



KIM HOLLAND
OKLAHOMA INSURANCE COMMISSIONER
P.O. BOX 53408, OKLAHOMA CITY, OK 73152
(405) 521-2828 www.oid.ok.gov

HUB CREDENTIALING TEAM

BASIC HUB COURSE OUTLINE

General Medical Insurance

1. Define plans available such as HMO, PPO, Traditional, HSA, Limited Medical, Short Term Medical, specified disease and critical illness, etc.
2. Role of the agent in the sales, underwriting and in-force servicing of the business (including recognition that agent is the agent of the insurer; broker is the agent of the insured)
3. Carriers, TPA's, reinsurers and General Agents and their various roles.
4. Carrier Financial ratings, i.e. AM Best, S&P, Weiss
5. Child rates: vary by carrier on how it's done. Some per child with no cap, others offer flat child rate no matter how many children are insured.
6. Copays and the variety of ways they work
7. Coinsurance options
8. Out-of-Pocket maximum versus stop loss (deductible included or not; copay portion considered out of pocket)
9. Family deductibles and out-of-pocket maximums
10. In and out of Network charges and deductibles; balance billing
11. Determination of usual, customary and reasonable for out-of-network.
12. Lifetime and calendar year maximums
13. Eligible and ineligible expenses, including limitations and exclusions
14. Definition of a sickness versus an injury
15. Inpatient and out-patient charges
16. PPO Networks
17. Dependent eligibility rules
18. Definition of grace period
19. Extension of benefits
20. Wellness/preventive benefits that are not mandated are not covered unless the benefits are included in the plan. Some plans include wellness, others it's an option to purchase.
21. Supplemental Accident Benefits
22. Last quarter carryover---deductible and/or coinsurance
23. Well baby care
24. Sterilization benefits

25. State mandates are different on group and individual products.
26. 24 hour coverage for owners, officers and partners. Some carriers charge for this and others include it in their rates. If a carrier charges premium for this benefit and the employer elects to not buy the option, work related claims are not covered.
27. Rate guarantees, initial and renewal, vary by carrier.
28. Pre-existing conditions clause
29. Pre-certification, utilization review, verification of benefits, second opinions and pre-admission testing
30. Coordination of benefits
31. Overview of subrogation
32. Underwriting process: age of app, what paperwork is needed to submit a case, premium check payable to carrier (not agent), etc.
33. ID and Rx cards
34. Effective dates and termination dates
35. Define Coinsurance

Employer Group Medical Insurance

1. Definition of a small employer group of 2-50 lives. The Carriers typically use the OK State Quarterly Wage and Contribution Report (OES-3) information to determine what size the group is.
2. Educate agents on Small Group Reform regulations, some of which are listed below.
 - a. Management Carve-outs, or not making the plan available to all employees if they work the minimum amount of hours to be eligible, is not allowed.
 - b. Maximum medical load is 67%, and that the medical history in the group determines the medical load and final rate.
 - c. Groups are guaranteed issue, they cannot be declined due to medical history.
 - d. Groups can be declined if they do not meet the carrier's participation, employer contribution requirements, or other non-medical underwriting requirements.
 - e. Employee Eligibility: Number of hours an employee must work to be eligible. Discuss 24 hour per week requirement versus the newly passed hourly requirement law.
3. Benefits cover services in and out of the hospital. A list of exclusions will apply. OK state mandates are covered. Educate agent on what the mandates are and how they work (i.e. if ded, copay or coinsurance apply, or if it's a 100% first dollar benefit, and if there is a maximum benefit amount).
4. Creditable Coverage rules. Here are some examples:
 - a. What types of prior coverage are considered creditable coverage, i.e. individual, group, IHS, Medicaid

