WHAT RIGHTS DO I HAVE REGARDING HEALTH INSURANCE?

A BROCHURE EXPLAINING HOW YOU ARE PROTECTED BY STATE LAW

A publication of the
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INTRODUCTION

Colorado law provides you certain protections regarding health insurance.

All companies selling health insurance in Colorado are to make sure their members receive:

- important health insurance information,
- fair treatment, and
- coverage for benefits allowed under an insurance contract.

This brochure is a guide explaining what insurers must do according to state law. It also explains what your rights are and how the Colorado Division of Insurance can help you.

Additional copies of this brochure are available by contacting the Colorado Division of Insurance at:

303-894-7425

and through our web site at

www.dora.state.co.us/insurance
under
main menu/consumer brochures

CONSUMER RIGHTS

People covered by health insurance plans regulated by the State of Colorado have certain rights through state law. Some of these rights apply to all types of plans; others apply only to managed care plans.

All Health Plans

Regardless of the type of health insurance plan you're insured under, you have a right to:

- Coverage for certain mandated benefits (see section entitled *"Required Benefits"*);
- Know exactly what your plan does and does not cover;
- Contact your insurer to complain and appeal all plan decisions with which you disagree (see section entitled *"Your Complaint and Appeal Rights"*);
- Receive a standardized form that outlines benefits for comparison between companies and between health plans (see *"Comparing Plans and Shopping for Insurance"*.) Your health insurer should provide you with a copy of this form.

- Get a written explanation of the reason, if a health insurer denies your application for enrollment, or excludes a health condition you may have from coverage;

- Coverage of emergency room care, if you had good reason to believe you were facing a life or limb threatening situation, even if this turned out not to be true; and

- Prompt payment of claims.

Managed Care Plans

Managed care plans, including health maintenance organization (HMO) and preferred provider organization (PPO) plans, encourage or require the use of specific doctors and hospitals, and closely review appropriateness of services.

In addition to the rights listed in the previous section, if you are enrolled in a managed care plan you also have the right to:

- Be informed by your doctor of all treatment options, even if they are not covered by your plan. Your doctor cannot be prevented from protesting a coverage denial issued by your insurer, or discussing his or her financial arrangements with a managed care company.

- Coverage for emergency care (if emergency services are normally covered under the plan) even if you received services outside the health plan network, as long as you had good reason to believe that an emergency existed at the time you sought care. This is true even if you failed to notify your plan beforehand that you were seeking emergency care.

- An adequate provider network. If your managed care network does not have a provider for a covered benefit, the health plan must arrange for an appropriate referral, at no additional cost to you, other than your normal coinsurance and deductible amounts.

- Prompt notification if your regular doctor's contract is terminating.

- A complete list of providers covered by the plan at the time of enrollment and re-enrollment, or upon request.

- Direct access to an obstetrician/gynecologist (ob/gyn) or nurse midwife participating under the plan, or a referral without unreasonable delay, for ob/gyn related services only.

- Review a managed care company's Access Plan. The Access Plan must describe the company's provider network, referral procedures, system for ensuring coordination and continuity of care, and efforts to accommodate people with diverse backgrounds and capacities.

SELF INSURED PLANS

Single employer self funded (self insured) plans are not regulated by the Colorado Division of Insurance.

Some employers choose to self insure, which means the employer acts as the health insurer for their employees. The employer actually pays the bills for their employees' health care, using an insurance company or third party administrator only to process the claims. These self insured plans are exempt from Colorado law (and thus the requirements outlined in this brochure) but must meet rules set forth by a federal law called ERISA. Check with your employer to find out if your plan is self insured.

For information and assistance with complaints about self insured plans, contact:

U.S. Department of Labor,
Pension and Welfare
1100 Main Street, Suite 1200
Kansas City, MO 64105
816-426-5131

REQUIRED BENEFITS

Colorado requires all comprehensive health plans[1] under its jurisdiction to cover certain benefits. Some benefit requirements apply to all plans (both group and individual); others apply to group plans only.[2] Mandated benefits include:

- **Pregnancy and Childbirth**
  Employer group plans must provide coverage for pregnancy and childbirth. If you change plans while you are pregnant, your new group plan must cover the pregnancy immediately, without a waiting period. All plans (both group and individual) must cover complications of pregnancy.

  All plans covering childbirth must also allow for up to a 48 hour hospital stay, for both the mother and the baby, following a normal delivery; and up to 96 hours for a cesarean section delivery.

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[1] "Comprehensive health plans" include all HMO, PPO, and most traditional major medical health insurance plans. The term excludes limited plans such as dental, medicare supplemental, cancer, and vision care plans.

[2] Group health plans are available only to members of a particular organization, such as plans offered to employees of a business. Individual health plans are sold directly to individuals or families who can keep their individual coverage regardless of job or other life changes, so long as they make their premium payments.

