

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

By

**Karen Pollitz
Stephanie Lewis
Mila Kofman
Eliza Bangit
Kevin Lucia**

**GEORGETOWN UNIVERSITY
INSTITUTE FOR HEALTH CARE RESEARCH AND POLICY**

Supported by a grant from

THE ROBERT WOOD JOHNSON FOUNDATION

June 2002

ACKNOWLEDGMENTS AND DISCLAIMER

The authors wish to express appreciation to the Robert Wood Johnson Foundation for its support of this project.

The authors also wish to express appreciation to Nicole Tapay, Lauren Polite, Jalena Specht, Elizabeth Hadley, and Robert Imes for their work developing the first edition of these guides.

Finally, the authors wish to express appreciation to the staff of the Iowa Insurance Division, the Iowa Department of Human Services, and the United States Department of Labor. Their help was invaluable in our research and understanding of state and federal law and policy. Without them, this guide would not have been possible. However, any mistakes that may appear are our own.

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

June 2002

© Copyright 2002 Georgetown University, Institute for Health Care Research and Policy.

All rights reserved. No portion of this guide may be reprinted, reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without permission from the authors. Permission can be obtained by writing to Institute for Health Care Research and Policy, 2233 Wisconsin Avenue N.W., Suite 525, Washington, D.C., 20007.

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

As a resident of Iowa, 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 resident of Iowa. 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 Iowa, 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 33. For information about how to find consumer guides for other states on the Internet, see page 33. A list of helpful terms and their definitions begins on page 34. These terms are in **boldface type** the first time they appear.

Contents	
1. A summary of your protections	2
How am I protected?.....	2
What are the limits on my protections?	3
2. Your protections under group health plans.....	5
When does a group health plan have to let me in?.....	5
Can a group health plan limit my coverage for preexisting conditions?	7
Limits to protections for certain government workers	10
As you are leaving group coverage... ..	10
3. Your protections when buying individual health insurance	11
Individual health insurance sold by private insurers	11
Standard and basic individual health plans	15
Iowa Comprehensive Health Association	17
COBRA and state continuation coverage	20
Conversion coverage	24
4. Your protections as a small employer or a self employed person.....	26
Do insurance companies have to sell me health insurance?	26
Can I be charged more because of my group's health status?	27
What if I am self-employed?.....	27
A word about association plans.....	27
5. Financial assistance	28
Medicaid	28
HIPP Health Insurance Premium Payment.....	31
AIDS/HIV Health Insurance Premium Payment Program	31
<i>hawk-i</i> : Healthy And Well Kids In Iowa	32
For more information.....	33
Helpful terms	34

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 plans**), so your protections may vary if you leave Iowa. 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 Iowa resident.

HOW AM I PROTECTED?

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

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status. This is called **nondiscrimination**. (See page 5.)*
- *All group health plans in Iowa must limit exclusion of preexisting conditions. There are rules about what counts as a preexisting 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 **preexisting condition exclusion period**, provided you did not have a 63 day break in coverage. (See page 7.)*
- *Your health insurance cannot be canceled because you get sick. All health insurance is **guaranteed renewable**. (See pages 14 and 26.)*

- *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 or **state continuation coverage**. It can help when you are between jobs or waiting for a new health plan to cover your preexisting condition. There are limits on what you can be charged for this coverage. (See page 20.)*
- *If you have had at least 12 months of group or individual health plan coverage and then lose it, you are guaranteed the right to buy a standardized health plan, either from a private insurance company or HMO, or from the **Iowa Comprehensive Health Association (ICHA)**. (See pages 15 and 17.)*
- *If you have been denied individual coverage because of your health status, you also can buy individual coverage from ICHA. In this case you may have a preexisting condition exclusion period. (See page 18.)*
- *If you lose your group health insurance, you may also be able to buy a group **conversion** policy. You will not face a new preexisting condition exclusion period. (See page 24.)*
- *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. Premiums can vary, within limits, based on the health status of your group. (See page 26.)*
- *If you have low or modest household income, you may be eligible for free or subsidized health coverage for yourself or members of your family. The Iowa **Medicaid** program offers free health coverage for certain families, children, pregnant women, elderly, and disabled individuals. (See page 28.)*
- *If your child is 18 years or younger, does not have health insurance, and meets other qualifications, you may be able to receive low cost or free health insurance for them through **Healthy and Well Kids in Iowa (hawk-i)**. (See page 32.)*

WHAT ARE THE LIMITS ON MY PROTECTIONS?

