Health Insurance

A Guide for Consumers

PRINTED 10/01

The Florida Department of Insurance

Tom Gallagher
The Treasurer of the State of Florida and Insurance Commissioner

Are You Prepared?

Contents

7 Traditional Versus Managed Care Coverage
12 Group Versus Individual Coverage
15 Other Health-Related Policies
19 Association-Based Coverage
20 Group Health Coverage Alternatives
22 Choosing a Health Care Plan
24 Questions and Answers About Premiums
26 Renewable Conditions and Premium Increases
27 Continuation of Coverage
29 Health Insurance Portability and Accountability Act (HIPAA)
35 Consumer Tips
38 Filing Claims
39 How to Select an Insurance Agent
40 How to Select an Insurance Company
41 Medical Privacy and Medical Information Bureau
42 Your Rights and Responsibilities
44 Chart A: Health Plan Coverage Requirements
49 Community Outreach Programs or COPs
50 Seniors: Need Help With Your Insurance Questions?
51 Insurance Fraud Costs Us All!
52 Glossary

The Florida Department of Insurance distributes this guide for educational purposes only; it does not constitute an endorsement for any service, company or person offering any product or service.

Copyright © 2001-2002 Florida Department of Insurance

You may obtain this guide in alternative formats such as Braille, audio tape or large print by calling the Insurance Consumer Helpline toll-free at 1-800-342-2762. You may also download this guide through the Internet at www.doi.state.fl.us; the hearing impaired may obtain it by using a TDD to call 1-800-640-0886.

Dear Consumer:

The need for insurance is a fact of life in many situations. Knowing how our insurance policies work, in addition to having the correct type and amount of insurance, can help us recover financially when we experience such things as illness, car accidents, natural disasters or even death. And since the insurance industry and insurance policies often change, it's essential to be aware of new developments.

The Florida Department of Insurance publishes a variety of consumer guides to help you in this task. They include: *Automobile Insurance* (also available in Spanish), *Life and Annuities, Small-Business Owner's Insurance, Insuring Your Home, Health Maintenance Organization, Long-Term Care Insurance and Other Options for Seniors* and *Medicare Supplement.* Each guide contains basic information, definitions of common terms and tips on selecting an insurance agent and company. Each guide also details your rights and responsibilities as an insurance consumer. You can have any of our guides sent to you by filling out and mailing the order form at the back of this guide, or by calling the Florida Department of Insurance Consumer Helpline toll-free at 1-800-342-2762.

If you have questions after reading this guide, please call our Insurance Consumer Helpline toll-free at 1-800-342-2762 between 8 a.m. and 4:45 p.m. Monday through Friday. The hearing impaired may use a TDD to call 1-800-640-0886. You may also contact the service office in your area (listed inside the back cover of this guide).

Sincerely,

Tom Gallagher
Florida's Treasurer, Insurance Commissioner
and State Fire Marshal

If you have an insurance question or problem, call the:

INSURANCE

CONSUMER

Helpline

1-800-342-2762

TDD Users Only

Telecommunications **D**evice for the **D**eaf

1-800-640-0886

Internet

Browse the Florida Department of Insurance Web site at:

www.doi.state.fl.us

Service Offices

DAYTONA BEACH
955 Orange Ave.
Suite E
Daytona Beach, FL 32114-4674
(386) 254-3920

FORT LAUDERDALE
499 N.W. 70th Ave.
Suite 301B
Plantation, FL 33317-7574
(954) 327-6027

FORT MYERS
2295 Victoria Ave.
Suite 163
Fort Myers, FL 33901-3867
(941) 332-6948

JACKSONVILLE
9000 Regency Square Blvd.
Suite 201
Jacksonville, FL 32211-8100
(904) 727-5505

MIAMI
401 N.W. 2nd. Ave.
Suite N-307
Miami, FL 33128-1700
(305) 377-5235

ORLANDO
400 W. Robinson St.
Suite N-401
Orlando, FL 32801-1794
(407) 245-0870

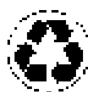
PENSACOLA
160 Governmental Center
Suite 515
Pensacola, FL 32501-5739
(850) 595-8040

ST. PETERSBURG-LARGO
11351 Ulmerton Road
Suite 240
Largo, FL 33778-1636
(727) 588-3638

TALLAHASSEE
Larson Building
200 E. Gaines St.
Tallahassee, FL 32399-0323
(850) 413-3132

TAMPA
5309 E. Fowler Ave.
Tampa, FL 33617-2221
(813) 987-6741

WEST PALM BEACH
400 N. Congress Ave.
Suite 210
West Palm Beach, FL 33401-2913
(561) 681-6392



This paper contains 50% recycled fiber.

Health Insurance

Nobody plans on getting sick or injured. But, life is full of unexpected events that force us to seek medical care. This includes everything from a common cold to a more prolonged illness or injury. When these situations arise, your best financial defense is to have adequate health insurance.

Health insurance can help protect your assets and pay medical expenses, but selecting the policy to best meet your needs can be challenging. This guide explains the various types of policies that are available, offers tips on choosing a policy, and provides definitions for the numerous health insurance terms you may encounter.

If you have any questions after reading this guide, please call the Florida Department of Insurance Consumer Helpline toll-free at 1-800-342-2762 between 8 a.m. and 4:45 p.m., Monday through Friday.

Traditional Versus Managed Care Coverage

Your first health insurance choice may be to decide between traditional health insurance or a managed-care option.

With traditional health insurance, you – the policyholder – select a health care provider, such as a doctor or hospital. You may have to pay for services when rendered and then submit the bill to the insurance company for reimbursement of the portion they agreed to pay under the policy terms. Frequently, the provider will submit the bill directly to the insurer and await payment.

The managed-care system combines the delivery and financing of health care services. This limits your choice of doctors and hospitals. In return for this limited choice, however, you usually pay less for medical care (i.e., doctor visits, prescriptions, surgery and other covered benefits) than you would with traditional health insurance. The managed-care network controls health care services.

Types of managed care

Health Maintenance Organizations (HMOs)

HMO members pay a monthly fixed dollar amount (similar to an insurance premium), which gives them access to a wide range of health care services. Members also pay a

predetermined amount, or copayment, for each doctor or emergency room visit and for prescription drugs, rather than paying the provider in full and obtaining a portion of the reimbursement later. HMO members often have little or no paperwork to complete due to the elimination of reimbursement. They must use the HMO's network of providers, which may include the doctors, pharmacies and hospitals under contract with that particular HMO.

