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Medical Plans

A. Medical Plan Concepts

1) Fee-for-service means the doctor receives payment when he or she performs a service such as an office visit. There are health plans known as fee-for-service or indemnity plans. The original major medical plan was and still is a fee-for-service plan and can be called by that name.

2) Prepaid HMOs have a pre-paid concept where the doctor is paid a fixed monthly regardless of whether or not the services were used.

3) Specified coverage only covers what is named. *E.g., A Cancer policy only pays on the diagnosis of cancer.* This coverage pays in addition to another policy, it does not coordinate benefits. It is designed to cover the copay or coinsurance owed after the insured's major medical policy pays. It is paid directly to the insured.

4) First Dollar Coverage the insurance company pays first, there is no deductible or out-of-pocket for the insured. *Wellness checks and flu shots would be an example of this today.*

5) Comprehensive Coverage complete and total coverage in one plan. An HMO is an example covering all of a person's medical needs, from immunizations and well-baby care to sports physicals to hospital care. Comprehensive plans are plans that cover a wide range of health services, unlike limited plans such as an AD&D policy or a Cancer plan. Since the ACA was implemented, there are 10 essential health benefits with no annual or lifetime cap required to be offed by all plans.

6) Dependent coverage spouse, children, or perhaps a dependent parent covered under an insured's medical coverage.

B. Provisions and Clauses

1) Deductible… A provision in an insurance policy that requires the insured to pay the first specified dollars of expense which will not be reimbursed by the insurer. Expenses above the deductible then will be paid by the insurer as indicated in the policy.

- ***The purpose of the deductible for the insurer is to eliminate coverage for small losses*** and minimize the abuse of insurance. The purpose of the deductible for the consumer is to lower premiums.
- **Per Injury or Sickness (Per Cause) vs. Cumulative Deductible (All Cause)…** Under the per sickness or ***per cause***, a new deductible is charged for each sickness or injury.

- Under the cumulative or ***all cause***, a deductible is charged for that benefit period. The ***Benefit Period*** usually begins and ends each calendar year (January 1st - December 31st). The insured pays all medical expenses until the deductible has been met. After that has happened, the insurer pays their percentage of the co-insurance until the insured has paid out to the stop loss limit.

  - The **Common Accident/Sickness** provision provides that only one deductible has to be met if two or more family members are injured in the same accident or have the same illness.

  - The **Family Maximum** provision waives any further deductibles once any two or three of the family members have paid enough toward deductibles in the same year. *For example, a policy may read "A $5,500 deductible per person or $11,000 per family*." This total may be reached through any combination of deductibles paid by all family members.

2) Stop Loss… a.k.a. Out-of-Pocket Maximum - A provision found in Major Medical policies states that once the total costs of eligible health care expenses received exceed a specific amount, such as $5,000, the insurance company will pay 100% of the eligible expenses above that amount. This covers only costs that are approved and 'in-network.' Premium is still due.

3) Impairment Rider - Due to the Affordable Health Care Act, the application for a medical policy is no longer allowed to exclude a pre-existing condition from coverage. Any other type of coverage (disability income, medigap, etc.) will still have a questionnaire to ferret out any pre-existing conditions. A pre-existing condition is something you had, were treated for, or advised to have treatment for. This rider limits or eliminates coverage for that condition for a period of time or completely.

C. Types of medical plans

Medical Expense Insurance provides benefits for medical care. Traditional Medical Expense contracts may provide for payment of medical expenses incurred on a/an:

- **Reimbursement basis** (paying benefits to the insured, such as a Major Medical Plan). The insured pays the bill and is reimbursed for the amount specified in the contract, after any deductible and coinsurance amounts, up to the policy limits.

- **Indemnity basis** paying a set amount [a.k.a. Stated Value] regardless of the actual charge for the medical expenses, *e.g., Hospital indemnity plan.* You are indemnified to what the contract states.

1) Major Medical Expense Insurance…

The **purpose** of major medical insurance is to provide complete coverage for all your covered medical needs. ***Major medical has a deductible, high limits, co-insurance, and stop-loss provisions.*** These plans offer coverage on a reimbursement basis.

