

Disability Rights Legal 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 District of Columbia

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.¹
- 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.

¹ 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.

- 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.

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.

District of Columbia Continuation Coverage

The District of Columbia has its own version of COBRA, called the “Continuation of Coverage Act” which does essentially the same thing as federal COBRA. It permits employees of small employers to continue coverage under their fully insured group health plan, even after they lose eligibility as a member of that group.

District of Columbia law defines the terms of their continuation coverage and its availability as follows:

- The District of Columbia’s continuation coverage applies to employers with 2-19 employees.²
- The District of Columbia’s continuation coverage is available for up to 3 months.
- To qualify for coverage you must apply within 45 days of losing your previous coverage.
- The cost for the District of Columbia’s continuation coverage cannot exceed 102 percent of the group rate.

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.

Information on HIPAA plans is available through the District of Columbia Department of Insurance.³

² 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. Therefore, the District of Columbia’s state continuation coverage option is not available to employees who have been covered by an employer’s self-insured 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-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. DC does not change the HIPAA maximum PECEP of 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.

³ For more information on health insurance options under HIPAA in the District of Columbia please contact the Department of Insurance online at <http://hc.rrc.dc.gov> or (202) 727-8000.

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 DC, reviews are conducted by the Director of the District of Columbia 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.

Every health benefits plan member has the right to appeal a decision by the health benefits plan that results in a denial, reduction, limitation, termination, or delay in covered health care services.

Under the District of Columbia law and regulations, each health benefits plan is required to provide members with the opportunity to resolve an appeal through a two-stage internal grievance process.

At the first stage of the grievance process, the individual filing the grievance will have the opportunity to discuss the grievance with the medical director and/or the physician or health care provider designee who rendered the decision. If the grievance is not resolved satisfactorily, it can be pursued to the second stage. At the second stage, the health benefits plan will select a panel of physicians, advanced practice registered nurses, or other health care professionals who have not been involved in the case to review the grievance.

The health benefits plan must make its determination in accordance with the medical exigencies of the case. However, it shall not exceed 14 business days for the informal internal review, 30 business days for the formal internal review, or 48 hours for all urgent or emergency reviews.

Then, you may request external review.

To file an external appeal, the health benefits plan member, or a representative, must submit a letter, with appropriate documents to the Department of Health, Office of the General Counsel, Grievance and Appeals Coordinator, within 30 business days of receipt of the health benefit plan's denial.

A member must comply with both the informal and formal internal review processes of the health benefits plan before an appeal can be made to the Director of the Department of Health.

An appeal to the Director of the Department of Health must be made within 30 business days of receiving a final formal internal review decision from the health benefits plan. Upon receipt of the request for appeal from the Department, a independent review organization will conduct a full review to determine whether, as a result of the health benefits plan's determination, the member was deprived of medically necessary covered services. The independent review organization shall complete its review and issue its recommended decision within 30 business days, or 72 hours in the case of an expedited appeal.

Additional Health Care Rights in the District of Columbia

Clinical Trials

In the District of Columbia, health plans must cover clinical trials undertaken for prevention, early detection, treatment, or monitoring of cancer. The trial must either involve a drug that is currently exempt under federal regulations from a new drug application or be a trial that is approved by a specified agency.

Resources in the District of Columbia

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

District of Columbia Department of Insurance

(202) 727-8000 <http://disb.dc.gov/>

For Questions About COBRA

U.S. Department of Labor

Employee Benefits Security Administration

(301) 713-2000 or (866) 275-7922

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

For Questions About HIPAA

District of Columbia Department of Insurance

(202) 727-8000 <http://disb.dc.gov/>

For Assistance For Children

DC Healthy Families Enrollment Office

(202) 639-4030 <http://providers-dchealthyfamilies.com/>

For Questions About Medicaid

Department of Human Services

(202) 724-5506 <http://dhs.dc.gov/>

For Questions About Medicare

U.S. Department of Health & Human Services

Centers for Medicare & Medicaid Services (CMS)

(800) 633-4227 <http://www.cms.hhs.gov/>

Health Insurance Counseling Project

2136 Pennsylvania Ave. NW

Washington, DC 20052

(202) 676-3900 or (202) 739-0668

<http://dcoa.dc.gov/dcoa/cwp/view,a,3,q,523610,dcoaNav,%7C31411%7C.asp>

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