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 Institute for Health Care Research and Policy 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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A CONSUMER'S GUIDE TO GETTING AND KEEPING HEALTH INSURANCE IN CALIFORNIA

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 plans. Chapter 4 highlights your protections as a small employer. 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 33. For information about how to find consumer guides for other states on the Internet, see page 33. A list of helpful terms and their definitions begins on page 34. These terms are in boldface type the first time they appear.

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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 plans**), so your protections may vary if you leave California. 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 page 7.)

- *All health plans in California must limit exclusion of pre-existing conditions. There are rules about what counts as a pre-existing condition 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 pages 9 and 16.)

- *Your health insurance cannot be canceled because you get sick. Most health coverage is **guaranteed renewable**. (See pages17 and 26.)*

- *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**. For example, 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 page 17.)

- *If you lose your group health insurance and meet other qualifications, you will be **federally eligible**.* If so, you are guaranteed the right to buy an individual health plan from any insurance company that sells individual coverage. You will not face a new pre-existing condition exclusion period if you are federally eligible. There are limits on what you can be charged for such a policy. (See page 14.)

- *If you have had difficulty obtaining affordable individual health coverage because of your health condition, you may be eligible for Major Risk Medical Insurance Program (MRMIP) coverage.* You may face a new pre-existing condition exclusion period when you join. If you qualify for MRMIP, there may be a waiting list for enrollment that will delay the start of your membership. (See page 22.)

- *If you are a small employer buying a fully insured **small group health plan**, 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 plans for small employers must be sold on a **guaranteed issue** basis. (See page 26.)

- *If you are a small employer buying a fully insured group health plan, the health status of your employees cannot be taken into account when your premiums are set.* Other factors such as the age of your employees can be taken into account. This is called **modified community rating.** (See page 26.)

- *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. In addition, California's **Healthy Families** program offers subsidized health coverage for certain uninsured children. (See page 28.)

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 coverage with you.* Except when you exercise your COBRA or Cal-COBRA rights, you are not entitled to take your actual group health coverage 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.

- *If you change jobs, your new employer may not offer you health benefits.* Employers are required only to make sure that their decision is based on factors unrelated to your health status.

- *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 impose **affiliation periods**. (See page 7.)

- *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.* If you had some prior health coverage, you may not have to satisfy the entire pre-existing condition exclusion period. (See pages 9 and 14.)

- *Even if your coverage is **continuous**, there may be a pre-existing condition exclusion period for some benefits if you join a group health plan that covers benefits your old group 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 page 9.)

- *If you work for certain non-federal public employers in California, not all of the group health plan protections may apply to you.* (See page 12.)

- *If you are not eligible for COBRA, Cal-COBR or federally eligible, insurers are free to turn you down because of your health status and other factors.*

- *Even if you are federally eligible, you can be turned down for some individual health insurance plans.* Insurance companies are allowed to limit your choices to two of the individual plans that they sell. (See page 14.)

- *Except for policies sold to federally eligible persons, state law does limit how expensive individual health plans can be.* You can be charged more because of your health status, gender, and other characteristics. (See page 14.)

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?

- *You have to be eligible for the group health plan*. For example, your employer may not give health benefits to all of its employees.

- *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 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, 30-day opportunity to enroll in your self-insured group health plan after certain events. If you are enrolled in a fully insured group plan, your **special enrollment period** must last 30 days. You can elect coverage during 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 special enrollment opportunity

- The birth, adoption, or placement for adoption of a child
- Marriage
- 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)
- Loss of no share-of-cost Medi-Cal coverage (only for persons joining a fully insured small group plan)

- *In California, newborns, adopted children, and children placed for adoption are automatically covered under the parents' fully insured group health plan for the first 30 days, if the plan covers dependents.* The health plan may require that the parent enroll the child within the 30 days in order to continue coverage beyond the 30 days.

- *In California, adult dependents who are physically disabled or mentally retarded are able to stay on their parents' fully insured group health plan after they have reached the age at which the health plan usually cancels dependent coverage.* In order to be eligible, the adult dependent must be incapable of self-support and must be dependent on the policyholder for support. Proof of incapacity must be provided to the health plan within 31 days of reaching the limiting age. The health plan may require that you show it proof of incapacity and dependency again in the future.

