Level-Funded Health Benefits

The Market Perspective of Agents, Brokers & Consultants
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National Association of Benefit & Insurance Professionals (NABIP)

- Over 100,000 professionals who work with the consumers of health & related products in America:
  - Health & Life Agents/Brokers/Producers
  - Employee Benefits Consultants
  - Related Professionals: Attorneys, CPAs
  - Human Resources Professionals
  - Service Providers: TPAs, Insurers, Stop Loss, PBMs

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Healthcare Consumer Bill of Rights

Affordable Healthcare	Quality of Care	Privacy & Confidentiality	Individual Autonomy	Health Equity
Health Education	Affordable Medications	Emergency Care	Healthcare Advocacy	States Rights

Policy Perspective

- From the street level, our members are directly connected to, and best positioned to advocate on behalf of, employers who are considering their options for:
  - How to finance health benefits
  - The impact of regulation
  - Balancing of risk, reward and unanticipated consequences of buying decisions on their employees and covered dependents

Background

- What is Level-Funded?
  - Alternative funding arrangement for health benefits where employer could purchase a health benefit option for their employees relying on stop-loss and other risk mitigation instead of group health insurance policy.
  - These are self-funded plans and therefore exempt from:
    - Certain ACA mandates (e.g., risk underwriting allowed) that would otherwise apply to fully-insured group health plans for small employers
    - State benefit mandates due to ERISA preemption
  - From a market perspective, increasing competitive alternatives vs. traditional markets where there are fewer carriers vs. 10 years ago

Background

- Why is this attractive to employers?
  - ACA rules eliminating group risk as an underwriting and pricing criteria was economically favorable to 70% of small employers, but cost some the “low risk” discount that they had previously enjoyed.
  - Enhanced options in various markets to access both networks and to take advantage of self-funded/ERISA exceptions that otherwise apply to group health insurance markets have improved competition and pricing options

Background

- Why is this attractive to carriers and service providers?
  - Greater flexibility in terms of pricing, underwriting and risk selection for some carriers/service providers
  - Avoiding compliance with state benefit mandates and some aspects of ACA mandates (e.g., MLR rules)
  - Better risk sharing arrangements with stop-loss carriers
  - Preserves access to lucrative PBM revenue for some carrier-based solutions

Ongoing Concerns

Difference between self-funded vs. fully-insured approach

- These products are marketed as being "just like fully-insured"
- Many employers do not appreciate the requirements of stop-loss coverage (e.g., eligibility, subrogation) and contract terms that apply to level-funded products (incurred vs. paid)

Compliance Obligations

- State continuation does not apply to employers with less than 20 COBRA FTEs
- 5500 reporting requirements for funded welfare plans
- ACA Reporting
- Excess claims fund handling and distribution
- 105(h) nondiscrimination
- MHPAEA Compliance (self-funded, no real guarantee that the administrator will prove compliance)
- NY Pool Reporting
- 105(h) Nondiscrimination

Emerging Risks

- Medicare estimation for employers with less than 20 employees
- New federal reporting requirements for RxDC, Gag Clause, Air Ambulance
- No Surprises Act
- State Requirements not otherwise preempted by ERISA (e.g., Mass MCC, Hawaii Prepaid Health Care Act, PBM reporting)
- Fiduciary Compliance

How Structured

- Employer is paying a monthly amount that typically includes three elements:
  - Stop-loss insurance
    - Specific stop-loss (limiting employer liability for each participant up to a specific amount incurred/paid during the contract term, if applicable)
    - Aggregate stop-loss (limiting employer liability for all covered participants below the specific stop-loss deductible, or for all claims incurred/paid during contract term)
  - Administration: paying for medical (and occasionally pharmacy benefit) claim administration
  - Claims Reserve: amount to be paid to administrator to be held during contract term for incurred/paid claims

