

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

By

**Karen Pollitz
Eliza Bangit
Kevin Lucia
Jennifer Libster
Jennifer Hersh
Mila Kofman**

**GEORGETOWN UNIVERSITY
HEALTH POLICY INSTITUTE**

December 2004

ACKNOWLEDGMENTS AND DISCLAIMER

The authors wish to express appreciation to Elizabeth Hadley, Robert Imes, Stephanie Lewis, Lauren Polite, Jalena Specht, and Nicole Tapay for their work developing earlier editions of these guides.

The authors also wish to express appreciation to the staff of the New Mexico Division of Insurance for their review of this document. Their help was invaluable in our research and understanding of applicable 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 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.

December 2004

© Copyright 2004 Georgetown University, Health Policy Institute.

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: Georgetown University, Health Policy Institute, 2233 Wisconsin Avenue N.W., Suite 525, Washington, D.C., 20007.

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

As a New Mexico 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 New Mexico 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 New Mexico, 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 40. For information about how to find consumer guides for other states on the Internet, see page 41. A list of helpful terms and their definitions begins on page 42. 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?	4
2. Your protections under group health plans	6
When does a group health plan have to let me in?	6
Can a group health plan limit my coverage for pre-existing conditions? ...	8
Limits to protections for certain government workers	11
As you are leaving group coverage... ..	11
3. Your protections when buying individual health insurance.....	13
Individual health insurance sold by private insurers	13
Cobra continuation coverage	16
Conversion coverage	21
New Mexico health insurance alliance (for individuals)	22
New Mexico Medical Insurance Pool (NMMIP)	24
4. Your protections as a small employer or self-employed person.....	28
Do insurance companies have to sell me health insurance?	28
What plan choices do I have?	28
Can I be charged more because of my group's health status?	29
What if I am self-employed?	29
A word about association plans.....	29
New Mexico Health Insurance Alliance (for small groups)	30
5. Financial assistance	33
For more information... ..	39
Helpful terms	41

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 New Mexico. 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 New Mexico resident.

HOW AM I PROTECTED?

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

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status. This is called **nondiscrimination**. (See page 6.)*
- *All health plans in New Mexico 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 health plan, your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage. (See page 8.)*
- *Your health insurance cannot be canceled because you get sick. Most health insurance is **guaranteed renewable**. (See pages 16 and 28.)*
- *If you leave your job, you may be able to remain in your old group health plan for a certain length of time. This is called **COBRA continuation coverage** or **state continuation coverage**. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage. (See page 16.)*

- *If you lose coverage under a fully insured group health plan in New Mexico, you can buy a **conversion policy**. This is an individual policy from the company that insured your former group. You will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for a conversion policy. (See page 21.)*
- *If you lose your group health insurance and meet other qualifications, you will be **HIPAA eligible** and guaranteed access to several types of individual health insurance. You can buy an individual coverage from the **New Mexico Medical Insurance Pool (NMMIP)** or from the **New Mexico Health Insurance Alliance (the Alliance)**. There are limits on what you can be charged for coverage under NMMIP and the Alliance. You will not have a pre-existing condition exclusion period. (See pages 22, 25 and 30.)*
- *You may also be able to buy insurance from NMMIP if you have had difficulty obtaining affordable health insurance from private companies because of your health condition. In this case you may face a new pre-existing condition exclusion period. There are limits on what you can be charged for an NMMIP policy. (See page 22.)*
- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group. All health plans for small employers must be sold on a **guaranteed issue** basis. (See page 28.)*
- *In addition, if you are self-employed with no other workers, you are eligible to obtain coverage through the Alliance if you enroll with a dependent. (See page 30.)*
- *If you are a small employer buying a group health plan outside of the Alliance, you can be charged more, within limits, based on the health status and other factors of those in your group. (See page 29.) Health plans sold in the Alliance cannot charge you more due to the health status of those in your group, however the Alliance can charge you more, within limits, based on age, gender, family size, where you live, and the plan that you choose. This is called **modified community rating**. (See page 32.)*
- *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 New Mexico **Medicaid** program offers free or reduced price health coverage for certain families, children, pregnant women, elderly, and disabled individuals. In addition, some women who are diagnosed with Breast or Cervical Cancer may be eligible for medical care through Medicaid. (See Chapter 5.)*

- *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 36.)*
- *If you are a retiree aged 55-65 and receiving pension benefits from **Pension Benefit Guaranty Corporation (PBGC)**, then you may also be eligible for the HCTC (See page 36.)*

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 or your special continuation rights in the Alliance, 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 any health benefits they do offer do not discriminate based on health status. (See page 6.)*
- *If you get a new job with health benefits, your coverage may not start right away. Employers can require **waiting periods** before your health benefits begin. **HMOs** can require **affiliation periods**. (See page 7.)*
- *If you are joining a new group health plan or the Alliance, you may have to satisfy a new pre-existing condition period if you have a break in coverage of 63 days or more. (See pages 8 and 31.) If you obtain individual health insurance or NMMIP, you may have to satisfy a new pre-existing condition period if you have a break in coverage of 31 days or more. (See pages 15 and 25.)*
- *Even if you have **continuous coverage**, there may be a pre-existing condition exclusion period for some benefits if you join a **group health plan** that covers certain benefits your old plan did not. For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition. (See page 10.)*

- *If you work for certain non-federal public employers in New Mexico, not all of the group health plan protections may apply to you. (See page 11.)*
- *In New Mexico, your access to individual health insurance may depend on your health status. Individual health insurers are not prohibited from turning you down, charging more, or limiting coverage because of pre-existing conditions. If you are HIPAA eligible, NMMIP and the Alliance are your only guaranteed access to individual health insurance though you may be able to buy individual health insurance from other insurance companies. Some people who have problems obtaining individual health insurance may be eligible for NMMIP. (See Chapter 3.)*
- *Except when you are HIPAA eligible, individual health policies can permanently exclude coverage for your pre-existing condition through a rider, which is an amendment to your insurance contract. (See page 15.)*

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?

