

## Government-Sponsored Programs

### Program Details

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### **Who is eligible for programs in this section?**

- Medi-Cal recipients with high cost medical conditions who need help paying for private health coverage
- Workers facing changes in employment who want to continue medical coverage for themselves or their dependents
- California residents who face problems getting and keeping health coverage or who have high premiums due to pre-existing health conditions

## **Health Insurance Premium Payment (HIPP) Program**

### **Who is this program for?**

The California Department of Health Care Services (DHCS) pays private health insurance premiums for certain Medi-Cal beneficiaries who have high-cost medical conditions. Medi-Cal refers individuals who might be eligible to DHCS for possible participation. There is also a HIPP Program called Care/HIPP that pays insurance premiums for HIV/AIDS patients who are unable to work full time.

### **What are the eligibility requirements?**

To be eligible, applicants must meet all of the following requirements:

- Currently enrolled in full-scope no-cost Medi-Cal or have a share-of-cost;
- Currently have health coverage or access to health coverage through an employer (individual policies, group health plans or self-pay\*, COBRA or conversion policies) at the time of application that covers the medical condition for which treatment is needed. HIPP will not pay for new policies nor will it pay premiums for the California Major Risk Medical Insurance Program (MRMIP);
- Not enrolled in a Medi-Cal managed care plan;
- Not enrolled in a County Organized Health Plan;
- Not Medicare eligible; and
- Have disabilities that result in high medical costs, for example, HIV/AIDS. Medical bills are generally required to be greater than twice the monthly premiums, but this requirement may be waived in some cases.

### **How to apply?**

Applications should be submitted early in the month to have premiums paid for the following month. HIPP will not cover current or past premiums. The following items should be included with the application:

- signed and dated copy of a physician's statement of diagnosis
- completed HIPP Referral Form (DHS 6172)
- proof of Medi-Cal eligibility (BIC number)
- copy of latest premium notice and policy booklet

Applications and documentation should be sent to:

Department of Health Care Services, HIPP Program  
MS 4719, P.O. Box 997422  
Sacramento, CA 95899-7422

### **Contact information:**

For additional information, call 1-866-298-8443 or visit [http://www.dhcs.ca.gov/services/Pages/TPLRD\\_CAU\\_cont.aspx](http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx).

**\*NOTE:** Under self-pay policies, beneficiaries pay a portion of their health care, either through deductibles or by paying out-of-pocket once a cap on benefits is reached, or both.



## Assistor Tips!!!

- If a patient is diagnosed with HIV/AIDS, they could be eligible for the CARE/HIPP Program. The CARE/HIPP Program will pay insurance premiums for patients that are disabled because of HIV and are at risk of losing their health insurance coverage.
  - In order to be eligible for the CARE/HIPP Program, individuals must be:
    - California residents;
    - Disabled by HIV/AIDS;
    - Have assets less than \$6,000;
    - Have incomes less than 400% of the Federal Income Guidelines (FIGs); and,
    - Have a monthly premium payment within the program limits.
- For more information, visit the Office of AIDS website:  
<http://www.cdph.ca.gov/programs/aids/Pages/OACAREHIPP.aspx> or call a Benefits Counselor nearest you. To find the nearest Benefits Counselor, please visit the following website:  
<http://www.cdph.ca.gov/programs/aids/Documents/CHBenefitsCounsDir.pdf>.

## **Consolidated Omnibus Budget Reconciliation Act (COBRA) and California Continuation Benefits Replacement Act (Cal-COBRA)**

### **Who is this program for?**

COBRA is a program that gives employees and their families an option to continue group health benefits for themselves and their dependents for a specific period of time under special circumstances. COBRA is the name of the federal program and Cal-COBRA (California Continuation Benefits Replacement Act) is California's state program.

