Society of Professional Benefit Administrators

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September 16, 2014

Ms. Christina Goe, Chair of the ERISA (B) Work Group
Mr. J.P. Wieske, Chair of the Regulatory Framework Task Force
Ms. Jennifer Cook, NAIC Staff, Health & Life Policy Counsel
National Association of Insurance Commissioners
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444 North Capitol Street, N.W.
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Subject: SPBA Comments on the ERISA (B) Work Group White Paper: Stop Loss Insurance, Self Funding and the ACA

Dear Ms. Goe and Mr. Wieske,

The following comments are submitted on behalf of the Society of Professional Benefit Administrators (SPBA).

SPBA is the national association of health & welfare plan Third Party Administrators (TPAs). SPBA member firms are often hired by employers and employee benefit plans to provide professional management of their self-funded healthcare plans. According to the Kaiser Family Foundations 2014 Employer Health Benefits Survey, 61% of all U.S. covered workers are in self-funded plans. Most of which are administered by TPA firms. TPA clients include employers of every size and variety, including non-federal public employees, collectively bargained multiemployer plans, and plans representing religious entities.

We would like to bring your attention to three documents attached to this letter:

- The SPBA Code of Ethics which imparts the responsibilities of our member firms, approved by the SPBA Board of Directors and distributed to SPBA member firms via the SPBA website.
- A copy of the SPBA Self-Funded Definitions drafted by our Stop-Loss Committee and distributed to SPBA member firms.
- A copy of the SPBA Self-Funding: Myths vs. Facts previously distributed to the NAIC ERISA (B) Work Group Chair and Committee as a resource on issues relating to self-funding.

SPBA seeks to clarify information about the self-funded industry and address inconsistencies presented in the NAIC White Paper draft. SPBA's comments draw on insights and feedback from SPBA member TPAs and Stop-Loss partners. The White Paper proposes to include a discussion on what employers should know about self-funding and stop-loss insurance. It is SPBA's opinion that any such conversation, without input from TPAs and Stop-loss insurers, is incomplete.

Self-funding, most often accomplished in conjunction with stop-loss insurance coverage, is a stable and successful alternative that allows many small businesses to provide affordable and customized employee health benefits to their workers. Self-funding of health benefits has proven to be a cost effective and stable option for employers of all sizes that provides flexibility and superior cost containment options for organizations that value the ability to offer healthcare as an employee benefit.

SPBA cannot support the idea that the NAIC ERISA (B) Work Group develop an Employer Guide because it would duplicate comprehensive information that is already provided by the U.S. Department of Labor which provides significant information related to the rights and responsibilities of employers under the Employee Retirement Income Security Act of 1974 (ERISA). Consumer protection has been the hallmark of ERISA for over 40 years.

The ERISA (B) Working Group previously received testimony from SPBA regarding issues unique to self-funding, as well as an offer to assist with the development of this White Paper. SPBA believes it is important for the committee to consider the following:

