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

By

Karen Pollitz
Stephanie Lewis
Mila Kofman
Eliza Bangit
Kevin Lucia

GEORGETOWN UNIVERSITY
INSTITUTE FOR HEALTH CARE RESEARCH AND POLICY

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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 MICHIGAN

As a Michigan 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 Michigan 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 or self-employed person. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from Michigan, 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 26. For information about how to find consumer guides for other states on the Internet, see page 26. A list of helpful terms and their definitions begins on page 28. 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 Michigan. 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 Michigan resident.

HOW AM I PROTECTED?

In Michigan, 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 5.)

- *All group health plans in Michigan 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. (See pages 7 and 12.)

- *Your health insurance cannot be canceled because you get sick.* All health insurance is **guaranteed renewable**. (See pages 14 and 20.)

- *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** continuation coverage. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage. (See page 14.)

- *If you lose your fully insured group health plan, you can buy individual health coverage under a **conversion policy***. You will not face a new pre-existing condition exclusion period. (See page 17.)

- *All Michigan residents are guaranteed the right to buy an individual health plan from Blue Cross Blue Shield of Michigan*. This is called **guaranteed issue**. (See page 11.)

- *If you are **federally eligible**, you are guaranteed the right to buy an individual health plan from Blue Cross Blue Shield of Michigan.* You will not face a new pre-existing condition exclusion period. (See page 13.)

- *If you are buying an individual health plan from Blue Cross Blue Shield of Michigan, you cannot be charged more for your health insurance due to health status or age*. This is called **community rating**.

- *If you are a small employer buying a 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 health plans for small employers must be sold on a guaranteed issue basis. (See page 20.)

- *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 Michigan **Medicaid** program offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes. (See Chapter 5.)

- *If your children are 18 years old or younger, do not have health insurance and meet other qualifications, you may be able to buy insurance for them through **MIChild***. (See page 25.)

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 health benefits with you.* Except when you exercise your federal COBRA continuation 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 the same doctors that your old 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 require **waiting periods** before your health benefits begin. (See page 6.)

- *If you are joining a group health plan that is not an HMO or a Blue Cross Blue Shield of Michigan and you have a break in coverage of 63 days or more, you may have to satisfy a new pre-existing condition exclusion period.* (See page 8.)

- *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 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 Michigan, not all of the group health plan protections may apply to you.* (See page 10.)

- *Individual health insurers other than Blue Cross Blue Shield of Michigan are free to turn you down because of your health status and other factors.*

- *If you are not federally eligible, you may have to satisfy a new pre-existing condition exclusion period when you join a new individual health plan, even though your coverage has been continuous.* The length of the exclusion period varies depending on the type of individual health plan. (See page 12.)

- *The law does not limit what you can be charged for most individual health plans, except for plans offered by Blue Cross Blue Shield of Michigan.* You can be charged substantially higher initial premiums because of your health status, age, gender, and other characteristics. (See page 13.)

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 employees. Or, your employer may offer an HMO plan that you cannot join because you live outside of the plan's service area.

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

Discrimination due to health status is not permitted

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

- *You must be given a special opportunity to sign up for your group health plan if certain changes happen to your family*. In addition to any regular **enrollment period** your employer or group health plan offers, you must be offered a special, 30-day opportunity to enroll in your group health plan after certain events. You can elect coverage at this time. If your group health 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)

- *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage.* These waiting periods, however, must be applied consistently and cannot vary due to your health status.

- *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 a **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job protected leave in these circumstances. 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.

  The FMLA applies to you if you work at a company with 50 or more employees.

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

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

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

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.

- *A group 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 within the 6 months immediately before you joined that plan*. This period is also called a look back period.

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

- *Under group health plans, coverage for pre-existing conditions can be excluded only for a limited time*. The maximum period varies, depending on the type and size of the health plan you are in. Also, if you enroll late (after you were hired and not during a regular or special enrollment period), coverage for your pre-existing condition can be excluded by self-insured plans for as long as 18 months. You will receive credit toward your pre-existing condition exclusion period for any previous continuous coverage.

