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## **FUNDAMENTALS OF HEALTH INSURANCE: What Health Insurance Products Are Available?**

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### **PURPOSE**

The purpose of this session is to acquaint the participants with the basic principles of health insurance, areas of health insurance regulation and what health insurance products are available in today's health insurance market.

### **OBJECTIVES**

After completing this topic, the participant will be able to:

- List the main types of health insurance policies.
- List the common types of state regulated health entities.
- Explain the two main categories of health coverage: *medical expense* and *disability income coverage*.
- List the types of expenses covered in *major medical expense* and *disability income coverage*.
- Describe the functions of managed care programs (PPOs and HMOs).
- List common group and individual policy provisions.

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## **OUTLINE**

- I. HEALTH INSURANCE - A 20TH CENTURY INDUSTRY**
  - A. Early Development
  - B. Rapid Growth Since World War II
  
- II. MEDICAL EXPENSE COVERAGE**
  - A. Major Medical Insurance
  - B. Specified Benefit Coverage
  - C. Specified Medical Expense Coverage
  - D. Supplemental or Limited Benefit Plans and Other Coverages
  
- III. DISABILITY INCOME INSURANCE**
  - A. Total Disability
  - B. Presumptive Disability
  - C. Elimination Period
  - D. Maximum Benefit Period
  - E. Disability Income Benefits
  
- IV. GROUP HEALTH INSURANCE POLICIES**
  - A. Master Policy
  - B. Policy Provisions
  
- V. REGULATING HEALTH INSURANCE**
  - A. Generally Regulated Policy Provisions
  - B. Regulating Alternative Providers
  - C. Federal Laws Affecting Regulation

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## HEALTH INSURANCE - A 20TH CENTURY INDUSTRY

- EARLY DEVELOPMENT

Although health insurance that covered the costs of a person's medical care was offered as early as 1847 and individual accidental insurance coverage became available in 1863, it was not until 1913 that group health insurance was underwritten.

The first group plans covered medical expenses. They were based on a review of claims generated by a certain group over a set period of time. The introduction of these group plans also created a need for state legislatures to pass laws that would regulate them.

- RAPID GROWTH SINCE WORLD WAR II

Price controls during World War II and the Korean War resulted in accelerated growth in the health insurance industry when unions bargained for health insurance benefits which were not controlled to increase the actual income of their members. In addition, health insurance benefits were not included in the workers taxable income. Insurance companies were willing to offer group insurance since the premiums they paid were deductible from their corporate taxes.

In the 1950s, group health coverage expanded from covering only the worker to include dependents. By 1970, three out of every five people in the United States were covered by private health insurance. In 2000, 86% of Americans were covered by some form of health insurance.

Today, health insurance can be divided into **medical expense coverage** which provides financial benefits to help the insured pay for costs of medical treatment for an illness or injury and **disability income insurance** which provides the insured with an income if the insured is unable to work because of sickness or injury.

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## MEDICAL EXPENSE COVERAGE

Medical expense coverage includes not only the medical and surgical services of a physician but also hospital, nursing, and related health services. Some plans offer benefits for preventive care.

- MAJOR MEDICAL INSURANCE

Today, most medical expense coverage plans are comprehensive major medical insurance policies. These provide coverage for large, unpredictable medical expenses for both in-patient and out-patient procedures.

Most major medical insurance policies set a lifetime maximum benefit amount such as \$1,000,000, and coverage continues until the insured has exhausted the benefits.

- Expense Participation

In most major medical insurance policies, the insured is required to pay a percentage of the medical expenses. The objective is to encourage the insured to keep medical expenses to a minimum and thereby help the insurer keep costs of coverage lower.

The three most common ways the insured participates in paying for expenses are deductibles, coinsurance and co-payments.

- . Deductible

This is usually a set amount of covered medical expenses that the insured must pay before benefits will be paid under the policy. Most deductibles are based on the calendar year.

- . Coinsurance

After the deductible amount has been paid, the insured is required to pay a certain percentage of the covered medical expenses.

