

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

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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 ARKANSAS

As an Arkansas 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 Arkansas 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. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from Arkansas, 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 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 policies**), so your protections may vary if you leave Arkansas. 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 Arkansas resident.

HOW AM I PROTECTED?

In Arkansas, 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 6)*
- *All group health plans in Arkansas 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 group health plan will begin to pay for care for that condition. Generally, if you join a new group health 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 13)*
- *Your health insurance cannot be canceled because you get sick. Most health insurance is **guaranteed renewable**. (See pages 14 and 22)*
- *If you are a small employer buying a group health plan, 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. All health plans for small employers must be sold on a **guaranteed issue** basis. (See page 23)*

- *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** 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 17)*
- *If you lose your group health insurance and meet other qualifications, you will be **HIPAA eligible**. If so, you can buy an individual health plan from the **Arkansas Comprehensive Health Insurance Pool (CHIP)**. You will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for a CHIP policy. (See page 14)*
- *If you have had difficulty obtaining affordable individual health insurance because of your health condition, you may be eligible for **CHIP** coverage. In this case you may face a new pre-existing condition exclusion period. There are limits on what you can be charged for a CHIP policy. (See page 16)*
- *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 **Arkansas Medicaid** program (including **ARKids First**) offers free or subsidized health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes. (See page 25)*
- *If you believe you may be at risk for cancer but are uninsured or underinsured, you may be eligible for screening and treatment. The **Arkansas BreastCare 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 27).*
- *If you have lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program** then you may be eligible for a federal income tax credit to help pay for new health coverage. This credit is called the **Health Coverage Tax Credit (HCTC)**, and it is equal to 65% of the cost of qualified health coverage, including COBRA, and a specific policy offered through the Arkansas Comprehensive Health Insurance Pool (CHIP). (see page 29)*
- *If you are a retiree aged 55-65 receiving pension benefits from **Pension Benefit Guaranty Corporation (PBGC)**, then you may also be eligible for the HCTC. (see page 29)*

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.

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- *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.*
- *Employers are not required to provide health benefits for their employees, so if you change jobs, you may find that 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. (See page 6)*
- *If you get a new job with health benefits, your coverage may not start right away. Employers 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 group health plan. Even if your coverage is **continuous**, there may be a pre-existing condition exclusion period for some benefits if you join a **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 one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition. (See page 10)*
- *If you work for certain non-federal public employers in Arkansas, not all of the group health plan protections may apply to you. (See page 10)*
- *If you are HIPAA eligible, CHIP is your only guaranteed access to individual health insurance, though you may be able to buy individual health insurance from other insurance companies. (See page 14)*
- *If you join CHIP and are not HIPAA eligible, you may face a pre-existing condition exclusion period. (See page 16)*
- *In Arkansas, your access to individual health insurance depends on your health status. Private insurers are not prohibited from turning you down, charging more, or limiting coverage because of pre-existing conditions. (See page 12)*
- *If you move away from Arkansas, you may not be able to buy individual health insurance in another state unless you are HIPAA eligible.*

- *If you are a small employer, you might be charged more for health insurance if someone in your group is sick.* While there are limits on what you can be charged based on health status, premiums can be significantly higher if someone in your group has a serious health condition. Also, the insurance carrier can turn you down if your small business does not meet the participation or contribution requirements. (See page 23)

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 an **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.* 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.

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 those employees who can pass a physical examination. This is not permitted under the law.

- *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage.* This waiting period, however must be applied consistently and cannot vary due to your health status. Unlike employers, insurers cannot require waiting periods. If your new job has health insurance through an HMO, the HMO may also require a waiting period called an HMO **affiliation period**, and you will not have health insurance coverage during this time. An affiliation period cannot exceed 2 months (3 months for late enrollees), and you cannot be charged a premium during this period.