The maximum pre-existing condition exclusion period varies

TYPE OF GROUP HEALTH PLAN	MAXIMUM EXCLUSION PERIOD
Fully insured, small group	12 months
Fully insured, large group	6 months
Fully insured, HMO and Blue Cross Blue Shield of Michigan (any size)	no exclusion allowed
Self-insured (any size)	12 months (regular and special enrollees)
Self-insured (any size)	18 months (late enrollees)

- *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.*

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

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

Coverage counts as continuous if it is not interrupted by a break of 63 or more days in a row.

What is continuous coverage?

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

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

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

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

- *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. The state of Michigan only requires group health insurers to issue a certificate of coverage. If you have trouble obtaining a certificate of coverage from an individual health insurer, you should contact the **Centers for Medicare and Medicaid Services**. If you cannot get a certificate of coverage, you can submit other proof, such as old health plan ID cards or statements from your doctor showing bills paid by your health plan.

- *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.

- *Your protections may differ if you move to a group health plan that offers more benefits than your old one did*. Blue Cross and Blue Shield of Michigan and HMO plans must credit previous coverage regardless of the benefits covered under your previous plan. However, other kinds of plans can elect to 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.

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 plan does cover prescription drugs. However, because her prior policy did not, the new plan refuses to cover her blood pressure medicine for a year.

Question: Is this permitted?

Answer: It depends. Blue Cross and Blue Shield of Michigan and HMOs are not allowed to do this, but some other plans are. If Sue's health plan uses this method for crediting prior coverage, it still must pay for covered doctor visits, hospital care, and other services for her high blood pressure. It also must pay for covered prescription drugs she needs for other conditions that were not pre-existing.

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

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

According to the latest list available from the federal government, ten public employers have decided that certain health insurance protections will not apply to their employees. If you have group health coverage through these employers, you should contact them for more information. Other non-federal public employers in Michigan 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.

Michigan public employers electing to exempt their covered employees from certain protections

City of East Lansing
City of Flint
City of Hazel Park
County of Clinton
HealthSource Saginaw
City of Ferndale
City of Grand Ledge
City of Sterling Heights
County of Tuscola
Thornapple Manor

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, state continuation coverage, and individual health plan coverage for "federally eligible individuals."

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group insurance, you may want to buy an individual health plan from a private insurance company. However, in Michigan – as in most other states – you have limited guaranteed access to individual health insurance. Whether you can buy an individual health plan may depend on your health status, the kind of coverage you want to buy, and other circumstances. Also, there are some alternatives to individual health insurance coverage such as COBRA or conversion policies. This chapter summarizes your protections under different kinds of health plan coverage.

INDIVIDUAL HEALTH INSURANCE SOLD BY OTHER PRIVATE INSURERS

In Michigan, you can buy an individual health insurance policy from a private insurance company as well as from Blue Cross Blue Shield of Michigan.

WHEN DO INDIVIDUAL HEALTH INSURERS HAVE TO SELL ME COVERAGE?

- *Individual health plans, other than those offered by Blue Cross Blue Shield of Michigan, are free to turn you down because of your health status and other factors*.

- *Blue Cross Blue Shield of Michigan, by law, must sell individual health insurance to any resident*. This is called guaranteed issue. In addition, HMOs must sell individual health insurance to any resident during the 30-day open enrollment each year. Check with your HMO for more information about open enrollment dates.

- *In Michigan, newborns are automatically covered under the parents' individual health plan for the first 31 days*. The insurer may require that the parent enroll the baby within the 31 days in order to continue coverage beyond the 31 days.

