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

By

Karen Pollitz
Kevin Lucia
Eliza Bangit
Jennifer Hersh
Jennifer Libster
Mila Kofman

GEORGETOWN UNIVERSITY
HEALTH POLICY INSTITUTE

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This guide is intended to help consumers understand their protections under federal and state law. The authors have made every attempt to assure that the information presented in this guide is accurate as of the date of publication. However, the guide is a summary, and should not be used as a substitute for legal, accounting, or other expert professional advice. Readers should consult insurance regulators or other competent professionals for guidance in making health insurance decisions. The authors, Georgetown University, and the Health Policy Institute specifically disclaim any personal liability, loss or risk incurred as a consequence of the use and application, either directly or indirectly, of any information presented herein.

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

As an Idaho resident, you have rights under federal and state law that will protect you when you seek to buy, keep, or switch your health insurance, even if you have a serious health condition.

This guide describes your protections as an Idaho resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group and individual health insurance. Chapter 4 highlights your protections as a small employer or self-employed person. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from Idaho, your protections may change. Since this guide is a summary, it may not answer all of your questions. For places to contact for more information, see page 29. For information about how to find consumer guides for other states on the Internet, see page 29. A list of helpful terms and their definitions begins on page 30. These terms are in **boldface type** the first time they appear.

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CHAPTER 1
A SUMMARY OF YOUR PROTECTIONS

Numerous state and federal laws make it easier for people with **pre-existing conditions** to get or keep **health insurance**, or to change from one health plan to another. A federal law, known as the **Health Insurance Portability and Accountability Act (HIPAA)** sets national standards for all health plans. In addition, states can pass different reforms for the health plans they regulate (**fully insured group health plans** and **individual health insurance**), so your protections may vary if you leave Idaho. Idaho has expanded protections for certain kinds of health insurance beyond what federal law requires. Neither federal nor state laws protect your access to health insurance in all circumstances. So please read this guide carefully.

The following information summarizes how federal and state laws do – or do not – protect you as an Idaho resident.

HOW AM I PROTECTED?

In Idaho, as in many other states, your health insurance options are somewhat dependent on your **health status**. Even if you are sick, however, the laws protect you in the following ways.

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status.* This is called **nondiscrimination**. (See page 5.)

- *All health plans in Idaho must limit exclusion of pre-existing conditions.* There are rules about what counts as a pre-existing condition and how long you must wait before a new health plan will begin to pay for care for that condition. Generally, if you join a new plan your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage. (See pages 7 and 12.)

- *Your health insurance cannot be canceled because you get sick.* This means that your health insurance is **guaranteed renewable**. (See pages 12 and 21.)

- *Idaho residents are guaranteed the right to buy **Individual High Risk Reinsurance Pool** (HRP) plans under certain circumstances.* You may be able to buy a HRP plan if an Idaho insurer turns you down due to health status or claims experience or offers to sell you coverage at a premium higher than that charged for HRP plans. You are also guaranteed the right to buy this coverage if you are **HIPAA eligible** or eligible for the Federal Heath Coverage Tax Credit (HCTC). This is called **guaranteed issue**. (See page 13.)

- *You cannot be charged more for a HRP plan coverage due to your health status.* Premiums can vary due to age, gender, individual tobacco use, family size, where you live, and the type of plan you seek. This is called modified community rating. (See page 15.)

- *If you leave your job, you may be able to remain in your old group health plan for a certain length of time.* This is called **COBRA** continuation coverage. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. You may also be able to buy a **conversion plan**. There are limits on what you can be charged for COBRA or conversion coverage. (See pages 15 and 19.)

- *If you are a small employer buying a group health plan for 2-50 employees, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group.* This is called guaranteed issue. (See page 21.)

- *If you are a small employer buying a group health plan, you cannot be charged more due to the health status of those in your group.* You can, however, be charged higher premiums, within limits, because of the age, gender, tobacco use, and location of those in your group. This is called **modified community rating**. (See page 21.)

- *If you have low or modest household income, you may be eligible for free or subsidized health insurance coverage through for yourself or members of your family.* The Idaho **Medicaid** program offers free health coverage for pregnant women, families with children, and elderly and disabled individuals. (See page 23.)

- *If you believe you may be at risk for cancer but are uninsured or underinsured, you may be eligible for screening and treatment.* The **Women's Health Check Program** provides free cancer screening for qualified residents. Some women diagnosed with breast or cervical cancer through this program may be eligible for medical care through Medicaid. (See page 25.)

- *If you lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program**, you may be eligible for a federal income tax credit to help you pay for new health coverage.* This credit is called the **Health Coverage Tax Credit (HCTC)**, and is equal to 65% of the cost of qualified coverage, including COBRA and health insurance offered through individual insurers participating in Idaho's High Risk Reinsurance Pool. (See page 26).

- *If you are a retiree aged 55-65 and receiving benefits from **Pension Benefit Guarantee Corporation (PBGC),** then you may be eligible for the HCTC.* (See page 26).

WHAT ARE THE LIMITS ON MY PROTECTIONS?

As important as they are, the federal and state health insurance reforms are limited. Therefore, you also should understand how the laws do not protect you.

- *If you change jobs, you usually cannot take your old group health benefits with you.* Except when you exercise your federal COBRA rights, you are not entitled to take your group health coverage with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did. (See page 10.)

- *If you change jobs, your new employer may not offer you health benefits.* If your employer does offer coverage, it is required only to make sure that their decision is based on factors unrelated to your health status. (See page 5.)

- *If you get a new job with health benefits, your coverage may not start right away.* Employers and managed care organizations (**MCOs**) can require **waiting periods** before your health benefits begin. (See page 6.)

- *If you have a break in coverage of 63 days or more, you may have to satisfy a new pre-existing condition exclusion period when you join a new plan.* (See page 8.)

- *Even if your coverage is **continuous**, there may be a pre-existing condition exclusion period for some benefits if you join a **self-insured group health plan** that covers benefits your old plan did not.* For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to six months or one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition. (See page 7.)

- *If you work for certain non-federal public employers in Idaho, not all of the group health plan protections may apply to you.* (See page 9.)