- *California requires fully insured group health plans to accept late enrollees, although you might have to wait 12 months to enroll after you request admission to the plan.*

- *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.

- *When you begin a new job with health insurance through an HMO, the HMO may require you to satisfy 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.

- *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 coverage 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 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) 700-2330 or visit the web at 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.

- *All employer sponsored group health plans and group plans with 3 or more persons can count as pre-existing conditions only those 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. Any group plan serving only one or two persons which is not employer sponsored may look back 12 months.

- *Group health plans cannot apply a pre-existing condition exclusion period for genetic information.* Also, these plans cannot apply a pre-existing exclusion period for pregnancy, newborns, newly adopted children, children placed for adoption, provided they are enrolled within 30 days.

- *Under group health plans, coverage for pre-existing conditions can be excluded for a limited time*. For fully insured group health plans, the maximum period is 6 months. For self-insured group health plans, the maximum period is 12 months. For group health plans serving one or two persons that are not employer sponsored the maximum exclusion period is 12 months.

  However, if you enroll late in your group health plan (after you are hired and not during a regular or special enrollment period), the rules are different. If you are a late enrollee in a fully insured group plan, you may not be able to get coverage for 12 months, and after that you may still face a 6-month pre-existing condition exclusion period. If you are a late enrollee in a self-insured group health plan, you may face a pre-existing condition exclusion period of up to 18 months.

- *When you join a new group health plan, the law protects you from a new pre-existing condition exclusion period, provided you maintain continuous* ***creditable coverage***.

Most health coverage counts as creditable coverage, including, but not limited to:

Federal Employees Health Benefits (FEHBP)
Group health insurance (including COBRA)
Indian Health Service
Individual health insurance
Medicaid
Medicare
Military health coverage (CHAMPUS, TRICARE)
State health insurance high risk pools

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, such as old health plan ID cards or statements from your doctor showing bills paid by your health plan.

- *Health coverage counts as continuous if it is not interrupted by a break of 63 days or more in a row.*

  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 preexisting condition exclusion period, you can credit time under your prior continuous

coverage toward it. If your employer requires a waiting period, the preexisting condition exclusion period begins on the first day of the waiting period. HMOs that require an affiliation period cannot exclude coverage for preexisting conditions.

When moving from one group plan to another, a fully insured group health plan must credit coverage if it is not interrupted by a break of more than *180 days*, instead of 63 days.

Fully insured and self-insured group health plans count continuous coverage differently in some cases

Art, who has diabetes, worked for the Ajax Company and was covered under its group health plan for 2 months, but then Ajax stopped offering health benefits. Ninety days later, Art changed jobs and began to work for Beta Corporation. He enrolled immediately in Beta's self-insured group health plan, which covers diabetes but requires a preexisting condition exclusion period. Because Art's lapse in coverage was more than 63 days, Beta does not have to give Art credit for his coverage under Ajax's plan. Art must wait for the full preexisting condition exclusion period to pass before Beta will cover care for his diabetes.

Now consider a slightly different situation. Assume Beta Corporation's group health plan is fully insured. In California, fully insured group health plans must credit prior group coverage not interrupted by a lapse of 180 days or more. In this case, Beta must give Art credit for his coverage under Ajax's health plan. Beta's preexisting condition exclusion period will be reduced by 2 months.

- *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 protections will not apply to their employees' group health plan.

According to the latest list available from the federal government, several public employers in California have decided that certain protections will *not* apply to their employees. (For a complete list, see the box below.) If you have group health coverage through these employers, you should contact them for more information. Other non-federal public employers in California may have made this choice after this guide was written. If you are not sure about your protections under your public employee health plan, you should contact your employer.

California public employers electing to exempt their covered employees from HIPAA protections.

El Dorado County
Imperial County
Orange County
Santa Cruz County Schools
City of Long Beach
Monterey Peninsula Unified School District
Monterey County Schools Insurance
School Employees Benefits Association
Los Angeles Fireman's Relief Association

AS YOU ARE LEAVING GROUP COVERAGE…

- *If you are leaving your job or otherwise losing access to your group health coverage, 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 coverage. See Chapter 3 for more information about COBRA continuation coverage, Cal-COBRA continuation coverage, and health coverage for "federally eligible individuals."