- *In Michigan, mentally retarded and physically disabled dependents are permitted to remain insured under their parents' individual health insurance policy after they reach the age at which dependent coverage is usually terminated, if certain conditions are met*. The adult dependent must not be married, must be incapable of self-support and maintenance, and must rely on the policyholder for support. In addition, proof of dependency and disability must be provided to the insurer within 31 days of the dependent reaching the limiting age.

WHAT WILL MY INDIVIDUAL HEALTH PLAN COVER?

- *It depends on what you buy*. Michigan does not require health insurers in the individual market to sell standardized policies. Health plans can design different policies and you will have to read and compare them carefully. However, Michigan does require all health plans to cover certain benefits—such as mammograms and diabetes care. Check with the Office of Financial and Insurance Services for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *In Michigan, the rules for pre-existing conditions in individual plans are somewhat different from those in group plans*. Individual plans can count as pre-existing any condition for which you received medical advice, diagnosis, care, or treatment in the six months before individual coverage begins.

  In general, you may face a 12-month pre-existing condition exclusion period. However, if your coverage is through an HMO, Michigan law limits the pre-existing condition exclusion period to six months. Individual health plans are not required to credit your prior coverage toward this pre-existing condition exclusion period. However, some individual health insurers in Michigan will waive your exclusion period if you are leaving certain types of group plans. Ask your insurer if you are eligible for a waiver of your exclusion period.

  Individual health plans can impose a pre-existing condition exclusion period on pregnancy. Individual health plans cannot apply a pre-existing condition exclusion period for genetic information.

- *If you are federally eligible, Blue Cross and Blue Shield plans cannot impose a pre-existing condition exclusion period.*

To be federally eligible, you must meet certain criteria

No matter where you live, if you are federally eligible you are guaranteed the right to buy an individual health plan with no pre-existing condition exclusion periods. In Michigan, you are guaranteed the right to buy coverage only from Blue Cross Blue Shield of Michigan. 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.

WHAT CAN I BE CHARGED FOR INDIVIDUAL HEALTH COVERAGE?

- *If you have an expensive health condition, your initial health insurance premiums may be very high*. The law does not prohibit Michigan health insurers other than Blue Cross Blue Shield of Michigan from charging you a higher initial rate because of your health status.

- *Blue Cross Blue Shield of Michigan cannot charge you higher premiums because of your age or health status*. This is called community rating. Contact Blue Cross Blue Shield Michigan for information about coverage and premiums.

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELLED?

- *Your coverage cannot be canceled because you get sick.* This is called guaranteed renewability. This protection applies to all individual policies even if they are not guaranteed issue. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of **managed care plans**, continue to live in the plan service area. Other than in HMOs and Blue Cross Blue Shield of Michigan, your premiums can increase substantially as you age or if your health declines.

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

COBRA CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

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

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

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

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

- *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.

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 be faced with 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.*

- *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 sometimes can extend it up to 36 months.

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.*

CONVERSION POLICIES

In Michigan, if you have coverage through an employer's fully insured group health plan and then lose it, and you exhaust any continuation coverage for which you are eligible, you can buy conversion coverage. This is an individual policy you get from the company that insured your employer's group plan.

WHEN DO I HAVE TO BE OFFERED CONVERSION COVERAGE?

- *To qualify for conversion coverage, you must have been covered under your prior group health plan for at least 3 months immediately preceding your loss of coverage*. In addition, when you apply you cannot be covered under or eligible for similar benefits through a group health plan or Medicare.

- *Fully insured group health plans must notify you of your conversion rights within 14 days after your loss of coverage.* You must apply for a conversion policy within 30 days after your loss of coverage. Spouses and dependent children covered under the group health plan may also be eligible to purchase a conversion policy.

- *You do not need to be federally eligible to buy a conversion policy.*

WHAT WILL A CONVERSION POLICY COVER?

- Coverage under a conversion policy does not have to be the same as under your prior group health plan, and will probably offer fewer benefits.

WHAT ABOUT MY PRE-EXISTING CONDITION?

