Lesson 7 – Federal Regulation & Consumer Driven Plans

Lesson 7 Introduction p1 (LHE)

Federal Regulations since the 1970's have impacted the health insurance sector of the U.S. economy. Since many of the provisions of recent health care reform legislation are still being decided, we will cover the major legislation that has shaped health insurance prior to the passage of the Patient Protection and Affordable Care Act, which became law as the Health Care and Education Reconciliation Act March of 2010.

The health care industry offers employers plenty of options in providing health care coverage as a benefit. Such "consumer driven" plans will be discussed in this section.

- ERISA – Employee Retirement Income Security Act
- HIPAA – Health Insurance Portability and Accountability Act
- MHPA – Mental Health Parity Act
- WHCRA – Women Health and Cancer Rights Act
- COBRA – Consolidated Omnibus Budget Reconciliation Act
- FMLA – Family Leave and Medical Act
- NMHPA – Newborns’ and Mothers’ Health Protection Act
- SCHIP – State Children’s Health Insurance Program

Lesson 7 Introduction p2 (LHE)

Learning Objectives:

1. List three types of consumer driven health plans.
2. Describe the benefits of Health Savings Accounts
3. List the four requirements an individual must meet to be eligible for a Health Savings Account (HSA).
4. Describe the rules regarding contributions into an HSA.
5. Describe Health Reimbursement Accounts (HRA)
6. Describe Flexible Spending Accounts (FSA).
7. Compare the differences of Health Reimbursement Accounts (HRA) and Flexible Spending Accounts (FSA).
8. Name and describe some of the ancillary, voluntary products that an individual may choose if offered by their employer.
9. Understand the role that federal legislation plays in health care coverage.
10. Explain the purpose of the Federal Regulation known as COBRA, and describe the benefit periods available and the premium payment requirement.
11. Describe the purpose of HIPAA.
12. Describe the Family Medical Leave Act (FMLA) requirements for employees and employers.
13. List the four major benefits an employer might realize if they choose to insure on a self-funded basis.
Lesson 7 Topic A – Consumer-Driven Health Plans

Lesson 7 Topic A Consumer-Driven Health p1 (LHE)

Learning Objective: List three types of consumer driven health plans.

Consumer-driven health plans originated in the late 1990s to encourage healthcare consumers (insureds and dependents) to shop more carefully for healthcare services.

In return for allowing insureds to establish a health-care financial reserve on a tax-favored basis, the federal government expected health care consumers to negotiate lower healthcare costs, placing pressure on the medical profession to keep costs low.

However, since consumers were inexperienced in negotiating healthcare costs, and did not fully understand the economics of the healthcare system, the results of this strategy had been disappointing. Current events and increased consumer involvement in health care related issues may be changing the situation.

We will study three types of consumer driven health plans:

- Health Savings Accounts (HAS)
- Health Reimbursement Accounts (HRA)
- Flexible Spending Accounts (FSA)

Lesson 7 Topic A Consumer-Driven Health p2 (LHE)

Additional Terms and Concepts

**Qualified medical expenses** - A type of expense that may be reimbursed by a health savings account, flexible spending account or health reimbursement account.

**Tax deferred growth** - Growth in the value of a plan, such as a Health Savings Account is not taxed each year.

**Tax exempt distributions** - A withdrawal from an account that the insured 'never' has to pay tax on, because it meets the criteria determined by the Federal Government as an 'eligible' expense.

**About Terms:** Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation contact the course mentor.
Lesson 7 Topic A Consumer-Driven Health p3 (LHE)

What is a High Deductible Health Plan (HDHP)?

Regardless of the early poor results, the concept of requiring the healthcare consumer to accept some of the risk of increasing medical costs was established and may yet prove to be successful. For Health Savings Accounts the insured must be covered by a High Deductible Health Plan.

A High Deductible Health Plan is a health plan that meets certain requirements. As an example, for the calendar year 2012 the HDHP must have a deductible of at least $1,200 per single person and $2,400 per family.

