CONSUMER GUIDE TO

Health Insurance

Oregon Insurance Division

About the Oregon Insurance Division

The mission of the Insurance Division is to administer the Insurance Code for the protection of the insurance-buying public while supporting a positive business climate.

We ensure the financial soundness of insurers, the availability and affordability of insurance, and the fair treatment of consumers by doing the following:

- Licensing insurance companies and monitoring their solvency
- Reviewing insurance products and premium rates for compliance
- Licensing insurance agents and consultants
- Resolving consumer complaints
- Investigating and penalizing companies and agents for violations of insurance law
- Monitoring the marketplace conduct of insurers and agents
- Educating the public about insurance issues
- Advocating reforms that protect the insurance-buying public

Call us for help

- **Consumer Protection Section — (503) 947-7984 or (888) 877-4894 (toll-free in Oregon)**
  You have the right to seek assistance from the Insurance Division at any time by filing a formal complaint against an insurance company or agent. A copy of the complaint is sent to the insurance company. A response from the insurance company or agent must be received at the Insurance Division within 21 days. If the response is not adequate, a consumer advocate will work with you and the insurance company to try to resolve the problem. The Insurance Division will forward a copy of the insurance company's response to you. If a law has been broken, the matter may be referred to the Insurance Division's Investigations Unit.

- **Financial Regulation Section — (503) 947-7982**
  To find out if a company is authorized to sell insurance in Oregon, call our Financial Regulation Section or visit our Web site, **insurance.oregon.gov;** click on "Company Information."

- **Producer Licensing Unit — (503) 947-7981**
  To find out if your insurance producer (agent) is licensed to do business in Oregon, call our Producer Licensing Unit or visit our Web site, **insurance.oregon.gov**; click on "Producer (Agent) Information."

Visit our Web site

The Oregon Insurance Division's Web site includes all of our publications as well as other useful information for consumers. You can file a complaint against an insurance company or agent, check to see if an insurer is authorized to do business in Oregon, and find out if your insurance agent is licensed in Oregon. Our Web address: **insurance.oregon.gov.**

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About this publication

Health insurance helps pay for many medically necessary services. Because medical services can be very expensive, most people want health insurance to help them get adequate medical treatment when they need it and to help them pay for it. There are many types of health-insurance policies that provide various benefits at differing costs.

This guide from the Department of Consumer & Business Services' Insurance Division can help you understand health insurance and make informed choices. It includes information about how to get insurance, kinds of coverage available, your health-care rights, and where to find additional information.

To discuss the coverage you have or may need, you should contact your employer, insurance producer, or insurance company. We recommend that you read this guide first.

How doctors are paid

Insurance companies negotiate contracts with physicians to provide medical services to health-plan members. A physician who contracts with an insurance company is called a "preferred" or "participating" provider. Participating providers are paid in various ways. The most common contract arrangements are "capitated arrangements" and "fee-for-service agreements."

Under a capitated arrangement, which is typical of managed-care and health-maintenance organizations (MCOs and HMOs), physicians get a guaranteed amount per enrolled patient from the insurance company. The doctors are paid whether or not the patients receive medical services — the doctors are expected to manage the care of the group of enrollees to maximize their health.

Under a fee-for-service agreement, physicians are reimbursed by insurance companies for services provided to patients. If patients don't go to the doctor, the physician receives no payment.

You have the right to find out from your insurer how your physician is reimbursed and whether she or he is rewarded or penalized for postponing or granting access to medical services.

If you see a non-participating provider, your insurance plan will limit the amount it pays toward your medical expenses. You are liable to pay the difference between what your insurer pays and the amount the provider charges, plus deductibles, co-insurance and co-pays.

Prompt payment of providers

An insurer must pay or deny a "clean claim" (a complete and accurate billing statement for medical services) no later than 30 days after the date on which the insurer receives the claim. If the insurer requires additional information before paying the claim, the insurer must notify the enrollee and the provider in writing and give the enrollee and the provider an explanation of the additional information needed to process the claim. The insurer must process the claim within 30 days of receiving the additional information.

How to get health insurance

Most people get health insurance through group plans offered by their employers; such plans are usually paid for by the employer and by the employee through payroll deductions.

At work

Employers are not *required* to provide health insurance for employees. However, if an employer *chooses* to offer health coverage, the policy must be available to all eligible employees, usually during an annual insurance sign-up period called open enrollment. Many employers offer health insurance only to full-time employees.

If, as an employee whose company offers health-insurance benefits, you do not enroll in the employer's insurance plan within 30 days of initial eligibility, the insurance company can require you to complete a questionnaire called a standard health statement. The health statement can be used only to determine pre-existing medical conditions, not to refuse you group health insurance.

Special rules apply to health insurance offered by employers with 50 or fewer employees. You can find information about insurance companies that offer small-employer health insurance (SEHI), their service areas, and their premiums on our Web site, **insurance.oregon.gov.**

Self-insured health plans

Some employers choose to pay employees' health costs instead of offering a plan from an insurance company. These plans, self-funded by employers, are called self-insured plans.

