

# Private Health Insurance and HMOs

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## Introduction

### Health insurance coverage in Wisconsin

Maintaining health insurance coverage can be an important means to ensure that individuals with disabilities have access to health care. Health insurance coverage, whether through a private insurer or a health maintenance organization (HMO), can prevent catastrophic effects on family resources. Most people in the United States have their health insurance through their employer or through their relationship to someone who is employed, such as a parent or spouse. Employers offering health insurance benefits typically pay all or most of the premium fee for single employees and offer the employee the ability to pay the additional premium cost for family insurance to include the employee's dependents. According to the Health Insurance Association of America, in 1997, Wisconsin had the highest private health insurance coverage in the country, with 86 percent of the population having coverage. In 1998, over three million people in Wisconsin were covered by health insurance. The majority are enrolled in managed care plans such as HMOs.



*When you are looking for health insurance coverage, start by determining your or your family's needs. Look at your health care records. Talk with your doctor about future needs. Get an accurate idea of your current and future needs so that you can determine if a particular policy will meet your needs.*

This chapter explains the basics of health insurance, including definitions of commonly used terms and types of insurance. It also gives ideas for obtaining health insurance and tells how to deal with problems with health insurance. You will learn about health care consumer protections in Wisconsin and what insurance companies are mandated to provide. Finally, this chapter provides an overview of federal laws affecting health insurance.

## Ideas for Obtaining Health Insurance

### Non-employer health care programs

If you don't have health insurance through employment or your relation to someone who is employed, there are several other ways you can try to get coverage. Either you or your spouse could investigate changing to a job with open enrollment for health insurance. If you or family members are veterans, there are veteran's health programs that can be accessed through the county Veterans' Service Officer. Also, check with patient financial staff at local medical clinics or hospitals. For example, the Hill-Burton program at certain hospitals may fund hospitalizations. Care provided by charitable programs can reduce

costs. Federally-funded Community Health Centers are also located throughout the state.

Tribal Health Centers may have funds available for Native Americans. Free or low-cost drug programs at pharmaceutical companies supply free drugs for many conditions. Check with any groups you belong to, such as AARP, church, the military, unions, AAA or professional organizations to see if they offer plans to members.

**Post-employment protections** If you recently left an employer who provided health insurance, you should have been offered the opportunity to continue your coverage by paying your premiums. If you did not, contact the Office of the Commissioner of Insurance to make a complaint. (*See below for instructions.*) People receiving Medicare often buy supplemental policies to cover items not paid for by Medicare. (*See Medicare Program chapter, pg. 71.*)

**Non-employer options** There are several programs you or your family may be eligible for through the Wisconsin Department of Health and Family Services or your local county human service agencies. These include Medicaid for children, parents, people with disabilities, pregnant women, or people over 65 years of age, BadgerCare, which provides health insurance for lower-income, uninsured families, and the Medicaid Purchase Plan (MAPP) for people with a disability who are working. (*See Medicaid & BadgerCare chapter, pg. 38.*) Wisconsin's Health Insurance Risk Sharing Plan (HIRSP), provides insurance coverage to high-risk and otherwise uninsurable individuals. (*See HIRSP chapter, pg. 75.*)

To reduce costs, shop around for the best price for medical services. Medical costs vary for the exact same treatment at different providers. Negotiate with providers, either before the services are rendered or after, for a time payment schedule or reduced costs. People with a terminal illness who have an immediate need for cash may sell their life insurance policies to viatical companies. Viatical companies buy the future benefit amount of a life insurance policy today. The policy owner's rights are assigned to the viatical company in exchange for a lump sum.

## Basics of Health Insurance

### Premium and policy

Traditionally, health insurance is a contract or agreement that obligates an insurer to pay for certain health care services in return for a periodic payment called a premium. What the insurer will pay for, or cover, is set out in the insurance policy. The policy explains the circumstances under which the insurer will pay for medical treatment and the limits on the amount the insurer will pay. A policy's benefits are the payments it makes or the services it provides. All policies limit the amount of benefits and the length of time that they will pay them. There are many types of limitations.

