Health Insurance

IN KANSAS

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Commissioner of Insurance

Health Insurance in Kansas

Dear Kansas consumer,

Health insurance is an important matter for each Kansas consumer. The financial impact of illness can cause emotional and financial stress, and health insurance can help protect you against enormous health care expenses.

This booklet is designed to help you understand the health insurance coverage options available in Kansas. It contains information about both individual health insurance and employer-based (group) health insurance. It also contains information on how you can obtain health insurance if you are currently uninsured. We are here to help you ask the right questions when choosing an insurance plan that is right for you and your family.

This guide also contains information and answers common questions you may have about the federal Affordable Care Act (ACA).

If you have questions or need assistance understanding insurance issues, do not hesitate to contact the Kansas Insurance Department's Consumer Assistance Hotline toll-free at **800-432-2484.** Our trained staff is dedicated to helping answer your insurance questions.

Sincerely,

Vicki Schmidt
Commissioner of Insurance

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Health Insurance in Kansas

Chapter 1:
If you have individual coverage

When shopping for individual health insurance, it is important to be sure you know exactly what you are buying. There are several different types of individual health insurance policies available to you. The most common types of individual health insurance policies include major medical expense, catastrophic plans, and managed care plans.

Major medical expense

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

Level 1: Deductible- The dollar amount that you must pay each year before the policy will begin to pay. *For example, If you have a $2,500 annual deductible, you will pay for the first $2,500 of covered expenes for each person insured.*

If you are buying coverage for your family, ask how the family deductible works.

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

Level 2: Coinsurance and copayments- You share in the payment of the covered expenses up to a certain limit.

Coinsurance applies to each person and starts over each year. Copayments may be due each time you visit the doctor, and may vary in amount depending on what plan you have or what doctor you see.

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

Out-of-pocket limit: This is the maximum amount that you pay in one year when you add together your deductible, copayments and your share of coinsurance. Once you have reached your out-of-pocket limit, the insurance company will pay all of your covered medical expenses. Medical care you receive that is not covered by your policy does not count toward your out-of-pocket limit. Noncovered balances that exceed the amount that your insurer allows for a given service do not count toward your out-of-pocket limit. Be sure you understand what your policy covers.

Catastrophic plans

A catastrophic health insurance plan covers essential health benefits but has a very high deductible. This means it provides a kind

of "safety net" coverage in case you have an accident or serious illness. Premiums for catastrophic plans may be lower than traditional health insurance plans, but deductibles are usually much higher. This means you will probably pay thousands of dollars out-of-pocket before full coverage kicks in.

In the marketplace, catastrophic plans are only available to people under 30 or to someone who has received "hardship exemption." Marketplace catastrophic plans cover 3 annual primary care visits and preventive services at no cost. After the deductible is met, they cover the same set of essential health benefits that other marketplace plans offer. People with catastrophic plans are not eligible to receive subsidies or tax credits to help pay the cost of their health insurance.

Managed care organizations

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

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

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

For example, the HMO pays the provider a negotiated monthly fee for every person enrolled in the plan. This fee does not increase in a month where the person might receive services in excess of that fee.

When you enroll in an HMO, you must choose one of the doctors in the network as your primary care physician to manage all of your health care. Then, when you need health care, you must first consult your primary care physician, who may then refer you to an HMO-approved specialist. Your primary care physician may be responsible for the cost of your care if he or she refers you to a specialist.

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

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

Point of Service plans - Point of Service plans combine many of the characteristics of both HMOs and PPOs. Like an HMO, people enrolled in a Point of Service plan choose a

primary care physician to serve as their "point of service." This physician then is responsible for referring the patient to any specialists they may need to see. Like a PPO, the patient is able to get care from physicians and specialists outside of the plan's network, though there may be an additional cost to do so, and the patient may be responsible for taking care of any paperwork related to the visit. Plan costs stay low when you stay in-network, but the Point of Service provides the option of going outside the network.

