

# Kansas Health Insurance in Kansas

*Updated August 15, 2013*



**Kansas Insurance Department**  
*Sandy Praeger, Commissioner*

# Health insurance in Kansas

August 2013

Dear Kansas consumer,

We all value our health. When we become ill, it can cause both emotional and financial stress. Insurance can help protect you against enormous health care expenses.

This booklet is designed to give you a general understanding of health care coverage available in Kansas. It contains information about individual health insurance, employer-based (group) health insurance and how individuals who are currently uninsured can get the health insurance coverage they need. We want to help you ask the right questions and avoid some common mistakes. We also try to answer some of the most common health insurance questions our department gets from Kansans.

This guide has been updated to include information on the Affordable Care Act (ACA), signed into law in 2010. **It is important to remember that the specifics concerning the ACA are still evolving. While the provisions about the ACA were accurate when this book was printed, things may have changed since then.** Contact our department if you have specific questions regarding health care reform.

If you have questions or need assistance understanding health insurance issues, don't hesitate to contact the Kansas Insurance Department's Consumer Assistance Hotline toll-free at 800-432-2484. Our trained staff is dedicated to helping answer your insurance questions and finding solutions to your problems.

Sincerely,



Sandy Praeger,  
Commissioner of Insurance



## Tell us what you think!

We are always looking for the best ways to assist consumers with their insurance needs. If you have a suggestion on how to improve this publication, send us an email: [commissioner@ksinsurance.org](mailto:commissioner@ksinsurance.org)



# Table of Contents

<b>Chapter 1: Changes in health insurance</b>	<b>2 - 7</b>
Changes since 2010	
Changes effective January 1, 2014	
Health Insurance Marketplace	
<b>Chapter 2: If you have individual coverage</b>	<b>8 - 20</b>
Summary of individual health policies	
What is covered under an individual policy	
Determining how much you pay	
Consumer protections for policyholders	
Individual responsibility	
Coverage on and off the marketplace	
Grandfathered health plans	
<b>Chapter 3: If you do not have health insurance</b>	<b>21 - 29</b>
What coverage am I eligible for?	
What coverage is right for me?	
How can I enroll in coverage?	
Things to consider before buying a policy	
<b>Chapter 4: If you have group health insurance</b>	<b>30 - 39</b>
Fully-insured plans vs. Self-insured plans	
How group health plans work	
What group health plans cover	
Joining a group health plan	
Leaving a group health plan	
Group health insurance and the Affordable Care Act	
<b>Chapter 5: Appealing a claim denial</b>	<b>40 - 47</b>
Independent Medical Review	
Filing a consumer complaint	
Preparing to purchase a policy	
Questions to ask before purchasing	
<b>Chapter 6: Frequently Asked Questions</b>	<b>48 - 51</b>
<b>Chapter 7: Glossary of health insurance terms</b>	<b>52 - 56</b>

## Chapter 1

# Changes in health insurance

These changes took place shortly after the health reform law was passed in 2010.

The federal health care reform law, the Affordable Care Act (ACA), was signed into law on March 23, 2010. The law was designed to make affordable health care and health insurance available to more individuals. Because of these changes, health insurance in Kansas has gone through significant changes in the past several years.

### Changes since 2010

The first of the ACA's changes began in 2010 and have been in place ever since. These changes include:

**Dependent coverage up to age 26** - Nearly all adult children are eligible to stay on their parents' group and individual health insurance policies until their 26th birthdays. This coverage is available to adult children regardless of marital status, financial dependency, enrollment in school or residency. This coverage is available with fully-insured and self-insured policies. Adult children with access to health insurance from an employer may not be eligible for this coverage. Check with your insurance company or your employer's human resources department for more information.

**No cost-sharing for some preventive services** - Some preventive services are now available to individuals without cost-sharing (including deductibles, copayments or coinsurance). Some of these services include colorectal cancer screenings for adults 50 and older; immunizations, including (but not limited to) influenza, meningococcal, pneumococcal, and tetanus; breast cancer screenings; and depression screenings. This does not cover other services provided at the same doctor's visit, and that visit may have a deductible, copayments or coinsurance due if other services are performed at the same time.

**Changes to annual and lifetime benefits** - Insurance companies are no longer allowed to set annual or lifetime limits for specifically identified essential health benefits. A lifetime limit is a maximum amount the insurance company will pay in claims during your entire lifetime. An annual limit is the maximum an insurance company will pay in claims during one policy year.

**New processes for internal appeals and external review** - If you have a claim denied by your insurance company, you have the right to request an internal appeal. If your appeal is denied, you have the right to have an independent reviewer examine your case (external review).



**No pre-existing condition exclusions for children** - Policies covering dependents are prohibited from limiting or excluding children under age 19 with a pre-existing condition from health coverage.

**No rescissions of coverage, except in cases of fraud or intentional misrepresentation** - Insurance companies are no longer allowed to cancel or rescind your health insurance policy just because you made an honest mistake on your insurance application. The insurance company can still cancel your coverage if you put false or incomplete information on your insurance application on purpose, or if you don't pay your premiums on time.

## Changes effective January 1, 2014

Most of the rest of the changes from the ACA take place beginning January 1, 2014. The open enrollment period beginning October 1, 2013, will include the following changes.

**Almost all individuals are required to have health insurance or pay a penalty** - Individuals without affordable options, or those with certain religious objections, are exempt from this requirement (*see full list in Chapter 2*). Penalties for those who do not purchase health insurance (and do not have an exemption) began January 1, 2014. For the year 2014, the penalty is \$95 per uninsured adult (\$47.50 per uninsured child) or 1% of your family income, whichever is greater (with a maximum family penalty of \$285). This penalty will increase every year. In 2015, the penalty is \$325 per uninsured adult (\$162.50 per uninsured child) or 2% of your family income, whichever is greater (with a maximum family penalty of \$975). In 2016 and beyond, the penalty is \$695 per uninsured adult (\$347.50 per uninsured child) or 2.5% of your family income, whichever is greater (with a maximum family penalty of \$2,085).

**All qualified health plans must cover a list of “essential health benefits”** - These essential health benefits include items and services in the following categories:

- ambulatory (outpatient) services
- emergency services
- hospitalization
- maternity and newborn care
- mental health and substance use disorder services, including behavioral health treatment
- prescription drugs
- rehabilitative and habilitative services and devices
- laboratory services
- preventive and wellness services and chronic disease management
- pediatric services, including dental and vision care

Beginning January 1, 2014, almost all individuals must have health insurance or pay a tax penalty.

This list of benefits must be included in every health insurance policy.

You may be eligible to receive help to pay for your health insurance.

Everyone is eligible to buy health insurance, even if you have a pre-existing condition.

Any health insurance plan purchased on or off the Health Insurance Marketplace will cover the items listed above. (See “qualified health plans” and “essential health benefits” in the glossary at the back of this book for more information.)

**Tax credits and subsidies are available to individuals and families with qualifying incomes** - Individuals and families with incomes from 100%

- 400% of the federal poverty level (FPL) will qualify to receive help paying for health insurance when they buy their insurance from the Health Insurance Marketplace. In 2013, any individual earning less than \$45,960 qualifies for help; a family of four earning less than \$94,200 would qualify for help. FPL numbers change every year, so these amounts will be different in 2014 and beyond.



**Health insurance companies may not deny you coverage just because you have a pre-existing condition** -

People with pre-existing conditions can enroll in coverage, just like everyone else, beginning October 1, 2013, and that coverage will begin as soon as January 1, 2014. If you have a pre-existing condition, it is important to get enrolled in coverage during the open enrollment period, which lasts until March 31, 2014. If you do not get enrolled in coverage during this time, you may not be able to get coverage until the next open enrollment period.

**Insurance companies can no longer “underwrite” you or your family for coverage** - Previously, insurance companies would use your health status and other factors to determine how much of a premium to charge you. Now companies may only use the following four factors when determining how much they charge you for health insurance:

- How old you are.
- Whether you are purchasing coverage for yourself or for yourself and family members.
- Where you live.
- Whether you use tobacco.

Companies may no longer charge you more just because you have been sick in the past. Companies may not charge women more for coverage than men.

**Small businesses with fewer than 25 full-time employees who provide health insurance to those employees are eligible to receive tax credits** -

To be eligible, the small business must have fewer than 25 full-time equivalent employees who make an average of \$50,000 a year or less. In 2014, the tax

credit is worth up to 50% of the contribution the employer makes towards employees' premium costs (up to 35% for tax-exempt employers). The credit is available only through the SHOP marketplace, and can only be claimed for two tax years. (See the glossary of terms for more information on the SHOP marketplace.) Consult your tax adviser or accountant for more information or to see if you qualify for coverage, or visit [www.IRS.gov](http://www.IRS.gov).

## Health Insurance Marketplace

Provisions under the ACA established a statewide Health Insurance Marketplace that would provide a way for individuals and businesses to buy health insurance. This marketplace makes it possible for you to find all of your health insurance options on one website, easily compare the coverage that each plan offers, and purchase your insurance policy. Visit [www.healthcare.gov](http://www.healthcare.gov) or [www.insureKS.org](http://www.insureKS.org) to apply for coverage from the marketplace.

### What will the marketplace look like?

The Health Insurance Marketplace is a website. Many times this website is compared to travel websites that let you compare flight or hotel rooms by cost and benefit. This marketplace shows you all of the health insurance policies that you are eligible to buy and provides side-by-side comparisons. There is even a cost comparison calculator that helps you figure out how much each policy will cost you. The comparison tools help you figure out which plan is suited for you based on where you live and what kind of coverage you need.

### Why should I buy my health insurance from the online marketplace?

This online marketplace is the only way you can get financial help in paying for your health insurance. You can still buy health insurance directly from companies or from insurance agents, but if you don't use the marketplace you can not receive tax credits or subsidies to help you pay for your insurance.

### Who runs the Health Insurance Marketplace?

In Kansas, the marketplace is run by the Centers for Medicare & Medicaid Services (CMS), which is a federal government agency. *The Kansas Insurance Department (KID) does not run the Health Insurance Marketplace.* However, you can always call KID with questions or concerns you have about your health insurance in general.

### How can I get help when using the online marketplace?

There are several different ways you can get help when using the marketplace. There is a toll-free telephone number set up to help. You can call **800-318-2596** to get help when using the marketplace.

Additionally, face-to-face assistance is available through the Health Insurance Marketplace's Navigator and Certified Application Counselor (CAC) program. Navigators and CACs are unbiased, trained individuals who can help you enroll in health insurance through the marketplace. Both groups can give you unbiased information because they do not represent any of the plans or companies

A new Health Insurance Marketplace is available to help you purchase your health insurance.



Trained Navigators and CACs are available to help you enroll in health insurance coverage.



selling policies on the marketplace. For more information on Navigators and CACs, visit [www.insureKS.org](http://www.insureKS.org).

Additionally, many insurance agents are also certified to sell health insurance plans through the marketplace. Ask your insurance agent if he or she can help you choose and enroll in a plan that is right for you.

**What kinds of insurance plans are available on the marketplace?**

All health insurance plans offered on the marketplace are qualified health plans and cover all essential health benefits (see page 3) required by law. Plans are categorized into four different types: bronze, silver, gold and platinum. All plans offer the same set of essential health benefits. The different levels do not reflect the quality or amount of care the plans cover. The categories differ as to how much your premium costs each month and the total amount of out-of-pocket costs you'll have.

As with all health insurance, the amount of premium a company charges will depend on that company's claims experiences. Because of this, costs for each plan in each tier level will vary. The following is a general guideline for how to select coverage.

In general, plans with lower premiums will have higher out-of-pocket costs. The bronze level plans tend to have the lowest premiums but higher out-of-pocket costs. Plans like this may be good for individuals who are relatively healthy and do not need a lot of medical care or prescription drugs.

On the other hand, plans with higher premiums generally have lower out-of-pocket costs. The platinum level plans tend to have the highest premiums on the marketplace, but you will pay less out-of-pocket costs with these plans. A



platinum level plan may be right for you if you expect a lot of doctor or hospital visits or require many prescription drugs.