**Limitations to full coverage** One type of limitation is a deductible. A deductible is a given amount of medical expense that must be paid by the insured before the insurance starts reimbursing. The deductible amounts can range from a few hundred to a few thousand dollars (usually during a one year period). Co-payments are another type of limitation. Co-payments are percentages of an expense that the policy will not cover. For example, a 20% co-payment means the consumer is paying 20% of covered expenses and the insurance company is paying 80%. As another example, HMOs may charge a \$10 co-pay for each doctor's visit for each family member. In addition, most health insurers limit benefit payments based upon a standard called "usual, customary and reasonable" (**UCR**). This means that the insurance company looks at what health care providers typically charge for a service, the charge in that geographical area and the reasonable cost of a service to come up with a fixed amount. Other common types of policy limitations are limits on the total lifetime medical expenses for a person or limits for a particular medical condition.

**Underwriting and pre-existing conditions**

When an insurer looks at a health care consumer's medical history and decides whether or not to insure, this is called underwriting. Families with members who have pre-existing conditions, or health problems, at the time of application for insurance, often have problems with denial of coverage when underwriting takes place. HIPAA, a law discussed below, severely restricts group insurers' rights to deny or exclude those with pre-existing conditions. Many managed group policies offer an open enrollment period, or time when a person can enroll without underwriting. Open enrollment usually occurs when new employment begins or another qualifying event occurs, such as marriage, adoption or birth.

**Coordination of benefits**

The coordination of benefits provisions in insurance policies explain who pays claims when people have more than one potential health insurer. A company that pays first is called the primary insurer and the company that pays next is the secondary insurer. For example, if two spouses with insurance through their employers have children, the policies will explain which insurer pays for the child's health expenses. Medicaid, for example, is always second. If a person on Medicaid has other coverage, that insurance pays first.

## **Types of Health Insurance**

**Fee-for-service plan**

Traditional health insurance policies are based on a fee-for-service plan, meaning the insurance company pays or reimburses the cost of the health care professional's services. Under this type of policy, the insured is usually able to choose the health care service provider. The insurance company then pays the bill or reimburses the insured. Some people prefer this type of plan because of the freedom of choice in providers. This may be particularly valuable to those who need regular care from specialists. It is generally more expensive than an HMO, but may provide more assurance of certain types of care, such as physical or speech therapy. Fee-for-service insurance can require more paperwork

than an HMO. Some doctors will file the claim, others require the insured to file. Some doctors expect payment before the insurance company reimburses the insured.

Fee-for-service insurance can be classified as either group or individual. A group policy is purchased by an employer, labor union or other organization for its employees or members. The employer or organization purchasing the policy is the policy holder and the people covered are the group members. An individual policy is purchased by and covers only one person or family. Because they tend to cost more than group policies, most people only buy them as a last resort.

### **Managed care plan**

Most people in Wisconsin who have health insurance participate in a managed care plan. HMOs are managed care programs with financing and health care delivery practices that are designed to limit costs and ration care. A basic feature of managed care is a limit in choice of provider to selected providers and hospitals that follow the rules established by the plan. HMO members pay the insurer to both pay for and provide the services. The HMOs usually handle claims, so members do not handle paperwork, nor receive bills. Most HMOs stress prevention and wellness, and thus cover annual physicals, well-baby care and immunizations. HMOs can create problems for people with special health care needs by limiting services and access to specialists. Referrals and prior authorizations are often used to screen access to specialists, thus limiting or delaying services.



### **Know what your policy covers**

*Health insurance almost never covers all health care expenses. Coverage for services varies enormously among insurance providers. Even specific companies have different plans, often tailored to the employer's request. Employers, who often pay at least a portion of the premium, frequently decide how much to cover and how generous the benefits package will be.*

## **How to Deal with Health Insurance Problems**

**ERISA**  
29 USC § 1001-1461

If you are covered through your employer and your employer self-insures your plan, your coverage is subject to a law called Employee Retirement Income Security Act (**ERISA**). If you have a problem, you can file a grievance with your plan administrator or employer. If you are a state employee, you can file a grievance with your plan administrator and can contact the State of Wisconsin Employee Trust Funds ombudsman to resolve the problem at 608-266-3285. If you are covered through your employer and your employer purchases insurance from one or more insurers on your behalf, contact the customer service department for your plan.

### **What to do in an emergency**

Keep track of who you speak to and document your contacts. If your problem is not resolved via telephone and the delay in resolving your dispute could jeopardize your life or health, ask the plan

administrator in writing for an expedited grievance. The plan must resolve an expedited grievance within four working days of receiving it.