Exclusive Provider Organization (EPO)- Companies may provide exclusive provider organization (EPO) health insurance plans. EPO plans require some or all health care services to be administered by participating providers, with the exception of emergency services. EPO plans may require a gatekeeper, an administrator who coordinates and authorizes all medical services, laboratory studies, specialty referrals and hospitalizations.

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

An Exclusive Provider Organization (EPO) is a type of managed care organization what provides health care coverage through preferred health care providers only.

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

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

Other types of individual health policies

Hospital indemnity, specified or dread disease, and short-term limited duration health coverage are also available to purchase. Watch for the statement "This is a limited policy." These kinds of policies may cost less but could be too limited to be your only health care coverage, or they might duplicate coverage you already have.

What is covered under an individual policy

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

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

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

Benefits required by law in your policy

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

Maternity & newborn coverage

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

Preventive and routine care

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

Prescription drugs and supplies

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

Other required coverage

- Coverage for breast reconstruction following a mastectomy
- Access to routine coverage of health care services upon a diagnosis of cancer and upon acceptance into a phase I, phase II, phase III, or phase IV clinical trial for cancer

- Coverage of general anesthesia for dental care for children younger than five, people with severe disabilities and people with a medical or behavioral condition requiring hospitalization

Benefits not typically covered (exclusions & limitations)

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

- Cosmetic surgery (except in the case of a mastectomy)
- Sickness or injury as a result of war
- Intentionally self-inflicted wounds
- Dental care, except for children up to age 19
- Vision (eye exams and glasses), except for children up to age 19
- Hearing aids
- Experimental or investigative procedures or medication (K.S.A. 2,168 & K.A.R. 40-4-43)
- Specific treatments: dental treatment for TMJ (temporomandibular joint), sterilization, etc.
- Services covered by workers' compensation
- Weight-loss surgery
- Long-Term Care

Medical necessity

Every major medical policy excludes coverage for treatment that is not "medically necessary." This provision allows insurance companies to determine (after the fact) if the treatment received was medically necessary.

For example, you were in the hospital for three days. Your insurance company says it will pay for only the first two days because it believes the third day was not medically necessary. Your doctor says the treatment was medically necessary. The insurance company's doctor says it was not.

If this happens to you:

- Appeal the decision to a higher level within the company according to the appeals process outlined in your policy.
- If you still do not get a satisfactory result, contact our Consumer Assistance Division and ask if your claim is eligible for independent medical review (see page 16).

Determining how much you pay

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

- Your age
- Where you live
- Tobacco use
- Whether you are looking for coverage for yourself or for your family

No other factors can be used to determine

how much to charge you for health insurance, including your health condition or gender

Hospital pre-authorization

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

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

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

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

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

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

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

Consumer protections for individual health insurance policyholders

Summary of Benefits and Coverage

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

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

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

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

Free-look provisions

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

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

Rate increases

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

The Kansas Insurance Department reviews all health insurance rate increases submitted in Kansas.

Coverage on and off the marketplace

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

Marketplace coverage

Individual health insurance policies can be purchased by visiting the Health Insurance Marketplace at **www.healthcare.gov.** The marketplace allows you to see all of the plan options available to you.

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

All marketplace health insurance plans cover the essential health benefits outlined in federal law, and all are considered "qualified health plans."

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

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

Health Insurance Navigators and Certified Application Counselors (CACs): Kansas has a group of trained individuals who are qualified to help answer your questions about the marketplace. These people have taken educational classes to understand health insurance and the marketplace, and are unbiased sources of information.

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

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

Coverage off the marketplace

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

Coverage purchased off the marketplace will cover all of the essential health benefits outlined in the Affordable Care Act.