Some employers hire an insurance company, a managed-care organization (MCO), or a third-party administrator (TPA) to handle their claims under a self-insured health plan. The self-insured health plan must be available to all eligible employees, and the employer is responsible for ensuring that it is.

Self-insured health plans are regulated by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA). State governments do not regulate self-insured plans; however, the Oregon Insurance Division may be able to provide consumer assistance if you have questions or complaints about such a plan.

For additional information or to file a complaint about a self-insured plan, contact the U.S. Department of Labor, Seattle District Office, 1111 Third Ave., Suite 860, MIDCOM Tower, Seattle WA 98101-3212. You may call the Department of Labor's office in Seattle, (206) 553-4244.

Club and association group plans

Some fraternal and professional organizations, associations, and clubs offer group health insurance to members. Like insurance offered by employers, this health insurance must be offered at some time to all eligible members. This is called "guaranteed issue." To find out whether an organization offers health insurance to its members, contact the organization's member services representative.

Individual insurance plans

If you do not have access to group coverage, you can often buy a policy for yourself and your family on the individual market. Premiums (the amount you pay for your health-insurance policy) vary, based on your age, family size, and the area in which you live.

Purchasing an individual policy requires careful shopping because costs, benefits, and underwriting standards (the guidelines and procedures used by insurance companies to decide whether to insure you) vary.

If you apply for an individual insurance plan, you will be asked to complete a questionnaire about your health called the Oregon Standard Health Statement. The health statement requests medical information from the past five years.

Be sure to fill out the health statement and application completely and accurately. You should disclose all health conditions that you have had during the past five years, including any condition for which you take medication. Be sure to explain on the form if you no longer have a medical problem.

If you make an error on the application, cross it out and initial the changes.

How to get health insurance

If the insurance company sells you a policy, your application becomes part of the policy and is considered a legal document. Your insurance company can investigate and rescind, or take back, your policy for up to two years after you apply if you provide inaccurate information on your application or fail to disclose a condition occurring within the past five years.

Should you answer "yes" to any question on the health statement, an insurance company has the right to request your medical records and use that information and any other information from your application to decide whether to offer you health insurance, even if the information is about a condition that you had more than five years ago.

Companies generally refuse to insure people with chronic illnesses. If you have a chronic illness, you may be able to get insurance through a government insurance program, described below.

Government programs

Oregon Medical Insurance Pool (OMIP)

OMIP offers individual health plans to those who have been refused individual health insurance because of their medical conditions. There is a 25 percent surcharge added to regular insurance rates for this coverage. There is no waiting period for treatment of pre-existing conditions for those who had health insurance within 63 days of the start of the new OMIP policy. This is called "creditable coverage." Without creditable coverage, you may have to wait up to six months for insurance coverage of pre-existing conditions.

Family Health Insurance Assistance Program (FHIAP)

This program helps uninsured Oregon families and individuals obtain health insurance by paying part of their premiums, including premiums for employer-sponsored insurance. For information about eligibility, call FHIAP toll-free, (800) 542-3104.

Oregon Health Plan (OHP)/Medicaid Program

The Oregon Health Plan is Oregon's version of Medicaid, the comprehensive federal health-insurance program for people with disabilities and those with very low incomes. For information, call the Oregon Health Plan, (800) 359-9517, toll-free, or call the Seniors and People with Disabilities office nearest you. To find the nearest Seniors and People with Disabilities office, call the Department of Human Services, Seniors and People with Disabilities, (800) 282-8096.

Medicare

Medicare is a federal program providing medical insurance for people 65 or older, those who draw Social Security disability payments, and those who have kidney disease. More information is available by calling 1-800-Medicare or on the Web: **www.medicare.gov**. Information about Medicare also is available from the Senior Health Insurance Benefits Assistance Program (SHIBA). SHIBA has volunteers throughout Oregon who provide one-on-one counseling about Medicare, Medicare-supplement insurance, Medicare health-maintenance organizations, and long-term-care insurance. Call (800) 722-4134 (toll-free in Oregon) to request a copy of *Free Help with Medicare and Other Health Insurance*. It includes a list of phone numbers for contacting SHIBA volunteers.

The Social Security Administration (phone: (800) 877-1213, toll-free) or local Social Security branch office can help you find out if you are eligible for Medicare and, if so, can enroll you and tell you what your monthly premium will be.

What if I lose my insurance?

You have several coverage options if you lose your employer-sponsored group coverage. These options are available through the Consolidated Omnibus Reconciliation Act (COBRA), state continuation programs, and portability of coverage, which is provided by state and federal programs.