> *Remember the claim provisions?* Rather than paying the doctor, filling out a claim form, sending it to the carrier, and waiting for reimbursement, an insured can choose to assign those claim provisions to the doctor and the carrier pays the doctor directly. The insured is then billed for the difference. This is especially important to use with PPO plans where there is a negotiated rate.

Major medical plans can also be called indemnity plans or fee-for-service plans. There is no Primary Care Doctor required, there are no referral requirements, and this is not managed care by a physician or carrier.

Many of these plans offer a higher deductible than traditionally was offered. If that is the case, they are known as High Deductible Health Plans and are eligible for an HSA or Health Savings Account. Originally, the high deductible meant a lower premium. If you did not need to use the plan very often you could open up a tax-free account to invest the difference between a high premium low deductible plan and a high deductible lower premium plan. The premium savings would go into this savings account to pay the high deductible when needed. There are tax benefits to the HSA as well. (More on that in the taxes section.)

Major Medical Coverage extends to Hospital, Medical, and Surgical expenses incurred by the insured, however, there may be ***internal limits*** within the policy. *E.g., ambulance service, speech therapy, or x-rays.*

Coinsurance… A provision found in Major Medical policies whereby the insurance company and the policy owner share covered losses in agreed proportions. The insured pays for a percentage of the expenses in excess of the deductible.

The purpose of the coinsurance feature is to prevent overuse of the contract benefits by making the claimant pay part of the claim. The insurance company is responsible for the higher of the two percentages.

Federal Law (ACA) categorizes co-insurance by values of metals. The plans vary in premium, co-insurance amounts, and internal limits.

Usual, Customary, and Reasonable (aka UCR) benefits depend on what is considered usual and customary in a certain geographical area. When benefits are not listed by a specific dollar amount in a schedule, a policy will pay based on what is considered usual, customary, and reasonable.

Common Exclusions for Basic and Major Medical Plans

- ∅ Self-inflicted injuries
- ∅ Injuries or illness from acts of war, or while on active military duty
- ∅ Dental and vision care –pediatric care for these is covered
- ∅ Benefits payable under workers' compensation
- ∅ Injury while committing a crime
- ∅ ***Injury or illness while under the influence of intoxicants or narcotics***
- ∅ Cosmetic surgery
- ∅ **Custodial care** (help with the Activities of Daily Living)

When there is a bill, the first dollar amount applies to the deductible. **After** the deductible has been met, i.e., paid by the insured, the co-insurance applies, and the insurance company pays its portion until the insured reaches the stop loss amount. At that time, the insurer pays all incoming approved bills.

If you have a math question, the process is as follows:

****

A policy has a $5000 deductible and 80/20 co-insurance.

A doctor's visit results in charges for the month of $8000

Subtract the deductible	$8,000 - 5,000 =	$ 3,000	
Multiply the balance by the co-insurance %	$3,000 * 20% =	$ 600	
Add the 2 numbers ($5,000+$600)	A total of	$ 5,600	was paid by the insur**ed**
	The difference (8000-3600) of	$ 2,400	was paid by the insur**er**

****

Miss Molly has a policy with a $1000 deductible and 90/10 coinsurance. Her doctor bills for the month are $1500. What does the insurer pay?

Subtract the deductible $1,500-1,000=$500

Miss Molly pays another 10% of the $500

The insur**er** pays the remaining 90% of the $500

****

Things to be aware of are:

Is the question of how much did the insur**ed** or the insur**er** pay? *Always check which one is being asked about once again after doing the math, and check that their values add up to the original just in case.*

Did you reach the stop loss limit? *Sometimes this creates an obvious answer:*

> Miss Molly has a policy with a $1,000 deductible, 90/10 coinsurance, and a $5,000 stop loss. Her doctor bills for the emergency surgery and hospital stay are $75,000. What does Miss Molly pay?
>
> Don't worry about the math, she pays her stop loss limit of $5,000 and that is it. The policy will read the number both with and without the deductible, so it is clear.

