A CONSUMER'S GUIDE TO GETTING AND KEEPING HEALTH INSURANCE IN CALIFORNIA

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This guide is intended to help consumers understand their protections under federal and state law. The authors have made every attempt to assure that the information presented in this guide is accurate as of the date of publication. However, the guide is a summary, and should not be used as a substitute for legal, accounting, or other expert professional advice. Readers should consult insurance regulators or other competent professionals for guidance in making health insurance decisions. The authors, Georgetown University, and the Health Policy Institute specifically disclaim any personal liability, loss or risk incurred as a consequence of the use and application, either directly or indirectly, of any information presented herein.

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As a California resident, you have rights under federal and state law that will protect you when you seek to buy, keep, or switch your health insurance, even if you have a serious health condition.

This guide describes your protections as a California resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group and individual health insurance. Chapter 4 highlights your protections as a small employer or self-employed person. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from California, your protections may change. Since this guide is a summary, it may not answer all of your questions. For places to contact for more information, see page 34. For information about how to find consumer guides for other states on the Internet, see page 35. A list of helpful terms and their definitions begins on page 36. These terms are in **boldface type** the first time they appear.

Contents

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CHAPTER 1
A SUMMARY OF YOUR PROTECTIONS

Numerous state and federal laws make it easier for people with **pre-existing conditions** to get or keep **health insurance**, or to change from one **health plan** to another. A federal law, known as the **Health Insurance Portability and Accountability Act (HIPAA)** sets national standards for all health plans. In addition, states can pass different reforms for the health plans they regulate (**fully insured group health plans** and **individual health insurance policies**), so your protections may vary if you leave California. California has expanded protections for certain kinds of health insurance beyond what federal law requires. Neither federal nor state laws protect your access to health insurance in all circumstances. So please read this guide carefully.

The following information summarizes how federal and state laws do – or do not – protect you as a California resident.

HOW AM I PROTECTED?

In California, as in many other states, your health insurance options are somewhat dependent on your **health status**. Even if you are sick, however the laws protect you in the following ways.

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status.* This is called **nondiscrimination.** (see Chapter 2)

- *All health plans in California must limit exclusion of pre-existing conditions.* There are rules about when a pre-existing condition exclusion period can be applied and how long you must wait before a new health plan will begin to pay for care for that condition. Generally, if you join a new health plan, your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage. (see Chapter 2 for Group Coverage, and Chapter 3 for Individual Coverage)

- *Your health insurance cannot be canceled because you get sick.* Most health insurance is **guaranteed renewable.** (see Chapter 3 for Individual Coverage, and Chapter 4 for Small Group Coverage)

- *If your son or daughter is in college and covered as a dependent under your group, but cannot maintain student status due to illness, he or she may still be able to remain covered as your dependent for up to one year.* (see Chapter 2)

- *If you leave your job, you may be able to remain in your old group health plan for a certain length of time.* This is called **COBRA** or **Cal-COBRA coverage**. It can help when you are between jobs, or when you retire early and are not yet eligible for Medicare. There are limits on what you can be charged for this coverage. (see Chapter 3)

- *If you lost your group health plan because of involuntary termination of employment that occurred between September 1, 2008 and December 31, 2009, you may be eligible for a federal tax credit that can help you pay for your COBRA or state continuation coverage premiums for up to nine months.* (see Chapter 3)

- *If you lose coverage under a fully insured group health plan in California, you may be able to buy a **conversion policy**.* This is an individual policy from the company that insured your former group. You will not face a new pre-existing condition exclusion period under a conversion policy. (see Chapter 3)

- *If you lose your group health plan and meet other qualifications, you will be **HIPAA eligible**.* If so, you are guaranteed the right to buy an individual health insurance policy from any insurance company that sells individual coverage. You will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for such a policy. (see Chapter 3)

- *If you have had difficulty obtaining affordable individual health insurance because of your health condition, you may be eligible for **Major Risk Medical Insurance Program (MRMIP).*** You may face a new pre-existing condition exclusion period when you join. There are limits on what you can be charged for a MRMIP policy. (see Chapter 3)

- *When you apply for an individual health insurance policy, insurance companies may not turn you down, charge you more or impose a pre-existing condition exclusion period because of your **genetic information**.* In addition, insurance companies are not allowed to even ask about your genetic tests or family history when you apply for coverage. (see Chapter 3)

- *If you are a small employer buying a fully insured **small group health plan policy**, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group.* All fully insured health insurance policies for small employers must be sold on a **guaranteed issue** basis. (see Chapter 4)

- *As a small employer, you cannot be turned down or charged more because of the genetic information of a member of your group.* In addition, insurance companies are not allowed to even ask about genetic tests or family history of people in your group when you apply for coverage. (see Chapter 4)

- *If you have low or modest household income, you may be eligible for free or subsidized health coverage for yourself or members of your family.* The California **Medi-Cal** program

(also called **Medicaid**) offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes. (see Chapter 5)

- *If your children are under the age of 19, do not have health insurance and meet other qualifications, you may be able to get coverage for them through the* **Healthy Families** *program.* (see Chapter 5)

- *If you have or are at risk for breast or cervical cancer, you may be eligible for free screening.* The **Every Woman Counts Program** provides qualified women with free breast and cervical cancer screening. In addition, women diagnosed with cancer may be eligible for treatment through the **Breast And Cervical Cancer Program (BCCTP)**. (see Chapter 5)

- *If you have breast or cervical cancer and meet certain income and insurance requirements, you may be eligible for free treatment.* The Breast And Cervical Cancer Treatment Program (BCCTP) is a state and federally funded program that provides cancer treatment certain qualified residents of California who are in need of treatment for breast and/or cervical cancer. BCCTP serves both men and women. (see Chapter 5)

- *If you lost your health insurance and are receiving benefits from the* ***Trade Adjustment Assistance (TAA) Program****, then you may be eligible for a federal income tax credit to help pay for new health coverage*. This credit is called the **Health Coverage Tax Credit** (HCTC), and it is equal to 80% of the cost of qualified health coverage, including COBRA. (see Chapter 5)

- *If you are a retiree aged 55-65 and receiving pension benefits from* ***Pension Benefit Guarantee Corporation*** *(PBGC), then you may also be eligible for the HCTC.* (see Chapter 5)

WHAT ARE THE LIMITS ON MY PROTECTIONS?

As important as they are, the federal and state health insurance reforms are limited. Therefore, you also should understand how the laws do *not* protect you.

- *If you change jobs, you usually cannot take your old group health plan with you.* Except when you exercise your COBRA or Cal-COBRA rights, you are not entitled to take your actual group health plan with you when you leave a job. Your new health plan may not cover all of the benefits or include the same doctors that your old health plan did. (see Chapter 2)

- *If you change jobs, your new employer may not offer you health benefits.* Employers are required only to make sure that any health benefits they do offer do not discriminate based on health status. (see Chapter 2)

- *If you get a new job with health benefits, your coverage may not start right away.* Employers can impose **waiting periods** before your health benefits begin. **HMO**s can require **affiliation periods.** (see Chapter 2)

- *If you have a break in coverage of 63 days or more, you may have to satisfy a new pre-existing condition exclusion period when you join a new group health plan.* (see Chapter 2)

- *Even if you have **continuous coverage**, there may be a pre-existing condition exclusion period for some benefits if you join a **group health plan** that covers certain benefits your old plan did not.* For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition. (see Chapter 2)

- *If you work for certain non-federal public employers in California, not all of the group health plan protections may apply to you.* (see Chapter 2)

- *If you are not HIPAA eligible, your access to individual health insurance may depend on your health status.* Generally, individual insurers in California are free to turn you down, charge more or limit coverage because of your health status and other factors. (see Chapter 3)

- *Even if you are HIPAA eligible, you can be turned down for some individual health insurance policies.* Insurance companies are allowed to limit your choices to two of the individual policies that they sell. (see Chapter 3)

- *If you are a small employer buying a fully insured group health plan, you can be charged more, within limits, based on health status, age and other factors related to your group.* Even with these limits, however, premiums can be significantly higher if someone in your group has a serious illness. (see Chapter 4)

CHAPTER 2
YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

This chapter describes the protections that you have in group health plans, such as those offered by employers or labor unions. Your protections will vary somewhat, depending on whether your plan is a fully insured group health plan or a **self-insured group health plan**. The plan's benefits information must indicate whether the plan is self-insured.

WHEN DOES A GROUP HEALTH PLAN HAVE TO LET ME IN?

- *In general you have to be eligible for the group health plan.* For example, your employer may not give health benefits to all of its employees. Or, your employer may offer an HMO plan that you cannot join because you live outside of the plan's service area.

