

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

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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 DELAWARE

As a Delaware 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 a Delaware 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 Delaware, your protections may change. Since this guide is a summary, it may not answer all of your questions. For places to contact for more information, see page 29. For information about how to find consumer guides for other states on the Internet, see page 29. A list of helpful terms and their definitions begins on page 30. These terms are 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 policies**), so your protections may vary if you leave Delaware. 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 a Delaware resident.

HOW AM I PROTECTED?

In Delaware, 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 Delaware 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 group 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 page 8).*
- *Your health insurance cannot be canceled because you get sick. All health insurance is **guaranteed renewable**. (See pages 15 and 20).*
- *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. If you work for an employer with 20 or more employees, 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 15).*

- *If you are **HIPAA eligible**, you can buy an **individual health insurance policy** from any insurance company that sells such plans in Delaware. Insurance companies must offer you a choice of at least two policies. However, they may charge you significantly higher premiums due to your health status, age, or other factors. (See page 13).*
- *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 page 20).*
- *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, industry, 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 20).*
- *If you are self-employed with no other workers, you are eligible to buy health insurance under the same rules that are applicable to other small employers.*
- *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 Delaware **Medicaid** program offers free health coverage for pregnant women, families with children, and elderly and disabled individuals with very low incomes. In addition, through the **Screening for Life Program**, some women diagnosed with breast or cervical cancer may be eligible for medical care through Medicaid. (See page 22).*
- *If you believe that you may be at risk for cancer but are uninsured or underinsured, you may be eligible for free screening and treatment. The **Screening for Life 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. In addition, the **Delaware Cancer Treatment Program** provides payment of medical expenses related to cancer treatment to qualified individuals. (See page 25).*
- *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 **Delaware Healthy Children Program**. (See page 24).*
- *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 26).*

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

WHAT ARE THE LIMITS ON MY PROTECTIONS?

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

- *If you change jobs, you usually cannot take your old health benefits with you. Except when you exercise your federal COBRA, 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. (See page 11).*
- *Employers are not required to provide health benefits for their employees, so if you change jobs, you may find that your new employer does not offer you health coverage. 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 and health maintenance organizations (HMOs) can require **waiting periods** before your health benefits begin. (See page 7.)*
- *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 health plan. (See page 9).*
- *Even if your coverage is **continuous**, there may be a pre-existing condition exclusion period for some benefits if you join a group 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 group health plan will pay for drugs prescribed to treat a pre-existing condition. (See page 10).*
- *If you work for a non federal government employer in Delaware, not all of the group health plan protections may apply to you. (See page 10).*
- *In Delaware, your access to individual health insurance may depend on your health status. Unless you are HIPAA eligible, private insurers in Delaware may turn you down, charging more, or limit your coverage because of pre-existing conditions. (See page 12).*

- *Even if you are HIPAA eligible, you can be turned down for some individual health insurance policies.* The law permits insurance companies to limit your choices to two policies, which are supposed to be comparable to others they sell in the individual market in Delaware. (See page 12).
- *If you move away from Delaware, 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, generally 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 20).

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. 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.*
 - *Under Delaware 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.*
 - *Under Delaware law, your disabled child may remain covered under your fully insured small group plan into adulthood. Your child must be unmarried, dependent on you and medically certified as totally disabled.*
 - *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.

- *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.*
- *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 18 months before they enroll you in the group health plan, and may impose up to an 18-month pre-existing condition exclusion period. The combined waiting period and pre-existing condition exclusion period may not exceed 18 months. You must be accepted.

- *Group 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)
Indian Health Service	State health insurance
Individual health insurance	high risk pools
Medicaid	

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.* The new coverage must be in place on the 63rd day in order to avoid any pre-existing condition exclusions.

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*.

- *Employer-imposed waiting periods and HMO 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 that require an affiliation period cannot exclude coverage for pre-existing conditions.

- *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**.*
- *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 Delaware 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**.

- *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 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, the city of Dover has decided that certain protections will not apply to their employees. Other non-federal public employers in Delaware 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 and individual health plan coverage for "HIPAA eligible individuals."*
- *If you lost your group 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 health coverage, including COBRA. (See page-)*
- *If you are a retiree aged 55-65 and receiving benefits from Pension Benefit Guaranty Corporation (PBGC), you may be eligible for the HCTC. (See page-)*

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 Delaware – as in most other states – you have limited guaranteed access to private individual health insurance. There are some alternatives to private individual health insurance – 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 Delaware, your ability to buy individual health insurance depends on your health status. There are certain circumstances, however, when you must be allowed to buy individual health coverage.