2) Health Maintenance Organizations (HMOs) provide for **comprehensive health care** in return for a pre-negotiated sum (a.k.a. **pre-paid premium**) or periodic payment. An HMO is a corporation that is financed by premiums and has physicians on staff (salaried) who focus on preventative care while still providing curative care to those who are subscribers.

An HMO has its own **network** of doctors, hospitals, and other healthcare providers who have agreed to accept payment at a certain level, a negotiated rate, for any services they provide. This allows the **HMO** to keep costs in check for its members. As a result, the premiums may be lower than other plans. The drawback is it can be very restrictive to the consumer.

- **The HMO Pays 100%** of expenses minus any co-payments for covered care.
- A co-payment is the dollar amount that an insured must pay each time he goes to visit a doctor (usually around $20).
- **The Plan Pays $0** if you see a doctor 'out of network' or without a referral from your Primary Care Doctor.
- An HMO has a **gatekeeper system** in which a member must select a **Primary Care Doctor** (a.k.a. Provider) who oversees the insured's care and must approve any treatment by other providers before it is given (a.k.a. ***Managed Health Care***). You must get a referral from your PCP for the visit to the specialist to be covered. You also must utilize only the specialists contracted through the HMO for the HMO to pay.
- HMOs operate within a specified geographical area known as the ***service area***.
- Some HMOs pay the doctor a ***Capitation Fee***, a fixed monthly amount per subscriber, **regardless of whether services are used or not.**
- **HMOs are required to provide basic benefits**: physician services, diagnostic lab services, out-of-area coverage, preventive care, emergency care, hospital in-patient care, and outpatient care.
- All HMOs are required to have a complaint system, often called a grievance procedure, to resolve written complaints by members.

The benefit to this is you know exactly how much the visit is before you go, and it is much less for an office visit than another plan where you need to pay for everything yourself until the deductible has been met. The drawback? You need to stay in network. *This can be easy in an urban area, but, if you live at the edge of the service area and the closest doctor is 35 miles away, that's where you go when you're sick.*

3) Preferred Provider Organizations (PPOs) are groups of health care providers who agree to provide services for less money than they might charge otherwise. For pre-set fees, all of the enrollees in a medical plan are given a list of names of the PPOs doctors and hospitals which must be used by the insured for their care. A primary care physician is not required.

- **A PPO is a form of managed care but pays on a fee-for-service or reimbursement basis**. **PPOs are usually combined with a major medical plan.**
- **If the insured does not use the prescribed doctors or hospitals, the insured will be required to pay a larger portion of the approved medical bills**. *For example, instead of 80-20 co-insurance, the insurer may pay on a 50-50 basis or may double the deductible.*
- **PPOs** were developed as a compromise between the benefits of the HMO and the traditional reimbursement plan offered by commercial insurers. Commercial insurers implemented PPOs as an answer to some of the perceived negative aspects of HMOs, such as a limited choice of physicians.

4) Point of Service (POS) Plans are a form of managed health care that looks like **HMO and PPO combinations**. Like an HMO, an insured must choose a primary care physician. ***This designated physician is the referral source for all other medical professionals***, i.e., referrals. The covered person selects a ***primary care physician*** from the list of practitioners that are acceptable to the plan administrators. 'In Network' care is paid for at the plan's higher rates, perhaps a co-pay is all the insured is required to pay. 'Out of Network 'care is covered, but the insured will have more out-of-pocket expenses, a deductible, and co-insurance instead of a copay.

