OLDER WOMEN'S HEALTH RESOURCE GUIDE: LEARNING TO DEMAND AND RECEIVE BETTER CARE

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PREFACE

Older Women's Health Resource Guide: Learning to Demand and Receive Better Care is intended to provide background information on basic healthcare rights in California. Receiving and/or reading this booklet does not make you a client of the California Women's Law Center. It is not intended to be, nor should it be relied upon, as legal advice.

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The California Women's Law Center works to ensure, through systemic change, that life opportunities for women and girls are free from unjust social, economic, and political constraints. CWLC programs are designed to enable individuals to use the law that governs their rights and assist them in addressing the legal issues that perpetuate women's growing poverty. By focusing on Gender Discrimination, Violence Against Women, Women's Health and Reproductive Justice, CWLC dedicates its resources to making the constitutional promise of equality a reality, and to protecting the rights of women and girls every day.

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INTRODUCTION

In today's complex healthcare system, it can be difficult to get quality medical care. With healthcare costs rapidly increasing and health insurers eager to contain these costs, health plans often deny coverage for medical services even when these services should be covered. As a result, patients are being discharged from hospitals "sicker and quicker" than before and there are an increasing number of restrictions on the medical treatments that patients can receive.

That's why it's more important than ever for you to be informed about your healthcare rights and options and have the knowledge and know-how to navigate through this complicated system. Knowing your healthcare rights and options means that you have a much better chance of getting the medical care that you need. Studies have shown that patients who speak up to complain and demand better care actually do get better care. They also recover faster.[1]

Knowledge about healthcare rights is particularly important for older women. Older women seek medical care more often than men or younger women. They are more likely to have chronic health conditions, such as diabetes or asthma, which require ongoing medical care, and are more likely to use prescription medications on a regular basis.[2]

Older women are also more vulnerable to the high costs of health care. They are more likely than men to be unemployed, employed part-time or work in jobs that lack healthcare benefits. Women who are financially dependent on their spouses are also vulnerable to losing their health benefits due to separation, divorce, their spouse's retirement, or their spouse's death. With lower incomes in retirement, older women find healthcare costs eating up a larger percentage of their limited incomes.[3]

In addition, older women not only need to make important healthcare decisions for themselves, but they are often also responsible for caring for and making healthcare decisions for other family members.[4] One in 10 women must care for a sick or aging relative.[5] Many others provide primary care for children. In fact, women caregivers are likely to spend 12 years out of the workforce raising children and caring for older family members.[6] Therefore, older women need to know about healthcare rights and options not only for themselves but also in their role as primary caregivers to other family members.

This Guide will hopefully be your first step to getting better care. It is intended to provide you with basic information about your rights to receive quality health care and what steps you can take if you encounter problems. It is meant to educate and empower you to know the law, demand your rights and to be your own, and your family's, best health advocate.

How to Use This Guide

This Guide provides only general information. Challenging the healthcare system can be difficult and often involves complex rules and procedures, not to mention many

exceptions and qualifications to the rules and procedures. For example, different rules may apply depending on whether you get your health care coverage through a group plan or buy coverage for yourself as an individual. If you get your health care coverage through your employer, the rules may be different depending on who your employer is (*e.g.,* private, government or religious), how your employer "funds" or pays for the health plan, and the number of workers your employer employs.

The purpose of this Guide is to provide you with a basic introduction to the *general* rules or the rules that apply in the majority of the cases. Although exceptions and qualifications are sometimes noted, that may not always be the case. If you need information about your specific case, you may want to consult with an attorney. There are also many different resources that can provide more individualized assistance and help you weigh your options and make good decisions. For example, the Health Insurance Counseling & Advocacy Program or HICAP has counselors on staff that can provide you with specific answers to questions about your health coverage. Information for HICAP and other resources are listed throughout the Guide and in the Resources section at the end.

You Need to Speak Up!

To get better care, you need to speak up. If you have problems getting the care you or your family needs, let your health plan know about it. Here are some general tips to get you started:

- **Take notes when you have a phone call or meeting.**
- **Write down the times, dates and names of the people that you talk to and what you talked about.**
- **Keep copies of any letters you send to your health plan and letters the health plan sends to you.**
- **If you are told you can't have the care that you want, ask your health plan to specify the reason they are denying your request in writing.**
- **If the person you talk to is not helpful, ask to speak to a supervisor.**
- **If different people tell you different things about the services you can get, ask to speak to a supervisor.**
- **If you have problems getting the care that you need, ask your doctor to help you. Your doctor's support carries a lot of weight with your health plan.**

USEFUL TERMS

Appeal: A request to review a health plan's decision with which you disagree. An appeal can refer to both review through the health plan's own complaint process and a review by other outside decision-makers, such as the Department of Managed Health Care and independent medical review organizations.

COBRA/Cal-COBRA: Laws that help employees keep their group health insurance if their job ends or their hours are cut.

Co-payment/Co-pay: A fee that you pay for each doctor's visit or prescription.

Coverage: The process by which a health plan determines what health care services or products will be paid for (or covered) by the plan.

Deductible: The amount you pay before your health insurance starts to pay.

Department of Managed Health Care (DMHC): The state agency in California with the authority to regulate health care plans.

Evidence of Coverage (EOC): Your contract with your health plan. The EOC tells you what your plan will and will not pay for.

Expedited Review Process: A shortened or quicker appeal or review process for situations that involve an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb or major bodily function.

Formulary: A list of the prescription drugs covered by your health plan.

Grievance: A complaint by a patient to the administration of a health care plan; such complaints may relate to quality of care, a denial or delay of coverage for a treatment or product or disputes over the amount that a health plan has paid towards health services received.

Group Coverage: Health insurance you get through a group, like your company or union.

Health Maintenance Organization (HMO): A kind of health insurance in which you must get your services from the doctors, labs and hospitals that have contracts with the HMO or work for it.

Independent Medical Review (IMR): An "independent" review of decisions made by health plans that deny patients' request for medical services or treatment. Program is administered by the Department of Managed Health Care.

Lumetra: An organization that contracts with the federal government to provide external reviews of Medicare decisions that are in dispute. Also known as a "Quality Improvement Organization" or QIO.

Maximus Center for Health Dispute Resolution (CHDR): An organization that contracts with the federal government to provide external reviews of Medicare decisions that are in dispute.

Medi-Cal: California's program to help people with low incomes pay for health care.

Medically Necessary Services: Services you need in order to stay healthy, cure a disease, heal an injury, or keep an illness or chronic condition from getting worse.

Medicare: A health insurance program provided by the federal government that covers the cost of health care for people 65 and older and for some younger people with certain disabilities.

Medicare Advantage Plan: A Medicare HMO or other kind of Medicare managed care plan.

Medicare HMO: An HMO that has a contract with Medicare to provide health care services to people with Medicare.

Medicare Part A: The part of Medicare that covers hospital care.

Medicare Part B: The part of Medicare that covers doctor care and lab tests.

Original Medicare Plan: One major type of Medicare plan. It is a fee-for-service health plan that consists of Medicare Parts A and B.

Premium: A monthly fee that you, the company you work for and/or the government pays to your health plan.

CHAPTER 1: MANAGED CARE PLANS

Managed Care Plans

In California, most people now receive their medical care through managed health care plans. Managed care plans contract with different healthcare "providers" which includes doctors, hospitals, and other healthcare facilities to handle your care. The healthcare providers that are selected to contract with your health plan are called a "network." You are expected to go to a doctor or hospital within this network for your medical care, except in emergencies. [7]

Managed care plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs) and point-of-service (POS) plans. Each plan has unique characteristics. HMOs require you to use doctors and hospitals that are in your plan's "network" or part of the HMO plan, except in emergencies. HMOs also require you to choose a primary care physician who will be in charge of your care. In general, before you can seek other types of care, such as seeing a specialist or going to the hospital, you must first get approval from your primary care physician. HMO members also pay a fixed monthly fee, regardless of how much medical care is needed in a given month. Instead of deductibles, members often have nominal co-payments.

PPO members, on the other hand, are not required to seek care from physicians within the "network". PPO plans allow you to see healthcare providers of your choice. However, you will pay less if you use providers that are part of the PPO network. PPO members also do not prepay for medical care – they must pay for services as they receive it.

POS plans combine the characteristics of both HMO and PPO plans. Like an HMO, you pay no deductible and usually pay only a small co-payment when you use healthcare providers within the plan's network. However, POS members can choose to go to doctors outside of the plan's network (with higher costs), like PPO members.

Managed care plans are thought to be a more organized and cost-efficient way of providing and paying for medical care. These plans "manage" care or keep healthcare costs as low as possible by monitoring the medical services that are used by its members and making sure that the requested services are both medically necessary and cost-efficient. Because of the emphasis on cost control and efficiency, there are sometimes financial incentives to limit services. This can result in restrictive practices such as difficulty in accessing physician specialists or specialty drugs.

Your Rights As An HMO Patient

As a member of a managed health care plan, you have many legal rights under California and federal law. For example, as an HMO patient, you have the following rights:

- **You have the right to get needed healthcare services without having to wait too long.**
- **You have the right to see a primary care doctor who is located near you (*e.g.*, generally within 15 miles or 30-minute drive from your home or workplace).**
- **You have the right to a second opinion by another doctor if you disagree with the diagnosis or the way your doctor proposes to treat you. In many cases, your HMO must pay for the second opinion.**
- **You have the right to see a specialist when you need to.**
- **You have the right to choose a gynecologist/obstetrician as your primary care doctor.**
- **You have the right to a quick response when requesting authorization for a medical referral (generally 5 business days or 72 hours for urgent requests).**
- **You have the right to file a grievance with your HMO if you are unhappy with the health care that you receive.**
- **You have the right to an independent medical review of your case.**
- **If it's an emergency, you have the right to get care at any hospital emergency room (without prior approval), even if it's not part of your HMO network.**
- **You have the right to a second opinion from another doctor in certain situations (*e.g.,* when your problem or the cause is unclear; when you have doubts about surgery; when you have doubts about a treatment for a serious problem; or when the proposed treatment is not working).**
- **You have the right to see and get a copy of your medical records. If you believe that the records are incomplete or incorrect, you have the right to add a written addendum.**
- **Your health coverage cannot be cancelled or not renewed because of your health condition or your requirements for healthcare services.** [8]

In general, HMOs must also provide coverage for certain health services for women. For example:

The Women's Health and Cancer Rights Act (WHCRA) protects women with breast cancer who require reconstructive surgery following a mastectomy. WHCRA requires most health plans that cover mastectomies to also provide coverage for:

- **All stages of reconstruction of the breast on which the mastectomy has been performed;**
- **Surgery and reconstruction of the other breast to produce a symmetrical appearance; and**
- **Prostheses and medical care for physical complications of all stages of the mastectomy.**[9]

Similar requirements for reconstructive surgery following a mastectomy are available under California law.[10] For more information on your rights after a mastectomy, call the Department of Health and Human Services at 410-786-1565.

HMOs are also generally required to provide coverage for mammograms, screening tests for cervical cancer, and for the diagnosis and treatment of osteoporosis.[11]

Moreover, as a woman, you can see a gynecologists/obstetrician *without* first getting a referral from your primary care physician.[12]

PROBLEMS GETTING CARE

There are state and federal laws that were specifically created to protect members of health plans. Members of HMOs are protected by a specific set of laws called The Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act").[13] The Department of Managed Health Care ("DMHC"), a state agency, is responsible for making sure that HMOs follow the requirements under the Knox-Keene Act.

Where can I find help?

The DMHC's website (www.dmhc.ca.gov) provides useful information about your healthcare rights. The DMHC also has an HMO Help Center that has a toll-free help line for all California HMO members. You can call 1-888-HMO-2219 24 hours a day, 7 days a week. The staff at the HMO Help Center can help you if you are having problems with your HMO. They may be able to solve your problem with a few phone calls. If you need to file a complaint, they can provide you with assistance. The HMO Help Center offers assistance in several different languages.

You can also write to:
Department of Managed Health Care
980 Ninth Street, #500
Sacramento, CA 95814-2725
Provider Complaints

You can also contact the Office of the Patient Advocate. The goal of the Office is to help HMO members secure the health services to which they are entitled. They also provide useful information on California HMOs. For example, the Office provides a report card that tells you how well HMOs care for their members. The report card also tells you what members think about their HMOs. You can contact the Office of the Patient Advocate by phone at 1-866-HMO-8900 or online at www.opa.ca.gov.

Some general tips to get better care.

TIP: If you are unhappy with an action or decision by your HMO, always ask the HMO to reconsider its response. Many times, health plans first say "no" to requests for certain kinds of care but later change their decision if you complain about the denial.

TIP: If you are worried about some symptoms that you are having and you feel that your doctor is not taking your concerns seriously, you can try the following:

- **First, write on the top of a piece of paper:**

  "From [insert your name]. Please put this in my file."

  Write this about one inch down from the top of the paper so that there will be room for the holes that will be punched when the paper goes into your file. If you have access to a two-hole punch, then pre-punch your paper.

- **Second, write on the next line:**

  "Things I need to talk about with the doctor."

- **Third, write down the problems that concern you.**

  Be specific. For example, if pain is one of the problems, explain when the pain starts or gets worse (*e.g.*, time of day, what you are doing when the pain gets worse). If you have trouble writing down the problems, get someone to help you.

  Give the piece of paper to your doctor (or his or her receptionist) at your next visit. If you are having problems getting an appointment, mail the piece of paper to the doctor or drop it off at his or her office.[14] Your doctor will

take your concerns/problems more seriously if they are documented in writing and made a part of your medical file.

You Have the Right to File a Complaint Against Your HMO

If you are not getting the care that you need, you have the right to file a complaint against your health plan.

- **Internal Grievance Procedure**

All members of a managed care plan (regardless of the type of plan) must be given certain basic information. This includes a general description of the plan and an explanation of medical treatments and services that are or are not covered. Managed care plans must also provide members with information about the plan's "internal" grievance procedures or how members can file a complaint or appeal an unfavorable decision or action by the plan.

- **External Grievance Procedure**

In addition to the "internal" grievance procedure offered directly by the health plan, most states, including California, also provide members of managed care plans with an "external" grievance procedure, often called an "external review." An "external review" is conducted by an entity *outside* of the health plan – an external third party. It provides members with an opportunity to have their dispute or complaint against their health plan reviewed by an entity that is independent of the health plan. The external party conducts an independent review and provides a decision that either upholds the health plan's original decision or finds in favor of the health plan member.

Whom do I contact for an "external review"?

It depends on the type of health plan you have. The majority of California's health plans are licensed and regulated by either the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). These state agencies are responsible for investigating and responding to complaints filed against managed care plans and providing an "external review" process for disputes between members and their plans. The DMHC regulates all HMOs and a few other health care service plans. As such, the majority of members in managed care plans will file complaints with DMHC. CDI regulates POS plans and some PPOs.

How do the "internal" and "external" grievance procedures work together?

The next section provides an example of how the two procedures work. Because HMOs are the most common type of managed care plans, this section will focus on how to file a complaint or appeal an unfavorable decision or action by an HMO. However, many of the health rights and complaint procedures discussed specifically for HMOs are the same or similar to those of other managed care plans.

APPEALING A DECISION BY YOUR HMO

What can I do if I'm unhappy with an action or decision by my HMO?

If you're unhappy with an action or decision by your HMO, you don't have to accept it. You can file a complaint or grievance through your HMO's "internal" grievance procedure and seek an "external" review from the DMHC. In general, you should file a complaint with your HMO first. If your HMO does not respond to your complaint within 30 days or to your satisfaction, you can file a complaint with the DMHC. If your problem is causing a serious threat to your health -- for example, you cannot get approval for a treatment for a life-threatening disease -- you can bypass your HMO's complaint procedure and call the DMHC first. You can also call the DMHC if you just aren't sure what to do.[15]

What can I file a complaint about?

You can file a complaint about many different problems. For example, you can file a complaint if:

- **Your HMO denies or delays medical treatment that you believe should be covered.**
- **Your HMO refuses to pay for medical treatment that you have already received.**
- **Your HMO will not let you see a medical specialist.**
- **You have to wait for a long period of time before you can get a medical appointment.**
- **Your doctor, nurse or other medical staff has been rude to you or treated you improperly.**

How do I file a complaint?

Under California law, your HMO must have a procedure in place to handle complaints from you and other plan members. Your HMO must also provide you with specific written information about how to file a complaint.[16] This information should be in your "Evidence of Coverage" – a written document that explains what is and is not covered by your HMO.

Who can file a complaint?

You can file the complaint on your own. Other people, like your doctor, a family member, or other appointed representative can also file a complaint on your behalf, although you may have to file something in writing to do so. Call your HMO's member services for the exact procedure on how to do this. Often, the HMO will send you a written document that asks for your permission to authorize someone else to file a complaint for you.

Does the complaint have to be in writing?

No. Complaints can be filed by phone or in writing. But, filing a complaint in writing is the best way to document your complaint and make sure that your health plan takes it seriously. Always be sure to keep a copy of the written complaint for your records.

If you file a complaint by phone, be sure to write down the name, date, department, location and phone number of the HMO representative you speak with. Your HMO must have a toll-free number or a local number for you to call to file your complaint.

