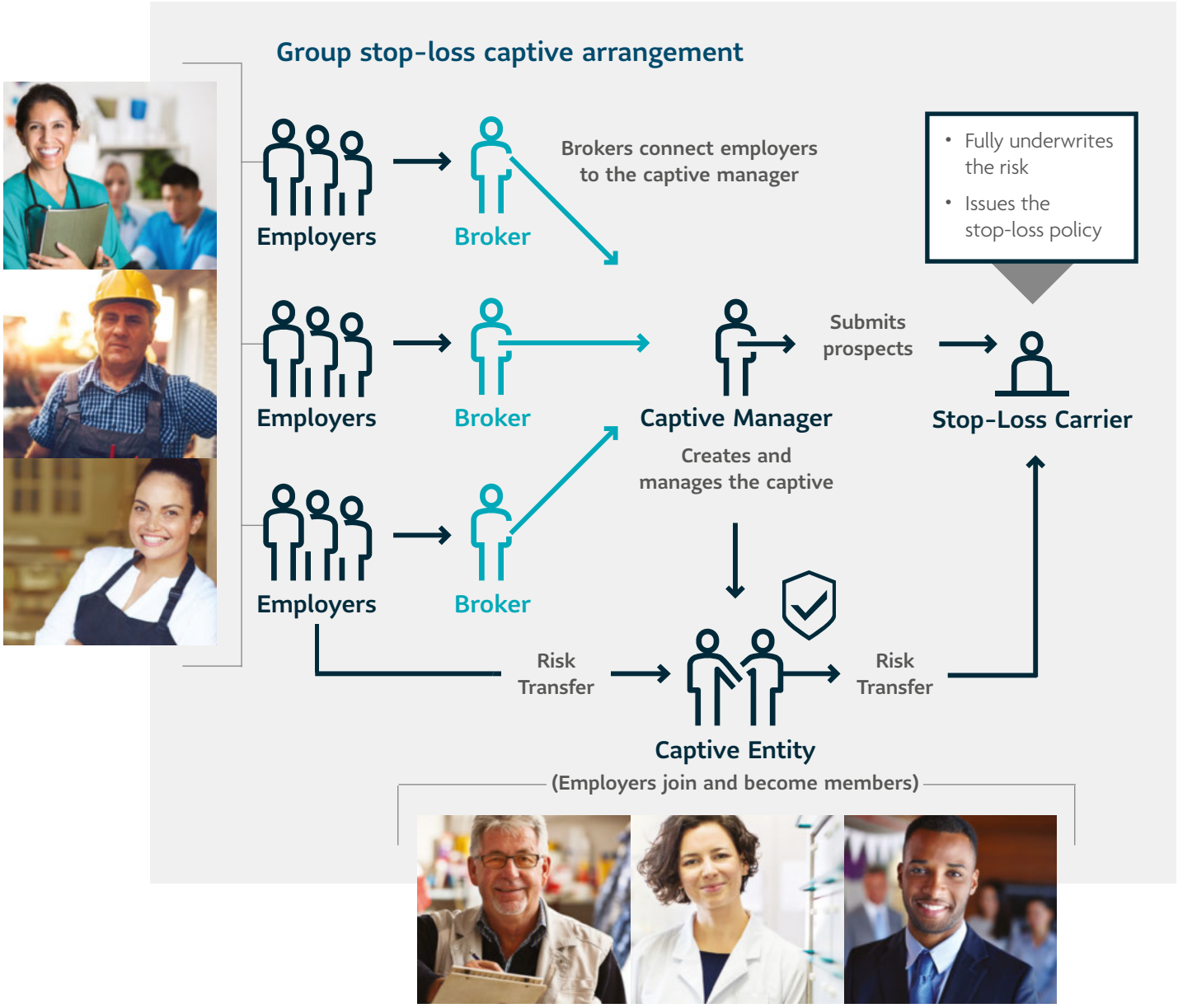
Types of stop-loss captives



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, you may be sharing about 20% of your total healthcare dollars with like-minded employers, but all of you will have your 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.



Action plan

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*

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	• Determine the business's benefits strategy and financial goals. Understanding its 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. Seek counsel from your broker and plan administrator.	☐

If the employer decides to become self-funded (or already is), it can decide which of the elements shown on the next few pages to incorporate into the action plan.

Claims administration

Action	Steps	Include
Finalize the medical plan document	• Using guidance from the broker and claims administrator, make sure the plan document follows all applicable laws and describes the benefits the employer is offering to the covered plan members.	☐
	• Confirm with the claims administrator that it can administer the plan document.	☐
Perform an annual plan document review	• 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.	☐
Select or change the claims administrator	• Consider what type of networks, service, data, vendors and programs the 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.	☐
	• Check to see if the 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.	☐
Apply data analytics	• Ask the broker or claims administrator for marketplace and industry benchmarks—this information can provide key insights to help make plan design and coverage choices.	☐
	• Ask the broker or claims administrator to 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.	☐

Stop-loss insurance

Action	Steps	Include
Select stop-loss coverage and deductibles	• 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.	☐
	• Ask the broker to investigate options to tailor stop-loss coverage to meet the needs of the particular employer.	☐
Perform an annual stop-loss review	• Using the factors described above, determine how to adjust deductibles and coverage. A special 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.	☐

Cost containment

Action	Steps	Include
Leverage resources	• Ask the broker to find out what's available and 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 contain costs and support better patient outcomes. For example, a claims administrator or stop-loss carrier might give access to specialized services or programs such as: –Cancer Centers of Excellence facilities network –Congenital heart disease Centers of Excellence facilities network –Hospital bill audit –Kidney dialysis –Medical review –Organ and tissue transplants –Out-of-network claim negotiation –Specialty pharmacy distribution and services –Utilization review and case management –Ventricular assist devices Some stop-loss carriers also have nurse consultants on staff who review claims data to identify cost savings and care optimization opportunities.	☐

Employers talk about self-funding

"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 a least a million dollars more a year than what we've experienced"

—*Human resources Vice President/Consultant, 12 years' experience, manufacturing industry, 500–1,999 employees*

Cost containment (continued)

Action	Steps	Include
Share cost-containment best practices	• 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.	☐
Follow the plan document	• Include clear cost-containment language and ensure that the claims administrator processes claims according to the plan document.	☐
Review the hospital charges	• Apply discounts and perform an accuracy review, so the employer pays the correct amount.	☐
Explore wellness programs	• 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. According to Forbes, although results can be challenging to quantify, "employees who joined the wellness program did become likelier to be screened for health issues, and also expressed that they thought their employer put a high priority on employee health and well-being."[16]	☐

Learn more

Additional stop-loss resources

Self-Insurance Institute of America, Inc.

Sun Life Switching to self-funding webinar

2018 report: High-cost claims and injectable drug trends

2017 Injectable drug trends report

Clinical 360 program

Group stop-loss captives whitepaper

Sun Life self-funded research highlights

Sample benchmark report

16. Kholl, Alan. Are you measuring the real impact of your employee wellness program? February 27, 2018 https://www.forbes.com/sites/alankohll/2018/02/27/are-you-measuring-the-real-impact-of-your-employee-wellness-program/#61b3012a23b5

Notes

Notes


Thank you!

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

Sun Life Financial®

GSLWP-5469w

SLPC 27244 02/19 (exp. 02/21)