Medical Expense Insurance

This chapter will teach you about the different types of medical plans available in today's market. As you read this section, focus on what the different types of coverage offer to policyholders and compare them in terms of advantages and disadvantages. As you are studying the material, ask yourself these questions, "If I were shopping for insurance, which type would I buy and why? If I were in a different state of health, how would that choice change?" Based on factors like financial, vocational, and health status, one person may find a given type of health insurance more desirable than another. There is a great deal of essential information to absorb in this chapter. Read it thoroughly and relate the material to real-life situations as often as possible.

TERMS TO KNOW

Appeal — a request for a higher authority to review the decision
Blanket policy — covers members of a particular group when they are participating in a particular activity, without naming individual insureds (such as students, passengers, sports teams)
Capitation — a payment arrangement that pays a physician or group of physicians a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care
Gatekeeper — a primary care physician (PCP) in an HMO plan
Indemnity plan — pays health policy benefits to the insured based on a predetermined, fixed rate, regardless of the actual expense incurred
Nonrenewal — policy termination at its expiration date
Out-of-pocket expenses — amounts an insured must pay for coinsurance and deductibles before the insurer will pay its portion
Reimbursement — the act of repaying a party who has spent or lost money
Stop-loss — the amount that the insured pays out of pocket during the year
Subscriber — a person who signs up for a prepaid health plan, such as an HMO

A. Types Of Plans

1. Basic

Basic hospital, surgical and medical policies, and major medical policies are commonly grouped into what are referred to as **Medical Expense Insurance**. They provide benefits for the cost of medical care that results from accidents or sickness.

The three basic coverages (hospital, surgical and medical) may be purchased separately or together as a package. These types of coverage are often referred to as *first-dollar* coverage because they usually do not require the insured to pay a deductible. This differs from **Major Medical Expense** insurance. However, the basic medical coverages usually have more limited coverage than the Major Medical Policies.

Major Medical Expense insurance functions through reimbursement. The insurance company reimburses the medical service provider for any amount due.

Basic Hospital Expense Coverage

Basic hospital expense coverage: Hospital expense policies cover hospital room and board, and miscellaneous hospital expenses, such as lab and x-ray charges, medicines, use of operating room and supplies, while the insured is confined in a hospital. There is no deductible and the limits on **room and board** are set at a specified dollar amount per day up to a maximum number of days. These limits may not provide for the full amount of hospital room and board charges incurred by the insured. *For example*, if the hospital expense benefit was $500 per day, and the hospital actually charged $650 per day, the insured would be responsible for the additional $150 per day.

Know This! There are no deductibles for basic hospital expense coverage.

Miscellaneous Hospital Expenses

The **miscellaneous hospital expenses** normally have a separate limit. This amount, which pays for other miscellaneous expenses associated with a hospital stay, can be expressed either as a multiple of the room and board charge (such as 10 times the room and board charge) or as a flat amount. In addition, the policy may specify a maximum limit for certain types of expenses, such as $100 for drugs or $150 for use of the operating room. As with the room and board charges, the hospital miscellaneous expense limits may not pay for the full amount needed by the insured in the event of a lengthy hospital stay.

Basic Medical Expense Coverage

Basic medical expense coverage is often referred to as *Basic Physicians' Nonsurgical Expense Coverage* because it provides coverage for nonsurgical services a physician provides. However, the benefits are usually limited to visits to patients confined in the hospital. Some policies will also pay for office visits. There is no deductible with benefits, but coverage is usually limited to a specific number of visits per day, a limit per visit, or a limit per hospital stay.

In addition to nonsurgical physician's expenses, basic medical expense coverage can be purchased to cover emergency accident benefits, maternity benefits, mental and nervous disorders, hospice care, home health care, outpatient care, and nurses' expenses. Regardless of what type of plan or coverage is purchased, these policies usually offer only limited benefits that are subject to time limitations. The insured is often required to pay a considerable sum of money in addition to the benefits paid by the medical expense policies.

Basic Surgical Expense Coverage

Basic surgical expense coverage: This coverage is commonly written in conjunction with Hospital Expense policies. These policies pay for the costs of surgeons' services, whether the surgery is performed in or out of the hospital. Coverage includes surgeons' fees, anesthesiologist, and the operating room when it is not covered as a miscellaneous medical item. As with the other types of basic medical expense coverage, there is no deductible, but coverage is limited. Each

contract has a **surgical schedule** that lists the types of operations covered and their assigned dollar amounts. If the operation is not listed, the contract may pay for a comparable operation. Special schedules may express the amount payable as a percentage of the maximum benefit, list a specified amount, or assign a relative value that when multiplied by its conversion factor gives the benefit payable.

2. Comprehensive Major Medical

A **comprehensive major medical plan** is a combination of basic expense coverage and major medical coverage, sold as one policy. They cover practically all medical expenses, hospital, physicians, surgical, nursing, drugs, laboratory tests, etc. Comprehensive major medical policies include a deductible (usually a single deductible per person and per family, but corridor deductible may also apply) and coinsurance, and are generally sold on a group basis.

3. Supplemental Major Medical

Supplementary Major Medical Policies are used to supplement the coverage payable under a basic medical expense policy. After the basic policy pays, the supplemental major medical will provide coverage for expenses that were not covered by the basic policy, and expenses that exceed the maximum. If the time limitation is used up in the basic policy, the supplemental coverage will provide coverage thereafter.

B. Managed Care Plans

Educational Objective:

III.A.1. Be able to identify the following:

a. Main types of Managed Care plans — HMO, PPO, POS, EPO
b. Self-funded/self-insured plans
c. Consumer Driven Health Plans (CDHPs) — FSA, HRA, HSA

1. HMO

General Characteristics

The HMO provides benefits in the form of **services** rather than in the form of reimbursement for the services of the physician or hospital. Traditionally, the insurance companies provide the financing, while the doctors and hospitals have provided the care. The HMO concept is unique in that the HMO provides both the financing and patient care for its members.

Combined Health Care Delivery and Financing

Traditionally the insurance companies have provided the financing while the doctors and hospitals have provided the care. The HMO concept is unique in that the HMO provides both the financing and the patient care for its members.

Limited Service Area

The HMO offers services to those living within specific geographic boundaries, such as county lines or city limits. If individuals live within the boundaries, they are eligible to belong to the HMO, but if they do not live within the boundaries, they are ineligible.

Limited Choice of Providers

The HMO tries to limit costs by only providing care from physicians that meet their standards and are willing to provide care at a prenegotiated price.

Copayments

A copayment is a specific part of the cost of care or a flat dollar amount that must be paid by the member. *For example,* the member may be required to pay $5, $10 or $25 for each office visit.

There is usually no deductible required under HMO plans.

Prepaid Basis

HMOs operate on a *capitated* basis: the HMO receives a flat amount each month attributed to each member, whether the member sees a physician or not. In essence, it is a prepaid medical plan. As a member of the plan, you will receive all services necessary from the member physicians and hospitals.

Preventive Care Services

The main goal of the HMO Act was to reduce the cost of health care by utilizing **preventive care**. While most insurance plans offered no benefits for preventive care prior to 1973, HMOs offer free annual check-ups for the entire family. In this way, the HMOs hope to catch diseases in the earliest stages, when treatment has the greatest chance for success. The HMOs also offer free or low-cost immunizations to members in an effort to prevent certain diseases.

Know This! The main focus for an HMO is preventive care.

Primary Care Physician

When an individual becomes a member of the HMO, they will choose their **primary care physician (PCP)** or **gatekeeper.** Once chosen, the primary care physician or HMO will be regularly compensated for being responsible for the care of that member, whether care is provided or not. It should be in the primary care physician's best interest to keep this member healthy to prevent future time for treatment of disease.

Referral Physician

In order for the member to get to see a specialist, the primary care physician (gatekeeper) must refer the member. The referral system keeps the member away from higher priced specialists unless it is truly necessary. In many HMOs, there is a financial cost to the primary care physician for referring a patient to the more

expensive specialist, thus the primary care physician may be inclined to use an alternative treatment before approving a referral. HMOs must have mechanisms to handle complaints which sometimes result in a delay of referral, or complaints about other patient care or coverage concerns.

Know This! In an HMO, a gatekeeper helps control the cost of healthcare by only making the necessary referrals.

Hospital Services and Emergency Care

The HMO provides the member with inpatient hospital care, in or out of the service area. The services may be limited for treatment of mental, emotional or nervous disorders, including alcohol or drug rehabilitation or treatment.

Emergency care must be provided for the member in or out of the HMO's service area. If emergency care is being provided for a member outside the service area, the HMO will make an effort to get the member back into the service area so that care can be provided by salaried member physicians.

Other Basic Services

HMOs must have mechanisms to handle complaints about patient care or about coverage concerns.