As of July 2003, every plan with a website is required to have procedures in place so that you can file a complaint online. If you file online, be sure to print out a copy of the completed complaint form and save it for your files.

TIP: Whether you file your complaint online, by phone, or by letter, be sure to make it clear that you are filing a complaint or grievance. Use the specific terms "complaint," "grievance" or "appeal" and tell them clearly that you want the complaint process to begin. Sometimes, health plans will try to argue that a complaint letter or call was simply an inquiry, which does not trigger the complaint process.

How long do I have to file a complaint?

You have at least 180 days following the incident, action or event (that lead to the complaint) to file a complaint against your HMO.

How long does the HMO have to respond to my complaint?

In general, once your HMO receives your complaint, they have 30 days to resolve it. The HMO must also send you a written letter regarding the status of your complaint within 5 days after receiving your complaint. The letter must include the date that they received your complaint, and the name, phone number and address of the HMO representative in charge of your complaint. If you do not receive this letter, contact your HMO and make sure that they received your complaint.

TIP: Sometimes, your HMO will tell you that you must first file a complaint with your medical group (if applicable) before you can file a complaint with the health plan. This is incorrect. You do not need to complain first to your medical group. In fact, you can file a complaint with your health plan AND your medical group at the same time. It is not necessary, but it could help speed things up if you discuss your complaint directly with your medical group, in addition to filing the complaint with your health plan.

What if my HMO does not respond within the 30 day time frame?

If your HMO does not respond to your complaint in a timely manner, you can file a complaint with the DMHC. The DMHC can penalize health plans for failing to follow proper complaint procedures. For example, in some cases, health plans have been fined penalties totaling $10,000 for failing to respond to complaints within the designated 30 day time period. These rules were enacted to protect you. The DMHC will not know about problems unless you alert them.

What if I can't wait 30 days to resolve my complaint?

If your complaint involves an emergency or a serious threat to your life or health, you have two options:

- **File a complaint with your HMO for an "expedited" review.**
- **File a complaint directly with DMHC for an "expedited" review.**

Your HMO must have a quicker complaint process, often called an "expedited review," for complaints regarding urgent matters. In these situations, your HMO must inform you of their decision or the pending status of your complaint within three days from when it received your complaint.

Your HMO must also inform you in writing that you have the right to contact the DMHC directly and request an "expedited" review without going through the health plan's internal complaint procedures for time-sensitive matters.

TIP: The right to an "expedited" or faster review procedure is available in other health plans as well and is not just a right for members in managed care plans. No matter which health plan you have, it is particularly important for you to get your doctor's support in expedited appeals. In some situations, you need your doctor's certification before you can get an expedited review.

What if I'm not happy with how my HMO handled my complaint?

If you're not happy with how your HMO handled your complaint, you can file an appeal with the DMHC. Your HMO must inform you of this right in a written notice. Also, if you need help with a grievance involving an emergency or a grievance that has remained unresolved for more than 30 days, you can contact the DMHC for help.

The DMHC provides complaint forms online (www.dmhc.gov). Telephone assistance is also available through the DMHC's HMO Help Center at 1-888-HMO-2219. The DMHC generally has 30 days from when it receives your request for review to resolve your complaint and will send you a written notice of its decision, including the reasons for the decision. The decision is final, meaning that you may not appeal the DMHC's decision. You can, of course, still pursue any other legal remedies and procedures that are available to you *outside* of this process such as filing a lawsuit. The grievance

procedures provided by your health plan and the DMHC are *in addition* to any other remedies that are available to you.

If the DMHC decides in your favor, your health plan must provide you with the disputed services, pay for your treatment or take any other action required by the DMHC. Moreover, if the DMHC finds that your health plan acted illegally, it could fine the plan with monetary penalties.

Do I have to complete the complaint procedure offered by my HMO or by the DMHC before I can file a lawsuit?

It depends on the type of complaint you have. For general complaints (that don't involve the independent medical review process discussed below), you generally may take legal action against your health plan without completing the complaint procedure offered by your health plan or the DMHC.[17] For complaints that qualify for independent medical review, you generally have to file a complaint with DMHC first before you can take other legal action (see below).

REQUESTING AN INDEPENDENT MEDICAL REVIEW

For some healthcare disputes, you have the right to ask an independent, medical organization to review your HMO's decision.[18] This is part of the "external" review process discussed above.

What is an Independent Medical Review?

Since 2001, the DMHC has offered members in HMOs an Independent Medical Review (IMR) program that allows an *independent* panel of doctors to decide whether your HMO was right or wrong in denying medical services or treatment. This is a way for doctors and other healthcare professionals *outside* of your health plan to make a decision about your health care.

How is the IMR different from the general complaint process?

The DMHC conducts two separate and distinct processes to review your healthcare complaints. The first is the general complaint process, discussed above, that applies to any type of dispute that you may have with your HMO, including disputes regarding whether medical services and benefits are covered by the plan.

The second -- the IMR -- is a more formal, independent review process. The purpose of this second process is much narrower -- it is to help you get care when your health plan decides that you do not medically need a service or treatment.

When can I request an IMR?

You can request an IMR:

- **If you asked for a service and your HMO says that you don't need it ("medically unnecessary").**
- **If your HMO denies you treatment outright, if there has been a delay that amounts to a denial, or if the plan has approved a different type of treatment than the one you requested.**
- **If you asked for an experimental treatment for a serious health problem and your HMO won't pay for it.**
- **If you had emergency or urgent medical treatment but your HMO won't pay for it on the ground that the treatment was not medically necessary.**[19]

In order to request an IMR, a doctor must state that the requested medical treatment is medically necessary. The doctor stating that the treatment is medically necessary does not have to be part of your HMO.

TIP: The key to ANY successful appeal is having the support of your doctor. If your doctor does not agree with you, you may want to switch to another doctor.

Another requirement is that the service that you are requesting is a covered benefit under your health plan. For example, if prescription drug coverage is not a benefit that is offered under your health plan, then you cannot request an IMR to challenge a decision denying coverage for an experimental prescription drug.

Do I have to complete my HMO's complaint process before I can get an IMR?

In general, yes. Once the HMO issues its initial decision (*e.g.*, denying your request for treatment), you must file a complaint with the HMO. In most situations, the IMR process can be initiated only if the denial is upheld by the HMO or the complaint has not been resolved within 30 days.

Is there a quicker procedure for complaints that involve emergencies?

There is a speedier, or "expedited," review process for complaints that involve health emergencies or health issues that pose a serious threat to your life and health. In such circumstances, you are required to participate in your health plan's complaint process for no more than three days before the IMR process can be started.[20] In some extraordinary cases, you may skip your HMO's complaint process entirely and request an IMR immediately.[21]

There is also a special review process for disputes that concern medical treatments that are considered to be experiments or investigational.[22] For more information, visit the DMHC website at www.dmhc.ca.gov.

Who decides if the treatment decision is subject to an IMR?

The DMHC gets to decide whether the claim is entitled to the independent review process or limited to the general grievance process.[23]

How can I request an IMR?

Your health plan must provide you with an application form when it notifies you of their decision to deny your requested health services. You can also call the DMHC's HMO Help Center at (888) HMO-2219. The Help Center staff will help you with the review process and let you know if you qualify for an IMR. Remember, not all disputes qualify for an IMR. You must ask for review within 6 months after your HMO denies your request.

When will a decision be made?

The IMR will generally be completed within 30 days (once you qualify for the review program) – or sooner if your problem is urgent. You do not attend the review and there is no application or processing fees.[24]

If the decision is in my favor, does my health plan have to provide the treatment?

Yes. If the independent review finds that the healthcare service should be provided, the health plan is **required** to provide the service to you or pay you back if you already got the service and paid for it yourself.[25]

What if the decision is not in my favor?

If you are unhappy with the decision from the independent review process, you may be able to take further action against your HMO. For example, you have the right to sue if you've suffered serious bodily harm. You must refer to your HMO's coverage plan to determine what legal remedies are available to you. Most health plans limit you to binding arbitration, which resolves cases out of court. Before you take any action, you should talk to a lawyer.

Do I have to complete the complaint procedure offered by my HMO or by the DMHC before I can file a lawsuit?

In general, you must go through the independent review process offered by the DMHC before you can file a lawsuit against your HMO. There are exceptions. If you have been or are in danger of being seriously harmed by your health plan's actions, you do not have to use the independent review process.[26] For example, if you need surgery right away and you may die or be seriously harmed without the surgery, and your health plan has denied coverage for the surgery, then you can go ahead with the surgery without using the independent review process before filing a lawsuit to recover what you had to pay for the surgery.

Are IMR decisions available to the public?

Yes. The DMHC has an online database of independent medical review decisions since the program began in 2001. It is helpful to review these decisions, especially if you have requested an independent review, because it can help you prepare for your own claim. The database allows you to search the database by diagnoses and treatments, so you can search for cases similar to your situation. This will help you focus on the important issues and prepare for your claim accordingly.

Example of IMR Decision Regarding Testing for Breast Cancer

- One case involved a patient who developed breast cancer at a relatively young age. The patient had a "significant" family history of breast cancer. She requested authorization for BRCA1 and BRCA2 genetic testing – a testing method that can determine whether a patient carries a gene mutation which puts them at an extremely high risk of developing both breast and ovarian cancer. The patient's HMO denied the request stating that the genetic testing was not medically necessary. However, a review by an independent physician overturned the HMO's denial and found the genetic testing to be medically necessary. The independent physician's decision was based on the fact that the patient had multiple family members with a history of breast cancer.

Example of IMR Decision Regarding Drug for Menopause

- In another case, a patient requested the prescription medication Evista, a drug not on her health plan's approved drug list, to treat symptoms due to menopause. The HMO denied the request stating that Evista is not medically necessary for the treatment of menopause and no documentation existed in the patient's medical records to indicate that she had tried other drug alternatives on the HMO's approved drug list and that those alternatives had been ineffective. A review by an independent physician upheld the HMO decision and denied the patient's request. The independent physician noted that Evista is indicated for the treatment of osteoporosis in postmenopausal women, yet no documentation in the patient's medical records indicated that she suffered from osteoporosis. Therefore, the independent physician found that the use of Evista was not medically necessary for her menopausal symptoms.

Health Plans Regulated by the Department of Insurance

What if my health plan is regulated by the California Department of Insurance ("CDI")?

The DMHC does not regulate all managed care plans. Some plans (*e.g.,* certain PPOs and POS plans) are regulated by the CDI. If your managed care plan is regulated by the CDI, you must file any complaints you have with your health plan to this agency, and *not* DMHC. If you don't know which state agency regulates your health plan, you can call

the DMHC at 1-888-HMO-2219 or the CDI at 1-800-927-HELP and ask a representative for this information.

How can I contact the CDI?

Here's how to contact the CDI:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013

Consumer Hotline:	1-800-927-HELP (4357) or 213-897-8921
TDD Number:	1-800-482-4TDD (4833)
Website:	www.insurance.ca.gov

How do I file a complaint with the CDI?

In general, before you file a complaint with the CDI, you need to first contact the health plan directly and try to resolve the problem. If you don't receive a satisfactory response from your plan, you can file a complaint with the CDI. To file a complaint, you need to submit a document called a "Request for Assistance" form. You can get a copy of the form by contacting the CDI at the information above or print a copy from the CDI's website at www.insurance.ca.gov.

Do I need to file any other documents besides the Request for Assistance form?

Yes. You need to attach copies of any important papers that relate to your complaint. For example, important papers might include relevant pages from your health insurance policy, cancelled checks, letters of claim denial or other communications with your health plan. Do not send the originals. Copies are fine.

What happens after I file a complaint with CDI?

Someone from the CDI will contact you about your complaint. If it has been more than 10 business days since you filed your complaint and you have not heard from CDI, call the Consumer Hotline listed above.

Does the CDI provide an external review process for healthcare disputes like the Department of Managed Health Care?

Yes. The CDI also provides an Independent Medical Review program where one or more independent doctors outside of your health plan can review a denial made by your health plan. A faster or "expedited" review process for urgent health matters is also available. The procedures for requesting an Independent Medical Review are similar to those discussed above for HMOs.[27]

Health Plans and the "ERISA" Factor

If your healthcare coverage is provided by a private employer, your healthcare appeal rights may be affected by a federal law known as the Employee Retirement Income Security Act or ERISA.[28]

What is ERISA?

It is a federal law that applies to all employee benefit plans provided by a private employer, including healthcare coverage benefits and union pension plans.[29]

Who is subject to ERISA?

Almost anyone who receives their health insurance through a private employer is subject to ERISA.[30] If you are self-employed, you are only subject to ERISA if you also employ others and provide them with health insurance through your plan.[31]

Who is *not* subject to ERISA?

The following individuals are *not* subject to ERISA:

- Employees of a government agency (federal,[32] state, county or municipal).
- Employees of a church and organizations related to the church (*e.g.*, church-run school or hospital).
- Individuals who purchase their own health insurance policies (and not through an employer).

How does ERISA apply to my health plan?

ERISA may restrict your ability to challenge your health plan's denial of benefits under state law, and instead, require you to bring a federal law claim under the procedures and remedies established by ERISA.

If I am subject to ERISA, can I still be protected by California laws?

It depends on how your employer funds the cost of health care. Only those who are in "self-funded" ERISA plans, meaning that their employer funds the cost of health coverage without using an HMO or insurer to finance the treatment, are totally restricted from using California law, and are limited to ERISA remedies. For "self-funded" health plans, ERISA pre-empts or trumps state law requirements and protections.[33] It is estimated that approximately 40% of those with health insurance are enrolled in self-funded plans, but exact numbers are not known.[34] Some individuals who work for large national companies have self-funded health plans. If you are not sure whether your employer has a self-funded health plan, ask your employer's human resources director or other person in charge of employee benefits.

If I am limited to ERISA remedies, what are my rights if my health plan denies my request for healthcare services?

Because some of your rights under state law may be superseded or pre-empted by ERISA, you should understand how to bring an action for denials of coverage under ERISA. Here is a general guide for pursuing claims under ERISA:

> Your health plan must give you written notice of the denial. The notice must include the reasons that your request for benefits was denied and information on the steps you need to take if you want to challenge the denial and request that your claim be reviewed - called an appeal.[35] You are entitled to a full and fair review as long as you file your appeal within 180 days of the denial notice.[36] For more specific information on how to file an appeal under ERISA, ask your employee benefits manager.
>
> The amount of time that your health plan can take in deciding your appeal depends on the nature of your claim, but is generally 30 or 60 days.[37] If the benefit you were denied qualifies as "urgent care," you must receive a decision within 72 hours.[38] In any case, you must receive a written decision which sets forth the specific reasons your appeal was denied and information on available procedures to further pursue the appeal.[39]

What can I do if my appeal is denied?

First, you have to participate in any and all internal review remedies offered by your health plan. You then have a right to file a lawsuit under ERISA.[40]

If I decide to file a lawsuit under ERISA, how will it differ from a lawsuit filed under California law?

The amount of money you can recover may be limited to the actual cost of the treatment or service that was denied.[41]

For example, if you need treatment for breast cancer and your health plan wrongfully refuses to pay for it, California law may allow you to recover for the cost of the actual breast cancer treatment *and* other expenses and losses, such as money damages for the emotional distress you suffered as a result of your health plan's misconduct. In contrast, under ERISA, all you would be able to recover is the actual cost of the treatment for the breast cancer.

Where can I go for help?

For more complete information on how to file an appeal under ERISA, ask your employer's benefits manager or contact an attorney. You can also contact the U.S. Department of Labor, Employee Benefits Security Administration (DOL-EBSA) at 1-866-444-3272 or view general information about ERISA and the steps to filing a claim

for benefits at www.dol.gov/dol/pwba. Assistance is also available from the following organizations:

- Patient Advocate Foundation (800) 532-5274 or www.patientadvocate.org.
- Center for Health Care Rights (213) 383-4519 or www.healthcarerights.org.
- Health Care For All (415) 695-7891 or www.healthcareforall.org.

What If I Have Problems Speaking and Understanding English?

You have the right to an interpreter when you need one. There are state and federal laws that require health plans to provide language assistance services, including interpretation and translation services, to individuals who have difficulty speaking or understanding English.[42] The type of assistance a health plan has to provide depends on the type of health plan you have, your specific healthcare needs and other factors, such as the number of non-English speaking individuals in your community.

In general, you have the right to an interpreter when you need to do the following:

- **Explain your symptoms or medical history to your doctor.**
- **Understand your health problem or treatment choices.**
- **Understand instructions about medications, medical equipment or follow-up care.**

If you need language services, be sure to call your doctor before the visit to ask for an interpreter.

Do I have to pay for interpreter services?

This service is usually free – check with your health plan.

Health Plans with Available Language Services

The following managed care plans provide free interpreter services to their members:

Aetna	(800) 624-0756
Blue Shield	(800) 431-2809
Blue Cross:	
Medi-Cal	(800) 407-4267
Healthy Families	(800) 845-3604
CIGNA	(800) 832-3211
Health Net	(800) 522-0088
Kaiser	(916) 614-4050
Molina	(562) 435-3666
Partnership Health Plan Of California	(800) 863-4155
Western Health Advantage	(888) 563-2250

The California Medical Association

The California Medical Association also provides a directory of community volunteers who can provide interpreter services as a safety net for those situations when other interpreter resources are unavailable. You can access this service by calling (866) 241-4CMA. For best results, arrangements for interpreter services should be made well before your scheduled visit.