- *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 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 lost because of death, divorce, legal separation, termination, retirement, or reduction in hours worked)

- *Under Arkansas law, newborns and adopted children must be automatically covered under the parents' fully insured health plan, if the plan covers dependents.* If you have a newborn, the insurer may require that you notify it of the child's birth within 90 days or before the next payment is due, whichever date is later. If you plan to adopt a child, coverage begins when you file to adopt the child, but you have to notify the insurer about the filing within 60 days. If you are adopting a newborn and you notify the insurer within 60 days of filing, the start of coverage will be backdated to the day the child was born.
- *Under Arkansas law, adult dependents who are physically disabled or mentally retarded are, at the option of the insured, able to stay on their parents' fully insured group health plan after they have reached the age at which the plan usually cancels dependent coverage.* In order to be eligible, the adult dependent must be incapable of self-support and must be dependent on the policyholder for support. Proof of incapacity must be provided to the insurer within 31 days of reaching the limiting age.
- *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 the 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 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. In some cases, your protections will vary depending on the type of group health plan you belong to.

- *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 called the look back period.*
- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns, newly adopted children, children placed for adoption, or genetic information.*
- *Group health plans can only exclude coverage for pre-existing conditions for a limited time. The maximum period allowed for exclusion 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.*
- *Group health plans that impose pre-existing condition exclusion periods must give you credit for any previous continuous **creditable coverage** that you've had. Most types of private and government-sponsored health insurance are considered creditable coverage.*

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

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

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 of prior coverage, 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.* The new coverage must be in place on the 63rd day in order to avoid any pre-existing condition exclusions. 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** towards it. If your employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period.

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.

- *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. Plans that use this method of crediting prior coverage must use it for everyone and must disclose this to you when you enroll.

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 fully 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 Arkansas Municipal League 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 Arkansas 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 coverage, individual health insurance, and coverage 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. (See page 29).*
- *If you are a retiree aged 55-65 and receiving benefits from Pension Benefit Guaranty Corporation (PBGC), then you may be eligible for the HCTC. (See page 29)*

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 policy** from a private health insurance company. However, in Arkansas – as in most other states – you have limited guaranteed access to individual health insurance in the private market. There are some alternatives to individual health insurance – such as COBRA coverage and CHIP. 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 AN INDIVIDUAL HEALTH INSURANCE POLICY?

In Arkansas, your ability to buy an individual health insurance policy depends on your health status.

- *In general, companies that sell individual health insurance in Arkansas are free to turn you down because of your health status and other factors.* When applying for an individual health insurance policy, 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.
- *If you are turned down by an individual health insurer, you may be able to buy a policy from CHIP.* (See page 14)
- *Under Arkansas law, newborns and adopted children must be automatically covered under the parents' individual health policy, if the plan covers dependents.* If you have a newborn, the insurer may require that you notify it of the child's birth within 90 days or before the next payment is due, whichever date is later. If you plan to adopt a child, coverage begins when you file to adopt the child, but you have to notify the insurer about the filing within 60 days. If you are adopting a newborn and you notify the insurer within 60 days of filing, the start of coverage will be backdated to the day the child was born.
- *Under Arkansas law, adult dependents who are physically disabled or mentally retarded are, at the option of the insured, able to stay on their parents' individual health insurance policy after they have reached the age at which the plan usually*

cancel dependent coverage. In order to be eligible, the adult dependent must be incapable of self-support and must be dependent on the policyholder for support. Proof of incapacity must be provided to the insurer within 31 days of reaching the limiting age.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy.* Arkansas does not require health insurers in the individual market to sell standardized policies. Insurers can design different policies and you will have to read and compare them carefully. However, Arkansas does require all health plans to cover certain benefits – such as post-delivery hospital stays and breast reconstruction following mastectomies. Check with the Arkansas Insurance Department for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Generally, there are no limits on how long individual health insurers in Arkansas can exclude coverage for your pre-existing conditions.* You may also be offered coverage that contains a permanent exclusion on a health condition, body part, or body system. Permanent exclusions are known as **elimination riders**.

Also, an individual health insurer may impose a pre-existing condition exclusion period. A pre-existing condition is a condition for which, in the 5 years, you received care, or – in the insurance company’s judgment – for which you should have sought care. This is called the **prudent person rule**. Generally, provided the individual health insurer asks you about your medical history, there is no limit on how long the insurer may apply a preexisting condition exclusion period. However, individual health insurers that do not ask about your pre-existing conditions when you apply for coverage can only exclude your pre-existing conditions for 12 months. Finally, individual health insurers do not have to give you credit for your prior coverage.