### **Filing a grievance**


If the problem is not resolved in writing and there is no danger to your life and health, write the plan a letter describing your problem and how you want to see it resolved. Include copies of any supporting documentation and keep copies of all correspondence. This is called filing a grievance. The plan must acknowledge your grievance within 10 days. The plan will probably tell you when their next meeting of the grievance committee takes place. They must give you at least ten days notice of when and where the meeting will take place. You have a right to be present at the grievance meeting. If you choose not to attend, the committee will base its decision on the written material that you submit. If you choose to attend, you may bring anyone with you such as a family member, friend, doctor or lawyer. A decision will probably be made soon after the committee meets, but the plan has up to 30 days to resolve your concern. If they need more information, the committee may postpone making a decision another 30 days if they let you know in writing. In addition to filing a grievance with your plan, you can also file a grievance with the Insurance Commissioner's office.

### **Role of Office of the Commissioner of Insurance**

The Office of the Commissioner of Insurance (OCI) was created to protect the welfare of insurance consumers. OCI is responsible for investigating and processing consumer complaints against agents, insurance companies and employee benefit plan administrators. OCI maintains a consumer information and complaints telephone helpline to answer insurance-related questions and offers consumer guides and fact sheets on most insurance topics to help you understand the terminology, requirements and options affecting your insurance purchasing decisions. To get a copy of a complaint form, see the OCI contact at the end of this chapter.

OCI will not intervene in determining medical necessity or investigating quality of care. If you are not satisfied with the outcome of your grievance with the plan or OCI, you may file your case in small claims court. At any point in your dispute, you can choose to contact a lawyer.

The Center for Public Representation, a public interest law firm, has a grievance form to use when filing a grievance against an HMO. The Center also provides other information about health issues. (See pg. 88.)



### **Examples of reasons to file a grievance**

*A grievance may be appropriate when claims or benefits are denied because care is considered experimental, not medically necessary, or for a pre-existing condition. Other reasons for a grievance may be when a denial is made stating the care is not covered by your policy, not pre-authorized, not provided by a provider who is part of your plan, or provided in an emergency setting but not considered an emergency. You may also want to file a grievance when part of a claim was not paid because the charge was considered above "usual, customary and reasonable" rates or a deductible or copayment was*

*mistakenly applied. Other times a grievance may be appropriate are when you are dissatisfied with the quality of care, you are denied certain drugs or medical devices or you experience problems getting appointments, referral requests or pre-authorizations.*

## **Consumer Protections and Mandated Benefits in Health Insurance Policies**

### **Choice of providers**

### **Standing referral**

### **Second opinion**

### **Emergency care coverage**

### **Physician availability**

### **Exchange of information on treatment options**

### **Disclosure of treatment limitations**

### **Mandated benefits**

Sec. 632.87(4), Wis. Stats.

In Wisconsin, there are many protections in place for health care consumers. For example, a managed care plan must include enough providers to give consumers a reasonable choice. If warranted by your health condition, a managed care plan must give you a standing referral to a specialist provider. The plan must also tell you under what conditions a standing referral will be granted and how to apply. Every managed care plan must cover a second opinion from another provider within the managed care network. Every health benefit plan offered in Wisconsin that covers emergency care must cover services required to stabilize a condition that a reasonably prudent layperson would consider to be an emergency, without prior authorization.

If your managed care plan listed a primary care physician as available during your open enrollment period, they must make the physician available to you at no additional cost during the entire plan year. A specialist provider must be made available for the lesser of the course of treatment or 90 days. The exceptions are for a provider no longer practicing in the area or who was terminated from the plan for cause.

A managed care plan may not limit your health care providers from disclosing information regarding all your treatment options. However, this does not mean all treatment options are necessarily covered under the plan.

If your health insurance plan limits coverage of an experimental treatment, procedure, drug or device, the insurer is required to clearly disclose those limitations to the policy. The insurer must also have a process for your doctor to present medical evidence to request coverage of a drug that is not on the approved list.

Health insurance policies sold in Wisconsin often include “mandated benefits,” benefits that an insurer must include in certain types of health insurance policies. For example, all health insurance policies must cover services provided by a chiropractor if the policy would provide coverage for the same services if performed by a physician or osteopath. All health insurance policies are required to provide coverage for diagnosis or treatment of a condition or complaint performed by a licensed dentist if the policy covers diagnosis or treatment of the condition by any other health care provider. All health insurance policies which cover dependent children must cover adopted children and children placed for adoption on the same terms and conditions as “natural” children.

