



Office of the
Healthcare
Advocate
STATE OF CONNECTICUT

KNOW YOUR RIGHTS

A PAMPHLET OF USEFUL INFORMATION ON MANAGED
CARE

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STEP 1. KNOW THE BASIC TERMS

Health insurance is essential. Before you buy it or pick a plan from your employer, you should understand, as best you can: what the insurance policy covers, how much it covers, how much you have to pay out of pocket, whether you'll have access to your current doctors, and whether access to other providers you might need is adequate.

**Arm yourself with your best defense, a great offense—
Understand the insurance company playbook.**

We all arm ourselves with the best information we can before we put ourselves, our lives, behind the wheel of a new car. We should exercise the same vigilance when purchasing health insurance to protect our lives and our finances.

Health insurance can be complicated. It is designed to protect people against random and unexpected losses. The most common way of financing health insurance is as an employer-sponsored benefit. Most employers in the United States offer their workers the opportunity to join a group health plan. Some employers buy coverage from an insurance company or an HMO. Other employers are self-insured, setting aside funds to pay employee health costs directly, and hiring an insurance company to process claims. There are a variety of different types of health insurance "products" sold in the United States, including:

Before you buy an insurance policy, make sure you read it. There may be terms in there that you don't understand. Most terms are defined in the policy. Even terms like covered services, co-payments, deductibles and co-insurance can be confusing. Know their meaning. Use our glossary at the end of this pamphlet to help you understand what these and other terms mean.

Federal law now requires that all insurers, including employers who offer insurance directly to their employees, develop standardized summaries of benefits offered under their plans. The summaries are required to have uniform definitions of certain terms, like co-payments, deductibles, prior authorization, among others. Consumers should be able to make better decisions in choosing a plan with uniform definitions of terms.

If your employer or your insurance broker does not provide you with access to the full insurance plans—summary plan descriptions (SPDs) or evidence of coverage (EOC)-- that you need to choose from, please call OHA at 1-866-466-4446.

STEP 2. KNOW YOUR OPTIONS

FIRST –DETERMINE YOUR CHOICES

You may be able to get group health coverage through your employer or your spouse's employer. If you are unable to purchase group insurance, you may be able to purchase individual insurance. Find out which health plan(s) are being offered, for example, is it an HMO, PPO or an Indemnity plan. To understand the differences between these types of options, go to the [Health Insurance](#) section.

After you review what your choices are, you can determine what is important to you and which choice meets your health needs best. Many things should be considered, such as, the services offered, choices of doctors, location of hospitals and other provider offices, and costs.



- [Compare Services Offered](#)

Most health plans will provide your basic medical coverage. It is important to compare the details of the services offered by each health plan, for example, what services are limited or not covered.

You need to determine if there is a good match between what is provided and what you think you will need. Some examples of what to think about would be:

- If you have a chronic disease, is there a special program for that illness?
- Will the plan provide the medicines/prescriptions that you currently use?
- Do you have any special medical equipment that you may need?
- Are there any "exclusions" from this plan - meaning types of care or services the plan won't pay for?
- How does the plan decide what is or is not experimental procedure?
- If a plan does not cover certain services or care that you think you will need, how much will you have to pay?
- Are there any limits to how much you must pay in case of major illness?
- Is there a limit on how much the plan will pay for your care in a year or over a lifetime?

[Compare Providers \(Choice & Location of hospitals, doctors, etc.\)](#)

In the managed care industry, the word "provider" refers to a physician, hospital, nursing home, pharmacy, lab or any individuals or group that provides a health care service.

Many managed care health plans have contracted with providers to deliver medical/health care services to the enrollees for an agreed upon charge – they would be called "participating providers."

Typically, a managed care health plan has a "network" of providers. This requires that those enrolled in that plan need to seek care from a provider in that network in order to receive the highest level of benefits. If the enrollee chooses to go "out of the network," this would generally provide coverage at a lower level of benefits.

It is important for you to understand which types of plans are offered to you and to know about the providers and the network of providers that your plan has a contracted with before you sign up for that plan.