Before you join an HMO, you should find out if the agent and company are licensed to sell health coverage in Florida and whether this coverage includes any limitations, such as prescription medication.

You may obtain the free "Health Maintenance Organization: A Guide for Consumers" by using the special order form on the survey card in the back of this booklet or by calling the Consumer Helpline toll-free at 1-800-342-2762.

EPOs or Exclusive Provider Organizations

In an EPO arrangement, an insurance company contracts with hospitals or specific providers. Insureds must use the contracted hospitals or providers to receive benefits by these plans.

PPOs or Preferred Provider Organizations

A PPO offers another kind of provider network to meet the health care needs of employees. A traditional insurance carrier provides the health benefits. An insurer contracts with a group of health care providers to control the cost of providing benefits to employees. These providers charge lower-than-usual fees because they require prompt payment and serve a greater number of patients. Employees usually choose who will provide their health services, but pay less in coinsurance with a preferred provider than with a non-preferred provider.

Point-of-Service Plans (POS)

These plans may be called by a variety of names and have various features. They combine some aspects of traditional medical expense insurance plans and other aspects of HMOs and PPOs.

In a POS plan, insured members may choose, at the point of service, whether to receive care from a physician within the plan's network or to go out of the network for services. The POS plan provides less coverage for health care expenses provided outside the network than for expenses incurred within the network. Also the POS plan will usually require you to pay

deductibles and coinsurance costs for medical care received out of network.

Basic medical insurance (hospital/medical/surgical)

Hospital insurance usually pays a portion of your room and board. It may also pay some expenses for other hospital services, such as operating room use, laboratory tests and X-rays.

Medical/surgical insurance helps pay for surgical and related costs (either in the hospital or doctor's office), and may pay for anesthesiology. It may also pay doctor fees for medical visits when you receive hospital care other than surgery.

Payments for surgical expenses are usually fixed amounts based on a surgical fee schedule. Insurance companies use fee schedules to determine the average cost of a procedure according to **usual**, **customary** and **reasonable** charges.

- **Usual** refers to the fee a doctor most frequently charges for a procedure.

- **Customary** involves the range of usual fees charged by doctors of the same specialty in a given geographic area for a specific procedure.

- **Reasonable** applies to a fee that differs from the "usual or customary" charges because of unusual circumstances. The procedure may involve medical complications that require additional time, skill and expertise.

This provision limits the amount the insurance company will pay under your policy. Be aware of what your company is willing to pay.

Basic medical insurance policies offer consumers differing benefits for room and board, physician, surgical and miscellaneous expenses. You should carefully check to see if policies offer equal benefits when comparing premium rates.

Major medical insurance

These policies provide protection against the high costs of hospitalization, injuries or serious or ongoing illnesses. Other possible coverages include the costs of blood transfusions, drugs and out-of-hospital costs, such as doctor visits.

Most group health policies fall under the category of major medical policies. This category

also includes the basic and standard plans issued under Small Group Health Access Coverage (see page 8).

Major medical policies cost extra and provide more benefits than basic policies. A major medical policy normally pays 80 percent of covered expenses, after you pay the deductible, and cannot contain a benefit limit less than $10,000. You would then pay the remaining 20 percent of covered expenses as coinsurance.

Insurance companies utilize fee schedules to determine the average cost of a procedure; however, this cost may differ from the actual charge you receive.

A **stop-loss limit** restricts the amount of coinsurance you pay. Not all policies include such limits, but those that do pay 100 percent of remaining covered expenses after you pay a stated amount of coinsurance.

Group Versus Individual Coverage

Health insurance may be obtained through two basic plan types: **group** and **individual.** The difference between the two types has little to do with coverage. In fact, a group plan and an individual plan may provide identical coverage. The difference is the way you ***access*** the two types. You may obtain a group plan through an employer or association. An individual plan is offered by an insurance company independent of any affiliation.

Group plans

Fulfilling your insurance needs may prove relatively simple if your employer offers a group plan or a choice of plans. Group plans cover several people or groups under one policy. You will receive a certificate that acts as your policy when you obtain insurance through a group plan.

Most group policies suit the average person and may include provisions to cover family members.

Employers of one to 50 employees may offer guaranteed-issue group plans known as Small Group Health Access Coverage. This coverage makes health insurance plans available to small business employers regardless of the health claims experience of an employee group or health status of an employee. Insurance companies and health maintenance organizations (HMOs) that offer coverage through an employer of one to 50 employees must offer the basic plan and the standard plan. Most insurers or HMOs offer other health-benefit plans in addition to the basic and standard plans.

The Florida Department of Insurance offers "Small-Business Owners Insurance: A Guide for Consumers" which contains additional information on the Small Group Health Access Act. You may call the Consumer Helpline toll-free at 1-800-342-2762 to order the guide, or fill out and return the order form in the back of this booklet.

Individual plans

Individual plans cover one person or all members of a family under one policy. Usually, people buy individual plans because they lack access to employer-based group policies or want to supplement these policies. Others use individual health policies during periods of unemployment when they lack coverage under group policies, or because they want to supplement Medicare benefits.

If you buy an individual policy, you may take 10 days from the date you receive the policy to decide whether to keep or cancel it. For a full refund, you must return the policy to the company within the allowed time. If you reject the policy, you should return it by registered or certified mail. This may help you to avoid a potential dispute with a particular insurer.

Facts to consider

Group and individual health insurance plans usually offer coverage for family members. Family policies generally pay benefits for your spouse and your dependent children up to the age specified in the policy. However, your insurance company cannot terminate coverage

for dependent children who lack other means of support due to mental or physical handicaps.

Both group and individual plans may include several kinds of coverage, such as "hospital," "medical/surgical" and "major medical."

Much of the health insurance sold in Florida as "individual coverage" actually involves association-based group plans marketed to individuals. In such cases, the association will require membership as a prerequisite for coverage. In addition, you will receive a "certificate of coverage" instead of a policy in your name. For more information about this type of individual coverage, see the section called "Association-Based Coverage" (page 14).

Other Health-Related Policies

Supplemental health insurance

These policies provide coverage beyond, or in addition to, what your basic policy provides.

