



This chapter includes information about:

[General Insurance Law](#)

[Health Insurance](#)

[Life Insurance](#)

[Disability Insurance](#)

[Credit Insurance](#)

Insurance availability and coverage can be a confusing area for many people. This chapter explains general insurance law in Vermont, health insurance, life insurance, disability insurance and credit insurance.

General Insurance Law

The insurance industry is prohibited from engaging in unfair or deceptive practices. **In Vermont, discriminating against people on the basis of sex, sexual orientation, or marital status in the areas of “underwriting” and “rating” is an unfair practice, and against the law.** The law protects people from unfair discrimination by agents, brokers, and insurance companies.

“Underwriting” is the way in which an insurance company decides whether or not to insure a particular person, group of people, business, home, etc. **“Rating”** is the way in which a company decides what rates to charge. **The law prohibits insurers from offering a different rating period, different deductibles, or other terms of insurance to women or non-married people than it does to men or married people in the same situations.** Some examples include:

- An application containing medical history questions cannot have a section labeled “females only”; and
- A company cannot require a woman to buy a family policy in order to obtain maternity coverage for herself

While it is illegal to discriminate in the areas of rating and underwriting, it is **legal to charge different premium rates for women and men** for certain kinds of insurance.

Health Insurance

Health insurance includes a variety of different insurance products including: indemnity plans, Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Medicare supplemental insurance, long-term care insurance, accident insurance, and other disease-specific insurance like coverage for cancer, student insurance, or dental insurance. Some health insurance products such as indemnity plans or HMOs provide comprehensive coverage. Other health insurance products such as dental insurance will provide only limited and specific coverage.

The law concerning health insurance is continuously changing to keep pace with the ongoing changes in both the traditional health insurance and managed health care systems.

While Vermont can regulate what health insurance companies must include in policies offered to individuals, or employers who buy health insurance plans for their employees in the state of Vermont, federal law prohibits states from regulating what businesses choose to offer to their employees. (See Self-Insured Plans section within this chapter.)

Under Vermont health insurance law, couples in a civil union are treated the same way as married couples.

Federal Health Care Reforms of 2010

Most people who have health insurance through their employers will be unaffected by the federal legislation passed in 2010: **the Patient Protection and Affordable Care Act (PPACA)** and the **Health Care Education and Reconciliation Act of 2010**. Many of the changes will not go into effect until 2014 or later.

Changes now in effect include:

- no lifetime limits on medical coverage for many insurance plans;
- insurers cannot drop you if you become sick;
- children under the age of 19 with pre-existing conditions cannot be denied coverage;
- dependent children can remain on your health plan until age 26;
- if you have been unable to obtain health insurance because of a pre-existing condition you would be eligible for subsidized coverage through a high-risk insurance program.

Self-Insured Group Health Plans (ERISA Plans)

Some Vermont businesses or national corporations that have employees in Vermont may choose to **self-insure**. That is, they offer a health plan to their employees where, instead of buying a health insurance policy for their employees from an insurance company such as Aetna, CIGNA, MVP or Blue Cross, they pay the medical costs incurred by their employees themselves.

In a self-insured group health plan (or a 'self-funded' plan as it is also called) the employer assumes the financial risk for providing health care benefits to its employees although they may buy "stop-loss" insurance for medical claims above a certain amount. **These plans are not subject to state health insurance regulations or state-mandated benefits but are regulated under federal law (ERISA).**

Businesses that choose to self-insure usually hire an insurance company like Blue Cross, Aetna or CIGNA to set the fees paid to doctors and other health care providers and to process their claims. In this case, the insurance companies are acting as plan administrators and are called third party administrators (TPA's).

The TPA will give you an "insurance card" that you will use when you go for medical care. The medical care provider will list you as having "Blue Cross" or "Aetna" or "CIGNA" as your insurance company. If you have a question about a claim or coverage, you will call the insurance company.

If you are not sure whether your employer has a group health insurance policy that must conform to

state insurance law or self-insures, you should contact your HR person at work and ask if the company has a group health insurance plan or a self-insured ERISA health plan. The State of Vermont ‘self-insures’ its employees.

Pregnancy & Pregnancy-Related Conditions

Federal and state laws require health insurance policies to treat pregnancy and pregnancy-related conditions the same as an illness or disease. In addition, under the federal **Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)**, a health insurance provider cannot exclude pregnancy from coverage as a pre-existing condition. This is true even if a woman is pregnant at the time she obtains a health insurance policy.

Maternity coverage must be provided on health insurance policies sold in Vermont. This includes coverage for medical expenses resulting from pregnancy, childbirth, prenatal care, and related conditions and complications. This coverage is subject to the same deductibles, durational limits and co-insurance factors as other conditions, illnesses or accidents covered by the policy.