COBRA

COBRA is a federal law requiring continuation of existing coverage to people who have lost their employer-sponsored group coverage because of reduced work hours or lost jobs. COBRA allows qualified individuals to purchase coverage for limited periods, usually 18 months. Spouses and dependents may be eligible for coverage if the primary insured has died or is divorced from the former spouse. COBRA may be available if your employer had 20 or more employees. COBRA coverage may include vision, dental, or prescription coverage. COBRA is regulated by the U.S. Department of Labor. Additional information is available on the Web, **www.dol.gov/ebsa**. You may write to the Seattle District Office, 1111 Third Ave., Suite 860, MIDCOM Tower, Seattle WA 98101-3212. You can call the U.S. Department of Labor, (206) 553-4244, or (866) 444-3272.

State continuation of coverage

You may be eligible to continue your group policy if your benefits have been affected by the loss of your job, divorce or legal separation, or if your spouse has died and you do not qualify for COBRA coverage. The employer that provided the group policy must have fewer than 20 employees in order for you to qualify for state continuation of coverage.

A continuation-of-coverage policy will provide protection for six months or until you are eligible for other coverage (including Medicare), whichever is shorter.

OMIP also provides health coverage to Oregonians who have exhausted their COBRA benefits and have no other portability plans available to them. OMIP portability rates are similar to insurance companies' rates. For more information, call (800) 848-7280, toll-free.

Portability of coverage

Portability makes ongoing insurance coverage available if you were enrolled in an employer-sponsored group health plan for at least six months immediately before your coverage ended. Except as noted on Page 6, the insurer that provided your group coverage must offer you an individual health policy covering you and your eligible dependents, regardless of health conditions. Premiums are determined by the insurer.

Highlights of portability:

- Plans must cover pre-existing conditions.
- Your current health insurer must provide a "certificate of creditable coverage" when your group coverage ends. This proves you had prior insurance, helps determine if you qualify for portability coverage, and ensures coverage for pre-existing conditions.
- If you're enrolled in a portability plan, you can keep your portability coverage even after you obtain other coverage. The portability plan will pay benefits, as will your individual, group, or Medicare policy. This coordination of benefits will pay up to 100 percent of qualifying medical expenses, but will not pay more than your actual medical expenses.

To qualify for portability:

- You must be an Oregon resident.
- You must apply for portability of coverage within 63 days of losing your group coverage.
- You can't be eligible to remain enrolled in your prior group coverage, can't be eligible for Medicare, and can't be enrolled in another health insurance plan.

You may qualify for portability under Oregon rules or federal Health Insurance Portability and Accountability Act (HIPAA) rules.

You qualify under Oregon rules if either of the following is true:

- You were enrolled in Oregon-based group coverage for at least six months.
- You were enrolled in non-Oregon based group coverage for at least six months while residing in Oregon.

What if I lose my insurance?

If your prior group coverage was in a self-insured plan, you must exhaust your state or COBRA continuation coverage before electing portability. If your prior coverage was in a commercially available plan, you do not need to exhaust COBRA.

You can qualify under federal HIPAA rules if both of the following are true:

- You have at least 18 months of prior health insurance coverage and the most-recent coverage was in a group plan.
- You have exhausted your state or COBRA continuation coverage. (You may become eligible under Oregon rules before your continuation coverage is exhausted.)

You have a choice of two portability plans:

- Prevailing Benefit Plan, with coverage similar to most group plans.
- Low-Cost Plan, with higher deductibles and copayments.

Exception: Portability coverage is provided by the Oregon Medical Insurance Pool (OMIP) if:

- You were enrolled in non-Oregon-based group coverage.
- You were enrolled in self-insured group coverage sponsored by an employer or employer group.
- You qualified for portability coverage from an Oregon insurance company but moved out of the insurer's service area (yet still reside in Oregon) or the insurance company discontinued serving the area in which you live.

You will not be charged extra for your premium if you qualify for a portability plan through the Oregon Medical Insurance Pool.

Your health-care rights

An insurance company cannot deny, limit, charge more for, or refuse to renew your coverage because of your race, color, religion, or national origin. Individuals with similar levels of risk (of the same rate class) cannot be offered different rates, policy terms, or benefits, nor can they be discriminated against in any other manner unless the insurer bases the refusal, limitation, or higher rate on sound actuarial principles.

Access to health information

The Health Insurance Portability and Accountability Act of 1996 provides the right of access to your health information. This means that your medical records must be released to you upon written request. HIPAA also restricts the release of your personal information, including your name and your medical history, by health insurers and providers.

Complaints about lack of access or possible violations of privacy related to your personal health information should be sent by e-mail to OCRcomplaint@hhs.gov. Letters can be sent to Region X Office for Civil Rights, U.S. Department of Health and Human Services, 2201 Sixth Ave., Suite 900, Seattle WA 98121-1831, or faxed to (206) 615-2297.

Be sure to include the name of the party about whom you have a complaint and a description of how your privacy was violated.

Complaints about possible privacy violations by an insurance company or an producer should be sent to the Oregon Insurance Division.

