Introduction to Health Insurance

Participant Guide

Version 2.0

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1 INTRODUCTION TO HEALTH INSURANCE

The Introduction to Health Insurance course covers the fundamentals of health insurance, which will be new for many consumers. It explains how health insurance works, how the ACA aims to decrease health insurance costs, improve access to care and quality, and the rules that govern health insurance in the State of California.

1.1 COURSE OBJECTIVES

At the end of this course, you will be able to do the following:

- ✓ Define health insurance and describe the different types of health insurance plans
- ✓ Understand how insurance works and the value of having health insurance
- ✓ Understand how the ACA aims to decrease health insurance costs, improve access to care and quality
- ✓ Describe the rules that govern health insurance including the California Insurance Code and the Knox-Keene Act

2 LESSON 1: HEALTH INSURANCE FUNDAMENTALS

This lesson will focus on the basics of health insurance, how it works and the value health insurance brings to individuals and families.

2.1 LEARNING OBJECTIVES

By the end of this lesson you will be able to:

- ✓ Define health insurance and describe the different types of health insurance plans
- ✓ Understand how insurance works and the value of having health insurance

2.1.1 WHAT IS HEALTH INSURANCE?

Many consumers who will buy health insurance through Covered California will be doing so for the first time. Some consumers will also be underinsured and looking for better coverage through Covered California plans. Many will need help in understanding the difference between health insurance plans, how health insurance plans work and the value of having health insurance.

Health insurance pays for some or all of a person's covered health care costs. In the Marketplace, the covered person will pay a premium (a monthly amount paid in advance in order to secure health insurance) and may share other costs for care, such as paying a $15 copayment for a doctor visit or prescription. Many preventive care and wellness services are available with no out-of-pocket cost.

In addition to preventive care and wellness services, one of the most important advantages of health insurance is protection from unexpected and overwhelming medical costs. Costs related to unexpected injuries or illnesses, such as injuries sustained in an accident or illness due to a chronic condition can quickly surpass the total cost of health insurance premiums. For example, a short hospital stay, even just a couple of days, can cost several thousand dollars. With health insurance, most of the cost is covered. Without it, families can quickly accumulate huge medical debt often leading to personal bankruptcy.

2.1.2 TYPES OF HEALTH INSURANCE

In the U.S., there are two kinds of health insurance:

- ***Private health insurance*** is provided by health insurance companies to individuals, families and businesses. Some people buy private insurance directly as an individual or as a family; others get insurance through their employers.
- ***Public health insurance*** is provided by the government. An example is Medicare, which provides coverage to people age 65 years and older, as well as people with disabilities. Medi-Cal in California is another type of public health insurance that assists low-income individuals. Both Medicare and Medi-Cal contract with private health insurance companies to provide these government programs for most of the people enrolled.

2.1.3 MANAGED CARE

In the United States, the majority of health plan products offered through both private and public health insurance are a type of managed care plan.

All managed care plans use a network of doctors and hospitals to provide care to members. Elements of managed care plans include:

- The networks are created by the health insurance company to provide quality care and predictable costs.
- In-network doctors, hospitals, and other providers contract with the health insurance company to coordinate care and provide services at negotiated rates. Some health plans employ their doctors and staff.
- Health insurance companies help ensure the health services provided are medically necessary.
- Some services or procedures may require preapproval from the health insurance company before they will be covered.
- Most managed care plans provide education and other programs to help people build healthy habits, as well as offer special support for people with chronic illnesses.
- Health insurers must provide access to qualified providers, including specialists, within a certain timeframe. Consumers can call their insurance company to help coordinate care if they are having difficulty getting an appointment.
- Providers must meet quality standards to be included “in-network” with a plan.

A Health Maintenance Organizations (HMO), a Preferred Provider Organization (PPO) and an Exclusive Provider Organization (EPO) are examples of the most common managed care plans. The amount paid by the person who is insured versus what the health insurance company pays depends on the value level of the health plan.

- **Health Maintenance Organization (HMO).** An HMO typically assigns or allows the member to select a primary care physician (PCP) or a team of physicians who work for or contract with the HMO. The PCP directly provides and coordinates the member’s care.
    - Doctors, specialists and hospitals in the HMO network provide all services.
    - HMOs generally require that a member receive a referral from the PCP before seeing other doctors, except in an emergency.
    - HMOs generally do not cover out-of-network care (visits to doctors who are not part of that HMO) except in an emergency.
    - HMOs require members to live in its geographic service area to be eligible for coverage.
    - All HMOs provide preventive care.

For example, if Joe has a sports injury and wants to see a sports medicine specialist, he must first be seen by his Primary Care Physician (PCP) or at his designated medical facility. Joe’s PCP will assess Joe’s injury and, if necessary, refer him to a sports medicine doctor in the HMO network.

