

Disability Rights Legal Center



Cancer Legal Resource Center

**Cancer Legal Resource Center**

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*The CLRC is a joint program of the Disability Rights Legal Center & Loyola Law School*

## Health Insurance in Arizona

### Types of Private Health Insurance

#### Group vs. Individual Insurance

*Group insurance* is usually offered through your employer or some form of a trade association (ex. a union, etc.). *Individual insurance* means that you are contracting directly with an insurance company (ex. when you purchase a plan from Blue Cross or Blue Shield, etc.). People who purchase group or individual health insurance plans are called “members” of that insurance company.

#### HMO, PPO, and POS Plans

There are three types of managed care plans. There are HMO, PPO, and POS plans.

*HMO* stands for a health maintenance organization. There are generally two forms: 1) independent physician associations (IPAs), and 2) stand alone facilities. IPAs have physicians that practice in their own offices and sometimes join with other providers to form a medical group.

*PPO* stands for Preferred Provider Organization. A PPO is a group of health care providers who have agreed to provide services to an insurance company’s members at a reduced rate.

*POS* stands for Point of Service Plan. A POS Plan is a cross between an HMO and a PPO. Members of a POS plan decide which type of service they want to use at the point when they are ready to use it.

HMO	PPO	POS
Participating doctors and hospitals. Generally have a primary care physician who coordinates care	Usually many health care provider and hospital choices	Can see providers in- or out-of-network
HMO	PPO	POS
Generally have to select doctors and hospitals from within the participating group	Can select from all participating providers	If selecting within network, generally have a minimal co-pay. If selecting from larger group, member will pay more
Limited choices	More choices in doctors, specialists, overall providers	More choice when needed
Usually less expensive	Usually more expensive	Cost is between that of a PPO and an HMO

## What to consider when choosing a health insurance plan

- 1) Look at the summary of *benefits*. What benefits are included? What benefits are excluded?
- 2) Look at *costs*. How much are the monthly premiums, annual deductibles, and co-payments?
- 3) When are the *enrollment periods*? Do they offer annual open enrollment periods to make changes to your policy?
- 4) How much *flexibility* do they offer? Can you change plans if you need to? How?

Health insurance companies are required to renew an individual's existing health coverage, but there is no cap on the rate increases companies may impose at the time of renewal. This is called guaranteed renewability. Guaranteed renewability is not portable, so you do not have the right to switch to another company or even another product offered by the same company.

## **Ways to Get and Keep Health Insurance**

### Employment-Based Health Insurance

The most common way that people obtain health insurance coverage is through their own employment or a family member's employment. There are certain rights that are guaranteed to people who are insured through their own or a family member's employment. These rights have to do with the continuation of coverage during certain leaves of absence (under the Family and Medical Leave Act) or upon termination of employment (see COBRA, discussed below). Persons with employment-based health insurance are also protected from health insurance discrimination based on their pre-existing conditions under the Health Insurance Portability & Accountability Act (see HIPAA, discussed below).

### COBRA

COBRA is a federal law that allows you to continue the same health insurance coverage that you had through your or your family member's employer. It's the same health insurance policy you had when you were employed, so you don't have to worry about changing providers.

COBRA is available to an employee or family member after an employee has terminated their employment or has reduced their work hours to a point that they are no longer eligible to receive coverage from their employer. This termination or reduction in hours is referred to as a "qualifying event." Other qualifying events for COBRA are divorce or death of a spouse (when the person seeking COBRA coverage was insured by a plan provided through the spouse's employment), or a child aging out of a parent's health insurance policy.

Federal law defines the terms of COBRA coverage and its availability as follows:

- COBRA applies to employers with 20 or more employees.
- COBRA coverage generally lasts for 18 months.<sup>1</sup>
- The cost of the monthly premium paid by the employee can be up to 102% of what the employer was paying for the same benefits.
- The person insured is responsible for the full premium for the coverage.
- Who is responsible for notifying the health plan of the qualifying event depends on which qualifying event has occurred.
- A health plan has 14 days after the plan administrator is notified of the qualifying event to notify the employee of the right to elect COBRA.

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<sup>1</sup> COBRA coverage can last up to 29 months if the person insured has a qualifying disability, or up to 36 months if the person became eligible for COBRA coverage because of certain qualifying events or a combination of qualifying events.

- An employee must elect COBRA within 60 days after being notified of their COBRA rights. The employee then has 45 days after electing coverage to pay the initial premium.

If you elect COBRA coverage, you will have to pay the premiums for each month since you became eligible. So, even if you wait until the last day of your eligibility to elect COBRA coverage, you will still have to back-pay the premiums to the date your eligibility began.

### Health Insurance Portability & Accountability Act (HIPAA)

HIPAA prohibits health insurance discrimination against individuals based on their pre-existing conditions, when going from a group health insurance plan to another group health insurance plan or from a group plan to a HIPAA guarantee issue plan.

