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

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

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

As an Ohio 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 Ohio resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group and individual health plans. Chapter 4 highlights your protections as a small employer or self-employed person. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from Ohio, 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 32. For information about how to find consumer guides for other states on the Internet, see page 32. A list of helpful terms and their definitions begins on page 33. These terms are printed 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 insurance plans they regulate (**fully insured group health plans** and **individual health plans**), so your protections may vary if you leave Ohio. 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 Ohio resident.

HOW AM I PROTECTED?

In Ohio, 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 Chapter 2.)

- *All health plans in Ohio 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 8 and 9.)

- *Your health insurance cannot be canceled because you get sick.* All health insurance is **guaranteed renewable**. (See pages 16, 25, and 27.)

- *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 or **state continuation coverage**. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage. (See page 16.)

- *If you lose your group health insurance and meet other qualifications, you can buy a conversion policy.* This is an individual health plan from the company that insured your employer group. You cannot be denied coverage because of your health status, and you will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for a conversion policy. (See page 22.)

- *All individual market health insurers in Ohio must have an annual **open enrollment period**, during which you can buy certain kinds of individual health coverage regardless of your health status.* This is called **guaranteed issue**. You must meet other requirements to be eligible to buy individual coverage during an open enrollment period. (See page 22.)

- *If you are **federally eligible**, you can buy an individual health plan any time during the year.* You do not have to wait for an open enrollment period. If you are federally eligible, you have additional protections when you buy either an individual health plan or a conversion policy. (See pages 16 and 23.)

- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any other factor that might predict the use of health services of those in your group.* All health plans for small employers must be sold on a guaranteed issue basis. (See chapter 4.)

- *If you are a small employer buying a group health plan, there are limits on how much your premiums can vary due to the health status, age, gender, or other characteristics of those in your group.* Even within these limits, however, premiums can be significantly higher if someone in your group has a serious health condition. (See page 26.)

- *If you have low or modest household income, you may be eligible for free or subsidized health coverage for yourself or members of your family.* The Ohio Medicaid program offers free health coverage for pregnant women, families with children, and elderly and disabled individuals with very low incomes. (See Chapter 5.)

- *If your children are 18 years old or younger, do not have health insurance and meet other qualifications, you may be able to buy insurance for them through the Healthy Start or Healthy Families program.* (See page 28.)

WHAT ARE THE LIMITS ON MY PROTECTIONS?

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

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

- *If you change jobs, your new employer may not offer you health benefits.* Employers are required only to make sure that their decision is based on factors unrelated to your health status.

- *If you get a new job with health benefits, your coverage may not start right away.* Employers and health maintenance organizations (**HMO**s), which are also called **health insuring corporations (HICs)** can require **waiting periods** before your health benefits begin. (See page 7.)

- *If you work for one of a number of local governments or school districts in Ohio, not all of the group health plan protections may apply to you.* (See page 11.)

- *If you have a break in coverage of one to two months or more (depending on the type of health plan), you may have to satisfy a new pre-existing condition exclusion period when you join a new health plan.* (See pages 8 and 15.)

- *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 certain benefits your old plan did not.* For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to one year before your new self-insured health plan will pay for drugs prescribed to treat a pre-existing condition. (See page 10.)

- *When you are buying an individual health plan, you may be limited in your choice of insurance companies, because insurers are only required to accept a certain number of new enrollees during annual open enrollment periods.* (See page 23.)

- *Premiums for individual health plans can vary due to your health status.* However, if you are buying a conversion policy or an individual health plan during an open enrollment period, there are some limits on how much you can be charged. (See pages 23 and 24.)

- *If you move away from Ohio, you may not be able to buy individual health insurance in another state unless you are federally eligible.* (See page 13.)

CHAPTER 2
YOUR PROTECTIONS
UNDER GROUP HEALTH PLANS

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

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

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

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

Discrimination due to health status is not permitted

The Acme Company 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 employees who can pass a physical examination. This is *not permitted* under the law.

- *You must be given a special opportunity to sign up for your group health plan if certain changes happen to your family*. In addition to any regular enrollment period your employer or group health plan offers, you must be offered a special, 30-day opportunity to enroll in your group health plan after certain events. You can elect coverage at this time. If your group health plan offers family coverage, your dependents can elect coverage as well. Enrollment during a **special enrollment period** is *not* considered **late enrollment**.

Certain changes can trigger a special enrollment opportunity

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

- *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage.* These waiting periods, however, must be applied consistently and cannot vary due to your health status. Small employers offering fully insured health plans may not impose waiting periods longer than 90 days.

