

GROUP INSURANCE – AN OVERVIEW OF THE BASICS

Group Insurance – What is it?

1. Contract with employee that health expenses will be paid according to the certificate of coverage – no matter the amount if it falls within plan maximums
2. Tax Favored Compensation – Group Insurance cost is a tax deduction for businesses and is not counted as income for the employee – 16% of GDP
3. PPOs – Preferred Provider Organizations
 - Contracts with Providers - Managed care and Fee discounts

4. Medical Plan Components

- Plan Design Components – How do you set up the member's cost share so it is not an impediment to seeking care but helps to control costs – credit card effect
- Co-pays – usually flat \$ amounts – office visit, UC, ER, Rx
 1. Gives member easy access to medical services
 2. Removes member from awareness of actual cost of care
- Deductibles – Member's responsibility – first \$s paid
 1. Need to know what expenses it's applied to – never copay expenses
 2. Single deductibles and family caps
 3. Last quarter carryover
- Coinsurance - % payment split between plan and member i.e. 80% Plan payment, 20% member
- Out of Pocket Maximums – Cap on the amount a member is responsible for
 1. Need to know what's included: Anthem includes the deductible, UHC doesn't
- Plan Maximums
 1. Service limits such as # of mental health visits – soon to change
 2. Maximum amounts such as lifetime payment max \$5,000,000
- Exclusions – Services that are not covered by the Plan
 1. If a service is not covered, it is NOT counted toward the Out of Pocket max
 2. Group health insurance is meant to cover medically necessary non-experimental services, provided by licensed medical practitioners in the treatment of illness + certain wellness exams
 3. Examples: cosmetic surgery, experimental treatment, weight loss programs, OTC Rx
- Rx Plans –
 1. Co-pay Tiers – Generic, Brand name, Non Formulary
 2. Drug formularies i.e. Preferred Drug Lists
 3. Keeping up with the Pharmaceutical industries pricing game
- Anthem vs UHC
- High Deductible Health Plans with Health Savings Accounts or Health Reimbursement Accounts

5. Dental Plan Components

- Services required for the prevention and treatment of dental disease – non cosmetic; Plan designed to encourage good dental hygiene to reduce costs
- Network & non-network dentists – silent PPO, no coinsurance difference
- Covered services categories:
 1. Preventive – almost always at 100% - no deductible
 2. Minor restorative – services in your mouth i.e. fillings – usually 80% w/ deductible
 3. Major restorative – Major things in your mouth i.e. crowns & bridges – usually 50% or 60% with deductible
 4. Orthodontia – Kids only or adults? – usually 50% or 60% w/ deductible
- Deductible – single & family cap, calendar year, last ¼ carryover
- Maximums: Dental, most common \$1500 per calendar year; Orthodontia, most common \$1000 per lifetime

6. Vision

- Network & non-network but significantly better coverage at network level
- Network contracts allow VSP to exert some influence over both cost and quality of care
- Copays & frequency of services

7. Life & AD&D – Sun Life

- Basic Group Life & AD&D – Employer paid - \$50,000 limit before imputed income tax
- Optional Life – Employee paid coverage for employee and spouse or kids

Group Insurance – How We Pay For It

8. Who takes on the Risk?

- **Insured** – Risk is passed on to the insurance company for a set premium expressed as an amount per covered employee (rates). Good year, no return of surplus; Bad year, no additional cost – until the renewal
- **Self funding** – Employer assumes the risk and pays a Third Party Administrator to manage the plan – pay claims, provide networks etc.
 1. Positives - Savings to employer – lower admin cost, keep surplus \$s in good year, no state premium tax, employer holds claim reserves and earns investment income
 2. Negatives – Risk of very large claims
 3. Stop Loss Insurance – insurance on the Plan
 - Specific – caps individual large claims – EPC \$400,000
 - Aggregate – caps total expected claims i.e. 120%

9. Group Insurance Pools – Why Pool Insurance

- **Law of Large Numbers** – the risk goes down as the group becomes larger and more predictable – nervous underwriters and company profits

- Administrative expense goes down as group becomes larger
- Makes self funding less risky
- Creates a group with more influence – clout – with the Carrier / TPA
- Decreases roller coaster rating – makes renewals more predictable
- Major question – How is risk spread within the group