- **Exclusive Provider Organization (EPO).** An EPO health plan is similar to an HMO but has some PPO features.
  - Like an HMO, EPO members have access to any doctor in the health plan's provider network.
  - Unlike an HMO, the EPO member does not need a referral from a PCP to receive care from an in-network specialist.
  - Like an HMO, out-of-network services are not covered except in an emergency.
- **Preferred Provider Organization (PPO).** A PPO is a health plan based on a network of preferred or participating providers (contracted doctors and hospitals).
  - PPO members may choose in-network or out-of-network providers.
  - PPO members pay less when they use a network provider but have the option to see an out-of-network provider at substantially higher cost for covered services.

It is more expensive to seek care outside of the PPO network because health plans pay a smaller percentage of allowed costs which are higher because members lose the benefit of negotiated rates with contracted doctors. Out-of-network providers may charge more than a plan's allowed amount, and the member will be responsible for 100 percent of costs in excess of the allowed amount. This remaining amount is the balance of the costs over the allowed amount. This is called "balance billing."

Example: Joe enrolls in a PPO. He has a sports injury and wants to see a sports medicine specialist. Joe can go directly to any sports medicine doctor. The doctor Joe sees will bill the insurance company and Joe will owe the doctor for any co-pay, co-insurance or deductible required by his PPO benefit plan. If his selected doctor is in-network, Joe's share of out-of-pocket costs will be less than if he chooses a doctor outside of his PPO network.

2.1.4 IMPORTANT TERMINOLOGY

Like every industry, the health insurance industry has its own language. Most people are not familiar with many of the specific terms and definitions.

Learning health insurance terms and definitions makes the often complex process easier to understand and explain, and helps educate consumers.

Covered California has a glossary of common terms that will be helpful to know. The glossary is a Job Aid included with these training materials and can also be found at http://www.coveredca.com/glossary.html. In addition, the U.S. Department of Health & Human Services has an in-depth glossary available at www.healthcare.gov/glossary/index.html.

For ease of reference, a few terms commonly used to explain health insurance coverage are defined below. All definitions are from the Covered California glossary. Some terms may not apply to certain public insurance, such as Medi-Cal.

Balance Billing

Balance billing occurs when an out-of-network provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for $30. A preferred provider has agreed to accept the allowed amount as payment in full and may not balance bill.

Coinsurance

Coinsurance is the consumer's share of costs of a covered health care service calculated as a percentage (for example, 20 percent) of the allowed amount for the service. The consumer pays coinsurance plus any deductible owed. For example, if the health insurance plan's allowed amount for an office visit is $100 and the consumer has met the deductible for the year, the coinsurance payment of 20 percent would be $20.

Copayment

A fixed amount (for example, $15) the consumer pays for a covered health care service, usually when the service is received. The amount can vary by the type of covered health care service. For example, office visits require a $15 per visit copayment and are often not subject to the deductible.

Cost-sharing

The member's share of costs for covered services received which is not covered by the insurance company is referred to as cost-sharing. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost-sharing in Medi-Cal and the Targeted Low-Income Children's Program (TLICP) also includes premiums.

Covered Services

Products and services covered under insurance plans. Covered benefits and excluded services are defined in the explanation of coverage or state program rules.

Deductible

The amount the consumer owes for health care services before the health insurance plan begins to pay. For example, if the deductible is $1,000, the plan will not pay for any services that are subject to the deductible until the consumer meets the deductible for covered services. However, the deductible often does not apply to all services.

Out-of-Pocket Limit

Every plan features an out-of-pocket limit which is the most a consumer will pay during a policy period (year) before the health plan pays 100 percent of the allowed amounts for covered services. This limit does not include the premium, balance-billed charges or health care not covered by the health plan. In PPO plans, there are two out-of-pocket limits; one for in-network care and one for out-of-network care. Some health plans do not count all of the copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit. In Medicaid and TLICP, the limit includes premiums.

Premium

A premium is the amount that must be paid in advance in order to receive health insurance or plan coverage. The consumer and/or the employer usually pay(s) it monthly, quarterly or annually.

2.1.5 HEALTH INSURANCE IN ACTION

People seeking health insurance coverage through Covered California may not have had regular access to prior health insurance coverage. This section explains the value of having insurance and provides examples of how insurance works.

Health insurance works a lot like other forms of insurance. For most private insurance, the insured person (or member) pays a monthly premium in advance to the health insurance company which then pays some or all of a person's health care costs. People enrolled in public insurance may not have a premium payment.

Once members are enrolled, in either public or private health insurance coverage, they can seek care from network providers. The type of plan selected (e.g., HMO, PPO, EPO) will dictate how members access primary care providers and specialists. Once a member uses network care, the health insurance company will pay a pre-determined, negotiated rate to the provider directly, and the member will only be responsible for the cost-sharing for that service.

