Benefits Toolkit

Reducing Costs With Self-insured Health Plans

Peoples First INSURANCE
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Introduction

As health care costs continue to climb, employers are actively looking for impactful mitigation strategies. Expanding cost-sharing methods, such as offering high deductible health plans, has been one approach; yet, shifting costs onto employees might affect recruitment in a tight labor market. Instead, some employers are switching to self-insuring to reduce costs and improve service.

Self-insuring may not be not suitable for every organization, but for some, it can be an extremely effective way to control health plan expenses. A self-insured health plan is funded entirely by an employer, who pays for employee health claims instead of an insurance company. This allows employers great control over their plan designs. For instance, they can set employee cost-sharing limits, choose their health care networks and establish stop-loss limits so they're guaranteed to never spend over a certain amount in a given year.

However, a switch from a fully insured health plan to a self-insured plan is a major undertaking, and curious employers will need to closely analyze the advantages and disadvantages before making a final decision.

This toolkit aims to help employers' decision-making and serves as an introductory guide to self-insurance. It provides a general overview of what self-insurance is, discusses how it differs from fully insured health plans and outlines its growth over time.

Note: This toolkit is not intended as legal advice. An employer should consult a legal professional or plan administrator before changing its health plan's funding structure. Employers should also consider any pertinent state or local laws that may affect their plan designs.

Background

This section briefly defines self-insurance and outlines its rising popularity in the market.

Self-insurance Overview

A self-insured health plan is one in which an employer assumes the financial risk associated with providing health care benefits to their employees. Instead of paying fixed premiums to an insurance company—which, in turn, assumes the financial risk of paying claims—the employer pays for medical claims out of pocket as they are incurred. Essentially, fully insured and self-insured health plans can be identical in their plan designs (depending on setup); the main difference is how the plan is funded.

The Past and Future of Self-insurance

Historical Trends

The percentage of private employers offering at least one self-insured health plan has generally increased year over year since the 1990s; in 1999, the percentage was 26.5%, and it rose to 40.7% by 2016, according to the Employee Benefits Research Institute (EBRI). While this upward trend has been relatively consistent across workplaces, it has varied significantly between employer sizes. The most noticeable trend is that smaller employers are adopting self-insured plans at a greater rate than large employers in recent years.

Nonetheless, large employers have utilized and continue to implement self-insuring to a much greater extent. Large employers (over 500 workers) are still far more likely to have at least one self-insured health plan compared to small (fewer than 100 workers) or medium-sized employers (100-499 workers).

Consider these recent workplace trends sourced from EBRI data:

- **Small employers**—Between 2018 and 2020, the rate of small employers offering at least one self-insured health plan increased from 13.3% to 16.1%.
- **Medium-sized employers**—Since 2015, the rate of medium-sized employers offering at least one self-insured health plan has steadily remained around 30%.
- **Large employers**—Between 2013 and 2020, the rate of large employers offering at least one self-insured health plan decreased from 83.9% to 75.2%.

Historically, worker enrollment in self-insured health plans has fluctuated but has remained relatively consistent in recent years. Between 2016 and 2020, worker enrollment in self-insured plans across all workplaces increased from 57.7% to 59.4%.

Current and Future Projections

According to the Kaiser Family Foundation and the Health Research and Educational Trust's Employer Health Benefits 2021 Annual Survey, 64% of covered workers are currently enrolled in a self-insured health plan. Covered workers in large organizations are significantly more likely to be enrolled in a self-insured health plan (82%) than those in small organizations (21%)*.

However, the increase in the percentage of workers covered under a small employers' health plan is particularly noteworthy. Between 2018 and 2020, this rate grew by 10%—rising from 13% to 23%, according to Kaiser data. This significant increase is a much higher leap than what has been seen over the last several years.

