STATE OF WISCONSIN
OFFICE OF THE COMMISSIONER OF INSURANCE

GUIDE *to*

Health Care Insurance

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Guide to HEALTH CARE INSURANCE

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Introduction

This publication focuses on comprehensive health insurance. The term “health insurance” refers to a wide variety of insurance policies. These range from comprehensive policies covering the costs of doctors and hospitals to those meeting a specific need, such as paying for long-term care.

In 2014, the federal Affordable Care Act (ACA) made significant changes to the rules applying to both the comprehensive individual (purchased by individuals and families) and group (mostly coverage purchased by employers) health insurance markets. One of the most significant market changes is referred to as “guaranteed issue.” This means insurance companies (insurers) are required to sell their health insurance plans to any consumer applying for coverage, regardless of their health status. Insurers are also prohibited from excluding or limiting coverage for preexisting conditions and can only vary premium between policyholders based on age, composition of family, geographic area, and tobacco use.

Many of the ACA changes are explained in this publication, including: the individual mandate, federal exchange/ marketplace, federal open enrollment and special enrollment periods, federal subsidies, and plan design.

The Individual Mandate: Requirement to Purchase Coverage

The individual mandate refers to federal law requiring individuals to have health insurance or pay a penalty, called the Shared Responsibility Payment. The law provides exemptions from the individual mandate based on income, religion, cost of insurance, and American Indian status. In 2017, Congress eliminated financial penalties associated with failing to comply with the mandate, effective January 1, 2019.

In other words, individuals without health insurance coverage after 2018 will not pay a penalty. For more information on the mandate and exemptions, visit www.healthcare.gov/fees/fee-for-not-being-covered, or the federal Internal Revenue Service (IRS) web page, Individual Shared Responsibility Provision.

The Federal Exchange

“Federal Exchange” or “Federally Facilitated Marketplace” (FFM)

Individuals can purchase health insurance coverage through the private market or through the federal exchange, also known as the Federally Facilitated Marketplace (FFM) or Marketplace, during an annual open enrollment period. The cost is the same whether purchased through the Marketplace, which is considered “on-exchange,” or from the individual or private market, which is considered “off-exchange.” However, federal subsidies are only available on the exchange. All plans available on the federal exchange are also available off-exchange directly from an insurer or a licensed insurance agent.

The federal exchange is a website for consumers to:

- Check their eligibility for government assistance programs, including any subsidies available to help pay for private health insurance
- Compare health insurance plans based on cost and quality
- Purchase health insurance

The federal exchange website is HealthCare.gov.

Wisconsin’s Health Insurance Market

Wisconsin has a competitive individual health insurance market with 12 insurers offering plans on exchange in 2019, and those same insurers plus 3 more offering plans off-exchange.

The Office of the Commissioner of Insurance (OCI) developed an **interactive map** allowing consumers to easily view the insurers offering coverage in each county. Insurer contact information is provided as well.

To access the map, visit oci.wi.gov/Pages/Consumers/FindHealthInsurer.aspx.

Open Enrollment and Special Enrollment Periods

Open enrollment is the annual timeframe during which consumers can purchase comprehensive individual health insurance plans, either on- or off-exchange. The federal government establishes the open enrollment timeframe annually. To purchase a plan for 2019, consumers must select a plan between November 1, 2018, and December 15, 2018. Plans must be purchased by December 15, 2018, to have a January 1, 2019, effective date. Consumers choosing to forgo purchasing health insurance during this time generally must wait until the next year's open enrollment period to buy a policy.

To purchase a plan for 2019, consumers must select a plan between November 1, 2018, and December 15, 2018.

After December 15, 2018, you can only enroll or change plans if you qualify for a **special enrollment period (SEP)**. SEPs are available for individuals to enroll outside of the open enrollment period. Events triggering eligibility for a SEP include:

- loss of coverage
- a life event such as birth, marriage, or divorce
- a change in residence

You generally have 60 days to enroll in new or alternative health insurance coverage. To learn more about SEPs visit www.HealthCare.gov/sep-list/.

Federal Subsidies

The federal government offers consumers a tax credit to help individuals afford health insurance coverage purchased through the federal exchange.

Advance Premium Tax Credits (APTC)

Advance payments of the tax credit can be used to lower monthly premium costs. When consumers apply for APTC, they estimate their expected income for the year. It is important to report any changes in income during the year as soon as possible to the federal exchange to avoid paying higher premiums or owing money when taxes are filed. If the advance payments for the year are more than the amount of the tax credit, individuals must repay the excess advance payments when they file their tax return. If the amount of the advance credit is less than the tax credit due, the consumer will get the difference as a refundable credit on their federal tax return.

