A CONSUMERS GUIDE TO INDIVIDUAL HEALTH INSURANCE IN ARIZONA

Published by the
Arizona Department of Insurance

Janet Napolitano, Governor

Charles R. Cohen, Director of Insurance

August 2003

Table of Contents

I.

What You Need to Know About Health Insurance

Rising health care costs have made it very expensive to be injured or ill. If you do not have good medical insurance to help pay the bills, a serious injury or illness can create major financial problems. **Having no coverage, too little coverage, or the wrong kind of coverage can be a costly mistake.**

Many types of health insurance are available at various prices. Some policies pay most of your health care bills for any serious injury or illness. Others pay only some of your bills or only for certain injuries or illnesses. Some policies pay an amount directly related to your actual health care costs. Others pay a specific amount for each day that you are in a hospital, without regard to your actual bills.

Even similar types of policies can vary in the details of their coverage. Health insurance should be selected carefully to make sure that you are getting adequate protection for your needs.

This brochure lists most types of health insurance. Your eligibility will vary from company to company, and may be determined by such things as your age, gender, health status and occupation.

II.

Types of Individual Health Insurance Policies

Individual health insurance may cover one person or all eligible members of a family under one policy. People usually buy individual health insurance policies because they do not have group insurance or they want to supplement their group insurance. Individual health policies also are used to supplement Medicare and to assure that a person has some continued coverage between jobs.

Health insurance policies contain certain benefits and policy provisions required by law. These benefits and provisions can vary depending on the policy and whether you are considering individual or family coverage. A policy may or may not have a deducible that must be paid by you before benefits begin.

There are several types of health insurance policies:

- **Basic Medical-Surgical Expense**

This insurance provides benefit payments for charges made by a physician for medical care and surgical procedures.

- **Hospital Confinement Indemnity**

This insurance pays a fixed amount for each day that you are confined in a hospital. The benefits paid are not based on your actual expenses. This policy is best as a supplement to other insurance and should not be used as a substitute for broader medical expense coverage.

- **Major Medical Expense**

This type of policy is usually effective in covering serious illness or injury where costs are high. Expenses you incur both in and out of the hospital, including drugs and doctors'

visits, usually are covered. Most major medical plans contain a deductible -- the amount you pay before the insurance company begins paying benefits. After your expenses exceed the deductible amount, benefits usually are paid as a percentage of actual expenses, often 80 percent.

- **Disability Income Protection**

This coverage provides for weekly or monthly benefit payments while you are disabled after a covered injury or sickness.

The disability payment is usually a set dollar amount not to exceed a certain percentage of your income. Usually the most you can qualify for is approximately 60 percent of your gross earnings.

Be aware that some disability income policies contain an elimination period, measured from the start of each disability. During that time, no benefits are paid. Elimination periods vary, generally from 30 days to six months. A longer elimination period may provide lower premium payments.

Also, many disability income policies reduce benefits based on other income to which you may be entitled, such as sick leave pay, disability retirement income, and Social Security disability benefits.

- **Accident Only Coverage**

This policy covers losses due to an accident. Benefits vary greatly. Coverage may be provided for death, loss of limb or sight, disability, or hospital and medical care.

- **Specified Disease or Specified Accident**

Some policies cover a specific disease, such as cancer, or a specific kind of accident, such as while traveling away from home. Benefits are not paid for any other sickness or injury. The benefits may be based on your actual medical expenses or payable as a lump sum indemnity.

- **Medicare Supplement**

The federal Medicare program pays most medical expenses for people 65 or older, or for individuals under 65 receiving Social Security disability benefits. However, Medicare does not pay all expenses. As a result, you may consider purchasing a Medicare Supplement policy that helps pay for certain expenses, including deductibles not covered by Medicare.

- **Long-Term Care**

This policy usually pays for skilled, intermediate and custodial care in a nursing home.

It usually pays a fixed amount per day while a person is in a nursing home. Most policies contain elimination periods, during which no benefits are paid. Some policies also cover alternative types of care such as home health care or adult day care. Some even cover home modification expenses.