Maximum out of pocket expense for a single person is $6,050 and $12,100 for a family. The Federal Government indexes these numbers each year. (http://www.irs.gov)

<table>
<thead>
<tr>
<th>Family</th>
<th>Single</th>
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</thead>
<tbody>
<tr>
<td>Deductible: $2,400</td>
<td>Deductible: $1,200</td>
</tr>
<tr>
<td>Out of Pocket: $12,100</td>
<td>Out of Pocket: $6,050</td>
</tr>
</tbody>
</table>

Lesson 7 Topic A Consumer-Driven Health p4 (LHE)

Learning Objective: Describe the benefits of Health Savings Accounts

Health Savings Accounts (HSA)

Tax-favored monetary contributions are made by or on behalf of eligible individuals (by employee or employer) to an account, and the contributed amounts and interest income can be distributed tax-free for eligible medical expenses.

2012 Max Annual Contribution – HSA
Single: $3,100
Family: $6,250

Example:

Lester works for a publishing company and this year his employer has announced that the firm is moving to a High Deductible Health plan with the option of contributing to a Health Savings Account.

“Oh, man, that means that I am going to have to pay way more than I’m currently paying for my health insurance!”
At first the high deductible on the plan is alarming, but once he learns more, he’s interested. For instance the premium on the HDHP is much lower than his old plan. He decides to open the HSA when his employer informs him that the company will match his contributions up to a certain point.

“Hmm, ok I’m listening, but I’m still worried about paying more out of my pocket. I like the idea.”

He decides to put a certain amount into his HSA each month. Contributions to his HSA decrease his annual tax liability, and the growth of the investment will also be tax exempt.

“Large Deductible, but

- Lower premiums
- No coinsurance
- Plenty of Qualified Expenses
- Ample maximum contributions
- Tax exempt Savings

And the money that I put in each year that is unused continues to grow in interest and is available next year. I like the sound of that!”

Even if his family has a bad health year and has to pay out expenses up to the deductible amount, the tax, premium and coinsurance savings still make it a better deal than his old plan would have been under the same circumstances.

“Whew, what a tough year! But you know what, when I compare what I paid this year (My High Deductible plus my share of the premiums) and compare it to what these medical bills would have cost me last year (My Previous Deductible, +Co-pays, + Coinsurance, + premium) I saved a lot of money this year.

And I didn’t use up all that my employer and I have contributed, so I have money in my account for next year to handle my deductible already. I think I could get used to this.”

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*Lesson 7 Topic A Consumer-Driven Health p5 (LHE)*

**Learning Objective:** List the four requirements an individual must meet to be eligible for a Health Savings Account (HSA).

**Health Savings Accounts – Eligible Individuals**

Money not used in an HSA is NOT subject to use it or lose it! It stays in the account and rolls over to be used in future years.

Eligible individuals are persons who:
1. Are covered by a High Deductible Health Plan (HDHP) on the first day of the month.
2. Are not covered by any other health plan that is not a HDHP.
3. Are not entitled to benefits under Medicare.
4. Cannot be claimed as a dependent on another person’s tax return.

Lesson 7 Topic A Consumer-Driven Health p6 (LHE)

Learning Objective: Describe the rules regarding contributions into an HSA.

Contributions:

Employer Contributions – Employer contributions are tax deductible by the employer. The contributions are not subject to Social Security taxes. Employers who offer a high-deductible plan with HSAs must make comparable contributions for all employees with comparable coverage.

Insured (or account holder) contributions – Contributions made by the insured are tax deductible. Contributions made by someone other than the insured are deductible by the account holder (except the employer.)

Withdrawals:

Qualified Expenses – To be excluded from Federal Income Tax, funds in an HAS must be used for qualified expenses (examples on page 8 of this section)

Non-Qualified Expenses – Prior to age 65, funds used for non-qualified expenses are subject to income tax and a 20 percent penalty, after 65, income tax only.

