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

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

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

As a Rhode Island 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 Rhode Island resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group and individual health plans. Chapter 4 highlights your protections as a small employer. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from Rhode Island, your protections may change. Since this guide is a summary, it may not answer all of your questions. For places to contact for more information, see page 32. For information about how to find consumer guides for other states on the Internet, see page 33. A list of helpful terms and their definitions begins on page 34. These terms are in **boldface type** the first time they appear.

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CHAPTER 1
A SUMMARY OF YOUR PROTECTIONS

Numerous state and federal laws make it easier for people with **pre-existing condition**s 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 policies)**, so your protections may vary if you leave Rhode Island. Rhode Island has expanded protections for certain kinds of health insurance beyond what federal law requires. 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 Rhode Island resident.

HOW AM I PROTECTED?

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

- *Coverage under your* **group health plan** *(if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status.* This is called **nondiscrimination**. (See page 6.)

- *All group health plans in Rhode Island must limit exclusion of pre-existing conditions.* There are rules about what counts as a pre-existing condition and how long you must wait before a new health plan will begin to pay for care for that condition. Generally, if you join a new plan your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage. (See pages 8 and 9.)

- *Your health insurance cannot be canceled because you get sick.* Most health insurance is **guaranteed renewable**. (See pages 16 and 22.)

- *If you leave your job, you may be able to remain in your old group health plan for a certain length of time.* This is called **COBRA** or **state continuation coverage**. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage. (See page 16.)

- *If you lose your coverage under a fully insured group health insurance plan and meet other qualifications, you are guaranteed the right to buy a* **conversion policy**. You will not face a new pre-existing condition exclusion period. (See page 21.)

- *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*. This is called **guaranteed issue**. (See page 23.)

- *If you are a small employer buying a group health plan, there are limits on how much your premiums can vary due to the health status, age, and other characteristics of those in your group*. However, you can be charged significantly higher premiums due to these factors. (See page 23.)

- *if you are self-employed, your rights regarding health insurance are generally the same as all other small employers in Rhode Island.* (See page 23.)

- *If you have had at least 12 months of prior health coverage with no gap***,** *regardless of your health status or any other factor, you cannot be turned down for individual health insurance.* You will not face a pre-existing exclusion period for services covered under your prior health plan. (See page 15.)

- *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 Rhode Island **Medicaid** program, also called the Medical Assistance Program, offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes. In addition, if you have access to health insurance through your job but cannot afford to pay for it, Medicaid might be able to help. (See page 25.)

- *If you believe that you may be at risk for cancer, you may be eligible for free screening and treatment.* The **Rhode Island Cancer Screening Program** provides free cancer screening for qualified residents. Some women diagnosed with breast or cervical cancer through this program may be eligible for medical care through Medicaid. (See page 28.)

- *If you lost your health insurance and are receiving benefits from the* ***Trade Adjustment Assistance (TAA) Program****, you may be eligible for a federal income tax credit to help you pay for new health coverage.* This credit is called the **Health Coverage Tax Credit (HCTC)**, and is equal to 65% of the cost of qualified coverage, including COBRA. (See page 29.)

- *If you are a retiree aged 55-65 and receiving benefits from* ***Pension Benefit Guarantee Corporation*** *(PBGC), then you may be eligible for the HCTC* *(See page 29).*

WHAT ARE THE LIMITS ON MY PROTECTIONS?

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

- *If you change jobs, you usually cannot take your old health benefits with you*. Except when you exercise your federal COBRA or state continuation rights, you are not entitled to take your actual group health coverage with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did.

- *If you change jobs, your new employer may not offer you health benefits*. Employers are required only to make sure that their decision is based on factors unrelated to your **health status**. (See page 6.)

- *If you get a new job with health benefits, your coverage may not start right away*. Employers and health maintenance organizations (**HMO's**) can require **waiting periods** before your health benefits begin. (See page 7.)

- *If you have a break in coverage, you may have to satisfy a new pre-existing condition exclusion period when you join a new group health plan*. (See pages 8.)

- *Even if your coverage is continuous, there may be a pre-existing condition exclusion period for some benefits if you join a group health plan that covers benefits your old plan did not*. For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition. (See page 10.)

- *In Rhode Island, unless you have had at least one year of prior health plan coverage, private insurers can refuse to sell you **individual health insurance** because of your health status*. (See page 13.)

- *Even if you are* **HIPAA eligible** *or have one year of prior health plan coverage, you can be turned down for some individual health polices*. The law permits insurance companies to limit your choices to two plans, which are suppose to be comparable to others they sell in the individual market in Rhode Island. (See page 13.)

