Health Insurance and Health Maintenance Organizations

a guide for consumers

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NOTE: Most health insurance rates in Florida are regulated by the Office of Insurance Regulation (OIR). Other financial services are regulated by the Office of Financial Regulation (OFR). Although both are administratively housed within the Department of Financial Services (DFS), they are separate entities that report to the Florida Cabinet. Because DFS handles consumer-related matters, consumers should remember that DFS is their point of contact for all problems and questions.

The Florida Department of Financial Services distributes this guide for educational purposes only; it does not constitute an endorsement for any service, company or person offering any product or service.

HEALTH INSURANCE

Nobody plans on getting sick or injured. But life is full of unexpected events that force us to seek medical care. These include everything from a common cold to a more prolonged illness or injury. When these situations arise, your best financial defense is to have adequate health insurance.

Health insurance can help protect your assets and pay medical expenses but selecting the policy to best meet your needs can be challenging. This guide explains the various types of policies that are available, offers tips on choosing a policy and provides definitions for the numerous health insurance terms you may encounter. This guide also includes information regarding the federal Affordable Care Act (ACA) – also known as federal health care reform. If you have any questions after reading this guide, please call the Florida Department of Financial Services (DFS) Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236) or 850-413-3089 if calling from an out of state number.

TRADITIONAL VERSUS MANAGED CARE COVERAGE

Your first health insurance choice may be to decide between traditional health insurance and a managed care option. Most individual and group policies sold today are managed care contracts. The difference between the two types of plans affects how you access care. With traditional health insurance, you – the policyholder – select a health care provider, such as a doctor or hospital. You may have to pay for services when rendered and then submit the bill to the insurance company for reimbursement of the portion it agreed to pay under the policy terms. Frequently, the provider will submit the bill directly to the insurer and await payment.

The managed care system combines the delivery and financing of health care services. This limits your choice of doctors and hospitals. In return for this limited choice, however, you usually pay less for medical care (i.e., doctor visits, prescriptions, surgery and other covered benefits) than you would with traditional health insurance. The managed care network controls health care services.

Types of Managed Care

Health Maintenance Organizations (HMOs)

HMO plans offer a wide range of health care services through a network of providers. An HMO gives subscribers access to certain doctors, hospitals and other providers within its network. The network is made up of providers who agreed to supply services to members for pre-negotiated rates as well as meet certain quality standards. Unlike some other insurance plan types, care is covered only if a subscriber sees a provider within the HMO's network, except in case of an emergency.

There are a few opportunities to utilize a non-network provider – primarily when services are not available in the network. As a member of an HMO, members are usually required to choose a primary care physician (PCP). PCPs direct most of a subscriber's health care needs. Some HMOs require a referral before a subscriber can visit a specialist. A Florida medical provider, whether contracted or not, is prohibited from balance billing an HMO subscriber if the service provided is covered by the health plan.

Preferred Provider Organizations (PPOs)

PPO plan members generally see specialists without a prior referral or authorization from the insurer. The member should only be responsible for the policy co-payment, deductible, or coinsurance amounts if covered services are obtained from in-network providers. However, if a policyholder chooses to obtain services from an out of network provider, the member can be billed for the difference between an out of network provider's charges and the insurer's approved amount.

Exclusive Provider Organizations (EPOs)

In an EPO arrangement, an insurance company contracts with hospitals, physicians, and other medical facilities. Insured members must use the contracted hospitals or providers to receive covered benefits from this type of plan. An EPO combines features of an HMO and a PPO plan.

Point-of-Service Plans (POS)

Point of Service plans are an HMO product with a rider that allows the subscriber to obtain services from out of network providers. These plans may be called by a variety of names with various features. They combine some aspects of traditional medical expense insurance plans with other aspects of HMOs and PPOs. In a POS plan, insured members may choose, at the point of service, whether to receive care from a physician within the plan's network or go out of network.

The POS plan provides less coverage for health care expenses obtained outside the network than for expenses incurred within the network through higher deductibles, coinsurance, co-payment or maximum out of pocket expenses. Subscribers can also be responsible for the difference between the out of network provider's charges and the HMO's approved amount.

The federal Affordable Care Act (ACA) requires all non-grandfathered health plans to provide a minimum set of ten benefits called Essential Health Benefits. These benefits are all provided through a form of managed care plan (PPO, EPO, HMO, or POS) beginning January 1, 2014. Consumers should pay close attention to the provider network under the available plan options. More details about coverage under the ACA is discussed later in this guide.

MAJOR MEDICAL INSURANCE

These policies provide protection against the high costs of hospitalization, injuries and serious or ongoing illnesses. Other possible coverages include the cost of blood transfusions, drugs and out-of-hospital costs, such as doctor visits as well as prescription drugs. Most group health policies fall under the category of major medical policies.

Major medical policies cost extra and provide more benefits than basic policies. A major medical policy normally pays 70% - 80% of covered expenses, after you pay the deductible. Most major medical plans stipulate that the contracted provider, if there is one, cannot charge for the actual cost more than the contracted amount. For non-contracted providers, the insurance companies use fee schedules to determine the average cost of a procedure; however, this cost may differ from the actual charge you receive and you will be responsible for the difference.

Maximum out-of-pocket limits restrict the amount of health care expenses you pay. This amount can include your deductible, copayments, and coinsurance amounts. It does not include your premium. Once the maximum out of pocket is reached, the plan will pay 100% of remaining covered expenses. Read your policy to determine the out-of-pocket maximum and the list of expenses that count toward this amount.

TYPES OF MAJOR MEDICAL COVERAGE

Group Plans

Fulfilling your insurance needs may prove relatively simple if your employer offers a group plan or a choice of plans. Group plans cover several people or groups under one policy. You will receive a certificate of coverage that acts as your policy when you obtain insurance through a group plan. Most group policies are suitable for the average person and may include provisions to cover family members.

Businesses with one to 50 employees will be referred to as small group health coverage. Employers must have at least one non-family member who is eligible for and enrolled in a group health plan to qualify for a small group policy. Self-employed individuals or businesses with only family members working or no non-family members enrolled in the plan will obtain coverage through the individual health insurance market.

FOR MORE INFORMATION ON SMALL GROUP PLANS, SEE THE SMALL BUSINESSOWNER HEALTH PLAN OPTIONS SECTION OF THIS GUIDE.

Some employers, of large and small businesses, may select an alternative to cover health expenses and meet employees' needs. This is known as a single-employer health plan. These plans fall under the guidelines of the federal Employee Retirement Income Security Act (ERISA). Employers establish these plans to provide health care and/or other employment benefits to employees, their families and dependents. An insurance carrier may fully insure a group health ERISA plan or the employer may opt for self-insurance.

Employers participating in a self-insured plan assume the financial risks involved, rather than transferring this risk to an insurance carrier. The employer pays for claims filed by employees covered by the plan. Many of these plans hire an insurance company to handle paperwork with the company acting as a third-party administrator, but it does not assume any legal obligation to pay claims. Self-insured, single-employer plans are not regulated by DFS nor the Office of Insurance Regulation (OIR) since they fall under the jurisdiction of the United States Department of Labor (USDOL). In addition, the Florida Life and Health Guaranty Fund, which pays losses to policyholders when certain insurance companies become insolvent, does not cover such plans.

If you are covered under a single employer, non-government entity and have been unable to resolve a service or claim issue by contacting the employer, then you may want to contact the USDOL for assistance by calling 1-866-444-3272 or by visiting their website at DOL.gov.

TYPES OF MAJOR MEDICAL COVERAGE con't

Individual Plans

Individual plans cover one person or all members of a family under one policy. Usually, people buy individual plans because they lack access to employer-based group policies. Others use individual health policies during periods of unemployment when they lack coverage under group policies. If you buy an individual policy, you have a free-look period of 10 days from the date you receive the policy to decide whether to keep or cancel it.

For a full refund, you must return the policy to the company within the allowed time. If you reject the policy, you should return it by registered or certified mail. This may help you avoid a potential dispute regarding the return of the policy within the required time frame.

Facts to Consider

Group and individual health insurance plans usually offer coverage for family members. Family policies generally pay benefits for your spouse and dependent children up to the age specified in the policy. However, your insurance company cannot terminate coverage for dependent children due to age who lack other means of support due to mental or physical handicaps.

Policy benefit requirements can vary depending on whether your group or individual health plan is considered a grandfathered or non-grandfathered health plan under the federal Affordable Care Act (ACA). You can verify the type of plan you have with your current insurer.

CONSUMER ALERT: By statute, applications for medical coverage not governed by Florida law must contain a disclosure statement in contrasting color near the signature block declaring what state governs the coverage and the ramifications of not purchasing coverage governed by Florida's consumer protections. Furthermore, certificates issued under a policy approved by another state must contain the following statement, generally found on the front page: "The benefits of the policy providing your coverage are governed primarily by the laws of a state other than Florida." These disclosures should prompt you to ask further questions about the laws governing this coverage and the resulting suitability of this coverage for your needs.

THE AFFORDABLE CARE ACT (ACA)

President Obama signed HR 3590, the Patient Protection and Affordable Care Act into law on March 23, 2010. The President also signed HR 4872, the Health Care and Education Reconciliation Act, into law on March 30, 2010. The two Acts combined are collectively referred to as the Affordable Care Act (ACA) or federal health care reform.

