

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

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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 MASSACHUSETTS

As a Massachusetts 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 Massachusetts resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group health plans and individual health insurance. 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 Massachusetts, 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 31. For information about how to find consumer guides for other states on the Internet, see page 32. A list of helpful terms and their definitions begins on page 33. These terms are in **boldface type** the first time they appear.

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CHAPTER 1

A SUMMARY OF YOUR PROTECTIONS

Numerous state and federal laws make it easier for people with **pre-existing conditions** to get or keep health insurance, or to change from one health plan to another. A federal law, known as the **Health Insurance Portability and Accountability Act (HIPAA)** sets national standards for all health plans. In addition, states can pass different reforms for the health plans they regulate (**fully insured group health plans and individual health insurance**), so your protections may vary if you leave Massachusetts. Massachusetts has enacted comprehensive reforms to expand your access to health insurance and to guarantee fair pricing of policies. 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 Massachusetts resident.

HOW AM I PROTECTED?

In Massachusetts, your health insurance options do not depend on your **health status**.

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status. This is called **nondiscrimination**. (See page 5.)*
- *All health plans in Massachusetts must limit exclusion of pre-existing conditions. There are rules about what counts as a pre-existing condition and how long you must wait before a new health plan will begin to pay for care for that condition. Generally, if you join a new plan your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage. (See pages 7 and 14.)*
- *You cannot be turned down for individual health insurance because of your health status, age, or any other factor that might predict your use of health services. This is called **guaranteed issue**. (See page 12.)*
- *If you are buying individual health insurance, you cannot be charged more due to health status, gender, or occupation. This is called **modified community rating**. (See page 15.)*

- *Your individual health insurance or group health plan cannot be canceled because you get sick. Most health insurance is **guaranteed renewable**. Note, however, that the precise definition of guaranteed renewable may vary based on what type of insurance you have. (See pages 5 and 15.)*
- *If you leave your job, you may be able to remain in your old group health plan for a certain length of time. This is called **COBRA** or **state continuation coverage**. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage. (See page 15.)*
- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group. All health plans for small employers must be sold on a guaranteed issue basis. (See page 21.)*
- *If you are a small employer buying a group health plan, you cannot be charged more due to the health status or gender of those in your group. This is called modified community rating. (See page 21.)*
- *If you have low or modest household income, you may be eligible for free or subsidized health coverage for yourself or members of your family. The **MassHealth** programs offer free or subsidized health coverage for pregnant women, families with children, elderly and disabled individuals with low-incomes among others. In addition, some women who are diagnosed with Breast or Cervical Cancer may be eligible for medical care through MassHealth. (See Chapter 5.)*
- *If your children are 18 years old or younger, have limited or no health insurance and meet other qualifications, they may be eligible to enroll in the **Children's Medical Security Plan**. (See page 26.)*
- *If you have lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program** then you may be eligible for a federal income tax credit to help pay for new health coverage. This credit is called the **Health Coverage Tax Credit (HCTC)**, and it is equal to 65% of the cost of qualified health coverage, including COBRA. (See page 27.)*
- *If you are a retiree aged 55-65 and receiving pension benefits from **Pension Benefit Guarantee Corporation (PBGC)**, then you may also be eligible for the HCTC (See page 27.)*

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. (See page 5.)*
- *If you change jobs, your new employer may not offer you health benefits. Employers are required only to make sure that any health benefits they do offer do not discriminate based on health status. (See page 5.)*
- *If you get a new job with health benefits, your coverage may not start right away. Employers can require **waiting periods** before your health benefits begin. (See page 6.)*
- *If you have a break in coverage of 63 days or more, you may have to satisfy a new pre-existing condition exclusion period or waiting period when you join a new health plan. If you had some prior health coverage, you may not have to satisfy the entire pre-existing condition exclusion period. (See pages 7 and 14.)*
- *Even if your coverage is **continuous**, there may be a pre-existing condition exclusion period for some benefits if you join a health plan that covers benefits your old plan did not. For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition. (See page 9.)*
- *If you work for a non-federal public employer in Massachusetts, not all of the group health plan protections may apply to you. (See page 10.)*
- *If you move away from Massachusetts, you may not be able to buy individual health insurance in another state unless you are **HIPAA eligible**. (See page 12.)*