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

- *If you change jobs, you usually cannot take your old health benefits with you. Except when you exercise your federal COBRA or state continuation rights, you are not entitled to take your actual group health coverage with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did.*
- *If you change jobs, your new employer may not offer you health benefits. Employers are required only to make sure that their decision is based on factors unrelated to your health status.*
- *If you get a new job with health benefits, your coverage may not start right away. Employers and health maintenance organizations (HMOs) can require **waiting periods** before your health benefits begin. (See page 6.)*
- *If you are joining a new group health plan and you have a break in coverage of 63 days or more, you may have to satisfy a new pre-existing condition period. (See page 8.)*
- *Even if your coverage is **continuous**, there may be a preexisting condition exclusion period for some benefits if you join a group health plan that covers certain benefits your old plan did not. For example, you move from a group plan that does not cover prescription drugs to a 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 preexisting condition. (See page 9.)*
- *If you work for a non-federal public employer in Iowa, such as a state or municipal government, not all of the group health plan protections may apply to you. (See page 10.)*
- *In Iowa, unless you are eligible to buy a standard or basic individual health plan, private insurers can refuse to sell you individual health coverage because of your health status. (See page 11.)*
- *Individual health plan premiums can vary, within limits, because of your health status. Premiums also can vary due to age, family size and where you live. (See page 14.)*

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.* 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 has 200 employees and offers two different health plans. Managers are offered a high option plan that covers prescription drugs; everyone else is 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 managers 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)
-
- *Under Iowa law, newborns are automatically covered under the parents' fully insured group health plan for the first 31 days, if the plan covers dependents. The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.*
 - *A fully insured group health plan that provides for dependent coverage must offer coverage for adopted children and children placed for adoption. The terms and conditions of the coverage must be the same as that which would be provided to a biological dependent child. The plan may not apply any pre-existing condition exclusion periods.*
 - *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage. These waiting periods must be applied consistently and cannot vary due to your health status.*
 - *When you begin a new job with health insurance through an HMO, the HMO may require a waiting period before coverage begins. This waiting period is 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 it.*
 - *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 of 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 PREEXISTING 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 also 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.*
- *Under group health plans, coverage for pre-existing conditions can be excluded for no more than 12 months. However, if you enroll late in your group plan (after you were hired and not during a regular or special enrollment period), you may have a longer pre-existing condition exclusion period for up to 18 months. You will receive credit toward your pre-existing condition period for any previous continuous coverage.*
- *When you join a new group health plan, the law protects you from a new pre-existing condition exclusion period, provided you maintain continuous **credible 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 high risk pools
Individual health insurance	Licensed O. D. S.
Medicaid	<i>hawk-i</i>
Short-Term Limited Duration Plans	

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

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

What is continuous coverage?

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

Take Art, who has diabetes. Ajax Company covered him under its group health plan for 9 months, but he lost his job and health coverage. Then, *45 days later*, Art found a new job at Beta Corporation and had health coverage for 9 more months. Art changed jobs again. His new company, Charter, has a health plan that covers care for diabetes but excludes preexisting 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 preexisting condition exclusion period. Charter's plan will begin paying for Art's diabetes care in 3 months (1 year minus 9 months). Art does not get credit for his coverage at Ajax since he had a break of *more than 63 consecutive days*.

- *In determining continuous coverage, employer-imposed waiting periods and HMO affiliation periods do not count as a break in coverage.* If your new plan imposed 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.
- *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 preexisting condition exclusion period for that category.

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

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

- *No preexisting 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, twenty public employers in Iowa have decided that certain health insurance protections will not apply to their employees. If you have group health coverage through these employers, you should contact them for more information. Other non-federal public employers in Iowa 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.

Iowa public employers electing to exempt their covered employees from group health plan protections

City of Boone	County of Floyd
City of Charles City	County of Hardin
City of Harland	County of Mahaska
City of Newton	County of Marion
City of Oskaloosa	County of Poweshiek
Clarinda Municipal Hospital	Davis County Hospital
County of Appanoose	Lucas County Health Center
County of Buchanan	Spencer Municipal Hospital
County of Cedar	Wayne County Hospital
County of Davis	Winneshiek County Memorial Hospital

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 coverage, conversion coverage, and ICHA coverage for “federally eligible individuals.”*

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. If you are federally eligible or eligible for a standard or basic health plan, you will have more protection than others buying individual plans. Also, there are some alternatives to individual health insurance coverage in the private market such as continuation coverage, conversion policies or ICHA. In some cases, protections under individual plans are different from those under group plans.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

WHEN DO INDIVIDUAL HEALTH INSURERS HAVE TO SELL ME COVERAGE?