In Arkansas, pregnancy and genetic information can be considered a pre-existing condition in individual health plans.

- *Individual health insurers can exclude from coverage certain health conditions or conditions affecting certain body parts for only 6 months.* These conditions and body parts are: hernia, disorder of reproductive organs, varicose veins, adenoids, appendix, and tonsils.

WHAT CAN I BE CHARGED FOR INDIVIDUAL HEALTH INSURANCE POLICY?

- *Generally, in Arkansas, there are no limits on how much individual premiums can vary due to age, gender, health status, family size, and other factors.*

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 the plan service area. However, guaranteed renewability does not protect you from having your premiums go up at renewal, and premiums can also increase within limits as you age or your health declines.*
- *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 expires, you will have to reapply and there is no guarantee that coverage will be re-issued at all or at the same price.*

ARKANSAS COMPREHENSIVE HEALTH INSURANCE POOL (CHIP) COVERAGE

Arkansas maintains a state health benefits risk pool, called the Arkansas Comprehensive Health Insurance Pool (CHIP) to provide insurance for eligible residents of Arkansas.

WHEN CAN I GET COVERAGE FROM CHIP?

- *You can buy an individual health insurance policy from CHIP if you have lived in Arkansas for at least 90 days and can demonstrate proof of eligibility. To be eligible, you must have been turned for an individual health insurance policy by an insurance company or were offered a policy by an insurance company at a rate at least 50% greater than that of a CHIP premium for a comparable policy. In addition, you must not be enrolled in or eligible for Medicaid or Medicare.*
- *In addition, if you are HIPAA eligible, you can buy health insurance from CHIP.*

To be HIPAA eligible, you must meet certain criteria

No matter where you live in the U.S., if you are HIPAA eligible you are guaranteed the right to buy individual health coverage of some kind. In Arkansas, you are guaranteed the right to buy coverage only from CHIP. To be HIPAA 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.

HIPAA 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.

- *If you are eligible for the Federal Health Coverage Tax Credit (HCTC) through the Trade Adjustment Assistance (TAA) Act, you must be guaranteed access to CHIP (see page 30).*
- *CHIP only offers individual coverage, so each member of your family needs to qualify on his or her own for a CHIP policy.*

WHAT DOES A CHIP POLICY COVER?

- *CHIP coverage is offered through a managed care plan.* After you satisfy your annual deductible, the plan will pay 80% of covered charges when you get care from a hospital, doctor, or other provider in the CHIP network. When your cost sharing reaches the “out-of-pocket” limit, CHIP will pay 100% of covered charges. If you get care from a provider outside the network, CHIP will pay 60% of covered services, after you satisfy your annual deductible. Your 40% share of cost for out-of-network care will not count toward the “out-of-pocket” limit.
- *CHIP offers 3 deductible options.* Your annual deductible can be \$1,000, \$5,000, or \$10,000, depending on which policy you choose.

- *Covered benefits include hospital and nursing facility care, physician care, and prescription drugs. There are special limits on treatment for mental disorders and chemical dependency. Routine maternity coverage can be purchased for an additional premium. There is a lifetime limit of \$1 million on all covered benefits.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are HIPAA eligible, no pre-existing condition exclusion will be imposed when you enroll in CHIP.*
- *If you are not HIPAA eligible, you may have a 6-month pre-existing condition exclusion period when you first enroll in CHIP. When you enroll, CHIP will look back 6 months to see if you had a condition for which you actually received – or for which most people would have sought – a diagnosis, medical advice, or treatment. This is called the prudent person rule. Pregnancy and genetic information can be considered pre-existing conditions.*
- *If you are not HIPAA eligible, CHIP may waive your pre-existing condition exclusion period if you meet certain conditions. You must have had at least 6 months of prior group coverage that was involuntarily terminated, and you must have satisfied a similar pre-existing condition exclusion under your prior coverage. You must apply for CHIP not later than 30 days following the involuntary termination, and you must be ineligible for continuation coverage. CHIP will also require that you pay a 10% surcharge on your premiums for 5 years.*
- *If you are eligible for the HCTC, you may be able to avoid the application of a pre-existing condition exclusion period. If you are HCTC eligible and maintained prior creditable coverage for a total period of three months as of the date that you applied for coverage, and there was no break in coverage greater than 63 days, insurers may not impose a pre-existing condition exclusion period against you.*

WHAT CAN I BE CHARGED FOR CHIP COVERAGE?