The problem with this approach is that of HMOs, if you are in a small geographic area, the choice of primary physicians may be very restricted or nonexistent. Comparable to a PPO, ***if an insured doesn't like that physician, he or she can choose to go to a doctor outside of the POS plan, but would need to pay a deductible and coinsurance percentage.*** *The POS plan will still make a payment 'out of network.' Note: if going out of network on an HMO $0 is paid by the insurance company.*

Comparison Chart between the plans

	Major Medical	**PPO**	**POS**	**HMO**
Managed Care	no	yes	yes	yes
Primary Care Doctor	no	no	yes	yes
Must use listed doctors or clinics	no	no, but will pay more if use listed	no, but will pay more if use listed	yes
Deductible	yes	yes	out of network	maybe
Co-insurance or co-pay	co ins	co ins	In-network = co-pay out of network = deductible and co-ins	Co-pay
Insurer will pay for care anywhere	yes	Yes, but the carrier will pay more if you use an in-network provider	Yes, but the carrier will pay more if you use an in-network provider	no
referral needed for payment by insurer	no	no, but will pay more if a referral is given	no, but will pay more if a referral is given	yes
Insurer will pay without a referral	yes	yes, but there may be a larger deductible and coinsurance	yes, but there may be a larger deductible and coinsurance	no

D. Cost Containment in Health Care Delivery

5) Managed Care imposes controls on the use of health care services and the providers of health care services, usually through health maintenance organizations or preferred provider arrangements. Controls are the use of a visit to the Primary Care Physician for a referral. The PCP may decide IF you need to see a specialist and WHICH specialist you should see. This can keep the overall costs down since a specialist is generally more expensive and may not need to be seen.

6) Preventative Care focuses on keeping people healthy through regular care. Numerous screenings are available at differing ages at no cost to the patient due to the Affordable Health Care Act. There is a list of required care, available without co-insurance or a copay or applying towards a deductible. There is NO COST to the consumer. Preventive care includes health services such as screenings, wellness check-ups, and patient counseling that are used to prevent illnesses, diseases, and other health problems. It is also used to detect illness at a potentially early stage when treatment is likely to work best. Getting recommended preventive services and making healthy lifestyle choices are key steps to good health and well-being.

7) Outpatient Benefits: Treating people on an outpatient basis rather than admitting them to the hospital for an overnight stay reduces costs for both the insured and the insurer. *Not being admitted to a hospital for day surgery or using a surgical center instead of a hospital are examples of outpatient care. This is also known as ambulatory care. Other examples include getting your flu shot at the pharmacy.*

8) Utilization Management for an individual is the process of a caseworker (an RN with UM training) coordinating care for an insured, evaluating, and advising treatment on a case-by-case basis. This could include new clinical activities, inpatient admissions, discharge planning, etc.

9) Utilization management for insurers is a cost containment tool for both the carrier and the insured.

There are 3 types involved:

i. A **Prospective** Review is to review the service before authorizing it to be paid. *E.g., is an MRI needed? Was an x-ray taken and physical therapy done?*

ii. **Concurrent** reviews will assess the situation right now - is everything being done that is necessary? Coordinate care for today *(meds, pt., etc.)*. Discharge planning if this is a hospital stay.

iii. **Retrospective** review to assess the appropriateness of the care given and verify the billing codes are the correct ones used. The ultimate goal is to reduce excess spending while at the same time managing and improving care and effectiveness.

10) Pre-certification (usually for the patient) and pre-authorization (usually for the procedure performed by the doctor or hospital): This process allows an insurance company to review and approve treatment for the insured, and to review and approve the expected hospital and surgical costs before the patient enters the hospital. Simply put, it is a cost-cutting method on the part of the carrier when they deem a service is not necessary or that the client has not done all they could do prior. *For example, if someone has a sore shoulder, operating immediately may not be the best solution. Medication and physical therapy may solve the issue and is safer. Do that program first.*

11) Primary Care Physician: An HMO and a POS have a **gatekeeper system** in which a member must select a Primary Care Doctor (a.k.a. Provider) who oversees the insured's care and must approve any treatment by other providers before it is given (a.k.a. ***Managed Health Care).*** They refer you to the specialist who can help the most (and who is in your network).

E. Limited Health Insurance Policies

1) Accidental Death and Dismemberment (A.D.& D.)

i. **The Principal Sum** pays for ***accidental death***, for the dismemberment of or loss of use of any two limbs, or for the total loss of sight, speech, or hearing.

ii. **The Capital Sum** (pays up to ½ of the principal sum) pays for loss of or loss of use of any one limb, loss of sight in one eye or one arm ***due to an accident***. The AD & D will have a *schedule* of benefits for other lesser types of dismemberments (*e.g., loss of a finger*).