A variety of market factors may have influenced more small employers to offer self-insured offerings in recent years beyond their own motivations and decision-making. Some potential influences include:

- The COVID-19 pandemic—The pandemic upended most aspects of daily life, with health plans included. As the pandemic continued, employers needed solutions to lower their surging health care claims. Offering self-insurance was one method for taking greater control over health care spending, especially as premiums rose in the wake of the pandemic.
- Greater visibility—Self-insurance has existed for decades, but it's only recently seen a notable uptick among smaller-sized organizations. One theory attributes this to more success stories shared by self-insured groups. For instance, there has been a recent shift away from fully insured plans; a greater number of insurance experts are encouraging small employers to consider self-insuring than in years past.
- Attraction and retention differentiation—Attraction and retention are other factors that may be contributing to the upward self-insuring trend. Self-insurance gives an employer more control over how their health plans are structured. In other words, self-insured employers can set worker cost sharing or design plans in ways that make them more attractive to current and potential employees.

While the factors listed above are speculative, they serve as examples of market influences that can possibly affect an employer's self-insuring decision-making.

Moreover, these considerable influences have the potential to continue shaping self-insuring trends for years to come. In the future, small and medium-sized employers are expected to increase their self-insuring buy-in as they have been doing for years; the number of workers covered under a self-insured plan among these employers has gradually increased for a decade with some ebb and flow.

*EBRI and Kaiser define employer sizes differently in their reporting.

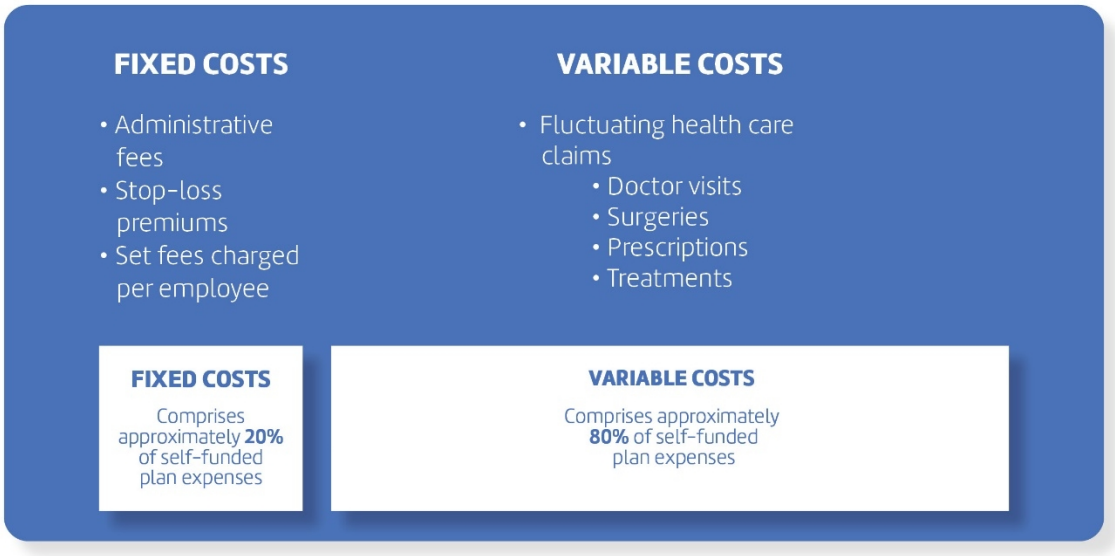
Self-insured vs. Fully Insured Plans

A **fully insured health plan** is the traditional way to structure an employer-sponsored health plan. With a fully insured health plan:

- The company pays a premium to the insurance carrier.
- The premium rates are typically fixed for a year, based on the number of employees enrolled in the plan each month.
- The monthly premium usually only changes during the year if the number of enrolled employees in the plan changes.
- The insurance carrier collects the premiums and pays the health care claims based on the coverage benefits outlined in the policy purchased.
- The covered persons (that is, employees and dependents) are responsible for paying any deductible amounts or copayments required for covered services under the policy.