Where can I get additional help?

For more information on your right to interpreter and translations services, contact the National Health Law Program:

Los Angeles Office
1101 14th Street, NW Suite 405
Los Angeles, CA 90034-2675
PH: 310-204-6010
FAX: 310-204-0891
nhelp@healthlaw.org

Washington, DC Office
2639 South La Cienega Boulevard
Washington, DC 20005
PH: 202-289-7661
FAX: 202-289-7724
nhelpdc@healthlaw.org

CHAPTER 2: THE MEDI-CAL SAFETY NET

For many Californians, getting private health insurance is not an option. This is particularly true for older working women. More than half of employed women over 50 work in service sector jobs that typically pay low wages, offer no benefits, and provide little job security or opportunity for advancement.[43] After paying the bills, there is often no money left to pay for necessities like health insurance.

California provides a small number of safety-net programs that help people, who could not otherwise pay for medical services, get basic care. Medi-Cal is the most comprehensive of these programs.

What is Medi-Cal ?

The federal Medicaid program provides funds to states to set up their own health insurance programs for low-income individuals. In California, this program is called Medi-Cal. You may qualify for Medi-Cal if you are low-income and have a dependent child or if you are aged, blind or meet Medi-Cal's definition of "disabled." In order for Medi-Cal to cover your medical expenses, you must use health providers that accept Medi-Cal.

Who can get Medi-Cal?

People in many different situations can qualify for Medi-Cal benefits. If you receive certain types of cash assistance, such as Supplemental Security Income, Refugee Assistance, Foster Care or Adoption Assistance or CalWORKs, you may automatically qualify for Medi-Cal benefits. Even if you don't meet the strict financial need requirements to receive cash assistance, you may still be eligible for Medi-Cal if you have limited resources and you are one of the following[44]:

- **65 or older;**
- **Blind;**
- **Disabled;**
- **Diagnosed with breast or cervical cancer;**
- **The parent or caretaker relative of a child under 21; or**
- **In a skilled nursing or intermediate care facility.**

Even if you are not eligible for regular Medi-Cal because you either make too much money to qualify or do not fit into one of the special categories listed above, you may still be eligible for Medi-Cal with a "share of cost." A share of cost is similar to a deductible. You must pay your share of cost in any month you incur medical costs. Once you pay your share of cost, Medi-Cal will pay the rest of your covered medical bills for that month. A share of cost, however, is *not* a monthly premium – it is due only in the months you have medical costs. The amount of your share of cost is based on your monthly income.

Your local County Welfare or Social Services Department manages Medi-Cal eligibility determinations and can tell you if you are eligible for Medi-Cal benefits. You can also find more detailed information on Medi-Cal eligibility at www.healthconsumer.org.

What does Medi-Cal cover?

Medi-Cal pays for "medically necessary" health care which includes: hospital care, doctor visits, lab tests, prosthetic and orthopedic services, medical equipment, ambulance services, dental care and hospice care.

It is also the prime source of coverage for individuals needing long-term nursing home care and adult day care. In California, nursing home care costs exceed $40,000 a year and many of these residents rely on Medi-Cal benefits to cover these costs. Neither Medicare nor commercial health insurance plans provide coverage for long-term care in a nursing home. In contrast, Medi-Cal generally will pay for much longer stays in a nursing home, as long as you remain financially eligible and continue to need the care. Financing the cost of long-term nursing home care can be a complex endeavor with many factors to take into consideration. If you can afford it, you should contact an attorney that specializes in elder law. You can also contact the Health Insurance Counseling and Advocacy Program ("HICAP") for assistance (800-434-0222). HICAP is a network of community-based programs that provide free education, counseling and assistance to Californians about health and prescription drug insurance coverage.

Gender Fact: Medi-Cal offers breast and cervical cancer detection and treatment programs. You can access these services even if you don't qualify for full Medi-Cal coverage. For example, the following programs are offered through Medi-Cal:

Cancer Detection Program: Every Woman Counts

This program provides free *screenings* for breast and cervical cancer for uninsured women. To qualify for free screenings, you must meet the following requirements:

- **40 or older [for breast cancer]; 25 or older [for cervical cancer];**
- **No health insurance or have a high insurance deductible or co-payment; and**
- **Must be at or below 200% of the Federal Poverty Level (*e.g.*, annual income of $33,200 or less for a family of 3 in 2006).**[45]

For more complete information on program services and requirements, call the Every Woman Counts Program at (800) 511-2300.

Breast & Cervical Cancer Treatment Program (BCCTP)

This program provides free breast and cervical cancer *treatment* services. To qualify, you must meet the following requirements:

- **Diagnosed with breast or cervical cancer and be in need of treatment;**
- **Must be at or below 200% of the Federal Poverty Level (*e.g.,* annual income of $33,200 or less for a family of 3 in 2006);[46] and**
- **Uninsured or underinsured (underinsured means you have insurance but you would have to pay over $750 per year in co-payments, premiums or deductibles).**

Only healthcare providers who are part of two particular programs can submit an application to enroll a patient into this program. These programs are Cancer Detection Programs: Every Woman Counts, mentioned above, and Family PACT, a state program which provides family planning services to eligible low-income residents. If your provider is not in one of these programs, you can call the free BCCTP Hotline number below and ask for a list of providers who are.

Some individuals may be eligible for full Medi-Cal benefits for the duration of their treatment if they meet certain federal requirements (female, under age 65, no health coverage, diagnosed with breast or cervical cancer, and need treatment).

For more complete information about program services and requirements, call the BCCTP hotline at 800-824-0088.

APPEALING MEDI-CAL DECISIONS

There are many potential problems that you may have with your Medi-Cal plan and depending on the problem at issue, your particular health history and the type of Medi-Cal plan you have (*e.g.,* whether you have a Medi-Cal managed care plan or have both Medi-Cal and Medicare), different rules may apply.

A number of resources can provide you with important information about the Medi-Cal appeals process and what you need to do in specific circumstances. The Health Consumer Alliance provides easy to understand information, including detailed manuals, about the Medi-Cal appeals process at www.healthconsumer.org. The Western Center on Law and Poverty also provides many useful publications about Medi-Cal at www.wclp.org.

In general, if you disagree with an action taken by Medi-Cal, you have the right to request a **Fair Hearing**.

How do I request a Fair Hearing?

If you are told that your Medi-Cal benefits will be taken away or that you cannot receive Medi-Cal, you have the right to have someone outside of the plan hear your story and decide what is right. Medi-Cal hearings – like other state benefits hearings – are heard by an administrative law judge (ALJ) from the State Hearings Division of the Department of Health Services.[47]

TIP: You are in a much stronger position to request a Fair Hearing when your doctor requests an authorization for a treatment or service and it is denied (as opposed to when your own doctor will not make a referral).

How does the Fair Hearing process generally work?

Here's how the process works, using a common problem as an example. Many Medi-Cal beneficiaries are denied medical services, even when those services are prescribed by doctors. Medi-Cal does so by denying a Treatment Authorization Request ("TAR"). In denying a TAR, Medi-Cal will generally claim that the medical services are either not medically necessary or are not covered under the state Medi-Cal plan. If this happens, you have the right to request a Fair Hearing and challenge this decision.[48] Hearing requests that deal with denied services are called "scope" hearings.

How will I know if my request for Medi-Cal benefits has been denied?

Medi-Cal must send you and your health provider a written notice of denial, called a "Notice of Action," which must explain why your request was denied and provide you with information on how to appeal the denial.[49]

TIP: Be sure to save the envelope from the Notice of Action. The date is important (discussed below) and you may want to show it to the ALJ during the Fair Hearing.

What if I'm already receiving services and Medi-Cal decides to reduce or stop my treatment?

Before Medi-Cal can terminate or reduce ongoing medical services, it must give you and your provider notice of this decision at least 10 days in advance. If you appeal during this 10-day period or before your services are reduced or terminated, Medi-Cal must continue your services until your hearing. This is known as "Aid Paid Pending."[50] Be sure to tell the state hearing office when you request a hearing that you want the service to continue until a decision is made on your case.

How long do I have to request a Fair Hearing?

You generally have 90 days (not 3 months) from the date of your Notice of Action to appeal the decision and request a Fair Hearing.[51] If you do not receive a written Notice

of Action, you have 90 days from the date the decision or action you disagree with occurred.[52] If you miss the 90 day deadline, consider making a new request for the services and then appealing the second denial.

TIP: In deciding whether or not to appeal, be sure to review the TAR that was sent in by your medical provider. Medi-Cal's decision on whether or not to approve your TAR is based on the information in the TAR and its supporting documents. If the TAR does not include a detailed letter from your doctor explaining why you need the service or other documents explaining why the service is medically necessary, it might be faster for you just to start the process over again by filing a new request – this time with adequate support that specifically documents your need for the service.

If there is good documentation on why you need the requested service, request a Fair Hearing right away.

How do I request a Fair Hearing?

You can request a Fair Hearing in writing, by phone or both. The Notice of Action should provide you with information on how to file a Fair Hearing request. You can also call your local welfare office or your eligibility worker for information on how to file. If you mail your request, be sure to include your name, address and telephone number, the name of your health plan, your social security number and a statement about what you feel is wrong and why.

TIP: If you have difficulty speaking or understanding English, be sure to include this information (specify your native language and dialect) in your request for a Fair Hearing. If you notify the State Hearings Division before your hearing that you need language services, a state-approved interpreter will be present at your hearing at no cost to you to assist you.[53]

Do I have access to any documents before the Fair Hearing?

You are allowed to have a copy of the county's typewritten position statement two working days before the hearing.[54] The position statement explains what the county has done and the reasons for its action. Call your county appeals unit to confirm that the position statement is ready.

If the papers are not ready or if the county makes substantial changes to the papers after giving them to you, you have the right to have the hearing postponed for good cause. This means that your hearing will be rescheduled and any aid pending the hearing will be continued.[55]

You also have a right to submit a written statement explaining your position on the matter. Both your statement and that of the county will become part of the hearing record and will be reviewed by the ALJ.

You also have the right to look at your case records and the regulations before the hearing. Call your county appeals unit to arrange this review.

You can also issue a subpoena for important documents or persons.

If you want to have a person or papers important to your case at your hearing, you may request that a subpoena be issued. A subpoena is a court order which requires a person to attend a court hearing or hand over specified documents. To request a subpoena **before** the date of the hearing, write or call the office listed below which is closest to you:

State Hearings Division
P.O. Box 944243
M.S. 19-44
Sacramento, CA 94244-2430
(916) 229-4187 (phone)

State Hearings Division
355 West Grand Ave., Suite 4
Escondido, CA 92025-2649
(760) 735-5070

State Hearings Division
Bay Area Regional Office
1515 Clay Street, #1203
Oakland, CA 94612
(510) 622-4000

State Hearings Division
2550 Mariposa Mall, #3088
Fresno, CA 93721
(559) 445-5775

State Hearings Division
811 Wilshire Boulevard, Suite 1118
Los Angeles, CA 90017
(213) 833-2200

You must tell the hearing office the name of the person or describe the documents you want subpoenaed, and explain why the person or documents are important to your hearing. The ALJ in your case will decide if a subpoena should be issued. It is your responsibility to deliver or "serve" the subpoena to the person that you want to be at your hearing or the custodian in charge of the documents that you need. In general, anyone other than yourself, can deliver the subpoena to the required individuals.

When will I find out the hearing date?

The Department of Health Services will set the hearing date within 30 working days after your request for a Fair Hearing is filed. At least 10 days before the Fair Hearing, the Department will send you a written notice specifying the time and place of the hearing.[56]

Where are hearings usually held?

Hearings are usually held at public buildings in the county. If you can't attend the hearing at the hearing location because of poor health or a disability, the hearing may be held in your home or in another agreed upon location, but you may have to provide

medical verification of your health or disability. The hearing can also be by telephone, but only with your agreement.

Who will be at the Fair Hearing?

Basically, you, a representative of the county and the ALJ will be at the Fair Hearing. It is not a court hearing and is not open to the public. You may have an attorney or other representative present with you at your own cost.[57] You may also bring witnesses.

You should be prepared to present your best case at the hearing. You will have an opportunity to tell the ALJ why you believe your medical services should not be reduced or terminated. The county representative will have an opportunity to state why the action was taken and try to prove that the action is correct. You and the county representative can question each other and any witnesses.

When will a decision be made?

The ALJ will generally issue a *proposed* decision to the Director of Health Services who will either adopt the decision, issue his/her own decision or order another hearing.[58] If the Director adopts the proposed decision or issues his/her own decision, that decision is binding and the county must comply with the decision immediately, even if a rehearing is requested.[59]

Federal regulations require Fair Hearing decisions to issue within 90 days of the Fair Hearing request.[60]

What if I'm unhappy with the Fair Hearing decision?

If you are unhappy with the decision, you can request a rehearing within 30 days of receiving the decision. Instructions on how to request a rehearing are provided in the decision notice. Your request for a rehearing may or may not be granted.[61]

What if I'm unhappy with the rehearing decision or my request for a rehearing was denied?

If you are still unhappy with the rehearing decision, you can ask for a review by a judge by appealing to the Superior Court within one year after receiving notice of the Director's final decision.[62]

For more complete information on the Medi-Cal appeal process, you can obtain a copy of "Your Rights under California Welfare Programs" (Pub 13) at your county welfare office or online at www.cdss.ca.gov.

What if I have a Medi-Cal managed care plan?

If you have a Medi-Cal managed care plan and you disagree with a decision or action taken by the health plan, you can do the following:

- **File a complaint or grievance directly with the health plan.**
- **File a request for a Medi-Cal Fair Hearing.**
- **File a complaint with the Department of Managed Health Care (if applicable).**

If you are a member of a Medi-Cal managed care plan, you have access to the plan's complaint procedure (discussed in Chapter 1). You do not have to go through the plan's complaint procedure first before filing a request for a Medi-Cal Fair Hearing. You may pursue both options at the same time. In fact, even if you file a grievance with your health plan, you should also request a Fair Hearing. You should never file a grievance instead of or in place of asking for a Fair Hearing because you could lose important rights. You should always file for a Fair Hearing – you can always withdraw your request if you get what you need.[63]

If your Medi-Cal plan is covered by the Knox-Keene Act, you have additional rights. You generally have the same consumer protections as other members with private insurance covered under the Act (see discussion in Chapter 1). You can also file a complaint with the Department of Managed Health Care (DMHC) if you have problems with your health plan. Visit the DMHC's website at www.hmohelp.ca.gov or call 1-888-HMO-2219 to find out if your plan is regulated by the Department and to file a complaint.

What other actions can I take?

If you are having problems, you can also do the following.

- **File a complaint with the county.**
- **Reapply for the denied Medi-Cal benefits.**

How can I file a complaint with the county?

You can file a formal complaint against the county with the California Department of Social Services. To file a complaint, call or write:

Public Inquiry and Response
P.O. Box 944243, M.S. 6-23
Sacramento, California 94244-2430
(800) 952-5253 (voice)
(800) 952-8349 (TDD)
(916) 229-4110 (FAX)

You should specifically state that you want your problem to be handled as a "complaint" and give the specific reason for the complaint. Social Services will contact the local county welfare department about your complaint and the county will look into the matter. If the county finds that your complaint has merit or that an error has been made, your complaint may be settled without further action on your part or the part of Social Services.

What if I have problems speaking or understanding English?

If you have problems applying for or receiving Medi-Cal benefits because of language barriers, you have a right to interpreter services provided by the county. If your county welfare office does not have an employee who speaks your native language, call 1-800-952-5253 for assistance.

Where can I go for additional help?

For more information on the Medi-Cal appeal process and strategies to prepare for the hearing, the Western Center on Law & Poverty has helpful written materials on online at www.wclp.org. You may also obtain a list of legal services representatives, voluntary legal service persons or welfare rights organizations that can provide you with more information about the Medi-Cal program from your local county welfare office.

CHAPTER 3: AS YOU AGE – INSURANCE ISSUES FOR THE MORE SENIOR WOMAN

As you get older, you will need to know about Medicare for your own health care. You may also need this information as a caregiver for an older family member.

What is Medicare?
Medicare is a health insurance program funded by the federal government and is generally available to:

- **Individuals age 65 and older; or**
- **Individuals under age 65 with certain disabilities.**

Gender Fact: Women comprise the majority of Medicare beneficiaries because they live longer than men. The costs of Medicare premiums, deductibles, coinsurance and medications have a greater impact on women because women over 65 have disproportionately lower incomes than men of the same age.[64]

In general, to be eligible for Medicare coverage, you (or your spouse) must have made certain contributions through payroll deductions to the Social Security program. Medicare coverage is in essence a health insurance policy that you purchased through premiums that were deducted from your payroll checks. You will automatically be enrolled in Medicare if you are receiving Social Security benefits at age 65. If you are entitled to, but not receiving Social Security benefits, you must apply for Medicare within the enrollment period (which begins three months before you turn 65) because your enrollment will not be automatic.[65]

Eligibility is not based on your income level or assets. This means that there is a cost-sharing -- you have to pay for deductibles, co-payments and, in some cases, a monthly premium. Medicare then pays the rest of the amount for covered services.
In addition, individuals who are not otherwise eligible for Medicare, but who are over age 65, may purchase coverage by paying a monthly premium.[66]

MEDICARE: PARTS A, B, C and D

Medicare has four components: Part A (Hospital Insurance), Part B (Medical Insurance), Part C (Medicare Advantage Plans) and Part D (Prescription Drug Plan). Medicare provides its services through several plans, which fall into two main categories: the Original Medicare plan and the Medicare Advantage plans.