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

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

INDIVIDUAL HEALTH COVERAGE SOLD BY PRIVATE INSURERS & HMOS

WHEN DO HEALTH PLANS HAVE TO SELL ME INDIVIDUAL COVERAGE?

In California, your ability to buy individual health coverage may depend on your health status.

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

- *Persons who are federally eligible are guaranteed the right to buy individual health plans from private insurers.* However, insurers are permitted to limit your choices to two policies – either their two most popular policies or two representative policies. The two representative policies mean that you get offered one policy with a high benefit package and one with a low benefit package. Insurers that only offer one individual policy are only required to offer you that one policy.

To be federally eligible, you must meet certain criteria

No matter where you live in the U.S., if you are federally eligible you are guaranteed the right to buy individual health coverage of some kind with no pre-existing condition exclusion periods. In California, you are guaranteed the right to buy coverage from any insurer selling individual coverage. To be federally 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 federally eligible.)
- You must apply for health insurance for which you are federally eligible within 63 days of losing your prior coverage.

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

- *In California, newborns, adopted children, and children placed for adoption are automatically covered under the parents' individual health plan for the first 30 days, if the plan provides coverage for dependents or maternity benefits.* The health plan may require that the parent enroll the child within the 30 days in order to continue coverage beyond the 30 days.

- *In California, adult dependents with physical disabilities or mental retardation are able to stay on their parents' individual health plan after they have reached the age at which the plan usually cancels dependent coverage.* In order to be eligible, the adult dependent must be incapable of self-support and must be dependent on the policyholder for support. Proof of incapacity must be provided to the health plan within 31 days of reaching the limiting age. The health plan may require that you show it proof of incapacity and dependency again in the future.

WHAT WILL MY INDIVIDUAL HEALTH PLAN COVER?

- *It depends on what you buy.* California does not require health plans in the individual market to sell standardized policies. Health plans can design different policies and you will have to read and compare them carefully. California does require all individual health plans

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 federally eligible, no pre-existing condition exclusion period can be imposed on your coverage.*

- *If you are not federally eligible, an individual health plan can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice before you joined that plan.* Individual health plans cannot apply a pre-existing condition exclusion period for genetic information. In addition, if enrolled within 30 days newborns, newly adopted children and children placed for adoption can avoid preexisting exclusion periods. Pregnancy can be considered a pre-existing condition.

- *The length of the look back and exclusion periods will vary based on how many people are covered by the individual policy you buy.* If one or two people are covered by the policy (for example, you and your spouse; you and a child; or you alone), the health plan can look back 12 months for pre-existing conditions and then exclude those conditions for 12 months. If three or more people are covered by the policy (for example, you, your spouse, and a child; or you and two or more children), the health plan can only look back 6 months and then exclude pre-existing conditions for 6 months.

- *Individual health plans have to give you credit for your prior continuous coverage in certain circumstances.* The same types of coverage that are creditable by group health plans are also considered creditable by individual health plans. Coverage is considered continuous if the gap between health plans is less than 63 days.

WHAT CAN I BE CHARGED FOR INDIVIDUAL HEALTH COVERAGE?

- *If you are federally eligible, California law limits the premium you can be charged to a percentage of certain benchmark premiums.* Even so, you may find that your premiums are quite expensive.

- *If you are not federally eligible, California law places few limits on what you may be charged.* If you have an expensive health condition, your individual health plan premiums may be very high.

  In addition, when you renew your individual health coverage, your premiums can increase as you age or your health declines.

CAN MY INDIVIDUAL HEALTH PLAN BE CANCELLED?

- *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. Your health coverage may also be cancelled if the insurer or HMO discontinues your health plan or withdraws from the individual market.

- *Some insurers sell short-term health plans.* Short-term 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 short-term health plan after it expires, you will have to reapply and there is no guarantee that the health plan 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 health coverage, you may be able to stay in your group health 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 it 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. (See below.)

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 coverage.

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.

- *To qualify as federally 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.