- *Individual health insurers can turn you down or charge you more for coverage other than HRP plans based on your health status.* (See page 11.)

- *Unless you are HIPAA eligible, you may not be able to purchase individual health insurance in another state.*

CHAPTER 2
YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

This chapter describes the protections that you have in group health plans, such as those offered by employers or labor unions. Your protections will vary somewhat, depending on whether your plan is a fully insured group health plan or a **self-insured group health plan**. The plan's benefits information must indicate whether the plan is self-insured.

WHEN DOES A GROUP HEALTH PLAN HAVE TO LET ME IN?

- *You have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees. Or, your employer may offer a MCO plan that you cannot join because you live outside of the plan's service area.

- *You cannot be turned away or charged more because of your health status.* Health status means your medical condition or history, genetic information or disability. This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (such as part time employment), as long as these are unrelated to health status and applied consistently. However, if you work for a small employer in Idaho, insurance companies must offer coverage to all eligible employees.

Discrimination due to health status is not permitted

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

- *You must be given a special opportunity to sign up for your group health plan if certain changes happen to your family.* In addition to any regular **enrollment period** your employer or group health plan offers, you must be offered a special, 60-day opportunity to enroll in your group health plan after certain events. You can elect coverage at this time. If your group plan offers family coverage, your dependents can elect coverage as well. Enrollment during a **special enrollment period** is not considered **late enrollment**.

Certain changes can trigger a special enrollment opportunity

- The birth, adoption, or placement for adoption of a child
- Marriage
- Loss of other coverage (for example, that you or your dependents had through yourself or another family member and loss because of death, divorce, legal separation, termination, retirement, or reduction in hours worked)

- *Under Idaho law, newborns and adopted children are automatically covered under the parents' fully insured health plan for the first 60 days.* The insurer may require that the parent enroll the baby within the 60 days in order to continue coverage beyond the 60 days, if your plan provides dependent coverage.

- *If you have a disabled child, that child may remain covered under your fully insured group health plan after he or she reaches the age at which dependent coverage is usually terminated*. To qualify, your adult son or daughter must be incapable of self-support because of mental retardation or physical disability and must be chiefly dependent on the policyholder for support. Proof of incapacity must be furnished to the insurer within 31 days of limiting age.

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

- *If you have to take leave from your job due to illness, the birth or adoption of a child, or to care for a seriously ill family member, you may be able to keep your group health coverage for a limited time.* A federal law known as the **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job-protected leave in these circumstances.

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

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

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

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

CAN A GROUP HEALTH PLAN LIMIT MY COVERAGE FOR PRE-EXISTING CONDITIONS?

When you first enroll in a group health plan, the employer or insurance company may ask if you have any pre-existing conditions. Or, if you make a claim during the first twelve months of coverage, the plan may look back to see whether it was for such a condition. If so, it may try to exclude coverage for services related to that condition for a certain length of time. However, federal and state laws protect you by placing limits on these pre-existing condition exclusion periods under group health plans.

- *A group health plan can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan*. This period is also called the **look back** period.

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

- *Under group health plans, coverage for pre-existing conditions can be excluded only for a limited time.* The maximum period is 12 months if you are in a group health plan. You will receive credit toward your pre-existing condition exclusion period for any previous continuous coverage.

- *If you enroll late in your group health plan (after you are hired and not during a regular or special enrollment period), you may have a longer pre-existing condition exclusion period.* If you are a late enrollee in a group health plan, you may have a pre-existing condition exclusion period or you may be excluded from all coverage for up to 18 months. If a pre-existing condition exclusion and waiting period are imposed, the combined length of time cannot exceed eighteen months.

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

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

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

In most cases, you should get a certificate of creditable coverage when you leave a health plan. You also can request certificates at other times. If you cannot get one, you can submit other proof, such as old health plan ID cards or statements from your doctor showing bills paid by your health insurance plan.

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

What is continuous coverage?

Take Art, who is diabetic. Ajax Company covered him under its group health plan for 9 months, but he lost his job and health coverage. Then, 45 days later, Art found a new job at Beta Corporation and had health coverage for 3 more months. Art changed jobs again. His new company, Charter, has a fully insured health plan that covers care for diabetes but excludes pre-existing conditions for 12 months. Charter must cover Art's diabetes care immediately, because his 12 months of prior continuous coverage are credited against the 12-month exclusion.

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

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

- *Your protections may differ if you move to a group health plan that offers more benefits than your old one did.* Plans can look back to determine whether your previous health plan covered prescription drugs, mental health, substance abuse, dental care, or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new group health plan may impose a pre-existing condition exclusion period for that category. In Idaho, fully insured health plans cannot impose pre-existing condition exclusions in this manner.

Even if coverage is continuous, there may be an exclusion for certain benefits:

Sue needs prescription medication to control her blood pressure. She had 2 years of continuous coverage under her employer's group health plan, which did not cover prescription drugs. Sue changes jobs, and her new employer's *self-insured* plan does cover prescription drugs. However, because her prior policy did not, the new plan refuses to cover her blood pressure medicine for 6 months.

Question: Is this permitted?

Answer: Yes. However, the plan must pay for covered doctor visits, hospital care, and other services for Sue's high blood pressure. It also must pay for covered prescription drugs she needs for other conditions that were not pre-existing.

- *No pre-existing condition exclusion period can be applied without appropriate notice.* Your group health plan must inform you, in writing, if it intends to impose such a period. Also, if needed, it must help you get a **certificate of creditable** coverage from your old health plan.

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

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

According to the latest list available from the federal government the County of Bannock, has decided that certain health insurance protections will not apply to their employees. If you have group health coverage through this employer, you should contact them for more information.

Other non-federal public employers in Idaho may have made this choice after this guide was written. If you are not sure about your protections under your public employee health plan, you should contact your employer.

AS YOU ARE LEAVING GROUP COVERAGE…

- *If you are leaving your job or otherwise losing access to your group health coverage, you may be able to remain covered under the group health plan for a limited time.* In addition, you may have special protections when buying certain kinds of individual health coverage. See Chapter 3 for more information about COBRA continuation coverage, conversion plans, Idaho Individual High Risk Reinsurance Pool, and individual health insurance for "HIPAA eligible individuals."

