Hospital expense coverage, as the name implies, pays for costs of medical care while the insured (or family members, if a family policy) is in the hospital. Amounts billed directly by the hospital are covered, subject to policy limitations, but separately billed items, such as doctor, surgeon, and x-ray fees for services performed outside of a hospital are not covered by a hospital expense policy. Many policies limit coverage to a specified number of days, such as 60, 90, or 180 days.

Physicians expense insurance provides coverage for fees charged by physicians for office visits and tests that are not performed in the hospital (such as blood work, x-rays, and non-surgical procedures).

Surgical expense insurance pays for surgeon's fees when a surgical procedure is not conducted in a hospital. If the surgical procedure was conducted in the hospital, these expenses would be covered by the hospital expense coverage policy.

TYPES OF GROUP AND INDIVIDUAL PLANS

Both group and individual health insurance plans can be written on an indemnity basis (reimbursement) or on a managed care basis.

INDEMNITY HEALTH INSURANCE

Indemnity health insurance is also referred to as a traditional health insurance plan. Indemnity health insurance plans allow participants the benefit of having a wide range of health care practitioners at their disposal. Indemnity plan participants are not limited to a service network system for medical care. Indemnity health insurance is the most flexible type of insurance policy, but participants also pay some of the highest premiums in order to have the flexibility of choosing their own health care providers. Typically, indemnity plans have deductibles, no copays, and coinsurance for major medical.

KEY CONCEPTS

1. Describe the differences and similarities between an HMO and a PPO.
2. Explain the reasoning behind the criticism of managed care insurance plans.

MANAGED CARE INSURANCE

Managed care insurance emerged from a desire to reduce the costs of health care while increasing competition among service providers. When compared to major medical plans, managed care approaches to health care restrict participant choice of health care providers and often require participants to obtain pre-approval from insurance company representatives (who are not always medically trained) as a condition of obtaining covered treatment that is not considered emergency care. Companies offering managed care have also been criticized for prohibiting physicians from discussing alternative options of care with the patients, creating an ethical dilemma for the health care provider who is determined to act in the best interest of the patient. Despite their shortcomings, managed care approaches to health insurance have assisted in somewhat containing the cost of medical services over time.

There are three main types of managed care approaches to health insurance coverage:

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Point-of-Service Plans (POS)

Health Maintenance Organizations (HMOs)

Health Maintenance Organizations (HMOs) were authorized by the HMO Act of 1973. HMOs consist of a group of physicians who provide comprehensive care for their patients and are organized in an effort to control the rising cost of healthcare. Physicians are employed by the HMO directly or may be physicians in private practice who have chosen to participate in the HMO network. The independent physicians are paid a fixed amount for each HMO member that uses them as a **primary care physician**. Some HMOs require that medical services be performed by the pre-approved physicians who are either employees or independent contractors of the HMO. These HMOs will not pay for health care services obtained outside of their physician network. Other HMOs permit their members to obtain service outside of the insurance company's provider network, but payments for services performed by an out-of-network provider will typically be smaller than claims allowed for similar services provided within the network, which effectively increases the cost to the participant.

One major disadvantage of HMOs is that patient choice is limited to an established network of approved health care providers. Americans, as a group, do not like having their options limited, which may explain why HMOs never became popular vehicles for providing health care services.

EXHIBIT 3.1

ADVANTAGES AND DISADVANTAGES OF HMOS

ADVANTAGES
• Fixed fee for health care • Low copayments • Total health care costs are generally lower and more predictable than with PPO or POS
DISADVANTAGES
• Gatekeeper for specialists services so it is often difficult and complicated to get specialized care • Longer waits for non-emergency doctor appointments • Any health care costs from out-of-network providers, except in emergencies, are not well covered if at all

Preferred Provider Organizations (PPOs)

A **Preferred Provider Organization** is an arrangement between insurance companies and health care providers that permits members of the PPO to obtain discounted health care services from the preferred providers within the network. Unlike an HMO, which limits choice of physicians and other health care providers, a PPO typically has a larger provider pool for participants to choose from. Participants are not required to receive services from preferred providers, but higher deductibles and coinsurance payments may apply when services are obtained from providers outside of the network. Health care providers are not employed by the PPO, but do receive a fee for serving as primary health care provider for a member of the PPO.