HOW LONG DOES COBRA COVERAGE LAST?

- *COBRA coverage generally lasts up to 18 months and cannot be renewed.* However, certain disabled people can opt for coverage up to 29 months, and dependents are sometimes eligible for up to 36 months of COBRA continuation coverage, depending on their qualifying event.

HOW LONG CAN COBRA COVERAGE LAST?

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

* Certain disabled persons and their eligible family members can extend coverage an additional 11 months, for a total of up to 29 months.

- *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 some California laws that are similar to COBRA.* Eligibility requirements for Cal-COBRA coverage are similar to those for COBRA. To get continuation coverage, you must have been gotten 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.) However, moving out of a plan's service area terminates Cal-COBRA.

- *For persons aged 60 or older, Cal-COBRA can last up to 5 years if you worked for your employer for at least 5 years prior to seeking continuation coverage and you meet other eligibility criteria.* This protection extends to persons who were enrolled in a fully insured group health plan, regardless of how many employees your former employer had. Some examples of people who may find this extended coverage helpful are early retirees and persons who are losing coverage under their spouses' insurance because their spouses enrolled in Medicare.

- *Ask your former employer, the California Department of Insurance, or the California Department of Managed Health Care about Cal-COBRA coverage if you think it applies to you.*

CONVERSION COVERAGE

WHEN DO I HAVE TO BE OFFERED CONVERSION COVERAGE?

- *In some situations, such as when you lose your health coverage because your employment has been terminated or you had coverage through your spouse and lost it because of divorce, health plans are required to offer you a conversion plan.* A conversion plan is an individual health policy that is not connected with the group policy that formerly covered you.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *A conversion policy will not contain any new pre-existing condition exclusion, but you may be required to complete an unfinished pre-existing condition exclusion period from your former health coverage.*

WHAT WILL MY INDIVIDUAL HEALTH PLAN COVER?

- *Your benefits under a conversion policy will probably differ from those provided by your former health coverage.*

WHAT CAN I BE CHARGED FOR CONVERSION COVERAGE?

- *Unlike COBRA, Cal-COBRA and HIPAA in California, conversion coverage premiums are not regulated can take into account your age and health status. You may find the rates expensive.*

CAN MY CONVERSION HEALTH PLAN BE CANCELLED?

- *Conversion policies are renewable in the same way that other individual policies are renewable.*

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP)

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

WHEN CAN I GET COVERAGE FROM MRMIP?

- *You can buy coverage from MRMIP if*
  (1) You are a California resident;
  (2) You are not eligible for Medicare Part A and Part B, unless you are eligible for both

Parts because of end-stage renal disease;

(3) You must not be eligible for COBRA or Cal-COBRA; and

(4) You can demonstrate proof of eligibility in one of the following ways:

(a) You were turned down for individual coverage during the last 12 months;

(b) Your health coverage was involuntarily terminated during the last 12 months for reasons other than nonpayment of premiums or fraud;

(c) You were offered individual coverage during the last 12 months at a rate that exceeded the MRMIP rates; or

(d) You are a member of a group of one and have been turned down for health coverage in the last 12 months.

You only need to show that you are eligible in one of these ways in order to get MRMIP coverage.

- *MRMIP offers family coverage, so if one person in your family qualifies, your entire family can get MRMIP coverage*.

- *MRMIP sometimes stops enrolling new members when it reaches an enrollment cap*. Applications are still accepted when enrollment has temporarily stopped. When enrollment begins again, people are admitted to MRMIP in the order that their applications were received.

- *If you move to a new area in California outside of your current MRMIP plan's service area, you are guaranteed the right to join a MRMIP plan that serves that area.*

- *If you have had problems establishing a good relationship with a provider or a plan, you may request permission from MRMIP to join a different MRMIP plan.*

WHAT WILL THE MRMIP 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. Deductible and co-payment requirements vary, but 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 enroll in a MRMIP PPO plan, the plan will count as pre-existing conditions only those 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*. The PPO plan is allowed to exclude your pre-existing condition for 90 days.