- *When you begin a new job with health insurance through an HMO or HIC, the HMO/HIC may require a waiting period before coverage begins*. This waiting period is called an **affiliation period**, and you will not have health insurance coverage during this time. An affiliation period cannot exceed 60 days, and you cannot be charged a premium during it.

- *Under Ohio law, newborns, adopted children and children placed for adoption are automatically covered under the parent's fully insured health plan for the first 31 days, if the plan covers dependents*. The insurer may require that the parent enroll the dependent within the 31 days in order to continue coverage beyond the 31 days.

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

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

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

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

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

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

When you first enroll in a group health plan, the employer or insurance company may ask if you have any pre-existing conditions. Or, if you make a claim during the first year of coverage, the plan may look back to see whether it was for such a condition. If so, it may 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. In some cases your protections will vary, depending on the type of group health plan.

- 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)
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?

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

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

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

In determining continuous coverage, employer-imposed waiting periods and HMO/HIC affiliation periods do not count as breaks 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. HMOs/HICs that require an affiliation period cannot exclude coverage for pre-existing conditions.

- *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**.*

- *Coverage for pre-existing conditions can be excluded under group health plans only for a limited time.* The maximum period is 12 months. However, if you enroll late in a group health plan (after you were hired and not during a regular or special enrollment period) you may have a pre-existing condition exclusion period of up to 18 months.

- *If you are applying to enroll late in a fully insured group health plan, insurance companies are permitted to wait up to 12 months or until the next open enrollment period before they enroll you in the group health plan, and then may impose an 18-month pre-existing condition exclusion period.* You must be accepted.

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

- *Your protections may differ if you move to a self-insured group health plan that offers more benefits than your old health plan did.* Self-insured 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 self-insured group health plan may impose a pre-existing condition exclusion period for that category. Fully insured group health plans in Ohio cannot do this.

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

Question: Is this permitted?

Answer: 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.

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

Federal law permits state, county, and local governments to exempt their employees in self-insured group health 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 protections will not apply to their employees' group health plan.

According to the latest list available from the federal government, many public employers in Ohio have decided that certain protections will not apply to their employees. If you have group health coverage through these employers, you should contact them for more information. Other non-federal public employers in Ohio 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, state continuation coverage, conversion policies, and individual health plan coverage for "federally eligible individuals."

List of State, County, and Local Governments Choosing To Exempt Employees From Protections Under HIPAA for 2001 Plan Year	
Ashland City Schools	Mapleton Local School District
Ashtabula County Board of MR/DD	Mid-Ohio Educational Service Center
Ashland County-West homes Joint Voc. School District	Mount Gilead Exempted Village Schools
Ashtabula Area City School District	Muskingum County
Barnesville Exempted School District	New Riegel Local School District
Belmont-Harrison Vocational School District	Newcomerstown Exempted Village Schools
Bettsville Local School District	Noble Local School District
Brown Local School District	North Central Ohio Educational Service Center
Caldwell Exempted Village School District	Northern Buckeye Educational Council
City of Ashland	Ohio Mid-Eastern Governments Association
City of Berea	Old Fort Local School District
City of Brecksville	Ottawa County
City of Canton	Pioneer Career and Technology Center
City of Lima	Portage Area School Consortium
City of Niles	Portage County
City of North Olmsted	Pymatuning Valley Local Schools
City of Port Clinton	Richland County
City of Shelby	Riverview Local School District
City of Wadsworth	Robinson Memorial Hospital
Clear Fork Valley Local School District	Sandusky County Educational Service Center
Coshocton County Board of MR/DD	Scioto County School District
Coshocton County JVS	Seneca East Local School District
Council of Allen County Schools	Shadyside Local School District
Crestview Local School District	Shawnee State University
Cuyahoga Falls City School District	St. Clarksville-Richland City Schools
East Guernsey Local Schools	Tiffin City School District
Erie County	Toronto City Schools
Fredricktown Local School District	Trumbill County Board of MR-DD
Green Local School District	Tuscarawas Valley Local Schools
Guernsey/Monroe/Noble Educational Service Center	Twinsburg City Schools
Harrison Hills City School District	Upper Valley Joint Vocational School District
Hillsdale Local School District	Village of Cuyahoga Heights
Indian Creek Local School District	Village of Valley View
Jackson Township	Wayne County
Jefferson County Educational Service Center	West Muskingum Schools
Jefferson County JVS	Westerville City Schools
Jefferson Metropolitan Housing Authority	Woodbridge Local School District
Lakewood Board of Education	Wooster Community Hospital
Lorain County	Worthington City School District

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group insurance, you may want to buy an individual health plan from a private health insurance company. However, in Ohio – as in most other states – you have limited guaranteed access to private individual health insurance. There are some alternatives to private individual health insurance coverage – such as COBRA 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 COVERAGE?