With a self-insured health plan, employers operate their own health plan as opposed to purchasing a fully insured plan from an insurance carrier. One reason that employers choose to self-insure is that it allows them to save the profit margin that an insurance company adds to its premium for a fully insured plan. However, self-insuring can expose the company to much larger risk in the event that more claims than expected must be paid. With a self-insured health plan:

- There are two main costs to consider: fixed costs and variable costs.



- Some employers use stop-loss or excess-loss insurance to limit risk. This coverage reimburses the employer for claims that exceed a predetermined level. It can be purchased to cover catastrophic claims on one covered person (specific coverage) or to cover claims that significantly exceed the expected level for the group of covered persons (aggregate coverage).

Self-insured Health Plans and Stop-loss Insurance

An extra component many self-insured plans use is called stop-loss insurance. The purpose of this insurance is to provide financial protection to a self-insured plan sponsor by capping and further defining the plan's financial exposure. A stop-loss contract operates differently from general insurance because it is actually insuring the employer and not the individual employee. When a plan is self-insured, the stop-loss contract insures the employer against catastrophic losses under the plan. In general, the employer accepts the responsibility for paying providers' claims for individuals but limits its risk with stop-loss coverage.

Stop-loss is most closely comparable to a catastrophic coverage plan that indemnifies a plan sponsor from abnormal claim frequency and severity. Stop-loss claim reimbursements can be made for a variety of benefits, including medical, prescription drug, dental and others. Severe, high-dollar claims such as cancer, organ transplants and dialysis are considered "shock loss" claims, giving plans the most concern when assessing self-insuring. But, the protection afforded by a comprehensive stop-loss coverage shows its value in helping to financially manage these catastrophic events.

Stop-loss insurance provides protections in two forms:

1. Specific stop-loss—Also referred to as individual stop-loss, it protects a plan against individual catastrophic claim occurrences. This type of stop-loss coverage shifts responsibility for a claim to the insurer once that claim exceeds a certain dollar amount.

    - Example: An employer with a specific stop-loss attachment point of $25,000 would be responsible for the first $25,000 in claims for each individual plan participant each year. The stop-loss carrier would pay any claims exceeding $25,000 in a calendar year for a particular participant.

2. Aggregate stop-loss—This limits a self-insured plan's financial exposure for the entire plan year (or policy year) and protects against abnormal claim frequency across the entire group of individuals. This type of stop-loss coverage protects the employer against high health plan claims, cumulatively (i.e., the total sum of claims for the entire group, rather than an individual claim).

    - Example: Aggregate stop-loss insurance with an attachment point of $500,000 would begin paying for claims after the plan's overall claims exceeded $500,000. Any amounts paid by a specific stop-loss policy for the same plan would not count toward the aggregate attachment point.

Pros and Cons of Self-insurance

Each company will have its own unique considerations when it comes to self-insurance. Therefore, self-insuring advantages and disadvantages will vary by organization, perhaps most notably when it comes to the size of a workplace.

However, there are still some general self-insurance factors that are important for employers to think about. The following section outlines common pros and cons.

Self-insurance Advantages

The primary reasons employers cite for self-insuring include:

The COVID-19 Pandemic and Rising Health Expenses

Expectedly, the pandemic has caused premium rates to grow even above the typical year-over-year increase of 5%. Self-insurance is a method employers can use to control these rising costs through careful plan design.

Attraction and Retention Advantages

In a tight labor market, offering the right perks can make all the difference. Self-insured health plans give employers more control over their offerings. For instance, they can set worker contribution levels and design plans to provide more benefits than a typical health plan. And, when health plans are designed with employees in mind, top performers are enticed to stay with a company longer.

Reduced Insurance Overhead Costs

Carriers assess risk charges and profit margins for insured policies (approximately 3%-5% annually), but self-insurance removes this charge.

Reduced State Premium Taxes

Self-insured programs, unlike insured policies, are not subject to state premium taxes, which typically amount to around 2-3% per year.