**Mandatory coverage for adopted children**

Sec. 632.896, Wis. Stats.

A policy cannot exclude or limit coverage of a disease or physical condition of the adopted child because the disease or condition existed before coverage under the policy began.

**Policy extension for handicapped children**

Sec. 632.88, Wis. Stats.

Hospital or medical expense policies which cover dependent children may end coverage when the child reaches an age specified in the policy. However, coverage of a dependent child cannot end while the child continues to be incapable of self-sustaining employment because of mental retardation or a physical handicap and is chiefly dependent upon the person insured under the policy for support and maintenance. This applies to both group and individual policies. Insurers can require notice of continued dependence after a child reaches the maximum age under the policy.

**Treatment of mental disorders and substance abuse**

Sec. 632.89, Wis. Stats.

Group policies must provide for inpatient treatment (for those policies generally providing for hospitalization), outpatient and transitional services (for those policies generally providing inpatient or outpatient services) for the treatment of nervous and mental disorders, alcoholism and other drug abuse. The combined coverage for inpatient, outpatient and transitional treatment services must be at least \$7,000 a year. For more details on this and other mandated benefits, contact the Office of the Commissioner of Insurance. (*See pg. 87.*)

**Mental Health Parity Act**

29 USC 1185a

Sec. 632.89, Wis. Stats.

The Mental Health Parity Act of 1996 was passed to make access to certain mental health benefits equal to other benefits. Group health plans, insurance companies and HMOs (with more than 51 employees) offering mental health benefits cannot set annual or lifetime limits on mental health benefits that are lower than any limits for medical and surgical benefits. This does not apply to benefits for substance abuse or chemical dependency. However, health plans are not required to include mental health coverage in their benefits package. Plans that offer mental health benefits can continue to set terms that limit the amount, duration and scope of mental health benefits, such as co-pays and limits on the number of visits.

**Home health care coverage**

Sec. 632.895(2), Wis. Stats.

Both group and individual health insurance policies that provide benefits for inpatient hospital care must provide coverage for the UCR fees for at least 40 home health care visits per year. Home health care may include intermittent home nursing care, home health aide services, various types of therapy, medical supplies, medication prescribed under the home care plan, nutrition, and counseling.

**Skilled nursing facility coverage****Treatment for kidney disease and diabetes**

Policies that cover hospital expenses must cover at least 30 days of skilled nursing care to patients who enter a licensed, skilled nursing facility within 24 hours after discharge from a hospital. Policies that cover hospital expenses must provide at least \$30,000 of coverage per year for inpatient and outpatient treatment of kidney disease, including dialysis, transplant, and donor-related services. A policy that covers expenses for diabetes treatment must provide coverage for insulin infusion pumps and other equipment and supplies, including insulin and diabetic self-management education programs.

## Health Insurance Portability and Accountability Act of 1996 (HIPAA)

### Protections when pre-existing conditions exist

29 USC § 1181

This law provides protection to workers and their families with pre-existing medical conditions or those who may face discrimination in health coverage based on a factor related to an individual's health. The law affects employer-sponsored *group* health plans, insurance companies and HMOs. HIPAA:

1. Limits exclusions for pre-existing conditions.
2. Prohibits discrimination against employees and their dependents based on their health status.
3. Guarantees renewability and availability of health coverage to certain employees and individuals.
4. Protects workers who lose health coverage by providing better access to individual health insurance.

**There is one major exception to HIPAA, it provides no protection to individuals switching from one individual plan to another.**

### Pre-existing Condition Exclusions Under HIPAA

Under HIPAA, if you've had insurance at a previous job, HIPAA generally prevents the new group plan or health insurance issuer from denying coverage due to pre-existing conditions. A participant or beneficiary can only be excluded due to a pre-existing condition if:

- the pre-existing condition relates to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six month period prior to an individual's enrollment date;
- the pre-existing exclusion may not last for more than 12 months (18 months for late enrollees) after an individual's enrollment date; or
- this 12 (or 18) month period must be reduced by the number of days the individual had prior creditable coverage, excluding coverage before any break in coverage of 63 days or more.

### Reduction of pre-existing condition exclusions

The "portability" provision means that once an employee has had health coverage, through a group plan or even through Medicaid or Medicare, this coverage can be used to reduce or eliminate any pre-existing condition exclusion that may be applied under a future employer group plan.

