Non-Governmental Payers

1. Fully Insured Accident and Health Insurance Plans

Accident and health insurance plans are regulated by state and federal law. The Patient Protection and Affordable Care Act of 2010 (ACA) made sweeping changes to the health insurance industry and imposed a number of requirements intended to control cost and expand the availability and quality of health insurance to consumers. There were unsuccessful attempts to appeal the ACA in 2017 and there are several lawsuits against it still pending. Past legal challenges, as well as regulatory, budgetary and legislative updates have resulted in many changes. The health care exchange created by the ACA suffered from steep premium increases and decreased enrollment for several years but began to stabilize in 2019. As of 2020, two new plans have entered the exchange market in Georgia, making six statewide, and premiums have stabilized or even declined in some instances.

An insurance company in the United States must be licensed by the state in which it issues coverage, although the current administration has endorsed proposals to sell insurance across state lines. It is possible for an insurer to issue coverage in one state that covers members that live in another. The Georgia Office of Insurance and Fire Safety Commissioner (OIC) is responsible for the licensing of companies to transact business in Georgia and for ensuring that those companies remain solvent and comply with all the requirements of Georgia laws and regulations. There are separate licensure requirements for certain types of health insurance, such as Health Maintenance Organizations (HMO), including Medicaid managed care plans, and Provider Sponsored Health Care Plans (PSHCP).

Most health insurance offered in the United States today is considered “managed care.” This term generally means a system for financing and, sometimes, delivery, of health care that is intended to control cost, utilization and quality of care. For plans licensed in Georgia, there are a number of state regulations that address the way they can do business, including the time within which the plan must pay claims, late payment interest and rules related to authorizations for services and appeals.

In recent years, the trend has been toward significantly increasing patient cost share amounts for both in- and out-of-network care to the point that the financial responsibility has become unaffordable for many patients and contributes to higher hospital bad debt. In fact, the need to reduce the cost of health care in the U.S. is a major issue in campaigns for the 2020 elections.

Types of Plans

The major differences between the most common types of plans are:

- Health Maintenance Organizations (HMO) are separately licensed and generally have higher financial reserve requirements than other health insurance plans. HMOs often have closed provider networks which means that, except for emergency care, services are covered only when rendered by providers within the HMO network. HMOs may also require that a covered person have a primary care provider coordinate his or her care.
- Point of Service (POS) Plans are typically very similar to HMOs except they will cover care for providers that are not in the plan's network. Many POS plans fall under an HMO license, although they may also be offered by non-HMO health insurers.
- Preferred Provider Organization (PPO) plans do not require separate licenses in most states, although the insurers that use PPOs for their benefit plans must meet licensure requirements. Typically, plan rules are not as stringent for PPOs as they are for HMO & POS plans and out-of-network care is usually, but not always, covered.
- High Deductible Health Plans (HDP or HDHP) combine a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) with medical coverage that has higher deductibles than traditional insurance plans. The HSA or HRA may be funded by either employer or employee contributions, or both, and are designed to encourage patients to be better consumers of care.

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There are many types of managed care plans, although the distinction between types has become more and more blurred over the past few years. All tend to share common characteristics to varying degrees, including:

- **Networks of contracted providers that agree to accept reduced rates for services in exchange for an expected higher volume of patients or the ability to have coverage for patients in some plans;**
- **Requirements for authorization of many services;**
- **Tiered cost-share amounts for prescription drugs;**
- **Scrutiny of medical necessity of care;**
- **Payment policies that may dictate the setting or other prerequisites for coverage of some services; and**
- **Variability in the patient's share of cost for health care services.**
  - **o Some plans may have no benefits for providers not in the network;**
  - **o When covered, cost share amounts are typically higher for lower-tier or out-of-network providers.**
  - **o Regardless of network participation, state and federal law require that emergency care be covered.**
  - **o The ACA requires that specified preventive care be covered in full when provided by in-network providers.**

Plan Billing and Payment

Billing and payment of claims for members of health plans can be very confusing to providers and patients and is determined by contract terms and benefit plan design as well as federal and state law. The degree to which hospitals and other providers can negotiate rates in a managed care contract varies considerably. Efforts to find new ways to reduce medical costs have led insurers to sometimes use "narrow networks," which have a limited choice of providers that are considered in-network, even though other providers have contracts with the same insurance company. A provider must be diligent in verifying eligibility and benefits before rendering non-emergent services to a patient in order to ensure that full insurance benefits will be available.

