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The Broker's Bridge to Success!

Q & A for Group Insurance

Q: What is Group Health Insurance?

A: Group health insurance plan is a key component of many employee benefits packages that employers provide for employees. Most Americans have group health insurance coverage through their employer or the employer of a family member. There are two categories – Fully Insured and Level Funded (Also referred to as Partially Self-Funded or ERISA based plans)

Q: What is Fully Insured?

A: A fully insured health plan is the more traditional way to structure an employer-sponsored health plan. With a fully insured health plan:

- The company pays a premium to the insurance carrier.
- The premium rates are fixed for a year, based on the number of employees enrolled in the plan each month.
- The monthly premium only changes during the year if the number of enrolled employees in the plan changes.
- The insurance carrier collects the premiums and pays the health care claims based on the coverage benefits outlined in the policy purchased.
- The covered persons (employees and dependents) are responsible to pay any deductible amounts or co-payments required for covered services under the policy.

Q: What is Level Funded?

A: With a self-insured (self-funded) health plan, employers operate their own health plan as opposed to purchasing a fully insured plan from an insurance carrier. Employers choose to self-insure because it allows them to save the profit margin that an insurance company adds to its premium for a fully insured plan. However, self-insuring exposes the company to much larger risk if more claims than expected must be paid. With a self-funded health plan:

- There are two main costs to consider: fixed costs and variable costs.
- The fixed costs include administrative fees, any stop-loss premiums, and any other set fees charged per employee. These costs are billed monthly by the TPA or carrier and are charged based on plan enrollment.
- The variable costs include payment of health care claims. These costs vary from month to month based on health care use by covered persons (employees and dependents).
- To limit risk, some employers use stop-loss or excess-loss insurance which reimburses the employer for claims that exceed a predetermined level. This coverage can be purchased to cover catastrophic claims on one covered person (specific coverage) or to cover claims that significantly exceed the expected level for the group of covered persons (aggregate coverage).