- *In general, you have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees. Or, your employer may offer an HMO plan that you cannot join because you live outside of the plan's service area.
- *You cannot be turned away or charged more because of your health status.* Health status means your medical condition or history, **genetic information**, or disability. This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (such as part time employment), as long as these are unrelated to health status and applied consistently.

Discrimination due to health status is not permitted

The Acme Company 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)
-
- *Under New Mexico law, newborns, adopted children and children placed for adoption are automatically covered under the parents' fully insured health plan for the first 31 days, if the plan covers dependents.* If the health plan does not provide dependent coverage, it must include an option to parents to provide dependent coverage for newborns, adopted children and children placed for adoption. The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.
 - *If you have a disabled child, that child may remain covered under your fully insured group 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.
 - *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage.* This waiting period, however, must be applied consistently and cannot vary due to your health status. Unlike employers, insurance companies cannot require waiting periods.
 - *When you begin a new job with health insurance through an HMO, the HMO may require a waiting period before coverage begins.* During this affiliation period, you will not have health insurance coverage. An HMO affiliation period cannot exceed 2 months (3 months for late enrollees), and you cannot be charged a premium during this time.
 - *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 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 PRE-EXISTING CONDITIONS?

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

- *A group health plan can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan. This period is called the look back period.*
- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns, newly adopted children, children placed for adoption, or genetic information.*
- *Group health plans can exclude coverage for pre-existing conditions only for a limited time. In fully insured group health plans, the maximum pre-existing exclusion period is 6 months. In self-insured group health plans, the maximum period is 12 months. You must be given credit toward your pre-existing condition exclusion period for any previous continuous coverage.*

If you enroll late in a group health plan (after you were hired and not during a regular or special enrollment period), coverage for your pre-existing condition can be excluded for as long as 18 months. However, if you are a late enrollee in an Alliance group health plan, the maximum pre-existing condition exclusion period is still 6 months.

- *Group health plans that impose pre-existing condition exclusion periods must give credit for any previous **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 (TRICARE)
Indian Health Service	State high risk pools
Individual health insurance	
Medicaid	

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

In determining continuous coverage, employer-imposed waiting periods and HMO affiliation 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. HMOs that require an affiliation period cannot exclude coverage for pre-existing conditions.

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

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

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

Question: Is this permitted?

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

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

Federal law permits state, county, and local governments to exempt their employees in self-insured plans from some of the protections discussed previously in this chapter. Public employers must make this choice annually. When they do so, they are required to notify the federal government and specify which health insurance protections will not apply to their employees' health insurance plan.

According to the latest list available from the federal government, the County of San Juan, the Cities of Carlsbad and Farmington, and New Mexico Self-Insurers' Fund 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 New Mexico may have made this choice after this guide was written. If you are not sure about your protections under your public employee health plan, you should contact your employer.

AS YOU ARE LEAVING GROUP COVERAGE...

- *If you are leaving your job or otherwise losing access to your group health coverage, you may be able to remain covered under the group health plan for a limited time.* In addition, you may have special protections when buying certain kinds of individual health coverage. See Chapter 3 for more information about COBRA and state continuation coverage, conversion coverage, Alliance coverage, and NMMIP 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 36.)*
- *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 36.)*

CHAPTER 3

YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group insurance, you may want to buy an individual health policy from a private insurer. However, in New Mexico – as in most other states – you have limited guaranteed access to individual health insurance. Whether you can buy an individual health policy may depend on your health status, the kind of coverage you want to buy, and other circumstances. There are some alternatives to individual health insurance coverage – such as COBRA and state continuation coverage, Alliance coverage, and NMMIP coverage. This chapter summarizes your protections under different kinds of coverage.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

WHEN DO INDIVIDUAL HEALTH INSURERS HAVE TO SELL ME COVERAGE?

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

- *In general, insurers that sell individual health insurance in New Mexico are free to turn you down because of your health status and other factors. When applying for individual health insurance, 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 been denied coverage because of your health status, you can buy individual health insurance from the New Mexico Medical Insurance Pool (NMMIP). (See page 25.)*
- *If you are HIPAA eligible, you can buy individual health insurance from NMMIP or the Alliance. You will not have a pre-existing condition exclusion period. There are limits on what you can be charged. (See pages 22 and 25.)*

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible in New Mexico, you are guaranteed the right to buy individual health insurance from the New Mexico Health Insurance Alliance or the New Mexico Medical Insurance Pool (NMMIP) and are exempted from pre-existing condition exclusion periods. 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 the NMMIP or 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.

- *In New Mexico, newborns, adopted children, and children placed for adoption are automatically covered under the parents' individual health insurance for the first 31 days, if the plan provides coverage for dependents.* If the health plan does not provide dependent coverage, it must include an option to parents to provide dependent coverage for newborns, adopted children and children placed for adoption. The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.
- *If you have a disabled child, that child may remain covered under your individual health insurance 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.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE COVER?