Advantages and Disadvantages of PPOs

EXHIBIT 3.2

Advantages
• Health care costs are low when using in-network providers • No gatekeeper required for specialist consultations, including out-of-network providers • Primary care physician is not required • Yearly out-of-pocket costs are limited
Disadvantages
• Out-of-network treatment is more expensive • Copayments are generally larger than with HMOs • May need to satisfy a deductible, especially with out-of-network providers • Co-insurance may apply when out of network

Point of Service Plans (POS)

A **point of service plan (POS)** is considered a managed care/indemnity plan hybrid, as it mixes aspects of in-network and fee-for-service, for greater patient choice. Members choose which option they will use each time they seek health care.

Like an HMO and a PPO, a POS plan has a contracted provider network. POS plans encourage members to choose a primary care physician from within the health care network. This physician becomes the patient's "point of service." If the patient prefers an out-of-network provider, the in-network primary care physician may make referrals outside of the network, but higher deductibles and coinsurance payments may apply if the insured is receiving services on the indemnity side.

Quick Quiz 3.3

1. PPOs typically have a wider network of health care providers from which to choose than HMOs.
   a. True
   b. False

2. The emergence of managed care plans was born from a desire to decrease competition among health care providers.
   a. True
   b. False

True, False.

POS plans are becoming more popular because they offer more flexibility, lower costs, and freedom of choice than standard HMOs, PPOs, or indemnity plans.

Advantages and Disadvantages of POS Plans

EXHIBIT 3.3

Advantages
• Freedom of choice for managed care • Not limited to only HMO network providers • Costs are minimal for in-network care • Annual out-of-pocket costs are limited • No referral is needed for choosing an out-of-network doctor
Disadvantages
• Copays for out-of-network providers are high • There are deductibles for out-of-network providers • Sometimes difficult and complicated to get specialized care with in-network providers

POLICY PROVISIONS OF GROUP AND INDIVIDUAL PLANS

Health insurance policy provisions for groups are very similar to the provisions typically found in individual policies and in disability insurance policies. A summary of some of the more important policy provisions that are relevant is provided below.

KEY CONCEPTS

1. Describe some health insurance policy provisions that are particularly relevant to financial planners.
2. Briefly describe the taxation of an individual's health care benefits.
3. Explain the different coverage periods for different individuals, under the COBRA plan.
4. Describe how HSAs work.

PREEXISTING CONDITIONS

Insurance works by spreading unknown risks (such as the risk of contracting health conditions that require medical treatment) across a pool of individuals. If it were possible for consumers to purchase insurance when they had a known condition or disease requiring medical treatment for a fraction of the cost of the treatment itself, a rational consumer would wait until he or she had a need for insurance (a pending medical expense) to obtain it. Under these circumstances, it would be impossible for the insurance company to spread those risks across the pool of insureds and generate a profit for performing that service.

The purpose of the preexisting condition clause is to prevent adverse selection against the insurance company, and to permit the risk-spreading function to work. If healthy individuals who will not require medical services for the current year are not part of the premium paying pool, there is no way to spread the risk across the pool, and the purchase of a policy by a sick person would be little more than a disguised attempt to transfer a known cost to the insurance company. Despite the potential for adverse selection, the Affordable Care Act does not permit exclusions for preexisting conditions after 2013. As a consequence, applicants cannot be denied insurance due to a preexisting condition. Some health insurance plans with grandfathered status under The Affordable Care Act, however, may contain pre-existing condition clauses and provisions."

INCONTESTABILITY CLAUSE

When a health insurance policy is issued on a non-cancelable or guaranteed renewable basis, the policy often includes an **incontestability clause**. The incontestability clause protects the insured by preventing the insurer from challenging the validity of the health insurance contract after it has been in force for a specified period of time unless the insured initially obtained coverage fraudulently.

GRACE PERIOD

As is the case with all insurance policies, an insurance company will only undertake the risk the insured is trying to transfer when the insured compensates the company for undertaking the risk. If policy premiums are not paid by the due date, the health insurance policy will lapse. However, when the policy includes a **grace period**, the policy will remain in force and will not lapse as long as the premium is paid within a specified number of days after the due date. A one-month grace period (which usually translates to a period of 31 days), is very common in health insurance policies.

Reinstatement Clause

Included in every health insurance policy is a procedure for policy reinstatement should coverage lapse due to nonpayment of premium. Certain policies specify a time limit within which the insured may reinstate the policy without proof of insurability. Other policies require the insured to again submit to the underwriting process before coverage is reinstated. Reinstated policies usually exclude coverage for illnesses incurred during the first ten days after reinstatement (again to control adverse selection problems).