Additionally, catastrophic plans will also be available on the marketplace for individuals exempt from the requirement to purchase insurance and for individuals under the age of 30. Catastrophic plans have a lower premium cost, but generally require you to pay all of your medical costs out-of-pocket up to a certain amount - usually several thousand dollars. Catastrophic plans are intended to protect from major injuries or illnesses. Individuals buying catastrophic plans are not eligible to get tax credits or subsidies to help pay for this coverage.

## **SHOP marketplace for small businesses**

The Small Business Health Options Program (SHOP) is similar to the health insurance marketplace, but allows small business owners to buy health insurance coverage for their employees. The SHOP is designed for small employers with 50 or fewer full-time employees. Enrollment on the SHOP marketplace begins October 1, 2013 and coverage begins as soon as January 1, 2014.

If you plan to use the SHOP marketplace to buy coverage for your employees, you must offer coverage to all full-time employees (in general, anyone who works at least 30 hours each week). In general, 70% of these full-time employees must enroll in the SHOP plan. You will decide how much you will pay towards your employees' premiums, and then your employees can use the SHOP to enroll.

In 2014, SHOP is open to any employer with 50 or fewer full-time employees. Beginning in 2016, all SHOPs will be open to employers with up to 100 full-time employees. If you have questions about the SHOP marketplace, you can call CMS' SHOP toll-free number at **800-706-7893**.

If you are self-employed and do not have any employees, you can get coverage through the individual Health Insurance Marketplace.



Small businesses who want to provide health insurance to employees may be eligible to purchase coverage from the small business marketplace.

# Chapter 2

## If you have individual coverage

Individual health insurance is a good option if you are self-employed or work for a company that doesn't offer health insurance. When shopping for individual health insurance, it is important to be sure you know exactly what you are buying. There are several different types of individual health insurance policies available to you. Whether or not you buy your policy on the new Health Insurance Marketplace will determine what exactly is included in that coverage.

The chart below provides a brief description of the most common individual health insurance policies.

### Summary of individual health policies

<b>Major medical expense</b>		Provides comprehensive benefits for medical expenses in or out of the hospital. Has a high maximum benefit. You share in the cost with deductibles, copayments and coinsurance. Sometimes include the use of a network to keep costs down.
<b>Catastrophic plans</b>		Doesn't cover any benefits other than 3 primary care visits per year before the plan's deductible is met. The premium amount for these plans will be lower, but the out-of-pocket costs are generally higher. To qualify, you must be under 30 years old or be exempt from the individual mandate.
<b>Managed care plans</b>		Use selected doctors and other providers as part of a network. Managed care plans provide comprehensive health services and offer financial incentives for patients who use providers in the network.
<b>Limited benefit plans</b>	<b>Hospital indemnity</b>	Pays you a specified amount of cash benefits for each day you are hospitalized, up to a set number of days. Cash benefit paid to you can be used for any purpose.
	<b>Specified or dread disease</b>	Provides benefits only if you get the specific disease named in the policy. For example, it might cover only medical care associated with cancer. Usually pays in addition to other insurance.
	<b>Short-term or temporary</b>	Coverage for a brief and specified length of time. For example, you might buy a one-month policy with major medical coverage for the month that you are between jobs.

These are the types of health insurance plans available to you.

## Major medical expense

Major medical plans provide the most comprehensive coverage for medical services either in or out of the hospital. Major medical plans typically require you to pay a deductible, copayments and coinsurance. The common structure for these plans includes:

**Level 1: Deductible** - The dollar amount that you must pay each year before the policy will begin to pay. For example: If you have a \$500 annual deductible, you will pay for the first \$500 of covered expenses for each person insured.

If you are buying coverage for your family, ask how the family deductible works. Some policies require you to pay a deductible for each illness or accident. Make sure you understand how the family deductible works before buying a policy.

**Level 2: Coinsurance and copayments** - You share in the payment of the covered expenses up to a certain limit. A common coinsurance arrangement is for the company to pay 80% and you to pay 20%. Coinsurance applies to each person and starts over each year. Copayments may be due each time you visit the doctor, and may vary in amount depending on what plan you have or what doctor you see.

**Out-of-pocket limit:** This is the maximum amount that you pay in one year when you add together your deductible, copayments and your share of coinsurance. Once you've reached your out-of-pocket limit, the insurance company will pay all of your covered medical expenses.

Medical care you receive that is not covered by your policy does not count toward your out-of-pocket limit. Noncovered balances that exceed the amount that your insurer allows for a given service do not count toward your out-of-pocket limit. Be sure you understand what your policy covers.



Major medical plans sometimes include the use of networks to keep costs for participants down.

A catastrophic plan may be a good option if you are under the age of 30 or have a very low income.

### **Catastrophic plans**

A catastrophic health insurance plan covers essential health benefits but has a very high deductible. This means it provides a kind of “safety net” coverage in case you have an accident or serious illness. Premiums for catastrophic plans may be lower than traditional health insurance plans, but deductibles are usually much higher. This means you must pay thousands of dollars out-of-pocket before full coverage kicks in.

In the marketplace, catastrophic plans are only available to people under 30 and to some low-income people who are exempt from paying the fee because other insurance is considered unaffordable or because they have received “hardship exemptions”. Marketplace catastrophic plans cover 3 annual primary care visits and preventive services at no cost. After the deductible is met, they cover the same set of essential health benefits that other marketplace plans offer. People with catastrophic plans are not eligible to receive subsidies or tax credits to help pay the cost of their health insurance.



### **Managed care organizations**

Managed care plans are health plans that use a network of doctors and other providers to offer comprehensive health coverage to individuals. People enrolled in managed care plans receive financial incentives to use the doctors within the network, thus keeping premium costs lower for these individuals. There are three types of managed care plans available to individuals looking for health insurance coverage in Kansas.

**Health Maintenance Organizations (HMO)** - HMOs provide health services through a network of doctors, hospitals, laboratories, and other providers. The HMO pays your primary care provider a set monthly fee regardless of the amount of services they perform for patients.

For example, the HMO pays the provider a \$25- to \$40-per-month fee for every person enrolled in the plan. This fee does not increase in a month where the person might receive services in excess of that fee.

When you enroll in an HMO, you must choose one of the doctors in the network as your primary care physician to manage all of your health care. Then, when you need health care, you must first consult your primary care physician, who may then refer you to an HMO-approved specialist. Your primary care physi-



cian may be responsible for the cost of your care if he or she refers you to a specialist.

Except in some emergency situations, you must receive your care from providers within the HMO network. If you do not get approval from your primary care physician before you seek medical care, you may be required to pay out of pocket for the actual charges of those services.

**Preferred Provider Organizations (PPO)** - Like an HMO, a PPO is a group of doctors, hospitals and other health care providers who have agreed to provide services to members of a health plan for discounted fees. However, you do not have to choose a primary care physician if you enroll in a PPO. You may get care from providers outside the PPO network, though you will pay more for these services. You do not need a referral to see a preferred provider specialist.

**Point of Service plans (POS)** - Point of Service plans combine many of the characteristics of both HMOs and PPOs. Like an HMO, people enrolled in a POS plan choose a primary care physician to serve as their “point of service.” This physician then is responsible for referring the patient to any specialists they may need to see. Like a PPO, the patient is able to get care from physicians and specialists outside of the plan’s network, though there may be an additional cost to do so, and the patient may be responsible for taking care of any paperwork related to the visit. Plan costs stay low when you stay in-network, but the POS provides the option of going outside the network.

**Consumer protections under managed care plans** - Certain consumer protections are in place for individuals enrolled in a managed care health insurance plan.

- The managed care plan must have enough doctors and hospitals in the plan so that you can get the care you need without unreasonable delay.
- The plan must notify you if your doctor, hospital or other health care facility leaves the plan’s network.
- You have a right to a list of all providers within your plan’s network (this list may be located online).
- Your managed care plan must notify you if it refuses to pay for a health care service. It must include the reasons for the denial and instructions on how to appeal.
- The managed care plan must pay for your treatment if a medical emergency occurs. This must be provided regardless of whether prior authorization was obtained to provide the service and even if the emergency provider is out of your plan’s network.

Call the Kansas Insurance Department’s Consumer Assistance Hotline at **800-432-2484** if you have more questions about your rights under managed care plans.

Be sure you understand how a managed care plan works before enrolling in one.

Limited benefit policies do not meet the individual mandate requirement of the Affordable Care Act.

### **Other types of individual health policies**

Hospital indemnity, specified or dread disease, and short-term or temporary health coverage are also available to purchase. Watch for the statement “This is a limited policy.” These kinds of policies may cost less but could be too limited to be your only health care coverage, or they might duplicate coverage you already have. These limited health policies do not fulfill the requirements of the individual mandate.

### **What is covered under an individual policy**

There is a list of factors that the health insurance company will review when determining what is and is not covered by your policy:

- Is the service listed in your policy?
- Is it a medically necessary service?

Generally, if the answer to those questions is “yes”, your health insurance policy should cover the service, although other limitations or exclusions may apply.

### **Benefits required by law in your policy**

Federal and state laws require certain individual insurance policies to provide the following benefits. Except where noted, you must still pay deductibles, co-payments and coinsurance.

#### **Maternity & newborn coverage**

- Childhood immunizations for children ages 0 - 72 months. Deductibles and copays do not apply.
- Automatic newborn coverage under a “family” plan for the first 31 days. To continue coverage, the policy or contract may require that notification of birth and payment of a specific premium is required in order to have the coverage continue beyond that 31 days.
- Coverage for a newborn adopted child from the moment of birth if petition for adoption is filed within 31 days of birth.



- The policy must pay for the mother to stay at the hospital for at least 48 hours for a vaginal delivery or 96 hours for a caesarean birth.

### **Preventive and routine care**

- Coverage for services related to the diagnosis, treatment and management of osteoporosis.
- Routine screenings for diseases, including mammograms, pap smears, and prostate cancer screenings.
- Services provided by health care providers other than a primary care physician, including (but not limited to): APRN nurses, optometrists, dentists, psychologists, podiatrists, and social workers.

### **Prescription drugs and supplies**

- Coverage of certain off-label drugs when used for treatment of cancer.
- Coverage for orally-administered drugs to treat cancer.
- Diabetic supplies (including needles) used for diabetes management and outpatient self-management training and education (when prescribed by a health care pro



### **Other required coverage**

- Coverage for breast reconstruction following a mastectomy.
- Access to routine coverage of health care services upon a diagnosis of cancer and upon acceptance into a phase I, phase II, phase III, or phase IV clinical trial for cancer.
- Coverage of general anesthesia for dental care for children younger than 5, people with severe disabilities and people with a medical or behavioral condition requiring hospitalization.

### **Benefits not typically covered (exclusions & limitations)**

Every policy has services and products that aren't covered. Below is a list of commonly excluded services. It isn't meant to be all-inclusive. Check your policy to determine whether a benefit is covered.

- Cosmetic surgery
- Sickness or injury as a result of war
- Intentionally self-inflicted wounds
- Dental care, except for children up to age 19
- Vision (eye exams and glasses), except for children up to age 19
- Hearing aids
- Experimental or investigative procedures or medication

The provisions listed on this page are required to be included in your individual health insurance policy by state and federal law.

Most health insurance plans exclude certain services. Your health insurance company will not help you pay for these services.

- Specific treatments: dental treatment for TMJ (temporo-mandibular joint), sterilization, etc.
- Services covered by workers' compensation
- Weight loss surgery

## Medical necessity

Every major medical policy excludes coverage for treatment that is not “medically necessary.” This provision allows insurance companies to determine (after the fact) if the treatment received was medically necessary. Example: You were in the hospital for three days. Your insurance company says it will pay for only the first two days because it believes the third day was not medically necessary. Your doctor says the treatment was medically necessary. The insurance company’s doctor says it was not. If this happens to you:

- Appeal the decision to a higher level within the company according to the appeals process outlined in your policy.
- If you still do not get a satisfactory result, contact our Consumer Assistance Division and ask if your claim is eligible for independent medical review (*see pages 40-41*).