Plans Available

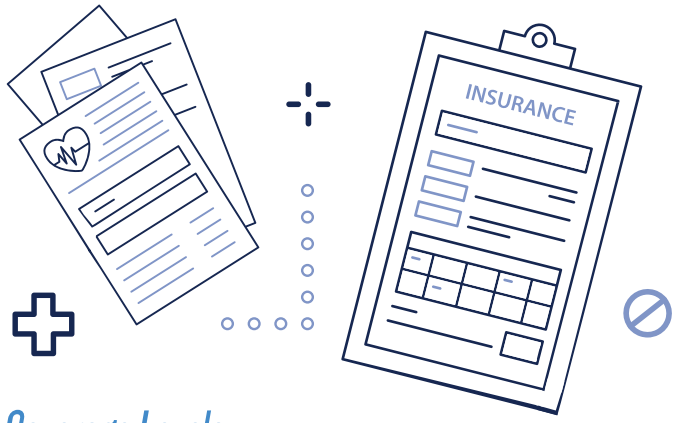
As of January 1, 2014, all comprehensive health coverage is guaranteed issue, which means you cannot be turned down due to your health history. Preexisting conditions will be covered and the insurer cannot charge you more because of a health condition. Only four rating factors can be used to determine your premium:

- Age
- Individual or family coverage
- Where you live
- Whether or not you use tobacco

There are four categories of plans (Bronze, Silver, Gold, and Platinum), plus a separate catastrophic plan for certain qualifying individuals that will be offered through the Marketplace. Each category of plan will offer the 10 Essential Health Benefits (EHB) as required by federal law. The plan benefits, premiums, provider network availability, and enrollee out-of-pocket expenses will vary depending on the plan chosen. Plans will cover 60% - 90% of the medical expenses, depending on which plan you select.

Catastrophic plans are available to people under age 30 or for those suffering a financial hardship as determined by the federal Department of Health and Human Services (HHS). These plans carry high deductibles equivalent to the out-of-pocket maximum. You cannot apply tax credits to these plans, either.

All plans sold or renewed in 2023 must limit the out-of-pocket exposure of consumers to $9,100 for individuals and $18,200 for families of two or more. The plans will have the deductible indexed to average premium growth in future years.



Coverage Levels

All plans must design their cost-sharing (deductibles, co-insurance, and co-payments) to fit into specific levels of coverage. The levels of coverage are defined as follows:

- Bronze Level – The plan must cover 60% of expected costs for the average individual
- Silver Level – The plan must cover 70% of expected costs for the average individual
- Gold Level – The plan must cover 80% of expected costs for the average individual
- Platinum Level – The plan must cover 90% of expected costs for the average individual

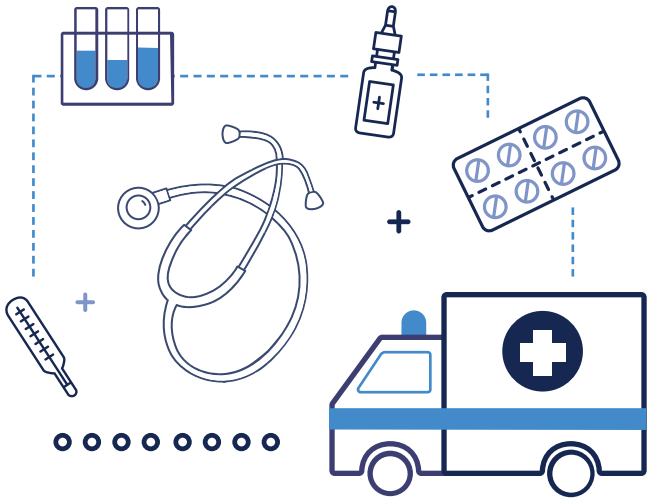
The Marketplace groups coverage by these “metal” levels, allowing you to easily evaluate comparable options. Higher metal levels mean the insurer will pay a higher portion of your claims should you need medical services. You need to pay close attention to the out-of-pocket expenses and the provider network available for all plans when reviewing your options. Keep in mind your preference when deciding if you want to pay more in premium and have lower out-of-pocket costs or, pay a lower premium and be prepared to pay more out of pocket if medical services are needed.

Required Benefits

All insurers that participate in the individual and small group markets are required to provide a package of Essential Health Benefits (EHB) to assure that the comparisons are "apples-to-apples". The law also requires that insurers and health benefit plans offered by employers cover mental health and addiction services on an equal footing with other medical coverage. Insurers will also be required to offer specified wellness and preventive services at no out-of-pocket cost to patients.

Every non-grandfathered health plan sold or renewed in the individual and small group market on or after January 1, 2014, whether purchased through the Marketplace or not, must include all of the following Essential Health Benefits (EHB):

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care



Marketplaces

As part of the ACA, health insurance marketplaces, also known as exchanges, were established to provide an easier means of shopping and purchasing individual and small group health coverage.

The State of Florida chose not to create a state-based exchange so Florida residents participate through a federally facilitated Marketplace (FFM).

There are two types of federal Marketplaces: the Marketplace through which individuals can purchase qualified coverage and the Small Business Health Options Program (SHOP), through which small businesses between 2 and 50 full time equivalent employees (FTE) can qualify for a Qualified Health Plan (QHP), as defined under federal law.

On October 1, 2013, the federal Marketplaces began enrolling individuals and small businesses into qualified health plans. The Marketplace provides information about your coverage options and what assistance is available. The Marketplace also administers the health insurance premium assistance and facilitates enrollment in private health insurance, Medicaid, or the Florida Healthy Kids Program.

The ACA does not require you to purchase health insurance through the Marketplace, though premium tax credits will only be available for plans sold through the Marketplace. You will be able to purchase this coverage through the Marketplace website, directly from an insurer or HMO approved for direct enrollment, or through your agent if he or she is approved to sell Marketplace plans. If you would rather buy coverage through an insurance agent or broker off the exchange, you are free to do so.

The individual Marketplace can be accessed at HealthCare.gov or call 1-800-318-2596 or TTY at 1-855-889-4325. The SHOP can be accessed at HealthCare.gov or by calling 1-800-706-7893 or TTY: at 1-800-706-7915.

Contact the Florida Department of Children and Families (DCF) directly at MyFlorida.com/accessflorida/ or call 1-866-762-2237 if you think you may qualify for Medicaid.

You may contact Florida Healthy Kids directly to find out about subsidized or full-pay health insurance for children between ages 5 and 18 at 1-888-540-5437 or by visiting their website at HealthyKids.org.

Enrollment Assistance

If you want to enroll in an individual plan, you have the option to use the Marketplace or you can purchase coverage off the exchange.

Enrolling through a Marketplace presents different options for assistance – you can use Navigators, Certified Application Counselors (CAC), or licensed insurance agents. Navigators can help consumers with electronic applications to establish eligibility and enroll in coverage through the Marketplace. The application process can identify the potential qualification for Advanced Premium Tax Credits (APTC), Cost Sharing Reduction (CSR), or possibly coverage through Medicaid or Florida Healthy Kids. Navigators will refer you to a health insurance ombudsman and consumer assistance program if necessary. Navigators are paid through a federal grant issued to a Navigator Entity and are prohibited from receiving any compensation from insurers.

Navigators are required to complete training and certification from the federal Department of Health and Human Services (HHS) as well as being registered with the Florida Department of Financial Services (DFS), Bureau of Licensing. You may call DFS toll free at 1-877-693-5236 or direct at 850-413-3089 or visit their website at www.MyFloridaCFO.com/Division/Agents/Industry/Navigators to confirm if a Navigator is properly registered.

Certified Application Counselors (CAC) have a similar role to Navigators but are not funded with federal grant money. Examples of where CACs may be located include community health centers, hospitals, or non-profit organizations. Certified application counselors are also required to complete HHS training and certification but are not required to be registered with DFS.

Visit localhelp.HealthCare.gov to locate a Navigator, CAC or agent near you. Once on the website you can input your zip code for a list of local help.

Licensed insurance agents can also assist with enrollment on the Marketplace or off the exchange. An agent must register with the Marketplace to assist you with these plans. You may call DFS toll free at 1-877-693-5236 or direct at 850-413-3089 to confirm if an insurance agent is licensed.

Enrollment Periods

Individuals Open Enrollment

The Open Enrollment Period (OEP) for ACA coverage is from November 1st to January 15th. Coverage must be purchased or changed on or before December 15th for a January 1 effective date. Coverage purchased or changes made on or between December 16th and January 15th will have a February 1st effective date.

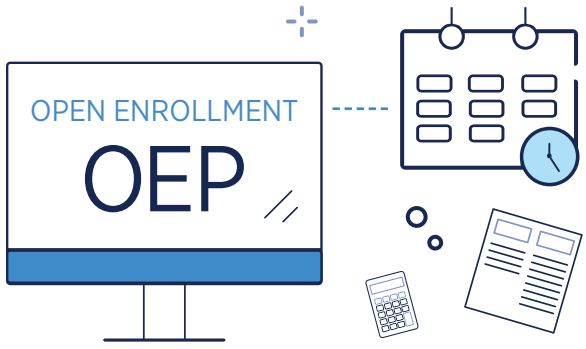
This will be the annual time period for you to purchase new coverage or change your current plan, if you wish. This is the only time of year you can purchase a policy or switch your plan unless you qualify for a Special Enrollment Period (SEP).