[Choice of Provider](#)

Make sure you look in your provider directory from each plan to verify that you have an appropriate choice of providers for you and your family. Understand that the more "managed" your plan is, the more likely you will need to use only the providers listed to receive your benefits. If you have an Indemnity-type plan, you probably will have more choice and flexibility.

Some suggestions:

- You need to review what doctors, hospitals, and other medical providers are part of the plan.
- How important is it if your current doctor is not part of this plan?
- Are there enough of the kinds of doctors you want to see?
- Do you need to choose a primary care doctor when you sign up?
- If you want to see a specialist, can you refer yourself or must your primary care doctor refer you?
- Do you need approval from the plan before going into the hospital or getting specialty care?
- What happens if your primary care physician leaves the network?

[Primary Care Physician \(PCP\)](#)

Your primary care physician (PCP) will serve as your regular doctor, managing your care and working with you to make most of the medical decisions about your care as a patient. In many plans, care by specialists is only paid for if you are referred by your primary care doctor.

An HMO or a POS plan will provide you with a list of doctors from which you will choose your primary care doctor (usually a family physician, internists, obstetrician-gynecologist, or pediatrician). This could mean you might have to choose a new primary care doctor if your current one does not belong to the plan.

PPOs allow members to use primary care doctors outside the PPO network (at a higher cost). Indemnity plans allow any doctor to be used.

Location of Providers

Make sure you look in the provider directory to determine the location of the hospitals, doctors and other providers that you would use if you join this plan. Only you can determine the distance that you are willing to travel to receive your health care.

Some questions to ask:

- How far will you travel to go for care?
- Are these places near where you work or live?
- How does the plan handle care when you are away from home?

Cost of Health Plans

No health insurance plan will cover every expense. To get a true idea of what your costs will be under each plan, you need to look at how much you will pay for your premium and other costs. Depending on what type of plans are offered, here are some questions to consider about each plan:

- What is the monthly premium?
- Are there co-payments you must pay for certain services, such as doctor visits?
- How much will the co-pay be?
- If you use doctors outside a plan's network, how much more will you pay to get care?
- How does your prescription coverage work – co-pay or deductible?
- Are there deductibles you must pay before the insurance begins to help cover your costs?
- After you have met your deductible, what part of your costs is paid by the plan?
- Does this amount vary by the type of service, doctor, or health facility used?
- Are there any annual limits for days or the amount spent on you?
- Is there a lifetime limit that you will be reimbursed for?

You can't know in advance what your health care needs for the coming year will be. But you can guess what services you and your family might need based on last year's records. Figure out what the total costs to your family would be for these services under each plan.

Quality of Health Plans

The "quality" of health care is hard to measure, but more and more information is becoming available. There are certain things you can look for and questions you can ask.

In Connecticut, the managed care plans are regulated by Federal and State agencies. You can also find out if the managed care plan you are interested in has been "accredited," meaning that it meets certain standards of independent organizations. Some employers will only contract with plans that are accredited.

Another approach is to ask the plan how it ensures good medical care. For example, find out what the qualifications are of the doctors before they are added to the plan. Some managed care plans survey members about their health care experiences. Ask the plan for a report of the survey results.

Finally, you can talk to current members of the plan. Ask how they feel about their experiences, such as waiting times for appointments, the helpfulness of medical staff, the services offered, and the care received. If there are programs for your particular condition, how are the patients in it doing?

Individual Insurance (when your employer does not offer insurance)

If your employer does not offer group insurance, or if the insurance offered is very limited, you can buy an individual policy. You can get fee-for-service, HMO, or PPO protection. But you should compare your options and shop carefully because coverage and costs vary from company to company. Individual plans may not offer benefits as broad as those in-group plans.

If you get a non-cancelable policy (also called a guaranteed renewable policy), then you will receive individual insurance under that policy as long as you keep paying the monthly premium. The insurance company can raise the cost, but cannot cancel your coverage. Many companies now offer a conditionally renewable policy. This means that the insurance company can cancel all policies like yours, not just yours. This protects you from being singled out. But it doesn't protect you from losing coverage.

Before you buy any health insurance policy, make sure you know what it will pay for...and what it won't. To find out about individual health insurance plans, you can call insurance companies, HMOs, and PPOs in your community, or speak to the agent who handles your car or house insurance.