There are many different birthing professionals that a pregnant woman may consider to aid her in the birthing process. Many women will choose to use an obstetrician (OB) or nurse midwife to give birth in a traditional hospital setting. Other women may want to use a midwife or a naturopathic physician to aid them in an alternative setting, like the home. Regardless of the birthing professional – obstetrician, midwife, you choose, that professional must be licensed by the state to practice in Vermont.

Home Births

Vermont law requires that a health insurance plan providing maternity benefits also provide coverage for the services of a certified nurse midwife or a licensed midwife for a home birth. Coverage for services provided by these professionals cannot have greater co-pays, deductibles or co-insurance charges than those for similar services. In addition, an insurance plan may require that the nurse midwife or midwife be a provider in their network. This law applies to all plans issued or renewed after October 1, 2011 and applies to all plans by October 1, 2012.)

If there is a question whether or not a particular professional or service will be covered by your insurance, you should first consult your policy and your provider.

Maternity Stays (Hospital Stays – Postpartum)

Federal law requires health care insurance providers to cover specific minimum maternity stays. These requirements ensure that providers will cover a woman’s stay in a hospital after giving birth for:

- at least forty-eight (48) hours after a vaginal delivery; and
- at least ninety-six (96) hours following a cesarean delivery.

Prescription Contraceptives & Outpatient Contraceptive Services

Under Vermont law, if your health insurance policy covers prescription drugs, then you are entitled to coverage for buying any prescription contraceptives and prescription contraceptive devices approved

by the federal Food and Drug Administration. You are also covered for any outpatient contraceptive services including office visits and sterilization procedures.

Mammograms

Vermont law requires that insurers provide coverage for low-dose mammography screening for breast cancer. The coverage includes both the low-dose x-ray procedure and the interpretation of the x-rays by a qualified physician. **If you are forty (40) years or older, your health insurance plan coverage must provide for an annual screening.** Otherwise, coverage for screening is available whenever a health care provider recommends it. For example, if you have a family history of breast cancer, you may be at a higher risk than other women. As a result, your health care provider may recommend a mammogram screening, regardless of your age.

Your insurance company must cover the full cost of the mammogram screening, but may charge you a co-pay. Your insurer can only charge you what you would regularly pay to see your primary care provider (a co-pay) or twenty-five dollars (\$25) whichever is less. In addition, your insurance company may not require you to pay a deductible or a percentage of the bill. **Thus you should never have to pay more than \$25 to have a mammogram.**

Colorectal Cancer

Vermont law requires that insurers provide coverage for colorectal cancer screening by providing individuals who are 50 years of age or older with the option of an annual fecal occult blood testing plus one flexible sigmoidoscopy every five years; or one colonoscopy every 10 years.

However if you are considered to be at high risk for colorectal cancer, **colorectal cancer screening examinations and laboratory tests will be covered as recommended by your treating physician.**

Your insurance company must cover the full cost of the colorectal cancer screening, but may charge you a co-pay. Your insurer can only charge you what you would regularly pay to see your primary care provider (a co-pay) or one hundred (\$100) dollars, whichever is less. In addition, your insurance company may not require you to pay a deductible or a percentage of the bill. **Thus you should never have to pay more than \$100 to have the chosen colorectal cancer screening.**

Diabetes

Under Vermont law, all health insurers must cover the equipment, supplies and outpatient self-management training and education - including medical nutrition therapy - for the treatment of diabetes. This applies to insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes.

Your diabetes treatment must be prescribed by a health care professional who is legally authorized to prescribe such items under Vermont law. The health insurer may require that your prescriptions be made, and your care be given, by a health care professional who is under contract with the insurer.

Coverage for diabetes can be subject to your policy's dollar limits, deductibles, and/or coinsurance requirements.

Chiropractic Coverage

Vermont law requires your health insurance plan to cover clinically necessary health care services provided by a licensed chiropractor. Your health plan may require that your chiropractic services be provided by a licensed chiropractic physician under contract with your insurer or upon referral by your health care provider. Additionally, you may be required by your insurer to pay reasonable deductibles, co-payment and co-insurance amounts, or subject to benefit limits.

There are some limitations on the type of chiropractic services that are covered, so check with your health plan or with the **Vermont Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA)**. (See [VCW's Resource Directory - Women's Health section](#) for the contact information for BISHCA)

Coverage for Craniofacial Disorders

Under Vermont law, all health insurers are required to provide coverage for the diagnosis and medically necessary treatment of musculoskeletal disorders that affect any bone or joint in the face, neck, or head. The musculoskeletal disorder must be the result of an accident, trauma, congenital defect, developmental defect, or disease.

