Consumer Guide to Health Insurance

DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Oregon Insurance Division

STATE OF OREGON 1859

The Department of Consumer and Business Services, Oregon's largest business regulatory and consumer protection agency, produced this guide. The department protects consumers and workers in areas ranging from insurance to financial services and from worksite safety to building codes.

Toll-free: 1-888-877-4894
Salem area: 503-947-7984
Website: insurance.oregon.gov

To order copies of this guide,
email DCBS.insmail@oregon.gov

This guide was published in April 2015.

Portions of the text may be out of date so be sure to check with specific agencies or programs for the most current information.

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Introduction

Toll-free hotline (888-877-4894)

Sometimes, you need to explain your situation to someone who is an expert in insurance. We staff an insurance hotline from 8 a.m. to 5 p.m. Monday through Friday, excluding holidays.

Our advocates help you understand insurance and resolve disputes with your insurer or agent. You can also email cp.ins@state.or.us or look up insurance tips at www.insurance.oregon.gov.

Through the Insurance Division, the department also:

- Licenses insurance companies and agents.
- Makes sure insurers have enough money to pay claims.
- Reviews policies for consumer protections.
- Investigates potential violations of insurance law by companies and agents.
- Approves health insurance rates for people with individual health plans or coverage through a small employer. Learn more about rate review at www.oregonhealthrates.org.

This guide offers basic information about how to use private health insurance.

This guide does not explain Medicare. If you have Medicare coverage, we publish the annual Oregon Guide to Medigap, Medicare Advantage, and Prescription Drug Plans. Call 800-722-4134 (toll-free) for help.

Health insurance basics

Before we explain how to use insurance, here are a few key points about who can buy insurance, and when and how to buy coverage.

Key health insurance rules

Since the Affordable Care Act became law, key rules about health insurance have changed. As a result:

- Everyone can get health insurance, even if they have pre-existing health conditions, as long as they apply during open enrollment periods.
- Most individuals, including young people, must have health insurance or pay a tax penalty.
- More people than ever before qualify for financial help to buy private insurance. For example, a family of four with an income of up to $95,400 (in 2014) now may qualify for federal help with private health insurance premiums.
- Insurance companies and employers that offer dependent coverage to children must cover adult children up to age 26.
- While small employers do not have to offer insurance, large employers with 100 or more full-time employees must offer health coverage or pay a penalty. The requirement extends to employers with 50 or more employees in 2016.

Shopping for health insurance

Both small employers with 50 or fewer employees and individuals who are on their own to buy coverage have these options:

- Visit the Health Insurance Marketplace at **healthcare.gov** to compare plans and prices and potentially qualify for financial help with insurance costs.
- Get help from an agent. Agents can help you shop through **healthcare.gov** or outside the Health Insurance Marketplace.
- Contact an insurance company directly.

Premiums

- Your monthly premium for health insurance depends on your plan choices, your age, where you live in the state, if you use tobacco, and your family size or number of family members on an employer plan. Your rates cannot be based on your health or claims history.
- Your rates can be changed annually and typically reflect changes in medical costs.
- If you are an employer, your annual rate changes will be based, in part, on the average age of those you cover. However, rates for the oldest people cannot be more than three times the rates for the youngest people.
- The same plan costs the same, regardless of whether you buy through healthcare.gov or outside the Health Insurance Marketplace.
- Financial help to pay for private insurance is available only through the Health Insurance Marketplace.

Plans

- There are many types of insurance policies with varying price tags. The key is to find the policy that best fits your medical needs and your budget.
- For example, if you are young and healthy, you may want a higher deductible plan with a lower premium.
- Make sure your doctor is in the plan's network so you pay the least possible amount. If you don't have a doctor, check to see if the doctors in your area who are taking new patients are approved under the plan. Decide if you are willing to change your doctor if he or she is not in the plan's network.

Open enrollment

If you have ever worked for an employer that offered health insurance, you know about open enrollment. This is the one time of year when you can change plans, change insurance companies, or choose to stay with the plan you have. Think of it as a health insurance shopping season.

Without open enrollment, people might wait until they become sick to buy insurance. If everyone waited until they were sick to buy coverage, insurance could not cover medical bills.

Employer open enrollment

- If you work for an employer that offers health insurance, ask your human resources department when open enrollment occurs.
- During open enrollment, your employer may change coverage options or decide whether your share of the costs changes.
- In general, small employers may start offering health insurance coverage to their employees at any time during the year.

