

HEALTH CARE SELF-ADVOCACY GUIDE

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**DISABILITY AND EMPLOYMENT RIGHTS ADVOCACY
LEGAL SERVICES OF NORTHERN CALIFORNIA**

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INTRODUCTION

For fifteen years Disability and Employment Rights Advocacy (DERA), a program of Legal Services of Northern California, has provided self-advocacy training and support to people with disabilities. This guide to self-advocacy in health care is intended to provide basic information about health care rights in the private and public health insurance context. In addition, the guide offers practical self-advocacy tips useful for health care consumers and also outside the health care context.

This guide is written for people with disabilities with several different types of health insurance coverage. It is important to remember which type of coverage each section discusses. The first two chapters include more general health care rights information. The third, fourth and fifth chapters are more specialized as to the type of health care coverage.

The information in this guide is current as of June 2008. Law and regulations that govern health care rights change periodically. Users of this guide should remember to verify the continuing validity of the rules mentioned in this guide.

CHAPTER 1

BEING YOUR OWN BEST ADVOCATE

Getting the quality medical care that you need can often be a challenging task. This manual is a resource to help you get the care that you need through self-advocacy. Self-advocacy is when you learn about something, in this case health care, so that you understand the processes and programs available to you and you use this information to get better care for yourself. Self-advocacy is a powerful tool for any person, especially when dealing with complex health care services. Remember, if self-advocacy doesn't work, you can always try to find someone else like a friend, family member, community member, advocate, or attorney to help you get the care that you need.

No one knows your goals, your concerns and your interests better than you. If you can act as your own advocate, you have the best chance of being satisfied with the result of any compromise reached when you have a conflict with an agency or another person. This chapter is designed to describe the skills of a good self-advocate and to give you the tools to both avoid conflicts and resolve them when they arise.

A. Avoiding Conflict

A person should rarely give up an important right just to avoid conflict, however, there are several strategies short of accepting defeat at the first sign of resistance that can help a person avoid unnecessary conflicts. We will list below several of these methods, most of which are effective prior to a disagreement. If you are already involved in a heated conflict, this will not be immediately helpful but may provide some guidance on how to proceed in the future. These strategies for averting conflict are:

- Organization
- Documentation
- Research

Organization

You do have rights in accessing health care and health insurance. This guide will explain many of those rights. Above all else, you always have the right to be treated with respect and dignity when accessing health care and health insurance services. Remember that you also have responsibilities. Some of these responsibilities include communicating your needs to your health plan, doctor, or health insurance company, keeping up with any communication that you receive from your doctor, health plan, or health insurance company, and following the processes outlined in this guide.

The more you know about your rights and responsibilities as a health care consumer, the more easily you can spot potential conflicts early, identify rules that apply and use those rules to resolve those issues. Having this knowledge is vitally important for you as a health care consumer and a person with disabilities because you likely cannot afford to spend time resolving conflicts that could have been avoided in the first place. Organization is the first key to avoiding such unnecessary conflicts with your landlord or public agencies.

The following is a series of organizational tips intended to prevent the need for you to scramble to collect information, should a conflict arise. Even if you are already in a conflict situation, you can use these methods to create organization as you prepare to go forward with your dispute.

1. Keep an Appointment Calendar

An appointment calendar is useful for more than noting important meetings or events. A calendar is a convenient and organized way to keep track of the date and time when you place calls to your health care providers, your health plan or your eligibility worker or when they contact you. You can also place reminders on the calendar for times when you should contact your provider or health plan. For example, if you expected a claim to be paid by a particular date, you could make a note to contact the provider to make sure your health plan paid the claim before you receive a bill.

Another type of event you should note on your calendar is when you receive notices from Health Families, Medi-Cal or Medicare, if you are enrolled in any of those programs. There are strict deadlines for submitting paperwork and appeal requests. If you miss a deadline, you could lose your health care coverage. At the very least, you might have to go to a hearing to try to maintain your health coverage. Keeping careful track of when you receive notices and when you send responses can be helpful if you ever have a disagreement and have to provide evidence about whether you complied with a deadline on time or if a notice was sent by a health plan or agency.

Remember, your providers and health plans are running a business and may keep detailed business records. You should treat your relationships with providers and health plans as business relationships and keep detailed records of your own.

2. Take Notes

We will discuss this in more depth in the section regarding documentation below, but taking notes is also very important to organization. Many people have trouble remembering events, appointments and what they have been told. Some disabilities, and even medications people have to take, make it more difficult for certain individuals to remember these things. Taking notes can help you to keep your thoughts and memory of events organized for future reference.

When you receive a phone call from a provider, health plan or eligibility worker, it is a good idea to ask him or her to hold on while you get a pen and paper to write with or your Braille lite, or to switch on the print function on your TTY. If you are able to take notes about your conversation while you are talking, or immediately afterwards, you are more likely to have information you may need to refer to later. Email, if available, is an excellent method of communication because it creates a dated record of your communications.

3. Keep track of phone calls from your providers, health plan or eligibility worker

If you feel that your provider, health plan or worker does not respond to you promptly, it is particularly important that you keep track of the dates and times that you contact that person or agency.

Sometimes you may not be available to receive phone calls because you are at work or resting. It is important to make sure there is a time you will be available, and to notify your provider, health plan or worker and let them know exactly when you are available. Ask that person to agree to contact you during that mutually convenient time. If the person still fails to contact you, you have a record of the fact that you tried to be available.

Also, make sure that your phone or TTY is working properly. If you have an answering machine or message service, you should make sure it is working properly and check your messages often. It is your responsibility to make sure that your provider, health plan or worker can get in touch with you either by telephone, TTY, mail, or e-mail. If you discover that your phone or answering machine is not working, you should make note of the day and time and take action to get it repaired as soon as possible. You should also contact anyone from whom you were expecting a call to make sure they have not been trying to reach you.

4. Keep a separate folder for your health care information

The most important aspect of organization is being able to *find* the information you have compiled. An easy way to do this is to keep a separate folder or file for your health care information. For example, you should have one folder for your health plan evidence of coverage and information, one folder for your medical records, and another folder for your public health program eligibility information (if applicable). All the folders should be kept in the same place, especially if you have trouble remembering where you keep things. A good location is near your phone or TTY so you can refer to the information in the folders when you receive or make phone calls about your health care.

Documentation

Producing evidence to support your argument or position can be an effective tool in avoiding conflict. Some of the best evidence you can compile is paper evidence or documentation. Some examples of documentation include

bills from your provider, medical records, lab results or x-ray copies, re-dertermination paperwork (Medi-Cal), Explanation of Benefits statements from your health plan, co-payment receipts, etc.

There are **three simple rules** that ensure that you will have adequate documentation should a conflict about your health care or health care coverage ever arise:

1. Never give any document to a provider, health plan or worker unless you keep a copy.
2. Never fill-out or sign a form unless you receive a copy.
3. Always get documentation of payments at provider offices, your health plan Evidence of Coverage, phone calls with your health plan.

If you follow these simple rules and keep the paper you collect organized by date, you should be able to produce documentation to support your position on most conflicts. Since conflicts often arise from miscommunication or misunderstanding, making a written record of agreements you reach with providers, health plans or your worker can be helpful. Sometimes, you may be surprised to find that you did not remember correctly the amount you agreed to pay your provider for a medical bill each month or the amount of your prescription deductible.

Below we list some documents specific to health care that are important to keep. The following are the **most vital documents**:

- Receipts for Payment
- Evidence of Coverage
- Eligibility Letter (Medi-Cal or Medicare)
- Medicare Card
- Benefit Identification Card (BIC)
- Explanation of Benefits Forms
- Certificate of Coverage
- COBRA Letter

Research

Another tool for avoiding conflict, or resolving an existing conflict, is research. For example, if your health plan tells you that you are responsible

for paying for a medical treatment cost, you should always check your Evidence of Coverage to determine whether the health plan is correct.

Research in documents you already have is fairly easy, but research is more difficult when you are looking for state laws or local rules about health care. The most common rules are discussed in this guide, but for matters that are not dealt with in this guide you may have to consult other resources. Your local public library and your county law library are good places to start to learn more about your health care rights on issues not discussed in this guide. You may also contact your local non-profit legal aid organization for advice and assistance. To find your local legal aid organization, use the internet to go to www.lsc.gov for a listing of programs by state.

B. Advocating Effectively

Most people wish to resolve conflicts quickly and achieve the best outcome possible for themselves. The following suggestions are intended to achieve those goals.

There are some conflicts, however, that go beyond the individuals involved. Sometimes an individual health care consumer will be one of many who have experienced unfair treatment by a particular provider or health plan. In those situations, that individual may wish to resolve his or her own issue and also bring the health plan's actions to the attention to the public or the government. In those cases, it is generally more effective to work with professional advocates. We urge people who have experienced discrimination because of their disabilities or other unfair treatment they believe is particularly severe or could affect others to contact an attorney or advocacy organization for assistance.