Information your insurer must provide to you

Your insurance company is required to provide the following written guidelines to you:

- Covered benefits, services, copays and co-insurance amounts.
- Participating providers, network and service-area restrictions.
- Referrals to specialists.
- Where to go for emergency care.
- Preauthorization requirements.
- How to choose and change primary-care providers (PCPs).
- General prescription-drug formulary guidelines.
- How enrollees will be notified of changes in benefits.

- How enrollees will be notified of changes in physician availability and how to obtain assistance.
- Language services available to non-English speakers.

The following information must be available from your insurance company at your request:

- How to get mental-health services, hospital services, and specialized treatments.
- Complaints and grievances received by the company.
- Information about how providers are paid for medical services.
- Providers' qualifications.
- Utilization-review procedures for specific diseases.
- Quality-improvement reports.

Medically necessary services

Within the coverage limitations of your insurance policy, you have a right to have your medical needs met. If a treatment plan does not meet your medical needs, you have a right to receive a different treatment if your physician agrees that it is medically necessary and the treatment meets current medical standards for medically necessary treatment.

Emergency services

Your insurance company must provide a written disclosure to you, clearly explaining the following:

- How the company defines "emergency."
- Coverage for emergency services.
- How and where to get emergency services.
- Appropriate use of 9-1-1 services.

Although many insurance plans require preauthorization (permission from the insurance company before services are rendered by a provider) for certain medical treatments, you are not required to obtain it for emergency medical services.

Oregon law defines emergency as "a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy."

Emergency services include stabilization of medical conditions, emergency medical screening exams, items and services furnished in the emergency room, and related services, including ambulance transportation from participating and nonparticipating providers.

Cancer screening

Women 40 and older can get a routine preventive mammogram every year without a referral from their primary-care physician. Your insurance company may require you to select from among participating providers for the mammogram.

Mammograms must be covered as often as needed for women at high risk for breast cancer or who are experiencing symptoms; they must be referred by a women's health-care provider.

If your primary-care physician is not a women's health-care provider, you may get care from a participating women's health-care provider for pregnancies and for at least one health examination a year without obtaining a referral from your primary-care physician. This means that a managed-care plan cannot require you to get a referral from your primary-care physician for these services. You can continue treatment without a referral for any medically necessary follow-up to the initial condition for which you sought care. However, you or your women's health-care provider should notify and consult with your primary-care provider.

Your health-care rights

Pregnancy and childbirth

You have the right to see an in-network women's health-care specialist for your pregnancy. You must be allowed a minimum hospital stay of 48 hours for a normal vaginal delivery and 96 hours for a Caesarean section. Your insurance company must begin calculating the hospital stay from the time of birth. For a home delivery that results in a hospital admission, the hospital stay begins at the time of admission. The attending physician and mother may decide that a shorter hospital stay is appropriate. Your insurance company cannot require you to leave the hospital after a stay shorter than these minimums.

Newborn and adopted children

Individual and employer-sponsored group health policies must provide benefits for newborn and adopted children if the policy provides coverage for dependents. Insurance policies may give you as little as one month to enroll new members of the family, so notify your insurance company promptly. If there is an additional premium due because of the new family member on the policy, it needs to be paid within 31 days after the birth or placement of the adopted child in your home.

A child is eligible for dependent coverage if a legal obligation exists for you to provide total or partial support, including when you are anticipating adopting the child. If the adoption is not finalized, the child may not be eligible for coverage on your policy.

Diabetes education

Many group and employer-sponsored health plans cover an initial diabetes self-management education program taught by a health-care professional. You must complete the program to be eligible for benefits. Be sure to review your benefit booklet to see if limitations apply to this coverage.

Mental health and treatment for chemical dependency

Individual plans and policies issued by labor unions may exclude mental health and chemical-dependency treatment or may provide very limited benefits.

Most group and employer health plans issued in Oregon must include minimal coverage for mental-health and chemical-dependency services.

Most policies that cover these services require you and your therapist to develop a treatment plan. Some companies may review this treatment plan to determine if it is medically necessary.

Review your benefits booklet or contact your insurance company to be certain you understand your mental-health and chemical-dependency coverage.

Get answers to the following questions:

- From which providers can I choose?
- Do I need a referral from my PCP?
- How often are treatment plans reviewed and what are the guidelines?
- How much will my insurance pay?
- Do I have to pay any deductibles or copays?

Your copay and deductible for mental health and chemical-dependency services must be the same as for any other medical condition. For example, if your copay is $10 for a doctor visit, it should be the same for outpatient mental health and chemical-dependency visits. Copay and benefit limitations for inpatient mental health and chemical-dependency care are different than those for outpatient care.

Effective Jan. 1, 2007, group policies must cover mental health and chemical dependency treatment at the same level as other medical conditions.

Managed-care rights

Standing referrals to specialists

Health-insurance plans that require a patient referral from a primary care physician to a specialist must have a procedure for granting standing referrals so that a patient is not required to get approval from the PCP for each specialist appointment beyond the first one. The plan must allow a standing referral if the patient's doctor determines that the patient needs continuing care from a specialist. If the patient and his or her PCP disagree about the need for a referral, the patient has a right to see another plan physician for a second opinion.