- *It depends on what you buy.* New Mexico does not require health insurers in the individual market to sell standardized policies. Insurers design different policies and

you will have to read and compare them carefully. Sometimes, individual health insurance provide less comprehensive coverage than group health plans, especially for certain services such as maternity care, mental health care, or prescription drugs. However, New Mexico does require all health plans to cover certain benefits – such as childhood immunizations and minimum hospital stays following mastectomies. Check with the New Mexico Division of Insurance for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Individual health insurance can impose **elimination riders**.* This is an amendment to your health insurance policy that permanently excludes coverage for a health condition or even an entire body part or system.
- *New Mexico insurers can also impose **pre-existing condition exclusion period**.* Pre-existing condition exclusion periods cannot exceed 6 months. If a 6-month exclusion period is applied, you can get credit for any prior continuous creditable coverage you have had as long as you have not had a gap of 31 days or more between your old and new coverage. No pre-existing condition exclusion periods can be applied if you are HIPAA eligible.

The definition of pre-existing condition is different under individual health insurance than under group health plans. Individual health insurance can count as pre-existing any condition for which you received, or – in your insurer's judgment, for which you should have sought – a diagnosis, medical advice, or treatment in the 6 months prior to obtaining the individual health policy. This is called the **prudent person rule**. In New Mexico, individual health policies can count pregnancy as a pre-existing condition, but not genetic information.

WHAT CAN I BE CHARGED FOR INDIVIDUAL HEALTH INSURANCE?

- *Except for coverage through the Alliance (see page 22), there are no limits on how much individual health insurance premiums can vary due to health status.* While your initial premium can be higher or lower to reflect your health status, your premium at renewal cannot increase solely because of a decline in your health status. Individual health insurance premiums can vary, within limits, because of your age and gender, where you live and whether you smoke. Your renewal premium can increase as you age.

CAN MY INDIVIDUAL HEALTH INSURANCE 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 temporary health insurance policies.* Temporary 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 temporary policy after it expires, you will have to reapply and there is no guarantee that coverage will be re-issued at all or at the same price.

COBRA CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

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

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

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

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 elect COBRA coverage even if you do not.
- *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.*

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.*
- *If you elect the 11-month disability extension, the premium will increase to 150% of the total cost of coverage. See below for more information about the disability extension.*
- *If you 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 36).*
- *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 36.)*

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 old employer stops offering a health benefit plan to its 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 NEW MEXICO CONTINUATION COVERAGE?

- *If your employer offers fully insured health benefits and has fewer than 20 workers, you may also be eligible for up to 6 months of continuation coverage under a New Mexico law that is similar to COBRA. Ask your former employer or the New Mexico Division of Insurance about state continuation coverage if you think it applies to you.*

- *If your employer offers health insurance through the New Mexico Health Insurance Alliance and you leave that job, you can continue your Alliance health plan indefinitely. You must have been covered under Alliance group health plan for at least 6 months to qualify for this continuation coverage. You are eligible for continuation coverage if you lost your group coverage for almost any reason, including losing or quitting your job, aging off your parents' policy, losing coverage you had through a family member due to death or divorce, and losing coverage because your employer goes out of business.*

If you had dependent coverage, you and your dependents can elect this continuation coverage independently. Premiums for Alliance continuation coverage are the same as those charged other individuals. Your premium will be about 9 percent higher than your old group premium (employer and employee share).

CONVERSION COVERAGE

WHEN DO INSURERS HAVE TO SELL ME CONVERSION COVERAGE?

- *In New Mexico, 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. You must apply for conversion coverage and pay your first premium within 31 days after receiving notice of your conversion rights. To qualify for a conversion policy, you first must have used up any COBRA or state continuation coverage and cannot be eligible for Medicare or any other federal or state insurance program.*
- *Conversion rights are also available to a surviving spouse and children upon the death of the insured, to a child when the child reaches that age at which dependent coverage is terminated, and to a former spouse and children at divorce.*
- *You do not need to be HIPAA eligible to buy a conversion policy.*

WHAT WILL CONVERSION POLICIES COVER?

- *Conversion policy benefits must be similar to those provided under your previous group policy.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Conversion policies cannot impose new pre-existing condition exclusion periods. However, if you were in the middle of a pre-existing condition exclusion period under your group health plan when it ended, you will have to finish it.*

WHAT CAN I BE CHARGED FOR CONVERSION COVERAGE?

- *Premiums for conversion coverage may be much more costly than your former group plan premiums. There are no limits on what can be charged for conversion policy premiums (although there are general requirements that premiums be set according to reasonable actuarial standards). If you have questions about conversion policy premiums, contact the New Mexico Division of Insurance.*

CAN A CONVERSION POLICY BE CANCELLED?

- *Your conversion coverage cannot be cancelled because you get sick. This is called guaranteed renewability. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of managed care plans, continue to live in the plan service area.*

NEW MEXICO HEALTH INSURANCE ALLIANCE (FOR INDIVIDUALS)

The New Mexico Health Insurance Alliance (the Alliance) is a state-run program that offers private health insurance coverage to HIPAA eligible individuals as well as to those individuals who lost their group coverage through the Alliance. The Alliance also offers group health coverage to small businesses and self-employed that meet specified requirements. For the Alliance group coverage, see page 30.

WHEN CAN I GET INDIVIDUAL HEALTH INSURANCE FROM THE ALLIANCE?

- *If you are HIPAA eligible, you are guaranteed the right to buy an approved health plan through the Alliance without limits on coverage for pre-existing conditions. You can buy coverage for yourself and your dependents.*

If you are HIPAA eligible, you have a choice between buying coverage through the Alliance or the New Mexico Medical Insurance Pool. (See page 25.) Compare the options to see which is best for you.

- *If you had group coverage through the Alliance and lost it, you can continue in your plan as an individual indefinitely.*

WHAT WILL THE ALLIANCE COVER?