Self-employed individuals and their families will participate in the individual health insurance market so they need to purchase coverage during the OEP for individuals instead of pursuing a small group policy.

Enrollment in Medicaid or Florida Healthy Kids is continuous year-round.

Special Enrollment

Special enrollment periods (SEP) exist for policies being purchased on or off the Marketplace. Unless otherwise stated in federal regulations, the special enrollment period will last a period of 60 calendar days for individual policies and 30 days for small group policies. Special enrollment periods exist for events such as birth, divorce, marriage, adoption, or loss of minimum essential health benefits. There is no special enrollment period if your coverage is terminated due to non-payment of premium. If you elect continuation coverage from an employer-based health plan under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation coverage (mini-COBRA), you must exhaust this coverage or wait for the next Open Enrollment Period to switch plans. For more information on special enrollment opportunities, contact the individual Marketplace at 1-800-318-2596 or visit HealthCare.gov.



Advanced Premium Tax Credits and Cost Sharing Reduction

The Advanced Premium Tax Credit (APTC) is also known as a premium subsidy and is intended to make individual health coverage more affordable. When you apply for coverage through the Marketplace at HealthCare.gov you will be asked to supply income and family information as part of the application process. You will be advised of the available APTC amount, if eligible, after the application has been completed. The amount of the APTC is based on the cost of a Silver plan but you can choose to purchase any metal level of plan once eligibility has been established. Coverage must be purchased through the Marketplace to have access to the APTC benefit.

Eligibility for the APTC is for individuals or families whose income is between 100% and 400% of the federal poverty level (FPL) and who are not eligible for other affordable coverage. The tax credit is based on a sliding scale with the lower income brackets receiving a higher tax credit. If your income fluctuates unexpectedly during the year, you should promptly notify the change to the Marketplace since a change in income can affect the APTC amount and your taxable income.

You have the choice to have the Internal Revenue Service (IRS) pay the APTC directly to the insurer in which you or your family enrolls on a monthly basis or you can claim the tax credit at the time you file your annual tax return. If you choose monthly, you will pay the insurer the dollar difference between the APTC amount and the total premium charged for the plan thus reducing your monthly out-of-pocket costs.

You may also qualify for cost-sharing reduction assistance (i.e. co-payments, coinsurance, and deductibles) if your income is at or below 250% of the FPL. You must purchase a Silver plan through the Marketplace to be eligible for cost sharing reduction (CSR) assistance.

If you have questions about eligibility for or the amount of the APTC or CSR, contact the federal Marketplace at 1-800-318-2596 or visit its website at HealthCare.gov.

ACA Benefits

Most provisions of the ACA were effective January 1, 2014; however, there are some protections that were implemented beginning in 2010:

- Lifetime limits are prohibited and annual limits are restricted for Essential Health Benefits.
- Enhanced appeal procedures are available if a claim is denied.
- Children up to age 26 may remain on a parent's policy.
- Certain preventive services must be covered with no cost-sharing.
- Higher cost sharing for out of network emergency services is prohibited.
- Medical loss ratio standards limit insurers' overhead.
- A standardized summary of benefits must be used by all insurers, allowing for easier comparison of plans.

For more information about the Affordable Care Act, visit HealthCare.gov or the Division's Health Care Reform webpage at MyFloridaCFO.com/Division/Consumers/Understanding-Insurance/HealthReform.

OTHER HEALTH-RELATED POLICIES

Short-term limited-duration insurance (STLDI)

Also known as temporary insurance, STLDI is health insurance policy that is primarily designed to fill temporary gaps in coverage which may occur when an individual is transitioning from one plan to another. Examples would be a limited period between jobs or during the waiting period for employee-sponsored group coverage. These policies have long been offered through the non-group (individual) market and through associations.

Short-term insurance plans are designed to protect against unforeseen accidents or illnesses, but typically do not include coverage for maternity, preventive care, prescription drugs, dental, vision care or cover pre-existing conditions. Short-term plans are not required to comply with the protections in the Affordable Care Act (ACA), which means insurance companies can deny coverage if you have pre-existing conditions. They also are not required to cover essential health benefits. Insurers can impose lifetime and annual dollar limits on these policies and may apply a pre-existing condition waiting period on the initial policy as well as policy extensions. Since STLDI plans do not include comprehensive coverage or protections as provided under the ACA, the premiums for the policies are much less expensive.

You can a purchase short-term, limited duration policy that:

- Is less than 12 months;
- Contains a disclaimer to help you understand the coverage you are getting; and
- May be renewed for up to 36 months.

Policies with an effective date on or after July 1, 2019, must display the following disclaimer prominently in at least a **14-point type** within the policy, on the application and any other materials that are provided:

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Patient Protection and Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

OTHER HEALTH-RELATED POLICIES

Short-term limited-duration insurance (STLDI) con't

The medical underwriting guidelines for short-term insurance policies are more lenient than comprehensive health coverage because the policy does not cover pre-existing conditions. If you have an existing medical condition, you may want to research whether you can extend your current insurance, if available. Employer-sponsored insurance can be extended under government-regulated options commonly referred to as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or state continuation (mini-COBRA). If your last coverage was Minimum Essential Coverage (MEC) as defined under the ACA and you lost coverage due to no fault of your own, you may qualify for a Special Enrollment Period (SEP) for an ACA individual policy. You can contact the federal Marketplace at 1-800-318-2596 to determine if you qualify for a Special Enrollment Period. STLDI coverage is not minimum essential coverage, so expiration of this coverage does not trigger a Special Enrollment Period.

Companies who wish to market short-term limited-duration policies must be authorized to do business in the State of Florida. Individual short-term policy forms and rates must be filed and approved by the Florida Office of Insurance Regulation (OIR) prior to being marketed. Group short-term policies, such as an association policy, issued outside of Florida must file their policy forms for informational purposes, but the rates are not approved by the OIR.

Hospital Confinement Indemnity Insurance

These policies pay a fixed amount or indemnity for each day, week, or month you stay in a hospital. Such policies pay a flat amount for benefits.

These policies provide coverage beyond, or in addition to, what your primary policy provides. You should use these policies as supplements, rather than substitutes, for major medical insurance. Some supplemental policies include an elimination period, which means companies will pay benefits only after you stay in the hospital for a specified number of days.

Disability Income Insurance

These policies pay a weekly or monthly income for a specific period if you suffer a disability and cannot continue or obtain work. The disability may involve sickness, injury or a combination of the two. Most disability insurance plans coordinate with Social Security benefits and workers' compensation to eliminate duplication of coverage.

You may select a disability policy that includes an elimination period, or length of time that you must wait after a covered illness begins, before receiving benefits. The longer the elimination period, the lower your premium. Premiums may also vary depending upon your occupation (and the risks involved) and your age. For example, a high-rise construction worker would likely pay higher premiums than a florist.

When buying a disability policy, you should find out the company's definition of a disability and the requirements that must be met. Individual and group disability income policies must provide coverage for a policyholder or eligible dependent who becomes disabled. This coverage applies during the first 12 months of the disability, but only if the person can no longer perform material and substantial duties of his or her occupation. After the first 12 months, the company may base the continuance of benefits on the person's ability to perform any work for which he or she is reasonably trained.

An insurance company paying for a disability claim may require the policyholder to provide a written doctor's report. The frequency of this requirement depends upon the particular policy. For example, a given insurer may require such medical updates every month. In addition, the insurer may monitor certain public activities by policyholders who file claims. Insurers may do so to fight fraud and keep insurance costs down.

Accident Insurance

These policies cover death, disability, hospital and medical care resulting from an accident. A common variation called “accidental death insurance” can pay additional benefits for death due to motor vehicle or at-home accidents.

Limited Benefit Insurance

These policies cover certain expenses from specifically named illnesses, injuries or circumstances. For example, cancer policies pay benefits for the actual treatment of cancer. Some also pay benefits for conditions or diseases caused or aggravated by cancer or its treatment.

Policies that pay for specified diseases are occasionally referred to as dreaded disease insurance.

Long-Term Care Insurance

Long-term care encompasses a wide range of medical, personal and social services. A person may need this care if they suffer from prolonged illnesses, disabilities or cognitive impairment. Private insurance companies offer individual or group long-term care insurance policies that provide benefits for a variety of services not covered by your regular health insurance, or by Medicare or Medicare Supplement insurance.

Levels of Nursing Care

There are various degrees of nursing care. The three levels often referred to in Medicare, Medicare supplement and other insurance policies include the following:

Skilled Nursing Care: This level of care provides daily (around-the-clock) nursing and rehabilitative care performed by or under the supervision of a registered nurse or a doctor.

Intermediate Care: This level of care provides less than 24-hour daily nursing and rehabilitative care performed by or under the supervision of skilled medical personnel. Care must be supervised by a registered nurse or a doctor.

Custodial Care: This lower level of care does not require a nurse to administer it. It may be provided in a nursing home or a private home but must be recommended by a doctor. This care includes help with activities of daily living.

A Medicare Supplement policy provides limited nursing care coverage, as it supplements Medicare payments for skilled nursing care, but not intermediate or custodial care.

For definitions of deductible, co-insurance and co-payment, see the Glossary in the back of this guide.