CHAPTER 2

YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

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

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

- *You have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees. Or, your employer may offer an HMO plan that you cannot join because you live outside of the plan's service area.
- *You cannot be turned away or charged more because of your health status.* Health status means your medical condition or history, **genetic information**, or disability. This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (such as part time employment), as long as these are reasons 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. Full time employees are offered a high option plan that covers prescription drugs; part time employees are offered a low option plan that does not. This is *permitted* under the law. By contrast, in a cost-cutting move, Acme restricts its high option plan to those employees who can pass a physical examination. This is *not permitted* under the law.

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

Certain changes can trigger a special enrollment opportunity

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

- *If your fully insured employer coverage covers minor children, it must cover newborns, newborns of dependents, and newly adopted children from moment of birth and thereafter. If you are adopting a foster child who resides with you, the child must be covered from date of filing of petition to adopt and thereafter, or, for adopted children, immediately upon placement for adoption. A premium may be charged for this additional coverage. The insurer may require notification of the birth, adoption, or placement for adoption to keep this coverage in place.*
- *Under Massachusetts law, disabled adult children can remain on their parent's group health plan after reaching the age at which dependent coverage is usually terminated if they meet certain requirements. The adult child must be mentally or physically incapable of self-sustaining employment and remain dependent on parents for support. Proof of incapacity must be furnished to the plan within 31 days of the child reaching the age at which dependent coverage would normally end.*
- *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage. This waiting period, however, must be applied consistently and cannot vary due to your health status.*
- *If you have to take leave from your job due to illness, the birth or adoption of a child, or to care for a seriously ill family member, you may be able to keep your group health coverage for a limited time. A federal law known as the **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job-protected leave in these circumstances.*

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

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

If you decide not to return to work at the end of the leave period, your employer may require you to pay back the employer's share of the health insurance premium. However, if you don't return to work because of factors outside your control (such as

a need to continue caring for a sick family member, or because your spouse is transferred to a job in a distant city), you will not have to repay the premium.

Under Massachusetts law, female employees of employers with between 6 and 50 employees are eligible for eight weeks of leave for birth or adoption of a child under the age of three. In addition, an eligible employee can have a total of 24 hours of leave during any 12-month period, in addition to leave available under the federal act, to participate in his or her child's school activity or to accompany a son, daughter, or elderly relative to routine medical appointments.

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

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

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

- *A group health plan can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan. This period is also called the look back period.*
- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns or newly adopted children, children placed for adoption, or genetic information.*
- *Under group health plans, coverage for pre-existing conditions can only be excluded for a limited time. The time limit varies depending on your type of group health plan. For fully insured group health plans in Massachusetts, the maximum pre-existing conditions exclusion period that can be imposed is 6 months. However, if you enroll in a self-insured group health plan (after you are hired and not during a regular or special enrollment period), you may have a 12-month pre-existing condition exclusion period. Late enrollees in self-insured health plans can be subject to an 18-month pre-existing condition exclusion period.*

- *Massachusetts law also allows your insurer to impose a waiting period regardless of whether you have a pre-existing condition.* A waiting period can be imposed for up to 6 months from when your coverage begins during which time you will pay premiums but will not receive coverage for non-emergency services. Federal law does not provide for insurer-imposed waiting periods as allowed under Massachusetts law in the group market and there are elements of this law that appear to be inconsistent with federal law. If you have questions about how they apply to you contact the Massachusetts Division of Insurance or the federal Center for Medicare and Medicaid Services (1-410-786-3000).
- *If you join a new group health plan, the law protects you from a new pre-existing condition exclusion period or waiting period, provided you maintain **continuous creditable coverage**.* Most types of private and government sponsored health coverage are considered to be creditable coverage. Coverage counts as continuous if it has not been interrupted by a break of 63 or more days in a row.