In Ohio, 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, companies that sell individual health insurance in Ohio are free to turn you down because of your health status and other factors.* When applying for individual coverage, you may be asked questions about health conditions you have now or had in the past. Depending on your health status, insurers might refuse to sell you coverage or offer to sell you a policy that has special limitations on what it covers.

- *In Ohio, during annual open enrollment periods, you cannot be turned down for an individual health plan because of your health status, age, or any other factor that might predict your use of health services.* This is called **guaranteed issue**. However, unless you are federally eligible, individual health plans can deny you coverage at other times during the year. Your plan may or may not have a pre-existing condition exclusion period, depending on your situation.

- *If you are federally eligible in Ohio you are guaranteed the right to buy a conversion policy or another individual health plan.* You are exempted from pre-existing condition exclusion periods. In addition, there are rules about what the plan must cover and what can be charged.

To be federally eligible, you must meet certain criteria

If you are federally eligible in Ohio you are guaranteed the right to buy a conversion policy or another individual health plan. You are exempted from pre-existing condition exclusion periods. In addition, there are rules about what the plan must cover and what can be charged. To be federally eligible, you must meet all of the following:

- You must have had 18 months of continuous creditable coverage, at least the last day of which was under a group health plan.
- You also must have used up any COBRA or state continuation coverage for which you were eligible.
- You must not be eligible for Medicare, Medicaid or a group health plan.
- You must not have health insurance. (Note, however, if you know your group coverage is about to end, you can apply for coverage for which you will be federally eligible.)
- You must apply for health insurance for which you are federally eligible within 63 days of losing your prior coverage.

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

- *If you are leaving your job and you had group coverage, you may be able to stay in your plan an extended time through COBRA or state continuation coverage.*

- *If you lose coverage under a fully insured group health plan in Ohio and meet other qualifications, you can buy a conversion policy.* This is an individual health plan sold by the company that insured your employer's group plan. You will not have a new pre-existing condition exclusion period. If you are federally eligible, there are rules about what your conversion policy must cover and what you can be charged. If you are not federally eligible, you have fewer protections when buying a conversion policy.

- *Under Ohio law, newborns, adopted children and children placed for adoption are automatically covered under the parent's individual health plan for the first 31 days, if the plan covers dependents.* The insurer may require that the parent enroll the dependent within 31 days in order to continue coverage beyond the 31 days.

- 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.

WHAT WILL MY INDIVIDUAL HEALTH PLAN COVER?

- *If an insurance company offers you an individual health plan during open enrollment, it must offer you a **basic** and **standard health plan.*** These are standardized plans with benefits similar to those under group health plans. Standardized plans help you compare the cost of policies. You may be offered non-standardized plans as well.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Individual health plans must limit pre-existing condition exclusion periods.* Plans can impose pre-existing condition exclusion periods for up to 12 months. Unlike group health plans, individual health plans count as pre-existing any condition for which you received – or, in your insurer's judgment, for which you should have sought – medical care, treatment, diagnosis or advice in the 6-month period prior to enrollment. This is called the **prudent person rule.**

- *Genetic information cannot be considered a pre-existing condition (note that the definition of "genetic information" is different in the individual and group markets).*

- *Pregnancy can be a pre-existing condition in an individual health plan.* Also, individual health plans can exclude coverage for maternity benefits – whether or not you are pregnant when you join the plan – for up to the first 270 days you are enrolled.

- *In individual health plans, you will get credit toward your pre-existing condition exclusion period for any prior creditable coverage you had, provided no more than 30 days lapse between your old and new coverage.*

- *No pre-existing condition exclusion periods can be imposed if you are federally eligible.*

- *HICs/HMOs are not allowed to have pre-existing condition exclusion periods for basic health care services.*

WHAT CAN I BE CHARGED FOR INDIVIDUAL HEALTH COVERAGE?

- *In Ohio, premiums must relate to the benefits offered.* However, generally there are no limits on how much individual premiums can vary due to age, gender, health status, family size, and certain other factors.

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELED?

- *If you have an individual plan, 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. However, guaranteed renewability does not protect you from having your premiums go up at renewal, premiums can also increase within limits as you age.