(1) In August 2013, the ERISA (B) Work Group was charged to "Develop a white paper discussing the issues surrounding the potential impact of small employer self-insurance on the small group market." The draft White Paper exceeds this charge, and discusses topics far outside of the scope of the charge.
(2) Self-funded employer welfare benefit plans, stop-loss insurance, and TPAs are all regulated by a myriad of Federal and state laws and state and federal agencies. The White Paper contains statements that indicate that self-funded plans lack regulation and are exempt from the requirements of the Affordable Care Act. Nothing could be further from the truth. In fact, self-funded plans are required to comply with the majority of ACA requirements. There are notable exceptions to this rule, however Self-Funded plans must comply with mandated waiting periods, eligibility requirements, financial requirements eliminating spending caps, as well as rescission and pre-existing condition rules. As is well understood, Self-Funded plans are governed by ERISA regulations. SPBA feels that is important for the Committee to recall that consumer protection has been the hallmark of ERISA for over 40 years. ERISA demands financial oversight, requires specific plan content, mandates document distribution, regulates market conduct, and specifies claims and appeals practices for welfare plans. Under ERISA, the plan administrator is typically responsible for most of the plan's administrative functions (e.g. benefit claims determinations and hiring plan professionals). Although the plan administrator may delegate certain responsibilities to others, such as a TPA, it generally cannot avoid ultimate legal responsibility. Violation of ERISA regulations can result in monetary penalties, civil liability, and possibly criminal prosecution. This issue is more fully explained in the attached SPBA Myth and Fact document.
(3) Third Party Administrators are often regulated entities, and most states have a TPA license requirement. The same is true of healthcare brokers and consultants that advise employers on the choices they have about healthcare plans. Both TPAs and healthcare brokers/consultants should be expected to accurately and ethically advise their clients about the positives, negatives, risks and exposures associated with all types of healthcare plans.
(4) SPBA supports maintaining disclosure and transparency of information about self-funded plans to employers. SPBA believes that marketing materials distributed by member TPAs and Stop-loss carriers already provide this information to employers.
(5) The draft White Paper refers to monthly aggregate accommodation as "advance claim funding." SPBA submits that this is an error in terminology, and refers the committee to the attached "SPBA Self-Funded Definitions" Document. Aggregate Monthly Accommodation is in fact a financial tool that some employers choose to purchase to help them manage the possibility of cash-flow fluctuations that may occur in Self-Funded arrangements. The White Paper misidentifies monthly aggregate accommodation as a "loan" when it clearly is not. Repayment provisions are limited to the accumulated aggregate deductibles, which are determined in advance and as a result should be within the financial comfort zone of the employer. There are not typically any financing fees or charges that would normally be associated with loans or cash advances.

(6) The White Paper suggests that employers are borrowing money from TPAs to fund claims. In fact, TPA's are not in the business of loaning money. The financing arrangement in TPA agreements requires the employer pre-fund the liability up to the aggregate stop-loss attachment point, with no flexibility. SPBA is not aware of any TPA member who loans money to employers, and we would not support such an action. Please see attached SPBA Myth and Fact document for further information.

(7) The White Paper recommends certain regulatory options to which SPBA can agree with the recommendation of disclosure of key terms and expectations in the stop-loss contract would be useful. We have attached a copy of the "SPBA Definitions in Self-Funded Plans" for reference.

(8) Employers, regardless of size, are in the best position to evaluate their unique situations and select an appropriate method to finance the risk of a health benefit plan after full disclosure by a TPA in conjunction with a stop loss carrier. The economic condition of the employer is a factor that determines when employers should opt to self-fund; their financial tolerance for risk, and desire for flexibility in designing a benefit plan to meet the needs of their employees at a significantly lower administrative cost. In actuality, the account of timing risk in the White Paper is misplaced; we believe that smaller firms with robust cash flow can be better suited for self-funding than larger firms with restricted cash flow.

(9) The decision to provide health coverage to their employees is just one of many decisions employers must make. Employers are expected to be knowledgeable and capable of analyzing their specific needs when purchasing commercial insurance, including non-standard (and complicated) professional liability, D&O and Cyber Liability insurance. The same standard of understanding is expected when looking to self-fund welfare benefits and in deciding to utilize stop-loss insurance.

(10) The White Paper discusses stop-loss provisions that appear onerous, including carve-outs / lasers, actively at work restrictions and risk reporting requirements. Most issuers of stop-loss permit elimination of carve-outs if endorsements are purchased in advance, or don't engage in the practice at renewal as a business choice. Actively at work restrictions are commonly waived. Requirements to report material changes to the risk insured are common to all insurance contracts, including fully insured health plans. It is the SPBA's opinion that many of these issues are represented as commonly invoked provisions and limitations that adversely affect employers, their plans and beneficiaries – when in fact they are rarely applied in actual practice.

On behalf of SPBA member Third Party Administration firms, and the thousands of self-funded employers who choose to self-fund their welfare benefit plans, SPBA reiterates our offer of assistance in the effort by the ERISA (B) Work Group to increase disclosure and transparency in all marketing materials. As stated previously, we do not believe there is an urgent need for an Employer Guide at this time, however we respectfully request to be included in the compilation of any information should the NAIC determine it is merited.