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

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

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.

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

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*.

- *No pre-existing condition exclusion period can be applied without appropriate notice.* Your group health plan must inform you, in writing, if it intends to impose such a period. Also, if needed, it must help you get a **certificate of creditable coverage** from your old health plan.
- *Your protections may differ if you move to a group health plan that offers more benefits than your old one did.* Plans can look back to determine whether your previous health plan covered prescription drugs, mental health, substance abuse, dental care, or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new group health plan may impose a pre-existing condition exclusion period or waiting period for that category. Plans that use this method of crediting prior coverage must use it for everyone and must disclose this to you when you enroll.

Even if coverage is continuous, there may be a pre-existing condition exclusion for certain benefits

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

Question: Is this permitted?

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

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 plan.

According to the latest list available from the federal government, there are no government entities in Massachusetts that have decided that certain health insurance protections will *not* apply to its employees. There may be non-federal public employers in Massachusetts that made this choice after this guide was written. If you are not sure about your protections under your public employee health plan, you should contact your employer.

AS YOU ARE LEAVING GROUP COVERAGE...

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

- *If you have 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 it is equal to 65% of the cost of qualified health coverage, including COBRA. (See page 27.)*
- *If you are a retiree aged 55-65 and receiving pension benefits from the Pension Benefit Guaranty Corporation (PBGC), you may also be eligible for the HCTC. (See page 27.)*

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 individual health insurance from a private insurer. Massachusetts has enacted extensive insurance reforms to guarantee residents access to this kind of insurance. There are some alternatives to individual health insurance – such as continuation and conversion coverage. This chapter summarizes your protections under different kinds of health plan coverage.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

WHEN DO INDIVIDUAL HEALTH INSURERS HAVE TO SELL ME COVERAGE?

In Massachusetts, your ability to buy individual health insurance does not depend on your health status.

- *Companies that sell individual health insurance in Massachusetts are not permitted to turn you down because of your health status and other factors.*
- *All plans that provide benefits for any minor must cover newborns, newborns of dependents and newly adopted children from moment of birth and thereafter. A child who has been residing as a foster child must be covered from date of filing of petition to adopt and thereafter, or for adopted children, immediately upon placement for adoption. A premium may be charged for this additional coverage. The insurer may require notification of the birth, adoption, or placement for adoption to keep this coverage in place.*
- *Under Massachusetts law, disabled adult children can remain on their parent's individual health insurance after reaching the age at which dependent coverage is usually terminated if they meet certain requirements. The adult child must be mentally or physically incapable of self-sustaining employment and remain dependent on parents for support. Proof of incapacity must be furnished to the plan within 31 days of the child reaching the age at which dependent coverage would normally end.*
- *If you are HIPAA eligible, you are guaranteed the same right to purchase individual health insurance as other individuals. However, private insurers cannot impose any pre-existing condition exclusion or waiting periods on the plan you purchase.*

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible you are guaranteed the right to buy individual health insurance and are exempted from pre-existing condition exclusion periods. In Massachusetts, where state law is more protective, you do not need to meet all of the requirements of HIPAA eligibility to have this protection. However, if you move out of Massachusetts, this information may be important to you.

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.

HIPAA eligibility ends when you enroll in individual health insurance, 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.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE COVER?

- *Massachusetts requires that individual insurers offer standardized policies to all consumers.* You may select either the medical plans, preferred provider plans or **managed care plans**. These versions offer comprehensive coverage, including hospital and physician care, maternity care, preventive checkups and immunizations, and prescription drugs.

The **medical plan option** allows you to seek care from any doctor or hospital. For a hospital stay and some other services, you will have to pay a deductible up to \$700 per member and \$1,400 per family before the plan begins to pay for your care. For most other services, the medical plan will pay for 80% of covered charges and you must pay the other 20%. For some services, such as well baby care, there is no cost sharing at all.