Example

ABC Group pays out $20,577.89 per month to cover 30 employees on their plan

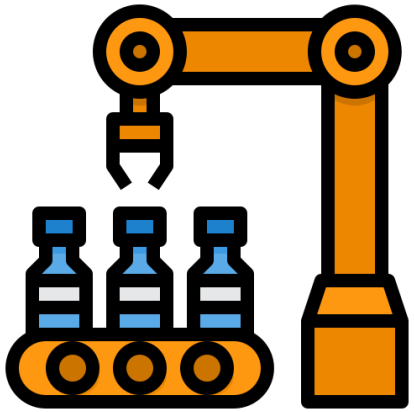
$108,957

Claims Reserve

$96,540

Stop-Loss Insurance

$41,436



Administration

Questions: Stop-Loss Elements

- **Common stop loss attachment points:**
  - Specific Stop-Loss: Depends on state requirements, but typically $10-$50,000 per participant incurred/paid during contract term
  - Aggregate Stop-Loss: Varies significantly based on underwriting, exposure, cost vs. fully insured
- **Annual or lifetime limits on stop loss:**
  - No lifetime limit on any participant
  - No annual specific stop-loss reimbursements (where applicable)
  - $1M cap on aggregate reimbursement

Questions: Stop-Loss Elements

- **Are there monthly limits for specific and aggregate stop-loss costs for the employer?**
  - Within small group market, we typically see a "monthly accommodation" type provision applying to level-funded plans offered, which limits employer having a deficit due to claims incurred/paid early in plan year
  - Some variation on the mechanism (either automatic advance toward aggregate limits or rolling calculation)
  - We have not seen a lot of charges by administrators or stop-loss carriers who are charging for this service (rarely quoted with or without monthly accommodation)
  - Reality: without operational monthly accommodation, these would likely rise to the level of regulatory attention

Questions: Stop-Loss Elements

- **Are there any situations in which a paid benefit claim might not be fully covered by the combination of the loss fund and the stop-loss insurance?**
  - Yes, especially based when the stop-loss contract terms have inadequate runout protection (e.g., 12/15 vs. 12/27 contract) or provisions of terminal liability provisions do not cover exposure concerns (e.g., requirement that they only apply if employer is returning to fully-insured)
  - Market Reality: Generally, larger players (ASO) make sure that employers do not purchase inadequate contracts to protect the groups, and to avoid the public scrutiny or regulatory attention

Questions: Stop-Loss Elements

- **What kind of tail coverage is provided?**
  - Varies significantly based on stop-loss contract terms and the excess claim fund calculation provisions in the administrative
- **Are there any circumstances where the plan year will end with the policyholder still owing money after paying all 12 monthly installments?**
  - Yes, we have seen that happen especially with service providers who have little experience as traditional fully-insured carriers or with non-network arrangements (e.g., reference-based pricing)

Questions: Stop-Loss Elements

- **If there are any gaps in protection, how are they disclosed to the customer?**
  - Examples that we see are common in the market:
    - Eligibility: actively-at-work, dependent,
    - Excluded benefits such as work-related accidents,
    - Provisions for right to recovery under subrogation
    - Application of retained rebates to aggregate accommodation
  - In our experience, these are rarely explained well in simple language for review by the employer and usually buried within the terms of the stop-loss and/or administrative agreement
    - Some level of "assumption" of experienced buyers (and producers) by those selling the products in the markets

Questions: Contract Terms

- **Is there a contractual commitment that monthly stop-loss premium, administrative fee, and/or loss-fund contribution cannot change during the plan year?**
  - Yes, that is a common element in stop-loss and administrative contracts, unless change in membership that exceeds thresholds
  - Usually tied to completion of contract term and meeting minimum participant count or minimum premium/attachment points being satisfied
  - Impact of early termination due to business needs (e.g., financial, going out of business, or merger/acquisition activity) varies in the market