- *If you lost your health insurance and are receiving benefits from the Trade Adjustment Assistance (TAA) Program, you may be eligible for a federal income tax credit to help you pay for new health coverage.* This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 65% of the cost of qualified coverage, including COBRA and health insurance offered through individual insurers participating in Idaho's High Risk Reinsurance Pool. (See page 26.)

- *If you are a retiree aged 55-65 and receiving benefits from Pension Benefit Guarantee Corporation (PBGC), then you may be eligible for the HCTC.* (See page 26.)

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group insurance, you may want to buy an individual health insurance policy from a private health insurance company. However, in Idaho, you have limited guaranteed access to individual health insurance only through the Idaho Individual High Risk Reinsurance Pool. There also are some alternatives to individual health insurance coverage – such as COBRA coverage and conversion coverage. This chapter summarizes your protections under different kinds of health plan coverage.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

WHEN DO INDIVIDUAL HEALTH INSURERS HAVE TO SELL ME A POLICY?

In Idaho, your ability to buy individual health coverage may depend on your health status. There are certain circumstances, however, when you must be allowed to buy individual health coverage.

- *In general your access to individual health insurance may depend on your health status.* You application can be turned down based on your health status.

- *If you are turned down by an individual health insurer because of your health status, you may be eligible to buy a High Risk Reinsurance Pool Plan (HRP) plan from that insurer.* (see below)

- *If you have a disabled child, that child may remain covered under you individual health insurance policy after he or she reaches the age at which dependent coverage is usually terminated*. To qualify, your adult son or daughter must be incapable of self-support because of mental retardation or physical disability and must be chiefly dependent on the policyholder for support. Proof of incapacity must be furnished to the insurer within 31 days of limiting age.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy.* In general, health insurers can design different policies and you will have to read and compare them carefully. However, Idaho does require all individual health insurance policies to cover certain benefits — such as mammograms. Check with the Idaho Department of Insurance for more information about mandated benefits.

- *The Idaho Department of Insurance provides a list of health insurance companies that sell health insurance to individuals.* The list is available on the web at http://www.doi.state.id.us/health/healthinfo.aspx.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you can buy an individual health insurance policy, there are limits on pre-existing condition exclusion periods that can be imposed.* In general, if you have been uninsured for more than 63 days before your individual health insurance becomes effective, you may face a 12-month pre-existing condition exclusion period. The definition of pre-existing condition is different under individual health insurance than under group health plans. Individual health benefits can count as pre-existing any condition for which you received, or — in your insurer's judgment for you should have sought — a diagnosis, or medical advice or treatment in the 6-month period prior to the effective date of the individual health insurance policy. This is called the **prudent person rule**. You will get credit for prior continuous coverage that was not interrupted by a break of 63 or more days in a row.

- *Individual health insurers can apply pre-existing condition exclusion periods for pregnancy, if you were pregnant on the effective date of coverage.*

WHAT CAN I BE CHARGED FOR AN INDIVIDUAL HEALTH INSURANCE POLICY?

- *In Idaho, your individual health insurance policy premiums can vary to reflect your health status, age, gender, individual tobacco use, family size, where you live, and the type of plan you seek.* In addition, when you renew your individual coverage, your premiums can increase substantially as you age.

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELLED?

- *Your coverage cannot be canceled because you get sick.* This is called guaranteed renewability. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of managed care plans, continue to live in a managed care plan's service area. However, your health coverage may be cancelled if the insurer does not continue to offer the coverage for all policyholders.

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

IDAHO INDIVIDUAL HIGH RISK REINSURANCE POOL (HRP)

All individual health insurers must participate in a program called the Idaho Individual High Risk Reinsurance Pool, to provide insurance for Idaho residents. There are rules about when you are eligible to buy individual health insurance under this program. There are limits on what you can be charged. Rates are based on choice of plan, age, individual tobacco use, and family size. There are also limits on pre-existing condition exclusion periods that can be imposed.

WHEN AM I ELIGIBLE FOR A HRP PLAN?

- *There are four ways that you may be eligible to buy a HRP plan.*

  First, if you applied for individual health insurance and were turned down, that insurer must offer you the option to buy a HRP plan.

  Second, if an individual health insurer offered to sell you a policy at a surcharged premium, that insurer must offer you the option to buy a HRP plan.

  Third, if you are HIPAA eligible, you are eligible to buy a HRP policy from any approved insurer in Idaho.

HIPAA eligible individuals

In Idaho, where state laws are more protective, all residents are guaranteed the right to buy certain individual health policies under certain conditions. If you are not HIPAA eligible, however, you may face a preexisting condition exclusion period. If you plan to move to another state, however, you may be guaranteed the right to buy an individual health insurance policy *only if* you are HIPAA eligible.

If you move out of Idaho, this information may be important to you.

To be HIPAA eligible, you must meet certain criteria:

- You must have had 18 months of continuous creditable coverage*, at least the last day of which was under a group health plan*.
- You also must have used up any COBRA or state continuation coverage for which you were eligible.
- You must not be eligible for Medicare, Medicaid or a group health plan.
- You must not have health insurance.
- You must apply for health insurance for which you are HIPAA eligible within 63 days of losing your prior coverage.

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

Finally, if you eligible for the Federal Health Coverage Tax Credit (HCTC) through the Trade Act of 2002, you are eligible to buy a HRP policy from any approved insurer in Idaho (see page -.)

A list of insurers approved to sell HRP plans can be found on the Idaho department of Insurance website at http://www.doi.state.id.us/health/individual_list.aspx

WHAT DOES A HIGH RISK PLAN COVER?

- *There are four HRP plans*. Companies must offer you basic, standard, and two catastrophic plans. All plans cover the same health benefits but cost sharing varies. All insurers sell the same HRP plans. This standardization of benefits will help you compare the cost of coverage from different companies.

- *HRP plans cover hospital and physician services, preventive care, maternity care, prescription drugs, and limited mental health and substance abuse treatment*.