Time Limit Clause

The time limit clause is attached to the policy so that an insurer may void a policy on the grounds of misrepresentation made by the insured on the application for coverage. The insurer must usually discover and contest the misstatement during the first two years the contract is in force. After that time, the policy is incontestable and misstatements may not be used against the insured to void a policy or deny a claim. This is similar to the incontestability clause in a life insurance contract.

Renewability Clause

Health insurance that is underwritten on an annual basis may prevent insureds from obtaining access to needed health care if they get sick. If, for example, the health insurance company does not reissue the policy when the renewal date is reached simply because the insured had contracted some form of disease or health condition in the prior policy period, access to treatment may be jeopardized. This is the opposite of adverse selection risk. In this instance, once a person becomes sick, the insurance company could decide to drop that person from coverage so that it does not have to pay health care providers for the care given to the participant.

To prevent this from happening, and to give policy holders some protection against policy cancellation, different renewability rights are provided in health insurance contracts, including:

- Non-cancelable
- Guaranteed renewable
- Conditionally renewable
- Optionally renewable

Non-cancelable

Non-cancelable policies prevent the insurance company from canceling the policy for any reason provided that the policy premium is paid. Usually, the policy will specify that it is non-cancelable for a specific period of time, or until the insured reaches a stated age. Some policies also specify that, during the non-cancelable period, no changes to the policy may be made, including changes to the premium. Non-cancelable policies provide the greatest degree of protection to the insured, since the insured can force the insurance company to provide continued coverage simply by paying the premium on the policy.

Guaranteed Renewable

Guaranteed renewable health insurance policies require the insurance company to renew the policy for a specified period of time or until the insured attains a certain age (such as age 65, when eligibility for Medicare is established). Provided the insured pays the premium, the insurance company must renew the policy during the stated period. Unlike the case with non-cancelable policies, which do not permit increases in premiums, the premium on a guaranteed renewable

policy may be increased on a class basis (i.e., increased across the board for all similarly situated insureds). The premium may not be increased for one participant simply because he or she has contracted a disease or health condition requiring treatment.

Conditionally Renewable

When a policy is conditionally renewable, the insurance company may not cancel it during the policy term (which is typically one year). However, the insurance company reserves the right to cancel the policy when it is up for renewal. The conditions that will cause the policy to be canceled on the renewal date are often specified in the contract itself. Planners should be attentive to these provisions when placing conditionally renewable insurance with clients.

Optionally Renewable

An optionally renewable policy permits the insurance company to cancel the policy at any time, except during the term of the existing contract. Unlike a conditionally renewable policy, which specifies the conditions that will result in loss of coverage, under an optionally renewable policy the insurance company can cancel coverage for any reason. Optionally renewable health insurance contracts give the client little peace of mind, and should be carefully considered prior to purchase.

TAXATION AND HEALTH INSURANCE

When an individual receives benefits under a health insurance policy, and those benefit payments are used to pay for health care, no taxable event occurs. In this instance, the benefits are received tax-free. Some health insurance policies, such as dread-disease policies (for example, a policy that pays a specified amount if the insured is diagnosed with cancer), pay a lump sum to the insured regardless of the actual expenses incurred in treating the condition or disease. When lump-sum payments such as these are received, there are no federal income tax consequences as long as the proceeds are used to pay for medical care. Amounts received in excess of the actual cost of care are subject to income tax.

When group health insurance benefits are provided by and paid for by an employer, there is no taxable event for the employee. Furthermore, when the policy pays the actual cost of medical care (as specified above), the insured will not have to report the benefits received as income. Normally, when an employee receives property (such as a health insurance policy) from an employer in return for his or her labor, the fair market value of that policy is subject to income tax the year it is received, under a tax rule known as the economic benefit doctrine. Congress has enacted a specific exception to this rule that allows employees to receive health benefits on an income-tax-free basis in an attempt to encourage employers to provide health insurance coverage to their employees. The employer can deduct the cost of providing group health insurance to its employees as an ordinary and necessary business expense.

QUICK QUIZ 3.4

1. Adverse selection occurs when health insurance plans refuse to renew health insurance for people if they become ill.
   a. True
   b. False

2. Employers may deduct the costs of providing health insurance only if the employee includes the monetary benefit derived from that insurance as income.
   a. True
   b. False

False, False.