Normally, these policies pay only for expenses in facilities that are licensed by the state and/or participate in Medicaid and Medicare, and meet the policy's definition of skilled, intermediate or custodial care. For this reason, it is important to find out about the types of nursing homes that are in your area before you buy the policy.

- **Health Maintenance Organizations (HMOs)**

These organizations provide health care services directly to their members, who pay a fixed monthly fee to the HMO. These services include such things as hospital care, surgery and routine office visits. The HMO is an alternative to traditional health insurance because it provides actual services rather than just reimbursement for health care expenses. Enrollees usually pay a small co-payment for care or services they receive.

There are various ways that HMOs can be set up. Some HMOs employ their own physicians, who treat patients at an HMO center. Others contract with individual physicians or

groups of physicians. Patients are treated at the physicians' offices or health centers. Usually, HMO members must receive health care treatment at a designated hospital, HMO facility or from physicians who contract with the HMO to provide services.

Before you pay a fee to join an HMO, ask questions about how it works and where you would receive care, and talk to people who belong to it. Consider whether you may have to stop seeing a specific physician and choose another.

- **Preferred Provider Organizations (PPOs)**

Under this program, an insurance company enters into contracts with selected hospitals and doctors to furnish services at discounted rates. As a member of a PPO, you might be able to seek care from a doctor or hospital that is not a preferred provider, but you will probably have to pay a higher deductible or co-payment.

III.

Waiting Periods, Preexisting Conditions, Exclusions and Limitations

These provisions limit or exclude the insurance company's obligation to pay benefits. **Policies have a list of exclusions and limitations.** Policies with fewer exclusions may be more expensive than policies with more exclusions. Make sure you understand what will and will not be covered.

- **Waiting Periods**

A waiting period is the amount of time that must pass after the policy takes effect and before coverage begins. If a policy has a waiting period, benefits will not be paid or they might be limited for expenses that arise during a specific number of days after the policy is in effect. Waiting periods are not applicable if an individual had certain types of prior coverage, and may only apply to certain conditions or services.

- **Preexisting Conditions**

Individual policies usually will not pay benefits until a certain time period has elapsed for a health condition you had when you bought the policy. This type of health condition is known as a "preexisting" condition. Exclusions for preexisting conditions are intended to preclude individuals with an illness or injury from waiting to buy a policy until they need treatment that would otherwise be paid for under the policy.

You should know the meaning of any provisions excluding benefits for preexisting conditions. Also, you should know how long the provision will exclude benefits for preexisting conditions. Many claims are denied because of these provisions.

Do not think that because the application asks no questions about your health or medical history or the policy requires no physical examination, the policy will cover conditions that you already have. It probably will not. If the company asks questions about your health history it is important to answer them truthfully.

Under some definitions a condition would be considered "preexisting" even if you did not know that you had the condition before you bought your policy. Also, you need to know how many previous years will be considered for determining a preexisting condition.

Policies vary regarding how long they exclude or limit benefits for preexisting conditions. Shop for a policy with the shortest exclusion for preexisting conditions.

- **Other Exclusions**

In addition to excluding preexisting conditions, health insurance policies usually exclude illness or injury resulting from war or military service or those covered under workers' compensation.

IV.

Know Your Rights When Buying Individual Health Insurance

HIPAA, the Health Insurance Portability and Accountability Act of 1996, limits insurers' power to deny or delay claims; reduces your chances of losing existing coverage; makes it easier and less risky to switch health plans; and prohibits insurance discrimination based on health problems. The following are your rights under HIPAA:

- Unless you are considered an "eligible individual" under federal and state law, you may be turned down for an individual insurance policy because of your health status and other factors.

- To be an "eligible individual," you must meet all of the following criteria:

1. You must have had 18 months of continuous creditable coverage, with at least the last day having been under a group health policy. (Coverage is considered continuous if it is not interrupted by a break of 63 or more consecutive days).