- Cost-sharing requirements come in the form of coinsurance, copayments and deductibles, which are all generally applied toward a member's out-of-pocket maximum limit. Out-of-pocket costs are the amount the consumer pays for the services used that are covered by the health plan.

The following items are generally not treated as out-of-pocket costs:

- Monthly premiums (except in public programs like Medi-Cal)
- Balance-billing amounts for out-of-network doctors and hospitals
- The cost of non-covered services, including services that are not medically necessary.

Once a member reaches an out-of-pocket maximum cost, the insurance company generally covers 100 percent of covered in-network expenses after that point, regardless of the type of plan selected.

For example, Ann has health insurance that includes the following costs:

1) Monthly premium = $200

2) Deductible = $5,000

3) Coinsurance = 20 percent

4) Out-of-pocket limit = $6,000

Ann is repairing her home and sustains a serious accident and incurs $50,000 in covered medical expenses. The following shows how Ann's out-of-pocket costs are calculated.

1) Ann is already paying $200 per month for her health insurance.

2) After Ann's accident, she is responsible for paying the first $5,000 of the medical expenses (the deductible).

3) Ann is also responsible for 20 percent coinsurance until she reaches the out-of-pocket limit. In this situation, 20 percent coinsurance would equal $9,000. Because the out-of-pocket limit is $6,000, and Ann already paid $5,000 (the deductible), she owes an additional $1,000.

4) The health insurer pays the hospital and doctors directly for the rest of Ann's medical expenses.

5) For the rest of the calendar year, the health insurer pays 100 percent of Ann's covered medical expenses.

The cost for the Incident:

Ann = $6,000

Health Insurer = $44,000

Total = $50,000

3 LESSON 2: HEALTH INSURANCE THROUGH COVERED CALIFORNIA

This lesson will focus on the positive impact the ACA will have on health insurance in California, including costs, access and quality. This lesson will also describe the regulations for health insurance in California.

3.1 LEARNING OBJECTIVES

By the end of this lesson you will be able to:

- ✓ Understand how the ACA aims to decrease health insurance costs, improve access to care and quality of care.
- ✓ Describe the rules that govern health insurance including the California Insurance Code and the Knox-Keene Act.

3.1.1 REQUIRING INDIVIDUALS TO HAVE HEALTH INSURANCE

Health insurance is based on the idea that most of a health insurance plan's members are healthy and not filing many claims. Unfortunately, some of those members will incur major medical expenses. Since nearly everyone who develops a serious medical problem gets treated with or without insurance the cost of treating the uninsured is passed on to those that are insured.

The ACA requirement that all individuals must have health insurance will have the following impacts:

- With more individuals paying into the risk pool (the group of insured members), the risk of catastrophic illness and injury and its resulting costs are spread over a larger number of people.
- Individuals and families with health insurance coverage will no longer risk the possibility of personal financial calamity or bankruptcy due to a catastrophic injury or illness.
- Health insurance coverage will enable formerly uninsured individuals to seek treatment for illness sooner and access preventive care, thus avoiding serious illness altogether or minimizing its impact by early intervention. This leads to better health outcomes and, ultimately, lower costs.

3.1.2 PREVENTIVE CARE

With proper preventive care, health problems can often be identified earlier, managed more effectively and treated before they develop into a more complicated, debilitating illness. Research has shown that evidence-based preventive services are not only cost-effective but also save lives.

Despite longstanding recommendations for use of preventive services, out of-pocket costs in the form of copayments and deductibles have often acted as a barrier, keeping even the insured from seeking recommended screenings, tests, counseling and immunizations. Under the ACA, health plans must provide coverage for a range of preventive services and may not impose cost sharing (such as copayments, deductibles, or coinsurance) on patients receiving these services. This will lead to better health outcomes as well as lower health care costs.

3.1.3 HEALTH INSURANCE EXCHANGES

Covered California, California's health insurance exchange, creates a more organized and competitive marketplace for health insurance. Health insurance companies must provide plans that meet certain rules relating to affordability, required benefits, and market standards, with standardized benefit options that make comparisons easier for consumers.

Covered California will increase the number of insured Californians through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value. Health insurance companies will compete for business leading to lower premium rates. Health plans will compete for consumers based on price, quality, customer service and network.

3.2 HOW INSURANCE IS REGULATED IN CALIFORNIA

Covered California is not a regulator; instead, it is creating a vibrant, competitive marketplace by offering approved health plans to consumers. It works closely with state agencies in California that regulate health insurance coverage. Individuals responsible for working on Covered California's behalf should be familiar with these agencies and the laws they enforce. The two agencies that regulate health insurance in California are the California Department of Insurance and the Department of Managed Health Care. They are described in more detail below.