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

- *In general, companies that sell individual health insurance in Iowa 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 have had at least 12 months of prior continuous health coverage and meet certain qualifications, you are guaranteed the right to buy a standardized individual health plan, regardless of your health status. Depending on what your prior coverage was, you can buy this plan either from a private health insurer or from the Iowa Comprehensive Health Association (ICHA). (See pages 15 and 17.)*

- *If you have been turned down by an individual health plan or are federally eligible, then you can buy coverage from ICHA. After you have been covered in IHCA for a year, you will be eligible to buy a standard or basic individual health plan from a private health insurer with no preexisting condition exclusion periods. (See page 17.)*

- *In Iowa, newborns are automatically covered under the parents' individual health plan for the first 31 days, if the plan provides coverage for dependents. The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.*
- *An individual health plan that provides for dependent coverage must offer coverage for adopted children and children placed for adoption. The terms and conditions of the coverage must be the same as that which would be provided to a biological dependent child. The plan may not apply any pre-existing condition exclusion periods.*
- *If you have a disabled child, that child may remain covered under your individual health plan after he or she reaches the age at which dependent coverage is usually terminated. To qualify, your adult son or daughter must be incapable of self-support because of mental retardation or physical disability and must be chiefly dependent on the policyholder for support. Proof of incapacity must be furnished to the insurer within 31 days of reaching the limiting age and may be required subsequently in the future.*
- *If you are planning on leaving Iowa in the future, you may need to be **federally eligible** to be guaranteed the right to buy individual health insurance in another state.*

Federal eligibility

In Iowa, if you have had 12 months of continuous coverage, you are guaranteed the right to buy some kind of individual health coverage without any preexisting condition exclusion periods. In many other states, however, you only have this protection if you are federally eligible. To be federally eligible, you must meet all of the following:

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

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

WHAT WILL MY INDIVIDUAL HEALTH PLAN COVER?

- *It depends on what you buy.* Iowa does not require health insurers in the individual market to sell standardized policies, except in certain situations (see below). Health plans can design different policies and you will have to read and compare them carefully. Sometimes, individual health plans provide less comprehensive coverage than group health plans, especially for certain services such as maternity care, mental health care, or prescription drugs. However, Iowa does require all health plans to cover certain benefits – such as cancer screening and diabetic supplies and services. Check with the Iowa Insurance Division for more information about mandated benefits.

WHAT ABOUT MY PRE-EXISTING CONDITION?

- *There are different ways that individual health plans can exclude a pre-existing condition.*

The plan can impose an **elimination rider**, which is an amendment to your health insurance contract that permanently excludes coverage for a health condition, body part, or body system. Or a plan can impose a pre-existing condition exclusion period temporarily on any pre-existing condition.

Pre-existing conditions are any conditions for which you received medical advice, care or diagnosis in the last five years. In addition, plans can count as pre-existing any condition for which the plan believes most people would have sought care. This is called the prudent person rule. You will not receive credit for your prior coverage.

Pregnancy can be considered a pre-existing condition by individual health plans. However, genetic information cannot be considered a pre-existing condition in the absence of a diagnosis.

WHAT CAN I BE CHARGED FOR INDIVIDUAL HEALTH INSURANCE?

- *There are limits on how much individual plans can charge because of your health status. Even within these limits, your premiums can be significantly higher if you have a serious health condition. Rates can also vary because of your age and other characteristics.*
- *At renewal, your rates will go up as you age and in plans offered by a few insurers, may also go up if you made claims in the prior year.*
- *Contact the Iowa Insurance Division with questions about your health insurance premiums.*

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.*
- *Some insurance companies sell short-term (or temporary) health insurance policies. Short-term policies are *not* guaranteed renewable. They will only cover you for a limited time, such as 6 months. If you want to renew coverage under a short-term 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.*

STANDARD AND BASIC INDIVIDUAL HEALTH PLANS

These are standardized health plans with comprehensive benefits. While preexisting condition exclusion periods are permitted, you will get credit for any prior creditable coverage. Like other individual health plans, there are limits on how much you can be charged for a basic or standard plan.

WHEN DO HEALTH INSURERS HAVE TO SELL ME A BASIC OR STANDARD PLAN?

