Major Medical

45M

Compared to the types of insurance discussed above, health insurance is easily the most complex insurance coverage. In the past, medical expenditure coverages were fragmented. Benefits were often limited to specific categories of services, and with the rising cost of health care, medical insurance did not adequately protect insureds.

Major medical insurance arose when different sources of health care costs were aggregated under one policy. It was introduced as a response to significant increases in medical costs once it became apparent that only covering hospital or physician costs was inadequate for policyholders. Thus, one distinguishing factor between major medical coverage and earlier coverages is that major medical coverage was the first time disparate sources of health care costs, such as hospital, physician, and ancillary, were combined into a common policy.

Regulators require a minimum combination of covered services to be provided if a policy is to be called "major medical". This is presumably to:

- Prevent insurers from misleading consumers with subpar policies that use the name "major medical".
- Prohibit policies with unexpected holes in the benefit plan that will disadvantage the policyholder.

Below is a list of services that are usually covered by a major medical insurance policy.

- **Inpatient Services**
- **Outpatient Services**
- **Ancillary Services**
  In health insurance, ***ancillary services*** refer to a wide range of medical services that support the work of a primary physician. Ancillary services can be categorized into diagnostic, therapeutic, and custodial.
- **Prescription Drugs**
  Prescription drugs can be classified as generic, brand-name, or specialty, as well as preferred or non-preferred. Each insurance carrier lists their preferred drugs in a ***formulary***.

We will begin by discussing networks, followed by benefit calculations, then related health products, and finally ACA restrictions.

Networks

Most health insurance carriers (i.e. insurers) have either developed or contracted with provider networks. A ***provider network*** is a collection of doctors and other health care professionals, hospitals, and clinics who have agreed to collaborate with insurers by servicing their insureds. In return, these health care providers are supplied with patients and are paid according to their contract. Recently, a few carriers developed multiple networks with different levels of breadth and discount.

Typically, the decision to either develop a network or contract with an existing network comes down to the **geographic concentration** of the insureds. Carriers with insureds who are geographically concentrated, like Blue Cross/Blue Shield, usually build their own network because they can efficiently allocate resources to manage their network.

However, choosing which providers to include in the network can be a daunting task for these insurers. Insurers have to decide how restrictive the network will be and then use a combination of cost and health care practice patterns (such as quality measures and efficiency of care) to evaluate health care providers.

Some common challenges that insurers face when choosing providers are the consolidation of health care providers and the limited number of providers in rural areas. Consolidation prevents the selection of specific providers when building a network. In rural areas, insurers cannot be as restrictive as there are fewer providers available.

On the other hand, carriers with customers who are geographically diverse typically contract with existing **networks for hire**. These networks are usually developed by companies who have invested resources with the intent of renting these networks to insurers. To decide which network to rent, insurers usually evaluate the cost savings from provider discounts.

There are two main types of health insurance plans:

- **Health Maintenance Organization (HMO)**
  Under an HMO plan, the insured is required to have a primary care provider. All health services must be rendered or approved by that doctor. This means that if an insured needs to see a specialist, a referral from that primary care doctor is needed. The doctor will refer the insured to a specialist within the network.

This type of insurance typically does not cover health services outside of the network.

- **Preferred Provider Organization (PPO)**
  A PPO plan is more flexible, as a primary care provider is not needed. In addition, insureds can visit providers outside of the network. However, visiting a health care professional within the network guarantees a lower cost and higher coverage for insureds.

Benefit Calculation

It is important to define how benefits are calculated and how expenses are divided among policyholders, insurers, and health care providers. Note that the amount of cost paid by policyholders is called ***cost sharing***.

- **Deductibles**
  A deductible is the amount the insured has to pay before the insurance coverage kicks in. In the context of health insurance, deductibles can be applied and defined differently for different categories of services.

  Some health insurance plans impose an ***overall deductible*** as opposed to separate deductibles for different benefits. This deductible is typically high and is an important feature of a ***High Deductible Health Plan (HDHP)***.

- **Provider Discounts**
  If a health care provider participates in an insurer's network, there is likely an agreement between them on the cost of services provided.