10. How Renewals are Calculated & Rates are Set

- Rate Renewal – Annual (10/1) projection of how much money the Plan will need to pay claims and administrative expenses
- 2 Year Cycle
 - i. Odd Years – all districts receive the same % rate change
 - ii. Even Years – districts rated individually based on their discounted claim experience
- Surplus Premium – the benefit of self funding – rate reductions, premium credits & Flu shots

11. How the EPC is Organized – Council of Governments

- Trust Agreement for the Plan with Participation Agreements signed by each district
- Insurance Committee – geographically and Anthem/UHC representative
- Annual Audit & Annual Financial Statement
- Service Provided
 - i. Plan Administration
 - ii. Benefits consulting & assistance with negotiations
 - iii. COBRA administration – Infinisource
 - iv. Online enrollment system – Benelogic
 - v. New endeavors – Wellness & Disease Management

Administration of Group Insurance Plans

Federal & State Benefits Regulations – a Brief Overview

1. **ERISA** – It doesn't apply to us – no protection from punitive damage lawsuits
2. **HIPAA** – Health Insurance Portability & Accountability Act
 - **Portability** – No Pre-existing condition exclusion if back in coverage < 63 days
 1. Notice of Creditable Coverage issued at termination for next employer Plan
 - **PRIVACY** – Claim questions & Enrollment Info – EPC is the Covered Entity
 1. Protected Health Information (PHI) – Claims and Enrollment Information
 2. School district office as part of the EPC Plan
 - i. Limit access to PHI especially Benelogic system
 - ii. Include confidentiality requirement in job description
3. **COBRA** – Extension of coverage available to be purchased by employee at termination
 - “Same as any other similarly situated employee”
 - How Infinisource works
4. **Medicare D** – Rx Creditable Coverage

5. **Medicare Secondary Payer** – Matching W2 income and Medicare records leads the Feds to overpaid claims - they want their money back
6. **USERRA** – Uniformed Services Employment and Reemployment Act
7. **Section 125 – Flexible Spending Accounts**
 - Premium Conversion – Employee's Contribution on Tax Free Basis
 - Spending Accounts – Medical & Dependent Care
 - Plan Documents
8. **FMLA** - Family Medical Leave Act – 12 weeks unpaid leave in the event of a serious illness of the employee or other family member, or birth or adoption
 - Who – Has been employed at least 12 months and has worked at least 1250 hours in the past 12 months
 - Health Insurance – Employer continues to pay employer share of premium during the 12 week FMLA leave
9. **School Employees Health Care Board** – First 4 Best Practice Requirements
 - Wellness plan – including Health Risk Assessments
 - Disease Management
 - Specialty Networks
 - Dependent Eligibility Audits
 - Effective the later of 12 months from the 1/1/09 effective date or the end of the current negotiated agreement

Eligibility & Enrollment Issues

1. **Dependent definition** – who is a dependent - same for all EPC plans, medical, dental & vision
 - Legal spouse – don't drop the spouse before the divorce
 - Kids – Yours, mine & ours to age 19; 19 – EoCY 24, full time student or IRS dependent
 - Dependent Eligibility Audits
2. **Who is eligible** – Eligibility for health insurance should be clearly stated in the Personnel Policy re part time / full time, Leave of Absences & termination
3. **Who is an employee** – when does coverage terminate?
4. **Open Enrollment** – the importance of employee notices – Special Enrollment, WHRCA, reference to other notices
5. **Special Enrollment** – change in family circumstances necessitating a change in enrollment other than during open enrollment

Plan Administration at the District Level

1. Premium Payment
2. Claim Questions from Employees
 - Refer them 1) to the carrier website 2) to the carrier Customer Service unit 3) to EPC
3. ID Cards
4. Address changes
5. Adding new dependents – 30 day special enrollment window
6. Communication with the EPC & within your District

Benelogic Online Enrollment

1. Review of the System and the importance of Benefit Class codes
 - ALL CHANGES **MUST** BE ENTERED INTO THE BENELOGIC SYSTEM BY THE DISTRICT
2. The Open Enrollment Process
 - What went well
 - What didn't
 - Individuals moving from one EPC district to another
3. Plans for Next Year & FEEDBACK