  Under the Basic Plan, the annual deductible is $500 per person. Basic plans pay for 50% of covered services. You pay the other 50% up to a maximum dollar amount, also called your out-of-pocket limit. There is a calendar year out of pocket limit maximum of $20,000 on all covered benefits. Also, there is a lifetime benefit maximum of $500,000

  Under the Standard Plan the annual deductible is $1,000 per person. Standard plans pay for 70% of covered services. You pay the other 30% up to an out-of-pocket limit. There is a calendar-year out of pocket limit maximum of $10,000 on all covered benefits. Also, there is a lifetime benefit maximum of $1,000,000.

  Under Catastrophic A Plan, the annual deductible is $2,000 per person. The plan pays 70% of covered services. There is a calendar-year out of pocket limit maximum of $10,000 on all covered benefits. Also, there is a lifetime benefit maximum of $1,000,000.

  Under Catastrophic B Plan, the annual deductible is $5,000 per person. The plan pays 80% of covered services. There is a calendar-year out of pocket limit maximum of $10,000 on all covered benefits. Also, there is a lifetime benefit maximum of $1,000,000.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *In general, HRP plans will exclude coverage for your pre-existing condition for 12 months*. The insurer will look back 6 months before your effective date of coverage to see if you have a condition for which you actually received advice, diagnosis, or treatment or have a condition that would cause an ordinarily prudent person to seek

medical advice, diagnosis, care or treatment during the 6-month period for the effective date of coverage. You will get credit for prior coverage if you apply for coverage within 63 days of termination.

- *If you are HIPAA eligible, no pre-existing condition period will be imposed.*

- *If you are HCTC eligible, you may be able to avoid the application of a pre-existing condition exclusion period.* If you have been continuously insured without a break of 63 days prior to buying the HRP plan.

HOW MUCH CAN I BE CHARGED FOR HIGH RISK POOL COVERAGE?

- *You cannot be charged more for a HRP plan because of your health status.* Premiums will vary based on age, gender, family size, where you live and your tobacco use. This is called modified community rating.

- *Premiums for the HRP plans are posted o the Idaho Insurance department webpage.*

- *New rates are set every three months, but the rate in effect when you buy a HRP plan will apply for one year.* Contact the Idaho Department of Insurance for more information about premiums or visit their web page on premiums rates for HRP plans at http://www.doi.state.id.us/health/healthinfo.aspx.

CAN MY HIGH RISK POOL COVERAGE BE CANCELLED?

- *You can remain enrolled as long as you pay your premium and continue to meet eligibility requirements*.

COBRA

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

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

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

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

- Second, you must be covered under the employer's group health plan as an employee or as the spouse or dependent child of an employee.

- Finally, you must have a qualifying event that would cause you to lose your group health coverage.

COBRA QUALIFYING EVENTS

For employees
- Voluntary or involuntary termination of employment for reasons other than gross misconduct
- Reduction in numbers of hours worked

For spouses
- Loss of coverage by the employee because of one of the qualifying events listed above
- Covered employee becomes eligible for Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee

For dependent children
- Loss of coverage because of any of the qualifying events listed for spouses
- Loss of status as a dependent child under the plan rules

- *Each person who is eligible for COBRA continuation can make their own decision.* If your dependents were covered under your employer plan, they may independently elect COBRA coverage as well.

- *You must be notified of your COBRA rights when you join the group health plan, and again if you qualify for COBRA coverage.* The notice rules are somewhat complicated and you should contact the U.S. Department of Labor for more information.

  In general, if the event that qualifies you for COBRA coverage involves the death, termination, reduction in hours worked, or Medicare eligibility of a covered worker, the employer has 30 days to notify the group health plan of this event. However, if the qualifying event involves divorce or legal separation or loss of dependent status, YOU have 60 days to notify the group health plan. Once it has been notified of the qualifying event, the group health plan has 14 days to send you a notice about how to elect COBRA coverage. Each member of your family eligible for COBRA coverage then has 60 days to make this election.

  Once you elect COBRA, coverage will begin retroactive to the qualifying event. You will have to pay premiums dating back to this period.

SPECIAL SECOND CHANCE TO ELECT COBRA FOR TRADE-DISLOCATED WORKERS

- *A second COBRA election period may be available for TAA eligible people who did not elect cobra when it was first offered*. The second election period can be exercised 60 days from the 1st day of TAA eligibility, but in no case later than 6 months following loss of coverage. Coverage elected during this second election begins retroactive to the beginning of the special election period – not back to qualifying event.
- Certain people who lost their job-based health coverage because of the impact of imports on their employers have a limited second chance to elect COBRA. People who are receiving benefits from the Trade Adjustment Assistance (TAA) Program are eligible for a federal income tax credit (the Health Coverage Tax Credit, or HCTC) that will pay 65% of their premiums.
- *For some laid off workers, TAA benefits begin after their 60-day period to elect COBRA continuation coverage has expired*. In this circumstance, TAA-eligible people have a second 60-day period, starting on the date of their TAA eligibility, to elect COBRA. (However, in no case can COBRA be elected more than 6-months following the original qualifying event (i.e. layoff) that caused the loss of group health plan coverage.)
- When COBRA is elected during this special, second election period, coverage starts on the first date of the special election period. Any time that has elapsed between the original qualifying event and the first date of the special election period is not counted as a lapse in coverage in determining continuous coverage history.

WHAT WILL COBRA COVER?

- *Your covered health benefits under COBRA will be the same as those you had before you qualified for COBRA*. For example, if you had coverage for medical, hospitalization, dental, vision, and prescription drug benefits before COBRA, you can continue coverage for all of these benefits under COBRA. If these benefits were covered under more than one plan (for example, a separate health insurance and dental insurance plan) you can choose to continue coverage under any or all of the plans. Life insurance is not covered by COBRA.

  If your employer changes the health benefits package after your qualifying event, you must be offered coverage identical to that available to other active employees who are covered under the plan.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Because your group coverage is continuing, you will not be faced with a new pre-existing condition exclusion period under COBRA.* However, if you were in the middle of a pre-existing condition exclusion period when your qualifying event occurred, you will have to finish it.