Open Panel or Closed Panel

When a medical caregiver contracts with a health organization to provide services to its members or subscribers, but retains the right to treat patients who are not members or subscribers, it is referred to as **open panel.** In an open panel arrangement, the doctors are not considered to be employees of the health organization.

When the medical caregiver provides services to only members or subscribers of a health organization, and contractually is not allowed to treat other patients, it is referred to as **closed panel.** In a closed panel arrangement, the doctors are considered employees of the health organization.

2. PPO

General Characteristics

A **PPO** is a group of physicians and hospitals that contract with employers, insurers, or third party organizations to provide medical care services at a reduced fee. The PPOs differ from the HMOs in two ways. First, they do not provide care on a prepaid basis, but physicians are paid a *fee for service*. Secondly, subscribers are not required to use physicians or facilities that have contracts with the PPO.

Know This! Unlike HMOs, PPOs allow more flexibility between in-network and out-network providers, in exchange for a higher premium.

Types of Parties to the Provider Contract

Any physician or hospital that qualifies and agrees to follow the PPO’s standards and charge the appropriate fees that the PPO has established can be added to the

PPO's approved list at any time. Physicians and providers may belong to several PPO groups simultaneously.

Primary Care Physician Referral

In a PPO, the insured does not have to select a primary care physician. The insured may choose medical providers not found on the preferred list and still retain coverage. The insured is allowed to receive care from any provider, but if the insured selects a PPO provider, the insured will pay lower out-of-pocket costs. If an out-of-network provider is used, the insured's out-of-pocket costs will be higher. In a PPO, all network providers are considered "preferred," and insureds can visit any of them, even specialists, without first seeing a primary care physician. Certain services may require plan pre-certification, an evaluation of the medical necessity of inpatient admissions and the number of days required to treat a physical condition.

Know This! In-network provider = lower out-of-pocket costs; out-of-network provider = higher out-of-pocket costs.

3. POS

The **Point-Of-Service (POS)** plan is merely a combination of HMO and PPO plans.

With the Point-Of-Service plan the employees do not have to be locked into one plan or make a choice between the two plans. A different choice can be made every time a need arises for medical services.

PPO plans, like HMOs, enter into contractual arrangements with health care providers who form a provider network. However, plan members do not have to use only in-network providers for their care.

Similarly, in a **POS plan** the individuals can visit an in-network provider at their discretion. If they decide to use an out-of-network physician, they may do so. However, the member copays, coinsurance and deductibles may be substantially higher.

In POS plans, participants usually have access to a provider network that is controlled by a primary care physician ("gatekeeping"). Plan members, however, have an option to seek care outside the network, but at reduced coverage levels. POS plans are also referred to as "open-ended HMOs."

If a non-member physician is utilized under the Point-Of-Service plan, then the attending physician will be paid a fee for service, but the member patient will have to pay a higher coinsurance amount or percentage for the privilege.

The Point-Of-Service (POS) plan combines "gatekeeping" arrangements with the ability to self-refer at increased out-of-pocket costs. A patient can obtain a higher level of benefits at a lower cost when care is provided by or arranged through the primary care physician (PCP). Benefits for covered services when self-referring (without having your primary care physician arrange for the service) are generally more expensive.

4. EPO

An **Exclusive Provider Organization (EPO)** is a type of preferred provider organization in which individual members use particular preferred providers rather than having a choice of a variety of preferred providers. An EPO is characterized by a primary physician who monitors care and makes referrals to a network of providers.

C. Self-Funded/Self-Insured Plans

An alternative method of protecting against risk of loss without transferring the risk to an insurance company or other entity is referred to as self-insurance. A self-insurer, instead of purchasing insurance, establishes its own reserves to cover potential losses. This can be an effective tool for those risks where losses are quite predictable. Most self-insurers, however, only insure for losses to a certain amount level and purchase stop-loss insurance that will provide insurance for losses above a certain maximum level.

Self-insured Association health plans are **prohibited by the CIC**.

D. Consumer Driven Health Plans

1. Medical Savings Accounts (MSAs)

A **Medical Savings Account (MSA)** is an employer-funded account linked to a high-deductible medical insurance plan. The employer raises the medical plan deductible and returns all or part of the premium savings to the employees to contribute to the MSA. The employee then uses the funds from the MSA to cover health insurance deductibles during the year. If there is a balance at the end of the year, the employee may leave in the account and earn interest or withdraw the remaining amount (as taxable income). If a distribution is made for a reason other than to pay for qualified medical expenses, the amount withdrawn will be subject to an income tax and an additional 20% tax.

Medical savings accounts are only available to small employers (with 50 or fewer employees) or a self-employed person. Generally, participants in the plan cannot have Medicare or any other health coverage that is not a high deductible health plan (HDHP). The following additional coverages are permitted:

- Workers compensation;
- Specific disease or illness;
- A fixed amount per day of hospitalization;
- Accidents and/or disability;
- Dental care;
- Vision care; and
- Long-term care.

Contributions to an MSA must be made in cash or its equivalent. There are 2 limits on the amount the employee and employer can contribute to an MSA: the annual deductible limit, and an income limit. Under the **annual deductible limit** rule, the maximum amount that can be contributed to an MSA is 65% of the high-deductible plan for individuals or 75% of the family deductible for those with

family coverage. Under the **income limit** rule, a person cannot contribute more than what was earned for the year from the employer through whom the person has an HDHP.

MSAs were created for the ease of use, as they are a cross between a self-funded plan and a traditional Medical Expense Contract. Also, if there is a balance at the end of the year, the employee may let it remain and earn interest, or withdraw the amount as taxable income.

2. Flexible Spending Accounts (FSAs)

A **Flexible Spending Account** (FSA) is a form of cafeteria plan benefit funded by salary reduction and employer contributions. The employees are allowed to deposit a certain amount of their paycheck into an account before paying income taxes. Then, during the year, the employee can be directly reimbursed from this account for eligible health care and dependent care expenses. FSA benefits are subject to annual maximum and "use-or-lose" rule. This plan does not provide a cumulative benefit beyond the plan year.

There are 2 types of Flexible Spending Accounts: a Health Care Account for out-of-pocket health care expenses, and a Dependent Care Account (subject to annual contribution limits) to help pay for dependent's care expenses which makes it possible for an employee and their spouse to continue to work.

An FSA is exempt from federal income taxes, Social Security (FICA) taxes and, in most cases, state income taxes, saving 1/3 or more in taxes. If the plan favors highly compensated employees, the benefits for the highly compensated employees are not exempt from federal income taxes.

Know This! FSAs may be used to pay medical and dental expenses for employees and their dependents.

Child and dependent care expenses must be for the care of one or more qualifying persons:

- A dependent who was under age 13 when the care was provided and who can be claimed as an exemption on the employee's Federal Income Tax return;
- A spouse who was physically or mentally not able to care for himself or herself; or
- A dependent who was physically or mentally not able to care for himself or herself and who can be claimed as an exemption (as long as the person is earning gross income less than an IRS-specified amount).

Persons who cannot dress, clean, or feed themselves because of physical or mental problems are considered not able to care for themselves. Also, persons who must have constant attention to prevent them from injuring themselves or others are considered not able to care for themselves.

The insured may change benefits during open enrollment. After that period, generally, no other changes can be made during the plan year. However, the insured might be able to make a change under one of the following circumstances, referred to as *qualified life event* changes:

1. Marital status;
2. Number of dependents;

3. One of dependents becomes eligible for or no longer satisfies the coverage requirements under the Medical Reimbursement plan for unmarried dependents due to attained age, student status, or any similar circumstances;
4. The insured, the insured's spouse's or qualified dependent's employment status that affects eligibility under the plan (at least a 31-day break in employment status to qualify as a change in status);
5. Change in dependent care provider; or
6. Family medical leave.

The IRS limits the annual contribution for Dependent Care Accounts to a specified amount that gets adjusted annually for cost of living. This is a family limit, meaning that even if both parents have access to flexible care accounts, their combined contributions cannot exceed the amount.

3. Health Reimbursement Accounts (HRAs)

Health Reimbursement Accounts (HRAs) consist of funds set aside by employers to reimburse employees for qualified medical expenses, such as deductibles or coinsurance amounts. Employers qualify for preferential tax treatment of funds placed in an HRA in the same way that they qualify for tax advantages by funding an insurance plan. Employers can deduct the cost of a health reimbursement account as a business expense.

The following are key characteristics of HRAs:

- They are contribution healthcare plans, not defined benefit plans;
- Not a taxable employee benefit;
- Employers' contributions are tax deductible;
- Employees can roll over unused balances at the end of the year;
- Employers do not need to advance claims payments to employees or healthcare providers during the early months of the plan year;
- Provided with employer dollars, not employee salary reductions;
- Permit the employer to reduce health plan costs by coupling the HRA with a high-deductible (and usually lower-cost) health plan; and
- Balance the group purchasing power of larger employers and smaller employers.