- *CHIP premiums vary depending on your age, deductible, whether you elect maternity coverage, and whether you receive a waiver of your pre-existing condition exclusion period.*
- *For example, as of January 1, 2005, the monthly premium for a 24-year-old man can range from \$77 to \$174, depending on the deductible he chooses and whether he pays the 10% pre-existing condition surcharge. By contrast, the monthly premium for a 64-year-old man can range from \$378 to \$971, depending on the deductible selected and whether the pre-existing condition surcharge is paid. Optional maternity coverage can add up to about \$200 to your monthly premiums, depending on your age.*

Contact CHIP for more information about plan and premium options at (800) 285-6477 or visit <http://www.chiparkansas.org/>.

HOW LONG DOES CHIP COVERAGE LAST?

- *CHIP policies are renewable as long as you pay your premiums, continue to reside in Arkansas, and meet other eligibility requirements.*

COBRA AND STATE CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

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

- *To qualify as HIPAA eligible, you must choose and use up any COBRA or state continuation coverage available to you.*

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 have 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 20)*

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. 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 of hours). You must obtain a disability determination letter from the Social Security Administration, and you must notify your group health plan within 60 days of receiving this disability determination letter, and before your original 18 months expires.*

LENGTH OF COBRA COVERAGE

<u>Qualifying event(s)</u>	<u>Eligible person(s)</u>	<u>Coverage</u>
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. 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.*

WHAT ABOUT ARKANSAS CONTINUATION COVERAGE?

- *If your employer offers fully insured health benefits and has fewer than 20 workers, you may also be eligible for up to 120 days of continuation coverage under a Arkansas law that is similar to COBRA. You must have had at least 3 months of continuous coverage under your group health plan in order to be eligible and you have to apply within 10 days of losing your old coverage. Ask your former employer or the Arkansas Insurance Department if you think this applies to you.*

CONVERSION

WHEN AM I ELIGIBLE FOR A CONVERSION POLICY?

- *If you were covered under a fully insured group health plan and you leave your job, you are able to buy a conversion policy. You are also able to buy a conversion policy at the end of your state continuation coverage. A conversion policy is an individual health plan from the insurance company that covered your former group. You cannot buy a conversion policy if you are eligible for Medicare or if you have another health plan that covers pre-existing conditions.*

WHAT WILL A CONVERSION POLICY COVER?

- *Conversion policy benefits must meet certain minimum benefit requirements, which may not be the same as those under your former plan.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Conversion policies cannot impose a new pre-existing condition exclusion period. However, you might have to satisfy the unexpired portion of any pre-existing condition exclusion period from your former health plan.*

WHAT CAN I BE CHARGED FOR A CONVERSION POLICY?

- *There is no limit on what your insurer can charge for a conversion policy. Premiums are determined based on the age and classification of risk of each person applying for a converted policy. These policies are often more expensive than your prior group coverage.*

CAN MY CONVERSION POLICY BE CANCELLED?

- *Your coverage cannot be cancelled 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. Arkansas has enacted reforms to 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 Arkansas Insurance Department 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 eligible 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 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 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, employers with 2-25 employees can be charged higher premiums based on the health, risk, and demographic characteristics of their groups.* Arkansas limits the difference in premiums and the annual increase that can be charged.
- *Arkansas law does not place similar limits on the premiums that can be charged to employers with 26 or more employees.*

- *If you have questions about your group health insurance premiums, contact the Arkansas Insurance Department.*

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 plans 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 Arkansas Insurance Department about your protections in association health plans.

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Arkansas who cannot afford to buy health insurance. **Medicaid** (including ARKids First), Arkansas BreastCare and other programs offer free or subsidized health insurance coverage, direct medical services or other help at little or not cost to you.

In addition, the Federal Trade Adjustment Assistance (TAA) program provides tax credits to 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 this program and contact information for further assistance.