- *You cannot be turned away or charged more because of your health status.* Health status means your medical condition or history, genetic information, or disability. This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (such as part time employment), as long as these reasons are unrelated to health status and applied consistently.

> **Discrimination due to health status is not permitted**
>
> The Acme Company has 200 employees and offers two different health plans. Full time employees are offered a high option plan that covers prescription drugs; part time employees are offered a low option plan that does not. This is *permitted* under the law. By contrast, in a cost-cutting move, Acme restricts its high option plan to those employees who can pass a physical examination. This is *not permitted* under the law.

- *You must be given a special opportunity to sign up for your group health plan if certain changes happen to your family*. In addition to any regular **enrollment period** your employer or group health plan offers, you must be offered a special opportunity to enroll in your group health plan after certain events. Depending on the event, these **special enrollment periods** can last either 30 or 60 days. You can elect coverage at this time. If your group plan offers family coverage, your dependents can elect coverage as well. Enrollment during a special enrollment period is *not* considered **late enrollment.**

Certain changes can trigger a 30-day special enrollment opportunity

- The birth, adoption, or placement for adoption of a child
- Marriage
- Involuntary loss of other coverage (for example, that you or your dependents had through yourself or another family member and lost because of death, divorce, legal separation, termination, retirement, or reduction in hours worked).

Certain changes can trigger a 60-day special enrollment opportunity

- Loss of eligibility under Medicaid or SCHIP
- Eligibility for a state Medicaid or SCHIP premium assistance subsidy applicable to premiums for a group plan.

- *Under California law, newborns, newly adopted children and children placed for adoption are automatically covered under the parents' fully insured group health plan for a certain period of time, as specified under the rules of the group health plan.* The group health plan may require that the parent enroll the child within a certain number of days in order to continue coverage.

- *Under California law, disabled adult children can remain on their parent's fully insured group health plan after reaching the age at which dependent coverage is usually terminated, if they meet certain requirements.* To qualify, your adult son or daughter must be incapable of self-sustaining employment because of a physically or mentally disabling condition and must be chiefly dependent on you for support. Proof of incapacity must be furnished within 31 days of reaching the time limit and may be required again in the future.

- *If your group health plan covers dependents, you may be able to keep your son or daughter covered under the plan after the age of majority.* Most group health plans will allow your son or daughter to remain covered under your family plan past the age of 19 if they are a full time student.

  If your son or daughter is in college and covered as a dependent under your group, but cannot maintain student status due to illness, he or she may still be able to remain covered as your dependent for up to one year. A new federal law allows dependent children who take a medically necessary leave of absence due to a serious illness or injury to remain covered as dependents under their parents' group plan for up to one year or until the coverage would otherwise end, whichever comes first. This law will apply to plan years beginning on or after October 9, 2009.

  Read you plan documents carefully to determine when your child will "age off" your group health plan.

For more information about this important protection, contact the U.S. Department of Labor at (866) 444-EBSA (3272).

- *When you begin a new job, your employer may impose a waiting period before you can sign up for health coverage*. This waiting period, however, must be applied consistently and cannot vary due to your health status. You will not have health insurance coverage during this time.

- *When you begin a new job with health insurance through an HMO, the HMO may require an affiliation period before coverage begins.* During this affiliation period, you will not have health insurance coverage. An HMO affiliation period cannot exceed 60 days, and you cannot be charged a premium during it. An affiliation period must run concurrently with any waiting period that your employer imposes.

- *California requires fully insured group health plans to accept late enrollees, although you might have to wait 12 months to enroll after applying for coverage.*

- *If you have to take leave from your job due to illness, the birth or adoption of a child, or to care for a seriously ill family member, you may be able to keep your group health plan for a limited time*. A federal law known as the **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job-protected leave in these circumstances. The FMLA applies to you if you work for a company with 50 or more employees.

  If you qualify for leave under FMLA, your employer must continue your health benefits. You will have to continue paying your share of the premium.

  If you decide not to return to work at the end of the leave period, your employer may require you to pay back the employer's share of the health insurance premium. However, if you don't return to work because of factors outside your control (such as a need to continue caring for a sick family member, or because your spouse is transferred to a job in a distant city), you will not have to repay the premium.

  For more information on your rights under the FMLA, contact the **U.S. Department of Labor**.

- *In addition, California law provides some additional rights to women who are taking pregnancy leave.* Contact the Department of Fair Employment & Housing for more information at (800) 884-1684 or visit them on the web at http://www.dfeh.ca.gov.

CAN A GROUP HEALTH PLAN LIMIT MY COVERAGE FOR PRE-EXISTING CONDITIONS?

When you first enroll in a group health plan, the employer or insurance company may ask if you have any pre-existing conditions. Or, if you make a claim during the first year of coverage, the plan may look back to see whether it was for such a condition. If so, it may try to exclude coverage for services related to that condition for a certain length of time. However, federal and state laws protect you by placing limits on these pre-existing condition exclusion periods under group health plans. In some cases your protections will vary, depending on the type of group health plan you belong to.

- *A group health plan can count as pre-existing conditions only those conditions for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan.* This period is known as the **look back** period.

- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns, newly adopted children, children placed for adoption, or genetic information.*

- *Group health plans can exclude coverage for pre-existing conditions only for a limited time.* The maximum exclusion period depends on the type of group health plan you are joining. If you are joining a fully insured group health plan in California, the maximum exclusion period is 6 months. If you are joining a self-insured group health plan, the maximum exclusion period is 12 months. You will receive credit toward your pre-existing condition exclusion period for any previous continuous coverage.

- *If you enroll late in your group health plan (after you are hired and not during a regular or special enrollment period), you may have a longer pre-existing condition exclusion period.* If you are a late enrollee self-insured group health plan, you may face a pre-existing condition exclusion period up to 18 months. A late enrollee of fully insured group plan may face a pre-existing exclusion period up to 12 months.

- *Group health plans that impose pre-existing condition exclusion periods must give you credit for any previous continuous **creditable coverage** that you've had.* Most types of private and government sponsored health coverage are considered creditable coverage.

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

Children's Health Insurance Program
Federal Employees Health Benefits (FEHBP)
Foreign National Coverage
Group health plan (including COBRA)
Indian Health Service
Individual health insurance
Medicaid
Medicare
Military health coverage (CHAMPUS, TRICARE)
State high-risk pools
Student health insurance
VA coverage

In most cases, you should get a **certificate of creditable coverage** when you leave a health plan. You also can request certificates at other times. If you cannot get one, you can submit other proof of prior coverage, such as old health plan ID cards or statements from your doctor showing bills paid by your health insurance plan.

- *Coverage usually counts as continuous if it is not interrupted by a break of 63 days or more in a row.* However, in California, if you lost access to coverage because of a job loss or because your employer no longer sponsored or offered a plan, a fully insured group health plan must give you credit your prior coverage, if it is not interrupted by a break of more than 180 days, instead of 63 days.

What is continuous coverage?

You can get continuous coverage under one plan, or under several plans, as long as you don't have a lapse of 63 or more consecutive days.

Take Art, who has diabetes. Ajax Company covered him under its group health plan for 9 months, but he decided to quit and lost his health coverage. Then, *45 days later,* Art found a new job at Beta Corporation and had health coverage for 9 more months. Art changed jobs again. His new company, Charter, has a health plan that covers care for diabetes but excludes pre-existing conditions for 12 months. Charter must cover Art's diabetes care immediately, because his 18 months of prior continuous coverage are credited against the 12-month exclusion.

Now consider a slightly different situation. Assume Art was uninsured for *90 days* between his jobs at Ajax and Beta. In this case, Charter will credit coverage only under Beta's plan toward the 12-month pre-existing condition exclusion period. Charter's plan will begin paying for Art's diabetes care in 3 months (1 year minus 9 months). Art does not get credit for his coverage at Ajax since he had a break of *more than 63 consecutive days.*

- *In determining continuous coverage, employer-imposed waiting periods and HMO affiliation periods do not count as a break in coverage.* If your new plan imposes a pre-existing condition exclusion period, you can credit time under your prior continuous coverage toward it. If your employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period. HMOs that require an affiliation period cannot exclude coverage for pre-existing conditions.

- *Your protections may differ if you move to a group health plan that offers more benefits than your old one did.* Some group plans can look back to determine whether your previous health plan covered prescription drugs, mental health, substance abuse, dental care, or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new group health plan may impose a pre-existing condition exclusion period for that category. Group plans that use this method of crediting prior coverage must use it for everyone and must disclose this to you when you enroll. In California, fully insured group plans cannot use this method of crediting prior coverage.