HRAs are open to employees of companies of all sizes; however, the employer determines eligibility and contribution limits.

An HRA has no statutory limit. Limits may be set by employer, and rollover at the end of the year based on employer discretion. Former employees, including retirees, can have continued access to unused HRAs, but this is done at the employer's discretion. HRAs remain with the originating employer and do not follow an employee to new employment.

Know This! HRAs allow employees to roll over unused benefits to the following calendar year, in addition to new benefits.

4. High Deductible Health Plans (HDHPs) and Health Savings Accounts (HSAs)

High-deductible health plans (HDHPs) are often used in coordination with Medical Savings Accounts (MSAs), Health Savings Accounts (HSAs), or Health Reimbursement Accounts (HRAs). The high-deductible health plan features higher annual deductibles and out-of-pocket limits than traditional health plans, which means lower premiums. Except for preventive care, the annual deductible must be

met before the plan will pay benefits. Preventive care services are usually first dollar coverage or paid after copayment. The HDHP credits a portion of the health plan premium into the coordinating MSA, HSA, or HRA on a monthly basis. The deductible of the HDHP may be paid with funds from the coordinating account plan.

Health savings accounts (HSAs) are designed to help individuals save for qualified health expenses that they, their spouse, or their dependents incur. An individual who is covered by a high deductible health plan can make a tax-deductible contribution to an HSA, and use it to pay for out-of-pocket medical expenses. Contributions by an employer are not included in the individual's taxable income.

To be eligible for a Health Savings Account, an individual must be covered by a high deductible health plan (HDHP), must not be covered by other health insurance (does not apply to specific injury insurance and accident, disability, dental care, vision care, long-term care), must not be eligible for Medicare, and cannot be claimed as a dependent on someone else's tax return.

HSAs are linked to high deductible insurance. A person may obtain coverage under a qualified health insurance plan with established minimum deductibles ($1,500 for singles and $3,000 for families in 2023).

Each year eligible individuals (or their employers) are allowed to save up to certain limits, regardless of their plan's deductible (current contribution limits are $3,850 for singles and $7,750 for families). When opening an account, an individual must be under the age of Medicare eligibility. For taxpayers aged 55 and older, an additional contribution amount is allowed (up to $1,000).

An HSA holder who uses the money for a nonhealth expenditure pays tax on it, plus a 20% penalty. After age 65, a withdrawal used for a nonhealth purpose will be taxed, but not penalized.

Know This! Nonhealth withdrawals before age 65 = 20% penalty;
nonhealth withdrawals after age 65 = no penalty.

HSAs are portable, so an individual is not dependent on a particular employer to enjoy the advantages of having an HSA. Like an individual retirement account (IRA), the HSA is owned by the individual, not the employer. If the individual changes jobs, the HSA goes with the individual.

Some high deductible health insurance policies have what is called an **embedded deductible**. As well as a non-embedded, or aggregate deductible that applies to the whole family covered, an individual deductible (smaller than the aggregate) applies to each covered family member. *For example*, a family can have an aggregate deductible of $2,000 and embedded deductible of $1,000. If one family member exceeds $1,000 in medical expenses, the insurer will cover further medical costs for that individual while other family members' medical expenses apply towards the aggregate deductible.

When a health plan has both the aggregate deductible and embedded deductibles, the annual contribution limit for a HSA is the lesser of

- The maximum annual contribution limit;
- The aggregate deductible; or
- The embedded deductible multiplied by the number of covered family members.

5. Consumer Driven Health Plans (CDHPs)

Consumer Driven Plans (also known as Consumer Driven Health Plans, CDHP, High-deductible plans, or patient directed plans) are health care plans that are controlled by the employer. Basically the employee member receives first-dollar coverage from a designated health account (can be an HRA or HSA) until funds are depleted, then a deductible gap must be met before an insurance plan is available to cover additional cost. While other types of plans restrict certain types of coverage, members of a consumer driven plan may use funds from the plan to pay for costs associated with genetic testing or a special nursery school for a child, for instance, without being denied coverage.

The employer determines eligibility of the employees. There are no national qualifying requirements for consumer driven plans.

The employer determines the contribution, the growth percent and the exit rules. Funds are allowed to rollover from year to year at the discretion of the employer.

E. Optional Coverages

Educational Objective:

III.A.2. Be able to define the optional coverages:

i. Adult dental
ii. Adult vision
iii. Know that limited pediatric dental and vision benefits are mandatory

1. Dental

Usually dental insurance distinguishes among several classes of dental expenses, and provides somewhat different treatment for each.

Routine and preventive maintenance is covered up to an annual maximum without a deductible or copayment. This coverage benefit usually includes routine examinations and teeth cleaning once a year, and perhaps full-mouth X-ray once every 3 years. The absence of a deductible and copayment is intended to encourage preventive maintenance.

Routine and major restorative care includes treatments for cavities, oral surgery, bridges and dentures. These procedures are covered up to a specific maximum, subject to an annual deductible per insured family member and coinsurance.

Orthodontic care, if included, will have a separate maximum and a separate deductible, which may differ from the deductible for restorative care.

Pediatric dental coverage is an essential health benefit under the Affordable Care Act that **must be available** as part of a health plan or as a stand-alone plan for

children 18 or younger. However, insurers do not have to offer adult dental coverage.

Depending on the state, pediatric dental benefits may be offered through one of the following types of plans:

- A qualified health plan that includes dental coverage;
- A stand-alone dental plan purchased in conjunction with a qualified health plan; or
- A contracted/bundled plan.

Know This! Health insurers must offer pediatric dental coverage (for children 18 or younger) as an essential health benefit under a health plan or as a stand-alone dental plan.

2. Vision

Some employers provide this form of group health insurance to their employees to cover eye examinations and eyeglasses, or hearing aids on a limited basis. Know that per the Affordable Care Act, pediatric vision benefits are mandatory.

It is common in most vision expense insurance plans to restrict benefits to one exam and one pair of glasses in any 12-month period.

3. Supplemental Accident

Accidental Death and Dismemberment (AD&D) coverage can be written as a rider or as a separate policy. However, most frequently, it is part of group life and group health plans. It provides for the payment of a lump-sum benefit in the event that the insured dies from an accident, as defined in the policy, or in the event of loss of certain body parts caused by an accident.

Accidental Death and Dismemberment coverage only pays for accidental losses and is thus considered a pure form of accident insurance. The **principal sum** is paid for accidental death. This amount is usually equal the amount of coverage under the insurance contract, or the face amount. In case of loss of sight or accidental dismemberment, a percentage of that principal sum will be paid by the policy, often referred to as the **capital sum**. The amount of the benefit will vary according to the severity of the injury.

The policy will usually pay the full principal for the loss of sight in both eyes, or two or more limbs; however, it may only pay **50%** for the loss of one hand or one foot. In addition, some policies will pay double or triple indemnity, meaning the policy will pay **twice** or **three times** the face amount in the event of accidental death.

Most policies will pay the accidental death benefit as long as the death is caused by the accident and occurs within **90 days**.

Know This! In AD&D policies, the principal sum means the full face amount (100%), and the capital sum is a percentage of the face amount.

F. Contract Issues And Clauses

Educational Objective:

III.A.d. & e. Be able to identify contract issues and provisions *(grace period, elimination periods, right to terminate, coordination of benefits, coinsurance, deductible, copays, maximum out of pocket expense)*; and common exclusions and limitations.

1. Family Deductible

The **family deductible** is written so that any claim filed by a family member within a year applies to the deductible for the entire family. Family deductibles are also usually written with a **common accident provision**. This provision states that if more than one family member is injured in the same accident, only one deductible will apply.

2. Grace Period

The grace period is the period of time after the premium due date in which premiums may still be paid before the policy lapses for nonpayment of the premium. Although the grace period may differ according to individual state laws, in most cases the grace period cannot be shorter than **7 days for weekly premium policies** (industrial policies), **10 days for monthly premium policies**, and **31 days for all other modes**. Coverage will continue in force during the grace period.

Know This! An accident and health insurance policy's grace period is directly tied to the premium payment mode.

3. Waiting Periods

The **waiting period** is the period of time before insurance benefits begin. During the waiting period, the policy is in effect, but insurance company has not started paying benefits for covered events.

4. Elimination Periods

The **elimination period** is the same as the waiting period. Insureds can choose elimination periods of 30, 60, 90, 180, or 365 days. Some policies, however, will begin paying benefits after only a 7 or 14-day elimination period. Longer elimination periods will lower premiums for disability policies. Giving clients a choice of the length of their elimination period allows them to make their own value judgment in regard to balancing premium expense and benefits.

5. Right to Terminate

Individual health and disability policies have a provision in them that gives the insurer the **right to terminate** policies. Right-to-terminate provisions change from policy to policy and affect all insureds covered under a particular type of policy or all insureds in a specific group. These insureds are known as a "class." A **class** of

insureds may be people who live in same geographical location, are the same age, or perhaps perform the same type of work.