- **Mammography**
  All plans must cover a baseline mammogram for women 35-40 years old, a screening once every two years for women 40-49 years old, and an annual screening for women 50-65 years old.

- **Reconstructive surgery after mastectomy**
  A new federal law requires all plans that cover mastectomies to also include reconstructive breast surgery.

- **Prostate cancer screening**
  All plans must cover an annual screening for the early detection of prostate cancer in men over the age of 50, and for men over 40 who are in high-risk categories.

- **Mental health**
  Group health plans must cover the following mental health conditions at the same level as other physical illnesses: major depressive, bipolar, obsessive-compulsive, schizophrenia, schizoaffective, and panic disorders. This means your group plan cannot pay for fewer visits or have higher copayments than for other medical services. Group plans must also provide state-defined minimum levels of coverage for all other mental illnesses.

- **Diabetes**
  All plans must cover diabetes treatment, including necessary equipment, supplies, and self-management training.

- **Newborns**
  All plans must cover babies from the moment of birth on their parent's plan, if the parent has coverage. However, you must notify your plan and pay the required premium within 31 days after the birth to guarantee continued coverage.

- **Adopted children**
  All plans must offer health insurance to an adopted child, and a child placed for adoption, on the same terms that apply to natural children.

- **Preventive care and dental general anesthesia for kids**
  All plans are required to cover immunizations and some well-child visits for covered children under age 13. Plans must also cover general anesthesia for dental procedures for children, under certain circumstances.

SPECIAL PROTECTIONS FOR SMALL EMPLOYER GROUPS

Colorado has established special health insurance rules for small employer groups (those with 50 or fewer employees), including qualified self-employed persons and household employees:

- Neither the group as a whole nor particular employees or dependents in the group can be denied health coverage because of a medical condition.

- An insurance company cannot cancel a health policy except for failure to pay premiums, or for fraud.

- An insurance company cannot raise a particular small group's premiums because that group has high medical expenses.

- Small employers have the right to buy coverage through one of Colorado's health care coverage cooperatives. Cooperatives offer the employees of a small employer a choice of health care plans from different insurers.

For more information, contact the Colorado Division of Insurance and request the brochure, *"What Small Employers Need to Know About Health Insurance."* This brochure is also on the Division's website under consumer brochures.

YOUR COMPLAINT AND APPEAL RIGHTS

All health plans must have written procedures for receiving and resolving complaints. Information on complaint procedures can be found in your policy or membership booklet, or by calling your plan's customer service representative.

The most common complaint occurs when a health plan denies coverage for a service or procedure on the grounds that it is not medically necessary, appropriate, efficient or effective. In such cases, Colorado requires insurance companies to have a two-level appeals process, followed by the right to an independent external review. Listed below are highlights of the appeal process:

- Denials must be in writing, state the particular reasons for the denial, explain how to appeal the decision, be signed by a plan physician, and be sent to you and your doctor.

- You can request a standard or expedited appeal of a denial from your plan. In either case, this is called the "first level appeal." An expedited review of a decision not to cover a procedure may be requested where your doctor believes this is necessary. The health plan must complete an expedited review within 72 hours.

- The plan's letter notifying you of the first level appeal decision must include the name and credentials of the doctor evaluating the appeal, the medical rationale for the decision, and how to file a second level appeal.

- A panel of qualified professionals who were not involved in the original denial must review second level appeals. You have the right to appear in person at the second level review to ask questions and/or provide information.

- The letter notifying you of the decision of the second level appeal must include the credentials of the panel members, the medical rationale for the decision, and a notice of your right to an independent external review.

- Effective June 1, 2000, if you are not satisfied with the second level decision, you can apply for an independent external review within 60 days of the final health plan denial. An independent external review entity will be assigned by the Division of Insurance. The external review findings will be provided within 30 working days and will be binding on both the carrier and the consumer.

For more information, contact the Colorado Division of Insurance and request the brochure, *"What Happens When Your Health Insurance Company Says No"*, which is also on the Division's website under consumer brochures.

COMPARING PLANS AND SHOPPING FOR HEALTH INSURANCE

Colorado requires health plans to make available to consumers a standard description form that covers many aspects of coverage. This form, which must be provided upon request, allows you to more easily decide which plan best fits your needs. Before you sign up for coverage, a health insurer must give you a copy of the *"Colorado Health Benefit Plan Description Form."* The information in the form is useful, whether you are comparison shopping between plans or simply want a handy, concise reference to the plan to which you belong.

- The standard description form describes benefits, deductibles, emergency, inpatient, and outpatient care, and out-of-pocket annual and lifetime expense maximums. It also shows the extent to which the plan covers prescription drugs, alcohol and substance abuse treatment, physical, occupational and speech therapy, durable medical equipment (such as wheelchairs), organ transplants, and nursing and hospice care.