- . Co-payment

A specified dollar amount that the insured is required to pay to a provider toward covered medical expenses for specified certain health care services.

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- . Out-of-pocket limit

The portion of coinsurance the insured is required to pay for covered medical expenses before the policy benefits will pay 100%, less deductibles and co-payments.

- Generally Covered Expenses

Covered expenses are those charges for health care that are specified in the policy and which the insurer will consider for payment. Major medical policies usually cover a wider range of expenses than basic medical expense policies.

The following are generally covered expenses in a major medical policy:

- . Hospital charges for room and board
- . Miscellaneous hospital charges, such as laboratory test fees and X-rays
- . Ambulance charges
- . Surgical charges
- . Anesthetics and oxygen
- . Physical and speech therapy
- . Surgeon and physician fees and services of registered nurses
- . Specified out-patient expenses, such as doctor visits, laboratory fees and X-rays
- . Childhood immunizations
- . Preventive screening services, such as mammograms
- . Durable medical equipment, such as necessary prosthetics
- . Prescription drugs

- Common Exclusions

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There are medical expenses that insurers generally exclude from major medical policies:

- . Cosmetic surgery, other than corrective surgery required as the result of an accidental injury or other medical reason
- . Organ transplants
- . Fertility drugs
- . Treatment for injury or illness occurring while the insured is in military service or that results from an act of war
- . Treatment for self-inflicted injuries
- . Treatment that is provided free of charge in a government facility or that is paid for by other organizations

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- **SPECIFIED BENEFIT COVERAGE**

This provides health insurance coverage on a specified-benefit basis with separate benefit provisions and amount limits for hospital, surgical, and physician's expenses, etc. although these benefits may be combined into a single contract within certain limits.

- Basic hospital expense coverage

Specified expenses incurred during a hospital stay such as room, board, nursing, medications, laboratory tests, operating room and other services provided by the hospital.

- Basic medical-surgical expense coverage

This benefit provides for payment of physician charges for surgical, anesthesia or in-hospital medical services.

- **SPECIFIED MEDICAL EXPENSE COVERAGE**

Some insurance policies cover only those expenses incurred within a limited treatment area. The most common of these are dental, vision, and prescription drug.

- Dental Coverage

Dental coverage is often a component of an employee health benefit package. It generally covers routine examinations, preventive work and dental procedures required to treat tooth decay and diseases of the teeth, gums, and jaw.

Dental coverage usually contains both deductible and coinsurance provisions.

- Vision Coverage

- . The cost of eye examinations and corrective lenses are covered in vision care insurance. Usually one eye examination is covered annually and the amount of benefits for eyeglass lenses, frames, or contact lenses is specified in the policy.

- Prescription Drug Coverage

This coverage provides benefits for the cost of medicines and drugs prescribed only by a physician. The insured is generally required to make a co-payment toward the cost of the prescription.

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- **SUPPLEMENTAL OR LIMITED BENEFIT PLANS COVERAGE**

- Specified disease coverage

This pays set dollar amounts of money with respect to a specific diagnosis.

- Hospital confinement indemnity coverage

This provides per diem payments while confined to a hospital.

- Accident-only coverage

This provides a set payment for death, dismemberment, disability or hospital and medical care caused by accident

- Other specialty lines

Medicare supplement and long-term care insurance are separate coverages under the health insurance heading. They are generally regulated under distinct portions of a state insurance code.

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## **DISABILITY INCOME INSURANCE**

- **TOTAL DISABILITY**

Covers condition where the injured party is not able to work at any gainful employment for his/her remaining lifetime. The conditions are defined by each provider.

- **PRESUMPTIVE DISABILITY**

Any person who suffers loss of eyesight, two limbs, speech, or hearing that is presumed to be a permanent and total disability.

- **ELIMINATION PERIOD**

A waiting period after disability has occurred before disability payments begin.

- **MAXIMUM BENEFIT PERIOD**

The longest time disability will be paid.

- **DISABILITY INCOME BENEFITS**

Usually a percentage of normal income, less than 100%.