Continuity of care

Should a provider leave a health plan's network, a patient receiving treatment is entitled to continue in that provider's care for up to 120 days after the provider leaves the network. Pregnant women past their third month of pregnancy also may get continuity of care for up to 120 days or until they give birth. Patients must request continuity of care from their health plans.

Insurers must give patients written notice when ending a contract with their provider. The written notice must explain the right to continuity of care and how to request it.

Grievances, complaints, and appeals

You have the right to file formal grievances and written complaints with your health-care providers and your insurance company. Grievances and complaints may express your dissatisfaction with services you have received or appeal denied claims.

Every health insurer has grievance and appeal procedures. When you appeal a decision, you have the following rights:

- To receive an explanation of grievance procedures.
- To get help writing and filing a grievance.
- To receive an easy-to-understand written decision at each appeal level.
- To appear before review committees or select a representative to appear.
- To file a complaint with the Oregon Insurance Division.

Your insurance company must acknowledge non-emergency complaints and grievances within seven days of receiving them, make a decision, and respond within 30 days. If an extension is needed by the insurance company, the company must notify you of the reason for delay and send a response within 15 additional days. Further extensions are not allowed in the grievance process. Your insurance company must have procedures for responding more quickly in emergencies.

Filing an insurance complaint

You have the right to be your own advocate and to ask for help from the Oregon Insurance Division at any time. To request help, file an insurance complaint online at **insurance.oregon.gov**, or call to request a complaint form, (888) 877-4894 (toll-free in Oregon). Our consumer advocates will investigate and try to solve your insurance-related problem.

External review

External review can help resolve disputes between patients and insurers. An external review is a review of your medical records by an independent review organization (IRO) that is certified by the Oregon Insurance Division. IROs have doctors in every medical specialty to evaluate treatments of illness and injury.

When a private health insurer in Oregon has denied a claim at every level of its appeals process, Oregon law requires the insurer to inform the enrollee of his or her right to an external review. Upon the enrollee's written request, the insurer must refer for external review a dispute about whether a treatment plan is medically necessary, whether a treatment plan is experimental or investigational, and whether a treatment plan that an enrollee is undergoing is eligible for continuity of care.

The patient must request external review from his or her insurance company.

Some health insurers use external review as part of their internal appeals process. External reviews are paid for by the insurer, regardless of whether the final decision is in favor of the patient or the insurer.

Consumers must request external review from their health insurer no later than 180 days after receiving the insurer's final written denial. Within two business days, the insurer must inform the Oregon Insurance Division's Consumer Protection Section of the request, and OID must assign an IRO (through a random-selection process) to review the medical record. The patient and insurer should receive the IRO's decision no more than 30 days after the date that the patient requested the external review. Most insurers comply promptly with a ruling from an IRO.

You have the right to an expedited external review (three days) if your physician or other provider states that a 30-day wait could seriously jeopardize your life, health, or your ability to regain maximum function.

Health-care concepts you should know

Pharmacy formularies

Insurance companies usually offer pharmacy benefits based on prescription drug formularies. A formulary is simply a list of pharmaceuticals or brands that are covered or not covered under an insurance plan. There are three types of formularies:

- An **open formulary** has no limitations on prescriptions.
- A **closed formulary** allows medical exceptions.
- A **mandatory closed formulary** does not allow medical exceptions.

Upon request, your insurance company must tell you if a medication is a covered benefit in a formulary and how it can be included in the formulary when exceptions are allowed. The insurance company must provide a summary of its prescription formulary policy, cost sharing, and restrictions. Your insurance company may exclude specific prescriptions from coverage.

Preauthorization

Insurance companies may require preauthorization for some medical procedures. This is often referred to as "prior approval," because you must get approval from the insurer before you have the medical procedures. Insurance companies must review preauthorization requests for non-emergency services within two days. Determinations are binding for 30 days. Preauthorizations affected by termination of coverage are binding for five days unless the insurance company knows coverage will end prior to the date of service and a termination date is specified.

On request, your insurance company should provide a written explanation of how preauthorization decisions are made.

Pre-existing conditions

Your policy may exclude or limit coverage of treatment for pre-existing conditions for six to 12 months. A pre-existing condition is a medical condition for which medical advice, diagnosis, care, or treatment was received or recommended during the six months before your enrollment. Your enrollment date is the earlier of the first day your coverage takes effect and the first day of your group plan's pre-eligibility waiting period.

When a plan sold in Oregon limits coverage for pre-existing conditions, the limit must end six months after enrollment or 12 months after the start of the plan's waiting period, whichever is earlier. If you enroll in a self-insured group plan after the initial enrollment period, the limit on pre-existing conditions may be extended to as long as 18 months.