- *The law does not limit what you can be charged for individual health insurance*. You can be charged substantially higher premiums because of your health status, age, gender, and other characteristics. (See page 15.)

- *If you move away from Rhode Island, you may not be able to buy individual health insurance in another state unless you are HIPAA eligible*.

CHAPTER 2
YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

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

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

- *You have to be eligible for the group health plan*. For example, your employer may not give health benefits to all employees. Or, your employer may offer an HMO plan that you cannot join because you live outside of the plan's service area.

- *You cannot be turned away or charged more because of your health status.* Health status means your medical condition or history, **genetic information** or disability. This protection is called **nondiscrimination**. Employers may refuse or restrict coverage for other reasons (such as part time employment), as long as these are unrelated to health status and applied consistently.

Discrimination due to health status is not permitted

The Acme Company 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 Rhode Island law, newborns and adopted children are automatically covered under their parents' fully insured health plan for the first 31 days after birth or the start of the adoption bonding period*. The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.

- *Under Rhode Island law, adult dependents who are physically disabled or mentally retarded are able to stay on their parents' fully insured group health after they have reached the age at which the plan usually cancels dependent coverage*. In order to be eligible, the adult dependent must be incapable of self-support and must be dependent on the policyholder for support.

- *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage*. These waiting periods, however, must be applied consistently and cannot vary due to your health status. Unlike employers, insurance companies cannot require waiting periods.

- *When you begin a new job with health insurance through an HMO, the HMO may require an affiliation 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 it.

- *If you have to take leave from your job due to illness, the birth or adoption of a child, or to care for a seriously ill family member, you may be able to keep your group health coverage for a limited time*. A federal law known as the **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job-protected leave in these circumstances. The FMLA applies to you if you work at a company with 50 or more employees.

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

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

- *A group health plan can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan*. This period is also called the look back period.

- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns or newly adopted children, children placed for adoption, or genetic information*.

- *If your pre-existing condition is newly diagnosed and you are entering a small group plan, you may have greater protections against a pre-existing condition exclusion period.* **Small group plans** cannot apply a pre-existing exclusion period against a medical condition if that condition was identified for the first time during your prior **continuous coverage**, even if you were covered for less than 6 months.

- *Pre-existing conditions can be excluded for different periods of time depending on the size of the group plan.*

  Under fully insured **small group health plan**s, coverage for pre-existing conditions can be excluded for no longer than 6 months when you join the plan as a regular or special enrollee. However, if you enroll late in a small group health plan (after you are hired and not during a regular or special enrollment period), you may have a 12-month pre-existing condition exclusion period.

Under self-insured group plans and fully insured large group plans, coverage for pre-existing conditions can be excluded for no longer than 12 months when you join the plan as a regular or special enrollee. However, if you enroll late, you may have a longer exclusion period. Large group plans can impose an18 month pre-existing exclusion period on late enrollees.

The maximum pre-existing condition exclusion period varies.

Health plan type	Maximum exclusion period
Fully insured small group (regular enrollee)	6 months
Fully insured small group (late enrollee)	12 months
Fully insured large group (regular enrollee)	12 months
Fully insured large group (late enrollee)	18 months
Self-insured group health plan (regular enrollee)	12 months
Self-insured group health plan (late enrollee)	18 months

- *If you join a new group health plan, the law protects you from a new pre-existing condition exclusion period, provided you maintain continuous* **creditable coverage**.

What is creditable coverage in the group market?

Most health insurance counts as creditable coverage, including:

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

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.

- *The definition of continuous coverage varies depending if you are enrolling in a small group health plan or a large group health plan.*

If you are enrolling in a fully insured small group plan then prior coverage is counted as continuous if it is not interrupted by a break of 90 or more days in a row.

If you are enrolling in a large group health plan or self-insured group health plan, prior coverage is counted as continuous if it is not interrupted by a lapse of 63 days or more in a row.

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 let your coverage lapse for a long time.

Art, who has diabetes, worked for Ajax Company and was covered under its group health plan for 18 months. He lost his job and was without coverage for 75 days. Fortunately, on the 76th day after leaving Ajax, Art found a new job at a small company called Beta Corporation. He enrolled immediately in Beta's fully insured small group health plan, which covers diabetes but imposes pre-existing condition exclusion periods. In Rhode Island, fully insured small group health plans count as continuous all creditable coverage that is not interrupted by a lapse of more than 90 days. Therefore, because Art's lapse in coverage was less than 90 days, Beta's fully insured plan will credit his coverage at Ajax against any exclusion period. Beta's plan will begin paying for Art's diabetes care immediately.