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage.* The first premium must be paid within 45 days of electing COBRA coverage.

- *If you elect the 11-month disability extension, the premium will increase to 150% of the total cost of coverage.* See below for more information about the disability extension.

- *If you are eligible for the Health Coverage Tax Credit (HCTC), the federal government will pay 65% of your COBRA premium.* (See page 26.)

HOW LONG DOES COBRA COVERAGE LAST?

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

LENGTH OF COBRA COVERAGE

Qualifying event(s)	*Eligible person(s*	*Coverage*
Termination Reduced hours	Employee Spouse Dependent child	18 months *
Employee enrolls in Medicare Divorce or legal separation Death of covered employee	Spouse Dependent child	36 months
Loss of "dependent child" status	Dependent child	36 months

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

- *Usually, COBRA continuation coverage ends when you join a new health plan.* However, if your new plan has a waiting period or a pre-existing condition exclusion period, you can keep whatever COBRA continuation coverage you have left during that period. For specifics, ask your former employer or contact the U.S. Department of Labor.

- *COBRA coverage also ends if your employer stops offering health benefits to other employees.*

- *COBRA coverage might end if you are in a managed care plan that is available only to people living in a limited geographic area and you move out of that area.* However, if you are eligible for COBRA and are moving out of your current health plan's service area, your employer must provide you with the opportunity to switch to a different plan, but only if the employer already offers other plans to its employees. Some examples of the other plans your employer may offer you are a managed care plan whose service area includes the area you are moving to, or another plan that does not have a limited service area.

CONVERSION

WHEN DO I HAVE TO BE OFFERED A CONVERSION POLICY?

- *When you lose coverage under a fully insured group health plan in Idaho you are guaranteed the right to buy a conversion policy.* This is an individual health insurance policy offered through the insurance company that covered your former group.

- *Idaho health insurance companies that do not sell individual health insurance are required to offer you a conversion policy if you lose eligibility for your fully insured group health plan.*

WHAT WILL MY CONVERSION POLICY COVER?

- *The conversion policy must provide benefits at least equal to those covered under a standard small employer health benefit plan.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *You will not have a new pre-existing condition exclusion period for your conversion policy.*

WHAT CAN I BE CHARGED FOR A CONVERSION POLICY?

- *There are limits on what you can be charged for a conversion policy*. Idaho sets these limits to be 25 percent higher than premiums typically charged to employers for comparable group policies.

CAN MY CONVERSION POLICY BE CANCELLED?

- *Your coverage cannot be canceled because you get sick.* This is called guaranteed renewability. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of managed care plans, continue to live in the plan service area.

CHAPTER 4
YOUR PROTECTIONS AS A SMALL EMPLOYER OR SELF-EMPLOYED PERSON

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. Idaho has enacted reforms to expand some of these protections. Small employers are those that employ 2-50 employees. Please note that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Idaho Department of Insurance to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down*. This is called guaranteed issue. If you employ at least 2 but not more than 50 people, health insurance companies must sell you any **small group health plan** they sell to other small employers. However, they can require that a minimum percentage of your workers participate in your group health plan. They can also require you to contribute a minimum percentage of your workers' premiums. If you are buying a **large group health plan** for 51 or more employees, your group can be turned down.

- *Your insurance cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or fraud.

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

- *Depending on the number of workers you employ, there are limits on what you can be charged for health coverage.* If you are a small group as defined under Idaho law, you cannot be charged higher premiums because someone in your group is seriously ill. You can, however, be charged somewhat more due to the age, gender and individual tobacco use of those in your group and where your business is located. This is called modified community rating. Modified community rating applies to the mandated standardized health benefit plans that insurers offer in the small employer market. If you have more than 50 workers, your group health plan premium can vary because of health status.

WHAT PLAN CHOICES DO I HAVE?

- *Insurance companies in the small employer market must offer small employers the following mandated standardized health benefit plans: the small employer basic health benefit plan, standard health benefit plan and catastrophic health benefit plans.* Standardization helps you compare differences in cost and coverage. Carriers must also make available to you all non-standardized plans that they offer in the small employer market.

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are not eligible to buy a group health plan on your own (though you may be able to join a group health plan through a family member).* Therefore, the laws that protect employers' access to group health insurance do not apply to you. Your access to health insurance is protected by the laws that apply to individuals. (See Chapter 3.)

- *If you are self-employed and buy your own health insurance, you are eligible to deduct 100% of the cost of your premium from your federal income tax.*

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Idaho who cannot afford to buy health insurance. Medicaid, which includes the **Children's Health Insurance Program** (CHIP), the Women's Health Check and other programs offers either free health insurance coverage, direct medical services or other help.

In addition, the federal Health Coverage Tax Credit (HCTC) Program provides tax credits to early retirees and some workers who lose their jobs or whose work hours and wages are reduced as a result of increased imports.

This chapter provides summary information about these programs and contact information for further assistance.

MEDICAID

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

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

  In Idaho you may be eligible for Medicaid if you are an infant, a child, pregnant, or a parent of a child and your family income meets the Medicaid income standards. You may also be eligible if you are disabled or age 65 or older and your income and resources meets the Medicaid standards.

  Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account, so you should contact the Office of Self-Reliance of the Idaho Department of Health and Welfare or your local Department of Health and Welfare office for more information.

Low income persons eligible for Medicaid in Idaho*

Category	Income eligibility (as percent of federal poverty level)
Child to age 5	150% (monthly income of about $1,959 for family of 3)
Child 6-18	150%
Parent (non-working)	24%
Parent (working)	31%
Pregnant woman	133%

* Eligibility information was compiled from *State Health Facts Online,* the Kaiser Family Foundation, and may have changed since this guide was published. Contact your state Medicaid program for the most up to date information and for other eligibility requirements that may apply.

To get an idea of how your income compares to the federal poverty level*, use the federal poverty guideline issued by the U.S. Department of Health and Human Services for the year 2004:

Size of Family Unit	Poverty Guideline (annual income)
1	$ 9,310
2	$ 12,490
3	$ 15,670

For larger families add $3,180 for each additional person

So, for example, using this guideline, 150% of the federal poverty level for a family of 3 would be an annual income of $23,505, or a monthly income of $1,959.