- *In Iowa, all health insurance companies must offer standard and basic health plans to those who are eligible. To be eligible to buy a standard or basic health plan from an insurance company, you must have lost or be about to lose health insurance for one of the following reasons:*
 - You are no longer eligible for health insurance coverage under a group health plan health plan;
 - You no longer qualify as a dependent under your previous plan;
 - You are no longer eligible for Medicaid or Medicare;
- *In addition, you must meet the following requirements:*
 - You must be an Iowa resident;
 - You must have at least 12 months of coverage under one of the following types of plans: hawk-i, a fully insured group health plan, a self-insured group health plan that participates in the Iowa Individual Health Benefit Reinsurance Association, an HMO, an individual health plan, or coverage through the Iowa Comprehensive Health Association (IHCA);
 - You must apply for individual health insurance within 63 days of the end of your prior coverage;
 - You must not be over the age of 64 or receiving Medicare benefits;
 - You must have exhausted COBRA or state continuation rights;

- You must have been declined coverage for a traditional plan;
- You must not be eligible for or enrolled under a group health plan or public plan, such as Medicaid.
- *You may also be eligible if you have an individual health plan and your premium will increase because of your health status.* In this case, you must apply for a standard or basic plan within 63 days of being notified of the premium increase.

WHAT WILL MY STANDARD OR BASIC HEALTH PLAN COVER?

- *Covered services are similar under both standard and basic health plans.* These include hospital care, physician services, and prescription drugs. Maternity care is covered if you purchase a separate rider. Standard health plans cover mental health care, alcoholism/substance abuse treatment and organ transplants, but basic health plans do not. Also, standard plans will pay benefits up to a \$1,000,000 life-time maximum, whereas the basic plan's life-time maximum is limited to \$250,000.
- *Cost sharing requirements vary by service and are higher in the basic plan than in the standard plan.* For example, in the standard plan you must pay 20% of the cost for most covered services after you have satisfied your annual deductible. In the basic plan, you must pay 40% of the cost for most covered services after you have satisfied a higher annual deductible.

Cost sharing also varies with the type of basic or standard plan you select. Both plans are available as indemnity, HMO, and PPO options.

WHAT ABOUT MY PRE-EXISTING CONDITION?

- *If you purchase a basic or standard plan, there are limits on pre-existing condition exclusion periods that can be imposed.* Pre-existing condition exclusion periods cannot exceed 12 months. These plans can look back 12 months to see if you actually received care or treatment for a condition. They can also look back to see if you had any conditions for which the insurer thinks that you should have sought care.

- *Pregnancy can be considered a pre-existing condition in these individual health plans. However, genetic information cannot be considered a pre-existing condition in the absence of a diagnosis.*
- *You will get credit for prior continuous coverage that was not interrupted by a break of not more than 63 days in a row. However, plans can look back to determine whether your previous health plan covered certain conditions or specific services for your pre-existing condition. If your previous plan did not cover a specific condition or service, then your new basic or standard health plan may impose a preexisting condition exclusion period for that service or condition.*

WHAT CAN I BE CHARGED FOR A BASIC OR STANDARD PLAN?

- *Premiums for basic and standard plans are subject to the same limits applied to other individual health plans. However, rates for basic and standard plans vary from company to company. Contact the Iowa Insurance Division with questions about basic and standard health plan coverage and premiums*

CAN MY BASIC OR STANDARD POLICY BE CANCELLED?

- *Your coverage cannot be canceled because you get sick. This is called guaranteed renewability. However, if you no longer meet the eligibility requirements for a basic or standard plan, then you will not be able to renew your coverage.*

IOWA COMPREHENSIVE HEALTH ASSOCIATION

Iowa maintains a high-risk pool, called the Iowa Comprehensive Health Association (ICHA) to provide insurance for people with expensive health conditions. There are several ways you can qualify for coverage.

WHEN CAN I GET ICHA COVERAGE?

- *If you are federally eligible but not eligible to buy a standard or basic plan from a private insurance company, you can buy coverage from ICHA with no preexisting condition exclusion period.*

- *If you had coverage under a self-insured group health plan that did not participate in the Iowa Individual Health Benefit Reinsurance Association, and you lost that coverage, you can buy individual coverage from the IHCA. To find out whether your self-insured group health plan participates in the Iowa Individual Health Benefit Reinsurance Association, contact your employer or the Iowa Department of Insurance.*
- *If you qualify for ICHA this way, you will not be required to use up any COBRA or state continuation coverage available to you or to purchase a conversion policy. However, if those options would have covered your preexisting condition and you did not take them, if available, then ICHA will not credit your prior continuous coverage, and may impose a 6-month preexisting condition exclusion period.*
- *If you are not federally eligible, you can also buy coverage from ICHA if you are a resident of the state and can demonstrate proof of uninsurability. You are considered uninsurable if you have been diagnosed with one of a list of serious health conditions (such as cancer, diabetes, or AIDS). You also are considered uninsurable if you have been denied coverage because of your health status, offered coverage that is more expensive than ICHA coverage, or offered a plan that restricts coverage of your preexisting condition more than ICHA.*
- *To buy ICHA coverage, you cannot be eligible to buy a standard or basic individual health plan, Medicare, or Medicaid or have terminated ICHA coverage within the last 12 months.*
- *ICHCA does not offer family coverage. Each member of the same family qualifies for ICHA on his or her own.*

WHAT WILL MY ICHA PLAN COVER?

