



Wisconsin Office of the  
**COMMISSIONER**  
**OF INSURANCE**

# Health Insurance 101

# Our Mission

The mission of the Office of the Commissioner of Insurance is to **protect and educate Wisconsin consumers by maintaining and promoting a strong insurance industry.**



# Evolution of Health Insurance

- First sighting of health insurance approximately 1929 large industrial employers creating access to health insurance for employees.
- Next between 1950s and 1960 labor unions and more individuals began seeking health insurance, typically creating a safety net for catastrophic health conditions.
- Passage of Medicare in 1965.
- Beginning in the 1970s with the concept of managed care through health maintenance organizations.



# Health Insurance Introduction

- Principles of insurance:
  - Definition of risk
  - Pooling concept





# Health Insurance

- Disability (accident & health) insurance is generally defined as any type of insurance that covers policy claims involving:
  - (1) medical and surgical expenses;
  - (2) indemnities for loss of income due to accident or health;
  - (3) accidental death and disability;
  - (4) hospital care; and
  - (5) long-term care.



# Commissioner's Role with Health Insurance

- Jurisdiction over group or blanket policies covering risks where at least 25 percent of certificate holders or insureds reside in Wisconsin
- Statutes define numerous terms for health insurance:
  - Group insurance policy,
  - Group health plan (ERISA definition),
  - Managed care (defined network) plans.



# Health Insurance

- Terminology within Health Insurance:
  - Statutes use terms for health insurance:
    - Health care plan
    - Comprehensive coverage
    - Disease specific or duration specific coverage





# Insurance policy designs

- Individual vs. Group coverage:
  - The laws of large numbers comes into play:
  - Small employer defined as at least 2 but not more than 50 employees
  - Large employer defined as on average at least 51 employees
- Product options:
  - Traditional 80/20 plans
  - Managed care
  - Federal or federal/state programs





# Managed Care Plans - Distinctions

- For comprehensive health insurance, mostly frequently consumers are offered various managed care type plans. A managed care plan is defined as any health benefit plan that requires or creates incentives for an enrollee to use providers that are owned, managed, or under contract with the insurer offering the health benefit plan.



# Managed Care Plans - Distinctions

- Insurer trade choice of health care providers (hospitals, clinic, physicians, therapists, etc.) with premium. The more choices you want the higher the premium likely will be. The reverse is also true, if you are willing to significantly restrict your access to a single group of providers, the insurer typically charges a lower premium.
- Least number of choices = EPO= Exclusive provider organization
- Greatest number of choices = POS=Point of service plans





