

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

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**March 2004**

## **ACKNOWLEDGMENTS AND DISCLAIMER**

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

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

This guide is intended to help consumers understand their protections under federal and state law. The authors have made every attempt to assure that the information presented in this guide is accurate as of the date of publication. However, the guide is a summary, and should not be used as a substitute for legal, accounting, or other expert professional advice. Readers should consult insurance regulators or other competent professionals for guidance in making health insurance decisions. The authors, Georgetown University, and the 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.

March 2004

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# A CONSUMER'S GUIDE TO GETTING AND KEEPING HEALTH INSURANCE IN SOUTH DAKOTA

As a South Dakota 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 South Dakota 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 South Dakota, 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 30. For information about how to find consumer guides for other states on the Internet, see page 30. A list of helpful terms and their definitions begins on page 31. These terms are in **boldface** type the first time they appear.

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# CHAPTER 1

## A SUMMARY OF YOUR PROTECTIONS

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

### HOW AM I PROTECTED?

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

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status. This is called **nondiscrimination**. (See page 5)*
- *All group health plans in South Dakota must limit exclusion of pre-existing conditions. There are rules concerning what counts as a pre-existing condition and how long you must wait before a new group health plan will begin to pay for care for that condition. Generally, if you join a new group health plan, your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage. (See page 7)*
- *Your health insurance cannot be canceled because you get sick. Most health coverage is **guaranteed renewable**. (See page 13 and 21)*
- *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 when you retire early and are not yet eligible for Medicare. There are limits on what you can be charged for this coverage. (See page 14)*
- *If you are a small employer buying a **small 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 fully insured health plans for small employers must be sold on a **guaranteed issue** basis. However, the insurance carrier can turn down the small employer if the small employer does not meet the participation requirements. (See page 21)

- *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.* Even so, you can be charged significantly higher premiums due to these factors. (See page 21)
- *If you are buying individual health insurance, there are limits on how much your premiums can vary due to your health status, age, and other characteristics.* Even so, you can be charged significantly higher premiums due to these factors. (See page 13)
- *If you have had at least 12 months of **creditable coverage** and then lose it, you may be guaranteed the right to buy a policy from the **South Dakota Risk Pool**.* You will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for a high risk pool policy. (See page 18)
- *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 South Dakota **Medicaid** program offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes. (See page 23)
- *If your children are 18 years old or younger, do not have health insurance and meet other qualifications, you may be able to buy insurance for them through the **Children's Health Insurance Program (CHIP)**.* (See page 25)
- *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. (See page 26)
- *If you are a retiree aged 55-65 and receiving pension benefits from **Pension Benefit Guarantee Corporation (PBGC)**, then you may also be eligible for the HCTC.* (See page 26)

## WHAT ARE THE LIMITS ON MY PROTECTIONS?

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

- *Employers are not required to provide health benefits for their employees, so if you change jobs, you may find that your new employer does not offer you health coverage.* Employers are required only to make sure that their decision is based on factors unrelated to your health status. (See page 5)
- *If you change jobs, you usually cannot take your old group health coverage 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 include the same doctors that your old health plan did. (See page 5)
- *If you get a new job with health benefits, your coverage may not start right away.* Employers can impose **waiting periods** before your health benefits begin. (See page 6)
- *If you have a break in coverage of 63 days or more, you may have to satisfy a new pre-existing condition exclusion period when you join a new group health plan.* (See page 8)
- *Even if your coverage is continuous, there may be a pre-existing condition exclusion period for some benefits if you join a self-insured group health plan that covers benefits your old group plan did not.* For example, say you move from a group plan that does not cover prescription drugs to a self-insured group that does. You may have to wait one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition. (See page 7)
- *If you have 12 months creditable coverage and then involuntarily lose it, the South Dakota Risk Pool is your only guaranteed access to an individual health insurance policy.* (See page 18)

Your access to other individual health insurance policies may depend on your health status. Private insurers can turn you down, charge more, or limit your coverage because of pre-existing conditions. (See page 11)

