

Disability Rights Legal Center



Cancer Legal Resource Center

**Cancer Legal Resource Center**

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## Health Insurance in Colorado

### 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.
- 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.

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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.

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.

### Colorado State Continuation Coverage

Colorado has a state version of COBRA which does essentially the same thing as federal COBRA. It lets you keep your health insurance when you experience a “qualifying event.”

Colorado state law defines the terms of their continuation coverage and its availability as follows:

- Colorado state continuation coverage applies to employers of any size who offer group coverage and are not subject to COBRA
- Colorado state continuation coverage lasts for a maximum of 18 months.
- Individuals or their dependents must have 6 months of continuous coverage under the group policy to be eligible and have 30 days from termination date to accept coverage continuation.
- The cost of the monthly premium paid by the employee is 100% of what the employer was paying for the same benefits.
- Colorado state continuation coverage does not apply to self-insured plans or federal plans.<sup>2</sup>

### Health Insurance Buy-In (HIBI) Program

Colorado has a program called the Health Insurance Buy-In Program. If you qualify for Medicaid and have private health insurance coverage, you may be able to get your premiums paid for through the HIBI program as an alternative to receiving Medicaid insurance. For more information contact the Colorado Department of Health Care Policy and Financing.

### 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.

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-

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<sup>2</sup>Some employers do not contract with an insurance company to insure their employees, but they have enough employees to do risk pooling like an insurance company would. These employers are “self insured.” Since self insurance does not involve a contract between an insurance company and an employer, it is not subject to state insurance regulations.

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.

For more information about HIPAA contact the Colorado Department of Insurance

### *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.

CoverColorado is a state-run insurance health plan available to persons that are eligible for HIPAA plans and persons who cannot obtain health insurance due to their pre-existing medical conditions.

Eligibility Requirements:

- You must be a legal resident of Colorado for at least 6 months prior to applying for coverage, unless you are HIPAA eligible or transferring from another state's high risk insurance pool
- You cannot be eligible for Medicaid, Medicare or any other health insurance
- If you have health insurance coverage and you have exceeded the amount allowed for a particular benefit or you have coverage that does not include a particular benefit (ex: prescription drug coverage) you are not eligible for CoverColorado. CoverColorado is not a supplemental to other health plans
- You cannot have been terminated from CoverColorado in the 12 months prior to your application or have received \$1,000,000 in benefits from the CoverColorado program; unless you are HIPAA eligible
- Inmates or residents of public institutions are not eligible for CoverColorado

If you have not been insured within the past 90 days prior to applying for CoverColorado, expenses related to any pre-existing medical condition will not be covered for the first 6 months that you are enrolled. This includes prescriptions. If you have been insured, for at least six continuous months, within 90 days of application to CoverColorado, you will not be subject to the 6-month pre-existing waiting period.

## **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 Colorado, insurance companies must have a two-level appeals process, followed by the right to an independent external review.

### *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. In Colorado, you must first exhaust your health plan's internal appeals process, and then you can request an external review of the decision.

### *External or independent review*

An external appeal is a request that you make to the state for an independent review of a denial of services by your insurance carrier. In Colorado, reviews are conducted by the Colorado Division 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.

If you have a problem with your health plan, you have the right to file a complaint with your health plan. A complaint can also be called a grievance or an appeal. You may be able to file your complaint by phone, mail, or on the internet.

Colorado has a two-level appeal system. A first level review may be requested within 180 days of receiving an adverse determination from your health plan. This first level of review is conducted by a doctor in clinical peers, none of whom were involved in the original denial. The plan has 30 days to notify you in writing or e-mail of its decision. You can submit written comments, documents and any material you wish but cannot attend the review.

If you are not satisfied with the decision after the first level of appeal, you have the right to a second level of appeal. You must file a request for a second appeal within 30 days of receiving the adverse decision of

the first appeal. A review meeting will be held within 60 days of receiving your request. At this meeting you have the right to be represented by an attorney and present any records, information or documents before the individual health care professional or panel reviewing your case. A decision must be made in writing 7 days after the review meeting is held.

You may request an expedited review if you require urgent care or if you have received emergency services but have not been discharged from a facility. The request need not be made in writing. Clinical peers not involved in the original denial will review your case and a decision must be reached within 72 hours of receiving notice of the request. You have the right to submit any comments, documents and additional information but you do not have the right to attend the review.

#### Then, you may request external review.

To file an external appeal, you must exhaust any internal appeals process with your health insurance provider. If you are not satisfied with the second level decision, you can apply for an independent *external review* within 60 days of the final health plan denial. An independent external review entity (currently a function of the Colorado Division of Insurance) will be assigned by the Division of Insurance. The external review findings will be provided within 30 working days and will be binding on both the carrier and the consumer.

### **Additional Health Care Rights in Colorado**

#### Second Medical Opinions

In Colorado, if the health plan provides coverage for a 2<sup>nd</sup> opinion, the insurance company and any entity that contracts with the insurance company shall disclose the availability of the second opinion.

### **Resources**

#### For Assistance With Insurance Disputes or Questions About State Health Insurance Continuation Coverage

##### **Colorado Division of Insurance**

(800) 930-3745

[www.dora.state.co.us/Insurance/](http://www.dora.state.co.us/Insurance/)

#### For Questions About COBRA

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

##### **Employee Benefits Security Administration**

(816) 426-5131 or (866) 275-7922

[www.dol.gov/ebsa/](http://www.dol.gov/ebsa/)

#### For Questions About HIPAA

##### **Colorado Division of Insurance**

(800) 930-3745

[www.dora.state.co.us/Insurance/](http://www.dora.state.co.us/Insurance/)

#### For Questions About CoverColorado

##### **CoverColorado**

425 South Cherry Street, Suite 160

Glendale, CO 80246

(800) 659-2656 or (877) 461- 811

[www.covercolorado.org](http://www.covercolorado.org)

#### For Questions About Medicaid

##### **Colorado Medicaid**

(303) 866-3513 or (800) 221-3943

[www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485591](http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485591)

#### For Questions About the Health Insurance Buy-In (HIBI) Program:

##### **Colorado Department of Health Care Policy and Financing**

(303) 866-5402 [www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)

#### For Questions About Medicare

##### **Senior Health Insurance Assistance Program**

1560 Broadway, Suite 850

Denver, CO 80202

(888) 696-7213, (800) 544-9181, (303) 899-5151

[www.dora.state.co.us/Insurance/senior/senior.htm](http://www.dora.state.co.us/Insurance/senior/senior.htm)

##### **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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