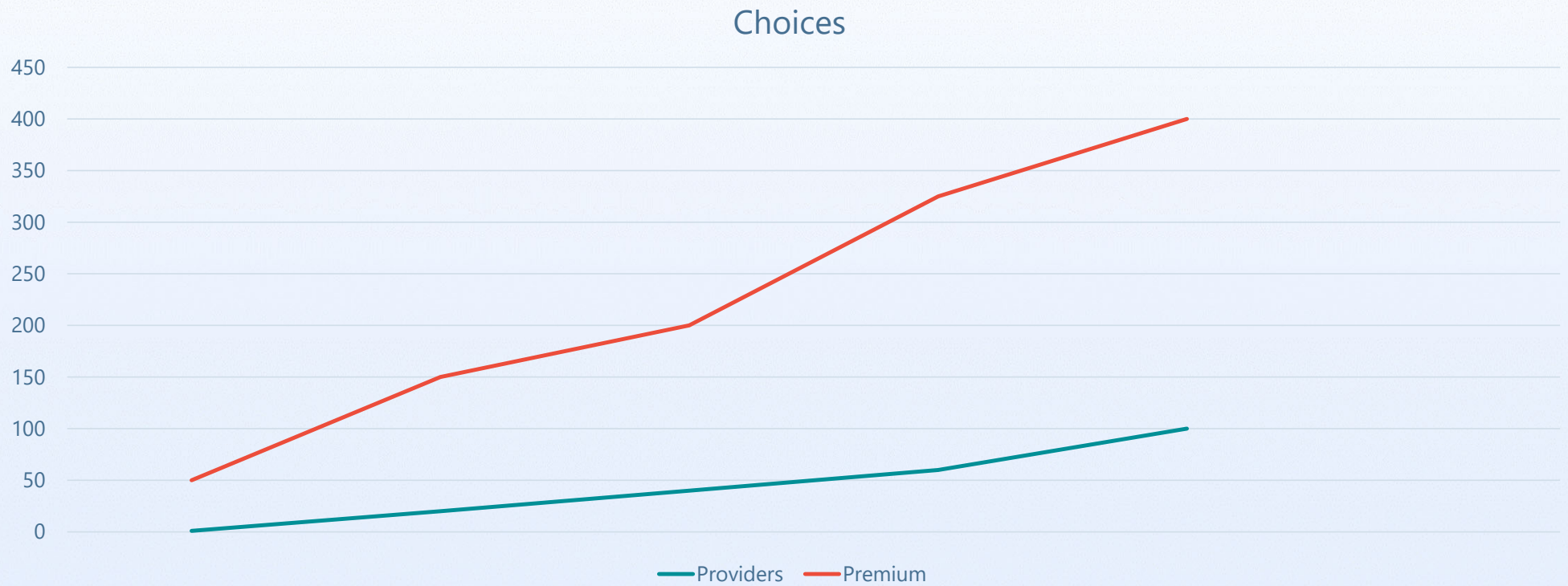
# Managed Care Plans - Distinctions

- A “health maintenance organization” (HMO) is a managed care plan that makes available to enrolled participants, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers selected by the organization.
- A “limited service health organization” (LSHO) is a managed care plan offers a limited range of health care services performed by providers selected by the organization. For example, dental care.
- A “preferred provider plan” (PPP) or “preferred provider organization” (PPO) is a managed care plan that pays a specific level of benefits if plan providers are used and a lesser amount if non-plan providers are utilized. A PPP offers financial incentives to use network providers through varied coinsurance and deductible amounts. Usually more flexible than an HMO.
- A “point-of-service plans” (POS), which you pay less if you use doctors, hospitals, and other health provider that belong to the plan’s network. POS may require referrals from a primary provider, but this plan will cover out-of-network doctors.





# Managed Care Plans – Distinctions Continued



# Excepted Health Policies – Fixed Indemnity

- Accident only
- Blanket Accident/Sickness
- Critical Illness
- Cancer Only
- HIV indemnity
- Intensive Care
- Hospital Indemnity
- Sickness Only



# Types of Policies/Coverage

- Qualified Health Insurance (QHP) – comprehensive coverage
- Medicare Supplement
  - Medicare Select
- Long Term Care
- Short-term Limited Duration (STLD)





# What is generally exempt from OCI Jurisdiction

- Self-funded ERISA Plans
- Labor Union Health & Welfare Plans
- Discount Plans
- Medicare Advantage Plans
- Medicare Part D Prescription Drug Plans
- Healthcare Sharing Ministries (HCSMs)
- Direct Primary Care



# Short-term Limited Duration Plans (STLD)

- A type of health insurance coverage that was originally designed to fill temporary gaps in coverage that occur when a person transitions from one plan to another.
- Not Qualified Health Plan under the ACA
- Do not qualify for ACA subsidies
- Loss of a STLD plan does not trigger a SEP on the ACA marketplace
  
- Application fees when solicited by associations
- Limited authority over out-of-state Association plans





# Federal Rule for STLD Policies

Federal rule requires short-term insurance policies to prominently display a specified consumer protection notice in the contract and in any application materials provided in connection with enrollment. The notice is designed to inform individuals of all the following:

- (1) The coverage under the short-term, limited duration plan is not ACA-compliant.
- (2) Individuals should check for exclusions or limitations on coverage for preexisting conditions and health benefits.
- (3) The policy may have lifetime or annual limits on health benefits.
- (4) Individuals may have to wait for the annual open enrollment window in order to obtain other health insurance coverage if the short-term policy coverage period expires.
- (5) The coverage under the short-term policy is not considered “minimum essential coverage,” under the ACA.