More Cost Control

When paired with stop-loss insurance, self-insured plans allow for a more accurate prediction of how much the employer may need to spend in a plan year. With this coverage, any costs over a certain amount are paid for by the carrier.

Avoidance of State-mandated Benefits

Although both fully insured and self-insured plans are governed by federal law (predominantly ERISA), self-insured plans are exempt from state insurance laws. State benefit mandates can add to the cost of insured employer benefit programs. For multistate employers, self-insuring can help create national consistency by elimination of the need for state-by-state compliance.

Employer Control, Generally

Employers who want to revise covered benefits and the levels of coverage are free from state regulations mandating coverage and the carrier negotiation typically required with changes in insured coverage. By self-insuring, employers are able to design their own customized health benefit packages.

Improved Cash Flow

Claims are paid as they become due; employers do not need to prepay for coverage. There is also a cash flow advantage in the year of adoption when "runout" claims are being covered by the prior insurance policy. Employers pay for claims rather than premiums and earn interest income on any unclaimed reserves.

Choice of Claim Administrator

An insured policy can be administered only by the insurance carrier. A self-insured plan can be administered by the company, an insurance company or independent TPA, which gives the employer greater choice and flexibility. When selecting a TPA, employers should consider whether the TPA efficiently handles claims; has contacts with stop-loss carriers, a strong reputation, cost management skills and negotiating clout; has medical expertise on staff; and provides excellent customer service and claims administration.

Greater Claims Projection

When a health plan is fully insured, a carrier owns the plan data. Self-insured plan data is completely owned by the employer, giving them access to more accurate claims analytics and health care utilization data that may otherwise be incomplete. Such data enables an employer to precisely budget for their annual health care spending.

Self-insurance Disadvantages

While self-insuring has its advantages, switching from a fully insured model can be a lengthy process for employers, and it can sometimes be a long time before they see cost benefits. This section outlines potential disadvantages to self-insuring.

Potential Payment Lag

Under a self-insured health plan, an employer pays for claims as they are incurred. Some claims have the potential to be very high and may trigger stop-loss insurance, which would make them eligible for reimbursement. However, there can sometimes be a significant delay between an employer paying for stop-loss-eligible claims and getting repaid by a carrier. Despite possible delays, self-insured employers are still responsible for paying for claims right away.

Greater Risk

The main risks of self-insuring involve situations where claims are higher than anticipated. While stop-loss insurance will protect employers from paying excessive claims in a given year, the cost of that coverage will likely increase, and it may be more difficult to get rates from other stop-loss providers. Claims that are higher than expected in a self-insured plan may also make it more difficult for employers to go back to a fully insured plan in the future. Furthermore, an employer's assets may be exposed to liability as a result of any legal action taken against the plan. Legal matters in regards to self-insured plans can be complex.

Greater Administrative Burden

The administrative costs can be significant for organizations that choose to run their self-insured plans internally. However, using TPAs to operate the plans will still likely involve lower administrative costs than those associated with fully insured plans.

Determining if Self-insurance Is Right for Your Workplace

When deciding if self-insuring is right for your organization, consider the following best practices to ensure your self-insuring strategy is appropriate and effective.

1. Evaluate stop-loss coverage. Most self-insured employers purchase stop-loss insurance on their self-insured health care benefit plans to reduce the risk of large individual claims or high claims for the entire plan. The employer self-insures claims up to the stop-loss attachment point, which is the dollar amount above which claims will be reimbursed by the stop-loss carrier. Obtain stop-loss quotes at several different levels.
2. Understand the volume and nature of your employee health claims for the past five years. Accounting for facts about your workforce—such as whether your employees are mostly young or old, whether the majority of claims were due to chronic illnesses or one-time incidents, and the total dollar amount of claims—will help you budget for claims in the future. Self-insurance should be viewed as a long-term strategy in which good and bad years average out in the employer's favor.
3. Analyze cash flow. Self-insured plans work best for companies that have a strong cash flow or reserves. Understand what your cash needs are so you have money available to make timely claim payments.
4. Decide whether it makes sense to administer the plan internally or through a TPA. If you decide it is best for your organization to use a TPA, make sure you factor TPA fees into your decision to self-insure. Obtain several different TPA quotes. Your TPA should offer a strong plan for monitoring the plan.
5. Make coverage goals. Decide on such factors as eligibility, benefit coverage, exclusions, cost sharing, policy limits and retiree benefits. Weigh the self-insured plan advantages of flexibility and lower average cost versus the increased risk and administrative responsibilities.

