

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 Pennsylvania

### 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.

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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.

- 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.

### Pennsylvania State Continuation Coverage

Pennsylvania has a mini-COBRA law that gives employees of businesses with 2-19 employees the right to purchase nine months of COBRA health insurance coverage. Because the mini-COBRA law is relatively new, you must have ended your employment on or after July 10, 2009 to be eligible to purchase benefits. You must elect mini-COBRA coverage within 30 days of your qualifying event.

Once you have exhausted your COBRA rights, you may obtain health insurance under Pennsylvania's conversion coverage law. Under this law, an employee working for an employer with 10 or more employees may obtain a "converted policy" within 31 days of losing the group policy. An employee is eligible for a converted policy as long as the reason for losing the group policy coverage is not that the employee failed to pay his or her required share of the insurance premium.

As long as the employee has been insured for 3 months prior to requesting the converted policy, the same insurer that issued the group policy is required to issue an individual policy to the employee without going through a medical underwriting process. The converted policy is effective the day after the termination of the group policy, and the converted policy must cover any dependents that were covered under the initial group policy.

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

- Pennsylvania state continuation coverage applies to employers with 10 or more employees.<sup>2</sup>
- The cost of the monthly premium paid by the employee is the insurer's standard rate for an individual policy for persons in the employee's risk and age group. There are no set limits on the cost of this policy.
- There is no pre-existing exclusion period on a converted policy.

### Health Insurance Premium Payment Program (HIPP)

Pennsylvania has a program called the Health Insurance Premium Payment Program. If you are eligible for the state Medical Assistance Program and have private health insurance coverage (generally COBRA coverage), you maybe be eligible to have the government pay your insurance premiums. This is done when the state government determines that your Medical Assistance costs are likely to be greater than the cost of your private insurance premiums.

### 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.

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<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, Pennsylvania's state continuation of option is not available to employees who have been covered by an employer's self-insured 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 from an insurer in your state. For information on where to purchase a HIPAA plan in Pennsylvania, contact the State Insurance Department.

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.

### Pennsylvania Major Risk Insurance Plan

Although Pennsylvania does not have a Major Risk Insurance Plan, the state has designated Blue Cross Blue Shield as the insurer of last resort. Blue Cross Blue Shield offers various plans to Pennsylvania residents with no medical underwriting, although certain preexisting condition exclusion periods may apply.

## **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 Pennsylvania, 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 Pennsylvania, reviews are conducted by both the Department of Health and the 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.

If you have a problem with your health plan, you have the right to file a grievance or complaint with your health plan.

Grievance: You file a grievance when you are denied coverage because your insurance provider does not believe the service is medically necessary or appropriate. The service in dispute must be a benefit covered under your plan. A grievance dispute will be evaluated by doctors that would normally be administering the service you are being denied.

Complaint: A complaint is any other type of dispute you may have with your insurance provider that does not fit into the grievance category. This would include a disagreement not over whether a service is medically necessary, but whether your provider has to cover the service. This review is not overseen by a doctor.

You should send a written statement of your complaint or grievance directly to your plan. Although it is permissible to file an oral complaint, an insurer only has to accept an oral grievance if you are unable to write or have a language barrier. Initiating your dispute in writing is also a helpful way of documenting your dispute.

Your plan will then send you a confirmation of your appeal and will notify you whether your dispute has been classified as a complaint or a grievance. If you disagree with your plan's classification of your complaint, you may contact the Department of Health at (888) 466-2787 to have an independent review of how your complaint should be classified.

First Level: Your insurer has 30 calendar days to make a decision on your appeal and then 5 business days to send you its decision in writing. The decision letter will also tell you how to file a second level appeal if you are not happy with the decision.

Second Level: The second level review will take place in the form of a hearing. Your plan has 45 calendar days to scheduling the hearing and 5 business days to render a decision and send a letter. You may attend the hearing in person or via telephone conference call. The hearing committee will listen to your story and likely ask you questions. You must submit any supporting documentation to your insurer before the hearing takes place.

Then, you may request external review.

Third Level: You will only have 15 days after receiving your decision letter from the second level appeal to initiate a third level appeal.

Third Level Grievances: You first must notify your health plan that you wish to file a third level grievance. Your plan will then notify the Department of Health, and the Department will give your case to a third party company assigned to handle third level grievances. Your file will be given to an independent doctor for review and a decision will be rendered within 60 calendar days. You must submit any additional supporting documentation directly to your insurer. Your insurer may also charge you a filing fee of up to \$25.

Third Level Complaints: You must send a third level appeal letter to either the Department of Health or the Department of Insurance. The two departments coordinate, so it does not matter which department you send it to. You will get a written decision from one of the Departments.

Expedited Appeals: You can also request an expedited external review. Expedited appeals are designed to help people in serious medical situations get through the appeals process quickly. If your doctor will certify that your life, health, or ability to return to normal functioning is in danger, you can request an expedited appeal by the health plan. This review will take place within 48 hours of

requesting the appeal. There is only one level of appeal with your health plan when you go through the expedited process.

## Resources

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

**Pennsylvania Insurance Department**  
1326 Strawberry Sq., 13<sup>th</sup> Floor  
Harrisburg, PA 17120  
(717) 787-2317 or (877) 881-6388  
<http://www.ins.state.pa.us/ins/site/default.asp>

For HMOs:

**Pennsylvania Attorney General's Health Care Unit**  
(877) 888-4877  
<http://www.attorneygeneral.gov/complaints.aspx?id=458>

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 the Health Insurance Premium Payment Program (HIPP)

**Pennsylvania Department of Public Welfare – HIPP Program**  
(800) 644-7730  
<http://www.dpw.state.pa.us/PartnersProviders/MedicalAssistance/DoingBusiness/003670053.htm>

For Questions About HIPAA

**Pennsylvania Insurance Department**  
(717) 787-2317 or (877) 881-6388  
[http://www.ins.state.pa.us/ins/lib/ins/consumer/brochures/2003\\_health.pdf](http://www.ins.state.pa.us/ins/lib/ins/consumer/brochures/2003_health.pdf)

For Questions about adultBasic  
**adultBasic**

(800) GO-BASIC  
<http://www.ins.state.pa.us/ins/cwp/view.asp?a=1278&q=527068>

For Assistance for Children

**Pennsylvania Children's Health Insurance Program**  
(717) 783-1437 or (800) 986-KIDS  
<http://www.chipcoverspakids.com/>

For Questions About Medicaid

**Pennsylvania Department of Public Welfare**  
(800) 692-7462  
<http://www.dpw.state.pa.us/ServicesPrograms/MedicalAssistance/>

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)

## APPRISE

555 Walnut St., 5<sup>th</sup> Floor  
Harrisburg, PA 17101  
(800) 783-7067  
<http://www.aging.state.pa.us/aging/cwp/view.asp?a=553&q=253802>