Questions: Benefits Offered

- **Are these plans offering comprehensive medical & prescription drug benefits compared to fully-insured?**
  - Yes, in our experience these plans do cover all EHB
  - However the benchmark plans used to ensure compliance may vary significantly based on carrier/service provider
  - Some variability in terms of what is covered outside of EHB/Benchmark plans (e.g., GLP-1, chiropractic) or limits on visits for certain services

Questions: Rating/Underwriting

- **How groups are rated (since there can be underwriting)**
  - Underwriting has been based on group level underwriting, renewal review and then other additional strategies to collect data:
    - Individual medical questionnaires
    - Artificial Intelligence Underwriting (e.g., GradientAI)
    - Review of Prescription Database Information on applicants
    - Review of CAA Data from current fully-insured (varies significantly in various markets and carriers)

Questions: Rating/Underwriting

- **What are the typical premium levels compared to ACA small group plans?**
  - In the market today, underwriting produces one of two outcomes:
    - Level-funded pricing is better than fully insured alternative (5-15% lower)
    - Decline to quote (underwriting says that they are not competitive)

Questions: Market Conditions

- **What is the amount of 'churn' for these types of plans?**
  - Varies significantly based on market competitiveness, new entrants and products, and the underlying risk of the employer
  - Renewals have remained competitive with numerous carriers and service providers (non-carriers with outside stop-loss) offering certain discounts or claims balance discounts
- **What is the actual dividend experience?**
  - Based on our experience, the number of employers who are getting a claims refund is low (less than 20%) usually because the expense ratio between claims, admin costs and stop-loss vary significantly

Questions: Market Conditions

- **What are the expense and profit ratios?**
  - Varies significantly based on numerous factors:
    - Percentage of monthly “rates” that is put into claims reserve
    - Amount of excess claims balance retained by the administrator/carrier as “additional administrative fees”

Specific Stop Loss Premium

Aggregate Stop Loss Premium

Terminal Liability Rider

Administration

Consultant Fee

Claims

Level-Funded

Traditional Self-Funded

Questions: Larger Employers

- **Is there any market for level-funded arrangements in the "small large group" market (50-250)?**
  - Yes, there are definitely products available in the market for groups above small group thresholds with varying degrees of approaches (minimum premium, balance funding)
- **Why do these employers self-fund rather than buying a large group policy with the same plan design?**
  - Market is trying to be a bit more variable to meet the risk assumption requirements that exist - moving away from binary choice - based on risk tolerance difference between decision makers

Questions: Larger Employers

- **Are there other requirements they would like to avoid by adopting level-funded vs. fully-insured?**
  - Dipping a toe into the self-funded world by better balancing exposure concerns (stop-loss contract)
  - Avoiding state benefit mandates that apply to fully-insured groups
  - Better reserving practices (someone else holding claims reserves)

Questions: Larger Employers

- **If allowed to buy a small group insurance policy with same plan design, at market rates set by insurer, would they do that instead?**
  - Assuming this question means without risk being a rating criteria for setting rates in the large group market… there is always the concern that employers are facing when their risk exceeds the fully-insured market's tolerance and rate concerns

Recommendations

- Common contract definitions for administrative and stop-loss
- Clearer disclosure requirements for level-funded groups
- Application of compensation transparency rules to all level-funded service providers (administrator, stop-loss, PBM) to understand cost impact

Recommendations

- Detailed data disclosure mandates (de-identified) for all group health products with requirements to disclose:
  - Provider, Diagnosis
  - High-cost claimant diagnosis and prognosis
  - Dates of service and payment
  - Billed, allowed and paid amounts for each claim
  - What was paid to provider vs. reported as paid

Awareness: Market Impact

- **Increasing Trend**
  - *As part of a small group ACA market-wide shift, recent increases in medical trend are largely due to healthier groups migrating to alternative funding models like Balanced Funded / Level-Funded and MEWAs. As these groups exit the fully insured pool, the remaining population tends to have greater healthcare needs, which raises average claims and trend. Other contributing factors include higher utilization, rising provider costs, and continued growth in pharmacy spend.*

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Thank You!