Premium tax credits are available to individuals and families with incomes between 100% and 400% of the federal poverty level (FPL) ($100,400.00 for a family of four and $25,100.00 for an individual in 2018). Individuals can use the premium tax credit to buy a bronze, silver, gold, or platinum plan (as defined by federal law described later in this publication). Individuals cannot receive premium tax credits if they are eligible for other minimum essential coverage including Medicare, Medicaid, or employer-sponsored health coverage considered adequate and affordable.

Cost-Sharing Reduction Subsidies (CRS)

CRS may be available to offset a consumer's out-of-pocket expenses, such as deductibles and copayments. To qualify, an individual's income must be between 100% and 250% of the FPL and a silver plan must be purchased on the federal exchange.

Types of Health Insurance Coverage

Most consumers have health insurance coverage from one of three sources:

- An individual health insurance policy
- A group health insurance policy
- A government-sponsored program.

Consumers in the individual market purchase a health insurance policy for themselves and their family, whereas group health insurance is accessed through an individual's employer, often referred to as "employer-sponsored coverage."

Government-sponsored programs include BadgerCare Plus, Medicaid, and Medicare. For more information on these programs, including eligibility requirements, visit www.dhs.wisconsin.gov/badgercareplus/index.htm and www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol/.

Individual Coverage

Individuals who do not have access to employer-sponsored coverage or are ineligible for government-sponsored coverage may choose to buy individual health insurance. The individual purchasing the policy is the policyholder and is responsible for the payment of premium. Coverage under this policy may include the policyholder's dependents (family members).

Employer-Sponsored Coverage

Employer-sponsored coverage is comprehensive group health insurance available to employees and their dependents. Coverage is provided to employees under a single master policy issued to the group policy owner (employer). A description of the benefits and coverage, often called the "certificate of insurance," is provided to the employees.

- **Small Employer**

  In Wisconsin, a small employer is defined as one who employs at least two but not more than 50 full-time equivalent employees. State law defines an **eligible employee** as one who works on a permanent basis and has a normal work week of 30 or more hours.

  This includes:

  - a sole proprietor,
  - a business owner, including the owner of a farm business,
  - a partner of a partnership, and
  - a member of a limited liability company

  if these individuals are included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a temporary or substitute basis, or less than 30 hours a week.

  Wisconsin small employers are not required by state law to offer employees health care benefits. However, many small employers offer health benefits to their employees in order to attract and keep good employees. Small employer health insurance is available in Wisconsin from several insurers and health care plans. For more information, review the *Health Insurance for Small Employers and Their Employees* (PI-206) publication available on OCI's website.

Small Business Health Options Program (SHOP)

SHOP is a way for employers with 50 or fewer full-time employees to offer health care benefits. Small employers may enroll directly with an insurance company offering SHOP plans or with the assistance of an agent or broker registered with the federally facilitated SHOP. Employers who complete an eligibility determination on HealthCare.gov and enroll in a SHOP plan will have access to the Small Business Health Care Tax Credit, if eligible.

Small employers with fewer than 25 full-time equivalent employees and paying average annual wages below $50,000.00 may qualify for a small business tax credit to offset some of the costs of health insurance premiums. The amount of the tax credit is based on the size of the employer's business. The credit is available only if the small employer receives coverage through SHOP. The small employer can find out if it qualifies for the small business health care tax credit by visiting www.IRS.gov.

- **Large Employer**

  A large employer is defined as one who employs more than 50 full-time equivalent employees. Large employers are required to offer health insurance coverage and are subject to Internal Revenue Service (IRS) reporting requirements and may be subject to IRS assessments. Further information is available at the IRS Information Center.

- **Fully Insured vs. Self-Insured**

  Employer-sponsored health plans are either fully insured or self-insured. Under a fully insured plan the employer purchases coverage from an insurance company. The insurance company receives premium payments from the employer, which are often a combination of employee and employer contributions, and assumes the risk to pay all medical claims. Insurers may require employers to guarantee a certain number of employees will take the insurance before agreeing to issue a policy to the employer. This is to help ensure there are enough individuals in the group who are in good health to counter the expenses the insurer will take on for those individuals with greater health care needs. Fully insured plans are regulated by OCI.