- *Once you obtain individual coverage, your ability to switch plans may be limited as well.* While you have protections when you move from an individual policy to a group plan, South Dakota law does not protect you from the imposition of an **elimination rider** when you move from one individual plan to another, even if you had prior **continuous coverage**. Furthermore, you are not assured the right to buy another individual policy. (See page 12)

## CHAPTER 2

# YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

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

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

- *You have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees. Or, your employer may offer an **HMO** plan that you cannot join because you live outside of the plan's service area.
- *You cannot be turned away or charged more because of your health status.* Health status means your medical condition or history, **genetic information**, or disability. This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (such as part-time employment), as long as these are 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 or other health insurance coverage.* 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 health insurance (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 South Dakota law, newborn, adopted children, and children placed for adoption are automatically covered under your fully insured group health plan for the first 31 days following birth or adoption, if the plan covers dependents. The insurer may require that the parent enroll the child within the 31 days and pay higher premiums in order to continue coverage beyond the 31 days.*
  - *Under South Dakota law, your disabled child can remain covered as a dependent under your fully insured group health plan into adulthood. This applies if your dependent was already disabled and covered under the health plan before he or she reached the limiting age for dependent coverage. You will be required to submit proof of your child's continued incapacity and dependency within 31 days following the date that your child reaches the limiting age and annually thereafter. Subsequently, if you change health plans, you might not be able to cover your disabled son or daughter as a dependent under the new health plan.*
  - *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 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 for 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 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 different 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. 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 conditions for which you have actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan. This is 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.*
- *Coverage for pre-existing conditions can be excluded under group health plans only for a limited time. The maximum period is 12 months. However, if you enroll late in a group health plan (after you were hired and not during a regular or special enrollment period) you may have a pre-existing condition exclusion period of up to 18 months. Note that South Dakota requires fully insured group health plans to accept late enrollees after no more than an 18 month waiting period, an 18 month pre-existing condition period, or a combination of the two not to exceed 18 months.*

- *Group plans that impose pre-existing condition exclusion periods must give you credit for any previous continuous **creditable coverage** that you have had.* Most types of insurance 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 coverage counts as creditable coverage, including, but not limited to:

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

### **What is continuous coverage?**

You are considered to have continuous coverage under one plan, or several plans, as long as you don't have a lapse of 63 or more 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, offers a health plan that covers care for diabetes but excludes pre-existing conditions for 12 months. Charter must cover Art's diabetes care immediately because he has more than 12 months of prior continuous coverage credited against the 12-month exclusion.

Now consider a slightly different situation. Assume Art was uninsured for *90 days* between his jobs at Ajax and Beta. In this case, Charter will credit coverage only under Beta's plan toward the 12-month pre-existing condition exclusion period. Charter's plan will begin paying for Art's diabetes care in 3 months (1 year – 9 months). Art does not get credit for his coverage at Ajax since he had a break in coverage of 63 or more consecutive days.

- *In determining continuous coverage, employer-imposed waiting periods and HMO affiliation periods do not count as a break in coverage.* If your new plan imposes a pre-existing condition exclusion period, you can credit time under your prior

continuous coverage towards 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.

- *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 obtain a certificate of creditable coverage from your old health plan.
- *Your protections may differ if you move to a self-insured group health plan that offers more benefits than your old plan 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 self-insured group health plan may impose a pre-existing condition exclusion period for that category. Fully insured group health plans in South Dakota are not allowed to use this method of crediting coverage.

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

Sue needs prescription medication to control her blood pressure. She had 2 years of continuous coverage under her employer's group health plan, which did not cover prescription drugs. Sue changes jobs, and her new employer's self-insured plan does cover prescription drugs. However, because her prior policy did not, the new plan refuses to cover her blood pressure medicine for 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 group health plans from some of the protections discussed previously in this chapter. Public employers must make this choice annually. When they do so, they are required to notify the federal government and specify which protections will not apply to their employees' group health plan.