Even if coverage is continuous, there may be an exclusion for certain benefits

Sue needs prescription medication to control her blood pressure. She had 2 years of continuous coverage under her employer's group health plan, which did not cover prescription drugs. Sue changes jobs, and her new employer's self-insured plan does cover prescription drugs. However, because her prior policy did not, the new plan refuses to cover her blood pressure medicine for 6 months.

Question: Is this permitted?

Answer: Yes. However, the plan must pay for covered doctor visits, hospital care, and other services for Sue's high blood pressure. It also must pay for covered prescription drugs she needs for other conditions that were not pre-existing.

- *No pre-existing condition exclusion period can be applied without appropriate notice.* Your group health plan must inform you, in writing, if it intends to impose such a period. Also, if needed, it must help you get a **certificate of creditable coverage** from your old health plan.

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

Federal law permits state, county, and local governments to exempt their employees in self-insured group health plans from some of the protections discussed previously in this chapter. Public employers must make this choice annually. When they do so, they are required to notify the federal government and specify which health insurance protections will not apply to their employees' group health plan.

In the past, a large number of public employers in California have decided that certain health insurance protections will not apply to their employees. The Center for Medicare and Medicaid Services (CMS) used to post a list of employers which had elected to exempt, however it has removed this information from its web site.

If you are not sure about your protections under your public employee health plan, you should contact your employer. In addition, you can contact CMS directly at (877) 267-2323 ext. 61565 or at (410) 786-1565 to see if your employer has elected to be exempt from certain protection.

AS YOU ARE LEAVING GROUP COVERAGE…

- *If you are leaving your job or otherwise losing access to your group health plan, you may be able to remain covered under the group health plan for a limited time*. In addition, you may have special protections when buying certain kinds of individual health insurance. See Chapter 3 for more information about COBRA, Cal-COBRA, conversion coverage, and individual health insurance for "HIPAA eligible individuals."

- *If you have lost your group health plan and are receiving benefits from the Trade Adjustment Assistance (TAA) program, you may be eligible for a federal income tax credit to help you pay for new health coverage.* This credit is called the Health Coverage Tax Credit (HCTC), and it is equal to 80% of the cost of qualified health coverage, including COBRA. (see Chapter 5)

- *If you are a retiree aged 55-65 and receiving pension benefits from the Pension Benefit Guaranty Corporation (PBGC), you may also be eligible for the HCTC.* (see Chapter 5)

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to an employer-sponsored group health plan, you may want to buy an individual health policy from a private insurer. However, in California – as in most other states – you have limited guaranteed access to individual health insurance. There are alternatives to individual health insurance coverage – such as COBRA coverage, Cal-COBRA, and Major Risk Medical Insurance Program (MRMIP) coverage. This chapter summarizes your protections under different kinds of coverage.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS & HMOS

WHEN DO INDIVIDUAL HEALTH INSURERS HAVE TO SELL ME A POLICY?

In California, your ability to buy individual health insurance policy may depend on your health status. There are certain circumstances, however, when you must be allowed to buy individual health insurance.

- *Unless you are HIPAA eligible, insurers that sell individual health insurance in California are free to turn you down because of your health status and other factors.* When applying for an individual policy, you may be asked questions about health conditions you have now or had in the past. Depending on your health status, insurers might refuse to sell you coverage or offer to sell you a policy that has special limitations on what it covers.

  However, under no circumstance can you be turned down, charged more or face a pre-existing exclusion period because of your genetic information. Genetic information includes the results of a genetic test and your family history of health conditions

- *If you have trouble buying private health insurance due to your health status, you may be eligible for the Major Risk Medical Insurance Program* (MRMIP).

- *Persons who are HIPAA eligible are guaranteed the right to buy an individual policy from private insurers.* However, insurers can limit your choices to two policies – either their two most popular policies or two representative policies. The two representative policies must include a high option policy and a low option policy.

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible you are guaranteed the right to buy individual health policy in every state and are exempted from pre-existing condition exclusion periods. In California, you are guaranteed the right to buy coverage from any insurer selling individual policies.

To be HIPAA eligible, you must meet all of the following:

- You must have had 18 months of continuous creditable coverage*, at least the last day of which was under a group health plan*.
- You also must have used up any COBRA or state continuation coverage for which you were eligible.
- You must not be eligible for Medicare, Medicaid or a group health plan.
- You must not have health insurance. (Note, however, if you know your group coverage is about to end, you can apply for coverage for which you *will* be HIPAA eligible.)
- You must apply for health insurance for which you are HIPAA eligible within 63 days of losing your prior coverage.

HIPAA eligibility ends when you enroll in an individual policy, because the last day of your continuous health coverage must have been in a group plan. You can become HIPAA eligible again by maintaining continuous coverage and rejoining a group health plan.

- *Under California law, newborns, adopted children, and children placed for adoption are automatically covered under the parents' individual health policy, if the plan provides coverage for dependents, for a certain number of days, as specified by the individual health insurance policy.* The policy may require that the parent enroll the child within a certain number of days in order to continue coverage.

- *If you have a disabled child, that child may remain covered under your individual health insurance policy after he or she reaches the age at which dependent coverage is usually terminated.* To qualify, your adult son or daughter must be incapable of self-sustaining employment because of a physically or mentally disabling condition and must be chiefly dependent on you for support. Proof of incapacity must be furnished within 31 days of reaching the time limit and may be required again in the future.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy.* In general, California does not require health plans in the individual market to sell standardized policies. Health insurers can design different policies and you will have to read and compare them carefully. California does require all individual health policies to cover certain benefits – for example, some cancer screenings. Check with the California Department of Insurance or the Department of Managed Health Care for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are HIPAA eligible, no pre-existing condition exclusion period can be imposed on your coverage.*

- *If you are not HIPAA eligible, the rules for pre-existing conditions for individual health insurance policies are somewhat different from those under group health plans*. In general, you may face a 6-month pre-existing exclusion period if the policy covers three or more people and 12 months if the policy covers one or two people. You can get credit for any prior continuous creditable coverage you had provided you became eligible for the new individual health insurance police within 62 days of termination of your prior coverage.

  The definition of pre-existing condition is different for individual health insurance policies than for group health plans. Individual health policies can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice in the 6-month period (if the policy covers 3 or more people) or 12-month period (if the policy covers 1 or 2 people) prior to obtaining the individual health policy.

- *Pregnancy may be considered a pre-existing condition in an individual health insurance policy.* However, genetic information cannot be used as a basis for a pre-existing condition

WHAT CAN I BE CHARGED FOR MY INDIVIDUAL HEALTH INSURANCE POLICY?

- *If you are HIPAA eligible, California law limits the premium you can be charged.* Even so, you may find that your premiums are quite expensive.

- *If you are not HIPAA eligible, California does not limit what you can be charged.* Individual premiums can vary due to health status, age, gender, family size, and other factors. However premiums cannot vary based on your genetic information.

  When you renew your individual health insurance policy, your premiums can increase as you age or your health declines.

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELED?

- *Your health coverage cannot be canceled because you get sick.* This is called guaranteed renewability. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of HMO plans, continue to live in the plan service area.
  However if you make a claim during the first two years of coverage under your policy, the insurer might re-investigate information you provided during the application process to determine whether you made a misstatement. If so, the insurer might try to take back your policy and void coverage altogether.

  If you become involved in one of these "post-claims" investigations, be sure to call the California Department of Insurance or, if your insurer is an HMO, the California Department of Managed Health Care to learn more about your rights.

- *Your health coverage may also be canceled if the insurer or HMO discontinues your health plan or withdraws from the individual market.* However, if you are covered under a health plan that has been discontinued by a company that still sells other health insurance in individual market, your insurance company must offer you one of those other individual policies.

- *Some insurance companies sell temporary health insurance policies.* Temporary policies are not guaranteed renewable. They will only cover you for a limited time, such as 12 months or less. If you want to renew coverage under a temporary policy after it expires, you will have to reapply and there is no guarantee that coverage will be reissued at all or at the same price.

COBRA AND STATE CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

If you are leaving your job and you had group coverage, you may be able to stay in your group plan for an extended time through COBRA and/or state continuation coverage. The information presented below was taken from publications prepared by the U.S. Department of Labor. You should contact them for more information about your rights under COBRA.

- *To qualify for COBRA continuation coverage, you must meet 3 criteria:*

  First, you must work for an employer with 20 or more employees. If you work for an employer with 2-19 employees, you may qualify for state continuation coverage.