  Billed charges are calculated using the retail, or undiscounted, price the provider charges for a service, while ***allowed charges*** are calculated as the amount permitted in the benefit calculation. For example, a service that usually costs 500 can be discounted to a lower amount, such as 400, if the provider is in the insurer's network. Then, the billed charges are 500, while the allowed charges are 400.

  Balance billing is the act of seeking payments from the insured for the difference between the billed charges and allowed charges. Most insurers do not allow in-network providers to do this.

  Note that in-network and out-of-network services both have billed and allowed charges; however, benefit calculations are required to be based on allowed charges. This means that if an insured goes to an out-of-network provider their benefit calculations are determined based on allowed charges.

Then, the out-of-network provider has the option to balance bill them in order to recoup the difference between billed charges and allowed charges.

- **Coinsurance**
  Despite sounding similar to the coinsurance provision in homeowners insurance, coinsurance has a completely different meaning in the context of health insurance. ***Coinsurance*** is the proportion of loss the **insurer** is responsible for. For example, if a covered service has a coinsurance of 80%, the insurer will pay 80% of the health cost of the allowed charges after any deductible.

- **Out-of-Pocket Limits**
  An ***out-of-pocket limit*** is a provision that relieves the insured from paying for additional medical costs if a specified threshold is met. It is also known as a stop-loss provision.

- **Maximum Limits**
  The maximum amount of benefits paid by an insurer under a policy is called the ***maximum limit***. Maximum limits can be expressed either on a yearly basis or over the life of the insured, or both. Some policies with lifetime maximum limits will still pay some benefits each year even after the lifetime maximum has been reached.

  Maximum limits were fairly popular in early versions of health insurance. However, it was slowly phased out due to the rising cost of health care. Under the Affordable Care Act (ACA), there is no lifetime dollar limit on essential health benefits, which will be explained later in this section.

Coach's Remarks

Out-of-pocket limits refer to the maximum amount that an **insured** pays under a policy for a policy period, while maximum limits refer to the maximum amount that an **insurer** pays under a policy.

- **Internal Limits**
  For health insurance policies, limits can also exist for specific subsets of benefits. They can either be expressed in dollars and/or number of visits. For example, benefits for chiropractor sessions can be limited to 25 dollars per visit and 40 visits per year.

The ACA does not allow any form of dollar limit on services considered to be essential health benefits. So, insurance carriers will often limit the number of visits for these benefits.

Health insurance policies must also comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). According to this law, the internal limits for mental health and substance abuse services cannot be more stringent than those applied to other services.

- **Copays**
  Copay refers to the cost sharing (i.e. the amount paid by the insured) that occurs every time a health care service is provided. There are two advantages of using copays instead of deductibles as a means of cost sharing:

  - **Prevent Over-Utilization**
    Some benefits such as physician office visits and emergency room visits are prone to over-utilization because insureds have significant control over their usage. The existence of copays reduces the number of non-essential visits.

  - **Separate Administration of Benefit**
    Benefits for prescription drugs are usually administered by a *pharmacy benefits manager (PBM)*, who does not have access to claim records kept by insurers. However, benefit calculations for prescription drugs usually occur when prescriptions are filled, so access to claim records is needed to determine the amount of cost sharing if a policy has a deductible. If the policy instead uses copays, this information is not needed (unless the copays contribute to an out-of-pocket limit). Therefore, insurers typically use copays instead of deductibles to share costs for prescription drugs.

    However, this does not mean that all prescription drug benefits are copay-structured. Some companies' benefit administration systems are able to handle more complexity, allowing them to use a deductible-structured system.

Below are two simplified examples of an individual health insurance plan. Note that there are many different types of health insurance plans in the market with varying deductibles, out-of-pocket limits, coinsurance, and copays.