Now consider a slightly different situation. Assume Beta Corporation's group health plan is self-insured. Self-insured plans must count as continuous all creditable coverage that is not interrupted by a break of 63 or more consecutive days. Therefore, in this case, Art's prior coverage at Ajax will not be credited toward any exclusion period because it was followed by a break greater than 63 days. Beta's plan will begin paying for Art's diabetes care at the end of his pre-existing condition exclusion period.

- *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 decide to measure

your prior **credible coverage** in this way must notify you when you join the plan and use this approach for everyone.

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 group 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, Sue's new 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 preexisting.

- *No pre-existing condition exclusion period can be applied without appropriate notice.* Your group health plan must inform you, in writing, if it intends to impose such a period. Also, if needed, it must help you get a **certificate of creditable coverage** from your old health plan.

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

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

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

AS YOU ARE LEAVING GROUP COVERAGE…

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

- *If you lost your health insurance and are receiving benefits from the Trade Adjustment Assistance (TAA) Program, you may be eligible for a federal income tax credit to help you pay for new health coverage.* This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 65% of the cost of qualified coverage, including COBRA. (See page 29).

- *If you are a retiree aged 55-65 and receiving benefits from* ***Pension Benefit Guarantee Corporation (PBGC)****, then you may be eligible for the HCTC* *(See page 29).*

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group insurance, you may want to buy an individual health policy from a private health insurance company. However, in Rhode Island – as in most other states – you have limited guaranteed access to individual health insurance. There are some alternatives to individual health insurance coverage – such as COBRA and state continuation coverage and conversion coverage. This chapter summarizes your protections under different kinds of health plan coverage.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

WHEN DO INDIVIDUAL HEALTH INSURERS HAVE TO SELL ME INSURACE?

In Rhode Island, your ability to buy individual health insurance may depend on your health status. There are certain circumstances, however, when you must be allowed to buy an individual health insurance policy.

- *In general, companies that sell individual health insurance in Rhode Island are free to turn you down because of your health status and other factors when you are uninsured*. 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 you coverage or offer to sell you a policy that has special limitations on what it covers.

- *If you have 12 months of prior creditable coverage with no gap or if you are HIPAA eligible, all insurance companies that sell individual health insurance must offer you a choice of at least two plans.* You cannot be turned down because of your health status.

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible you are guaranteed the right to buy an individual health plan 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. (Note, creditable coverage for purposes of federal law is somewhat different from Rhode Island law. Consult the consumer guide for the state you are moving to for more information.)
- You also must have used up any COBRA or state continuation coverage for which you were eligible.
- You must not be eligible for Medicare, Medicaid or a group health plan.
- You must not have health insurance. (Note, however, if you know your group coverage is about to end, you can apply for coverage for which you *will* be HIPAA eligible.)
- You must apply for health insurance for which you are HIPAA eligible within 63 days of losing your prior coverage.

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

In Rhode Island, you do not need to meet all of these requirements in order to have protections when buying individual coverage. If you plan on leaving Rhode Island, you may need to be HIPAA eligible to be guaranteed the right to buy individual health insurance in another state.
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- *Under Rhode Island law, newborns and adopted children are automatically covered under their parents' individual health plan for the first 31 days after birth or the start of the adoption bonding period*. The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days

- *Under Rhode Island law, adult dependents who are physically disabled or mentally retarded are, at the option of the insured, able to stay on their parents' fully insured group health plan or be issued a separate conversion policy after they have reached the age at which the plan usually cancels dependent coverage*. In order to be eligible, the adult dependent must be incapable of self-support and must be dependent on the policyholder for support. Proof of incapacity must be provided to the insurer within 31 days of reaching the limiting age.

WHAT WILL MY INDIVIDUAL HEALTH ISURANCE POLICY COVER?

- *It depends on what you buy.* Health insurance companies design policies and you will have to read and compare them carefully. However, Rhode Island does require all health plans to cover certain benefits – such as treatment for diabetes and post-delivery hospital stays. Check with the Rhode Island Insurance Division for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you buy an individual policy on a guaranteed issue basis either because you have 12 months of prior continuous coverage or are HIPAA eligible, you will not face a pre-existing condition exclusion period.*

- *If your policy is not guaranteed issue, there are different ways that individual health insurance can exclude a pre-existing condition.*

  The insurer can impose an **elimination rider**, which is an amendment to your health insurance contract that permanently excludes coverage for a health condition, body part, or body system. The policy can also include a 12-month pre-existing condition period on any pre-existing condition.