Discount Plans

Discount plans are programs a consumer pays a fee to join in return for discounts on products and services from participating providers. The plans can be related to discounts for medical services, prescriptions, and dental or vision services. Discount plans are not insurance and it is essential that you understand their benefits and conditions. The Florida Office of Insurance Regulation (OIR) licenses discount plan organizations offering discount plans, but not their marketers. Be sure to confirm the licensure of a discount plan organization before providing any personal or financial information. Before buying a discount plan, consumers need to consider these important factors:

- Plans may contain administrative costs and fees.
- Discounts may vary depending upon the type of provider being used and the type of service being provided and may change or only apply to certain services or prescriptions. Check the list of providers advertised for the plan you are thinking of joining to verify they will honor the discount and be aware the list of providers contracted by the plan may change without advance notice to members.
- Some plans require you to notify them in advance of a doctor's visit or hospitalization in order to receive the discount. When using a discount plan in conjunction with health insurance, most providers are not obligated to reduce fees because they have already agreed to reduce their fees with the health insurance plan. Discount plans do not pay for any products or services and members are responsible for paying the medical provider or facility at the time service is received.
- Certain plans offer discounts only on specific drugs. In some cases, applying the discount to a name-brand drug is more expensive than buying a generic drug. Check with your local pharmacist to confirm participation and note the discounts offered.
- If you terminate your health insurance to join a discount plan, it may limit your ability to purchase insurance at a later date. Individual health coverage can only be purchased during the annual open enrollment period unless you qualify for a special enrollment period.
- A few plans use marketing tactics that lead you to believe you are buying health insurance coverage. Before you sign up for any discount plan, be sure its benefits are clearly spelled out. All health insurance policies effective on or after January 1, 2014, must contain the 10 Essential Health Benefits as required under the federal Affordable Care Act (ACA).
- The cancellation and refund policies of discount plans may be restrictive. Consider paying monthly instead of paying all costs up front.

HEALTH SAVINGS ACCOUNTS

Health Savings Accounts (HSAs) are tax-free savings plans Floridians can take advantage of to pay for qualified medical expenses. This program allows you to deposit pre-tax dollars into an HSA up to the level of your deductible plan and must be used in conjunction with a high-deductible health plan. To qualify, the health plan must have a minimum deductible of $1,400 in 2021 for an individual policy and $2,800 for a family policy. The insurance premium is paid for in addition to the HSA. Nothing in the ACA will infringe upon the ability of an individual to contribute to a Health Savings Account (HSA) or discourage an individual from doing so. The minimum level of coverage required to meet the individual mandate was specifically designed to allow for the purchase of a qualified high deductible health plan that would complement the HSA. For more information on HSAs, please visit Treasury.gov or call 1-800-829-1040. If you are a business, call 1-800-829-4933.

CONTINUATION OF COVERAGE

COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) allows retiring employees, or those who lose coverage due to loss of employment or reduced work hours, to continue group coverage for a limited period. This also applies to their dependents that lose coverage because of divorce or legal separation; death of the covered employee; the covered employee qualifying for Medicare; or a loss of dependent status under the health plan's provisions such as for age. COBRA applies only to employers with 20 or more employees.

If you qualify for COBRA benefits, your health-plan administrator must give you a notice stating your right to choose to continue benefits provided by the plan. You then have 60 days to accept coverage or lose all rights to the benefits. Once you elect COBRA coverage, you will pay 100% of the total insurance premium, plus a 2% processing fee. Coverage will be retroactive to the date of the qualifying event so there is no loss of coverage. To obtain a free publication that explains COBRA in more detail, call the Employee Benefits Security Administration at 1-866-444-3272 or visit their website at DOL.gov/EBSA.

Mini-COBRA

Florida's state continuation or "mini-COBRA" law provides similar continuation of coverage protection for employees who work for employers with two to 19 employees. Once you elect mini-COBRA coverage, you will pay 100% of the total insurance premium plus a 15% processing fee.

NOTE: *Under Florida's mini-COBRA law, the employee must notify the insurer within 63 days of losing group eligibility that he or she is eligible to continue coverage.*

Time Periods for COBRA and Mini-COBRA

Continuation of coverage runs from a minimum of 18 months to a maximum of 36 months under COBRA, depending upon the individual situation. The coverage may continue for an additional 11 months for an insured's disability that occurs during a qualifying event such as termination (except for gross misconduct) or a reduction in work hours for the employee; however, it may not exceed the limit of 36 months under COBRA.

Mini-COBRA has a maximum continuation period of 18 months unless you qualify for a disability extension up to 29 months. The employer must maintain a group health plan for COBRA or mini-COBRA to be available.

You may choose to purchase an ACA individual policy during a 60-day special enrollment period once the group coverage has terminated as an alternative to electing COBRA or mini-COBRA. However, this individual coverage will not be retroactive to the termination of the group health plan if coverage is purchased after this date.

If you elect COBRA or mini-COBRA and exhaust the appropriate time period, you can qualify for another special enrollment period to purchase an individual policy under the ACA. Non-payment of a COBRA or mini-COBRA premium does not trigger a special enrollment period for an individual policy. You will have to wait for the next open enrollment period to purchase a new policy.

Conversion

After you exhaust COBRA or mini-COBRA, you may qualify for a conversion plan, which is guaranteed issue, individual coverage that the group plan insurer must offer you. There should be at least two conversion plan options with different levels of comprehensive, major medical benefits. However, these benefits may differ from those offered by your previous group plan. If an you elect to purchase a conversion plan, the coverage is retroactive to the date of termination under the group health plan.

If you have any questions regarding your options, you may call the Insurance Consumer Helpline toll-free at 1-877-MY- FL-CFO (1-877-693-5236) or direct at 850-413-3089 for assistance.

THINGS TO CONSIDER WHEN COMPARING HEALTH CARE OPTIONS

Choosing a health care plan is an important decision. A health care plan provides financial protection from the costs of an unforeseen event or condition. You should make sure the company you are purchasing coverage from, as well as the agent, are licensed in Florida. Your financial needs and your ability to absorb routine costs will affect the type of policy you purchase. Purchasing a policy that provides for first dollar protection is very expensive. You need to evaluate your financial needs and decide what level of costs you can handle and for what level of costs you need to purchase financial protection. The greater the cost sharing between you and the company, the lower the premium cost will be to you. If you purchase coverage at a lower premium, but the policy will not pay costs, such as a deductible, until a certain dollar value is reached, you need to be able to meet this cost responsibility. Consider the following features when comparing health care options.

What Will You Pay Out-Of-Pocket?

Premium: The amount paid, often on a monthly basis, for health insurance.

Out-of-pocket Maximum: A yearly cap on the amount of money individuals are required to pay out of pocket for covered health care costs, excluding the premium cost. This amount can include the deductible, co-insurance, or co-payments for covered services. These amounts will be higher for out of network covered services. Not all medical expenses will count toward the out-of-pocket maximum for all policies so you need to read each plan's specific requirements.

Usual, Customary or Reasonable (UCR): This is the amount of a claim that the contract will reimburse based on an average range of fees for given procedures, geographic areas, etc. Some companies may refer to this as the allowable amount of a claim. Often, the provision will limit the amount the company will pay, so be aware of UCR provisions. This is an important feature that should be considered. Two otherwise identical policies could provide substantial reimbursement differences based on how the company defines UCR. The amount is not consistent between carriers and you can be held liable for the difference between the company's definition and the provider's charges under an indemnity policy or when services are provided out of network under a managed care plan (PPO, EPO, or POS).

CONSUMER ALERT: Florida law rewards individuals who find improper charges on their health care bills. The law attempts to help contain the ever-increasing costs of insurance and health care. You should carefully review the charges when you receive a bill from your hospital, doctor, or other health care provider. You should verify that your bill covers only procedures you received. This will also help you to watch out for "double billing," or being charged twice for the same procedure. If you see a mistake, you should notify your insurance company in writing. You may receive 20% of the reduction amount, up to $500, for an incorrect bill that merits a reduction.

QUESTIONS AND ANSWERS ABOUT PREMIUMS

Why Do Companies Raise Premiums?

Insurance companies often raise premiums when the cost of claims they must pay increases.

Medical-cost inflation, a major factor that contributes to premium increases, measures the increased cost of a procedure each year.

Medical utilization, or the number of times doctors perform a procedure each year, also causes premium increases if utilization is higher than expected.

Cost shifting occurs when hospitals raise their rates for services to offset the cost of caring for non-paying or indigent patients or to offset low reimbursement rates under Medicaid and Medicare. In addition, new technologies, tests and medical malpractice claims can contribute to cost shifting and increase the cost of health insurance.