MEDICAID

Medicaid is a program that provides health coverage to some low-income Arkansas residents. Medicaid covers families with children and pregnant women, medically needy individuals, 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 cannot enroll in Medicaid, unless they are considered to have a life-threatening medical emergency and if certain conditions are met. If eligible for emergency Medicaid, the individual can only be certified for the emergency period.

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

In Arkansas 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.

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 Arkansas Department of Human Services for more information.

Low income persons eligible for Medicaid in Arkansas*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Child 0-19	200% (monthly income of about \$2,612 for family of 3)
Non-Working Parent	16%
Working Parent	20%
Pregnant Woman	200%
Medically Needy Individual	15%
Medically Needy Couple	22%

* 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:

<u>Size of Family Unit</u>	<u>Poverty Guideline (annual income)</u>
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, 200% of the federal poverty level for a family of 3 would be an annual income of \$31,340, or a monthly income of \$2,612.

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

- *Families who get cash assistance from TANF (also known as **Temporary Assistance for Needy Families**) can get Medicaid.* Parents should also know that when your family's TANF benefits end, your children may also qualify for transitional Medicaid coverage for 12 months. Or, they may qualify for Medicaid if your family's income meets the Medicaid income standards. (See below.)
- *Very poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits can also qualify for Medicaid.* You do not need to submit a separate application 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 at least for a limited time.

- People who have high medical expenses may also qualify for Medicaid. *You may qualify as medically needy if you are a child, parent or a dependent child, pregnant, elderly, or disabled and have high medical expenses that, when subtracted from your income, would make you eligible for Medicaid coverage. For example, people who have to pay a lot for prescription drugs, nursing home care, or other long term care services sometimes qualify as medically needy if they don't have health insurance that covers these services.*
- *Retired or disabled people who have low incomes and are enrolled in Medicare may also qualify for help 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 County Department of Human Services 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 Arkansas Department of Human Services at (800) 482-8988.

ARKANSAS BREASTCARE PROGRAM

- *The Arkansas BreastCare Program provides a qualified woman with full health care benefits through Medicaid at no cost or for a nominal copayment.* 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 addition, Medicaid will cover all of your medical needs including treatment for non-cancer related medical services.

- *In order to be eligible for screening through the BreastCare Program, you must live in Arkansas and be at least 40 years of age. In addition, to qualify for cancer screening services, which includes a Pap test, you must meet income eligibility requirements, be uninsured or underinsured, and be ineligible for Medicaid and/or Medicare.*
- For more information or to enroll, call the Arkansas BreastCare Hotline at (877) 670-CARE or visit <http://www.arbreastcare.com/>.

ARKIDS FIRST

The Arkansas ARKids First Program is a program that provides health insurance coverage to low income children and pregnant woman. ARKids can also help in paying premiums of employer-based or private health insurance plans.

- *If a child or pregnant woman does not have insurance, KidCare provides payment of medical expenses at little or no cost. The price a family pays depends on your family income.*
- *Depending on your income, your child may be eligible for either ARKids A or ARKids B. If your family's income is at or below 133% of the federal poverty level, ARKids enrolls children in ARKids A. There are no deductibles, premiums, or copayments for ARKids A coverage. Children whose family's income is at or below 200% of the federal poverty level may enroll in ARKids B. There are no deductibles or premiums for ARKids B, but you may be asked to make a copayment of \$10 when your child visits the doctor.*
- *ARKids First provides comprehensive coverage to enrollees. This includes doctor and nurse care, immunization and preventative care, health clinic care, laboratory test and x-rays, prescription drugs, medical equipment and medical transportation, dental care, eye care, hospital care, prescriptions, mental health services, and preventative well-child visits, as well as other services.*
- *For more information or to enroll your child, call ARKids toll free at (888) 474-8275 or visit <http://www.arkidsfirst.com/>*

OTHER PROGRAMS

There may be other financial assistance programs available. Please call the Arkansas Department of Health at (800) 235-0002.