According to the latest list available from the federal government, no public employer in South Dakota is exempt from these requirements. Some non-federal public employers in South Dakota, however, 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 plan, 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, and high- risk pool coverage.*
- *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 is equal to 65% of the cost of qualified health coverage. (See page 27)*
- *If you are a retiree aged 55-65 and receiving pension benefits from the Pension Benefit Guaranty Corporation (PBGC), you may also be eligible for the HCTC. (See page 27)*

## CHAPTER 3

# YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored health coverage, you may want to buy an individual health policy from a private insurer. However, in South Dakota – as in most other states – you are not guaranteed access to individual health insurance in the private market and may not be able to buy a policy if you are sick. There are some alternatives to private individual health insurance coverage – such as COBRA coverage, state continuation coverage, and South Dakota Risk Pool coverage. This chapter summarizes your protections under different kinds of health plan coverage.

### INDIVIDUAL HEALTH COVERAGE SOLD BY PRIVATE INSURERS & HMOS

#### ***WHEN DO HEALTH INSURERS HAVE TO SELL ME AN INDIVIDUAL HEALTH INSURANCE POLICY?***

In South Dakota, your ability to buy individual health coverage may depend on your health status.

- *In general, companies that sell individual health policies in South Dakota are free to turn you down because of your health status and other factors. When applying for individual health coverage, you may be asked questions about health conditions you have now or have had in the past. Depending on your answers, insurers might refuse to sell you coverage or offer to sell you a health plan with specific limitations on what it covers.*
- *If you have had at least 12 months of **creditable coverage** and then lose it, you may be guaranteed the right to buy a policy from the South Dakota Risk Pool. (See page 18).*
- *Under South Dakota law, newborns and adopted children must be automatically covered under the parents' individual health insurance policy for the first 31 days following birth or adoption, if the policy covers dependents.*
- *Under South Dakota law, your disabled child can remain covered as a dependent under your individual health insurance policy into adulthood. This applies if your dependent was already disabled and covered under the health plan before he or she reached the limiting age for dependent coverage. You will be required to submit*

proof of your child's continued incapacity and dependency within 31 days following the day your child reaches the limiting age. Furthermore, you may be required by the insurer to continue submitting proof of incapacity no more than once a year thereafter. Subsequently, if you change health plans, you might not be able to cover your disabled son or daughter as a dependent under the new health plan.

### ***WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?***

- *It depends on what you buy.* South Dakota does not require health insurers in the individual market to sell standardized policies. Insurers can design different policies and you will have to read and compare them carefully. However, South Dakota does require all individual health insurance policies to cover certain benefits – such as treatment for biologically-based mental diseases and post-maternity delivery hospital stays. Check with the South Dakota Division of Insurance for more information about mandated benefits.

### ***WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?***

- *If you buy individual health insurance policy, there might be an **elimination rider** on any medical condition that you currently have or have had in the past.* An elimination rider is an amendment to your health insurance contract that temporarily or permanently excludes coverage for a health condition, body part, or body system.
- *An insurance company may also impose a pre-existing condition exclusion period.* Pre-existing condition exclusion periods cannot exceed 12 months. If you make a claim during your first year of coverage, your individual health plan can look back 12 months to see if you actually received care or treatment for a condition. Your insurer can also look back to see if you had any symptoms or conditions for which the insurer thinks you should have gotten care. This is called the **prudent person rule**. In South Dakota, pregnancy can be considered a pre-existing condition in individual health plans, but **genetic information** cannot be considered a pre-existing condition in the absence of a diagnosis.
- *If you had prior continuous coverage that was not interrupted by a break of more than 63 days, the insurer cannot impose a pre-existing condition exclusion period and you will receive credit for your previous coverage.* However, the insurer can still apply an elimination rider to your individual health insurance policy.
- *Creditable coverage in the individual market is somewhat different from creditable coverage in the group market.* See box below that lists the types of insurance that are creditable in the individual market.

### **What is creditable coverage in the individual market?**

Most health insurance counts as creditable coverage, including:

Church Plans	Medicaid
College Plans	Medicare
Federal Employees Health Benefits (FEHBP)	Military health coverage (CHAMPUS, TRICARE)
Group health insurance (including COBRA)	Short Term Disability Plans
Indian Health Service	State health insurance high risk pools
Individual health insurance	

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.

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

- *There are limits on how much individual health insurers can charge because of your health status, age, and other characteristics.* Even within these limits, your premiums can be very high if you have a serious health condition.