  Employers choosing to self-insure do not purchase a health insurance policy from a health insurer. Instead, these employers directly pay for medical claims. The funds used to pay claims are the same as under a fully insured model, which are a combination of employee and employer funds. In many cases, employers choosing to self-insure will contract with an insurance company or other entity to serve as a third-party administrator (TPA). The TPA receives a fee from the employer to process claims, respond to customer service needs, and to access their provider network. Employers who self-insure are governed by federal laws enforced by the U.S. Department of Labor (DOL). OCI has no authority to investigate complaints involving self-funded plans. State laws requiring coverage of specific benefits in health plans generally do not apply to self-insured plans.

Government-Sponsored Coverage

- **BadgerCare Plus & Medicaid**

  BadgerCare Plus is a program funded by the state and federal government offering low-income Wisconsin residents coverage for their health care needs. Medicaid is a state and federally funded program for elderly, blind, or disabled residents. The Wisconsin Department of Health Services administers these programs. For more information, visit www.dhs.wisconsin.gov.

- **Medicare**

  Medicare is the federal health insurance program administered by the federal Centers for Medicare & Medicaid Services (CMS) for people 65 and over, as well as for some people under 65 who are disabled. Medicare was designed to increase access to health care services and reduce its financial burden on older, retired, or disabled Americans. To learn more about Medicare visit www.ssa.gov/medicare.

  Additional options available to consumers include: Medicare supplement coverage, available for purchase through an insurer to provide coverage in addition to Medicare benefits, or Medicare Advantage plans offered by insurers who have entered into special arrangements with the federal government. The insurers agree to provide all Medicare benefits and some additional benefits. Medicare Part D, an optional prescription drug benefit, is also available for assistance in paying for some outpatient prescription medications.

  OCI publishes several consumer publications to assist Medicare-eligible consumers in their shopping for insurance (listed below). The publications are meant to be used only as a guide and are available at the links below or by calling OCI at (800) 236-8517.

- *Medicare Supplement Insurance Approved Policies*—Lists all policies available in Wisconsin including benefits and current premiums.
- *Medicare Advantage in Wisconsin*—Explains options available to Medicare-eligible persons age 65 and over, and some Medicare-eligible disabled individuals under age 65, who are looking for information about the Medicare Advantage program.
- *Wisconsin Guide to Health Insurance for People with Medicare*—Explains Medicare and supplemental insurance to cover those expenses not paid by Medicare.

Plan Types

The cost of health care services coupled with competition among health insurers has resulted in the development of many different types of health plans.

Defined Network/Managed Care Plans

A health plan which makes health care services available to its enrollees performed by providers selected by the plan and seeks to manage the cost, accessibility, and quality of care is known as a "managed care plan" or "defined network plan."

- **Exclusive Provider Organization (EPO)**

  An EPO is a health plan paying for services only if you use doctors, specialists, or hospitals in the plan's network, except for emergency medical services provided in a hospital emergency facility.

- **Health Maintenance Organization (HMO)**

  An HMO is a health plan providing comprehensive coverage for medical care when services are received by providers within the plan's provider network. HMOs often provide integrated care and focus on prevention and wellness. Generally, HMOs will not cover services rendered by out-of-network providers without prior approval. HMOs are required to cover emergency medical services in a hospital emergency facility outside the service area.

- **Point of Service Plan (POS)**

  A POS health plan typically offers more flexibility in utilizing out-of-network providers than an HMO. In some cases, enrollees may need to select a primary care provider and will likely need a referral to see a specialist. With a POS plan, enrollees have the choice to use doctors, hospitals, and other providers not in their health plan's network. However, they will have to pay more for using out-of-network providers.

- **Preferred Provider Organization (PPO)**

  Similar to a POS plan, a PPO plan pays a specific level of benefits if providers in the plan's provider network are used and a lesser amount if out-of-network providers are utilized. PPO plans often offer broad network options and often do not include the level of integrated or managed care as HMOs and POS plans and do not require a referral to see a specialist.

- **Limited Service Health Organization (LSHO)**

  An LSHO is the same as an HMO except it provides a limited range of health care services. For example, a dental LSHO provides only specific dental services. Like an HMO, an LSHO operates in a certain geographic area, is limited to specific providers, and is regulated by OCI. The LSHO will normally not pay for services received from a provider who is not affiliated with the organization.