The **preferred provider plan option** lets you decide whether to get care from providers in or out of the network. When you get care in-network, your out-of-

pocket costs will be smaller. If you go out of network, your out-of-pocket costs will be higher. For in-network care, the plan will only pay 90% of covered charges once you have paid a deductible of \$250 per member and \$500 per family. You will have to pay the other 10%. For out of network care, the plan will only pay 70% of the cost of covered services.

The **managed care plan option** requires you to seek care only from doctors and hospitals that contract with the HMO. You will have to pay a co-payment of \$15 for office visits and \$500 for hospital stays for the standard plans.

- *Individual health insurers may also offer a plan that has the same benefits as the standard plan but has higher co-payments, deductibles and excludes prescription drug coverage.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you buy individual health insurance, there are limits on pre-existing condition exclusion periods that can be imposed. No pre-existing condition exclusion period can be applied unless you have a break of 63 or more days of continuous coverage. Pre-existing condition exclusion periods cannot exceed 6 months. Individual health insurers can look back 6 months to see if you actually received care or treatment for a condition. In Massachusetts, pregnancy can be considered a pre-existing condition in individual health insurance. Genetic information cannot be considered a pre-existing condition.*
- *In Massachusetts, if you buy individual health insurance you may be subject to a waiting period for up to six months. Individual health insurers can impose either a pre-existing condition exclusion period or a waiting period but not both. If you are subject to a waiting period you will pay premiums but not receive coverage for non-emergency services during that time. No waiting period can be applied unless you have a break of 63 or more days of continuous coverage.*
- *In Massachusetts, individual health insurers are not allowed to impose **elimination riders**, which permanently exclude coverage for a health condition, body part, or body system.*

WHAT CAN I BE CHARGED FOR INDIVIDUAL HEALTH INSURANCE?

- *Premiums for individual health insurance in Massachusetts cannot vary due to your gender, health status, or occupation. This is called modified community rating. Premiums may vary depending on your age, family size, and where you live in the state. Check with the company for the most current premium rates.*

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.*

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 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 his or her 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.

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

- *In Massachusetts, you can buy individual health insurance regardless of whether you used up your COBRA coverage. Compare the options to see which is best for you. If you are planning to move to another state, you may need to be HIPAA eligible to buy individual coverage. In this case, you may want to consider COBRA.*

SPECIAL SECOND CHANCE TO ELECT COBRA FOR TRADE-DISLOCATED WORKERS

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

WHAT WILL COBRA COVER?

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

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Because your group coverage is continuing, you will not 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.*
- *A state program called the Medical Security Plan (MSP) helps unemployed residents pay COBRA premiums. See Chapter 5 for more information on MSP.*
- *If you have 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 it is equal to 65% of the cost of qualified health coverage, including COBRA. (See page 27).*
- *If you are a retiree aged 55-65 and receiving pension benefits from PBGC, and receiving benefits from the Trade Adjustment Assistance (TAA) Program, then you may be eligible for a federal income tax credit to help pay for new health coverage. This credit is called the Health Coverage Tax Credit (HCTC). (See page 27.)*

HOW LONG DOES COBRA COVERAGE LAST?

- *COBRA coverage generally lasts up to 18 months and cannot be renewed.* However, dependents are sometimes eligible for up to 36 months of COBRA continuation coverage, depending on their qualifying event. In addition, special rules for disabled individuals may extend the maximum period of coverage to 29 months. To qualify for the disability extension, you must have been disabled at the time of your COBRA qualifying event (such as termination of employment or reduction in hours) or be determined to have become disabled within 60 days of that qualifying event. You must obtain this disability determination from the Social Security Administration, and you must notify your group health plan within 60 days of this disability determination.