- *In general, insurers that sell individual health insurance in Delaware 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.*
- *If you are HIPAA eligible, all insurance companies that sell individual insurance policies must offer you a choice of at least two policies.*

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible in Delaware 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 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 HIPAA eligible.)
- You must apply for health insurance for which you are HIPAA eligible within 63 days of losing your prior coverage.

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

- *Under Delaware law, newborns 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.*

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy.* Delaware does not require health insurers in the individual market to sell standardized policies. Health plans can design different policies and you will have to read and compare them carefully. Health plans are required to provide you with written descriptions of their products so that you can compare the differences.
- *If you are HIPAA eligible, insurance companies must offer you a choice of two state approved policies with benefits similar to policies sold to everyone else.* Companies that do not designate two policies must offer you a choice of all of their policies.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *There are different ways insurers are allowed, at the time you purchase the policy, to exclude coverage for your pre-existing conditions.*

The insurer can impose an **elimination rider**. This is an amendment to your health insurance contract that permanently excludes coverage for a health condition, body part, or body system.

An individual health insurer may also impose a pre-existing condition exclusion period. Generally, the insurer can decide how long a pre-existing condition period will last.

When determining if a condition is pre-existing, an individual health insurer is allowed to look back 5 years to see if you actually received care for a condition. In addition, the insurer can look for evidence of symptoms for which most people, in the insurer's opinion, would have sought care. This is called the **prudent person standard**.

Individual health insurers do not have to give you credit for your prior continuous coverage.

- *After you purchase your individual health insurance policy, insurers can still exclude coverage for a pre-existing condition, even if it wasn't specifically excluded by the terms of the policy. If you make a claim during the first 2 years of coverage, the insurer can look back 5 years from the time of your application to see if the claim is for a condition that would have been considered a pre-existing condition. If the insurer determines, using the prudent person standard, that the condition is a pre-existing condition, it can refuse to pay for related expenses.*
- *Pregnancy can be considered a pre-existing condition in an individual health insurance policy. However, genetic information cannot be used as a basis for a pre-existing condition.*
- *If you are HIPAA eligible and buying a guaranteed issue policy, you will not face a pre-existing condition exclusion period.*

WHAT CAN I BE CHARGED FOR INDIVIDUAL HEALTH INSURANCE POLICY?

- *In Delaware, 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 CANCELLED?

- *If you have an individual health insurance policy, 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 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 lost your group 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 COBRA 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 -).*
- *If you are a retiree aged 55-65 and receiving benefits from Pension Benefit Guarantee Corporation (PBGC), then you may be eligible for the HCTC (see page -).*

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.*

HOW LONG CAN COBRA COVERAGE LAST?

<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.*

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. Delaware has enacted some reforms that expand some of these protections. Generally, small employers are those that employ 1-50 employees. Please note, however, that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Delaware 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 one person (including yourself) 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 (including a basic and standard plan). 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, 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 Delaware Department of Insurance if you have questions about your group health plan premiums.

- *Delaware also limits annual increases that can be charged for small group health plans.*

WHAT IF I AM SELF EMPLOYED?

- *If you are self-employed with no other workers, you are eligible to buy a group health plan on your own. You are guaranteed access to all health insurance sold to small employers (including a basic and standard plan).*
- *If you are self-employed and buy your own health coverage, 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 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 Delaware Department of Insurance about your protections in association health plans.*

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Delaware who cannot afford to buy health insurance. Medicaid, the Delaware Healthy Children Program and the Screening Program for Life 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.

In addition, the federal Health Coverage Tax Credit (HCTC) Program provides tax credits to early retirees and some workers who lose their jobs or whose work hours and wages are reduced as a result of increased imports. This chapter provides summary information about these programs and contact information for further assistance.

MEDICAID

Medicaid is a program that provides health coverage to some low-income Delaware residents. Medicaid covers low-income, uninsured individuals, families with children, pregnant women, the elderly, and people with disabilities. Legal residents who are not U.S. citizens may be eligible for Medicaid. Non-citizens who do not have immigration documents may receive Emergency Services and Labor and Delivery services only.

- *Eligibility for Medicaid is based on the amount of your household income.*

In Delaware you may be eligible for Medicaid if you are an individual, a child, a parent of a child, or pregnant, and your family income meets the Medicaid income standards.