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

Grandfathered health plans

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

Grandfathered health plans must:

- End lifetime limits on coverage
- End arbitrary cancellations and rescissions of coverage
- Cover adult children up to age 26
- Provide a Summary of Benefits and Coverage
- Meet medical loss ratio requirements
- Not require longer than 90 days' waiting period for group coverage

Grandfathered health plans do not have to:

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

Chapter 2:
If you have group health insurance

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

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

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

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

Exclusive Provider Organization (EPO) Companies may provide exclusive provider organization (EPO) health insurance plans. EPO plans require some or all health care services to be administered by participating providers, with the exception of emergency services. EPO plans may require a gatekeeper, an administrator who coordinates and authorizes all medical services, laboratory studies, specialty referrals and hospitalizations.

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

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

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

Fully-insured plans vs. Self-insured plans

Under a fully-insured plan, the employer purchases coverage from an insurance

company. The insurance company assumes the risk to pay all health insurance claims. **Fully-insured plans are regulated by the Kansas Insurance Department.**

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

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

Self-insured plans are regulated by the U.S. Department of Labor. States do not regulate these plans. This means that state laws requiring specific benefits and protections in health care plans do not apply to self-insured plans.

Beware that some fraudulent health plans may be described or offered as "self-insured" when, in fact, they are operating without state or federal approval. If a health insurance policy seems too good to be true, check with the Kansas Insurance Department.

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

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

How group health plans work

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

Level 1: Deductible- The dollar amount that you must pay each year before the policy will begin to pay. Most deductibles begin on January 1. *For example, if you have a $2,500 annual deductible, you will pay for the first $2,500 of covered expenses for each person insured.*

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

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

Level 3: 100 percent payment- The insurance company will pay 100 percent of eligible expenses after you have reached the annual out-of-pocket limit for your plan. The 100 percent payment is for covered expenses only

and will be paid until the end of the calendar year. Coverage only includes eligible expenses. If your policy does not cover a service, you will still have to pay out-of-pocket for it.

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

What group health plans cover

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

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

Benefits required by law in your policy

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

Maternity & newborn coverage

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

Preventive and routine care

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

Prescription drugs and supplies

- Coverage of certain off-label drugs when used for treatment of cancer
- Coverage for orally-administered drugs to treat cancer
- Diabetic supplies (including needles) used for diabetes management and outpatient

self-management training and education (when prescribed by a health care professional)

- Psychotherapeutic drugs for the treatment of mental illness

Other required coverage

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

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

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

Medical necessity

Every major medical policy excludes coverage for treatment that is not "medically necessary." This provision allows insurance companies to determine (after the fact) if the treatment received was medically necessary.

For example, You were in the hospital for three days. Your insurance company says it will pay for only the first two days because it believes the third day was not medically necessary. Your doctor says the treatment was medically necessary. The insurance company's doctor says it was not.

If this happens to you:

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

Hospital pre-authorization

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

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

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

- Whether coverage is in force when the

services are performed

- Discrepancies in the information received for the pre-authorization as compared to your actual medical records
- Whether other limitations or exclusions of the policy are applicable

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

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

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

Other cost-control features

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

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

Joining a group health plan

Sometimes employers have an employment waiting period that must be satisfied before you can enroll in their group health plan. This is often called a "probation period." Make sure you know if your new employer has a probation period and how long it is. Employers are not allowed to implement a waiting period of more than 90 days.

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

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

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

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

- The employee has new dependents because of marriage, birth or adoption

- The court has ordered coverage for a spouse and/or minor child
- The employees/dependents initially decided not to join the plan because they were insured under another employer-sponsored plan and then lost that coverage

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

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

Leaving a group health plan

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

Coverage after you leave a group

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

Kansas continuation: If you are leaving an insured group plan of fewer than 20 employees, or a large group plan under circumstances not protected under the COBRA laws, you may be eligible for state continuation benefits. State continuation:

- Allows for 18 months of continuation of coverage if your group insurance coverage terminates for any reason except nonpayment of premium or fraud
- You must have been covered under the group plan continuously for three months in order to be eligible
- You pay the full cost for the coverage - both the employer's share and the employee's share
- You have 31 days to apply for these continuation benefits
- At the end of the 18-month continuation period, you have 31 days to apply for an individual conversion plan

Federal continuation (COBRA): If you are leaving a group of 20 or more employees, COBRA (Consolidated Omnibus Budget Reconciliation Act) laws apply. COBRA allows

you to continue your group coverage for a limited time for yourself, your spouse and any dependent children.