You should use these policies as *supplements* rather than *substitutes* for basic medical insurance. Some policies include elimination periods, which means companies will pay benefits only after you stay in the hospital for a specified number of days.

Hospital confinement indemnity insurance

These policies pay a fixed amount or indemnity for each day, week or month you stay in a

hospital. Such policies pay a flat amount for benefits.

Disability income insurance

These policies pay a weekly or monthly income for a specific period if you suffer a disability and cannot continue or obtain work. The disability may involve sickness, injury or a combination of the two.

Most disability insurances coordinate with Social Security benefits and workers' compensation to eliminate duplication of coverage.

You may select a disability policy that includes an **elimination period**, or length of time that you must wait after a covered illness begins, before receiving benefits. The longer the elimination period, the lower your premium. Premiums may also vary depending upon your occupation (and the risks involved) and your age. For example, a high-rise construction worker would likely pay higher premiums than a florist.

When buying a disability policy, you should find out the company's definition of a disability and the requirements that must be met.

Individual and group disability income policies must provide coverage for a policyholder or eligible dependent who becomes disabled. This coverage applies during the first 12 months of the disability, but only if the person can no longer perform material and substantial duties of his or her occupation. After the first 12 months, the company may base the continu-

ance of benefits on the person's ability to perform any work for which he or she is reasonably trained.

An insurance company paying for a disability claim may require the policyholder to provide a written doctor's report. The frequency of this requirement depends upon the particular policy. For example, a given insurer may require such medical updates every month. In addition, the insurer may monitor certain public activities by policyholders who file claims. Insurers may do so to fight fraud and keep insurance costs down.

Accident insurance

These policies cover death, disability, hospital and medical care resulting from an accident. A common variation called "accidental death insurance" can pay additional benefits for death due to motor vehicle or at-home accidents.

Limited benefit insurance

These policies cover certain expenses from specifically named illnesses, injuries or circumstances. For example, cancer policies pay benefits for the actual treatment of cancer. Some also pay benefits for conditions or diseases caused or aggravated by cancer or its treatment.

Long-Term Care Insurance

Long-term care encompasses a wide range of medical, personal and social services. A person may need this care if they suffer from prolonged illnesses, disabilities, or cognitive impairment.

Private insurance companies offer individual or group long-term care insurance policies that provide benefits for a variety of services not covered by your regular health insurance, or by Medicare or Medicare supplement insurance.

Home Health Care Policy

This type of policy covers services prescribed by a physician and from a Medicare-certified or a state-licensed home health care service. The care must help with activities of daily living or the supervision or protection of a patient with cognitive impairment (such as Alzheimer's disease or senility). Some policies offering nursing home coverage automatically offer home health care as well. Some companies offer home health care as an option or rider to a long-term care policy. A few compa-

nies offer policies covering only home health care. You may obtain more information about policy options from your agent.

Nursing Home Care Policy

This limited-benefit insurance policy offers an alternative for some people and covers either one level or several levels of care. In Florida, the levels of care include custodial, intermediate and skilled (defined on page 48). Cognitive imparement or the inability to perform one or more of the activities of daily living will activate the benefit trigger of this care.

You may obtain a free guide “Long-Trem Care Insurance: A Guide for Consumers” by calling the Consumer Helpline toll-free at 1-800-342-2762.

Association-Based Coverage

An insurance company that markets an association-based certificate to a Florida resident must obtain a license from the Florida Department of Insurance. However, the insurer may keep the master policy in the name of an association or trust based outside of Florida. In addition, the insurer may file its policy forms and rates for approval in the associations home state.

Please be aware that this means some of Florida’s most important insurance laws covering benefits and rate increases may not apply to out-of-state, association-based coverage, even though the insurance is sold to Floridia residents.

In particular, the government of the home state (the state where the policy was issued) may not closely review or approve the rates involved. Without close regulation, questionable rating practices can occur. For example, some insurers will "low-ball" or reduce their initial premium, only to allow heavy increases later. This can present problems for a policyholder who starts out healthy enough to qualify for coverage, but later develops a medical condition. If premium increases exceed available resources, the policyholder may be forced to drop their coverage and may no longer qualify for another policy.

Consumer Alert

By statute, certificates issued under a policy approved by another state must contain the following statement: **"The benefits of the policy providing your coverage are governed primarily by the laws of a state other than Florida."** This statement should prompt you to find out what protections you might lack under the coverage.

Group Health Coverage Alternatives

Traditional health insurance and managed-care plans form major parts of the American health care system. However, employers may select another alternative to cover health expenses and meet employees' needs. This is known as a single-employer plan.

Single-employer plans

These plans fall under the guidelines of the Federal Employee Retirement Income Security Act (ERISA). Employers establish these plans to provide health care and/or other employment benefits to employees, their families and dependents. An insurance carrier may fully insure a plan of this type or the employer may opt for self-insurance.

Employers participating in a self-insured plan assume the financial risks involved, rather than transferring this risk to an insurance carrier. The employer pays for claims filed by employees covered by the plan. Your employer might hire an insurance company to administer the plan, but this company does not take responsibility for paying claims.

The Florida Department of Insurance does not regulate self-insured, single-employer plans. In addition, the Florida Guaranty Fund, which pays losses to policyholders when certain insurance companies become insolvent, does not cover such plans.

An insurance company's name or logo may appear on the forms and paperwork you receive from your single-employer, but this should not fool you. Many of these plans hire an insurance company to handle paperwork. The insurance company acts as a third-party administrator, but does not assume any legal obligation to pay claims.

You should determine whether your coverage comes from a self-insured plan. An insurance company may appear to underwrite a plan without actually doing so.

You should also check the history of the group offering the plan, and talk to current members to see if they have experienced any trouble getting claims paid.

Choosing a Health Care Plan

Consider the following features when comparing health care options:

What will you pay out-of-pocket?

Deductible — This is the initial dollar amount you must pay before your insurance company begins paying for health services. Usually, the higher the deductible, the lower your premium. The contract will dictate the specific amount you pay per year for your family. You should choose a deductible you can afford to pay under your monthly or annual budget. The deductible you must pay each year will vary depending on the number of people covered by the policy.