1. Define Your Goals

When a conflict becomes contentious, there is sometimes a temptation to prove your opponent wrong. It is possible to forget your original goal if you are determined to "win." When you realize that you are in a disagreement with a provider, health plan, worker or another person who is making a decision that will affect your interests, be sure to take the time to decide what you hope to gain. Once you identify your actual goal, you can approach the conflict with the right focus and avoid unnecessary conflict.

For example, if you want your health plan to pay for a particular medication you have used in the past but it is not on the plan's formulary, take the time to think about exactly why you need the particular medication and whether or not your doctor could recommend another medication that is on the formulary that would satisfy your needs. You may start by asking the health plan for the medication you really want, but if he or she offers another medication that will work just as well, you might choose to take that medication. You might also choose to continue to advocate for yourself to get the medication you prefer, however, if the health plan's offer satisfied your initial goal and you accepted it, your conflict would end much sooner.

2. Make Your Request

When you make a request for an accommodation or something else that you need, you should try to give the decision-maker every reason to grant your request. Using again the example of the medication, you could begin by asking the health plan to pay for medication "A," the one you prefer. Then the health plan might respond with a number of reasons it cannot pay for medication "A." A better strategy would be to provide the health plan with information from your doctor that explains why medication "A" is medically necessary or superior to other medications for the treatment of your particular condition. Now, when the health plan responds, it will have a more difficult time denying your request because you have established your need, provided specific information about your needs from your doctor and made a request for the particular medication that meets those needs. Now the health plan must either refuse to provide the necessary medication, suggest another equally suitable medication or give you the medication you need.

Including information about your rights, being specific about your needs and providing options for how to satisfy your request can result in you getting what you need more quickly. Rather than having to respond to the health plan's request for additional information, you will have provided the information up front. While you might need to clarify some issues for the health plan, it will be able to make a decision faster because you have provided most of the necessary information with your request.

3. Gather Evidence and Support

Be sure to do your research before making a request to make sure you understand your rights to whatever you request. For example, if you need a sign language interpreter for an appointment with a provider, you may need to educate your provider about your right to an interpreter.

If you are asking for an accommodation because of specific needs you have related to your impairments, you may need to gather information about your impairment to educate your provider, health plan or worker about your needs. You can be required to provide proof that you need the accommodation because of your disability.

4. Take Action

Unfortunately, even when you make it as easy as possible for your health plan, provider or worker to agree with you, you still may not get what you want. When you have made a reasonable request that is refused, you may have to begin to take formal steps to enforce your rights. First, be sure you understand your rights and whether your request was clearly within those rights. If so, find out which state or federal government agency has the authority to enforce the rights of health care consumers in your situation.

Once you know where to go next, you must decide whether to go forward alone or to try to find a professional advocate to support your efforts. If you decide to work with an advocate, you should be aware that you will need to coordinate any advocacy with the advocate. Some advocates prefer that you stop contacting your provider, health plan or worker anymore after they agree to represent you. Others will let you continue to communicate with those individuals or plans while they coach you on what to say and do. It is important when you work with a professional advocate that both of you understand your responsibilities and expectations. You must also be sure your advocate understands your goals. When working with an attorney advocate, the general rule is that the client defines the goals and the attorney determines what kind of advocacy to use to achieve your goals.

If you choose to go forward alone, be sure to continue to use all of the self-advocacy skills described above as you proceed. However, if you think you will have to file a lawsuit to achieve your goals, you should seek legal counsel before you proceed as court proceedings can be extremely

complicated and self-represented (pro per) litigants are often at a great disadvantage, particularly if the other party is represented.

Talking with Your Provider

If you have a medical condition, it is very important that you talk to your doctor so that you can understand your condition and what you need to do to take care of yourself. You have the right to ask your doctor questions about your condition. It may help to bring a list of questions to your doctor appointments. This way, you will remember to ask all of the questions that you have. If you have additional questions about your condition after you leave your doctor's office, you can call them and ask to speak with the doctor or schedule another appointment to get your questions answered.

CHAPTER 2

ACCESSING HEALTH CARE

As a person with a disability accessing health care services, you have a right to:

- Be free from discrimination based on your disability;
- Equal access to health services and benefits;
- To receive communication aids and assistance free of charge if you need it them to communicate with your doctor or health care provider;
- Accessible medical equipment;
- Accessible facilities;
- Accessible phone services for the deaf or hard of hearing;
- Removal of physical or communication barriers that do not place an undue burden on the health care facility allowing you to receive services from your health care provider or get transportation to your health care provider;
- To be accompanied by your service animal in the hospital or health care facility; and
- To appeal decisions by your health care provider or health insurance company that you do not agree with.

A. Paying for Health Care

There are many different forms of health care and health insurance plans available. Some are available through an employer or through public programs, or you may sign up for insurance on your own. Some of the most common forms of health insurance are:

Employer Sponsored Health Care

This type of health insurance coverage is provided through your employer or because you are employed. You might also have coverage through your parent or spouse's employment. Your employer may pay for all of your coverage or may require you to pay for some portion or all of your health coverage. Generally, your employer can get better rates for health insurance than you can get through a private individual plan. Also, there is no medical examination required to obtain coverage through an employer. There are two main types of managed care coverage:

- Health Maintenance Organization (HMO): A health maintenance organization is a managed care organization that provides health care coverage to clients through doctors, hospitals, and other health care providers that have a contract with the HMO.
- Preferred Provider Organization (PPO): A preferred provider organization is a managed care organization of medical doctors, hospitals, and other health care providers who have joined with an insurer to provide health care at reduced rates to the insurer's clients.

If your insurance coverage through your employer ends, you are entitled to continuing coverage for a specified period of time. You must pay for the coverage yourself, but it allows you to maintain health insurance until you secure other coverage. COBRA, which stands for Consolidated Omnibus Budget Reconciliation Act, is a federal program, but California has a supplementary COBRA plan. When you are terminated or quit your job, you should receive a COBRA notice, if you don't you may file a complaint with the Department of Labor.

Government Sponsored Health Care

There are several health care and health insurance programs available through the federal, state or local government. The main programs are Medicare, Medicaid (California's program is called Medi-Cal) and County-run indigent health care programs.

Medicare

Medicare is an insurance plan administered by the United States Government that provides health insurance for certain adults over the age of 65 and some people with disabilities. People with end stage renal disease can qualify for Medicare, as well as people with disabilities who receive Social Security Title II or Railroad Retirement benefits for more than 24 months. Costs for insurance are generally proportional to your income and plan.

Medi-Cal

Medi-Cal is a state and federally funded program that provides health insurance to people who are low income, over 65 years of age, disabled, pregnant, medically needy or indigent and children in foster care. Medi-Cal has many different programs for which you may qualify. This guide will discuss some of the specific Medi-Cal programs later.

County Medical Services Program (CMSP/CMISP)

Counties are required by state law to provide basic medical care for indigent adults who are not eligible for other government health insurance programs. Several California counties run a County Medical Services Program, that operates as a managed care plan. Other counties call the program by a different name and offer services and coverage on a fee for service, or non-managed basis.

Major Risk Medical Insurance Program (MRMIP)

MRMIP is a state-funded program that provides health insurance for Californians who cannot get private health insurance because of their pre-existing medical conditions. In order to qualify for MRMIP you must be a resident of California, you must *not* be eligible for Medicare, Medi-Cal, or able to pay for COBRA benefits, and be unable to get any other health coverage.

Individual Health Plans

Private insurance consists of medical insurance programs, both managed and fee for service, that a health care consumer pays for him or herself. Each private insurance program has a list of specific covered services and may have several different plans to fit differing needs and ability to pay. To find out about individual plans and rates, you can contact the private health insurance companies and ask for information about their plans to talk with a health insurance agent. Be aware that private insurance companies cannot discriminate against you because of your disability, but they can decline to offer you a policy based on what is called “pre-existing” conditions, which could include your disabling impairments. Also, private insurance companies can charge higher rates to people who pose a higher “risk” of having expensive health care needs.

B. Choosing a Health Care Plan

If you are looking for a health care plan or trying to choose a managed care plan through Medi-Cal or Medicare, you should try to find a plan that best meets your individual health care needs. You may want to consider whether the plan provides coverage of your health conditions, whether it covers prescription medications that you are taking (whether your prescriptions are on the plan's drug formulary), whether the plan offers preventative care or educational health programs. You should also consider whether or not your present doctors and health care providers are contracted providers under the plan. If you need alternative care, chiropractic care, physical therapy, or experimental treatments you should also check to see which plans cover these services.

Additionally, you should consider what kind of premium, deductible, and co-payment costs are associated with the plan. A premium is an amount you must pay for health care services each month to be enrolled in the coverage. A deductible is a certain amount that you must pay for health care before your health insurance begins to pay. A deductible is generally a once yearly payment amount. A Medi-Cal share of cost is similar to a deductible, however it applies each month. A co-pay is a payment that you make directly to your health care provider each time you visit the doctor or get a prescription medication from a pharmacy. Co-insurance is similar to a co-pay, but is a percentage of care that you are responsible paying for such as 20% (and the insurance company will pay for the remaining 80%). If you are low income or you have a disability, you should look into programs that provide health insurance for low income people such as Medi-Cal and Medicare.