Tips when shopping for individual insurance:

- Shop carefully. Policies differ widely in coverage and cost. Contact different insurance companies, or ask your agent to show you policies from several

insurers so you can compare them.

- Make sure the policy protects you from large medical costs.
- Read and understand the policy. Make sure it provides the kind of coverage that's right for you. You don't want unpleasant surprises when you're sick or in the hospital.
- Check to see that the policy states the date that the policy will begin paying (some have a waiting period before coverage begins), and what is covered or excluded from coverage.
- Make sure there is a "free look" clause. Most companies give you at least 10 days to look over your policy after you receive it. If you decide it is not for you, you can return it and have your premium refunded.
- Beware of single disease insurance policies. There are some policies that offer protection for only one disease, such as cancer. If you already have health insurance, your regular plan probably already provides all the coverage you need. Check to see what protection you have before buying any more insurance.

[Pre-existing Health Conditions](#)

A pre-existing condition is a medical condition diagnosed or treated before joining a new plan. In the past, health care given for a pre-existing condition often has not been covered for someone who joins a new plan until after a waiting period. However, a new law—called the Health Insurance Portability and Accountability Act—changes the rules. And the recently passed Patient Protection and Affordable Care Act of 2010 (PPACA), Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010 (HCERA), Public Law 111-152.

Under PPACA, insurers are no longer able to deny an insurance policy to children under the age of 18 on the basis of a pre-existing condition. Neither can the plan exclude coverage for the pre-existing condition once the policy is issued. By 2014, plans will no longer be able to discriminate against adults with a pre-existing condition.

Under current law, the Health Insurance Portability and Accountability Act (HIPAA), most of which went into effect on July 1, 1997, a pre-existing condition will be covered without a waiting period for an adult when he or she joins a new group plan if he or she has been insured the previous 12 months under “creditable coverage”. (If your coverage is “creditable”, your insurer should provide you with a certificate of creditable coverage upon leaving your previous coverage.) This means that if you remain insured for 12 months or more, you will be able to go from one job to another, and your pre-

existing condition will be covered—without additional waiting periods—even if you have a chronic illness.

If you have a pre-existing condition and have not been insured the previous 12 months before joining a new plan, the longest you will have to wait before you are covered for that condition is 12 months.

To find out how this new law affects you, check with either your employer benefits office or your health plan.

SECOND – KNOW THE TYPES OF HEALTH INSURANCE

Indemnity Insurance

Health insurance plans are usually described as either indemnity (fee-for-service) or managed care. Indemnity and managed care plans differ in their basic approach. Put broadly, the major differences concern choice of providers, out-of-pocket costs for covered services, and how bills are paid. Usually, indemnity plans offer more choice of doctors (including specialists, such as cardiologists and surgeons), hospitals, and other health care providers than managed care plans. You can choose any doctor you wish and change doctors any time. You can go to any hospital in any part of the country. Indemnity plans pay their share of the costs of a service only after they receive a bill.

Indemnity is the most traditional form of insurance. Although indemnity insurance used to be the most common form of coverage, there are very few such policies in today's market. To view the Indemnity health plans that are available in Connecticut, [click here](#).

How Indemnity Plans Work

With an indemnity plan (sometimes called fee-for-service), you can use any medical provider (such as a doctor and hospital). You or the provider sends the bill to the insurance company, which pays part of it. Usually, you have a deductible—such as \$200—to pay each year before the insurer starts paying.

Once you meet the deductible, most indemnity plans pay a percentage of what they consider the "Usual and Customary" charge for covered services. The insurer generally pays 80 percent of the "Usual and Customary" costs and you pay the other 20 percent, which is known as coinsurance. If the provider charges more than the "Usual and Customary" rates, you will have to pay both the coinsurance and the difference.



The plan will pay for charges for medical tests and prescriptions as well as from doctors and hospitals. It may not pay for some preventive care, like checkups.

With Indemnity health plans, the insurer only pays for part of your doctor and hospital bills. Typically, this is what you would pay:

(a) A monthly fee, called a premium.

(b) A certain amount of money each year, known as the deductible, before the insurance payments begin. In a typical plan, the deductible might be \$250 for each person in your family, with a family deductible of \$500 when at least two people in the family have reached the individual deductible. The deductible requirement applies each year of the policy. Also, not all health expenses you have count toward your deductible. Only those covered by the policy do. You need to check the insurance policy to find out which ones are covered.