Coinsurance — This is the share or percentage of covered expenses you must pay in addition to the deductible. For example, your policy may pay 80 percent of "usual and customary" charges after you pay the deductible. You would then owe the remaining 20 percent as coinsurance, plus the excess charge of the provider's "usual and customary" charge.

Copayment — This is the specified dollar amount you pay for covered health care services under a managed-care plan. You pay this amount to the medical provider at the same time they provide the service.

Premium — This is the monthly or annual amount you pay for your insurance policy.

Maximum out of pocket — This is a provision that limits the amount you pay out of pocket.

What provisions might affect your coverage?

Coordination of benefits — With this provision, you will not receive more benefits than your actual hospital and medical expenses, even though you may obtain another policy. A husband and wife with family coverage under separate group policies can't collect for the same claim twice, even if they paid two premiums.

Renewal and premium increase — This provision determines the cases when your insurance company can renew your policy or increase your premiums.

Conversion privileges — This provision allows you to convert coverage to a different insurance plan when you lose eligibility, without a medical exam to prove good health.

Questions and Answers About Premiums

Why do companies raise premiums?

Insurance companies often raise premiums when the cost of claims they must pay increases.

Medical-cost inflation, a major factor that contributes to premium increases, measures the increased cost of a particular procedure each year.

Medical utilization, or the number of times doctors perform a procedure each year, also causes premium increases.

Cost shifting occurs when hospitals raise their rates for services to offset the cost of caring for non-paying or indigent patients. In addition, new technologies, tests and medical malpractice claims can contribute to cost-shifting and increase the cost of health insurance.

What do your premiums pay for?

Premiums help pay policyholders' claims and other expenses, such as agent commissions, premium taxes and administrative expenses.

How do insurance companies determine premiums?

An insurance company considers many factors when setting premiums, such as:

- medical-care costs
- coverage
- age of the policyholder (both current age and the age which the policy was issued.)
- gender
- lifestyle habits (such as smoking)
- geographic area
- riders purchased

One example from the last category, called a waiver of premium rider, would require you to pay higher monthly premiums if selected. In return, the company would pay your premium if you became sick and couldn't pay it.

Consumer Bulletin

A Florida law rewards individuals who find improper charges on their health care bills. The law attempts to help contain the ever-increasing costs of insurance and health care. You should carefully review the charges when you receive a bill from your hospital, doctor or other health care provider. You should verify that your bill covers only procedures you actually received. This will also help you to watch out for "double billing," which is being charged twice for the same procedure. If you see a mistake, you should notify your insurance company in writing. You may receive 20 percent of the reduction amount, up to $500, for an incorrect bill that merits a reduction.

Renewable Conditions and Premium Increases

Conditions for renewals and premium increases vary from policy to policy; ask your insurance agent or company representative about the conditions of the policy under consideration. You should also know these key terms:

Conditionally Renewable
Under this condition, an insurance company may renew a policy until a policyholder reaches a certain age. The company may decline renewal or increase premiums under specified contract conditions. For example, a company may decline the renewal of your policy because of a career change. Most companies decline renewals for reasons *other than* a policyholder's failing health.

Guaranteed Renewable
This means a company must renew a policy for a specific period. Companies must raise premiums consistently for all insureds in the same class.

Non-Cancelable
Under this condition, an insurance company can't cancel or increase your premium if you pay on time.

Optionally Renewable
This means an insurance company may cancel a policy at the end of the contract period for any reason, and increase premiums at any time.

Short Term, Non-Renewable
This means that you can't renew your policy at the end of the policy term. Premiums remain constant for the policy period, which usually lasts a few months.

Under Florida law, your company must give you a 45-day notice, in writing, of cancellation, non-renewal or premium change. However, your company must only provide a 10-day notice, in writing, for a cancellation due to your failure to pay premiums.

The law exempts a health insurer from written notice of cancellation for a policy in which you pay monthly or more frequent premiums that a licensed agent collects. This could create a problem, particularly if you pay your premiums through an automatic withdrawal system at your bank or other financial institution. In such cases, you should carefully monitor your account to help make sure your insurance coverage remains in effect.

Continuation of Coverage

COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) allows retiring employees, or those who lose coverage due to quitting a job or reduced work hours, to continue group coverage for a limited period of time. This also applies to their dependents who lose coverage because of divorce or legal separation; death of the covered employee; the covered employee qualifies for Medicare; or a loss of dependent status under the health plan's provisions. COBRA applies only to employers with 20 or more employees.

If you qualify for COBRA benefits, your health-plan administrator must give you a notice stating your right to choose to continue benefits provided by the plan. You then have 60 days to accept coverage or lose all rights to the benefits. Once you select COBRA coverage, you may have to pay 100 percent of the total insurance cost plus a 2 percent processing fee.

To obtain a free publication that explains COBRA in more detail, contact the U.S. Department of Labor at 1-800-998-7542. You can also write to: Pension and Welfare Benefits Administration, Atlanta Regional Office, 61 Forsyth St., SW, Suite 7B54, Atlanta, GA 30303; or Pension and Welfare Benefits Administration, Miami District Office, 8040 Peters Road, Building H, Suite 104, Plantation, FL 33324.

Mini-COBRA

Florida's Mini-COBRA law provides similar continuation of coverage protection for employees who work for employers with *fewer than 20 employees.*

Note: Under Florida's mini-COBRA law *the employee must notify the insurer* within 30 days of losing group eligability, that he or she is eligible to continue their coverage.

Qualifying as COBRA and Mini-COBRA

Continuation of coverage runs from a minimum of 18 months to a maximum of 36 months, depending upon the individual situation. The coverage may continue an additional 11 months for an insured's disability that occurs during a **qualifying event** such as termination (except for gross misconduct) or a reduction in work hours for the employee; however, it cannot exceed the limit of 36 months. Other qualifying events may include:

- a beneficiary loses coverage due to the employee's death;
- a divorce or legal separation of the employee and a spouse;
- the employee's qualification for Medicare; and a dependent child's loss of status under the health plan's provisions.

In addition, Florida law gives you the option of converting your policy to an individual plan if you leave the group. If you terminate employment, get divorced, or reach age 25 and no

longer qualify under a parent's group plan, you may convert your group policy to an individual policy. A conversion policy usually costs more than a group policy. It may provide fewer benefits, but you don't need a physical exam to qualify for coverage.