Original Medicare Plan

The Original Medicare plan is a fee-for-service plan and consists of Parts A and B.

- Medicare Part A is referred to as Hospital Insurance and basically covers inpatient care in hospitals, some skilled nursing and home health care and hospice care. If you automatically qualify for Medicare (through your own or your spouse's Social Security record), you do not have to pay a monthly premium for Part A coverage. If you do not automatically qualify, you must pay for some or all of the monthly premium ($393 in 2006).

- Medicare Part B is referred to as Medical Insurance and it provides coverage for additional medical services – it may cover doctors' services, outpatient hospital care, some ambulance services, physical and occupational therapy, medical equipment, and some home health care. Enrollment in Part B is voluntary. To enroll, you must pay the Part B monthly premium ($88.50 in 2006).

Gender Fact: In general, women who have the Original Medicare plan can get a Pap test, pelvic exam and clinical breast exam once every two years. In terms of payment, women must pay 20% of the Medicare-approved amount for these services and may also have to pay for any portion of the costs that Medicare did not approve.[67]

Medicare Part C: Medicare Advantage Plans

The Medicare Advantage or MA plans are part of the overall Medicare program and are referred to as Part C of the program. MA plans are an alternative to the Original Medicare plan and include four different types of plans:

- **Medicare Health Maintenance Organizations;**
- **Medicare Preferred Provider Organizations;**
- **Medicare Private Fee-for-Service plans; and**
- **Medicare Special Needs plans.**

MA plans contract with Medicare on an annual basis. Medicare pays the MA plan a fixed monthly amount for each Medicare member. In return, the MA plan must provide all Medicare-covered services. In order to join one of these plans, you have to have Medicare Part A and Part B and you must continue to pay the Part B premiums. Once you join one of these plans, you receive all of your Medicare-covered benefits through the plan. These benefits can include prescription drug coverage.

MA plans cover more services than the Original Medicare plan, including preventive care, and hearing, dental and eye exams. They also have lower out-of-pocket costs than the Original Medicare plan. However, you generally have to see doctors that belong to the plan or go to certain hospitals to get services.

For example, Medicare through Health Maintenance Organizations or Medicare HMOs are the most popular kinds of MA plans in California. Medicare HMOs provide comprehensive health care to members who have Medicare Parts A and B. If you join a Medicare HMO, you are still on Medicare, and you retain the full rights and protections of the Medicare-eligible person. However, when you enroll in a Medicare HMO, you will be required to use only doctors and facilities that contract with that particular HMO. You will have a primary care doctor who manages your healthcare needs and you will generally need to get a referral from your primary care doctor before you can see a specialist.

Gender Fact: Women who have Medicare HMOs can get a mammogram screening once a year.

Medicare Part D: Prescription Drug Plan

In January 2006, Medicare began providing drug coverage through a new Part D prescription drug plan. The new Part D drug benefit is offered through private insurance plans. There are two main ways to get Medicare prescription drug coverage. The majority of Medicare beneficiaries who remain in the Original Medicare plan will be able to purchase drug coverage through prescription drug plans that offer only prescription drug coverage. Others can get drug coverage under a Medicare Advantage plan or other Medicare Health plan that offers drug coverage.[68]

Like other insurance plans, the Part D drug plans require a monthly premium and a yearly deductible. You will also pay a part of the cost of your prescriptions, including a co-payment or co-insurance.[69]

Participation in the Part D program is voluntary, except for those Medicare beneficiaries who are also eligible for Medicaid benefits. Those who are eligible for both programs are automatically enrolled in a Medicare Part D plan, if they do not choose a program on their own. Moreover, beginning in January 2006, Medicaid officially stopped providing prescription drug coverage for beneficiaries that are eligible for both programs.[70]

Part D requires beneficiaries who want drug coverage to actively enroll in a prescription drug plan during specific time periods. That means that if you want the drug benefit, you have to choose a drug plan from the options that are available in your area and then enroll in that specific program. There are financial penalties if you miss these time frames and enroll late. [71]

Part D allows you to choose from a variety of prescription drug plans. Keep in mind, however, that these private insurance plans vary – in the amount of their premiums, deductibles, co-payments, and importantly, the prescription drugs that they cover. Part D drug plans are given wide discretion to establish their own drug formularies or the list of covered drugs that they will pay for. Moreover, the new Part D program provides a low-income subsidy or "extra help" to assist with premiums and other cost sharing to beneficiaries with incomes up to 150% of the federal poverty level (*e.g.*, $24,900 for a

family of three in 2006).[72] The amount of financial help you get will vary depending on your income and other factors.

The new Part D program is complex and can be quite confusing. Moreover, it is important that you choose the right drug plan that best meets your specific needs. Choosing the wrong plan could result in significant out-of-pocket costs to you and your family. Therefore, before you enroll in a plan, do the research. Resources are available that can help you make an informed decision. You can start by calling the Health Insurance Counseling and Advocacy Program ("HICAP") at 1-800-434-0222 and speaking with a counselor or calling 1-800-MEDICARE (633-4227).

What is Medigap?

The Original Medicare plan is not a comprehensive healthcare plan; there are gaps in coverage. It does not cover all the healthcare services you may need. Medigap is a supplemental health insurance that can help pay some of the expenses that are not covered by Medicare. It is one option for supplementing or filling the gaps in Medicare.

For example, Medicare will only pay for, at most, 100 days of skilled nursing home care. Of those 100 days, only the first 20 days are paid in full. For days 21 through 100, the beneficiary must pay a daily co-payment of $119 (for 2006).[73] Many Medigap policies will cover this co-payment. You must be enrolled in Medicare Part B in order to buy a Medigap policy.

Medigap plans are sold by private insurance companies. There are different Medigap benefit packages you can choose from, although all of them must include certain basic benefits. Your premiums depend on the company that issues your policy. Some companies base premiums on your age; others don't. Some charge more for smokers and others offer a variety of discounts. You need to research the different plans and choose the one that is most beneficial to you.

As of 2006, new Medigap policies cannot offer prescription drug coverage because Medicare now handles such coverage through Part D.

What if I have an employer-based health plan and become eligible for Medicare?

Faced with soaring healthcare costs and shrinking retirement plans, many older individuals have either come back to the workplace or simply stayed on the job. The number of workers who are at least 65 has significantly increased in the last decade. There are approximately 5 million people age 65 and older in today's workforce, almost half of whom are women.[74]

If you or your spouse intends to continue working past age 65 – after you become eligible for Medicare – and either one of you is also covered by an employer group health plan, then the following rules apply:

- **Rule for employers with fewer than 20 employees.**

Employers with fewer than 20 employees are not required to provide the group health plan as primary coverage to employees with Medicare. When an employer does provide health benefits to employees on Medicare, those benefits *supplement* Medicare's benefits and are paid only after Medicare pays.

- **Rule for employers with 20 or more employees.**

If the employer has 20 or more employees, the employer must offer you the same group health coverage as it offers younger employees. That means that your employer must provide you with full group coverage and not rely on Medicare to provide you with primary health coverage.

Employer group health plans often provide better benefits and coverage than Medicare. As such, many workers who have access to both decide to sign up for their employer's plan and delay enrollment in Medicare Part B. That's fine until your employer group health plan ends. Once it ends, you generally have 8 months to sign up for Medicare Part B without incurring any penalties. If you fail to sign up within this time period, your Part B benefits could be delayed for many months and you may have to pay a higher premium for the rest of your life. So don't delay!

The Centers for Medicare and Medicaid Services has a website that provides information about coordination of benefits with Medicare at www.cms.hhs.gov/medicare/cob.

Your Rights as a Medicare Beneficiary

As a Medicare beneficiary (one who receives benefits from Medicare), you have certain healthcare rights. Generally, you have the right to:

- **Receive appropriate and timely medical care.**
- **Be fully involved in your care.**
- **Be informed of what medical treatment and services Medicare covers and what you have to pay.**
- **Receive emergency services.**
- **Receive second opinions (in certain circumstances).**[75]

Medicare provides a booklet -- "Your Medicare Rights and Protections" -- which includes more detailed information about your rights as a Medicare beneficiary. To order a copy, call 800-633-4227.

As a Medicare beneficiary, you also have the right to appeal a healthcare decision that you disagree with. This is a very important right. If you think you're being treated unfairly, you should speak up and challenge the decision. Few people do this, but more than half of all denied claims that are challenged result in either the claims being paid or Medicare agreeing to pay a greater proportion of the bill.

What if I have problems speaking or understanding English?

Medicare requires healthcare providers to provide you with interpreter services when needed, at no cost to you, and to advise you of your right to have such services. You cannot be required to utilize a friend or family member as your interpreter.

Where can I find help?

If you have questions or need help with your Medicare plan, you can contact the following resources:

- **The Health Insurance Counseling & Advocacy Program ("HICAP") at 1-800-434-0222.**
- **The California Healthcare Foundation ("Cal Medicare") at 1-888-430-2423 or www.calmedicare.org.**
- **1-800-Medicare at 1-800-633-4227 or www.medicare.gov.**

APPEALING A DECISION BY MEDICARE

This is a *general* overview on how to appeal a denial by Medicare for benefit claims that arose in 2006. The purpose of this section is to provide you with a basic framework of how the Medicare appeals process works. Keep in mind, however, that this process can be very complex and the specific procedures can change depending on the particular dispute at issue and type of Medicare plan you have. For example, if you are appealing a coverage denial for inpatient hospital services, your appeal rights may differ from those who are appealing a coverage denial for services from a skilled nursing facility.

However, even though the specific details may change depending on your particular circumstances, the basic procedures that you need to follow to appeal a decision are generally the same. Therefore, knowing the general framework of the Medicare appeals process can help you to understand your options and better prepare you to advocate on behalf of yourself and your family in any situation.

There are also different resources that can provide you with additional information about the Medicare appeals process and what you need to do in specific circumstances. The California Health Advocates provides useful, easy to understand information about the Medicare appeals process at www.calmedicare.org. The U.S. Department of Health and Human Services, Office of Medicare Hearings and Appeals at www.hhs.gov/omha is also a good resource for additional information as are the Medicare resources listed above.

The Five Level Appeals Process

The Medicare appeals process under the Original Medicare Plan has 5 different levels from which you can appeal. Therefore, if you lose at level 1, you can appeal to level 2; if you lose at level 2, you can appeal to level 3; and so on. Do not give up if you believe that you have a good case but you lose early on. Many times you will have to go through several different levels before you achieve a satisfactory result. For example, in the past, about 70% of all appeals that were taken to level 3, which is a hearing before an Administrative Law Judge ("ALJ"), were successful.[76] Unfortunately, recent changes in the Medicare appeals process may make it harder for you to win at this level.

TIP: The Medicare appeals process is a complex system that can be very confusing. Part of the confusion stems from the fact that many different entities are involved. The government contracts with different organizations, such as hospitals, nursing homes and medical groups, to provide medical services to Medicare members. The government also contracts with outside agencies to check and improve the quality and level of care given to Medicare patients. Some or all of these entities may be involved in your appeal, depending on the disputed service. The important point to remember is to keep challenging an unfair decision, regardless of who made the decision.

Initial Determination

Usually, the first notice that you receive informing you that your care will not be covered by Medicare is from the healthcare provider, such as a hospital. In order for you to appeal a denial, however, the decision must come from Medicare. A denial from a hospital or other healthcare provider does *not* trigger your appeal rights. Therefore, if you do not have a denial from Medicare, ask your healthcare provider, in writing, to submit your claim to Medicare for a formal review. You need to do this even if the healthcare provider tells you that Medicare will deny coverage.[77] You need that initial determination from Medicare to trigger your appeal rights. Moreover, sometimes Medicare will grant coverage that was initially denied by the healthcare provider.

TIP: Keep in mind that healthcare providers have a financial incentive to issue denial notices if they are unsure about whether a treatment or service will be covered by Medicare because they may have to pay for the cost of the care if they make a mistake and tell you that the care is covered when it is not.[78]

Once a claim for Medicare benefits is submitted, Medicare will make an initial determination on the claim within 30 days of receiving the claim.[79] You will receive a written notice of this "initial determination," called a Medicare Summary Notice ("MSN"). This notice will tell you whether or not Medicare will pay for the services and how much you must pay. If Medicare will not pay for the services, the MSN should provide the reason why coverage was denied.[80] If you are not satisfied with Medicare's determination, you can appeal. As stated above, there are potentially five different levels of appeal.[81]

TIP: Unfortunately, many claims are denied due to insufficient information and mistakes. When you receive the MSN, you should call the carrier and ask them specific questions as to why your Medicare benefits were denied. A "carrier" is a private company that has a contract with Medicare specifically to handle payment issues. You will often find that inadequate information or documentation was mailed to the carrier and that the coverage denial can sometimes be resolved simply by providing better documentation.[82]

STEP 1: REQUEST A REDETERMINATION[83]

The first step in the process is to ask for a redetermination of the initial decision.[84]

- **Must be in writing.**
- **Must be made within 120 days from receiving notice of initial determination.**

To appeal the initial determination, you must submit a written, signed request for a redetermination.[85] A redetermination is an independent review of the initial decision. You must make this request within 120 days from when you received notice of the initial determination. The notice should tell you where and how to file the request, including the specific contractor or entity that will handle your appeal.

In requesting a redetermination, you must explain why you disagree with the initial determination and you must provide support for your position. Within 60 days of receiving your request for redetermination, the contractor you appeal to will send you a written notice of his or her decision (assuming no extensions were given).[86]

TIP: Keep in mind that the timeframes given in the appeals process can be extended or changed for many different reasons. For example, time extensions can be given when new evidence is submitted or when someone asks for a time extension and they have a good reason for asking for the extension.

Tip: It is not unusual for good claims to be denied at this stage of the appeal.[87] Don't give up!

STEP 2: REQUEST A RECONSIDERATION

- **Must be in writing.**
- **Must be made within 180 days from receiving notice of the redetermination.**

If you are dissatisfied with the redetermination decision and you want to continue the appeals process, you can request an *external* review of the decision – a reconsideration of the decision by an entity that did not take part in making the initial decisions.

The federal government contracts with different outside organizations to provide external reviews of Medicare decisions that are in dispute. One such entity is known as the Qualified Independent Contractor ("QIC"). As of May 2005, the QIC contractor is Maximus CHDR (Center for Health Dispute Resolution).

If you want a reconsideration, your request must be in writing and filed within 180 days from when you received the notice of redetermination.[88]

As in Step 1, you must explain why the redetermination decision is incorrect. If the notice of redetermination points to any missing information or other reasons for the unfavorable decision, be sure to address these issues in your request for reconsideration. You may submit any additional support for your position. The QIC will provide a written notice of its decision within 60 days of receiving your request (assuming no extensions were given). [89]

TIP: At certain levels of the appeals process, you have the right to "escalate" or move a case that is not decided on time to the next appeal level. For example, if the QIC does not issue a decision within the given timeframe (and assuming no extensions were given), you can request that the appeal be "escalated" to the next appeal level – in this case, a fair hearing before an Administrative Law Judge.

STEP 3: REQUEST A FAIR HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE

- **Must be in writing.**
- **Must be made within 60 days from receiving notice of the reconsideration.**
- **At least $110 must be in controversy.**
- **Any new evidence must be submitted within 10 days of receiving the notice of hearing.**

If you are dissatisfied with the reconsideration decision by the QIC, you have the right to a fair hearing before an Administrative Law Judge (ALJ).[90] Your request must be in writing and must be made within 60 days of when you received the notice of reconsideration. The notice of reconsideration will tell you the specific entity to whom you must send your request.[91] In order to get a hearing before an ALJ, the amount in dispute (*e.g.*, the cost of the denied treatment or service) must be at least $110 (in 2006).[92]

You (and the other parties to the matter) will receive a notice with information about the hearing. If you have any new evidence to present, it must be submitted to the ALJ within 10 days of receiving this notice. The hearing may be held by video-teleconference, telephone or in-person. However, in-person hearings are generally limited to special or extraordinary circumstances.[93] The ALJ must issue a decision no later than 90 days after receiving the request for a hearing (assuming no extensions were granted). The notice of

the ALJ decision should include the specific facts and law that were relied on in making the decision.[94]

STEP 4: ASK FOR A MEDICARE APPEALS COUNCIL REVIEW

- **Must be in writing.**
- **At least $110 must be in controversy.**
- **Must be made within 60 days of receiving the ALJ's decision.**

If you are dissatisfied with the decision by the ALJ, your next step is to ask for a review before the Medicare Appeals Council ("MAC") of the United States Department of Health and Human Services. You must do this in writing and within 60 days of when you received the decision by the ALJ. Most MAC reviews will not be in person. Instead, the MAC will review the relevant documents and issue a decision.[95]

The MAC is generally limited to reviewing only the evidence that was before the ALJ. One exception, however, is if a new issue is presented and this issue was not addressed by the ALJ in the previous hearing. In that case, the MAC may consider new evidence with respect to that issue.[96] After reviewing the record, the MAC will issue a decision or remand the case back to the ALJ. All parties will be notified of the decision in writing. The MAC has 90 days to issue its decision.[97]

STEP 5: FILE SUIT IN FEDERAL DISTRICT COURT

If you are dissatisfied with the decision by the MAC, you may file suit in federal court within 60 days of receiving the MAC decision. Generally, a MAC decision is a prerequisite before you can proceed with an individual Medicare appeal in federal court. In order to file suit in federal court, the amount in dispute must be at least $1,090 (in 2006). You must also name the Secretary of the Department of Health and Human Services, in his or her official capacity, as the defendant.[98]

TIP: You should consider seeking professional legal advice before appealing to an Administrative Law Judge, the Medicare Appeals Council, or federal court.