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

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

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

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

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

Affordable Care Act (ACA) benefits included in your group health plan

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

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

"Grandfathered" health plans

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

Grandfathered health plans do <u>not</u> have to:

- Cover preventive care without cost
- Guarantee your right to appeal

Chapter 3:
Appealing a claim denial

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

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

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

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

Independent Medical Review

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

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

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

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

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

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

In case of emergency

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

Plans not eligible for review

Some plans are **not** eligible for independent reviews. They include the following:

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

Filing a consumer complaint

If you have tried unsuccessfully to resolve a claim dispute with your company or agent, contact the Department. Often companies resolve the matter after our department intervenes. If you file a written complaint with the Department, include the following information to speed up the processing of your inquiry:

- Your name, address and daytime phone number
- A brief summary of your case, explaining the problem and what type of insurance is involved
- The name of your insurance company, policy number and the name of the agent (if one was involved)
- Documentation you have to support your case, including notes from telephone conversations
- What has been done to resolve your problem, including who you have talked to and what you were told

Keep a copy of your letter to us for reference.

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

Limited intervention

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

Chapter 4:
Purchasing a policy

Preparing to purchase a policy

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

Find out about the insurance company

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

Customer service - Find out how the company services its policyholders. Does it have a toll-free customer service number? Is the toll-free number directory easy to follow? How long does it take you to reach a live person?

Complaint history - Has the company had an unusually high number of consumer complaints? This information is available in the most recent edition of the "Consumer Complaint Index Report" issued by the Department. Download copy from **www.ksinsurance.org**, or call **800-432-2484** to request a copy.

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

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

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

Moody's Investor Services

212-553-0377, www.moodys.com

Standard & Poor's Insurance Rating Services

212-438-7280, www.standardandpoors.com

TheStreet.com Ratings

800-289-9222, www.thestreet.com

A.M. Best Company

www.ambest.com

What if my insurance company goes bankrupt? Kansas policyholders are provided limited benefits through the Kansas Life and Health Guaranty Association if an insurance company becomes insolvent. To be protected by

guaranty funds, the insurance company must be licensed to do business in Kansas. The guaranty association may pay up to $500,000 in health insurance benefits on any one person. Benefits not covered under these types of plans:

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

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

Questions to ask before purchasing

Buying an individual policy

When shopping for an individual health insurance policy, it is important to make sure you are buying a health care plan you want and can afford. You should make a list of your needs to compare with the benefits offered by a plan you are considering. The following are questions you should ask when shopping for a health insurance policy.

Questions about coverage:

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

Questions about premiums:

- How much do you have to pay when you receive health care services (copayments and deductibles)?
- What is the limit on how much you must pay for health care services you receive (out-of-pocket maximum)?

Questions about customer service:

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

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

Chapter 4: Purchasing a policy

Buying a managed care plan

What is covered?

Be sure to ask for the detailed written description that legally defines your benefits (generally known as the "certificate of coverage"). Do the services provided, as well as the fees and copayments charged, meet your medical needs and financial circumstances? Also, make sure that you thoroughly understand what is not covered and the circumstances in which coverage is limited.

What are your rights and responsibilities as a plan member?

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

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

How are providers selected?

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

How are providers compensated?

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

What restrictions are placed on providers?

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

What out-of-network care is covered?

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

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

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

Chapter 4: Purchasing a policy

Buying an HMO policy

Consider the basics

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

Consider quality

All managed care plans in Kansas must be accredited by a national accrediting organization that meets the standards of the Commissioner of Insurance. Through accreditation reviews and standardized measures of health plan performance, these organizations hold health plans accountable for the quality of care and services they deliver.