### **What are the eligibility requirements?**

Employees of companies with 20 or more employees are covered by federal COBRA which generally provides coverage for up to 18 months. Cal-COBRA is a program for California residents which expands the scope of federal COBRA by providing coverage to:

- employees in companies with 2-19 employees who are therefore not eligible for federal COBRA,
- AND
- employees in companies of more than 20 employees who wish to extend the time period beyond the 18 month time period offered under federal COBRA to up to 36 months.

The length of time employees are eligible to continue receiving COBRA depends on the qualifying event or reason that coverage was lost. Examples of qualifying events for employees or dependents are the following:

- Loss of a job, voluntary or involuntary, unless the reason for termination was for gross misconduct
- Shorter working hours that would result in an employee no longer being eligible to participate in the employer's group health plan
- Eligibility of an employee for Medicare
- No remaining family leave benefits (some circumstances)
- Worker becomes eligible for Social Security Disability Insurance (some circumstances)
- Loss of health benefits by a spouse or dependent due to death, divorce or loss of dependent status

COBRA allows employees who experience one of these qualifying events to continue coverage under their group health plans for a limited time by paying for the coverage out of their own pockets. There are no income requirements for COBRA eligibility. Federal health plans and some church organization health plans are excluded from COBRA requirements.

### **How does immigration status affect eligibility?**

In order to qualify for COBRA or Cal-COBRA, individuals must be legally eligible to work in California.

### **What is the cost?**

The cost to employees under COBRA is no more than 102% of the health plan premium for active employees for the first 18 months (the cost of the coverage for the employee plus an

administrative fee). After 18 months, the cost is no more than 150% of the health premium for active employees. Payment is due **45 days** after electing COBRA coverage. Disabled individuals may be able to have their Cal-COBRA premiums paid through Medi-Cal HIPP or Care/HIPP for HIV/AIDS. Certain employees may be eligible for COBRA premium reduction. Please refer to the COBRA Premium Reduction Fact Sheet.

### **What benefits are covered?**

- COBRA beneficiaries receive the same benefit options as active employees.
- Depending on the qualifying event, the coverage period is either 18 or 36 months. Qualifying events for 36 months are death of an employee, divorce/legal separation, loss of dependent status or Medicare entitlement.
- Individual plans have the option to offer COBRA beneficiaries coverage beyond that which is required under COBRA if they choose to do so. However, non-medical benefits such as vision or dental care under a specialized plan cannot be extended when moving from COBRA to extended coverage under Cal-COBRA.
- Individuals who become eligible for Medicare or who are covered by other health plans are not eligible for Cal-COBRA unless that coverage has pre-existing exclusions that affect the individuals in question.

### **How are services delivered?**

COBRA beneficiaries have the same options for health coverage and the same covered benefits as active employees. In many cases, that will be the same coverage employees had before the qualifying events occurred. COBRA enrollees make their selections during Open Enrollment at the same time as active employees.

### **What about other insurance?**

Individuals can have both Medi-Cal and COBRA, but if they are eligible for both programs, they should consider their situations. If they have a high share of cost, Medi-Cal can actually be more expensive than COBRA. But in cases where there is no share of cost or a low share of cost, since Medi-Cal would pay last, it might be better for the family to enroll in Medi-Cal and not elect COBRA coverage.

### **How to apply:**

Paperwork needs to be completed within **60 days** of the qualifying event or after receiving notice of COBRA rights, whichever is later. Employers need to inform employees within 30 days of a qualifying event that they are eligible for COBRA and should make booklets on COBRA available to all eligible employees.

### **Contact information:**

- For general information on COBRA: <http://www.dol.gov/dol/topic/health-plans/cobra.htm>
- Members of group health plans (HMOs) can call the Department of Managed Care at 1-888-HMO-2219 or visit the website at <http://www.hmohelp.ca.gov>. Employees who have fee-for-service health coverage can contact the Department of Insurance at 1-800-927-4357.