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

- *Parents who receive benefits under **TANF** (also known as Temporary Assistance for Families in Idaho) should know that when you get a job and your TANF benefits end, you generally can stay on Medicaid for a 12-month transitional period.*

  In addition, your children may qualify for transitional Medicaid coverage for 12 months. Or, you may qualify for Medicaid yourself if your family's income meets the Medicaid income standards.

- *Very poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits can also qualify for Medicaid.*

Some people whose income is too high to qualify for SSI may still qualify for Medicaid if they meet state income eligibility requirements. Disabled individuals should know that if your income earned from a job increases so that you no longer qualify for SSI, you may be able to continue your Medicaid coverage at least for a limited time.

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

  If your household income is below the poverty level, Medicaid will pay your Medicare monthly premium and your Medicare deductibles and coinsurance. This is called the Qualified Medicare Beneficiary (QMB) program.

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

  Contact your local Department of Health and Welfare for more information about other eligibility requirements.

- *There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify for Medicaid, contact the local Department of Health and Welfare office.

WOMEN'S HEALTH CHECK PROGRAM

- *The Women's Health Check Program provides qualified woman with free screenings for breast and cervical cancer.* Women screened through this program and diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid which extends throughout the duration of treatment.

- *In order to be eligible for screening through the program, you must meet certain qualifications.* You must be an uninsured or underinsured resident of Idaho over the age of 30 with income at or below 200% of the federal poverty level. Depending on your age, there may be other requirements.

- *For more information, please contact the Women's Health Check Program by dialing the 2-1-1 Idaho Care Line or contact them on the web at* http://www.healthandwelfare.idaho.gov/

OTHER PROGRAMS

- *There may be other financial assistance programs available.* Please contact Idaho Department of Health and Welfare by dialing the 2-1-1 Idaho Care Line or contact them on the web at http://www.healthandwelfare.idaho.gov/

THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)

A federal income tax credit is available to help certain trade dislocated workers and early retirees, and their dependents, buy qualified health insurance coverage. The Health Coverage Tax Credit (HCTC) covers 65% of the insurance premium for qualified coverage. Under this program, you can either claim the tax credit at the end of the year on your tax return or you can elect to have the money paid directly to your qualified health plan each month by the Internal Revenue Service.

WHEN AM I ELIGIBLE FOR THE HCTC?

- To be eligible for the tax credit, you must be receiving Trade Adjustment Assistance (TAA) benefits or retirement benefits from the PBGC. If you are receiving PBGC benefits, you also must be at least 55 years old.

- *In addition, you must meet other requirements.* Specifically, you are not eligible for the HCTC if any of the following apply to you:

  You have a health plan maintained by an employer or former employer that pays at least 50% of the cost of your coverage. Any share of your premium that is paid by you or your spouse on a pre-tax basis is considered to have been paid by your employer and must be included as such when determining the percentage of employer coverage.

  You are enrolled in Medicare (Part A or B).

  You are enrolled in the Federal Employees Health Benefits Program (FEHBP), Medicaid, or State Children's Health Insurance Program (SCHIP).

  You are entitled to health coverage through the U.S. military health system (Tricare/CHAMPUS).

  You can be claimed as a dependent on someone else's federal tax return.

  You received a lump sum payment of your entire PBGC benefit before August 6, 2002.

As of the first day of the current month in which you are otherwise eligible, you are imprisoned under a federal, state or local authority.

- *HCTC may apply to your family, too.* If you are eligible, you can use the credit to help purchase qualified health coverage for your qualified family members. Qualified family members are your spouse and dependents that you can claim on your federal tax return. Family members are not eligible if they are enrolled in another group health plan where the employer pays at least 50% of the cost of coverage, or in Medicaid, SCHIP, FEHBP, Tricare/CHAMPUS.

- *Eligibility for HCTC is not based on income.* In addition, the HCTC is refundable. This means you can claim the credit even if you do not earn enough income to owe federal income tax.

HOW MUCH OF MY HEALTH COVERAGE COST WILL THE TAX CREDIT COVER?

- *The HCTC is equal to 65% of health insurance premiums for qualified health insurance coverage.*

WHAT HEALTH COVERAGE IS ELIGIBLE FOR THE TAX CREDIT?

- The HCTC can only be used to help pay for "qualified" health coverage. Qualified health coverage includes:

  COBRA continuation coverage, as long as your employer or former employer contributes less than 50% of the total health plan premium.

  State qualified plans: Currently, state qualified plans offered in Idaho include a health insurance offered through individual insurers participating in Idaho's High Risk Reinsurance Pool

  Individual heath insurance in which you were enrolled for at least the last 30 days before you were separated from the job that makes you eligible for TAA benefits or for payments from the PBGC.

  Your husband's or wife's insurance from work, as long as the employer contributes less than 50% of the total health plan premium. **(**At this time, you can only claim the credit with this type of coverage when you file your federal tax return and not in advance.)

HOW DO I CLAIM THE HCTC?

- *You can claim the HCTC on your tax return and be reimbursed for 65% of the premium you paid for qualified coverage while you were eligible for the HCTC.* Currently, this is the only way to claim the HCTC if your qualified health plan is provided through a spouse's employer.

- *Alternatively, you can choose to have your credit sent directly to your qualified health plan each month.* To do this, you must register with the HCTC customer service center by calling 1-866-628-HCTC (1-866-628-4282), Monday through Friday between the hours of 7 am and 7 pm, Central time. TDD/TYY callers, please call 1-866-626-HCTC (1-866-626-4282).

- *You will have to fill out a registration form verifying your eligibility for the HCTC and your enrollment in qualified coverage*. You will also fill out a payment invoice. Each month, you will send the HCTC program your 35% share of the premium for qualified coverage. The HCTC program will combine this payment with the tax credit covering the other 65% of the premium and forward the entire payment to your qualified health plan.

- *You must register in advance to have the HCTC paid directly to your health plan each month.* Usually, the direct payments won't begin until at least a month after you register with the HCTC program. Call the HCTC customer service center for more information.