- ***The Capital Sum may also pay for the loss of an organ, such as a kidney or spleen, as long as the loss is due to an accident.***

iii. **Exclusions:** AD & D policies will **not** pay if death or dismemberment occurs more than **90 days** after the accident. (WA State expanded that time period to 1 year.)

These policies **will not pay** for death due to:

- illness, suicide, war, or intentional acts of the insured.
- air travel other than as a fare-paying passenger.
- ***the insured's illegal activities***, *e.g., committing assault or felony.*
- the use of any drugs (unless the insured is under a doctor's care).

Special Note: Should an insured die from a cause or situation which is "**excluded**" in the policy, no death benefit will be paid, **nor will there be any refund of paid premiums**.

2) Critical Illness Plans are used to cover high-cost illnesses. They encompass a broad range of illnesses such as heart disease, cancer, stroke, kidney disease, etc., including benefits for MRIs, radiation treatment, and chemotherapy. If the insured has a plan and is diagnosed with a disease listed, the plan will pay a lump sum to the insured. The money can be used to cover the costs not covered on the medical insurance, pay the deductible, pay a driver to bring the insured to and from treatment, etc.

- ***These plans usually pay a lump sum benefit to the insured, such as $50,000 if the insured is diagnosed with cancer or $25,000 for kidney failure***.

- **Critical Illness Plans** should be purchased as a supplement to the insured's other health plan. Since these plans are supplements, they will pay in addition to the insured's other health plans with no coordination of benefits. They should not be confused with a major medical plan.

- The plan also may pay a specific amount per treatment. *E.g., $50 for an office visit, $75 for radiology, or $200 per night in the hospital.* These figures are paid directly to the consumer and the plan does not coordinate benefits with an insured's major medical plan. They are designed to cover the copayment or coinsurance amounts and are paid in addition to the health insurance coverage.

3) Dental Insurance usually is offered only under group plans. It is most often excluded from medical expense insurance, therefore, the coverage must be added as an additional or optional benefit or purchased as a separate plan. Individual plans range from those like traditional major medical or PPOs or HMOs. Individual Benefits offered may be on a ***scheduled or non-scheduled basis,*** or a combination plan of scheduled and non-scheduled benefits.

- A scheduled plan has specific categories of dental treatment and dollar amounts for each category of dental care. A scheduled plan might include categories such as: preventive care, diagnostic care, restoration (fillings and crowns), and root canals.

- Most dental plans, as with most medical plans, have a deductible and a coinsurance provision. The deductible usually is not required for preventive care. The plans will usually have a maximum limit per year (*e.g., $1,000, $5,000*).

- New plans will also have a probation period for certain items. *For example, cavities may not be covered for 8 months.*

- Indemnity plans will pay the dentist a percentage of the cost. There will be a deductible, co-insurance, or co-payment which will change depending on the procedure, waiting periods, and annual limitations.

- Plans are available as a major medical, HMO, PPO, or POS.

4) Vision Care can be offered as an optional benefit under most group health plans. It might be a benefit on your individual health plan, or it can be purchased as a stand-alone individual vision plan. These plans will usually pay either a specific (fixed) amount or the entire cost of eye exams. It also covers a listed amount (*e.g., $150*) of the cost of prescribed eyeglasses or contacts annually.

5) Hearing Even though hearing loss is one of the most common disabilities, it is also one of the most misunderstood and underestimated disabilities. Hearing testing may be covered on a health insurance policy, but hearing aids may not be. *There are a few plans in the market aimed at hearing aids, generally, they are aimed at the population on Medicare as a supplement.*

It has been called the "invisible" condition because it is not possible to "see" a hearing loss directly, only its effects on behavior and communication. The fact that these effects can be so variable depending upon the individual and the situation is what makes hearing loss such a confusing condition. We do not want to trivialize the impact that impaired communication can have on the life and well-being of an affected person, regardless of age. 80% of people who could benefit from hearing aids do not get them. It can be a covered item in insurance policies, but the amount paid out is very limited and not enough to cover more than a small percentage of the total cost.