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

COBRA CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

- *If you are leaving your job and you had group coverage, you may be able to stay in your group plan for an extended time through COBRA 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 less than 20 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 his or her own decision.* If your dependents were covered under your employer plan, they may independently elect COBRA coverage as well.

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

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

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

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

WHAT WILL COBRA COVER?

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

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage.*

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

HOW LONG DOES COBRA COVERAGE LAST?

- *COBRA coverage generally lasts up to 18 months and cannot be renewed.* However, dependents are sometimes eligible for up to 36 months of COBRA continuation coverage, depending on their qualifying event. In addition, special rules for disabled individuals may extend the maximum period of coverage to 29 months. To qualify for the disability extension, you must have been disabled at the time of your COBRA qualifying event (such as termination of employment or reduction in hours). You must obtain this disability determination from the Social Security Administration, and you must notify your group health plan of this disability determination.

HOW LONG CAN COBRA COVERAGE LAST?

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

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

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

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

WHAT ABOUT OHIO CONTINUATION COVERAGE?

Ohio permits certain individuals to continue coverage under their fully insured group health plan, even after they lose eligibility as a member of that group.

- *If your employer offers fully insured health benefits, you may also be eligible for up to 6 months of continuation coverage under an Ohio law that is similar to COBRA.* If your employer has fewer than 20 workers, state continuation coverage is the only continuation coverage available to you.

- *To qualify for state continuation coverage, you must have been covered under your fully insured group health plan for at least three months, be eligible for unemployment, not be eligible for Medicare, and not enrolled in or eligible for other group insurance or COBRA.* Also you must apply within 10 days of losing your coverage or from the day you were notified about continuation coverage, whichever is later. Continuation coverage is not required to include dental, vision care, prescription drugs, or any other benefits under the group plan above hospital, surgical or major medical benefits. Ask your former employer or the Ohio Department of Insurance about state continuation coverage if you think it applies to you.

- *In Ohio, you are not guaranteed the right to buy individual health insurance unless you have used up the COBRA or state continuation coverage available to you.*

CONVERSION POLICIES

WHEN AM I ELIGIBLE FOR CONVERSION COVERAGE?

- *In Ohio, if you have coverage through an employer's fully insured group health plan and you leave that job, you can buy conversion coverage.* This is an individual policy you get from the company that insured your employer's group plan. To qualify, you must have been continuously covered under the group plan for at least one year. If you are covered by a HIC/HMO, the one year coverage requirement does not apply to you. In addition, you first must use up any COBRA or state continuation coverage. Finally, you must apply for conversion coverage and pay your premium for the first calendar quarter of coverage within 30 days of termination of your former group (or continuation) coverage.

You can also buy a conversion policy if you lost your group health coverage due to death or divorce of the covered employee, or if you no longer qualify as a dependent child of the covered employee.

WHAT DOES A CONVERSION POLICY COVER?

- *Covered benefits under a conversion policy may not be the same as under your former group health plan.* Benefits covered under the conversion plan available to you will vary depending on your situation.

- *If you are federally eligible, you must be offered a choice of a "standard" or "basic" conversion policy.* These policies are similar to those offered to small employers, though coverage may not be the same as under your old employer plan. Insurers can offer you other conversion plans as well.

  A state board defines benefits that must be offered under basic and standard health plans and may change these definitions periodically. These descriptions that follow were current as of December 2001.

  The **standard health plan** covers hospital and physician services, limited prescription drug benefits, and other health services. Certain benefits, such as mental health care, maternity care, preventive services, and organ transplants, are subject to special limits. Coverage for all services is limited to a lifetime maximum of $1 million. An annual deductible of $750 applies. Other cost sharing for covered services will vary depending on the type of plan you choose. For example, some plans pay 80% for covered services and you pay 20%. Others pay 60% and you pay 40%. Benefits and cost sharing may be somewhat different in standard health plans offered by HMOs or HICs.

  The **basic health plan** covers hospital and physician services, limited prescription drug benefits, and other health services. Routine maternity care is not covered. The basic health plan pays 50% of the cost of covered services after an annual deductible of $1,000. All coverage is limited to $50,000 per calendar year. In addition, special limits apply to coverage for certain services, such as mental health care, preventive services, and organ transplants. Benefits and cost sharing may be somewhat different in basic health plans offered by HMOs or HICs.

- *If you are not federally eligible, the insurer can decide which conversion policy to offer you, this may or may not include a basic or standard plan.* In this case, conversion plan benefits might be very different from those covered under your former group health plan.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

HOW MUCH CAN I BE CHARGED FOR CONVERSION COVERAGE?