For providers in a contracted provider network, the patient can be billed only for the patient cost share amount (copayments, coinsurance and deductibles) and for services not covered by the plan, regardless of the "allowed amount" determined by the insurer (which should be consistent with the provider's contract rate). Even then, the provider is often required to obtain the patient's consent prior to rendering non-covered services in order to bill for them.

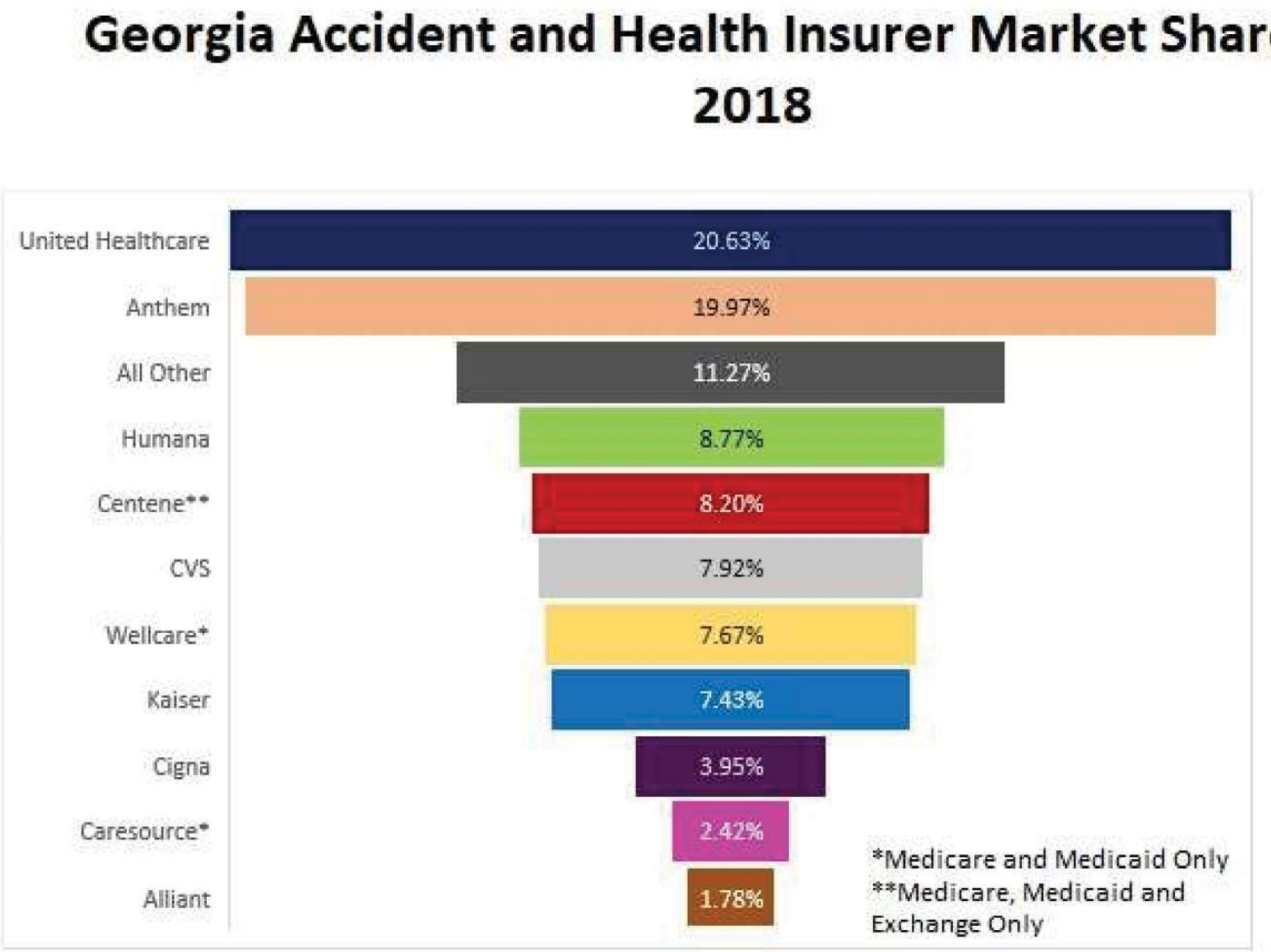
When a provider is not in the plan's network, there is no contract to dictate the amount that the plan must pay or the amount that can be billed to the patient. However, both aspects of the claim may be addressed by federal or state law. Many insurers will set the allowed amount at what they consider to be a reasonable fee for the service and then pay a portion of that at the lower out-of-network percentage. It is called "balance billing" when an in-network provider bills the patient for the discount he or she has agreed to in his or her contract or when an out-of-network provider bills the patient for the difference between the allowed amount and the provider's charges. The latter situation has received a great deal of attention in the media and among legislators recently as the financial burden for patients has increased. It is very likely there will be increasing regulation of the amount paid or the amount billed to the patient in the next few years.