In addition, when you renew your individual health coverage, your premiums can increase substantially as you age or if your health declines.

### ***CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELLED?***

- *Your health 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 continue to live in the plan service area. Furthermore, your health coverage may be cancelled if the insurer discontinues your health policy altogether, for all policy holders, or withdraws from the individual market.
- *Some insurers 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 coverage under a temporary policy after it expires, you will have to apply for a new contract and there is no guarantee that coverage will be re-issued at all or at the same price.

## COBRA AND STATE CONTINUATION COVERAGE

### ***WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?***

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

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

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

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

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

### **COBRA QUALIFYING EVENTS**

#### *For employees*

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

#### *For spouses*

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

#### *For dependent children*

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

- *Each person who is eligible for COBRA continuation can make his 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 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**

- *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 the 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 (e.g. 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 federally 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.*
- *Certain dislocated workers who receive benefits under the Trade Adjustment Assistance (TAA) program may be eligible for a federal income tax credit to help pay for COBRA. The tax credit will cover 65% of your premium. (See page 27)*
- *If you are a retiree aged 55-65 and are receiving pension benefits from PBGC, then you may be eligible for a federal income tax credit to help pay for new health coverage. This credit is called the Health Coverage Tax Credit (HCTC). (See page 27)*

**HOW LONG DOES COBRA COVERAGE LAST?**

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

In addition, special rules for disabled individuals may extend the maximum period of coverage to 29 months. To qualify for the disability extension, you must have been disabled at the time of your COBRA qualifying event (such as termination of employment or reduction of hours) or have been determined to have become disabled within 60 days of that qualifying event. Before your original 18 months of COBRA coverage expires, you must obtain a disability determination letter from the Social Security Administration, and you must notify your group health plan within 60 days of receiving this disability determination letter.

<b>HOW LONG CAN COBRA COVERAGE LAST?</b>		
<u>Qualifying event(s)</u>	<u>Eligible person(s)</u>	<u>Coverage</u>
Termination Reduced hours	Employee Spouse Dependent child	18 months *
Employee enrolls in Medicare Divorce or legal separation Death of covered employee	Spouse Dependent child	36 months
Loss of "dependent child" status	Dependent child	36 months
* Certain disabled persons and their eligible family members can extend coverage an additional 11 months, for a total of up to 29 months.		

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

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

### **WHAT ABOUT SOUTH DAKOTA STATE CONTINUATION COVERAGE?**

- *If your employer offers a fully insured group health plan and has fewer than 20 workers, and if you have been covered under your group health plan for at least 6 months, you may also be eligible for up to 18 or 36 months of state continuation coverage under a South Dakota law. Ask your former employer or the South Dakota Division of Insurance if you think this applies to you.*
- *If your employer ceases its operations and stops offering its fully insured group health plan, and you had been covered under the plan for at least 6 months, you may be able to choose continuation coverage from the insurer that provided your former policy. Ask your former employer or the South Dakota Division of Insurance if you think this applies to you.*

<h3><b>SOUTH DAKOTA HIGH RISK POOL</b></h3>
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South Dakota maintains a high risk pool, called the South Dakota Risk Pool. The South Dakota Risk Pool provides health insurance coverage only to federally eligible persons and those with 12 months of prior creditable coverage who have lost access to their prior coverage involuntarily.

### **WHEN CAN I GET COVERAGE FROM SOUTH DAKOTA RISK POOL?**

- *You must be a resident of South Dakota.*
- *If you are federally eligible, you can buy health insurance for the South Dakota Risk Pool. Federal eligibility lasts up to 63 days. If you are uninsured and have been for 63 days or longer of losing your coverage, you are not eligible to buy coverage through the South Dakota Risk Pool.*

- *If you have 12 months of prior creditable coverage and then lose access to that prior creditable coverage involuntarily or receive notice that your coverage will be ending, you can buy health insurance from the South Dakota Risk Pool.*

Your prior creditable coverage must not have been terminated due to nonpayment of premiums or fraud.