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 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: In Arkansas, a policy offered through the Comprehensive Health Insurance Pool (CHIP) is the state qualified plan.
 - Individual health 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 State continuation coverage Conversion coverage Fully insured group health insurance	<i>Arkansas Insurance Department</i> (800) 282-9134 (in-state only) (501) 378-2010 http://www.state.ar.us/insurance
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor, Dallas Regional Office</i> (214) 767-1055, or contact <i>U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C.</i> (202) 219-4377 <i>For Department of Labor publications:</i> (800) 998-7542 http://www.dol.gov/dol/pwba
Comprehensive Health Insurance Program (CHIP)	<i>Arkansas Blue Cross Blue Shield (plan administrator)</i> (800) 998-7542 (outside Little Rock) (501) 378-2010 (Little Rock)
Medicaid (including ARKids First)	<i>Arkansas Department of Human Services</i> (800) 482-8988 (in-state) http://www.medicaid.state.ar.us <i>For information on ARKids First:</i> (888) 474-8275 http://www.arkidsfirst.com
Arkansas BreastCare Program	<i>Arkansas Department of Public Health</i> (877) 670-CARE http://www.arbreastcare.com/ .
Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service</i> (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

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. See also HMO.

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 workers 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.

ARKids First. A health insurance program run by the state which provides comprehensive health insurance to children from low income families who meet certain eligibility requirements.

Arkansas BreastCare Program. Program which provides free screening for breast and cervical cancer to eligible residents of Arkansas. Eligible women diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid for treatment of their condition.

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.

CHIP. Comprehensive Health Insurance Pool, the state-run program for people with high health risks (called a high risk pool). CHIP sells individual coverage to those who are HIPAA eligible and to others with serious health conditions who cannot buy affordable coverage from private health insurance companies.

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. 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. See also Creditable Coverage, HIPAA Eligible.

Conversion Policy. Your right, when leaving a fully insured group health plan in Arkansas, to convert your membership in a group policy to an individual health policy. Conversion coverage may be different from your former group plan, and it can be significantly more expensive. See also Fully Insured Group Health Plan.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; an individual health plan; Medicare; Medicaid; CHAMPUS and TRICARE (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.

Elimination Rider. An amendment permitted in individual health plan contracts that permanently excludes your coverage for a health condition, body part, or body system.

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 Arkansas. 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 group 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 with 2 to 50 employees in Arkansas are guaranteed issue. Federally eligible persons are guaranteed issue of CHIP coverage. 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. 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 health coverage tax credit, you must be 1) receiving Trade Readjustment Allowance benefits (TRA), 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 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 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 was 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, HIPAA eligibility gives you greater protections than you would otherwise have in Illinois and in other states. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

HMO. Health maintenance organization. A kind of health insurance plan. HMOs usually limit coverage to 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. If you are covered under an HMO, the HMO might require an affiliation period before coverage begins. See also Affiliation Period.

Individual Health Policy. Policies for people not connected to an employer group. This term also refers to coverage purchased by self-employed persons who have no other employees. Individual health plans are regulated by Arkansas.

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.

Managed Care. A type of health insurance that has a limited network of providers and that generally requires prior authorization before you can receive some services or visit certain providers. Sometimes a managed care plan will cover visits to providers outside of its network, but you will be responsible for a greater portion of the fees than if you had gone in-network. HMOs are a type of managed care. See also HMO.

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

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, and 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 (CHIP). Any condition for which medical advice, diagnosis, care or treatment was recommended or received, or for which an ordinarily prudent person would have sought medical advice, care or treatment, within the 6-month period immediately preceding enrollment in CHIP. Pregnancy and genetic information can be counted as pre-existing conditions. See also Prudent Person Rule.

Pre-existing Condition (Group Health Insurance). 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, or for which an ordinarily prudent person would have sought medical advice, care or treatment. In Arkansas, under individual health insurance policies, pregnancy can be counted as a pre-existing condition. Genetic information can also trigger a pre-existing condition exclusion in individual health plans. Health plans can look back 5 years to see if you have any pre-existing conditions; if you have any, there are no general limits on how long they can be excluded from coverage. See also Prudent Person Rule.

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 and CHIP 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 prior to enrolling in an 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 Arkansas.

Small Group Health Plans. 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.

State Continuation Coverage. A state program similar to COBRA for small employers with fewer than 20 employees. State continuation coverage can last up to 120 days. 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.

Temporary Assistance for Needy Families (TANF). A program (also known as TEA) 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.