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## GROUP HEALTH INSURANCE POLICIES

- MASTER POLICY

The provisions of a group health insurance contract are negotiated by the insurer and the group policyholder. The individuals insured are not a party to the contract. Each insured is given a certificate of insurance that specifies the coverage provided by the plan. The provisions of the contract that determine the kind of coverage and amount of benefits are negotiated between the organization purchasing the plan and the health insurance provider.

- POLICY PROVISIONS

These are common provisions included in policies.

- Grace Period Provision

This is the minimum amount of time during which coverage must continue after a premium payment is past due.

- Incontestability Clause

The insurer may not contest the validity of an insurance contract after it has been in force for 2 (sometimes 3) years.

- Physical Examination Provision

This gives the insurer the right to require an applicant for health insurance to have a physical examination by a physician of the insurer's choice at the insurer's cost before underwriting an insurance policy.

- Pre-Existing Conditions Provision

A pre-existing condition is one in which the insured has been treated for in the last 6 months. Benefits will be paid for costs incurred in the treatment of this condition after the policy has been in force for a period of time, usually 12 months, or if the condition has not required treatment for a certain period of time.

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- Creditable Coverage Provision

The preexisting condition exclusion period may be reduced by the amount of time the insured was immediately previously continuously covered under another policy.

- Conversion Provision

Under group health insurance policies, members who leave the group have a limited right to purchase individual health insurance without proving insurability.

- Coordination of Benefits Provision

If an insured is covered by more than one group medical expense insurance policy, one policy is designated the primary policy and the other a secondary policy. Benefits are paid by the primary policy and then submitted to the secondary policy but limited to no more than the actual costs incurred.

- Usual, Customary, and Reasonable Fees (UCR)

This is the maximum amount an insurer will pay for a specified medical procedure and is based statistically on fees charged in the region served. The fee the insurer set as UCR is what will be paid for that procedure.

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## REGULATING HEALTH INSURANCE

Laws on both state and federal levels have been passed to regulate the health insurance industry.

- **GENERALLY REGULATED POLICY PROVISIONS**

There are regulations concerning certain provisions that must be included in an individual or group health insurance policy. Most states have laws covering the following provisions:

- Individual Policy Regulations

- . Grace period
- . Cancellation and renewal provisions

These state when the insurer has the right to refuse to renew or cancel the policy and the insurer's right to increase premiums.

- . Reinstatement provision

These are conditions under which resumption of coverage will occur after a policy has lapsed for non-payment of premiums. These usually include payment of overdue premiums and a definition of when coverage begins after reinstatement.

- Group Policy Regulations

- . Conversion provision
- . Coordination of benefits provision
- . Minimum size of group
- . Eligibility requirements

- Group and Individual Policy Regulations

- . Incontestability clause
- . Time limits on pre-existing conditions

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- **GENERALLY REGULATED INSURANCE ENTITIES**

Most states have passed legislation regulating specific entities:

- **Health Maintenance Organizations (HMO)**

An entity that contracts with physicians and hospitals to provide or arrange medical services for enrollees in return for periodic payments that do not vary with the extent or type of services provided. This payment is often referred to as a capitated amount.

The enrollees must use only the doctors, hospitals and clinics in the HMO network unless a referral is made elsewhere. Enrollees pay a small fee for co-payment at each doctor's visit.

If enrollees do not use providers contracted with the HMO, either a smaller percentage (e.g. larger coinsurance) or, in some cases, nothing will be reimbursed.

- **Preferred Provider Organizations (PPO)**

A network of doctors and hospitals that agree to perform medical services for a rate that is less than the actual billed charge (discounted fee-for-service).

- **Utilization Review Companies**

An entity that manages the use of health care services through pre-admission certification, second surgical opinions, concurrent review and case management.

- **Third-Party Administrators (TPA)**

An entity that directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims.

- **Multiple Employer Welfare Arrangements (MEWA)**

Employee welfare benefit plan or any other arrangement established or maintained for the purpose of offering or providing benefits to the employees of two or more employers.

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- FEDERAL LAWS AFFECTING REGULATION

- ERISA—Employee Retirement Income Security Act of 1974

Includes benefits for medical, surgical, or hospital care as well as sickness, accident, and disability.