Insurance Industry Evolution

Merger and acquisition activity in the insurance industry took a different turn after the US Department of Justice (DOJ) blocked large consolidation efforts in 2016. While there have been a few mergers of smaller plans, the industry has moved toward more vertical integration with a focus on reducing cost through new opportunities to improve care management and customer experience. CVS and Aetna announced a $69 million merger in December 2017, which was finalized in late 2018. Also 2018, Cigna and ExpressScripts announced a $52 billion deal and Humana and two private equity firms finalized the purchase of Kindred's home health and hospice services unit. Optum, a sister company of United Healthcare, has long focused on vertical integration, acquiring surgery, urgent care and physician practices over the past few years.

The most current market share information published by the National Association of Insurance Commissioners for Georgia health insurers is shown in Figure 11 on page 38.[57]

Figure 11



2. Health Insurance Marketplace

As a requirement of the 2010 Patient Protection and Affordable Care Act (ACA), most U.S. citizens and legal residents were required to have health insurance beginning in 2014. In Georgia, residents can purchase insurance coverage through the federally operated Health Insurance Marketplace. Individuals or families with incomes between 100 percent and 400 percent of the federal poverty level who purchase coverage through the Health Insurance Marketplace are eligible for tax credits, which will help offset their premium costs.

In 2014, 317,000 Georgians enrolled in a Health Insurance Marketplace plan offered by one of five insurers.[58] ***In more recent years, enrollment has been declining after a spike in 2015 (see Figure 12).*** For the 2019 plan year, enrollment was down by 5 percent as compared to 2018 with 458,000.[59] Georgians enrolled in Marketplace plans offered by one of four insurers.[60] Almost one-third of the 2019 enrollees were new to the Marketplace while the remaining enrollees were previously covered by the Marketplace in 2018. A majority of Georgia's 2019 enrollees (88 percent) were eligible for tax credits to help offset their premium costs and 65 percent received cost sharing reductions. On average, available tax credits reduced monthly premiums by $471 per month.[61]