HIPAA also: 1) provides a federal right to an individual health insurance plan (called a guarantee issue plan); 2) reduces the maximum pre-existing condition exclusion period to 12 months; and 3) gives you credit for the time that you had health insurance coverage in the past to eliminate or reduce a pre-existing condition exclusion period.

### *Guarantee Issue Plan*

Normally when you apply for an individual health insurance plan, you are required to go through a process called medical underwriting. During this process, the insurance company looks at your past and current medical condition in order to decide whether or not they want to issue you a health plan. If you currently have, or in the past have had, a serious medical condition, the insurance company will likely decide that it is not worth the risk to them to issue you a health plan, and they will deny you coverage.

A guarantee issue plan, also known as a “federally insured plan” or “HIPAA plan,” is an individual health insurance plan that you have a right to purchase under federal law. A HIPAA plan isn’t a specific plan – it’s just a right to purchase an individual plan. In Arizona, any insurer that offers individual health insurance plans in the state is required to offer at least two HIPAA plan options. For information on where you can purchase a HIPAA plan in Arizona, contact the Arizona Department of Administration, Statewide HIPAA Coordinator at (602) 542-7770.

A HIPAA plan is different than COBRA coverage. Under COBRA, you keep the same health insurance you had through your employer. Under HIPAA you are buying new insurance, so you need to compare all of the available plans and pick the one that is right for you. Compare the premiums, deductibles, and co-payments. Check to make sure your healthcare providers accept any insurance plan you are considering, and check to make sure that your prescription drugs are on the formulary list of drugs covered by the plan.

You must meet the following requirements to be eligible for a HIPAA plan:

- You must exhaust your COBRA coverage, meaning that you use all 18 months of COBRA coverage, and any additional COBRA coverage available to you.
- You cannot have a break in coverage longer than 63 days.
- You must be ineligible for Medicare, Medicaid, or any other form of group coverage.

### *Pre-existing Condition Exclusion Period (PECEP)*

When you are going from one employer’s group health plan to another employer’s plan, the new plan is required to insure you, but they can impose a PECEP, which means that for a certain period of time, they will not cover any treatment or services related to a pre-existing medical condition. Before

HIPAA, a two-year PECEP was the industry standard. HIPAA limited the maximum PECEP that may be imposed to one year.

### *Creditable Coverage*

Creditable coverage is any previous period of health insurance coverage that was not interrupted by a break in coverage of more than 63 days. HIPAA reduces any PECEP by the length of time that you previously had creditable coverage. Example: If you previously had coverage for four months, have not had a break in coverage of more than 63 days, and your new insurance plan has a PECEP of 12 months, then you get a credit for your 4 previous months of coverage, leaving you with only 8 months left on your PECEP. So, if you have 12 months or more of previous health insurance coverage, and you never have a break in coverage of more than 63 days, you will never face a PECEP.

Almost all types of health insurance can qualify as creditable coverage. (Medicare, Medicaid, group, individual, COBRA, and HIPAA plans can all qualify.) One exception is student health insurance plans because they are not typically a full policy with catastrophic coverage. If a particular condition was not covered by the policy that you are claiming as creditable coverage, then your new health plan may still subject that condition to a PECEP.

To show that you have creditable coverage, call your insurance company to request a “certificate of creditable coverage,” which lists the dates that you have been insured by that company. If you have been insured by multiple companies, you need certificates of creditable coverage from each one.

### **Handling Health Insurance Disputes**

If you disagree with a decision that your health insurance provider has made regarding coverage, you have the right to appeal that decision. The appeals process varies depending on what state you live in. In Arizona, you must first exhaust your health plan’s internal appeals process, and then you can request an external review of the decision.

#### *Internal review*

This is the health plan’s own review of its decision. There are state and federal laws and rules that apply to internal review processes.

#### *External or independent review*

This is a reconsideration of the health plan’s determination by an outside, independent organization. In Arizona, reviews are conducted by the Arizona Department of Insurance.

#### Before you begin an appeal, understand your coverage and applicable laws.

An *employer-sponsored* health plan is one that a person can get through their own employment or through a family member’s employment. The employer usually makes a contribution toward the cost of the employee’s coverage. An *individually-purchased* plan is one that you purchase directly from a health plan. The person purchasing the insurance pays the entire premium. Different laws apply depending on whether your plan is employer-sponsored or individually-purchased.

If your plan is an employer-sponsored plan, you need to know whether it is a *self-insured* plan. A self-insured plan is one in which the employer does not contract with an insurance company to insure their employees. Instead, the employer does their own risk pooling like an insurance company would, and pays directly for their employees’ health costs. Since self-insurance does not involve a contract between an insurance company and an employer, it is not subject to state insurance regulations. Federal laws still apply to self-insured plans.

Know *what is covered* and what is not covered by your plan. Also know what *procedures* and *deadlines* are required by your plan.