Health Insurance Portability and Accountability Act (HIPAA)

A federal law called the Health Insurance Portability and Accountability Act (HIPAA) made some important changes concerning

health insurance in the United States. The Florida Legislature passed a law implementing these requirements. In some cases, state law already met or exceeded the new federal standards. However, HIPAA and the state law that implements it are subject to differing interpretations due to the complexity and variety of situations addressed. State laws will likely evolve to clarify and address HIPAA for many years to come.

For this reason, you may call the Consumer Helpline toll-free at 1-800-342-2762 to discuss your options under HIPAA and state law. The Helpline staff may have more current information to help answer your questions.

In general terms, HIPAA and the state law that implements it apply to persons who have maintained continuous health care coverage but leave or move from one group to another.

In some cases, these laws apply to persons who lose individual coverage.

Portability

One of the most important changes involves **portability**, or allowing your time under previous coverage to reduce any waiting period for a pre-existing condition under a new group plan you want to join. The law also limits these waiting periods to 12 months for a new employee joining the plan or18 months if an employee decides to join the plan at a later date.

Credit for previous coverage

The law will also affect any person who changes health insurance policies.

Your insurance company or employer plan will now provide a "Certificate of Previous Coverage" when you leave a major medical or comprehensive health plan. This certificate will include a statement of how long you and any dependents were insured. It will also

explain to your new employer or company the range of benefits and coverage you had under that plan or policy.

You may have had health plan benefits for the most recent 12 months from either a group plan or an individual insurance policy. In either case, your previous coverage will generally reduce any waiting period for a pre-existing condition if you apply for a new group plan within 63 days.

Pre-existing conditions

Florida law has already addressed many of the federal changes for pre-existing conditions. For example, it limits waiting periods for pre-existing conditions to 12 or 18, months depending upon when you join a group plan.

Our state law includes one important change that prevents insurers from considering pregnancy a pre-existing medical condition. This means a pregnant woman who changes jobs and joins a new plan does not have to fulfill a waiting period before the health plan must pay for health care services associated with the pregnancy.

"Guaranteed-issue" individual health insurance policies

The term **guaranteed-issue** means an insurance company must issue a health insurance policy to you regardless of any health conditions. Before this change, if you had a pre-existing condition or certain chronic health conditions, an insurer could deny your applica-

tion or exclude coverage for that condition.

Under the new law, if you leave a group plan or have your Florida individual policy terminated, you may now qualify for an individual policy on a guaranteed-issue basis.

Who qualifies for a “guaranteed-issue” policy?

There are three important requirements that determine whether you qualify for a guaranteed-issue, individual health insurance policy:

- You previously held membership under a group health, governmental, or church plan, and no longer qualify for that plan or any other group plan;
- You exhausted COBRA or similar continuation of coverage periods; and
- You have had no “break in coverage” for a period greater than 63 days in which you lacked group or COBRA insurance.

What do I qualify for ?

Eligible individuals who leave a group plan may obtain access to a guaranteed-issue individual policy in one of three ways:

- Your group’s health insurance plan was issued in Florida.
- You belonged to an employer’s “self-insured” or “self-funded” plan, a group church plan, or any other type of group health plan not regulated by Florida law.

- The insurer or HMO terminated your coverage due to insolvency, dropping all individual coverage in Florida, or by moving out of your service area.

After you exhaust COBRA, you may qualify for a **conversion plan,** which refers to guaranteed-issue, individual coverage that the group-plan insurer must offer you. You should receive an offer for a choice of two conversion

options with different levels of comprehensive, major medical benefits. However, these benefits may differ from those offered by your previous group plan.

After you have exhausted your COBRA coverage, you may choose an individual health insurance policy. You can then apply for a policy from any insurance company that sells such coverage in Florida, with one exception. This exception applies when the administrator of a self-insured, group health plan offers a conversion option that complies with Florida law. In this case, you will not qualify for any other guaranteed-issue plan except for a choice between the two conversion options above.

When you apply for coverage, the company must offer you a choice between its first and second most popular policies marketed in Florida. The "most popular" means the policy issued to the largest and second largest group of individuals insured by that company in this state.

New protections for "guaranteed-issue" policies

Guaranteed-issue individual policies include the following new protections:

Credit for prior coverage — If you have 18 months of previous group and/or COBRA coverage, you will not have a pre-existing condition waiting period for your individual policy to begin. Your previous coverage acts as a "credit" against the longest of such periods (12 months) that an insurer may require for a guaranteed-issue policy. Any previous coverage of your spouse or dependents also acts as a credit.

Coverage for a pre-existing condition — The policy may not completely exclude coverage for pre-existing conditions on you, your spouse or dependents.

Coverage for a newborn or newly adopted child — If your child was born or adopted within the last 18 months, the child does not have to meet a "prior coverage" requirement. The child qualifies for benefits as soon as the policy begins.

The Florida Department of Insurance stands ready to help you. If you or your insurance agent has a question, call the Consumer Helpline toll-free at 1-800-342-2762. You may also call the Helpline to find out if a company sells individual health insurance in Florida.

Consumer Tips

The following tips will help you when comparison shopping for health insurance.

- List all pre-existing conditions on your application; an insurance company may refuse to pay your claim or cancel your policy due to an incorrect or incomplete application.

- Watch out for "telemarketing fraud," or high-pressure schemes in which a telephone caller may try to sell you unnecessary or unwanted insurance. Such a caller may use deceptive tactics, such as asking you to pay premiums in cash for a "last-chance" offer. Ask for written policy information and thoroughly research the insurance agent and company credentials. If you suspect this type of crime has occurred, you may call our Fraud Hotline toll-free at 1-800-378-0445, or the Florida Department of Agriculture and Consumer Service at 1-800-HELP-FLA (1-800-435-7352). For a nominal fee, the Department of Agriculture and Consumer Services can even add you to a list that telemarketers are forbidden to call.

- Contact your policy administrator if you want to convert from group to individual coverage because of divorce, age restrictions, etc.

- Your company must notify you in writing at least 45 days before canceling or not renewing your contract, or changing your premiums. You may contact the Consumer Helpline toll-free at 1-800-342-2762 if you do not receive such notification.

- You are entitled to a "free look" period of 10 days when you purchase an individual health insurance policy. You should return the policy by registered or certified mail within the allowed time if you decide not to keep it.