Exclusion periods

An exclusion period is a period during which certain treatments or services are excluded from coverage for all new enrollees. For example, some policies have a 24-month exclusion period for organ transplants.

Creditable coverage

Exclusion periods may not apply if a new enrollee has changed insurers with no lapse in coverage. Creditable coverage means prior health-care coverage; it includes coverage remaining in force when an enrollee gets new coverage. If you went no longer than 63 days without coverage before obtaining another health plan, you have the right to apply the time you were covered under your old policy toward any pre-existing-condition exclusion period on your new policy. You will need to get a certificate of creditable coverage from your previous insurance company to present to your new insurance company as proof of coverage.

Example 1: You were covered under Plan A for 12 months. You enroll in Plan B within 63 days of Plan A's termination date. Plan B's 12-month pre-existing-condition exclusion will not apply.

Example 2: You were covered under Plan A for 12 months. You enroll in Plan B within 63 days of Plan A's termination. You need a transplant covered under Plan B, but Plan B has a 24-month exclusion period. If Plan A also covered transplants, you get 12 months' credit toward the 24-month transplant-exclusion period. You would have to wait 12 months instead of 24 months to have insurance coverage for the transplant.

Group health benefit plans, COBRA, state continuation, managed care/HMO, individual health insurance policies, OMIP, Medicaid, and Medicare all provide creditable coverage. Limited plans such as accident-only, dental-only, or vision-only do not.

Finding information about insurers

Cost is just one factor to consider when reviewing policies to purchase insurance. It's also important to look at the insurance company's financial condition and how the company treats its policyholders.

A health-insurance company's financial information is available from the following rating organizations, which may charge a fee for these services:

AM Best Company
(908) 439-2200
www.ambest.com

Fitch, Inc.
(800) 853-4824
www.fitchratings.com

Moody's Investor Services
(212) 553-0377
www.moodys.com

Standard & Poor's
(212) 438-2400
www.standardandpoors.com

Weiss Ratings, Inc.
(800) 289-9222
www.weissratings.com

One source of information about how companies treat their policyholders is the *Consumer Guide to Oregon Insurance Complaints*, which ranks insurers from best to worst based on the number of consumer complaints to the Oregon Insurance Division each year. To request a copy, call (503) 947-7984 or (888) 877-4894 (toll-free in Oregon). The guide is on our Web site, **insurance.oregon.gov.**

Also on our Web site, you will find patient-protection reports, which tell what kinds of complaints health insurers received from enrollees and how the insurer responded with those complaints.

Another method of finding out how insurers treat their policyholders is to discuss health insurance with friends and family. Ask them if they have filed claims and if they were happy with the way their insurer handled their claims. Be sure to get the correct name of the insurance company, as many insurance companies have similar-sounding names.

Settling your insurance claims

Your insurance company must acknowledge claims within 30 calendar days and complete investigations within 45 calendar days. An extension is allowed if a notice is sent from the insurer to you stating the reason for the delay and telling you what information is being sought.

Insurance companies must comply with the Unfair Claims Settlement Act, which prohibits an insurance company from the following:

- Misrepresenting facts or policy provisions in settling claims.
- Failing to acknowledge or act promptly with claims communications.
- Failing to adopt and implement reasonable standards for a prompt investigation.
- Refusing to pay claims without a reasonable investigation of available information.
- Failing to affirm or deny coverage of claims within a reasonable time.
- Not attempting, in good faith, to promptly and equitably settle claims.
- Attempting to settle claims at a lower benefit than what a reasonable person would believe they were entitled to based on written or printed advertising material.
- Attempting to settle a claim on the basis of an altered application without notifying and obtaining your consent.
- Delaying investigation or payment of claims by requiring duplicate information.
- Failing to inform you under which benefit a claim was paid, if you ask.
- Failing to settle claims under one coverage of the policy in order to pay claims under a different benefit of the policy.
- Failing to promptly provide the proper explanation for denying a claim.

Finding information about insurers

Patient-protection reports

Health insurance companies licensed in Oregon are required to file annual reports with the Oregon Insurance Division. These reports are public information and are available from your insurance company and on the division's Web site, **insurance.oregon.gov**. The following reports are available:

Complaint and grievance reports

Each year, your insurance company must report the number of complaints and grievances it has processed in the following categories:

- Access
- Referral issues
- Medical necessity
- Eligibility
- Other coverage/not covered
- Quality of care
- Quality of plan services
- Emergency services
- Administrative issues

Utilization-review reports

Utilization review is a set of formal procedures your insurance company might use to determine which medical procedures to cover. UR is used to save the company money and to monitor medical care. If your insurance company uses utilization review, it must report how utilization-review decisions are made.

You have the right to receive information pertaining to utilization-review procedures for specific conditions or diseases. Some information might be considered proprietary or confidential and will be shared only orally.

All medical-necessity decisions and decisions about appropriateness of service must be made by a licensed medical doctor or a doctor of osteopathic medicine. You have the right to request a timely external review of denials for medically necessary or experimental procedures.