- *When you enroll in a MRMIP HMO plan, you will face a 90-day affiliation period*. 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 period or your affiliation period may be waived if*:
  (1) You have been on the MRMIP waiting list for longer than 6 months. In this case, the pre-existing condition exclusion period or affiliation period is completely waived.
  (2) You were covered by other health insurance for at least 90 days when you applied to MRMIP. In this case, the pre-existing condition exclusion period or affiliation period is completely waived.
  (3) You had been covered by other health insurance, but you lost it and you applied to MRMIP within 62 days. If you had 90 days of coverage, then the pre-existing condition exclusion period or affiliation period is completely waived. If you had 30 to 89 days of prior coverage, then the pre-existing condition exclusion period or affiliation period will last either 30 or 60 days.
  (4) You had been covered under the high risk pool of another state sometime during the past year. In this case, the pre-existing condition exclusion period or affiliation period is completely waived.

WHAT CAN I BE CHARGED FOR MRMIP COVERAGE?

- *Premiums will vary based on the health plan you choose, your age, and where you live*. Contact MRMIP for a brochure listing all coverage options and the most current premiums.

HOW LONG DOES MRMIP COVERAGE LAST?

- *Coverage under the MRMIP is renewable as long as you pay your premiums, continue to reside in California, and meet other eligibility requirement*s. If you cancel your MRMIP coverage, you will not be able to reapply for coverage under MRMIP for 12 months.

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 they sell to other small employers. However, they can require that a minimum 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** for 51 or more employees, your group can be turned down.

- *Your group health coverage cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans 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 plans they sell to groups of your size.

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

- *As a small employer, you cannot be charged higher premiums because someone in your group is seriously ill.* You can, however, be charged somewhat more due to the age and family size of those in your group and where your business is located. This is called modified community rating. For groups with more than 50 employees, California

does not limit premium variation or increases. 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 (though you may be able to join another group health plan through a family member).* 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 coverage, you are eligible to deduct an increasing percentage of the cost of your premium from your federal income tax.* This deduction is 60% for 2001, 70% for 2002, and 100% in 2003 and thereafter.

A WORD ABOUT ASSOCIATION PLANS

- *Some small employers, self-employed people, and other individuals buy health coverage 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, and Access for Infants and Mothers (AIM) offer free or subsidized health insurance coverage, direct medical services or other help. 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 (including parents or caregiving relatives) 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 however, questions concerning immigration status and eligibility should be directed to the California Department of Health Services.

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

  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. (916) 636-1980

Low income persons eligible for Medi-Cal in California

Category	Income eligibility (as percent of federal poverty level)
Infant	200% (monthly income of $2,438 for family of 3)
Child 1-5	133%
Child 6-18	100%
Parent (and Caregiver Relatives)	100%
Pregnant woman	200%

* Eligibility information was compiled from secondary sources, including Center for Budget and Policy Priorities, the Henry J. Kaiser Family Foundation, Families USA, and the Robert Wood Johnson Foundation Covering Kids Program, 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 2000:

Size of Family Unit	Poverty Guideline (annual income)
1	$ 8,590
2	11,610
3	14,630

For larger families add $3,020 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 $29,260, or a monthly income of $2,438.

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

- *People receiving SSI,,CalWORKS, foster care, adoption assistance, In-Home Support Services (IHSS), or Entrant or Refugee Cash Assistance benefits receive Medi-Cal benefits automatically, without having to apply for it.*

- *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 transitional period.*

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

- *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 below the 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.

  Contact your local Department of Health Services (916) 636-1980 for more information about other eligibility requirements.

- *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 Services.

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 are not eligible for Medicaid and who have limited or no health coverage.

- *A child whose family has a household income below 250% of the federal poverty level is eligible for CHIP*. For a family of 3, this works out to an annual income of about $36,575, or a monthly income of about $3,048.

- *Eligibility is guaranteed for one year unless the child moves from the state, enrolls in Medicaid, or is found to have other health coverage.*

- *No child is denied eligibility based on disability.*

- *For more information, call (800) 880-5305.*

ACCESS FOR INFANTS AND MOTHERS (AIM)

Access for Infants and Children (AIM) is a state-run program that provides low-cost health 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:*
  (1) You must not be more than 30 weeks pregnant by the time your complete application is received;
  (2) You must have lived in California for the last 6 months;
  (3) You must not be receiving no-cost Medi-Cal or Medicare benefits;
  (4) 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.
  (5) You meet the AIM income guidelines. Women with family incomes of 200% to 300% of the federal poverty level are eligible for AIM.