A person who has at least 12 months of creditable coverage under a prior plan, or Medicaid or Medicare, will not be subject to any pre-existing condition clause under a new plan. If a person has less than 12 months of prior creditable coverage, the new plan must credit the person for every month s/he did have coverage under the old plan.

In order to receive full protection, the person may not have more than a 63 day break in coverage. This means that s/he cannot have been uninsured for more than 63 days before applying for the new insurance.

Under HIPAA, individuals can't be excluded from coverage under the terms of the plan or charged more for benefits offered by a plan or issuer, based on specified factors related to health status. This means that group health plans and issuers can't establish rules for eligibility based on "health status-related factors." These factors include health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. For example, a person cannot be excluded or dropped from coverage because of a particular illness. (*See the Wisconsin Department of Labor website for more information.*)

[www.dol.gov/dol/pwba](http://www.dol.gov/dol/pwba)

## Family and Medical Leave Act

29 USC § 1161 Both the federal and state Family Medical Leave Act (**FMLA**) laws require employers to allow employees who meet certain criteria the right to take family or medical leave. If an employee is on such leave, the employer must maintain group health insurance coverage under the same conditions that applied prior to the leave. The employee is required to make the same premium contributions he or she would have made if not on leave. An employee who is unable to return to work at the end of the leave is then eligible for continuation (*see below*). The 18 months of eligibility for continuation begins when the family or medical leave ends or when the health insurance coverage would otherwise terminate, not when the leave began. (*For further discussion of Family and Medical Leave see Insurance Discrimination chapter, pg. 93.*)

## COBRA

29 USC § 1161 The Consolidated Omnibus Budget Reconciliation Act of 1986 (**COBRA**) gives many people who would otherwise lose their group health coverage the right to continue temporary coverage under the group plan. The law covers employers with more than 20 employees and gives employees who terminate employment for any other reason other than gross misconduct or reduced hours, and dependents of those employees, the right to continue group coverage for up to 18 months by paying the monthly premiums. Dependents may continue coverage for up to 36 months if they lose coverage for reasons such as the death of the employee, divorce or legal separation from the employee, the dependent has reached the maximum age under the policy, or the employee becomes eligible for Medicare. Disabled employees can continue coverage for up to 29 months.

### Post employment protection



*COBRA allows beneficiaries of a covered plan to change their minds about their continuation rights within 60 days of termination of employment.*

**Wisconsin law on continuation of health insurance policies**

Sec. 632.897, Wis. Stats.

Wisconsin has laws relating to continuation and conversion rights in health insurance policies. In some ways the state and federal laws are the same, in other ways different. Both laws may apply to a policy. The opinion of the Office of the Commissioner of Insurance (**OCI**) is that when state and federal laws differ, the law that applies is the most favorable to the insured.

Wisconsin state law applies to insured group plans that provide hospital or medical expenses. In the case of divorce or annulment, the law applies to individual policies that offer the same type coverage. The law gives most employees and their dependents who have been covered continuously for at least three months the right to continue their group hospital and medical coverage or to convert to an individual policy providing similar benefits if they would otherwise lose eligibility for the group policy. Spouses who would otherwise lose their coverage because of divorce or annulment also have the right to continue coverage under the group policy or to convert to an individual policy providing similar benefits. Coverage continues until premiums are not paid, the person becomes eligible for similar coverage under another group policy, the former spouse of a divorced person loses eligibility for the group policy, or 18 months of continued group coverage elapse.

For more information about COBRA, contact the U.S. Department of Labor, see below. For more information about Wisconsin law related to continuing health insurance, contact the OCI, see below.



*A person who becomes eligible for a similar group coverage under another group policy can continue the previous coverage until the end of any waiting periods for pre-existing conditions under the new policy. If you leave one company before starting another, consider using COBRA to keep your old coverage so that your coverage stays continuous. That way you can't be excluded under your new coverage for a period due to pre-existing conditions.*

**Office of the Commissioner of Insurance**

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608- 266-3585

800-236-8517 (voice) (TTY users use WI TRS - 800-283-9877)

[www.state.wi.us/agencies/oci/oci\\_home.htm](http://www.state.wi.us/agencies/oci/oci_home.htm)

**Pension and Welfare Benefits**

U.S. Department of Labor/PWBA  
200 W. Adams Street, Suite 1600  
Chicago, IL 60606  
312-353-0900

**Center for Public Representation**

P.O. Box 260049  
Madison, WI 53726-0049  
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