Quality assessment reports

Quality-assessment reports describe the company's efforts to identify and address customer concerns about quality of care and service. Each year, the company must report how it identifies quality-improvement goals for the health-care services delivered through its providers and the providers' progress toward these goals. This report is required of managed-care organizations only.

Adequacy of provider network

Your managed-care company reports to the Oregon Insurance Division how it monitors its contracted providers to ensure reasonable access to services in the following areas:

- Number of providers, including specialists, in relation to enrollees.
- Time frames for access to services.
- Continuity of care when services are disrupted.
- Access to services for those with special needs.
- Identification and resolution of access problems.
- Communication with enrollees and providers.
- Network evaluation.

Frequently asked questions

Q: How can I avoid getting stuck with uncovered expenses?

A: There are many things you can do to improve your situation, but you *will* have to pay some of your medical expenses. First of all, if you have insurance, review your member handbook, noting what is and isn't covered. Budget for your share of the expenses you know you will have and try to anticipate expenses you may face. Identify your family's needs, which may include medications, allergy treatments, physical therapy, well-child examinations, immunizations, etc.

You can also do the following:

- Review the coverage and benefit limits for each type of treatment. Find out if they require preauthorization or a referral to a specialist.
- Read the grievance explanation in your member handbook and know your rights.
- Talk to your insurance company's customer-service department if you have questions.
- Determine whether you need more insurance and set aside money to pay additional premiums.

Q: My plan is a health-maintenance organization. How do I select a primary-care provider?

A: If you have a doctor now, and you are satisfied with the level of care, call your plan to find out if he or she can be your PCP. If you don't have a doctor or aren't satisfied with your care, ask for a list of participating doctors from your insurance company. Tell friends, co-workers, and neighbors you're looking for a new doctor, and ask for recommendations. Contact the state medical society and hospitals for lists of physicians accepting new patients in your area. Find out if any of these doctors participate with your insurance company.

Find out which doctors are convenient to where you live and work.

Call the physician's office to verify that the physician will accept you as a patient. Talk to the receptionist about office policies. Find out office hours, how emergencies are handled, how long it will take to schedule an appointment, and which hospitals the doctor uses.

Once you have selected a physician, notify your insurance company.

A good way to get established with your new primary-care provider is to schedule a physical examination. Make sure the examination is covered by your insurance company or plan to pay for it yourself.

Q: What if I don't like my new primary-care provider? Can I switch to a different doctor?

A: You can change your PCP. Notify your insurance carrier of the change. An insurance company may limit changes to two selections in a 12-month period. Refer to your member handbook or call customer service for additional guidelines.

Q: Can my obstetrician/gynecologist be my primary-care provider?

A: You may select a participating OB/GYN as your PCP if he or she contracts with your insurance company to provide primary care.

Q: What can I do if my doctor says I need a medical procedure and my insurance company says it's not medically necessary?

A: You have the right to request a copy of the utilization-review policy and procedures that your insurance company uses to determine medical necessity. You can file a grievance requesting reconsideration. Consult your doctor and submit important information with your grievance. Your insurance company must have a medical doctor determine whether a treatment is covered as a medical necessity.

Frequently asked questions

Q: My new HMO doctor will only refer me to a specialist within the clinic even though the specialist that I have been seeing for years is participating with my insurance company. What are my options?

A: You may not be allowed to go outside the clinic and have your medical bills covered. Tell your primary-care provider about all of your physical- and emotional-care needs, as he or she is responsible for arranging your health care while you are enrolled in the HMO or managed-care organization. If you are uncomfortable with your PCP or feel that she or he doesn't listen to you, you may want to call the specialist's office that has treated you to see which PCPs the specialist works with closely. Verify that the recommended provider is a participating provider in your HMO and see if he or she is accepting patients. Call your HMO and tell them you've switched PCPs.

Q: My doctor received prior authorization for a surgery that I had, but now my insurance company is denying my claim.

A: Find out specifically why the claim was denied and be certain that the error was not on your part. Preauthorization is binding for 30 days. However, eligibility determinations are binding for five days unless the insurance company knows that coverage will end before then and a termination date is known. Exercise your grievance rights once you know why the claim was denied, if it was unjustified. You also have the right to seek assistance from the Oregon Insurance Division by filing a formal complaint.

Q: Do I have a choice of insurance companies when I elect portability?

A: No. You must obtain coverage from the same insurance company that provided your group plan, unless you qualify for portability through the Oregon Medical Insurance Pool.

Q: If I enroll in a portability plan within the 63 days allowed, when does the coverage begin?

A: It begins on the day following the termination of your group coverage. Normally, your first premium also must be paid by that date.

Advocate
To speak, write, and argue in favor of something — such as health-care needs. As a noun, "advocate" means a person who does those things.

Alternative or complementary care
Non-medical health-care interventions such as massage therapy, naturopathy, chiropractic, and acupuncture.