(c) After you have paid your deductible amount for the year, you share the bill with the insurance company. For example, you might pay 20 percent while the insurer pays 80 percent. Your portion is called coinsurance.

To receive payment for fee-for-service claims, you may have to fill out forms and send them to your insurer. Sometimes your doctor's office will do this for you. You also need to keep receipts for drugs and other medical costs. You are responsible for keeping track of your medical expenses.

Customary Fee

Most insurance plans will pay only what they call a reasonable and customary fee for a particular service. If your doctor charges \$1,000 for a hernia repair while most doctors in your area charge only \$600, you will be billed for the \$400 difference. This is in addition to the deductible and coinsurance you would be expected to pay. To avoid this additional cost, ask your doctor to accept your insurance company's payment as full payment. Or shop around to find a doctor who will. Otherwise you will have to pay the rest yourself.

Questions to Ask About Indemnity Health Insurance

- How much is the monthly premium? What will your total cost be each year? There are individual rates and family rates.
- What does the policy cover? Does it cover prescription drugs, out-of-hospital care, or home care? Are there limits on the amount or the number of days the

company will pay for these services? The best plans cover a broad range of services.

- Are you currently being treated for a medical condition that may not be covered under your new plan? Are there limitations or a waiting period involved in the coverage?
- What is the deductible? Often, you can lower your monthly health insurance premium by buying a policy with a higher yearly deductible amount.
- What is the coinsurance rate? What percent of your bills for allowable services will you have to pay?
- What is the maximum you would pay out of pocket per year? How much would it cost you directly before the insurance company would pay everything else?

[Managed Care](#)

Types of Managed Care Plans

Managed care is actually a broad category of health insurance coverage -- there are several forms of managed care. Generally, managed care plans have agreements with certain doctors, hospitals, and health care providers to give a range of services to plan members at reduced cost. In general, you will have less paperwork and lower out-of-pocket costs if you select a managed care type plan.

Typically, the types of managed care health plans are HMO, PPO or POS plans. To find out more about these types of managed care plans, select from below.

- [HMO \(Health Maintenance Organization\)](#)

Health maintenance organizations are prepaid health plans. As an HMO member, you pay a monthly premium. In exchange, the HMO provides insurance coverage for you and your family, including doctors' visits, hospital stays, emergency care, surgery, lab tests, x-rays, and therapy.

You arrange for this care either directly through the HMO's own group practice and/or through doctors and other health care professionals under contract with the HMO -- the HMO network. Usually, your choices of doctors and hospitals are limited to those that have agreements with the HMO to provide care. However, exceptions are made in emergencies or when medically necessary.

With some HMOs, you will pay nothing when you visit doctors. With others, there may be a small co-payment for each office visit, such as \$15-\$25 for a doctor's visit or \$50-\$100 for hospital emergency room treatment. Your total medical costs will likely be lower and more predictable in an HMO than with fee-for-service insurance.

HMOs are the oldest form of a managed care. There are different kinds of HMOs. If doctors are employees of the health plan and you visit them at central medical offices or clinics, it is a staff or group model HMO. Other HMOs contract with physician groups or individual doctors who have private offices. These are called individual practice associations (IPAs) or networks.

HMOs will give you a list of doctors from which to choose a primary care doctor. This doctor coordinates your care, which means that generally you must contact him or her to be referred to a specialist. This is one way that HMOs can limit your choice.

If you belong to an HMO, the plan only covers the cost of charges for doctors in that HMO. If you go outside the HMO, you are obligated to pay the bill.

Because HMOs receive a fixed fee for your covered medical care, it is in their interest to make sure you get basic health care for problems before they become serious. HMOs typically provide preventive care, such as office visits, immunizations, well-baby checkups, mammograms, and physicals. The range of services covered varies in HMOs, so it is important to compare available plans. State and federal law prohibit fully-funded HMOs from placing undue restrictions on access to mental health care.

Many people like HMOs because they do not require claim forms for office visits or hospital stays. Instead, members present a card, like a credit card, at the doctor's office or hospital.