- *If you are federally eligible, premiums for standard and basic conversion health plans are limited to twice the rate insurers charge other individuals or groups buying that plan.* Similar premium limits apply if you are not federally eligible. Contact the Ohio Department of Insurance if you have questions about conversion plan premiums.

- *Depending on your health status, you may have a choice between buying a conversion policy or a private individual insurance policy.* Check out both options to see which is best for you.

CAN MY POLICY BE CANCELED?

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

INDIVIDUAL HEALTH PLAN OPEN ENROLLMENT

- *Generally, private individual health insurers in Ohio must have an open enrollment period for at least 30 days each year.* During this time, if you meet other requirements, you can buy individual health coverage regardless of your health status.

- *If you are federally eligible and meet other requirements, you can buy an individual health plan at any time during the year.* You do not have to wait for an annual open enrollment period. There are currently two HICs/HMOs that sell individual health policies to federally eligible individuals. In addition, indemnity insurance companies sell these policies. Check with the Ohio Department of Insurance for information on companies selling individual insurance to federally eligible individuals. Also, you must be offered a basic and a standard health plan. (See page 24)

- *If you are not federally eligible, you may be able to buy health insurance during open enrollment.* **Indemnity health plans** must have an open enrollment period beginning in January of each year. Managed care plans must have a 30-day open enrollment period each year as well, although the time of year may vary.

  Generally, individual health insurers are required to advertise their open enrollment periods in newspapers at least 2 weeks prior to, and then throughout, their open enrollment periods.

- *Even during open enrollment periods, individual health plans are required to enroll only a limited number of people.* Once a plan reaches its state-approved enrollment cap, it can refuse to sell you individual health coverage for that year. Also, plans are not required to enroll you if you are confined to a health care facility because of a chronic illness. A health insurer is also not required to hold open enrollment if the insurer is not financially sound.

- *To buy an individual health plan during an open enrollment period, you must not be eligible for any other group health coverage, COBRA or state continuation coverage, or Medicare.*

- *Unless you are federally eligible, you may have a pre-existing condition exclusion period.* As noted at the beginning of this chapter, individual health plans can exclude coverage for pre-existing conditions for up to one year. You must be given credit for any prior creditable coverage you had. Individual plans also can require a one-year waiting period before they will cover organ transplants. However, federally eligible individuals and newborn infants cannot be subjected to this waiting period for transplant coverage or any other benefit offered by the plan. HICs/HMOs are not allowed to apply pre-existing conditions to basic services such as maternity care.

- *Premiums for the basic and standard health plans are limited.* If you are federally eligible, there is a limit on what you can be charged. This limit works out to be about twice the rate charged to other people who do not come in through open enrollment.

- *If you are not federally eligible, there also are limits on what you can be charged for basic and standard health plans during open enrollment.* Contact the Ohio Department of Insurance if you have questions about individual health plan premiums.

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

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. Ohio has enacted some reforms that expand some of these protections. Generally, small employers are those that employ 2-50 employees. Please note, however, that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Ohio 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 eligible for health benefits, health insurance companies must sell you any small group health plan they sell to small employers. However, they can require that a minimum percentage of your employees sign up for coverage. They can also require you to pay a minimum share 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 seriously ill.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud, or if they are discontinuing that insurance product. In the latter case, they must give you a chance to buy other plans they sell to groups of your size.

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

- *Within limits, premiums for small group health plans can vary based on the health status, age, gender, industry, and other characteristics of those in your group.* Even within these limits, however, premiums can be significantly higher if someone in your group has a serious health condition. If you have 51 or more eligible employees, there are no limits on premium variation. Check with the Ohio Department of Insurance if you have questions about your group health plan premiums.

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 another 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 an increasing percentage of the cost of your premium from your federal income tax.* This deduction is 60% for 2000 and 2001, 70% for 2002, and 100% in 2003 and thereafter.

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Ohio who cannot afford to buy health insurance. Medicaid, Healthy Start, and Healthy Families offer free or subsidized health insurance coverage, direct medical services or other help. 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 Ohio residents. Medicaid covers families with children and pregnant women, the elderly, and people with disabilities, if state and federal guidelines are met. Those who qualify for Medicaid programs must be Ohio residents and U.S. citizens. Additionally, certain legal residents who are not U.S. citizens may be eligible for coverage. Non-citizens who do not have immigration documents cannot enroll in Medicaid programs.

For all categories of Medicaid, eligibility is based on the amount of your household income. For children with family incomes over 150% of the federal poverty level, eligibility is restricted to uninsured children who have not had health insurance for at least 6 months. For those who are applying for coverage because they are elderly or have a disability, eligibility is also based on the amount of assets an individual may have. Assets are things like cash, savings, stocks and bonds, etc. Contact your local county department of job and family services for more information.

