Members Brief

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Author: Yosef Schiff, Attorney
Reviewer: Michael J. O'Neill, Division Chief

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Types of Health Insurers

Members of the General Assembly periodically have questions about which types of health insurers and insurance plans a particular law or bill governs, and what the differences are between them. This brief is intended to clarify these issues. It describes each type of insurer and plan. It then discusses the broad terms "health plan issuer" and "health benefit plan," which the law uses to refer to most types of insurers and plans collectively. It ends with a brief discussion of what is commonly meant when referring to the individual, small group, and large group markets.

Approximately half of all people with health insurance are covered by self-funded ERISA plans, which are subject solely to federal regulation. Therefore, if Ohio enacts a law governing health plans, such as a new mandated benefit or cost-sharing regulations, that law likely cannot apply to a large number of plans.

Contents

Types of insurers and plans

In general, there are six types of health insurers and health insurance plans:

1. Health insuring corporations (HICs);
2. Sickness and accident insurers;
3. Public employee benefit plans;
4. Fraternal benefit societies;

5. Multiple employer welfare arrangements (MEWAs); and
6. Self-funded employee benefit plans under the federal Employee Retirement Income Security Act of 1974 (self-funded ERISA plans).[1]

The first five are collectively known as "health plan issuers" and "health benefit plans" when they are providing comprehensive health insurance, and they are subject to both state and federal law (see "**Health plan issuers and health benefit plans**," below). The sixth is not included in these catch-all terms and is subject only to federal law (see "**ERISA plans**," below).

Health insuring corporations

A health insuring corporation (HIC) is a corporation that reimburses or provides health care services through a plan that incentivizes or requires an enrollee to use participating providers. The use of such incentives and requirements is commonly known as "managed care." In some cases, providers are actually employees of the HIC, as in the case of health maintenance organizations (HMOs). An HIC may offer comprehensive health insurance or something more limited in scope such as a supplemental dental plan.[2]

Sickness and accident insurers

A policy of sickness and accident insurance covers a person for loss or expense resulting from sickness or accidental injury. Thus, there are two aspects to this type of coverage: sickness on the one hand and accident on the other. Sickness coverage is what you would normally think of as health insurance, while accident coverage refers to reimbursement for accidental injuries that goes beyond health care services and includes reimbursement for reduced income following an injury. As with plans offered by HICs, not all sickness plans constitute comprehensive coverage. For example, a sickness plan might cover supplemental services or even a specified disease such as cancer.[3]

The primary difference between HICs and sickness and accident insurers is that HICs utilize stricter managed care models. For example, a plan under which an enrollee is *required* to use participating providers or that utilizes an HMO would be offered by an HIC. A plan that merely *incentivizes* (rather that requires) an enrollee to use in-network providers could be offered by either an HIC or a sickness and accident insurer. A plan that does not utilize managed care at all would not be offered by an HIC, but could be offered by a sickness and accident insurer.[4]

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[1] Strictly speaking, a health insurer is an entity to which a person or other entity such as an employer pays a premium in exchange for the insurer assuming the financial risk of reimbursing health care costs. Therefore, a *self-funded* plan (a plan under which an entity such as an employer or group of employers directly covers the health care costs of its employees or members) is not technically an *insurance* plan. However, this Member's Brief will use the terms "insurer" and "insurance" in a broad sense to capture the idea of an entity reimbursing a person for the person's health care costs, including a self-funded plan.

[2] R.C. 1751.01(E), (O), and (S) and 1751.20(E). See also the Ohio Association of Health Plans, *Glossary of Terms* and National Association of Insurance Commissioners, *Glossary of Insurance Terms*.

[3] R.C. 3923.01 and National Association of Insurance Commissioners, *Glossary of Insurance Terms*.

[4] R.C. 1751.01(O).