Capitation
A contracted payment that a physician receives from an insurance company for providing health care. This payment is usually a set amount per member per month. The physician is paid whether or not the patient receives medical services.

Claim
The bill for health-care services that is submitted to an insurance company for payment.

Co-insurance
The amount of charges that you must pay on a claim, i.e., the portion of the claim that your insurance does not cover.

Copay
A set amount that you must pay when you get a doctor's prescription filled at a pharmacy, i.e., the portion of the cost of the prescribed medicine that your insurance company requires you to pay.

Complaint
A written expression of dissatisfaction that includes a request for a response that can be sent to your health-care provider, insurance company, or the Oregon Insurance Division.

Continuity of care
Continuing care for a limited period, at the insurer's expense, from a provider who has left the insurer's provider network.

Coordination of benefits
When two or more companies insuring the same patient work together to pay medical bills.

Creditable coverage
Insurance coverage that a person has just before starting coverage under a new policy.

Deductible
An amount you must pay out-of-pocket for health care before an insurance company begins to pay your claims. Some plans do not have deductibles.

Enrollee
A person enrolled in an insurance plan. The policy may be paid for by the enrollee or someone else.

ERISA
Employee Retirement Income Security Act, a federal law that covers most private, self-insured benefit plans through which employers provide health care and other benefits to employees.

Exclusions and limitations
Medical conditions and services and some illnesses and causes of accidents that a health-insurance plan will not pay for.

External review
Decision by an independent review organization certified by the state in a dispute between a patient and an insurer.

Formulary
A list of prescription medications covered by an insurance company.

Gag clause
An insurance company's requirement that physicians not tell patients about medical-treatment options that the company does not cover. Gag clauses are unlawful.

Grievance
A written expression of dissatisfaction that includes a request for a response. It can be sent to your health-care provider or insurance company.

Health-benefit plan
Comprehensive health insurance or medical insurance.

Network
The doctors and clinics authorized by an insurer to provide health care to the patient members of a managed-care group.

Insurance terms

Pre-existing condition
A medical problem or illness that you had before your insurance policy took effect.

Premium
A monthly fee paid to an insurance company for coverage.

Policyholder
A person or employer who pays the premiums for an insurance contract or policy.

Preauthorization
A written promise, which may include some conditions, from an insurer to pay for a specific medical treatment for a patient who made the request.

Proprietary
Information that a company considers a trade secret that it will not disclose to the public.

Self-insured health plan
A method some employers use to pay for employee health care instead of buying health insurance from an insurance company.

Service area
The geographical area in which an insurance company offers coverage and in which it has contracted providers.

Usual, customary and reasonable
The amount allowed as a benefit for a medical expense, reduced further by deductibles, co-insurance and co-pays.

Utilization review
A process that insurance companies use to reduce their costs by paying only for medically necessary services.

Insurance publications

A variety of consumer publications are available from the Oregon Insurance Division. You may view these publications on our Web site, or request a copy by:

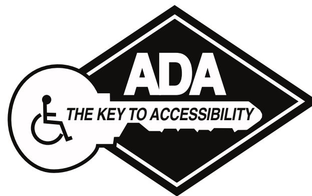
Mail:	**Publications** Oregon Insurance Division P.O. Box 14480 Salem, OR 97309-0405
Telephone:	(503) 947-7984 or (888) 877-4894 (toll-free in Oregon)
E-mail:	dcbs.insmail@state.or.us

There is no charge for copies of publications, unless otherwise noted. Publications are also available on our Web site, **insurance.oregon.gov**; click on publications.

- ***Consumer Guide to Auto Insurance***
  Compares auto insurance premiums and provides money-saving tips for drivers.
- ***Guía Básica de Oregon para seguro de autos***
  Explica los requisitos en Oregon para seguro de autos.
- ***Consumer Guide to Health Insurance***
  Provides an overview of health insurance and your health-care rights.
- ***Consumer Guide to Homeowner and Tenant Insurance***
  Compares premiums and provides money-saving tips for homeowners and renters.
- ***Consumer Guide to Oregon Insurance Complaints***
  Ranks insurers from best to worst, based on the number of consumer complaints received by the Insurance Division.

Insurance publications

- ***Oregon Insurance Division - Protecting the Insurance-buying Public***
  An overview of services provided by the Insurance Division and where to call for answers to common insurance questions.
- ***La División de Aseguradoras - Protegiendo al Público en la Compra de Seguros***
  Una sintesis de servicios provistos por la División de Seguros y a donde llamar para obtener respuestas acerca de comunes preguntas de seguros.
- ***A Shopper's Guide to Long-Term-Care Insurance***
  Provides an overview of long-term-care insurance, including costs and benefits. Published by the National Association of Insurance Commissioners.
- ***Oregon Long-Term-Care Insurance***
  Describes long-term-care insurance and lists providers doing business in Oregon.



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Oregon Insurance Division
P.O. Box 14480
Salem, OR 97309-0405