Conclusion

Self-insuring health plans can provide many advantages for employers. However, it is important for employers to do their due diligence before deciding whether self-insurance is the right choice.

To successfully manage their health benefits, an employer must have certain attributes, including the following:

- A high risk tolerance
- A steady employee population
- A stable claims experience
- Employee involvement in cost-saving strategies

Because the employer assumes the financial risk of providing health care benefits, a company can either save or lose money depending on the level of claims incurred by its employees. The most important step to ensure you make the best decision is to have an experienced professional assist you. Your Peoples First Insurance Services, LLC representative has experience with self-insurance programs and can answer your questions and assist you with the decision to self-insure your company health plan.

Peoples First Insurance Services, LLC welcomes the opportunity to help your organization examine its plan designs and make recommendations for improvement.

Appendix

The resources included in this section are for employers to print and use as they see fit. Speak with Peoples First Insurance Services, LLC if you have any questions about these resources.

Note that some content may require customization.

Printing Help

There are many printable resources in this appendix. Please follow the instructions below if you need help printing individual pages.

1. Choose the "Print" option from the "File" menu.
2. Under the "Settings" option, click on the arrow next to "Print All Pages" to access the drop-down menu. Select "Custom Print" and enter the page number range you would like to print, or enter the page number range you would like to print in the "Pages" box.
3. Click "Print." For more information, please visit the Microsoft Word printing support page.

Self-insured vs. Fully Insured

Self-insured		Fully-insured
The employer does not pay premiums; instead, they pay fixed costs (administrative fees and stop-loss premiums) and variable costs (employee health care claims).	**PAYMENTS**	The employer pays monthly premiums to an insurance carrier.
The employer assumes the risk.	**ASSUMPTION OF RISK**	The insurance company assumes the risk.
Employers have more control and freedom in their plan designs.	**PLAN DESIGN**	Employers are more limited by insurers' plan design options.
The Employee Retirement Income Security Act of 1974 (ERISA) preempts state regulations.	**COMPLIANCE REQUIREMENTS**	The plan must comply with state regulations.

SELF-INSURANCE EVALUATION

A self-insured health plan is one in which the employer assumes the financial risk associated with providing health care benefits to their employees. Rather than paying fixed premiums to an insurance company—which, in turn, assumes the financial risk—the employer pays for medical claims out of pocket as they are incurred.

It's important to remember that self-insurance may not be the best solution for every organization. However, it is worth asking Peoples First Insurance Services, LLC about self-insured plan designs that may save your organization money.

Instructions: Answer the following questions to determine whether your organization is a good candidate for self-insurance.

QUESTIONS

1. How many employees does your organization employ?	
2. What is the average employee age at your organization?	
3. When is the last time your health care costs decreased?	

	YES	NO
4. Are you willing to assume additional liability and risk to potentially save on health care costs?	☐	☐
5. Have you ever wanted increased flexibility in plan design?	☐	☐
6. Do you anticipate growing in employee count?	☐	☐
7. Do you do business across state lines?	☐	☐
8. Do you desire the ability to have access to better benchmarking information?	☐	☐
9. Do you want better overall data on your health plan?	☐	☐
10. Do you have concerns about medical claim fraud or double-billing?	☐	☐

If you answered "yes" to many of these questions, you may be a good candidate for plan design changes. Return this evaluation to Peoples First Insurance Services, LLC to start a conversation about implementing a self-insured health plan at your organization.