## Assistor Tips!!!

- Since premiums are likely to be costly under COBRA, clients may ask why they should enroll in COBRA rather than purchasing private insurance.
  1. For individuals with incomes that are too high to qualify for no-cost Medi-Cal or other low-cost health care options, group health coverage is generally more comprehensive and less expensive than individual health coverage.
  2. COBRA does not take into account pre-existing health conditions, whereas individuals who have pre-existing health conditions may not qualify for individual coverage or may be subject to coverage limitations or exclusions or may have to pay higher than normal premiums.
- Some situations where it might make sense for clients to consider enrolling in COBRA are the following:
  - Client's new job does not offer health insurance.
  - Client's current plan covers dental whereas a private plan may not, so dental expenses could be high without COBRA.
  - Client needs medications that might not be covered under another plan.
  - Client has health conditions that might make it difficult to qualify for an individual plan.
  - Client or covered dependent is pregnant and not eligible for private insurance.
- Employees are responsible for informing their employers in writing within 60 days of the qualifying events that they want to sign up for COBRA. The first premium is due within 45 days of electing coverage. Premium rules are strict. If an employee signs up for COBRA but fails to pay premiums, they will be responsible for the full cost of their medical care.

## **Major Risk Medical Insurance Program (MRMIP)**

### **Who is this program for?**

MRMIP is for California residents who are not able to obtain individual insurance coverage because of pre-existing health conditions. MRMIP can help those who 1) have been denied coverage, have limited coverage or coverage under which certain health conditions are excluded (not covered); or 2) have very high premiums because of those pre-existing health conditions. The program is subsidized by contributions from enrollees and the State of California through tobacco tax dollars.

### **What are the eligibility requirements?**

- Applicants must be residents of California.
- Applicants must not be eligible for Medicare Part A or Part B unless they have a disability.
- Applicants must not be able to purchase health insurance under COBRA or Cal-COBRA, although COBRA or Cal-COBRA enrollees may apply in advance for MRMIP for coverage to begin when their COBRA benefits end.
- Applicants must have been denied coverage under **one** of the following circumstances and submit written proof:
  - They were denied coverage during the previous 12 months.
  - They were offered premium rates that were higher than the rate established by MRMIP.
  - They were members of a group that was denied coverage during the previous 12 months.

### **What benefits are covered?**

- MRMIP enrollees receive comprehensive medical benefits for inpatient and outpatient hospital and physician services. Applicants can call participating health plans or MRMIP or go online to request Evidence of Coverage or a Certificate of Insurance booklet.
- MRMIP benefits cover up to \$75,000 per calendar year and a maximum of \$750,000 per lifetime.
- Individuals who enroll in HMOs (Health Maintenance Organization) will have a 3-month waiting period during which time they will pay no contributions and will not be eligible for services. For those enrolling in PPOs (Preferred Provider Organization), there is a pre-existing period of 3 months during which no services will be provided related to the pre-existing condition. However, contributions are paid during this period. There are some exceptions to the waiting period, including being on a waiting list for MRMIP coverage for over 60 days.
- Subscribers' dependents can also be covered under the plan.
- Subscribers will continue to be enrolled into MRMIP for as long as they are eligible for the program.

### **How does immigration status affect eligibility?**

Immigration status is not taken into consideration.

### **How are services delivered?**

Enrollees will select a plan from those offered in their counties. Participating health plans in Los

Angeles County are Anthem Blue Cross and Kaiser Permanente Southern California (Kaiser Permanente is not available on Catalina Island).

### **What is the cost?**

- MRMIP has an annual household deductible of \$500 that the applicant must pay before MRMIP begins to pay for services.
- Premiums vary by the age of the subscriber, the health provider and the health plan selected. If dependents are included in the coverage, the premium is based on the age of the subscriber.
- Subscribers pay MRMIP established fixed amounts for certain services. If co-payments are required, they cannot exceed 25% of the cost of the covered service, and deductibles cannot exceed \$500 per calendar year per household. Maximum out-of-pocket expenses for services offered by the subscribers' plans and covered by MRMIP are \$2,500 per person per calendar year and \$4,000 per household per calendar year.
- Transfers to other parts of the State or changing to another health plan may affect contribution rates.