For your information, SPBA has attached a copy of the SPBA Code of Ethics; SPBA Self-Funding: Myths vs Facts, and the SPBA Self-Funding Definitions. SPBA would be happy to meet with members of the NAIC ERISA (B) Committee and NAIC staff to discuss any issues related to, or raised by, our comments herein.

Sincerely,

Elizabeth Ysla Leight
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Society of Professional Benefit Administrators (SPBA)

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SPBA CODE OF ETHICS

As a member of SPBA, I believe it to be my responsibility:

To identify standards of conduct enabling us to fulfill our responsibility to our clients and our industry.

To perform Professional Services[i], and take reasonable steps to ensure that Professional Services rendered under our supervision are performed, with honesty, integrity, skill, and care.

To ensure all Professional Communication[ii] is appropriate to the circumstances.

To provide no Professional Communication to a Plan Sponsor that misrepresents either the type of plan funding mechanism being offered, or the benefits or advantages of a particular plan funding mechanism.

To engage in no Advertising[iii] with respect to Professional Services that we know or should reasonably be expected to know is false or misleading.

To be knowledgeable about Federal and State Laws[iv] that affect benefit plans and our industry.

Except as authorized by the Plan Sponsor[v] or as required by Law, to safeguard Confidential Information[vi] obtained in rendering Professional Services to or for a Plan Sponsor.

To make full and timely disclosure to a current or prospective Plan Sponsor of all sources of direct or indirect compensation or other consideration that we have received or may receive in relation to the services being provided or proposed to such Plan Sponsor.

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[i] Professional Services: services provided to a Plan Sponsor, including the rendering of advice, administration, and/or recommendations related to a health or health related benefit plan.

[ii] Professional Communication: a written, electronic or oral communication issued with respect to Professional Services.

[iii] Advertising: all communications by whatever medium, including oral communications, which may directly or indirectly influence any Plan Sponsor to decide on the funding mechanism of its sponsored plan, whether there is a need for Contract Administration Services for its sponsored plan or to select a specific person or firm to perform such services.

[iv] Laws: statutes, regulations, judicial decisions, and other statements having legally binding authority.

[v] Plan Sponsor: any entity that sponsors a health or health related benefit plan whether on an insured or self-insured basis.

[vi] Confidential Information: information not in the public domain which becomes known during the course of rendering Professional Services to a Plan Sponsor either directly or on behalf of a sponsored plan. It may include information of a proprietary nature, information that is legally restricted from circulation, or information, which there is reason to believe, that the Plan Sponsor would not wish to be divulged.

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Self-Funding: Myths vs. Facts

1. Myth: Self-funded plans are exempt from market reform changes under the Affordable Care Act (ACA).

Fact: Self-funded plans are subject to the substantive ACA market reforms, as well as numerous other Federal laws, including (but not limited to) the Employee Retirement Income Security Act of 1974 (ERISA) (P.L. 93-406), the Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination rules (P.L. 104-191), HIPAA privacy and security (P.L. 104-191), the Americans with Disabilities Act (P.L. 110- 325), the Mental Health Parity Act (P.L. 104-204), COBRA continuation coverage (P.L. 99-272), IRS nondiscrimination rules prohibiting benefit differences based on employee status (P.L. 95-600).

ACA Market Reforms Applicable to Self-Funded Plans

>> Prohibition on Lifetime and Annual Limits (PHSA §2711)

>> Prohibition on Preexisting Condition Exclusions (PHSA §2704)

>> Prohibition on Rescinding Health Coverage after coverage begins (PHSA §2712)

>> Coverage of Dependents up to age 26 (PHSA §2714)

>> Summary of Benefits and Coverage and Uniform Glossary of Coverage and Medical Terms (PHSA §2715)

>> Tax on Plans to Fund Temporary Reinsurance Program>> Wellness Incentives (PHSA §2705)

>> Employer/Plan Information Reporting (IRC §6055 and §6056)>> Automatic Enrollment (ACA §1511)

>> Out of Pocket Maximums* (PHSA §2707)

>> Coverage of Preventive Care without Cost Sharing * (PHSA §2713)

>> Claims Appeal and External Review Requirements* (PHSA §2719)

>> Limitation on Waiting Periods * (PHSA §2708)

>> Nondiscrimination Based on Health Status* (PHSA 2705)

>> Patient Protections (choice of primary care provider and emergency services without prior authorization)* (PHSA §2719A)

>> Prohibition on Discrimination against Providers* (PHSA §2706) >> Coverage of Clinical Trials* (PHSA 2709)

* Grandfathered plans, whether self-funded or fully insured, are not subject to certain market reforms. Most

self-funded plans will have lost grandfather status by 2014.