LENGTH OF COBRA COVERAGE		
<u>Qualifying event(s)</u>	<u>Eligible person(s)</u>	<u>Coverage</u>
Termination Reduced hours	Employee Spouse Dependent child	18 months *
Employee enrolls in Medicare Divorce or legal separation Death of covered employee	Spouse Dependent child	36 months
Loss of “dependent child” status	Dependent child	36 months
*Special rules may extend coverage an additional 11 months for certain disabled individuals and their eligible family members		

- *Usually, COBRA continuation coverage ends when you join a new health plan.* However, if your new plan has a waiting period or a pre-existing condition exclusion period, you can keep whatever COBRA continuation coverage you have left during that period. For specifics, ask your former employer or contact the U.S. Department of Labor.
- *COBRA coverage also ends if your employer stops offering health benefits to other employees.*
- *COBRA coverage might end if you are in a managed care plan that is available only to people living in a limited geographic area and you move out of that area.* However, if you are eligible for COBRA and are moving out of your current health plan’s service area, your employer must provide you with the opportunity to switch

to a different plan, but only if the employer already offers other plans to its employees. Some examples of the other plans your employer may offer you are a managed care plan whose service area includes the area you are moving to, or another plan that does not have a limited service area.

WHAT ABOUT MASSACHUSETTS CONTINUATION COVERAGE?

- *If your employer has 2-19 employees and offers small group health benefits, you may also be eligible for up to 36 months of continuation coverage under a Massachusetts law that is similar to COBRA. Ask your former employer or the Massachusetts Division of Insurance about state continuation coverage if you think it applies to you.*
- *In Massachusetts, you can buy individual health insurance regardless of whether you are eligible for or used up your federal or state continuation coverage. Compare the options to see which is best for you. If you are planning to move to another state, you may need to be HIPAA eligible to buy individual coverage. In this case, you may want to consider continuation coverage.*

CONVERSION COVERAGE

WHEN DO I HAVE TO BE OFFERED CONVERSION COVERAGE?

- *If you were covered under a fully insured group health plan and leave it, you may be able to buy a conversion policy. This is individual health insurance from the insurance company that covered your former group and is offered at the option of the insurer or as a result of the contract with your employer.*

If the insurer offers a conversion policy, it must follow the rules for individual health insurance discussed at the beginning of this chapter.

CHAPTER 4

YOUR PROTECTIONS AS A SMALL EMPLOYER OR SELF-EMPLOYED PERSON

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. Massachusetts has enacted comprehensive reforms to expand small employer's access to health insurance and to limit premium variation due to health status. Generally, small employers are those that employ 50 or fewer employees. Check with the Massachusetts Division 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 1 but not more than 50 people, health insurance companies must sell you any **small group health plan** they sell to other small employers. However, they cannot require that a minimum percentage of your eligible employees participate in your group health plan. If you are buying a **large group health plan** for 51 or more employees, your group can be turned down.
- *Your insurance cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud.

CAN MY GROUP BE CHARGED MORE BECAUSE OF ITS MEMBERS' HEALTH STATUS?

- *Premiums for all health plans sold to small employers in Massachusetts are modified community rated.* That means your premium cannot vary due to the health status, claims experience, or gender. Premiums may vary due to the age, family size, geographic location, or occupation of people in your group.

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you can to buy a group health plan on you own, like other small employers. You also have the option of buying individual health insurance. (See Chapter 3.)*
- *If you are self-employed and buy your own health insurance, you are eligible to deduct 100% of the cost of your premium from your federal income tax.*

MASSHEALTH INSURANCE PARTNERSHIP

- *The Insurance Partnership helps small employers pay for health insurance for workers with incomes up to 200% of the federal poverty level. To learn more about the Insurance Partnership call the Massachusetts Division of Medical Assistance at (800) 399-8285.*

A WORD ABOUT ASSOCIATION PLANS

- *In some states, some small employers, self-employed people, and other individuals buy health coverage through professional or trade associations. Check with the Massachusetts Division of Insurance for more information on whether a particular association plan is permitted and how association plans are regulated in your state.*

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Massachusetts who cannot afford to buy health insurance. MassHealth, the Children's Security Plan and the Medical Security Plan (MSP) offer free or subsidized health insurance coverage, direct medical services or other help. In addition, the federal government, under the Trade Adjustment Assistance (TAA) Program, provides tax credits to some workers who lose their jobs or whose work hours and wages are reduced as a result of increased imports. This chapter provides summary information about these programs and contact information for further assistance.