Fee-for-Service Health Plans

Under a fee-for-service health plan, you are free to seek necessary medical care from any doctor and hospital you wish. The doctor often bills the insurance company directly for the services provided, and the insurance company pays for the items covered by the policy. In some cases consumers must fill out claim forms and send them to the insurance company. This type of health plan offers the most choices of doctors and hospitals.

Most health insurance plans covering expenses associated with serious illness or hospitalization have a deductible you must pay each year before the plan begins to pay benefits. Once your deductible has been met, the insurance company will typically pay your claims at a set percentage of the "usual, customary and reasonable" (UCR) rate for the service. The UCR rate is the amount health care providers in your area typically charge for any given service.

Plan Design

Actuarial Value

For individual and small group plans, federal law limits all plan designs to four categories based on the "actuarial value" of the plan categorized into metal tiers. A plan's actuarial value is the average percentage of benefits the insurer is expected to pay based on all consumers' health care utilization. As a result, consumers, on average will pay 40% of the claims cost for covered services (through deductibles, copayments, or other cost-sharing arrangements) on a bronze plan and the insurer will pay 60%. Consumers choosing a platinum plan will experience a higher monthly premium than plans with lower actuarial values. However, on average, they will pay 10% of the claims cost for covered services while the insurer will pay 90%.

The following are the four plan designs:

- **Bronze**—covers 60% of the total average costs of care
- **Silver**—covers 70% of the total average costs of care
- **Gold**—covers 80% of the total average costs of care
- **Platinum**—covers 90% of the total average costs of care

In addition to the metal tiers, federal law allows for the sale of catastrophic health plans to individuals under the age of 30. These plans have low monthly premiums and a high deductible. For 2019, the deductible is $7,900.00.

Features Included in Most Health Plans

- **Deductible**

  In some plans, you must meet a deductible. The deductible is the dollar amount you must pay each year before the insurance company pays its share. Read the policy carefully. Some policies require you to pay a deductible on a calendar year basis or on a per sickness or injury basis. Some plans may also have separate deductibles for certain services, like prescription drugs. If you are buying coverage for your family, ask how the family plan works. Family plans may have family and individual deductibles that need to be paid before the health plan pays towards the medical expenses.

- **Coinsurance**

  Coinsurance is your share or the percentage of covered expenses you must pay in addition to the deductible. A common coinsurance arrangement is for the insurance company to pay 80% and you pay 20% as coinsurance until an out-of-pocket maximum expense is reached. Coinsurance applies to each person and starts over again each year. Sometimes the policy will cover all expenses after a certain point. Review the list of covered expenses for the policy to see how comprehensive it is.

- **Out-of-Pocket Limit**

  The out-of-pocket limit is the maximum dollar amount you pay for covered services and supplies during a specified period, generally a calendar year. Federal law does not allow insurers to set an out-of-pocket limit beyond a certain amount. For 2019, the amount is $7,900.00 for individual plans and $15,800.00 for family plans. The maximum may be defined to include or exclude the deductible and can be separate based on whether services are in-network or out-of-network. Once the out-of-pocket maximum is paid, benefits are paid at 100% of the costs incurred after that time.

- **Medically Necessary**

  All health benefit plans contain a provision allowing insurance companies to evaluate whether a service or treatment is "medically necessary" in treating a patient and whether it could adversely affect the patient's condition if it were omitted. Insurance companies can deny payment for a treatment not medically necessary. Many health benefit plans require a review and authorization by the plan before certain medical procedures are done. Consumers have the right to challenge a treatment denial (see "Grievance and Independent Review Process" on page 18 of this publication). An authorization does not guarantee payment. Payment of benefits is subject to the benefits and cost-sharing of the contract.

- **Prescription Drug Formularies**

  Many health plans establish a list of covered prescription drugs the plan considers medically appropriate and cost effective. Prescription drugs are usually grouped into tiers, and the policyholder's share of the cost is determined by the tier.

- **Provider Networks and Directories**

  Managed care plans provide an enrollee with a provider directory listing hospitals, primary care physicians, and specialty providers from whom the enrollee may obtain services. These directories are generally available on the plan's Web site, but a paper copy must be provided upon request. Providers may terminate their participation with the insurer at any time during the year, so an enrollee should inquire with the insurer at the time of making an appointment as to whether the provider is currently participating in the insurer's network. Insurers often have more than one provider network. The coverage an enrollee chooses at the time of enrollment determines the provider network available. Generally, an enrollee must stay within the specific provider network in order for medical services to be covered at the in-network level.