The precise language and notice requirements that insurers must follow can be found at 83 Fed Reg. 38212 (August 3, 2018).





# Limitations of STLD plans

## Limited Coverage

- Can medically underwrite
- Can exclude coverage for pre-existing conditions
- Waiting periods for sickness

## High Deductibles

## Caps on Coverage

## Lack of Renewability



# Healthcare Sharing Ministries

- By definition, HCSMs are **not insurance**
- There are specific requirements charitable & religious associations must comply with. (Wisconsin Statute § 600.01 (b) 9.)
- Organizations meeting all the requirements are exempt from the requirements set forth in the insurance statutes and regulations.
- States potentially have regulatory authority if it is determined that the organization is not exempt – i.e. if it is doing the business of insurance.



# Characteristics of HCSMs

- Membership is limited to people who share a common religious faith, and who agree to a variety of rules.
- Some HCSMs may help to negotiate expenses on behalf of the member like insurance companies, but many do not offer this service to their members.
- Unlike traditional health insurance plans, there is typically no provider network. The HCSM member can often visit the provider of their choice, unless restricted to certain providers by the HCSM





# Limitations of HCSM

- Can have annual and lifetime benefit caps
- Not required to
  - cover pre-existing conditions
  - cap out-of-pocket costs, or
  - cover essential health benefits
- No guarantee of reimbursement for anything
- It is reimbursement, often must pay up front
- Reimbursement not claim based
- Not cover mental health/addiction/ not birth control - PTSD



# Federal Laws

- Medicare (Title XVIII of the Social Security Act)
- ERISA
- COBRA
- Mothers' Health Protection Act of 1996
- Women's Health and Cancer Rights Act of 1998
- HIPAA
- Mental Health Parity & Addiction Equity (MHPAEA)
- PPACA (Affordable Care Act)
- No Surprises Act (NSA)



# Affordable Care Act (ACA)

- Most significant change to the health insurance market since Medicare
- Federal law that was phased in
- Regulatory and sub-regulatory guidance
- Repeals of parts by regulation and case law.
- Even after the passage of ACA, OCI's mission remains the same and we continue to be the primary regulator of the insurance industry in Wisconsin.





# ACA Overview – Market Reforms

- Beginning January 1, 2014
  - Health insurers are required to sell a plan to anyone who applies for comprehensive coverage and resides in their service area
  - No longer can refuse or limit coverage based on health status
  - Individual and small group plans must cover the Essential Health Benefits
  - Covered out-of-pocket expenses limited
    - 2024 Individual = \$9,450
    - 2024 Family = \$18,900



# Market Reforms continued

- Insurers may only vary premium for a particular plan based on:
  - Whether coverage is for an individual or family;
  - The area of the state the plan is sold; location
  - Age;
  - Tobacco use (now only as of age 21)
  - Plan Category
- Plans categorized into metal tiers, based on actuarial value (AV); meaning the average amount of covered health care services the plan is expected to pay
  - Bronze: 60%
  - Silver: 70%
  - Gold: 80%
  - Platinum: 90%





# 2024 Open Enrollment Timeframe

- Open enrollment is the annual timeframe during which consumers can purchase individual health insurance plans, either on or off the federal Exchange
- November 1, 2023, through January 15, 2024
- Plans sold during open enrollment period by December 15, 2023, would have an effective date of January 1 of the follow year.
- Outside the Open Enrollment Period, a person generally can enroll in a health insurance plan only if s/he qualifies for a Special Enrollment Period (SEP)





# Open Enrollment: SEPs

- Special Enrollment Periods (SEPs) are available for individuals to enroll outside of the open enrollment period
  - Basic types of qualifying life events:
    - Loss of coverage thru loss of employment or divorce/legal separation
    - Change in residence
    - No longer eligible for Medicaid
    - Newly obtained citizenship
    - Life event
      - Birth, marriage, adoption or child placed in foster care



# Polling Slide #1

- Special Enrollment Periods (SEPs) allow individuals to enroll in the ACA outside of the normal enrollment period when that person:
  - A. Decides a different plan would be more cost-effective.
  - B. Receives a promotion at work.
  - C. Loses eligibility for Medicaid.
  - D. Is diagnosed with a severe illness.



