GROUP HEALTH BENEFITS 101

Things every employer needs to know if they offer group health benefits

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Introduction

The information in this ebook is designed to help educate and guide you through the management of your group health benefits.

David Hickman and the cost management team at the HIC Agency have worked with numerous employers and have saved hundreds of thousands of dollars for employers of all sizes through practical management and sound financial advice.

Understanding the components of a group health benefits plan and how they work

1. Insurance / reinsurance contract
2. Plan benefits
3. Plan administrators - third-party administrators (TPA)
4. Pharmacy benefit managers (PBM)
5. Networks
6. Claims reserve

Insurance / Reinsurance Contract

The insurance/reinsurance contracts by definition and design are for large unexpected medical claims. This policy transfers the risk of those claims to the insurance carrier at specific thresholds in the contract.

Aggregate coverage can often be purchased to limit the total claims liability in reinsurance contracts as a claims cap.

Based on our statistics we commonly see the following:

Members of the groups fall into the following claims thresholds within a 12-month period.*

- 0 to 2% > $20,000
- 0 to 4% > $10, 000
- 0 to 12% > $5,000
- 66% of any group will not reach $1,000
- 98% of all claims are under $20,000 and 96% are under $10,000

We need to purchase insurance/reinsurance for only that 2 to 4% of the claims. Insurance has to be purchased for which it was designed: large and unexpected claims.

*Claims threshold based on independent analysis of multiple third-party administrators

Plan Benefits

Summary Plan Description - This is the document that dictates coverage within the health benefits plan. Some of the typical information found would be deductible coinsurance, doctor's office co-pays, etc.

This document will also designate whether there is a HMO, PPO or network affiliation and any difference in network and out of network.

Administrators - Third Party Administrator (TPA)

The TPA handles all or part of the plan administration, from eligibility and premium administration to payment of claims. The following is a list of some services TPAs can provide:

- Medical, Dental, Vision Claims Administration
- Auto Claims Adjudication
- Clinical Editing Services
- Prescription Drug Card administration
- Pharmacy benefits management
- Utilization Review, large case management, disease management
- Web-based services
- Health risk screenings
- Predictive Modeling with Potential Large Claims Early Identification
- Access to local, regional and national PPO networks
- Comprehensive cost management reporting
- Health Savings/Health Reimbursement accounts administration
- Flexible spending accounts administration
- COBRA / HIPAA administration
- Benefits management
- Stop loss placement
- Plan document development and production
- Eligibility and premium billing administration
- Federal tax reporting assistance
- Government compliance reporting

Pharmacy Benefit Manager (PBM)

Most insurance plan insurers contract an independent PBM to administer the pharmacy benefits. The PBMs have negotiated contracts with local independent and chain retail pharmacies across the nation. Additionally, many of the PBMs have contracts with mail order warehouses that may provide a cost break for many medications.

PBMs typically work from Average Wholesale Price (AWP); however, that can be deceiving since there are several different pricing sources. You will want to be certain your PBM uses the Red Book or lesser of the Red Book pricing or any other source.

Online Reporting — track your pharmacy costs and get reports that will allow you to manage your benefits and educate employees.

- Generic
- Preferred Brand
- Non-Preferred Brand
- Rebates, Rebate Pumping
- Transparent Model
- Over The Counter (OTC)

Networks - HMO, PPO, POS

Health Maintenance Organizations

Health Maintenance Organizations (HMOs) gained popularity in the 80s. HMOs require participants to select a Primary Care Provider and then they are limited to that provider unless they get a referral. HMOs are typically very closely held smaller networks of physicians and hospital providers with very little flexibility. Many HMOs have no out-of-network benefits. Through the limited networks, HMOs have strong discounts for the members and often have capitated reimbursement rates.

Preferred Provider Organization networks

With Preferred Provider Organization (PPO) networks, no Primary Care Provider needs to be selected and members simply select a provider from the network directory. Members are not required to get a referral to change network providers, so PPOs are often seen as more flexible and user friendly. PPO networks can range from smaller regional networks to national networks that go from coast to coast. Typical PPO networks are more flexible and generally have more providers.

POS organizations

POS organizations are typically smaller than the PPO but do have similar flexibility in that no Primary Care Provider need be selected, no referrals are needed, and there are often out-of-network benefits.

All the above types of organizations, whether HMO, PPO or POS, are designed to provide discounts with providers, from hospital facilities to physician groups. To get the network discount, the insurer or employer TPA leases the network by paying a monthly fee for each employee. Typical fees run from $4.00 to $7.00 per member per month. Some networks will not charge a monthly fee but charge a percent of the discount on claims processed. Typical discounts vary widely based on competitive pressure and other providers in that market, but you can expect to see a range from 7 to 54%.

Getting the most from your network!

There is more to selecting a network than seeing if your physician or hospital is on the network. Many networks contain the same providers and facilities. The best network will have a strong utilization matched with the deepest discounts for your group.

A quality TPA will run software programs to compare previous claims and different networks. This allows you to see if another network would be a better, less expensive option for your group based on your utilization. The analysis shows the alternative networks and what the cost for those same services would be with their contracts.

Don't be mislead by the percent of discount! The bigger issue is the final cost. This software will allow you to see the dollar impact of the different networks and any physicians or facilities that are participating in the network.

Sometimes you will find tens of thousands of dollars by simply switching networks. Same doctors, same services, better discounts.

Claims Reserve / Funding

Funding is the means by which an employer pays for insurance coverage and for partial self-funded or self-funded plans claims under the deductible in the reinsurance contract.

The fully insured contract is not unlike auto insurance. The fully insured contracts require the employer to pay the insurance premiums in advance. In addition, within the fully funded premiums are included reserve account contributions for the insurance company and expected profit margins.

The self-funded approach works more like a gas or electric bill: if claims are low, the employers pays a low cost; if claims are high, the employer pays more, up to the specific or stop loss ceiling, or set maximum. You pay for what you use and the reserve cash accumulates in your account. The profit for the insurance carrier is limited to the stop loss and aggregate coverage, normally a fraction of the overall cost or premium of a fully funded plan.

Questions to ask current broker / carrier:

- How many people had claims in excess of the following numbers the last 2 years?

  $1,000 ___ $5,000 ___ $10,000___ $20,000 ___ $30,000 ___ $40,000 ___

- Out of the large claims over $10,000, how many are chronic (ongoing)?

- What type of reinsurance contracts do you offer?

  12/12 12/15 12/24 15/12

- What is the total broker's commission? Are there any additional fees built in?

- Is the reinsurance put out to bid in the independent market year-to-year? If not, and it's kept in house, how many reinsurance carriers do you have bidding?

- Do you use lasers as a management tool?

- Do you use a transparent model for everything covered by the health plan?

- Are you getting paid or participating in rebates from the PBM?

Putting It All Together

1. Set your budget based on current premiums. Purchase a group policy that covers any large unknown unexpected medical services that you can not afford.
2. The savings from your current premium goes into your cash reserve account.
3. Pay cash for the small day-to-day routine medical claims processed and paid through a TPA.
4. Look at positive modifications in plan design to lower cost and enhance employee participation in plan management.
5. Work with a broker who will analyze your medical cost and understands how to structure the most cost efficient plan design for your group.

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