2. Myth: Self-funded group health plans are unregulated.

Fact: Self-funded group health plans are regulated by a myriad of Federal agencies including the Department of Labor, the Department of Treasury, the Department of Health and Human Services, and the EEOC. Most self-funded plans (other than government and church plans) are subject to ERISA, which imposes strict disclosure rules, fiduciary financial management controls, claims and appeal rules, government reporting and potential civil and criminal penalties. States have the authority to regulate non-federal governmental plans and many States have developed rules reflecting the needs of their respective constituencies.

3. Myth: Stop-Loss coverage is virtually unregulated.

Fact: State Insurance Departments regulate all insurance companies and their products. Stop-Loss is one of the many regulated products, with at least 30 states addressing Stop- Loss insurance in law, regulation or by Bulletin.

4. Myth: Stop-Loss insurance is just like health insurance.

Fact: Stop-Loss insurance does not insure plan participants. Stop-Loss insurance insures employers against excess loss. Small and mid-sized self-funded employers retain Stop-Loss insurance to provide a financial buffer to guard against catastrophic claims. Stop-Loss reimburses the plan sponsor or the plan for health payments in excess of a pre-determined level, commonly known as an “attachment point." The role of Stop-Loss is essentially the same for self-funded employers as reinsurance is for insured health plans - a financial risk management tool.

5. Myth: Some employers are too small to self-fund.

Fact: The economic condition of the employer, their financial risk tolerance, the desire for flexibility in designing a benefit plan to meet the needs of a group, and the significantly lower administrative costs are the factors determining whether an employer will self-fund. The notion that employer size should be a threshold issue in the decision to self-fund is misplaced. Smaller firms that have more robust cash flows can be better suited for self-funding than larger firms with restricted cash flows. Employers, regardless of size, are in the best position to evaluate their unique situations and select an appropriate method to finance the risk of a health benefit plan.

6. Myth: Small employers with healthier workers will disproportionately self-fund, creating adverse selection in the fully insured markets (including the SHOP) and increasing premiums for the small employers who continue to fully insure.

Fact: Self-funded plans cover a wide range of employee risk, including participants with high-cost chronic and non-chronic conditions. Historically, self-funded plan participants have not had more favorable health risk profiles than fully insured plan participants. Since the inception of HIPAA in 1997, small employers (in most states those with fewer than 51 benefit eligible employees) have participated in an insurance market with features comparable to the ACA. These features have included guaranteed issue requirements, and in many states, a limited ability to price based on the group’s actual experience. During this 17-year history, a trend has not emerged of small employers moving into or out of insurance primarily on the basis of known employee health factors.

There are significant transition costs and barriers to switching between benefit funding methods, and the health status of employees is only one of many factors considered when an employer selects a benefit funding approach. Employers will not abandon one method simply because of employee health status changes. The adoption of self- funding in lieu of insurance also introduces additional compliance, financial and Plan management obligations for employers. This will continue to deter many from choosing this option. And for

employers with fewer than 25 employees, SHOP participation may generate an employer tax credit, a feature that self-funding cannot offer.

The premise that small employers with healthier workers will disproportionately utilize self-funded plans is unsubstantiated. Each employer that decides to provide benefits weighs a number of elements in choosing a method; population health is but one of those.

7. Myth: Self-funded plans will adversely impact state health insurance marketplaces.

Fact: The statement that self-funded plans contribute to adverse selection and will lead to the decline of the health insurance marketplace has no basis in fact. In particular, the RAND Corporation concluded the exact opposite. According to a Technical Report published by the RAND Corporation in 2011 ("Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010") that predicts firms' decisions to self-insure using a microsimulation model, "the option to self-insure does not lead to substantial adverse selection in the exchange market." http://www.rand.org/pubs/technical_reports/TR971.html

8. Myth: Regulating Stop-Loss attachment points will protect small employers.

Fact: Minimum Stop-Loss attachment points would deprive small businesses of cost- effective health care options and the flexibility to choose the best coverage option for their employees' needs. Many small businesses will choose not to offer coverage if their options are limited, rather than purchase a fully insured policy. According to the RAND Technical Report noted above, "eliminating the option to self-insure also leads to a decline in the number of people with insurance, because some firms opt not to offer coverage (and some offered workers choose not to enroll)."