- You are entitled to a "grace period," which is a specified time frame when you can submit an overdue payment and still maintain coverage under your policy.

- Ask your agent if the coverage involves an out-of-state policy; if so, you should make sure it contains all the coverage you need before you buy it. Read everything carefully, and if your coverage document says it is a "certificate," you have an out-of-state policy.

- Before buying additional policies, it pays to understand how your current coverage will work with another policy. Do not overinsure; you cannot collect on the same claim twice.

- Maintain continuous coverage by not canceling your old policy until you are certain that your new company has accepted your application. Some companies do not begin coverage until they approve your application and notify you.

- Pay your premiums even if a dispute arises with your company. Otherwise, they may cancel your policy for nonpayment of premiums.

What about coverage for "alternative" therapies?

Due to increasing consumer interest, some health insurance companies and health maintenance organizations now offer coverage for "alternative" medicine and therapies, such as

herbal supplements, acupuncture, massage, etc. In some cases, alternative treatments cost less than conventional approaches. However, widespread coverage for alternative medicines will probably not occur until medical experts can conduct long-term studies and additional research. The existing coverage generally involves limited reimbursement and other restrictions.

For more information, contact your insurance company or HMO representative, or your employer's human resources office. You should also seek competent medical advice from your doctor and other health care professionals.

Filing Claims

Florida law standardizes the claim forms used for health insurance. Many doctors and hospitals keep claim forms on hand and will file them for you.

The following guidelines can help speed up the claims process.

- Inform your insurance company about a claim in writing within 20 days of the accident or illness. You must file your claim within 90 days.

- Contact your agent if you need help filing your claim. You should fill out all claim forms accurately and completely; attach copies of bills when requested, and keep your originals. Have your doctor and hospital representative complete (and sign, if necessary) their sections of the form right away.

- Keep copies of everything you send the company or the company sends to you, including a record of the date you filed the claim.

Note: Your company should pay a claim promptly after it receives a completed claim form. The company should also provide an explanation for a partial payment or a rejected claim.

How to Select an Insurance Agent

It is important to remember that most agents are reputable professionals. Insurance agents must take classes and pass certain tests to become licensed. In addition to required exams, some agents choose to take further courses. These courses are optional and provide the agent with additional training in various areas of insurance. They can also lead to professional insurance designations. Some designations an agent can have include:

CEBS .... Certified Employee Benefits Specialist
CFP .... Certified Financial Planner
ChFC .... Chartered Financial Consultant
CIC .... Certified Insurance Counselor
CLU .... Chartered Life Underwriter
CPCU .... Chartered Property & Casualty Underwriter
LUTCF .... Life Underwriting Training Council Fellow
RHU .... Registered Health Underwriter

When selecting an agent, choose one who is licensed to sell insurance in Florida. Also, choose an agent with whom you feel comfortable and who will be available to answer your questions. To verify whether an agent is licensed, call the Consumer Helpline toll-free at 1-800-342-2762.

How to Select an Insurance Company

As with any major purchase, it is a good idea to shop around to ensure you are getting the most for your money. When selecting an insurance company, it is wise to check on a company's rating. Several organizations publish insurance company ratings, available in your local library or on the Web. These organizations include: A.M. Best Company, Standard and Poor's,Weiss Ratings Inc., Moody's Investors Service and Duff & Phelps. Companies are rated on a number of elements,

such as financial data (including assets and liabilities), management operations and the company's history. You may also wish to review a company's stock analysis reports or browse the Internet to see if a company maintains a Web site.

Before purchasing insurance, it is important to verify whether a company is an authorized insurer in Florida. In most circumstances, benefits would be guaranteed through the

Florida Insurance Guaranty Association (FIGA) and the Florida Life and Health Insurance Guaranty Association (FLHIGA). If you buy from an unauthorized company, you will not be protected by the many Florida laws and rules that regulate the way a company does business.

- FIGA pays the claims of property and casualty authorized insurers if the company becomes insolvent and cannot pay.

- FLHIGA pays the claims of life and health authorized insurers if the company becomes insolvent and cannot pay. Call the service office in your area or the Consumer Helpline toll-free at 1-800-342-2762 for more information.

Medical Privacy and Medical Information Bureau

The Medical Information Bureau (MIB) is a data bank of medical and non-medical information on nearly 15 million Americans. Are you one of them? You may be if you have ever applied for health insurance from any of the MIB's 800 insurance company members.

The companies send the MIB any information you have written on any applications, enrollment forms, or requests for upgrading coverage for health, life or disability insurance. The MIB also records information from medical exams, blood and lab tests, and hospital reports when such information is legally obtainable.

If you have been denied life or disability insurance, and you wonder why, your file at the MIB may be the answer. Although the MIB's database seems like an invasion of your privacy, it prevents fraud and abuse of the nation's private insurance system. However, you have the right to make sure the information in your MIB file is correct. Call the MIB and ask for a copy of your records at (617) 426-3660, or access their Web site at **www.mib.com.**

Now that you know about the MIB, you understand why it is important to provide truthful information on any insurance application. If the MIB spots false information, your insurer may cancel your policy. Even worse, you may never be issued another policy.

Your Rights and Responsibilities

When you buy insurance, you have certain rights and responsibilities.

Your Rights

You have the right to receive a copy of the insurance policy or certificate governing your coverage.

You have the right to receive copies of all forms and applications signed by you or the agent.

You have the right to appeal any denied claims.

Your Responsibilities

You are responsible for reading and understanding your insurance policy.

You are responsible for reading and understanding any "explanation of benefits" forms sent by your insurance company. These forms usually state: "This is not a bill." However, you should still closely study them to make sure you actually received the medical services that your insurance company was billed for.

You are responsible for reporting suspected fraud to the Department of Insurance. If you suspect a crime has occurred, call our Fraud Hotline toll-free at 1-800-378-0445.

You are responsible for making sure your application is accurately completed. This includes information on pre-existing conditions. If you make a fraudulent or unintentional misstatement on your application, the company may cancel your policy or refuse to pay a claim.

You are responsible for knowing what your policy covers and excludes.

You are responsible for paying your premiums, even while involved in a dispute with your company.

You are responsible for paying the deductibles outlined in your policy.