- The form also includes pre-existing condition requirements, information on whether referrals or prior authorization are needed for specialty care, the main customer service number, and where to write if you have a complaint.

When shopping for insurance, please consider the following consumer information.

- Read the policy. Most issues regarding coverage are a matter of contract law. In the case of insurance, the contract is the policy or evidence of coverage document. If you have questions, call your insurance company or agent.

- Review the section in the policy entitled "**exclusions and limitations**" for benefits that may not be covered, particularly if you think you may need a special or unique treatment.

- Find out how rates will increase as you age, and how often rates can be changed.

- If you are considering a managed care plan, check the plan's provider directory to see which doctors, hospitals, and other health care providers participate in the plan.

- Find out if any "health plan report cards" are available that assess consumer satisfaction with, and/or the quality of care of, various health care plans.

- Call the insurer's customer service phone number to see how quickly you can access someone.

- If you have special needs, such as a specific disease, consult your doctor or call the disease support organization for recommendations.

IF YOU HAVE A PRE-EXISTING CONDITION

If you have, or recently have had, a health problem when you apply for insurance, this is called a "pre-existing condition."

Colorado law strictly regulates the ability of health insurers to limit covered benefits for pre-existing conditions. These rules vary, however, depending on whether the plan is a group or individual plan.

Group Health Plans

A group health plan may exclude coverage for a pre-existing condition for no more than 6 months. Pregnancy under a group plan is **not** considered a pre-existing condition and must be covered immediately.

Once you have fulfilled the waiting period for pre-existing condition exclusion, you don't have to do it again even if you change jobs or health plans, provided that there has been a gap of no more than 90 days between health plans.

Some employers do not offer health insurance until you have been employed for a certain amount of time. The time you wait to get health coverage however, counts toward fulfilling the pre-existing condition exclusion period.

Individual Health Plans

An individual plan may exclude coverage for a pre-existing condition for up to 12 months. The plan can also permanently exclude a specific, documented condition you have, if they attach a written statement excluding such a condition from your coverage at the time of sale.

LEAVING YOUR JOB

In most cases, if you leave your job, either voluntarily or otherwise, you have the right to continue insurance through your employer for an additional 18 months. However, your payments will most likely be higher than before you left employment.

You may qualify for guaranteed issuance of an individual policy, regardless of any health problems you may have, if you have used up your 18 months of continuation coverage and apply to an insurance company selling individual coverage within 63 days. However, your premiums may be much more expensive than through a group health plan.

IF INSURERS WILL NOT SELL YOU COVERAGE

If you are not insured through the work place and have tried to get individual health coverage but have been turned down because you have a medical condition, you may be eligible for the Colorado Uninsurable Health Insurance Plan (CUHIP).

CUHIP is a subsidized state program for uninsurable individuals. Because of their higher medical risk, CUHIP subscribers pay about 30 percent more than healthy people do. Monthly premiums vary, depending on the deductible, your age, gender, county of residence, and whether or not you smoke.

For more information, call the CUHIP administrator at 1-800-672-8447.

IF YOU CANNOT AFFORD PRIVATE INSURANCE COVERAGE

Colorado has a number of special programs for those who cannot afford private health insurance for themselves and/or their children due to limited incomes. Examples are:

- **Medicaid**
  Medicaid is a state-federal health insurance program for persons with very low incomes who meet certain categorical eligibility requirements. For more information, call 1-800-221-3943.

- **Child Health Plan Plus**
  This is a subsidized health insurance program for uninsured children with family incomes below 185% of the federal poverty level who are not eligible for Medicaid. For more information, call: 303-692-2960 or 1-800-359-1991.

- **Colorado Old Age Pension Health and Medical Fund**
  This plan provides medical coverage for individuals over age 60 who qualify for state Old Age Pension but do not qualify for federal Supplemental Security Income. For more information, contact your county social services department.

- **Colorado Indigent Care Program**
  Colorado Indigent Care is a state program that provides partial reimbursement to providers for some of the care they provide eligible low-income uninsured and under-insured Coloradans. For more information, call 303-866-2580.

IF YOU ARE COVERED BY MEDICARE OR MEDICAID

Medicare beneficiaries have additional rights. To learn more about these rights, Medicare coverage issues, or to find out about Medicare supplemental insurance and Medicare HMOs, contact Centura Health Insurance Counseling for Seniors at 1-800-544-9181 (metro Denver call 303-899-5151). Volunteer Medicare counseling programs are also available in many areas of Colorado.

Medicaid clients enrolled in one of Medicaid's managed care plans who need help filing a complaint should contact the Ombudsman for Managed Care at 303-744-7667 or 1-877-435-7123. All other Medicaid clients should call 303-866-3513 or 1-800-221-3943.