Medical services may be provided by either a physician or dentist. However, **a referral may be required from your plan's participating health care provider**. Additionally, your insurer may require you to receive treatment from a physician or dentist under contract with the insurer. Coverage for craniofacial disorders does not include dental services for dental disorders or dental disease mainly affecting the gums, teeth, or alveolar ridge.

Nutritional Treatment of Inherited Metabolic Diseases

Vermont law requires all health insurers to provide coverage for medical foods prescribed by a health care provider for the necessary treatment of certain inherited metabolic diseases. An insurer must provide coverage for the purchase of low protein modified food products that are prescribed for medically necessary treatment of an inherited metabolic disease, at least up to two thousand and five-hundred dollars (\$2,500) for any continuous period of twelve (12) months.

Mental Health and Substance Abuse Disorders

Vermont law recognizes that treatment for mental health conditions is an important part of health care. Thus, **all health insurers must provide coverage in their health insurance plans for the treatment of mental health conditions – any condition or disorder involving mental illness, alcohol or substance abuse.**

Under this law, health insurance plans:

- Cannot set different deductibles or out-of-pocket limits for mental health conditions and physical health conditions - **they must provide the same benefit coverage for physical and mental health conditions.**
- Cannot put a greater financial burden on you to access mental health treatment than for treatment of a physical health condition. For example, if there is no limitation on the number of visits you can make to the doctor for a physical condition, then no limits can be placed on mental health visits. If any limits are set, they have to be the same for mental health as for physical

problems. However, your insurer may charge you the same deductible and/or co-pay that you would be charged for visiting a specialist for a physical condition.

The Vermont Department of Banking, Insurance, Securities and Health Care Administration reviews health insurance plans to ensure that they do not lessen or try to counteract the purpose of Vermont's mental health law.

Medically Necessary Care and Treatment of Cancer

All health insurance plans are required by Vermont law to cover “medically necessary growth cell stimulating factor injections” which are taken as part of a chemotherapy program. Additionally, insurers are mandated to cover the cost of orally administered medications and the off-label use of prescription drugs to kill or slow the growth of cancer.

All health benefit plans issued in Vermont must also provide coverage for routine costs for patients who participate in cancer clinical trials.

HIV/AIDS

Insurance companies can require applicants for insurance to be tested for their HIV status. This test may be used by the insurance company to decide whether or not to sell you insurance coverage. Testing for HIV may only be carried out after the insurance company provides you with appropriate notification and after you have given written informed consent. Your consent to the test must be voluntary and can be given only after you have been given both an oral and written explanation. The explanation of the test must include: the test's relationship to AIDS, the insurer's purpose for seeking the test, potential uses and disclosures of the results, accuracy limitations of and the meaning of the test's results.

You have the option to consult with a personal physician, counselor, or the Vermont Department of Health before deciding whether to consent to the test. If you decide to pursue this option, it will be at your own expense. Additionally, you can obtain an anonymous test before deciding to consent to the insurance policy test.

If you consent to be tested, the insurance company may request a sample of your blood, urine, or oral fluids to conduct the test. The insurance company must pay for the test. You have the choice to receive the test results directly or designate another person through whom you want to receive the results. Your test results will be treated confidentially, but **any HIV-positive test will be reported by the insurance company to the Vermont Department of Health and the Medical Information Bureau using a code identifier.** There are retesting procedures available, but will depend on the results of your test.

It is important to know that refusal to consent to the test could cancel your insurance application.

In addition to testing requirements, **an insurance company cannot ask if you have sought AIDS-related counseling or have been tested for HIV/AIDS in the past.** This does not prevent the insurance company from asking you if you have ever been treated for or diagnosed as having HIV or AIDS.

You should be aware that two kinds of HIV testing are available in Vermont: “anonymous” and “confidential.” In **anonymous testing**, all information regarding your HIV test is recorded by a

random testing code number, not your name. Your name will not be recorded with the HIV test information, reported to the laboratory, or the Vermont Department of Health. In **confidential testing**, you will provide your name only to your test counselor. Your test is assigned a unique identifier code that will be used by the laboratory and the department of health. Your results and the fact that you had an HIV test may be placed in your medical records.

Although no law requires you to have an HIV test, **the Health Department strongly recommends that all expectant mothers get tested for HIV**. Early detection of HIV can help a physician better treat you and prevent your child from becoming infected with HIV. You may want to contact your insurance provider to find out whether your policy will cover your HIV test.

See [VCW's Resource Directory – Women's Health section](#) for community agencies and hotlines that can help you.

See the [Public Assistance and Government Benefits chapter in *The Legal Rights of Women in Vermont*](#) for information on state insurance programs for individuals with HIV/AIDS who may have been denied health insurance because of their HIV status or who have exhausted their health plan benefits.