## Pre-existing medical conditions

A pre-existing medical condition is defined as a physical or mental condition for which medical diagnosis or treatment is recommended or received before the date of health insurance coverage begins.

Prior to January 1, 2014, health insurance companies were allowed to deny or delay your health insurance coverage if you had a pre-existing condition. Alternatively, they could have excluded treatment for pre-existing conditions or used an elimination rider to name a specific condition that was permanently excluded from coverage. *The Affordable Care Act, passed into federal law in 2010, now prohibits companies from denying you health insurance coverage just because you have a pre-existing condition.* Every health insurance company must offer you coverage, even if you are in poor health, though you may be





required to apply for that coverage during certain times of the year. No health insurance company can use health underwriting to determine whether to offer you a health insurance policy.



If you were enrolled in the Kansas Health Insurance Association's (KHIA) state high-risk pool or the federal Pre-existing Condition Insurance Program (PCIP) because you had a pre-existing medical condition, you can now get regular insurance coverage through the Health Insurance Marketplace. Both of these high-risk pools will cease enrollment on December 31, 2013.

## Determining how much you pay

Health insurance companies will decide how much to charge you for your health insurance based on the following four factors:

- How old you are.
- Where you live (geographically).
- Whether or not you use tobacco products.
- Whether you are looking for coverage for only yourself or for your family.

No other factors can be used to determine how much to charge you for health insurance, including your health condition or gender.

## Hospital preauthorization

Most health plans require you to tell them before you check into the hospital for nonemergency services. This is referred to as preauthorization, precertification or pre-admission approval.

The insurance company reviews the medical necessity for your hospitalization and either approves or disapproves the length of stay. Preauthorization **does not** guarantee the insurance company will pay your bills; it is merely a confirmation that the proposed service is medically necessary and that the setting is appropriate.

The company will also review the following before approving your claim:

- Whether coverage is in force when the services are performed.
- Discrepancies in the information received for the preauthorization as compared to your actual medical records.
- Whether other limitations or exclusions of the policy are applicable.

The instructions about preauthorization should be clearly spelled out in your policy. The number you or your doctor can call will be shown there, too. Often this phone number is also included on your medical ID card, along with your policy number and any personal identification number.

Beginning January 1, 2014, all individuals are eligible to enroll in health insurance coverage, even if you have a pre-existing condition.

Save the  
“Summary of  
Benefits and  
Coverage”  
page that  
comes with  
your policy  
to easily see  
what is and is  
not covered.

The patient is responsible for making sure preauthorization is completed prior to admission. If your doctor’s office fails to make the call on your behalf, you can be held responsible for the entire cost of the hospital stay. If time permits, get the approval in writing.

Be sure the company’s notice makes it clear what exactly has been approved for coverage.

## Consumer protections for individual health insurance policyholders

### Summary of Benefits and Coverage

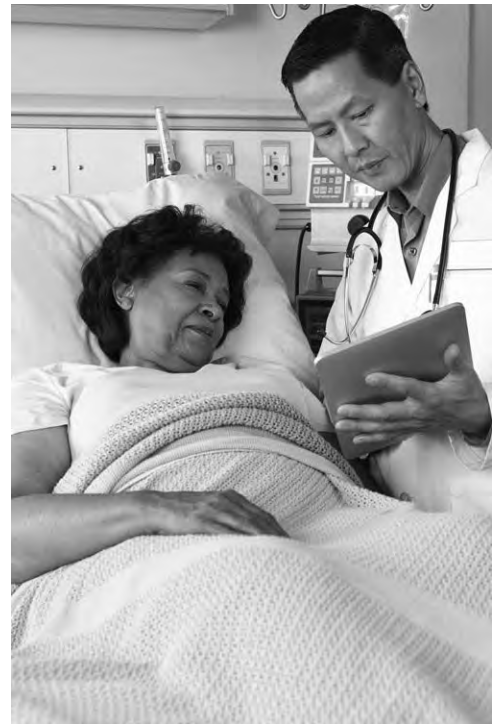
Federal law requires all insurance companies to clearly and truthfully disclose certain information in their insurance policies. A “Summary of Benefits and Coverage” page must be included with your policy that outlines:

- What is and is not covered under the policy.
- Details on what costs you will incur under the policy.
- A glossary of terms with standardized definitions (*you can also find these definitions in the back of this book*).
- A list of providers included in the plan (list may be Internet-based).

Insurers are required to provide this summary to you every plan year, and the page must be formatted in a way that complies with the Affordable Care Act.

### Free-look provisions

Once you receive your health insurance policy, you are entitled to a 10-day free look at the policy. This 10-day period begins the day you receive the policy. Be sure to keep a record of when the policy arrived. If you are dissatisfied for any reason, you can return the policy within the 10 days and get your money back, no questions asked. Use the free-look period to make sure the policy provides the benefits you expected and check for limitations and exclusions.



### Right to renew

Unless you don't pay the premiums on time, your policy must be continued as long as the insurance company continues to maintain major medical coverage in Kansas.

### Rate increases

Companies cannot increase premiums for an individual policyholder unless they increase premiums on all people with the same policy. This means your premium cannot be raised because you had a lot of claims or high claims against your plan. There are no state laws regarding when notice of a rate increase must be sent, but most companies usually give you 30 days' notice before implementing a rate change. Check your policy to find out the specific notification requirements of the company.



increases of more than 10% by visiting [www.ksinsurance.org/consumers/hfai.php](http://www.ksinsurance.org/consumers/hfai.php) or [www.healthcare.gov](http://www.healthcare.gov).

## Individual responsibility

Beginning January 1, 2014, nearly every person in the United States is required to buy and maintain adequate health insurance coverage, or be required to pay a tax penalty. There are a few groups of people exempt from this mandate, including:

- Members of federally recognized Indian tribes.
- Individuals who experience a financial hardship.
- People experiencing a short gap in coverage. A short gap is less than three consecutive months without insurance.
- Members of certain religious groups.
- Members of a health care sharing ministry.
- People in jail or prison.
- People in the country unlawfully, and U.S. citizens living abroad.

Use the free-look period that comes with your policy to verify that you understand everything included in your policy.

Most major medical plans purchased from insurance companies will meet the individual mandate requirement.

All plans purchased from the Health Insurance Marketplace meet the individual mandate requirement.

Penalties for not buying and maintaining adequate coverage are as follows:

***Annual penalties if you don't maintain adequate health insurance coverage***

	<b>Per adult penalty</b>	<b>Per child penalty</b>	<b>Family maximum</b>
<b>2014</b>	\$95 per adult, or 1% of family income*	\$47.50 per child	\$285
<b>2015</b>	\$325 per adult, or 2% of family income*	\$162.50 per child	\$975
<b>2016 &amp; beyond</b>	\$695 per adult, or 2.5% of family income*	\$347.50 per child	\$2,085

*\*penalty is the greater of the two numbers*

In order to avoid paying this penalty, you must have *adequate* health insurance coverage. It is your responsibility to ensure you have this coverage. Adequate health coverage is defined as the following:

- Government-sponsored programs, including Medicare, Medicaid, Children's Health Insurance Program (CHIP) coverage, TRICARE (military health coverage), coverage through Veteran's Affairs, and Health Care for Peace Corps volunteers.
- Employer-sponsored plans, including governmental plans, grandfathered plans, and other plans offered in the small or large group market.
- Individual market plans, including grandfathered plans.

Virtually every major medical plan sold by a health insurance company in Kansas is considered adequate coverage, regardless of whether you purchased this coverage on or off the Health Insurance Marketplace.

## **Coverage on and off the marketplace**

Individual health insurance coverage can be purchased in two different ways: on the new Health Insurance Marketplace, or through insurance companies and/or insurance agents off the marketplace.

### **Marketplace coverage**

Individual health insurance policies can be purchased by visiting the Health Insurance Marketplace at [www.insureKS.org](http://www.insureKS.org) or [www.healthcare.gov](http://www.healthcare.gov). The marketplace allows you to see all of the plan options available to you.

Tax credits and subsidies are available to individuals who qualify, but these are only available to you if you buy your plan from the marketplace. You cannot



get these subsidies or tax credits if you buy your health insurance outside the marketplace.

All marketplace health insurance plans cover the essential health benefits outlined in federal law (*see page 3*), and all are considered “qualified health plans.” Buying a plan from the marketplace will keep you from paying the tax penalties outlined by the individual mandate.

If you need help enrolling in coverage through the marketplace, there are several different ways to get assistance.



**Ask your insurance agent:** Many insurance agents who are already licensed to sell health insurance are also qualified to help you enroll in a plan through the marketplace. Ask your insurance agent if he or she can help you.

**Health insurance Navigators and Certified Application Counselors (CACs):** Kansas has a group of trained individuals who are qualified to help answer your questions about the marketplace. These people have taken educational classes to understand health insurance and the marketplace, and are unbiased sources of information. For more information on Navigators and CACs, visit **[www.insureKS.org](http://www.insureKS.org)**.

**Marketplace call center:** The marketplace has a dedicated call center to answer your questions and address your concerns about buying a plan online. To reach this call center, call **800-318-2596**.

The Kansas Insurance Department Consumer Assistance Hotline is always available to answer any questions you might have about your health insurance. You can reach us at **800-432-2484**.

### **Coverage off the marketplace**

Individual health insurance policies are still available to purchase from health insurance agents and directly from health insurance companies. You are not eligible for any tax credits or subsidies when purchasing off the marketplace.

Coverage purchased off the marketplace will cover all of the essential health benefits outlined in the Affordable Care Act (*see page 3*). As long as it is not a limited benefit policy, this should qualify as adequate coverage and you will not be required to pay the individual mandate penalty.

Call your insurance agent or insurance company if you have questions about your insurance plan. The Kansas Insurance Department can also help answer your questions.

Visit  
**[insureKS.org](http://insureKS.org)**  
to find out  
how to get  
help enrolling  
in a health  
insurance  
plan.

You can still get health insurance off the market-place. Contact your insurance agent or insurance company to get coverage.

## Grandfathered health plans

Any individual health policy purchased on or before March 23, 2010, *may* be considered “grandfathered.” Grandfathered plans are health insurance plans that are exempt from certain changes required under the Affordable Care Act. Plans lose this “grandfathered” status if the policy makes certain significant changes that reduce benefits or increase cost to consumers. A health plan must disclose to its policyholders if it considers itself to be “grandfathered.”

### Grandfathered health plans must:

- End lifetime limits on coverage.
- End arbitrary cancellations and rescissions of coverage.
- Cover adult children up to age 26.
- Provide a Summary of Benefits and Coverage.

### Grandfathered health plans do not have to:

- Cover preventive care for free.
- Guarantee your right to appeal.



## Chapter 3

# If you do not have health insurance

The Affordable Care Act became federal law in March 2010. It requires nearly every citizen in the United States to buy and maintain health insurance coverage beginning January 1, 2014. If you do not currently have health insurance coverage, this chapter will help you figure out what kind of health insurance you are eligible to receive, how to decide what coverage is right for you, and how to enroll in that coverage.

### What coverage am I eligible for?

In Kansas there are three different ways you can get health insurance that meet the standards outlined in the Affordable Care Act:

- Health insurance purchased from private insurance companies
- Employer-based (group) health insurance
- Medicaid (known in Kansas as KanCare)

If you are currently uninsured, there is a good chance that you do not receive employer-based group coverage, so this chapter will focus on private insurance and Medicaid. If you would like to know more about employer-sponsored health insurance, you can read about it in Chapter 4.

### Medicaid

Medicaid provides health coverage for some low-income individuals, families and children, pregnant women, the elderly, and people with disabilities. The Kansas Insurance Department does not regulate or enroll people in Medicaid. If you have questions about Medicaid (known as KanCare in Kansas) not addressed in this chapter, you should contact the Kansas Department of Health and Environment by calling **866-305-5147** or on the web at **[www.kancare.ks.gov](http://www.kancare.ks.gov)**.