Questions to Ask About an HMO

Before choosing an HMO, talk to people you know who are enrolled in an HMO managed care plan. Ask them how they like the services, the care that is provided and the range of benefit coverage under their plans.

Some questions you should consider:

- Are there many doctors to choose from? Do you select from a list of contract physicians (a network) or from the available staff of a group practice? Which doctors are accepting new patients? How hard is it to change doctors if you decide you want someone else? How are referrals to specialists handled?
- Is it easy to get appointments? How far in advance must routine visits be scheduled? What arrangements does the HMO have for handling emergency care?
- Does the HMO offer the services I want? What preventive services are provided? Are there limits on medical tests, surgery, mental health care, home care, or other support offered? What if you need a special service not provided by the

HMO?

- What is the service area of the HMO? Where are the facilities located in your community that serve HMO members? How convenient to your home and workplace are the doctors, hospitals, and emergency care centers that make up the HMO network? What happens if you or a family member are out of town and need medical treatment?
- What will the HMO plan cost? What is the yearly total for monthly fees? In addition, are there co-payments for office visits, emergency care, prescribed drugs, or other services? How much?

[PPO \(Preferred Provider Organization\)](#)

A "PPO" is a form of managed care closest to an indemnity plan. A PPO has arrangements with doctors, hospitals, and other providers of health care who have agreed to accept lower fees from the insurer for their services. As a result, your cost sharing should be lower than if you go outside the network. In addition to the PPO doctors making referrals, plan members can refer themselves to other doctors, including ones outside the plan.

If you go to a doctor within the PPO network, you will pay a co-payment (a set amount you pay for certain services—say \$20 for a doctor or \$25 for a prescription). Your coinsurance will be based on lower charges for PPO members.

If you choose to go outside the network, you will have to meet the deductible and pay coinsurance based on higher charges. In addition, you may have to pay the difference between what the provider charges and what the plan will pay.

The preferred provider organization is a combination of traditional fee-for-service and an HMO. Like an HMO, there are a limited number of doctors and hospitals to choose from. When you use those providers (sometimes called "preferred" providers, other times called "network" providers), most of your medical bills are covered.

When you go to doctors in the PPO, you present a card and do not have to fill out forms. Usually there is a small co-payment for each visit. For some services, you may have to pay a deductible and coinsurance.

As with an HMO, a PPO requires that you choose a primary care doctor to monitor your health care. Most PPOs cover preventive care. This usually includes visits to the doctor, well-baby care, immunizations, and mammograms.

In a PPO, you can use doctors who are not part of the plan and still receive some coverage. At these times, you will pay a larger portion of the bill yourself (and also fill

out the claims forms). Some people like this option because even if their doctor is not a part of the network, it means they don't have to change doctors to join a PPO.

Questions to Ask About a PPO

- Are there many doctors to choose from? Who are the doctors in the PPO network? Where are they located? Which ones are accepting new patients? How are referrals to specialists handled?
- What hospitals are available through the PPO? Where is the nearest hospital in the PPO network? What arrangements does the PPO have for handling emergency care?
- What services are covered? What preventive services are offered? Are there limits on medical tests, out-of-hospital care, mental health care, prescription drugs, or other services that are important to you?
- What will the PPO plan cost? How much is the premium? Is there a per-visit cost for seeing PPO doctors or other types of co-payments for services? What is the difference in cost between using doctors in the PPO network and those outside it?
- What is the deductible and coinsurance rate for care outside of the PPO? Is there a limit to the maximum you would pay out of pocket?

[POS \(Point-of-Service\)](#)

Many HMOs offer an indemnity-type option known as a POS plan. The primary care doctors in a POS plan usually make referrals to other providers in the plan. But in a POS plan, members can refer themselves outside the plan and still get some coverage.

If the doctor makes a referral out of the network, the plan pays all or most of the bill. If you refer yourself to a provider outside the network and the service is covered by the plan, you will have to pay coinsurance.

STEP 3. KNOW YOUR RESPONSIBILITIES

[Know what type of plan you have: self-funded or fully-funded](#)

Differences Between State and Federal Regulation

Private health insurance coverage protects people from the potentially extreme financial costs of medical care if they become ill and it ensures access when they need it. Health coverage is subject to significant requirements at both the state and federal level. While new laws and regulations have created important protections for consumers, they have also produced overlapping and sometimes duplicative or conflicting state and federal rules.