2. You must have used up any COBRA group continuation coverage for which you were eligible. COBRA, which gets its name from the Consolidated Omnibus Budget Reconciliation Act of 1986, is a federal program that gives many individuals the right to continue coverage under a group plan. This law applies to insured plans and self-funded, employer plans.

3. You must not be eligible for Medicare, Medicaid or a group health policy.

4. You must not have other health insurance.

5. You must apply for health insurance for which you are deemed an "eligible individual" within 63 days of losing your prior coverage.

- If you meet the criteria, all insurance companies that sell individual health insurance must offer you a policy. This applies to traditional insurance companies and HMOs. Preexisting condition exclusions or waiting periods cannot be imposed on "eligible individuals."

- Your status as an "eligible individual" ends when you enroll in an individual policy. You can become an "eligible individual" again by maintaining 18 months of continuous coverage and rejoining a group health policy.

Additional Rights

- If you are leaving a fully insured group or individual health plan, you may be able to buy a health policy from the company that provided your prior coverage. This is called a conversion policy, but the benefits may not be as generous.

- Under Arizona law, if an individual or group health policy provides family coverage, newborns, adopted children and children placed for adoption are automatically covered under the parents' fully insured health policy for the first 31 days. The insurer may require notification of birth within 31 days to continue coverage beyond the 31-day period.

- If you have a serious or chronic health condition, your individual health insurance premiums may be high. The law does not prohibit health insurers from determining your initial premium rates based on your health status. Premiums may also be increased in the future if they are justified and apply to everyone with the same policy.

- Unless you are an "eligible individual" eligible for a guaranteed issue individual health policy, there are no time

limits for exclusions or preexisting conditions. Coverage for preexisting conditions may be temporarily or permanently excluded. Individual policies can impose exclusion periods for preexisting conditions on pregnancy, but not on newborns if they are covered within 31 days.

- Most individual health insurance policies have a “free look” period, generally from 10 to 30 days, during which they can be returned for a full refund if you are not satisfied. After that period you most likely will not be able to get a refund.

V.

Renewal Provisions and Changing of Premium Rates

The renewal provision defines how the policy can be renewed as well as the insurance company’s right to revise the policy and the premium rates. This provision can affect the cost of a policy. Here are the basic renewal provisions:

- **Noncancelable**

Under this policy, the insurance company cannot change, cancel or refuse to renew the policy as long as premiums are paid on time. The premium rates cannot be changed, but can provide for scheduled rate increases as you age.

- **Guaranteed Renewable**

This policy permits a renewal until a specified age.

- **Conditionally Renewable**

This type of policy allows you to renew until a specified age, subject to the insurance company’s right to decline renewal under conditions specified in the contract.

- **Term or Nonrenewable**

These policies cannot be renewed, and are often purchased to provide coverage for a short period of time.

VI.

Health Care Appeals

If, after you have purchased a health insurance policy, you disagree with the insurance company regarding a denial of a claim or a request for a medical procedure, you can file a formal appeal. The first step is for the consumer to appeal directly to the insurance company. If the insurer denies a formal appeal, the consumer has 30 days to request an external, independent review. Those appeals are referred to the Arizona Department of Insurance or to an independent medical reviewer approved by the Insurance Department. An Expedited Medical Review is available when denial of a treatment or service could cause a negative change in your medical condition. A free brochure that spells out in detail how the Health Care Appeals process works is available from the Arizona Department of Insurance.

VII.

Medicare

Medicare is a federal program administered by the Health Care Financing Administration of the U.S. Department of Health and Human Services. Questions should be directed to HCFA at (1-800) MEDICARE, which is (1-800) 633-4227; or to the State Health Insurance Assistance Program (SHIP) at (602) 542-6446.

If you have questions or complaints, contact the Consumer Services Section of the Arizona Department of Insurance at one of the following offices: 2910 North 44th Street, Suite 210
Phoenix, Arizona, 85018
Phone: 602-912-8444 (Maricopa County)
Toll Free: 1-800-325-2548

400 West Congress Street, Suite 152
Tucson, Arizona 85701
Phone: 520-628-6370 (Tucson)
Website: www.id.state.az.us