  Second, you must be covered under the employer's group health plan as an employee or as the spouse or dependent child of an employee.

Finally, you must have a qualifying event that would cause you to lose your group health plan.

COBRA QUALIFYING EVENTS

For employees
- Voluntary or involuntary termination of employment for reasons other than gross misconduct
- Reduction in numbers of hours worked

For spouses
- Loss of coverage by the employee because of one of the qualifying events listed above
- Covered employee becomes eligible for Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee

For dependent children
- Loss of coverage because of any of the qualifying events listed for spouses
- Loss of status as a dependent child under the plan rules

- *Each person who is eligible for COBRA continuation can make their own decision.* If your dependents were covered under your employer plan, they may independently elect COBRA coverage as well.

- *You must be notified of your COBRA rights when you join the group health plan, and again if you qualify for COBRA coverage.* The notice rules are somewhat complicated and you should contact the U.S. Department of Labor for more information.

  In general, if the event that qualifies you for COBRA coverage involves the death, termination, reduction in hours worked, or Medicare eligibility of a covered worker, the employer has 30 days to notify the group health plan of this event. However, if the qualifying event involves divorce or legal separation or loss of dependent status, you have 60 days to notify the group health plan. Once it has been notified of the qualifying event, the group health plan has 14 days to send you a notice about how to elect COBRA coverage. Each member of your family eligible for COBRA coverage then has 60 days to make this election.

  Once you elect COBRA, coverage will begin retroactive to the qualifying event. You will have to pay premiums dating back to this period.

SPECIAL SECOND CHANCE TO ELECT COBRA FOR TRADE-DISLOCATED WORKERS

- *A second COBRA election period may be available for TAA eligible people who did not elect COBRA when it was first offered*. The second election period can be exercised 60 days from the 1st day of TAA eligibility, but in no case later than 6 months following loss of coverage. Coverage elected during this second election begins retroactive to the beginning of the special election period – not back to qualifying event.
- *Certain people who lost their job-based health coverage because of the impact of imports on their employers have a limited second chance to elect COBRA*. People who are receiving benefits from the Trade Adjustment Assistance (TAA) Program are eligible for a federal income tax credit (the Health Coverage Tax Credit, or HCTC) that will pay 80% of their premiums.
- *For some laid off workers, TAA benefits begin after their 60-day period to elect COBRA continuation coverage has expired*. In this circumstance, TAA-eligible people have a second 60-day period, starting on the date of their TAA eligibility, to elect COBRA. (However, in no case can COBRA be elected more than 6-months following the original qualifying event (i.e. layoff) that caused the loss of group health plan coverage.)
- *When COBRA is elected during this special, second election period, coverage starts on the first date of the special election period*. Any time that has elapsed between the original qualifying event and the first date of the special election period is not counted as a lapse in coverage in determining continuous coverage history.

- *To qualify as HIPAA eligible, you must choose and use up any COBRA or state continuation coverage available to you.*

WHAT WILL COBRA COVER?

- *Your covered health benefits under COBRA will be the same as those you had before you qualified for COBRA.* For example, if you had coverage for medical, hospitalization, dental, vision, and prescription drug benefits before COBRA, you can continue coverage for all of these benefits under COBRA. If these benefits were covered under more than one plan (for example, a separate health insurance and dental insurance plan) you can choose to continue coverage under any or all of the plans. Life insurance is not covered by COBRA.

  If your employer changes the health benefits package after your qualifying event, you must be offered coverage identical to that available to other active employees who are covered under the plan.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Because your group coverage is continuing, you will not have a new pre-existing condition exclusion period under COBRA.* However, if you were in the middle of a pre-existing condition exclusion period when your qualifying event occurred, you will have to finish it.

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage.* The first premium must be paid within 45 days of electing COBRA coverage.

- *If you elect the 11-month disability extension, the premium will increase to 150% of the total cost of coverage.* See below for more information about the disability extension.

- *If you lost your group health plan because of involuntary termination of employment that occurred between September 1, 2008 and December 31, 2009, you may be eligible for a federal tax credit that can help you pay for your COBRA premiums for up to nine months.* This tax credit was created as part of The American Recovery and Reinvestment Act of 2009 (ARRA) and covers 65% of the your COBRA premium. For more information call the Employee Benefits Security Administration at the United State Department of Labor at (866) 444-3272 or visit the COBRA/AARA information center at http://www.dol.gov/ebsa/cobra.html. Information about the COBRA tax credit is also available from the IRS at http://www.irs.gov/newsroom/article/0,,id=204505,00.html and Department of Health And Human Services at http://www.cms.hhs.gov/COBRAContinuationofCov/.

- *If you are eligible for the Health Coverage Tax Credit (HCTC), the federal government will pay 80% of your COBRA premium*. (see Chapter 5)

- *Call the Department of Labor at (866) 444-3272 to find out if other temporary COBRA subsidies are available to you.*

HOW LONG DOES COBRA COVERAGE LAST?

- *COBRA coverage generally lasts up to 18 months and cannot be renewed.* However, dependents are sometimes eligible for up to 36 months of COBRA continuation coverage, depending on their qualifying event.

In addition, special rules for disabled individuals may extend the maximum period of coverage to 29 months. To qualify for the disability extension, you must have been disabled at the time of your COBRA qualifying event (such as termination of employment or reduction in hours) or be determined to have become disabled within 60 days of that qualifying event. You must obtain this disability determination from the Social Security Administration, and you must notify your group health plan within 60 days of this disability determination.

LENGTH OF COBRA COVERAGE

Qualifying event(s)	*Eligible person(s)*	*Coverage*
Termination Reduced hours	Employee Spouse Dependent child	18 months *
Employee enrolls in Medicare Divorce or legal separation Death of covered employee	Spouse Dependent child	36 months
Loss of dependent child status	Dependent child	36 months

*Special ruled may extend coverage an additional 11 months for certain disabled individuals and their eligible family members

- *Usually, COBRA continuation coverage ends when you join a new health plan*. However, if your new plan has a waiting period or a pre-existing condition exclusion period, you can keep whatever COBRA continuation coverage you have left during that period. For specifics, ask your former employer or contact the U.S. Department of Labor.

- *COBRA coverage also ends if your employer stops offering health benefits to other employees.*

- *COBRA coverage might end if you are in a managed care plan that is available only to people living in a limited geographic area and you move out of that area.* However, if you are eligible for COBRA and are moving out of your current health plan's service area, your employer must provide you with the opportunity to switch to a different plan, but only if the employer already offers other plans to its employees. Examples of the other plans your employer may offer you are a managed care plan whose service area includes the area you are moving to, or another plan that does not have a limited service area.

WHAT ABOUT CAL-COBRA COVERAGE?

- *If your employer offers a fully insured group health plan, you may also be eligible for continuation coverage under a California law that is similar to COBRA.* This law is called Cal-COBRA. To be eligible, you must have had health benefits from an employer with 2-19 employees and you must request continuation coverage within a certain time limit. The time limits for how long you are entitled to keep Cal-COBRA are generally the same as those that apply to persons who are enrolled in COBRA. (see box above)

- *For some qualifying events, Cal-COBRA coverage lasts longer than COBRA.* Generally Cal-COBRA lasts up to 36 months and cannot be renewed.

- *If you lost your group health plan because of involuntary termination of employment that occurred between September 1, 2008 and December 31, 2009, you may be eligible for a federal tax credit that can help you pay for your state continuation coverage premiums for up to nine months.* This tax credit is part of The American Recovery and Reinvestment Act of 2009 (ARRA), and covers 65% of the your state continuation premium. For more information call the Employee Benefits Security Administration at the United State Department of Labor at (866) 444-3272 or visit them online at *http://www.dol.gov/ebsa/cobra.html*. In addition, see "Health Information About State Continuation Coverage And ARRA" available the website of the Department of Health And Human Services at http://www.cms.hhs.gov/COBRAContinuationofCov/.

- There may other state protections that allow you to stay covered under a group plan during reasons such as a period of disability or a labor strike. Contact your former employer, the California Department of Insurance, or the California Department of Managed Health Care about Cal-COBRA coverage and other state continuation coverage options, if you think these protections may apply to you.

CONVERSION COVERAGE

WHEN AM I ELIGIBLE FOR A CONVERSION POLICY?

- *In California, if you have coverage through an employer's fully insured group health plan and you lose it, you may be eligible to buy conversion coverage.* This is an individual policy you get from the company that insured your employer's group plan.

  The employee who lost coverage is eligible for conversion as is the spouse and any dependent children who were covered under the plan when the coverage was terminated. In addition, spouses and dependent children can elect conversion coverage following the death of a covered employee. Spouses also can elect conversion coverage following divorce or termination of marriage and children when they reach an age where they cease to qualify as dependents.