Income eligibility levels for these categories are described below. You should contact the Division of Social Services for more information.

Low income persons eligible for Medicaid in Delaware*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Child up to 19	200% (monthly income of about \$2,504 for a family of 3)
Children (1-5)	133%
Children (6-19)	100%
Working Parent	100%
Non-working Parent	120%
Pregnant woman	200%

* 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 and children under age 18 participating in Delaware's cash assistance program are automatically covered.*
- *Parents who receive benefits under **Temporary Assistance for Needy Families (TANF)** should know that when you get a job and your TANF benefits would normally end, you generally could stay on Medicaid for a 24-month transitional period.*

In addition, your children may qualify for Medicaid if your family's income meets certain income standards. (See above.)

- *Poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits are automatically eligible 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.

- *Elderly 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 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 the DHSS office 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 Delaware Health and Human Services at (302) 255-9500 or 1-800-372-2022 or <http://www.state.de.us/dhss/dss/medicaid.html>

DELAWARE HEALTHY CHILDREN PROGRAM

The Delaware Healthy Children Program (Healthy Children) is a Medicaid expansion program that provides health coverage to low-income children under the age of 19 who are not eligible for Medicaid and who have no health insurance and pregnant women ineligible for Medicaid.

- *A child whose family has a household income above 150% and at or below 200% of the federal poverty level (FPL) is eligible for the Delaware Healthy Children Program.* For a family of 3, 200% of the federal poverty level works out to an annual income of up to \$31,340, or a monthly income of up to \$2,612.
- *The Delaware Healthy Children Program provides comprehensive coverage to enrollees.* Comprehensive coverage includes doctor visits, hospital care, prescriptions, mental health services, preventive well-child exams, immunizations, and vision services.
- *There is a low monthly premium rate but no co-payments.* The Delaware Healthy Children Program is different from the Medicaid program. If your child is enrolled in Medicaid, there is no monthly premium.

- *To be eligible for the Delaware Healthy Children Program, your child must be a US citizen (or qualified non-citizen) and a Delaware resident and be uninsured.*
- *For more information, please contact the Delaware Healthy Children Program at (800) 996-9969 <http://www.state.de.us/dhss/dss/dhcp.html>*

SCREENING FOR LIFE: PROMOTING BREAST AND CERVICAL CANCER HEALTH

Screening for Life is a program which provides free screening for breast and cervical cancer to eligible Delaware residents. Eligible women diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid for treatment of their condition.

- *The **Screening for Life Program** provides qualified woman with full healthcare benefits through Medicaid at no cost or for a nominal co-payment. 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 of non-cancer related services.*
- *In order to be eligible for screening through the Screening for Life Program, you must meet age, income and insurance guidelines. You must have an income at or below 250% of the federal poverty level (FPL), be over the age of 18 years old and be uninsured or underinsured.*
- *For more information, please contact the Screening for Life Program at (888) 459-2943 or (302) 744-4700 or <http://www.state.de.us/dhss/dph/dpc/sfl.html>*

DELAWARE CANCER TREATMENT PROGRAM

The Delaware Cancer Treatment Program is a state funded program which provides payment for medical services related to the treatment of cancer for qualified Delaware residents.

- *To qualify you must meet certain requirements. You must have an income less than 650% of the federal poverty level, be uninsured or underinsured and diagnosed with cancer on or after July 1, 2004.*
- *Benefits are limited to certain medical services. The Delaware Cancer Treatment Program only pays for medical services related to the treatment of your cancer.*

- *For more information, please contact the Delaware Cancer Treatment Program at 1-800-996-9969, extension 5.*

OTHER ASSISTANCE PROGRAMS

There may be other financial assistance programs available. Please contact the Delaware Health and Human Services, Division of Social Services at (302) 255-9500 or (800) 372-2022. or <http://www.state.de.us/dhss/dss/medast.html>

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 (CHIP).*
 - *You are entitled to health coverage through the U.S. military health system (Tricare/CHAMPUS).*
 - *You can be claimed as a dependent on someone else's federal tax return.*

- *You received a lump sum payment of your entire PBGC benefit before August 6, 2002.*
- *As of the first day of the current month in which you are otherwise eligible, you are imprisoned under a federal, state or local authority.*
- *HCTC may apply to your family, too. If you are eligible, you can use the credit to help purchase qualified health coverage for your qualified family members. Qualified family members are your spouse and dependents that you can claim on your federal tax return. Family members are not eligible if they are enrolled in another group health plan where the employer pays at least 50% of the cost of coverage, or in Medicaid, SCHIP, FEHBP, Tricare/CHAMPUS.*
- *Eligibility for HCTC is not based on income. In addition, the HCTC is refundable. This means you can claim the credit even if you do not earn enough income to owe federal income tax.*

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

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

WHAT HEALTH COVERAGE IS ELIGIBLE FOR THE TAX CREDIT?