- *If you were covered under another state's high risk pool and move to South Dakota, you can buy coverage from South Dakota Risk Pool.*

**To be federally eligible, you must meet certain criteria:**

No matter where you live in the U.S., if you are federally eligible you are guaranteed the right to buy individual coverage of some kind with no pre-existing condition exclusion periods. In South Dakota, you are guaranteed the right to buy coverage only from the South Dakota Risk Pool. To be federally eligible, you must meet all of the following:

- You must have had 18 months of continuous creditable coverage, at least the last day of which was under a group health plan.
- You also must have used up any COBRA or state continuation coverage for which you were eligible.
- You must not be eligible for Medicare, Medicaid, or a group health plan.
- You must not have health insurance. (Note, however, if you know your group coverage is about to end, you can apply for coverage for which you will be federally eligible.)
- You must apply for health insurance for which you are federally eligible within 63 days of losing your prior coverage.

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

***WHAT WILL THE HIGH RISK POOL COVER?***

- *South Dakota Risk Pool offers three plan options.* Each plan offers similar benefits including daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care including pharmaceuticals.

- *Each plan has similar benefits but different cost sharing options.*

Plan A. After a \$1,000 deductible has been met, the plan will pay 75% of eligible expenses and you are responsible for the balance of charges. After you have paid an annual out-of-pocket maximum of \$3,250, the plan will pay the rest. However, there is a separate \$1500 annual out-of-pocket maximum for pharmacy benefits.

Plan B. After a \$3,000 deductible has been met, the plan will pay 75% of eligible expenses and you are responsible for the balance of charges. After you have paid an annual out-of-pocket maximum of \$5,250, the plan will pay the rest. However, there is a separate \$1500 annual out-of-pocket maximum for pharmacy benefits

Plan C. After a \$10,000 deductible has been met, the plan will pay 75% of eligible expenses and you are responsible for the balance of charges. After you have paid an annual out-of-pocket maximum of \$12,250, the plan will pay the rest. However, there is a separate \$1500 annual out-of-pocket maximum for pharmacy benefits

### ***WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?***

- *The South Dakota Risk Pool does not impose pre-existing condition exclusion periods.*

### ***WHAT CAN I BE CHARGED FOR HEALTH POOL COVERAGE?***

- *Premiums can vary based on age, the plan option you choose, and whether or not you use tobacco products.*

For example, a man aged 25-29 who doesn't use tobacco products would pay \$122.40 per month under Plan A, \$101.16 under Plan B, and \$75.01 under the Plan C. On the other hand, a using woman aged 60 to 64 who doesn't use tobacco products would pay \$514.37 under Plan A, \$424.37 under Plan B, and \$ 314.70 under Plan C.

Please note that premiums may have changed since this guide was written, so contact the South Dakota Risk Pool for the most current information.

### ***HOW LONG DOES HEALTH POOL COVERAGE LAST?***

- *Coverage under the South Dakota Risk Pool is renewable as long as you pay your premiums, continue to reside in South Dakota, 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. South Dakota has enacted reforms to expand some of these protections. Generally, small employers are those that employ 2-50 employees. Please note, however, that the definitions of small employer and employee are somewhat different under federal and state law. Check with the South Dakota 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 employees, health insurance companies must sell you any small group health plan they sell to other small employers if the employer group meets the participation requirements. A plan 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 group health coverage cannot be canceled if 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, or if they are discontinuing that health plan or if they are withdrawing from the small employer market. In the case of discontinuance, 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?

- *In South Dakota, there are limits on what you can be charged based on the health status, age, and other characteristics of your age groups.* Premiums can vary significantly within these limits. If you have questions about the premiums you have been charged, contact the South Dakota Division of Insurance.

## WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you cannot buy a group health plan. Therefore, the laws that protect small 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.*
- *If you are self-employed and buy your own health insurance, you are eligible to deduct the entire 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 coverage through professional or trade associations. The laws applying to association health coverage can be different than those for other health plans. Check with the South Dakota Division of Insurance about your protections in association health plans.*

## CHAPTER 5

# FINANCIAL ASSISTANCE

Help is available to certain low-income residents of South Dakota who cannot afford to buy health insurance. Medicaid and the Children's Health Insurance Program (CHIP) offer free health insurance coverage, direct medical services or other help.