# 2024 Open Enrollment: Plan Options

- WI has a very competitive individual health insurance market with 14 insurers offering plans on Exchange.
- On Exchange issuers must offer their plans off Exchange as well, so those same insurers plus 1 additional are offering plans available in the individual market off Exchange
- OCI has an interactive map on its Web site, including names and contact information for insurers offering coverage throughout the state:
  - <https://oci.wi.gov/Pages/Consumers/FindHealthInsurer.aspx>





# Pre-Existing Conditions (Pre-Ex)

- Not allowed under ACA QHP plans
- Applicable to short term limited duration policies, fixed indemnity policies
- Different definition from that used by physicians and other health care providers
- Medical records indicating chronic or recurring conditions or diseases



# Appeals, Grievances and Independent Review

Insureds have the right to appeal a health plan denial of benefits for covered services that you or your provider believe are medically necessary

Many insureds do not know about the appeal process

- Kaiser Study

Two kinds of appeals

- Internal Appeal
- External Review



# Medical Necessity

- Not defined by Wisconsin statute or rule
- Defined by the insurer
- Different than physician's or other health care provider's definition of medical necessity
- OCI doesn't make medical determinations, so resolution is through grievance and IRO
- Examples of complaints:
  - Number of Physical therapy sessions
  - Surgical Procedures





# Interest on Claims

- Requires sufficient documentation to make a determination of liability
- Doesn't apply to self-funded plans or Medicare Advantage or Medicaid
- Doesn't apply to providers with provider agreements



## Polling Slide #2

- Which of the following is true?:
  - A. Short term plans are required to provide coverage for Pre-Existing Conditions.
  - B. Qualified Health Plans under the ACA are required to provide coverage for Pre-Existing Conditions.
  - C. OCI is able to make medical determinations regarding Pre-Existing Conditions.
  - D. Filing an action in court is the only way to resolve disputes regarding Pre-Existing Conditions.



# Network Adequacy

- Sufficient number and type of plan providers to adequately deliver all covered services based on the demographics and health status of current and expected enrollees served by the plan
- EPOs have narrow (skinny) networks but must still have an adequate network of providers.
- Consumer Affairs Section of OCI wants to be notified of challenges by filing a complaint to accessing care due to network limitations or insufficient providers.
- OCI conducts desk audits and exams and reviews the insurer's data.





# ACA and Deductibles

- The passage of the ACA resulted in changes to the standards regarding out-of-pocket maximums.
  - What cost sharing is accumulated to the max?
- All family deductibles must be no more than double the individual deductible rate under the ACA.
  - For example, if the individual deductible is \$3,000, the family deductible can be no more than \$6,000. This measure too is an effort to alleviate the financial stress on smaller families.



# Deductibles

- **Deductible** - the amount of money that must be paid for covered services before the health insurance company begins paying for expenses.
  - **Embedded Deductible** - Each family member has an individual deductible in addition to the overall family deductible. This means if an individual in the family reaches his or her deductible before the family deductible is reached, his or her services will be paid by the insurance company for the rest of the policy term which helps to relieve financial stress on smaller families
  - **Non-Embedded Deductible** - There is no individual deductible. The overall family deductible must be reached, either by an individual or by the family, in order for the insurance company to pay for services for the remainder of the policy term.
  - Non-embedded deductibles may be problematic for small families. For example, if those on the plan consist of only a member and spouse, they have fewer people to help reach the high deductible.





# Cost Sharing Examples

- **Deductible + Coinsurance + Copayment = Amount out of pocket**
  - Deductible: Pay attention to in-network/out of network differences if any
  - Coinsurance: this is a calculation based upon the charge that you are unlikely to know prior to receipt of a service.
  - Copayment: this would include office visit fee or set fee for using a facility like an Emergency Room or Ambulance fee. However, there can be instances where a co-pay would NOT go towards the out-of-pocket maximums.







