

Health Care 101
Understanding the Basics

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Health Care
Who Delivers the Package?

- Individual School Districts
- Jointly Managed Trust (JMT)
- Joint Powers Authority (JPA)
- Other Risk Pools (i.e. CalPERS, Medicare, etc.)

What are the Main Plans?

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Point of Service (POS)

How Do They Differ?

HMO

- ✓ A pre-paid medical group practice that provides comprehensive predetermined medical care.
- ✓ Access is restricted to a prescribed set of providers.
- ✓ Access to non-HMO providers is severely restricted—generally out-of-network emergency services only
- ✓ Few patient choices
- ✓ Less costly since a portion of the physician compensation is provided on a pre-paid, capitation basis (puts physicians on risk)

How Do They Differ?

PPO

- ✓ A managed care plan that contracts with physicians and hospitals to provide comprehensive medical services. Contract providers exchange discounted services for increased volume—termed In-Network benefits.
- ✓ Access to all providers is allowed
- ✓ Reduced benefits, however, for non-network utilization.

How Do They Differ?

POS

- ✓ A managed care plan that allows members to choose, at the point where service begins, to receive services from an HMO or PPO plan of benefits.
- ✓ 3 levels of benefits available to participants:
 - 1) HMO: in-network only
 - 2) PPO: in-network
 - 3) PPO: out-of-network
- ✓ POS plans are generally more costly than an HMO but not as expensive (premium) as a PPO.

How are the Plans Funded?

- Fully Insured
- Partially Self-Funded
- Self-Funded

How Do They Differ?

Fully Insured Plans –

- The Insurance Company takes the risk
- The Group may be pooled with others
- The Group may be Experienced Rated, which could result in refunds or deficits.
- All services come from the selected carrier, such as the network, billing, claim payments, etc.

How Do They Differ?

Partially Self-Funded Plans –

- The Employer or Group and the Insurance Company share the risk
- Mixture of Specific & Aggregate Stop-Loss contracts are purchased to cover the costs when claims reach a certain level
- Stop-Loss Insurance is purchased where costs are high and the risk is predictable. This is usually done for “Carve Outs”
- The most common carve outs are for pharmaceutical benefits, vision, and dental

How Do They Differ?

Self-Funded Plans –

- The Employer or Group assumes the full risk
- Benefits are administered by the Employer or Group, or may be handled through an Administrative Service Only (ASO) agreement with an Insurance Carrier or Third party Administrator (TPA)
- Mixture of Specific & Aggregate Stop-Loss contracts are purchased to cover the costs when claims reach a certain level

Components of the Rates

- Paid Claims
- Incurred But Not Reported Reserves (IBNR)
- Administrative Expense
- Margin
- Profit

Paid Claims

Claims that result in a payment during a specific period of time.

IBNR

Claims that have not been reported to the Insurer as of some specific date for services that have been provided. The estimated value of these claims is a component of an Insurer's current liabilities.

Administrative Expense

- Billing/Eligibility
- Claim Paying Services
- Medical Network
- Identification Cards
- Communication Materials
- Client services
- Stop Loss Premium

Margin

An amount added to the rates to help ensure that the Insurance Company will have a profit.

Sometimes this is referred to as...
the "Fudge Factor"

Profit

In most plans, the profit margin is in the range of...

1-2%

What is the Basis for Rate Changes?

The Million Dollar Question!!!

Just To Name a Few...

Paid Claims Utilization

 Trend

Plan Design Demographics

 Quality of Health care

Formularies Disease Management Programs

 Margin

Wellness Programs Rx Plan

 Opt Outs