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

Gather information

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

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

Ask questions

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

Make an informed decision

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

Call Kansas Insurance Department if you have any questions about your health insurance.

Consumer Assistance Hotline

800-432-2484

Chapter 5:
Glossary of health insurance terms

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

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

Balance billing: When a provider bills you for the difference between the provider's charge and the allowed amount. *For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. Typically a preferred provider may not balance bill you for covered services.*

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

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

Community rating: A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status, or other factors.

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

Copayment: A fixed amount (for example, $25) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.

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

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

Disease management: A broad approach to coordinate and manage the successful

treatment of a specific disease with the goal of making more expensive inpatient and acute care unnecessary. Disease management includes the use of preventive medicine, patient counseling, education, and outpatient care. The process is intended to reduce health care costs and improve the quality of life for individuals by preventing or minimizing the effects of a disease, usually a chronic condition.

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

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

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

Essential health benefits: A set of health care service categories that must be covered by certain plans.

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

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

Exchange: See *"Health Insurance Marketplace"*

Exclusive Provider Organization (EPO): Companies may provide exclusive provider organization (EPO) health insurance plans. EPO plans require some or all health care services to be administered by participating providers, with the exception of emergency services. EPO plans may require a gatekeeper, an administrator who coordinates and authorizes all medical services, laboratory studies, specialty referrals and hospitalizations.

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

Chapter 5: Glossary of health insurance terms

Excluded services: Health care services that your health insurance or plan does not pay for or cover.

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

Grandfathered health plan: As used in connection with the Affordable Care Act: A group health plan that was created - or an individual health insurance policy that was purchased - on or before March 23, 2010. Grandfathered plans are exempt from some changes required under the ACA. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions. (Note: If you are in a group health plan, the date you joined may not reflect the date the plan was created. New employees and new family members may be added to grandfathered group plans after March 23, 2010).

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

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

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

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

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

Health Insurance Marketplace: A transparent and competitive health insurance market where individuals, families, and small businesses can learn about their health coverage options, compare health insurance plans based on costs, benefits, and other important features, choose a plan, and enroll in coverage. The Marketplace also includes information on programs that help people pay for coverage, including ways to save on monthly premiums and out-of-pocket costs, and other programs, like Medicaid and the Children's Health Insurance Program (CHIP). Individuals and families can apply for coverage online, by phone, or with a paper application.

Health Savings Account (HSA): A health savings account available to taxpayers who are enrolled in a high deductible health plan. The funds contributed to the account are not subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical

expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if you do not spend them.

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

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

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

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

Individual market: The market for health insurance coverage offered to individuals other than in connection with a group health plan.

Internal review: The review of the health plan's determination that a requested or provided health care service or treatment is

not or was not medically necessary by an individual(s) associated with the health plan.

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

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

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

Medical loss ratio: A basic financial measurement used to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80 percent. A medical loss ratio of 80 percent indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. The minimum medical loss ratios vary for different markets.

Medically necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Chapter 5: Glossary of health insurance terms

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

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

Non-preferred provider: A provider who does not have a contract with your health insurer or plan to provide services to you. You will pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

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

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

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

Preferred provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

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

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

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

Primary care provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides,

coordinates or helps a patient access a range of health care services.

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

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

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

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

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

Small group market: The market for health insurance coverage offered to small businesses with between two and 50 employees on January 1, 2016.

Special enrollment period: A specific period during which a person may be eligible to enroll in coverage mid-year due to a specific qualifying event, such as marriage, birth, divorce or adoption.

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

Waiting period: In job-based coverage, the time that must pass before coverage can become effective (cannot exceed 90 days) for an employee or dependent, who is otherwise eligible for coverage under a job-based health plan. Also known as a "probation period."

CONTACT US:

Consumer Assistance Hotline:

800-432-2484

Kansas Insurance Department Website:

www.ksinsurance.org

Live Chat Feature:

The Kansas Insurance Department has a chat feature on its website. Use it to ask a consumer representative any question you might have about insurance.

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