- *ICHCA coverage includes hospital and physician care, diagnostic tests and x-rays, prescription drugs, home health care, and other services. ICHA does not cover routine maternity care. However, you have the option of adding on a maternity benefit for an additional premium. Maternity benefits are subject to a 10-month preexisting condition exclusion period.*
- *ICHCA offers you the choice of four cost sharing arrangements. The annual deductible options are \$500, \$1,000, \$1,500 and \$2,000. In addition, you will be responsible for a coinsurance charge each time you receive care.*

Following the payment of your deductible, for most services, you will be charged 20% coinsurance for care. After you pay a maximum amount for covered services (also called out-of-pocket limit), ICHA will pay 100% of the cost of your covered care.

- *There is a lifetime limit of \$1 million for all benefits under ICHA.*

WHAT ABOUT MY PRE-EXISTING CONDITION?

- *If you are federally eligible, you will not receive a pre-existing condition exclusion when you enroll in ICHA.*
- *If you are not federally eligible, ICHA can exclude coverage for preexisting conditions for 6 months. When you enroll, ICHA will look back 6 months to see if you had a condition for which you actually received medical advice, diagnosis, care or treatment.*

Generally, ICHA will not be able to credit your prior coverage against this pre-existing condition exclusion period. However, ICHA will credit prior continuous creditable coverage toward your preexisting condition exclusion if your prior coverage was terminated involuntarily and you apply for ICHA coverage within 63 days of losing your prior coverage.

- *ICHA will not impose pre-existing condition exclusion periods on adopted children, newborns or pregnancies covered by the maternity rider.*

WHAT CAN I BE CHARGED FOR MY ICHA COVERAGE?

- *ICHA premiums are set at 150% of the average rate charged for comparable coverage by the five insurance companies with the largest health insurance premiums or payment volumes doing business in Iowa.*
- *ICHA premiums vary depending on your age, plan and deductible you choose.*

For example, as of July 1, 2001, the monthly premium for a 24-year-old single man ranges between \$305 to \$344, depending on the deductible he chooses. By contrast, the monthly premium for a 64-year-old single man ranges from \$844 to \$1,307, depending on which deductible he chooses.

- *Your premiums will increase as you get older and when IHCA is reassessed for new rates. Contact the IHCA plan administrator for more information about premiums*

HOW LONG DOES ICHA COVERAGE LAST?

- *ICHA policies are renewable as long as you pay your premiums, continue to reside in Iowa, 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 coverage, you may be able to stay in your group plan for an extended time through COBRA or state continuation coverage. The information presented below was taken from publications prepared by the U.S. Department of Labor. You should contact them for more information about your rights under COBRA.

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

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

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

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

COBRA QUALIFYING EVENTS

For employees

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

For spouses

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

For dependent children

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

- *Each person who is eligible for COBRA continuation can make his or her own decision.* If your dependents were covered under your employer plan, they may independently elect COBRA coverage as well.
- *To qualify as federally eligible, you must choose and use up any COBRA or state continuation coverage available to you.*
- *You must be notified of your COBRA rights when you join the group health plan, and again if you qualify for COBRA coverage.* The notice rules are somewhat complicated and you should contact the U.S. Department of Labor for more information.

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

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

WHAT WILL COBRA COVER?

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

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage.* 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 next page for more information about the disability extension.

HOW LONG DOES COBRA COVERAGE LAST?

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

<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.*
- *In Iowa, you must use up any available COBRA coverage in order to be guaranteed issue of a basic or standard individual health plan.*

WHAT ABOUT IOWA CONTINUATION COVERAGE?

- *If your employer offers fully insured health benefits and has fewer than 20 workers and you have been covered under your group plan for at least 3 months, you may also be eligible for up to 9 months of continuation coverage under an Iowa law that is similar to COBRA. Ask your former employer or the Iowa Insurance Division about state continuation coverage if you think it applies to you.*
- *In Iowa, you must use up any available state continuation coverage in order to be guaranteed issue of a basic or standard individual health plan.*

CONVERSION COVERAGE

WHEN DO I HAVE TO BE OFFERED CONVERSION COVERAGE?