The regulation of insurance has traditionally been a state responsibility. However, there are primarily two different types of entities that provide employer-based private health insurance:

(1) State-licensed health plans, and (2) self-funded (federal) health plans. The employer offering the private group health coverage determines which type.

State-licensed Health Plans (offered by fully funded plans):

- State-licensed managed care organizations are regulated under state law, although federal law may add additional standards and in some cases supersede state authority.
- In Connecticut, state-licensed health plans cover approximately 50% of the privately insured citizens.
- Each state has laws that require state-licensed managed care organizations to offer or include coverage for certain benefits or services (known as mandated benefits or consumer protections).

Self-funded (Federal) Health Plans:

Although the business of insurance is primarily regulated by the state, a number of federal laws contain requirements that apply to private health coverage, including ERISA and HIPAA. ERISA was enacted in 1974 to protect workers from the loss of benefits provided through the workplace; and in 1996, HIPAA, was motivated by concern that people faced lapses in coverage when they change or lose their jobs.

- Self-funded health plans operate under federal law and are health benefit arrangements sponsored by employers or employee organizations. Under a self-funded arrangement, the employer retains the responsibility to pay directly for health care services of the plan participants.
- In Connecticut, self-funded health plans cover approximately 50% of the privately insured citizens.
- ERISA does not require employers or to establish any type of employee benefit plan, but contains requirements applicable to the administration of the plan; such as, requirements for disclosure, reporting and fiduciary standards, claims and continuation coverage.
- In general, ERISA preempts state laws that would regulate the operation of health plans. Therefore, state mandates do not apply to those covered by self-funded plans.

Other Federal Mandated Benefits

These standards apply to all covered persons under state or self-funded health plans:

- If a health plan provides coverage for mastectomies it must also cover breast reconstruction surgery following a mastectomy.
- Health plans are prohibited from restricting hospital stays following childbirth to less than 48 hours (or 96 hours following delivery by cesarean section).
- Self-funded health plans sponsored by employers with at least 50 employees cannot impose numeric or qualitative limits on mental health benefits that are more stringent than for medical and surgical benefits.

[Know your plan: Read your Insurance Contract and Keep all Documents](#)

If you are enrolled in an insurance plan, your insurer is required to provide you with a copy of your insurance contract, more commonly called a “Summary Plan Description,” “Evidence of Coverage” or “Subscriber Agreement”. This document is often lengthy, but it is important because it contains the terms of your insurance agreement. Contracts for fully-funded plans are approved by the Insurance Department before your health insurer can send it to you.

All contracts contain definitions of terms and describe what kinds of services will be paid for. Contracts also contain conditions for coverage. For instance, just because a service is listed as a covered benefit, for the service to be paid for by your insurer, you have to be enrolled with the plan on the date of service, go to a participating provider—if required and get the service prior-authorized if necessary.

It’s important to carefully read your contract, but if you have questions about requirements under the contract, you should call the plan. Remember to write down the name of the person at the plan that you talk to and the date and time of your call. Or you can call OHA: we will coach you through the process of understanding your contract, and intervene on your behalf with the insurer, if necessary.

You should keep any correspondence from your insurance company, whether it’s an approval of a service, a denial or a record of the processing of your provider’s claim, also called an “Explanation of Benefits”. These documents can be critical if you need to appeal a denial of coverage or contest the processing of a claim. We recommend that you hang onto these documents for seven years.

STEP 4. KNOW HOW TO ENFORCE YOUR RIGHTS

[Know your appeal rights](#)

Your insurance contract will describe your right to grieve or appeal a decision of the insurer to deny or partially deny coverage of a service. You should review the appeal rights on a frequent basis.

Managed care health plans and agencies that oversee health plans have formal procedures for you to follow if you have a problem. The following represents the general procedure, but it may vary depending on your particular managed care health plan.