Coverage for Treatment with Natural Medicine (naturopathic medicine)

Under Vermont law, a health insurance plan must pay a physician licensed to practice natural medicine (a naturopathic physician) in Vermont for providing medical services that are covered by the plan. However, the treatment provided by the naturopathic physician must fall within the scope of practice described by Vermont law. For example, an insurance company would not be required to cover most surgical procedures provided by a naturopathic physician.

Your insurance company's coverage of health care services provided by naturopathic physicians may be subject to reasonable deductibles, co-payment and co-insurance amounts, and fee or benefit limits. Any amounts or limits cannot be used to discriminate against naturopathic care and cannot be more restrictive than those imposed on other services provided by a health care professional. A health insurance plan may require you receive your naturopathic care from a licensed naturopathic physician under contract with the insurer.

Continuing your Group Policy Coverage

If you receive your health (medical, dental or hospital) coverage through your or your spouse's employer or association's group policy, **you may be eligible to continue your hospital and medical insurance if your coverage is terminated for one of the following reasons:**

- termination of your employment;
- divorce or legal separation of the covered employee from you
- ceasing to be a dependent child under the policy;
- covered employee receiving Medicare;
- death of the covered employee.

If your employer had more than 20 employees, you may be eligible under federal law (COBRA). If the employer had fewer than 20 employees you may be eligible under the Vermont law (VIPER). To continue your coverage you must notify the insurer, policyholder, or agent in writing of your **decision within sixty (60) days of your termination or your receiving your notice of eligibility for continuation of insurance.**

To continue your coverage, you will be required to pay the insurance plan's full premium (your own share of the premium plus the employer's share plus no more than a 2% administrative fee.) However, since it is at a group health insurance rate, it is generally less expensive than individual health coverage.

The length of time that you remain eligible depends on the reason for termination and the law that applies. Coverage continues for eighteen (18) months under both federal and state law. However if you lost coverage due to a divorce or became disabled during the initial 18 months, and your company falls under the federal law COBRA, you remain eligible for thirty-six (36) months. If you become disabled, the premium can increase to 150% of the original premium during the second 18 months.

Depending on your family income, it may be less expensive for you to enroll in one of the state-sponsored health insurance programs. (See the [Public Assistance and Government Benefits chapter in *The Legal Rights of Women in Vermont*](#).)

Coverage for Pre-Existing Conditions & Changes in Employment

If you change your group health plan due to a change in employment, federal law provides some protection against insurance companies that limit or even deny coverage for “**pre-existing conditions.**”

A pre-existing condition is any physical or mental health condition that you have received medical advice, diagnosis, care, or treatment for; or that a health care provider recommended that you receive medical advice, diagnosis, care, or treatment for generally during the six (6) months before you enroll in a new health insurance program. **Health information obtained from genetic testing cannot be used as evidence of a pre-existing condition.** For example, breast cancer would not be a pre-existing condition if you only took a genetic test that showed that you are at higher risk of developing breast cancer. Additionally, **pregnancy may never be considered a pre-existing condition.**

A health insurance plan may exclude a pre-existing condition from coverage, but only for a limited period of time that will vary. Some plans may choose to offer a shorter time period or none at all, so it is important to check your specific health insurance plan.

Additionally, you may be able to reduce the exclusion period even further if you have a history of prior health insurance coverage – called “creditable coverage.” Most comprehensive health insurance can be used as creditable coverage. The time period when you had creditable coverage will be counted towards the exclusion. For example, if you had insurance under your old plan for two (2) years, the exclusion period under your new plan will be eliminated.

If you want to count your previous coverage towards the exclusion period there cannot be a “significant break” in your insurance coverage. The amount of time that constitutes a significant break will vary depending on what health insurance market you are in. Thus, **you will want to avoid any periods in which you are uninsured by enrolling promptly in another health insurance plan.**

Family members covered under your group health plan have the same protection under federal law as you.

As a result of the 2010 Federal Health Care legislation, all exclusions for pre-existing conditions will end in 2014. In addition, as noted earlier in this chapter, insurance companies can no longer exclude children under 19 who have pre-existing conditions.

Health Insurance Coverage of Children

Newborns

Vermont law requires all health insurance policies – whether for a single person or a family - to **provide coverage for newborns for the first thirty-one (31) days after birth.** The policy must cover the newborn regardless of whether you informed the insurance company of the child's anticipated birth. The policy must include coverage for injury, sickness, and for the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

The insurance company cannot require you to pay any additional premium for the newborn's coverage for the first thirty-one (31) days after birth. **However, the company can require an additional premium for coverage beyond the first thirty-one (31) days. Coverage may terminate after the thirty-one (31) days have passed, if you do not pay the additional premium, but the termination cannot be retroactive back to birth.**

Health Insurance and Child Support Orders

Vermont law makes it easier for divorced parents to obtain health care coverage for their children under their own health plan.