- *In Iowa, if you have coverage through an employer's fully insured group health plan and you leave that job, you are eligible to buy conversion coverage. This is an individual policy you get from the company that insured your employer's group plan.*

To qualify, though, you must have been covered under your employer's plan for the entire 3 months immediately prior to termination, must have used up any COBRA or state continuation coverage, and cannot be eligible for any other group coverage.

You must apply for a conversion policy within 31 days of termination of coverage under your group health plan or any COBRA continuation coverage or state continuation coverage. You do not need to be federally eligible to buy a conversion policy.

- *Conversion rights are also available to a surviving spouse and child upon the death of an insured or in the case that they cease to be qualified family member under a group policy.*

WHAT WILL A CONVERSION POLICY COVER?

- *You must be offered the choice of at least three basic conversion policies covering hospital stays and surgery. Each of the three basic options offers the same hospital room and board services, but with different levels of coverage (i.e. 100%, 75%, and 50% of covered services). In addition, if you were eligible for a major medical policy under your group health plan, you must also be given the opportunity to convert that coverage.*

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 CONVERSION COVERAGE?

- *Conversion coverage will be more costly than your former plan. Conversion policies are not subject to the same limits applied to other individual health plans. Contact the Iowa Insurance Division if you have questions about your conversion policy premium.*

CAN MY CONVERSION POLICY BE CANCELLED?

- *Conversion policies, like other individual health insurance policies, are guaranteed renewable. Your coverage cannot be cancelled if you get sick.*

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. Iowa 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 Iowa Insurance Division 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 people, but not more than 50 eligible employees, 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 wish to buy a **large group health plan** (one that covers more than 50 eligible employees), insurers are allowed to refuse to sell you a policy.

- *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?

- *As a small employer, you can be charged higher premiums, within limits, based on your group's health status or claims experience. Premiums also can vary based on other characteristics of your group. If you have questions about your small group health plan premiums, contact the Iowa Insurance Division.*

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are not eligible to buy a group health plan on your own (though you may be able to join another group health plan through a family member). Therefore, the laws that protect employers' access to group health insurance do not apply to you. The laws that apply to individuals protect your access to health insurance. (See page 11.)*
- *If you are self-employed and buy your own health insurance, you are eligible to deduct an increasing percentage of the cost of your premium from your federal income tax. This deduction is 70% for 2002 and 100% for 2003 and thereafter.*

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 Iowa Insurance Division about your protections in association health plans.*

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Iowa. Medicaid, *hawk-i*, HIPP, and AIDS/HIV HIPP, offer free or subsidized health insurance coverage, direct medical services or other help. This chapter provides summary information about these programs and contact information for further assistance.

MEDICAID

Medicaid is a program that provides health coverage to some low-income Iowa residents. Medicaid covers families with children and pregnant women, medically needy persons, the elderly, persons with disabilities, and persons with breast or cervical cancer. Legal residents who are not U.S. citizens may be eligible for Medicaid however, questions concerning immigration status and eligibility should be directed to the Iowa Department of Human Services.

- *Eligibility depends on financial factors, such as income resources.* However, in Iowa, family resources in most cases, are ignored when determining eligibility for children. In addition, people must meet certain other criteria, such as blindness, disability, or age, or the need to support a dependent child.

The following are ways a person may be eligible for Medicaid in Iowa:

- *The Family Medical Assistance Program (FMAP) provides Medicaid to children and their parents or other specified relatives who meet financial and non-financial eligibility requirements.* Parents or specified relatives must have a dependent child under age 19 in their care to be eligible.

Parents who receive Medicaid under FMAP should also know that when you get a job and your Medicaid benefits end, you generally can stay on Medicaid for a 12-month transitional period.

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

- *The Child Medical Assistance Program (CMAP) provides Medicaid to children under age 21 who meet all of the FMAP eligibility requirements except for age and living with a specified relative.*

- *People who are aged, blind or disabled may be eligible for Medicaid under the **Supplemental Security Income (SSI)**-related programs.* Eligibility is determined by following the general policies of the Supplemental Security Income (SSI) program.

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.