In order to receive health insurance through KanCare, you must fall into one of the following groups:

- Children up to age 19, including those who are in foster care or who get adoption support payments.
- Pregnant women.
- Persons who are blind or disabled (by Social Security rules).
- Persons age 65 and older.
- Persons receiving inpatient treatment for tuberculosis.
- Low income families with children.
- Persons screened and diagnosed with breast or cervical cancer through the Early Detection Works program.

Income rules for KanCare vary, but if you are a single adult, under age 65, without children (and you are not pregnant or disabled), you are not eligible for

If you do not have health insurance through your employer, an individual insurance policy may be the best way for you to get coverage.

When choosing which health insurance plan is right for you, keep in mind how often you think you will need to visit the doctor and how many prescriptions you think you will need.

Medicaid assistance in Kansas, regardless of your income level.

### **Private health insurance**

Most uninsured people in Kansas will need to purchase private health insurance in order to comply with the ACA's health insurance requirement. The rest of this chapter will help you figure out what kind of coverage is right for you and how to get enrolled in that coverage.

## **What coverage is right for me?**

When searching for a health insurance policy, it is important to keep in mind two issues: your health status and your budget.

### **Your health status**

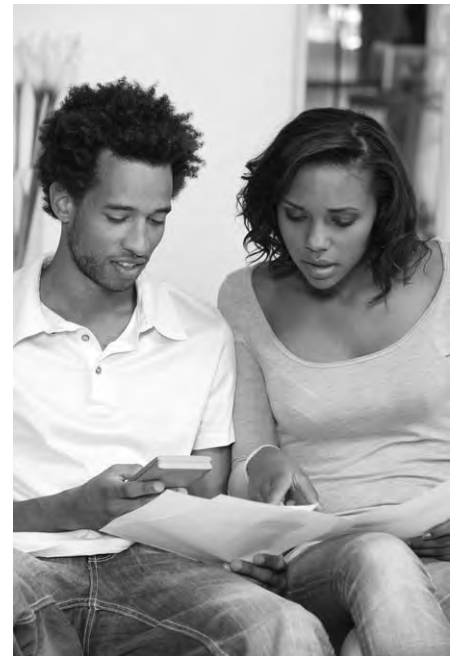
Beginning January 1, 2014, health insurance companies are no longer allowed to deny you health insurance just because you are sick or have a pre-existing condition. Even those who couldn't get health insurance before this date will be able to enroll in any health insurance plan in 2014. However, when choosing which health insurance plan is right for you, it is important to keep in mind how often you think you will need to visit the doctor and how many prescriptions you think you will need. This will help you determine whether you will need to buy a more expensive health insurance plan with less out-of-pocket costs, or a less expensive plan with higher out-of-pocket costs.

### **Your budget**

Though all health insurance plans are required to cover the same basic services (like covering the cost of an ambulance or laboratory services), each plan will vary in costs based on how much the plan will pay towards those services. You will need to decide how much you can afford each month in premium costs and in annual out-of-pocket costs (should you need a lot of health care). This is especially important if you choose to purchase your health insurance from the Health Insurance Marketplace.

To determine how much your premiums for health insurance are, companies will use the following four factors:

- How old you are.
- Where you live (geographically).
- Whether you use tobacco products.
- Whether you are looking for coverage for only yourself or for your family.



No other factors can be used to determine how much to charge you for your health insurance, including your health condition or gender.



## Basic costs in health insurance

If you are looking for a comprehensive health insurance plan, you will probably end up purchasing a major medical plan, a catastrophic health plan, or a plan from a managed care organization (see Chapter 2 for more details). These plans typically require you to pay a set amount out of your pocket before the plan will begin to help you pay for costs. These costs include a deductible, copayments and coinsurance.

**Step 1: Pay your premiums** - You must pay a monthly premium to keep a health insurance policy in force. If you stop paying monthly premiums, your health insurance policy will no longer be valid and you will not have any coverage from the insurance company. You must continue to pay these premiums until you no longer want health insurance coverage, even after you have met your out-of-pocket limit (see below).

**Step 2: Meet your deductible** - A deductible is a dollar amount that you must reach each year before the insurance company will begin paying your claims. This deductible resets at the beginning of each plan year. For example, a plan with a \$500 annual deductible will require you to pay the first \$500 of covered expenses for each person insured in the plan per year.

If you are buying coverage for your whole family, ask your company how the family deductible works. Some policies require you to pay a deductible for each illness or accident. Make sure you understand how the family deductible works before purchasing a policy.

**Step 3: Pay your coinsurance and copayments** - You share in the payment of the covered expenses up to a certain limit. A common coinsurance arrangement is for the company to pay 80% and you to pay 20%. Coinsurance applies to each person and resets each year. Copayments may be due each time you visit the provider, and may vary in cost depending on what provider you see. You will continue to pay copayments and coinsurance until you reach your out-of-pocket maximum.

**Step 4: Your out-of-pocket limit** - This is the maximum amount that you pay in one year when you add together your deductible, copay-

You must pay your premium on time every month, or you will lose your health insurance coverage.



Be wary of limited benefit policies. They do not fulfill the individual mandate requirement and can leave you with high medical bills if you get sick or injured.

ments and your share of coinsurance. Once you've reached your out-of-pocket limit, the insurance company will pay all of your covered medical expenses. Medical care you receive that is not covered by your policy does not count toward your out-of-pocket limit. Noncovered balances that exceed the amount that your insurer allows for a given service do not count toward your out-of-pocket limit. Be sure you understand what your policy covers.

### **Other types of health insurance policies**

In addition to major medical, catastrophic and managed care organization policies, you can also find more limited types of health insurance policies. In general, these will not fulfill the legal requirement to have health insurance. These types of policies include hospital indemnity policies, specified or dread disease policies, and short-term or temporary health insurance policies. Watch for the statement "This is a limited policy." These kinds of policies may cost less, but they are too limited in coverage to fulfill the legal requirement.

### **Benefits available under health insurance policies**

Federal and state laws require that certain benefits be available in health insurance policies sold in Kansas. When considering whether

to pay for your claim, the insurance company will ask two specific questions:

- Is the service listed as a covered service in your policy?
- Is the service medically necessary?

Generally, if the answer to those questions is "yes", your health insurance policy should cover the service, although other limitations or exclusions may apply.

You can find a detailed list of what Kansas state law requires in all individual health insurance policies in Chapter 2 (pages 12-13). In addition to these benefits, nearly all insurance policies must contain coverage for a list of "essential health benefits." These benefits include the following:

- Ambulatory (outpatient) services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services



- Preventive and wellness services and chronic disease management
- Pediatric services, including dental and vision care

The following benefits are typically **not** covered under individual health insurance policies:

- Cosmetic surgery.
- Sickness or injury as a result of war.
- Intentionally self-inflicted wounds.
- Dental care, except for children up to age 19.
- Vision (eye exams and glasses), except for children up to age 19.
- Hearing aids.
- Experimental or investigative procedures or medication.
- Specific treatments: dental treatment for TMJ (temporomandibular joint), sterilization, etc.
- Services covered by workers' compensation.
- Gastric bypass surgery.

## How can I enroll in coverage?

Private individual and family health insurance can be purchased in two different ways: On the new Health Insurance Marketplace, and through insurance companies and insurance agents off of the marketplace.

### Marketplace coverage

Individual health insurance policies can be purchased by visiting the Health Insurance Marketplace found at **[www.insureKS.org](http://www.insureKS.org)** or **[www.healthcare.gov](http://www.healthcare.gov)**. This marketplace allows you to see all of the plan options available to you. Plans can be compared side-by-side, and a cost calculator is available to help you see how much each plan will cost you.

Tax credits and subsidies are available to individuals who qualify, but these are only available to you if you buy your plan from the marketplace. You cannot get these subsidies or tax credits if you buy your health insurance outside the marketplace.

All marketplace health insurance plans cover the essential health benefits outlined in federal law (*see pages 24-25*), and all are considered “qualified health plans.” Buying a plan from the marketplace will keep you from paying the tax penalty outlined by the individual responsibility mandate.



Before you buy a policy, make sure you understand what it does and does not cover.

Subsidies and tax credits are only available through the Health Insurance Marketplace.

Visit  
**insureKS.org**  
to find  
information  
on Navigators  
and CACs.

If you need help enrolling in coverage through the marketplace, there are several different ways to get assistance.

**Ask your insurance agent:** Many insurance agents who are already licensed to sell health insurance are also qualified to help you enroll in a plan through the marketplace. Visit with an independent insurance agent to see if he or she has a plan that would work for you.

**Health insurance Navigators and Certified Application Counselors**

**(CACs):** Kansas has a group of trained individuals who are qualified to help answer your questions about the marketplace. These volunteers have taken educational classes to understand health insurance and the marketplace, and they are unbiased sources of information. You can find information on Navigators and CACs by visiting **www.insureKS.org**.

**Marketplace call center:** The marketplace has a dedicated call center to answer your questions and address your concerns about buying a plan online. To reach this call center, call **800-318-2596**.



The Kansas Insurance Department Consumer Assistance Hotline is always available to answer any questions you might have about your health insurance. You can reach us at **800-432-2484**.

**Coverage off the marketplace**

Individual health insurance policies are still available to purchase from health insurance agents and directly from health insurance companies. You are not eligible for any tax credits or subsidies when purchasing off the marketplace.

Coverage off the marketplace will cover all of the essential health benefits outlined in the Affordable Care Act (*see page 3*). As long as it is not a limited benefit policy, the coverage you purchase off the marketplace should qualify as adequate coverage, and you will not be required to pay the individual mandate penalty.



Call your insurance agent or insurance company if you have questions about your insurance plan. The Kansas Insurance Department can also help answer your questions.

## Things to consider before buying a policy

### Individual responsibility

Beginning January 1, 2014, nearly every person in the United States is required to buy and maintain adequate health insurance coverage, or be required to pay a tax penalty. There are a few groups of people exempt from this mandate, including the following:

- Members of federally recognized Indian tribes.
- Individuals who experience a financial hardship.
- People experiencing short gap in coverage. A short gap is less than three consecutive months without insurance.
- Members of certain religious groups.
- Members of a health care sharing ministry.
- People in jail or prison.
- People in the country unlawfully, and U.S. citizens living abroad.



Beginning January 1, 2014, nearly everyone in the United States are required to have minimum health insurance coverage. Only the groups listed on this page are exempt from this mandate.

Penalties for not buying and maintaining adequate coverage are as follows:

### *Annual penalties if you don't maintain adequate health insurance coverage*

	Per adult penalty	Per child penalty	Family maximum
<b>2014</b>	\$95 per adult, or 1% of family income*	\$47.50 per child	\$285
<b>2015</b>	\$325 per adult, or 2% of family income*	\$162.50 per child	\$975
<b>2016 &amp; beyond</b>	\$695 per adult, or 2.5% of family income*	\$347.50 per child	\$2,085

*\*penalty is the greater of the two numbers*

It is a good idea to get approval in writing from your insurance company before you check into the hospital.

In order to avoid paying this penalty, you must have *adequate* health insurance coverage. It is your responsibility to ensure you have this coverage. Adequate health coverage is designated as one of the following:

- Government-sponsored programs, including Medicare, Medicaid, Children's Health Insurance Program (CHIP) coverage, TRICARE (military health coverage), coverage through Veteran's Affairs, and Health Care for Peace Corps volunteers.
- Employer-sponsored plans, including governmental plans, grandfathered plans, and other plans offered in the small or large group market.
- Individual market plans, including grandfathered plans.

Virtually every major medical plan sold by a health insurance company in Kansas is considered adequate coverage, regardless of whether you purchased this coverage on or off the Health Insurance Marketplace.