When a child support order requires a parent to provide health insurance coverage for a child, and the parent is eligible for family health coverage, **the parent's employer and the health care insurer must allow the child to be enrolled regardless of any "enrollment season" restrictions.**

The child cannot be eliminated from coverage unless: this portion of the child support order is no longer in effect; the child is or will be enrolled in comparable health coverage through another insurer; or the employer has eliminated family health coverage for all its employees.

The parent, who is required by a child support order to provide medical support for the child, must notify the health insurer of the court child support order. **The insurer will have ten (10) days from the notice to enroll the child.**

A health insurer cannot deny a child enrollment under a parent's health plan because: the child's parents were not married at the time of birth; the child was not claimed as a dependent on the parent's federal tax return; or the child does not reside with the parent or in the insurer's service area.

When a child has coverage under one parent's health plan, the insurer must provide information to both parents about how the child can obtain benefits and make claims for the child. Each parent has the right to appeal any denials of claims without the approval of the other parent.

Adopted Children

Vermont law requires all health plans that provide coverage for participants or beneficiaries' dependent children treat adopted children the same as biological children. This applies to **all children who have been placed for adoption, even if the adoption has not become final.**

Childhood Vaccines

Under Vermont law, a health insurer must maintain their childhood vaccine coverage at the same level as plans issued on or before May 1, 1993 for similar health insurance plans issued today. Effectively, **this mandates coverage for childhood vaccines in Vermont.**

Managed Care Health Plans

Managed care is a kind of health insurance where your health plan provides you health care and coverage through its own network of doctors, hospitals, and other health care providers. There are several different types of managed care health plans available to consumers. Health Maintenance Organizations (HMOs) are the best-known type of managed care. However, other managed care plans exist, such as Preferred Provider Organizations (PPO) or Point-of-Service (POS) plans that combine some elements of more traditional “fee-for-service” plans.

Under some managed care health plans, such as HMOs, you must choose a doctor from your plan’s health network to be your “primary care provider.” Your primary care provider will keep track of all your health care and provide you with referrals when you need to see a specialist.

When choosing between managed health care plans, you should consider the following questions to determine which plan works best for you and your family:

- What are the health needs of you and your family?
 - Which doctors, hospitals, and pharmacies are included in each network?
 - How much will you pay for the premium, office visits, prescription drugs, and other services?
- As an individual insured through a managed care plan, you have certain rights and protections under Vermont law.

These protections include your right to quality health care, information about how your plan works, and the right to covered services under the terms of your contract. Other areas covered include:

- **The right to emergency services.** If you have a medical problem that you reasonably believe poses serious risks to your health, managed care plans must pay for your visit to an emergency room, even if it later turns out there was no emergency. (If possible, contact your insurance provider before your visit. Otherwise, you should contact your insurer promptly afterwards as to the reasons why you sought emergency care.)
- **Reasonable access to the plan’s providers.** Managed care plans are required to have enough providers, both primary and specialty care, to care for all of their members. This means that you should be able to see providers relatively close to your home and without having to wait an unreasonable time to get an appointment.
- **Access to specialty services.** Plans must allow you to see specialists as necessary. This includes the use of “standing referrals” to specialists if you have a condition requiring ongoing care. Plans must also allow specialists to coordinate your care if you have life-threatening, degenerative or disabling conditions.
- **Direct access by women to gynecological health care services.** Plans must allow women to see their network gynecological health care providers (OB/GYNs or Planned Parenthood, for example) at least twice a year without a referral from their primary care provider for reproductive and gynecological health care services, plus any necessary follow-up services.
- **Continuity of care.** If you are pregnant and in your second or third trimester when you join an HMO, or if you have a life-threatening, disabling or degenerative condition, the plan must allow you to continue using your out-of-network provider for up to 60 days after your enrollment. You

get the same 60-day transition period if your provider is in the plan's network, but decides to leave.

- **Consumer information.** When you enroll, or upon request, plans must give you basic information about how their plans work and what services are covered. You will also get a handbook that clearly describes in detail what you need to do to get services.
- **Confidentiality of medical records.** Managed care plans must ensure the confidential handling of your personal health care information. They must also allow you to see your medical records, and to copy them for reasonable fees.

You have additional rights regarding your questions and complaints. These rights include:

- The right to be told in writing why you were denied treatment that you and your doctor think is necessary
- The right to file a complaint or appeal with your plan concerning any problems
- The right to a quick response, in writing, to your complaint or appeal; and
- The right to file an appeal outside of your plan

If you have a problem or question about your managed health care plan, you should start by calling the member services department of your plan. Additional help can be found by contacting the Vermont Department of Banking, Insurance, Securities and Health Care Administration, or calling the Office of Health Care Ombudsman. See [VCW's Resource Directory – Women's Health section](#) for contact information.)