C. Physical Access to Health Care Facilities

The ease with which people can physically enter and use the facilities of a medical provider's place of business is measure of the physical accessibility of that office. All health care facilities must be "accessible" to people with disabilities. This means that they must be free from barriers that prevent people from accessing services equally with people who do not have disabilities. Health care providers must ensure their sites have accessible main entrances, waiting areas, examination rooms, therapy rooms, pharmacies, labs, bathrooms, elevators, emergency exits, and paths from the parking areas and public transportation stops to the health care facility. This may also include wheelchair accessible ramps, exam tables that lower, seated mammograms, scales that can weigh patients who use wheelchairs,

and blood pressure cuffs that can be used on legs rather than arms. You can ask your health plan or public health care program to help you find an accessible health care facility.

Any facility that receives federal or state funding must provide accessible facilities and cannot discriminate on the basis of disability. This includes a right to access services such as Medi-Cal and Medicare. These facilities must provide physical and communicative access and must also make aids and services available to give patients equal access. This includes making applications for programs and paperwork accessible. If you need help filling out or reading an application or paperwork you can ask your health care provider to assist you or to provide materials in an accessible format (such as braille or large print). The health care provider also needs to provide signs in braille and formats that people with low vision can read and provide emergency signals that are both visual and auditory.

If needed, you may ask the health care provider for a “reasonable accommodation” in order for you to be able to access the health care provider's services. This means that the health care provider must provide aids or services that are not an “undue burden” on their business in order to help you access the services that you need. An undue burden is a service that would be extremely difficult or expensive for the health care provider. The health care provider should not charge you for these aids and services. If you use a service animal, your health care provider must allow your service animal access to the health care facility as well, unless it causes a health or safety risk to other people.

A doctor or other health care provider also cannot refuse to provide you care because you have a disability. They must also provide you with health care services in an integrated setting. This means that they have to provide you care in the same setting as other patients. A health care provider must also give you equivalent care to any other patient and only refer you to a specialist if they would refer any other patient in a similar situation. And, as always, you have the right to be treated with dignity and respect. Doctors and health care services do have the right to accept only certain types of insurance or to restrict the number of new patients they accept.

D. Communication/Language Access

Health care providers must ensure that their patients can communicate with the office regardless of their disabilities or English language fluency. Patients must be able to communicate with their providers at each stage of treatment, from completing a new patient questionnaire to discussing treatment options and receiving medication dosage instructions. Signs posted in offices must be accessible or alternatives must be provided in an accessible format.

If you are blind or have low vision, ask for an accommodation when you call for an appointment or when you reach the health care facility. If you need help filling out a form or application, ask for help. The health care facility should provide a person to help you with reading and filling out any forms. If you would like information in Braille, ask for the “interpreter services liaison” or for the person who is in charge of providing translated materials.

If you are deaf or hard of hearing, let the health care facility know that you need an accommodation when you make your appointment. Ask for an interpreter or for assistance in a communication form that is best for you (for example, real time captioning or tactile interpreting).

If a doctor or health care provider does not speak the same language you do, ask for an interpreter when you schedule your appointment. If your health care provider refuses to provide an interpreter for an appointment, call the customer service number on the back of your insurance card to complain. If your health care provider still refuses to provide an interpreter for your appointment, write a complaint in your preferred language and mail it to the Department of Health and Human Services at:

Office for Civil Rights
U.S. Department of Health and Human Services
50 United Nations Plaza – Room 322
San Francisco, CA 94102

or call (800) 368-1019 and ask for a copy of the complaint form or ask for help with understanding how to file a complaint.

E. Using the Emergency Room

You have a right to emergency room care if you have an “emergency medical condition” even if you do not have insurance or are unable to pay

for the services. An condition is considered an “emergency medical condition” if there are acute symptoms (including pain) severe enough that not getting immediate medical attention could seriously jeopardize your health or cause serious damage to a bodily function, organ, or part. An emergency medical condition can also be due to a psychiatric problem or substance abuse. A pregnant woman may have an “emergency medical condition” if she has acute symptoms severe enough that the her health or her fetus' health will be in serious jeopardy without immediate medical attention or if the she is having contractions and there is not enough time for a safe transfer to an appropriate facility.

The hospital must evaluate the patient, provide emergency care, stabilize the patient, and make transfers only in appropriate situations regardless of a patient's ability to pay. An emergency room provider cannot refuse to treat you because you do not have the means to pay for your care. Any hospital that provides emergency services must accept any patient with an emergency medical condition if the hospital has the staff and facilities to provide the needed care. A hospital may refer you elsewhere if you do not have a true emergency medical condition.

If you have health insurance, it is important to provide your insurance information at the time of your visit or as soon as possible afterward to avoid receiving a bill for the services. If you have Medi-Cal or Medicare, you should care your cards with you whenever you seek medical care because the provider must be made aware you are enrolled in those programs. Some providers, including some emergency room providers, do not accept Medi-Cal or Medicare coverage.

If your emergency room visit results in a bill you cannot pay, you may request financial assistance. Financial assistance policies for California hospitals must be on file with the state Office of Statewide Health Planning and Development (OSHPD). Hospitals must provide their policy to you if you ask for it. OSHPD also posts the hospital financial assistance and fair pricing policies of each hospital on its website at:

<http://syfphr.oshpd.ca.gov/search.aspx>.

CHAPTER 3

PUBLIC AND GOVERNMENT SPONSORED HEALTH INSURANCE

A. Medi-Cal

Medi-Cal is California's Medicaid program. Medi-Cal has many different programs that are funded by both the federal and California governments. Some people with disabilities, children, seniors, Supplemental Security Income (SSI) recipients, and other low income or medically needy people may be eligible for Medi-Cal.

Eligibility for Medi-Cal

Medi-Cal's programs each have different eligibility requirements and rules. Some of the most common programs have income limitations, asset limitations, and requirements such as having a disability or having a child. All programs require that the recipient of Medi-Cal is a resident of California. You may apply for Medi-Cal at your county social services office. Counties call these offices by different names. Once you make a Medi-Cal application, an eligibility worker will determine your eligibility. You have a right to make an application, even if the staff at the county office thinks you may not be eligible. Ask that they process your application and send you a notice about whether or not you are eligible.

This guide will focus on eligibility requirements for common programs for which a person with a disability may qualify. These programs are CalWORKs linked Medi-Cal, SSI linked Medi-Cal, Aged or Disabled Medi-Cal, programs for pregnant women and children, the Working Disabled Program, and medically needy programs. Medi-Cal is also available to people who have private health insurance, however Medi-Cal will only pay for a health care service or need if your private health insurance does not pay or only pays part of the cost. Medi-Cal also has a program called Medi-Cal/HIPP which helps people who have high cost medical conditions pay their private insurance premiums. Additionally, Medi-Cal has programs that pay Medicare premiums, deductibles, and co-pays for individuals who qualify. These programs are covered in the Medicare section below.

Cal-WORKs-linked Medi-Cal

If you receive Cal-WORKs, you automatically qualify for Medi-Cal. This is program is referred to as “Section 1931” Medi-Cal. All members of your family who are on CalWORKs should also be enrolled in Medi-Cal with no share of cost. This is a program for low income people with children. Section 1931 Medi-Cal recipients receive full scope Medi-Cal with no share of cost, but are required to join a managed health plan and receive medical services through that plan.

Families who are eligible for CalWORKs, but are not receiving cash assistance also qualify for Medi-Cal. A family or an individual must meet all the qualifications to receive CalWORKs, including the income and asset restrictions in order to receive Medi-Cal in this program.

SSI-linked Medi-Cal

If you receive Supplemental Security Income (SSI), you automatically qualify for and receive full scope Medi-Cal without a share of cost. If you are still disabled under SSI rules, but no longer receive cash assistance, you should also have SSI-linked Medi-Cal.

If you receive Social Security Disability Insurance (SSDI), you are not necessarily eligible for Medi-Cal. However, if you have both SSDI and SSI, you will have SSI-linked Medi-Cal, but you may have a share of cost.

Medi-Cal for the Aged and Disabled

If you are age 65 or older or disabled you may qualify for Medi-Cal with no share-of-cost. Your countable income must be at or below 100% of the federal poverty level in order to qualify for this program. If you want to qualify based on a disability, you must meet the SSI eligibility criteria for disability. This means that you must show that you cannot work because of a severe physical or mental impairment expected to result in death or last at least 12 continuous months.

If you receive a denial of eligibility from SSI stating that you do not meet their definition of disability, Medi-Cal will use this denial to show that you

are also not eligible for their program. Therefore, you may benefit if you can qualify for Medi-Cal under this program before applying for SSI.