6. Take-Over Benefits

Coinsurance & Deductible Carryover

The **carry-over provision** allows an insured who incurs medical expenses during the last 90 days (calendar quarter) of a calendar year to apply the expenses toward the new year's deductible.

No Loss, No Gain

When a health policy is replaced for a client with an ongoing claim, the **no-loss/no-gain** law says that the pre-existing condition provision in the new policy is not allowed to apply. The new policy must automatically take over payment of the claim immediately.

7. First Dollar Coverage

Policies designed around either a **corridor** or **integrated** deductible each provide **first dollar coverage.** With first dollar coverage, up to 100% of covered claims are covered beginning with the first dollar of actual expense incurred by an insured. A **corridor** plan provides basic medical expense coverage of 100% for all covered expenses, but only to a pre-established limit, such as $3500, $5000, $7500, or perhaps as high as $10,000. After the basic benefits are spent, and before the major medical benefits take over, the next $3500-$10,000 of covered expenses are paid by the insured. So first dollar coverage provides coverage to a certain limit, followed by 100% insured expense, followed once again by 100% major medical coverage. Plans using an **integrated** deductible also offer first dollar coverage in that all covered expenses up to a pre-established limit will be shared by the insurer and the insured using an 80-20 (%) coinsurance split, with the stop-loss limit set between $5000 and $25,000. Under this type of plan, an insured will pay $1000-$5000 of the total first dollar claims expenses.

8. Restoration of Benefits

The **restoration of benefits** provision allows an insured to regain his or her full lifetime benefit level over a period of time after a large or catastrophic loss.

9. Exclusions and Limitations

The purpose of policy exclusions is to protect the insurer from claims for losses which were not included in the initial risk assessment. The insurer is entitled to control its risk, and by specifically excluding certain types of intentional, catastrophic, criminal or excess losses, this is possible. The most common types of losses excluded from coverage are those resulting from the following:

- Military service;
- War or acts of war;
- Attempted suicide;
- Intentionally self-inflicted injuries;
- Attempting to commit or committing a felony; and

- Serving as the pilot or crew member of an aircraft. Most insurance policies will cover an insured as a fare-paying passenger on a regularly scheduled airline.

G. Group Health Insurance

Educational Objective:

III.B.1. Know the following characteristics of group medical expense insurance:

a. Eligible groups (CIC 10270.5, 10270.505, 10270.55 and 10270.57)
   i. Small groups (100 employees)
   ii. Large groups (101 + employees)
   iii. Contributory vs. noncontributory participation requirements

1. Eligible Groups

In order to qualify for group coverage, the group must be formed for a purpose other than obtaining group health insurance. In other words, the coverage must be incidental to the group. There are generally 2 types of groups eligible for group insurance: employer-sponsored, and association-sponsored.

With an **employer-sponsored group**, the employer (a partnership, corporation or a sole proprietorship) provides group coverage to its employees. Eligible employees usually must meet certain time of service requirements and work full-time. The same as group life insurance, group health insurance may be either contributory or noncontributory.

An **association group** (alumni or professional) can buy group insurance for its members. The group must have at least 100 members, be organized for a reason other than buying insurance, have been active for at least two years, have a constitution, by-laws, and must hold at least annual meetings. These groups include, but are not limited to, trade associations, professional associations, college alumni associations, veteran associations, customers of large retail chains, and saving account depositors, to name a few. Association group plans may be either contributory or noncontributory.

Creditor group insurance, also called credit life and credit disability income insurance, is a specialized use of group life and group health insurance that covers debtors (borrowers). It protects the lending institution from losing money as the result of a borrower's death or disability. The contract owner is the creditor, such as a bank, a small-loan company, or a credit union. Generally, the debtor is the premium payor, but the lending institution is the beneficiary of the policy. If the debtor dies or becomes disabled, the insurance proceeds are paid to the creditor to liquidate the indebtedness. The amount of insurance cannot exceed the amount of indebtedness.

Self-funded plans are funded by the insured (usually the employer) and administered by a third party. A successful self-funded program will have the following characteristics:

- A group large enough to reasonably predict future loss experience;

- Sound statistical data to support the self-funding concept;
- A stop-loss contract to assume losses beyond the insured's retention;
- A third party administrator who services claims; and
- Flexibility in plan design and administrative procedures.

Small Employer

Small employer means any person, firm, corporation, partnership or association that is actively engaged in business that, on at least **50%** of its working days during the preceding calendar year, employed no more than **100 eligible employees**, the majority of whom were employed within the state.

As a condition of transacting business in this state with small employers, every small employer carrier is required to actively offer to small employers **at least 2 health benefit plans:**

1. Basic health benefit plan; and
2. Standard health benefit plan.

Basic Care is a managed plan developed in conjunction with the Health Benefit plan committee. The Basic Care is lower in cost than the Standard Benefit Plan. A Standard Benefit Plan is a managed care plan developed in conjunction with the Health Benefit plan committee that provides better benefits at a higher cost than the Basic Care Plan.

Each small employer carrier is required to provide the small employer health benefit plan on a **guaranteed issue basis**, or without regard to health status related factors. Each small employer carrier must issue the plan chosen by the small employer to small employers that elect to be covered under the plan and agrees to satisfy the other requirements of the plan.

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

Small employers who does not offer group health coverage may assist in the payment of employee medical expenses through a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA). QSEHRAs are a ACA compliant health plan, designed to pay for medical expenses and monthly premiums associated with medical plans purchased through the individual market.

In a QSEHRA, the employer is considered the sole funder of the arrangement. Employee salary reductions are prohibited. For 2020, maximum reimbursement payments cannot exceed an annual amount of:

- $5,150 for individual employees; or
- $10,450 for individual employees and family members.

For an employer to offer QSEHRAs, a business cannot employ more than 50 full-time employees.

Employer's may exclude QSEHRA plans to employees who:

- Have not completed 90 days of service;
- Do not reach age 25 before the beginning of the plan year;
- Are part-time or seasonal employees;
- Are covered by a collective bargaining agreement; or

- Are nonresident aliens with no earned income from sources within the United States.

2. Contributory vs. Noncontributory

The same as group life insurance, group health insurance may be either contributory or noncontributory. With a **contributory** plan the eligible employees *contribute* to payment of the premium (both the employee and employer pay part of the premium). If a plan is contributory, at least 75% of all eligible employees must participate in the plan. If the plan is **noncontributory,** 100% of the eligible employees must be included, and the participants do not pay part of the premium. The employer pays the entire premium. The reason for these participation requirements is to guard the insurer against adverse selection and to reduce administrative costs.

3. Occupational vs. Nonoccupational

Nonoccupational policies exclude coverage of claims that arise from job-related accidents. (Usually the employer is covered by workers compensation, which is the primary coverage for employee disability and medical costs for claims arising out the performance of a job.)

Occupational policies would cover accidents on or off the job.

4. Coordination of Benefits

The purpose of the coordination of benefits (COB) provision, found only in group health plans, is to avoid duplication of benefit payments and overinsurance when an individual is covered under multiple group health insurance plans. This provision limits the total amount of claims paid from all insurers covering the patient to no more than the total allowable medical expenses.

The COB provision establishes which plan is the **primary** plan, or the plan that is responsible for providing the full benefit amounts as it specifies. Once the primary plan has paid its full promised benefit, the insured submits the claim to the **secondary**, or **excess**, provider for any additional benefits payable (including deductibles and coinsurance). In no case will the total amount the insured receives exceed the costs incurred or the total maximum benefits available under all plans.

Loss - Amount covered by Primary Plan = Amount covered by Secondary Plan

If all policies have a COB provision, the order of payments is determined as follows:

- If a married couple both have group coverage in which they are each named as dependents on the other's policy, then the person's own group coverage will be considered **primary**. The **secondary** coverage (the spouses' coverage) will pick up where the first policy left off.
- If both parents name their children as dependents under their group policies, then the order of payment will usually be determined by the **birthday rule**, i.e., the coverage of the parent whose birthday is earlier in the year will be considered primary. Occasionally, the **gender rule** may also apply, according to which the father's coverage is considered primary.

- If the parents are divorced or separated, the policy of the parent who has custody of the children will be considered primary.

Know This! Coordination of benefits provision ensures that benefits are not paid in excess of the total losses incurred.

5. Dependents of Insured Employees

Under group insurance policies that offer hospital, medical, or surgical expense benefits, insurance may be extended to insure dependents, and in amounts in accordance with some plan which precludes individual selection. If a group disability insurance policy pays dividends or refunds premiums, the dividend or excess premium must be applied by the policyholder for the benefit of insured employees or their dependents.

Group policies must provide equal benefits for the registered domestic partner of an employee, insured, or policyholder as to a spouse of an employee, insured, or policyholder. Insurers cannot discriminate in coverage between spouses or domestic partners of a different sex and spouses or domestic partners of the same sex.

