Addendum: for use with New Mexico Health and Life & Health online ExamFX courses and study guide version 17943en, per exam content outline updates effective 4/30/2019.

*The following are **content additions** to supplement your existing text unless otherwise indicated:*

HEALTH

Health Insurance Basics

D. Limited Policies

3. Types of Limited Policies

Expected Benefits Plans

The renewability, eligibility, and benefit requirements for the individual health insurance market do not apply to the following limited lines coverages and are considered **excepted benefits** under all circumstances:

- Accident-only coverage;
- Disability income insurance; and
- Credit-only insurance.

In addition, the following are also excepted benefits if provided under a separate policy, certificate, or contract of insurance and if they meet certain requirements:

- Limited dental or vision benefits;
- Specified disease or illness (for example, cancer policies); and
- Hospital indemnity or other fixed indemnity insurance.

Medical Plans

A. Medical Plan Concepts

Expense Based Basis vs. Indemnity

Indemnity-based plans pay health policy benefits to the insured based on a predetermined, fixed rate, regardless of the actual expense incurred. Most indemnity policies are offered as deductible health care plans. The insured may choose the deductible amount (the higher the deductible, the lower the premium rate). Most plans have co-payment requirements that are determined by percentages applied after the deductible amount has been reached.

Expense-based plans pay health policy benefits as a reimbursement of actual expenses.

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Exclusive Provider Organization (EPOs)

An Exclusive Provider Organization (EPO) is a type of preferred provider organization in which individual members use particular preferred providers rather than having a choice of a variety of preferred providers. An EPO is characterized by a primary physician who monitors care and makes referrals to a network of providers.

Open Network

Open networks allow participants to consult with other participating providers of services without a referral. This is also known as "open access".

Closed Network

In closed networks, covered insureds must select a primary care provider. That provider is the only one allowed to refer the insured to other health care providers within the plan. This is also known as "closed access" and "the gatekeeper model".

B. Types of Providers and Plans

Provisions Affecting Cost to Insureds

A **copayment** provision is similar to the coinsurance feature in that the insured shares part of the cost for services with the insurer. Unlike coinsurance, a copayment has a **set dollar amount** that the insured will pay each time certain medical services are used.

Qualified Health Plans (QHPs)

State insurance exchanges offer coverage through **qualified health plans (QHPs)**. Qualified health plans may not have pre-existing condition limitations, lifetime maximums, or annual limits on the dollar amount of essential health benefits.

A health plan's status as a qualified health plan will be based on the following characteristics of the plan:

- Benefit design;
- Marketing practices;
- Provider networks, including community providers;
- Plan activities related to quality improvement; and
- The use of standardized formats for consumer information.

Essential Health Benefits (EHB)

The Affordable Care Act (ACA) requires that all health care plans include the following **10 essential benefits**:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;

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- 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.

Cost-Sharing Reduction (CSR)

A **cost-sharing reduction (CSR)**, also called extra savings, provides a discount to the amount an insured will pay for deductibles, copayments and coinsurance. Once the Marketplace application has been filled out, an applicant is able to determine their eligibility for tax credits or a CSR. A CSR is only applicable to insureds that have selected a Silver plan.

Included in CSRs is a lower out-of-pocket maximum. After the out-of-pocket maximum has been reached, the insurance plan will cover 100% of covered services.

Members of a federally recognized tribe or shareholders of an Alaska Claims Settlement Act (ANCSA) Corporation may be eligible for additional cost-sharing reductions.

Advance Payments of the Premium Tax Credit (APTC)

Advance payments of the premium tax credit, or **APTC**, is a tax credit that can help individuals afford coverage bought through the Marketplace. These tax credits can be used right away to lower the monthly premium costs for insurance. If the insured qualifies, he or she may choose how much advance credit payments to apply the premiums each month, up to a maximum amount. If the amount of advance credit payments for the year is less than the tax credit due, the insured will get the difference as a refundable credit when the insured files the federal income tax return. If the advance payments for the year are more than the amount of the credit, the insured must repay the excess advance payments with the tax return.

APTC is paid on a sliding scale, from 100% of FPL to 400% of FPL. It is generally calculated based on attested projected annual income for the upcoming coverage year. Maximum APTC is calculated with reference to income and applicable second lowest cost silver plan.

Special Enrollment Period

State insurance exchanges must provide for an **initial open enrollment period, annual open enrollment** periods after the initial period (currently scheduled from November 1 through January 31), and **special enrollment** periods. Unless specifically stated otherwise, individuals or enrollees have 60 days from the date of a triggering event to select a qualified health plan. Triggering, or qualifying, events include marriage, divorce, birth or adoption of a child, change in employment, or termination of health coverage.

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Qualified individuals and enrollees may enroll in or change from one qualified health plan to another as a result of the following triggering events:

- A qualified individual or dependent loses minimum essential coverage;
- A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
- An individual who was not previously a citizen or lawfully present individual who gains such status;
- A qualified individual's enrollment or non-enrollment in a qualified health plan is unintentional or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the exchange;
- An enrollee adequately demonstrates that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract;
- An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan;
- A qualified individual or enrollee gains access to new qualified health plans as a result of a permanent move;
- A Native American, as defined by the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month; and
- A qualified individual or enrollee demonstrates that he or she meets other exceptional circumstances as the exchange may provide.

Preventive Care Services

Most health plans must cover a set of preventive services like shots and screening tests **at no cost to the insured**. This includes Marketplace private insurance plans. Approved preventive services must be offered without any copayment or coinsurance, even if the insured has not met the annual deductible. The no-cost requirement only applies if the services are delivered by a network provider.

Maximum Out-of-Pocket Limit

The **maximum out-of-pocket limit (MOOP)** is the most the policyowner will have to pay for covered services in a plan year. After that amount is spent on deductibles, copayments, and coinsurance, the health plan pays 100% of the costs of covered benefits. Note, however, that the out-of-pocket limit does not include the monthly premiums, or any services not covered by the plan.

The current maximum out-of-pocket limit for any Marketplace plan is $7,900 for an individual plan and $15,800 for a family plan.

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High-Deductible Health Plans (HDHPs)

High-deductible health plans (HDHPs) are often used in coordination with MSAs, HSAs, or HRAs. The high-deductible health plan features higher annual deductibles and out-of-pocket limits than traditional health plans, which means lower premiums. Except for preventive care, the annual deductible must be met before the plan will pay benefits. Preventive care services are usually first dollar coverage or paid after copayment. The HDHP credits a portion of the health plan premium into the coordinating MSA, HSA, or HRA on a monthly basis. The deductible of the HDHP may be paid with funds from the coordinating account plan.

C. Cost Containment in Health Care Delivery

Network Adequacy

In contrast to traditional broad provider networks, narrow networks contain a smaller number of providers and in-network facilities, which typically results in lower premiums. The use of narrower networks usually allows insurers to gain greater leverage to negotiate lower prices with providers, especially hospitals and large medical groups.

Narrow networks can be advantageous to insurers as a risk-selection mechanism because poor risks are likely to be more attracted to broad network plans. Many of the health plans initially sold on the state exchanges offered limited networks of hospital and medical providers. The ACA has since been addressing these limitations by establishing the federal standard for **network adequacy** in the commercial insurance market, applicable nationwide to plans available through the insurance marketplaces. To encourage insurer participation in the marketplaces and to allow consumers access to a broader choice of plans, insurers now have more flexibility to satisfy network standards.

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