Next, exhaust your plan's internal complaint process.

*For urgently needed services that have not yet been provided:*

Expedited Medical Review: This option is only available if your doctor certifies in writing that delaying your health care could cause you significant harm. Your insurer has one business day to make a decision and notify both you and your doctor of the decision in writing.

Expedited Appeal: If you wish to appeal the result of the Expedited Medical Review, your doctor must submit an appeal to your insurer in writing. This written appeal should include any additional justification or support documents relating to the service you are requesting. Your insurer has three business days to make a decision and notify both you and your doctor of the decision in writing. If you wish to appeal this decision, you may request an external review.

*For standard services or denied claims (denied claims are services you have received, but your insurer is refusing to pay for):*

Informal Reconsideration: You have two years after your insurer denies your coverage to request an Informal Reconsideration. You may request this by calling, faxing or writing your insurer. Your insurer then has 30 days to render a decision. An insurance company may also opt to skip the Informal Reconsideration stage and move directly to the Formal Appeal.

Formal Appeal: You have 60 days after an Informal Reconsideration to file a Formal Appeal, or two years after the last denial if your insurer requires you to begin with the Formal Appeal. For denied services, your insurer has 30 days to make a decision. For denied claims, your insurer has 60 days to make its decision. If you wish to appeal this decision, you may request an external review.

Then, you may request external review.

*For urgently needed services that have not yet been provided:*

Expedited External Independent Review: You have 5 days after your Expedited Appeal is denied to request an Expedited External Independent Review. Your insurer then has one day to send all of your medical and supporting documents that it used to make its denial to the Arizona Department of Insurance.

For cases involving a question of medical necessity, the Department of Insurance will send your materials to an independent reviewer that is not affiliated with your insurer or doctor within two business days. The independent reviewer then has five business days to make a decision on your file, and the Department of Insurance has one business day to notify you and your insurer of the decision. Your insurance company will pay for the cost of this independent review.

For denials based on a question of whether the treatment you seek is covered under your insurance policy, the Department of Insurance will conduct the review and notify both you and your insurer of its decision within two business days.

*For standard services or denied claims (denied claims are services you have received, but your insurer is refusing to pay for):*

External Independent Review: You have 30 days after your insurer has notified you that your Formal Appeal was denied to request an External Independent Review. Your insurer has five days to send

all of your medical and supporting documentation used to make the earlier decision to the Department of Insurance.

For cases involving a question of medical necessity, the Department of Insurance will send your materials to an independent reviewer that is not affiliated with your insurer or doctor within two business days. The reviewer then has 21 days to notify the Department of its decision, and the Department then has five business days to notify you and your insurer of the reviewer's decision. Your insurance company will pay for the cost of this independent review. This External Independent Review is legally binding, but in cases involving a question of medical necessity, either your insurer or you may go to court to dispute the decision.

For denials based on a question of whether the treatment you seek is covered under your insurance policy, the Department of Insurance will conduct the review and notify both you and your insurer of its decision within 15 business days. If the Department is unable to make a decision, it will send your file to an independent review organization that then has 21 days to make a decision. The Department will then notify you and your insurer of the outcome. This External Independent Review is legally binding, but in cases involving a question of coverage, either you or your insurer may request a hearing with the Office of Administrative Hearings.

Please note, the Department of Insurance and the Office of Administrative Hearings cannot require an insurer to pay a claim or provide a service that is excluded from coverage by your policy.

## Resources in Arizona

For Assistance With Insurance Disputes

### **Arizona Department of Insurance**

2910 North 44<sup>th</sup> St., Suite 210

Phoenix, AZ 85018-7256

(800) 325-2548 or (602) 364-2499

<http://www.id.state.az.us/consumer.html>

For Questions About COBRA

### **U.S. Department of Labor**

Employee Benefits Security Administration

(626) 229-1000 or (866) 275-7922

<http://www.dol.gov/ebsa/>

For Questions About HIPAA

### **Arizona Department of Administration**

Statewide HIPAA Coordinator

100 N 15th Ave, Suite 401

Phoenix, AZ 85007

(602) 542-7770

For Assistance for Children

### **AHCCCS KidsCare**

(602) 417-5437 or (877) 764-5437

<http://www.azkidsicare.gov/>

For Questions About Medicaid

### **AHCCCS: Arizona Health Care Cost Containment System Administration**

801 East Jefferson Street

Phoenix, AZ 85304

(602) 417-4000 or (800) 654-8713

<http://www.azahcccs.gov/>

For Questions About Medicare

### **Arizona Medigap Information and Referral**

(800) 432-4040 or (602) 542-6595

<https://egov.azdes.gov/cmsinternet/intranet.aspx?menu=28&id=2466>

### **U.S. Department of Health & Human Services**

Centers for Medicare & Medicaid Services

(800) 633-4227

[www.medicare.gov](http://www.medicare.gov)

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