## KEY CONCEPTS

**Cost Sharing** – methods for paying for health insurance coverage.

- **Co-payments** - Fixed dollar amounts paid for covered services. For example, under the current Kaiser and Providence plans, when you receive certain services you pay $15 at the time of the visit; this is called an office visit co-pay. Generally, copays are applicable only for PPO or In-Network providers.

- **Deductible** – An annual out-of-pocket, lump-sum payment for medical services that a consumer must pay before medical insurance provides reimbursement.

- **Coinsurance** – A fixed specific percentage of the charges for health plan services usually after paying the deductible. For example, a typical PPO plan might pay 80% or 90% of a charge instead of a flat dollar copay.

- **First Dollar Coverage** - A benefit plan that provides reimbursement for incurred health care costs "from the first dollar," with no deductible.

- **Covered Services** - Services you may secure through your healthcare provider that are included as a part of your health insurance plan. For example, a covered service may be lab or x-ray that is paid at 100%.

- **Maximum Out-of-Pocket** - The maximum amount of money you pay for covered services during the calendar year. Once the "max" is met, the plan will pay 100% for the remainder of the plan year.

- **Employee Cost Share & Pre-Tax Deduction** – A pre-tax deduction through payroll is a form of employee cost share and can be used to help keep the cost of the plan within budget. For example if the cost of the plans exceed the budget instead of changing copays and other features, employees may be required to contribute a portion of the monthly premium through payroll deduction. Pre-tax contributions for health insurance is a way to help offset the financial impact to employees deduction(s) from their pay. Pre-tax deductions are also used for participants of the Flexible Spending Accounts.

  - Pre-tax for this purpose includes pre – Federal, State (if applicable) and FICA.

**Components of Designing Health Plans**

- **Plan Design** –Components of the health plans to determine the types of services covered, the cost to the member and maximum coverage levels, and any mandated benefits such as Mental Health & Chemical Dependency coverage. Plan design is used to evaluate the overall cost of the plan. Components of the plan can be adjusted to meet budgetary limits.

- **Preferred Provider** (PPO) – This is a medical care provider with whom the insurance company has an agreement as to the discount offered for specific procedures. This saves you and the insurance company money. In a preferred provider plan, you pay a lower portion of the bill for services when you see a preferred provider than when you see a medical provider (non-PPO provider) not on the list.

- **Primary Care Physician** – A physician specializing in family practice, general practice, internal medicine, obstetrics/gynecology or pediatrics. They serve as your overall health care provider and as gatekeeper to specialist. This is used more in HMO plans, however the member may choose a primary care physician under a PPO plan.

- **Specialist** – a specialist provides care generally focused in one specific area of health care such as a cardiology or oncology.

- **Claims** – When an employee participates in a preferred provider plan and goes to the doctor, the employee or the doctor submits the bill to the insurance company which then pays the agreed upon portion of the bill. This is called a claim.

- **Employer Mandates** – requirements by State and Federal governments or the carriers to cover certain types of coverage. For example: Mental Health & Chemical Dependency. With a fully insured plan employers must comply with the mandates.

- **Prescription Drugs – Generic:** A drug that is bioequivalent to a brand name drug, but the patent has expired and drug companies can mass produce them. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. Every brand-name drug does not have a generic drug. When new drugs are first made they have drug patents. Most drug patents are protected for 17 years. The patent, which protects the company that made the drug first, doesn't allow anyone else to make and sell the drug. When the patent expires, other drug companies can start selling a generic version of the drug. But, first, they must test the drug and the FDA must approve it.

  Creating a drug costs lots of money. Since generic drug makers do not develop a drug from scratch, the costs to bring the drug to market are less; therefore, generic drugs are usually less expensive than brand-name drugs. But, generic drug makers must show that their product performs in the same way as the brand-name drug.

  All generic drugs are approved by FDA.

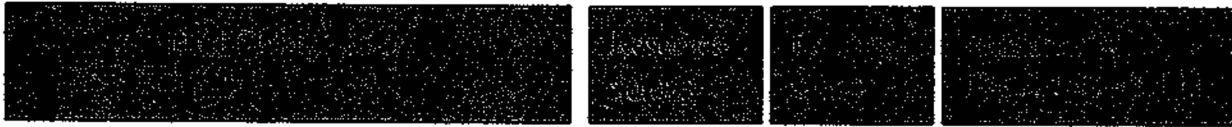
- **Prescription Drug – Formulary** – a list of prescription medications that will be covered by a plan or insurance contract that often foster substitution of generic or therapeutic equivalents on a cost-effective basis. Drug formulary lists are developed by the insurance company.

