Medical Plans

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. Medical Plan Concepts

Basic medical expense insurance refers to various essential medical, hospital and surgical benefits. The early health insurance policies sold after the Great Depression were basic plans, which were offered separately as hospital, medical, and surgical plans. Basic plans were characterized by first-dollar coverage (no deductible) and low dollar limits, which meant they afforded no protection to an individual or family against catastrophic medical expenses that could be financially disastrous.

The broad category of medical expense coverages can provide a wide range of benefits, or policies may be narrowly written and provide only one or two

types of coverage.

1. Fee-for-service Basis vs. Prepaid Basis

Medical expense plans could be **fee-for-service** where providers receive a payment for their billed charges for each service provided. **Prepaid plans** provide medical and hospital benefits in the form of service rather than dollars. In prepaid plans the providers are compensated regularly whether or not they provide service, but no additional compensation is provided when services are rendered.

2. Specified Coverages vs. Comprehensive Care

Specified coverage policies are those insurance policies that limit coverage to one illness or one limiting group of coverages, e.g., cancer policies, prescription drug coverage, dental plans, and other limited coverage plans. These policies are commonly written as a stand-alone individual policy or to complement a traditional fee-for-service Major Medical Expense Policy.

Comprehensive care policies are those plans that provide coverage for most types of medical expenses: a comprehensive package of health care services that typically includes preventive care, routine physicals, immunizations, outpatient services and hospitalization, such as HMOs.

B. Types Of Providers And Plans

Health care insurers (carriers) include stock and mutual insurance companies, Blue Cross/Blue Shield, health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Care is administered not only in the doctors' offices or the hospital but also in surgicenters, urgent care centers, and skilled nursing facilities.

1. Major Medical Insurance (Indemnity Plans)

Major Medical expense plans were developed from basic hospital expense policies as a result of the increased sophistication and expense involved with medical procedures and techniques.

Regular basic medical expense policies are characterized by their low dollar limits and first dollar coverage, but they afforded no protection to an individual or family against catastrophic medical expenses that would be financially disastrous. The Major Medical policy was designed to provide protection against catastrophic loss. By using deductibles and coinsurance, this coverage was made affordable because the policy did not respond to the small claims (those that could be covered under a basic plan, or absorbed by the insured), and provides coverage for the less frequent, but financially disastrous, catastrophic losses.

Characteristics

Major medical expense contracts are characterized by high maximum limits,

blanket coverage, coinsurance, and a deductible. Dollar deductibles are paid up front, and the coinsurance, or sharing of the cost, is paid after the deductible is met and the claim is submitted.

Common Limitations

Generally, most major medical plans cover most medical expenses in and out of the hospital, and they have high maximum benefit limits. These plans are called covered or eligible expense plans.

Exclusions from Coverage

The following are among the **exclusions** found in major medical insurance policies:

- Injuries caused by war;
- Intentionally self-inflicted injuries;
- Regular dental/vision/hearing care;
- Custodial care;
- Injuries covered by workers compensation insurance; and
- Cosmetic surgery (unless necessitated by a birth defect or an accident).

Provisions Affecting Cost to Insureds

Major medical policy premiums vary depending on the amount of the deductible, the coinsurance percentage, the stop-loss amount and the maximum amount of the benefit.

Deductibles

Most companies incorporate an annual **deductible** into their major medical policy. A typical deductible could range from $100 to $2,500. The deductible amount is the portion of medical expenses that are paid by the insured each year before the insurance benefits start. The higher the deductible, the lower the annual premium for the coverage will be. In other words, if you accept more risk through a higher deductible, the insurance company lowers your premium.

Know This! Higher deductible = lower premium.

Coinsurance Feature

Once the deductible has been met, the insured and the insurance company share the following expenses in what is called **coinsurance**. Generally the insurance company pays the larger share of 90/10, 80/20, or 70/30, or can also pay an equal share of 50/50. The smaller the percentage that the insurance company pays, the less the premium will be. Coinsurance helps keep costs down by requiring the insured's participation in the ongoing expense.

Stop-loss Feature

Many insurance companies include a **stop-loss feature** in their major medical policies. The stop-loss amount would be the amount that the insured

pays out of pocket during the year. When the insured's out-of-pocket expenses reach the stop-loss, the insurance company then provides coverage at 100% of eligible expenses for the remainder of the year. The out-of-pocket expenses that qualify for the stop-loss would be the insured's portion of the coinsurance and it may or may not include the deductible. The higher the stop-loss, the lower the premium will be.