  Pre-existing conditions are any conditions for which you received medical advice, care or diagnosis in the last 36 months. In addition, insurers can count any condition for which the plan believes most people would have sought care. This is called the **prudent person rule.** If you make a claim for treatment of a condition during the first year of coverage under our individual policy, your insurance may investigate your medical records for evidence that the condition was pre-existing.

  In Rhode Island, pregnancy can be considered a pre-existing condition in individual health plans. However, genetic information cannot be considered a pre-existing condition in the absence of a diagnosis.

- *Blue Cross & Blue Shield of Rhode Island typically imposes shorter preexisting condition exclusions or does not impose them at all.*

WHAT CAN I BE CHARGED FOR AN INDIVIDUAL HEALTH INSURANCE POLICY?

- *Generally, in Rhode Island, there are no limits on how much individual premiums can vary due to age, gender, health status, family size and other factors, then policies are first issued or at renewal.*

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELLED?

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

- *Some insurance companies sell short-term (or temporary) health insurance policies.* Short-term policies are *not* guaranteed renewable. They will only cover you for a limited time, such as 6 months. If you want to renew coverage under a short-term policy after it expires, you will have to reapply and there is no guarantee that coverage will be re-issued at all or at the same price. If you purchase a short-term policy, you should keep in mind that it will not count for purposes of guaranteed issue if it was the last policy you had.

COBRA AND STATE CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

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

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

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

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

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

COBRA QUALIFYING EVENTS

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

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

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

- *Each person who is eligible for COBRA continuation can make their own decision*. If your dependents were covered under your employer plan, they may independently elect COBRA coverage as well.

- *You must be notified of your COBRA rights when you join the group health plan, and again if you qualify for COBRA coverage*. The notice rules are somewhat complicated and you should contact the U.S. Department of Labor for more information.

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

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

SPECIAL SECOND CHANCE TO ELECT COBRA FOR TRADE-DISLOCATED WORKERS

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

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

WHAT WILL COBRA COVER?

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

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage*. The first premium must be paid within 45 days of electing COBRA coverage.

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

- *If you lost your group health insurance and are receiving benefits from the Trade Adjustment Assistance (TAA) Program, you may be eligible for a federal income tax credit to help you pay for COBRA coverage.* This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 65% of the cost of qualified coverage, including COBRA (see page 29).

- *If you are a retiree aged 55-65 and receiving benefits from Pension Benefit Guarantee Corporation (PBGC), then you may be eligible for the HCTC* (see page 29).

HOW LONG DOES COBRA COVERAGE LAST?

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

HOW LONG CAN COBRA COVERAGE LAST?		
Qualifying event(s)	*Eligible person(s)*	*Coverage*
Termination Reduced hours	Employee Spouse Dependent child	18 months *
Employee enrolls in Medicare Divorce or legal separation Death of covered employee	Spouse Dependent child	36 months
Loss of "dependent child" status	Dependent child	36 months

* Certain disabled persons and their eligible family members can extend coverage an additional 11 months, for a total of up to 29 months.

- *Usually, COBRA continuation coverage ends when you join a new health plan.* However, if your new plan has a waiting period or a pre-existing condition exclusion period, you can keep whatever COBRA continuation coverage you have left during that period. For specifics, ask your former employer or contact the U.S. Department of Labor.

- *COBRA coverage also ends if your employer stops offering health benefits to other employees.*

- *COBRA coverage might end if you are in a managed care plan that is available only to people living in a limited geographic area and you move out of that area.* However, if you are eligible for COBRA and are moving out of your current health plan's service area, your employer must provide you with the opportunity to switch to a different plan, but only if the employer already offers other plans to its employees. Examples of the other plans your employer may offer you are a managed care plan whose service area includes the area you are moving to, or another plan that does not have a limited service area.

WHAT ABOUT RHODE ISLAND CONTINUATION COVERAGE?

- *If your employer offers fully insured health benefits, in certain circumstances you may also be eligible for up to 18 months of continuation coverage under a Rhode Island law that is similar to, but narrower than, COBRA.*

  You are eligible for state continuation coverage in a limited number of situations: if you were laid off involuntarily; if you are the spouse or dependent of an employee

who died; if your workplace ceased to exist; or if your employer's workforce was permanently reduced.

Ask your former employer or the Rhode Island Insurance Division about state continuation coverage if you think that it applies to you.