Individuals

- Starting in 2014, if you buy insurance on your own, you will also have an open enrollment period.

Medicaid

- People who qualify for the Oregon Health Plan (Medicaid) can sign up any time.

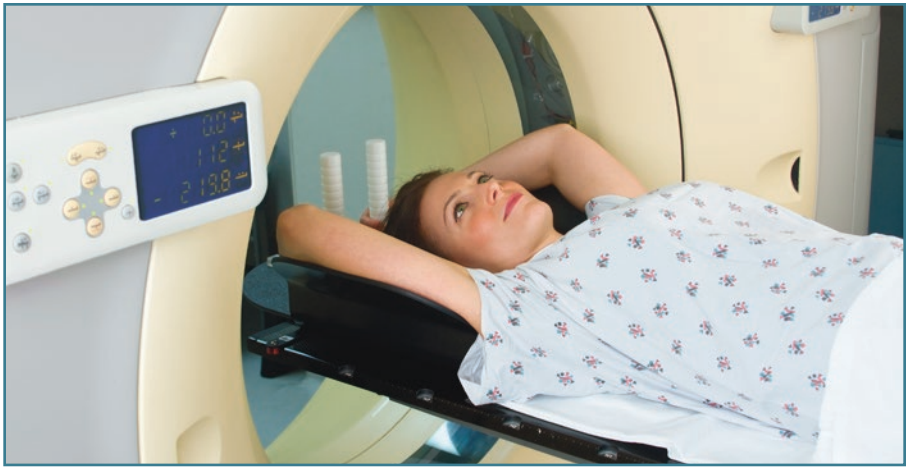
Special enrollment times

- If your marriage status changes, you have a child, lose your job, become a U.S. citizen, or experience other specified life events, you may be eligible to sign up for coverage outside of open enrollment. The insurance advocates can help with questions about special enrollment. Call 888-877-4894 (toll-free) or email cp.ins@state.or.us.

Types of health plans

Whether you get insurance at work or buy a plan on your own, understanding how your policy works will help you make the best use of your benefits.

- Most people have some type of managed care. These plans control health care costs and ensure quality by tying insurance policy benefits to a network of preferred providers such as doctors and hospitals. These providers contract with the insurance company.
- Preferred provider organizations or PPO plans, for example, sign contracts with selected hospitals, physicians, and others who agree to provide a discount for services. If you use doctors outside this network, you will generally pay more.
- You may need approval from the insurance company before you obtain services from an out-of-network provider. If you do not get approval in advance, the insurance company may refuse payment.
- Plans usually require you to choose a primary care provider from a list of in-network providers. Your primary care provider manages all of your health care. Except for emergencies, if you need care from another provider, your primary care provider may need to give you a referral.



Limited-benefit plans

These types of plans are intended to be used with comprehensive health insurance plans. They are not intended to be your only health insurance. If you have only this type of plan, you could be penalized because they do not offer the basic benefits required by the Affordable Care Act.

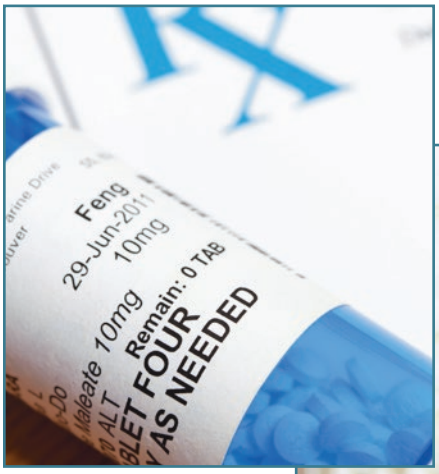
- **Basic hospital expense plans:** These plans cover a specific number of days of continuous inpatient hospital care and specific outpatient hospital services.
- **Basic medical-surgical expense plans:** These plans pay only for medically necessary surgery costs and a specific number of hospital care days.
- **Hospital confinement indemnity plans:** These plans pay a fixed amount for each day that you are in the hospital.
- **Accident-only plans:** These plans may pay for death, dismemberment, disability, hospital, and medical care caused by an accident.
- **Specified disease plans:** These plans pay for diagnosis and treatment of a specific disease or diseases, such as cancer.
- **Other limited plans:** You may purchase insurance covering only dental or vision or other specified care.

What is covered?