- *Persons who are disabled but employed and have higher income levels may be eligible for Medicaid benefits under the **Medicaid For Employed People With Disabilities (MEPD)** program.* To qualify for MEPD, you must be employed, disabled and under the age of 65 with a family income of less than or equal to 250% of the poverty level. MEPD enrollees with income levels over 150% of the federal poverty level must pay a premium based on income level.
- *The **Medically Needy** program provides Medicaid coverage to people who have too much income or too many resources to qualify for SSI or other Medicaid coverage groups but not enough income for medical care.* This coverage group includes aged, blind, or disabled people, members of families with children, pregnant women, and children under age 21. The Medically Needy program does not have income limits. When income is above the Medically Needy Income Level, the person has a spend down (which is like a deductible) to meet. The amount of the spenddown will depend on the person's income.
- *People age 65 and over 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. The following are the Medicare Savings Programs:

If your household income is 100% of the poverty level or below, Medicaid will pay your monthly premium for Medicare Part A and B, your Medicare deductibles and coinsurance. This is called the Qualified Medicare Beneficiary (QMB) program.

If your household income is above 100% but below 120% of the poverty level, Medicaid will pay for your monthly Medicare Part B premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

If your household income is 120% or below 135% of the poverty level, Medicaid will cover the costs of your Medicare Part B premiums. This is called the Expanded Specified Low-Income Medicare Beneficiary Program.

- *Women under the age of 65, diagnosed with breast or cervical cancer, who are otherwise uninsured, may be eligible for Medicaid.* Eligibility for this program is only available to persons who have been screened under the Center for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program.
- *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 Iowa Department of Human Services.

To obtain the locations and telephone numbers of Iowa Department of Human Services branch offices near you, call (515)-281-8621 or <http://www.dhs.state.ia.us/locations/locations.asp>.

HIPP HEALTH INSURANCE PREMIUM PAYMENT

The Health Insurance Premium Payment (HIPP) Program allows Medicaid funds to be used to pay for a Medicaid eligible person's private health insurance. If it is cost-effective, Medicaid will pay for a client to receive either individual health insurance or employer based health insurance.

Though eligibility is based on the Medicaid individual or individuals, other family members who are not Medicaid eligible may get their premiums paid if payment of their premiums is necessary to obtain coverage for the Medicaid eligible persons. There are no income guidelines for HIPP beyond those for Medicaid eligibility.

AIDS/HIV HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

The AIDS/HIV Health Insurance Premium Payment Program pays for continuing health insurance coverage for people with AIDS or HIV, who can no longer pay their health insurance premiums. This program differs from the Health Insurance Premium Payment (HIPP) program mentioned above in the individuals eligible for this program must meet the following criteria:

- *A person with a diagnosis of AIDS or HIV, who has a family income of less than 300% of the federal poverty level may be eligible for this program.*
- *A participant of this program must be a resident of Iowa and ineligible for Medicaid.*

- *A specific application is required for this program.* The application for the AIDS/HIV HIPP Program is included with The Iowa AIDS/HIV Health Insurance Premium Payment Program brochure. You may request a brochure from your local county Department of Human Services office. Or you may call the toll-free number of 1-888-346-9562 and request a brochure.

***hawk-i*: HEALTHY AND WELL KIDS IN IOWA**

hawk-i is a program that provides health insurance coverage to low income children under the age of 19 who do not qualify for Medicaid and who have no health insurance.

- *A child whose family has a household income below 200% of the federal poverty level is eligible for hawk-i.* For a family of 3, this works out to an annual income of about \$30,040 or a monthly income of about \$2,504.
- *hawk-i provides comprehensive coverage to enrollees.* Services include doctor visits, hospital care, prescriptions, mental health services, preventative well-child exams, immunizations, and vision services, as well as other services.
- *hawk-i is low cost or free, depending on your family income.* Some families pay no monthly premiums, while others may have to pay a maximum of \$20 dollars a month.

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:
<ul style="list-style-type: none"> • Individual health Insurance • Fully insured group health insurance 	Iowa Insurance Division (515) 281 5705 http://www.iid.state.ia.us/
<ul style="list-style-type: none"> • Self-insured group health plans • COBRA continuation coverage • Family and Medical Leave Act 	U.S. Department of Labor, Kansas City Regional Office (816) 426-5131 U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C. (202) 219-8776 For Department of Labor Publications: (800) 998-7542 http://www.dol.gov/dol/pwba
<ul style="list-style-type: none"> • ICHA 	Iowa Comprehensive Health Association Coverage (800) 877-5156 http://www.onlinehealthplan.com/oasys/
<ul style="list-style-type: none"> • Medicaid 	Iowa Department of Human Services (515) 281-8621 http://www.dhs.state.ia.us/bes/bes.asp
<ul style="list-style-type: none"> • HIPP 	Iowa Department of Human Services (888) 346-9562 http://www.dhs.state.ia.us/MedicalServices/Hipp.asp
<ul style="list-style-type: none"> • HIV/AIDS HIPP 	Iowa Department of Human Services (888) 346-9562 http://www.dhs.state.ia.us/MedicalServices/hivHipp.asp
<ul style="list-style-type: none"> • hawk-i 	Iowa Department of Human Services (800) 257-8563 http://www.hawk-i.org/

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 preexisting conditions. Premiums cannot be charged during HMO affiliation periods. Iowa law allows for the use of HMO affiliation periods in small group health plans. See also HMO, Small Group Health Plans.