CONVERSION

WHEN DO I HAVE TO BE OFFERED A CONVERSION POLICY?

- *In Rhode Island, if you have had coverage through a fully insured group health plan for at least 3 months and you leave that job, you are eligible to buy a conversion policy*. This is an individual policy you get from the company that insured your employer's group plan. To qualify, though, you must first have used up any COBRA or state continuation coverage. You can buy a conversion policy without regard to health status.

WHAT WILL A CONVERSION POLICY COVER?

- *Insurers must offer you the choice of a variety of conversion policies.* The benefits under a conversion policy will probably not be the same as those under your former plan.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

WHAT CAN I BE CHARGED FOR A CONVERSION POLICY?

- *A conversion policy will be more costly than your former plan.* Premiums will vary depending on your health status and may be high if you have a pre-existing condition. Also, your premiums also can vary depending other characteristics such as age and gender.

  Contact the Rhode Island Insurance Division if you have questions about your conversion policy premium.

CAN MY CONVERSION POLICY BE CANCELLED?

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

CHAPTER 4
YOUR PROTECTIONS AS A SMALL EMPLOYER OR SELF-EMPLOYED PERSON

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. Rhode Island has enacted reforms to expand some of these protections. Generally, small employers are those that employ 1-50 employees. Please note that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Rhode Island Insurance Division to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down.* This is called guaranteed issue. If you employ not more than 50 people, health insurance companies must sell you any small group health plan they sell to other small employers. However, they can require that a minimum percentage of your workers participate in your group health plan. They can also require you to contribute a minimum percentage of your workers' premiums. If you are buying a **large group health plan** for 51 or more employees, your group can be turned down.

- *Your insurance cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans of all sizes. However, insurers can impose other conditions. 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. If insurers discontinue an insurance product that you bought, they must give you a chance to buy other plans they sell to groups of your size.

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

- *Within limits, you can be charged higher premiums based on the health status of those in your group.* For small employers, Rhode Island limits how much your premiums can vary due to health status and family composition.

  You can also be charged more for the age and gender of persons in your group. In addition, there are limits on the annual increases that can be charged. For groups with more than 50 eligible employees, Rhode Island does not limit premium variation or increases. If you have questions about the premiums you have been charged, contact the Rhode Island Insurance Division.

WHAT IF I AM SELF EMPLOYED?

- *If you are self-employed with no other workers, you are eligible to buy a small group health plan on your own*. However, insurers may require proof that you are self-employed.
- *If you are self-employed and buy your own health insurance, you are eligible to deduct 100% of the cost of your premium from your federal income tax*.

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of *Rhode Island* who cannot afford to buy health insurance. Medicaid**, Rhode Island Cancer Screening Program** and other programs offer free or subsidized health insurance coverage, direct medical services or other help. This chapter provides summary information about these programs and contact information for further assistance.

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

MEDICAID (MEDICAL ASSISTANCE PROGRAM)

Medicaid, also called the Medical Assistance Program, is a program that provides health coverage to some low-income *Rhode Island* residents. Medicaid covers families with children and pregnant women, the elderly, and people with disabilities, if state and federal guidelines are met. Certain legal residents who are not U.S. citizens may be eligible for Medicaid. For children and families, Medicaid offers 2 special programs called **RIte Care** and **RIte Share**.

RITE CARE

RIte Care is Rhode Island's Medicaid managed care program that provides families on the Family Independence Program and eligible uninsured pregnant women, parents, and children up to age 19 with comprehensive health insurance coverage.

- *Families who are eligible for or receiving cash assistance from Family Independence Program (or TANF), are eligible for RIte Care.*

  Parents should know that when you get a job and your TANF and/or Low Income Families Medicaid benefits end, your family generally could stay on Medicaid for a 18-month transitional period.

  In addition, your children may qualify for RIte Care if your family's income meets certain income standards.

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

Income eligibility levels for these categories are described below. You should contact the Rhode Island Department of Human Services for more information.

Low income persons eligible for RIte Care in Rhode Island*

Category	Income eligibility (as percent of federal poverty level)
Child 0-18	up to 250% (250% of FPL is $37,550 for a family of 3)
Family coverage	up to 185%
Pregnant woman	up to 250%
Medically needy	
Individual	up to 87%
Couple	up to 69%

* Eligibility information was compiled from the Rhode Island DHS website and may have changed since this guide was published. Contact your local DHS office 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:

Size of Family Unit	Poverty Guideline (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, 250% of the federal poverty level for a family of 3 would be an annual income of $39,175, or a monthly income of $3,265.