APPEALING A DECISION BY A MEDICARE ADVANTAGE PLAN

If you are part of a Medicare Advantage or MA plan (*e.g.*, Medicare HMO), there is a slightly different appeals procedure that you must follow.[99] The differences are only in the beginning steps of the appeals process.

If you have an MA plan, the initial decisions are made by your specific MA plan and are called "organization determinations." In general, if you are requesting approval for a medical service that has not yet been performed, the MA plan must notify you of its decision regarding your request as soon as possible or within 14 calendar days. If, on the other hand, you are requesting payment for a service that has already been done, the MA

plan has more time to make a decision. The plan must process most requests within 30 days and all claims within 60 days after receipt.

If the MA plan denies a Medicare service or payment, the plan must give you written notice of the denial. The denial must include the following information:

- **The reason for the denial in understandable language.**
- **Information on how to appeal the denial.**
- **Information on how to obtain an expedited appeal.**

If you are unhappy with the denial, you can appeal. The MA appeals process includes up to 5 steps and is the essentially the same as the appeals process for the Original Medicare plan, but with different deadlines and timeframes. Here is a brief overview of the process.

STEP 1: REQUEST A REDETERMINATION[100]

- **Must be in writing.**
- **Must be made within 60 days of the initial organization decision.**

If you are unhappy with the MA plan's initial decision, you have 60 days to submit a written request asking the plan to reconsider its decision. The MA plan must respond to your request within 30 days (for treatment issues) or 60 days (for payment issues).

STEP 2: REQUEST A RECONSIDERATION REVIEW

Like in the Original Medicare plan, the next step in the appeals process is to ask for an external review by an outside organization. The external review organization for MA plan denials is Maximus CHDR. Maximus must issue its decision by the following timeframes:

- **Within 72 hours to 17 days for expedited reviews.**
- **Within 30 to 44 days for service denials.**
- **Within 30 to 60 days for payment denials.**

STEP 3: REQUEST A FAIR HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE

If you are unhappy with the decision made by Maximus CHDR, you have the right to request a fair hearing before an Administrative Law Judge (ALJ). This part of the appeal process is essentially the same as the one under the Original Medicare plan. To appeal a decision to an ALJ, follow the necessary procedures outlined in Step 3 of the Medicare appeals process discussed above.

STEP 4: ASK FOR A MEDICARE APPEALS COUNCIL REVIEW

If you are unhappy with the ALJ's decision, you can ask for a review before the Medicare Appeals Council (MAC). Again, this part of the appeal process is essentially the same as the one under the Original Medicare plan. To appeal a decision to the MAC, follow the necessary procedures outlined in Step 4 of the Medicare appeals process discussed above.

STEP 5: FILE SUIT IN FEDERAL DISTRICT COURT

If you are unhappy with the MAC's decision, you may file suit in federal district court. Again, this part of the appeal process is essentially the same as the one under the Original Medicare plan. To file a suit in federal court, follow the necessary procedures outlined in Step 5 of the Medicare appeals process discussed above.

EXPEDITED APPEALS PROCESS

Many medical conditions require immediate action when a medical service has been denied or terminated. In these circumstances, you have the right to an "expedited" form of appeal. An "expedited" or "fast" appeal is a way to get a faster review for problems of an urgent nature. Basically, decisions must be made in a shorter timeframe. Expedited appeals are reserved for medically serious situations in which your life or health may be jeopardized without immediate care. The "expedited" appeals process can differ depending on the type of Medicare plan you have and the type of service termination you are appealing. Here's an example of how the expedited review process works in the case of an appeal regarding an early hospital discharge.

Hospital Discharge Appeals

A frequently cited problem is that patients are being released from hospitals "sicker and quicker" than before. As a Medicare beneficiary, you have the right to appeal an early discharge from the hospital. When you are first admitted to the hospital, you should receive a form called "An Important Message from Medicare." This form outlines the steps you need to take to appeal an early hospital discharge. If you do not get a copy of this form, be sure to ask for one.

How much does it cost to appeal?

There is no cost to appeal.

How do I file a hospital discharge appeal?

The following is a brief outline of how to request an "expedited" review when you feel you are being released from the hospital before you are medically ready to be discharged (under the Original Medicare plan). Before filing an appeal, talk to your doctor or the discharge planner and see if they will agree to extend your stay in the hospital.

If your stay is not extended, inform your healthcare provider that you disagree with the discharge decision and that you plan to appeal Medicare's denial of continued hospital coverage. Ask the provider for a written notice, often called a "Notice of Discharge." This document should provide you with the following information:

- **The reason you are being discharged.**
- **The date you are scheduled to be discharged.**
- **The date your Medicare coverage for the hospital stay will end and you will be financially responsible for the costs.**
- **How to appeal the decision to discharge you from the hospital.**

In hospital discharge cases, you can request an "expedited" review directly to a Quality Improvement Organization ("QIO"), an outside agency hired by the federal government to oversee problems with Medicare. In California, the QIO is an agency called Lumetra. Once you receive notice of your discharge from the hospital, you need to contact Lumetra as soon as possible.

Step 1: Appeal to Lumetra

You must contact Lumetra and request an "expedited" review by noon of the first working day after receiving notice of the discharge decision. If you call Lumetra within this timeframe, you will be able to remain in the hospital while your case is being reviewed. It may take a few days, but you cannot be sent home or billed by the hospital (except for deductibles and other items not covered by Medicare) until the review of your case is completed.[101]

In your request for review, you should explain to Lumetra why you disagree with the discharge decision. Be specific. You can call Lumetra at 800-841-1602 or 800-881-5980 (TDD- hearing impaired number). Translation services are available.

TIP: You can contact Lumetra by phone or fax. It's best, however, to send your request for review by fax. That way, you have a written confirmation of when you sent your request. You should also write "I want an immediate review" on your request.

Step 2: Lumetra must issue a decision in 72 hours.

Lumetra has 72 hours from the time that they received your request for an expedited appeal to issue a decision. The initial notice of their decision will be by telephone; followed by a written notice. The written decision must include:

- **A detailed explanation of the decision.**
- **The time and date you become liable for paying the hospital costs, assuming an unfavorable decision. For example, the written decision should include the following type of language (" . . . if you decide to remain in the hospital**

after 12 noon on 6/12/06, you will be responsible for payment of all costs of hospital services you receive after that time.").

- **Information about your appeal rights and how to request a reconsideration.**

Step 3: Request a Reconsideration by the Qualified Independent Contractor.

If you are dissatisfied with the decision by Lumetra, you have the right to request a reconsideration by the Qualified Independent Contractor ("QIC"), which in California is an agency called Maximus CHDR.[102] Your request must be in writing or by telephone and must be submitted no later than noon of the calendar day following the *initial* notification (whether by telephone or by writing) from Lumetra about their decision. Maximus CHDR must issue a decision within 72 hours after your request for expedited reconsideration is received. You can request that this timeframe be extended up to 14 days if you need more time to collect medical records.

TIP: Unlike in Step 2, you may be liable for all hospital costs that are incurred during the timeframe of your reconsideration appeal (*e.g.*, if you lose your appeal). Call Lumetra and get specific information about when you will be liable for costs.

TIP: At the "reconsideration" level and beyond, you can "escalate" your case to the next level. The concept of "escalation" can apply if a decision is not given within a set time frame. In such a situation, a party to the appeal can "escalate" the appeal to the next level. For example, if Maximus CHDR does not comply with the time frame given above, you may be able to "escalate" the case to the next level – a hearing before an administrative law judge. Remember, however, that there are many possible situations by which the time frame can be extended (e.g., submission of additional evidence).

If you are unhappy with the reconsideration decision by Maximus CHDR, you can continue your appeal. The remaining steps in the "expedited" review process are similar to Steps 3, 4 and 5 in the standard appeals process (discussed above). Information on how to appeal to each succeeding level will be explained in your decision notices.

Filing a "Quality of Care" Complaint

As a Medicare beneficiary, you also have the right to file a "quality of care" complaint if you are concerned about the quality of the care that you have received. This is a complaint system separate from the appeal process discussed above. Common "quality of care" complaints include the following:

- **Wrong medication;**
- **Unnecessary surgery or diagnostic testing; and**
- **Inadequate care or misdiagnosis by any Medicare hospital or doctor.**

A team of independent medical professionals will review your complaint. To file a quality of care complaint, call Lumetra at 1-800-633-4227.

APPEALING MEDICARE PART D: PRESCRIPTION DRUGS

As discussed above, the new Part D prescription drug plan is offered through private insurance plans. Each plan is required to have an appeal process, including a process for expedited requests for time-sensitive, urgent health matters when the standard time frame could jeopardize the life or health of the beneficiary or the beneficiary's ability to regain maximum function (see discussion of expedited requests above). The appeal process for the Part D program is very similar to the appeal process for Medicare Advantage plans.

Insurance plans that participate in the Part D program are given broad discretion on the type and scope of benefits they will provide. For example, the plans are allowed to decide which drugs they will pay for and at what dosage, and how much they will charge for different drugs (*e.g.*, co-payments). Plans are also allowed to make changes during the course of a given year. For example, a plan may decide midway through the year to stop paying for a drug or increase the co-payment on a drug, with certain restrictions. Moreover, insurance plans can require that beneficiaries try particular medications on the plan's approved drug list before those prescribed by their doctors.[103]

This particular set-up, although good for the private insurance plans, can result in many "coverage" disputes and problems for Part D beneficiaries. However, a plan's decision whether or not to pay for or provide a drug, called "coverage determinations," are decisions that can be formally appealed. Therefore, if you are having problems getting your drug plan to provide a medication that you need, you do have the option of filing an appeal.

Coverage determinations include a number of different problems. For example, a drug plan may decide not to pay for a medication, citing the following reasons:

- **The drug is not on the plan's formulary or approved drug list.**
- **The drug is not considered to be medically necessary.**
- **The drug is provided by an out-of-network pharmacy.**
- **The drug is not one of those that Medicare will pay for under Part D.**

All of these responses are deemed to be coverage determinations that can be appealed. Coverage determinations also include problems getting a coverage decision from the drug plan in a timely manner; dissatisfaction with the amount of the co-payment required for a drug; a requirement that you try another medication before the drug plan will cover the medication that was prescribed for you by your doctor; and restrictions or limitations on the quantity or dose of the prescribed drug.[104]

What can I do if my drug plan won't pay for my prescription drug?

Here's a general outline of what you need to do if your plan won't pay for a prescription drug that you think should be covered. Your first step is to ask your drug plan for a formal coverage determination. A statement by your pharmacist that the plan will not cover a requested drug is *not* a coverage determination. The coverage determination can only be made by the Part D drug plan or an entity that is acting on behalf of the plan. Therefore, you must contact your drug plan.

TIP: You could also first pay for the medication yourself and then request that the plan pay you back by requesting a coverage determination. However, if you file an appeal after paying out of pocket for a needed prescription, you are not eligible for the "expedited" review process.[105]

If your drug plan denies your request for coverage, it must notify you in writing within 72 hours and explain the reason for the denial and how to appeal the decision.[106] If you were granted a request for an "expedited" review of the coverage determination, your drug plan must notify you of its decision within 24 hours. For "expedited" reviews, the plan may first notify you within 24 hours by telephone but it must also mail you a written notice within three calendar days after it verbally informs you of its decision.[107]

How do I appeal a coverage determination?

If you are unhappy with your drug plan's coverage determination decision, you can file an appeal. Again, the appeal process for prescription drug coverage issues is very similar (with some exceptions) to the appeal process for Medicare Advantage plans discussed above.[108] It's the same basic 5 steps, with some different details. Reread that section for more information. Here are the highlights:

Step 1: Ask for a redetermination through your drug plan.[109]

- **Must request within 60 days from the date of the coverage decision.**
- **Must be in writing unless your plan accepts telephone requests.**
- **Can get expedited review (if applicable).**
- **Redetermination decision must be made by persons other than those who made the initial coverage determination.**
- **Upon receipt, the plan has 7 days (standard) or 72 hours (expedited) to notify you of its decision.**

If you are unhappy with the redetermination decision, move on to Step 2.

Step 2: Ask for a reconsideration by an Independent Review Entity (IRE).[110]

- **Must request within 60 days from the date of the redetermination decision.**
- **Must be in writing and sent directly to the IRE, called Maximus CHDR.**
- **Can get expedited review (if applicable).**

- **Once request is filed, IRE has 7 days (standard) or 72 hours (expedited) to notify you of its decision.**
- **IRE is required to ask for your doctor's opinion regarding the appeal and must include a written account of the doctor's input in the redetermination documentation.**

If you are unhappy with the reconsideration decision, move on to Step 3.

Step 3: Ask for a hearing with an Administrative Law Judge (ALJ).[111]

- **Must request within 60 days from the IRE decision.**
- **Must be in writing.**
- **Must send the hearing request to the entity specified in the IRE's reconsideration notice.**
- **At least $110 must be in dispute (in 2006).**
- **Upon receipt, ALJ generally has 90 days to make a decision.**

TIP: There are several ways to meet the required dollar amount: (1) you could use the projected value of the drug (or drugs) in question over the course of the calendar year; (2) you could combine two or more of your appeals; or (3) two or more appeals by several different people (who are all in the same drug plan) can be combined if they all involve the same drug.

If you are unhappy with the decision by the ALJ, move on to Step 4.

Step 4: Ask for a review by the Medicare Appeals Council (MAC).[112]

- **Must request within 60 days from the date of the notice of the ALJ's decision.**
- **Must be in writing.**
- **Upon receipt, MAC generally has 90 days to make a decision.**

If you are unhappy with the decision by MAC, move on to Step 5.

Step 5: Ask for a review by a federal court.[113]

- **Must request within 60 days of the date of the notice of the MAC's decision.**
- **Must be in writing.**
- **Must send the request to the entity specified in the MAC's decision notice.**
- **At least $1,090 must be in dispute (in 2006).**

What is the exceptions process?

Part D plans that use formularies or approved drug lists must have an exceptions process -- a procedure by which plan members can seek coverage for non-formulary drugs (*i.e.*, those not on the approved drug list) or request that a formulary drug be provided at a

lower cost.[114] An exception request basically asks for an exception to the design of the drug plan's formulary. You are essentially asking the drug plan to find that formulary requirements apply to all plan members "except" you. The exceptions request can be an important tool for you to use to get access to medically necessary drugs that you need.

The exceptions request is a type or subset of the coverage determinations that can be appealed and are governed by the same rules.[115] Unlike other coverage determinations, however, the exceptions request can require some different procedures depending on the type of request that you make. For example, in order to get an exception to require the plan to cover a non-formulary drug, you need the participation and support of your doctor. Your doctor must show that all of the drugs on the plan's formulary for treating the same condition would not be as effective and/or would have negative consequences for you. If the plan approves the exceptions request, the drug will be treated as other drugs on the formulary.[116]

Filing a Grievance

All drug plans must also establish a process for hearing and resolving grievances. Grievances are separate and distinct from appeals, which usually involve coverage and payment issues. Grievances can come from dissatisfaction with any aspect of a drug plan's operations, activities or behavior. Examples of why you might file grievance include:

- **You have to wait too long for your prescriptions.**
- **You were treated rudely by a customer service representative.**
- **You believe your plan's customer service hours of operations should be different.**
- **The pharmacy is charging you more than you think you should have to pay. (In this case, call the drug plan to get the most up-to-date price. If the plan doesn't take care of your complaint, call 1-800-MEDICARE).**

If you have a grievance against your drug plan, you need to file a complaint within 60 days of the incident. You can file a grievance orally or in writing, although writing is recommended. Plans must generally resolve grievances within 30 days, though this timeframe can be extended. The plan may respond to an oral grievance orally or in writing, unless you request a written response. A written grievance must be responded to in writing.

The plan must respond to a grievance involving a quality of care complaint in writing. For example, a complaint about a mail order pharmacy sending you the wrong prescription is a quality of care complaint. The written response must include an explanation of your right to file a complaint with the Quality Improvement Organization.

Dual Coverage Issues

What if I have both Medicare and Medi-Cal?