- *To qualify for a conversion policy, you must have had at least 3 months of continuous coverage through an employer's fully insured group health plan*. However, insurers may refuse to offer you a conversion policy if your fully insured group health plan is terminated due to nonpayment, good cause or fraud. In addition if you are covered for similar benefits by another individual policy or contract or covered under Medicare or another group health plan, then your group plan is not required to offer you a conversion policy.

WHAT DOES A CONVERSION POLICY COVER?

- *Conversion policies are required to meet minimum standards set out in state regulations.* Even so, the benefits may be less generous than what you received under your former group coverage.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Your conversion policy cannot impose a new pre-existing condition exclusion period.* However, you might have to satisfy the unexpired portion of any pre-existing condition exclusion period from your former health plan.

HOW MUCH CAN I BE CHARGED FOR MY CONVERSION POLICY?

- *Generally premiums for conversion policies can vary depending on your health status, age, and other factors.* However, if your prior group coverage was a fully insured HMO, then California law limits the premium you can be charged. Even so, you may find that your premiums are quite expensive.

- Contact the California Department of Managed Care or California Department of Insurance, if you have questions about conversion policy premiums.

CAN MY CONVERSION POLICY BE CANCELED?

- *Your coverage cannot be canceled because you get sick.* This is called guaranteed renewability. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of managed care plan, continue to live in the plan service area.

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP)

California has a risk pool program called the Major Risk Medical Insurance Program (MRMIP). MRMIP offers health coverage for people with expensive health conditions who have trouble obtaining individual insurance coverage.

WHEN CAN I GET COVERAGE FROM MRMIP?

- *If you are "uninsurable" you can buy coverage from MRMIP.* You are considered uninsurable if you were turned down for coverage within the last 12 months by an insurer or HMO because of your health. In addition, if you were offered individual health insurance that is considered by MRMIP to be inadequate to cover you medical needs, such as a policy that excludes or limits coverage for your pre-existing health condition, or if you were offered individual insurance that is more expensive than MRMIP, you are considered uninsurable.

  In addition, you may be able to get MRMIP coverage if you have been involuntarily terminated from health insurance coverage within the 12 months for reasons other than nonpayment of premium or fraud.

- *You can also buy coverage from MRMIP if you have moved to California from another state's high risk pool as long as complete application is received within 62 days of losing the prior coverage.*

- *MRMIP offers both individual and family policies, so dependents are also eligible for coverage under the high risk pool*.

- *To be eligible for MRMIP, you must be a California resident and not be eligible for employer-sponsored group health plan, including COBRA and CalCOBRA, or Medicare (unless on Medicare solely because of end-stage renal disease*).

WHAT WILL MRMIP COVERAGE COVER?

- *MRMIP coverage includes hospital and physician care, maternity services, prescription drugs, treatment for serious mental health illness, and other services*. HMO and PPO plans are available from the different companies that participate in the program. For all plans, you must satisfy a $500 deductible. In addition, although co-payment requirements vary depending on the plan and service provided, all MRMIP plans have an out-of-pocket maximum of $2,500 for individuals and $4,000 for families. MRMIP plans will pay up to $75,000 in benefits per calendar year and $750,000 in a lifetime.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *When you first enroll, MRMIP will look back 6 months to see if you had a condition for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received by a licensed health practitioner.*

- *For individuals enrolled in a PPO plan, there is a pre-existing condition exclusion period of 90 days*. For individuals enrolled in an HMO plan, there is an affiliation period of 90 days.

During this time you will not be eligible for health care services and you will not be charged any premium in addition to the premium you submitted with your MRMIP application. At the end of the 90 days, your pre-existing conditions will be covered.

- *In some circumstances, your pre-existing condition exclusion period or your affiliation period may be waived if you had prior health insurance.* Call MRMIP to see if you are eligible for a pre-existing condition exclusion period waiver.

WHAT CAN I BE CHARGED FOR MRMIP COVERAGE?

- *Premiums will vary based on the health plan you choose, your age, your family size and where you live.*

  For example, a 24-year old single person in Sacramento would pay $695 per month for a Blue Shield HMO plan and $275 for the Kaiser plan. A 60-year old with one dependent in Sacramento would pay $3,486 per month for a Blue Shield HMO plan and $1,258 for the Kaiser plan.

  Please note that premium may have changed since this guide was written, so contact MRMIP for the most current information.

HOW LONG DOES MRMIP COVERAGE LAST?

- *MRMIP policies are renewable as long as you pay your premiums, continue to reside in California and meet other eligibility requirements.* If you commit fraud against MRMIP or become eligible for Medicare (unless eligible solely because of end-state renal disease), you will be allowed to continue in MRMIP.

CHAPTER 4
YOUR PROTECTIONS AS A SMALL EMPLOYER OR SELF-EMPLOYED PERSON

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. California has enacted reforms to expand some of these protections. Generally, small employers are those that employ 2-50 employees. Please note, however, that the definitions of small employer and employee are somewhat different under federal and state law. Check with the California Department of Insurance or the Department of Managed Health Care to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down.* This is called guaranteed issue. If you employ at least 2 but not more than 50 employees, insurance companies must sell you any small group health plan policy they sell to other small employers.

  However, they can require that a minimum percentage of your eligible employees participate in your small group health plan. They can also require you to pay a minimum share of your workers' premiums. If you are buying a **large group health plan policy** for 51 or more employees, your group can be turned down.

- *Under no circumstances may you be turned down or charged more because of the genetic information of someone in your group.* In addition, insurance companies may not even ask about genetic test results or family history of people in your group when you apply for coverage.

- *Your group health plan cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group insurance policies of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud, or if they are discontinuing that health plan or if they are withdrawing from the small employer market. In the case of discontinuance, they must give you a chance to buy other health insurance policies they sell to groups of your size.

CAN I BE CHARGED MORE BECAUSE OF MY GROUP'S HEALTH STATUS?

- *As a small employer in California, you can be charged higher premiums, within limits, because someone in your group is seriously ill.* In addition, you can also be charged somewhat more due to the age and family size of those in your group and where your business is located. However, insurers cannot charge higher premiums based on the genetic information of those in your group.

  For groups with more than 50 employees, California does not limit premium variation or increases, except that large groups also cannot be charged more based on genetic information. If you have questions about your group health plan premiums, contact the California Department of Insurance or the California Department of Managed Health Care.

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are not eligible to buy a small employer group health plan on your own.* Therefore, the laws that protect employers' access to group health plans do not apply to you. Your access to health coverage is protected by the laws that apply to individuals. (see Chapter 3)

- *If you are self-employed and buy your own health insurance, you are eligible to deduct 100% of your premium from your federal income tax.*

A WORD ABOUT ASSOCIATION PLANS

- *Some small employers, self-employed people, and other individuals buy health insurance through professional or trade associations.* The laws applying to association health coverage can be different than those for other health plans. Check with the California Department of Insurance about your protections in association health plans.

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of California who cannot afford to buy health insurance. Medi-Cal, Healthy Families, **Access for Infants and Mothers (AIM)** and other programs offer free or subsidized health insurance coverage, direct medical services or other help. In addition, the federal government, under the Trade Adjustment Assistance (TAA) Program, provides tax credits to some workers who lose their jobs or whose work hours and wages are reduced as a result of increased imports. This chapter provides summary information about these programs and contact information for further assistance.

MEDI-CAL

Medi-Cal (also called Medicaid) is a program that provides health coverage to some low-income California residents. Medi-Cal covers families with children and pregnant women, medically needy individuals, the elderly, and people with disabilities, if state and federal guidelines are met. Legal residents who are not U.S. citizens may be eligible for Medi-Cal. Questions concerning immigration status and eligibility should be directed to the California Department of Health Care Services.

- *For certain categories of people, eligibility for Medi-Cal is based on the amount of your household incom*e.

  In California you may be eligible for Medi-Cal if you are an infant, a child, a pregnant woman, or a parent of a dependent child and your family income meets the Medicaid income standards.

  Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account, so you should contact the California Department of Health Services for more information.

Low income persons eligible for Medi-Cal in California*

Category	Income eligibility (as percent of federal poverty level)
Infant	200% (monthly income of $3,052 for family of 3)
Child 1-5	133%
Child 6-19	100%
Non-working Parents	100%
Working Parents	106%
Pregnant woman	200%
Medically Needy(Single)	83%
Medically Needy(Couple)	97%

* Eligibility information was compiled from *State Health Facts Online,* the Henry J. Kaiser Family Foundation and may have changed since this guide was published. Contact your state Medicaid program for the most up to date information and for other eligibility requirements that may apply.