2. Health Maintenance Organizations (HMOs)

By means of the Health Maintenance Act of 1973, Congress strongly supported the growth of **health maintenance organizations** (HMOs) in this country. The act forced employers with more than 25 employees to offer the HMO as an alternative to their regular health plans. (The part of the act requiring dual choice has expired and has not been reenacted).

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.

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 vs. Referral (Specialty) Physician

Care is provided to members of the HMO by a limited number of physicians that are approved to practice in the HMO.

Primary Care Physician (PCP)

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 (Specialty) 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.

Urgent Care

Urgent care centers provide services in an emergency medical service center that is separate from any hospital or clinic. These centers are usually

supported by laboratory and radiology services but provide primary and urgent care on a less-than-24-hour-a-day basis.

Basic Services

HMOs are *required* to provide the following **basic benefits**:

- Hospital inpatient services;
- Physicians' services;
- Outpatient medical services;
- Preventive services;
- Urgent care services;
- Emergency care services;
- Diagnostic laboratory services; and
- Out-of-area coverage.

HMOs have the *option* of providing one or more of the following **supplemental benefits**:

- Long-term care;
- Nursing services;
- Home health care;
- Prescription drugs;
- Dental care;
- Vision care;
- Mental health care; or
- Substance abuse services.

3. Preferred Provider Organizations (PPOs)

The Preferred Provider Organizations (PPOs) could be seen as the traditional medical systems' answer to HMOs. In the PPO system, the physicians are paid fees for their services rather than a salary, but the member is encouraged to visit approved member physicians that have previously agreed upon the fees to be charged. This encouragement comes in the form of benefits. While the members can utilize any physician they choose, the PPO may provide 90% of the cost of a physician on their approved list while possibly only providing for 70% of the cost if the member chooses to utilize a physician not included on the PPO's approved list.

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.

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.

In and Out of Network

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.

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.

4. Point-Of-Service (POS) Plans

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

Nature and Purpose

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.

Out-of-network Provider Access (Open-ended HMO)

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."

PCP Referral (Gatekeeper)

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.

Indemnity Plan Features

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.

C. Cost Containment In Health Care Delivery

With the dramatic rise in the cost of medical care over the past few decades, the concept of **managed care** has become a necessity for insurance companies. Managed care plans, such as HMOs and PPOs, are designed to control costs by controlling the behavior of the plan participants.

1. Cost-saving Services

Cost-saving services or case-management provisions provide plans with controlled access of providers, large claim management, preventive care, hospitalization alternatives, second surgical opinions, preadmission testing, catastrophic case management, risk sharing, and providing high quality of care. Insurance companies use the services of case managers for large, ongoing claims through a process of utilization management. The case manager evaluates the appropriateness, necessity, and quality of health care, and may include prospective and concurrent review.

Preventive Care

Managed care plans encourage preventive care and living a healthier lifestyle. Annual physical exams, mammograms, and other procedures used to detect medical problems before symptoms appear can result in considerable cost savings if a problem is detected early and treated quickly.

Hospital Outpatient Benefits

Because hospital confinement has become so costly, many plans require the patient to take advantage of outpatient services when possible.

Alternatives to Hospital Services

Alternatives to hospital care might include home health care where the patient stays at home and is visited periodically by a health professional. A home health aide that could work in conjunction with a family member may meet daily needs. Terminally ill patients may elect hospice care rather than a hospital stay. Hospice attends to the patient's daily needs and provides pain relief but attempts no curative procedures. Within cost containment, painkillers and special hospital beds are paid for, but operations or antibiotics are not.

Managed Care

Managed care plans' main characteristic is that they try to contain costs of health care services while providing efficient services. Strategies used by managed care plans are

- Providing financial incentives for members to use providers and procedures approved by the plan;
- Controlling lengths of hospital stay;
- Using utilization reviews to improve case management;
- Focus on preventive health care.

HMO and PPO plans are some of the examples of managed care plans.

2. Utilization Management

Utilization management is a system for reviewing the appropriateness and efficient allocation of health care services and resources that are being given or are proposed to be given to an insured. It also covers the review of claims for services that may be covered by a health care provider. There are different types of utilization management reviews: prospective, retrospective, and concurrent review.

