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

Health Insurance in Utah

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.

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- 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.

Utah State Continuation Coverage

If you have been covered by a Utah employer's group medical insurance policy for at least 6 months, then you may continue that same benefit for up to 6 months, but you must pay the total monthly premium. You must elect coverage within 30 days under the Utah state continuation coverage. Please contact the Utah Department of Insurance for further state continuation coverage information.

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 Utah, HIPAA plans are available through the Utah Department of Insurance. They also offer non-HIPPA plans, so be sure to use words “HIPAA plan” when you apply.

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.

HIPUtah Comprehensive Health Insurance Pool (HIPUtah)

The Utah Comprehensive Health Insurance Pool (HIPUtah) is the state's major risk insurance option for people who have medical conditions that make it hard to obtain health insurance. HIPUtah also serves as the states HIPAA alternative.

To be eligible for a HIPUtah plan you must have resided in the state for at least 12 months and denied coverage by a private health insurer because of your health condition. A 6-month exclusion period will be imposed on you if it is determined that you had a pre-existing condition within the 6 month prior to your enrollment date.[2] The state of Utah contracts with SelectHealth to administer HIPUtah.

[2] For HIPUtah purposes a pre-existing condition is a medical condition that was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received.

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Handling Health Insurance Disputes

If you disagree with a decision that your health insurance provider has made regarding your coverage, you have the right to appeal that decision. The appeals process varies depending on the state in which you live.

In Utah, you can appeal any decision to deny, reduce or terminate a benefit based on the fact that it is deemed experimental, investigational and not medically necessary. You must first exhaust your health plan's internal appeals process, before you can request an independent review.

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
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 Utah, an insured who disagrees with the results of an internal review has the right to an independent review.

The Insurance Commissioner sets up rules and standards for independent reviews, including the timing of the review process. Expedited reviews are available when medically necessary.

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.

A health plan must provide an internal appeal process for all consumers. The health plan must inform you of their decision within 18 days of receiving your appeal. In emergency situations, your appeal can be expedited and a decision regarding your appeal must be made within 72 hours.

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. The external appeal is then

assigned to an independent external appeal agency. The independent external appeal panel will review the appeal and a decision will be made within 21 days after the appeal is filed or 72 hours for emergency situations. The decision is binding on the health plan.

Resources in Utah

For Assistance With Insurance Disputes or Questions About State Health Insurance Continuation Coverage
Utah Insurance Department
(801) 538-3877 or (866) 350-6242
www.insurance.utah.gov

For Questions About COBRA
U.S. Department of Labor - Employee Benefits Security Administration
(415) 975-4600 or (866) 275-7922
www.dol.gov/ebsa

For Questions About HIPAA
Utah Department of Insurance
(801) 538-3877 or (866) 350-6242
www.insurance.utah.gov

For Questions About HIPUtah
SelectHealth
(801) 442-6660 (Salt Lake area) or (800) 705-9173
www.selecthealth.org

For Assistance for Children
CHIP
(877) KIDS-NOW
www.utahchip.org

For Questions About Medicaid
Utah Medicaid
Department of Health
(800) 662-9651 or (801) 538-6155
http://health.utah.gov/medicaid/

For Questions About Medicare
U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services (CMS)
(800) 633-4227
www.cms.hhs.gov

Health Insurance Information Program
(877) 424-4640 or (801) 538-3910
www.hsdaas.utah.gov

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