- *The HCTC can only be used to help pay for “qualified” health coverage. Qualified health coverage includes:*
 - *COBRA continuation coverage, as long as your employer or former employer contributes less than 50% of the total health plan premium.*
 - *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 Fully insured group health insurance	<i>Delaware Department of Insurance</i> (800) 282-8611 or (302) 739-4251 www.state.de.us/inscom
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor</i> (215) 596-1134 (Philadelphia Regional Office for Delaware), or <i>U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C.</i> (202) 219-8776 <i>For Department of Labor publications:</i> (800) 998-7542 http://www.dol.gov/dol/pwba
Medicaid	<i>Delaware Health and Social Services</i> (800) 372-2022 or (302) 255-9500 http://www.state.de.us/dhss/dss
Delaware Healthy Children Program	<i>Delaware Health and Social Services</i> (800) 996-9969 http://www.state.de.us/dhss/dss/dhcp.html
Screening For Life Program <i>Promoting Breast and Cervical Health</i>	<i>Delaware Health and Social Services</i> (888) 459-2943 or (302) 744-4700 http://www.state.de.us/dhss/dph/dpc/sfl.html
Delaware Cancer Treatment Program	<i>Delaware Health and Social Services</i> (800) 996-9969
Other Programs	<i>Delaware Health and Social Services</i> (800) 372-2022 or (302) 255-9500 http://www.state.de.us/dhss/dss
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. Delaware law allows for the use of HMO affiliation periods in group health plans. See also HMO, Small Group Health Plan.

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

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

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 HIPAA eligible, when you buy an individual health plan. See also Creditable Coverage, HIPAA 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.

Delaware Cancer Treatment Program. A state funded program which provides payment for medical services related to the treatment of cancer for qualified Delaware residents.

Delaware Healthy Children Program. Healthy Children 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 that live in families with qualifying incomes.

Elimination Rider. An amendment permitted in an individual health plan issued by an insurer that permanently excludes health 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, 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.

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 Delaware. See also Self-Insured Group Health Plans.

Genetic Information. 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.

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 Delaware are guaranteed issue. Standard and Basic plans must be sold on a guaranteed issue basis to all small employers including self-employed individuals. Two state approved plans must be sold to HIPAA eligible individuals. 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 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 credit, you must be 1) receiving Trade Readjustment Allowance (TRA) benefits or 2) will receive TRA benefits once your unemployment benefits are exhausted or 3) receiving benefits under the **Alternative Trade Adjustment Assistance** (ATAA) program or 4) aged 55 or older and receiving benefits from the Pension Benefit Guaranty Corporation (PBGC).

Health Insurance or Health Plan. In this guide, the term means benefits consisting of medical care (provided directly or through insurance or reimbursement) under any hospital or medical service policy, plan contract, or 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, 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.

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, 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 Delaware 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 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 Delaware can require affiliation periods in the group market. See also Affiliation Period.

Individual Health Insurance Policy. Policies for people not connected to an employer group. Individual plans are regulated by the state of Delaware.

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. 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.

Medicaid. A program providing comprehensive health insurance coverage and other assistance to certain low-income Delaware 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, 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.

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

Pre-existing Condition (Group Health Plans). Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a 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. Delaware does not limit the use of pre-existing conditions in individual health plans.

Pre-existing Condition (Individual Health Insurance). Any symptoms for which medical advice, diagnosis, care or treatment was ever recommended or received, or for which an ordinarily prudent person would have sought medical advice, care or treatment within a 5-year period preceding enrollment. In Delaware, under individual health policies, pregnancy can be counted as a pre-existing condition. 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 Standard. 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.

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

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 Delaware.

Small Group Health Plan. Plans with at least 1 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 program similar to COBRA. In some states, if you are in a fully insured group health plan sponsored by an employer with 2 to 19 employees, you also have rights to continue your health coverage when your job ends. However, Delaware does not have a state continuation coverage requirement. 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.

Temporary Assistance for Needy Families (TANF). A program 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.