Distributions and Investment – Any amounts not used by year end are not forfeited and they can continue to accumulate tax deferred. Distributions because of death or disability are not subject to income tax. Upon death, HSA ownership may transfer to the spouse on a tax-free basis.

Portability – HSA’s are portable: If an employee leaves the company, he or she can continue the plan.

Lesson 7 Topic A Consumer-Driven Health p7 (LHE)

Learning Objective: Describe the rules regarding contributions into an HSA.

Health Savings Accounts - Examples of Eligible Expenses
Learning Objective: Describe Health Reimbursement Accounts (HRA).

Health Reimbursement Accounts (HRA)

An HRA is funded solely by contributions from an employer to be used for qualified medical expenses on behalf of current, former, or retired employees, including dependents. In addition to supplying the funds, the employer owns the account, maintains control of the funds, and determines the plan design to fit the individual needs of their employees.

While there is no requirement for an accompanying health insurance plan as there is with an HSA, it would be advisable for the employer to have an HDHP in place to handle any potential catastrophic claim expenses.

If an employer moves from a traditional health insurance plan to an HDHP, the resultant decrease in premium should assist in offsetting the contributions made to the HRA. There is no IRS prescribed maximum contribution limit and the contributions are tax deductible to the employer and are not taxable for the employee.

Example: An employer provides a Health Reimbursement Account for his employees. He provides a High Deductible Health Plan for his employees as well, to handle catastrophic illness, although with an HRA an associated HDHP is not required.

He likes the tax advantage he receives on the contribution amounts. Further, it represents a tax free benefit to his employees. He controls the amounts, whether or not contributions roll over and the range of qualified expenses.
He also likes the flexibility of the HRAs. Although he knows what his maximum reimbursement cost will be annually, he only has to pay out what he incurs. In addition to an HRA, he can provide his employees with other health plan options, such as an FSA.

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**Learning Objective: Describe Flexible Spending Accounts (FSA).**

**Flexible Spending Accounts (FSA)**

Health care Flexible Spending Accounts are employer-established benefit plans that reimburse employees for specified medical expenses as they are incurred. These accounts are allowed under section 125 of the Internal Revenue Code and are also referred to as “cafeteria plans” or “125 plans”. The employee contributes funds to the account through a salary reduction agreement with their employer and is able to withdraw the funds set aside to pay for “eligible medical expenses”, as well as dependent expenses such as child and senior daycare, as defined by the employer.

**Here’s an example:**

Jennifer is a single mom whose employer offers a Section 125 plan. A total of $1200 is deducted from 25 paychecks in the amount of $50 each to pay for this benefit. This amount is the maximum set by her employer, and it applies to all the employees at Jennifer’s company.

Jennifer uses this account to reimburse herself for child care expenses, and with the cost of child care these days, she’s not a bit worried that she must “use or lose” all of the $1200 she is able to set aside, before tax, from her wages.

The deduction that happens with each paycheck, $50.00, reduces the amount of Jennifer’s income that is subject to withholding for Federal and State taxes. So, she realizes the actual tax benefit of participating in this plan each month. From Jennifer’s perspective, she gets a discount on her child care costs by participating in the plan.

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**Learning Objective: Describe Flexible Spending Accounts (FSA).**

**Contributing to an FSA**

There is no statutory limit on the amount of money that can be contributed to health care flexible spending accounts, although the employer must set a maximum limit or percentage of salary.
Once the employee has set an amount of contribution during the open enrollment period that occurs once each year, the employee is not allowed to change the amount or drop out of the plan during the year unless he or she experiences a change of family or employment status. By law, the employee forfeits any unspent funds in the account at the end of the plan year.

Lesson 7 Topic A Consumer-Driven Health p11 (LHE)

Learning Objective: Compare the differences of Health Reimbursement Accounts (HRA) and Flexible Spending Accounts (FSA).