### **What about other insurance?**

Medi-Cal beneficiaries can apply for the program but will need to pay premiums and deductibles for coverage under MRMIP, which can be expensive. Medi-Cal will not pay for those costs. Medi-Cal may cover some services that private plans do not, such as dental care.

### **How to apply:**

Interested applicants can request an application from MRMIP at 1-800-289-6574 or download the application from the MRMIB website at <http://www.mrmib.ca.gov>. When applying for MRMIP and/or Pre-Existing Condition Insurance Plan (PCIP), the application will be reviewed for both health care programs to inform the applicant of his/her coverage options. In order for eligibility to be determined for both programs, the applicant must fill out both the MRMIP Application and the PCIP Supplemental Application.

### **Contact information:**

- For more information please visit: <http://www.mrmib.ca.gov/mrmib/MRMIPBRO.pdf>
- MRMIB: <http://www.mrmib.ca.gov>
- Department of Managed Care: <http://www.hmohelp.ca.gov> or call 1-888 466-2219
- Department of Insurance: <http://www.insurance.ca.gov> or call 1-800-927-4357



### **Assistor Tips!!!**

- Make certain that applicants understand about the waiting period, health plan choices, co-payments and deductibles and payment plans.
- Since MRMIP may have a waiting list, anyone who anticipates a loss of coverage should be placed on the waiting list as soon as possible.

## **Pre-Existing Condition Insurance Plan (PCIP)**

The Pre-Existing Condition Health Insurance Plan (PCIP) was authorized by the Patient Protection and Affordable Care Act (ACA) of 2010. PCIP is a federally funded program that was designed to provide coverage to uninsured individuals who have been denied health insurance or who have been offered unaffordable rates.

### **Who is eligible?**

To be eligible for PCIP, applicants must:

- Not have had creditable coverage within the six months prior to application; and
- Have a preexisting condition as evidenced by proof of denial by an insurance carrier within the past 12 months or have been offered coverage above the premium level of the Major Risk Medical Insurance Program (PCIP) PPO rate.
- Be a U.S. Citizen, U. S. National or lawfully residing in the U.S.
- Not enrolled in Medicare Part A & B; or COBRA or Cal-COBRA benefits

### **How does immigration status affect eligibility for the PCIP program?**

Citizenship, U.S. National or Lawfully residing in the U.S. status is a requirement for PCIP.

### **What are the income limits?**

There are no income limits for this program.

### **Are there resource limits?**

PCIP does not take resources into consideration.

### **What is the cost?**

Monthly premium rates for PCIP vary according to age and region (effective until December 31, 2011):

<b>Age band</b>	<b>Region 1</b>	<b>Region 2</b>	<b>Region 3</b>	<b>Region 4</b>	<b>Region 5</b>	<b>Region 6</b>
<b>0 – 18</b>	\$ 119	\$ 118	\$ 124	\$ 107	\$ 110	\$ 108
<b>19 – 29</b>	\$ 164	\$ 162	\$ 171	\$ 147	\$ 152	\$ 149
<b>30 – 34</b>	\$ 237	\$ 234	\$ 247	\$ 211	\$ 218	\$ 214
<b>35 – 39</b>	\$ 264	\$ 261	\$ 275	\$ 237	\$ 244	\$ 240
<b>40 – 44</b>	\$ 292	\$ 289	\$ 305	\$ 261	\$ 269	\$ 265
<b>45 – 49</b>	\$ 332	\$ 329	\$ 346	\$ 297	\$ 306	\$ 301
<b>50 – 54</b>	\$ 411	\$ 406	\$ 428	\$ 370	\$ 381	\$ 375
<b>55 – 59</b>	\$ 492	\$ 487	\$ 514	\$ 442	\$ 455	\$ 447
<b>60 – 64</b>	\$ 535	\$ 530	\$ 557	\$ 481	\$ 494	\$ 485
<b>65 – 69</b>	\$ 535	\$ 530	\$ 557	\$ 481	\$ 494	\$ 485
<b>70 – 74</b>	\$ 535	\$ 530	\$ 557	\$ 481	\$ 494	\$ 485
<b>&gt; 74</b>	\$ 535	\$ 530	\$ 557	\$ 481	\$ 494	\$ 485
Region 1 Northern: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba						
Region 2 Valley: Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus						
Region 3 Bay Area: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara						
Region 4 South Coast: Orange, Santa Barbara, Ventura						
Region 5 Los Angeles: Los Angeles						
Region 6 South: Riverside, San Bernardino, San Diego						