If your income is above 100% of the federal poverty level, but you meet the SSI definition of disabled, you may qualify for the ABD-Medically Needy Medi-Cal program. This program generally requires that recipients pay a monthly share of cost for any month that they receive benefits. Your share of cost is calculated by subtracting a monthly maintenance need level (\$600 for one person, \$750 for two people) from your countable income. Whatever is left over will be your monthly share of cost. In order to meet your share of cost, you can use health insurance premiums or health care costs that you pay for out of pocket.

Programs for Pregnant Women and Children

There are three Medi-Cal programs with no share of cost for pregnant women and children. A pregnant woman is considered two people for federal-poverty-level purposes until she gives birth and this number is used to calculate how many members there are in the family. In determining eligibility, the county only considers income, not assets, for these programs.

The Income Disregard Program provides Medi-Cal coverage to pregnant women and babies up to age one, if family income is at or below 200% of the federal poverty level. Women receive pregnancy-related care during and after the pregnancy (for 60 days after the end of the pregnancy plus the remaining days in the month). Pregnancy-related care includes all services needed to ensure the health of the woman and her developing baby. Infants who are citizens or qualified immigrants receive full coverage, and babies who are not qualified immigrants receive emergency coverage.

A woman who satisfies certain income and residency requirements can receive prenatal care (but not labor or delivery) under the Presumptive Eligibility Program without waiting for her Medi-Cal application to be processed. A health care provider registers the patient for the program. After she receives care, the pregnant woman must apply for Medi-Cal. If her pregnancy and eligibility is verified, Medi-Cal will place her in one of their programs. Otherwise, she leaves the Presumptive Eligibility Program the next month. In order to receive care under the Presumptive Eligibility Program, the chosen health care provider must participate in the program.

A pregnant woman who is income-eligible for Medi-Cal can self-declare that she is pregnant and receive pregnancy-related benefits without having to provide proof of pregnancy upon application to Medi-Cal. A pregnant woman can request and receive full-scope Medi-Cal services, or emergency and pregnancy-related services, pending proof of pregnancy, within 60 days of applying for Medi-Cal.

Children who are between one and six years old may qualify for Medi-Cal under one of the Federal Poverty Level Programs if their family income (after allowable deductions) is not more than 133% of the federal poverty level. Children who are between six and nineteen years of age may qualify for Medi-Cal if their family income (after allowable deductions) is not more than 100% of the federal poverty level. Undocumented children can qualify for Restricted Medi-Cal (with zero share-of-cost), which covers emergency and pregnancy-related care.

The 250% Working Disabled Program

The 250% Working Disabled Program provides full scope, no share of cost Medi-Cal to individuals with disabilities who are working and whose countable income is at or below 250% of the federal poverty level and who have countable assets of \$2,000 or less for an individual and at or \$3,000 or less for a married couple. Again, you must meet the SSI definition of disabled in order to qualify for this program. You must also be working, but you may be working only minimally, for example you may work only one hour per month.

If you are eligible for this program, you will pay a monthly premium for Medi-Cal. The premium ranges between \$20 per month to \$250 per month for an individual and is based upon your income. This premium is often much lower than what you would pay if you had a share of cost under the ABD-Medically Needy program.

Medi-Cal HIPP Program

The Medi-Cal HIPP program is a special program designed to help people with low income to stay on private insurance so that they can continue receiving care for a high cost medical condition. A high cost medical condition is one that results in an average monthly medical expenses that equal or exceed twice the monthly health insurance premium and is verified

by your physician. The Medi-Cal HIPP program pays private health insurance premiums so people with high-cost medical conditions may continue their private health care.

To qualify for the Medi-Cal HIPP program you must qualify for a Medi-Cal program with no share of cost or with a share of cost less than \$200, you must also have a high cost medical condition such as HIV/AIDS, cancer, organ transplantation, or pregnancy, and be enrolled under a private health insurance plan that does not exclude your condition (including COBRA or Cal-COBRA policies). If your share of cost is more than \$200 per month, you may use medical bill payments to reduce your share of cost and qualify for the program. Medi-Cal will cover other services that are not available under the private policy in addition to your deductibles and co-payments. If you have a share of cost, you must meet it before you can use Medi-Cal services.

Meeting Your Share of Cost

Some Medi-Cal beneficiaries will have a monthly share of cost for Medi-Cal services. A share of cost is the amount that you must pay each month for medical and health care services before Medi-Cal will begin paying. You only need to meet your share of cost in the months that you get health care services. Your share of cost might be very high in comparison to your income due to the way that Medi-Cal calculates the share of cost. If you think your share of cost is too high, you can ask your worker to recalculate your share of cost or to check for other Medi-Cal programs that you might qualify for such as the 250% Working Disabled Program. If your income is only slightly over the level that you would receive Medi-Cal without a share of cost, you may want to consider purchasing a supplemental dental or vision care insurance plan. Ask your worker for the amount that your income is over the level that you would receive no share of cost Medi-Cal. The cost of a supplemental health, dental, or vision care plan will be subtracted from your countable income and may cause you to qualify for no share of cost Medi-Cal. If you receive a notice that your share of cost is changing or that you now have a share of cost, ask your Medi-Cal worker to explain your share of cost and ask for a state fair hearing if you do not agree with the share of cost.

There are methods that can help you avoid paying more than is necessary for your share of cost. First, you should plan to get all of your non-urgent

medical and dental appointments in the same month. After you meet your share of cost, Medi-Cal will pay for all of the rest of your care that you receive in that month. By putting all non-urgent appointments into one month, you can maximize the amount that Medi-Cal will pay for that care. Second, if you are on prescription medications you can ask your doctor to prescribe two or three months of medication at one time. Once you meet your share of cost for one month, Medi-Cal will pay for all of your medically necessary medications. Third, you can use your receipts for health items to meet your share of cost. You can apply what you have already paid in a month for health care items toward your share of cost even if these items are not generally covered by Medi-Cal.

Medi-Cal Benefits

Medi-Cal provides coverage under many circumstances for doctor visits, hospital stays, prescription drugs, rehabilitation, and other medical services. Medi-Cal beneficiaries may receive full scope Medi-Cal or partial scope Medi-Cal depending on what program they qualify for. Full scope Medi-Cal includes (among other things):

- Inpatient and outpatient hospital services;
- Physician services;
- Medical and surgical dental services;
- Nursing services and home health care;
- Family planning and supplies;
- Laboratory and x-ray services;
- Pediatric and family nurse practitioner services;
- Early and periodic screening;
- Diagnosis and treatment services;
- Prenatal and delivery services including nurse-midwife services;
- Home health services;
- Clinic services;
- Optometrist services and eyeglasses;
- Prescribed medications;
- Prosthetic devices;
- Preventative and rehabilitative services;
- Home respiratory care services;
- Personal care services (IHSS);
- Medical equipment and appliances; and
- Diagnostic screening.

Like other health coverage plans, Medi-Cal has rules about what it will cover. For example, Medi-Cal only pays for prescriptions that are on its list of accepted drugs. Medi-Cal will only pay for medically necessary medicines. Medically necessary means that your doctor verifies that you need these medicines to stay healthy or to treat a medical condition. Medi-Cal has a list of approved medications that you can get through the program. If you need a medication that is not on the list, you may still be able to get it, but your doctor will need to explain to Medi-Cal why you need it. Medi-Cal may also refuse to pay for certain procedures like cosmetic surgery, in particular if the procedure is not medically necessary.

Medi-Cal will also require you to get prior authorization for some services. For example, a pharmacy may require pre-approval from Medi-Cal if you need more than six prescriptions in one month, if the medicine that you take is not on Medi-Cal's pre-approved list, or if the medicine that you need is in a different form than the one on Medi-Cal's approved list. If Medi-Cal or the pharmacy does require pre-authorization you can ask your pharmacist or doctor to send a Treatment Authorization Request (TAR) form to Medi-Cal. The TAR asks Medi-Cal to approve your prescription; it usually takes 24 hours for Medi-Cal to approve a TAR. If you do not hear from Medi-Cal within 30 days, your prescription is presumed to be approved. If Medi-Cal does not approve your medication, it must send you a letter explaining why it did not approve your medication. If you receive a denial, first ask your doctor if there is another medication that you can take for your condition. If there is not another medication, then you should file for an appeal.

If Medi-Cal refuses to pay for something and you think it should, you can appeal the decision. See the section below entitled “Appealing Medi-Cal Decisions” for more information on how to appeal.

Medi-Cal Fee For Service versus Managed Care

Some Medi-Cal programs, for example CalWORKs-linked Medi-Cal require that you join a Medi-Cal managed health care plan. When you are approved for Medi-Cal, you should receive a booklet describing the different managed care plans available. Managed care means that you are part of a Health Maintenance Organization (HMO) such as Kaiser, Health Net, Molina, Blue Cross, Western Health Advantage, or Care 1st.

Each HMO has a network or group of doctors, labs, hospitals, and other providers that work with the HMO. You get your health care from the providers in this network. You usually have a primary care doctor who provides you with most of your health care and handles your treatment. A Medi-Cal health plan may make it easier for you to manage your health care and the plan can help you find doctors and services such as labs and specialists. You also do not have to ask plan doctors whether they take Medi-Cal so it is usually easier to find a doctor or specialist. The health plans also generally offer special care services and health education programs that may not be covered by standard Medi-Cal. The managed health care plan must cover all services that standard Medi-Cal covers and there is no cost for services.