Recap of Consumer-Driven Health Plans

<table>
<thead>
<tr>
<th></th>
<th>HSA</th>
<th>HRA</th>
<th>FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligibility</strong></td>
<td>Requires an HDHP</td>
<td>No requirement for an HDHP</td>
<td>No requirement for HDHP</td>
</tr>
<tr>
<td><strong>Contributions</strong></td>
<td>May not be covered by another plan</td>
<td>Employer owns the account and controls the funds</td>
<td>Employer establishes benefit plans to reimburse employees</td>
</tr>
<tr>
<td><strong>Withdrawals</strong></td>
<td>May not be entitled to benefits under Medicare</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eligibility</strong></td>
<td>Requires an HDHP</td>
<td>Employer owns the account and controls the funds</td>
<td>Employer establishes benefit plans to reimburse employees</td>
</tr>
<tr>
<td><strong>Contributions</strong></td>
<td>Contributions can come from either the Employer, Employee or both. However, they cannot exceed the stated maximum for that year.</td>
<td>Employer makes the contributions</td>
<td>Employee makes contributions</td>
</tr>
<tr>
<td><strong>Withdrawals</strong></td>
<td>Contributions by employer are not taxable to employee</td>
<td>No IRS prescribed maximum contribution limit</td>
<td>Employer sets the maximum annual contribution</td>
</tr>
</tbody>
</table>

Contributions are not subject to use it or lose it; un-used contributions roll over and gain on the account is tax-exempt.
<table>
<thead>
<tr>
<th><strong>Eligibility</strong></th>
<th><strong>Contributions</strong></th>
<th><strong>Withdrawals</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>HSA</td>
<td>Prior to age 65, withdrawals for non-medical uses are possible but are subject to a 20% penalty plus income tax.</td>
<td>After age 65, income tax only.</td>
</tr>
<tr>
<td>HRA</td>
<td>Employees are reimbursed tax free for qualified medical expenses up to a maximum dollar amount for a coverage period. HRA’s only reimburse for those items agreed to by the employer which are not covered by the company’s selected standard insurance plan.</td>
<td></td>
</tr>
<tr>
<td>FSA</td>
<td>Use it or lose it for qualified medical expenses.</td>
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</table>

Please refer to Lesson 7 Topic A Consumer-Driven Health p12-14 to complete the Knowledge Checks at this time.
Lesson 7 Topic B – Ancillary Health Products

Learning Objective: Name and describe some of the ancillary, voluntary products that an individual may choose if offered by their employer.

Travel Insurance – Travel Insurance is typically sold to people traveling from the United States to foreign countries, and variations exist that cover citizens of other countries while visiting and traveling in the U.S.

- Designed to cover expenses resulting from accidents
- May provide limited benefits for illnesses
- May provide limited coverage for transferring an ill or injured back to their home country (repatriation expenses)

Accidental Death and Dismemberment Insurance – This coverage can be written as a separate policy or added as a rider to a life insurance policy.

AD&D is often provided as an additional benefit for a member of an association or perhaps a trade group. Employers include it as part of a group life insurance or as a stand-alone elective benefit.

AD&D will provide a defined benefit for death due to an accident; or Partial benefit for loss of limbs, loss of sight, or permanent paralysis.

Credit Insurance – This can be either life insurance or loan disability insurance as part of a loan package.

- Covers life of the debtor
- Pays benefits to creditor
- Pays off loan in the event of death
- Pays payments in the event of disability of the debtor

Ancillary Health Products continued

Dental Plans – Dental plans come with varying levels of benefits. They can be part of an employee group benefit package, or they can be written on a stand-alone policy. Typical plans include:
• Payment of 100% of basic service charges
• Deductible with internal dollar limitations on more complicated procedures
• Coverage without deductible for basic services (such as teeth cleaning) one visit every six months or once per year.