### Hospital preauthorization

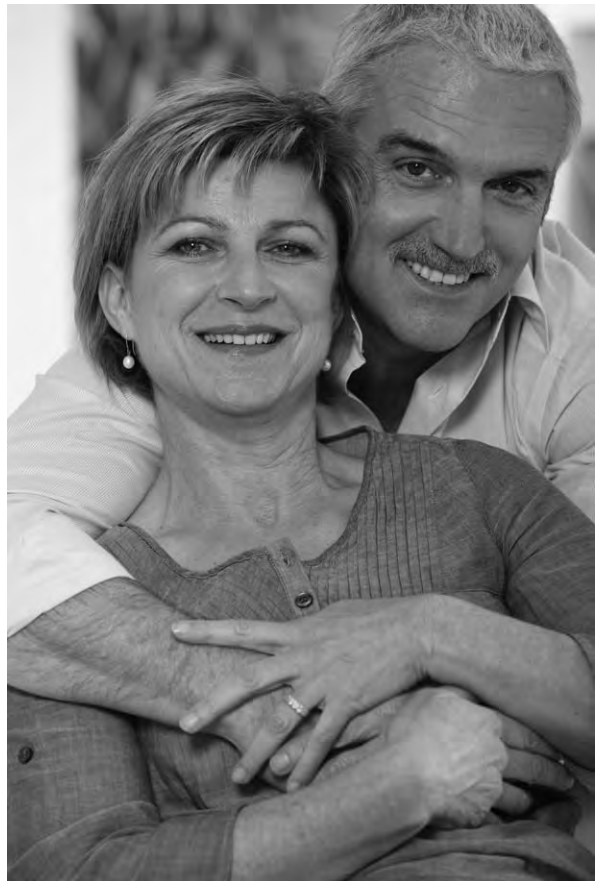
Most health plans require you to tell them before you check into the hospital for nonemergency services. This is referred to as preauthorization, precertification or pre-admission approval.

The insurance company reviews the medical necessity for your hospitalization and either approves or disapproves the length of stay. **Preauthorization does not guarantee the insurance company will pay your bills; it is merely a confirmation that the proposed service is medically necessary and that the setting is appropriate.**

The company will review the following before approving your claim:

- Whether coverage is in force when the services are performed.
- Discrepancies in the information received for preauthorization as compared to your actual medical records.
- Whether other limitations or exclusions of the policy are applicable.

The instructions about preauthorization should be clearly spelled out in your policy. The number you or your doctor can call will



be shown there, too. Often this phone number is included on your medical ID card, along with your policy number and any personal identification number.

The patient is responsible for making sure preauthorization is completed prior to admission. If your doctor's office fails to make the call on your behalf, you can be held responsible for the entire cost of the hospital stay. If time permits, get approval in writing.

Be sure the company's notice makes it clear what exactly has been approved for coverage.

### **If your health insurance claim is denied**

There are appeals processes in place to help you if your health insurance claim is denied by the insurance company. Follow the steps outlined in Chapter 5 if your claim is denied. You can also call the Kansas Insurance Department's Consumer Assistance Hotline if you have questions about your health insurance in general, or if your claim is denied.

**Kansas Insurance Department**  
**Consumer Assistance Hotline: 800-432-2484**  
**(TTY: 877-235-3151)**  
**[www.ksinsurance.org](http://www.ksinsurance.org)**  
**[www.insureKS.org](http://www.insureKS.org)**

If your health claim is denied, call KID's Consumer Assistance Hotline. See Chapter 5 for more information.

## Chapter 4

# If you have group health insurance

Sometimes major medical plans use a network of doctors, similar to some managed care plans.

Group health insurance plans are sold to business owners who want to offer health insurance as an employee benefit. Most employer-based health plans are either major medical plans or managed care plans. Other plans, like specified or dread disease policies (that provide benefits only if you get a specific disease), may be available to purchase in addition to a major medical or managed care plan, but are usually not the only coverage available.

**Major medical plans** provide comprehensive benefits for medical expenses in or out of the hospital. You share in the cost of the plan through deductibles, copayments and coinsurance. You are free to see any doctor or provider who accepts your plan as payment.

**Managed care plans** use selected doctors and other providers as part of a network. The plan provides comprehensive health services and offers financial incentives for patients who use providers only in the network. Managed care plans can come in several different forms, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of service plans (POS). See chapter 2 for more details on managed care plans.

The employer likely pays a portion of the premium, and the employee pays the rest. Sometimes that coverage is deducted from the employee's pay before a paycheck is issued. A group health insurance policy in Kansas may cover groups as small as two people.

There are a few important features of group plans to keep in mind concerning group health insurance plans:

- When you join your employer's health plan, your employer is the policyholder and you are the member or plan participant.
- As the policyholder, the employer does not need the consent of the plan participants to change insurance companies, make changes to the plan, cancel the policy or agree to new premiums or benefits.





Employer group health insurance plans are either fully-insured or self insured.

## Fully-insured plans vs. self-insured plans

Under a fully-insured plan, the employer purchases coverage from an insurance company. The insurance company assumes the risk to pay all health insurance claims. **Fully-insured plans are regulated by the Kansas Insurance Department.**

Self-insured plans are set up by employers to pay the health claims of its employees. The employer sets aside funds for the health claims. The employer assumes the risk of providing the benefits and is obligated to pay claims.

*Sometimes self-insured plans are confused with fully-insured plans because employers may hire an insurance company to pay the claims and administer the plan. If you do not know what kind of plan you have, ask your employer or plan administrator.*

Self-insured plans are governed by federal laws enforced by the U.S. Department of Labor. States are not allowed to regulate these plans. This means that



state laws requiring specific benefits and protections in health care plans do not apply to self-insured plans.

Beware that some fraudulent health plans may be described or offered as “self-insured” when, in fact, they are operating without state or

federal approval. If a health insurance policy seems too good to be true, check with our Department.

Discount health plans are not health insurance plans and therefore are also not regulated by the Kansas Insurance Department.

## How group health plans work

Traditional group health plans pay benefits on a fee-for-service basis, which means the insurance benefit is paid after you receive the service. You choose which doctor or hospital you would like to use. A common plan design for a group health plan is a comprehensive major medical plan. Major medical plans require you to pay a share of the covered expenses. A typical major medical plan is structured as follows:

Self-insured plans sometimes look like fully-insured plans because an employer might use an insurance company to run the plan.

You must meet your deductible before the plan will begin paying towards your covered claims.

Group health plans must meet the same essential health benefits that individual plans cover, unless they are grandfathered.



**Level 1: Deductible** - The dollar amount that you must pay each year before the policy will begin to pay. Most deductibles begin on January 1. For example, if you have a \$500 annual deductible, you will pay for the first \$500 of covered expenses for each person insured.

If you are buying coverage for your family, ask how the family deductible works. Some plans may not require each family member to pay the deductible after two people in the family have paid it. Other policies require you to pay a deductible for each illness or accident.

**Level 2: Coinsurance and copayments** - You share in the payment of the covered expenses up to a certain limit. The most common coinsurance arrangement is for the company to pay 80% and you pay 20%. Coinsurance applies to each person and starts over each calendar year.

**Level 3: 100% payment** - The insurance company will pay 100% of eligible expenses after you have reached the annual out-of-pocket limit for your plan. The 100% payment is for covered expenses only and will be paid until the end of the calendar year. Coverage only includes eligible expenses. If your policy does not cover a service, you will still have to pay out-of-pocket for it.

**Out-of-pocket limit** - This is the maximum amount that you pay in one year when you add together your deductible, copayments and share of coinsurance.

## What group health plans cover

Your group health policy will only pay for covered expenses. The following are factors considered by the insurance company when choosing to pay or deny your claim:

- Is the expense listed as covered in your policy?
- Is it a medically necessary service or supply?
- Does the service or supply require a preauthorization for you to receive your benefit?

## Benefits required by law in your policy

Federal and state laws require *fully-insured* group health insurance policies to provide the following benefits. Except where noted, you must still pay deductibles, copayments and coinsurance.

### **Maternity & newborn coverage**

- Childhood immunizations for children ages 0 - 72 months. Deductibles and copays do not apply.
- Automatic newborn coverage under a “family” plan for the first 31 days. To continue coverage, the policy or contract may require that notification of birth and payment of a specific premium is required in order to have the coverage continue beyond that 31 days.
- Coverage for a newborn adopted child from the moment of birth if petition for adoption is filed within 31 days of birth.
- The policy must pay for the mother to stay at the hospital for at least 48 hours for a vaginal delivery or 96 hours for a caesarean birth.



### **Preventive and routine care**

- Coverage for services related to the diagnosis, treatment and management of osteoporosis.
- Routine screenings for diseases, including mammograms, pap smears, and prostate cancer screenings.
- Policy must cover services provided by health care providers other than a primary care physician, including (but not limited to): APRN nurses, optometrists, dentists, psychologists, podiatrists, and social workers.

### **Prescription drugs and supplies**

- Coverage of certain off-label drugs when used for treatment of cancer.
- Coverage for orally-administered drugs to treat cancer.
- Diabetic supplies (including needles) used for diabetes management and outpatient self-management training and education (when prescribed by a health care professional).

### **Other required coverage**

- Coverage for breast reconstruction following a mastectomy.
- Access to routine coverage of health care services upon a diagnosis of cancer and upon acceptance into a phase I, phase II, phase III, or phase IV clinical trial for cancer.
- Coverage of general anesthesia for dental care for children younger than age 5, people with severe disabilities and people with a medical or behavioral condition requiring hospitalization.

If your group health plan is self-insured or otherwise regulated by an agency other than the Kansas Insurance Department, these covered benefits may differ.

Your health plan will only cover your care if it is medically necessary.

The above list of required benefits only apply to those health plans regulated by the Kansas Insurance Department. If your group plan is self-insured, or otherwise regulated by an agency other than KID (such as the Department of Labor), these benefits may not be part of your plan.

Other than the essential health benefits required by federal law, group health plans are not standardized. Benefits vary by plan, so refer to your specific policy or certificate to find out exactly what your policy covers and excludes.

## Medical necessity

Every major medical policy excludes coverage for treatment that is not “medi-

cally necessary.” This provision allows insurance companies to determine (after the fact) if the treatment received was medically necessary.



Example: You were in the hospital for three days. Your insurance company says it will pay for only the first two days because it believes the third day was not medically necessary. Your doctor says the treatment was medically necessary. The insurance company’s doctor says it was not. If this happens to you:

- Appeal the decision to a higher level within the company according to the appeals process outlined in your policy.
- If you still do not get a satisfactory result, contact our

Consumer Assistance Division and ask if your claim is eligible for independent medical review (see pages 40-41).

## Pre-existing medical conditions

A pre-existing medical condition is defined as a physical or mental condition for which medical diagnosis advice or treatment is recommended or received before the date of health insurance coverage begins.

Prior to January 1, 2014, health insurance companies were allowed to limit or delay your health insurance coverage if you had a pre-existing condition. *The Affordable Care Act, passed into federal law in 2010, now prohibits companies from denying or limiting health insurance coverage just because you have a pre-existing condition.* Every health insurance company must offer you coverage, even if



you are in poor health, though you may be required to apply for that coverage during certain times of the year. No health insurance company can use health underwriting to determine whether to offer you a health insurance policy.

## Hospital preauthorization

Most health plans require you to tell them before you check into the hospital for nonemergency services. This is referred to as preauthorization, precertification or pre-admission approval.

The insurance company reviews the medical necessity for your hospitalization and either approves or disapproves the length of stay. Preauthorization **does not** guarantee the insurance company will pay your bills; it is merely a confirmation that the proposed service is medically necessary and that the setting is appropriate.



The company will also review the following before approving your claim:

- Whether coverage is in force when the services are performed.
- Discrepancies in the information received for the preauthorization as compared to your actual medical records.
- Whether other limitations or exclusions of the policy are applicable.

The instructions about preauthorization should be clearly spelled out in your policy. The number you or your doctor can call will be shown there, too. Often this phone number is also included on your medical ID card, along with your policy number and any personal identification number.

The patient is responsible for making sure the preauthorization review is completed prior to admission. If your provider's office fails to make the call on your behalf, you can be held responsible for the entire cost of the hospital stay. If time permits, get the approval in writing.