MASSHEALTH

MassHealth is a program that provides health coverage to some low-income Massachusetts residents. It covers families with children and pregnant women, medically needy individuals, the elderly, and people with disabilities if state and federal guidelines are met. Some immigrants will not be eligible for MassHealth but may be eligible for other programs. Legal residents who are not U.S. citizens may receive coverage if they have emergency needs under a program called MassHealth Limited.

- *Families who get cash benefits from **TANF** (also known as **Transitional Aid to Families with Dependant Children**) can get MassHealth.*

Parents should know that when you get a job and your TANF benefits end, you generally can stay on MassHealth for a 12-month transitional period.

Parents should know that when your family's TANF benefits end, your children may also qualify for transitional MassHealth coverage for 12 months or more. Or, they may qualify for MassHealth themselves if your family's income meets the MassHealth income standards. (See below.)

- *Very poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits also qualify for MassHealth.*
- *Being on TANF or SSI, is not the only way to qualify for MassHealth.* For certain categories of people, eligibility for MassHealth is based on the amount of your household income. If you are in one of these eligibility categories but your income is above Medicaid levels, you may also qualify for Medicaid as "medically needy." Your net income, after subtracting medical expenses, would have to be at or below Medicaid income levels.

In Massachusetts you may be eligible for MassHealth if you are an infant, a child, a pregnant woman, or a parent of a child, and your family income meets the MassHealth income standards.

Income eligibility levels for these categories are described below. Contact your local department of social services for more information.

Low-income persons eligible for MassHealth in Massachusetts*

<u>Category</u>	<u>Income eligibility (as percent of federal poverty level)</u>
Infants 0-1	200% (monthly income of \$2,617 for family of 3)
Child 1-5	150%
Child 6-18	150%
Parent	133%
Pregnant woman	200%
Disabled Adult	100%

* Eligibility information was compiled *State Health Facts Online*, the Henry J. 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 \$2,617.

* Contact your local department of social services for the most up to date information and for other eligibility requirements that may apply.

- *There may be other ways that MassHealth can help.* To find out if you or other members of your family qualify for MassHealth, contact the department of social services.

For questions on eligibility or to apply for MassHealth benefits, call the MassHealth Customer Center at (800) 841-2900.

OTHER MASSHEALTH PROGRAMS

- *Working disabled adults and non-working disabled adults under age 65, and disabled children may qualify for the MassHealth CommonHealth Program. There are no income standards for this program. Those with incomes above 133% of the federal poverty level, however, may have to pay a premium or meet a one-time deductible. The amount of the premium is based on monthly income, family size, and other health insurance you may have.*
- *Retired or disabled people who have low-incomes and are enrolled in Medicare may also qualify for help through the MassHealth Senior Buy-In program. If your household income is below the poverty level, MassHealth will pay your Medicare monthly premium and your Medicare deductibles and coinsurance. This is called the Qualified Medicare Beneficiary (QMB) program.*

If your household income is between 100% and 135% of the federal poverty level, MassHealth will pay for your monthly Medicare premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

- *If you receive long term unemployment benefits, are under age 65 and have no health insurance, you may be eligible for the MassHealth Basic program. Your family's income must not be more than 133% of the federal poverty level.*
- *If you are a working adult under age 65, have a family income that is not more than 200% of the federal poverty level and are not eligible for MassHealth or MassHealth CommonHealth, you and your family may be eligible for a program that helps you pay for part of your employer-sponsored health plan premium called MassHealth Family Assistance.*
- *If you are HIV positive and under age 65, the MassHealth Family Assistance program may pay for part of your employer-sponsored health insurance premium or provide some direct medical services. To qualify you cannot be eligible for MassHealth or MassHealth CommonHealth and your family's income cannot be more than 200% of the federal poverty level.*

Contact the Division of Medical Assistance for more information about eligibility requirements for these and other MassHealth programs.