Public employee benefit plans

Ohio law also contains a number of requirements governing public employee benefit plans. Although not defined in the Revised Code or Administrative Code, a public employee benefit plan appears to be any health plan offered by a public employer, such as the state employee health plan. The state employee plan is a type of self-funded plan, or a plan in which the employer reimburses health care costs directly rather than through an insurer, although an insurer may be involved in processing and administering benefits.[5]

Fraternal benefit societies

A fraternal benefit society is an organization formed to provide some kind of benefit for its members. A common example is a local Elks Lodge. These groups offer benefit contracts to their members, which can include health benefits. Benefits contracts offered by fraternal benefit societies do not appear to fill a large portion of the health plan market.[6]

ERISA plans

Multiple employer welfare arrangements

Another type of plan is a "multiple employer welfare arrangement" (MEWA). An MEWA is an arrangement established to provide health, sickness, accident, or other similar benefits to the employees of a group of employers. As discussed below, these arrangements are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA). An MEWA can be either fully insured or self-funded. If the MEWA is fully insured, the employers pay a premium to an insurer which provides the benefits. That insurer would be a separate entity, such as an HIC or a sickness and accident insurer. If the MEWA is self-funded, it is exempt from certain provisions of federal law that otherwise apply to self-funded plans under ERISA (see "**Different rules apply to different types of ERISA plans**," below).[7]

Other ERISA plans

The last major type of health plan is a self-funded employee benefit plan under ERISA (a self-funded ERISA plan). Like a self-funded MEWA, this is a type of employer sponsored plan that is funded by the employer rather than fully insured. The difference is that an MEWA involves multiple employers pooling their resources, while a self-funded ERISA plan is a self-funded plan offered by a single private nongovernmental employer. Self-funded ERISA plans are often offered by large employers. And as discussed below, these plans comprise a large portion of the health insurance market and are generally not subject to state regulation.[8]

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[5] R.C. Chapter 3923.

[6] R.C. Chapter 3921.

[7] R.C. 1739.01(F).

[8] Employee Retirement Income Security Act of 1974 (ERISA), 29 United States Code (U.S.C.) 1001, *et seq*. ERISA governs employer-sponsored health insurance, whether fully insured or self-funded. Under ERISA, the formal name for an employer sponsored health plan is "employee welfare benefit plan."

Different rules apply to different types of ERISA plans

ERISA governs both fully insured and self-funded employee benefit plans. An employee benefit plan is a plan established by an employer for the purpose of providing benefits such as health, disability, death, pension, or other benefits. This brief only discusses the plans in the context of health benefits, which are more commonly known as "employer sponsored health plans." Congress enacted ERISA with the stated goal of enacting minimum standards and ensuring uniform regulation of the plans.[9]

One of the most important provisions of ERISA is the so-called "preemption clause," under which a state's ability to regulate ERISA plans is limited. Under the preemption clause, a state may not *directly* regulate any ERISA plan other than a self-funded MEWA. In practice, this means that a state generally may not regulate self-funded ERISA plans at all, but may regulate fully insured ones indirectly by regulating the health insurance plans offered by employers. Put another way, regulations targeting *employers* are generally preempted, but regulations targeting *insurers* are not. So, if a state law requires an *employer* to offer coverage for services relating to a specified disorder, that law is likely preempted. But a state law requiring an *insurer in the group market* to offer the same benefits is generally allowable. Approximately half of all people with health insurance are covered by self-funded ERISA plans, and their plans are therefore not subject to state law.[10]

Type of ERISA Plan	Subject to State or Federal Regulation?
Fully insured ERISA plans	Federal; state insofar as regulation governs insurers and not employers
Self-funded ERISA plans (other than self-funded MEWAs)	Federal only
Self-funded MEWAs	Federal and state

At a glance

The following table summarizes the most important aspects of the preceding information.

Type of Insurer or Plan	Key Attributes
Health insuring corporation (HIC)	Corporation; more managed care
Sickness and accident insurer	Any business entity; less or no managed care

[9] 29 U.S.C. 1001 and 1002.

[10] 29 U.S.C. 1144(a) and 1144(b)(6); U.S. Department of Labor, *Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation*, pg. 27-28; and National Academy for State Health Policy, "ERISA Preemption Primer," pg. 3.