Small employers or individuals

All health plans purchased by a small employer or that you buy on your own after Jan. 1, 2014, must cover these essential health benefits:

- Emergency services
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Mental health and substance abuse treatment (including counseling and psychotherapy)
- Outpatient (ambulatory) care
- Pediatric (children's) services, including vision and dental care
- Prescription drugs
- Preventive care, including chronic disease management
- Rehabilitative and habilitative care (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)



Other benefit information

- Plans must provide certain preventive benefits (such as immunizations) to you without any co-pays or co-insurance (percentage of costs). Examples are colorectal cancer screenings for people older than age 50; immunizations and vaccines for adults and children; stop-smoking counseling; and well-woman checkups, including mammograms and cervical cancer screenings.
- Plans used to limit how much insurers would pay for a person's medical bills over a lifetime. This is now illegal, so you do not have to worry about your coverage running out.
- Your plan can no longer set annual dollar limits on what it pays for essential health benefits. However, the plan can set other types of limits, such as how many doctor visits or days in the hospital it covers.
- Your annual out-of-pocket costs (such as co-pays) cannot be more than $6,600 for individuals and $13,200 for families. Some plans have lower annual out-of-pocket costs than these federally allowed maximums. Out-of-pocket costs are important considerations when shopping and choosing the right plan for you. These limits will increase based on the amount of average premium growth in future years.

Self-insured employers

The U.S. Department of Labor, not the state Insurance Division, regulates self-insured employers. See dol.gov/ebsa.

A self-insured group health plan is one in which the employer assumes the financial risk for providing health care benefits to its employees. Self-insured employers pay claims instead of paying premium to an insurance carrier.

What medical care must my insurer pay for?

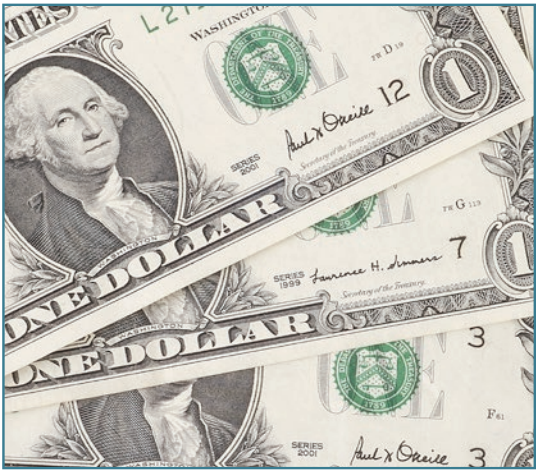
- Insurers pay for the medical treatments defined in your policy. Your policy will list certain treatments, such as cosmetic surgery, that insurance won't pay for.
- Insurers pay only for treatments that are medically necessary. Medically necessary is defined in your insurance policy.
- Insurers do not pay for medical treatments that are experimental or investigational.
- Most plans must cover specific preventive care services without cost sharing to consumers. This means you will not have co-pays, co-insurance, or deductibles for certain services as long as in-network doctors or medical staff provide them. Some examples of preventive services are screenings for breast and colon cancer, diabetes, high cholesterol and high blood pressure, routine vaccines, regular pediatrician visits, vision and hearing screening, counseling to address obesity, and all FDA-approved contraceptive services as prescribed. Check with your insurer and doctor to verify that the treatment is covered as preventive care.
- Insurers may require that you get prior approval from the insurance company for medical treatment before the insurance company will pay for the treatment. However, you are not required to get preauthorization for emergency medical treatment. Insurance companies must give you a written explanation about emergency medical treatment.

••• Tip: What medical bills are covered •••

Insurance companies have detailed guidelines on when coverage is allowed. You can ask for the guidelines for your particular treatment. However, advance information is often incomplete. Final coverage decisions are usually based on details in medical records.

What an agent or company representative says does not change how the policy covers a procedure. The company may, in fact, say that prior authorization is not needed. That does not mean it will cover the procedure. The procedure still must meet medical guidelines. On the other hand, if prior authorization is required and obtained, the company may be required to cover the care you received.

Paying the bills



You and your insurance company share the costs of care covered by your policy and your policy explains exactly who pays for what. Call the customer service number on your insurance card to find out how your policy works. Here is an example of how health insurance typically works:

1. You give the doctor or hospital your insurance card at the time you seek medical care.
2. You pay the doctor or hospital any co-payment required by the insurance plan.
3. Usually, the doctor bills the insurance company. You must bill your insurance if the doctor does not do this for you.
4. The insurance company sends you an explanation of benefits. It lists what the doctor or hospital charged, the maximum amount the insurance company allows for that procedure, what the insurance company paid as its share, and your share of costs.