Medicare & Medicare Supplemental Health Insurance

Medicare is a health insurance program for people age sixty-five (65) or older, and people under age sixty-five (65) with certain disabilities. Medicare has different parts that help to cover specific services.

- **Medicare Part A (Hospital Insurance)** - helps cover inpatient care in hospitals, skilled nursing facilities, hospices, and home health care.

Note that coverage for skilled nursing facilities is only provided for rehabilitation services such as when you are recovering from hip replacement surgery or a stroke or services that lead to a higher level of functioning. It does not cover routine long-term care services provided in either a nursing home or at home. Also Medicare will only cover home health care services provided by a "Medicare-certified" provider or agency.

- **Medicare Part B (Medical Insurance)** - helps cover doctors' services and outpatient care. It provides coverage for some preventive services to help maintain your health and to keep certain illnesses from getting worse.

If you do not apply for Medicare Part B when you turn become age 65 and you are not covered by a employer-sponsored health insurance plan, it can cost you a 10% increase in premiums for every year that you delay.

Medicare Part C (Medicare Advantage Plans) – is an optional managed care system that is run by private companies approved by Medicare. Enrollment in a Medicare Advantage Plan excludes you from coverage under Medicare Part A and B and perhaps D. There is an open enrollment period each year if you wish to change plans or go from an advantage plan to a traditional plan.

- **Medicare Part D (Medicare Prescription Drug Coverage)** - optional required plan that helps individuals pay the cost of prescription drugs. However unless you are covered by another prescription drug plan that offers the same or better coverage than Medicare Part D, **every year that you delay in enrolling in Part D will cause a premium increase.**

Part D plans are offered by private insurance companies. They may have different premiums and different costs for different drugs. **Make sure that when you choose a Part D provider that the plan covers the drugs you are prescribed.** There are calculators available on the Medicare website that will help you evaluate the costs of each plan offered in Vermont for the drugs that you are currently taking. There is an open enrollment period each year from November 15 to December 31 if you wish to change drug plans.

If you are on Original Medicare (Medicare Part A & B), you may want to purchase additional insurance to cover health care expenses not covered by Medicare. One type of additional insurance coverage available is Medicare Supplemental Insurance. Medicare Supplemental Insurance is health insurance provided by private insurance companies that helps you pay for some of the gaps in Original Medicare like copayments, coinsurance, deductibles and prescription drugs.

Having Medicare Supplemental Insurance plan may help lower your out-of-pocket costs and give you more health insurance. However, purchasing Medicare Supplemental Insurance may not reduce everyone's out-of-pocket costs – especially if you are already covered for health care expenses not paid by Medicare through group health insurance or Medicaid. **Therefore, you should consider your personal coverage needs before purchasing any Medicare Supplemental Insurance plan.**

Medicare Supplemental Insurance is regulated by both federal and state laws. Insurance companies can only sell certain “standardized” Medicare Supplemental Insurance plans. There are a number of different standardized Medicare Supplemental Insurance plans available. Each type of Medicare Supplemental Insurance plan must offer the same set of basic benefits. However, different insurance companies can sell each type of Medicare Supplemental Insurance plan at different rates. Since prices can vary widely between insurance companies, you will want to comparison shop and carefully weigh your options.

Generally you must have Medicare Part A and Part B to buy a Medicare Supplemental Insurance plan. In Vermont, all companies selling Medicare Supplemental Insurance must accept you into any plan of your choice during an “open enrollment” period. Your six-month open enrollment period begins on the first day of the first month in which:

- You turn 65 years old or older; and
- You are enrolled in Medicare Part B

If you apply for a Medicare Supplemental Insurance plan after this six-month period, you may be subject to some pre-existing condition benefit limitations or denied coverage.

In Vermont, all Medicare Supplemental Insurance plans are “guaranteed renewable.” A guaranteed renewable plan means that an insurance carrier can only cancel your coverage because of non-payment of premiums or material misrepresentation on your application.

It is important to know that Medicare Supplemental Insurance policies only cover the policyholder. **Thus, each spouse would have to purchase their own Medicare Supplemental Insurance plan in order to be covered.** Additionally, individuals covered under a Medicare Advantage Plan (Part C) do not need and cannot use Medicare Supplemental Insurance policies.

For more information on Medicare Supplemental Insurance and choosing a policy:

- Read “Choosing a Medigap Policy” published by the U.S. Department of Health and Human Services. (For a copy of this publication, you can contact Medicare at 1-800-MEDICARE or visit the Medicare website at www.medicare.gov)
- Read “Shopping for Medicare Supplement Insurance” published by the Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA). (For a copy of this publication, you can contact BISHCA toll-free at 1-800-631-7788 or through the “Consumer Publication” link on BISHCA’s website at www.bishca.state.vt.us)

Green Mountain Care

Vermont has managed care health insurance programs for uninsured and underinsured individuals. (For information on these programs please see the [Public Assistance and Government Benefits chapter of *The Legal Rights of Women in Vermont*](#).)