Essential Health Benefits

Every comprehensive individual and small group health insurance policy is required to include "essential health benefits." Policies may not contain annual or lifetime dollar limits for these essential health benefits.

The following are the 10 benefit categories:

1. Ambulatory services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services
10. Pediatric services, including oral and vision care

Mandated Benefits

Health insurance policies sold in Wisconsin often include "mandated benefits." These are benefits an insurer must include in certain types of health insurance policies depending on the market covered.

The mandated benefits required by Wisconsin state law include coverage for:

- health care services provided by certain non-physician health care providers
- adopted children
- handicapped children

- nervous and mental disorders, alcoholism, and other drug abuse
- home health care
- skilled nursing care
- kidney disease
- mammography
- newborn infants
- grandchildren born to dependent children under the age of 18 who are covered by the policy
- diabetes
- lead screening
- temporomandibular joint treatment
- breast reconstruction following a mastectomy
- anesthesia for certain dental procedures
- maternity coverage for all persons covered under the policy if it provides maternity coverage for anyone
- immunizations for children under the age of 6
- coverage of certain health care costs in cancer clinical trials
- coverage of a student on medical leave
- treatment for autism spectrum disorders
- hearing aids, cochlear implants, and related treatment for infants and children
- contraceptives and services
- colorectal cancer screening
- coverage of dependents under age 26

Health insurers covering injected or intravenous chemotherapy and oral chemotherapy are prohibited from requiring a higher copayment, deductible, or coinsurance amount for oral chemotherapy than they require for injected or intravenous chemotherapy. If a health plan limits copayments to no more than $100 for a 30-day supply of an oral chemotherapy medication, the company would be considered in compliance with the mandate. For high-deductible health plans, the limitation applies only after the enrollee's deductible has been satisfied for the year.

Every managed care plan must cover a second opinion from another provider within the managed care plan provider network. Every health plan covering emergency care, including managed care plans, must cover services required to stabilize a condition most people would consider to be an emergency, without prior approval. Managed care plans are permitted to charge a reasonable copayment or coinsurance for this benefit.

For more information on mandated benefits, review the *Fact Sheet on Mandated Benefits in Health Insurance Policies* publication available on the OCI website or call OCI at (800) 236-8517 to request a copy.

Exclusions and Limitations

Every health benefit plan includes a listing of services the plan will not cover, often because the services are not considered medically necessary. In addition, some services may be limited. It is important for consumers to review each plan's exclusions and limitations. Keep in mind you must pay the full cost of care that is not covered.

Considering Health Plan Options

Choosing a Plan

When choosing a plan, consumers should identify what is most important to them in a health plan, such as, low cost; availability of a specific physician, clinic, or hospital; freedom to see any physician they want; or convenient location of facilities. It is important to remember there may be trade-offs when shopping for coverage. For example, a plan may be less expensive but may have higher out-of-pocket costs or a narrower provider network.

When shopping for coverage, consumers should ask themselves:

- What are the policy's deductibles, copayments, and maximum annual and lifetime payouts?
- Are there different out-of-pocket expenses for different kinds of care, such as specialty services?
- What are the differences among the metal levels—platinum, gold, silver, and bronze—and the amount of out-of-pocket costs you will need to pay?
- Does the plan allow me to see the providers I want?
- If benefits are provided for out-of-network services, what claim payment methodology does the insurer use for out-of network services (maximum allowable amount/usual and customary)?
- Will the plan cover the prescription drugs you are currently taking and what cost-sharing or limitations apply?
- Is there a separate deductible for prescription drugs?
- What is in the fine print? Be aware of the circumstances under which a policy will and will not cover some services. Ask specifically about limitations and exclusions on experimental procedures, transplants, infertility treatments, drug therapies, durable medical equipment, and whether the policy covers farm or work-related accidents.
- Is one type of plan better suited to provide the services you need if you have a specific health condition?

To ensure an accurate understanding of plan options available on and off the federal exchange, consumers may work with a local health insurance agent or go to HealthCare.gov.

Health Plan's Provider Network

Understanding a plan's provider network is another important factor to consider when choosing a health plan. Different plan types handle the ability for consumers to access out-of-network providers differently. Some include coverage for out-of-network providers but at a greater cost to the consumer and others do not cover any expenses for services performed by out-of-network providers. It is important for consumers to understand whether their preferred practitioners, clinics, and hospitals are included in the plan's provider network when shopping for a plan. If the plan provides for non-network benefits, consumers need to understand the claim payment methodology. Consumers should also understand the breadth of a provider network, meaning how narrow or broad it is. The network may include several large provider systems covering large portions of the state or may be more limited in nature and cover fewer provider systems.