WHERE CAN I GET MORE INFORMATION?

- *For more information about the HCTC, contact the HCTC customer service center at 1-866-628-HCTC, or see the IRS website at http://www.irs.gov/individuals/index.html (click on HCTC)*

- *For more information about TAA benefits contact, http://www.doleta.gov/tradeact/2002act_summary.asp*

- *For more information about PBGC, contact, http://www.pbgc.gov or call 1-202-326-4000 with general inquiries.*

FOR MORE INFORMATION…

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

For questions about:	Contact:
Individual health insurance Fully insured group health insurance Individual High Risk Reinsurance Pool	*Idaho Department of Insurance* (208) 334-4250 http://www.doi.state.id.us
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	*U.S. Department of Labor, Seattle Regional Office* (206) 553-4244, or contact *U.S. Department of Labor, San Francisco Regional Office* (415) 975-4600, or contact *U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C.* (202) 219-4377 *For Department of Labor publications:* (800) 998-7542 http://www.dol.gov/dol/pwba
Medicaid CHIP	*Idaho Department of Health and Welfare* *Dial the 2-1-1 Idaho Care Line* http://www.healthandwelfare.idaho.gov/
Women's Health Check	*Idaho Department of Health and Welfare* *Dial the 2-1-1 Idaho Care Line* http://www.healthandwelfare.idaho.gov/
Other Programs	*Idaho Department of Health and Welfare* *Dial the 2-1-1 Idaho Care Line* http://www.healthandwelfare.idaho.gov/
Federal Health Coverage Tax Credit (HCTC)	*Internal Revenue Service* 1-866-628-HCTC http://www.irs.gov/individuals/index.html

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

HELPFUL TERMS

Alternative Trade Adjustment Assistance (ATAA). ATAA is a benefit for workers at least 50 years old who have obtained different, full-time employment within 26 weeks of the termination of adversely-affected employment. These worker may receive 50% of the wage differential (up to $10,000) during their 2 year eligibility period. To be eligible for the ATAA program, workers may not earn more than $50,000 per year in their new employment. Also, the firm where the workers worked must meet certain eligibility criteria.

Certificate of Creditable Coverage. A document provided by your health plan that lets you prove you had coverage under that plan. Certificates of creditable coverage will usually be provided automatically when you leave a health plan. You can obtain certificates at other times as well. See also Creditable Coverage.

Children's Health Insurance Program The Idaho Child Health Insurance Program is a part of the Medicaid program and provides health coverage to low-income children under the age of 19 who's families meet income eligibility criteria.

COBRA. Stands for the Consolidated Omnibus Budget Reconciliation Act, a federal law in effect since 1986. COBRA permits you and your dependents to continue in your employer's group health plan after your job ends. If your employer has 20 or more employees, you may be eligible for COBRA continuation coverage when you retire, quit, are fired, or work reduced hours. Continuation coverage also extends to surviving, divorced or separated spouses; dependent children; and children who lose their dependent status under their parent's plan rules. You may choose to continue in the group health plan for a limited time and pay the full premium (including the share your employer used to pay on your behalf). COBRA continuation coverage generally lasts 18 months, or 36 months for dependents in certain circumstances.

Continuous Coverage. Health insurance coverage is continuous if it is not interrupted by a break of 63 or more consecutive days. Employer waiting periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. Federal rules apply to you in group health plans and, if you are HIPAA eligible, when you buy an individual health insurance policy. See also Creditable Coverage, HIPAA eligible, Fully Insured Group Health Plan, Individual Health Insurance Policy, Self-Insured Group Health Plan.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; an individual health insurance policy; Medicare; Medicaid; CHAMPUS (health coverage for military personnel, retirees, and dependents); the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; or a state health insurance high risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Insurance Policy.

Enrollment Period. The period during which all employees and their dependents can sign up for coverage under an employer group health plan. Besides permitting workers to elect health benefits when first hired, many employers and group health insurers hold an annual enrollment period, during which all employees can enroll in or change their health coverage. See also Group Health Plan, Special Enrollment Period.

Family and Medical Leave Act (FMLA). A federal law that guarantees up to 12 weeks of job protected leave for certain employees when they need to take time off due to serious illness, to have or adopt a child, or to care for another family member. When you qualify for leave under FMLA, you can continue coverage under your group health plan.

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by the Idaho Department of Insurance. See also Self-Insured Group Health Plans.

Genetic Information. Includes information about family history or genetic test results indicating your risk of developing a health condition. A health plan cannot consider pre-existing (and therefore exclude coverage for) a condition about which you have genetic information, unless that health condition has been diagnosed by a health professional.

Group Health Plan. Health insurance (usually sponsored by an employer, union or professional association) that covers at least 2 employees. See also Fully Insured Group Health Plan, Self-Insured Group Health Plan.

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All health plans sold to Idaho small employers with 2 to 50 employees are guaranteed issue. If you are HIPAA eligible, insurance companies that sell individual health insurance coverage must offer you the Idaho Individual High-Risk Pool health benefit plans that are guaranteed issue.

Guaranteed Renewability. A feature in health plans that means your coverage cannot be canceled because you get sick. HIPAA requires all health plans to be guaranteed renewable. Your coverage can be canceled for other reasons unrelated to your health status.

Health Coverage Tax Credit (HCTC). The Health Coverage Tax Credit (HCTC) is a program that can help pay for nearly two-thirds of eligible individuals' health plan premiums. In general, in order to be eligible for the tax credit, you must be 1) receiving Trade Readjustment Allowance (TRA) benefits or 2) will receive TRA benefits once your unemployment benefits are exhausted or 3) receiving benefits under the **Alternative Trade Adjustment Assistance (ATAA)** program or 4) aged 55 or older and receiving benefits from the Pension Benefit Guaranty Corporation (PBGC).

Health Insurance or Health Plan. In this guide, the term means benefits consisting of medical care (provided directly or through insurance or reimbursement) under any hospital or medical service policy, plan contract, or MCO contract offered by a health insurance company or a group health plan. It does not mean coverage that is limited to accident or disability insurance, workers' compensation insurance, liability insurance (including automobile insurance) for medical expenses, or coverage for on-site medical clinics. Health insurance also does not mean coverage for limited dental or vision benefits to the extent these are provided under a separate policy.

