

HEALTH INSURANCE

INTRODUCTION:

Typically people get health insurance from their employer. Thus, a health insurance policy is a contract between you and/or your employer and the health insurance company.

Prior to picking a health insurance plan, it is important to look at the summary of benefits. Specifically, what benefits the particular plan provides and even more importantly, what the plan excludes. Prior to enrolling in a plan, if you have the option, look at costs including premiums, deductibles, and co-pays. Finally, consider open enrollment periods and the ability to change plans if necessary.

I. TYPES OF PRIVATE HEALTH INSURANCE¹

- A. **Group vs. Individual Insurance:** *Group insurance* is usually offered through your employer or some form of a trade association (e.g., a union, etc.). *Individual insurance* means that you are contracting directly with an insurance company (e.g., when you purchase a plan from Blue Cross or Blue Shield, etc.). People who purchase group or individual health insurance plans are called “members” of that insurance company.
- B. **HMO, PPO, and POS Plans:** There are three types of managed care plans.
- 1) **HMO Plans:** HMO stands for a Health Maintenance Organization. There are generally two forms: independent physician associations (IPAs), and stand alone facilities. IPAs have physicians that practice in their own offices and sometimes join with other providers to form a medical group. Examples of IPAs are Blue Cross, Blue Shield, and Aetna. Kaiser Permanente is an example of a stand alone facility.
 - 2) **PPO Plans:** PPO stands for Preferred Provider Organization. A PPO is a group of health care providers who have agreed to provide services to an insurance company’s members at a reduced rate.
 - 3) **POS Plans:** POS stands for Point of Service Plan. A POS Plan is a cross between an HMO and a PPO. Members of a POS plan decide which type of service they want to use at the point when they are ready to use it.

HMO	PPO	POS
Participating doctors and hospitals. Generally have a primary care physician who coordinates care	Usually many health care provider and hospital choices	Can see providers in- or out-of-network
Generally have to select doctors and hospitals from within the participating group	Can select from all participating providers	If selecting within network, generally have a minimal co-pay. If selecting from larger group, member will pay more
Limited choices	More choices in doctors, specialists, overall providers	More choice when needed
Usually less expensive	Usually more expensive	Cost is between that of a PPO and an HMO

¹ For a visual representation of private health insurance options, see Appendix HI1 (page 38)

C. **What to Consider When Choosing a Health Insurance Plan:**

- 1) **Look at the Summary of Benefits:** What benefits are included? What benefits are excluded?
- 2) **Look at the Cost:** How much are the monthly premiums, annual deductibles for the individual or the family, and co-payments?
- 3) **When are the Enrollment Periods?** Do they offer annual open enrollment periods to make changes to your policy?
- 4) **How Much Flexibility Do They Offer?** Can you change plans if you need to? If so, how?
- 5) **Guaranteed Renewability:** Under state and federal law, health insurance companies are required to renew an individual's existing health coverage, but there is no cap on the rate increases companies may impose at the time of renewal. This is called guaranteed renewability. Guaranteed renewability is not portable, so you do not have the right to switch to another company or even another product offered by the same company.

II. **WAYS TO GET AND KEEP HEALTH INSURANCE**

- A. **Employment-Based Health Insurance:** The most common way that people obtain health insurance coverage is through their own employment or a family member's employment. There are certain rights that are guaranteed to people who are insured through their own or a family member's employment. These rights have to do with the continuation of coverage during certain leaves of absence (under the Family and Medical Leave Act) or upon termination of employment (see COBRA, discussed below). Persons with employment-based health insurance are also protected from health insurance discrimination based on their pre-existing conditions under the Health Insurance Portability & Accountability Act (see HIPAA, discussed below).
- B. **COBRA:** COBRA is a federal law that allows you to continue the same health insurance coverage that you had through your or your family member's employer. It is the same health insurance policy you had when you were employed, so you do not have to worry about changing providers.
- 1) **Who can elect COBRA:** COBRA is available to an employee or family member after an employee has terminated their employment or has reduced their work hours to a point that they are no longer eligible to receive coverage from their employer. This termination or reduction in hours is referred to as a "qualifying event." Other qualifying events for COBRA are divorce or death of a spouse (when the person seeking COBRA coverage was insured by a plan provided through the spouse's employment), or a child aging out of a parent's health insurance policy.
 - 2) **Terms of COBRA:** Federal law defines the terms of COBRA coverage and its availability as follows:
 - (i) COBRA applies to employers with 20 or more employees;