- b. 63 day gap rule and how it coordinates with the date of employment, not the effective date of coverage.
5. Pre-existing conditions clause definition, and late enrollee pre-ex clause of 6/18/18. Some carriers have annual open enrollment; others allow late enrollee to come on the plan with the longer pre-ex clause.
6. Waiting Period for new employees
7. Seasonal and temporary employees may be excluded from eligibility.
8. 1099s are eligible if the carrier allows it. Varies by carrier.
9. Dependent eligibility rules
10. Employee and Dependent participation rules vary by carrier.
 - a. Break this out by dependents – define same sex, common law, what Oklahoma Law is, qualifying events.
11. Employer contribution rules vary by carrier. But the employer must contribute something, most common not less than 50% of the employee premium.
12. Rate guarantees, initial and renewal, vary by carrier.
13. Extension of benefits
14. Explain that some carriers don't have pre-ex and some do and what that means (this would include the 63 day HIPAA provision)
15. Credit for deductibles
16. Medicare is Primary on 2-19 lives and secondary on 20+ lives.
17. Conversions
18. Certificates are issued from a Master Policy
19. Maternity benefits. Optional versus built into the product based on carrier. Required to be covered as any other illness on 15+ groups.
20. Maternity, adoption, and birth are not considered a pre existing condition.
21. MET's, PEO's and MEWA's.

Individual insurance

1. All Comprehensive plans are medically underwritten not guaranteed issue.
2. Explain that you can be declined.
3. Carriers base rates on age, gender and residence zip; by county; and if tobacco products were or are being used.
4. Some carriers decline, some carriers offer exclusion riders, some carriers rate up for medical conditions, and some carriers offer condition-specific deductibles in lieu of an exclusion rider.
5. Importance of submitting applications to carriers correctly
6. Explain commissions.
7. Regulations in OK
8. Direct vs. through an agent
9. Define plans available such as PPO, HMO, HSA, Limited Medical and Short Term Medical
10. Benefits variations
11. Licensed to do business in Oklahoma

12. Specified illness—limited benefit products: minimum benefit standards for these are set out in regulation.

Comprehensive Individual Major Medical Plans

1. Contracts can be filed on an individual or as an association group plan. Individual policies have free look period, whereas association group plans typically do not have a free look period.
2. Benefits include all OK state mandates. Educate agent on what they are and how they work (i.e. if ded, copay or coinsurance apply, or if it's a 100% first dollar benefit, and if there is a maximum benefit amount).
3. Typically they are fully underwritten to determine if the offer is a preferred or standard rate, a rate up, a condition specific exclusion rider, condition specific deductible or decline.
4. Oklahoma Confirmation of Source of Payment: Employer cannot pay any portion of the premium. Client signs on the application or separate form stating this, and premium reimbursement cannot happen through payroll reimbursement.
5. How should an agent handle the Oklahoma Confirmation of Source of Payment requirements when the current carrier is not enforcing it? It's a delicate subject an agent runs into when working with clients.
6. Confirmation of Sole Employee Entity for sole proprietors. Form is required when a sole proprietor writes a business check for its premium. Discuss how this is different than the OK Confirmation of Source of Payment for employees.
7. List billing allowed through an employer, but only if the employer is payroll deducting 100% of the premiums from the employees' paychecks. The employer is not allowed to contribute any part of the premium.
8. HIPAA Eligibility and how it works.
9. There is no creditable coverage when moving from group coverage to individual coverage.
10. Time frames for pre-existing condition clauses vary by carrier. Medical history revealed on the application and not excluded may or may not be covered during the pre-ex period; it varies by carrier.
11. Applicant and Dependent Eligibility
12. 24 hour coverage for owners, officers and partners. Some carriers charge for this benefit and others include it in their rates. If a carrier charges premium for this benefit and the applicant elects to not buy the option, work related claims are not covered.

