

Disability Rights Legal 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 Vermont

### 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.

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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.

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.

### Vermont Continuation of Coverage Program

Vermonters who work for employers with fewer than 20 employees, have the right to continue group health insurance coverage after their job ends. Under Vermont law<sup>2</sup>, employees who have lost their job voluntarily or involuntarily, can choose to continue the same group health benefits, *at their own cost*, for up to six (6) months.

#### *Eligibility*

- Employee must have been covered under the company's health insurance plan for the three months before their employment ended
- Employee must not be eligible for other group health insurance coverage (i.e. through a spouse) or Medicare
- Employee must not be terminated as a result of the employee's misconduct

Also, in cases where work ended due to the death of the employee or if there is a divorce or legal separation from the employee, the employee's spouse and/or any dependents who were covered under the group health plan may continue coverage for up to six months.

A dependent child whose coverage ends because he or she reached the dependent age maximum (for example, 22 years of age) may also continue coverage under the plan for a period of six months.

An employee has thirty days from the end of employment (sixty days if the job ended due to the employee's death) to choose the Vermont Continuation of Coverage.

### Health Insurance Portability & Accountability Act (HIPAA)

HIPAA prohibits health insurance discrimination against individuals based on their preexisting 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.

Every insurance company that writes policies in the individual insurance market in your state also has to offer a HIPAA plan. The insurance company cannot deny you a HIPAA plan, but you need to use the

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<sup>2</sup> 8 V.S.A. §4090a–c

buzz words (guaranteed issue or HIPAA plan) when you apply for the plan. Otherwise the insurance company will assume you want a regular individual plan and may deny you coverage.

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, including Cal-COBRA.
- You cannot have a break in coverage longer than 63 days.
- You must be ineligible for Medicare, Medi-Cal, 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.

### Vermont Health Access Plan (VHAP)

VHAP is a health insurance program for adults 18 years old and older and who meet any of the following criteria: 1) do not qualify for Medicare; 2) do not have other insurance that covers doctor and hospital visits; or 3) have been living without health insurance for 12 months or more.

However, the 12 month requirement may be waived if health coverage was lost due to any of the following reasons:

- Lost job, employer reduced hours or job ended
- Divorce, separation or dissolution of civil union from policy holder
- Policy holder passed away
- No longer qualify as a dependent

- No longer can continue health insurance through COBRA or state continuation coverage
- Lost college-sponsored insurance due to graduation, reduced credits, a leave of absence or stopped going
- Lost private health insurance and household income is at or below 75% of Federal Poverty Level (FPL)
- No longer eligible for Catamount, Dr. Dynasaur or Medicaid

### Catamount Health

Catamount Health is a health insurance option, offered in cooperation with the state of Vermont, by Blue Cross Shield of Vermont and MVP Health Care. It provides comprehensive, quality health coverage at a reasonable cost. Depending on an individual's income level, premium assistance may be available.

Catamount Health policies start counting the 12-month exclusion period for preexisting conditions from the date of earliest application, rather than the effective date of coverage, and does not continue counting a break in coverage after the date of application.

Catamount Health is for adults 18 years old and older who are not currently eligible for other Green Mountain care plans such as Medicaid, VHAP or Dr. Dynasaur, or have been living without health insurance for 12 months or more. However, the 12 month requirement may be waived if one of the following exceptions are met:

- You have insurance that only covers hospital care or Doctor visits (but not both)
- Within the last 12 months, you had insurance but lost it because you: 1) lost your job, your employer reduced your work hours, or your job ended; 2) got divorced or your civil union dissolved; 3) had insurance through someone who passed away; 4) no longer continue your health insurance through COBRA or state continuation coverage; 5) are no longer a dependent on your parent's or caretaker's health insurance; or 6) were getting your insurance through college and can no longer do so because of graduation, leave of absence, reduced credits or stopped going to college
- You are no longer eligible for Vermont Health Access Plan (VHAP), Dr. Dynasaur or Medicaid
- You have been enrolled for at least six months in a non-group insurance plan with an annual deductible of \$10,000 or more for an individual or \$20,000 or more for two or more people
- Have an income of more than \$1,307 a month or parents with income of more than \$1,612 a month and do not have access to insurance through your employer unless you meet any of the following conditions:
  - Your monthly income is \$2,718<sup>3</sup> or less;
  - You do not have access to comprehensive health insurance benefits through your employer;
  - Your employer offers comprehensive benefits, but it is more cost-effective for the state to provide premium assistance to enroll in Catamount Health or VHAP than to provide premium assistance to enroll in your employer's plan; or
  - You are waiting for the open enrollment period to enroll in your employer's plan.