TPA Carrier Questionnaire

The following questionnaire is fully customizable and can help employers in their search for a TPA.

GENERAL INFORMATION: Questions must be answered for each coverage you are quoting.

1. Describe the history, organization and ownership of your company.
2. Explain your ownership, listing all separate legal entities and their relationships.
3. Do you contemplate any agreements or are agreements being negotiated between you and other parties which may affect the plan's ownership, corporate structure or management during the next year?
4. Provide the name and address of your company and all outside vendors used in this request for proposal (RFP). Include local, toll-free telephone and fax numbers.
5. Supply an organizational chart identifying the functions and reporting relationships of key people directly responsible for administrative services to .
6. Give the name and title of the person(s) with overall responsibility for planning, supervising and performing the day-to-day administrative services for .
7. Will you assign an underwriter or another group benefit professional with similar knowledge and experience to ?
8. Will Peoples First Insurance Services, LLC have direct contact and access to all of the above named person(s)?
9. Explain in detail the steps you anticipate will be needed to ensure a smooth implementation. Include a definition of specific activities and a timetable of events. The timetable should assume an award notification date and plan implementation schedule, which includes completion of all enrollment packets, enrollment meetings, system updates and ID card issuance by .
10. requires that you provide year-end financial information and renewal rates and fees 120 days prior to the policy anniversary date. Additionally, Peoples First Insurance Services, LLC will be provided all service agreements, contracts, amendments, reports and claims data. Will you agree to this?
11. Will you agree to performance-based administrative fee structures as outlined in this RFP?
12. Describe any previous or pending material lawsuits in the last 10 years.

13. Have any of the principals in your firm or any of your employees (former or current) ever been indicted or convicted of mishandling or misappropriating any insurance company or client funds? If yes, please explain.
14. Are you HIPAA electronic data interchange (EDI) compliant?

Please respond to the following questions, recognizing that your organization will be expected to underwrite and administer the program as stated in this RFP unless specifically noted here.

1. Will your organization insure and/or administer the program exactly as shown in this RFP?
2. Will your organization require any additional information or impose restrictions on benefit selections?
3. Does your organization agree to the performance objectives outlined in this RFP?

REFERENCES

1. Please provide three references of current clients and two references of clients you have lost in the past two years. Ideally, these references would be similar in size to .
2. Please provide a reference from a similar product or service offering.

CLAIMS PROCESSING AND ADMINISTRATION

1. Do you have an automated claim processing and payments system?
2. How long has this system been operational?
3. Who can add or change eligibility information?
4. How does the system keep track of noncovered expenses? Are all denied claims tracked?
5. How is hard copy stored? How long is it retained?
6. How are providers identified (tax identification number, name/zip, phone number, other)?
7. Does the system track carry over deductible amounts and adjust out-of-pocket sequence claims?

8. Define “turnaround time” for claim processing purposes.
9. Describe the procedures for administering coordination of benefits (COB) in-network versus out-of-network, specifying whether COB is system-calculated or manually calculated.
10. What is the current collection/return rate for COB (as a percent of paid claims)?
11. Do you routinely capture, maintain and access a spouse’s coverage and employment data for COB? What specific data elements do you store in these files? How do you update them?
12. Describe the quality management program which is applied to the claims administration function (e.g., coding, processing, paying), specifying audit procedures and error categories.

CLAIM ADMINISTRATION AND ADJUDICATION

1. Where will you process medical claims? Where will drafts and explanation of benefits be issued?
2. Describe the organization, methods and procedures for responding to routine claim inquiries from employees.
3. Is your software leased or owned? If owned, when was it purchased?
4. Describe your procedures for auditing and/or negotiating provider bills.