- (ii) COBRA coverage generally lasts for 18 months;²
- (iii) The cost of the monthly premium paid by the employee can be up to 102% of what the employer was paying for the same benefits;
- (iv) The person insured is responsible for the full premium for the coverage.
- (v) Responsibility for notifying the health plan of the qualifying event depends on which qualifying event has occurred;
- (vi) A health plan has 14 days after the plan administrator is notified of the qualifying event to notify the employee of the right to elect COBRA; and
- (vii) An employee must elect COBRA within 60 days after being notified of their COBRA rights. The employee then has 45 days after electing coverage to pay the initial premium.

C. **Cal-COBRA:** Cal-COBRA is California's state version of COBRA. Cal-COBRA serves the same purpose as COBRA. It allows you keep your health insurance when you experience a "qualifying event." California has a relatively new law that extends Cal-COBRA coverage up to 36 months. Cal-COBRA also provides that if you have federal COBRA and you have exhausted your 18 months, you can extend it for an additional 18 months under Cal-COBRA.³

- 1) **Terms of Cal-COBRA:** State law defines the terms of Cal-COBRA coverage and its availability as follows:
 - (i) Cal-COBRA applies to employers with 2-19 employees;
 - (ii) Cal-COBRA extends both COBRA & Cal-COBRA to 36 months; and
 - (iii) The cost of the monthly premium paid by the employee can be up to 110% of what the employer was paying for the same benefits.

D. **Health Insurance Premium Payment Program (HIPP):** California has a program called the Health Insurance Premium Payment Program. If you qualify for Medi-Cal and currently have COBRA coverage, you may be able to get your COBRA premiums paid for through the HIPP program rather than receive Medi-Cal insurance. Your monthly medical costs must be twice your monthly premium amount in order to participate in the HIPP program.

E. **Health Insurance Portability & Accountability Act (HIPAA):** HIPAA prohibits health insurance discrimination against individuals based on their pre-existing conditions, when moving from a group health insurance plan to another group health insurance plan or from a group plan to a HIPAA guarantee issue plan.

- 1) **Other HIPAA Protections:** HIPAA also:
 - (i) Provides a federal right to an individual health insurance plan (called a guarantee issue plan);
 - (ii) Reduces the maximum pre-existing condition exclusion period to 12 months; and
 - (iii) Gives you credit for the time that you had health insurance coverage in the past to eliminate or reduce a pre-existing condition exclusion period.

² COBRA coverage can last up to 29 months if the person insured has a qualifying disability, or up to 36 months if the person became eligible for COBRA coverage because of certain qualifying events or a combination of qualifying events.

³ Some employers do not contract with an insurance company to insure their employees, but have enough employees to do risk pooling as an insurance company would. These employers are "self-insured," and not subject to state insurance regulations which have been preempted by a federal law called ERISA. Therefore, Cal-COBRA is not available to employees who are covered by an employer's self-insured plan. These employees are only eligible for 18 months under federal COBRA and only if they meet the federal requirements.

- 2) **Guarantee Issue Plan:** Typically when you apply for an individual health insurance plan, you are required to go through a process called medical underwriting. During this process, the insurance company looks at your past and current medical conditions in order to decide whether or not they want to issue you a health plan. If you currently have, or in the past have had, a serious medical condition, the insurance company will likely decide that it is not worth the risk to them to issue you a health plan, and they will deny you coverage.
- (i) **“Federally Insured Plan” or “HIPAA Plan”:** A guarantee issue plan, also known as a “federally insured plan” or “HIPAA plan,” is an individual health insurance plan that you have a right to purchase under federal law. A HIPAA plan is not a specific plan – rather it is a right to purchase an individual plan. Every insurance company that writes individual insurance policies in your state also is required to offer a HIPAA plan.⁴ The insurance company cannot deny you a HIPAA plan, but you need to use the “buzz” words (guaranteed issue or HIPAA plan) when you apply for the plan. Otherwise the insurance company will likely assume you want a regular individual plan and may deny you coverage.
- (ii) **HIPAA vs. COBRA:** A HIPAA plan is different than COBRA coverage. Under COBRA, you keep the same health insurance you had through your employer. Under HIPAA you are buying new insurance, so you need to compare all of the available plans and pick the one that is right for you. Compare the premiums, deductibles, and co-payments. Check to make sure your health care providers accept the insurance plan you are considering, and that your prescription drugs are on the formulary list of drugs covered by the plan.
- (iii) **Requirements:** In order to be eligible for a HIPAA plan:
- You must exhaust your COBRA coverage, meaning that you use all 18 months of COBRA coverage, and any additional COBRA coverage available to you, including Cal-COBRA;
 - You cannot have a break in health insurance coverage longer than 63 days; and
 - You must be ineligible for Medicare, Medi-Cal, or any other form of group coverage.
- 3) **Pre-Existing Condition Exclusion Period (PECEP):** When you are going from one employer’s group health plan to another employer’s plan, the new plan is required to insure you, but they may impose a PECEP, which means that for a certain period of time, they will not cover any treatment or services related to your pre-existing medical condition. Before HIPAA, a two-year PECEP was the industry standard. HIPAA limited the maximum PECEP that may be imposed to 12 months for employers with 2 or less employees and 6 months for employers with 3 or more employees.
- 4) **Creditable Coverage:** Creditable coverage is any previous period of health insurance coverage that was not interrupted by a break in coverage of more than 63 days. HIPAA reduces any PECEP by the length of time that you previously had