Most families with children have to sign up with a Medi-Cal health and dental plan. It is important to review the materials that you receive about the plans to determine which plan is best for you. If you do not sign up for a managed care plan and you are required to, the state will automatically enroll you in a plan which may not be the plan that best fits your needs.

You do not have to sign up for a managed care plan if you or a family member have and are being treated for certain “complex medical conditions” such as cancer, if you are disabled, or if you are on SSI. If you are pregnant and getting care from a doctor who is not in a Medi-Cal health plan you may also not have to sign up for a Medi-Cal managed care plan.

If you are not in a managed care plan, you have fee for service Medi-Cal. When you look for providers, you must ask if they accept Medi-Cal fee for service patients. If you have trouble finding a doctor who accepts fee for service patients, you might consider enrolling in a managed care plan. Once you are enrolled in managed care, your health plan has an obligation to find a physician who will accept you as a patient.

Appealing Medi-Cal Decisions

At some point during your medical care, you may disagree with a decision that Medi-Cal, your managed care plan, or your doctor or health care provider makes about your care. If you ever do not agree with a decision about your health care, you may appeal that decision. The way that you appeal depends on what type of Medi-Cal plan you are on, fee for service Medi-Cal or Medi-Cal managed care.

If you are on fee for service Medi-Cal or are contesting an eligibility decision about Medi-Cal services, you may ask for a State Fair Hearing. To ask for a State Fair Hearing, call or write to the State Fair Hearing office at:

State Fair Hearings
744 P Street, MS 19-37
Sacramento, CA 95814
Phone: (800) 952-5253.

You can also fill out the back of any notice of action that you receive to ask for a hearing and mail that to the State Fair Hearings office at the above address. You must ask for a state fair hearing within 90 days of the date you know your Medi-Cal benefits are denied, reduced, or stopped. If you want to continue receiving Medi-Cal until your hearing resolution, you must ask for "Aid Paid Pending." This means that Medi-Cal must let you keep your benefits until the judge makes a decision in your hearing. You must ask for a hearing and aid paid pending before the date your benefits are denied, reduced, or stopped or within 10 days of getting the notice that your benefits will end. It is very beneficial to ask for aid paid pending so that you continue receiving the medical care you require while you wait for the outcome of your hearing.

If you are in a Medi-Cal managed care plan or dental plan you may file a grievance instead of a fair hearing if your health or dental plan reduces, denies, or stops a service like a medication or treatment. A grievance is an official complaint that your health or dental plan must review. You must file your grievance within 90 days of the date your health or dental plan denies, reduces, or stops the service.

To file a grievance with your health or dental plan: (1) Call the customer service telephone number on the back of your health or dental plan and tell the customer service representative that you want to file a grievance, OR (2) write out your grievance and send it to the address of your health or dental plan. You can get the address by calling the customer service number on the back of your plan card. You can file a grievance and ask for a state fair hearing at the same time.

If you are not happy with the response that you receive from your health care or dental plan about your grievance or if your plan did not contact you

within 30 days, or your health plan said that the service that you requested was not medically necessary, you may call the HMO Help Center at 1-888-466-2219. If your plan said that the service was not medically necessary, it means that they do not think that you need the care that you requested. In this case, ask for an Independent Medical Review. At an Independent Medical Review a doctor outside of your health plan will decide if you need the requested service. However, you cannot file for an Independent Medical Review if you already requested a state fair hearing about the same problem.

B. Medicare

Medicare is a federally funded program that provides medical insurance for people over 65 years of age, certain people with disabilities, and people with end stage renal failure. Eligibility for Medicare is based on work history, generally your own work history, but sometimes may be based on the work history of a spouse or parent. Medicare has a number of programs including Part A – hospital insurance, Part B – medical insurance, Part C – Medicare Advantage plans, and Part D – prescription drug plans. Because Medicare is a federal program, it is the same in all states.

Eligibility for Medicare Programs

Eligibility for Medicare programs is based on work history. In order to be eligible for Medicare you must be:

- Over 65 years of age,
- A person with a disability who is a beneficiary of Social Security Disability Insurance (SSDI), OR
- Under 65 years of age with permanent kidney failure treated with dialysis or a kidney transplant, known as end stage renal disease, or with amyotrophic lateral sclerosis (ALS) or Lou Gehrig's disease.

Generally, you are eligible for Medicare if you or your spouse worked for at least 10 years in Medicare-covered employment and you are 65 years or older and a citizen or permanent resident of the United States. You can get Medicare when you reach age 65 even if your Social Security retirement benefits will not begin until age 67.

If you are disabled and younger than 65, you can receive Medicare if you have been on Social Security Disability Insurance (SSDI) for twenty-four (24) months. Qualification for SSDI depends in your work history and whether you paid Social Security and Medicare taxes while you were working. If you have end stage renal disease or amyotrophic lateral sclerosis (ALS), then you qualify for Medicare without the two year waiting period.

If you have a child with a disability, that child may be eligible for Social Security. If your child has a “severe disability” that is diagnosed before age 22, they may be able to collect SSDI and receive Medicare based on your work history after they turn 18. He or she will also have to receive those benefits for two years before he or she begins receiving Medicare.

You may also qualify to receive Social Security and Medicare through your spouse. If you are a widow and are disabled, you may qualify to receive SSDI based on your spouse's work history. You will still have to be on SSDI for two years before you receive Medicare, unless you have end stage renal disease.

Any person who has paid into the Medicare system and qualified for benefits based on their work history is eligible for Medicare at age 65. If you are divorced, you may be able to collect Medicare benefits based on you former spouse's work history, but you must have been married for over 10 years and you must not remarry before you are 60.

Medicare Programs

Medicare is made up of a number of programs called Part A, Part B, Part C, and Part D. Part A is hospital insurance, Part B is medical insurance, Part C is called “Medicare Advantage” and provides hospital and medical insurance through a private health plan, and Part D is prescription medication insurance. Medicare programs generally pay for some portion of “medically necessary” care, defined as services or supplies that are needed for the diagnosis or treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.

Part A

Part A is part of what is termed “original Medicare.” If you do nothing when first enrolling in Medicare, you will generally be enrolled in “original Medicare.” Part A covers inpatient hospital care and care in a skilled nursing facility following hospital admission for a period of time. It may also cover hospice or in home care, depending on whether you meet certain conditions. Any service covered by Part A must be medically necessary.

You may have to pay some of your costs for this plan, depending on the circumstances of your hospitalization, but you will normally not have a monthly premium. Generally, you will have a deductible (\$1,024 in 2008) and then have a co-payment depending on the length of time that you require services. For hospital stays you will not have a co-payment until the 61st day, and for skilled nursing facilities you will not have a co-payment until the 21st day.

Part B

Medicare Part B is also part of the “original Medicare plan.” Most people who are on the original plan have both Part A and Part B coverage. Part B is medical insurance and covers out patient medical care. You do usually have to pay a monthly premium for Part B depending on your yearly income. You will also have a deductible (\$135) for Part B services. After you meet your deductible, Medicare will generally pay for 80% of your outpatient medical costs. The other 20% will be your co-payment for services.

Generally, if you qualify for Part A, then you will also be offered Part B. If you choose not to enroll in Part B, you may enroll during an open enrollment period from January 1 through March 31 each year. Note that if you do not have health insurance and choose not to enroll in Part B when you first become eligible, you will likely pay a higher premium as a penalty if and when you do enroll. This “lifetime penalty” is 10% each 12 months that you are not enrolled in Part B.

With Medicare Part B, you can go to any doctor, supplier, hospital, or other facility that accepts Medicare and is accepting new Medicare patients. You use your red, white, and blue Medicare card to receive services. If a doctor or health care provider is not participating in Medicare, you can make a contract with that provider to receive health care services, but Medicare will

not pay for these services and the provider can charge you any rate for the services. Also, a doctor who is a Medicare provider can provide some services outside of Medicare. If a particular service is not covered, the provider must notify you in advance through an Advance Beneficiary Notice. If you have been notified and still need the service, you can pay for the service out of pocket, but Medicare will not cover the expense of the service.

Part B covers outpatient care, preventative care, and medical supplies such as:

- Doctor visits including diagnostic tests, X-rays, and MRIs and other covered preventative services;
- Emergency room services and ambulance rides;
- Diabetes screenings, supplies and self-management training;
- Kidney treatments, dialysis, and transplants;
- Eye exams, treatment, and glasses;
- Mental health services;
- Physical therapy;
- Mammograms and prostate cancer screenings;
- Durable medical equipment (DME) including wheelchairs, oxygen equipment, hospital beds, walkers, and braces;
- Prostheses including artificial limbs, and special shoes for people with diabetes;
- Home health care not covered under Part A; and
- Medical supplies such as surgical dressings and splints.