 Plans may require a coinsurance payment for major services such as root canals and crowns, and most plans have a calendar year maximum benefit.

**Vision Plans** – Vision plans also come with varying levels of benefits:

• Basic plans – discounts on contacts, eyeglasses, and frames
• Better plans – coverage for eye examinations, and full coverage for eyeglasses and contact lenses.

Please refer to Lesson 7 Topic B Ancillary Health p3 to complete the Knowledge Check at this time.
Lesson 7 Topic C – Federal Regulations

Learning Objective: Understand the role that federal legislation plays in health care coverage.

Insurance companies, seeking to reduce the overall cost of insurance plans, began to reduce or eliminate coverage for certain types of care. Over time, complaints from consumers caused the Federal Government to review the industry’s practices.

Numerous laws followed, each designed to inhibit the ability of the insurance company to unfairly discriminate against selected groups of individuals.


ERISA sets minimum standards to make sure employers establish and maintain employee benefits plans in a fair and financially sound manner.

**COBRA – Consolidated Omnibus Budget Reconciliation Act**

Covering groups of 20 or more employees, COBRA allows for the continuation of the employee and dependent health, dental and vision coverage after employment ends.

**FMLA – Family Medical Leave Act of 1993**

Allows an employee to take up to 12 weeks of unpaid leave for specific situations, such as the birth of a child.

**NMHPA – Newborns’ and Mothers’ Health Protection Act of 1996**

This act provides health coverage for a hospital stay following a normal delivery.
MHPA – Mental Health Parity Act of 1996

This act requires employers to provide coverage for the diagnosis and treatment of mental illness under the same terms and conditions applied to other medical conditions.

HIPAA – Health Insurance Portability and Act of 1996

HIPAA legislation was passed to protect workers and their families from losing coverage or limiting benefits, and primarily to make it easier for anyone to change jobs, even with a significant health condition.

SCHIP – State Children’s Health Insurance Program of 1997

The State Children’s Health Insurance Program (SCHIP) established a low-cost health insurance designed for families who earn too much money to qualify for Medicaid, yet cannot afford to buy regular private insurance for their children.


This act sets requirements of a group health plan that provides coverage for medical and surgical benefits for mastectomy.

Lesson 7 Topic C Federal Regulations p3 (LHE)

Learning Objective: Understand the role that federal legislation plays in health care coverage.

Employment Retirement Income Security Act of 1974 (ERISA)

Employers have an obligation to provide the promised benefits and satisfy ERISA’s requirements for managing and administering employee benefit plans.

• The provisions of ERISA cover most private sector employee benefit plans if the group has 15 or more employees.
• ERISA covers employee benefit plans that are voluntarily established and maintained by an employer.
• Typically, ERISA does not apply to plans that are established or maintained by government organizations or churches for their employees.
• ERISA also does not apply to plans maintained solely to comply with workers compensation, unemployment, or disability laws.
Lesson 7 Topic C Federal Regulations p4 (LHE)

Learning Objective: Explain the purpose of the Federal Regulation known as COBRA, and describe the benefit periods available and the premium payment required.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA applies to health, dental and vision benefits; it does not apply to group life or disability income coverage. COBRA covers group plans of 20 or more enrollees.

An employee or covered dependent has at least 60 days from the date of a status change to advise if he wants to continue his health benefits. The discharged employee or covered dependent must pay the entire premium directly or through the employer and the employer may charge a fee of 2%.

**Employee: 18 months** – Employees may elect an 18-month continuation of coverage if employment is terminated, or if a reduction of hours (to part-time status) causes a loss of coverage.

**Dependent: 36 months** – Employee’s dependents may elect a 36 month continuation of coverage if death, divorce, or legal separation causes loss of coverage from the covered employee.

**COBRA and Social Security Disability Recipients** – Employees may choose a 29-month continuation of coverage if Social Security disability applies to the employee.