Lower attachment points are accompanied by higher Stop-Loss policy costs. The economic surcharge of low attachment points functions as a deterrent for small employers in selecting this option. Small employers, aided by their benefit advisors, are skilled in weighing the risks and rewards associated with varying Stop-Loss coverage levels.

9. Myth: Small employer decisions to self-fund their benefit plans are based on incomplete information about the arrangement they are entering.

Fact: Providing information about risk exposure and ERISA fiduciary duties is a common business practice for brokers, agents and third party administrators (TPAs) who work with employers in reaching their decisions about the appropriate methods to use in financing their health care benefits. Because brokers, agents and TPAs seek a long-term relationship with an employer client, they have strong motivations to ensure that employers make financially sound choices. The decision to self-fund should be made by a well-educated employer no matter what the size. There is no reason to believe that small employers are less educated in their decision than larger ones.

State Insurance Departments impose varying professional conduct standards on brokers, agents and TPAs. States have the authority over these standards and require brokers, agents and TPAs to provide additional education materials to small employers on self- funding.

10. Myth: Stop-Loss policy terminations occur frequently.

Fact: Stop-Loss policy terminations are rare events. Guaranteed renewable coverage is available.

11. Myth: Stop-Loss lasers (specific deductible levels that vary by a particular risk from the general level offered to the employer plan) are frequently a problem for small employers.

Fact: There are many sources of Stop-Loss coverage that offer employers numerous options, far greater than

the choices available in the fully-insured market. No-laser renewal products are commonly offered and effectively provide employers with a guaranteed renewable product.

12. Myth: Stop-Loss contract lasers change or eliminate actual plan coverage for individual participants in a group health plan.

Fact: If utilized, lasers are a financial tool feature of the Stop-Loss contract between the employer/plan and the Stop-Loss carrier that help to minimize the fixed cost of the Stop-Loss coverage, and place no condition on, or change in, the plan's coverage provision to individual participants.

In addition, the HIPAA final regulations on nondiscrimination (29 CFR 2590.702) prohibit a group health plan from denying an individual eligibility for benefits based on a health factor and from charging an individual a higher premium than a similarly situated individual based on a health factor. Health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability. Brokers, agents and TPAs assist employers in locating products that permit their plans to comply with this Federal law.

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Terms are identified by ***Bold Italics*** for cross reference to another definition within the document.

Administrative Service Agreement	Reflects the ***Plan Sponsor's*** and ***Third Party Administrator's*** intentions and identifies which plan-related services will be provided, including any limitations or restrictions on those core services.
Advance Funding	A policy feature that provides expedited ***Reimbursement*** under ***Specific Coverage*** if specified requirements are satisfied.
Aggregate Corridor	A multiplier that is used in determining the ***Annual Aggregate Attachment Point***. The corridor is typically set at a level that is 25% higher than anticipated actual claims. This feature limits the policyholder's catastrophic risk at the determined percentage above the likely paid claims.
Aggregate Coverage	The insurance coverage that provides policyholder Reimbursement if the accumulated paid claims during the Benefit Period (other than those that exceed the ***Specific Deductible***) exceed the ***Annual Aggregate Attachment Point***.
Aggregate Factor(s)	A dollar denominated factor that is multiplied by the number of covered units, individual or family, for a month of ***Aggregate Coverage*** exposure, used to determine the cumulative ***Annual Aggregate Attachment Point***. This factor typically is set to exceed expected actual claims by a multiple of 1.25
Aggregating Specific or Split Funding	A policy feature that accumulates all amounts that exceed the individual ***Specific Deductible*** in an additional pooled retention layer which must be satisfied before any ***Specific Coverage Reimbursement*** will be made. This feature results in reduced premium for the ***Specific Coverage***. The accumulated amount that must be satisfied under this feature is called the Aggregating Specific Deductible.
Annual Aggregate Attachment Point	The accumulated amount of ***Plan*** claims that must be paid by the policyholder before the ***Aggregate Coverage*** provides Reimbursement. This point is determined by calculating a monthly amount that is the product of the ***Aggregate Factor(s)*** and the covered units, then adding the monthly calculations for the entire policy period. Claim payments that are eligible for ***Specific Coverage Reimbursement*** do not accumulate to the ***Annual Aggregate Attachment Point***.
Application	The document completed and executed by the policyholder defining the covered party, risk characteristics and selected coverage terms. It is generally attached to the policy and becomes a part of the insurance contract. Deviation from the established risk characteristics, such as a significant increase in enrollment, may permit a change contract terms.
ASO (Administrative Services Only)	A marketing term for self-funded services offered by health plan insurers for self-funded clients. There is logically no difference between a TPA arrangement and an ASO arrangement.
Benefit Period	The time period during which claims must be incurred (typically 12 to 24 months), as well as the time period during which such claims must be paid by the ***Plan***, also typically 12 to 24 months, in order to be eligible for coverage calculations under the