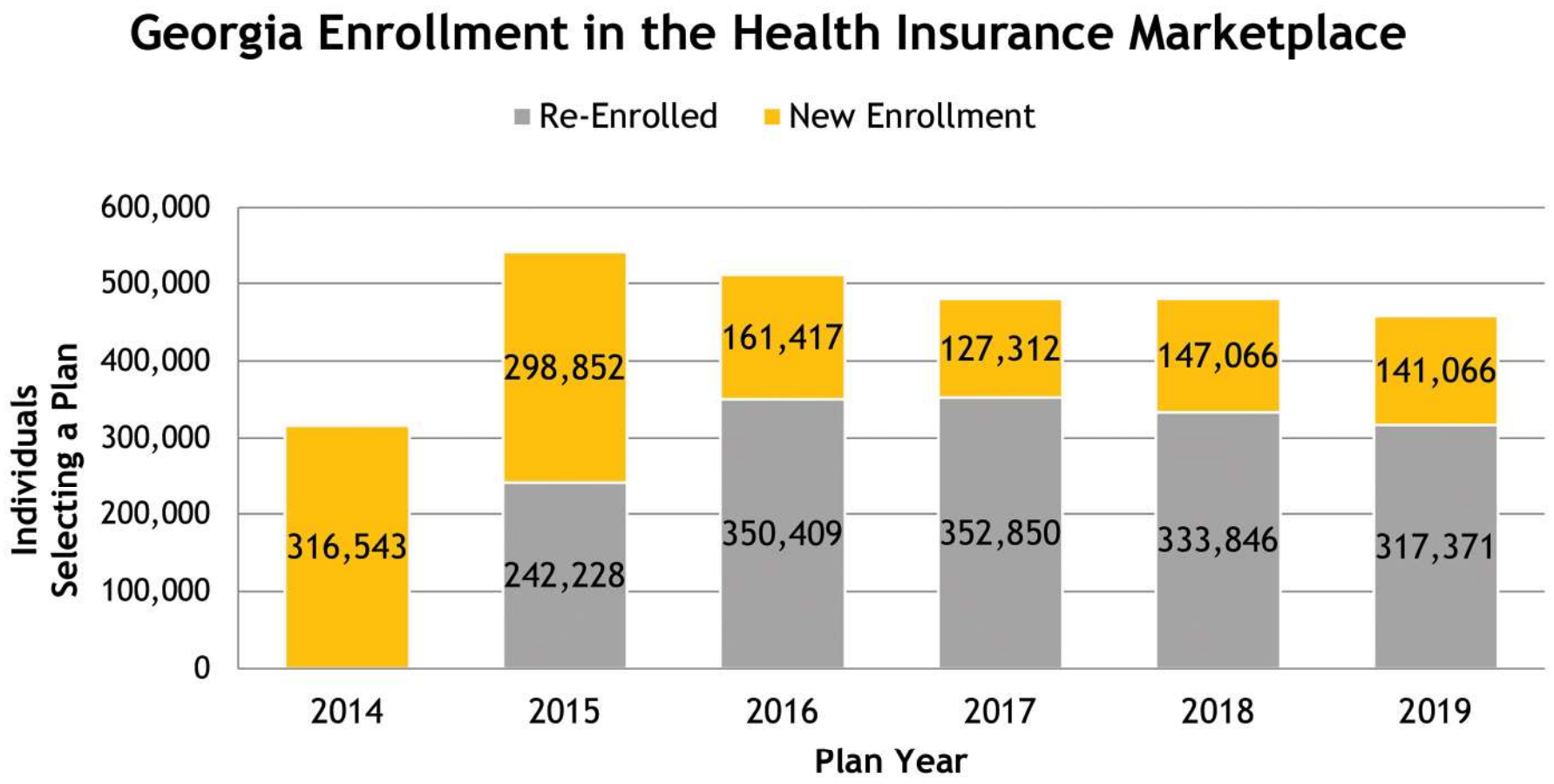
Health Insurance Marketplace consumers in Georgia have access to multiple benefit plan designs offered by different insurers. Insurers do not offer their products in all counties of the state and for 2020, almost 47 percent of the counties in the state must pick from plans offered by only one insurer.[62] Although the federal government operates the Marketplace, the plans are offered by insurance companies licensed in Georgia. All plans are required to offer the same set of essential health benefits but may have different networks of providers. Plans are classified into four categories: Bronze, Silver, Gold, and Platinum. Plan designs differ by the percentage of health care costs paid by the consumer, which range from 10 percent (Platinum) to 40 percent (Bronze).

A consumer's share of the cost is paid through premiums, deductibles, and co-payments or coinsurance. In general, the more a consumer is willing and able to pay each time for a health care service, the lower the plan's premium. For example, premiums for Bronze plans are typically lower than the other plan types; however, the consumer's share of cost is much higher when he or she actually accesses services.

Except for premiums, which are paid to the insurer on a monthly basis, providers must collect the consumer's share of the cost directly from the consumer when health care services are rendered. Consumers who cannot pay their share may be eligible for indigent or charity care, in which case, they may pay a discounted amount or nothing at all. Consumers who can afford to pay but fail to may be subject to the provider's collection efforts. In either case, a consumer's failure to pay the provider for the care received results in increased uncompensated care that must be covered by other payer sources.