⁴ To find out which providers offer HIPAA plans in California, contact the California Department of Managed Health Care, or visit: www.dmhc.ca.gov/dmhc_consumer/hp/hp_hipaacp.asp.

creditable coverage. Example: If you previously had coverage for four months, have not had a break in coverage of more than 63 days, and your new insurance plan has a PECEP of 12 months, then you get a credit for your four (4) previous months of coverage, leaving you with only eight months left on your PECEP. So, if you have 12 months or more of previous health insurance coverage, and you never have a break in coverage of more than 63 days, you will never face a PECEP.

- (i) **Qualifying for Creditable Coverage:** Almost all types of health insurance can qualify as creditable coverage. Medicare, Medi-Cal, group, individual, COBRA, and HIPAA plans can all qualify. One exception is some student health insurance plans because they are not typically a full policy with catastrophic coverage. If a particular condition was not covered by the policy that you are claiming as creditable coverage, then your new health plan may still subject that condition to a PECEP.
- (ii) **Demonstrating Creditable Coverage:** To show that you have creditable coverage, call your insurance company to request a “certificate of creditable coverage,” which lists the dates that you have been insured by that company. If you have been insured by multiple companies, you need certificates of creditable coverage from each one.

F. **Major Risk Medical Insurance Plan (MRMIP):** If you are not able to obtain insurance through COBRA, and are not eligible for a HIPAA plan because you did not exhaust your available COBRA coverage or you had a break in coverage of more than 63 days, then you may be eligible for MRMIP. MRMIP provides limited health insurance for Californians who are unable to obtain coverage in the individual health insurance market due to a pre-existing condition.

- 1) **Requirements:** In order to be eligible for MRMIP, you must meet the following requirements:
 - (i) Be a resident of California;
 - (ii) Not be eligible for COBRA, Cal-COBRA, HIPAA, Medicare or Medi-Cal; and
 - (iii) Be unable to secure adequate coverage.
- 2) **Plans offered through MRMIP:** Three plans are offered through MRMIP: a Blue Cross PPO, a Blue Shield HMO, and a Kaiser HMO. The premiums for the coverage depend on where you live, your age, and which plan you choose. If you do not have creditable coverage, the PPO has a PECEP of three months, during which you must pay the premiums, but do not receive coverage for your pre-existing condition. The HMO has a three-month waiting period, during which you do not pay premiums, but you do not have access to MRMIP coverage until the waiting period is over.
- 3) **Duration of MRMIP Coverage:** MRMIP is limited to 36 months and then you can move to a HIPAA plan the same way you can after exhausting your COBRA coverage.

III. HANDLING HEALTH INSURANCE DISPUTES

A. **Disagreements:** If you disagree with a decision that your health insurance provider has made regarding coverage, you have the right to appeal that decision. The appeals process varies depending on what state you live in. In California, you must first exhaust

your health plan's internal appeals process, and then you can request an external review of the decision.

- 1) **Internal Review:** This is the health plan's own review of its decision. There are state and federal laws and rules that apply to internal review processes.
- 2) **External or Independent Review:** This is a reconsideration of the health plan's determination by an outside, independent organization. In California, reviews are conducted by either the Department of Managed Health Care (DMHC) or the Department of Insurance.