- *The Alliance offers HMO, PPO, and indemnity plans. Benefits are the same under these options, but cost sharing varies.*

Indemnity plans offer a choice of annual deductibles, ranging from \$500 to \$10,000, a choice of coinsurance (the plan pays either 50%, 70%, or 100% of covered charges after the deductible is met), and a choice of out-of-pocket limits, ranging from \$5,000 to \$10,000. All indemnity plans have a lifetime maximum of \$2 million on covered benefits.

You can also choose from three PPO options: (1) a plan with a \$1,000 annual deductible, 50% coinsurance, and a \$10,000 out-of-pocket limit; (2) a plan with a \$2,500 annual deductible, 50% coinsurance, and a \$10,000 out-of-pocket limit; or (3) a plan with a \$10,000 annual deductible and no coinsurance (this means that the plan pays 100% of covered charges after the deductible is met). All PPO plans have a lifetime maximum of \$2 million on covered benefits.

The HMO plan requires no deductible and there is no maximum lifetime benefit. The maximum out-of-pocket for per calendar year for covered services is \$2,500 for individuals and \$5,000 for family. The copayments vary based on the services received – \$30 copayment for physician services and \$100 for emergency care.

- *Alliance plans cover hospital care, physician services, wellness care, prescription drugs, maternity care, mental health services, and other services. Alcohol and substance abuse services are covered in the HMO plan but offered as optional coverage in the indemnity and PPO plans.*
- *Once you enroll in an Alliance plan as an individual, you can change your benefit options annually on the anniversary date of your coverage. (For example, you can choose a higher or lower deductible.) However, you will not be allowed to switch to a different insurance company or HMO except in two circumstances. If your insurer stops offering coverage through the Alliance you can choose another insurer. In addition, if you are enrolled in an HMO and you are moving out of the service area, including out of state, you can buy coverage from an indemnity or PPO insurer in the Alliance.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are HIPAA eligible, you will not have a pre-existing condition exclusion period.*

- *If you lose your group coverage that you had through an Alliance plan and elect to continue coverage through that plan as an individual, you will not have a new pre-existing condition exclusion period.*

WHAT CAN I BE CHARGED FOR ALLIANCE INDIVIDUAL COVERAGE?

- *Premiums will not vary because of your health status. However, they may vary, within limits, based on your age, gender, family size, where you live, and the plan that you choose. This is called modified community rating.*

For example, the monthly premium for a 24-year-old male in Bernalillo County ranges from \$118 to \$313, depending on which plan option is selected; and the monthly premium for a 64-year-old male ranges from \$326 to \$860.

The monthly premium for a 24-year old male buying family coverage in Torrance County ranges from \$466 to \$1,229, depending on which plan option is selected; and the monthly premium for a 64-year old male buying family coverage ranges from \$778 to \$2,055.

- *Alliance health plan premiums for individuals are usually about 9 percent higher than premiums charged for similar coverage sold to small employers.*

HOW LONG DOES ALLIANCE INDIVIDUAL COVERAGE LAST?

- *You can remain enrolled in the Alliance as long as you pay your premiums.*
- *Unlike COBRA, continuation coverage in the Alliance lasts indefinitely. You can remain with your plan as long as you need it, even if you move to another state, as long as you continue to pay your premiums. Each year, you will have an opportunity to change benefit packages, but you will not be allowed to change insurance companies except in limited circumstances.*

NEW MEXICO MEDICAL INSURANCE POOL (NMMIP)

New Mexico has a high-risk pool program, called the New Mexico Medical Insurance Pool (NMMIP), which provides access to health insurance coverage to all residents of New Mexico who are denied adequate health insurance and are considered uninsurable and for people who are HIPAA eligible.

WHEN CAN I GET COVERAGE FROM NMMIP?

- *If you are HIPAA eligible, you can buy health insurance from the NMMIP without limits on coverage for pre-existing conditions.* You also can buy coverage from the New Mexico Health Insurance Alliance. (See page 22.) Compare the options to see which is best for you.
- *If you are not HIPAA eligible, you can buy insurance from NMMIP if you are a New Mexico resident and can demonstrate proof of uninsurability.* You are considered uninsurable if you have been turned down for comprehensive health insurance coverage, offered health insurance that excludes coverage for your pre-existing condition, have individual health insurance that has been in effect for at least six months at a premium higher than NMMIP premiums, or have been diagnosed with one of NMMIP's pre-qualifying medical conditions.

You are also eligible for NMMIP coverage if your health plan is terminated involuntarily because the insurer stopped issuing coverage in New Mexico, your coverage in another state's high-risk pool ended due to non-residency, or your current coverage in another state is not valid in New Mexico.

In addition, if you have a policy from the Alliance, you can transfer into NMMIP.

- *You are not eligible for NMMIP coverage if you have terminated NMMIP coverage within the past 12 months, if you are an inmate of a public institution, or if other coverage has been terminated because of nonpayment or fraud.*
- *Family coverage is available in the NMMIP.* Dependents' coverage ends when they reach 19 years of age or, if the dependent is a full-time student, when they reach 25 years of age. Adult dependents who are incapable of self-sustaining employment because of developmental disability or physical handicap and are primarily dependent on the policyholder can remain covered after the limiting age. Proof of incapacity and dependency must be provided within 120 days of reaching the limiting age and may be required subsequently in the future.

WHAT WILL NMMIP COVER?

- *The NMMIP offers coverage with a choice of annual deductibles (\$500, \$1,000, \$2,000, \$7,500, or \$10,000).* After the deductible is met, the NMMIP will pay 80% of the claims until your out-of-pocket limit for the plan is met. The maximum out-of-pocket limits for the different deductible options are \$2,500, \$3,500, and \$5,000, respectively. There is no out-of-pocket maximum for the \$7,500 and \$10,000 deductible options and NMMIP pays 100% for most covered services once the annual deductible has been met.