6. Blanket Insurance

A **blanket** policy covers members of a particular group when they are participating in a particular activity. Such groups include students, campers, passengers on a common carrier, or sports teams. Often the covered insureds names are not known because they come and go. Unlike group health insurance, the individuals are automatically covered, and they do not receive a certificate of insurance. Blanket policies are commonly written and pay on an accident-only basis.

The California Insurance Code permits insurers to offer blanket insurance to the following entities:

- Newspapers, magazines, or other similar publications for the purpose of insuring the following persons:
  - Those who deliver publications or collect payments for the publication;
  - Those who supervise the deliveries or collections;
  - Those who are wholesalers; or
  - Others in the distribution, sales, or marketing process of the publication;
- Religious, charitable, recreational, educational, athletic, or civic organizations;
- Employers who pay the benefits afforded by a voluntary plan of unemployment compensation disability insurance;
- Employers who provide benefits to any group of workers, dependents, or guests, limited to specified hazards incident to activities or operations of the policyholder; and
- An entertainment production company that provides benefits to any group of participants, volunteers, audience members, or contestants.

Blanket life insurance may be issued for a **term not exceeding one year** with premium rates less than the usual rates for such insurance. Blanket policies may be renewed.

When the insured pays the policy premiums, the insured may request from the insurer a copy of the policy in the form of a certificate.

A person may elect not to be covered by a blanket insurance plan by submitting a written request to the insurer. If more than 10% of the persons eligible for coverage elect not to participate, the insurance contract cannot be put into effect, or if it has been in effect, it cannot be renewed.

7. Group Underwriting

Underwriting of group policies is unique in that when a group policy is written every eligible member of the group must be covered regardless of physical condition, age, sex or occupation. Therefore, the underwriting of group policies concentrates on the group as a whole. Cost of the policy will vary by ratio of males to females and the average age of the group. Evidence of insurability normally is not required since an annual reevaluation makes adjusting of the premium possible based upon the group claim experience. Making the premium retroactive for the year is often allowed. Any group replacement underwriting will consider loss history, group stability and composition.

The underwriting process is designed to **avoid adverse selection** by the following requirements:

- The insurance must be **incidental** to the group. In other words, the group cannot have been formed for the sole purpose of purchasing insurance;
- There should be a **steady flow** of persons through the group, with the older or unhealthy individuals being replaced by younger or healthier individuals;
- The **persistency** of the group: insurers do not want to write risks that frequently change insurers;
- A method of **selecting benefits** that prevents the individual selection of benefits;
- How **eligible participants** are selected: employees are usually full-time only and meet minimum service requirements;
- Whether the group is **contributory or noncontributory**;
- The **size and composition** of the group, as well as the industry the group is involved in; and
- The **prior claims experience** of the group.

8. Eligibility and Rating Factors

When a group is applying for medical expense insurance, there are several factors insurers will take into consideration in determining the group's eligibility and rating structure.

Demographics (Gender, Age, or Occupation)

The underwriter's function is to select risks that are acceptable to the insurance company. The selection criteria used in this process, by law, must be only those items that are based on sound actuarial principles or expected experience. The underwriter cannot decline a risk based on blindness or deafness, genetic characteristics, marital status, or sexual orientation.

When underwriting health insurance policies, the prime considerations are age, gender, occupation, physical condition, avocations, moral and morale hazards, and financial status of the applicant.

Industry

In determining an applicant's eligibility for insurance, insurers will consider the specific duties of the applicant's occupation. Such things as high employee turnover or dangerous job duties may affect an applicant's rating. Insurers will take into consideration the types of industry applying for group coverage.

Location or Zip Code

Insurers will also take into consideration the location of the business (city or county). These factors aide insurers because they can use information based both on industrial classification and the demographics and health care costs in a particular area or zip code to assess risks and possible losses.

Carrier History

Insurers will also look at a group's **carrier history**. "Carrier" is another term for insurer or insurance company. In looking at a group's carrier history, insurers will look at the group's "stability," or how many different insurers a group has used in the past. "Longevity" is another factor insurers take into consideration when looking at a group's carrier history. Longevity refers to the amount of time a group has been with a certain carrier. The longer the group has been with a carrier, the lower the group's rates will be.

Medical History

Disability income insurance provides monthly or weekly income payments to replace a portion of a worker’s lost salary due to an illness or injury. When an application for a disability income policy is submitted, disability insurers need to eliminate those applications that would be likely to have losses more severe than rates would anticipate. This is how disability underwriting works when considering medical history.

Chronic or Ongoing Conditions

When writing medical expense insurance, insurers will take into consideration whether the applicant has any chronic or ongoing conditions. **Chronic** or **ongoing** is defined as prolonged, continuing, or lingering illness or disability. Issuance of health policies to insureds with chronic or ongoing conditions could result in immediate or very high claims within a short period of time. This results in adverse selection and, consequently, higher overall costs and premiums.

Catastrophic Conditions

Catastrophic conditions (i.e. earthquakes, floods, fires, etc.) are also taken into consideration when writing medical expense insurance. Unusually large numbers of catastrophic losses in a very short period of time from the types of perils which are usually excluded from coverage and which do not allow for an accurate pattern of predictability will adversely slant the law of large numbers.

Disabled Employees and Dependents (Not Actively at Work, Extended Benefits of a Former Carrier)

Insurers will also take into consideration whether the group applying for medical expense insurance is providing benefits for disabled employees who are not

actively at work or disabled dependents of employees. As discussed earlier, the extension of benefits provision allows disabled employees to be treated the same as if they were not disabled at the time of termination of the previous group policy (from a former carrier).

Contribution (Policy - Contributing or Noncontributing)

Another factor insurers will use in determining a group's eligibility for medical expense insurance is whether or not the policy will be **contributing** or **noncontributing**. Contributing means that the cost of the insurance is shared by the employer and employees. If the policy will be **contributing,** insurers require that at least 75% of all eligible members of the group elect to participate and be covered by the plan. Insurers do this to avoid adverse selection because naturally people with poor health will elect to be in the plan. The "75% requirement" insures that some good and average risks will also elect to be covered, thus balancing out the poorer risks.

Participation (Employees and Dependents - Covered and Eligible)

Finally, insurers will consider the number of employees participating in the group plan. As discussed in the last section, insurers have a participation percentage requirement. The number of employees and their eligible dependents is also taken into consideration. There should be no consideration of the disability of a dependent when the group member qualifies for coverage, beyond set guidelines which will apply to all dependents of those covered, so the dependent's insurability doesn't enter into rating or eligibility.

9. Benefit Schedule

Some medical expense insurance plans contain a **benefit schedule**, which very specifically states exactly what is covered in the plan and for how much. Other plans may incorporate the term **usual/reasonable/customary**. *Usual/reasonable/customary* means that the insurance company will pay an amount for a given procedure based upon the average charge for that procedure in that specific geographic area.

H. Regulation Of Providers

Educational Objective:

I.C4.2. Be able to identify that the Department of Insurance has jurisdiction over entities that provide coverages designed to pay for health care providers' services and expenses unless the health care providers are appropriately licensed or certified by other governmental agencies (CIC 740).

Department of Insurance has jurisdiction over entities that provide coverages designed to pay for health care providers' services and expenses unless the health care providers are appropriately licensed or certified by other governmental agencies.

The Department of Insurance has primary jurisdiction concerning the regulation of the activities of persons transacting insurance in the state of California. This includes all insurers, agents, and others, regardless of whether they are licensed or admitted. However, the Insurance Code also has made a unique provision for "any person or other entity that provides coverage" for a variety of medically-related expenses, including medical, surgical, chiropractic, physical therapy, speech pathology, audiology, mental health, dental, hospital, or optometry services.

This special provision places the Department of Insurance in a secondary position as the regulator over these "persons" whenever they can demonstrate that another regulatory agency has primary responsibility for their activities. This other regulator could be an agency of the federal government, of another state, or another agency of the state of California. If a provider of such plans of insurance cannot show that it is regulated by another agency, then it will be regulated by the Department of Insurance.

The Insurance Code specifically states that a **health care services plan**, as defined in the Health and Safety Code, will still fall under the jurisdiction of the Department of Insurance. These types of plans include those operated by the following:

- Nonprofit agencies (unless they are both the provider of the insurance and the owner-operator of the facilities providing care under the contract of insurance);
- Schools, colleges, or universities;
- Public agencies providing care or coverage for employees, students, or faculty; and
- Self-funded plans operated by other employers.

Note that **California Department of Insurance** is the primary regulator of issuers of most PPO and EPO plans and other disability insurance companies.