Contact the Rhode Island DHS for the most up to date information and for other eligibility requirements that may apply.

- *Families receive most of their health care through one of three participating health plans: Neighborhood Health Plan of Rhode Island, United Healthcare of New England and Blue CHIP.*
- *RIte Care coverage is free to families with incomes up to 150% of the federal poverty level, and is available to other eligible families with higher income for a small premium.* Depending on their income, families pay between $61 and $92 per month.

RIte Share: MEDICAID

RIte Share is a Medicaid program that helps families get health insurance coverage through their employer (or spouse's employer). If a family qualifies, RIte Share will pay for all or part of the employee's share of the group health insurance premium. RIte Share also pays for co-payments in the employer's health insurance plan.

- *Eligibility for RIte Share is the same as RIte Care.* It is based on family income and family size.
- *If an applicant is eligible for Medicaid and their employer (or spouse's employer) offers a DHS-approved health insurance plan, then the applicant will be enrolled in RIte Share.*
- *RIte Care coverage is free to families with incomes up to 150% of the federal poverty level, and is available to other eligible families with higher income for a small premium.* Depending on their income, families pay between $61 and $92 per month.

MEDICAID FOR OTHER RHODE ISLAND RESIDENTS

- *Elderly or disabled people who get* **Supplemental Security Income (SSI**) *benefits can also qualify for Medicaid*.

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

- *People who have high medical expenses may also qualify for Medicaid.* You may qualify as medically needy if you are a child, parent of a dependent child, pregnant, elderly, or disabled and have high medical expenses that, when subtracted from your income, would make you eligible for Medicaid coverage. For example, people who have to pay a lot for prescription drugs, nursing home care, or other long term care services sometimes qualify as medically needy if they do not have health insurance that covers these services.
- *Retired or disabled people who have low incomes and are enrolled in Medicare may also qualify for help from Medicaid.* Even though your income may be too high to qualify for Medicaid insurance coverage, there may be other ways Medicaid can help you.

If your household income is below the poverty level and your resources, such as savings, are less than $4,000, 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 and your resources, such as savings, are less than $4,000, Medicaid will pay for your monthly Medicare premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

If your household income is below 135% of the federal poverty level and your resources, such as savings, are less than $4,000, Medicaid will pay your monthly Medicare premiums only. This is called the Qualifying Individuals-1 (QI-1) program.

If your household income is between 135% and 175% of the federal poverty level and if your resources are less than $4,000, Medicaid may pay a small amount to offset the cost of your Medicare premiums. This is called the Qualifying Individuals-2 (QI-2) program.

If your income is less than 200% of the federal poverty level and you are working, Medicare may pay your Medicare Part A premium. This is called the Qualified Disabled and Working Individuals (QDWI) program.

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

  To obtain the locations and telephone numbers of the Department of Human Services offices near you, call (401) 462-5300.

RHODE ISLAND CANCER SCREENING PROGRAM

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

- *The Rhode Island Cancer Screening Program provides qualified woman with free screenings for breast and cervical cancer.* Women screened through this program and diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid which extends throughout the duration of treatment.

- *In order to be eligible for screening through the Rhode Island Cancer Screening Program, you must income guidelines and insurance requirements*. You must have an income at or below 250% of the federal poverty level (FPL), be uninsured or underinsured. In addition, you may have to meet certain age requirements.
- *For more information, please contact the Rhode Island Cancer Screening Program at 1-401-222-6843 or* http://www.health.ri.gov/disease/cancer/women-screening.php

OTHER STATE PROGRAMS

There may be other financial assistance programs available. Please contact the Rhode Island Department of Human Services at 1-401-462-5300 or http://www.dhs.state.ri.us/index.htm

THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)

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

WHEN AM I ELIGIBLE FOR THE HCTC?

- *To be eligible for the tax credit, you must be receiving Trade Adjustment Assistance (TAA) benefits or retirement benefits from the PBGC.* If you are receiving PBGC benefits, you also must be at least 55 years old.
- *In addition, you must meet other requirements*. Specifically, you are not eligible for the HCTC if any of the following apply to you:
- *You have a health plan maintained by an employer or former employer that pays at least 50% of the cost of your coverage*. Any share of your premium that is paid by you or your spouse on a pre-tax basis is considered to have been paid by your employer and must be included as such when determining the percentage of employer coverage.
- *You are enrolled in Medicare (Part A or B).*
- *You are enrolled in the Federal Employees Health Benefits Program (FEHBP), Medicaid, or State Children's Health Insurance Program (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 COST WILL THE TAX CREDIT COVER?

