TIPS TO HELP YOU UNDERSTAND AND APPEAL HEALTH PLAN DECISIONS WHEN THE COVERAGE IS SELF-INSURED

If your coverage for health care is provided through your employer, it is very important to know whether the coverage is self-insured or fully-insured. The following terms help to explain self-insured coverage.

KEY TERMS YOU SHOULD KNOW

Managed Care Health Insurance plan (MCHIP) – a health carrier, such as a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO) that designs arrangements to provide covered services in an efficient and cost-effective manner, to help control the cost of your coverage.

Group Health Insurance – health insurance provided by an employer to employees and in some cases family members, and paid for by the employer, the employees, or both; coverage may be through an MCHIP or other type of health insurance.

Fully-insured (Fully-funded) – group health insurance where an employer pays a premium to an MCHIP or other insurer and in return, the MCHIP or insurer assumes the financial risk of paying claims. There is an insurance contract between the employer and the MCHIP or other insurer.

Self-insured (Self-funded) – group coverage where the employer acts as its own insurer, and uses an MCHIP, "insurer", or administrator to administer the plan: establish a provider network, process claim payments, and conduct other tasks necessary to run the plan. There is no insurance contract between the employer and the administrator because the employer bears the risk for payment of claims.

ERISA – Employee Retirement Income Security Act that Congress passed in 1974 that provides exclusive federal jurisdiction over single employer benefit plans, including self-insured plans. State insurance laws, however, are not pre-empted for fully-insured plans.

DOL – U.S. Department of Labor, part of the federal government and responsible for ensuring employers comply with ERISA.

If you are unsure whether your coverage is self-funded or fully insured, check with your plan's Benefits Administrator or Plan Administrator, or your employer's Human Resource office. You may also find clues in documents provided by the plan if any language states the plan is only acting as an administrator or providing "administrative services only" to the employer.

Large companies frequently self-insure for a variety of reasons, including consideration of the costs involved. Some large companies offer both self-insured and fully-insured coverage, so be sure to check for your specific coverage.

If you have a dispute with a self-insured plan, you may exercise appeal options offered by the plan. Check your Summary Plan Description (SPD) for a description of your appeal rights. You can also seek assistance from your employer or by contacting the Plan Administrator or Benefit Administrator.

The Bureau of Insurance regulates insurance companies; not employers. Since there is no insurance contract between the employer and administrator in a self-insured plan, the Bureau of Insurance does not have regulatory authority over these arrangements. Along with exemption from regulatory jurisdiction by the Bureau of Insurance, self-insured plans are exempt from Virginia insurance laws, including those specific to mandated benefits, appeals, and consumer rights. However, your plan may be subject to provisions of the Affordable Care Act and certain other federal laws. Beginning in July 2011, you may be eligible to request an external review of certain adverse decisions you receive.

ERISA gives the federal government exclusive regulatory jurisdiction over self-insured plans. To contact the DOL for assistance, call toll-free 866-444-EBSA (3272) or visit www.dol.gov/ebsa . If you live in Virginia, the EBSA office nearest you is:

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