**Medicare Recipients** – Coverage under COBRA automatically ends when the employee is eligible for Medicare.

Please refer to Lesson 7 Topic C Federal Regulations p5 to complete the Knowledge Check at this time.

Lesson 7 Topic C Federal Regulations p6 (LHE)

Learning Objective: Describe the purpose of HIPAA.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA legislation was passed to protect workers and their families from losing coverage or limiting benefits, and primarily to make it possible for anyone to change jobs, even with a significant health condition.

The new health insurance company must accept individuals with pre-existing conditions under certain rules:

- The new insurer may impose a pre-existing condition limitation if an individual receives medical care, treatment, consultation, or prescription drugs during the six-month period immediately
preceding that individual’s new effective date of coverage. Pre-existing conditions treated earlier than the 6 month period could be covered.

- The waiting period for coverage that is imposed under a pre-existing condition limitation can be no longer than 12 months, and waiting periods for coverage cannot apply to pregnancy, newborn children, or newly adopted children.

However, HIPAA rules dictate that the preexisting condition limitation must be reduced by the amount of time the employee was covered on the previous plan. The law goes on to say that the employee cannot have any breaks in health coverage exceeding 63 days within the last year.

In other words, if the employee had creditable coverage for 12 months prior to the new employer, the pre-existing condition is covered.

Please refer to Lesson 7 Topic C Federal Regulations p7 to complete the Knowledge Check at this time.

Lesson 7 Topic C Federal Regulations p8 (LHE)

Learning Objective: Describe the Family Medical Leave Act (FMLA) requirements for employees and employers.

Family Medical Leave Act of 1993 (FMLA)

FMLA generally applies to employers of 50+ employees and allows an employee to take up to 12 weeks of unpaid leave for certain reasons. The law also allows for intermittent leave and reduced work schedule.

The employee may take 12 weeks of unpaid leave for:

- the birth of a child,
- his or her own serious health condition,
- caring for an immediate family member with a serious health condition (child, spouse, parent), or
- the placement of a child with the employee for adoption or foster care.

The FMLA requires employers to:

- Allow eligible employees to take up to 12 weeks of unpaid leave for the above circumstances.
- Provide continued health benefits during leave.
• Restore employees to the same position upon return from leave (or to a position with the same pay, benefits, and terms and conditions of employment).
• Notify employees of their rights and responsibilities under the Act.

More: Spouses working for the same employer are limited to a total of 12 weeks combined unpaid leave. An exception to this is when one spouse is caring for the other spouse who has a serious health condition.

Please refer to Lesson 7 Topic C Federal Regulations p9-10 to complete the Knowledge Checks at this time.

Lesson 7 Topic C Federal Regulations p11 (LHE)

Learning Objective: Understand the role that federal legislation plays in health care coverage.

Mental Health Parity Act of 1996 (MHPA)

This act requires employers to provide coverage for the diagnosis and treatment of mental illness under the same terms and conditions applied to other medical conditions. A plan must provide equal lifetime and annual maximums for medical and mental health benefits.

• A plan must provide equal lifetime and annual maximums for medical and mental health benefits.
• A plan cannot impose dollar limits for hospital stays or outpatient visits. However, it can impose day limits on hospital stays and outpatient visits.
• The act excludes substance abuse and chemical dependency from the requirement of equal maximums.
• Health plans are not required to include mental health coverage in their benefits package. The requirements under the act apply only to plans offering mental health benefits. This act applies only to companies with 51 or more employees.

Lesson 7 Topic C Federal Regulations p12 (LHE)

Learning Objective: Understand the role that federal legislation plays in health care coverage.

Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA)
This act provides health coverage for a hospital stay following a normal delivery. Coverage may not be limited to less than 48 hours for both the mother and newborn child. This limit is extended to 96 hours following a cesarean section birth.

This Act applies to both group health insurance and individual policies. A plan cannot offer incentives to the health providers to encourage the mother and baby to leave the hospital earlier than the minimum time stated, however the provider may decide, after consulting with the mother, to discharge earlier.