- *A conversion policy cannot impose a new pre-existing condition exclusion period*. However, if you were in the middle of an exclusion period under your former group health plan coverage, you may have to finish it.

WHAT CAN I BE CHARGED FOR CONVERSION COVERAGE?

- *Conversion policy premiums may be much more expensive than your former group plan premiums.*

CAN MY POLICY BE CANCELLED?

- *Conversion policies, like other individual health insurance policies, are guaranteed renewable.*

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. Some of these reforms apply to groups of different sizes. In Michigan, the Office of Financial and Insurance Services allows insurance companies to use their own definition of "large and "small" group. Check with the Office of Financial and Insurance Services 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 people, health insurance companies must sell you any **small group health plan** they sell to other small employers. Currently this protection for small groups is in place as a matter of federal law. The state of Michigan only requires Blue Cross Blue Shield of Michigan to guarantee issue coverage to small employers. If you are a small employer and have questions about your right to buy coverage regardless of the health status of those in your group, contact the Centers for Medicare and Medicaid Services.

  Even though you cannot be denied coverage due to your group's health status, insurers can require that a minimum percentage of your eligible workers participate in your group health plan. They can also require you to contribute a minimum percentage of your workers' premiums. If you are buying a large group health plan for 51 or more employees, your group can be turned down, except by Blue Cross Blue Shield of Michigan.

- *Your insurance 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 insurance product. In the latter case, 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 can be charged higher premiums because someone in your group is seriously ill, unless your coverage is through Blue Cross Blue Shield of Michigan*. Blue Cross Blue Shield of Michigan is prohibited from varying small group premiums based on the health status and age of group members. This is called community rating. The law does not prohibit other Michigan health insurers from charging you more because of the health status of your group or other factors. HMOs, while not prohibited by law, do not vary small group premiums based on the health status of those in your group. In most cases, however, your group premiums may vary based on age.

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed and buy your own health insurance, you are eligible to deduct an increasing percentage of the cost of your premium from your federal income tax*. This deduction is 70% for 2002 and it reaches 100% in the year 2003 and thereafter.

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Michigan who cannot afford to buy health care coverage. Medicaid and MIChild offer subsidized health insurance coverage, direct medical services or other help at no cost to you. This chapter provides summary information about these programs and contact information for further assistance.

MEDICAID

Medicaid is a program that provides health care coverage to some low-income Michigan residents. Medicaid covers families with children and pregnant women, medically needy individuals, the elderly, and people with disabilities, if state and federal guidelines are met. Legal residents who are not U.S. citizens may be eligible for Medicaid. Non-citizens who do not have immigration documents can receive emergency services only.

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

  In Michigan you may be eligible for Medicaid if you are an infant, a child, a parent of a child, or pregnant and your family income meets the Medicaid income standards.

  Income eligibility levels for these categories are described below. For some Medicaid categories, your assets and some expenses also may be taken into account, so you should contact the Family Independence Agency for more information.

Low income persons eligible for Medicaid in Michigan*

Category	Income eligibility (as percent of federal poverty level)
Infant	185% (monthly income of about $2,316 for family of 3)
Child 1-19	150%
Parent	100%
Pregnant woman	185% (200%, Effective 10/1/02)
Medically needy (individual)	61%
Medically needy (couple)	60%

* 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 2002:

Size of Family Unit	Poverty Guideline (annual income)
1	$ 8,860
2	11,940
3	15,020
For larger families	add $3,080 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 $30,040, or a monthly income of $2,504.

Contact the Family Independence Agency for the most up to date information and for other eligibility requirements that may apply.

- *Parents who receive benefits from TANF (also known as FIP or Family Independence Program) should know that when you get a job and your TANF benefits end, you generally can stay on Medicaid for a 12-month transitional period.*

  In addition, your children may qualify for Medicaid 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 Medicaid.

  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 Medicaid coverage at least for a limited time.