Type of Insurer or Plan	Key Attributes
Public employee benefit plan	Plan offered by a public employer to its employees; could be fully insured or self-funded[11]
Fraternal benefit society	Organization that provides benefits for its members, such as an Elks Lodge; could be fully insured or self-funded
ERISA plan: MEWA	An arrangement by a group of employers to reimburse employees for health care; could be fully insured or self-funded
ERISA plan: non-MEWA	A plan by a private employer to reimburse employees for health care; could be fully insured or self-funded[12]

Health plan issuers and health benefit plans

All insurers and plans identified in this brief except for self-funded non-MEWA ERISA plans are collectively known as "health plan issuers" and "health benefit plans," but only when they are providing comprehensive health insurance as opposed to something more limited in scope such as supplemental insurance. A health insurance law may be drafted as regulating health plan issuers and health benefit plans when the intent is to regulate all types of insurers and plans. For example, Ohio's Prompt Pay Law requires *health plan issuers* to reimburse providers within certain time periods depending on the nature of the claim. Alternatively, a law may be drafted to only apply to some or even a single type of insurer, such as the requirement that a MEWA maintain a minimum surplus of at least $500,000 for the protection of the members and their employees.[13]

Ohio law defines a "health plan issuer" as an insurer that reimburses the costs of health care services under a health benefit plan, including an HIC, a sickness and accident insurer, a nonfederal, government health plan (which appears to mean a public employee benefit plan), a fraternal benefit society, and a self-funded MEWA. "Health plan issuer" also includes a third-party administrator, which is a company that adjusts or settles claims in connection with an insurance plan. A pharmacy benefit manager is one type of third-party administrator.[14]

[11] If fully insured, the plan would be offered by an HIC or sickness and accident insurer. If self-funded, the risk associated with paying benefits would fall on the sponsor, although an HIC or sickness and accident insurer might be involved in administering the plan as a third-party administrator.

[12] If self-funded, a non-MEWA ERISA plan is not subject to state regulation at all, while a fully insured one is indirectly subject to state regulation insofar as a regulation governs an insurer offering a plan in the group market.

[13] R.C. Chapter 3922 and R.C. 1739.13.

[14] R.C. 3922.01(P).

A "health benefit plan" is coverage offered by a health plan issuer to reimburse the costs of health care services. Coverage under Medicare and Medicaid are explicitly excluded from this definition. The term also includes limited benefit plans, except for accident-only plans, supplemental dental and vision plans, specified disease plans, long-term care plans, etc. The list of exclusions is quite long, raising the question of what kind of limited benefit plan actually qualifies as a health benefit plan. Although there is no comprehensive list of such plans, one example is a short-term, limited-duration plan, which is a plan that lasts less than one year. An individual might purchase such a plan if that person is temporarily not working. Therefore, a health benefit plan is any plan (excluding Medicare, Medicaid, and self-funded ERISA plans) you would normally think of as providing comprehensive health coverage.[15]

Because these two terms only apply in the context of comprehensive coverage, a supplemental dental plan offered by an HIC, a specified disease plan offered by a sickness and accident insurer, or other similarly limited plan is not a health benefit plan and is therefore not subject to any regulations that apply only to health benefit plans. For example, while a health benefit plan must cover telemedicine services on the same basis and to the same extent as in-person services, a supplemental dental plan is *not* required to do so.[16]

Individual, small group, and large group plans

A plan may be offered in the individual, small group (50 or fewer employees), or large group (more than 50 employees) market. Different state and federal requirements apply to plans offered in these different markets. For example, Ohio law regarding the continuation of group sickness and accident coverage following termination of employment by definition does not apply to individual plans. And under the federal Affordable Care Act, individual and small group plans are prohibited from imposing annual or lifetime limits on benefits, while large group plans are generally exempt from this prohibition.[17]

[15] R.C. 3922.01(L) and Ohio Department of Insurance Bulletin 2018-05, Short-Term, Limited-Duration Health Insurance.

[16] R.C. 3902.30.

[17] R.C. 3923.38 and 42 U.S.C. 300gg and 29 U.S.C. 1185d. There is no definition of "small group" or "large group" in Ohio law. However, the federal Affordable Care Act defines "large group" to be any group larger than 50. See 26 U.S.C. 4980H(c)(2)(A) and Healthcare.gov, *Large Group Health Plan*.