Insure Oklahoma Employer Sponsored Insurance--- Insure Oklahoma

1. Discuss what the program does and from where the funding comes. At some point there will be a limit on the number of groups receiving subsidy due to funding limitations.
2. Website: www.insureoklahoma.org
3. Agents can become qualified by taking a CE course provided by the OHCA and meeting the criteria to become a Qualified Agent.
4. Provide Oklahoma Health Care Authority and EDS contact information, and who you go to for what types of questions. 1-888-365-3742 option 2.
5. Carriers have the same underwriting and administrative rules on Insure OK cases as they do with non-Insure OK cases. This element does not change from that perspective. Develop best practice approaches within their Agency-develop working relationships with Carriers and Reps.
6. Carrier pays the agents the same commissions as non-Insure OK cases.
7. Employer eligibility for Insure OK
 - a. Employers with multiple locations or tax ids, when they don't file payroll taxes with the state what is needed and other situations that may arise that are not published on the website.
8. Employee eligibility and annual re-approval process for Insure OK subsidy. Income requirements apply.
9. The timing and coordination of getting the Group Medical Plan approved, the employer doing the application and when the employees do their applications. The agent must understand what needs to be done in what order.
10. QHP requirements: Only the plans on the website can be sold/implemented; not plans an agent may think meets the QHP requirements.
11. Employer/Employee/Subsidy
12. How to make changes for terms and adds.
 - a. Teach the group contact to submit monthly New Hires and Terminated Employees by using the Small Business Change Form (from the website)..
 - b. Add new Hires in order to get their PIN to enroll
 - c. Remove terminated ees from their former ER rosters so they can re-enroll in their new ER's plans (if they have IO).
13. Explain that Insure Oklahoma is separate from Group Health Plan or Individual Health Plan and how each option works.
14. Reimbursement
 - a. How it works and how long it lasts
 - b. ESI is reimbursed only after the ER is approved, employees enrolled and approved, and the carrier monthly invoice is received.
 - c. Payout is only made when the invoiced rates match the system built rates submitted with the ER paperwork
15. Insure OK subsidy is for employees, spouses, college students and out-of-pocket expenses.

16. Children are not eligible for subsidy. The children of parents who qualify for subsidy will typically be eligible for Soonercare.

Insure Oklahoma---Individual Plan

1. Agents do not sell this plan. It is available directly to the public via the OHCA.
2. Eligibility Requirements
3. Income Requirements apply and are designed for people with family incomes of 200% or less of the federal poverty level. Income levels vary based on the size of the family and if anyone is self employed.
4. Premium is capped at 4% of the monthly gross household income.
5. IP will reimburse for out-of-pocket expenses upon receipt of the proper forms and once the family has spent 5% of their annual gross household income.
6. Basic benefits are available with copays. Not a comprehensive plan.
7. College student coverage
8. No medical underwriting/guaranteed issue/no pre-ex exclusions
9. An agent can use this plan as a service to offer if the prospect is not economically able or medically able to have an individual policy written. The agent can give each prospect the brochure or 1-888 number, and the prospect can contact OHCA.

SoonerCare

1. What is SoonerCare? Include various programs available.
2. General eligibility to qualify for Sooner Care?
3. Application Process: where to go for assistance with eligibility and application assistance. Including Local DHS office, Dr.'s office and on www.okhca.org.
4. What does SoonerCare cover? Including schedule of benefits and plan design.
5. Network of Providers? Available on OHCA website.
6. When is the individual eligible/effective?
7. How long does the coverage last?

Medicare

1. Medicare eligibility, under and over age 65
2. Medicare Part A and B benefits
3. Medicare Advantage Plans (Part C)
 - a. Product and marketing regulations are under CMS jurisdiction.
 - b. Initial 8 hour CE course, with 4 hour biannual CE course required to sell these products.

- c. Annual certification courses required for each carrier for each product being sold, which includes marketing regulations is required for all agents selling MA products.
 - d. Product types available: HMO, Private Fee for Service (PFFS), PPO and POS
 - e. General differences in the products
 - f. Underwriting: GI except if person has ESRD and must have Part A & B.
 - g. General Plan designs: no deductibles, have copays and coinsurance. Some plans have maximum out-of-pocket expense, but not all.
 - h. Pre-existing conditions covered
4. Part D Plans
- a. Product and marketing regulations are under CMS jurisdiction.
 - b. 8 and 4 hour CE course requirement does apply to selling Part D.
 - c. Annual certification courses required for each carrier for each product being sold, which includes marketing regulations is required for all agents selling Part D products
 - d. Eligibility for over and under 65, and Part A and/or B requirement.
 - e. Penalty for not enrolling
 - f. No medical underwriting
 - g. Pre-existing conditions covered
 - h. Standardized plan design from the Feds, and what the general plan variances are in the market place.
 - i. Formulary lists
5. Medicare Supplement Plans
- a. Standardized Plans
 - b. Initial open enrollment time frame
 - c. Underwriting
 - d. Pre-existing clause
6. Basic Knowledge of Group Medicare Supplement

Medicare Part A pays for:

Hospital Stays

Hospital stays are covered under Medicare Part A. This includes:

- A semi-private room
- Meals
- Nursing
- Hospital services and supplies
- Inpatient mental health care (lifetime limit of 190 days)

Skilled Nursing Facility Care

After a three-day related hospital stay:

- Semi-private room
- Meals
- Skilled nursing
- Rehabilitation (such as physical therapy)

Other services and supplies

Skilled nursing facility care is not the same as long-term nursing home care.