The federal government, under 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 South Dakota residents. Medicaid covers families with children, 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.

- *Elderly or disabled people who get **Supplemental Security Income (SSI)** benefits automatically 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 for a limited time. Your SSI Representative will determine continued eligibility.

- *SSI is not the only way to qualify for Medicaid.* For certain categories of people, eligibility for Medicaid is based on the amount of your household income.

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

Low-income children with or without insurance may qualify for Medicaid.

Low-income pregnant women with or without insurance may qualify for Medicaid.

Parents and children with or without private health insurance who meet income and resource guidelines may be eligible for Medicaid through the Low Income Families (LIF) program. The family must consist of a parent or other adult caretaker relative and a dependent child. Parents should know that when your income earned from a job increases and your Low Income Families Medicaid benefits end, you generally can stay on Medicaid for a 12-month transitional period.

Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account.

<b>Low income persons eligible for Medicaid in South Dakota</b>	
<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Child 0-18	140% (monthly income of about \$1,780 for family of 3)
Parent	63%
Pregnant woman	133%

\* Eligibility information was compiled from secondary sources, including Center for Budget and Policy Priorities, the Henry J. Kaiser Family Foundation, Families USA, and the Robert Wood Johnson Foundation Covering Kids Program, and may have changed since this guide was published.

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 2003:

<u>Size of Family Unit</u>	<u>Poverty Guideline (annual income)</u>
1	\$ 8,980
2	\$12,120
3	\$15,260

For larger families add \$3,140 for each additional person

So, for example, using this guideline, 200% of the federal poverty level for a family of 3 would be an annual income of \$30,520, or a monthly income of \$2,543.

- *People who need long-term care may also qualify for Medicaid.* For example, people who have to pay for nursing home care, or other long term care services sometimes qualify.

- *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 100% of 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 135% of the poverty level, Medicaid will pay for your monthly Medicare premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

- *There may be other ways that Medicaid can help.* To find out if you, or other members of your family, are eligible for Medicaid or for more information, call (800) 305-3064 or go to <http://www.state.sd.us/social/MedElig/index.htm>

## CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

The Children's Health Insurance Program (CHIP) is a state program that provides health insurance to low-income children under the age of 19 who have no health insurance.

- *CHIP eligibility is based on income and insurance status.* To be eligible, a child's family income must be at or below 200% of the federal poverty level and the applicant cannot be eligible for Medicaid or other health insurance. For a family of 3, this works out to an annual income of about \$30,520 or about \$2,543 per month
- *CHIP does not impose a pre-existing condition exclusion period.* If a family meets the eligibility guidelines, a child's pre-existing medical condition does not exclude him from coverage.
- *CHIP provides comprehensive coverage to enrollees including doctor's visits, hospital care, prescriptions, mental health, dental, vision, and hearing services.*
- *To find out if you, or other members of your family, are eligible for the Children's Health Insurance Program or for more information, call (800) 305-3064 or go to <http://www.state.sd.us/social/medicaid/chip>*

## **BREAST AND CERVICAL CANCER CONTROL PROGRAM: THE ALL WOMEN COUNT! PROGRAM**

- *The Breast and Cervical Cancer Control Program provides free clinical screening services to eligible residents of South Dakota to detect breast or cervical cancer*
- *Women who have been screened through the Breast and Cervical Cancer Control Program (The All Women Count! Program) and diagnosed with breast or cervical cancer may be eligible for Medicaid.*
- *In order to be eligible you must meet the income requirements for the program, be a woman between the ages of 30 and 64, be a South Dakota resident, be uninsured or underinsured, and be in need of medical treatment.*
- *To find out if you are eligible for this program, call the Department of Health at 1-800-738-2301 or your local Community Health Office.*

For a listing of local Community Health Office phone numbers, go to: [www.state.sd.us/doh/Address/com.htm](http://www.state.sd.us/doh/Address/com.htm).

## **THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)**

A federal income tax credit is available to help certain trade dislocated workers, 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.*
  - *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.)*
  - *State-qualified health plans. At this time, South Dakota has not designated a state qualified health plan.*

## **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 the 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/> (click on HCTC)*
- *For more information about TAA benefits contact, <http://www.doleta.gov/tradeact/>*
- *For more information about PBGC, contact, <http://www.pbgc.gov> or call 1-202-326-4000 with general inquiries.*

## FOR MORE INFORMATION...

As it is 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.