Low income persons eligible for Medicaid in Ohio*

Category	Income eligibility (as percent of federal poverty level)	
Uninsured Children (up to 19)	151-200%	(monthly income of about $2,439 for a family of 3)
Children	150%	(monthly income of about $1,828 for a family of 3)
Pregnant women	150%	
Parents	100%	(monthly income of about $1,219-family of 3)
Elderly∗	64%	(monthly income of about $457- per individual)
People w/ Disabilities∗	64%	

∗ Deductions and exception apply. This is a proxy amount. People with higher incomes may have medical expenses deducted from income calculations to "spenddown" to this level.

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 2001:

Size of Family Unit	Poverty Guideline (annual income)
1	$ 8,590
2	$11,610
3	$14,630

For larger families add $2,900 for each additional person.

So, for example, using this guideline, 200% of the federal poverty level for a family of 3 would be an annual income of $29,268, or a monthly income of $2,439.

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

WHAT IS HEALTHY START?

- *The name of the Medicaid program for low income children and pregnant women in Ohio is Healthy Start.* Eligibility requirements are as follows:

- *A child whose family has a household income between 151 – 200% of the federal poverty level (FPL) must be uninsured in order to be eligible for Healthy Start*. For a family of 3, this is an annual income of about $29,268 – or $2,439 per month.

- *A child whose family has an income below 150% FPL can be eligible for Healthy Start regardless of insurance status*. For a family of 3, this is an annual income of about $21,945 – or $1,828 per month.

- *A pregnant woman whose family income is below 150% FPL is also eligible for Healthy Start.* When determining eligibility, a pregnant woman, at minimum, is considered a family of two. In addition, babies born to mothers on Healthy Start are automatically eligible for coverage for one full year.

- *Healthy Start does not impose a pre-existing condition exclusion period.* If a family meets the eligibility guidelines, a child's pre-existing medical condition does not exclude him or her from coverage.

- *Healthy Start provides comprehensive coverage to enrollees including, but not limited to, doctor visits, hospital care, prescriptions, mental health services and substance abuse, preventive well-child exams, immunizations, dental, and vision services.*

- *To apply, families must complete a short, mail in application.* No face to face interview is required. Applications can be obtained by contacting 1-800-324-8680/TDD 1-800-292-3572, or by visiting the local county Department of Job and Family Services, or on the internet at www.state.oh.us/odjfs/ohp.

WHAT IS HEALTHY FAMILIES?

- *The name of the Medicaid program for low income families - both parents and children – is Healthy Families*. A family with income less than 100% FPL is eligible. (See page 27 for poverty level for 2001).

- *Healthy Families provides comprehensive coverage to enrollees including doctor visits, hospital care, prescriptions, mental health services and substance abuse, preventative well-child exams, immunizations, dental, and vision services.*

  To apply, families must complete a short, mail in application. No face to face interview is required. Applications can be obtained by contacting 1-800-324-8680/TDD 1-800-292-3572, or by visiting the local county Department of Job and Family Services, or on the internet at www.state.oh.us/odjfs/ohp.

WHO ELSE IS ELIGIBLE FOR MEDICAID COVERAGE?

- *Families and children participating in Ohio Works First (OWF) cash assistance program are automatically covered.* Families who leave OWF for employment are eligible for 6 to 12 months during a transitional period, in addition, your children may qualify for Healthy Start if your family's income meets those income standards, even if your income rises above 100%FPL.

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

Disabled individuals should know that if your income earned from a job increases so that you no longer qualify for SSI, you may be able to continue your Medicaid coverage if you are elderly or you are still considered disabled and you continue to have medical need.

- *Retired or disabled people who have low incomes and are enrolled in Medicare may also qualify for help from Medicaid through the Ohio Medicare Premium Assistance Program.* Even though your income may be too high to qualify for Medicaid 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.

  If your household income is above 100% but below 135% of the poverty level, Medicaid will pay for your monthly Medicare premiums only.

  Contact your county Job and Family Services office for more information about other eligibility requirements. Call 1-800-324-8680/ TDD 1-800-292-3572 to obtain the location and telephone number of this office.

OTHER ASSISTANCE PROGRAMS

- *Beginning in 1992, the Ohio Department of Health through its BCMH, Hemophilia and AIDS programs, started paying health insurance premiums for families who could not afford to keep their employer-based insurance*. The Ohio Department of Health only pays insurance premiums where it is cost effective to maintain a person's private coverage.