### Employer-Sponsored Insurance (ESI) Premium Assistance

If you are an insured Vermonter, you can get help paying your employer's health insurance premiums. The employee must meet all of the following requirements:

- The employee meets the eligibility criteria to enroll in Catamount Health or Vermont Health Access Plan (VHAP)
- The employee's household income is under \$2,718<sup>4</sup> a month for one person (higher for larger households)
- The employer's plan has comprehensive benefits and the deductible is \$500 or less
- The cost of providing premium assistance to enroll in an employer's plan is less than the cost of providing premium assistance to enroll in Catamount Health or Vermont Health Access Plan (VHAP)

<sup>3</sup> May still qualify if monthly income is higher if you have earned income and/or child care expenses.

<sup>4</sup> May still qualify if monthly income is higher, if you have earned income and/or child care expenses

## Dr. Dynasaur

Dr. Dynasaur provides low-cost or free health coverage for children, teenagers under age 18 and pregnant women. Benefits include doctor visits, prescription medicines, dental care, skin care, hospital visits, vision care, mental health care, immunizations and special services for pregnant women (lab work, tests, prenatal vitamins and more). Note, this is the name of the Medicaid program for children and pregnant women.

## **Prescription Assistance**

Vermont has several Prescription Assistance Programs to help uninsured Vermonters and those enrolled in Medicare pay for prescription medicines based on income, disability status and age. *VPharm* assists Vermonters who are enrolled in Medicare part D with paying for prescription medicines. This includes people age 65 and older as well as people of all ages with disabilities. *VHAP-Pharmacy* and *VScript* are programs that help Vermonters age 65 and older and people with disabilities, who are not enrolled in Medicare, to pay for eye exams and prescription medicines and includes an affordable monthly premium. *Healthy Vermonters* provides a discount on short-term and long-term prescription medicines. There are no monthly premiums and eligibility is based on your family income.

## **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.

Under the Vermont Consumer Bill of Health, you have the right to fully understand your health care needs and to complain to the plan if you do not receive services you or your doctor think are necessary. This includes:

- The right to know the reason your managed care plan said "no" to a service you or your doctor think you need. Plans must tell you, in writing, the medical reason for denying payment for a specific service, and tell you how to file a formal complaint (grievance) with the plan if you are unhappy with the decision.
- The right to file complaints with the managed care plan concerning a denial of service or problems in getting the kind, quality or amount of services you think you need. If you cannot file a written complaint yourself, the plan must help you do it. If you ask for them, the managed care plan must give you copies of all records relating to your complaint at no cost to you.

## 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. You have the right to have your complaint handled quickly. Your managed care plan must review your case within certain time limits. If your doctor thinks the situation is urgent, the plan has 3 days to get back to you. Otherwise, the plan has 15 days to answer medical complaints and 30 days to handle other kinds of complaints (like a delay in getting an appointment). If you still disagree with the result, you can ask for a second review, which has to be decided within 2 days (for emergency care) or 30 days (all other complaints).