B. Pre-Appeal Process: Before you begin an appeal, understand your coverage and applicable laws. An *employer-sponsored* health plan is one that a person can get through their own employment or through a family member's employment. The employer usually makes a contribution toward the cost of the employee's coverage. An *individually purchased* plan is one that you purchase directly from a health plan. The person purchasing the insurance pays the entire premium. Different laws apply depending on whether your plan is employer-sponsored or individually-purchased.

- 1) **Self-Insured Plan:** If your plan is an employer-sponsored plan, you need to know whether it is a *self-insured* plan. A self-insured plan is one in which the employer does not contract with an insurance company to insure their employees. Instead, the employer does their own risk pooling like an insurance company would, and pays directly for their employees' health costs. Self-insured plans are not subject to state insurance regulations that have been preempted by the federal law, ERISA.

- (i) **Note:** It is important to know what is covered and what is not covered by your plan. You should also know what procedures and deadlines are required by your plan.

C. Exhaust Your Plan's Internal Complaint Process: If you have a problem with your health plan, you have the right to file a complaint with your health plan. However, you must exhaust your plan's internal grievance process before you may pursue external review through the DMHC or the Department of Insurance. A complaint can also be called a grievance. You may be able to file your complaint by phone, mail, or on the internet. If you need assistance finding your plan's contact information, you can go to the DMHC's website (www.hmohelp.ca.gov) and type in the name of your plan to get the necessary contact information.

- 1) **Response Time:** If your problem is not urgent, your health plan must give you a decision within 30 days. If your problem is urgent, meaning there is a serious threat to your health, your health plan must give you a decision within three days.

D. Request an External Appeal: Once you have exhausted your plan's internal complaint process, you may then request an external review. You can file a complaint with the DMHC or the Department of Insurance (depending on which type of plan you have) if you are not satisfied with your health plan's decision, if you have not received the plan's decision within 30 days, or if the problem is urgent. The DMHC oversees HMOs and all Blue Cross and Blue Shield plans. The Department of Insurance oversees all other health plans.⁵

⁵ Medicare and Medi-Cal have their own dispute resolution procedures. However, DMHC will handle a Medi-Cal HMO dispute if someone does not want to go through the fair hearing process offered by Medicare & Medi-Cal.

- 1) **Independent Medical Review (IMR):** In California, you have the right to receive an external review of your plan's decisions, called Independent Medical Review (IMR). IMR decisions are based on the medical necessity of the treatment and are binding on the plan. Complaint forms are available on the DMHC website at www.hmohelp.ca.gov/dmhc_consumer/pc/pc_forms.aspx and on the Department of Insurance website at www.insurance.ca.gov/contact-us/0200-file-complaint/index.cfm. See the DMHC and Department of Insurance websites for more information on the types of disputes that can be appealed to the two Departments.⁶

IV. **ADDITIONAL HEALTH CARE RIGHTS IN CALIFORNIA**

- A. **Clinical Trials:** In California, a health insurance plan must cover the routine costs associated with cancer clinical trials. Covered costs may include, but are not limited to, hospitalization, physician visits, X-rays, blood tests, CAT scans, and PET scans. Some costs are covered by the group that is administering the clinical trial (e.g., the drug that is being tested). Your health insurance plan should cover most costs that are not covered by the group that is administering the clinical trial.
 - 1) **Trial Specifications:** The trial must either involve a drug that is exempt under federal regulations from a new drug application, or be approved by the National Institutes of Health, the U.S. Food and Drug Administration in the form of an investigational new drug application, the U.S. Department of Defense, or the U.S. Department of Veterans Affairs.
 - 2) **Therapeutic Intent:** The trial must have a "therapeutic intent" for patients and be recommended by the patient's physician. In many cases, the patient must get clinical trial care from a doctor or hospital within the state. However, health plans must pay for care at treatment centers outside the state if there is no provider in California taking part in the study.
 - 3) The statutes regarding clinical trials apply to most health plans licensed to do business in California, including health care service plan providers (not including specialized health care service plan contracts), disability insurers (that provide hospital, medical or surgical coverage in California), County Organized Health System plans, and Medicare. These entities and programs must cover and pay for routine health care services related to Phase I, II, III, or IV clinical trials.
- B. **Second Medical Opinions:** In California you have the right to a second medical opinion and to have it paid for by your health plan. If you are in an HMO, the HMO may offer you a second opinion within their network. However, if there is not a second specialist in the network, the insurance company may have to pay for you to go out of network to receive the second opinion. The patient is responsible only for any applicable co-payments.