Finally, consumers should consider what kind of specialty care is available. For example, some networks encourage the use of centers of excellence (facilities which may be some distance away from the consumer but specialize in difficult-to-treat conditions like transplants) for certain conditions while others allow the use of local providers.

No one plan design is best for all consumers. Narrower network plans may be less expensive and may coordinate care between different medical specialties. Wider networks provide consumers with more choices but may be more expensive. It is important to review each plan's provider directory and plan rules before purchasing coverage.

Additional Considerations

Continuity of Care

If a managed care plan during an open enrollment period represented a primary care physician (defined as a physician specializing in internal medicine, pediatrics, or family practice) as being available, it must make the physician available at no additional cost for the entire plan year. A specialist provider must be made available for the lesser of the course of treatment or 90 days. If an enrollee is in her second trimester of pregnancy, the provider must be available through postpartum care. The exceptions are for a provider who is no longer practicing in the managed care plan's service area or who was terminated from the plan for misconduct.

Referral Procedure

Some managed care plans require a referral from a primary care physician before an enrollee can see another plan provider. Information from the insurance policy will include details on the procedure to follow and any notification requirements.

- **Standing Referrals**

  A standing referral authorizes an enrollee to be seen by a specialist provider for a specific duration of time or specific number of visits without having to obtain a separate referral from the primary provider for each visit to the specialist. Managed care plans must have a procedure allowing for standing referrals.

- **No Referral Required**

  In some cases, a managed care plan cannot require a patient to obtain a referral to see certain providers. For example, the plan must allow a woman to receive obstetrical and gynecological services from a plan physician who specializes in obstetrics or gynecology without requiring a referral from her primary care provider. A managed care plan also may not require a referral from a physician for services from a plan chiropractor.

Losing your Employer-Sponsored Health Insurance Coverage

Both state and federal law give certain individuals who would otherwise lose their group health coverage under an employer or association plan the right to continue their coverage for a period of time. The two laws are similar in some ways but also have very different provisions. Most employers having 20 or more employees must comply with the federal law, while most group health insurance policies providing coverage to Wisconsin residents must comply with the state law. When both laws apply to the group coverage but differ, it is the opinion of OCI the law most favorable to the insured should apply.

Both state and federal law give certain individuals who would otherwise lose their group health coverage under an employer or association plan the right to continue their coverage for a period of time.

Under ACA, if you leave your job for any reason or you lose your employer-sponsored coverage, you qualify for a special enrollment period and can choose to buy coverage in the federal exchange. You may be eligible for premium tax credits to help pay your premiums and cost-sharing reductions that can lower your out-of-pocket costs.

- **Federal Law**

  The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law allowing most employees, spouses, and their dependents who lose their health coverage under an employer's group health plan to continue coverage, at their own expense, for a period of time. This law applies to both insured health plans and self-funded employer-sponsored plans in the private sector and those plans sponsored by state and local governments. However, COBRA does not apply to certain church plans, plans covering less than 20 employees, and plans covering federal employees.

  Under federal law, if an employee terminates employment for any reason other than gross misconduct or loses eligibility for group coverage because of a reduction in work hours, the covered spouse and dependents of the employee may continue the group coverage for up to 18 months. A spouse and

dependents may continue coverage for up to 36 months if they lose coverage due to the death of the employee, divorce from the employee, loss of dependent status due to age, or due to the employee's eligibility for Medicare. If within the first 60 days of COBRA coverage an individual or dependent is determined to be disabled by Social Security, the disabled individual and other covered family members may continue coverage for up to 29 months.

- **Wisconsin Law (s. 632.897, Wis. Stat.)**

  Wisconsin's continuation law applies to most group health insurance policies providing hospital or medical coverage to Wisconsin residents. The law applies to group policies issued to employers of any size. The law does not apply to employer self-funded health plans or policies covering only specified diseases or accidental injuries.

  Under Wisconsin's continuation law an employee would need to be continuously covered under the employer's group policy for at least three months. Employees have 30 days from the date they are notified of their continuation rights to make a decision and pay the premium required.

For more information review the *Fact Sheet on Continuation and Conversion Rights in Health Insurance Policies* which describes both state and federal law available on the OCI website or call OCI at (800) 236-8517 to request a copy.