Medicare Part A does not cover long-term nursing home care.

Home Health Care

Home health care benefits include:

Part-time or intermittent skilled nursing care

Home health aide services

Physical and occupational therapy

Speech therapy

Medical social services

Durable medical equipment (wheelchairs, walkers, etc.)

Hospice Care

Hospice care is for people with a terminal illness. It covers:

Doctors' services

Nursing care

Durable medical equipment (wheelchairs, walkers, etc.)

Medical supplies (bandages, catheters, etc.)

Drugs to control symptoms

Drugs for pain relief

Short-term hospital care

Short-term respite care (although this requires a small co-payment)

Home health aide services

Homemaker services

Physical and occupational therapy

Speech therapy

Social worker services

Dietary counseling

Grief and loss counseling for you and your family

Hospice care is usually given at home, but Medicare will cover "respite care." Respite care is a short-term stay at a hospice facility. This gives the usual caregiver a chance to rest. Respite care may last up to five days at a time. There is no limit to how many periods of respite care hospice patients may have.

Medical supplies

Blood

You pay for the first three pints of blood.

Unless You or someone else you know donates three pints of blood.

Medicare Part B pays for:

Medical and Other Services

Doctors' services (including office visits, but not routine physical exams)

Outpatient medical and surgical services and supplies

Diagnostic tests

Ambulatory surgery center facility fees for approved procedures

Durable medical equipment (such as wheelchairs, walkers, etc.)

Second and sometimes third surgical opinions

Outpatient mental health care

Outpatient occupational and physical therapy

Speech therapy

Laboratory and Radiology Services

Clinical lab services are covered, including:

Blood tests

Clinical diagnostic tests
X-rays, CT scans, MRI scans, and EKG tests
Urinalysis
Some routine screening tests (see Preventive Services)

Outpatient Hospital Services

Medicare Part B covers services and supplies you get while being treated as an outpatient in a hospital

Blood

Pints of blood you get for transfusions are covered.

Preventive Services

Medicare covers the following preventive services:

Service How Often Who Can Get It

Bone mass measurements (to look for bone thinning osteoporosis) Once every two years (or more if needed) People at risk of osteoporosis

Cardiovascular Screening Blood Tests (including tests of cholesterol, lipids, triglycerides, and other markers of cardiovascular disease) Every 5 years.

Colorectal Cancer Screening (includes one or more of the following tests: colonoscopy, fecal occult blood test, flexible sigmoidoscopy, and/or a barium enema.

Diabetes Screening Tests (tests of blood glucose levels)

Digital rectal exam (a prostate cancer screening test) Once a year Men aged 50 and older

Flu shot (vaccination) Once a year in fall or winter Everyone

Glaucoma testing (a vision-robbing condition) Once a year People who are at high risk of glaucoma.

Hepatitis B shot (vaccination) N/A Certain people at risk for Hepatitis B

Mammogram Once a year All women aged 40 and older

Pap test and pelvic exam, includes breast exam Once every two years; or once a year if you are at high risk All women

Pneumonia shot (vaccination) Ask your doctor Everyone

Prostate Cancer Screening (digital rectal exam and PSA test) Once a year Men aged 50 and older

"Welcome to Medicare" Physical Examination (includes measurements of height, weight, blood pressure, an EKG, education and counseling.) One time only Everyone whose Part B coverage began after January 1, 2005

Not Covered by Medicare A or B

With a few exceptions, these things are not covered by Medicare Parts A or B:

Prescription drugs (Medicare Part D will cover drugs starting in 2006)

Long-term nursing home care, if you only need help with daily activities

Cosmetic surgery

Acupuncture

Hearing aids and hearing exams

Eyeglasses and eye exams

Foot care

Diabetic insulin and syringes - will be covered under Part D

Health care outside the United States

Dental care and dentures

Routine or yearly physical exams (If your Part B coverage begins on or after January 1, 2005, Medicare will cover a one-time only physical exam within the first 6 months of coverage.)

Custodial care (help with bathing, dressing, eating, and using the bathroom)

Orthopedic shoes

(CHART of Plans A-L)