AUDITING PRACTICES

1. What are your standard claim audit procedures for claims in process and those that are already paid?
2. How are overpayments handled, and to what extent does your company go to recover those overpayments?

UTILIZATION REVIEW SERVICES

1. To what extent do you involve the patient and/or family in the review process? Be specific.
2. What percent of all cases are reviewed by a physician and what determines whether a physician becomes involved?
3. What is your fee structure? Do you charge on a monthly or case rate?

NETWORKS

1. Provide a response for the following questions describing the capabilities for each PPO network that would be applicable to this RFP.
    a. PPO network
    b. Location(s)
    c. Date established
    d. Total enrollment
    e. Average hospital discount—break down inpatient/outpatient
    f. Average professional discount
    g. Percent PCPs Board Certified

2. What is your service area? Please describe by county and zip code.

3. Chiropractic
    a. Indicate the chiropractic services currently available.
    b. Describe the method used by subscribers to access such services.

4. Do you have the capability to coordinate a drug testing program for all locations? If yes, is there a separate cost?

    If not, would you be willing to develop a program? If yes, is there a separate cost?

5. Please indicate whether your physician application and credentialing process requires the following;
    a. Written verification of education and experience
    b. Verification of current license and DEA certificate
    c. Investigation for adverse action on license and/or hospital privileges
    d. Verification of letters of recommendation
    e. Regular recertification of participating physicians
    f. Verification that physicians complete continuing education requirements
    g. Documentation on malpractice claims, settlements and judgments for the previous five years

6. Are physicians prevented from balance billing?

7. How are radiology services reimbursed?

8. How are laboratory services reimbursed?

9. How are anesthesiology services reimbursed?

10. What screens do you use to audit coding accuracy?

11. What physician services are not available through the network? How are they handled?

SELF-INSURED QUOTATION ASSUMPTION/CONDITIONS

1. Are the fees quoted for firm and guaranteed for:
    a. Administrative services?
    b. Individual stop-loss?
    c. Aggregate stop-loss?
2. Do quoted rates and fees include all services described within this RFP? If not, please indicate which services are not included.
3. Will individual medical underwriting of self-insured members ever be required? Under what circumstances?
4. What is the maximum percentage the quoted fees will increase for:
    a. Administrative services?
    b. Individual stop-loss?
    c. Aggregate stop-loss?
5. Please outline the reimbursement process and banking arrangements for your self-insured quotes. Attach copies of any agreements related to this process.
6. Please describe the process and timing of reimbursements to when the stop-loss threshold has been exceeded for:
    a. Individual stop-loss
    b. Aggregate stop-loss
7. Does individual and aggregate stop-loss coverage include:
    a. COBRA participants?
    b. All other covered members as of the effective date?

Know Your Benefits

Self-insured Health Plans

The health plan that offers is called a self-insured health plan. You need to know how this type of health plan works and what it means for the way you receive health care benefits.

What Is Self-insurance?

With a self-insured (or self-insured) group health plan, the employer assumes the financial risk associated with providing health care benefits to its employees.

Rather than paying fixed premiums to an insurance company—which, in turn, assumes the financial risk— pays for medical claims out of pocket as they are incurred.

Why Do Employers Choose Self-insurance?

An employer may choose to offer a self-insured health plan for a number of reasons.

- Self-insured plans can be customized to fit the needs of an employer's workforce instead of trying to purchase a "one-size-fits-all" health plan.
- Employers with self-insured plans control the health plan cash reserves, allowing them to maximize interest income (insurance companies generate interest income for themselves by investing premium dollars).
- Self-insured coverage is not prepaid as it is when the employer pays premiums to an insurance company. Therefore, companies that self-insure their health plans have improved cash flow.
- Self-insured plans are not subject to conflicting state health insurance regulations and benefits mandates. Instead, these plans are regulated by federal law.
- Employers with self-insured plans are not subject to state health insurance premium taxes.
- Employers can contract with the providers or a particular provider network that will best meet the needs of its employees.