Prospective Review

Under the **prospective review** or **precertification process**, the physician can submit claim information prior to providing treatment to know in advance if the procedure is covered under the insured's plan and at what rate it will be paid.

Concurrent Review

Under the **concurrent review** process, the insurance company will monitor the insured's hospital stay to make sure that everything is proceeding according to schedule, and that the insured will be released from the hospital as planned.

D. Pennsylvania Mandated Benefits (Individual And Group)

1. Coverage for Dependent Children

Newborn Children

All individual and group health insurance policies providing coverage on an expense incurred basis, and that provide coverage for a family member of the insured must also provide **coverage for a newborn child of the insured from the moment of birth.** This coverage must include coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital birth defects and birth abnormalities. Notification of the birth of the newborn child and payment of the required premium must be furnished to the insurance company within **31 days** after the date of birth in order to have coverage continue beyond such 31-day period.

Adopted Children

Adopting parents must inform their insurer within **31 days** that a child has been added to the family. Subsequently, this adoptive child will be treated the same as any other dependent under that policy.

Physically and Mentally Handicapped Children

A policy stating that coverage of a dependent child will terminate once the child reaches a certain age will not end any hospital or medical coverage – if the child's handicap prevents self-sustaining employment. In these instances, the child must also be primarily dependent on the policyholder.

Proof of such incapacity and dependency must be furnished to the insurance company by the policyholder at least **31 days** before the child's attainment of the limiting age.

Dependent Child Age Limit

The state health regulations stipulate that children and stepchildren of the insured are considered dependent if under a specified age. Federal law requires that if an individual or group health insurance plan covers dependents, young adults up to the age of 26 may be covered with their family, with some minor exceptions. Under Pennsylvania law, in some cases, young adults may stay insured through the group plan up to age 30 if the employer allows it.

Childhood Immunizations

All health insurance policies must include benefits for childhood immunizations. The health insurance policy must provide coverage for medically necessary booster doses of all immunizing agents used in childhood immunizations.

2. Postpartum Coverage

Every health insurance policy that provides maternity benefits must also provide coverage for a minimum of 48 hours of inpatient care following a normal vaginal delivery and 96 hours of inpatient care following a Caesarean delivery.

A health insurance policy also may provide for shorter stays but only if the

attending physician decides that the mother and newborn can be discharged safely.

The health insurance policy must provide coverage for at least one home health care visit within 48 hours after discharge when discharge occurs earlier than the prescribed times.

3. Annual Gynecological Examinations and Routine Pap Smears

All health insurance policies must provide health insurance benefits applicable under the policy for routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists, and an annual gynecological examination, including a pelvic examination and clinical breast examination.

4. Mammography Coverage

All group health insurance policies must cover mammographic examinations. The minimum coverage required must include all costs associated with a mammogram every year for women age 40 or older and with any mammogram based on a physician's recommendation for women under age 40. This does not mean that the insurer is required to cover mastectomy surgical procedures.

Coverage for mammograms may be subject to deductibles and copayment provisions contained in the policy.

5. Treatment for Alcohol Abuse and Dependency

All group health insurance policies must provide alcohol abuse and chemical dependency benefits. In the first instance or course of treatment for alcohol abuse and dependency, no deductible or copayment may be less favorable than those applied to similar classes or categories of treatment for other conditions of physical illness or injury.

Nonhospital residential alcohol treatment services that are included as a covered benefit must be covered for a minimum of **30 days** per year. Outpatient alcohol treatment services that are included as a covered benefit will be covered for a minimum of **30 outpatient, full-session visits** or equivalent partial visits per year.

These treatment services may be subject to a lifetime limit for a covered individual of **90 days** of nonhospital, residential alcohol treatment services and **120 outpatient, full-session visits** or equivalent partial visits.

Inpatient detoxification treatment may also be covered, subject to a lifetime limit of **4 admissions**. Reimbursement for each admission may be limited to **7 days** of treatment.

6. Serious Mental Illness

All health insurance policies that cover **50 or more employees** must cover the treatment of serious mental illness according to the following terms:

- Benefits are for at least **30 inpatient days** and **60 outpatient days** annually.
- A person receiving inpatient benefits will be able to convert the inpatient days to outpatient days on a one-for-two basis.
- There will be no difference either in the annual or lifetime dollar limits in the coverage for serious mental illness for other illness.
- Cost-sharing arrangements, such as deductibles and copayments, for coverage of serious mental illness cannot prohibit access to care.