Be sure the company's notice makes it clear what exactly has been approved for coverage.

You are responsible for making sure that your insurance company has preauthorized your treatment.

If you do not enroll during your initial enrollment and later decide you want to join the plan, you may have to wait until the next open enrollment period to get coverage.

## Other cost-control features

Along with hospital preauthorization, group health plans may also control medical expenses by requiring one or more of the following cost-saving measures:

- A review of patient records to see if continued hospitalization is justified.
- A second surgical opinion on nonemergency surgery (at the insurance company's expense).
- A review of patient records and denial of "unnecessary" expenses, including expenses related to experimental and investigative procedures and those judged not medically necessary.



## Joining a group health plan

Sometimes employers have an employment waiting period that must be satisfied before you can enroll in their group health plan. This is often called a "probation period." Make sure you know if your new employer has a probation period and how long it is.

After this probation period, employees have an initial open enrollment period to enroll in benefits. New employees have 31 days from the end of the probation period to enroll in health insurance for themselves and their family.

**Late enrollment:** If you do not enroll during your initial enrollment period and later decide you (or a spouse or dependent) would like to join the plan, you will be considered a late enrollee. As a late enrollee, you may have to wait until the next employee open enrollment period to get health coverage.

**Special enrollment periods:** All health insurance plans must provide special enrollment periods. These special enrollment periods allow individuals and family members to join the plan when a qualifying event occurs.

All employees in large group plans (more than 50 employees included in the plan) have at least 30 days for special enrollment when one of the following occurs:

- Employee has new dependents because of marriage, birth or adoption.
- The court has ordered coverage for a spouse and/or minor child.
- Employees/dependents initially decided not to join the plan because they were insured under another employer-sponsored plan and then lost that coverage.

All employees in small group plans (2-50 employees in the plan) have 31 days for special enrollment when one of the following occurs:

- Employee/dependents initially decided not to join the plan because they were insured under another employer-sponsored plan and then lost that coverage.
- Employee loses coverage as a result of a) termination of employment, b) reduction in the number of hours of employment, or c) termination of employer contributions toward coverage.
- The other plan's coverage terminates.
- The spouse dies.
- A couple divorces or legally separates.
- The court has ordered coverage for a spouse and/or minor child.
- Employee has new dependents due to marriage, birth or adoption.

## Leaving a group health plan

Federal and state laws provide important consumer protections for those who leave a group health plan or move from one job to another.

### Coverage after you leave a group

When you leave a group you usually have the opportunity to temporarily continue your group health benefits. The time period for temporary coverage varies depending upon the situation. When you have used up your temporary continuation benefits, you can convert your group plan to an individual health policy. This conversion policy is often a last resort option because of the limited benefits and high costs associated with this kind of coverage. If you lose employer-sponsored coverage, you may find better options for individual coverage on the Health Insurance Marketplace.



If you have questions about what continuation coverage you are eligible for, talk to the human resources department of your employer.

**Kansas continuation:** If you're leaving an insured group plan of fewer than 20 employees, or a large group plan under circumstances not protected under the COBRA laws (see page 38), you may be eligible for state continuation benefits. State continuation:

- Allows for 18 months of continuation of coverage if your group insurance coverage terminates for any reason except nonpayment of premium or fraud.
- You must have been covered under the group plan continuously for three months in order to be eligible.

For more information on the Affordable Care Act, see Chapters 1 and 2.

- You pay the full cost for the coverage - both the employer's share and the employee's share.
- You have 31 days to apply for these continuation benefits.
- At the end of the 18-month continuation period, you have 31 days to apply for an individual conversion plan.

**Federal continuation (COBRA):** If you're leaving a group of 20 or more employees, COBRA (Consolidated Omnibus Budget Reconciliation Act) laws apply. COBRA allows you to continue your group coverage for a limited time for yourself, your spouse and any dependent children.

Under COBRA, you must pay the full amount of the coverage plus a 2% administrative fee. You have 60 days to apply for COBRA benefits. Coverage may continue for 18 to 36 months, depending on the circumstances surrounding termination of coverage.

COBRA benefits are not available if your plan has been discontinued and not replaced. In some cases, the Kansas continuation benefits described on page 37 may apply.

Detailed information on COBRA is available from the U.S. Department of Labor's Pension and Welfare Benefits Administration at 866-487-2365 or online at [www.dol.gov/dol/topic/health-plans/cobra.htm](http://www.dol.gov/dol/topic/health-plans/cobra.htm).

**Continuation of in-patient coverage:** If you are confined in the hospital or disabled for a specific condition when you lose your group health insurance coverage, you have the right to continuation of your coverage for an additional 31 days, or until you are discharged from the hospital.

## Group health insurance and the Affordable Care Act

The Affordable Care Act (ACA), a federal law passed in March 2010, requires nearly everyone to purchase a minimum amount of health insurance coverage beginning in 2014 or pay a tax penalty. Virtually every employer-sponsored group health plan fulfills this requirement; if you have a health insurance policy through your employer, you probably don't need to worry about paying the tax penalty.

### ACA benefits included in your group health plan

The ACA made some reforms to group health plans. ALL group health plans, regardless of whether they are self-insured or fully-insured or grandfathered (see below), must include the following reforms in their policies:

- End all lifetime and annual limits.





- Health insurance policies cannot be rescinded, except in cases of fraud or intentional misrepresentation.
- Extend coverage to dependents up to age 26.
- Cover all persons, regardless of whether they have a pre-existing condition.

### **“Grandfathered” health plans**

Any group health policy created on or before March 23, 2010, *may* be considered “grandfathered.” Grandfathered plans are health insurance plans that are exempt from certain changes required under the Affordable Care Act. Keep in mind that the date you joined the plan does not determine whether it is grandfathered. Plans lose this “grandfathered” status if the policy makes certain significant changes that reduce benefits or increase cost to consumers. A health plan must disclose to its policyholders if it considers itself to be “grandfathered.” If you are unsure, check with your employer’s human resources department.

### **Grandfathered health plans do not have to:**

- Cover preventive care for free.
- Guarantee your right to appeal.

### **Buying coverage on the SHOP marketplace**

In some cases, your employer may choose to have you select your group health plan from the small business Health Insurance Marketplace. This marketplace, designed especially for group health plans, is known as the SHOP (Small business Health Options Program) marketplace. Through the SHOP marketplace, you will be able to compare price, coverage and quality of plans available to you through your employer. Your employer will still pay a portion of your premiums, but you will have the opportunity to choose which plan is best for you. Beginning in 2014, the SHOP marketplace is only available to small group plans with 50 or fewer employees, but will be available for larger employers in the years after that. You can get more information on the SHOP marketplace, or get help enrolling in coverage, by calling **800-706-7893**.



Starting in 2014, small employers may have employees sign up for coverage on the SHOP marketplace.

## Chapter 5

# Appealing a claim denial

If you have tried unsuccessfully to resolve a health insurance claim, contact the Kansas Insurance Department.

In most cases, your health care provider (doctor, hospital, etc.) will file a claim on your behalf for services that they render. In some cases, a claim filed by your provider may be denied by your health insurance company. If your claim is denied:

- The reason for the denial should be stated on your explanation of benefits. If you disagree, you may file an appeal.
- Check your policy for the company's appeal procedures.
- The company should be able to answer procedural questions over the phone about how to file an appeal.
- Your appeal should be in writing and may require information from your doctor.

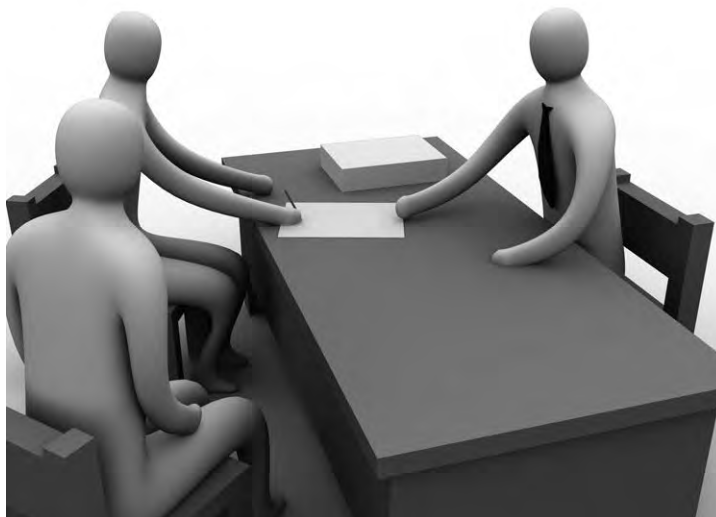
If you have tried unsuccessfully to resolve a health insurance claim, contact the Kansas Insurance Department for assistance. There are two ways we may be able to help you resolve the matter:

- Appeal your claim through an independent medical review.
- File a written complaint, which will allow us to contact the company on your behalf.

### **Independent Medical Review**

Consumers in Kansas are protected by a law that allows patients to appeal adverse health plan decisions to an independent medical specialist. You can ask the Kansas Insurance Department for an independent review of your case *if these two conditions exist*:

- Your health claim has been denied by a health insurance provider because it was said to be experimental, investigational or medically unnecessary.
- You have gone through your company's internal appeal process.



You have 120 business days from the date of the final decision by your health insurer to request an independent review from our office. We will need the following documents:

- A letter summarizing your dispute, including copies of correspondence with your insurer, letters from your provider(s), or any other documents supporting your case. Please include a daytime phone number in case we have questions.
- A completed independent medical review request form and medical release form. (If you need the forms, contact our office at **800-432-2484**.)

KID will determine if your health claim is eligible for an independent medical review within 10 working days of receiving all necessary records. If your request is approved, KID will contract with an independent medical review organization to take a closer look at your situation.

A written decision by the independent medical review organization will be issued to you within 30 business days. This decision is binding and comes at no cost to you.

### **In case of emergency**

If your health insurer refuses to provide you with urgently needed care, you may request an expedited independent medical review. If you have questions, call the Kansas Insurance Department's Consumer Assistance Hotline at **800-432-2484** and ask for an independent medical review coordinator.

### **Plans not eligible for review**

Some plans aren't eligible for independent reviews. They include the following:

- Medicare/Medicare supplement.
- Medicaid.
- Federal employee plans.
- Workers' compensation.
- Self-insured employer plans. (Non-grandfathered self-insured plans are required to provide a similar external review, but that process is not managed by the Kansas Insurance Department.)

## **About independent medical reviews**

The independent medical review is intended to be truly "independent," with no bias toward you or your insurance company. The decision may or may not be in your favor. **After your claim has gone through the independent review process, there is no further appeal process other than the courts.**

An independent medical review decision is binding and comes at no cost to you.

The types of plans listed here are not eligible for independent review.

Complaints may be mailed to KID or submitted on our website: [ksinsurance.org](http://ksinsurance.org)

KID cannot require a company to make a payment to you unless state insurance law has been clearly violated.

## Filing a consumer complaint

If you've tried unsuccessfully to resolve a claim dispute with your company or agent, contact KID. Often companies resolve the matter after our department intervenes. If you file a written complaint with KID, include the following in-



formation to speed up the processing of your inquiry:

- Your name, address and daytime phone number.
- A brief summary of your case, explaining the problem and what type of insurance is involved.
- State the name of your insurance company, policy number and the name of the agent (if one was involved).
- Supply any documentation you have to support your case, including notes from telephone conversations.
- State what has been done to resolve your problem, including who you have talked to and what you were told.
- Keep a copy of your letter to us for reference.

Complaints may be mailed to KID or submitted online. Upon receipt of your complaint, KID will investigate your complaint and keep you advised of developments. You will receive a letter giving the name of your consumer assistance representative, and your representative will contact the insurance company on your behalf.

### Limited intervention

If a company insists your complaint or claim is not valid, KID cannot require the company to make payment unless state insurance law has been clearly violated. In some cases, legal action is the only way to resolve a dispute over health insurance issues and legal obligations. You may want to talk to an attorney if your complaint can't be resolved and it involves a significant amount of money. KID employees are prohibited from providing legal advice or opinions or acting as your attorney.