Grievance and Independent Review Process

All health insurance plans are required to have an internal grievance procedure for those who are not satisfied with the service they receive. The health insurance plan must provide each enrollee with complete and understandable information about how to use the grievance procedure. An enrollee has the right, but is not required, to appear in person before the grievance committee and present additional information.

Both state and federal law give enrollees the right to request an independent external review when their health plan denies or reduces coverage based on medical judgement. Plans subject to the ACA must follow the federal process. The independent review process provides the enrollee with an opportunity to have medical professionals who have no connection to the health plan review the dispute. The enrollee may request an independent review organization (IRO) evaluate the health plan's decision. The IRO assigns the dispute to a clinical peer reviewer who is an expert in the treatment of the enrollee's medical condition. The IRO has the authority to determine whether the treatment should be covered by the health plan. A decision by the IRO is binding on the insurance company and the insured person.

For more information on the independent review process, see the *Fact Sheet on the Independent Review Process in Wisconsin* publication available on the OCI website or call OCI at (800) 236-8517 and request a copy.

A Resource for Questions and Concerns

The Information and Complaints section at OCI is dedicated to answering insurance-related questions and assisting individuals who are experiencing problems with their insurance company or their insurance agent. Examples of when to contact OCI include: delays in paying claims, underwriting problems including refusal to insure, deceptive or false advertising, misrepresentation by the insurer, failure to provide services guaranteed by the policy, and lack of disclosure about what is or is not covered by the policy.

OCI does not have the authority to force a company to insure anyone. However, OCI may take action against agents or insurers who misrepresent coverage, unfairly discriminate, or violate Wisconsin's insurance laws.

To file a complaint, complete an online complaint form available on OCI's website at ociaccess.oci.wi.gov/complaints/public/.

All insurance companies and agents doing business in Wisconsin are licensed by OCI. Information regarding licensed insurance companies and agents is available on the OCI website at oci.wi.gov or by calling toll-free at (800) 236-8517.

Health Care Provider Complaints

The Department of Safety and Professional Services (DSPS), through its professional boards, licenses physicians and most other health care providers and takes disciplinary action against a licensee who is proven not to meet minimum standards of professional conduct.

DSPS' contact information:

The Department of Safety and Professional Services
P.O. Box 8935
Madison, WI 53708-8935
(608) 266-2112
dsps.wi.gov

Definitions

Bronze Plan
One of four plan categories, in addition to silver, gold, and platinum. Bronze plans are designed to cover 60% of the total average cost of care.

Case Management
A process by which an enrollee with a serious, complicated, or chronic health condition is identified by a managed care plan and a plan of treatment is established in order to achieve optimum health in a cost-effective manner.

Catastrophic Plan
Health plans meeting all of the requirements applicable to other Qualified Health Plans (QHPs) but that do not cover any benefits other than 3 primary care visits per year before the plan's deductible is met. The premium amount you pay each month for health care is generally lower than for other QHPs, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally higher. To qualify for a catastrophic plan, you must be under 30 years old or get a "hardship exemption" because the Marketplace determined you are unable to afford health coverage.

Claim Payment Methodology
The method a health insurer uses to determine the eligible amount of a health insurance claim. An individual's share of costs which must be paid out of pocket is based on the insurer's eligible amount determination, which may vary greatly from the billed amount.

Closed Panel
A type of health plan requiring enrollees to seek care from a medical provider who is either employed by or under contract to the health maintenance organization or limited service health organization.

Coinsurance
A provision in an insurance policy requiring the enrollee to pay a percentage of the eligible medical expenses in excess of the deductible.

Copayment
A provision in insurance policies requiring the enrollee to pay a fixed amount for certain medical services. The copayment amount can vary by the type of health care service.

Cost-sharing Reduction
A discount lowering the amount you have to pay for deductibles, copayments, and coinsurance if you purchase a silver plan on the federal exchange.

Deductible
The portion of eligible medical expenses the enrollee must pay before the plan will make any benefit payments. The deductible may not apply to all services.

Defined Network Plan
Any health benefit plan requiring or creating incentives for an enrollee to use providers owned, managed, or under contract with the insurer offering the plan. This type of plan is sometimes referred to as a managed care plan.

Emergency Care
A medical emergency includes severe pain, an injury, sudden illness, or suddenly worsening illness causing a reasonably prudent layperson to expect delay in treatment may cause serious danger to the person's health if immediate medical care is not received.

