

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 Georgia

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.
- 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.

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.

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.

Georgia State Continuation Coverage

Georgia 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.”

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

- Georgia state continuation coverage applies to employers who have less than 20 employees.²
- Georgia state continuation coverage generally lasts for the remaining days in the month that you lose your coverage and then for 3 full months.
- In order to qualify you must have had coverage under the policy for at least 6 months.

Health Insurance Premium Payment Program (HIPP)

Georgia has a program called the Health Insurance Premium Payment Program. At least one person living in the family household must be a recipient of Medicaid or be Medicaid eligible. Health insurance must be available to cover the Medicaid recipients through an employer or a private policy. Thus, if you qualify for Medicaid and have private health insurance coverage (generally COBRA coverage), you may be able to get your premiums paid for through the HIPP program as an alternative to receiving Medicaid insurance.

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 Georgia, HIPAA plans are available through Georgia Department of Community Health.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. Risk pools are state-sponsored programs to help people with a history of medical problems in their family to purchase coverage. These pools are for people who can afford to buy health insurance, but are not able to get underwritten in the private market because of a pre-existing health condition. These programs can vary significantly from state-to-state in price, benefits and number of people served. Often insurance companies doing business in the state are required to contribute to the pool to keep it in the black. In the best cases they allow people to be able to switch jobs or become self-employed without the fear of losing their health insurance coverage.

³ For information about Georgia’s premium rates, contact the Georgia Department of Community Health at (404) 656-4507.

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.

Georgia 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.

In Georgia, 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 Georgia, reviews are conducted by the External Quality Review Organization which is governed by the Georgia Department of Community Health (a government agency).

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.

Under Georgia law an insurance company must pay, deny or request additional information within 15 working days of receipt of the claim.

You must exhaust your plan's internal grievance process before you may pursue external review through the Department of Insurance.

Then, you may request external review.

If you receive an adverse determination from your health plan, meaning that the plan has decided that the treatment provided or requested is not medically necessary or is experimental or investigational, then you can ask your plan to arrange external review of their decision.

You may file a complaint with the Georgia Department of Insurance if you cannot resolve your dispute directly with your company or if you haven't been through the appraisal process. There is no specified time frame as to when you will get back the decision.

If you disagree with the Department's response to your complaint contact the Consumer Services Division and ask to speak with a Supervisor.

You may wish to consult an attorney to discuss your concerns. You may also request alternative dispute resolution (ADR) to settle disputes with your insurance company on property claims. ADR uses techniques such as mediation with a neutral third party to help settle a dispute outside a formal court of law.

Additional Health Care Rights in Georgia

Clinical Trials

In Georgia, health plans must cover routine costs in Phase I, II, III or IV cancer clinical trials for patients with cancer and recommended by a treating physician. 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 Georgia

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

Georgia Department of Insurance

2 Martin L. King Jr.
Dr. Floyd Memorial Bldg., 604 West Tower
Atlanta, GA 30334
(800) 656-2298

For Questions About COBRA

U.S. Department of Labor

Employee Benefits Security Administration
61 Forsyth St., Suite 7B54
Atlanta, GA 30303
(404) 562-2156 or (866) 275-7922

For Questions About the Health Insurance Premium Payment Program (HIPP)

Georgia Department of Community Health

(800) 282-4536 Main number
(800) 766-4456 Enrollment & claims

For Questions About HIPAA

Georgia Department of Insurance

2 Martin L. King Jr.
Dr. Floyd Memorial Bldg., 604 West Tower
Atlanta, GA 30334
(800) 656-2298

Division of Public Health

Two Peachtree Street, NW
Atlanta, Georgia 30303-3186
(404) 657-2700

For Questions About Medicaid

Georgia Department of Community Health

(800) 282-4536 Main number
(800) 766-4456 Enrollment & claims

For Questions About Medicare

Health Insurance Counseling for the Aging

2 Peachtree Street, NW, Suite 9-210
Atlanta, GA 30303
(800) 669-8387 or (404) 657-5334

For Questions About External Review

Georgia Department of Insurance

2 Martin Luther King Jr. Drive, Suite 716
West Tower, Atlanta, Georgia 30334
(800) 656-2298

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