	policy. Typically stated as two numbers, such as 12/18, or 24/12, or any combination of accumulation periods. Conventionally the first number defines the incurred period and the second number defines the period during which claims must be paid. **Example 1, 24/12-** means that the policy covers any claim incurred during the 12 months prior to the policy effective date plus the 12 months of the policy period, (24 months), that are paid in the 12 months commencing with the policy effective date. **Example 2, 12/18-** means that the policy covers any claim incurred during the 12 months commencing on the policy effective date, that are paid in the 18 months commencing with the policy effective date.
Covered Person	Any individual who is eligible for coverage and benefits under the ***Plan*** and is covered by the ***Plan***.
Disclosure Statement	A document executed by the policyholder at the inception of the policy identifying covered persons that have certain diagnoses or eligibility characteristics, such as COBRA qualification or disability. Failure by the policyholder to identify individuals known to meet the disclosure requirements may invalidate stop loss ***Reimbursement*** to the policyholder for ***Plan*** benefit payments relating to that individual.
ERISA Fiduciary	ERISA incorporates a broad, functional definition of the term "fiduciary" which includes individuals and business entities depending on the duties they undertake and perform in connection with ERISA plans. The term broadly defines which fiduciary responsibilities apply to acts taken in a fiduciary capacity. ERISA fiduciaries that breach their duties can be personally liable for damages to the ERISA plan and for DOL penalties imposed in connection with fiduciary breaches. While subject to changes in case law, TPAs and Stop Loss insurers are usually not in a fiduciary position with respect to the ***Plan***.
Incurred	The date on which covered services or supplies are rendered or purchased by the ***Covered Person***.
Individual Limit, Aggregate	The maximum amount of ***Plan*** claims associated with a ***Covered Person*** that will accrue in meeting the ***Annual Aggregate Attachment Point***. Typically equal to the ***Specific Deductible***.
Individual Risk Limitation or Laser	A higher ***Specific Deductible*** associated with a specific ***Plan*** participant that varies from the ***Specific Deductible*** applied to other participants. The additional amount is not covered by the ***Aggregate Coverage*** and remains the risk of the ***Plan Sponsor***; it does not limit the ***Plan Sponsor***'s obligation to provide ***Plan*** benefits. This feature, if accepted, by the ***Plan Sponsor*** will result in a reduction in premium.
Laser	See above ***Individual Risk Limitation.***
Minimum Aggregate Attachment Point	The lowest allowable ***Annual Aggregate Attachment Point***. It is generally stated in the policy as a dollar amount or a percent of the first month's calculated Aggregate Attachment Point times the number of months in the ***Policy Period***.
Monthly Aggregate Accommodation	An optional policy feature that allows the ***Plan*** to request ***Reimbursement*** if claims paid by the ***Plan*** exceed the pro-rated ***Annual Aggregate Attachment Point*** at the end of any month during the ***Policy Period***. If at the end of the ***Benefit Period*** the ***Plan***'s paid claims are less than the ***Annual Aggregate Attachment Point***, any funds paid to the policyholder under this feature must be returned.
Notification Requirements	Policy stipulations that require the policyholder, or their designated representative, to provide notice to the insurance company of certain events. Common notification events include the accumulation of ***Plan*** claims to a percentage of the ***Specific Deductible***, or diagnosis of a specific medical condition, such as cancer.
Original Effective Date	The date the original stop loss policy is effective.
Paid Date	The date the ***Plan*** paid a claim for benefits for a ***Covered Person***. Generally to be