Health Status. When used in this guide, refers to your medical condition (both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. See also Genetic Information.

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

HIPAA Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. When you are buying individual health coverage, federal eligibility confers greater protections on you than you would otherwise have in Idaho and in other states. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

Individual Health Insurance. Policies for people not connected to an employer group. Individual health insurance is regulated by the Idaho Department of Insurance.

Individual High Risk Reinsurance Pool. A state program for people with high health risks. The program requires individual health insurers to sell pool plans to residents who have been denied coverage access to the insurer's preferred benefit plans because of their health status or are enrolled in a substantially similar coverage at a higher rate.

Large Group Health Plan. One with more than 50 employees.

Late Enrollment. Enrollment in a health plan at a time other than the regular or a special enrollment period. If you are a late enrollee, you may be subject to a longer pre-existing condition exclusion period. See also Special Enrollment Period.

Look Back. The maximum length of time, immediately prior to enrolling in a health plan, that can be examined for evidence of pre-existing conditions. See also Pre-existing condition.

MCO. Managed care organization. A kind of health insurance plan. MCOs usually limit coverage to care from doctors who work for or contract with the MCO. They generally do not require deductibles, but often do charge a small fee, called a copayment, for services like doctor visits or prescriptions.

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

Modified Community Rating. A requirement that Idaho health insurance companies establish a rate for each small group policy (covering 50 or fewer employees) that does not vary due to the health status of those who buy that health insurance. For individual and small group health plans, premiums can vary within limits based on age, gender, individual tobacco use and geographic location.

Nondiscrimination. A requirement that group health plans not discriminate against you based on your health status. Your coverage under a group health plan cannot be denied or restricted, nor can you be charged a higher premium, because of your health status. Group health plans can restrict your coverage based on other factors (such as part time employment) that are unrelated to health status. See also Group Health Plan, Health Status.

Pension Benefit Guaranty Corporation (PBGC). PBGC is a federal government corporation established by Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) to encourage the continuation and maintenance of defined benefit pension plans, provide timely and uninterrupted payment of pension benefits to participants and beneficiaries in plans covered by PBGC. It currently guarantees payment of basic pension benefits earned by American workers and retirees participating in private-sector defined benefit pension plans. The agency receives no funds from general tax revenues. Operations are financed largely by insurance premiums paid by companies that sponsor pension plans and by PBGC's investment returns.

Pre-existing condition (Group Health Plans). Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan. Pregnancy cannot be counted as a pre-existing condition. Genetic information about your likelihood of developing a disease or condition, without a diagnosis of that disease or condition, cannot be considered a pre-existing condition. Newborns, newly adopted children, and children placed for adoption covered within 30 days cannot be subject to pre-existing condition exclusions.

Pre-existing condition (Individual Health Insurance). Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period immediately preceding enrollment in an individual health insurance policy or for which an ordinarily prudent person would have sought medical advice, care or treatment. Under individual health insurance, pregnancy can be counted as a pre-existing condition.

Pre-existing condition Exclusion Period. The time during which a health plan will not pay for covered care relating to a pre-existing condition. See also Pre-existing condition.

Prudent Person Rule. In individual health insurance, a rule that permits insurers to exclude as pre-existing any condition for which — in the insurer's judgment — most people would have sought care or treatment in the 6 months prior to enrolling in the individual health insurance policy. See Pre-existing condition (Individual Health Insurance Policy).

Self-Insured Group Health Plans. Plans set up by employers who set aside funds to pay their employees' health claims. Because employers often hire insurance companies to run these plans, they may look to you just like fully insured plans. Employers must disclose in your benefits information whether an insurer is responsible for funding, or for only administering the plan. If the insurer is only administering the plan, it is self-insured. Self-insured plans are regulated by the U.S. Department of Labor, not by Idaho.

Small Group Health Plans. Plans with at least 2 but no more than 50 employees.

Special Enrollment Period. A time, triggered by certain specific events, during which you and your dependents must be permitted to sign up for coverage under a group health plan. Employers and group health insurers must make such a period available to employees and their dependents when their family status changes or when their health insurance status changes. Special enrollment periods must last at least 30 days. Enrollment in a health plan during a special enrollment period is not considered late enrollment. See also Late Enrollment.

Supplemental Security Income (SSI). A program providing cash benefits to certain very low income disabled and elderly individuals. When you qualify for SSI, you generally also qualify for Medicaid. In addition, Medicaid coverage often continues for a limited time if your income increases so that you no longer qualify for SSI.

Temporary Assistance for Needy Families (TANF). A program (also known as Temporary Assistance for Families in Idaho) that provides cash benefits to low income families with children. When you qualify for TANF, you generally also qualify for Medicaid. In addition, Medicaid coverage often continues for a limited time or longer if you no longer qualify for TANF. See also Medicaid.

Trade Adjustment Assistance (TAA) Program. A program authorized by the Trade Adjustment Assistance Reform Act of 2002. This program provides aid to workers who lose their job or whose hours of work and wages are reduced as a result of increased imports. The TAA Program offers six benefits and reemployment services to assist unemployed workers prepare for and obtain new suitable employment. In addition, TAA offers a significant tax credit that covers 65% of health insurance premiums for certain plans.

U.S. Department of Labor. A department of the federal government that regulates employer provided health benefit plans. You may need to contact the Department of Labor if you are in a self-insured group health plan, or if you have questions about COBRA or the Family and Medical Leave Act. See also COBRA, Family and Medical Leave Act

Waiting Period. The time you may be required to work for an employer before you are eligible for health benefits. Not all employers require waiting periods. Waiting periods do not count as gaps in health insurance for purposes of determining whether coverage is continuous. If your employer requires a waiting period, your pre-existing condition exclusion period begins on the first day of the waiting period. See also Pre-existing condition Exclusion Period.

Women's Health Choice. Program which provides free screening for breast and cervical cancer to eligible residents of Idaho. Eligible women diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid for treatment of their condition.