You are responsible for verifying licenses of an insurance agent and company by calling the Consumer Helpline toll-free at 1-800-342-2762. Remember, a business card is not a license!

Chart A: Health Plan Coverage Requirements

The following pages alphabetically list specified benefit requirements in Florida for different types of private insurer and HMO health plans as of June 2001.

EPO .... Exclusive Provider Organization
PPO .... Preferred Provider Organization
PCP .... Primary Care Provider
Note .... These benefits could be provided by the contract or required by federal law. However, if you are making your purchase decision based on the need for these specific benefits, check with your insurance agent to be sure YOUR policy provides them.

* Certain insurance plans marketed to individuals in Florida do not provide all the listed benefits. Such individual plans are offered through group associations and are governed by states other than Florida. (See page 14 for details.)

INSURER HEALTH PLANS

Q: Covered on Insurer & HMO Health Plans?

Health Benefit	Individual		Small Employer (Basic/Standard plans)	Large or Other Small	
	Insurer*	HMO*		Insurer	HMO
1. Acupuncturists	Yes	Note	Yes	Yes	No
2. Ambulatory surgical centers	Yes	Note	Yes	Yes	No
3. Birthing centers	Yes	Yes	Yes	Yes	Yes
4. Bone marrow transplant procedures must include donor-patient	Yes	Yes	No (limited coverage-standard)	Yes	Yes

INSURER HEALTH PLANS *continued*

Q: Covered on Insurer & HMO Health Plans?

Health Benefit	Individual: Insurer*	Individual: HMO*	Small Employer (Basic/Standard plans)	Large or Other Small: Insurer	Large or Other Small: HMO
5. Bone marrow transplants	Yes	Yes	No (limited coverage-standard)	Yes	Yes
6. Cancer: certain rarely used cancer drug therapies	Yes	Note	No	Yes	No
7. Children: adopted & foster	Yes	Yes	Yes	Yes	Yes (adopted children)
8. Children: handicapped children services	Yes	Yes	Yes	Yes	Yes
9. Children: newborn	Yes	Yes	Yes	Yes	Yes
10. Children: well-child care	Yes	Yes	Yes	Yes	Yes
11. Chiropractors	Yes	Yes	Yes	Yes	No
12. Cleft palate	Yes	Yes	Yes	Yes	Yes
13. Continuity of care from same provider, for up to 6 months, or through post-partum care, if pregnant, if a provider leaves an HMO network	No	Yes	No	No	Yes
14. Conversion to non-group	Yes	Yes	Yes	Yes	Yes

INSURER HEALTH PLANS *continued*

Q: Covered on Insurer & HMO Health Plans?

Health Benefit	Individual: Insurer*	Individual: HMO*	Small Employer (Basic/Standard plans)	Large or Other Small: Insurer	Large or Other Small: HMO
15. Dental treatment: general anesthesia & hospitalization	Yes	Yes	No	Yes	Yes
16. Dependent coverage	Yes	Yes	Yes	Yes	Yes
17. Dermatologists: access to care	Yes	Yes	No	Yes (EPO/ PPO)	Yes
18. Diabetes treatment	Yes	Yes	Yes	Yes	Yes
19. Emergency room screening coverage for non-emergencies	Note	Yes	Note	Yes (EPO)	Yes
20. Enteral feeding supplies	Yes	No	No	Yes	No
21. Extension of benefits	No	No	Yes	Yes	Yes
22. HIV protections	Yes	Yes	Yes	Yes	Yes
23. Home health care services	No	No	Yes	Yes	No
24. Mammogram coverage	Yes	Yes	Yes	Yes	Yes
25. Massage	Yes	Note	No	Yes	No
26. Mastectomy: coverage for prosthetic devices and breast reconstructive surgery incident to a mastectomy	Yes	Yes	Yes	Yes	Yes

INSURER HEALTH PLANS *continued*

Q: Covered on Insurer & HMO Health Plans? **Health Benefit**	**Individual**		**Small Employer (Basic/Standard plans)**	**Large or Other Small**	
	Insurer*	**HMO***		**Insurer**	**HMO**
27. Mastectomy: length of stay	Yes	Yes	Yes	Yes	Yes
28. Mastectomy: out-patient	Yes	Yes	Yes	Yes	Yes
29. Maternity care: length of hospital stay	Yes	Yes	Yes	Yes	Yes
30. Maternity care: nurse-midwives/midwives	Yes	Yes	Yes	Yes	Yes
31. Maternity care: post-delivery	Yes	Yes	Yes	Yes	Yes
32. Mental/nervous disorders: optional coverage	No	No	Yes (different limits)	Yes	Yes
33. OB/GYN: access to care	Yes	Yes	No	Yes (EPO)	Yes
34. Ophthalmologists	Yes	Yes	Yes	Yes	Yes
35. Optometrists	Yes	Yes	Yes	Yes	Yes
36. Osteopathic hospitals	Yes	Yes	Yes	Yes	Yes
37. Osteoporosis diagnosis and screening	Yes	Yes	No	Yes	Yes
38. Out-of-hospital services	Yes	Yes	Yes	Yes	No

INSURER HEALTH PLANS *continued*

Q: Covered on Insurer & HMO Health Plans?

Health Benefit	Individual: Insurer*	Individual: HMO*	Small Employer (Basic/Standard plans)	Large or Other Small: Insurer	Large or Other Small: HMO
39. Podiatrists	Yes	Yes	Yes	Yes	Yes
40. Pre-existing condition	Yes	Yes	Yes	Yes	Yes
41. PCP: Chiropractor	N/A	Yes	No	N/A	Yes
42. PCP: OB/GYN	N/A	Yes	Yes	N/A	Yes
43. PCP: Osteopath	N/A	Yes	Yes	N/A	Yes
44. PCP: Podiatrist	N/A	Yes	Yes	N/A	Yes
45. Psychotherapeutic services	Yes	No	No	Yes	No
46. Substance abuse: optional coverage	No	No	No	Yes (optional coverage)	Yes (optional coverage)
47. TMJ: medically necessary	Yes	Yes	Yes	Yes	Yes

Community Outreach Programs or COPs

The Department of Insurance offers free Community Outreach Programs (COPs) on a number of insurance topics. Speakers will talk to your group or organization on the insurance topic you choose, and try to help answer any general questions you have about insurance. For more information, please contact the service office in your area. A list of the service offices is located inside the back cover of this guide.