- **Prescription Drug – Non-Formulary** - name brand drugs that are not included in the health plans formulary list.

**Costing Benefit Plan Designs to Meet Budget Limits**

Under a fully insured arrangement the carrier charges premiums to covers four major expense categories: Paid claims, reserves, pooling charges (stop loss), and retention (administrative expenses and profit). The full premium is sent to the carrier each month and they internally distribute the appropriate monies to each of the expense areas. *The carrier has 100% liability for the payment of the plan benefits as long as the County pays the premium.*

The example below shows the distribution of each $1.00 of group insurance paid. As you can see, claims make up the vast majority of the premium paid.



- **Paid Claims** - Represents the benefit dollars reimbursed under the plan to pay providers of services for covered expenses.

- **Reserves** - Reserves, sometimes called "incurred but not reported reserves" (IBNR), represent the liability a carrier has at any one point in time for claims that have been incurred as a liability under the plan but have yet to be paid. It can take anywhere from 2 weeks to 5 months for a covered medical expense to go from an event (i.e., hospitalization, office visit, etc.) to a paid claim, and the contract allow providers a full 12 months to submit a claim. Typically, reserves come into play at the cancellation of the contract for expenses incurred prior to the cancellation date that will be paid by the cancelled carrier several weeks or months afterwards.

  In a mature group (a group witb several years with the same carrier – e.g., Providence), the annual increase to reserves is generally about 3% of total claims paid. In a first-year group (e.g., when the relationship with the employer and the carrier is new), a reserve must be built very quickly from $0, so reserves with a new carrier are usually about 15% of annual premium or 25-35% of total claims paid. This represents a very large plan expense in Year 1 of the relationship between the carrier and the employer.

- **Pooling or Stop Loss** - This part of the group insurance dollar is earmarked for the cost of providing specific stop loss coverage (extra insurance) for large claims in excess of a predetermined dollar amount. For example, a pooling point might be $150,000. What this means is that once a member's Medical claims for the year exceed $150,000 (cumulative, not just per specific condition), the charges for it come from another, secondary insurance and do not count in the County's experience rating.

- **Retention** - This is the portion of the rate that covers the administrative expenses, regulatory charges (e.g., Oregon premium tax, OMIP assessment) and profit (if any) for a carrier.

- **Utilization** – This is the use members make of the insurance plans. Every time you make use of your County medical or dental plan, it becomes part of utilization. The more use, the higher the utilization.

- **Experience Rating** – a method used by insurance companies to establish insurance premiums based on the expected benefits paid out as a result of individual health risk factors.

- **Community Rating** – a method traditionally used by HMO type plans (Kaiser) to establish insurance premiums based on the average benefits paid out for the total population serviced. In this case, premiums reflect the average health risk factors for the entire population. Kaiser has recently started using more Experience Rating for large groups.

- **Health Care Cost Trend –** An assumption about the annual rate of change in the cost of health care benefits due to factors other than changes in the composition of the plan population by age and dependency status, for each year from the measurement date until the end of the period in which benefits are expected to be paid. Considers estimated health care inflation, changes in utilization and delivery patterns, advances in technology and changes in health status of plan participants. Different health care services may have different trend rates.

- **Adverse Selection –** Certain plan designs and/or funding strategies can lead to "adverse selection" which basically means the higher utilizing members have a disproportionate benefit. Adverse selection impacts pricing because plan utilization ends up greater than projected.

- **Premiums –** Each month the County pays a specific amount for each enrolled employee's medical and dental insurance. For medical insurances, the premiums vary between plans and for the number of family members covered. The premiums pay the insurance companies to cover the care you receive.

**The Renewal Process -**

Each year the carrier estimates the requirements in each of the expense areas and builds the rate they think they will need to fund the projected liability for the contract year. Current claims are trended by the projected amount of medical inflation plus a "margin for error." Reserves are adjusted for enrollment, utilization and trend. Pooling charges and retention needs are calculated based on actual and projected costs.

- **Per Employee Per Month (PEPM)** – This is an average monthly premium amount which accounts for all the medical and dental insurance plans at all the family levels and is based upon the number of employees enrolled in each plan at each level.

- **Composite Rate –** a rate derived from the blend of cost for single, two party, and family members times rate divided by the total number of members (not family members) that are covered.