6) Hospital Indemnity Plan is a supplemental plan that is **not intended** to cover the costs of hospitalization. Its purpose is to assist with the copays and coinsurance or deductibles that will result from a stay.

a) **Room and Board** pays on a dollar amount basis, that is, a pre-established amount (stated value) per day for a maximum number of days, **regardless of the total of actual hospital expenses**. *For example, if an insured has a $ 200-a-day room and board limit and spends 10 days in the hospital, the policy will pay $2,000 total, regardless of actual charges.*

b) **Intensive Care** pays a multiple of the semi-private room rate of the hospital. The number of days of coverage also is limited to a stated number of days.

c) **Miscellaneous Charges,** a.k.a. *Ancillary Coverage*, covers such expenses as convalescent care, nurses, medical expenses, charges to cover non-surgical hospital expenses, X-rays, lab fees, and miscellaneous supplies. It may pay the full cost or, more likely, a specific amount for each item. *Such as $75 for an x-ray.*

F. HIPAA… The Health Insurance Portability and Accountability Act

1) Eligibility Requirements

HIPAA law forbids the new insurance company from holding an insured to a pre-existing condition exclusion if they:

- previously had coverage with another plan for 18 months and
- were covered for that condition and
- they applied for the new coverage within **63** days of losing the old coverage and
- no other coverage was available, including COBRA and
- the old coverage was not lost due to fraud or non-payment of premium

2) Privacy

Accountability means holding accountable for sharing a person's health information. This cannot be done without their express permission. The HIPAA Privacy Rule provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights concerning that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes.

The Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity, and availability of electronic protected health information.

3) Who is covered?

Health plans covered include all health, dental, vision RX, etc. If an insurance entity has separable lines of business, one of which is a health plan, the HIPAA regulations apply to the entity concerning the health plan line of business. Every health care provider, regardless of size, who electronically transmits health information in connection with certain transactions, is a covered entity.

4) What is protected?

"Individually identifiable health information" is information, including demographic data, which relates to:

- the individual's past, present, or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual,
- and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.

The main reason for HIPAA is to help keep personal information ***confidential***. Proper disclosure is required under the HIPAA Privacy Rule.

> **Disclosure: The HIPAA Privacy Rule's** purpose is to define and limit the circumstances in which an individual's protected health information may be used or disclosed to other parties. ***No entity*** may use or disclose health information unless ***the individual authorizes it in writing***.

(Visit HHS.gov for more information)

5) Portability

5) Portability means to take it with you. *Due to the Affordable Health Care Act, an exclusion for a pre-existing condition is not allowed in health insurance so a person can always qualify.*

The Affordable Health Care Act (ACA) took care of that issue with health care, no pre-existing conditions may be excluded period, from health insurance. Any other type of disability insurance is subject to the pre-existing condition exclusion. HIPAA allows an individual to sign up for coverage at a new employer within 63 days of losing coverage and not have to do a medical questionnaire.

An example of violating HIPAA law would be discussing or reviewing a client's application with a co-worker while not behind closed office doors.

6) Terms

(Some of these do not need a separate definition)

- **Business Associate Agreement**
- **Business Associates** Anyone who has access to patient information
- **Civil Penalties** are based on the level of misconduct below
    - **Due Diligence**
    - **Reasonable Cause**
    - **Willful Neglect**
- **Covered Entities (CE)** anyone who provides treatment, payment, or operations in healthcare
- **Criminal Penalties**
- **Electronic Data Interchange (EDI)**
- **Electronic Health Records (EHR)**
- **Electronic Protected Health Information (EPHI)**
- **Health Information** patient information collected by any healthcare organization
- **Health Information Technology for Economic and Clinical Health (HITECH)**
- **Healthcare Clearinghouse** is an organization that standardizes health information
- **Healthcare Insurance Portability and Accountability Act (HIPAA)**
- **HIPAA Audit**
- **HIPAA Violations**
- **Individually Identifiable Health Information** is a means of recognizing the individual addressed
- **OCR HIPAA Audit Protocol** is a standard protocol for audits
- **Privacy Rule** the rule addressing the saving, accessing, and sharing of personal medical information
- **Protected Health Information (PHI)** everything
- **Security Rule** the rule protecting health data being shared