Part C

Medicare Part C encompasses the several “Medicare Advantage Plans.” Advantage Plans provide your health care services using an HMO or PPO format. If you choose a Medicare Advantage Plan you will have both hospital and medical coverage. You generally have to see doctors and health care providers within the plan that you choose. You also generally have to pay a co-payment for any medical services that you receive. However, you may receive extra benefits above and beyond what “original Medicare” provides or have lower payments. Your costs, extra benefits, and rules will depend on which plan you choose.

Many Medicare Advantage plans cover prescription medications, but some do not. You generally do not need to purchase a Medigap plan (see below) if you sign up for a Medicare Advantage plan.

If you do choose to enroll in a Medicare Advantage Plan, be sure to review the plan benefits, costs, and coverage. Look for your specific medications and treatment needs to be sure that the Medicare Advantage Plan covers your needs. Also, consider the extra benefits that each plan offers such as prescription medications, vision, and/or dental coverage.

To join a Medicare Advantage Plan you must have Medicare Parts A and B, live in a participating Advantage Plan service area, and not have Medigap coverage. To find out which Advantage Plans are available where you live, call Medicare at 800-633-4227 (voice) or 877-486-2048 (TDD) or check www.medicare.gov . If you want to cancel your enrollment in a Medicare Advantage Plan, you must be within three months of enrolling in the Medicare Advantage Plan. If you are, you may switch to an original Medicare plan (Part A/ Part B). You must contact your Medicare Advantage Plan in writing to tell them that you want to cancel your enrollment. Your Medicare Advantage Plan will be cancelled and you will be switched to original Medicare on the first day of the first month after your plan receives your cancellation request. If you want to switch Medicare Advantage Plans, you may switch during the Medicare open enrollment period from January 1 through March 31 of each year.

Part D

Part D is the Medicare Prescription Drug Plan. Original Medicare enrollees may add prescription drug coverage by joining Part D. These plans are available through private companies that are approved by Medicare to provide prescription drug coverage. There are multiple plans available and each plan has different coverage and costs.

When choosing a prescription drug plan, you should consider whether or not the plan covers the medication that you need, what the plan charges for your medications, and if there are pharmacies available in the plan that are accessible to you. Choose a plan that meets your needs based on coverage, cost, and convenience. If Medicare automatically enrolled you in a plan, you can change to a different plan.

If you need help choosing a plan, you can call a number of different places for advice. In California, either check with or call:

- Visit <http://www.medicare.gov> on the web. Under Search Tools, select Compare Medicare Prescription Drug Plans.”
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call the Health Insurance Counseling and Advocacy Program (HICAP) of California (SHIP) at 1-800-434-0222 or 1-916-419-7540.

If you have drug coverage through a previous or current employer or union, contact your benefits administrator before you make any changes to your prescription drug coverage. If you join a Medicare drug plan, you could lose employer or union health and/or prescription drug coverage for yourself, your spouse, and your dependents.

Part D covers medications including prescription drugs, vaccines, insulin and related medical supplies including syringes, needles, alcohol swabs, and gauze. The types of medications that are covered by individual plans will vary. However, Part D basic coverage does not cover some types of medications including:

- benzodiazepines,
- barbiturates,
- medications for anorexia, weight loss, or weight gain,
- medications used to promote fertility,
- medications used for cosmetic purposes or for hair growth,
- medications used for symptomatic relief of cough and colds,
- prescription vitamins and mineral products, except prenatal vitamins and fluoride preparation products,
- non-prescription medications.

You may be able to get coverage for some of these types of medications under Part D, but you may pay higher co-pays or premiums if you choose one of these plans.

People with limited income and resources may qualify for extra help (also called the Low Income Subsidy) paying their Medicare prescription drug coverage costs. If you automatically qualify for extra help, you won't pay a premium if you join certain basic Medicare drug plans. You automatically

qualify for this program if you are on no share of cost Medi-Cal, if you receive Supplemental Security Income (SSI), or if you belong to a Medicare Savings Program. If you don't automatically qualify, you may still get help to pay your prescription drug costs. If you qualify for help, depending on your income and resources and your plan's premium, you will pay a reduced premium or no premium at all for a basic prescription coverage plan. If you would like an enhanced plan, you must pay a portion of the premium for the extra coverage. This program will assist with paying any yearly deductible, paying prescription coinsurance and co-payments.

Assistance Paying for Medicare

If you cannot afford to pay for Medicare plan premiums or for your co-payments or deductible, you may qualify for assistance depending on your situation, income, and resources. The section below discusses some of the assistance available to low income Medicare recipients.

Medi-Cal

Medi-Cal is program found in the state of California that provides health insurance coverage to low income people. Medi-Cal is known as Medicaid in other states and is a federal and state run program. In order to qualify for Medi-Cal, you must have limited income and assets. Medi-Cal has a number of programs that you may qualify for based on your situation which are discussed in detail in Section A above of this Chapter 3 of this guide. If you do qualify for both Medicare and Medi-Cal, you may be referred to as a "Dual Eligible" or a "medi/medi" recipient. If you are a "dual eligible" person, Medi-Cal will pay for all of your out of pocket expenses for your health insurance fees such as deductibles, co-pays, and premiums that are medically necessary.

Qualified Medicare Beneficiaries (QMB)

A person who is low-income may qualify for a QMB Medicare plan even if they do not qualify for Medi-Cal (Medicaid). QMB is a Medicaid program for people with Medicare who need help in paying for Medicare services and whose income is at or below 100% of the federal poverty level. The person with Medicare must have Medicare Part A and limited income and resources. For those who qualify, the

Medicaid QMB program pays Medicare Part A and Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services. In order to apply for QMB, contact your local social services agency.

Specified Low Income Medicare Beneficiaries (SLMB)

The SLMB program is another Medicare program designed to help low-income Medicare recipients pay for their coverage. In order to qualify for SLMB, you must have Medicare Part A, a low monthly income, and limited resources. SLMB has programs for people with incomes at or below 135% and 175% of the federal poverty level. If you qualify, the SLMB program will pay your Part B monthly premiums. In order to apply for SLMB, contact your local social services agency.

Medigap

Medigap insurance plans are Medicare supplement insurance plans sold by private insurance companies to fill "gaps" in original Medicare coverage. You will pay a premium directly to the private insurance company for your Medigap coverage. There are up to twelve standardized Medigap policies labeled Medigap plans A through Plan L. Medigap policies only work with original Medicare. In order to find which plan works best for your situation, check the "Find and Compare Medigap Policies" page on Medicare's website at: <http://www.medicare.gov/MPPF/Include/DataSection/Questions/SearchOptions.asp> .

After enrolling for Medicare Part B, you will have a six month enrollment period for Medigap policies. During this time, you can't be denied coverage or charged more due to past or present health problems.

If you enroll in a Medigap plan, you get help paying for some of the health care costs that original Medicare does not cover. You also get benefits that original Medicare does not cover, such as emergency health care outside of the United States.

Care Denials for Medicare Beneficiaries

If you do not agree with a decision that Medicare or your Medicare Advantage Plan makes, you have the right to appeal that decision. You may appeal if Medicare does not pay for an item or service you received or if you are not given an item or service you think you should get. You may appeal whether you are in original Medicare, a Medicare Advantage plan, or a Medicare prescription drug plan. The details of how to appeal a decision are outlined below depending on the type of Medicare plan involved. Remember, it is always a good idea to talk with your doctor or care provider to determine whether they can help you resolve the problem before you appeal.

If you are admitted to a Medicare participating hospital, you should be given a copy of An Important Message From Medicare. It explains your rights as a hospital patient such as: you have the right to get all of the hospital care that you need, and any follow-up care after you leave the hospital and what to do if you think that hospital is making you leave before you should. If you have questions about this, call 1-800-MEDICARE. You may ask for a Quality Improvement Organization (QIO) to review your case before you leave the hospital. The hospital cannot force you to leave before the QIO makes a decision and you may be able to stay in the hospital at no charge during the review.

Original Medicare Plan Appeals

If you are enrolled in original Medicare (Part A/Part B), you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case.

The back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare will tell you what your appeal rights are and how to appeal. The notice will also tell you why your bill was not paid and what appeal steps you can take.

The first level of appeal is called a “redetermination” and is determined by the same group who made the original decision. If you disagree with the results of a redetermination, you may ask for a “reconsideration” within 120

days of the redetermination decision. A Qualified Independent Contractor (QIC) will review your request and make a determination.

If you disagree with the decision of the QIC, you may file a request for a hearing with an Administrative Law Judge (ALJ). You must file this request within 60 days of the reconsideration decision and the amount in controversy must be more than \$110.

After the ALJ level, you may appeal to the Medicare Appeals Council within 60 days if you do not agree with the Administrative Law Judge's decision. Finally, you may appeal the Medicare Appeals Council's decision to a federal District Court if your case meets certain requirements such as a certain level of dollar amount in controversy, or the dollar value of your dispute with Medicare.