To get an idea of how your income compares to the federal poverty level,* use the federal poverty guideline issued by the U.S. Department of Health and Human Services for the year 2009:

Size of Family Unit	Poverty Guideline (annual income)
1	$10.830
2	$14,570
3	$18,310

For larger families add $3,740 for each additional person.

So, for example, using this guideline, 200% of the federal poverty level for a family of 3 would be an annual income of $36,620, or a monthly income of $3,052.

Contact your state Medicaid program for the most up to date information and for other eligibility requirements that may apply.

- *People enrolled in SSI/SSP, CalWORKS, Refugee Assistance, Foster Care or Adoption Assistance Program or In-Home Support Services (IHSS) can get Medi-Cal.*

- *Parents should know that when you get a job and your CALWORKS (also called TANF) benefits end, you generally can stay on Medi-Cal for a 24-month up to one year for kids) transitional period.*

In addition, your children may qualify for Medi-Cal if your family's income meets certain income standards.

- *Very poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits can also qualify for Medi-Cal.*

  Disabled individuals should know that if your income earned from a job increases so that you no longer qualify for SSI, you may be able to continue your Medi-Cal coverage at least for a limited time.

- *People who have high medical expenses may also qualify for Medi-Cal.* You may qualify as medically needy if you have high medical expenses that, when subtracted from your income, would make you eligible for Medi-Cal coverage. For example, people who have to pay a lot for prescription drugs, nursing home care, or other long term care services sometimes qualify as medically needy if they do not have health insurance that covers these services.

- *Retired or disabled people who have low incomes and are enrolled in Medicare may also qualify for help from Medi-Cal.* Even though your income may be too high to qualify for Medi-Cal insurance coverage, there may be other ways Medi-Cal can help.

  If your household income is at or below 100% of the Federal Poverty Level, Medi-Cal will pay your Medicare monthly premium and your Medicare deductibles and coinsurance. This is called the Qualified Medicare Beneficiary (QMB) program.

  If your household income is below 120% of the poverty level, Medi-Cal will pay for your monthly Medicare premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

- *There may be other ways that Medi-Cal can help.* To find out if you or other members of your family qualify for Medi-Cal, contact the California Department of Health Care Services at 1-800-541-555 (in-state) or 916-445-4171 (out-of-state) or visit them online at http://www.dhcs.ca.gov/Pages/default.aspx.

HEALTHY FAMILIES PROGRAM

The Healthy Families program is a state-designed program that provides health coverage to low-income children under the age of 19 who do not have insurance today and do not qualify for no-cost Medi-Cal.

- *A child whose family has a household income at or below 250% of the federal poverty guideline may be eligible for CHIP.* The guidelines are based on the size of the family and the ages of children in the family. For a family of 3 with a 2-year old child, this works out to an annual income ranging from $24,372 to $47,780, or a monthly income between $2,031 to $3,815.

- *Families pay premiums of $4-$15 per child per month (maximum of $45 per family).* In addition, you may have to pay a co-pay of up to $5 for some benefits.

- *Healthy Families offers health, dental and vision care through contracts with selected insurance plans that vary county to county.* Some of the Health Family health benefits include hospital care, physician services, prescription drugs, well child services, mental health, alcohol and drug treatment services, dental care, eye care, lab and x-ray services, and physical, speech, and occupational therapy. In addition, some plans include acupuncture, chiropractic and biofeedback benefits, among other services.

- *For more information about Healthy Families, call (800) 880-5305 or visit them online at http://www.healthyfamilies.ca.gov/About/Contact.aspx*

ACCESS FOR INFANTS AND MOTHERS (AIM)

Access for Infants and Mothers (AIM) is a state-run program that provides low-cost health insurance coverage for some middle-income mothers and their newborns with no health coverage or health coverage with limited maternity benefits.

- *AIM has five eligibility requirements:*

    - You must not be more than 30 weeks pregnant by the time your complete application is received;

    - You must live in California with plans to stay;

    - You must not be enrolled in no-cost Medi-Cal or Medicare benefits;

    - You do not have private health insurance that covers maternity care, or if you do have private health insurance, your maternity coverage must be subject to a deductible or co-payment of more than $500.

    - You meet the AIM income guidelines. Women with family incomes of 200% to 300% of the federal poverty level are eligible for AIM. Certain expenses will be deducted from your income to determine your eligibility.

- *The total cost for AIM coverage will be exactly 1.5% of your adjusted annual household income after income deductions.* So for example, if you are pregnant with your first child and married, you would be counted as a family of three. If you and your husband's monthly income after deductions is $3,053, your cost would be $549. This will cover you throughout your pregnancy and 60 days after your pregnancy has ended.

- *AIM's web site has a chart which will calculate for you the cost of AIM coverage based on your income. Visit them at http://www.aim.ca.gov.*

- *AIM offers medical services through contracts with selected insurance plans that vary county to county.* Benefits include, among others, physician services, hospitalization, prescription drugs, mental health, prenatal and maternity care and well-baby care.

- *For more information concerning the AIM program, call (800) 433-2611 or visit the them online at http://www.aim.ca.gov/*

EVERY WOMAN COUNTS

The Every Woman Counts program (EWC) serves low-income California residents who are at risk for breast and/or cervical cancer.

- *The EWC program provides qualified women with breast and cervical cancer screening at no cost.* Women who are screened through this program and diagnosed with breast and/or cervical cancer may be eligible for treatment through Medicaid.

- *For free EWC cancer screenings, you must meet certain qualifications.* You must be a California resident. To receive free cervical cancer screening you must be at least 25 years old, and at least 40 years old for breast cancer screening. In addition, you must meet the income eligibility standards and be uninsured or underinsured.

- *For more information about the Every Woman Counts Program, call (800)-511 2300 or visit the program online at http://www.cdph.ca.gov/programs/cancerdetection/*

BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP)

The Breast And Cervical Cancer Treatment Program (BCCTP) is a state and federally funded program that provides cancer treatment to low-income residents of California that are in need of treatment for breast and/or cervical cancer. BCCTP serves both men and women.

- *To be eligible for treatment through BCCTP, you must meet certain qualifications.* You must be screened by a provider of the Every Women Counts Program (EWC) or the Family Planning, Access, Care and Treatment Program (Family PACT) program found to be in need of treatment for breast and/or cervical cancer or follow-up care for cancer or precancerous

cervical lesions or conditions. In addition, you have to meet certain income and insurance related criteria. BCCTP serves both men and women.

Even if you have already been diagnosed with breast or cervical cancer, prior to seeing a EWC or Family PACT provider, you may still be eligible for treatment through BCCTP.

- *The Every Woman Counts program provides eligible women with breast and cervical cancer screenings at no cost*. To qualify, you must be a California resident and 25 years old for cervical cancer screening and at least 40 years old for breast cancer screening. In addition, you must meet the income eligible standards, be uninsured or underinsured and not getting screening services through private or public coverage.

  For more information about the Every Woman Counts Program, call (800)-511-2300 or visit the program online at http://www.cdph.ca.gov/programs/cancerdetection/

- *The Family Planning, Access, Care and Treatment Program (Family PACT) provides comprehensive family planning services, including routine breast and cervical screenings, to certain eligible low-income men and women and teens.*

  For more information about Family PACT, email fampact@cdph.ca.gov or visit the program online at http://familypact.org/en/Home.aspx

- *If you are eligible for BCCTP, depending on certain qualification, you may receive treatment through federally funded BCCTP or state funded BCCTP*

  Federal BCCPT provides full-scope Medi-Cal and eligibility continues during the duration of cancer treatment.

  State funded BCCTP provides breast cancer treatment for 18 months and cervical cancer treatment for 24 months.

- *For more information, call BCCTP at (800) 824-0088 or visit the program online at http://www.dhcs.ca.gov/services/medi-cal/Pages/BCCTP.aspx.*

OTHER STATE PROGRAMS

There may be other financial assistance programs available. For more information, call California Department of Health Care Services at (916) 445-4171 or visit them online at http://www.dhcs.ca.gov/Pages/default.aspx. /.

THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)

A federal income tax credit is available to help certain trade dislocated workers and early retirees, and their dependents, buy qualified health insurance coverage. The Health Coverage Tax Credit (HCTC) covers 80% of the insurance premium for qualified coverage. Under this program, you can either claim the tax credit at the end of the year on your tax return or you can elect to have the money paid directly to your qualified health plan each month by the Internal Revenue Service.