3.2.1 THE CALIFORNIA DEPARTMENT OF INSURANCE (CDI)

The California Department of Insurance (CDI) regulates all insurance companies, including traditional indemnity health insurance companies that are subject to the California Insurance Code. In exchange for premium payments, indemnity health insurers will reimburse insured individuals or their designated providers for approved services under the terms of the individual's health insurance policy. In this way, indemnity health insurers operate similarly to other types of non-health insurers by reimbursing an insured individual or their designated provider for losses.

Because the CDI regulates traditional insurers, it performs the activities generally associated with insurance regulation: examining and certifying insurers; ensuring that insurance companies have adequate reserves to meet anticipated losses; conserving, rehabilitating or liquidating troubled insurers; reviewing and approving health insurance company rates; licensing insurance brokers and agents; ensuring that insurers operate in an honest, open and fair manner; investigating insurance fraud; and in some cases, taking legal action against those who violate the Insurance Code.

The CDI is headed by the California Insurance Commissioner, an elected Constitutional officer.

3.2.2 California Insurance Code

The California Insurance Code is a set of California laws regarding insurance. It covers a variety of different types of insurance, including health insurance.

California insurance laws most relevant to individuals working on Covered California's behalf include:

- The business of each insurance company must be examined by the California Insurance Commissioner regularly, and no less than once every five years. The Commissioner may review all insurance company records during these examinations to ensure that the company is financially sound and is otherwise conducting business in an appropriate manner.
- Health insurers are required to submit proposed rate increases to their policyholders and the CDI for review. The Commissioner will review such proposed rate increases to determine whether they are justified and may either ask the insurer to amend unjustified proposed rate increases or make an official public determination that a proposed rate increase is unreasonable.

3.2.3 Agent Licensure

The California Department of Insurance is also responsible for issuing agent licenses. Agents must meet certain standards and must receive a license to transact the business of insurance. When dealing with consumers, these licensed agents may make recommendations regarding insurance products, but must not make any misleading statements in order to induce an individual to purchase a policy of insurance.

Certified Insurance Agents are separate and distinct from Certified Enrollment Counselors, who also help individuals gain access to health insurance coverage through Covered California.

3.2.4 The Department of Managed Health Care (DMHC)

The Department of Managed Health Care (DMHC) regulates health care service plans, which are entities that arrange for health care services to be provided to consumers, or pay for any part of the cost for those services, in exchange for a prepaid or periodic charges paid by the consumer. Health care service plans may be HMOs, EPOs or some PPOs, which contract with healthcare providers and develop various provider networks for members enrolled in the plan.

The DMHC, like the CDI, has various responsibilities, such as consumer assistance which involves answering consumer questions about health plans, ensuring that consumers receive an independent medical review when dissatisfied with health plan service denials, reviewing consumer complaints and determining whether plans are complying with the relevant laws. DMHC responsibilities also include litigation and enforcement of health plan requirements under the Knox-Keene Act, oversight of health plan operations, evaluation of health plans' financial viability and review of proposed rate increases. Virtually all of these responsibilities belong to the CDI for the health plans they regulate.

The DMHC is overseen by its director, who is appointed by the California governor.

3.2.5 THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT (KNOX-KEENE ACT) AND COVERED CALIFORNIA

The DMHC is primarily responsible for ensuring that health plans meet the requirements of the Knox-Keene Act, as codified in a chapter of the California Health & Safety Code. The Knox-Keene Act focuses on the provision of health care services rather than the payment for specified expenses or losses. Thus, this set of laws and accompanying regulations includes detailed requirements for plans to provide access to certain provider types for defined services and to ensure quality of the care provided. For example, individual or small group health care service plan contracts issued, amended, or renewed on or after January 1, 2014 are required by the Knox-Keene Act to include coverage for essential health benefits pursuant to the ACA. The Insurance Code contains parallel requirements. Accompanying this statutory language are the newly-enacted essential health benefit regulations that require all small group and individual health plans to file an essential health benefit worksheet with the DMHC, reporting on the ways in which the plans cover all of the required benefits.

3.2.6 INTERSECTIONS OF INSURANCE REGULATIONS

While the two agencies are subject to different regulatory requirements, there is considerable overlap in the jurisdiction of the CDI and the DMHC. Health insurance companies often offer several different products that fall across the jurisdictions of the two agencies. For example, a health insurance company that offered an HMO that would be subject to regulatory oversight by the DMHC. The same insurer would also be subject to oversight by the CDI if it were to offer any traditional indemnity health insurance products. In addition, if that health insurer offers products in the Covered California Marketplace, it would also be subject to the regulations applicable to the Marketplace.

Covered California, the California Department of Insurance and the Department of Managed Health Care are all working together to ensure effective oversight and regulation of health insurance markets in California and to ensure that the ACA rules and requirements are implemented in California.