- Make sure the service is not excluded in your health plan contract
- Appeal "internally" to your insurer first; Connecticut State law requires your that your appeal is to be reviewed and resolved within sixty (60) days from the date you submit the request for appeal
- Obtain a written denial from your plan's internal appeals process
- File for an external appeal with the State of Connecticut within 30 days



Internal Appeal Process

Most states require managed care health plans to have an internal appeals process that consumers can use to appeal a decision to deny or curtail coverage of care. In a growing number of states – including Connecticut – laws have been passed that allow patients to appeal such decisions to an external group of experts. In most cases, health plans are required to abide by a decision to overturn a denial of coverage.

Connecticut has a law requiring managed care plans to have an internal appeals system available for consumers who disagree with a plan decision (sometimes called an "adverse determination"). Those internal appeals requirements *generally* include the following features:

- **Notice:** The consumer must be told in writing that they have the right to appeal the plan's decision along with information on how to file such an appeal. The patient also must be notified in writing of the reviewer's decision and given copies of documentation supporting that decision.
- **Timeline:** Plans must respond to a patient's appeal in a timely manner – usually within 15 – 30 days. In emergency cases, plans have to respond with 24 – 72 hours.
 - **Review by qualified professionals:** Plans must have a qualified health care professional (generally a physician trained in the field of care that is involved) review the case. This doctor should not have been involved with the initial decision to deny coverage.

- **Levels of appeal:** Typically the health plans provide for two levels of internal appeal. In the first level, another doctor in the plan may review the decision to deny coverage. If that doctor agrees with the denial, the patient can appeal to a higher level – often the plan’s medical director. If your appeal has been denied, you also need a copy of the second denial letter. This letter will outline the process for the next level of appeal. This second level of appeal will, typically, be reviewed by a different group of people at the managed care plan. The second denial letter may instruct you that if you wish to initiate a second level appeal you must submit another appeal packet with new information specifically addressing the current reason for denial.
- **Care during the review process:** Some health plans continue to pay for the care in dispute while the appeal is being considered.

Managed care plan enrollees have the right to question decisions regarding their health care coverage. Connecticut state law requires that each managed care health plan establish and maintain an internal grievance procedure to insure that enrollees may seek a review of any grievance that may arise from the plan’s action or inaction.

External Appeal Process

To be eligible for the external appeal process through the Connecticut Insurance Department, you must satisfy the following requirements:

- You must have exhausted the internal appeals procedure of your managed care plan
- You must file for an external appeal within 60 days of receiving the written notification that the internal appeals have been exhausted
- You must be an enrollee in the managed care plan at the time the service was requested
- You must appeal for a service or procedure that is covered in your contract
- The denial of coverage must be based on "medical necessity" or “experimental and investigational” (according to the NCQA the determination and intervention recommended by a treating practitioner is (1) the most appropriate service for the individual in question, considering potential benefits and harms to the individual, and (2) known to be effective in improving health outcomes)
- Your appeal cannot be for workers’ compensation claims

- Your plan cannot be a "self-insured" plan
- Your plan cannot be offered as part of a Medicaid or Medicare program
- A non-refundable filing fee of \$25 is required

The Connecticut Insurance Department contracts with an independent entity to review the appeal. If your appeal does not meet the conditions required for eligibility for external appeal (outlined previously), your appeal will be ruled ineligible. The external appeal entity will contact you and the Insurance Commissioner within 5 business days of its receipt as to whether the appeal has been accepted or denied for full review. If the appeal is denied in the preliminary phase, the external appeal process ends. The reviewing entity will complete the full review and forward its recommendation to the Insurance Commissioner within 30 business days of completing the preliminary review. The Insurance Commissioner will accept the decision of the external appeal entity and notify you and your managed care plan of the decision.

You can call the Department of Insurance at **(860) 297-3862** for a copy of the External Appeal Consumer Guide and the External Appeal Application. These documents are also available on the State of Connecticut Insurance Department's web site: www.ct.gov/CID.

STEP 5. KNOW WHERE TO GET HELP—CALL OHA

If you need help with a problem that you are having with your managed care plan or your doctor/health care provider, we can offer you free assistance.

The Office of the Healthcare Advocate can provide Connecticut consumers with information and assistance so you can understand your rights and effectively resolve your managed care problem or situation. Call us at 1-866-HMO-4446.