- *Benefits are the same under these options.* NMMIP plans cover hospital and physician care, prescription drugs, and other services. Limited home health visits and organ transplant coverage are available. There is no lifetime maximum per member except for certain benefits (e.g., \$250,000 lifetime maximum per member for organ transplant). Maternity coverage is available for an additional premium.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *You will not have a pre-existing condition exclusion when you enroll in NMMIP if any of the following applies to you:*

You are HIPAA eligible;

Your prior coverage was terminated involuntarily;

You have individual health insurance that has been in effect for at least six months at a premium higher than NMMIP premiums;

Pre-existing condition exclusions have been satisfied under prior policies;
or

You have been covered by another state's high-risk pool and it ended due to non-residency.

- *If you are not HIPAA eligible or none of the above applies to you, NMMIP can exclude coverage for your pre-existing condition for 6 months.* NMMIP follows the rules of other individual health insurers for pre-existing conditions. It will look back 6 months, using the prudent person rule, for evidence of a pre-existing condition. Pregnancy can be counted as a pre-existing condition and is subject to special rules.

NMMIP will credit prior continuous coverage toward your pre-existing condition exclusion if you apply for NMMIP coverage within 31 days of losing your prior coverage.

WHAT CAN I BE CHARGED FOR POOL COVERAGE?

- *Premiums will vary based on the plan you choose.* In addition, the NMMIP charges enrollees different rates based on their age and gender. Under New Mexico law, the NMMIP rates cannot be more than 50% higher than the average premium a healthy person would pay if he or she bought a similar plan sold by a private insurer in New Mexico.

The monthly NMMIP premium for a 24-year-old male ranges from \$128 to \$256, depending on which plan option is selected. By contrast, the monthly premium for a 64-year-old male ranges from \$433 to \$863, depending on which plan option is selected.

Contact the New Mexico Medical Insurance Pool for the most current information about premium and coverage options.

HOW LONG DOES POOL COVERAGE LAST?

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

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. New Mexico has enacted reforms to expand some of these protections. Some of these reforms apply to groups of different sizes. 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 New Mexico 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 2 but not more than 50 people eligible for health benefits, health insurance companies must sell you any **small group health plan** they sell to 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. Small group health plans in the Alliance cannot impose minimum contribution requirements and must follow Alliance rules about minimum participation rates. (See page 32.) If you are buying a **large group health plan** for 51 or more eligible employees, your group can be turned down.
- *Your insurance cannot be canceled because someone in your group becomes seriously ill.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud, or if they are discontinuing that insurance product, or if they are withdrawing from the small employer market. In case of discontinuance, they must give you a chance to buy other plans they sell to groups of your size.

WHAT PLAN CHOICES DO I HAVE?

- *New Mexico health insurers offer a variety of small group health plans.* As a small employer, you must be offered a choice of all these plans.

- *In addition, if you are a small employer with 2 to 50 eligible employees, or if you are self-employed and buying coverage for yourself and at least one other family member, you may also obtain coverage through the New Mexico Health Insurance Alliance. See page 30 for Alliance eligibility requirements.*

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

- *You can be charged higher premiums, within limits, based on the health status of those in your group. Premiums also can vary, within limits, based on age, gender, geography, occupation, and smoking status.*
- *There are also limits on the annual increase that can be charged. For groups with more than 50 workers, New Mexico does not limit premium variation or increases. If you have questions about your group health plan premiums, contact the New Mexico Division of Insurance.*

WHAT IF I AM SELF-EMPLOYED?

- *Usually, if you are self-employed with no other workers, you are not eligible to buy a group health plan on your own outside of the Alliance. Therefore, the laws that protect employers' access to group health plans do not apply to you. Your access to health insurance is protected by the laws that apply to individuals. (See Chapter 3.)*
- *If you are buying coverage for yourself and at least one other family member, you can buy a group health plan through the New Mexico Health Insurance Alliance and will be protected by the rules that apply to other small groups. (See page 30.)*
- *If you are self-employed and buy your own health insurance, you are eligible to deduct 100% of your premium from your federal income tax.*

A WORD ABOUT ASSOCIATION PLANS

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

NEW MEXICO HEALTH INSURANCE ALLIANCE (FOR SMALL GROUPS)

In New Mexico, small employers can buy small group health coverage through the New Mexico Health Insurance Alliance. The Alliance was organized to improve access to health insurance coverage for small employers. It has been expanded to include access to health insurance coverage for individuals who meet eligibility criteria, including HIPAA eligible individuals. See page Chapter 3 for information about individual coverage under the Alliance.

WHEN CAN I GET GROUP COVERAGE FROM THE ALLIANCE?

- *If you are an employer with 2 to 50 eligible employees, you can buy health insurance from the Alliance.*
- *If you are self-employed and want to buy coverage for yourself and at least one other family member, you can buy health insurance from the Alliance.*
- *You must meet other eligibility standards listed below:*

At least 50% or all employees (eligible or not) must live within New Mexico.

At least 50% of eligible employees must enroll. (Note: When counting eligible employees, subtract those who have coverage already, those meeting an employer waiting or probationary period, seasonal employees, and those working fewer than 20 hours per week.)

Employer must not already offer other health insurance to employees.

Employer premium contributions are not required.

Employees must work at least 20 hours per week to qualify as full-time employee.