Note: *If you have more than one health insurance plan, insurance companies may coordinate payment of benefits. This means that the companies determine how much each of them will pay toward your medical treatment.*

5. You pay your share of the bills.

••• Tip •••

You can call your insurance company or visit the company's website to find out in advance what your share of costs would be for an office visit, diagnostic test, birth, immunization, or certain other common procedures.

Key billing terms

Allowed amount: The most the insurance company will pay for medical care it covers. If an out-of-network provider (doctor or hospital, for example) charges more than the allowed amount, you may have to pay the difference. (See balance billing.)

Balance billing: When a doctor, hospital, or other provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider cannot balance-bill you.

Co-insurance: Your share of the costs for care that is covered. It is a percent (for example, 20 percent) of the allowed amount. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you have met your deductible, your co-insurance payment of 20 percent would be $20. The health insurance or plan pays the rest of the allowed amount.

Co-payment: A fixed amount (for example, $15) you pay for covered care, usually when you receive the service. The amount can vary. For example, it might be $15 for a regular doctor visit and $30 for a specialist visit. Your prescription drug co-payment could vary depending on the type of prescription drugs. For example, a brand-name drug could have a higher co-pay than a generic drug.

Deductible: The annual amount you pay for care before your plan begins to pay. For example, if your deductible is $1,000, your plan will not pay anything until you have paid $1,000 worth of care. The deductible may not apply to all services. For example, it does not apply to preventive care. Co-payments typically are not included in your deductible.

Family deductible: If your family is covered under your plan, check to see how your family deductible works. Here are two key ways it might work. Let's say you have an individual deductible of $1,000 and a family deductible of $3,000.

1. With some plans, the $3,000 deductible can be met by one person or any number of family members.
2. Other plans require each family member to meet an individual deductible until the family deductible is met. In this case, three family members each have to meet their $1,000 deductible.

Out-of-network provider: A doctor, hospital, or other medical provider that does not have a contract with your health insurer or plan to provide services to you. You will pay more to see an out-of-network provider.

Out-of-pocket limit: The most you pay during a policy period (usually a year) before your plan begins to pay 100 percent of the allowed amount. This limit never includes your premium, balance-billed charges, or health care your health insurance or plan does not cover. Some health insurance or plans do not count all of your co-payments, deductibles, co-insurance payments, out-of-network payments, or other expenses toward this limit.

In-network provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all in-network providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Premium: The amount you pay for health insurance regardless of whether you use services. You, your employer, or both usually pay it monthly, quarterly, or yearly. The amount you pay is not based on how much medical care you use. Generally, the lower your premium, the more you will pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance.

UCR (Usual, customary, and reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Understanding insurance billing

How you and your insurer share in-network costs

Deductible: $1,500	Co-insurance: 20%	Out-of-pocket limit: $6,350
Jan. 1 Start of policy year	Mid-year	Dec. 31 End of policy period
Jane hasn't reached her $1,500 deductible yet	Jane reaches her $1,500 deductible; co-insurance begins	Jane reaches her $6,350 out-of-pocket limit by fall
Her plan doesn't pay any of the allowed costs	Now her plan pays some of the allowed costs for her next visits	Now her plan pays the full cost of covered health care for the rest of the year
Office visit costs $125 **Jane pays.....$125** **Plan pays.....$0**	**Office visit allowed costs.....$125** **Jane pays 20% of $125 .....= $25** **Plan pays: 80% of $125 .....= $100**	**Office visit allowed costs .....$125** **Jane pays .....$0** **Plan pays $125**

The chart above shows cost savings if you use in-network providers — doctors and others who contract with your insurer so you get discounted rates. The chart below shows how your costs might increase if you use an out-of-network provider. It's easy to end up with an out-of-network provider if you are not careful. Doctors move in and out of networks. Even if your doctor is in network, some services (for example, lab work your doctor orders or anesthesiology at a hospital) may be provided by out-of-network providers. Knowing whether services will be from in-network or out-of-network providers will help you understand your potential bills.

How in-network and out-of-network costs compare

	In-network provider	Out-of-network provider
Provider charge	$1,000	$1,000
Maximum insurance allowed amount	$700	$700
Insurance payment	$560 (80% of $700)	$420 (60% of $700)
You pay	$140 ($700-$560)	$280 ($700-$420)
Amount you pay above allowed amount	$0	$300
Your total cost:	**$140**	**$580**

My claim was denied: Now what?

You can file a complaint with the Oregon Insurance Division by going to www.insurance.oregon.gov or calling 888-877-4894 (toll-free). We will help you through the process.