Plan 1

Type of Service	Benefit Provision	
	In-Network	Out-of-Network
Hospital Inpatient Stays		
Per Stay Copay	$250	$500
Physician Visit Copay	$10	$30
Hospital Outpatient		
Emergency Room Copay	$100	$200
X-Ray Copay	$15	$30
Coinsurance	80%	60%
Out-of-Pocket Limit	$3,500	$7,500
Prescription Drug Copay (Generic/Brand/Specialty)	$10/$30/$100	$10/$30/$100

Plan 2

Type of Cost Sharing	Benefit Provision	
	In-Network	Out-of-Network
Overall Deductible	$3,500	$7,000
Coinsurance (%)	100%	70%
Out-of-Pocket Limit	$3,500	$10,500

Example S1.1.7.1

Ashe has an individual health insurance policy from Sigma Insurance Co. with the following provisions:

	Benefit Provision
Overall Deductible	$4,000
Coinsurance	80%
Out-of-Pocket Limit	$5,000

There are no other deductibles for specific health care services, but Ashe has to pay all costs until the overall deductible is reached before Sigma begins to pay for covered services. The deductible resets on January 1st of every year.

The coinsurance is Sigma's share of the costs of a covered service. The coinsurance applies only after the overall deductible is reached.

In 2018, Ashe experiences the following events:

Date	Event	Allowed Charges
6/18/18	Annual physical exam	$150
6/30/18	MRI	$2,500
7/15/18	Specialty drug	$300
8/26/18	Emergency room	$1,750

Calculate

1. the percentage of the allowed charges in 2018 that Sigma will pay for this policy.
2. the minimum allowed charges for the next event that guarantees no additional payment from Ashe for the rest of 2018.

Solution to (1)

Ashe has to pay for the first three expenses because the overall deductible has not been met after those events.

$$150 + 2{,}500 + 300 = 2{,}950 < 4{,}000$$

When the 4th expense occurs, the overall deductible is met.

$$2{,}950 + 1{,}750 = 4{,}700 > 4{,}000$$

So, Ashe has to pay the expenses up to the overall deductible plus 20% of the cost after the deductible. This means that Sigma pays:

$$0.8(4{,}700 - 4{,}000) = 560$$

Then, the percentage of allowed charges that Sigma pays is:

$$\frac{560}{4{,}700} = \mathbf{11.91\%}$$

Solution to (2)

As of the 4th expense, Ashe has paid $4{,}700 - 560 = 4{,}140$. Her out-of-pocket limit is 5,000, which means that she will still need to pay up to 860 for the remainder of the year before she won't need to make any additional payments.

If there is another medical cost before the year ends, Ashe would not have to pay anything after an expense of at least:

$$860\left(\frac{100\%}{20\%}\right) = \mathbf{4{,}300}$$

In other words, if the next event costs at least 4,300, Ashe will pay exactly 860, having reached her out-of-pocket limit under this policy.

Related Products

COMPREHENSIVE MAJOR MEDICAL COVERAGE

Major medical coverage by itself typically has a high deductible because it aims to protect insureds against large unexpected health care costs, instead of covering

smaller frequent costs. Over time, insurers introduced ***comprehensive major medical coverage***, which covers both smaller frequent costs and large unexpected costs, resulting in lower deductibles.

Some insurers permit insureds to customize their policies, allowing them to pick and choose the benefits they find most valuable in relation to cost. However, this practice is prone to anti-selection, as insureds are likely to select benefits that they will most likely use. Anti-selection, also known as adverse selection, refers to the tendency of individuals who expect to experience higher-than-average losses to purchase insurance.

CATASTROPHIC MAJOR MEDICAL COVERAGE

Catastrophic major medical coverage is for certain expenses not covered by comprehensive major medical coverage. Its purpose is to protect insureds against very large, infrequent medical expenses that are higher than regular major medical expenses. These products typically have very high deductibles, usually in the $25,000 to $100,000 range.

However, this product has ceased to exist because under the current ACA rules, the out-of-pocket maximum would be less than those deductible amounts.

SHORT-TERM MEDICAL COVERAGE

Short-term medical coverage arose because of substantial lapse rates for newly issued individual major medical policies. Insurance carriers would typically spend a sizable amount of money to sell, underwrite, and issue these major medical policies, and it would usually take them over a year to recoup their investments.