CHILDREN'S MEDICAL SECURITY PLAN (CMSP)

Children's Medical Security Plan (CMSP) is a state-designed program that provides health coverage to low-income children under the age of 19 who are not eligible for MassHealth and who have limited or no health insurance.

- *Coverage is free to families with gross household income below 200% of the federal poverty level, and is available to families with higher income for a small premium. For a family of three, 200% of the federal poverty level works out to be an annual income of about \$31,340, or a monthly income of \$2,617.*
- *Covered services include well-child visits and immunizations, doctor visits, vision and dental care, laboratory tests and x-rays. Limited prescription drug benefit and mental health and substance abuse coverage are also available.*
- *For more information, call CMSP at (800) 909-2677, MassHealth Central Processing Unit at (800) 841-2900, or MassHealth Enrollment Center at (888) 665-9993. You can also visit CMSP's website at www.cmspkids.com.*

MEDICAL SECURITY PLAN (MSP)

Medical Security Plan (MSP) is a state-designed program that provides health coverage or premium assistance for Massachusetts residents receiving or eligible to receive unemployment benefits.

- *Monthly premium subsidies are provided to unemployed residents who are eligible for COBRA and to those who are continuing their individual health insurance. The Division of Employment and Training currently pays for 75 percent of the actual premium paid up to \$523 per month for a family plan and \$217 per month for individual health insurance.*
- *If you lose your job and you are not eligible for COBRA or do not already have individual health insurance, you may be eligible for the direct coverage plan. This is a comprehensive benefits package provided to unemployed residents that includes doctor visits, hospital care, and treatment for mental health and substance abuse. Effective February 1, 2004, the cost is \$15 per week, which will be deducted from your unemployment benefit check. In addition, there are also some required co-payments and deductibles for certain services provided.*
- *For more information on MSP, contact the Medical Security Plan Customer Service Office at (800) 914-4455.*

BREAST AND CERVICAL CANCER TREATMENT PROGRAM

- *Women who are diagnosed with breast or cervical cancer through the Massachusetts Women's Health Network (WHN) can apply for full healthcare coverage through MassHealth, which will cover the costs of treatment.*
- *For more information about eligibility, contact the WHN at (877) 414-4447. To find a Women's Health Network enrollment site near you, visit the Women's Health Network website at <http://www.mass.gov/dph/fch/whn/sites.htm>*

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 PREMIUM 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.* (See Chapter 3 for COBRA and state continuation coverage.)
 - *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 spouse'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 State continuation coverage Conversion coverage	<i>Massachusetts Division of Insurance</i> (617) 521-7777 (Boston) (413) 785-5526 (Springfield) (617) 521-7490 (TTY/TTD) http://www.mass.gov/doi/
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor, Boston Regional Office</i> (617) 565-9600 <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
MassHealth	<i>Office of Health and Human Services of Massachusetts</i> (617) 628-4141 (800) 841-2900 http://www.mass.gov/portal/index.jsp?pageID=eohhs2agencylanding&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=MassHealth&sid=Eeohhs2
Children's Medical Security Plan (CMSP)	<i>Massachusetts Department of Public Health</i> (800) 909-2677 (CMSP) (888) 665-9993 (MassHealth Enrollment Center) http://www.cmspkids.com/
Medical Security Plan (MSP)	<i>Massachusetts Division of Employment and Training</i> (800) 914-4455 (617) 956-3801 (TTY/TDD) http://www.detma.org/WSmsp.htm

For questions about:	Contact:
Breast and Cervical Cancer Screening (and Treatment) Program	<i>Women's Health Network</i> (877) 414-4447 (617) 624-5992 (TTY) http://mass.gov/dph/fch/whn/index.htm
The Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service (IRS)</i> (866) 628-HCTC http://www.irs.gov/individuals/index.html (Click on HCTC); or call HCTC customer service center
Finally, if you would like to obtain a consumer guide for a different state, visit the web at http://www.healthinsuranceinfo.net	

HELPFUL ERMS

Affiliation Periods. The time an HMO may require you to wait after you enroll and before your coverage begins. HMOs that impose an affiliation period cannot exclude coverage of pre-existing conditions. Premiums cannot be charged during HMO affiliation periods. Massachusetts does not permit HMOs to impose affiliation periods but other states may.