Long-term Care Insurance

Another type of insurance you may want to consider is “long-term care insurance.” Long-term care insurance is a policy that covers necessary health services – such as therapy or rehabilitation – provided in a setting other than an acute care unit of a hospital for a period of twelve (12) or more successive months.

In Vermont, long-term care insurance policies must cover nursing home care, home health care, options for adult day care as well as inflation protection.

As noted in the previous section on Medicare, Medicare only covers care in a nursing home or in your home for short periods of time when the objective is rehabilitation following joint replacement, or a stroke or an illness where your functioning can be improved by care.

Like life insurance, the older you are when you take out a long-term care policy, the more expensive are the premiums.

Consumer Help with Health Insurance

The Vermont Department of Banking, Insurance, Securities and Health Care Administration (commonly called “BISHCA”) offers a number of consumer assistance services focused on health

insurance. BISHCA's Division on Health Care Administration services can:

- give you information on health insurance and health insurance law. (BISHCA publishes a number of health insurance guides to help consumers.)
- help you understand your health insurance policy by explaining the provisions in your health plan.
- confirm what health insurance products and premium rates can be sold in Vermont.
- make suggestions on how you can resolve complaints with your insurer.
- review your insurance complaint information to determine if your insurer has violated applicable laws and if a denial of a health claim qualifies for an independent external review.

Additionally, there are a number of other consumer assistance programs available to help you with health insurance. Some of these include:

- Vermont's Office of Health Care Ombudsman – assists Vermonters in resolving problems and complaints with their health insurance. (A free statewide service)
- Office of Vermont Health Access-Green Mountain Care – provides Vermonters with information on state-sponsored health insurance programs.

[\(See VCW's Resource Directory – Women's Health section](#) for links to these offices.)

Appealing Your Insurer's Denial of a Health Insurance Claim

When your insurer denies you a health care benefit that you believe your insurance should cover, you must first attempt to settle any dispute with your insurer yourself.

This means you must go through your insurers "internal appeal process." If you cannot resolve your problem through the insurer's internal appeal process, you may have the right to pursue an independent external appeal. There is one appeal process for medical claims and another for mental health claims.

If your medical claim was denied coverage, you should promptly contact BISHCA's Division of Health Care Administration to find out if you have the right to appeal this denial to an independent review organization. To qualify for an external review, the medical service being appealed must be covered by your contract and cost at least a hundred dollars (\$100). If it appears that you qualify, the Division will send you an application, collect documents from you and your insurer, and submit the documents to the independent review organization. The independent review organization will make a decision within thirty (30) days of receiving all information.

You must request an external independent review within ninety (90) days of receiving the final denial letter from your insurer. (Call Division of Health Care Administration, BISHCA at 1-800-631-7788 as soon as possible to find out if you qualify.)

If you were denied coverage for a mental health or substance abuse problem, you may have the right to a review by the Independent Panel of Mental Health Providers. The Independent Panel will collect documents from you and your insurer, hold a telephone conference and decide your case. **If your case is medically urgent or an emergency, the time frame may be shorter.** Call the Division of Health Care Administration at BISHCA immediately. Your medical information will be kept confidential.

To file an external appeal to the Independent Panel, call the Division of Health Care Administration, BISHCA at 1-800-631-7788 or 1-802-828-2900.

Health Privacy

Under the Health Insurance Portability and Accountability Act (HIPAA), the United States Department of Health and Human Services issued “Privacy Rules” that define and limit the circumstances in which your protected health information may be used or disclosed by “covered entities.” These covered entities include:

- most doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other health care providers;
- health insurance companies, HMOs, most employer group health plans; and
- certain government programs that pay for health care, such as Medicare and Medicaid.

The information that can or could be used to identify you is protected under these Privacy Rules. This information includes:

- your past, present, or future information on your physical or mental health or condition;
- the health care that is provided to you; and
- the past, present, or future payments made for your health care.