WHEN AM I ELIGIBLE FOR THE HCTC?

- *To be eligible for the tax credit, you must be receiving Trade Adjustment Assistance (TAA) benefits or retirement benefits from the PBGC.* If you are receiving PBGC benefits, you also must be at least 55 years old. In addition, you must not be enrolled in Medicare, Medicaid, or in other employer-sponsored coverage for which the employer contributes at least half of the premium

- *HCTC may apply to your family, too.* If you are eligible, you can use the credit to help purchase qualified health coverage for your qualified family members. Qualified family members are your spouse and dependents that you can claim on your federal tax return. Family members are not eligible if they are enrolled in another group health plan where the employer pays at least 50% of the cost of coverage, or in Medicaid, SCHIP, FEHBP, Tricare/CHAMPUS.

- *Eligibility for HCTC is not based on income.* In addition, the HCTC is refundable. This means you can claim the credit even if you do not earn enough income to owe federal income tax.

HOW MUCH OF MY HEALTH COVERAGE COST WILL THE TAX CREDIT COVER?

- *The HCTC is equal to 80% of health insurance premiums for qualified health insurance coverage.*

WHAT HEALTH COVERAGE IS ELIGIBLE FOR THE TAX CREDIT?

The HCTC can only be used to help pay for "qualified" health coverage. COBRA continuation coverage is considered qualified health coverage (see Chapter 3 for more information about COBRA). In addition, California has designated a plan offered through Kaiser Permanente as qualified health coverage. For more information, call Kaiser Permanente at (800) 464-4000. (see Chapter 3)

HOW DO I CLAIM THE HCTC?

- *You can claim the HCTC on your tax return and be reimbursed for 80% of the premium you paid for qualified coverage while you were eligible for the HCTC.* Currently, this is the only way to claim the HCTC if your qualified health plan is provided through a spouse's employer.

- *Alternatively, you can choose to have your credit sent directly to your qualified health plan each month.* To do this, you must register with the HCTC customer service center by calling (866) 628-HCTC (866-628-4282), Monday through Friday between the hours of 7 am and 7 pm, Central time. TDD/TYY callers, please call (866) 626-HCTC (866-626-4282).

WHERE CAN I GET MORE INFORMATION?

- *For more information about the HCTC, contact the HCTC customer service center at (866)628-HCTC, or see the IRS website at http://www.irs.gov/individuals/article/0,,id=187948,00.html.*

- *For more information about TAA benefits, visit http://www.doleta.gov/tradeact/.*

- *For more information about PBGC, call (202) 326-4000 or visit online at http://www.pbgc.gov/.*

FOR MORE INFORMATION…

As a summary, this guide will not answer every question for every person in every circumstance. In addition, it is not a substitute for legal advice. If you have more questions, contact the agencies listed below or consult an attorney.

For questions about:	Contact:
Individual Non-HMO policies Fully insured Non-HMO group plans (Indemnity, PPOs)	*California Department of Insurance* (800) 927-4357 (in-state only) (800) 482-4833 (TDD) (213) 897-8921 (L.A. area or out-of-state) http://www.insurance.ca.gov
Individual HMO policies Fully insured HMO group plans	*California Department of Managed Health Care* (888) 466-2219 (877) 688-9891 (TDD) http://www.dmhc.ca.gov
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	*U.S. Department of Labor,* *Employee Benefits Administrator* *Employee & Employer Assistance Hotline and Publications:* (866) 444-EBSA (3272) http://www.dol.gov/ebsa/
California Family Rights Act Leave Fair Employment and Housing Act Leave	*California Department of Fair Employment & Housing* (800) 884-1684 (in-state only) (916)-478-7200 (out-of-state) http://www.dfeh.ca.gov
Major Risk Medical Insurance Program (MRMIP)	*Managed Risk Medical Insurance Board* (916) 324-4695 (800) 289-6574 http://www.mrmib.ca.gov
Medi-Cal	*California Department of Health Services* ((800)-541-5555 (in-state) (916) 636-1960 (out-of-state) http://www.medi-cal.ca.gov
Healthy Families	*Managed Risk Medical Insurance Board* (800) 880-5305 http://www.healthyfamilies.ca.gov
Access for Infants and Mothers (AIM)	*Managed Risk Medical Insurance Board* (800) 433-2611 http://www.aim.ca.gov
Every Woman Counts program (EWC)	*Department of Health Care Services* (800) 511-2300 http://www.cdph.ca.gov/programs/cancerdetection/
The Breast and Cervical Cancer Treatment Program (BCCPT)	*Department of Health Care Services* (800) 824-0088 http://www.dhcs.ca.gov/services/medi-cal/Pages/BCCTP.aspx

Last Reviewed July 2009

Federal Health Coverage Tax Credit (HCTC)	*Internal Revenue Service* (866)-628-HCTC http://www.irs.gov/individuals/article/0,,id=187948,00.html

Finally, if you would like to obtain a consumer guide for a different state, visit the web at http://www.healthinsuranceinfo.net

HELPFUL TERMS

Access For Infants And Mothers (AIM). A state-run program that provides low-cost health insurance coverage for some middle-income mothers and their newborns with no health coverage or health coverage with limited maternity benefits.

Affiliation Period. The time an HMO may require you to wait after you enroll and before your coverage begins. HMOs that impose an affiliation period cannot exclude coverage of pre-existing conditions. Premiums cannot be charged during HMO affiliation periods. See also HMO.

Alternative Trade Adjustment Assistance (ATAA). ATAA is a benefit for workers at least 50 years old who have obtained different, full-time employment within 26 weeks of the termination of adversely-affected employment. These worker may receive 50% of the wage differential (up to $10,000) during their 2 year eligibility period. To be eligible for the ATAA program, workers may not earn more than $50,000 per year in their new employment. Also, the firm where the workers worked must meet certain eligibility criteria.

Breast And Cervical Cancer Treatment Program (BCCTP). A state and federally funded program that provides cancer treatment to residents (men and women) of California, meeting certain income and insurance related qualifications, that are in need of treatment for breast and/or cervical cancer or follow-up care for cancer or precancerous cervical lesions or conditions.

Cal-COBRA. Cal-COBRA provides continuation coverage to persons who are not eligible for COBRA because their former employers had 2-19 employees. See also COBRA.

Certificate of Creditable Coverage. A document provided by your health plan that lets you prove you had coverage under that health plan. Certificates of creditable coverage will usually be provided automatically when you leave a health plan. You can obtain certificates at other times as well. See also Creditable Coverage.

COBRA. Stands for the Consolidated Omnibus Budget Reconciliation Act, a federal law in effect since 1986. COBRA permits you and your dependents to continue in your employer's group health plan after your job ends. If your employer has 20 or more employees, you may be eligible for COBRA continuation coverage when you retire, quit, are fired, or work reduced hours. Continuation coverage also extends to surviving, divorced or separated spouses; dependent children; and children who lose their dependent status under their parent's health plan's rules. You may choose to continue in the group health plan for a limited time and pay the full premium (including the share your employer used to pay on your behalf plus a 2% administrative charge). COBRA continuation coverage generally lasts 18 months, or 36 months for dependents in certain circumstances.

Continuous Coverage. If you are joining a group health plan or determining if your HIPAA eligible, health insurance coverage is continuous if it is not interrupted by a break of 63 or more consecutive days. Employer waiting periods and HMO affiliation periods do not count as gaps in health coverage for the purpose of determining if coverage is continuous. If you not HIPAA eligible and are buying an individual health insurance policy insurance, health insurance coverage is continuous if the enrollee becomes eligible for coverage under the new policy within 62 days. See also Creditable Coverage, HIPAA Eligible.

Conversion Policy. Your right, when leaving a fully insured group health plan in California, to convert your policy to an individual health policy. You must have been covered under the group health plan for at least 3 months before you can buy a conversion policy. There are rules about what conversion policies must cover and what premiums can be charged. See also Fully Insured Group Health Plan

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance in Colorado; Medicare; Medicaid; CHAMPUS and TRICARE (health coverage for military personnel, retirees, and dependents); the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country); State Children's Health Insurance Program; or a state health insurance high risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Insurance Policy.

Every Woman Counts (EWC). The EWC program provides qualified women with breast and cervical cancer screening at no cost. Women who are screened through this program and diagnosed with breast and/or cervical cancer may be eligible for treatment through Medicaid.

Enrollment Period. The period during which all employees and their dependents can sign up for coverage under an employer group health plan. Besides permitting workers to elect health coverage when first hired, many employers and group health insurers hold an annual enrollment period, during which all employees can enroll in or change their health coverage. See also Fully Insured Group Health Plan, Special Enrollment Period.