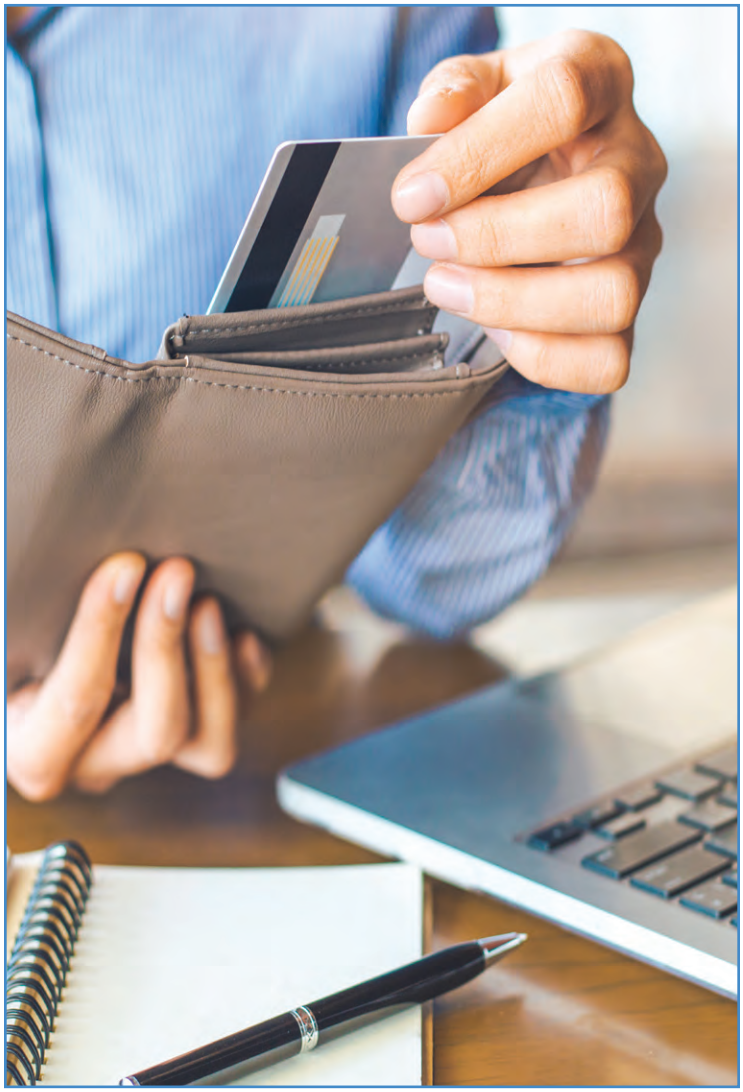
What Do Your Premiums Pay For?

Premiums help pay policyholders' claims and other expenses, such as agent commissions, premium taxes and administrative expenses.

How Do Insurance Companies Determine Premiums?

An insurance company considers many factors when setting premiums, such as:

- Medical-care costs,
- Cost sharing amounts,
- Plan benefits,
- Age of the policyholder
- Lifestyle habits such as smoking,
- Geographic area, and
- Riders for additional benefits



Can an insurer charge me a higher premium under an ACA policy if I have a pre-existing condition?

No, only four factors can be used when an insurer is calculating the premium for an individual or small group policy under the Affordable Care Act:

- Age
- Geographic area
- Individual or family coverage
- Tobacco usage

Beginning on January 1, 2014, major medical insurers cannot charge you more because of your medical history or gender.

Renewable Conditions and Premium Increases

Conditions for renewals and premium increases vary from policy to policy; ask your insurance agent or company representative about the conditions of the policy under consideration. You should also know these key terms:

Guaranteed Renewable: This means a company must renew a policy for a specific period other than for non-payment of premium or fraud. If an insurer has a rate increase it must raise premiums consistently for all insureds in the same class. This is the most common type of renewal provision.

Non-cancelable: Under this condition, an insurance company can't cancel your policy or increase your premium if you pay on time.

Optionally Renewable: This means an insurance company may cancel a policy at the end of the contract period for any reason and increase premiums at any time.

Short Term, Non-renewable: This is also referred to as a temporary policy and means that you can't renew your policy at the end of the policy term. Premiums remain constant for the policy period, which usually lasts a few months.

Under Florida law, your company must give you a 45-day notice, in writing, of cancellation (other than non-payment of premium), non-renewal or premium change; HMOs must provide notice within 30 days. If an insurer or HMO non-renews a policy form, it must provide you at least a 90-day notice before the date of non-renewal. If a company is withdrawing from the market, it must provide at least a 180-day notice. You may contact the Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236) or direct at 850-413-3089 if you don't receive such notification.

Policies purchased off the exchange must only provide a 10-day notice, in writing, for a cancellation due to your failure to pay premiums. Policies purchased on the Marketplace that include an advanced premium tax credit have a 90-day grace period to pay the overdue premium before the policy is cancelled. If a policy on or off the Marketplace lapses for nonpayment of premium, you will have to wait for the next open enrollment period before you can purchase another policy.

What About Coverage For "Alternative" Therapies?

Due to increasing consumer interest, some health insurance companies and HMOs offer coverage for "alternative" medicine and therapies, such as herbal supplements, acupuncture, massage, etc.In some cases, alternative treatments cost less than conventional approaches. However, widespread coverage for alternative medicines will probably not occur until medical experts can conduct long-term studies and additional research. The existing coverage generally involves limited reimbursement and other restrictions.

CONSUMER TIPS

- Watch out for "telemarketing fraud," or high-pressure schemes in which a telephone caller may try to sell you unnecessary or unwanted insurance. Such a caller may use deceptive tactics, such as asking for immediate payment of premiums for a "last chance" offer. Ask for written policy information and thoroughly research the insurance agent and company credentials before supplying any personal financial information. If you suspect this type of crime has occurred, you may call our Fraud Hotline toll-free at-1-800-378-0445 or the Insurance Consumer Helpline at 1-877-MY-FL-CO (1-877-693-5236). The Department of Agriculture and Consumer Services can add you to a list that telemarketers are forbidden to call. You can contact their office at 1-800-435-7352 for more information. You can also register with the National Do Not Call Registry by visiting DoNotCall.gov or by calling 1-888-382-1222.
- Contact the Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236) or the federal Marketplace at 1-800-318-2596 if you want information about getting a replacement individual policy if your current individual or group plan is being terminated due to circumstances such as a death, divorce, age restrictions or job loss.
- You are entitled to a "free look" period of 10 days when you purchase an individual health insurance policy. You should return the policy by registered or certified mail within the allowed time if you decide not to keep it.
- You are entitled to a "grace period," which is a specified time frame when you can submit an overdue payment and still maintain coverage under your policy.
- Before buying additional policies, it pays to understand how your current coverage will work with another policy. Do not over-insure as you cannot collect on the same claim twice.
- Maintain continuous coverage by not canceling your old policy until you are certain when your new policy will be effective.
- Pay your premiums, even if a dispute arises with your company. Otherwise, it may cancel your policy for non-payment of premiums.

FILING CLAIMS

Florida law allows medical providers and facilities to file claims electronically or on paper. If a medical provider or facility is contracted with the insurer or HMO, it will file the claim for you. Out of network providers may file the claim for you or make you pay the claim and then you seek reimbursement from your company. The following guidelines can help speed up the claims process:

- Inform your insurance company about a claim in writing within 20 days of an accident or illness. You must file your claim within 90 days or the deadline outlined in your policy, whichever is later.
- Contact your agent if you need help filing your claim. You should fill out all claim forms accurately and completely; attach copies of bills when requested and keep your originals. Have your doctor and hospital representative complete (and sign, if necessary) their sections of the form right away.
- Keep copies of everything you send the company, or the company sends to you, including a record of the date you filed the claim. Keep a log of all phone calls or e-mails you have with the insurer about the claims.
- Send claims to the insurer via registered or certified mail or another form of delivery where confirmation of receipt is available.

NOTE: *Your company should pay a claim promptly after it receives a completed claim form. The company should also provide an explanation for a partial payment or a rejected claim.*

All health insurance plans must have a formal appeal process for adverse benefit determinations as outlined in the policy or contract. The appeal process may require that the internal appeals process be exhausted prior to eligibility for an external review. In addition, adverse benefit determination claim denial notices must include a discussion of the issuers' decision, plus a description of the available internal appeals and external review process. The insured, enrollee, member, or certificate-holder must have at least four months to file a request for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.

The appeal process must include the ability to request an expedited review under certain urgent situations.

For more information, contact your insurance company or HMO representative or your employer's human resources office if you are under an employer group health plan.

HOW TO SELECT AN INSURANCE COMPANY

When selecting an insurance company, it is wise to know that company's rating. Several organizations publish insurance company ratings, available at your local library and on the Internet. These organizations include: A.M. Best Company, Standard & Poor's, Weiss Ratings Inc., Moody's Investors Service and Duff & Phelps. Companies are rated on a number of elements, such as financial data (including assets and liabilities), management operations and the company's history.

Before buying insurance, verify whether a company is licensed to sell insurance in Florida by calling our Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236) or direct at 850-413-3089. Be sure to have the full, legal name of the insurance company when you call. You can also go to MyFloridaCFO.com/Division/Consumers/ and click on "Purchasing Insurance" and then "Verify Before You Buy" in order to verify a company's licensure.

HOW TO SELECT AN INSURANCE AGENT

When selecting an agent, choose one who is licensed to sell insurance in Florida. In addition, some agents have professional insurance designations such as the following:

CEBS - Certified Employee Benefits Specialist

CFP - Certified Financial Planner

ChFC - Chartered Financial Consultant

CIC - Certified Insurance Counselor

CLU - Chartered Life Underwriter

CPCU - Chartered Property and Casualty Underwriter

LUTCF - Life Underwriting Training Council Fellow

RHU - Registered Health Underwriter

Make sure you select an agent with whom you feel comfortable and who will be available to answer your questions. Remember, an agent may represent more than one company. To verify whether an agent is licensed, call our Insurance Consumer Helpline toll-free at 1-877-MY-FLCFO (1-877-693-5236) or direct at 850-413-3089. You can also go to MyFloridaCFO.com/Division/Agents/ and click on "Licensee Search", under the "Portals" section.