- *People who are under the age of 21, disabled, blind, or 65 or older and who have high medical expenses may also qualify for Medicaid under the "spend-down" option*. You may qualify as medically needy if you have high medical expenses that, when subtracted from your income, would make you eligible for Medicaid 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 don't have health insurance that covers these services.

- *People who are age 65 or over and who have low incomes and are enrolled in Medicare may also qualify for help from Medicaid.* Even though your income may be too high to qualify for Medicaid insurance coverage, there may be other ways Medicaid can help you.

  If your household income is below the poverty level, Medicaid 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 between 100% - 120% of the federal poverty level, Medicaid will pay for your monthly Medicare premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

  If your household income is between 120% - 135% of the federal poverty level, Medicaid will pay your monthly Part B premiums only. This is called Additional Low-Income Medicare Beneficiaries.

  If your household income is between 135% - 175% of the federal poverty level, Medicaid will reimburse a portion of the Medicare Part B premium.

  Contact the Family Independence Agency for more information about other eligibility requirements.

- *There may be other ways that Medicaid can help*. To find out if you or other members of your family qualify for Medicaid, contact the Michigan Department of Community Health. You can apply for Medicaid at your local Family Independence Agency (FIA) or by mail. In addition, there are a number of local community agencies, such as your local health department, that offer help in applying for Medicaid.

MICHILD

MIChild 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 no health care coverage.

- *A child whose family has a household income below 200% of the federal poverty level is eligible for MIChild.* For a family of 3, this works out to an annual income of about $30,040, or a monthly income of $2,504.

- *To be eligible, your child must be a resident of the state (except for newborns), cannot have any other health insurance coverage, including Medicaid, and must meet certain family income guidelines*.

- *Benefits include but are not limited to well-child visits, immunizations, emergency care, dental care, vision and hearing, prescription drugs, and mental health and substance abuse services.*

- *For help, contact your health plan or MIChild at (888) 988-6300.* An application can be downloaded by going to http://www.mdch.state.mi.us/MSA/mdch_msa/App.htm.

OTHER ASSISTANCE PROGRAMS

- *MOMS (Maternity Outpatient Medical Services) is a program made available to pregnant women for the entire pregnancy and two months after the pregnancy ends*. The program covers outpatient pregnancy related services. To apply, contact your local health department.

FOR MORE INFORMATION…

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

For questions about:	Contact:
Individual health insurance Fully insured group health insurance	***Office of Financial and Insurance Services*** (517) 373-0240 (877) 999-6442 (Toll-free) http://www.cis.state.mi.us/ofis/ Pending further clarification of how federal protections will be enforced in Michigan, you may also wish to direct questions about fully insured group health plans to the ***Centers for Medicare and Medicaid Services*** (312) 886-6432 (Chicago Regional Office, for Michigan) or check the Internet for CMS publications at http://www.hcfa.gov/
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	***U.S. Department of Labor, Cincinnati Regional Office*** (606) 578-4680, 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
Blue Cross Blue Shield of Michigan	***Blue Cross Blue Shield of Michigan*** For membership, call (313) 225-8100 or (800) 637-2227, or visit Blue Cross Blue Shield of Michigan on the web at http://www.bcbsm.com/hp/index.html General questions can be addressed through your local BCBSM offices. Check the yellow pages for local listings.

For questions about:	Contact:
Medicaid MIChild	***Michigan Department of Community Health*** (517) 373-3500 (517) 373-3573 (TDD) http://www.michigan.gov/mdch ***MIChild*** (888) 988-6300 (888) 263-5897 (TTY) or visit http://www.mdch.state.mi.us/MSA/mdch_msa/what.htm General questions can be addressed through your local Family Independence Agency (FIA). Check the yellow pages for local listings.
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 require an affiliation period cannot exclude coverage of pre-existing conditions. Premiums cannot be charged during HMO affiliation periods. Michigan HMOs tend not to require affiliation periods, though HMOs in other states may do so. See also HMO.