- *Family coverage is available in the Alliance.* Dependent coverage ends when they reach 19 years of age or, if the dependent is a full-time student, when they reach 25 years of age. Adult dependents who are incapable of self-sustaining employment because of developmental disability or physical handicap and are primarily dependent on the policyholder can remain covered after the limiting age. Proof of incapacity and dependency must be provided within 120 days of reaching the limiting age and may be required subsequently in the future.

WHAT WILL THE ALLIANCE COVER?

- *The Alliance offers HMO, PPO, and indemnity plans.* Benefits are the same under these options, but cost sharing varies.

Indemnity plans offer a choice of annual deductibles, ranging from \$500 to \$10,000, a choice of coinsurance (the plan pays either 50%, 70%, or 100% of covered charges after the deductible is met), and a choice of out-of-pocket limits, ranging from \$5,000 to \$10,000. All indemnity plans have a lifetime maximum of \$2 million on covered benefits.

You can also choose from three PPO options: (1) a plan with a \$1,000 annual deductible, 50% coinsurance, and a \$10,000 out-of-pocket limit; (2) a plan with a \$2,500 annual deductible, 50% coinsurance, and a \$10,000 out-of-pocket limit; or (3) a plan with a \$10,000 annual deductible and no coinsurance (this means that the plan pays 100% of covered charges after the deductible is met). All PPO plans have a lifetime maximum of \$2 million on covered benefits.

The HMO plan requires no deductible and there is no maximum lifetime benefit. The maximum out-of-pocket for per calendar year for covered services is \$2,500 for individuals and \$5,000 for family. The copayments vary based on the services received – \$30 copayment for physician services and \$100 for emergency care.

- *Alliance plans cover hospital care, physician services, wellness care, prescription drugs, maternity care, mental health services, and other services.* Alcohol and substance abuse services are covered in the HMO plan but is offered as an optional coverage in the indemnity plans.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are a small employer or if self-employed enrolling with at least one other family member, the Alliance can exclude coverage for your pre-existing condition for 6 months.* The Alliance will look back 6 months before you enroll to see if you had a condition for which you actually received a diagnosis or medical advice or treatment. The Alliance will give you credit for prior continuous coverage if your break in coverage is not 63 days or more. Pregnancy and genetic information cannot count as pre-existing conditions.

WHAT CAN I BE CHARGED FOR ALLIANCE GROUP COVERAGE?

- *If you are buying a small group health plan through the Alliance, you cannot be charged higher premiums because of the health status of those in your group.* However, you can be charged more, within limits, based on age, gender, family size, where you live, and the plan that you choose. This is called modified community rating.

For example, the monthly premium for a 24-year-old male in Bernalillo County ranges from \$109 to \$288, depending on which plan option is selected; and the monthly premium for a 64-year-old male ranges from \$300 to \$791.

The monthly premium for a 24-year old male buying family coverage in Torrance County ranges from \$428 to \$1,131, depending on which plan option is selected; and the monthly premium for a 64-year old male buying family coverage ranges from \$716 to \$1,891.

- *Premiums for the Alliance usually are about 15% higher than premiums for similar plans typically sold to small employers outside of the Alliance. Contact the New Mexico Health Insurance Alliance for the most current information about premium and coverage options.*

HOW LONG DOES ALLIANCE GROUP COVERAGE LAST?

- *Alliance group policies are guaranteed renewable as long as you pay your premiums and meet other eligibility requirements.*

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of New Mexico who cannot afford to buy health insurance. Medicaid offers free or subsidized health insurance coverage, direct medical services and 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.

MEDICAID

Medicaid is a program that provides health coverage to some low-income New Mexico residents. Medicaid covers families with children and pregnant women, the elderly, and people with disabilities, if state and federal guidelines are met. Legal residents who are not U.S. citizens may be eligible for Medicaid. Non-citizens who do not have immigration documents cannot enroll in Medicaid, but may be covered if treated for an emergency condition.

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

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

Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account, so you should contact the New Mexico Human Services Department, Income Support Division for more information.

Low income persons eligible for Medicaid in New Mexico*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Child 0-19	235% (monthly income of about \$3,069 for family of 3)
Pregnant woman	185%
Working parents	71%
Non-working parents	31%

* 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>U.S. Poverty Guideline</u> (annual income)
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, 235% of the federal poverty level for a family of 3 would be an annual income of \$36,825, or a monthly income of \$3,069.

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

- *Parents who receive benefits under **TANF (also known as NM Works)** should know that when you get a job and your TANF benefits end, you generally can stay on Medicaid for a 12-month transitional period.*

In addition, your children may continue to qualify for Medicaid if your family's income meets certain income standards.

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

Disabled individuals should know that if your income earned from a job increases so that you no longer qualify for SSI, you may be able to continue your Medicaid coverage at least for a limited time.

- *People who are 65 and over and who have low incomes and are enrolled in Medicare may also qualify for help from Medicaid.* Even though your income may be too high to qualify for Medicaid insurance coverage, there may be other ways Medicaid can help you.

If your household income is below the poverty level, Medicaid will pay your Medicare monthly premium and your Medicare deductibles and coinsurance. This is called the Qualified Medicare Beneficiary (QMB) program.

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

Contact the Human Services Department, Income Support Division for more information about other eligibility requirements.

- *There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify for Medicaid, contact the Human Services Department, Medical Assistance Division.

NEW MEXI KIDS

New Mexi Kids provides health coverage to low-income New Mexico children under the age of 19 who are not eligible for Medicaid and who have no health insurance.