- *Children with Medical Handicaps (CMH) is a health care program that provides services for children with special health care needs*. To receive CMH services a child must be an Ohio resident under age 21and is under the care of a CMH approved doctor. Families must also meet income eligibility criteria.

- *Child and Family Health Services (CFHS) Program is also administered by the Ohio Department of Health and provides child and adolescent health care, prenatal care, and/or family planning care.* All of the clinics offer physicals, nutrition counseling, social services, laboratory tests, health education and more. The cost of the clinic services is based on your family size and income, but no one is turned away if they cannot pay. Families can apply using the Medicaid application used to apply for Healthy Start or Healthy Families programs or by visiting their local CFHS clinic.

- *Women, Infants, and Children (WIC) Program gives nutritious foods, important nutrition information and breast feeding education.* It also helps eligible families find a doctor or any other services they might need. To be eligible, you must be pregnant or breast feeding or have just had a baby. Children from birth to age 5 also qualify. Families can apply using the Medicaid application used to apply for Healthy Start or Healthy Families or by visiting their local WIC clinic.

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 State continuation coverage	Ohio Department of Insurance (800) 686-1526 (in-state only) (614) 644-2673 http://www.ohioinsurance.gov
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	U.S. Department of Labor (606) 578-4680 (Cincinnati City Regional Office) (314) 539-2693 (St. Louis District Office), or U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C. (202) 219-8776 For Department of Labor publications: (800) 998-7542 http://www.dol.gov/dol/pwba
Medicaid Healthy Start Healthy Families	Ohio Department of Job and Family Services (614) 466-6282 (800) 292-3572 (TDD) (800) 324-8680 http://www.state.oh.us/odjfs/ohp/0001general.stm
Finally, if you would like to obtain a consumer guide for a different state, visit the web at http://www.healthinsuranceinfo.net	

HELPFUL TERMS

Affiliation Period. The time an HMO may require you to wait after you enroll and before your coverage begins. HMOs that require an affiliation period cannot exclude coverage of pre-existing conditions. Premiums cannot be charged during HMO affiliation periods. Ohio law allows for the use of HMO affiliation periods in group health plans. See also HMO, Small Group Health Plan.

Basic Health Plan. A health plan established by the state of Ohio to offer people the choice of buying coverage for a minimum set of specified benefits. The basic health plan imposes a high level of cost sharing, including a $1000 annual deductible, 50% coinsurance for most covered services, and an annual limit of $50,000 on all covered benefits. Benefits and cost sharing under the basic health plan vary somewhat, depending on whether you are purchasing coverage from an HIC. The basic health plan must be offered by all individual health insurance companies during their annual open enrollment periods. See HIC, Individual Health Plan, Open Enrollment Period.

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.

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

Continuous Coverage. Under federal rules, health insurance coverage that is not interrupted by a break of 63 or more consecutive days. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. Federal rules apply to you if you are joining a group health plan and, if you are federally eligible, when you buy an individual health plan. Under Ohio rules, coverage is continuous if not interrupted by a break of more than 30 days in a row. Ohio rules apply when you are buying an individual health plan and you are not federally eligible. See also Creditable Coverage, Federally Eligible.

Conversion Policy. Your right, when leaving a fully insured group health plan in Ohio, to convert your policy to an individual health plan. You will not face a new pre-existing condition exclusion period. Unless you are federally eligible, you must be offered a hospital, surgical, or medical expenses policy currently being sold by the insurance company. If you are federally eligible, you must be offered a choice between a standard and basic health plan. Conversion coverage also extends to surviving, divorced or separated spouses; dependent children; and children who lose their dependent status under their parent's plan rules. See also Federally Eligible.

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

Enrollment Period. The period during which all 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, Open Enrollment Period, Special Enrollment Period.

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

Federally Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be federally eligible, you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare, Medicaid, or a group health plan; 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 Ohio and in other states. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

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

Genetic Information **(Group Health Plans)**. Includes information about family history or genetic test results indicating the 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.

***Genetic Information* (Individual Health Plans)**. Includes laboratory tests of a person's genes or chromosomes that are linked to physical or mental disorders or impairments, or that indicate the 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 small employers in Ohio are guaranteed issue. Standard and Basic individual health plans must be sold on a guaranteed issue basis year-round to federally eligible individuals, and to other people during annual open enrollment periods. Plans that are guaranteed issue can turn you away for other reasons.

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

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

Health Plan Year. That calendar period during which your health plan coverage is in effect. Many group health plan years begin on January 1, while others begin in a different month.

