Know Your Benefits

Self-funded Health Plans

Employers who contract with Varipro offer with a plan this is called a self-funded. You need to know how this type of plan works, and what it means for the way you receive health care benefits.

What Is Self-funding?

An employer has a self-funded (or self-insured) group health plan if 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-funding?

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

- Instead of trying to purchase a "one size fits all" health plan, self-funded plans can be customized to fit the needs of an employer's workforce.
- Employers with self-funded 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-funded coverage is not prepaid, as it is when the employer pays premiums to an insurance company. Therefore, companies that self-fund their health plans have improved cash flow.
- Self-funded plans are not subject to conflicting state health insurance regulations and benefits mandates. Instead, these plans are regulated by federal law.
- Employers with self-funded 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-funded 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

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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-funded Plan

Self-funded 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-funded 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)
- No rescissions of coverage, except in the case of fraud or intentional misrepresentation of material fact
- 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

Do Your Part

Because assumes the financial risk of providing you with health care benefits, we can either save or lose money depending on the level of claims incurred by employees.

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Self-funded plans 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 your 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 Preferred Provider Organization (PPO) or Point-of-Service (POS) 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.