	considered "paid" the money's must be disbursed to the provider by the ***Plan***.
Plan	The self-insured health care plan established by the policyholder to provide certain benefits to ***Covered Persons***.
Plan Administrator	Under ERISA Section 3(16)(A), the Plan Administrator is either the person whom the plan instrument specifically designates as the Plan Administrator; or In the absence of such a designation, the ***Plan Sponsor***. The entity responsible for most issues of legal compliance with regard to the ERISA plan. The ***Plan Sponsor*** assumes the numerous statutory responsibilities and is ultimately liable for the statutory penalties that may be imposed for failure to properly discharge those responsibilities. Under ERISA, the Plan Administrator is responsible for most of the plan's administrative functions (e.g. benefit claims determinations and hiring plan professionals). The plan administrator may delegate certain responsibilities to others, such as a ***Third Party Administrator***. The Plan Administrator cannot void ultimate legal responsibility.
Plan Document	The written document, approved by the ***Plan Sponsor***, which describes the Plan and its benefits, and is on file with the ***Third Party Administrator*** and the ***Stop Loss*** insurance company.
Plan Sponsor	The plan sponsor is: 1. The employer, if the plan is established or maintained by a single employer; 2. The employee organization, if the plan is established or maintained by an employee organization; or 3. The association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the plan, if the plan is established or maintained by tow or more employers or jointly by one or more employers and one or more employee organizations. ERISA Section 3(16); 29 U.S.C. Section 1002 (16)(A)
Policy Period	The period during which the policy is in effect. This is generally 12 months.
Reimbursement	The payment to the ***Stop Loss*** policyholder for claims previously paid by the ***Plan*** for benefits provided to ***Covered Persons***.
Reimbursement Percentage	The percentage amount of an eligible claim under a policy that will be reimbursed. Typically this is 100%.
Run-in Limit	An optional policy feature that sets a limit on the dollar amount of claims that can be incurred prior to the policy effective date and be eligible for ***Reimbursement***.
Run-in Period	The period of time prior to the policy effective date during which claims can be incurred and be eligible for ***Reimbursement***. See Example 1 in ***Benefit Period*** above.
Run-out Period	The period of time after end of the ***Policy Period*** during which eligible claims can be paid by the ***Plan*** and be eligible for Reimbursement. See Example 2 in ***Benefit Period*** above.
Specific Coverage	The insurance coverage that provides policyholder ***Reimbursement*** if the paid claims during the ***Benefit Period*** for an individual ***Plan*** participant exceed the ***Specific Deductible***.
Specific Deductible	The amount that the ***Plan*** must pay for the claims of an individual ***Plan*** participant before the policy will provide ***Reimbursement*** under ***Specific Coverage***. It is generally at least $20,000.
Stop Loss	An insurance policy which reimburses the policyholder for eligible benefits paid for ***Covered Persons*** in excess of the ***Specific Deductible*** or the ***Annual Aggregate Attachment Point***.
Terminal Liability	An optional policy feature that triggers a conditional ***Run-out Period*** in the event that

	the ***Plan Sponsor*** terminates the ***Plan*** at the expiration date of the policy. Generally offered in the first ***Policy Period***, and not on a renewal basis.
Third Party Administrator (TPA)	A professional business entity that specializes in providing services on behalf of and under contract with the ***Plan Sponsor*** in the administration of a self-funded ***Plan***. Services may include but are not limited to claim adjudication and payment, enrollment services, compliance services and COBRA services. TPAs (and insurance companies under ASO arrangements) do not assume the financial risk of the ***Plan Sponsor***.