However, the **Department of Managed Health Care**, which began operation in July 2000, is the primary regulator of activities, management, and operations of HMOs and other providers of managed health care services, such as Point of Service plans, and some PPO and EPO plans. Because this agency has primary responsibility for enforcing the Insurance Code and other laws concerning the managed health care industry, the Department of Insurance exercises only limited oversight over providers in this area.

I. Legislative Issues

Educational Objective:

III.B.4. Be able to identify the impact offollowing legislation on group health insurance:

a. ERISA
b. COBRA
c. Americans with Disabilities Act (ADA)
d. HIPAA
e. Family and Medical leave Act (FMLA)

f. Pregnancy Discrimination Act
g. Mental Health Parity Act
h. Affordability under PPACA
i. Cal-COBRA

1. ERISA

The **Employee Retirement Income Security Act of 1974 (ERISA)** is a federal law that requires those who establish and maintain group health insurance and KEOGH Plans to file annual reports with the Department of Labor and the IRS. The annual reports must detail the following information:

- Documentation of the trust agreement;
- The method of investment;
- Claim and benefit denials;
- Enrollment forms;
- Certificates of Participation;
- Annual statements; and
- Administrative records.

The goal of ERISA was to increase the rate of national participation in pension plans, prevent loss of benefits by persons who terminate employment before retirement, establish minimum standards for funding and vesting, and provide for the overall control of new and existing pension plans.

While the law does not require an employer to establish and maintain a pension plan, if such a plan exists, it must conform to the provisions of the law. The law prescribes which employees must be included in a plan, establishes minimum vesting requirements, specifies the amounts that must be contributed, and sets forth minimum funding requirements.

In addition to the Secretary of Labor and to the Internal Revenue Service, the plan must disclose information regarding its operation and financial condition to those covered under the plan, as well as their beneficiaries.

There have been many amendments added over the years that have attempted to expand the protection to plan participants and beneficiaries in regard to retirement benefits and health coverage specifically promised to employees and their dependents.

There is employer's assistance available to assist the employer in acting in compliance with the law.

2. COBRA and Cal-COBRA

The **Consolidated Omnibus Budget Reconciliation Act of 1985** (**COBRA**) requires any employer with 20 or more employees to extend group health coverage to terminated employees and their families after a qualifying event. **Qualifying events** include the following:

- Voluntary termination of employment;
- Termination of employment for reasons other than gross misconduct (e.g. company downsizing); and

- Employment status change: from full time to part time.

For any of these qualifying events, coverage is extended up to **18 months.** The terminated employee must exercise extension of benefits under COBRA within **60 days** of separation from employment. The employer is permitted to collect a premium from the terminated employee at a rate of no more than 102% of the individual's group premium rate. The 2% charge is to cover the employer's administrative costs.

For events such as **death** of the employee, **divorce** or legal separation, the period is **36 months** for the dependents.

It is important to remember that COBRA benefits apply to group health insurance, not group life insurance. In addition, unlike the conversion privilege in which the individual converts coverage to an individual health insurance policy, COBRA continues the same group coverage the employee had and the employee pays the group premium that the employer paid (or employer and employee paid if the plan was contributory).

Note that under the Patient Protection and Affordable Care Act, coverage for children of the insured must extend until the adult child reaches the **age of 26** (unless the child qualifies as a disabled dependent). The same age limit applies to COBRA coverage for eligible children of the insured. In addition, in the event of loss of dependent child status under the group plan, the dependent child qualifies for a maximum period of continuation coverage of **36 months.**

There are also several **disqualifying events** under which the COBRA benefits may be discontinued. These include failure to make a premium payment, becoming covered under another group plan, becoming eligible for Medicare, or if the employer terminates all group health plans.

Know This! Coverage for dependents under COBRA may be extended to 36 months in the event of the employee's divorce or death.

In California, there are two COBRA programs available depending on the size of the company.

Federal COBRA regulations apply only to companies with 20 or more employees. If the company has 2-19 employees, however, it falls under a state program called Cal-COBRA.

Cal-COBRA is a state program modeled after the federal program and is administrated by the health insurance company directly. People signed up for COBRA or Cal-COBRA are eligible for up to 36 months of continuation coverage.

Cal-COBRA requirements do not apply to the following individuals:

- Eligible to Medicare benefits (even if it's only Medicare Part A);
- Covered by another hospital, medical or surgical plan, or another group plan;
- Eligible for federal COBRA;
- Covered or eligible under Chapter 6A of the Public Health Service Act; or
- Those who fail to submit the required premium.

3. Mandated Benefits - ADA and FMLA

Under the **Family Medical Leave Act of 1993**, an eligible employee is entitled to a total of 12 workweeks of leave during any 12-month period for one or more of the following:

- The birth of a child of the employee and in order to care for the newborn child within one year of birth;
- The placement of a child for adoption or foster care with the employee for adoption within one year of placement;
- In order to care for the spouse, child, or parent of the employee who has a serious health condition;
- Because of a serious health condition that makes the employee unable to perform the duties of his/her job; or
- Any qualifying need arising out of the fact that the employee's spouse, child, or parent is a covered military member on covered active duty.

Except if the employee takes leave on an intermittent or reduced-leave schedule, any eligible employee who takes leave under FMLA for the intended purpose of the leave is entitled, on return from leave to following:

- To be restored to the position of employment held when the leave began; or
- To be restored to an equivalent position with equivalent employment benefits, pay, and other terms and conditions of employment.

According to the law, taking leave under FMLA cannot result in the loss of any employment benefit, such as group medical expense insurance, earned prior to the date on which the leave began.

The **Americans With Disabilities Act (ADA)** prohibits employers from rejecting job applicants with disabilities on the foundation that disabled employees will increase costs of group health care benefits. Additionally, this law prohibits employers from rejecting applicants for employment whose spouses, children, or dependents are disabled on the grounds that they would be covered by the group plan.

4. Pregnancy Discrimination Act

California's Fair Employment and Housing Act (FEHA) prohibits employers from discriminating against an employee who has become pregnant or who is requesting leave associated with pregnancy.

According to the California Pregnancy Disability Leave Act (PDLL), employers are required to provide up to 4 months of leave for an employee whose disability was caused by pregnancy or pregnancy-related conditions.

5. Mental Health Parity Act

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that requires coverage parity for mental health benefits with benefits under the insured's medical/surgical coverage. The following coverage requirements apply to **large group plans** (with more than 50 employees) that offer mental health benefits along with medical/surgical benefits:

- Deductibles, copayments, and treatment limitations for mental health benefits cannot be more restrictive than for any other medical benefit; and
- Providers cannot impose separate cost sharing requirements for mental health benefits.

The Affordable Care Act enacted rules on how health insurance issuers carry out these requirements.

6. HIPAA

Legislation that took effect in July 1997 ensures "**portability**" of group insurance coverage and includes various required benefits that affect small employers, the self-employed, pregnant women, and the mentally ill. HIPAA (Health Insurance Portability and Accountability Act) regulates protection for both **group health plans** (for employers with 2 or more employees) and for **individual insurance policies** sold by insurance companies.

HIPAA includes the following protection for coverage:

Group Health Plans:

- Prohibiting discrimination against employees and dependents based on their health condition; and
- Allowing opportunities to enroll in a new plan to individuals in special circumstances.

Individual Policies:

- Guaranteeing access to individual policies for qualifying individuals; and
- Guaranteeing renewability of individual policies.

Eligibility

HIPAA has regulations regarding eligibility for employer-sponsored group health plans. These plans cannot establish eligibility rules for enrollment under the plan that discriminate based on any health factor relating to an eligible individual or the individual's dependents. A **health factor** includes any of the following:

- Health status;
- Medical conditions (both physical and mental);
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Disability; or
- Evidence of insurability, which includes conditions arising out of acts of domestic violence and participation in such activities as motorcycling, skiing, or snowmobiling.

Employer-sponsored group health plans may apply waiting periods prior to enrollment as long as they are applied uniformly to all participants.

To be eligible under HIPAA regulations to convert health insurance coverage from a **group plan** to an **individual policy**, an individual must meet the following criteria:

- Have 18 months of continuous creditable health coverage;
- Have been covered under a group plan in most recent insurance;

- Have used up any COBRA or state continuation coverage;
- Not be eligible for Medicare or Medicaid;
- Not have any other health insurance; and
- Apply for individual health insurance within 63 days of losing prior coverage.

Such HIPAA-eligible individuals are guaranteed the right to purchase individual coverage.

Guaranteed Issue

If the new employee meets the requirements, the employer must offer coverage on a guaranteed issue basis.

Pre-existing Conditions

Under HIPAA, a *pre-existing condition* is a condition for which the employee has sought medical advice, diagnosis, or treatment within a specified period of time prior to the policy issue.

Creditable Coverage

The concept of **creditable coverage** means that an insured must be given day-for-day credit for previous health coverage against the application of pre-existing condition exclusion period when moving from one group health plan to another, or from a group health plan to an individual plan.

