

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 Ohio

### 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.

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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.

- 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.

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.

### Ohio State Continuation Coverage

Ohio has a state version of COBRA which allows someone who is covered by an employer's group health plan to keep their health insurance when they would otherwise lose it because the employee is involuntarily laid off from work.

Ohio's state continuation coverage eligibility requirements:

- Coverage is available to employers with 10-19 employees.<sup>2</sup>
- Coverage is available for up to 12 months.
- Employees must be involuntarily terminated, other than for gross misconduct

### 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 Ohio, HIPAA plan information is available through the Ohio Department of Insurance<sup>3</sup>.

<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. Therefore, Ohio's state continuation coverage option is not available to employees who have been covered by an employer's self-insured plan.

<sup>3</sup> For more information on HIPAA plans available in Ohio contact the Ohio Department of Insurance online at <http://www.insurance.ohio.gov/> or call them at 800-686-1526.

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.

Ohio 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 Ohio, 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 Ohio, reviews are conducted by the Ohio Department of Insurance through the use of Independent Review Organizations (IRO).

### 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.

To initiate an external review, contact your insurance company. First you must go through your insurance company's internal appeal process.

If the appeal regards service that is not covered under your policy and is not a medical necessity, you can appeal with the Ohio Department of Insurance instead of your health plan. The Department of Insurance will review this appeal and will work with you and the insurance plan on coming to an agreement.

For other appeals, you must exhaust all internal appeals processes before appealing externally with the Department of Insurance and IRO.

### 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 must request an external review within 60 days of being notified about the denied internal decision. The IRO will make its decision within 30 days. Decisions must be expedited within 7 days in emergency situations. Decisions by the IRO in favor of the consumer are binding on the insurance plan.

## **Additional Health Care Rights in Ohio**

### Clinical Trials

In Ohio health plans must cover clinical trials with therapeutic intent for patients with cancer. The trial must be approved by a specified government agency. Health plans are not required to cover the service or product that is being tested in the clinical trial, any service or product not used in the direct clinical management of the patient, any investigational drugs or devices not approved for marketing by the FDA.

### Resources in Ohio

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

##### **Ohio Department of Insurance**

2100 Stella Ct.  
Columbus, OH 43215  
(800) 686-1526 or (614) 644-2658  
[www.ins.state.oh.us/](http://www.ins.state.oh.us/)

#### For Questions About COBRA

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

Employee Benefits Security Administration  
1885 Dixie Hwy., Suite 210  
Ft. Wright, KY 41011-2664  
(859) 578-4680 or (866) 275-7922  
<http://www.dol.gov/ebsa/>

#### For Questions About HIPAA:

##### **Ohio Department of Insurance**

2100 Stella Ct.  
Columbus, OH 43215  
(800) 686-1526 or (614) 644-2658  
[www.ins.state.oh.us/](http://www.ins.state.oh.us/)

#### For Assistance for Children

##### **Ohio Department of Job and Family Services**

30 E. Broad St., 32<sup>nd</sup> Floor  
Columbus, OH 43215-3414  
(614) 466-6282 or (800) 324-8680

#### For Questions About Medicaid

##### **Ohio Department of Job and Family Services**

30 E. Broad St., 32<sup>nd</sup> Floor  
Columbus, OH 43215-3414  
(614) 466-6282 or (800) 324-8680

#### For Questions about Medicare

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

Centers for Medicare & Medicaid Services (CMS)  
(800) 633-4227

##### **Senior Health Insurance Information Program**

2100 Stella Ct.  
Columbus, OH 43215  
(614) 644-2658 or (800) 686-1526  
[www.ins.state.oh.us/](http://www.ins.state.oh.us/)

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