## Preparing to purchase a policy

This section provides additional shopper's information if you need to purchase a health insurance policy. It is designed to help you make an informed buying decision.



## Find out about the insurance company

Before you buy a health insurance policy, find out about the company selling the plan. The following factors should be considered.

**Customer service** - Find out how the company services its policyholders.

Does it have a toll-free customer service number? Is the toll-free number easy to follow? How long does it take you to reach a live person?

**Complaint history** - Has the company had an unusually high number of consumer complaints? This information is available in the most recent edition of the "Consumer Complaint Ratio Report" issued by KID. Download a free copy from the KID website or Facebook page, or call **800-432-2484** to request a copy.

**Licensing status** - If you're not familiar with the insurance company or agent, call KID to find out if the the company and/or agent is licensed to do business in Kansas.

**Cost** - Premiums for health insurance will vary. When you look at rates from several companies, you will also need to look carefully at the benefits offered. Health insurance policies are required to include a Summary of Benefits and Coverage with each policy issued to a consumer. If possible, compare this summary to help make your decision. You may go online to **www.insureKS.org** and use the plan finder to help compare the costs and benefits of each plan offered.

**Financial stability** - Fi-

nancial stability helps ensure that a company can pay its claims. The Kansas Legislature established requirements that each company must follow, and KID continually monitors the financial stability of insurance companies operating in the state. Independent organizations also rate the financial stability of insurance companies. We have listed several of these organizations below. Remember, these ratings are opinions only and don't guarantee that a company is financially sound. Your public library may also have published ratings from these sources.

### Moody's Investor Services

212-553-0377, [www.moody.com](http://www.moody.com)

### Standard & Poor's Insurance Rating Services

212-438-7280, [www.standardandpoors.com](http://www.standardandpoors.com)



Use the online Health Insurance Marketplace to compare plans and the costs that are associated with them.

**TheStreet.com Ratings**  
800-289-9222, [www.thestreet.com](http://www.thestreet.com)

**A.M. Best Company**  
[www.ambest.com](http://www.ambest.com)

**What if my insurance company goes bankrupt?** Kansas policyholders are provided limited benefits through the Kansas Life and Health Guaranty Association if an insurance company becomes insolvent. To be protected by guaranty funds, the insurance company must be licensed to do business in Kansas. The guaranty association may pay up to \$100,000 in health insurance benefits on any one person. Benefits not covered under these types of plans:

- HMO contracts.
- Mandatory state pooling plans.
- Mutual assessment companies.
- Policies issued by a nonprofit hospital or medical service organization.
- Self-insured plans.
- Other, less commonly known arrangements.

The existence of the Kansas Health Guaranty Association should not be a substitute for your selection of an insurance company that is well managed and financially stable. Protect your interests by finding out about the financial condition of the insurance company.

## Questions to ask before purchasing

### Buying an individual policy

When shopping for an individual health insurance policy, it is important to make sure you are buying a health care plan you want and can afford. You

should make a list of your needs to compare with the benefits offered by a plan you are considering. The following are questions you should ask when shopping for a health insurance policy.



#### Questions about coverage:

- What does the plan pay for?
- What does the plan not pay for (exclude)?
- Is there a provider network and, if so, is it adequate to provide the comprehensive care you need in your area?

#### Questions about premiums:

- Do rates increase as you age?
- How often can rates be changed?
- How much do you have to pay when you receive health care services (copayments and deductibles)?

Ask these questions before purchasing an individual health policy.

- What is the limit on how much you must pay for health care services you receive (out-of-pocket maximum)?

### **Questions about customer service:**

- Has the company had an unusually high number of consumer complaints?
- What happens when you call the company's consumer complaint number?
- How long does it take to reach a real person?
- Does the company have an easy-to-use website that is helpful?

## **Buying a managed care plan**

### **What is covered?**

Be sure to ask for the detailed written description that legally defines your benefits (generally known as the "member contract" or "certificate of coverage"). Do the services provided, as well as the fees and copayments charged, meet your medical needs and financial circumstances? Also, make sure that you thoroughly understand what's not covered and the circumstances in which coverage is limited. What's the extent of coverage for home health care, hospice care, or durable medical equipment? What mental health coverage does the plan provide, particularly for hospitalization for mental illness or outpatient therapy?

### **What are your rights and responsibilities as a plan member?**

Are you required to fill out any paperwork when it comes to filing medical claims? Is that paperwork easy to understand and complete? How does the plan maintain confidentiality of medical records?

### **How are providers selected?**

Ask how the plan picks doctors, hospitals and other providers it contracts with, and how it ensures that they are qualified to treat patients. Are the providers conveniently located? How difficult are referrals to obtain? Can the plan override the doctor's referral order?

### **How are providers compensated?**

How are physicians and other providers in the health plan paid - by flat monthly per-patient fees, or by a negotiated fee schedule for each procedure provided? Are primary care physicians paid in such a way that they have a built-in incentive not to refer patients to specialists? Does the plan pay providers in such a way that they have incentives to improve the quality of care (for example, by rewarding them for improved results in treating patients)?



Ask these questions before purchasing a managed care plan.

Make sure the managed care plan you are considering has been accredited by an approved national accrediting organization.

**What restrictions are placed on providers?**

Does the plan have any restrictions limiting physicians' discussions of treatment options with patients? Does the health plan dictate standardized procedures for certain medical conditions? How much leeway do providers have to depart from these norms if they decide to do so?

**What out-of-network care is covered?**

Can you visit a provider outside the network, and if so, will your health plan cover all or part of the expense? Under what circumstances will the plan cover out-of-network emergency care or nonurgent care if you happen to need it while traveling?

**What procedure does the plan have for resolving complaints and handling appeals?**

How would you appeal a decision by the plan to deny coverage for treatment that you and your doctor think is warranted? Who is on the appeals board, and how quickly are complaints usually resolved?

**Buying an HMO policy****Consider the basics**

Make a list of the things that are most important to you. Consider coverage, choice of providers, convenience and cost. Be prepared to make some trade-offs.

**Consider quality**

All managed care plans in Kansas must be accredited by a national accrediting organization that meets the

standards of the Commissioner of Insurance. Through accreditation reviews and standardized measures of health plan performance, these organizations hold health plans accountable for the quality of care and services they deliver.

To get a free accreditation status list, contact an accrediting organization.





## **Gather information**

Most health plans have marketing brochures that explain how the plan works and where its physicians are located. Ask if the plan:

- Holds informational meetings for people who are thinking about joining.
- Has a quality “report card” and if it has been audited by an outside organization. Get a copy of the report.
- Call the plan’s customer relations department and request copies of recent consumer publications to see how well the health plan communicates with its members.

## **Ask questions**

No matter how much information you gather, you may have additional questions. Health plans may not be able to provide you with objective measures related to these issues, but you should relay your concerns to a health plan customer service representative and decide when you are satisfied with the response.



## **Make an informed decision**

After all this, you probably have a pretty good idea about the strengths and weaknesses of the plans you are considering. This is when you need to decide what is most important to you, and try to match your priorities with the health plan that would best meet your needs.

Call KID if you have any questions about your health insurance.

Our Consumer Assistance Hotline is **800-432-2484**.

# Chapter 6

## Frequently Asked Questions

Since it was signed into law, the Affordable Care Act has been confusing to many people. This chapter aims to answer some of the most frequently asked questions the Kansas Insurance Department gets about purchasing health insurance and health insurance reform.

### Questions about insurance benefits

#### **Will dental and/or vision insurance be included in plans that I buy from the health insurance marketplace?**

Plans that cover children must include both dental and vision care for children up to 19 years of age, but most plans will not cover these benefits for adults. If you need dental or vision insurance, you will have to buy a separate policy for each.

#### **My employer offers health insurance coverage, but it isn't very good. Does my employer have to offer better coverage starting in 2014?**

Your employer does not have to offer health insurance at all if he or she has fewer than 50 full-time employees. If he or she has 50 or more employees, your employer must offer comprehensive coverage that meets federal laws - or may be subject to a penalty beginning in 2015. If you cannot get coverage through your employer, you can buy coverage from the individual health insurance marketplace or from the private market.

#### **I have never had health insurance before, and I have no idea what I am eligible for. How can I find out?**

You can log onto the Health Insurance Marketplace, fill out the application, and it will tell you whether you may be eligible for a public program, like Medicaid or the Children's Health Insurance Program (CHIP), or whether you are eligible to receive tax credits or subsidies to help you pay for coverage. The marketplace has a "no wrong door" policy, which means that it can direct you to whatever program you are eligible for, even if you aren't sure. See Chapter 3 in this book for more information.

#### **I am under age 26 and have a job that offers health insurance coverage, but it isn't very good. Can I choose to stay on my parents' plan instead?**

Beginning January 1, 2014, you are able to choose to stay on your parents' plan instead of buying your employer's plan. Some grandfathered plans will not let you stay on your parents' health insurance policy if you have an employer who offers insurance coverage as an employee benefit.

#### **I have had coverage in the state or federal high-risk pool because of my pre-existing condition. How do I move out of the high-risk plan to a regular health insurance plan?**

Open enrollment for health insurance policies available on the Health Insurance Marketplace begins October 1, 2013. At this time, you can go onto the marketplace and select a new plan - without having to worry about reporting your pre-existing condition. Coverage will begin as early as January 1, 2014. Be sure you don't cancel your high-risk pool policy before your new policy begins. As soon as standard health insurance coverage is available to all individuals, regardless of health status, the high-risk pools will no longer exist.

**Why does the law require me to buy health insurance coverage?**

The key goal of the Affordable Care Act is to ensure that nobody can be denied coverage or be charged extreme amounts for coverage due to a health problem. If you allow people to wait until they have a health problem to purchase insurance, the health insurance market won't work. There would be a small number of very expensive choices for everyone.

**What will happen if I choose not to buy health insurance coverage beginning in 2014?**

If you choose not to buy adequate health insurance in 2014, you will probably be required to pay an additional tax when you file your taxes in April 2015. The penalties for choosing not to buy insurance are outlined on page 18. If you do not pay the IRS the tax penalty, they can take it out of any tax refund you are scheduled to receive in the future. However, if you do not pay the tax and never get a tax refund, you will not be criminally prosecuted for not buying insurance, and the IRS cannot put a lien or file a levy on any of your property. If you have further questions about how the individual mandate affects your taxes, talk to your tax adviser.

**I am a veteran. What do these changes do to my health insurance coverage?**

The Affordable Care Act does not make any changes to TRICARE or VA benefits.

## Questions about cost

**I have heard that buying a health plan through the Health Insurance Marketplace means I could qualify to receive tax credits or subsidies. How do I know how much I qualify for?**

Individuals and families who earn from 100% to 400% of the federal poverty level (FPL) will qualify for help in paying their premiums if they buy a plan from the health insurance marketplace. The amount you qualify for will depend on your income and how many dependents you have. The lower you are on the FPL, the more assistance you will receive. You can visit the health insurance marketplace at **[www.insureKS.org](http://www.insureKS.org)** or **[www.healthcare.gov](http://www.healthcare.gov)** to get a better idea of what you will qualify for.

**I don't want to take a handout (subsidy) from the government. What can I do?**

You may continue to buy an individual policy as you have in the past. If you don't want government assistance, you do not have to accept it. You can simply buy a health insurance policy that meets your needs, as long as the policy meets the minimum benefits that are required.

**Will I pay more for my health coverage because of the law?**

The answer to this will vary from person to person. All people enrolled in a particular health plan share the costs associated with that plan. Since the ACA requires that nearly every adult purchase health insurance or pay a penalty, more people may be enrolling in coverage. If more individuals enroll in your plan, the costs will be spread among a larger group, and your costs could go down. Costs may increase for some. For others, costs might stay the same or be lower, depending on how many people are enrolled in their plan and how much their health care costs.