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

WHAT HEALTH COVERAGE IS ELIGIBLE FOR THE TAX CREDIT?

- *The HCTC can only be used to help pay for "qualified" health coverage*. Qualified health coverage includes:

- *COBRA continuation coverage, as long as your employer or former employer contributes less than 50% of the total health plan premium.*

- *Individual heath insurance in which you were enrolled for at least the last 30 days before you were separated from the job that makes you eligible for TAA benefits or for payments from the PBGC.*

- *Your husband's or wife's insurance from work, as long as the employer contributes less than 50% of the total health plan premium*. **(**At this time, you can only claim the credit with this type of coverage when you file your federal tax return and not in advance.)

HOW DO I CLAIM THE HCTC?

- *You can claim the HCTC on your tax return and be reimbursed for 65% of the premium you paid for qualified coverage while you were eligible for the HCTC.* Currently, this is the only way to claim the HCTC if your qualified health plan is provided through a spouse's employer.

- *Alternatively, you can choose to have your credit sent directly to your qualified health plan each month.* To do this, you must register with the HCTC customer service center by calling 1-866-628-HCTC (1-866-628-4282), Monday through Friday between the hours of 7 am and 7 pm, Central time. TDD/TYY callers, please call 1-866-626-HCTC (1-866-626-4282).

- *You will have to fill out a registration form verifying your eligibility for the HCTC and your enrollment in qualified coverage*. You will also fill out a payment invoice. Each month, you will send the HCTC program your 35% share of the premium for qualified coverage. The HCTC program will combine this payment with the tax credit covering the other 65% of the premium and forward the entire payment to your qualified health plan.

- *You must register in advance to have the HCTC paid directly to your health plan each month*. Usually, the direct payments won't begin until at least a month after you register with the HCTC program. Call the HCTC customer service center for more information

WHERE CAN I GET MORE INFORMATION?

- *For more information about the HCTC, contact the HCTC customer service center at 1-866-628-HCTC, or see the IRS website at http://www.irs.gov/individuals/index.html (click on HCTC)*

- *For more information about TAA benefits contact, http://www.doleta.gov/tradeact/2002act_summary.asp.*

- *For more information about PBGC, contact, http://www.pbgc.gov or call 1-202-326-4000 with general inquiries.*

FOR MORE INFORMATION…

As a summary, this guide will not answer every question for every person in every circumstance. In addition, it is not a substitute for legal advice. If you have more questions, contact the agencies listed below or consult an attorney.

For questions about:	Contact:
Individual health insurance State continuation coverage Conversion coverage Fully insured group health insurance	*Insurance Division* *Rhode Island Department of Business Regulation* (401) 222-2223 http://www.dbr.state.ri.us/insurance.html
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	*U.S. Department of Labor, Boston regional Office* (617) 565-9600, or contact *U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C.* (202) 219-8776 *For Department of Labor publications*: (800) 998-7542 http://www.dol.gov/dol/pwba
Medicaid (Rhode Island Medical Assistance Program)	*Rhode Island Department of Human Services* (401) 462-5300 http://www.dhs.state.ri.us/dhs/adults/dmadult.htm
Rite Share	*Rhode Island Department of Human Services* (401) 462-5300 http://www.dhs.state.ri.us/dhs/famchild/shcare.htm
Rite Care	*Rhode Island Department of Human Services* (401) 462-5300 http://www.dhs.state.ri.us/dhs/famchild/shcare.htm
Rhode Island Cancer Control Program	*Rhode Island Cancer Screening Program* (401) 222-6843 http://www.health.ri.gov/disease/cancer/women-screening.php

For questions about:	Contact:
Other State Programs	*Rhode Island Department of Human Services* (401) 462-5300 http://www.dhs.state.ri.us/index.htm
Federal Health Coverage Tax Credit (HCTC)	*Internal Revenue Service* (866) 628-HCTC http://www.irs.gov/individuals/index.html

Finally, if you would like to obtain a consumer guide for a different state, visit the web at **http://www.healthinsuranceinfo.net**

HELPFUL TERMS

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

Alternative Trade Adjustment Assistance (ATAA). ATAA is a benefit for workers at least 50 years old who have obtained different, full-time employment within 26 weeks of the termination of adversely-affected employment. These 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. If you are joining a group health plan or if you want to be HIPAA eligible, health insurance coverage is continuous if it is not interrupted by a break of 63 or more consecutive days. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. See also Creditable Coverage, HIPAA eligible.