- *A child whose family has a household income below 185% of the federal poverty level is eligible for New Mexi Kids at no cost.* For a family of three, this work out to an annual income of about \$28,990, or a monthly income of about \$2,416.
- *A child whose family has a household income between 185% and 235% of the federal poverty level is eligible for New Mexi Kids and may be required to make co-payments.*
- *Some of the benefits include doctor visits, hospital care, prescriptions, and vision and dental care.*
- *You can apply for New Mexi Kids at most clinics, hospitals, primary care providers, and schools.* You can also visit your local Income Support Division office or you can call the New Mexi Kids at (888) 997-2583 for more information.

BREAST AND CERVICAL CANCER TREATMENT PROGRAM

- *Women who are diagnosed with breast or cervical cancer or a precancerous condition through the New Mexico Breast and Cervical Cancer Early Detection Program (BCC) can apply for full healthcare coverage through Medicaid, which will cover the costs of treatment. For more information about eligibility, contact BCC at (505) 841-3896.*
- *Women who do not qualify for Medicaid coverage can get financial assistance through other programs, including the Anita Salas Memorial Fund. Call (505) 841-5896 for more information about this program.*

THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)

A federal income tax credit is available to help certain trade dislocated workers and early retirees, and their dependents, buy qualified health insurance coverage. The Health Coverage Tax Credit (HCTC) covers 65% of the insurance premium for qualified coverage. Under this program, you can either claim the tax credit at the end of the year on your tax return or you can elect to have the money paid directly to your qualified health plan each month by the Internal Revenue Service.

WHEN AM I ELIGIBLE FOR THE HCTC?

- *To be eligible for the tax credit, you must be receiving Trade Adjustment Assistance (TAA) benefits or retirement benefits from the PBGC. If you are receiving PBGC benefits, you also must be at least 55 years old.*
- *In addition, you must meet other requirements. Specifically, you are not eligible for the HCTC if any of the following apply to you:*

You have a health plan maintained by an employer or former employer that pays at least 50% of the cost of your coverage. Any share of your premium that is paid by you or your spouse on a pre-tax basis is considered to have been paid by your employer and must be included as such when determining the percentage of employer coverage.

You are enrolled in Medicare (Part A or B).

You are enrolled in the Federal Employees Health Benefits Program (FEHBP), Medicaid, or State Children's Health Insurance Program (SCHIP).

You are entitled to health coverage through the U.S. military health system (Tricare/CHAMPUS).

You can be claimed as a dependent on someone else's federal tax return.

You received a lump sum payment of your entire PBGC benefit before August 6, 2002.

As of the first day of the current month in which you are otherwise eligible, you are imprisoned under a federal, state or local authority.

- *HCTC may apply to your family, too.* If you are eligible, you can use the credit to help purchase qualified health coverage for your qualified family members. Qualified family members are your spouse and dependents that you can claim on your federal tax return. Family members are not eligible if they are enrolled in another group health plan where the employer pays at least 50% of the cost of coverage, or in Medicaid, SCHIP, FEHBP, Tricare/CHAMPUS.
- *Eligibility for HCTC is not based on income.* In addition, the HCTC is refundable. This means you can claim the credit even if you do not earn enough 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>New Mexico Division of Insurance</i> (800) 947-4722 (New Mexico calls only) (505) 827-4601 http://www.nmprc.state.nm.us/insurance/inshm.htm
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor, Dallas Regional Office</i> (214) 767-6831, or <i>U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C.</i> (202) 219-8776 <i>For Department of Labor publications:</i> (800) 998-7542 http://www.dol.gov/dol/pwba
New Mexico Health Insurance Alliance	(505) 989-1600, or (800) 204-4700, or write to P.O. Box 5095 Santa Fe, NM 87502-5095 http://www.nmhia.com/
New Mexico Medical Insurance Pool (NMMIP)	<i>Call Blue Cross and Blue Shield of New Mexico</i> (505) 816-4248, or (800) 432-0750 option #4, or write to P.O. Box 27630 Albuquerque, NM 87125-7630 http://www.nmmip.com/
Medicaid New Mexi kids	<i>New Mexico Human Services Department, Medical Assistance Division</i> (505) 827-3100 (888) 997-2583 http://www.state.nm.us/hsd/mad/Index.html
Breast and Cervical Cancer Early Detection Program	<i>New Mexico Department of Health, Cancer Programs</i> (877) 852-2585 http://www.cancernm.org/

For questions about:	Contact:
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 TERMS

Affiliation Period. The time an HMO may require you to wait after you enroll and before your group coverage begins. HMOs that require an affiliation period cannot exclude coverage of pre-existing conditions. Premiums cannot be charged during HMO affiliation periods. See also HMO.

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

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

COBRA. Stands for the Consolidated Omnibus Budget Reconciliation Act, a federal law in effect since 1986. COBRA permits you and your dependents to continue in your employer's group health plan after your job ends. If your employer has 20 or more employees, you may be eligible for COBRA continuation coverage when you retire, quit, are fired, or work reduced hours. Continuation coverage also extends to surviving, divorced or separated spouses; dependent children; and children who lose their dependent status under their parent's plan rules. You may choose to continue in the group health plan for a limited time and pay the full premium (including the share your employer used to pay on your behalf). 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 consecutive days. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. Federal rules apply to you in group health plans and, if you are HIPAA eligible, when you buy a health plan through the New Mexico Medical Insurance Pool (NMMIP) or the New Mexico Health Insurance Alliance. Under New Mexico rules, coverage is continuous if not interrupted by a break of 31 consecutive days. New Mexico rules apply when you are buying individual health insurance or coverage through the NMMIP and you are not HIPAA eligible. See also Creditable Coverage, HIPAA Eligible.