Many people receive both Medicare and Medi-Cal. Both programs help pay for medical care. If you have both plans, Medicare is the primary payer while Medi-Cal is the secondary payer. That means that Medicare pays first for any Medicare-covered benefits and Medi-Cal is the secondary payer and pays whatever is left of the balance. Medi-Cal will also cover any Medicare deductibles, co-payments or premiums. For benefits that are only covered by Medi-Cal, such as dental care or long-term nursing home care, Medi-Cal will be the only payer.[117]

TIP: Medi-Cal applications should be submitted as soon as possible. The application process can take some time (several months). You can, however, ask Medi-Cal to pay retroactively for the three months prior to the month in which you apply.

TIP: Be sure to tell your doctor, hospital or other healthcare provider that you have more than one kind of insurance. Always show your health insurance card(s) to your providers and ask them to make a copy for their records. This will let your providers know to send the bills to the correct health plan and cut down on billing errors.

As of January 1, 2006, Medi-Cal is no longer covering most prescription drugs if you have both Medicare and Medi-Cal. Instead, those with dual coverage should seek coverage through Medicare's new prescription drug program.

Remember, if you have dual coverage, you must use providers that accept both your Medicare and Medi-Cal card in order for services to be covered.

Medi-Cal, Medicare & Medigap – How do they fit together?

If you have Medi-Cal and Medicare, you do not need a Medigap policy. In general, Medi-Cal will pay for more benefits than most Medigap policies. In fact, if you have Medi-Cal, it is illegal for an insurer to sell you a Medigap policy. However, if you already had a Medigap policy when you became qualified for Medi-Cal, you may keep your Medigap policy if it provides you with access to healthcare providers who do not take Medi-Cal.

If you are in a Medicare Advantage plan (like an HMO), you also do not need Medigap coverage.

Medicare HMOs and Medi-Cal

As of January 1, 2006, Medi-Cal will no longer pay the HMO monthly premiums for those with a Medicare HMO plan and Medi-Cal. Some Medicare HMOs, like Kaiser

Senior Advantage, may decide to waive these premiums but there is no requirement to do so.

If you are in a Medicare HMO and also have Medi-Cal, you must use HMO providers for all your Medicare-covered services.

CHAPTER 4: PROTECTING YOURSELF IN A NURSING HOME

Because we live longer than men and are the ones most likely to care for older family members, many women will either be in a nursing home or will care for relatives in a nursing home.

Gender Fact: Almost 75% of all nursing home residents are women.[118]

It is particularly important to speak up and take action if you or a family member is in a nursing home. Why? Unfortunately, the standard operating procedures in many nursing homes often violate the federal Nursing Home Reform Law, which provides important protections for residents in nursing homes.[119] The Nursing Home Reform Law applies to every nursing home that is certified to accept payment from Medicare or Medicaid, which is about 95% of all nursing homes.[120]

Studies have found that you get better health care if you SPEAK UP. This is even more true if you or a family member is in a nursing home. If you don't speak up and ask for individualized care, you most assuredly won't get it. There is no need to be timid. A nursing home receives thousands of dollars a month to care for a resident and should be expected to provide a certain level of personalized care. You should not feel limited to the one-size-fits-all care plan presented by some nursing homes.[121]

Another important reason you need to speak up is because the cost of being passive is high in a nursing home. Unfortunately, many nursing homes have policies and procedures that are illegal and actually harmful to residents. The National Senior Citizens Law Center provides a guide that discusses some of the most common nursing home violations and provides specific strategies that residents and family members can use to avoid or reverse these illegal procedures and assert their rights.[122]

For example, a nursing home has specific obligations to its residents. A nursing home must provide all necessary care, such as specific treatment requirements stated in a doctor's order. A claimed shortage of staff or money is no excuse for not providing this care. Nursing homes must also make reasonable adjustments to honor resident needs and preferences. A resident has the right to choose activities, schedules and health care that is based on her needs and interests and not that of the nursing home.

As a resident in a nursing home, you also have rights. For example, if you are a Medicaid-eligible resident, you are entitled to the same level of service that is provided to any other resident in the nursing home. Don't let anyone treat you like a second-class citizen! Your family and relatives can visit you at any time of the day or night. You cannot be evicted from the nursing home for being "difficult." In fact, there are only six legitimate reasons for eviction:

- **You failed to pay for your expenses.**
- **You no longer need nursing home care.**
- **Your needs can no longer be met in a nursing home.**

- **Your presence in the nursing home endangers other residents' safety.**
- **Your presence in the nursing home endangers other residents' health.**
- **The nursing home is going out of business.**

A nursing home also cannot require you to do certain things before they will admit you as a resident. For example, a nursing home cannot require anyone but you -- the resident -- to be financially responsible for your nursing home expenses. A family member or friend cannot be required to be financially liable for your expenses if you run out of money. A nursing home also cannot require you to sign an arbitration agreement. By signing an arbitration agreement, you agree that future disputes between you and the nursing home will not go to court, but instead will be handled by a private judge, called an arbitrator. In general, the arbitration process is not a good option for nursing home residents. The arbitration process is often more expensive for residents than a state or federal lawsuit and arbitrators are often less sympathetic to residents' concerns and grievances than are judges or juries.

For more information on these and other important rights and obligations, contact the National Senior Citizens Law Center at (202) 289-6976 or www.nsclc.org.

CHAPTER 5: GETTING AND STAYING INSURED

Many employers currently offer or pay for health insurance as a benefit that comes with employment. Employers, however, are not required to offer or pay for health insurance for their employees and an increasing number of employers are choosing *not* to provide this benefit. Unfortunately, women are much more likely than men to be unemployed, employed part-time or work in jobs that do not provide health benefits. Consequently, many women currently do not have any form of health coverage.[123]

It is important to have health coverage at all times. Studies have repeatedly shown the negative consequences of being uninsured – not only for your health but also for your finances. For example, people who are uninsured are not only more likely to need emergency room services but are also at a higher risk for bankruptcy and poverty.[124] Continuous healthcare coverage is particularly important if you have an ongoing health condition or a pre-existing condition.

What is a pre-existing condition?

A pre-existing condition generally refers to any health condition that you have had prior to enrolling in your current health plan.

Under California law, a pre-existing condition is more narrowly defined as a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six months (in some cases 12 months) immediately preceding the enrollment date in a new health plan or effective date of coverage.[125]

What is an exclusionary period?

Health plans can restrict coverage of treatment for pre-existing conditions for limited time periods due to your medical history. This is called an "exclusionary" period.

If you are enrolling in a group plan, the plan can exclude coverage for pre-existing medical conditions for up to 6 months (with some exceptions).

If you are enrolling in an individual plan, the insurer can exclude coverage for pre-existing conditions for up to 12 months (with some exceptions).

The exclusionary period is decreased, however, by the amount of time you have had "creditable coverage." Creditable coverage is the continuous health insurance you may have had through any previous health plan.[126]

EXAMPLE: Let's say you had health insurance for 8 months and then decided to join a new group plan. Even if this new plan has a 6 month exclusionary period, your new insurance carrier cannot refuse to treat your pre-existing condition. Why not? It's because you had creditable coverage for at least 6 months before joining this new group plan.

TIP: Because health plans may have exclusionary periods for pre-existing conditions, it is important that you avoid any "gaps" in your healthcare coverage. A gap in coverage is when you go more than 62 days in a row without health insurance coverage. In some situations, the gap can be even longer – it is when you go more than 180 days without coverage. Depending on your situation, if you have more than a 62 day gap in coverage or more than a 180 day gap in coverage, you will not get the benefit of creditable coverage during an exclusionary period as discussed above.[127] Contact your health plan administrator or the Department of Managed Health Care (1-888-HMO-2219) for more information on pre-existing conditions and gaps in coverage.

How can I show that I have had creditable coverage?

Your health insurance company or plan administrator must give you a certificate of creditable coverage within a reasonable time after you request it. You can show this certificate to your new insurer to prove you had creditable coverage and reduce or eliminate any exclusionary period. Other ways to show that you have had insurance coverage are:

- **Pay stubs that show deductions for health insurance premiums.**
- **Evidence of Coverage or Explanation of Benefits forms from your health plan.**
- **Benefit termination notice from Medicare or Medi-Cal.**
- **Verification by a doctor or your former healthcare provider that you had prior health coverage.**

GET INSURED

If your job does not provide healthcare benefits, you should look into government sponsored health plans like Medi-Cal (see Chapter Two). If your job does not provide healthcare benefits and you do not qualify for government sponsored health plans, you might consider getting health insurance on your own.

What is individual health insurance?

Individual health insurance is insurance that you buy on your own. You can contact different health plans directly or online to find out how much individual health insurance will cost. The cost of the health coverage and the type of benefits offered to you will be

based on different factors, including your age, sex, and health history. Health plans can also decide to refuse to insure you based on these factors. For example, health plans may offer you insurance at a higher premium rate or refuse to insure you if you are overweight or obese. People with long-term illnesses or other health problems also have a more difficult time getting a health plan to insure them. You do, however, have a right to know why you are being charged a certain rate or why the health plan is refusing to insure you.[128]

What are my rights to getting individual health insurance?

A health plan may refuse to insure you based on your medical history, but it may *not* deny you insurance:

- **Just because of your race, gender, national origin, ancestry, religion, marital status or sexual orientation.**
- **Just because you have a physical or mental disability.**
- **Just because you have a family history of breast cancer or genetic disease (and are not diagnosed with breast cancer or the genetic disease now).**
- **Just because you are a victim of domestic violence.[129]**

A health plan also cannot require you to get an HIV test as part of the application.[130]

When can a health plan cancel my insurance?

A health plan can cancel your insurance for the following reasons:

- **You did not pay your premiums.**
- **You intentionally provided false information or left out important facts on your enrollment application.**
- **The health plan is no longer offering individual insurance in California.**

Your health plan, however, cannot cancel your insurance (once you have it) because of your medical condition or your requirements for medical care.[131]

Are there health conditions or problems that will cause a health plan to refuse to insure me?

Yes. There are many medical conditions that may cause a health plan to automatically deny your application. These may include the following:

- **Health problems for which you have not seen a doctor.**
- **Health problems that a doctor can not explain.**
- **Health problems for which you have not completed treatment.[132]**

A health plan may also automatically deny your application if you have the following conditions:

- **AIDS**
- **Cancer (under treatment)**
- **Cirrhosis**
- **Diabetes with complications**
- **Heart disease**
- **Hepatitis**
- **Multiple Sclerosis**
- **Muscular Dystrophy**
- **Renal failure or kidney dialysis**
- **Severe mental disorders, such as major depression, bipolar disorder, schizophrenia or psychopathic personalities**[133]

STAY INSURED

If your health insurance is connected to your job, it is important to take immediate action to secure your group health coverage when you experience a change in your job status. If you switch jobs, lose a job or have your work hours reduced, you may be at risk for losing your group health coverage.

Through some special programs, California and federal law now offer valuable protection for you in these situations. Each one of these laws, however, requires that you take action to receive the benefits. Also, these programs follow one another in a certain order. If you qualify for a program but fail to sign up for it, you will not only lose the program benefits but you will also lose the chance to enroll in the next program.

You should consider the programs in the following order:

- **Federal COBRA or Cal-COBRA**
- **HIPAA**
- **Conversion coverage**
- **Mr. MIP**

Keep your group health plan through COBRA.

There is a federal law – known as the Consolidated Omnibus Budget Reconciliation Act of 1986 or COBRA – that allows you (and certain family members) to continue your employer-based group health insurance with the same benefits even if you lose your job or your hours are cut. This federal law applies to employers and health plans that cover 20 or more employees. Your employer will no longer make a contribution to the payment of your health insurance premiums – you have to pay the entire premium yourself. But this law allows you to keep your group health insurance for at least 18 months.[134]

Cal-COBRA is a California law that is like the federal law. It applies to employers with 2 to 19 employees and lets you keep your employer-based health insurance for up to 36 months. Cal-COBRA is also for people who use up their Federal COBRA. When your 18 months of Federal COBRA ends, you may be able to buy another 18 months of health insurance under Cal-COBRA.[135]

Why should I keep my employer's group health plan?

Keeping your employer's group health plan often costs less than getting insurance on your own and the benefits are often better. Therefore, you should try to keep your employer's group health plan benefits for as long as you can before you consider individual health plans. And if you have an ongoing health problem or a pre-existing condition, you may find it hard to get insurance on your own.

Who can enroll in Federal COBRA or Cal-COBRA?

Once a "qualifying event" occurs, certain people become eligible for Federal COBRA or Cal-COBRA for a specific amount of time. Find the qualifying event that applies to your situation in the chart below to see whether you may be eligible and for how long.

"Qualifying Event"	Who is Eligible?	Maximum Coverage Time
• Termination of Job (for any reason other than being fired for "gross misconduct") • Reduced work hours	• Employee • Spouse • Dependent Child	• Up to 36 Months
• Employee entitled to Medicare • Divorce or legal separation • Death of covered employee	• Spouse • Dependent Child	• Up to 36 Months
• Loss of "dependent child" status	• Dependent Child	• Up to 36 Months

Note: There are special rules for people who become disabled and also for persons who have more than one "qualifying event."[136]

As you can see from the chart above, you (and certain family members) can get up to 36 months of continued coverage on an employer-based group health plan if you lose your health coverage under certain circumstances. For example, a child who turns 21 (and loses "dependent child" status) can get COBRA benefits for 36 months. As discussed above, although Federal COBRA lasts only 18 months, you may be able to keep your health insurance for another 18 months under Cal-COBRA if you exhaust your federal benefits.

How do I sign up for Federal COBRA or Cal-COBRA?

If your employment ends or your hours are reduced, your employer must notify both you and the health plan that a qualifying event has occurred. If you experience any other qualifying event, you need to notify both the employer and the health plan.

In general, within 60 days of the qualifying event, you must inform your health plan – *in writing* – that you want to sign up for COBRA benefits. The 60 days do not start to run until you receive notice that COBRA benefits are available to you. As noted above, if you miss the deadline, you lose the chance to sign up for these programs. There are strict deadlines for enrolling and for paying the premiums. You will not have a second chance to apply for the programs if you do not sign up and pay the premiums on time. [137]

Therefore, in order to protect your COBRA rights, if any of the qualifying events occur, take immediate action and inform your employer and your health plan. They should send you information about your eligibility for the COBRA programs and the forms you need to fill out to enroll. If you have problems getting this information or the necessary forms, you can also call the Department of Managed Health Care's Help Center at 1-888-HMO-2219.

What happens to the coverage I have through my spouse if I get divorced?

Your marital status may be important if you are receiving health insurance through your spouse (for example, if you are a full-time homemaker or work full or part-time without your own employer-based health coverage). If you and your spouse become legally separated or divorced, the insurance benefits automatically end for you if you had been receiving health insurance coverage through your spouse. Unless you have other comparable coverage in place, you should continue your coverage through Federal COBRA or Cal-COBRA. [138]

When does coverage for Federal COBRA or Cal-COBRA end?

Your coverage ends when:

- **The time period ends (up to 18 months of Federal COBRA followed by up to 18 months of Cal-COBRA, or up to 36 months if you only have Cal-COBRA).**
- **You fail to pay your premiums on time.**
- **The employer no longer offers any health insurance.**
- **You move outside of the health plan's service area.**
- **You enroll in Medicare.**
- **You enroll in another health plan.[139]**

What are my healthcare options after I use up all of my Federal COBRA or Cal-COBRA coverage?

If you use up all your Federal COBRA or Cal-COBRA benefits (*i.e.,* the legal time period for coverage is up), you still have some options, including the following:

- **HIPAA plans.**
- **Conversion plans.**
- **Major Risk Medical Insurance Program (MR. MIP).**

These plans, however, only offer you the option of buying an *individua*l health policy. Benefits from an individual policy are generally less generous and more expensive than benefits under a group health plan. That's why you should first try to extend your employer's group health plan benefits by applying for COBRA continuation coverage, if you qualify, before considering these other options.

What is a HIPAA plan?

The Health Insurance Portability and Accountability Act or HIPAA is a federal law that protects your rights to get insurance on your own. HIPAA allows people to buy individual health insurance policies when they lose their group health insurance, even if they have a pre-existing health condition. If you qualify, all health plans that sell individual plans must offer you health insurance. You cannot be denied coverage because of your medical history. Although California law limits the amount of the premium that can be charged, it can still be quite expensive.[140]

Who can enroll in a HIPAA plan?

You can enroll in a HIPAA plan if:

- **You had coverage for the last 18 months without a gap of 63 or more days.**
- **Your most recent coverage was through a group health plan.**
- **You have used up all of your COBRA coverage (if you qualified).**
- **You have no other health coverage (*e.g.*, Medicare or Medi-Cal).**
- **You did not lose your most recent health coverage because you did not pay the premiums or you tried to deceive the health insurance company.[141]**

If you meet these requirements, you are entitled to buy an individual health insurance policy regardless of your health condition as long as you apply within 63 days after the end of your COBRA benefits. The premiums may be expensive but you cannot be turned down for coverage.

How do I apply for HIPAA?