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

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

Children's Medical Security Plan. Massachusetts's Children's Medical Security Plan provides insurance for children under the age of 19 who are not eligible for MassHealth and who have limited or no health insurance.

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

Continuous Coverage. If you are joining a self-insured group health plan or if you want to be HIPAA eligible, health insurance coverage is continuous if it is not interrupted by a break of 63 or more consecutive days. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. See also Creditable Coverage, HIPAA Eligible, Fully Insured Group Health Plan, Individual Health Insurance, Self-Insured Group Health Plan.

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

Elimination Rider. An amendment permitted in health plan contracts in some states that permanently excludes your coverage for a health condition, body part, or body system. Elimination riders are not permitted in Massachusetts.

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

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

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

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

Group Health Plan. Health insurance (usually sponsored by an employer, union or professional association) that covers 1 or more employees and includes the self-employed. 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 individuals and small employers with 1 to 50 employees in Massachusetts 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. HIPAA requires all health plans to be guaranteed renewable. The precise definition of guaranteed renewable may vary based on what type of insurance you have. Your coverage can be canceled for other reasons unrelated to your health status.

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

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

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

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

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

HIPAA Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or MassHealth; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. No matter where you live in the U.S., if you are HIPAA eligible you must be offered at least some type of individual health insurance with no pre-existing condition periods. In Massachusetts, you do not need to meet all the requirements of federal eligibility to have this protection. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

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

Individual Health Insurance. Policies for people not connected to an employer group. Individual health insurance are regulated by Massachusetts.

Kassebaum-Kennedy. See HIPAA.

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

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

Look Back. The maximum length of time, immediately prior to enrolling in a health plan, that can be examined for evidence of pre-existing conditions. In Massachusetts, insurers can not look back further than 6 months. See also Pre-existing Condition.

Managed Care Plans . A standardized plan individual health insurers are required to offer to all consumers.

MassHealth. A program providing comprehensive health insurance coverage and other assistance to certain low-income and moderate income Massachusetts residents. There are several components to the program includes MassHealth, Masshealth CommonHealth, and MassHealth Family Assistance. All other states have similar programs, typically called Medicaid, though eligibility levels and covered benefits will vary.

Medical Plan Option. A standardized plan individual health insurers are required to offer to all consumers.

Modified Community Rating. A rule that prohibits health plan premiums in Massachusetts from varying premiums based on your health status. Both small group health plan and individual health insurance premiums are subject to modified community rating.

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

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

Pre-existing Condition. Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan. Pregnancy cannot be counted as a pre-existing condition in group health plans. 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 are covered from moment of birth or date placed for adoption and cannot be subject to pre-existing condition exclusions.

Pre-existing Condition Exclusion Period. The time during which a health plan will not pay for covered care relating to a pre-existing condition. Fully insured group health plans and individual health insurance cannot exclude coverage for pre-existing conditions for more than 6 months. Self-insured group health plans cannot exclude coverage for pre-existing conditions for more than 12 months. See also Pre-existing Condition.

Preferred Provider Plan Option. A standardized plan individual health insurers are required to offer to all consumers.

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 Massachusetts.

Small Group Health Plans. Plans with 1 to 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 Massachusetts, if you are in a fully insured group health plan sponsored by an employer with 2 to 19 employees and meet other requirements, you also have rights to continue your health coverage for up to 18 months when your job ends. In some cases dependents can continue coverage for up to 36 months. 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 MassHealth. In addition, MassHealth coverage often continues for a limited time if your income increases so that you no longer qualify for SSI.

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

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. Some insurers can also impose a waiting period for up to 6 months before you receive coverage for non-emergency services. See also Pre-existing Condition Exclusion Period.