YOUR RIGHTS AND RESPONSIBILITIES

When you buy insurance, you have certain right and responsibilities.

Your Rights

- You have the right to receive a copy of the insurance policy or certificate governing your coverage.
- You have the right to receive copies of all forms and applications signed by you or the agent.
- You have the right to appeal any denied claims.

Your Responsibilities

- You are responsible for reading and understanding your insurance policy.
- You are responsible for reading and understanding any "explanation of benefits" forms sent by your insurer. These forms usually state: "This is not a bill." However, you should still closely study them to make sure you received the medical services that your insurer was billed for.
- You are responsible for reporting suspected fraud to DFS. If you suspect a crime has occurred, call our Fraud Hotline toll-free at 1-800-378-0445.
- You are responsible for making sure your application is accurate. If you make a fraudulent or intentional misstatement on your application, it may affect coverage for future claims.
- You are responsible for knowing what your policy covers and excludes.
- You are responsible for paying your premiums on time, even while involved in a dispute with your company.
- You are responsible for paying the deductibles, co-insurance, and co-payments outlined in your policy.
- You are responsible for verifying licenses of an insurance agent and company by calling the Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236) or by visiting our website at MyFloridaCFO.com.

INSURANCE DISCRIMINATION AGAINST VICTIMS OF ABUSE

Florida law prevents insurance companies from discriminating against victims of domestic violence or abuse. If an insurer refuses to pay a claim, demand in writing that the insurer explains, in writing, why it took this action. If you believe you have been discriminated against, call the Florida Domestic Violence Hotline at 1-800 500-1119 or the Battered Women's Justice Project at 1-800-903-0111. You can also file a complaint through our Insurance Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236), or go to the Department's Website at MyFloridaCFO.com/Division/Consumers/.

SENIORS: NEED HELP WITH YOUR INSURANCE QUESTIONS?

The Florida Department of Elder Affairs has developed a program to help seniors with their Medicare and health insurance questions.

SHINE (Serving Health Insurance Needs of Elders) trains senior volunteers to assist other seniors with their questions about Medicare, Medicare supplement, long-term care and other health insurance issues.

To find out if a SHINE program operates in your community, please contact the Elder Helpline toll-free at 1-800-96-ELDER (1-800-963-5337) or the Florida Department of Elder Affairs at (850) 414-2000.

SMALL BUSINESS OWNER HEALTH INSURANCE OPTIONS

PROVIDING INSURANCE FOR EMPLOYEES

Health coverage for your employees

While not required by law for employers with fewer than 50 employees, employers sometimes offer benefits, such as group life and health coverage, to attract and keep good employees.

Starting in 2016, large employers with 50 or more employees must offer affordable insurance to their employees and their dependent children or they may pay a federal tax penalty. The rules for calculating the penalty are complex. We suggest you contact your tax advisor or the Internal Revenue Service (IRS.gov) about the federal tax penalty, or for further administrative or legislative changes to the federal employer mandate.

Self-funded, single employer insurance plans are regulated by the United States Department of Labor (USDOL) and are subject to federal laws and regulations, including parts of the Affordable Care Act. For more information on requirements for self-funded health insurance plans, visit the USDOL's website at DOL.gov/General/Topic/Health-Plans.

Association-Based Coverage

An insurance company that markets a fully insured association-based certificate to a Florida resident or employer must obtain a license from Office of Insurance Regulation (OIR). The insurer may keep the master policy in the name of an association or trust based outside Florida. In addition, the insurer may file its policy forms and rates for approval in the association's home state. The insurance company must still file its policy forms with the OIR for informational purposes but not approval. Please be aware that this means some of Florida's most important insurance laws covering benefits and rate increases may not apply to out-of-state, association-based coverage, even though the insurance is sold to Florida residents. The government of the home state (the state where the policy was issued) may not closely review or approve the rates involved.

Some association-based coverage is provided on a self-insured basis and under the federal Employee Retirement Income Security Act (ERISA) is considered a Multiple Employer Welfare Arrangement (MEWA). This type of plan must get licensed by the Florida OIR per section 624.438, Florida Statutes. More information about the licensure of MEWAs can be found on the OIR's website at FLOIR.com/.

Small Employers Health Care Access Act and the Affordable Care Act (ACA)

The Small Employers Health Care Access Act and the ACA makes health insurance plans available to small-business employers regardless of the health-claims experience of a group of employees or the health status of any individual employee in that group. All eligible employees and their dependents must be offered coverage if a small group plan is offered by the employer.

Insurers are required to offer all health benefit plans to eligible small-business employers with one to 50 eligible employees on a guaranteed-issue basis as long as required participatory and contribution requirements are met. If you are a sole proprietor or the sole officer of your corporation seeking coverage, or there are no non-family member employees participating in a group health policy, you are not considered a small group employer and need to access coverage through the individual market. The open enrollment for individual health policies under the Affordable Care Act is from November 1st through January 15th. Coverage must be purchased on or before December 15th for a January 1 effective date. Coverage purchased on or between December 16th and January 15th will have a February 1st effective date. You may qualify for a Special Enrollment Period (SEP) if you experienced a qualifying event such as a birth, marriage, divorce, or move from your current plan service area. You can contact the federal Marketplace at 1-800-318-2596 or visit their website at HealthCare.gov for more information.

Small employers who do not meet the insurers' or HMOs' participation requirements have an open enrollment period once a year from November 15th through December 15th when you can purchase a group health plan from any company participating in the small group market. The plan would be effective on January 1.

Guaranteed issue means that the policy must be issued regardless of the employer's or an individual employee's claims history, pre-existing condition(s) or health status. In addition to coverage being guaranteed issue, a policy meeting the requirements under the Affordable Care Act (ACA) cannot exclude coverage for pre-existing conditions nor can it charge an additional premium due to the health status of the group. The only rating factors that can be used to determine the premium for a qualified health plan are ages of the employees, geographic location of the employer, whether it is individual or family coverage, and whether there is tobacco usage by covered individuals.

Even though pre-existing condition exclusions are no longer allowable, the ACA still allows an employer to maintain a waiting period before offering coverage to a new employee. The waiting period may not exceed 90 days and premiums are not collected during this period.

All small group policies effective on or after January 1, 2014, must provide the following 10 Essential Health Benefits (EHBs):

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

For a list of companies participating in Florida's small group market, visit our website at MyFloridaCFO.com/Division/Consumers/PurchasingInsurance/ and select Find Insurance Coverage under "How to Protect Yourself."

High deductible health plans (HDHP)

Since September 1, 2004, small-employer group coverage providers have been required to offer at least one HDHP that meets federal requirements of a health savings account (HSA) or health reimbursement arrangement (HRA—see next section).

These tax-advantaged accounts will be used to pay for qualified medical expenses as defined by the Internal Revenue Service. DFS does not have authority over HSAs or HRAs. However, the Office of Insurance Regulation (OIR) has authority to review and approve HDHP insurance contracts.

What is an HRA?

An HRA (health reimbursement arrangement) is an employer-funded account that reimburses employees for qualified medical care expenses, typically combined with a high-deductible health plan.

What is an HSA?

An HSA (health savings account) is a tax-exempt trust or custodial account established to pay qualified medical expenses. The account allows an individual to save money on a tax-preferred basis to be used for future qualified medical and retiree health expenses. In order to be eligible to use a HSA, individuals need to be covered by a qualified high-deductible health plan.

Who can establish an HSA?

An "eligible individual" means, with respect to any month, any individual who:

- Is covered under an HDHP on the first day of such month;
- Is not also covered by any other health plan that is not an HDHP with certain exceptions for plans providing certain limited types of coverage;
- Is not entitled to benefits under Medicare (generally, has not yet reached age 65); and
- May not be claimed as a dependent on another person's tax return.

What is a "high-deductible health plan" (HDHP)?

A type of health insurance plan that typically requires greater out-of-pocket spending than other health insurance plans, although premiums may be lower. HDHPs are often paired with an HSA or other medical savings account that allows money to be deposited into a separate account on a tax-preferred basis to help pay for the higher out-of-pocket spending. An HDHP must satisfy certain federally imposed annual deductible and out-of-pocket expense requirements. For 2023, the required deductibles and out of pocket expenses are:

SELF-ONLY COVERAGE:

- Annual deductibles of at least $1,500
- Annual out-of-pocket expenses not exceeding $7,500

FAMILY COVERAGE:

- Annual deductibles of at least $3,000
- Annual out-of-pocket expenses not exceeding $15,000

ADDITIONAL HDHP ATTRIBUTES INCLUDE:

- In the case of family coverage, there is only one deductible. It does not matter which family member incurs the expenses to meet the deductible.
- Amounts are indexed for inflation.
- A plan does not fail to qualify as an HDHP merely because it does not have a deductible (or has a small deductible) for preventive care (i.e., annual physicals; obesity weight loss programs; screening services such as mammograms; tobacco cessation programs; child and adult immunizations; and routine prenatal and well-child care).

NOTE: *Out-of-network copayments don't count toward out-of-pocket maximums.*

What other kinds of health coverage may an individual maintain without losing eligibility for an HSA?

An individual does not fail to be eligible for an HSA merely because, in addition to an HDHP, the individual has coverage for any benefit provided by "permitted insurance."