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

Healthy Start. Healthy start insurance is intended to meet the needs of working families, who cannot afford health insurance coverage for their children, yet earn too much to qualify for Medicaid. Coverage is available for uninsured children age 18 and younger who live in families with qualifying incomes and pregnant women.

Healthy Families Healthy Families is Medicaid insurance intended to meet the needs of working families who cannot afford health insurance coverage.

HIC. Health Insuring Corporation. A term in Ohio law for several kinds of health insurance plans. Any insurance company that uses managed health care techniques must be registered as an HIC. HICs may require you to seek covered care from hospitals, doctors and other providers that they contract with, also known as network providers. Or they may require you to pay more for covered services provided outside the HIC network. HICs also often require you to get a referral from your primary care physician in order to see a specialist. All HICs must offer a state-defined package of health care services during a 30-day annual open enrollment period. See also HMO, Open Enrollment Period.

HIPAA. The Health Insurance Portability and Accountability Act, better 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.

HMO. Health maintenance organization. A kind of health insurance plan. HMOs usually require you to get care from doctors who work for or contract with the HMO. They generally do not require deductibles, but often do charge a small fee, called a copayment, for services like doctor visits or prescriptions. HMOs in Ohio can require affiliation periods in the group market. See also Affiliation Period.

Indemnity Health Plan. A kind of health plan that reimburses you or your health care provider on the basis of services rendered. Indemnity plans generally do not restrict you to a limited network of providers for covered care. However, indemnity plans often impose other restrictions on covered services. For example, plans can require prior authorization of hospital care or other expensive services.

Individual Health Plan. Policies for people not connected to an employer group. This term also refers to coverage purchased by the self-employed for themselves (or their family members) but for no other employees. Individual health plans are regulated by the state of Ohio. All residents without access to employer-sponsored or government-sponsored health insurance can buy such coverage for themselves and their families from a variety of private carriers during a plan's annual open enrollment period, and may be able to purchase such coverage at other times as well. See Open Enrollment Period.

Kassebaum-Kennedy. See HIPAA.

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

Late Enrollment. Enrollment in a health plan at a time other than a regular or special enrollment period. Ohio requires fully insured group plans to cover you if you are a late enrollee. However, insurance companies are only required to enroll you within 12 months of your request to enroll, and you may be subject to an 18-month pre-existing condition exclusion period upon enrollment. See also Special Enrollment Period.

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

Managed Care Plan. See HIC.

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, due to 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.

Open Enrollment Period **(Individual Health Plans).** A period each year during which all private individual health insurers must accept individuals who apply for coverage. Individual insurers must offer you the same standard and basic health plans that are offered to small employers. An indemnity health plan open enrollment period begins in January of each year and remains open until the plan has enrolled a specified number of individuals required by law. To date, very few health plans have reached this maximum. An HIC must have an open enrollment period of at least 30 days in length each year, beginning on the anniversary date of receiving its license to operate in Ohio.

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 group 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. See also Genetic Information.

Pre-existing Condition **(Individual Health Plans).** Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan, or for which an ordinarily prudent person would have sought medical advice, care or treatment during that period. Under individual health plans only, pregnancy can be counted as a pre-existing condition and a waiting period of up to 270 days can be imposed for maternity benefits. Newborns and newly adopted children covered within 30 days cannot be subject to pre-existing condition exclusions. Genetic information cannot be counted as a pre-existing condition in individual health plans. See also Prudent Person Rule. HICs/HMOs may not use pre-existing condition exclusion periods for basic health services.

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 plans only, 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 an individual health plan. See Pre-existing Condition (Individual Health Plan).

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 Ohio.

Small Group Health Plan. Plans with at least 2 but not 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.

Standard Health Plan. A health plan established by the state of Ohio that covers a specified set of benefits. Compared to the basic health plan, the standard health plan offers more extensive coverage with lower cost sharing. Standard health plans offered by HICs and HMOs have somewhat different benefits and cost sharing. The standard health plan must be offered by all individual health insurance companies during their annual open enrollment periods. See Basic Health Plan, HIC, HMO, Individual Health Plan, Open Enrollment Period.

State Continuation Coverage. A program similar to COBRA. In Ohio, if you are eligible for unemployment insurance and in a fully insured group health plan sponsored by an employer with less than 20 employees, you also have rights to continue your health coverage for up to six months when your job ends. See also COBRA.

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

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. Employers with fully insured group health plans may not have a waiting period that exceeds 90 days. See also Pre-existing Condition Exclusion Period.