The covered entities cannot use or disclose your protected health information, unless it is permitted or required by law, or you approve the use or the disclosure in writing. **Generally, this means that your health information cannot be given to your employer, used or shared for sales calls or advertising, or used or shared for most other purposes unless you give permission.**

Life Insurance

There are many life insurance products on the market today that were not available in the past. Some examples of the types of life insurance policies available are:

- **“Term” life insurance** provides you with coverage for a specific period of time (or a “policy term”) with specific beginning and ending dates. The insurance will only pay the benefit if you die within the policy term. Term insurance generally provides the largest amount of insurance protection for the least cost for a young individual in good health, but may become unaffordable for older individuals.
- **“Whole” life insurance** provides you with coverage for your whole life as long as you continue to pay the premiums. Coverage includes both a death benefit and a cash savings feature that places some of your money into an interest-bearing account. The plan accumulates cash value that you may borrow against or if you decide to “surrender” (cash in) your policy. In this situation, the insurance company will pay you.
- **“Universal” life insurance** provides permanent insurance with a cash value element – like whole life insurance. However, your premiums are placed into the insurance company’s investment fund. Gains or losses in the company’s investments will determine the premiums you pay and your plan’s cash value. Your cash value can be used in the same manner as in a whole life insurance plan.
- **“Variable” life insurance** provides permanent insurance in which you invest your premiums into a variety of investment options, such as bond funds or stock funds. The amount of your death benefit and cash value will depend on the performance of your investments – this means your policy’s value can potentially go down to zero.

- An “**annuity**” – there are many different types of annuities available. One example of an annuity is an insurance policy that provides an annual or monthly income for as long as a person lives, rather than a lump sum when a person dies.

You may receive your life insurance plan through either an individual or a group policy. A **group policy** is often available to you through your employer, union, or an association in which you are a member. It is important to consider your purpose for purchasing life insurance, to calculate the amount you will be able to pay in premiums, and determine the amount of insurance you need or want. Additionally, you should note any charges – such as surrender or cancellation charges – and taxes that will apply to different policies’ benefits. These factors will help you compare different policies to find the one that is most appropriate for you and your family. You may want to shop around to find the best rate for you.

Disability Insurance

This type of protection is designed to help replace lost income if you become sick or are injured – either mentally or physically. There is great variability in the market for disability insurance, which may make it a difficult type of insurance to obtain – especially for homemakers.

- disability insurance is sold according to a formula that allows for Social Security benefits (see below).
- coverage and availability of disability insurance may depend on the company, the salary level, and the length of the policy. Coverage and availability can also depend on whether the policy rate is guaranteed to be renewed from year to year. If it is, the company’s selling guidelines are probably stricter.

Don’t buy life or disability insurance without first considering the benefits you may be entitled to from the Social Security Administration. Depending on eligibility status, you may be entitled to receive child-rearing or retirement benefits. If your Social Security benefits are high, you may not need as much life or disability insurance.

Credit Insurance

When you borrow money for a car, house, or other major purchase, credit insurance is frequently offered by the lender. Credit insurance will pay off the loan if you die (credit life insurance) or make monthly payments if you are disabled (credit accident and health insurance). **The lender cannot make you buy credit insurance as a condition of receiving the loan.**

Credit insurance is generally more expensive than other types of life or disability insurance for younger borrowers. Your existing life or disability policies often can cover you for the additional obligation of a new loan. If you are interested in purchasing credit insurance, you should check existing policies and comparison shop before checking the “yes, I want credit insurance” box on your loan papers.

Credit insurance generally has three conditions that must be met, including:

- good health;
- gainful employment; and
- appropriate age at the time of the loan – usually under sixty-five (65) years of age

Many people do not realize that even though an insurance certificate is issued with the loan papers, an insurance company may try to deny coverage when a claim is made if you have made false statements about any of the conditions. **To protect yourself against this carefully check all the information you provided on the form before you sign your name.** Additionally, you may want to bring a complaint to the Vermont Department of Banking, Insurance, and Health Care Administration (BISHCA) if an insurer attempts to deny coverage due to innocent false statements.

Remember, you do not have to purchase credit insurance when obtaining a loan.

Relevant Laws

Vermont:

Continuity of Group Coverage (VIPER), 8 V.S.A. § 4090

Credit Insurance, 8 V.S.A. § 4101, et seq.

Health Insurance, 8 V.S.A. § 4061, et seq.

HIV/AIDS, 8 V.S.A. §§ 4724(20); 18 V.S.A. § 1001

Home Births, 8 V.S.A. § 4099d

HMO's, 8 V.S.A. § 5101, et seq.

Insurance Trade Practices, 8 V.S.A. § 4721, et seq.

Life Insurance, 8 V.S.A. § 3701, et seq.

Long-Term Care Insurance, 8 V.S.A. § 8081, et seq.

Vermont Legislature 2009 - Act 61: Implementing Health Care Provisions of the American Recovery and Reinvestment Act

Federal:

COBRA 1986

Health Care and Education Reconciliation Act of 2010

Health Insurance Portability and Accessibility Act of 1996 (HIPAA), Pub. Law 104-191

Patient Protection and Affordable Care Act (PPACA) Pub. Law 111-148

U.S. Department of Health and Human Services, Standards for Privacy of Individually Identifiable

Health Information ("Privacy Rule") - 45 C.F.R. Part 160 and Part 164, Subparts A and E

Updated 11-7-11 - LT