Family and Medical Leave Act (FMLA). A federal law that guarantees up to 12 weeks of job-protected leave for certain employees when they need to take time off due to serious illness, to have or adopt a child, or to care for another family member. When you qualify for leave under FMLA, you can continue coverage under your group health plan.

Fully Insured Group Health Plan. Health plan purchased by an employer from an insurer or HMO. Fully insured group health plans are regulated by California. See also Self-Insured Group Health Plans.

Genetic Information. Genetic test results indicating your or a member of your family's risk of developing a health condition. Genetic information includes the presentation of a disease or disorder in a family member. Genetic services, including genetic counseling and education, received by you or a family member, is considered part of your genetic information.

Group Health Plan. Health insurance (sponsored by an employer or union or professional association) that covers at least 2 employees. See also Fully Insured Group Health Plan, Self-Insured Group Health Plan.

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All health plans sold to small employers with 2 to 50 employees in California are guaranteed issue.

Guaranteed Renewability. A feature in health plans that means your coverage cannot be canceled because you get sick. HIPAA requires all health plans to be guaranteed renewable. Your coverage can be canceled for other reasons unrelated to your health status.

Health Coverage Tax Credit (HCTC). The Health Coverage Tax Credit (HCTC) is a program that can help pay for nearly 80% of an eligible individuals' health plan premiums. In general, in order to be eligible for the health coverage tax credit, you must be 1) receiving Trade Readjustment Allowance benefits (TRA), or 2) will receive TRA benefits once your unemployment benefits are exhausted, or 3) receiving benefits under the Alternative Trade Adjustment Assistance (ATAA) program, or 4) aged 55 or older and receiving benefits from the Pension Benefit Guaranty Corporation (PBGC).

Health Insurance or ***Health Plan***. In this guide, the term means benefits consisting of medical care (provided directly or through insurance or reimbursement) under any hospital or medical service policy, plan contract, or HMO contract offered by a health insurance company or a group health plan. It does not mean coverage that is limited to accident or disability insurance, workers' compensation insurance, liability insurance (including automobile insurance) for medical expenses, or coverage for on-site medical clinics. Health insurance also does not mean coverage for limited dental or vision benefits to the extent these are provided under a separate policy.

Health Status. When used in this guide, refers to your medical condition (both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. See also Genetic Information.

Healthy Families. The Healthy Families program is a state-designed program that provides health coverage to low-income children under the age of 19 who do not have insurance today and do not qualify for no-cost Medi-Cal.

HIPAA. The Health Insurance Portability and Accountability Act was passed in 1996 to help people buy and keep health insurance, even when they have serious health conditions, the law sets a national floor for health insurance reforms. Since states can and have modified and expanded upon these provisions, consumers' protections vary from state to state.

HIPAA Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or Medicaid; you must not have other health coverage; and you must apply for individual health coverage within 63 days of losing your prior creditable coverage. No matter where you live in the U.S., if you are HIPAA eligible you must be offered at least some type of individual health policy with no pre-existing condition exclusion periods. See also COBRA, Continuous Coverage, Creditable Coverage.

HMO. Health maintenance organization. A kind of health plan. HMOs usually limit coverage to care from doctors who work for or contract with the HMO. They generally do not require deductibles, but often do charge a small fee, called a copayment, for services like doctor visits or prescriptions. If you are covered under an HMO, the HMO might require an affiliation period before coverage begins. See also Affiliation Period.

Individual Health Insurance Policy. Policies for people not connected to an employer group. This term also refers to coverage purchased by self-employed persons who have no other employees. Individual health policies are regulated by California.

Large Group Health Plan Policy. One with more than 50 eligible employees.

Late Enrollment. Enrollment in a health plan at a time other than the regular or a special enrollment period. If you are a late enrollee self-insured group health plan, you may face a pre-existing condition exclusion period up to 18 months. A late enrollee of fully insured group plan may face a pre-existing exclusion period up to 12 months. See also Special Enrollment Period.

Look Back. The maximum length of time, immediately prior to enrolling in a health plan, that can be examined for evidence of pre-existing conditions. See also Pre-existing Condition.

Major Risk Medical Insurance Program (MRMIP). The state-run program that provides health coverage for people with high health risks (called a high risk pool).

Medicaid or Medi-Cal. A program providing comprehensive health insurance coverage and other assistance to certain low-income California residents. All other states have Medicaid programs, too, though eligibility levels and covered benefits will vary.

Nondiscrimination. A requirement that group health plans not discriminate against you based on your health status. Your coverage under a group health plan cannot be denied or restricted, nor can you be charged a higher premium, because of your health status. Group health plans can restrict your coverage based on other factors (such as part time employment) that are unrelated to health status. See also Group Health Plan, Health Status.

Pension Benefit Guaranty Corporation (PBGC). PBGC is a federal government corporation established by Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) to encourage the continuation and maintenance of defined benefit pension plans, provide timely and uninterrupted payment of pension benefits to participants and beneficiaries in plans covered by PBGC. It currently guarantees payment of basic pension benefits earned by American workers and retirees participating in private-sector defined benefit pension plans. The agency receives no funds from general tax revenues. Operations are financed largely by insurance premiums paid by companies that sponsor pension plans and by PBGC's investment returns.

Pre-existing Condition **(Group Health Plans).** Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan. Pregnancy cannot be counted as a pre-existing condition. Genetic information about your likelihood of developing a disease or condition, without a diagnosis of that disease or condition, cannot be considered a pre-existing condition. Newborns, newly adopted children, and children placed for adoption covered within 31 days cannot be subject to pre-existing condition exclusions.

Pre-existing Condition **(Individual Health Policies).** Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period (if 1-2 people are covered by the policy) and 6-month period (if policy covers 3 ore more people) immediately preceding enrollment in a health plan. Under individual health policies, pregnancy can be counted as a pre-existing condition. Genetic information cannot be considered a pre-existing condition. Newborns, newly adopted children, and children placed for adoption covered within 31 days cannot be subject to pre-existing condition exclusions.

Pre-existing Condition Exclusion Period. The time during which a health plan will not pay for covered care relating to a pre-existing condition. See also Pre-existing Condition.

Self-Insured Group Health Plans. Plans set up by employers who set aside funds to pay their employees' health claims. Because employers often hire insurers or HMOs to run these plans, they may look to you just like fully insured plans. Employers must disclose in your benefits information whether an insurer is responsible for funding, or for only administering the plan. If the insurer is only administering the plan, it is self-insured. Self-insured plans are regulated by the U.S. Department of Labor, not by California.

Small Group Health Plans. Plans with at least 2 but not more than 50 employees.

Special Enrollment Period. A time, triggered by certain specific events, during which you and your dependents must be permitted to sign up for coverage under a group health plan. Employers and group health insurers must make such a period available to employees and their dependents when their family status changes or when their health coverage status changes. Special enrollment periods must last at least 30 to 60 days, depending on the qualifying event. Enrollment in a health plan during a special enrollment period is not considered late enrollment. See also Late Enrollment.

Supplemental Security Income (SSI). A program providing cash benefits to certain very low income disabled and elderly individuals. When you qualify for SSI, you generally also qualify for Medicaid. In addition, Medicaid coverage often continues for a limited time if your income increases so that you no longer qualify for SSI.

Temporary Assistance for Needy Families (TANF). A program (also known as CALWORKS) that provides cash benefits to low-income families with children. When you qualify for TANF, you generally also qualify for Medicaid. In addition, Medicaid coverage often continues for a limited time or longer if you no longer qualify for TANF. See also Medicaid.

Trade Adjustment Assistance (TAA) Program. A program authorized by the Trade Adjustment Assistance Reform Act of 2002. This program provides aid to workers who lose their job or whose hours of work and wages are reduced as a result of increased imports. The TAA Program offers six benefits and reemployment services to assist unemployed workers prepare for and obtain new suitable employment. In addition, TAA offers a significant tax credit that covers 60% of health insurance premiums for certain plans.

U.S. Department of Labor. A department of the federal government that regulates employer provided health benefit plans. You may need to contact the Department of Labor if you are in a self-insured group health plan, or if you have questions about COBRA or the Family and Medical Leave Act. See also COBRA, Family and Medical Leave Act.

Waiting Period. The time you may be required to work for an employer before you are eligible for health coverage. Not all employers require waiting periods. Waiting periods do not count as gaps in health coverage for purposes of determining whether coverage is continuous. If your employer requires a waiting period, your pre-existing condition exclusion period begins on the first day of the waiting period. See also Pre-existing Condition Exclusion Period.