ERISA provides that group health insurance plans must be established and maintained under a written document and must include a description of:

- . the benefits provided by the plan;
- . how the plan will be funded; and
- . the procedure to be followed to amend the plan.

A summary description of the plan must be distributed to each plan participant and filed with the Department of Labor. An annual report must be filed with the IRS.

Although ERISA gives states the right to regulate the insurance portions of employee benefit plans, state insurance laws may not apply if the plan is self-funded or if ERISA preempts the state insurance law.

State insurance laws do not apply to self-funded group health insurance plans because these plans are exempt from state regulation under ERISA. State insurance laws are preempted if they relate to an employee welfare benefit plan but are not preempted if the state law regulates insurance.

A state insurance law regulates insurance if it

- a) transfers policyholder risk;
- b) is limited to entities in the insurance industry; and
- c) is directed at a practice which is an integral part of the relationship between the insurer and insured.

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- HIPAA - Health Insurance Portability and Accountability Act of 1996

HIPAA amends the Internal Revenue Code of 1986, the Public Health Service Act and ERISA to establish federal insurance requirements for health insurance carriers offering coverage in the individual, small and large group markets, and imposes specific insurance reform requirements on self-funded employer benefit plans. HIPAA became effective for group health plan years beginning on or after July 1, 1997.

The key provisions of HIPAA include the following:

- ▶ Group health plans, both insured and self-funded of all sizes, must have:
  - special enrollment periods;
  - give credit for prior continuous coverage to waive any applicable pre-existing condition exclusion;
  - provide certification of coverage;
  - limit pre-existing conditions to 12 months or 18 months for late enrollees;
  - only apply pre-existing condition exclusions to conditions for which medical advice, diagnosis, care or treatment was recommended or received six months prior to the effective date of coverage; and
  - may not exclude an otherwise eligible individual based upon health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, genetic information or disability.
- ▶ Health insurance carriers must guarantee renewal of all group health plans unless termination of coverage is for fraud, nonpayment of premium, noncompliance with contribution requirements, market exit or service area limitations.

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- ▶ Health insurance carriers in the small group market must accept all small employers who apply for coverage. Small groups are defined as employers with 2-50 employees. Small group carriers are also required to make certain disclosures as part of their solicitation materials.
  - ▶ Health insurance carriers in the individual market are required to provide certain products on a guarantee issue basis with no pre-existing condition waiting period. These products should be available to individuals leaving group health plans and meeting certain other requirements. Carriers must also guarantee renewal of individual coverage of all individuals unless termination of coverage is for non-payment of premium, fraud, market exit, service area limitations or termination of association membership.
- COBRA—Consolidated Omnibus Budget Reconciliation Act

Employers with 20 or more employees that provide group health plans to their employees, are required to offer continued health care coverage to their covered employees or their "qualified beneficiaries" if health care coverage is lost due to one of the following reasons: death of the covered employee, voluntary or involuntary termination of the covered employee's employment, reduction in hours of the covered employee's employment, divorce or legal separation of the covered employee from the employee's spouse, covered employee becomes entitled to benefits under Medicare, dependent child ceasing to be a dependent under the plan and an employer's bankruptcy with respect to retirees and their families.

- Employment Discrimination Laws Affecting Health Insurance

- . Age Discrimination in Employment Act (ADEA)

Requires that active employees in companies with 20 or more employees be eligible for the same medical expense coverage, at the same cost, regardless of age.

- . Civil Rights Act of 1964 and 1978 Pregnancy Discrimination Act

Under Title VII, group health insurance must be provided without discrimination on basis of gender. Pregnancy,

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childbirth, or related medical conditions must be treated the same as any other medical condition and included in a group health coverage to employees and dependents.

- . Americans with Disabilities Act (ADA) of 1990

ADA requires that employees who are disabled be covered under group health insurance plans.

- . Family and Medical Leave Act

Requires employers with 50 or more employees to continue group health insurance to workers while they are on family and medical leave as provided for in the act.