You have 63 days from the date your group health insurance ends, or if you qualify, your Federal COBRA or Cal-COBRA ends, to apply for HIPAA. When you apply for a

HIPAA plan, you should provide a Certificate of Creditable Coverage from your last health plan. This is a letter that says how long you have been covered and helps to prove that you have had 18 months of health coverage.[142]

What about a conversion plan?

In California, if you have health coverage through an employer's group health plan and you lose that coverage, you may be eligible to buy conversion coverage. This is an individual policy you get from the company that insured your employer's group plan. It is called a conversion plan because you convert from the group to an individual plan and pay for the premiums on your own. If you qualify for a conversion plan, you cannot be denied insurance because of your medical history.[143]

Who can enroll in a conversion plan?

Whether conversion coverage is available depends on certain factors, like how your employer pays for the group health plan, and should be indicated in your Evidence of Coverage – your contract with your health plan. You can also ask your employer regarding the availability, terms and conditions of any conversion coverage. In general, you can enroll in a conversion plan if your employer is ending your group health insurance and you were in this group plan for at least 3 continuous months before your health insurance ended.[144] Of course, other basic rules apply as well – *e.g.*, you cannot enroll if your insurance was cancelled because you did not pay your premiums or because you were dishonest with the health plan.

How do I sign up for a conversion plan?

Your employer should notify you within 15 days after your group health plan ends if you qualify for a conversion plan. Your health plan must receive your application and first premium payment within 63 days after your group health insurance ends. If you qualify for COBRA benefits, your group coverage is deemed to have ended after you have exhausted all your benefits under the COBRA program.[145]

Can I apply for a HIPAA plan if I have a conversion plan?

No. If you accept a conversion plan or any other individual plan after you use up your Federal COBRA or Cal-COBRA benefits, you cannot apply for a HIPAA plan. Therefore, you should compare the benefits of the conversion plan with the benefits of a HIPAA plan and choose the plan that better meets your needs.

Moreover, the benefits and premiums that are offered to you under a HIPAA or conversion plan may not be the same as the benefits or premiums that you had under your group health plan.[146]

What if I can't get a HIPAA or conversion plan?

If you can't get a HIPAA or conversion plan, you might consider the Mr. MIP plan.

What is the Mr. MIP plan?

Mr. MIP stands for Major Risk Medical Insurance Program. Mr. MIP is California's insurance program for people with serious health problems who are not able to buy individual health insurance. It can be an important resource for people who cannot buy insurance because no insurance company will cover them (*e.g.*, if you have had a gap in coverage or pre-existing medical condition). You can stay on Mr. MIP coverage for 36 months.[147]

Who can enroll in Mr. MIP?

Mr. MIP is available to California residents who:

- **Do not have insurance through an employer.**
- **Have applied for and been denied coverage through an individual plan.**
- **Are no longer eligible for coverage through Federal COBRA or Cal-COBRA.**
- **Do not qualify for Medicare or Medi-Cal.**

Mr. MIP coverage is provided through private insurance carriers.

Mr. MIP will require you to show that you have been rejected by at least one private health plan. You have been "rejected" if:

- **A plan refused to cover you during the past 12 months;**
- **You used to have insurance but your plan dropped your coverage without your consent within the past 12 months; or**
- **You were accepted into an individual plan but that plan's premiums would be above Mr. MIP rates.**

The premiums for Mr. MIP can be expensive and there is a 36 *consecutive* month enrollment limitation. The coverage available through Mr. MIP is also limited to $75,000 per year with a lifetime maximum coverage of $750,000. There are no deductibles, but depending on the plan you choose, there may be a co-payment provision. If you are unable to find coverage on your own, and you can afford it, you may want to enroll through Mr. MIP. This way you will be insured and prevent gaps in your coverage.

For individuals who have used the full 36 consecutive months of Mr. MIP coverage, you can get additional coverage through a Mr. MIP graduate program plan. The cost is 110% of the rate for regular Mr. MIP coverage.

For more information and details on how you can apply, you can reach Mr. MIP at 1-800-289-6574 or online at www.mrmib.ca/gov.

Where can I find more help?

For more information on these and other programs, you can contact the Department of Managed Health Care at 1-888- HMO-2219 or online at www.hmohelp.ca.gov or the Department of Insurance at 1-800-927-4357 or online at www.insurance.ca.gov.

CHAPTER 6: KEEPING YOUR JOB AND YOUR WAGES

Health concerns are particularly significant for older working women. They not only have to deal with their own health problems, but often have to take care of sick family members as well. Working women provide the vast majority of the care needed by children as well as disabled, sick and elderly family members in California. An estimated 59% to 75% of the caregivers are women.[148]

For many women, these dual caregiving roles lead to many work-related difficulties. Among working caregivers caring for a family or friend aged 65 or older, two-thirds report having to rearrange their work schedules, decrease their hours or take an unpaid leave in order to meet their caregiving responsibilities. Difficulties due to work and caregiving are even higher among those caring for someone with dementia.[149]

If you have to take time off from work to care for your own health problems or those of a family member, there are state and federal laws that may allow you to take time off from your job and still get paid.

JOB PROTECTED LEAVE

There are federal and state laws that allow you, if you qualify, to take time off from work to care for your own serious health condition or that of a certain family members with the right to return to the same or equivalent job at the end of the leave period.

The Family and Medical Leave Act and the California Family Rights Act

Under the federal law, the Family and Medical Leave Act (FMLA) and the state law, the California Family Rights Act (CFRA), "eligible" employees are allowed the following:

- **Up to 12 weeks of unpaid leave per year;**
- **Continuation of health benefits (during leave); and**
- **Job protection (during leave).** [150]

Under both laws, eligible employees can take time off from work to take care of their own serious medical condition or to take care of a seriously ill child, spouse, domestic partner (under the CFRA only) or parent. Eligible employees can also take time off to care for a newborn child or newly adopted or foster child.

Both the FMLA and CFRA are minimum standards. That means that your employer can offer you a more generous leave policy in addition to the FMLA and CFRA leave. Collective bargaining agreements can also offer more generous leave policies.

If you do not qualify for the FMLA/CFRA leave, your employer may still choose to provide leave to you under the employer's own leave policy.

Who is an "eligible" employee?

Whether you qualify for medical leave under the FMLA and CFRA depends on the number of employees working for your employer, where these employees are located, and how long you have been working for your employer.

To be eligible for the FMLA/CFRA leave, employees must meet the following requirements:

- **Have worked for their employer for at least one year.**
- **Have worked at least 1,250 hours in the year prior to the first day of leave. This works out to be about 25 hours per week, 52 weeks per year.**
- **Have worked for an employer with at least 50 employees within a 75-mile radius. The 50 employees do not have to work at the same location or be employed full-time. Moreover, public employers (*e.g.*, federal and state government employers) are subject to the FMLA and CFRA requirements even if they do not have 50 employees.** [151]

The provisions of the FMLA and CFRA are virtually identical except in the area of pregnancy leave. Eligibility for protection is the same under both laws. In some areas, California law is more generous than the federal protections and offers additional benefits to California employees.

What is a "serious health condition"?

In general, an illness, injury, or physical or mental impairment that involves the following is a "serious health condition" for purposes of the FMLA or CFRA:

- **Inpatient care, that is, an overnight stay in a hospital, hospice or residential care facility; or**
- **Continuing treatment by a healthcare provider.** [152]

The "continuing treatment" requirement can include several different situations. For example, if you are unable to work or perform other regular activities for more than 3 days and you require treatment by a healthcare provider, your condition qualifies as a serious health condition under the "continuing treatment" requirement. Possible examples of health conditions that meet this requirement include back injury and pneumonia.

Other examples of serious health conditions requiring "continuing treatment" by a healthcare provider include:

- **Incapacity or treatment for chronic health conditions such as diabetes, epilepsy or migraines;**
- **Incapacity or treatment for terminal or incurable conditions such as terminal cancer or Alzheimer's disease; and**

- **Any period of absence needed to receive multiple treatments for a condition that would be incapacitating without the treatment such as chemotherapy for cancer or dialysis for kidney disease.**

However, conditions like the common cold or flu, ear aches, upset stomachs, minor ulcers, and routine dental problems, barring unusual circumstances, are not considered to be serious health conditions under the FMLA or CFRA.

What counts as "caring for" a family member with a serious health condition?

Remember, under both the FMLA and CFRA, eligible employees can take time off from work to take care of their own serious medical condition or to care for a family member with a serious health condition. Caring for a family member with a serious health condition includes the following:

- **Driving to doctor appointments.**
- **Providing psychological comfort and care.**
- **Providing for medical, hygienic, nutritional needs and safety.**
- **Making arrangements for changes in care (*e.g.*, move into a nursing home).**

How do I ask for medical leave?

There is no required format that you must use to request leave and you do not have to use the exact words, "I am requesting leave under the FMLA/CFRA," but it is recommended. You must state the reason leave is needed. If your employer provides a request form, you should use the form to make your leave request.

You must give your employer reasonable advance notice that you want to take leave, usually 30 days, if possible. Without prior notice, your leave may be delayed but not denied. You should notify your employer in writing and get documentation of your employer's response. In emergency situations, notify the employer of your need for leave as soon as possible (*e.g.*, 1-2 business days). [153]

What medical documentation needs to be provided to my employer?

Before your request for leave is approved, your employer may ask you for a written communication (medical certification) from the healthcare provider caring for you or your family member. You may be asked to certify the date on which the serious health condition commenced, the probable duration of the condition if it is your own health condition, and/or an estimate of the time required to care for a family member. The employer, however, may not require identification of the serious health condition.[154] **In other words, the employer can ask how long you will be out but cannot ask for your diagnosis because of California's strict privacy laws.**

If the leave is for your own serious health condition, the medical certification must contain a statement that you are unable to perform one or more of the essential functions

of your job.[155] If the leave is requested to care for a family member, the statement must certify that the participation of a family member is necessary. The employer must comply with all applicable laws regarding the confidentiality of medical information.

What rights do I have while I am on medical leave?

- **Continuation of health coverage.**

Remember, although the leave is **unpaid**, your employer is still obligated to maintain your existing health coverage under any group health plan while you are on the CFRA or FMLA leave including family member coverage, dental coverage and mental health coverage. **This means that your employer must continue to pay your health insurance premiums while you are on leave.[156]** For example, if an employer normally pays 80% of your medical and dental insurance premiums, the employer must continue to pay 80% of these premiums while you are on medical leave.

Under the FMLA, your employer is not required to pay for non-health benefits (*e.g.*, life insurance, disability insurance, pensions). Under the CFRA, an employee is entitled to slightly greater protection. If an employer in California pays for non-health benefits for employees on other unpaid leaves, then the employer must continue to pay for those benefits while the employee is on the CFRA leave.[157]

- **Job protection.**

Under the FMLA or CFRA, when you return from your medical leave, you are entitled to return to your previous job or to an equivalent job with the same pay, benefits and other conditions.[158] You are not, however, entitled to any greater reinstatement rights when you return. For example, if your job was eliminated in a lay-off, your employer does not have to provide you with another job just because you are returning from medical leave. With regard to seniority, you are entitled to the same level of seniority when you return to work as you had when you went on leave. You are not entitled to accrue additional benefits or seniority during unpaid FMLA leave.

Do I have to take my leave at one time?

No. You can split up the 12 weeks into shorter time periods. Leave may be taken intermittently or on a reduced work schedule when medically necessary for treatment of a serious health condition, for recovery from treatment for a serious health condition, or to provide care or psychological comfort to an immediate family member with a serious health condition.[159] Instead of taking the 12 weeks all at once, you can take it in smaller blocks of time, such as two hours for a medical exam one week, and two weeks to recover from treatment (*e.g.*, chemotherapy) another week.

FINANCIAL ASSISTANCE WHILE TAKING LEAVE

What if I'm not working and I need financial assistance?

If you cannot work because of your own medical condition or that of a family member, here are some programs that could help you.

Disability Insurance

If you are covered though a private or employer-based disability insurance plan, you may be eligible for a percentage of your salary during the time when you are not able to work.

State Disability Insurance

If you are on a medical leave of absence from work, State Disability Insurance ("SDI") can be a source of weekly income. The SDI program provides benefits to workers who are unable to work due to their own non work-related illness, injury or pregnancy. The program is financed entirely by California workers through a payroll tax on their earnings.

For disabilities beginning on or after January 1, 2006, benefits range from $50 to a maximum of $840 per week and are payable for a maximum of 52 weeks. To receive benefit payments, you must:

- **File a claim.**
- **Serve a 7 day non-payable waiting period.**
- **Have been paid at least $300 in wages that were subject to SDI taxes during the 12-month base period of the claim.**
- **Submit to a reasonable medical examination, if required.**
- **File a certificate of disability signed by a duly authorized medical practitioner.**

Claims are filed by mail and checks are usually mailed to clients every 2 weeks. For additional information on the SDI program, visit the California Employment Development Department ("EDD") website at www.edd.ca.gov or call 1-800-480-3287.

Paid Family Leave

California is the first state in the nation to create a comprehensive Paid Family Leave (PFL) benefits program – a new program specifically targeted for caregivers. The SDI program was expanded to include a Family Temporary Disability program which allows you to take paid leave when certain family members have a serious health condition. For example, PFL allows you to take paid leave from work when your mother or father has a serious health crisis, like a heart attack, or your husband or wife has a chronic health problem like diabetes. This is a particularly important benefit for women, as they tend to

be the primary caregivers for their families. In fact, almost 70% of all PFL claims so far have been filed by women.

What counts as family leave and how long can I take it?

The PFL program provides workers with a maximum of six weeks of partial pay each year if they need to take time off from work to:

- **Care for a seriously ill parent, child, spouse or registered domestic partner; or**
- **Bond with a newborn baby, adopted or foster child (both parents can apply).**[160]

Most workers will receive just over half (55%) of their usual pay, up to a maximum of $840 per week (in 2006), while on leave. The program is 100% employee-funded and payments are distributed by the EDD.

Who is eligible for the PFL program?

Almost all working Californians can use the program. Employees do not have to work a certain number of hours or days to be eligible for PFL. Everyone who pays into the State Disability Insurance ("SDI") program is eligible for paid leave; the size of the employer's workforce is not relevant. There is, however, a 7-day waiting period before benefits start. Look for the "SDI" or "DBL" on your pay stub or ask your employer, union or human resources department to see if you qualify.

What do I need to show in order to take PFL?

To care for a seriously ill family member, you need to file a medical certificate from a doctor that establishes the serious health condition of the family member that requires your care. The certificate must include the following information:

- **The date, if known, on which the medical condition began;**
- **The probable duration of the condition;**
- **An estimate of the amount of time that the physician believes that you are needed to care for the ill family member; and**
- **A statement that the ill family member has a serious health condition that requires your care.**

Can I take paid leave even if I am not a U.S. citizen?

Yes. You are eligible to take paid leave if you pay into the SDI program. You do not have to be a U.S. citizen.

Do I need to take all of my Paid Family Leave at one time?

No, the leave can be taken intermittently. The law does not establish a minimum number of hours, days or weeks that an employee must take leave in order to receive PFL benefits. It only establishes the maximum benefit time of six weeks within a 12-month period.

I don't speak English. How do I find out about Paid Family Leave?

The EDD will make every effort to communicate with you in your native language. Brochures are currently available in Spanish, Chinese, Cambodian, Korean, Laotian, Thai and Vietnamese.

How do I apply?

Fill out a claim form and send it to EDD. You can get claim forms from you healthcare provider or by calling EDD's toll-free numbers:

- **1-877-BE-THERE (English)**
- **1-877-379-3819 (Spanish)**
- **1-800-547-3506 (Cantonese)**
- **1-800-547-2058 (Vietnamese)**
- **1-800-563-2441 (TTY)**

You can also visit EDD online: www.edd.ca.gov.

My employer says she can't hold my job for me if I take PFL. What can I do?

The PFL law does not expressly provide the right to reinstatement or job protection. However, workers may be protected under other leave laws such as the Family Medical Leave Act or the California Family Rights Act (discussed above). Consult with an attorney or legal advocate to learn more about the laws and your rights.

You can also contact:

- Employment Law Center - Legal Aid Society at 800-880-8047; or
- Equal Rights Advocates at 800-839-4372.

For additional information on the PFL law, contact the EDD or the Paid Family Leave Collaborative at www.paidfamilyleave.org.

Family Sick Leave or Kin Care Leave

California employers are not required to provide sick leave for their employees. If they do provide this benefit, however, they must allow you to use a portion of your sick leave to take time off of work to take care of an ill child, parent, spouse or domestic partner.[161]

Moreover, unlike the FMLA or CFRA leave, a family member need not have a "serious" health condition before you can use your sick leave to care for them. This right to take sick leave to care for an ill family member is also referred to as "kin care."

Under family sick leave or kin care leave, you have the right to use up to 50% of your annual accrued and available sick leave to take care of ill family members.

The law applies to all employers who provide sick leave; it is not limited to companies of a certain size. It also applies to the state, political subdivisions of the state and municipalities.