Prior to the enactment of the Affordable Care Act (ACA), individual insureds were entitled to receive credit for previous creditable coverage that occurred without a break of 63 (or more) consecutive days.

The ACA has prohibited pre-existing condition exclusions and eliminated waiting period in excess of 90 days; it also eliminated the requirement to issue HIPAA group health plans certificates of creditable coverage after December 31, 2014.

Renewability

At the plan sponsor's option, the issuer offering group health coverage must renew or continue in force the current coverage. However, the group health coverage may be discontinued or nonrenewed because of nonpayment of premium, fraud, violation of participation or contribution rules, discontinuation of that particular coverage, or movement outside the service area or association membership cessation.

J. Patient Protection And Affordable Care Act (PPACA)

1. Overview

The **Patient Protection and Affordable Care Act** (PPACA), or the Affordable Care Act (ACA), for short, was signed into law on March 23, 2010, as part of the Health Care and Education Reconciliation Act of 2010, to be implemented in phases until fully effective in 2018. Since the bill is a federal law, state regulations are superseded by the PPACA and must conform accordingly.

The Affordable Care Act has mandated increased preventive, educational, and community-based health care services, and was designed to do the following:

- Set up a new competitive private health insurance market;
- Hold insurance companies accountable by keeping premiums low, preventing denials of care and allowing applicants with pre-existing conditions to obtain coverage (pre-existing conditions exclusions have been eliminated as of January 2014);
- Help stabilize budget and economy through reducing the deficit by cutting government overspending; and
- Extend coverage for adult children in both individual and group health plans until age 26.

In addition, it gives small businesses and nonprofits a tax credit for an employer's contribution to health insurance for employees. It prohibits insurance companies from rescinding health coverage when an insured becomes ill, and eliminates lifetime benefit limits.

Specific health coverage plans, such as retiree-only, stand-alone dental plans, Medigap, and long-term care insurance are generally **exempt** from the PPACA changes.

Because these provisions are controversial and health care laws are being challenged in the courts, agents should review current laws to be certain they are giving up-to-date advice.

Eligibility: The Health Insurance Marketplace makes health coverage available to any uninsured individuals. To be eligible for health coverage through the Marketplace, the individual

- Must be a U.S. citizen or national or be lawfully present in the United States;
- Must live in the United States; and
- Cannot be currently incarcerated.

If an individual has Medicare coverage, that individual is **not eligible** to use the Marketplace to buy a health or dental plan.

Health status (no discrimination): A group health plan or a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility based on any of the following health status-related factors related to individuals or their dependents:

- Health status;
- Medical condition (including both physical and mental illnesses);
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability (including conditions arising out of acts of domestic violence);
- Disability; or
- Any other health status related factor.

When health insurers set their **premium rates**, they are only permitted to base those rates on 4 standards:

1. Geographic rating area (location of residence within the state);

2. Family composition (single or family enrollment);
3. Age; and
4. Tobacco use.

For individual plans, the location is the insured's home address; for small group plans, the location is the employer's principal place of business.

Essential benefits: Essential benefits include hospitalization, maternity, emergency services, wellness and preventive services, and chronic disease management.

- Note that all Health Insurance Marketplace plans must cover pregnancy and childbirth, even if pregnancy begins before the coverage takes effect.

Guaranteed issue: Insurance companies must accept any eligible applicant for individual or group insurance coverage. Enrollment for coverage may be restricted to open or special enrollment periods.

Guaranteed renewability: An insurance company that offers either group or individual health insurance coverage must renew or continue the policy at the option of the plan sponsor or the individual.

Pre-existing conditions: The law creates a new program, the Pre-Existing Condition Insurance Plan, to make health coverage available to individuals who have been denied health insurance by private insurance companies because of a pre-existing condition.

Appeal rights: If an insurer *rescinds* individual or group coverage for reasons of fraud or an intentional misrepresentation of material facts by the insured, the insurer must provide at least **30 days' advance notice** to allow the insured time to appeal. An enrollee or insured has the right to review their file, to present evidence and testimony as part of the appeal process, and to keep their coverage in force pending the outcomes of the appeals process.

Coverage for children of the insured: The law extends coverage for children of the insured to age 26 regardless of their marital status, residency, financial dependence on their parents, or eligibility to enroll in their employer's plan. Coverage for dependent children may continue beyond the limiting age (the child's 26th birthday) if the child continues to be:

- Incapable of self-sustaining employment because of an intellectual or physical disability; and
- Chiefly dependent upon the policyholder or subscriber for support and maintenance.

Lifetime and annual limits: Health plans are restricted from applying a dollar limit on essential benefits, nor can they establish a dollar limit on the amount of benefits paid during the course of an insured's lifetime.

Emergency care: Emergency services must be covered, even at an out-of-network provider, for amounts that would have been paid to an in-network provider for the same services.

Preventive benefits: The ACA requires that 100% of preventive care be covered **without cost sharing**. Preventive care includes routine checkups, screenings, and

counseling to prevent health problems.

Cost-sharing under Group Health Plans: A group health plan must ensure that any annual cost-sharing imposed does not exceed provided limitations.

The ACA has established **insurance exchanges** that will administer health insurance subsidies and facilitate enrollment in private health insurance, Medicaid and the Children's Health Insurance Program (CHIP). An exchange can help the applicant to do the following:

- Compare private health plans;
- Obtain information about health coverage options to make educated decisions;
- Obtain information about eligibility or tax credits for most affordable coverage; and
- Enroll in a health plan that meets the applicant's needs.

Know This! Children of an insured must be covered under the parent's health plan until age 26.

Know This! The Affordable Care Act (ACA) requires all individual and group health insurance plans be issued on a guaranteed issue basis.

2. Metal Tiers

Under PPACA, plans are classified into 5 categories of coverage in the Marketplace: four "metal level" plans and catastrophic plans.

The **metal levels** plans pay different amounts of the total costs of an average person's care. The actual percentage the insured will pay in total or per service will depend on the services used during the year. On average, the metal level plans will pay as follows:

1. Bronze: 60%
2. Silver: 70%
3. Gold: 80%
4. Platinum: 90%

Under the bronze plan, for example, the health plan is expected to cover 60% of the cost for an average population, and the participants would cover the remaining 40%. Participants with severe disease may pay significantly more.

All insurers that offer adult and family coverage under the metal levels must also offer child-only coverage.

Young adults under age 30, and individuals who cannot obtain affordable coverage (have a hardship exemption) may be able to purchase individual **catastrophic plans** that cover essential benefits. These plans offer lower monthly premiums but also feature high deductibles (several thousand dollars). The insured is usually required to pay all medical costs up to a certain amount. After the insured reaches the deductible, costs for essential health benefits will be covered by the catastrophic plan with no copayment or coinsurance.

Know This! Individual catastrophic plans that cover essential benefits are available for adults under age 30 and individuals who cannot obtain affordable coverage.

Know This! Under the ACA, premium discounts may be awarded to low-income individuals, regardless of the chosen metal levels.

3. Medical Loss Ratio (MLR)

The **Medical Loss Ratio (MLR)** indicates how much of the health coverage premium must go toward actual medical care, as opposed to administrative costs and profits. Under the Affordable Care Act, consumers will receive more value for their premium dollar because insurance companies are required to spend 80% (individual and small group markets) or 85% (large group markets) of premium dollars on medical care and health care quality improvement, rather than on administrative costs. That means that only 15%-20% of the premium may be applied to administrative expenses.

Insurers who fail the MLR test for a calendar year will be required to provide a rebate to their customers and refund excess premiums.

4. Qualified Health Plan

State insurance exchanges offer coverage through **qualified health plans (QHPs)**. Qualified health plans may not have pre-existing condition limitations, lifetime maximums, or annual limits on the dollar amount of essential health benefits.

A health plan's status as a qualified health plan will be based on the following characteristics of the plan:

- Benefit design;
- Marketing practices;
- Provider networks, including community providers;
- Plan activities related to quality improvement; and
- The use of standardized formats for consumer information.

5. Essential Health Benefits

As mandated by the Affordable Care Act, all private health insurance plans offered in the Marketplace must provide the same set of essential health benefits. All health care plans must include at least the following **10 essential benefits**:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Pregnancy, maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

6. Enrollment

State insurance exchanges must provide for an **initial open enrollment period**, **annual open enrollment** periods after the initial period (currently scheduled from

November 1 through January 31), and special enrollment periods. Unless specifically stated otherwise, individuals or enrollees have 60 days from the date of a triggering event to select a qualified health plan. Triggering, or qualifying, events include marriage, divorce, birth or adoption of a child, change in employment, or termination of health coverage.