Thus, insurers introduced short-term medical coverage, which has a single limited term, usually 3, 6, 9, or 12 months. Underwriting of such policies is typically simpler, resulting in substantially less cost. However, due to the limited term, these policies generally have a pre-existing condition exclusion. This complicates the claim administration process, as claims need to be investigated for potential pre-existing conditions.

Under the ACA, the ***individual mandate*** requires most individuals in the U.S. to have basic health insurance coverage. Otherwise, they will be penalized for not having sufficient insurance. Even though the short-term medical coverage discussed here does not meet the minimum requirements of the individual mandate, there are other short-term health care coverages that do. As of this writing, the ACA allows gaps in coverage for up to three months in a year. This creates a loophole that

allows healthy individuals to purchase cheaper short-term health care coverage to avoid penalties under the individual mandate.

HIGH RISK POOL PLANS

High risk pool plans were created to insure people who either do not have access to medical insurance because of a pre-existing condition or have limited insurance coverage due to a health condition. Beginning in 2014, the ACA stopped allowing insurance carriers to underwrite policies using health status. Therefore, high risk pool plans have been terminated.

CONSUMER DIRECTED PLANS

A ***consumer directed plan*** is typically a health insurance plan with a high deductible combined with an underlying personal spending account.

We will cover two examples of personal spending accounts: ***Medical Savings Accounts (MSAs)*** and ***Health Savings Accounts (HSAs)***. Both spending accounts are similar, as HSAs were created to replace MSAs, which were part of a retired pilot program.

Both MSAs and HSAs can only be opened if the insured has a High Deductible Health Plan (HDHP). Any contributions to the account are made pre-tax, and earnings on the account are tax-free. Consumers can withdraw money from the account to pay for health expenses, and they will never be taxed. However, if withdrawals are made before the age of 65 and not used for medical purposes, the withdrawals are taxable and subject to a 15% penalty. At age 65 and up, any withdrawals that are not used for medical purposes will be taxable, but they won't be subject to a penalty.

MSAs are limited to self-employed individuals and small businesses. HSAs, on the other hand, are available to everyone with an HDHP. There are other differences between these two programs, but we will not discuss these further.

ACA Restrictions on Plan Design

Under the ACA, there are a number of restrictions on plan design. These restrictions are important for two main reasons.

1. They define what constitutes a health insurance policy, which is important as most individuals in the U.S. are required to have basic health insurance

under the ACA's individual mandate.

2. They partially standardize health insurance, which makes it easier for consumers to compare health insurance policies.

Below is a summary of several restrictions put in place by the Affordable Care Act.

- All individual and small group health insurance plans that are not grandfathered in, i.e. not exempted from the ACA restrictions, must cover the following ***essential health benefits (EHBs)***:
    - Ambulatory patient services
    - Emergency services
    - Hospitalization
    - Pregnancy, maternity, and newborn care
    - Mental health and substance use disorder services, including behavioral health treatment
    - 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

    Note that prior to the ACA, it was common for plans to exclude several of these categories, or made them available only as riders that were subject to underwriting approval. Common examples included:

    - Mental health and substance use disorder services
    - Maternity and newborn care
- Cost sharing is not permitted for many preventive services, such as standard vaccinations and blood pressure screenings. Furthermore, lifetime and annual dollar limits are not allowed on EHBs.
- Plans must meet an ***actuarial value (AV)*** metal level (platinum, gold, silver, bronze). Actuarial value is the percentage of total claim expenses that are expected to be paid by the insurer for a standard population. Each metal level is assigned a target range of AV: 90% for platinum, 80% for gold, 70% for silver, and 60% for bronze. Insurers are are allowed a range of +/- 2% from the target. Thus, for example, silver has an AV range of 68-72%.
- Plans must set an out-of-pocket limit that cannot exceed the limit specified by the government. All cost sharing must contribute to the out-of-pocket

limit.

- Plans that are sold on the public exchange need to satisfy the following tests/standards:
    - Tests for meaningful difference
    - Tests for network adequacy
    - Tests for discriminatory service areas