In December 2019, the State of Georgia requested approval of a federal Section 1332 Waiver[63] to implement a two-phased approach to address the growing health care access and affordability challenges facing many residents across the state. The Section 1332 Waiver application was designed to reduce premiums, increase coverage, and promote a more competitive private insurance marketplace with the introduction of a state reinsurance program for Plan Years 2021 through 2025 and the Georgia Access Model (a state-operated marketplace in lieu of the federal Health Insurance Marketplace) for Plan Years 2022 through 2025.[64]

Figure 12



3. Self-Insured Employee Benefit Plans

In 2017 in the United States, about 49 percent of people received health care coverage through an employer's benefit plan.[65] Employers that offer health benefits may either purchase insurance from a licensed insurer or set up their own plans in accordance with state and federal law. Sixty-one percent of those in group health plans were in one that was completely or partially self-funded.[66]

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry. The motivation behind ERISA is to provide uniform oversight under a set of national standards for employee benefits. Prior to the passage of ERISA, self-insured employee benefit plans were governed by state insurance law. Employers complained of the high administrative costs associated with maintaining plans that were subject to the laws of multiple states.

ERISA makes the regulation of these plans consistent throughout the country and, under the Supremacy Clause of the U.S. Constitution, pre-empts state laws that "relate to" employee benefit plans. In general, ERISA does not cover benefit plans established or maintained by governmental entities, churches for their employees, or plans that are maintained solely to comply with applicable workers compensation, unemployment or disability laws. ERISA also does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans.

Under self-insured employee benefit plans, the employer or employer organization funds the plan but may have a Third Party Administrator (TPA) or an insurer provide the provider network, care management services and claims processing. For an insurer, this is referred to as an Administrative Services Only (ASO) business. This can be confusing to hospitals because it is difficult to tell whether a patient is covered by a fully insured or an ASO plan. This is important because state law and the plan's rules, including payment policies, may vary significantly between the different types of plans. For example, Georgia law specifies a timely payment period for claims and requires interest on late payment. However, ERISA plans are not subject to these or other provisions Georgia lawmakers have put in place to ensure fair business practices between insurance companies and providers.

In recent years, an increasing number of self-insured, employer-sponsored benefit plans have elected not to enter into contractual agreements with hospitals, either directly or through an established provider network. These plans seek to limit payment for hospital services provided to plan beneficiaries by repricing the services at a plan-determined allowable benefit amount based upon a reference price, or RBP. This amount is typically far below the traditional commercial health insurance payments for the same services.

Generally, a hospital is not required to discount its billed charges absent a written agreement. However, these plans attempt to create a contractual agreement with hospitals by including language on plan identification cards, explanation of benefits (EOB), and/or other documents stating that by accepting the payment, completing the form, or accepting assignment of benefits from the plan beneficiary, the hospital agrees to accept the plan-determined allowable benefit amount as payment in full.

Administrators of these plans will zealously refute the hospital's ability to balance bill the patient for the shortfall and often offer legal counsel to patients to assist in the event of any threat of a collection action. Regardless of the outcome, the patient is placed in the middle of a dispute between the hospital and the plan.

4. Workers' Compensation

In Georgia, state law requires that any employer with three or more regular employees have workers' compensation coverage for disability, rehabilitation and medical care for a worker who is injured on the job. Georgia law allows employers to require injured employees with a non-emergent condition to obtain treatment from designated providers as long as the employer has followed state law regarding notice to the providers. That may be done through either prominently posting (1) a list or panel of providers or (2) a Workers' Compensation Managed Care Organization (WC/MCO) certified by the Board.

While workers' compensation is highly regulated by state law, the coverage for disability, rehabilitation and medical services is typically provided by property and casualty insurance companies or self-insured employers. Coverage of an injured worker's care may be contingent on both the employee and the employer following the rules promulgated by the Georgia State Board of Workers' Compensation. The Board publishes an annual Medical Fee Schedule that sets the rates for hospital and physician payments. Inpatient payments depend on the patient's diagnosis and treatment, much like Medicare rates. Additional payment is made for implanted devices based on the device's cost.

Because workers' compensation has its own statutory requirements, it is generally excluded from any legislative provisions enacted with respect to other insurance plans or health plans. In Georgia, state law requires that any employer with three or more regular employees have workers' compensation coverage for disability, rehabilitation and medical care for a worker who is injured on the job.