

Disability Rights Legal Center



Cancer Legal Resource Center

**Cancer Legal Resource Center**

919 Albany Street • Los Angeles, CA 90015

Toll Free: 866.THE.CLRC (866.843.2572)

Phone: 213.736.1455

TDD: 213.736.8310 Fax: 213.736.1428

Email: [CLRC@LLS.edu](mailto:CLRC@LLS.edu)

Web: [www.CancerLegalResourceCenter.org](http://www.CancerLegalResourceCenter.org)

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

## Health Insurance in New Jersey

### 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.

---

<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.

### New Jersey State Continuation Coverage

New Jersey 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.”

State law defines the terms of New Jersey’s state continuation coverage and its availability as follows:

- New Jersey state continuation coverage applies to employers with 2-19 employees.
- New Jersey state continuation coverage lasts up to 18 months, while extending this period to 29 months if the person is disabled.
- The cost of the monthly premium paid by the employee is 102% of what the employer was paying for the same benefits.
- State continuation coverage applies to domestic partners.

### 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-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.

### New Jersey Individual Health Coverage Program

The **Individual Health Coverage (IHC) Program** was designed to offer people without access to employer or government sponsored health care programs the option to buy health coverage from various private carriers regardless of their medical condition.

Individuals in New Jersey are guaranteed coverage under standard individual plans designed by the Individual Health Coverage Program Board, as well as under the Basic and Essential Plans sold by carriers. Carriers include Aetna, Health Net, Horizon Blue Cross and Oxford.

To be eligible, you must be a resident of New Jersey, not eligible for coverage under a group health plan, government or church plan, and not eligible for Medicare. You cannot be turned down because of a pre-existing medical condition, but an exclusion period of 12 months will be imposed if you have not had coverage for more than 31 days prior to enrollment.

For more information about the Individual Health Coverage Program contact the New Jersey Department of Banking and Insurance.<sup>2</sup>

### **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 New Jersey, you have the right to appeal an adverse decision by your insurance provider that results in a denial, termination or limitation of covered services.

---

<sup>2</sup> [http://www.state.nj.us/dobi/division\\_insurance/ihcseh/ihcmain.htm](http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcmain.htm)

### *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. New Jersey has a three-stage level of appeals that requires you to exhaust your internal appeals before you can request an external review.

### *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 managed care insurer. In New Jersey, external reviews are conducted by the Independent Health Care Appeals Program (IHCAP).

You have 60 days after receiving an adverse decision from the second level of appeal to request and independent review. The review must be filed with the Office of Managed Care Consumer Protection Services a sub-division of the Department of Banking and Insurance. The cost of an external review is \$25.00 but the fee can be reduced to \$2.00 for low-income individuals.

### 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.

In New Jersey, the first level of the appeals process must be initiated within 180 days following the receipt of an adverse determination. This first level of appeal is typically informal and a decision will generally be reached in five business days but in any event must be reached within 30 days of filing the initial appeal. If you are not satisfied with the outcome at this first level, you can file a second-level internal appeal.

The second level of appeal must be initiated within 180 days of receiving the adverse decision of the first level of appeal. During this second level, a panel of doctors and other health care professionals who have not been involved with the case but are familiar with the facts and records will review the case. The panel is chosen by the insurance carrier and may include a combination of health care professionals who are part of the carrier's network or outside consultants. Insurance carriers have the option to allow the person appealing to speak to the panel (you can check your health plan for more information). A decision must be rendered within 20 days of receipt of the request for the second level of appeal.

At either level of the internal appeals process, if your situation is urgent or an emergency, the carrier must make its decision within 72 hours of receiving your request for an appeal.

### Then, you may request external review.

To file an external appeal, you must exhaust any internal appeals process with your health insurance provider.

IHCAP will review the request to see if it is appropriate for review and if so will forward the information to the Independent Utilization Review Organization (IURO). The IURO will conduct a review of your case to determine whether your insurance carrier inappropriately denied you medically necessary services. The IURO relies on medical records, documents and reports submitted by both sides in addition to using professional medical consultants. All final decisions must be approved by the IURO's medical director. The carrier's decision may be upheld, reversed or modified. A decision must be reached within 30 days and the decision the IURO makes is binding on the insurance carrier.

## **Additional Health Care Rights in New Jersey**

### Clinical Trials

In New Jersey, all insurers in the state are required to cover the costs of all phases of cancer clinical trials run by:

- National Institutes of Health (NIH)
- NIH cooperative group or center
- U.S. Food and Drug Administration
- U.S. Department of Defense
- U.S. Department of Veterans Affairs

## **Resources**

### For Questions About Access to Health Care

#### **New Jersey HealthLink**

<http://www.nj.gov/njhealthlink/>

### For Questions About State Health Insurance Coverage

#### **New Jersey Dept. of Banking & Insurance**

(800) 446-7467 or (609) 292-7272

[http://www.state.nj.us/dobi/division\\_consumers/in\\_surance/ins\\_menu.htm](http://www.state.nj.us/dobi/division_consumers/in_surance/ins_menu.htm)

### For Assistance With Insurance Disputes

#### **NJ Department of Health and Senior Services**

Office of Managed Care

(888) 393-1062

<http://www.state.nj.us/health/>

### **Consumer Inquiry and Case Preparation Unit (CICPU)**

Consumer Inquiries and Complaints

(609) 292-7272 or (800) 446-7467

<http://www.state.nj.us/dobi/consumer.htm>

### For Questions About COBRA

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

Employee Benefits Security Administration

(215) 861-5300 or (866) 275-7922

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

### For Questions About HIPAA

#### **New Jersey Dept. of Banking & Insurance**

(800) 446-7467 or (609) 292-7272

[http://www.state.nj.us/dobi/division\\_consumers/in\\_surance/health.htm](http://www.state.nj.us/dobi/division_consumers/in_surance/health.htm)

### For Questions About Coverage for Children

#### **Dependent Under 31 Law**

[http://www.state.nj.us/dobi/division\\_consumers/du31.html#HowEnroll](http://www.state.nj.us/dobi/division_consumers/du31.html#HowEnroll)

### **New Jersey Family Care**

(800) 701-0710 <http://www.njfamilycare.org/>

### For Questions About Medicaid

#### **New Jersey Department of Health Services**

Division of Medical Assistance & Health Services

(800) 356-1561 or (609) 588-2600

<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

### For Questions About Medicare

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

Centers for Medicare & Medicaid Services (CMS)

(800) 633-4227 [www.medicare.gov](http://www.medicare.gov)

### **State Health Insurance Assistance Program**

(800) 792-8820 or (609) 943-3433

<http://www.state.nj.us/health/senior/ship.shtml>

---

**DISCLAIMER:** This publication is designed to provide general information on the topics presented. It is provided with the understanding that the author is not engaged in rendering any legal or professional services by its publication or distribution. Although these materials were reviewed by a professional, they should not be used as a substitute for professional services. Copyright Cancer Legal Resource Center 2009

---