The term *serious mental illness* means any of the following mental illnesses as defined by the American Psychiatric Association: schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder and delusional disorder.

7. Cancer Therapy

Whenever individual or group health insurance policies cover cancer chemotherapy and cancer hormone treatment and services that have been approved by the United States Food and Drug Administration for general use in the treatment of cancer, the covered individual will be entitled to the benefits, whether performed in a physician's office, an outpatient department of a hospital, a hospital as an inpatient or any other medically approved treatment setting.

8. Medical Foods

Healthcare insurers must provide benefits for the costs of nutritional supplements, otherwise known as formulas. Supplements must be medically necessary for the treatment of rare hereditary genetic metabolic disorders.

Health insurers must also provide coverage for infants and children requiring a medically necessary amino acid-based elemental medical formula for the treatment of the following health conditions:

- Food protein allergies;
- Food protein-induced enterocolitis syndrome;
- Eosinophilic disorders; and
- Short-bowel syndrome.

Benefits for nutritional supplements may be subject to the same copayments and coinsurance provisions as any other medical services covered under a health insurance policy. However, they are exempt from deductible provisions. The exemptions must be explicitly provided for in the policy. Coverage for supplements is not required if the insured is currently employed outside of the Commonwealth or if the insured's employer provides insurance as an employment benefit.

9. Orally Administered Chemotherapy Medication

Health insurance policies must provide coverage on the same favorable basis to orally administered chemotherapy medication as it would for intravenously

administered or injected chemotherapy medications. *Chemotherapy medication* means a medication prescribed by a treating health care practitioner that is necessary to kill or slow the growth of cancerous cells. Cost sharing for chemotherapy mediations may be increased, as long as it is applied generally to other medical or pharmaceutical benefits administered in a similar health care setting under the contract.

10. Mental Health Parity and Addiction Equity

The Affordable Care Act enacted rules on how health insurance issuers carry out the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). MHPAEA stipulates that the financial requirements (such as coinsurance) and treatment limitations imposed on mental health and substance use disorder benefits cannot be more restrictive than the requirements and treatment limitations that apply to all other medical and surgical benefits.

The MHPAEA categorizes benefits into 6 classifications to determine parity. If medical/surgical benefits are provided, the policy must also provide the same standards to mental health and substance abuse. The 6 classifications include:

1. Inpatient in-network;
2. Inpatient out-of-network;
3. Outpatient in-network;
4. Outpatient out-of-network;
5. Emergency care; and
6. Prescription drugs.

E. HIPAA (Health Insurance Portability And Accountability Act) Requirements

For your state licensing exam, you are required to understand HIPAA regulations that apply to individual and group health coverage and the concept of pre-existing conditions restrictions. Please note, however, that the recently enacted health care reform (Affordable Care Act) eliminates pre-existing conditions restrictions in health insurance plans.

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.

1. 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.

2. Guaranteed Issue

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

3. 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.

4. 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.

5. 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.

F. Affordable Care Act (ACA)

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.

Pennsylvania has chosen to have a Marketplace established and operated by the federal government, also known as a federally facilitated marketplace.

1. Federally-Facilitated Marketplace

Each state is required to set up and maintain **Affordable Insurance Exchanges, referred to as Marketplaces**. These exchanges either serve individuals and small businesses separately, or have a combined exchange to serve both individual and small business clients under one organization. In states that have chosen not to build their own Marketplace, a **Federally-Facilitated Marketplace** (healthcare.gov) is available that helps with comparison shopping tools, eligibility, enrollment, plan management, and consumer support. Coverage may be purchased through the Marketplace's call center, website, or by postal mail.

Under the proposed regulations, states that choose to set up an Exchange for Small Business Health Options Program (SHOP) must adopt the federal standards for the program or have a state law or regulation that implements the federal standards. Each state will establish insurance options for small employer participation. A SHOP is intended to give small employers the same purchasing power that large employers have, the opportunity to make a single monthly payment, and the ability to offer a choice of plans.

PPACA defines *small employers* as those with at least one but not more than 100 employees. Since 2017, states have been allowing large employers to purchase coverage through SHOP exchanges.

Insurance exchanges may or may not have open enrollment periods for small employers, but must admit small employers whenever they apply for coverage.

2. Qualified Plans

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. 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.