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 2% administrative fee. COBRA continuation coverage generally lasts 18 months, or 36 months for dependents in certain circumstances. See also State Continuation Coverage.

Continuous Coverage. Health insurance coverage that is not interrupted by a break of 63 or more days in a row. 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, Federally Eligible.

Conversion. Your right, when leaving a fully insured group health plan, to convert your policy to an individual health plan. In Iowa, conversion coverage also extends to surviving or divorced spouses, dependent children and children who lose their dependent status under their parent's plan rules. You must use up any COBRA or state continuation coverage before you can buy a conversion policy. See also, COBRA, State Continuation Coverage.

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

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

Elimination Rider. A feature permitted in individual health plans that permanently excludes coverage for a health condition, body part, or body system.

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

Federally Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be federally eligible, you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare, Medicaid, or a group health plan; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. When you are buying individual health coverage, federal eligibility confers greater protections on you than you would otherwise have in most other states. In Iowa you do not need to meet all of the requirements of federal eligibility to have these protections. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

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

Genetic Information. Includes information about family history or genetic test results indicating your risk of developing a health condition. A health plan cannot consider preexisting (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 Iowa are guaranteed issue. 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.

hawk-i. A state designed program that provides health insurance coverage to low income children under the age of 19 who do not qualify for Medicaid and who have no health insurance.

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 basic requirements that health plans must meet. Since states can and have modified and expanded upon these provisions, consumers' protections vary from state to state.

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

Individual Health Plan. Policies for people not connected to an employer group. This term also refers to coverage purchased by the self-employed for themselves (or their family members) but for no other employees. Individual health plans are regulated by the state of Iowa.

Iowa Comprehensive Health Association (ICHA). The state-run program for people with high health risks (called a high-risk pool). ICHA also sells individual and family coverage to those who are federally eligible, and to certain individuals not eligible for a standard or basic individual health plan. See also Federally Eligible.

Iowa Individual Health Benefit Reinsurance Association. An association established by the State of Iowa to help spread the cost of insuring people with serious health conditions broadly across all participating insurance companies. Every insurance company in the state of Iowa is required to participate. Self-insured group health plans can participate on a voluntary basis. See also Self-Insured Group Health Plan.

Kassebaum-Kennedy. See HIPAA.

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

Late Enrollment. Enrollment in a health plan at a time other than the regular or a special enrollment period. Iowa requires fully insured group plans to cover you if you are a late enrollee. However, you may be subject to a longer preexisting 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 preexisting conditions. See also Preexisting Condition.

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

Managed Care. A kind of health insurance plan. Like an HMO, managed care plans can limit coverage to health care provided by doctors and hospitals that work for or contract with them - also called "network providers." Often managed care plans will require you to get permission (a "referral") from your family doctor before you get care from a specialist in their network. Some managed care plans will reduce coverage for your care if you go to a non-network provider or if you get specialist care without a referral. See also HMO.

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

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

Pre-existing Condition. (Individual Health Insurance Plans) Pre-existing conditions are any conditions for which you received medical advice, care or diagnosis in the last five years. In addition, plans can count as pre-existing any condition for which the plan believes most people would have sought care. Pregnancy can be counted as a preexisting condition. Genetic information about your likelihood of developing a disease or condition, without a diagnosis of that disease or condition cannot be considered a preexisting condition. Newborns covered within 30 days and adopted children cannot be subject to preexisting condition exclusions.

Preexisting Condition Exclusion Period. The time during which a health plan will not pay for covered care relating to a preexisting condition. See also Preexisting 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 the state of Iowa.

Small Group Health Plans. Plans with at least 2 but not more than 50 eligible 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 for small employers. In Iowa, if you are in a fully insured group health plan sponsored by an employer with 2 to 19 employees, you have the right to continue your health coverage for up to 9 months when your job ends. Under state continuation coverage, you will be required to pay the full premium (including the share you employer used to pay on your behalf). 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.

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 preexisting condition exclusion period begins on the first day of the waiting period. See also Preexisting Condition Exclusion Period.