Insurance Topics:

Health Insurance
Automobile Insurance
Disaster Preparedness
Small Business Insurance
Life Insurance
Health Maintenance Organizations (HMOs)
Medicare Supplement Insurance
Long-Term Care Insurance
Insurance Fraud

Seniors: Need Help With Your Insurance Questions?

The Florida Department of Elder Affairs has developed a program to help seniors with their Medicare and health-insurance questions.

SHINE, (Serving Health Insurance Needs of Elders) trains senior volunteers to assist other seniors with their questions about Medicare, Medicare supplement, long-term care and other health insurance issues.

The Florida Department of Insurance serves as SHINE's technical advisor and recommends the program to consumers. To find out if a SHINE program operates in your community, please contact the Elder Helpline toll-free at **1-800-96-ELDER (1-800-963-5337)** or the Florida Department of Elder Affairs at **(850) 414-2060.**

Insurance Fraud Costs Us All!

Insurance fraud costs each Florida family an additional $1,500 per year* in increased premiums. In fact, it can inflate your premiums by as much as 30 percent, according to the National Insurance Crime Bureau. This includes the money you pay for life, auto, health, homeowner's and other types of insurance.

You can protect your personal and family pocketbook by learning about the many different types of fraud schemes and scams. Some common examples include:

Fictional visit — A health care provider bills the federal Medicare program for unnecessary, unauthorized or fictional visits to a patient's home.

Rogue agent commits "stacking" — An insurance agent commits "stacking" by deliberately selling unnecessary health insurance that duplicates existing coverage to a consumer.

Applicant fraud — An applicant deliberately withholds information about a pre-existing condition in hopes of obtaining health insurance.

Unauthorized referral — A laboratory bills a health insurer for a patient's tests using information stolen from a referring physician. In actuality, the physician has never seen the patient.

Deceptive billing — A senior sells insurance information to a health care provider who bills Medicare for services never rendered. In some cases, such providers bill for as many as 800 phony services for one senior in a three-month period.

Many other types of insurance fraud exist. If you suspect such a crime has occurred, call the Florida Insurance Department's Fraud Hotline toll-free at 1-800-378-0445.

*Source: The Coalition Against Insurance Fraud

Glossary

Application
This document is a signed statement of facts that an insurer uses to determine whether to issue coverage. The application includes your name, age, address, and may include questions about your medical history. It becomes part of your health insurance contract.

Assignment
An assignment is a document signed by a policyholder authorizing a company to pay benefits directly to a hospital, doctor or other health care provider.

Coinsurance
This is the costs that a policyholder must pay out-of-pocket. Coinsurance usually involves a percentage of what a procedure costs. Many policies require the buyer to pay 20 percent up to a certain dollar amount.

Conversion Policy
A conversion policy is an individual policy or certificate issued when a person no longer qualifies as a certificate holder under group coverage or as a dependent under a group certificate or individual policy.

Copayment
This is a specified dollar amount a subscriber in a managed-care plan must pay for covered health care services. The subscriber pays this amount to the provider at the time of service.

Cost Shifting
This practice, used by hospitals, increases the cost of hospital services to offset the cost of caring for non-paying or indigent patients.

Customary Charge
This is the range of usual fees charged by doctors of the same specialty in a given geographic area for a specific procedure.

Deductible
This is the amount you must pay out-of-pocket before an insurance company pays its share. Usually, the higher the deductible, the lower the premium.

Effective Date

This is the date on which health insurance protection begins.

Elimination Period

This is the length of time a policyholder has to wait after a covered illness begins before receiving benefits.

Exclusions

These are certain conditions (or life events) specified in a health policy for which there is no coverage.

Free Look Period

This is a 10-day period after you receive a health policy which allows you time to decide whether to keep it. This applies only to individual health policies.

Grace Period

This is a specified period in which a policyholder may submit an overdue payment and still retain coverage.

Guaranteed-Issue Policy

This type of policy is one that an insurance company must issue to you under certain circumstances, regardless of any health conditions you suffer from.

Insolvency

This is the inability of a company to meet financial obligations or debts; bankruptcy.

Levels of Nursing Care

There are various degrees of nursing care. The three levels often referred to in Medicare and Medicare supplement and insurance policies include the following:

Skilled Nursing Care – This level of care provides daily (around-the-clock) nursing and rehabilitative care performed by or under the supervision of a registered nurse or a doctor.

Intermediate Care – This level of care provides less than 24-hour daily nursing and rehabilitative care performed by or under the supervision of skilled medical personnel. Care must be supervised by a registered nurse or a doctor.

Custodial Care – This lower level of care does not require a nurse to administer it. It may be provided in a nursing home or a private home, but must be recommended by a doctor. This care includes help with activities of daily living. A Medicare supplement policy provides limited nursing care coverage, as it supplements Medicare payments for skilled

nursing care, but *not* intermediate or custodial care.

Medical-Cost Inflation
This is an increase in insurance premium due to a rise in the cost of medical care. It measures the additional cost of medical services from one year to the next. It does not consider the number of times doctors perform the procedure in a year.

Medical Utilization
This is the frequency of a policyholder's use of medical services in a given year resulting in an insurance claim. This term also refers to the number of times doctors perform a procedure in a year.

Medically Necessary
This is a medical procedure or treatment necessary to maintain or resume good health. Many insurance policies will only pay for medically necessary treatments.

Pre-existing Condition
This is an illness diagnosed or treated before buying a health insurance policy that existed during the six-month period immediately preceding the policy's effective date. A policy usually will not cover a pre-existing condition until some time after the policyholder purchases the coverage.

Reasonable Charge
This is a fee that differs from usual or customary charges because of unusual circumstances involving medical complications that require additional time, skill and expertise.

Rider
This is an attachment to an insurance policy that specifies conditions or benefits the policy covers in addition to the original contract benefits.

Small Business
This is a business that has one to 50 employees.

Stop-Loss Limit
This is a provision that limits the amount of coinsurance a policyholder must pay.

Surgical Schedule
This is a list of cash allowances payable for various kinds of surgery. The severity of an operation determines the maximum amount payable.

Usual Charge

This is the fee a doctor most frequently charges patients for a procedure.

Waiting Period

This is the time between the date a policy becomes effective and the date benefit payments begin.