Permitted insurance includes coverage for:

- Accident
- Disability
- Dental care
- Vision care
- Long-term care

Modified Community Rating

All small-group health plan premiums are determined using a modified community rating. Under the ACA, the modified community rating allows four factors to be considered in determining an individual's health plan rate: geographic area, age, tobacco usage and family composition.

For small-business owners seeking coverage, the rate can be increased if the employer does not have workers' compensation insurance. Base rates can also increase annually due to health care cost increases.

COBRA Benefits

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires insurance companies that cover employee groups of 20 or more employees to provide health coverage to employees who lose eligibility to participate in the company's health plan. Employers, or their designated administrator, are responsible for the notice requirements and administration of COBRA benefits.

Employees typically lose their eligibility when they retire, resign, lose their jobs or have their work hours reduced below the minimum amount required to participate in the company's health plan. COBRA allows employees enrolled in group plans to receive coverage for themselves and their insured dependents for an additional 18 months following the termination of regular health plan coverage.

An employee or insured dependent who is disabled at the time of job termination can receive a total of 29 months of continued coverage. Dependents losing coverage (spouse or dependent children) can receive up to 36 months of coverage under certain conditions. Under this federal law, the employer or its designee (usually its insurance company) is required to inform the employees of their COBRA rights when they lose their eligibility.

Mini COBRA

Florida's Mini-COBRA law provides similar continuation of coverage protection for employees who work for employers with fewer than 20 employees.

NOTE: *Under this law, the employee must notify the insurer within 63 days of losing group eligibility that he or she is eligible to continue coverage. The employer should keep individuals under their group health plan advised of any changes involving the plan. If you have specific questions, call the Consumer Helpline toll free at 1-877-MY-FL-CFO (1-877-693-5236) for assistance.*

Disability Income Insurance

You also may offer your employees disability income insurance to provide them with income if they become disabled from illness or injury and cannot work. Disability income insurance replaces a significant portion of an individual's income through periodic payments while the individual is disabled due to sickness or injury. Disability income benefits provide monthly or weekly payments of a specified amount for a period of time stated in the policy. Disability income insurance comes in both short- and long-term coverage.

SHORT-TERM disability income insurance generally refers to policies with a maximum benefit coverage of two years or less, although some companies may apply this designation to policies with benefit coverage of up to five years.

LONG-TERM coverage includes policies with maximum benefit periods of 10 years, to age 65, or in a few instances, for the lifetime of the insured. For the first 12 months of the disability, this type of income policy must provide benefits if the policyholder is unable to perform material and substantial duties of his or her regular occupation. After the first 12 months, the company may base the continuance of benefits on the person's ability to perform any work for which he or she is reasonably trained.

MEDICAL PRIVACY AND THE MEDICAL INFORMATION BUREAU

The Medical Information Bureau (MIB) is a data bank of medical and non-medical information on millions of Americans, collected from the MIB's insurance company members.

The companies send the MIB information you have written on applications, enrollment forms, and requests for upgrading coverage for health, life or disability insurance. The MIB also records information from medical exams, blood and lab tests, and hospital reports, when such information is legally obtainable.

If you have been denied life or disability insurance and wonder why, your file at the MIB may be the answer. You have the right to make sure the information in your MIB file is correct. Call the MIB at 1- 866-692- 6901 and ask for a copy of your records or access its Website at MIB.com.

INSURANCE FRAUD COSTS US ALL!

The Coalition Against Insurance Fraud estimates over $308 billion is lost annually in the United States due to insurance fraud. This includes all lines of insurance. It's also a conservative figure because much insurance fraud goes undetected and unreported. Insurance companies generally pass the costs of bogus claims – and fighting fraud – onto its policyholders. This includes the money you pay for life, auto, health, homeowners and other types of insurance. You can protect your personal and family finances by learning about the many different types of fraud schemes and scams. Some common examples include:

ROGUE AGENTS — An agent sells a policy by misrepresenting important terms of the insurance contract or deliberately sells unnecessary health insurance to a consumer that duplicates existing coverage.

INSURANCE COMPANY GOES BANKRUPT — Companies are closely examined by the Office of Insurance Regulation (OIR) to ensure their financial stability. However, if the company is in financial trouble and misrepresents its financial status, policyholders may find that the company will be unable to pay their claims.

APPLICANT FRAUD — A consumer applying for a health insurance policy deliberately withholds information out of fear of being denied coverage.

UNLICENSED AGENT — Health insurance agents must be licensed by the Department of Financial Services. An unlicensed agent can defraud or otherwise financially harm an insurance consumer.

UNAUTHORIZED MARKETPLACE ENROLLMENT — An agent enrolls a consumer in a Federally Facilitated Marketplace policy without their knowledge or consent which can have tax implications and disrupt other health insurance coverage.

UNAUTHORIZED REFERRAL — A laboratory bills a health insurance company for patient's testing using stolen health insurance information.

THERE ARE MANY OTHER TYPES OF INSURANCE FRAUD. IF YOU SUSPECT SUCH A CRIME HAS OCCURRED, CALL THE DFS FRAUD HOTLINE TOLL-FREE AT 1-800-378-0445 OR VISIT FIRST.FLDFS.COM.

GLOSSARY

ADVANCED PREMIUM TAX CREDITS (APTC): The ACA created a refundable tax credit for eligible individuals and families who purchase health insurance through the Marketplace. The tax credit amount is based on multiple factors, including income and family size. The IRS pays the premium assistance credit amount directly to the insurer in which the individual or family is enrolled. The individual then pays to the insurer the dollar difference between the premium assistance credit amount and the total premium charged for the plan.

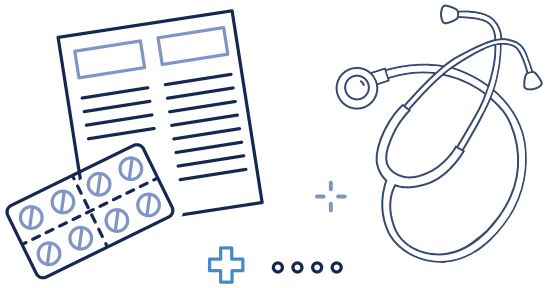
ADVERSE BENEFIT DETERMINATION: An adverse benefit determination is defined as, "a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based on the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and the requested service or payment for the service is therefore denied, reduced, or terminated".

AFFORDABLE CARE ACT (ACA): President Obama signed HR 3590, the Patient Protection and Affordable Care Act into law on March 23, 2010. The President also signed HR 4872, the Health Care and Education Reconciliation Act, into law on March 30, 2010. The two Acts combined are collectively referred to as the Affordable Care Act (ACA) or federal health care reform.

The law put in place a significant number of health insurance reforms that rolled out since March 2010. Some of the final and most notable changes of the law took effect on January 1, 2014. Policy benefits requirements can vary depending on whether your individual or group plan was purchased on, after, or before March 23, 2010.

ANNUAL LIMIT: Many health insurance plans placed dollar limits upon the claims the insurer will pay over the course of a plan year. ACA prohibits annual limits for essential benefits for plan years beginning after September 23, 2010.

APPLICATION: This document is a signed statement of facts that an insurer uses to issue coverage. The application becomes part of your health insurance contract.



ASSIGNMENT: An assignment is a document signed by a policyholder authorizing an insurer to pay benefits directly to a hospital, doctor, or other health care provider.

CO-INSURANCE: This is the cost that a policyholder must pay out-of-pocket. Co-insurance usually involves a percentage of what a procedure costs. Many policies require the buyer to pay 20 to 30% up to a certain dollar amount after the deductible has been met.

COORDINATION OF BENEFITS: With this provision, you will not receive more benefits than your actual hospital and medical expenses, even though you may obtain another policy. A husband and wife with family coverage under separate group policies can't collect for the same claim twice, even if they paid two premiums. This provision also applies if you have Medicare as a primary or secondary payer. Federal or state regulations or the coordination of benefit contract provision will specify the order of benefits.

COST SHARING: A feature of health plans where beneficiaries are required to pay a portion of the costs of their care. Examples of costs include co-payments, co-insurance, and annual deductibles.

COST SHARING REDUCTION: Assistance is available, based on income and family size, with out of pocket expenses for deductibles, co-insurance, and co-payments for in-network benefits in a Silver level Marketplace plan.

CO-PAYMENT: This is a fixed dollar amount paid by an individual for covered health care services. The individual pays this amount to the provider at the time of service. The required fee varies by the medical service provided.

COST SHIFTING: This practice, used by hospitals, increases the cost of hospital services to insureds to offset the cost of caring for non-paying or indigent patients.

CUSTOMARY CHARGE: This is the range of usual fees charged by doctors of the same specialty in a given geographic area for a specific procedure.

CERTIFIED APPLICATION COUNSELORS (CAC): Certified application counselors have a similar role to Navigators but are not funded with federal grant money through the Marketplace. Examples of possible application counselors can include staff at community health centers or hospitals or consumer non-profit organizations. Certified application counselors are required to complete comprehensive federal Department of Health and Human Services training but are not required to be registered with the Florida Department of Financial Services.

CONVERSION POLICY: A conversion policy is an individual policy or certificate issued when a person no longer qualifies as a certificate holder under group coverage or as a dependent under a group certificate or individual policy.

DEDUCTIBLE: This is the amount you must pay out of pocket before an insurer pays its share unless stated otherwise in the contract. Generally, the higher the deductible, the lower the premium.