How Self-insured Benefits Work

Imagine you make an appointment with your doctor because you are sick. When you arrive at your doctor's office, you are asked to provide your insurance card to your physician's office personnel. Your insurance card tells the doctor's office what type of health plan you have and how it is administered, including to whom your claim should be sent.

After you have seen your doctor, a claim for payment for the office visit is generated. Someone in your doctor's office prepares the claim and submits it to the administrator—the entity that will determine how your claim will be paid—listed on the insurance card you provided. Some employers administer employee health care claims in-house, while some use a third-party administrator (TPA).

The administrator then adjudicates your claim. Adjudication is the process of paying health care claims according to your health plan's contract. Your health plan's administrator will determine how your health benefits work and what payment is required for your doctor. Your plan may require you to pay coinsurance or a deductible before your health plan pays its portion of your bill. Or, your doctor may participate in a Preferred Provider Organization (PPO) or another type of managed care plan and, therefore, will charge discounted fees to your plan. These and other

Know Your Benefits

factors determine how much of the claim the plan will pay, how much you will pay and how much the doctor will eventually receive.

Once all of the payment issues are cleared up and it is determined that your expense will be covered by the plan, your plan administrator contacts your employer for approval of your claim's payment (and any other current claims). Your employer approves payment of the claim.

After receiving payment approval from your employer, the administrator requests payment from your employer's bank. The bank will wire the appropriate funds to the administrator, who will then send payment to your physician. Your claim is paid.

This payment process generally takes two to four weeks.

The Explanation of Benefits

After your visit with your physician, you will receive an informational statement from your health plan administrator. This is the explanation of benefits, or EOB. An EOB summarizes your claim, the payments you must make, the payments your health plan (employer) must make and any other payment information regarding your claim. This statement is not a bill or request for payment; it is simply informational.

Your Rights Under a Self-insured Plan

Self-insured health plans are regulated under the federal Employee Retirement Income Security Act (ERISA) rather than state law as insured health plans are. They fall under the jurisdiction of the U.S. Department of Labor.

Federal regulations require your employer to provide you with a summary description of your health plan and certain other documents related to the plan. You can also request to see a copy of the plan document that determines what benefits are available and how they get paid.

Self-insured group health plans are also regulated by other applicable federal laws including the:

- Health Insurance Portability and Accountability Act (HIPAA)
- Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Americans with Disabilities Act (ADA)
- Pregnancy Discrimination Act
- Age Discrimination Employment Act
- Civil Rights Act

The Impact of Health Care Reform

Many health care reform regulations apply to all group health plans, regardless of whether they are fully insured or self-insured, but self-insured plans are exempt from certain provisions of health care reform. The following are examples of reforms that do and do not apply to self-insured plans.

Reforms that do apply:

- Dependent coverage until age 26
- Preventive health coverage without cost sharing (grandfathered plans are exempt)
- Improved internal claims and appeals process and minimum requirements for external review (grandfathered plans are exempt)

Reforms that do not apply:

- Essential health benefits package
- Premium rating restrictions
- Review of premium increases
- Rescissions of coverage, except in the case of fraud or intentional misrepresentation of material fact

Do Your Part

Because assumes the financial risk of providing you with health care benefits, the company can either save or lose

Know Your Benefits

money depending on the level of claims incurred by our employees.

We want to be able to provide you with high-quality health benefits, but as the cost of providing health care rises, you too must do your part to keep benefits high and costs low.

Some ways that you can help save money for yourself and our company are:

- Eliminate unnecessary visits to your doctor.
- Discuss healthy living and preventive care with your doctor.
- Follow prescription drug directions precisely, and be sure to take all of your medication, even if you feel better.
- Use in-network providers if you have a PPO or Point-of-Service plan.

To help keep your health care costs down, do your best to be a wise health care consumer and always ask questions if you do not understand the benefits available to you. Contact HR if you would like more information on our self-insured health plan.