RESOURCES

California Health Advocates
Information on Medicare
1-916-231-5110
www.cahealthadvocates.org

California Medical Association
1-916-444-5532
www.cmanet.org

California Medical Review
Medicare HMO quality of care problems
1-800-841-1602
www.lumetra.com

Cal Medicare (California HealthCare Foundation)
Information on Medicare and other health insurance
1-888-430-2423
www.calmedicare.org

Centers for Medicare & Medicaid Services
Information on Medicare, Medicaid and HIPAA
1-877-267-2323
www.cms.hhs.gov

Department of Insurance
Information and help for California consumers
1-800-927-4357
www.insurance.ca.gov

Department of Managed Health Care
Information and help for California HMO members
1-888-HMO-2219
www.dmhc.ca.gov

Foundation for Taxpayer and Consumer Rights
Information on healthcare rights and remedies
1-310-392-0522
www.consumerwatchdog.org

Health Insurance Counseling & Advocacy Program
Information, counseling and advocacy for Medicare members
1-800-434-0222

Health Consumer Alliance
Information on health care coverage and services for low-income Californians
www.healthconsumer.org

HMO Help Center
Information and help for California HMO members
1-888-HMO-2219
www.hmohelp.ca.gov

Lumetra
Organization that provides external reviews of Medicare decisions in dispute
1-800-841-1602
info@lumetra.com

Maximus Center for Health Dispute Resolution
Organization that provides external reviews of Medicare decisions in dispute
1-800-MAXIMUS
info@maximus.com

Medi-Cal Fair Hearing (Department of Social Services)
Where to file an appeal if Medi-Cal denies you services you need
1-800-952-5253

National Senior Citizens Law Center
Advocates and litigates on behalf of senior citizens
1-213-639-0930
www.nsclc.org

Office of the Patient Advocate
Information on California HMOs
1-866-466-8900
www.opa.ca.gov

Western Center on Law & Poverty
Information about public benefits
1-213-487-7211
1-707-552-5306
1-916-442-0743
www.wclp.org

U.S. Department of Labor
Information about COBRA and HIPPA
1-866-444-3272
www.dol.gov

[1] Office of the Patient Advocate, *Getting the Most from Your HMO* (2005); available online at www.opa.ca.gov.

[2] The Henry J. Kaiser Family Foundation, Publication No. 7350, *A Consumer Guide to Handling Disputes with Your Private or Employer Health Plan* (Aug. 2005); available online at www.kff.org.

[3] National Endowment for Financial Education, *Frozen in the Headlights: The Dynamics of Women and Money,* A Report on the "Women & Money Program Incubator" (2000).

[4] The Henry J. Kaiser Family Foundation, Publication No. 7350, *A Consumer Guide to Handling Disputes with Your Private or Employer Health Plan* (Aug. 2005); available online at www.kff.org.

[5] *Id*.

[6] Family Caregiver Alliance, *Selected Caregiver Statistics Fact Sheet* (2005); available online at www.caregiver.org.

[7] Office of the Patient Advocate, *Your Rights as an HMO Patient* (2001); available online at www.opa.ca.gov.

[8] *Id*.

[9] 29 U.S.C. §§ 118b(a)(1) - (3).

[10] Cal. Health & Safety Code § 1367.635.

[11] Cal. Health & Safety Code §§ 1367.65, 1367.66, 1367.67.

[12] Cal. Health & Safety Code§ 1367.695.

[13] Cal. Health & Safety Code § 1340 *et seq*.

[14] Health Consumer Alliance, *Overview of the Medi-Cal System*, Chapter 15 at pp. 213-214 (March 2002); available online at www.healthconsumer.org.

[15] Cal. Health & Safety Code §§ 1368 *et seq*.

[16] Cal. Health & Safety Code § 1368(a)(1)-(2).

[17] Cal. Health & Safety Code § 1368(d).

[18] Cal. Health & Safety Code §§ 1374.30 *et seq*.

[19] Cal. Health & Safety Code § 1374.30(b).

[20] Cal. Health & Safety Code § 1374.30(j)(3).

[21] Cal. Health & Safety Code § 1374.31.

[22] Cal. Health & Safety Code § 1370.4(a).

[23] Cal. Health & Safety Code § 1374.30(d)(2)-(3).

[24] Cal. Health & Safety Code § 1374.33.

[25] Cal. Health & Safety Code §§ 1368(b)(6), 1374.33(f).

[26] Cal. Civil Code § 3428(k).

[27] Cal. Ins. Code §§ 10145.3, 10169 – 10169.5.

[28] *See* Foundation for Taxpayer and Consumer Rights, *Your Health Care Rights and Remedies*, Chapter VIII at 50-55 (2001) for additional information; available on at www.calpatientguide.org.

[29] 29 U.S.C. §§ 1001 *et seq.*; 29 C.F.R. § 2510 *et seq*.

[30] 29 U.S.C. § 1003.

[31] 29 C.F.R. § 2510.3-3(b).

[32] Federal employees are subject to the Federal Employee Health Benefits Act (FEHBA) which may restrict your ability to use state law in other ways.

[33] Judith A. Stein & Alfred J. Chiplin, *2005-2006 Medicare Handbook* § 9.02 at 4 (Aspen Publishers 2006).

[34] U.S. General Accounting Office, *Employer-Based Managed Care Plans: ERISA's Effect on Remedies for Benefit Denials and Medical Malpractice* (1998), available online at www.gao.gov.

[35] 29 C.F.R. § 2560.503-1(g).

[36] 29 C.F.R. § 2560.503-1(h)(3)(i).

[37] 29 C.F.R. § 2560.503-1(i)(2).

[38] 29 C.F.R. § 2560.503-1(i)(2)(i).

[39] 29 C.F.R. § 2560.503(1)(j).

[40] 29 U.S.C. § 1132(a).

[41] *Mertens v. Hewitt Assoc*., 508 U.S. 248, 255 (1993).

[42] *See e.g.*, Title VI of the Civil Rights Act of 1964; Cal. Health & Safety Code §1259; Cal. Govt. Code § 11135.

[43] California Coalition for Older Working Women, *Comments on California's Two-Year Strategic Plan for WIA and Wagner-Peyser Act for 2005-2007* (April 2005); U.S. Department of Labor, *Quick Facts on Older Workers, Ages 55 and Over* (Feb. 2006).

[44] California Health Advocates, *Medi-Cal: The Federal Medicaid Program in California* (April 2006); available online at www.calmedicare.org.

[45] 3848 Federal Register, Vol. 71, No. 15, January 24, 2006. These numbers are subject to change every year. For updates, visit the U.S. Department of Health & Human Services website at http://aspe.hhs.gov/poverty.

[46] *Id*.

[47] Cal. Welf. & Inst. Code § 10953.

[48] Cal. Welf. & Inst. Code § 10950.

[49] 42 C.F.R. §§ 431.206, 431.210; Cal. Code Regs. Tit. 22 § 51014.1; Cal. Welf. & Inst. Code § 10967.

[50] Health Consumer Alliance, *Overview of the Medi-Cal System*, Chapter 17 at 241 (March 2002); available online at www.healthconsumer.org.

[51] Cal. Welf. & Inst. Code § 10951.

[52] California Health and Human Services Agency, Department of Social Services, Pub. No. 13, *Your Rights under California Welfare Programs* (Nov. 2005); California Health and Human Services Agency, Department of Social Services, Pub. No. 412, *State Hearing Information* (April 2004).

[53] *Id.*

[54] Cal. Welf. & Inst. Code § 10952.5. However, administrative law judges have not required the State Department of Health Services to follow this rule.

[55] California Health and Human Services Agency, Department of Social Services, Pub. No. 13, *Your Rights under California Welfare Programs* (Nov. 2005); California Health and Human Services Agency, Department of Social Services, Pub. No. 412, *State Hearing Information* (April 2004).

[56] Cal. Welf. & Inst. Code § 10952.

[57] Cal. Welf. & Inst. Code § 10955.

[58] Cal. Welf. & Inst. Code § 10959.

[59] Cal. Welf. & Inst. Code § 10960.

[60] 42 C.F.R. § 431.244(f).

[61] Cal. Welf. & Inst. Code § 10962.

[62] Cal. Welf.& Inst. Code § 10962.

[63] Health Consumer Alliance, *Overview of the Medi-Cal System*, Chapter 15 at 207-208 (March 2002); available online at www.healthconsumer.org.

[64] The Henry J. Kaiser Family Foundation, Pub. No. 6000-04, *Women's Health Insurance Coverage* (Mar. 2006); The Henry J. Kaiser Family Foundation, Pub. No. 7184, *Health Care & The 2004 Elections: Women's Health Policy* (Sept. 2004); both available online at www.kff.org.

[65] The Henry J. Kaiser Family Foundation, Pub. No. 7240, *Navigating Medicare and Medicaid, A Resource Guide for People with Disabilities, Their Families and Their Advocates* (Feb. 2005) at 7-8; available online at www.kff.org.

[66] 42 U.S.C. § 1395i-2.

[67] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Pub. No. 02248, *Women with Medicare: Visiting Your Doctor for a Pap Test, Pelvic Exam and Clinical Breast Exam* (July 2005).

[68] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Prescription Drug Coverage: Basic Information* (Nov. 2005).

[69] Judith A. Stein & Alfred J. Chiplin, *2005-2006 Medicare Handbook* § 11.05 at 11-8 (Aspen Publishers 2006).

[70] *Id*.

[71] 42 U.S.C. § 1395i-2(c)(6); 42 U.S.C. § 1395r(b); 42 C.F.R. § 408.22; and 42 U.S.C. § 1395ww-113(b).

[72] 42 U.S.C. § 1395w-114.

[73] Judith A. Stein & Alfred J. Chiplin, *2005-2006 Medicare Handbook* § 10.06 at 10-25 (Aspen Publishers 2006).

[74] U.S. Department of Health and Human Services, Administration on Aging, *A Profile of Older Americans* (2005), available online at www.aoa.gov.

[75] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicare & You 2006* at 5; available online at www.medicare.gov.

[76] Judith A. Stein & Alfred J. Chiplin, *2005-2006 Medicare Handbook* § 1.07 at 1-35 (Aspen Publishers 2006).

[77] *Id.* at 2-27.

[78] *Id*. at 2-25 to 2-26.

[79] 42 C.F.R. § 405.922.

[80] 42 C.F.R. § 405.921(a).

[81] 42 C.F.R. § 405.904.

[82] Judith A. Stein & Alfred J. Chiplin, *2005-2006 Medicare Handbook* § 1.07 at 1-28 (Aspen Publishers 2006).

[83] *See* California Health Advocates, *If Your Medicare Part A or Part B Claim is Denied*, available online at www.calmedicare.org for more information on the five-step appeals process.

[84] 42 C.F.R. § 405.940 *et seq*.

[85] 42 C.F.R. § 405.944.

[86] 42 C.F.R. § 405.950(a).

[87] Judith A. Stein & Alfred J. Chiplin, *2005-2006 Medicare Handbook* § 1.07 at 1-24 (Aspen Publishers 2006).

[88] 42 C.F.R. §§ 405.962 – 405.964.

[89] 42 C.F.R. § 405.970.

[90] 42 C.F.R. §§ 405.1000 *et seq*.

[91] 42 C.F.R. § 405.1014.

[92] 42 C.F.R. § 405.1006.

[93] 42 C.F.R. §§ 405.1022 - 405.1036.

[94] 42 C.F.R. § 405.1046.

[95] 42 C.F.R. §§ 405.1100 *et seq*.

[96] 42 C.F.R. § 405.1122(a).

[97] 42 C.F.R. § 405.1128.

[98] 42 C.F.R. § 405.1136.

[99] 42 C.F.R. §§ 422.1 *et seq*.

[100] See California Health Advocates, *Medicare Advantage Plans: Appeals & Grievances*, available online at www.calmedicare.org for more information on the five-step appeals process.

[101] Lumetra, *Hospital Discharge Appeals*; available online at www.Lumetra.com.

[102] 42 C.F.R. § 405.960.

[103] The Henry J. Kaiser Family Foundation, Pub. No. 7433, *The Exceptions and Appeals Process: Issues and Concerns in Obtaining Coverage Under the Medicare Part D Prescription Drug Benefit* at 1-3 (Nov. 2005).

[104] Judith A. Stein & Alfred J. Chiplin, *2005-2006 Medicare Handbook* § 11.09 at 11.21 (Aspen Publishers 2006); 42 C.F.R. § 423.566.

[105] Judith A. Stein & Alfred J. Chiplin, *2005-2006 Medicare Handbook* § 11.09 at 11.20 (Aspen Publishers 2006).

[106] 42 C.F.R. § 423.568.

[107] 42 C.F.R. § 423.572.

[108] *See* California Health Advocates, *Medicare Prescription Drug Coverage: Complaints, Coverage Determinations, and Appeals*, available online at www.calmedicare.org for more information on the appeals process.

[109] 42 C.F.R. §§ 423.580-423.590.

[110] 42 C.F.R. §§ 423.600-423.604.

[111] 42 C.F.R. §§ 423.610-423.612.

[112] 42 C.F.R. § 423.620.

[113] 42 C.F.R. § 423.630.

[114] 42 U.S.C.A. § 1395w-104(g), (h); 42 C.F.R. § 423.578.

[115] Judith A. Stein & Alfred J. Chiplin, *2005-2006 Medicare Handbook* § 11.09, 11.22 (Aspen Publishers 2006).
[116] *Id*. at §§ 11.09, 11-21 to 11-22.
[117] *Id*. at § 10.01 at 5.
[118] U.S. National Institutes of Health, National Institute on Aging, Press Release, *Well-Being Improves for Most Older People, But Not for All* (Aug. 2000); available online at www.nia.nih.gov.
[119] Eric Carlson, National Senior Citizens Law Center, *20 Common Nursing Home Problems – and How to Resolve Them*, 2005 at 1.
[120] *Id*.
[121] *Id*. at 3.
[122] *Id*.
[123] The Henry J. Kaiser Family Foundation, Pub. No. 7336, *Women and Health Care: A National Profile, Key Findings from the Kaiser Women's Health Survey, Chapter 3: Women and Health Insurance Coverage* (July 2005); available online at www.kff.org.
[124] *Id.*
[125] Cal. Health & Safety Code § 1357.51(a)-(b).
[126] Cal. Health & Safety Code § 1357.51.
[127] Cal. Health & Safety Code § 1357.51(e).
[128] California Department of Managed Health Care, HMO Help Center, *Individual Health Insurance*, (2006); available online at www.dmhc.ca.gov.
[129] *Id.*
[130] *Id.*
[131] *Id*.
[132] California Department of Managed Health Care, HMO Help Center, *Individual Health Insurance*, (2006); available online at www.dmhc.ca.gov.
[133] *Id.*
[134] 42 U.S.C. § 300bb-1 *et seq*; 29 U.S.C. § 1161 *et seq*.; 26 U.S.C. § 4980B.
[135] Cal. Health & Safety Code §§ 1366.20 *et seq*.; Cal. Welf. & Inst. Code § 10952.5. *See also*, California Department of Managed Health Care, HMO Help Center, *Federal COBRA and Cal-COBRA* (2006); available online at www.dmhc.ca.gov.
[136] 26 U.S.C. § 4980B(f)(2)(B)(i); Cal. Health & Safety Code §§ 1366.27(a)(5) – 1366.27(a)(6).
[137] California Department of Managed Health Care, HMO Help Center, *Federal COBRA and Cal-COBRA* (2006); available online at www.dmhc.ca.gov.
[138] California Department of Managed Health Care, HMO Help Center, *Federal COBRA and Cal-COBRA* (2006); available online at www.dmhc.ca.gov.
[139] *Id*.
[140] *Id.*
[141] *Id.*
[142] *Id.*
[143] *Id.*
[144] Cal. Health & Safety Code § 1373.6.
[145] Cal. Health & Safety Code §§ 1366.25; 1373.6.
[146] *Id.*
[147] *Id.*
[148] Family Caregiver Alliance, *Selected Caregiver Statistics Fact Sheet* (2005); available online at www.caregiver.org.
[149] *Id*.
[150] 29 U.S.C. § 2612; Cal. Govt. Code § 12945.2.
[151] 29 U.S.C. §§ 2611, 2612; Cal. Govt. Code § 12945.2; 2 C.C.R. §§ 7297.0, 7297.5.
[152] 29 C.F.R. 825.114(a)-(e); Cal. Gov. Code § 12945.2(c)(8).
[153] 29 U.S.C. § 2612; 29 C.F.R. § 825.100(d); 2 C.C.R. § 7297.4(a)(1)-(2).
[154] 29 U.S.C. §2613; 29 C.F.R. § 825.100(d); Cal. Govt. Code § 12945.2; 2 C.C.R. § 7297.4.
[155] 29 C.F.R. § 825.100(d); 29 C.F.R. § 825.115; 2 C.C.R. § 7297.4(b)(1).
[156] 29 C.F.R. § 825.100(b); Cal. Gov. Code § 12945.2(f)(1).
[157] Cal. Gov. Code § 12945.2(f)(2).

158 29 C.F.R. § 825.100(c); 2 C.C.R. § 7297.5(d).
159 29 U.S.C. § 2612(b)(1); 29 C.F.R. § 825.203(c); 2 C.C.R. § 7297.3.
160 Cal. Unemp. Ins. Code §§ 3300-3305.
161 Cal. Lab. Code § 233.