**I am self-employed. Will I still qualify for a subsidy, ?**

Yes, you may be eligible for a premium tax credit, depending on your income and family size. Check with your tax adviser for more information.

**I am not poor, but I cannot afford health insurance because my employer does not help me pay for it. What are my options?**

Low- and moderate-income individuals and families who do not get help from their employers to pay for health insurance coverage may be eligible for tax credits and subsidies by purchasing insurance through the Health Insurance Marketplace. These subsidies may reduce the premium costs and out-of-pocket expenses for deductibles, copayments and coinsurance. The amount of financial help you receive will depend on the size of your family and your household income.

## **Questions about the Health Insurance Marketplace**

**I heard that Kansas has a federally-run marketplace (exchange) instead of a state marketplace. What's the difference?**

The biggest difference between a federal marketplace and a state marketplace is who is in charge of running it. In Kansas, the marketplace website and marketplace telephone help line are both run by the federal government. The Kansas Insurance Department is responsible for reviewing plans, benefits, and rates to be offered on the federal marketplace. The Department is still responsible for ensuring the financial integrity of all insurance companies doing business in Kansas, licensing insurance agents, and addressing concerns and complaints from Kansans.

**Will I still be able to buy my health insurance from an insurance agent after the Health Insurance Marketplace is in place?**

Yes. Using insurance agents is still a valuable method in deciding what health insurance policy is right for you. As always, you can call the Kansas Insurance Department at 800-432-2484 to verify that your insurance agent and/or company is licensed to do business in Kansas.

**I see that there are several different options on the Health Insurance Marketplace. How do I know whether I should buy a bronze, silver, gold or platinum plan?**

It depends on your health care needs and your budget. Each plan provides the same essential health benefits. The difference between the four levels is how much you pay in premiums and how much out-of-pocket expense you will have. In general, if you are generally healthy, and would rather pay less in premiums (but have a higher out-of-pocket cost should you get sick), a bronze plan might work for you. If you need a lot of health care or have a lot of prescriptions to fill, a platinum plan may be right for you, because it has higher premium costs, but lower out-of-pocket expenses. Keep in mind that, no matter which plan you choose, your out-of-pocket cost will be capped. Use the calculator on [www.insureks.org](http://www.insureks.org) or [www.healthcare.gov](http://www.healthcare.gov) to explore how much each plan would cost you.

**Will there be anyone to help me use the Health Insurance Marketplace?**

The Affordable Care Act designates certain organizations and individuals who will help Kansans get the health insurance coverage they need and can afford. Community groups and organizations are designated by the federal government as Navigators. These Navigators have received training and funding to help Kansans navigate the Health Insurance Marketplace and answer questions about the ACA and health insurance in general. Other individuals, not necessarily associated with these organizations, will also be available, and are known as "certified application counselors (CACs)" and can also help you enroll in coverage. You can find more information about Navigators or CACs by visiting [www.insureKS.org](http://www.insureKS.org). You can also call the Health Insurance Marketplace's consumer hotline, at **800-318-2596**. As always, the Kansas Insurance Department is always available to answer your health insurance concerns and questions. You can visit our website at [www.ksinsurance.org](http://www.ksinsurance.org) or call our toll-free hotline at **800-432-2484**.



## **What is the difference between an insurance agent, a Navigator, and a Certified Application Counselor (CAC)?**

Insurance agents, Navigators and CACs are all helpful resources when trying to figure out which health insurance plan is right for you. Insurance agents are a great resource to turn to if you are not sure which plan is right for you and you need someone to recommend a plan that is best for you. Navigators and CACs can help you use the marketplace. They can give you information you need about the plans available to you, but they cannot recommend what plan you choose and they cannot sell insurance.

## **Other frequently asked questions**

### **How do I know if a high deductible health plan (HDHP) or catastrophic plan is right for me?**

If you are generally in good health, don't need very many prescriptions, and don't intend to become pregnant in the near future, an HDHP or catastrophic plan might be right for you. However, it is important that you be able to pay the out-of-pocket expenses since your health insurance won't pay for anything up front. Depending on your plan, these out-of-pocket expenses can cost you up to \$6,350 for an individual and \$12,700 for a family plan.

### **My spouse is losing his/her job and will no longer have insurance. Do I have to wait until open enrollment to put him/her on my health insurance plan?**

No. Termination of employment is usually considered a *qualifying event*, which means that you have a period of time after your spouse has lost insurance benefits to add him/her to your plan - usually 60 days. If you do not add your spouse to your policy at this time, you may have to wait until the next open enrollment period to do so.

### **My insurance company has denied a claim for a medical service I received. What can I do about it?**

The first step when dealing with a claim denial is calling your insurance company and asking about the denial. At this time, you can also ask them how to go through the internal appeals process. Sometimes an internal appeal will fix the claim dispute. If the internal appeal does not solve the problem, call the Kansas Insurance Department's Consumer Assistance Hotline at **800-432-2484**. If you have gone through the internal appeals process, we may be able to help by either contacting the company on your behalf or by setting up an independent medical review.

## Chapter 7

# Glossary of health insurance terms

**Allowed Amount:** Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See *Balance billing*).

**Appeal:** A request for your health insurer or plan to review a decision or a grievance again.

**Balance billing:** When a provider bills you 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 the remaining \$30. Typically a preferred provider may not balance bill you for covered services.

**Coinsurance:** Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan’s allowed amount for an office visit is \$100 and you’ve met your deductible, your coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.

**Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage:** A federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent to the covered employee, or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

**Community rating:** A rule that prevents health in-

surers from varying premiums within a geographic area based on age, gender, health status, or other factors.

**Complications of pregnancy:** Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren’t complications of pregnancy.

**Copayment:** A fixed amount (for example, \$15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.



**Cost sharing:** The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn’t include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.

**Deductible:** The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is \$1,000, your plan won’t pay anything until you’ve met your \$1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

**Disease management:** A broad approach to coordinate and manage the successful treatment of a specific disease with the goal of making more expensive inpatient and acute care unnecessary. Disease management includes the use of preven-

tive medicine, patient counseling, education, and outpatient care. The process is intended to reduce health care costs and improve the quality of life for individuals by preventing or minimizing the effects of a disease, usually a chronic condition.

**Durable Medical Equipment (DME):** Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

**Emergency medical condition:** An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

**Emergency services:** Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

**Essential health benefits:** A set of health care service categories that must be covered by certain plans, starting in 2014.

The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Insurance policies must cover these benefits in

order to be certified and offered in the Health Insurance Marketplace, and all Medicaid state plans must cover these services by 2014.

**Exchange:** See “Health Insurance Marketplace”

**External review:** A review of a plan’s decision to deny coverage for or payment of a service by an independent third-party not related to the plan. If the plan denies an appeal, an external review can be requested. In urgent situations, an external review may be requested even if the internal appeals process isn’t yet completed. External review is available when the plan denies treatment based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, when the plan determines that the care is experimental and/or investigational, or for rescissions of coverage. An external review either upholds the plan’s decision or overturns all or some of the plan’s decision. The plan must accept this decision.

**Excluded services:** Health care services that your health insurance or plan doesn’t pay for or cover.

**Formulary:** A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.



**Grandfathered health plan:** As used in connection with the Affordable Care Act: A group health plan that was created - or an individual health insurance policy that was purchased - on or before March 23, 2010. Grandfathered plans are exempt from some changes required under the ACA. Plans or policies

may lose their “grandfathered” status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions. (*Note: If you are in a group health plan,*

*the date you joined may not reflect the date the plan was created. New employees and new family members may be added to grandfathered group plans after March 23, 2010).*

**Group health plan:** In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

**Guaranteed issue:** A requirement that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some states, guaranteed issue doesn't limit how much you can be charged if you enroll.

**Guaranteed renewability:** A requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums. In Kansas, guaranteed renewal doesn't limit how much you can be charged if you renew your coverage.

**Habilitation services:** Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**Health insurance:** A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

**Health Insurance Marketplace:** A transparent and competitive health insurance market where individuals, families, and small businesses can learn about their health coverage options, compare health insurance plans based on costs, benefits, and other important features, choose a plan, and enroll in coverage. The Marketplace also includes

information on programs that help people pay for coverage, including ways to save on monthly premiums and out-of-pocket costs, and other programs, like Medicaid and the Children's Health Insurance Program (CHIP). Individuals and families can apply for coverage online, by phone, or with a paper application.

**Health Savings Account (HSA):** A medical savings account available to taxpayers who are enrolled in a high deductible health plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if you don't spend them.

**High Deductible Health Plan (HDHP):** A plan that features higher deductibles than traditional insurance plans. HDHPs can be combined with a Health Savings Account (HSA) or a health reimbursement arrangement to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

**Hospitalization:** Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

**In-network provider:** A health care provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an HMO or PPO). The provider agrees to the managed care organization's rules and fee schedules in order to be part of the network and agrees not to balance bill patients for amounts beyond the agreed upon fee.

**Individual mandate:** A requirement that everyone maintain health insurance coverage. The ACA requires that everyone who can purchase health insurance for less than 8% of their household income do so or pay a tax penalty.





**Individual market:** The market for health insurance coverage offered to individuals other than in connection with a group health plan. The ACA makes numerous changes to the rules governing insurers in the individual market.

**Internal review:** The review of the health plan's determination that a requested or provided health care service or treatment is not or was not medically necessary by an individual(s) associated with the health plan. The ACA requires all plans to conduct an internal review upon request of the patient or the patient's representative.

**Limited benefits plan:** A type of health plan that provides coverage for only certain specified and limited health care services or treatments or provides coverage for health care services or treatments for a certain amount during a specified period.

**Mandated benefit:** A requirement in state or federal law that all health insurance policies provide coverage for a specific health care service.

**Medicaid:** A state-administered health insurance program for low-income families and children, pregnant women, the elderly, and people with disabilities. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies state by state. In Kansas, Medicaid is known as KanCare.

**Medical loss ratio:** A basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead



expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. The ACA sets minimum medical loss ratios for different markets.

**Medically necessary:** Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or

its symptoms and that meet accepted standards of medicine.

**Medicare:** A federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (a permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

**Medicare Advantage (Medicare Part C):** A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage plans offer prescription drug coverage.

**Medicare supplement insurance:** Private insurance policies that can be purchased to "fill-in the gaps" and pay for certain out-of-pocket expenses (like deductibles and coinsurance) not covered by original Medicare (Part A and Part B).

**Network:** The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

**Non-preferred provider:** A provider who doesn't

have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

**Out-of-pocket limit:** The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit.

**Plan year:** A 12-month period of benefits coverage under a group health plan. This 12-month period might not be the same as the calendar year. To find out when your plan year begins, you can check your plan documents or ask your employer. (Note: For individual health insurance policies this 12-month period is called a "policy year").

**Preauthorization:** A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called "prior authorization," "prior approval" or "pre-certification." Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

**Preferred provider:** A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health

insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

**Premium:** The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

**Prescription drug coverage:** Health insurance or plan that helps pay for prescription drugs and medications.

**Preventive services:** Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

**Primary care provider:** A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

**Qualified health plan:** Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other

requirements.

**Rate review:** A process that allows state insurance departments to review rate increases before insurance companies can apply them to you.



**Rehabilitation services:** Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

**Rescission:** The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel your entire policy if you made a mistake on your initial application when you buy an individual market insurance policy. Under the Affordable Care Act, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

**Self-insured:** Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrator, or they can be self-administered.

**SHOP marketplace:** The Small business Health Options Program is a marketplace, similar to the individual Health Insurance Marketplace, that offers health insurance coverage to employees of small businesses. Over time, large businesses will be included in the marketplace.

**Small group market:** The market for health insurance coverage offered to small businesses - those with between 2 and 50 employees. The ACA will broaden the market to those with between 1 and 100 employees on January 1, 2016.

**Specialist:** A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

**Waiting period:** In job-based coverage, the time that must pass before coverage can become effective for an employee or dependent, who is otherwise eligible for coverage under a job-based health plan. Also known as a "probation period."

# Kansas Insurance Department



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