4. Preventive Benefits

Most health plans must cover a set of preventive services like shots and screening tests **at no cost to the insured**. This includes Marketplace private insurance plans.

The following preventive services must be offered without any copayment or coinsurance, even if the insured has not met the annual deductible. The no-cost requirement only applies if the services are delivered by a network provider.

REQUIRED PREVENTIVE CARE SERVICES

For ALL Insured Screening for alcohol misuse, blood pressure, depression, and HIV for those at higher risk
Immunization vaccines
Prevention counseling for sexually transmitted infection (STI) for those at higher risk

For Adults Screening for aspirin use for certain ages, cholesterol for certain ages or those at higher risk, colorectal cancer screening for adults over 50, Type 2 diabetes for adults with high blood pressure, obesity, and tobacco use for all adults and cessation interventions
Diet counseling

For Men Abdominal aortic aneurysm one-time screening (for men of specified ages who have never smoked)

For Women Gynecological and obstetrical care including screenings, when needed for anemia, BRCA genetic testing, breast cancer mammography, cervical cancer (for women at higher risk), and other conditions

Contraception with FDA-approved contraceptive methods, sterilization procedures, and education and counseling, not including abortifacient drugs
Well-woman visits and comprehensive support and counseling for breastfeeding for pregnant and nursing women

For Children Screenings for autism, behavioral disorders, blood disorders, congenital hypothyroidism, developmental progress including height, weight and body mass index, hearing, lead poisoning, oral health, phenylketonuria (PKU), tuberculin testing and vision

5. Shared Responsibility Provision

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.

6. Appeals Rights

All plans must state the insured's right to appeal the insurer's decision to deny a claim or end coverage, as well as the right to have the decision reviewed by a third party.

Claim denials that can be appealed include the following factors:

- Benefits that are not covered under the plan;
- Benefits that are excluded because treatment began before the insured's enrollment;
- The use of out-of-network providers;
- A service is not medically necessary;
- A treatment or service is considered to be experimental;
- Eligibility issues; and
- Benefit cancellations due to false or incomplete information on the enrollment application.

There are 2 ways to appeal a health plan decision: internal appeal and external review.

Internal appeals may be filed at no cost within **180 days** (6 months) after a claim denial. The insurer must complete the appeal review within 30 days for a pre-service claim, and within 60 days if the insured has already received the service. Insurers are then required to provide a written decision. If the claim is still denied, the written decision is called a **final internal adverse benefit determination**, and must state the reasons for the denial. The insurer then must notify the insured how to request an external review.

After an insured has received a written, final internal adverse benefit determination, the insured has **60 days** (*time limit may vary by state*) to file a written request for an **external review**. In urgent situations, where a person's health is in jeopardy, an external appeal may be filed at the same time an internal appeal is filed. Expedited appeals may be filed verbally, but must be followed by a written determination in 48 hours.

Insureds may appoint a representative to file the external appeal on their behalf. If the insurer uses the US Department of Health and Human Services (HHS) administered external review process, there is no cost for an external review. If the insurer uses an independent or state review organization, the fee for the external review may not exceed $25.

External appeal determinations are considered final and the insured must accept the decision.

G. 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

COST CONTAINMENT IN HEALTH CARE DELIVERY

Cost Saving Services

- Preventive care
- Hospitalization alternatives
- Second opinions
- Preadmission testing
- Catastrophic case management
- Risk sharing
- High quality of care

Utilization Management

- *Prospective review* - claim information submitted before treatment
- *Retrospective review* - claim information submitted after treatment

	• *Concurrent review* - insured's hospital stay monitored and planned for release
Managed Care	• Financial incentives for using approved providers or procedures • Primary focus of preventive care • Improved case management through utilization review • Controlled length of hospital stay
	FEDERAL REGULATIONS
Affordable Care Act (ACA)	• 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: - Bronze 60% - Silver 70% - Gold 80% - Platinum 90% • Each state sets up Affordable Insurance Exchanges (Marketplaces) • *Grandfathered plan* - existing provisions that are not required to change in response to new laws, restrictions or requirements • *Essential benefits* - hospitalization, maternity, emergency services, wellness and preventive services, chronic disease management
Mental Health Parity and Addiction Equity Act	• Required coverage parity for mental health benefits • For large groups (50 employees or more): - Deductibles, copayments and treatment limitations cannot be more restrictive than medical benefits - Cannot require separate cost sharing requirements