Centers for Medicare and Medicaid Services. An agency within the federal Department of Health and Human Services (HHS) which handles the enforcement of some of the protections described in this guide for residents of Michigan.

Certificate of Creditable Coverage. A document provided by your health plan that lets you prove you had coverage under that plan. Certificates of creditable coverage will usually be provided automatically when you leave a health plan. Note that the state of Michigan only requires group health insurers to issue a certificate of creditable coverage. 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 plan 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 fee. COBRA continuation coverage generally lasts 18 months, or 36 months for dependents in certain circumstances.

Continuous Coverage. Health insurance coverage that is not interrupted by a break of 63 or more days in a row. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. See also Creditable Coverage.

Conversion Policy. Your right, when leaving a fully insured group health plan in Michigan, to convert your policy to an individual health plan. You will not face a new pre-existing condition exclusion period. There are limits on what you can be for conversion policies. See also Fully Insured Group Health Plan, Individual Health Plan.

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

Enrollment Period. The period during which all eligible employees and their dependents can sign up for coverage under an employer group health plan. Besides permitting workers to elect health benefits when first hired, many employers and group health insurers hold an annual enrollment period, during which all eligible employees can enroll in or change their health coverage. See also 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, the last day of your most recent health coverage must be group coverage; 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 insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. When you are buying individual health coverage, federal eligibility gives you greater protections than you would otherwise have in Michigan and in other states. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by the state of Michigan. 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. A health plan 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 (usually sponsored by an employer, union or professional association) that covers at least 2 employees, or the self-employed. 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 in Michigan are guaranteed issue. If you are federally eligible, Blue Cross Blue Shield of Michigan must issue you a policy and cannot impose a pre-existing condition exclusion period.

Guaranteed Renewability. A feature in health plans that means your coverage cannot be canceled because you get sick. HIPAA requires certain 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.

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 insurance, even when they have serious health conditions, the law sets basic requirements that all health plans must meet. Since states can and have modified and expanded upon these provisions for state regulated health plans (fully insured group and individual plans), consumers' protections vary from state to state.

HMO. Health maintenance organization. A kind of health insurance 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 purchased by individuals who are not connected to an employer group. Individual health plans are regulated by the state of Michigan.

Kassebaum-Kennedy. See HIPAA.

Large Group Health Plan. One with more than 50 employees. Note, although this definition is established under federal law, the state of Michigan allows insurance companies to use their own definition of what constitutes a large group health plan.

Late Enrollment. Enrollment in a health plan at a time other than the open or a special enrollment period. If you are admitted as a late enrollee, you may 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.

Managed Care Plans. A kind of health insurance plan. Like an HMO, managed care plans can limit coverage to health care provided by doctors or hospitals who work for or contract with them also called ‘network" providers. Often managed care plans will require you to get permission (a "referral") from your family doctor before you get care from a specialist in their network. Some managed care plans will cover your care at a lower rate if you go to a non-network provider or if you get specialist care without a referral.

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

MIChild. MIChild, a state-designed program that provides health coverage to low-income Michigan children under the age of 19 who are not eligible for Medicaid and who have no health care coverage.

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, based on your individual 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. 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. In group health plans, pregnancy cannot be counted as a pre-existing condition. In individual health plans, pregnancy can be considered a pre-existing condition, except if you are federally eligible and therefore not subject to any pre-existing condition exclusion.

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 insurance companies to administer 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 Michigan.

Small Group Health Plans. Plans with at least 2 but no more than 50 eligible employees. Note, although this definition is established under federal law, the state of Michigan allows insurance companies to use their own definition of what constitutes a small group health plan.

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 insurance 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. See also Medicaid.

Temporary Assistance for Needy Families (TANF). A program 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 benefits. Not all employers require waiting periods. Waiting periods do not count as gaps in health insurance 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.