Conversion Policy. Your right, when leaving a group health plan in New Mexico, to convert your policy to a similar individual health insurance. While conversion policies must offer coverage similar to your former plan, they can be significantly more expensive. See also Group Health Plan.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; individual health insurance; Medicare; Medicaid; CHAMPUS/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, as well as certain coverage under state program. See also Continuous Coverage, Group Health Plan, Individual Health Insurance.

Elimination Rider. An amendment permitted in individual health insurance contracts that permanently excludes your coverage for a health condition, body part, or body system. Elimination riders are permitted in New Mexico.

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

HIPAA Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. Under federal law, to be HIPAA eligible you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. 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 New Mexico, you are guaranteed the right to buy coverage through the New Mexico Medical Insurance Pool (NMMIP) or the New Mexico Health Insurance Alliance if you are HIPAA eligible. See also NMMIP, New Mexico Health Insurance Alliance, COBRA, Continuous Coverage, Creditable Coverage.

HMO. Health maintenance organization. A kind of health insurance plan. HMOs usually limit coverage to care from doctors who work for or contract with the HMO. They generally do not require deductibles, but often do charge a small fee, called a copayment, for services like doctor visits or prescriptions. If you are covered under a group policy through an HMO, the HMO might require an affiliation period before coverage begins. See also Affiliation Period.

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

Individual Health Insurance. Policies for people not connected to an employer group. Individual health insurance are regulated by the state of New Mexico.

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. See also Pre-existing Condition.

Managed Care Plans. A kind of health insurance plan. Like an HMO, managed care plans can limit coverage to health care provided by doctors or hospitals who work for or contract with them—also called "network" providers—and therefore may limit enrollment to those people who live within a particular coverage area. Managed care plan may 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 cover your care at a lower rate if you go to a non-network provider or if you get specialty care without a referral. See also HMO.

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

Modified Community Rating. A requirement in the New Mexico Health Insurance Alliance that plans charge the same premium to all small groups, regardless of health status. Premiums can vary, within limits, due to age, gender, and family size of the members of the group and geographic location of the business. Individual health insurance premiums in the Alliance also are subject to modified community rating.

New Mexi kids. New Mexi kids provides health coverage to low-income children under the age of 19 who are not eligible for Medicaid and who have limited or no health insurance.

New Mexico Health Insurance Alliance. A not for profit, independent, public corporation created for the purpose of providing increased access to health insurance for small employers in the state. All insurance companies licensed to sell health insurance in the state are required to be members of the Alliance. Approved health plans are available to certain eligible small groups and individuals.

NMMIP. New Mexico Medical Insurance Pool, the state-run insurance program for HIPAA eligible persons and for people with high health risks (called a high risk pool).

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 (Group Health Plans). Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan. Pregnancy cannot be counted as a pre-existing condition. Genetic information about your likelihood of developing a disease or condition, without a diagnosis of that disease or condition, cannot be considered a pre-existing condition. Newborns, newly adopted children, and children placed for adoption covered within 31 days cannot be subject to pre-existing condition exclusions.

Pre-existing Condition (Individual Health Insurance). Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period preceding enrollment in a health plan, or for which an ordinarily prudent person would have sought medical advice, care or treatment. In New Mexico, under individual health insurance policies, pregnancy can be counted as a pre-existing condition, but genetic information cannot. See also Prudent Person Rule.

Pre-existing Condition Exclusion Period. The time during which a health plan will not pay for covered care relating to a pre-existing condition. See also Pre-existing Condition.

Prudent Person Rule. In individual health insurance and New Mexico Medical Insurance Pool, a rule that permits insurers to exclude as pre-existing any condition for which – in the insurer's judgment – most people would have sought care or treatment prior to enrolling in individual health insurance.

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 New Mexico.

Small Group Health Plan. Plans with at least 2 but not more than 50 employees.

Special Enrollment Period. A time, triggered by certain specific events, during which you and your dependents must be permitted to sign up for coverage under a group health plan. Employers and group health insurers must make such a period available to employees and their dependents when their family status changes or when their health insurance status changes. Special enrollment periods must last at least 31 days for fully insured plans and 30 days for self-insured plans. 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 New Mexico, if you are in a fully insured group health plan sponsored by an employer with 2 to 19 employees, you also have rights to continue your health coverage for 6 months when your job ends. State continuation coverage also extends to surviving, divorced or separated spouses in fully insured group or individual health insurance. See also COBRA.

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

Temporary Assistance for Needy Families (TANF). A program that provides cash benefits to low income families with children. When you qualify for TANF, you generally also qualify for Medicaid. In addition, Medicaid coverage often continues for a limited time if you no longer qualify for TANF. See also Medicaid.

Trade Adjustment Assistance (TAA) Program. A program authorized by the Trade Adjustment Assistance Reform Act of 2002. This program provides aid to workers who lose their job or whose hours of work and wages are reduced as a result of increased imports. The TAA Program offers six benefits and reemployment services to assist unemployed workers prepare for and obtain new suitable employment. In addition, TAA offers a significant tax credit that covers 65% of health insurance premiums for certain plans.

U.S. Department of Labor. A department of the federal government that regulates employer provided health benefit plans. You may need to contact the Department of Labor if you are in a self-insured group health plan, or if you have questions about COBRA or the Family and Medical Leave Act. See also COBRA, Family and Medical Leave Act.

Waiting Period. The time you may be required to work for an employer before you are eligible for health benefits. Not all employers require waiting periods. Waiting periods do not count as gaps in health insurance for purposes of determining whether coverage is continuous. If your employer requires a waiting period, your pre-existing condition exclusion period begins on the first day of the waiting period. See also Pre-existing Condition Exclusion Period.