

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

Web: www.CancerLegalResourceCenter.org

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

Health Insurance in Oklahoma

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.

Oklahoma State Continuation Coverage

Oklahoma 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.

Oklahoma's state continuation coverage:

- is available for up to 6 months.
- applies to employers with 2 to 19 employees.²
- requires you to pay the full premium.

Health Insurance Premium Payment Program (HIPP)³

Oklahoma has a program called the Oklahoma Employer/Employee Partnership for Insurance Coverage (Insure Oklahoma/O-EPIC). Insure Oklahoma is designed and intended to assist in the purchase of health coverage. Oklahomans can participate in either Employer Sponsored Insurance (ESI) or Individual Plan (IP).

In order to participate in either insurance program, the employee must be an Oklahoma resident, U.S. Citizen or qualified alien, and between the ages of 19-64. Each program has different conditions for eligibility.

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

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

³ For more information on Oklahoma Employer/Employee Partnership for Insurance Coverage please visit <http://www.insureoklahoma.org/>

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 Oklahoma, HIPAA plan information is available from Oklahoma Insurance Department.⁴

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. Oklahoma 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.

⁴ For more information on HIPAA plans contact Oklahoma Insurance Department at (800) 522-0071 or visit them online at <http://www.ok.gov/oid>.

Oklahoma Major Risk Insurance Plan

Oklahoma's major risk insurance plan, the Oklahoma High Risk Pool (OHRP),⁵ provides access to health insurance coverage to all residents of the state who are unable to obtain individual health insurance.

Coverage is available if you are a resident of the State of Oklahoma, and you must meet one of the eligibility categories (medical eligibility or federally defined eligibility). To be medically eligible you must be a legal resident of the State of Oklahoma for the past 12 months and you have been rejected by two health insurance carriers because of a health condition. To be eligible under the federal definition (no length of residency required), you must have aggregate creditable coverage of at least 18 months and have exhausted continuation coverage such as COBRA.

OHRP offers two comprehensive preferred provider plans, Original Plan and Alternate Plan (each with pharmacy benefits). All benefits are subject to the terms, conditions, limitations, exclusions, deductibles, co-payments, and any and all other contract provisions. If you are medically eligible, you will be subject to 12 month pre-existing condition exclusion. OHRP plans are not available to Medicare eligible enrollees.

Premium rates are determined according to the OHRP plan you select, your age and gender.

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.

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

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. Your health plan will determine whether or not to grant an external review based upon criteria established by Oklahoma state law.

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.

⁵ For more information on Oklahoma High Risk Pool contact them at 877-793-6477 or visit them online at <http://okhrp.org>.

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.

You must exhaust your plan's internal grievance process before you may pursue an external review.

Then, you may request external review.

After all internal appeals procedures established by the health plan have been exhausted; you have the right to an external review by an independent review organization (IRO). You must file the external appeal within 30 days from receipt of the final adverse decision and the IRO will review the decision of the health plan.

Your health plan will select an IRO. You have the right to object to the selected reviewer, and you must notify the Department of Health within 3 days of your objection to possibly select a different reviewer. You are then required to submit in writing a request for external review, including the reasons why you are requesting the review, a copy of the decision to deny coverage from your health plan, and a medical records release. Your health plan will be contacted for further documentation. The IRO will provide you with a decision within 30 days after receiving all documentation for review, an expedited review and decision is available within 72 hours for emergency situations.

Resources in Oklahoma

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

Oklahoma Insurance Department
(800) 522-0071 or (405) 521-2991
www.ok.gov/oid

For Questions About COBRA

U.S. Department of Labor
Employee Benefits Security Administration
(972) 850-2500 or (866) 444-3272
www.dol.gov/ebsa

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

Oklahoma Employer/Employee Partnership for Insurance Coverage
(888) 3-OK-EPIC (1-888-365-3742)
www.oepic.us

For Assistance for Children

The Oklahoma Health Care Authority
(405) 522-7300 www.ohca.state.ok.us

For Questions About HIPAA

Oklahoma Insurance Department
(800) 522-0071 or (405) 521-2991
www.ok.gov/oid

For Questions About the Oklahoma High Risk Pool

Oklahoma High Risk Pool OHRP
(877) 793-6477 www.okhrp.org

For Questions About Medicaid

Oklahoma Department of Human Services
(800) 987-7767 www.okdhs.org

For Questions About Medicare

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
(800) 633-4227 www.medicare.gov

Oklahoma Department of Human Services
(405) 521-3679 www.okdhs.org