The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.\[insert\].com](#) or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$500 / individual or \$1,000 / family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$300 for <a href="#">prescription drug coverage</a> and \$300 for occupational therapy services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$2,500 individual / \$5,000 family; for <a href="#">out-of-network providers</a> \$4,000 individual / \$8,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="#">www.[insert].com</a> or call 1-800-[insert] for a list of <a href="#">network providers</a> .  <small>(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022) (HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)</small>	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> for anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <a href="#">copay</a> /office visit and 20% <a href="#">coinsurance</a> for other outpatient services	40% <a href="#">coinsurance</a>	None
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	60 visits/year
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	60 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	60 visits/calendar year
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service.

#### Excluded Services & Other Covered Services:

##### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

##### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Chiropractic care
- Hearing aids
- Weight loss programs

**Your Right to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

#### Does this plan provide Minimum Essential Coverage? **Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

#### Does this plan meet the Minimum Value Standards? **Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

#### Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:  
[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

**Total Example Cost** \$12,700

**In this example, Peg would pay:**

Cost Sharing	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$1,800
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,560</b>

**Managing Joe's Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:  
[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

**Total Example Cost** \$5,600

**In this example, Joe would pay:**

Cost Sharing	
<a href="#">Deductibles*</a>	\$800
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$100
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,820</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:  
[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

**Total Example Cost** \$2,800

**In this example, Mia would pay:**

Cost Sharing	
<a href="#">Deductibles*</a>	\$500
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$400
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

# Wisconsin Insurance Mandates

- Wisconsin's mandate applies to all group health plans policies covering hospital care, with an exception for groups less than 10.
- Mandates beginning with s. 632.895 (9), Wis. Stat., Coverage of Drugs for Treatment of HIV, apply to self-insured by a county board by a city or village by a local governmental unit or technical college district by a town or by a school district.
- Some self-insured plans and governmental units use Third Party Administrators (TPAs) to administer plan and pay claims



# Alcoholism, Drug Abuse and Mental Health

- The Affordable Care Act (ACA) provides that mental health and substance use disorder services including behavioral health treatment are essential health benefits (EHBs). Health plans issued on or after January 1, 2014, in the comprehensive individual and small group markets are required to cover mental health and substance use disorder services including behavioral health treatment.





# Preventative Care Services

- Preventive care services are not subject to cost-sharing when delivered by doctor in the insured's network
- COVID-19 immunizations is a preventive care service
- High deductible plans - first dollar coverage is only available for certain preventive care benefits, such as an annual physical.
- Refer to list of preventive services on Healthcare.gov or U.S. Preventive Services Task Force at:
  - <https://www.uspreventiveservicestaskforce.org>



# Continuation Rights Group Health Insurance

- Both state and federal laws give certain individuals, who would otherwise lose their group health insurance coverage under an employer or association plan, the right to continue their coverage for a period of time.
- Federal Law Consolidated Omnibus Budget Reconciliation Act (COBRA)
  - Most employers with 20 or more employees must comply with federal law Up to 18 months for employee, spouse and dependents
  - Up to 36 months for spouse and dependent if the loss of insurance was due to death of the employee.





# Continuation Rights cont.

State continuation law, Wis. Stat. § 632.897

- Wisconsin statutes give the following individuals who have been continuously covered under a group health insurance policy for at least three months the right to continue group coverage:
  - A former spouse whose coverage ends due to divorce or annulment
  - An employee who voluntarily or involuntarily ends their employment
  - A covered spouse and/or dependents of an employee who has died
- If the federal and state laws conflict, OCI opinion is that the law most favorable to the insured should apply.





# Continuation Rights cont.

- Key points:
  - Separation from the employer cannot be for gross misconduct
  - The individual continuing insurance must pay 100% of the premium
  - You may be eligible for a Special Enrollment Period (SEP) during which you can enroll in an individual health insurance plan including purchasing on the federal marketplace. However, if you initially take COBRA you are **not** eligible for an SEP. You must exhaust COBRA benefits and wait for next open enrollment period.
  - Employers must notify the enrollee employee of their rights for COBRA or continuation.



