Health Insurance 101: Understanding Your Options

1

INTRODUCTION

Mark Schlagheck

CFO,
Jefferson Health Plan

Bill Kocher

Growth and Experience Director, Jefferson Health Plan

2

Sources of Health Insurance

EMPLOYEE SPONSORED

•This health insurance coverage is also called group or small group coverage. This is the type of health insurance you usually get through work. Group health insurance allows you to split the cost of your monthly premium with your employer, and you'll pay other cost-sharing payments.

INDIVIDUAL AND FAMILY PLANS

•This health insurance is coverage you enroll in by yourself. These plans, also called Affordable Care Act (ACA) plans or Obamacare plans, are available to everyone. You can either buy them through your state or federal marketplace, health insurance companies, or brokers.

MEDICARE

•Medicare is a federal health insurance program that insures seniors aged 65+. Beneficiaries can choose to get their coverage through a private insurance company with a Medicare Advantage plan, also called Medicare Part C, or through the government. If they stick with Original Medicare, they can get extra coverage with a Medicare Supplement Insurance plan and prescription drug coverage through Medicare Part C.

3

Insurance Definitions and Acronyms

PREMIUM - Money paid to health insurance company to maintain coverage.

DEDUCTIBLE - Money you must pay out-of-pocket before our health insurance starts paying.

COPAYS - Cost sharing payments you may have to make out-of-pocket when you receive certain healthcare services or medications.

MOOP - Maximum Out of Pocket

CO-INSURANCE - The amount or percentage an insured must pay, after a deductible is met. This spreads the risk among multiple parties.

IN-NETWORK - Health care provider that has a contract with your health plan to provide health care services at a pre-negotiated rate. Because of this relationship, you pay a lower cost.

OUT-of-NETWORK - Health care provider who does not have a contract with your health insurance plan. If you use an out-of-network provider, your could cost more since the provider doesn't have a pre-negotiated rate with your health plan. Potentially, depending on your health plan, the health care services may not be covered at all.

4

Insurance Definitions and Acronyms

SPD (Summary Plan Description)-

This lists health plan terms and conditions, written for a particular employer or organization. The SPD defines the benefit coverage and exclusions.

SBC (Summary of Benefits and Coverages) -

An easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You can compare options based on price, benefits, and other features that may be important to you.

PREVENTATIVE CARE -

Preventive healthcare, or prophylaxis, is the application of healthcare measures to prevent diseases.

5

Types of Health Insurance Networks

HMO - (Health Maintenance Organization) generally require you to seek care within their network, except in emergencies, and are known for offering lower premiums and minimal copayments. However, the trade-off is less flexibility in choosing healthcare providers outside of the HMO network.

PPO - (Preferred Provider Organization) offers greater flexibility in choosing healthcare providers and doesn't require referrals to see specialists.

6

Players in the Health Insurance Market

- Broker
  - Insurance brokers act as intermediaries between clients and insurance providers. Their primary role is to assess the insurance needs of their clients and identify suitable policies from a range of insurance companies. Brokers typically gather quotes, negotiate terms, and present options to their clients.
- Third Party Administrators (TPA)
  - Is a company that provides operational services such as claims processing and employee benefits management under contract to another company. Insurance companies and self-insured companies often outsource their claims processing to third parties.
- Pharmacy Benefits Manager (PBM)
  - are primarily responsible for developing and maintaining the formulary, contracting with pharmacies, negotiating discounts and rebates with drug manufacturers, and processing and paying prescription drug claims.
  - What is a formulary: *the main function of a prescription formulary is to specify particular medications that are approved to be prescribed at a particular hospital, in a particular health system, or under a particular health insurance policy.*
- Stop Loss Carriers
  - Stop-loss insurance is a type of commercial insurance that protects self-insured businesses in case of catastrophic or large claims. This coverage is utilized by businesses that have opted to pay their employees health benefits out-of-pocket instead of using traditional group health insurance. With stop-loss insurance, businesses can receive reimbursement for claims that exceed a pre-determined level.

7

Insurance Coverage Options in the Public Sector

- Fully Insured Health Plans
- Self-Funded Health Plans
- Pooled Self-Funded Health Plans

8

Fully Insured Health Plans

- Fixed premium
- Known costs for budgeting
- Employer transfers risk to the health insurance company
- Not very transparent
- Limited access to plan data
- Plan design changes may be limited
- Excess funding is retained by the health insurance company

9

Self-Funded Health Plans

- Employer takes claim risk
- Funding Fluctuations
- Volatile Stop Loss
- Administrative Responsibilities
- Contract Limitations
- Underwriting is difficult for smaller groups
- Employer immediately keeps any savings and is responsible for any deficits

10

Insurance Definitions for Self-Funded Health Plans

- Stop Loss Insurance
  - Coverage designed to protect self-funded employers from the risk of catastrophic claims beyond a predetermined liability.
- Stop Loss Specific Deductible
  - The limit of liability under stop loss coverage on an individual employee covered under an employer's heath care plan. The employer chooses this amount based on total group size and selected risk tolerance.
- Aggregate Annual Deductible
  - Is the maximum amount policyholders need to pay within a policy period before their insurer pays for covered losses. In other words, if a policyholder files several claims or one large claim, they must pay out of pocket up to a certain dollar sum. Subsequently, coverage kicks in, and the insurer starts making payments.
- Run-in Claims Period
  - Claims incurred prior to the first contract year and received after the new effective date. These claims can be paid under a "current year" contract that includes a run- in provision. Not all plans allow for run-in claims to be paid.
- Run-out Claims Period
  - This refers to the period of time immediately following termination of your insurance contract, during which time all claims incurred prior to the termination date are being paid. Not all plans allow for run-out claims to be paid, in some cases the reserves that are built up pay these claims.

11

Pooled Self-Funded Health Plans

- Groups with a common interest form a pool to share the risk for health insurance.
  - Numerous offerings in Ohio:
    - Jefferson Health Plan
    - County based plans for schools
    - Plan that serves schools in multiple counties
    - Plan that only serve County governments
    - Geographic plans

12

Questions to ask about a Pooled Self-Funded Health Plan

- Reserves – do the individual groups have ownership of the reserves of the pool?
- Transparency – does the pool provide regular updates its financial condition?
- Data Control – does the pool allow for individual member groups to have access to their own specific claims data?
- Plan Design – who determines the plan design offered to the employees? Does the group have the ability to modify the plan offerings?
- Administration – how much administrative work is done by the group? Who handles eligibility?

13

Questions to ask about a Pooled Self-Funded Health Plan

- Underwriting – who is responsible in determining which groups are allowed in the pool?
- Stop Loss – what is the stop loss limit and how is it established?
- Funding – how is the amount paid by the group determined?
- Renewals – is the annual renewal based on individual group experience, all member group experiences, or a combination of both?
- Value Added Programs – does the pool offer any other programs related to health (i.e. wellness, care management, etc.)?
- Termination/Withdrawal – how much notice does the group need to provide to leave the pool? Will run-out claims be paid by the pool after termination?

14

Making the Right Decision for your Organization

- If currently fully insured, explore options for self-funding or pooled self-funding.
- Use the expertise of a broker, consultant or other health insurance professional you trust.
  - Most local brokers do not understand public entities and their health insurance needs.
  - Ensure that the broker or consultant is open to all health care options.
  - It is important that the brokers have other public entities within their book of business.

15

16