Conversion. Persons leaving fully insured group health plans in Rhode Island may be permitted to convert their group coverage into an individual health insurance policy. A conversion policy may be different from your former group plan, and it can be more expensive. See also Fully Insured Group Health Insurance.

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

Elimination Rider. A feature permitted in non-standardized individual health insurance policy that permanently excludes coverage for a health condition, body part, or body system.

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

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

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by Rhode Island. 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 Rhode Island small employers with 2 to 50 employees are guaranteed issue. Basic and standard individual health policies are guaranteed issue to people with at least 12 months of prior health coverage. Plans that are guaranteed issue can turn you away for other reasons.

Guaranteed Renewability. A feature in health plans that means your coverage cannot be canceled because you get sick. HIPAA requires all health plans to be guaranteed renewable. Your coverage can be canceled for other reasons unrelated to your health status.

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

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

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

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

HIPAA eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or 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. In most other states, being HIPAA eligible means you have more protections than you would otherwise have when buying individual health insurance. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

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

Individual Health Insurance. Health insurance for people not connected to an employer group. Individual health insurance policies are regulated by Rhode Island.

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. Rhode Island requires fully insured group plans to eventually cover you if you are a late enrollee, but federal law does not provide that protection for people who are in self-insured plans. See also Special Enrollment Period.

Look Back. The maximum length of time, immediately prior to enrolling in a health plan, that can be examined for evidence of pre-existing conditions. See also Pre-existing Condition.

Managed Care. A kind of health insurance plan. Managed care plans can limit coverage to health care provided by doctors and hospitals that work for them or contract with them. These doctors and hospitals are called network providers. Often managed care plans will require you to get permission (called a "referral") from your primary 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 specialist care without a referral. See also HMO.

Medicaid. Also called the Rhode Island Medical Assistance Program. A program providing comprehensive health insurance coverage and other assistance to certain low-income Rhode Island residents. All other states have Medicaid programs, too, though eligibility levels and covered benefits will vary.

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

Pension Benefit Guaranty Corporation (PBGC). PBGC is a federal government corporation established by Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) to encourage the continuation and maintenance of defined benefit pension plans, 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, or any condition which, in the insurer's judgment, most people would have sought care or treatment within the last 36 months. Under individual health insurance only, pregnancy can be considered a pre-existing condition. Genetic information cannot be considered a pre-existing condition in the absence of a diagnosis. Newborns, newly adopted children, and children placed for adoption covered within 31 days cannot be subject to pre-existing condition exclusions. See also Prudent Person Rule.

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

Prudent Person Rule. In individual health plans only, part of the Rhode Island's law regarding pre-existing conditions. The prudent person rule allows insurers to exclude as pre-existing any condition for which – in the insurer's opinion – most people would have sought care or treatment prior to enrolling in an individual health plan. See also Pre-existing Condition (Individual Health Insurance).

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

RIte Care. RIte Care is Rhode Island's Medicaid managed care program that provides families on the Family Independence Program and eligible uninsured pregnant women, parents, and the children up to age 19 with comprehensive health insurance coverage.

RIte Share. A Medicaid program that helps families get health insurance coverage through their employer (or spouse's employer). If a family qualifies, RIte Share will pay for all or part of the employee's share of the health insurance premium. RIte Share also pays for co-payments in the employer's health insurance plan.

Self-Insured Group Health Plans. Plans set up by employers who set aside funds to pay their employees' health claims. Because employers often hire insurance companies to run these plans, they may look to you just like fully insured plans. Employers must disclose in your benefits information whether an insurer is responsible for funding, or for only administering the plan. If the insurer is only administering the plan, it is self-insured. Self-insured plans are regulated by the U.S. Department of Labor, not by Rhode Island.

Small Group Health Plans. Plans with 2 to 50 employees.

Special Enrollment Period. A time, triggered by certain specific events, during which you and your dependents must be permitted to sign up for coverage under a group health plan. Employers and group health insurers must make such a period available to employees and their dependents when their family status changes or when their health insurance status changes. Special enrollment periods must last at least 30 days. Enrollment in a health plan during a special enrollment period is not considered late enrollment. See also Late Enrollment.

State Continuation Coverage. In Rhode Island, if you are in a fully insured group health plan sponsored by an employer and meet other requirements, you may be able to keep your group coverage for a limited time under a state law that is similar to 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 or longer if you no longer qualify for TANF. See also Medicaid.

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

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

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