Health benefit plans define appeal procedures in your policy. You can appeal an insurance company's decision to deny a claim or a decision to pay less than the allowed amount.

Appeals

Your first appeals through the insurance company are internal reviews.

Internal review

For group and individual health benefit plans, you have a right to an internal review (appeal) by people not previously involved in the dispute.

- Generally, your insurance company must make a decision and respond within 30 days.
- If your insurance company needs more time, it must notify you of the reason and send a decision within 15 additional days. No further extension is allowed.
- If your insurance company denies your internal appeal, you may have the right to seek an impartial external review.

External review (independent third party)

You have the right to an independent external review of any "adverse benefit determination." This occurs any time an insurer denies, ends, or refuses to pay for all or part of a medical service because:

- It terminated or rescinded your plan.
- The service would normally be covered but the insurance company imposed a pre-existing condition exclusion, provider network exclusion, or other exclusion or limitation.
- It refused to pay for the service because it is experimental, investigational, or not medically necessary.
- It determined that the claim is part of ongoing treatment that should be paid by your previous health care provider, due to Oregon's continuity of care law.

For more information on external reviews, go to www.insurance.oregon.gov.

Expedited review

Your insurance company must have a process for responding more quickly to emergencies. This is called "expedited review." The whole process, including external review, must be conducted within 72 hours or sooner, if necessary.

What if I lose my job?

If you lose your job and your health insurance, you may qualify for financial help through **healthcare.gov** that will allow you to keep private insurance or gain coverage through a public program.

Other options:

- If a spouse or domestic partner gets insurance at work, he or she may be able to add you and family members to his or her insurance policy. Contact the employer as soon as possible.
- If you lose your job and your employer stays in business and has 20 or more employees, a federal law known as COBRA allows you to purchase and continue your same insurance plan. You are eligible to keep your insurance for 18 months as long as you pay the premium. In some cases, you can keep your insurance for 36 months. Your insurance company will send you a notice of your COBRA options.
- If you lose your job and your employer has fewer than 20 employees, you can purchase and continue your same employer plan for nine months. You pay the full cost of the insurance. Immediately notify your employer if you are interested in this option. You must have been covered for at least three months and cannot be eligible for Medicare.
- If you are age 55 or older and were insured through a spouse but become widowed, divorced, or legally separated, Oregon law allows you to keep the employer's insurance until you become Medicare eligible. This applies only to employers with 20 or more employees.

More questions?

Oregon Insurance Division: Consumer advocates answer general insurance questions and help people resolve complaints against an insurance company or agent.

Phone: 503-947-7984 (Salem area) or 888-877-4894 (toll-free)
Email: cp.ins@state.or.us
Website: insurance.oregon.gov

Health Insurance Marketplace: Starting Nov. 15, 2014, you can visit the Health Insurance Marketplace to compare and enroll in health insurance and access financial help.

Phone: 800-318-2596 (toll-free)
Website: healthcare.gov

Oregon Prescription Drug Program: This state program provides discounts on prescription drugs, especially generics. It is available to all Oregonians, regardless of age, income, or insurance status.

Phone: 888-411-6737 (toll-free)
Website: www.opdp.org

U.S. Department of Health and Human Services (HHS): This agency provides a website that explains federal health care reforms.

Website: www.healthcare.gov

U.S. Department of Labor (Employee Benefits Security Administration): Information and rules for people whose employers are self-insured.

Phone: 866-444-3272 (toll-free)
Website: www.dol.gov/ebsa

Medicare help

Medicare: Health insurance for people age 65 and older, some people younger than 65 with disabilities, and people with kidney failure.

Phone: 800-633-4227 (24 hours a day, seven days a week, toll-free)
Website: medicare.gov

Senior Health Insurance Benefits Assistance (SHIBA): State program that offers personalized help understanding Medicare choices.

Phone: 800-722-4134 (toll-free)
Email: shiba.oregon@state.or.us
Website: oregonshiba.org

Social Security Administration: Where Medicare beneficiaries apply for "extra help" with Part D prescription drug costs.

Phone: 800-772-1213 (7 a.m. to 7 p.m. Monday to Friday, toll-free)
Website: ssa.gov

Need help with an insurance question or complaint?

Contact a consumer advocate

Phone: 503-947-7984 or
Toll-free: 1-888-877-4894
E-mail: cp.ins@state.or.us
www.insurance.oregon.gov
www.oregonhealthrates.org

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