### Then, you may request external review.

This is a reconsideration of the health plan's determination by an outside, independent organization. In Vermont, if you have been denied payment or provision of health care benefits and believe that your insurance should have covered the benefits that were denied, you must first attempt to settle any dispute with your insurer yourself, through their internal appeal process. If you are unable to resolve the problem, you may then pursue an external appeal.<sup>5</sup>

#### *External or independent review*

If you were denied coverage for medical services, you may have the right to appeal this denial to an independent review organization (IRO). The insurer must have denied coverage for one of the following reasons:

- Service is not medically necessary, or
- Selection of a health care provider is limited in a way that is not allowed by your contract or by law, or
- Service is considered to be experimental, investigational, or an "off-label" use of a drug, or
- A medically based decision was made that your condition was "pre-existing."

You must request an external independent review within 90 days of receiving the final denial letter from your insurer. Call the Division of Health Care Administration at (800) 631-7788 as soon as possible to find out if you qualify.

The service being appealed must be one that is covered by your contract, and it must cost at least \$100. If it appears that you qualify, the Division will send you an application. There is a \$25 filing fee that may be waived. The Division will collect documents from you and the insurer and submit them to the IRO. Decisions by the IRO are made within 30 days of receiving all information.

#### *Appeals for State-Sponsored Health Insurance Programs*

If you receive your health care through a state-sponsored health insurance program such as Medicaid, Vermont Health Assistance Program, or Dr. Dynasaur, call the Office of Vermont Health Access at (800) 250-8427 to appeal a health care denials or file a complaint.

### **Resources in Vermont**

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

**Department of Banking, Insurance, Securities  
& Health Care Administration (BISHCA)**

(800) 631-7788

[http://www.bishca.state.vt.us/HcaDiv/consumer\\_help/consumer\\_info\\_assistance.htm](http://www.bishca.state.vt.us/HcaDiv/consumer_help/consumer_info_assistance.htm)

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<sup>5</sup> To access the necessary appeals form, go to [http://www.bishca.state.vt.us/HcaDiv/consumer\\_help/AppealApp\\_EA08\\_denial\\_medical.pdf](http://www.bishca.state.vt.us/HcaDiv/consumer_help/AppealApp_EA08_denial_medical.pdf) to download and print a copy. Copyright Cancer Legal Resource Center 2009

For Questions About COBRA

**U.S. Department of Labor**

**Employee Benefits Security Administration**

(859) 578-4680 or (866) 275-7922

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

For Questions about Vermont Health Access Plan (VHAP)

**Green Mountain Care**

Health Access Member Services

(800) 250-8427 or (888) 834-7898 (TDD)

[http://www.greenmountaincare.org/about/green\\_mountain\\_care\\_programs.html#vhap](http://www.greenmountaincare.org/about/green_mountain_care_programs.html#vhap)

For Assistance for Children (Dr. Dynasaur)

**Green Mountain Care**

Health Access Member Services

(800) 250-8427

[http://www.greenmountaincare.org/about/green\\_mountain\\_care\\_programs.html#drdynasaur](http://www.greenmountaincare.org/about/green_mountain_care_programs.html#drdynasaur)

For Questions About Medicaid

**Green Mountain Care**

Health Access Member Services

(800) 250-8427

[http://www.greenmountaincare.org/about/green\\_mountain\\_care\\_programs.html#medicaid](http://www.greenmountaincare.org/about/green_mountain_care_programs.html#medicaid)

For Questions about Catamount Health Program

[http://www.greenmountaincare.org/about/green\\_mountain\\_care\\_programs.html#catamount](http://www.greenmountaincare.org/about/green_mountain_care_programs.html#catamount)

**Catamount Blue**

Blue Cross Blue Shield of Vermont (BCBSVT)

(888) 445-5805

[www.bcbsvt.com/catamount](http://www.bcbsvt.com/catamount)

**MVP Catamount Choice**

MVP Health Care

(888) 687-6277

[www.mvpvermont.com/member/#viip](http://www.mvpvermont.com/member/#viip)

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)

Vermont State Health Insurance Program (SHIP)

(800) 642-5119

<http://www.medicarehelpvt.net/> or [http://www.medicarehelpvt.net/VTSHIP\\_FINAL\\_FY07.pdf](http://www.medicarehelpvt.net/VTSHIP_FINAL_FY07.pdf)

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