<b>For questions about:</b>	<b>Contact:</b>
Individual health insurance State continuation coverage Fully insured group health insurance	<i>South Dakota Division of Insurance</i> (605) 773-3563 <a href="http://www.state.sd.us/drr2/reg/insurance/">http://www.state.sd.us/drr2/reg/insurance/</a>
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor, Kansa City Regional Office</i> (866).275.7922, or contact  <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> (866) 444-EBSA (3272) <a href="http://www.dol.gov/ebsa/">http://www.dol.gov/ebsa/</a>
South Dakota Risk Pool	<i>South Dakota Risk Pool</i> (605) 773-3148 <a href="http://www.state.sd.us/bop/RiskPool.htm">http://www.state.sd.us/bop/RiskPool.htm</a>
Medicaid	<i>South Dakota Department of Social Services</i> (800)305-3064 <a href="http://www.state.sd.us/social/medicaid/chip">http://www.state.sd.us/social/medicaid/chip</a>
Children's Health Insurance Program	<i>Children's Health Insurance Program:</i> (800) 305-3064 <a href="http://www.state.sd.us/social/medicaid/chip">http://www.state.sd.us/social/medicaid/chip</a>
Breast and Cervical Cancer Screening Control Program: <i>The All Women Count!</i> Program  Women's Breast and Cervical Cancer Health Program	<i>South Dakota Department of Health</i> (800) 738-2301 <a href="http://www.state.sd.us/doh/Disease2/cancer.htm">http://www.state.sd.us/doh/Disease2/cancer.htm</a>
Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service (IRS)</i> (866)-628-HCTC (4282) <a href="http://www.irs.gov/individuals/">http://www.irs.gov/individuals/</a> (Click on HCTC)

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 workers may receive 50% of the wage differential (up to \$10,000) during their 2 year eligibility period. To be eligible for the ATAA program, workers may not earn more than \$50,000 per year in their new employment. Also, the firm where the workers worked must meet certain eligibility criteria.

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

***Children's Health Insurance Program (CHIP).*** The Children's Health Insurance Program is part of the South Dakota Medicaid program. CHIP provides health insurance to some children from low income families.

***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 federally 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, Federally Eligible.

***Creditable Coverage (Group Health Plans).*** 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. Fully insured group health plans will also count short-term, limited duration plans and college plans as creditable. See also Continuous Coverage, Group Health Plan, Fully Insured Group Health Plan.

**Creditable Coverage** (Individual Health Plans). 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; a state health insurance high risk pool; a short-term, limited duration plan; a college plan; or a church plan. If you are applying for a guaranteed issue individual health plan in South Dakota, conversion coverage does not count as creditable coverage unless you are federally eligible. See also Continuous Coverage, Individual Health Plan.

**Elimination Rider.** A feature permitted in individual health plans 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.

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

**Fully Insured Group Health Plan.** Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by South Dakota. 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 South Dakota small employers with 2 to 50 employees 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 was 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.

**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 Plan.** Policies for people not connected to an employer group. Individual health plans are regulated by South Dakota Division of Insurance.

**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. South Dakota 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.

**Low-Income Families (LIF) program-** A state medical assistance program for low-income South Dakota families with or without private health insurance. The family's resources may not exceed \$2,000.

**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.** A program providing comprehensive health insurance coverage and other assistance to certain low-income South Dakota 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 30 days cannot be subject to pre-existing condition exclusions.

***Pre-existing Condition*** (Individual Health Plans). 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. Under individual health plans 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 South Dakota'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 Plans).

***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 South Dakota Division of Insurance.

***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 South Dakota, 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.

***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

***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 Readjustment Allowance (TRA).*** Funding that may be available to eligible workers following their exhaustion of unemployment benefits. Usually, TRA benefits will be paid only if an individual is enrolled in a TAA approved training program. This group includes people who are eligible for a TRA but have not used up their unemployment insurance (UI) benefits.

***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).