**Is California residency a requirement?**

Applicants must live in California in order to qualify for PCIP.

**What about other insurance?**

Applicants will not qualify for PCIP if they currently have, or have had, health insurance within the previous 6 months.

**How are services provided under PCIP?**

MRMIB is responsible for the implementation and operation of PCIP. Maximus is the administrative vendor and HealthNow provides third-party administrator services. PCIP provides all the components of a comprehensive health care plan.

**Where can individuals apply?**

Persons interested in receiving an application can call the toll free number of 1-877-428-5060 Monday through Friday from 8 a.m. to 8 p.m., Saturdays from 8 a.m. to 5 p.m. or visit the PCIP website to download an application, <http://www.pcip.ca.gov/Home/default.aspx>.

**Where can more information be found?**

Visit the PCIP website: <http://www.pcip.ca.gov>. Additionally, outreach information is available on the website, under the Outreach Materials tab.

## **Health Insurance Portability and Accountability Act (HIPAA)**

### **What is HIPAA?**

HIPAA is a Federal law passed in 1996. This law protects the rights of all health consumers by giving them rights over their health information and how that information can be used and shared. In addition, the law also offers continuity of coverage protection both for individuals enrolled in group health plans who might otherwise lose their ability to obtain new health insurance or renew existing policies because of pre-existing health conditions.

### **Who does HIPAA apply to?**

The “accountability” sections of the law apply to all health consumers. The “portability” section of the law guarantees continuity of coverage to qualified individuals enrolled in group health plans and also guarantees individual policies to eligible individuals who have no group health plan coverage and who have used up their COBRA or other continuation coverage. Individuals must show proof that they had this type of “creditable coverage” without a significant break (generally 63 days or more) prior to enrolling in a new health plan.

### **What rights and protections does HIPAA provide?**

Since HIPAA is not a health insurance program, the benefits are the rights and protections provided by law which is briefly summarized below.

#### Accountability-Privacy Issues

- Information in patients’ medical records, conversations among health care providers about patients’ treatment, billing and computer data and most other types of health information are protected by limiting who can receive that information and how it can be used.
- Patients have a right to see and obtain copies of their health records, have misinformation corrected and receive notice of how their health information may be used and shared. They also have the right to give permission on how their information is used for certain purposes, such as marketing.

#### Portability

- The law protects individuals who are leaving an employment-based plan from losing coverage by limiting the exclusions a new employer can impose for preexisting conditions and prohibits discrimination by an employer against employees and dependents because of certain health conditions.
- The law also guarantees access to individual policies for certain individuals and offers some protections by guaranteeing that those policies can be renewed.

### **Contact Information:**

To learn more about privacy issues under HIPAA, call 1-866-627-7748 to receive a fact sheet called “*Your Health Information Privacy Rights*” or visit <http://www.hhs.gov/ocr/hipaa/>.

For more details on portability of insurance coverage under HIPAA, visit [http://www.dol.gov/ebsa/faqs/faq-consumer\\_hipaa.html](http://www.dol.gov/ebsa/faqs/faq-consumer_hipaa.html).