Essential Health Benefits (EHB)
The minimum level of covered services insurers must offer in the individual and small group markets beginning January 1, 2014.

Exclusive Provider Organization (EPO)
A health plan requiring the use of a specific network of providers participating in the plan. EPOs do not cover care outside the network chosen by the enrollee except for emergency medical condition treatment.

Federally Facilitated Marketplace (FFM)
A federal Web site allowing consumers to: (1) check their eligibility for any subsidies available to help pay for private health insurance; (2) compare health insurance plans based on cost; and (3) link consumers to insurers for the purchase of health insurance after they choose a plan they are interested in. It is also referred to as the federal exchange or Marketplace. The web address for the federal exchange is HealthCare.gov.

Formulary
A list of prescription medications covered by an insurance plan.

Gold Plan
One of four plan categories, in addition to bronze, silver, and platinum. Gold plans are designed to cover 80% of the total average cost of care.

Grievance
Any dissatisfaction with the administration, claims practices, or provision of services by a health care plan, limited service health organization, or preferred provider plan expressed in writing to the insurer by, or on behalf of, an enrollee.

Health Maintenance Organization (HMO)
A health care financing and delivery system providing comprehensive health care services for enrollees in a particular geographic area. HMOs require the use of specific plan providers.

Independent Review
An appeal process in which a health care professional with no connection to an enrollee's health plan reviews a dispute involving a medical judgment. This is also referred to as an external appeal.

Limited Service Health Organization (LSHO)
A health care plan making available to its enrollees a limited range of health care services, such as dental or eye care, performed by providers selected by the plan.

Managed Care Plan
A health plan making available to its enrollees health care services performed by providers selected by the plan and seeking to manage the cost, accessibility, and quality of care.

Minimum Essential Coverage
Any insurance plan meeting the Affordable Care Act requirement for having health coverage.

Network
The facilities, physicians and medical professionals, and suppliers the health plan has contracted with to provide health care services.

Network Provider
A provider who has a contract with the managed care plan or LSHO to provide health care services to enrollees. Some plans may use the terms plan providers, preferred providers, or participating providers to refer to network providers.

Open Panel
A type of health plan other than a closed panel plan allowing covered enrollees to receive care from the provider of their choice and allowing any provider to participate. These plans may provide incentives for the enrollee to use providers participating in the plan.

Out-of-Pocket Maximum
This is the most an individual or family pays for covered services in a plan year under ACA. In 2019, the federal out-of-pocket maximum is $7,900.00 for an individual plan and $15,800.00 for a family plan.

Platinum Plan
One of four metal plan categories, in addition to bronze, silver, and gold. Platinum plans are designed to cover 90% of the total average cost of care.

Point-of-Service Plan (POS)
A type of managed care plan providing financial incentives to encourage enrollees to use network providers but allows enrollees to choose providers outside the plan.

Premium Tax Credit
A tax credit you can use to lower your monthly insurance payment (called your "premium") when you enroll in a plan through the federal exchange. Your tax credit is based on the income estimate and household information you put on your Marketplace application. If your estimated income falls between 100% and 400% of the federal poverty level for your household size, you qualify for a premium tax credit.

Prior Authorization/Precertification
A provision in insurance policies requiring prior approval by a health care plan or limited service health organization in order for services to be covered by the plan. Prior authorization is not a guarantee of coverage.

Preferred Provider Plan (PPP)
A health care plan making available to its enrollees either comprehensive health care services or a limited range of health care services performed by providers selected by the plan. It allows enrollees to use providers outside the network, but enrollees may be liable for a significant portion of these claims.

Primary Care Provider
A provider the enrollee selected in the health care plan or LSHO to provide or arrange health care services for the enrollee.

Referral
A process for making a request to a managed care plan to receive medical care from a nonparticipating provider or specialist. Some managed care plans require a referral from a primary care provider before the enrollee receives services from another plan provider.

Silver Plan
One of four plan categories, in addition to bronze, gold, and platinum. Silver plans are designed to cover 70% of the total average cost of care.

Small Business Health Options Program (SHOP Marketplace)
A federal Web site allowing small employers with 50 or fewer employees to compare health plans.

Special Enrollment Period (SEP)
A time outside the yearly open enrollment period when an individual can purchase health insurance. Certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child can qualify.

Urgent Care
Medically necessary care for an accident or illness needed sooner than a routine doctor's visit.