Qualified individuals and enrollees may enroll in or change from one qualified health plan to another as a result of the following triggering events:

- A qualified individual or dependent loses minimum essential coverage;
- A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
- An individual who was not previously a citizen or lawfully present individual who gains such status;
- A qualified individual's enrollment or non-enrollment in a qualified health plan is unintentional or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the exchange;
- An enrollee adequately demonstrates that the qualified health plan in which they are enrolled substantially violated a material provision of its contract;
- An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan;
- A qualified individual or enrollee gains access to new qualified health plans as a result of a permanent move;
- A Native American, as defined by the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month; and
- A qualified individual or enrollee demonstrates that they meet other exceptional circumstances as the exchange may provide.

7. Tax Credits

Enrollment in the Health Insurance Market place began in October 2013, and tax credits for those who qualify became available in 2014.

After submitting an application for health insurance for a qualified health plan, individuals will be able to take an advance tax credit to reduce the cost of their health care coverage if purchased through an exchange. For the purposes of the premium tax credit, household income is defined as the Modified Adjusted Gross Income (MAGI) of the taxpayer, spouse, and dependents. The MAGI calculation includes income sources such as wages, salary, foreign income, interest, dividends, and Social Security.

Legal residents and citizens who have incomes between 100% and 400% of the Federal Poverty Level (FPL) are eligible for the tax credits. States have the option of extending Medicaid coverage to people under 138% of the FPL. Persons who receive public coverage like Medicare or Medicaid are not eligible for the tax credits.

Persons who are eligible for a premium tax credit and have household incomes between 100% and 250% of FPL are eligible for cost-sharing subsidies (reductions). Eligible individuals will be required to purchase a silver level plan in order to receive the cost-sharing subsidy.

The tax credit is sent directly to the insurance company, and reduces the insured's monthly health care premiums. Tax credits are based upon the individual's or family's expected annual income.

Small employers that offer health plans may be eligible for federal tax credits, depending on the average wages and size of the employer. These tax credits, available to low-wage employers (under $50,000 average per employee) with 25 or fewer workers, may cover up to 50% of premiums paid for small business employers and 35% of premiums paid for small tax-exempt employers.

In California, small businesses with fewer than 25 employees may be eligible for the federal premium tax credit as long as they purchase health insurance through the **Covered California for Small Business (CCSB) program**.

The credit is available to eligible employers for 2 consecutive taxable years.

Advanced Premium Tax Credits

Advance payments of the premium tax credit, or **APTC,** is a tax credit that can help individuals afford coverage bought through the Marketplace. These tax credits can be used right away to lower the monthly premium costs for insurance. If the insured qualifies, he or she may choose how much advance credit payments to apply the premiums each month, up to a maximum amount. If the amount of advance credit payments for the year is less than the tax credit due, the insured will get the difference as a refundable credit when the insured files the federal income tax return. If the advance payments for the year are more than the amount of the credit, the insured must repay the excess advance payments with the tax return.

APTC is paid on a sliding scale, from 100% of FPL to 400% of FPL. It is generally calculated based on attested projected annual income for the upcoming coverage year. Maximum APTC is calculated with reference to income and applicable second lowest cost silver plan.

Know that in California, advance premium tax credits (APCTs) may be available to certain households with income not exceeding 400% FPL. The credit is calculated by California Health Benefit Exchange (Covered California) and paid by the Exchange to insurers.

8. Penalties and Fines

Originally, the Affordable Care Act required all U.S. citizens and legal residents to have qualifying health care coverage. This was known as the **individual mandate**, and was part of the Act's **Shared Responsibility Provision**. If the individual did not have qualifying health care, a federal tax penalty would be assessed, based on the individual's taxable income, number of dependents, and joint filing status.

As of 2019, the individual mandate and shared responsibility penalty **no longer apply**. However, many states have their own individual health insurance mandate. In these states, an individual must have qualifying health coverage or pay a **state tax penalty**.

Employer Penalties: The following are penalties for employers with more than 50 full-time employees if at least one employee receives a premium tax credit for health care coverage:

Coverage	Penalty Tax
Employer does not offer coverage	$2,000 per full-time employee (first 30 employees are excluded)
Employer offers coverage	The lesser of $3,000 per employee who receives a premium tax credit or $2,000 per each full-time employee (first 30 employees are excluded)

Employers who have fewer than 50 full-time employees are exempt from these penalties.

9. California Health Benefit Exchange

Covered California is the state's benefit Exchange under reform law. It provides coverage to households above 138% of FPL, with subsidies available up to 400% FPL. Covered California offers 4 health plan levels: platinum, gold, silver, or bronze, that range from 10% to 40% of the customer's share of health care costs. Subsidies are available for low income households: Advanced Premium Tax Credit (APTC) for households under 400% FPL and Cost-Sharing Reductions (CSR) for households under 250% FPL.

Covered California for Small Business (CCSB)

Covered California for Small Business (CCSB) is a health insurance marketplace available from Covered California for businesses with **1 to 100 eligible employees**. Enrollment in CCSB is available year round. Employers may choose plans from 4 levels of coverage: Bronze, Silver, Gold, and Platinum, as well as Dual Tier Choice, which allows them to select 2 adjoining metallic tiers.

Small businesses that buy health insurance through Covered California may qualify for federal tax credits to offset part of their costs. To qualify for the federal premium tax credit, employers must have fewer than 25 full-time equivalent employees, pay employees an average annual salary of less than $54,000, and contribute at least 50% towards qualified employee premium costs.

Agent Training

All agents interested in selling for the Covered California marketplace must have a valid license with the California Department of Insurance and complete Covered California's training and certification program. Initial agent certification training is provided entirely online through a computer-based system and covers a range of information and instruction on the following topics:

- The Affordable Care Act;
- Covered California for Small Business;
- Agent roles and responsibilities;
- Eligibility for individuals and families; and
- Privacy requirements.

K. Chapter Recap

This chapter explained key concepts and major types of medical plans, including cost containment measures and federal regulations. Let's recap them:

MEDICAL PLANS CONCEPTS

Medical Plan Characteristics

- *Prepaid plans* - payments are made continuously, regardless of services provided
- *Specified coverages* - limit services to one illness or group of coverage
- *Comprehensive care* - provide coverage for most types of medical expenses
- *Benefit schedule* - state exact coverages under a plan and given costs

TYPES OF PROVIDERS AND BENEFITS

Major Medical Insurance (Indemnity Plans)

- High maximum limits
- Blanket coverage
- Deductibles paid up front
- Cost shared after meeting deductible

Health Care Services Organization (HMOs)

- Preventive care
- Prepaid basis
- Limited to service area
- *Basic benefit services* - hospital inpatient, physician, outpatient medical, preventive, urgent care, emergency, diagnostic laboratory, out-of-area coverage
- *Optional benefits* - long-term care, nursing services, home healthcare, prescription drugs, dental/vision care, mental health care, substance abuse services

Preferred Provider Organizations (PPOs)

- Physicians are paid on a fee for service basis
- No PCP referrals
- Members can use any physician they choose, but are encouraged to use approved physicians who have previously agreed upon fees

Point-of-Service Plans (POS)

- Combination of HMO and PPO plans
- Employees not locked into one plan; allowed to choose depending on the need for medical services
- Non-member physicians are paid service fee; patient pays higher coinsurance

Consumer Driven Health Plans

- *Medical savings account (MSA)* - employer-funded account; linked to high deductible medical plan
- *Flexible spending account (FSA)* - benefits funded by employee contributions (salary reduction)
- *Health reimbursement account (HRA)* - reimbursement by employer for qualified medical expenses
- *High deductible health plan (HDHP)* - high deductible; low premiums
- *Health savings account (HSA)* - employee and employer funded account; linked to high deductible medical plan

GROUP INSURANCE

Types of Eligible Groups

- Employer sponsored
- Association

- Creditor groups
- Self-funded
- Small employer - less than 100 employees

Provisions

- Conversion to individual coverage - within 31 days without evidence or insurability
- Coordination of benefits
- Change of insurers - carryover of coinsurance and deductibles
- *Contributory* - employees and employer pay part of premium (75% of eligible employees must participate)
- *Noncontributory* - employer pays entire premium (100% of eligible employees must participate)

Consolidated Omnibus Budget Reconciliation Act (COBRA)

- Qualifying event:
  - Voluntary termination of employment
  - Termination of employment for reasons other than gross misconduct (e.g. company downsizing)
  - Employment status change: from full time to part time
- Length of coverage:
  - 18 months - after qualifying event
  - 36 months - for dependents after events such as death of an employee, divorce or legal separation

AFFORDABLE CARE ACT (ACA)

Features and Coverages

- Mandates preventive, educational, and community based health care
- Premium rates may be based on geographic rating area, family composition, age, and tobacco use
- Children are covered until age 26
- Coverage for pre-existing conditions
- Enrollment period: November 1 to January 31
- Metal levels/plan covers:
  - Bonze 60%
  - Silver 70%
  - Gold 80%
  - Platinum 90%

Essential Benefits

10 essential benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Pregnancy, maternity and newborn care
- Mental health and substance use
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care