G. Affordable Care Act (ACA) is a comprehensive health care reform enacted in 2010.

There were 3 primary goals of this law, make health care more affordable to more people, expand the Medicaid program, and support innovative medical care delivery methods. It required every citizen to get and maintain health insurance or pay a penalty. The penalty dropped in 2018. It also stopped exclusions for pre-existing conditions in health care.

Purchasing a plan through a marketplace: a health insurance marketplace is where you can shop for health insurance plans, also called the 'exchange.' They sell plans that may be subsidized by the federal government, depending on your family's income and family size. If you qualify for a plan here, your premiums may be reduced. Washington state, along with a few other states, has its own exchange. Private marketplaces exist as well that carry both ACA plans as well as other plans.

There is an open enrollment period where an individual may purchase an individual plan. This is the only time to purchase with a few exceptions. The reason for that is to avoid adverse selection by carriers. Insurers are not allowed to exclude a pre-existing condition nor are they allowed to turn someone down due to that condition. *If, for example, someone did not want to pay for insurance until they needed it, bought it, used it, and dropped it; or hopped from an inexpensive policy to one with better coverage when needed, the premiums would increase dramatically for everyone else.*

The exceptions for purchasing insurance outside of the open enrollment period are changes in the household, changes in residence, loss of health insurance, and just gained access to an individual coverage HRA or a QSEHRA. Other special circumstances may qualify you for a special enrollment.

1) Eligibility is for every US citizen who is not on Medicare or incarcerated and lives in the United States. Everyone who fits these parameters is eligible for an individual health care plan through the marketplace.

For employers with 50 or more employees, all full-time (30 hours per week) employees are required to be offered coverage of at least a bronze plan with the employees' portion of the premium being affordable. This is for the employee and their children up through age 26.

2) Dependent Coverage is available through the ACA for dependent children through age 26. **Note: this may not cover their children's children (grandkids).** Both married and single individuals qualify for this coverage on all plans, individual- or employer-sponsored. Once an individual 'ages out' by reaching age 26 they may be able to choose COBRA benefits to remain in the plan or simply purchase their own by enrolling within 60 days of losing coverage.

Dependent child coverage is required to be offered by employers, but not spouse coverage. If a spouse has coverage through their employer that's what they use. If not, they can be added to the covered spouse's plan or shop around for an individual plan.

3) Essential Health Benefits are those 10 benefits that are required to be covered by the ACA. They are:

1. Outpatient care
2. Emergency services
3. Hospitalization
4. Maternity
5. Mental health and substance abuse disorder services
6. Prescription medication
7. Rehabilitative services and devices
8. Laboratory services
9. Preventative and wellness services
10. Pediatric services must include oral and vision care through age 19

4) Levels of Coverage (metallic plans)

Think of the Olympic medals - bronze, silver, and gold - and you have 3 of the 4 levels of coverage. The last and best one is platinum. The plans vary in not only premium cost but in what you pay out of pocket for the deductible, the coinsurance, and the internal limits. A bronze plan will cover radiology but only up to $300 for the entire year. Anything beyond that is out of pocket and does not count towards the deductible. A silver plan will have a higher internal limit.

For example, Platinum plans are 90/10 meaning the consumer will pay 10% of the cost after the deductible up to the stop loss limit and the carrier pays 90% of the cost. This plan has the most expensive premium but the lowest out-of-pocket cost. The differences in premium from one level to another can be as low as $10 per month with a better benefit in the higher plan.

A bronze plan is 60/40 coinsurance, but if someone is healthy and seldom goes to the doctor this may be preferred due to its low premium.

Plan	Insurance company pays	Consumer pays
Platinum	90%	10%
Gold	80%	20%
Silver	70%	30%
Bronze	60%	40%