ELIGIBLE EMPLOYEE: Under Florida law, an eligible employee means an employee who works full time, having a normal work week of 25 or more hours, and who has met any applicable waiting-period requirements. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include a part-time, temporary, or substitute employee.

EXTERNAL REVIEW: Issuers or plans must provide a description of the external review process for adverse benefit determinations in or attached to the summary plan descriptions, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to participants, beneficiaries, or enrollees. The external review process involves an independent third-party review of the plans' or health insurance issuers' decision.

ESSENTIAL HEALTH BENEFITS: A set of 10 health care service categories that must be covered by qualified health plans starting in 2014.

EFFECTIVE DATE: This is the date on which health coverage protection begins.

ELIMINATION PERIOD: This is the length of time a policyholder must wait after a covered illness begins before receiving benefits.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA): Federal legislation enacted in 1974 to protect workers from the loss of benefits provided through the workplace. ERISA does not require employers to establish any type of employee benefit plan but contains requirements applicable to the administration of the plan when a plan is established. The requirements of ERISA apply to most private employee benefit plans established or maintained by an employer, an employee organization, or both.

EXCHANGE OR MARKETPLACE: A term used to describe the exchanges that were created under the ACA to assist individuals and small businesses in comparing and purchasing qualified health plans. The Marketplace also determines eligibility for Medicaid or Florida Healthy Kids, as well as eligibility for premium and cost sharing assistance.

EXCLUSIONS: These are certain conditions, life events, procedures, or services specified in a health policy for which there is no coverage.

EXCLUSIVE PROVIDER ORGANIZATION (EPO): In an EPO arrangement, an insurance company contracts with hospitals or specific providers for some or all services. Insured members must use the contracted hospitals or providers to receive benefits from these plans unless out-of-network benefits are included for some services in the policy. Emergency services are covered regardless of the network status of the medical provider or facility.

FLORIDA HEALTHY KIDS: Florida Healthy Kids is a joint federal and state funded program under the federal Children's Health Insurance Program (CHIP) that provides health insurance coverage for children ages 5 through 18 regardless of family income.

FREE LOOK PERIOD: This is a 10-day period after you receive a health policy which allows you time to decide whether to keep it. This applies only to individual health policies.

GRACE PERIOD: This is a specified period in which a policyholder may submit an overdue payment and still retain coverage.

GRANDFATHERED HEALTH PLAN: A health plan that an individual was enrolled in prior to March 23, 2010. Grandfathered plans are exempt from most changes required by ACA. New employees may be added to group plans that are grandfathered, and new family members may be added to all grandfathered plans.

GUARANTEED-ISSUE POLICY: A requirement that health insurers sell a health insurance policy to any person who requests coverage, regardless of health history. The ACA requires that all major medical health insurance be sold on a guaranteed-issue basis beginning in 2014.

HEALTH MAINTENANCE ORGANIZATION (HMO): HMO members pay a monthly fixed dollar amount (similar to an insurance premium), which gives them access to a wide range of health care services. In many cases, members also pay a pre-determined amount, or co-payment, for each doctor or emergency room visit and for prescription drugs, rather than paying the provider in full and obtaining a portion of the reimbursement later. Members must use the HMO's network of providers, which may include the doctors, pharmacies and hospitals under contract with that HMO. Emergency services are covered regardless of the network status of the medical provider or facility. The HMO contract may contain a deductible and co-insurance provision.

INSOLVENCY: This is the inability of an insurer or HMO to meet financial obligations or debts.

INTERNAL REVIEW: The plan's internal review requirements and process must be outlined in the insurance policy or contract. Your appeal will be filed with your insurer or HMO for it to review its initial adverse benefit determination. You may be required to exhaust the plan's internal review process prior to filing for an external review.

LIFETIME BENEFIT MAXIMUM: Many health insurance plans place dollar limits upon the claims the insurer will pay over the lifetime of the insurance contract. The ACA prohibited lifetime limits on essential health benefits beginning on September 23, 2010.

MANDATED BENEFITS: This term has different requirements under the ACA for grandfathered and non-grandfathered plans. Policies purchased on or after March 23, 2010, must contain 10 essential health benefits as outlined in the ACA as well as meet Florida state-mandated benefits. Grandfathered individual and small group plans must meet just Florida mandated benefits.

MEDICAID: Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a federal program that provides health and long-term care coverage to certain categories of low-income Americans. States design their own Medicaid programs within broad federal guidelines.

MEDICAL-COST INFLATION: This is an increase in insurance premium due to a rise in the cost of medical care. It measures the additional cost of medical services from one year to the next. It does not consider the number of times doctors perform the procedure in a year.

MEDICAL LOSS RATIO (MLR): The MLR is the required percentage of health insurance premiums that are spent by an insurer on medical care as opposed to administrative costs or profits. The ACA requires that large group plans spend 85% of premiums on clinical services and other activities for the quality of care for enrollees. Small group and individual market plans must devote 80% of premiums to these purposes. Amounts not within the medical loss ratio requirements must be returned to the policyholder in the form of a rebate.

MEDICAL UTILIZATION: This is the frequency of a policyholder's use of medical services in a given year resulting in an insurance claim. This term also refers to the number of times doctors perform a procedure in a year.

MEDICALLY NECESSARY: This is a medical procedure or treatment necessary to maintain or resume good health. Many insurance policies will only pay for medically necessary treatments or services.

MEDICARE: Enacted in 1965 under Title XVII of the Social Security Act, Medicare is a federal program that provides health insurance coverage, including people age 65 and older, and younger people with permanent disabilities, end-stage renal disease, and Lou Gehrig's disease.

NAVIGATORS: Individuals who will help consumers prepare electronic applications to establish eligibility and enroll in coverage through the Marketplace and potentially qualify for an insurance affordability program (including a premium tax credit, Medicaid and Florida Healthy Kids). They will also provide outreach and education to raise awareness about the individual Marketplace, and will refer consumers to health insurance ombudsman and consumer assistance programs when necessary.

Navigators must complete comprehensive training and be certified by the federal Department of Health and Human Services. Navigators will also be required to be registered through the DFS, Division of Insurance Agent & Agency Services, Bureau of Licensing.

OUT-OF-POCKET MAXIMUM: A yearly cap on the amount of money individuals are required to pay out of pocket for covered health care costs before the company begins paying 100% of covered medical expenses. This expense does not include the premium cost.

PREFERRED PROVIDER ORGANIZATION (PPO): PPOs offer a provider network to meet the health care needs of its insureds. An insurer contracts with a group of health care providers and facilities to control the cost of providing benefits to its insureds. These providers charge lower-than-usual fees because they require prompt payment and serve a greater number of patients. Insureds usually choose who will provide their health care, but typically pay a lower deductible and less in co-insurance with a preferred provider than with a non-preferred provider. Most group health policies fall under this category of major medical coverage.

PLAN LEVELS OF COVERAGE: There are basically four levels of coverage under the ACA, called the metal plans (Platinum, Gold, Silver, and Bronze). These plans offer essentially the same benefits but the cost sharing requirements for the member is the difference.

PRE-EXISTING CONDITION: This is an illness, diagnosed or treated before buying a health insurance policy that existed during a specified period immediately preceding the policy's effective date. Under the ACA, individual major medical and health maintenance organization health plans may no longer exclude or limit coverage for pre-existing conditions.

PREMIUM: The amount paid, often on a monthly basis, for health insurance. The cost of the premium may be shared between employers or government purchasers and individuals.

QUALIFIED HEALTH PLAN: An insurance plan that is certified by the Marketplace, provides essential health benefits, follows established limits on cost-sharing and meets other requirements.

REASONABLE CHARGE: This is a fee that differs from usual or customary charges because of unusual circumstances involving medical complications that require additional time, skill and expertise.

RIDER: This is an attachment to an insurance policy that specifies conditions or benefits the policy covers in addition to the original contract benefits.

Small Business: This is a business that has one to 50 full-time equivalent employees.

SURGICAL SCHEDULE: This is a list of cash allowances payable for various kinds of surgery. The severity of an operation determines the maximum amount payable.

USUAL CHARGE: This is the fee a doctor most frequently charges patients for a procedure.

WAITING PERIOD: This is the time between the date a policy becomes effective and the date benefit payments begin.

Key Points to Remember for ACA Plans:

- Consumers have the choice to purchase coverage directly from private insurers and HMOs.
- Individuals need to be mindful of enrollment periods.
- Coverage will be certified to contain certain minimum benefits.
- All coverage is guaranteed issue with no pre-existing waiting periods.
- Policies cannot be rated up due to a person's health history.
- Insurance can be purchased in or outside of the Marketplace.
- The Marketplace is the only place for individuals to get tax credits and cost sharing assistance.
- Consumers can obtain assistance from Navigators, Certified Application Counselors, or agents when applying through the individual Marketplace.
- Small businesses can purchase coverage through the SHOP and possibly get tax credits.

How to Reach Consumer Services

Submit a General Insurance Question
If you have a general insurance related question and do not wish to file an insurance concern, please Email Us.

Submit an Insurance Concern
Submit concerns related to insurance products, including bonds, warranties and annuities, online below. Requests are assigned to insurance specialists to provide necessary assistance.

Phone
Online filing may expedite the handling of your questions or concerns.

1-877-693-5236
Out of State Callers:
(850) 413-3089

NOTES

FLORIDA DEPARTMENT OF
Division of
Consumer
Services
FINANCIAL SERVICES

JULY 2025