Medicare Managed Care Plans Appeals

If you are in a Medicare managed care plan, you can file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. The plan's original decision is called an "organization determination." If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for an expedited decision. The plan must answer you within 72 hours. Otherwise, the plan has 30 days to make a decision about services that you request and 60 days to make decisions about payment appeals. Note that a request for payment cannot be expedited. This is referred to as a "health plan reconsideration."

The Medicare managed care plan must tell you in writing how to appeal. After you file an appeal, the plan will review its decision. Then, if your plan does not decide in your favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan. This second level is called a "Independent Review Entity (IRE) reconsideration." The IRE has 30 days to make a decision about a service request and 60 days to make a decision about a payment request. If you have an expedited request, the IRE has 72 hours to make a decision.

If you do not agree with the IRE decision, you may appeal to the Office of Medicare Hearings and Appeals where an Administrative Law Judge will review the decision. You may then appeal to the Medicare Appeals Council

if you do not agree with the Administrative Law Judge's decision. Finally, you may appeal the Medicare Appeals Council's decision to a federal District Court. See your plan's membership materials or contact your plan for more details about your Medicare appeal rights.

You may also file a grievance if you are dissatisfied with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested. If you have a problem, such as you are unable to get an appointment or someone in your Medicare Advantage Plan such as a doctor, nurse, or other care provider is disrespectful or rude to you or your family, you may consider filing a grievance. You must file a grievance either orally or in writing no later than 60 days after the event that triggered the complaint.

For more information about the grievance, organization determination, and appeals processes under Medicare Advantage plans, see the Medicare Managed Care Appeals & Grievances webpage on the cms.gov website: <http://www.cms.hhs.gov/MMCAG> .

Appeal Rights Under Medicare Prescription Drug Plans

If you are in a Medicare prescription drug plan, you can appeal a plan's decision not to provide or pay for a Part D prescription medication. The word "provide" includes authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been receiving. If your plan refuses to provide or pay for a prescription medication, you may appeal their decision.

If you request a standard appeal, the plan must answer you within seven days after receiving your request. If you or your doctor think your health may be seriously harmed by waiting up to seven days for a decision, you or your doctor can ask the plan for an expedited appeal. If the request is approved, the plan must answer your request within 72 hours.

The plan will review its decision about your prescription medication after you file an appeal. If the plan does not decide in your favor, you can appeal the plan sponsor's decision to an independent organization that works for Medicare. For more information about your appeal rights, see your plan's membership materials or contact your plan.

If you have concerns or problems with your prescription drug plan that are not about the plan sponsor providing or paying for a Part D prescription drug, you have a right to file a grievance. For example, if you have trouble getting through to the plan sponsor on the telephone or if someone related to your plan is rude to you, you can file a grievance.

For detailed information about the grievance, coverage determination, and appeals processes under Medicare Part D, and the forms you or your doctor should use to make or support requests under Medicare Part D, see the Medicare Prescription Drug Appeals & Grievances webpage on the cms.gov website: <http://www.cms.hhs.gov/MedPrescriptDrugApplGriev> .

C. County Programs

The County Medical Services Program (CMSP)

CMSP provides health coverage for low-income, indigent adults in thirty-four, primarily rural California counties. These counties are:

Alpine	Imperial	Modoc	Solano
Amador	Inyo	Mono	Sonoma
Butte	Kings	Napa	Sutter
Calaveras	Lake	Nevada	Tehama
Colusa	Lassen	Plumas	Trinity
Del Norte	Madera	San Benito	Tuolumne
El Dorado	Marin	Shasta	Yuba
Glenn	Mariposa	Sierra	
Humboldt	Mendocino	Siskiyou	

Eligibility

In order to qualify for CMSP, you must be a medically indigent adult (between 21 and 64 years of age) who does not qualify for Medi-Cal. You must reside in a CMSP county (see above) and for full benefits you must be a United States citizen or a lawfully admitted permanent resident. If your immigration status is undetermined, you can receive emergency services only. If you are a single parent with minor children, have minor children and have become unemployed, receive SSDI, are pregnant, or feel that you are disabled, you should apply for Medi-Cal benefits.

Both your income and your resources (or assets) must be within certain limits to qualify for CMSP. Your income must be at or below 200% of the federal poverty level. You also must not have personal property that is worth more than \$2,000 for one person or \$3,000 for two people, \$3,150 for three people, \$3,300 for four people, and \$150 for each additional person. One personal vehicle is exempt from the resources calculation. If you are over the resource limit, you may be able to spend down your resources so that you qualify for CMSP. You should talk to a county social services worker to determine acceptable ways to spend down your resources.

Even if you qualify CMSP, you may have a share of cost for services. In order to determine your share of cost, CMSP will take your non-exempt income minus a maintenance need value (\$600 for one person, \$750 for two people).

If the county determines that you are eligible for CMSP, you will receive an approval notice, and shortly after, a Benefits Identification Card (BIC). You will also receive a CMSP/BC Life & Health identification (ID) card. To receive CMSP benefits you will need to go to a CMSP/Blue Cross Life & Health network provider to receive all services, except emergency services. You must present your BIC and your CMSP/BC Life & Health ID cards to the provider when you get services. If you receive non-emergency services from a medical provider who is not a part of the CMSP/BC Life & Health provider network, you will be responsible for paying for those services.

Blue Cross Life & Health (BC Life & Health) assumes responsibility for CMSP medical, dental and vision benefit administration. In carrying out this responsibility, BC Life & Health subcontracts with Doral Dental for dental services administration and Vision Service Plan (VSP) for vision benefit administration. MedImpact Healthcare Systems, Inc. (MedImpact) administers the CMSP prescription drug benefit provided through retail pharmacies. The CMSP prescription drug benefit emphasizes the use of generic medications, where available and appropriate, and requires prior authorization and other utilization controls for selected medications based upon clinical efficacy, medical necessity and cost. If you have another prescription drug coverage plan, that plan will be required to pay for prescriptions first, then CMSP will pay.

The CMSP program provides a number of inpatient and outpatient services. You will likely have to get a treatment authorization before receiving certain services and you may be subject to utilization limits. Some of the covered services are:

- Acute inpatient hospital care;
- Chronic hemodialysis services;
- Dental services;
- Durable medical equipment;
- Emergency ambulance services, medically necessary transportation;
- Hearing aids;
- Laboratory and radiology services;
- Optometry services (eye exams, low vision aids, allowance for lenses and frames);
- Prescription drugs;
- Outpatient occupational and physical therapy services;
- Prostheses and orthotic appliances; and
- Psychiatric services.

CMSP does not cover acupuncture, chiropractic services, pregnancy-related services, long-term care or skilled nursing facility services, psychological services provided by non-psychiatrist providers, replacement eye glasses and repairs, contact lenses that are not medically necessary; methadone maintenance, and all services not covered by the Medi-Cal program.

Appealing a CMSP Decision

If you disagree with an action the county CMSP program has taken, you may appeal that action. This may include not providing care that you believe is necessary, not paying for medical services, or finding you ineligible for CMSP. You may want to discuss the action with your eligibility worker or the eligibility worker's supervisor, however you should also request a hearing if you are dissatisfied. If you currently have benefits and request a hearing before the date the negative action is to take place, your benefits will continue until your appeal has been resolved. The county in which you received your benefits is responsible for conducting the hearing and ruling on the issues.

Changing Counties

If you move out of your present county and have CMSP, you must reapply for CMSP in the county that you move into. Remember to find out if the county that you are moving into has a CMSP program. If your new county does not have a state run CMSP program, they must have a program for low income single adults without other insurance. Talk to a local social services agency or health care advocacy group for help in finding a similar county program.

CHAPTER 4

PRIVATE HEALTH INSURANCE

A. Types of Health Plans

Private health insurance coverage may be provided through your employer or you may purchase an individual or family plan directly through a health insurance provider. If your employer provides health insurance it may pay for all of your coverage or may require you to pay for some portion or all of your health coverage. Generally, your employer can get better rates for health insurance than you can get through a private individual plan. You may also be able to get a private insurance plan through a professional or membership organization with which you are affiliated.

There are four common types of private health insurance providers. They are HMOs, PPOs, indemnity health plans, and COBRA.

Health Maintenance Organization (HMO)

An HMO is a managed care organization that provides health care coverage to clients through doctors, hospitals, and other health care providers that have a contract with the HMO. You will generally have to choose a primary care physician who will manage your care and provide referrals to specialists for any other health care services you may need.

You may be able to find a point of service plan as well. A point of service plan is an HMO plan that allows you to see doctors outside of the HMO network. A point of service plan is generally more expensive than a standard HMO plan because of the increased flexibility.

Preferred Provider Organization (PPO)

A PPO is a managed care organization of medical doctors, hospitals, and other health care providers who have joined with an insurer to provide health care at reduced rates to the insurer's clients. You may have restrictions on which doctors and health care providers you can use, but your costs will likely be lower than with an indemnity health plan.

A PPO will usually allow you to see out of network doctors and will permit you to see a specialist without a referral.