Lesson 7 Topic C Federal Regulations p13 (LHE)

Learning Objective: Understand the role that federal legislation plays in health care coverage.

Woman’s Health and Cancer Rights Act of 1998 (WHCRA)

This act states that a group health plan that provides coverage for medical and surgical benefits for a mastectomy shall provide for a participant who elects breast reconstruction coverage for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications during all stages of the mastectomy

This coverage may be subject to annual deductibles and coinsurance provisions.

Lesson 7 Topic C Federal Regulations p14 (LHE)

Learning Objective: Understand the role that federal legislation plays in health care coverage.

State Children’s Health Insurance Program 1997 (SCHIP)

The State Children’s Health Insurance Program (SCHIP) established low-cost health insurance designed for families who earn too much money to qualify for Medicaid, yet cannot afford to buy regular private insurance for their children.

Run by state governments, SCHIP coverage provides eligible children, as well as pregnant mothers, and some other eligible adults with coverage for a full range of health services including regular checkups, immunizations, prescription drugs, lab tests, X-rays, hospital visits, and more.
Lesson 7 Topic D – Self-Insured Health Plans

Lesson 7 Topic D Self-Insured Health p1 (LHE)

Learning Objective: List the four benefits an employer might realize if they choose to insure on a self-funded basis.

Some employers choose to self-insure employee health benefits. They establish funding for the plan based on a premium equivalent, or the cost per covered employee for the costs of claims paid, administration, and stop-loss premiums.

The employer gains several benefits from self-insuring:

- Avoidance of state-mandated benefits requirements and premium taxes.
- Potentially reduced cost of plan administration.
- Plan costs based on the group’s own claims experience, not the experience of other groups.
- Potential investment earnings from claim reserves, which may be used to pay plan expenses.

Lesson 7 Topic D Self-Insured Health p2 (LHE)

Additional Terms and Concepts

Third Party Administrator (TPA) - An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policy holder or the insurer.

Stop Loss Coverage - A form of reinsurance for self-insured employers that limits the amount the employers will have to pay for each person’s health care (individual limit) or for the total expenses of the employer (group limit).

About Terms: Other important terms will be defined on the topic pages. If you find any terms or concepts that need more explanation, go through the topic once more, and check the glossary. If you still need explanation, contact the course mentor.

Lesson 7 Topic D Self-Insured Health p3 (LHE)

Learning Objective: List the four benefits an employer might realize if they choose to insure on a self-funded basis.

Entities Involved with Self Insurance Plans
Self-insured companies may contract with insurers or third-party plan administrators to design the plan and handle the day-to-day management of the plan including:

- claims payment
- prescription drug cards
- establishing provider networks, and
- ensuring compliance with the Employee Retirement Income Security Act (ERISA) fiduciary obligations.

Self-insured companies may also purchase “stop loss” coverage through an insurer to pay for the costs of an extraordinary illness for an individual group member, or for a particularly bad year for the group.

**Lesson 7 Topic D Self-Insured Health p4 (LHE)**

**Learning Objective: List the four benefits an employer might realize if they choose to insure on a self-funded basis.**

**Types of Self Insurance Plans**

In a Minimum Premium Plan, the premium paid to the insurer is small because the self-insured employer, which is the group policyholder, pays all of the claims, or most of the claims up to an agreed level. The insurance company fully administers the plan and would pay only claims above an agreed amount.

Along with Minimum Premium Plans, the other types of plans (Conventional Indemnity, PPO, EPO, HMO, POS, and PHOs) can be financed on a self-insured basis.

Considering that the government regulates the way employers deliver insured plans, but not self-insured plans, some employers choose to offer a combination of self-insured and fully insured plans to employees.

Please refer to Lesson 7 Topic D Self-Insured Health p6 to complete the Knowledge Check at this time.

Refer to the end of Lesson 7 Topic D to complete Self Quiz 7.