- *The AIM program requires its enrollees to pay a modest share of the costs of coverage.*

- *The AIM program provides comprehensive benefits to its enrollees, including physician services, hospitalization, prescription drugs, mental health, prenatal and maternity care, and well-baby care*.

- *Women remain enrolled in AIM until 60 days after giving birth. Children remain enrolled until their second birthday*s. Your coverage will end sooner if you move from California, defraud the program, or ask to be disenrolled. If you are disenrolled, you will not be able to rejoin AIM during the same pregnancy.

  For more information concerning the AIM program, call (800) 433-2611.

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:
Indemnity and PPO plans Individual health coverage Conversion coverage Cal-COBRA coverage Fully insured group health insurance	*California Department of Insurance* (800) 927-4357 (800) 482-4833 (TDD) (213) 897-8921 (L.A. area or out-of-state) http://www.insurance.ca.gov
HMO plans Individual health coverage Conversion coverage Cal-COBRA coverage Fully insured group health insurance	*California Department of Managed Health Care* (888) 466-2219 (916) 324-8176 (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, Los Angeles Regional Office (Southern California)* (626) 583-7862, or contact *U.S. Department of Labor, Los Angeles Regional Office (Northern California)* (415) 975-4600, or contact *U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C.* (202) 219-8776 *For Department of Labor publications:* (800) 998-7542 http://www.dol.gov/dol/pwba
California Family Rights Act Leave Fair Employment and Housing Act Leave	*California Department of Fair Employment & Housing* (916) 227-0551 (800) 884-1684 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* (916) 636-1980
Healthy Families	*Managed Risk Medical Insurance Board* (800) 880-5305 http://www.healthyfamilies.ca.gov
Access for Infants and Mothers (AIM)	*Healthcare Alternatives* (800) 433-2611 (888) 387-6924 (TTY) http://www.mrmib.ca.gov

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

HELPFUL TERMS

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.

Cal-COBRA. Cal-COBRA provides continuation coverage to persons who are not eligible for COBRA because their former employers had 2-19 employees. Persons who are 60 years old or older and were enrolled in a fully insured group plan for 5 years prior losing their group plan eligibility may be able to keep their Cal-COBRA coverage for up to 5 years. 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. Health coverage that 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. See also Creditable Coverage, Federally Eligible.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; an individual health plan; 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; or a state health insurance risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Plan.

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.

Federally Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be federally 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 federally eligible you must be offered at least some type of individual health plan with no pre-existing condition exclusion periods. See also COBRA, Continuous Coverage, Creditable Coverage.

Fully Insured Group Health Plan. Health insurance 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. Includes information about family history or genetic test results indicating your risk of developing a health condition. Group and individual health plans cannot consider pre-existing (and therefore exclude coverage for) a condition about which you have genetic information, unless that health condition has been diagnosed by a health professional.

Group Health Plan. Health insurance (sponsored by an employer or union) 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 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 Plan Year. That calendar period during which your health plan coverage is in effect. Many group health plan years begin on January 1, while others begin in a different month.

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. Healthy Families is a state program that provides health coverage to some children from low-income families.

HIPAA. The Health Insurance Portability and Accountability Act, sometimes known as Kassebaum-Kennedy, after the two senators who spearheaded the bill. Passed in 1996 to help people buy and keep health coverage, even when they have serious health conditions, the law sets a national floor for health coverage reforms. Since states can and have modified and expanded upon these provisions, consumers' protections vary from state to state.

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 Plan. 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 plans are regulated by California.

Kassebaum-Kennedy. See HIPAA.

Large Group Health Plan. 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. California requires fully insured group plans to cover you if you are a late enrollee, although you may have to wait 12 months before you can enroll. Late enrollees in self-insured group health plans can be subject to a longer pre-existing condition exclusion period. 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.

Pre-existing Condition. 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 by group health plans, but individual health plans can consider it 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 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 days. 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.

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.