Indemnity Health Plans

Indemnity health plans are insurance plans that allow you to pick your doctors and health care providers, but often cost more and have deductibles, premiums, and co-pays. Indemnity health plans require that you save your receipts and records of medical care and submit claim forms to the insurance company to get reimbursed for care.

Indemnity health plans offer three types of plans: basic plans, major medical plans, and comprehensive plans. Basic plans cover only costs associated with hospital care. Major medical plans cover only long term care expenses for injury or illness. Comprehensive plans usually cover both hospital charges and long term care expenses. In general, indemnity health plans do not provide preventative care or health education programs.

COBRA

COBRA is medical insurance provided under the Federal Consolidated Omnibus Budget Reconciliation Act. This Act mandates insurance providers to continue providing health insurance coverage to employees who leave their jobs. COBRA benefits are limited in time and scope and usually require the recipient to pay for the services

B. Enrollee Rights

The federal government and the State of California both protect your rights as a health insurance and health care consumer. The Medical Board of California, the California Knox-Keene Act, and the Employee Retirement Income Security Act of 1974 (ERISA) are the three major protectors of health care consumer rights. You are entitled to a number of protections including:

- The right to privacy;
- The right to know your condition and your treatment options including the risks involved, costs, and side effects of treatment;
- The right to make your own decisions about care;

- You have the right to not be denied coverage on the basis of your health status, medical condition or history, genetic information, disability or insurability if you are joining a group health care plan;
- You have the right to receive coverage for preexisting conditions in most cases within 12 months (or, in some instances, 6 months) of enrolling in a health care plan;
- If you are enrolling in an individual plan, you have the right not to be denied coverage if you have had 18 months of continuous coverage previously and meet certain other requirements;
- The right to have an Advanced Health Care directive;
- The right to receive information about your health insurance program;
- The right to information about COBRA benefits (when you leave an employer provided plan);
- The right to continue your health plan (under certain conditions);
- The right to maternity coverage which covers at least a 48-hour hospital stay following childbirth or a 96-hour hospital stay after a cesarean section;
- The right to mental health care annual dollar amount limits that are equal to medical and surgical benefits (referred to as mental health parity); and
- Protections for patients undergoing breast reconstruction in connection with a mastectomy.

A preexisting condition is a health problem or condition that you had before joining a plan. A new insurance plan may have a waiting or exclusion period before it will cover a preexisting condition. During this period, a health plan may refuse to pay for care related to your preexisting condition, however they must provide care for other covered conditions and health care issues. In order to determine whether you have a preexisting condition, an insurance company can “look back” at your care for the past 6 months if you are in a group plan with more than two employees or an individual plan covering three or more people and can look back up to a year for an individual plan covering only one or two people or an employee plan that covers only you. Your plan must tell you in writing about its policy regarding preexisting conditions. If you can show that you had “creditable coverage” (most private and group plans), then your preexisting condition exclusion period may be shortened. If a plan has a preexisting condition exclusion period, it must

calculate the time of your creditable coverage, let you know how long the exclusion will apply, explain how it reached its decision, and tell you how to appeal their decision. Preexisting condition exclusions cannot apply to pregnancy-related care or care for a newborn or newly adopted child if they are enrolled within 30 days of their birth or adoption.

Your right to an Advance Health Care directive allows you to choose what decisions you want made about your health care and who is in charge of your care in the event that you cannot make those decisions for yourself. Completing an Advance Health Care Directive is important for all individuals over 18 years of age as they may unexpectedly be in a position where they cannot speak for themselves, such as an accident or severe illness. An Advance Health Care Directive allows you to appoint a person who has power of attorney to make care and treatment decisions on your behalf, and give instructions about your health care wishes. If you complete an Advance Health Care Directive, you will have to get it notarized. You should also distribute a copy to your health care providers (e.g., your doctor's offices) and tell the person that you chose to have power of attorney where you keep your copy. You can find more information about Advance Health Care Directives and sample forms at the California Attorney General's office at: http://ag.ca.gov/consumers/general/adv_hc_dir.htm .

You have a right to continue receiving care from a health plan under certain circumstances. Your plan can not cancel your plan or refuse to renew your plan if you become sick or disabled. However, your plan can discontinue care if you do not pay your premiums on time, you commit fraud or misrepresent a material fact (for example, you do not disclose that you have a medical condition on your application for insurance), there is good cause for termination under the contract that you made with the plan, you are no longer a member of the group that you received health insurance through, or the insurer is no longer providing new plans or removes a health care benefit entirely from its insurance packages (in both of these situations, the insurer must notify you in advance). Also, if you cancel your insurance policy, your insurer does not have to renew the plan.

3. How to choose a health plan

If you are looking for a health care plan or trying to choose a managed care plan you should try and find a plan that best meets your needs. You may want to consider whether the plan provides coverage for your health

conditions, whether it covers prescription medications that you are taking, whether the plan offers preventative care or educational health programs. You should also consider whether your present doctors and health care providers are part of the new plan. If you need alternative care, chiropractic care, physical therapy, or experimental treatments you should also check to see which plans cover these services.

Additionally, you should consider what kind of premiums, deductibles, and co-payments you can afford. A premium is a monthly payment that you pay to an insurance company to continue receiving insurance coverage. A deductible is a certain amount that you must pay for health care before your health insurance begins to pay. A deductible is generally a once yearly payment amount. A co-pay is a payment that you make directly to your health care provider each time you visit the doctor or get a prescription medication from a pharmacy. If you are low income or you have a disability, you should look into programs that provide health insurance for low income people, such as Medi-Cal and Medicare.

C. When You Cannot Qualify for Private Insurance

If you cannot get insurance due to a pre-existing condition, California has a program called the Major Risk Medical Insurance Program (MRMIP) that may provide you with coverage. With MRMIP, you pay part of the premiums and the state pays another part of the premiums. MRMIP is expensive and generally has a waiting list. You can apply for deferred enrollment in MRMIP if you are not eligible now but expect to be eligible in the near future.

In order to qualify for MRMIP, you must be a resident of California, not be eligible for Part A and Part B Medicare, not be eligible for COBRA or Cal-COBRA, and be unable to get adequate health coverage. “Unable to get adequate health care coverage” means that for the past year you were denied individual health care coverage, your health insurance was involuntarily terminated, you were offered health insurance, but the premium was higher than you would pay for MRMIP, or you were denied group coverage as a business with only one employee.

Your spouse and/or dependent children may also receive coverage from MRMIP. A child is only a dependent until he or she gets married or turns 23.

Coverage for an unmarried child over 23 can continue if that person developed a disability before age 23 that prevents the person from being self-supporting.

MRMIP offers a number of health plans that provide benefits for inpatient and outpatient hospital care and physician services. If you enroll in a PPO plan, your pre-existing conditions will not be covered for the first 90 days. If you are enrolled in an HMO, no health services are covered for the first 90 days. The waiting period may be waived depending on your health insurance circumstances before you enrolled in MRMIP. The annual cap on coverage is \$75,000; the lifetime cap is \$750,000.

If you have a problem with the care you are receiving, eligibility, or coverage with MRMIP, you should follow your managed care or PPO plan's rules for resolving disputes. Then if your dispute is not resolved and is about coverage, eligibility, or a decision to disenroll you or transfer you to a different plan, file an appeal with the Managed Risk Medical Insurance Board. For an application or information about appeals, contact the Managed Risk Medical Insurance Board at 800-289-6574; 888-877-5378 TDD; or 800-400-0815.

CHAPTER 5

CARE DENIALS

Your health plan must provide information materials (such as a Policy Agreement, Evidence of Coverage, or Members' Guide) explaining the criteria for covering medical care. If your health coverage is through an employer, you may receive a Summary Plan Description explaining how the plan works, what benefits are covered, how you can get or lose benefits, and your rights are under a federal law. Each plan may have a different procedure for filing a claim; some plans may have you pay the bill and then reimburse you while others will pay the provider directly. If you have an HMO, a network provider should not bill you directly for services provided as a benefit. If you get such a bill, inform your HMO and the Department of Managed Health Care. Whether or not your plan is through an employer, always be careful to follow the plan's rules for getting your care covered.

If your health care plan will not authorize coverage for the diagnosis or medically necessary treatment of a condition, you should contact your health plan's Member Services Department for assistance. The member services department should tell you why recommended care is or is not covered by your health plan.

If after talking to the Member Services Department, your plan continues to deny, delay, or modify the medically necessary care your provider requested, you have the right to file a grievance. For most issues you must first file a grievance with your health plan. Your health plan must resolve your grievance within 30 business days. If the plan's original decision is upheld or remains unresolved after 30 days, you have the right to file a request for an Independent Medical Review (IMR) through the Department of Managed Health Care. You should contact the California HMO Help Center for assistance in requesting an IMR. Call 888- HMO-2219 / 877-688-9891 (TDD) or visit their website <http://www.hmohelp.ca.gov> . If you have an "imminent and serious" threat to your health, you may contact the HMO Help Center immediately without having to file a grievance with your health plan.