V. **FEDERAL HEALTH INSURANCE PROGRAMS**

- 1) **Medicare and Medicaid:** Both Medicare and Medicaid are federal health insurance programs. There are only two ways to qualify for Medicare services: you must be 65 or older OR be on Social Security Disability Insurance (SSDI) for 2 years. Medicaid

⁶ For more information about the external review process, see Appendix HI2.

however, provides health insurance for certain people who are low income, have limited resources and meet other eligibility requirements. In the cancer arena, people often qualify for Medicaid through its aged, blind, and disabled program, which provides coverage to individuals with low incomes who are over 65 or who have disabilities. Medicaid may be called other things in different states. For example, in California Medicaid is called Medi-Cal. For more information or questions about either program, please call the Cancer Legal Resource Center at (866) THE – CLRC (866-843-2572).

VI. CONTACT INFORMATION

<p>For insurance questions: California Department of Insurance (213) 897-8921 or (800) 927-4357 Consumer Help Line (213) 346-6801 www.insurance.ca.gov</p>	<p>For COBRA questions: U.S. Department of Labor Employee Benefits Security Administration 1055 E. Colorado Blvd., Suite 200 Pasadena, CA 91106 (626) 229-1000 or (866) 275-7922 www.dol.gov/ebsa/</p>
<p>For assistance with insurance disputes or questions about Cal-COBRA: California Department of Managed Health Care HMO Help Center (888) 466-2219 (For HMOs or Blue Cross & Blue Shield Plans)</p>	<p>California Department of Insurance (213) 897-8921 or (800) 927-4357 (213) 346-6801 www.insurance.ca.gov (For all other health plans)</p>
<p>For HIPAA questions: California Department of Insurance (213) 897-8921 or (800) 927-4357 www.insurance.ca.gov (For all other health plans)</p>	<p>California Dept. of Managed Health Care (888) 466-2219 (For HMOs and all Blue Cross and Blue Shield plans)</p>
<p>For HIPP questions: Department of Health Care Services (800) 952-5294 www.dhcs.ca.gov/FORMSANDPUBS/FORMS/Pages/HIPPforms.aspx</p>	<p>For MRMIP questions: Major Risk Medical Insurance Program (MRMIP) (916) 324-4695 or (800) 289-6574 www.mrmib.ca.gov/MRMIB/MRMIP.html</p>
<p>Resources for Children: CaliforniaKids (818) 755-9700 or www.californiakids.org (Provides premium subsidized health care services to children ages 2-18)</p>	<p>California Children’s Services (CCS) www.dhs.ca.gov/pcfh/cms/ccs (Treats children with certain disabilities and health problems)</p>

<p>Kaiser Cares for Kids (800) 225-5053 (Provides premium subsidized health care services to children ages 2-18) www.ladpss.org/dpss/health_care/children_youth/kaiser_permanente_cares_for_kids.cfm</p>	<p>Healthy Kids Plans (800) 234-1317 (County based programs.) www.coverageforall.org</p>
<p>Healthy Families (877) 543-7669 or (800) 880-5305 or (888) 747-1222 www.healthyfamilies.ca.gov/hf/hfhome.jsp</p>	
<p>For assistance with Medi-Cal: Center for Medicare & Medicaid Services (800) 633-4227 www.cms.hhs.gov</p>	<p>Department of Health Care Services (916) 445-4171 or (800) 735-2922 or (800) 877-5379 or www.dhcs.ca.gov</p>
<p>Health Consumer Alliance (888) 354-4474 www.healthconsumer.org</p>	
<p>For Breast & Cervical Cancer Early Detection Program questions: Every Woman Counts (800) 511-2300 www.cdph.ca.gov/programs/cancerdetection/Pages/default.aspx</p>	<p>For Breast & Cervical Cancer Treatment Program (BCCTP) questions: BCCTP (800) 824-0088 www.dhcs.ca.gov/services/medical/Pages/BCCTP.aspx</p>
<p>For Family Planning, Access, Care and Treatment (PACT) services: Department of Health Care Services (916) 445-4171 or (800) 735-2922 or (800) 877-5379 or www.dhcs.ca.gov</p>	

Appendix H11 – Continuum of Private Health Insurance Options



