

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

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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 UTAH

As a Utah 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 Utah 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 Utah, your protections may change. Since this guide is a summary, it may not answer all of your questions. For places to contact for more information, see page 33. For information about how to find consumer guides for other states on the Internet, see page 34. A list of helpful terms and their definitions begins on page 35. 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 Utah. 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 Utah resident.

HOW AM I PROTECTED?

In Utah, 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 Utah must limit exclusion of pre-existing conditions. There are rules about what counts as a pre-existing condition and how long you must wait before a new health plan will begin to pay for care for that condition. Generally, if you join a new health plan, your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage. (See pages 8 and 13.)*
- *Your health insurance cannot be canceled because you get sick. Most health insurance is **guaranteed renewable**. (See pages 14 and 24.)*
- *If you leave your job, you may be able to remain in your old group health plan for a certain length of time. This is called **COBRA** or **state continuation** coverage. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage. (See page 15.)*
- *If you lose your group health plan coverage, you also may be able to buy a **conversion policy**. This is an individual policy sold by the insurance company that*

covered your former group. There are rules about what conversion policies must cover and limits on what you can be charged. (See page 19.)

- *If you lose your group health insurance and meet other qualifications, you will be able to buy individual health insurance from either the Utah Comprehensive Health Insurance Pool (HIPUtah) or an individual market insurer. You will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for this coverage. (See page 20.)*
- *If you apply to buy individual health insurance from a private insurer and you are turned down, you can buy health insurance from HIPUtah. In addition, because HIPUtah only covers very sick individuals, if you do not qualify as a high health risk, you will be given a certificate of insurability that will guarantee you the right to buy an individual health insurance policy from a individual market insurer. (See page 21.)*
- *There are limits on what you can be charged for individual health insurance. (See page 14.)*
- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group. All health plans for small employers must be sold on a **guaranteed issue** basis. (See page 24.)*
- *If you are a small employer buying a group health plan, there are limits on what you can be charged due to the health status, age, gender, or occupation of those in your group. (See page 24.)*
- *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 Utah **Medicaid** program offers free health coverage for pregnant women, families with children, and elderly and disabled individuals with very low incomes. (See Chapter 5.)*
- *If you believe that you may be at risk for cancer, you may be eligible for free screening and treatment. The Utah Cancer Control 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 29.)*
- *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 a program*

which is part of the Medicaid program called Children's Health Insurance Program. (See page 29.)

- *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, state continuation coverage and a policy offered by the State of Utah Department of Workforce Services. (See page 30).*
- *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 30).*

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 can require **waiting periods** before your health benefits begin. **HMOs** can require **affiliation periods**. (See page 7.)*
- *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 individual or group health plan. (See pages 8 and 13.)*
- *If you have a break in coverage of 63 days or more and you are not **HIPAA eligible**, you may have to satisfy a new pre-existing condition exclusion period when you join **HIPUtah**. (See page 22.)*

- *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.)
- *If you work for certain non-federal public employers in Utah, not all of the group health plan protections may apply to you.* (See page 10.)
- *In Utah, your access to individual health insurance may depend on your health status.* Individual insurers can turn you down if you have a serious health condition. They also can charge you higher premiums (within limits) because you are sick, and because of your age. (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.* 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)

- *In Utah, newborns, adopted children and children placed for adoption are automatically covered under their parents' fully insured health plan for the first 30 days, if the plan covers dependents.* The insurer may require that the parent enroll the child and pay a premium within 30 days of birth or placement in order to continue coverage beyond the first 30 days. For newborns placed for adoption, this coverage can be backdated to the date of birth, if the child is placed for adoption within 30 days of birth.
- *In Utah, adult dependent children who are physically handicapped or mentally retarded must be allowed to remain on their parents' fully insured group health plan beyond the age at which the plan usually terminates dependent coverage.* The adult child must be incapable of self-sustaining employment. The health plan may require that you show it proof of your child's incapacity within 30 days of your child's reaching the limiting age, and no more frequently than once every 2 years after that.
- *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage.* This waiting period, however, must be applied consistently and cannot vary due to your health status.
- *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 a **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 about your rights under 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, newly adopted children, children placed for adoption, or **genetic information**.*
- *Under group health plans, coverage for pre-existing conditions can be excluded for no longer than 12 months when you join a plan as a regular or special enrollee. However, if you enroll late in a group health plan (after you are hired and not during a regular or special enrollment period), you may have an 18-month pre-existing condition exclusion period.*
- *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?

Most health insurance counts as creditable coverage, including:

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

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

What is continuous coverage?

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

Take Art, who has diabetes. Ajax Company covered him under its group health plan for 9 months, but he lost his job and health coverage for 9 more months. Art changed jobs again. His new company, Charter, has 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 his 18 months of prior continuous coverage are credited against the 12-month exclusion.

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

- *In determining continuous coverage, employer-imposed waiting periods and **HMO affiliation periods** do not count as a break in coverage.* If your new plan imposes a pre-existing condition exclusion period, you can credit time under your prior coverage toward it. If your employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period. HMOs that require an affiliation period cannot exclude coverage for pre-existing conditions.

- *Your protections may differ if you move to a group health plan that offers more benefits than your old one did.* Plans can look back to determine whether your previous health plan covered prescription drugs, mental health, substance abuse, dental care, or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new group health plan may impose a pre-existing condition exclusion period for that category. Plans that use this method of crediting prior coverage must use it for everyone and must disclose this to you when you enroll.

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

Sue needs prescription medication to control her blood pressure. She had 2 years of continuous coverage under her employer's group health plan, which did not cover prescription drugs. Sue changes jobs, and her new employer's 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, 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.

- *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, the County of Salt Lake has decided that certain health insurance protections will not apply to their employees. If you have group health coverage through this employer, you should contact them for more information. Other non-federal public employers in Utah may have made this choice after this

guide was written. If you are not sure about your protections under your public employee health plan, you should contact your employer.

AS YOU ARE LEAVING GROUP COVERAGE...

- *If you are leaving your job or otherwise losing access to your group health coverage, you may be able to remain covered under the group health plan for a limited time. In addition, you may have special protections when buying certain kinds of individual health coverage. See Chapter 3 for more information about COBRA and state continuation coverage, conversion coverage, and individual health insurance for “HIPAA eligible individuals” and the Utah Comprehensive Health Insurance Pool (HIPUtah)*
- *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, state continuation coverage and a policy offered by the State of Utah Department of Workforce Services. (See page 30).*
- *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 30).*

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. However, in Utah — as in many other states — you have limited guaranteed access to individual health insurance. There are some alternatives to individual health insurance — such as COBRA coverage and the Utah Comprehensive Health Insurance Pool (HIPUtah). This chapter summarizes your protections under different kinds of individual health insurance.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

WHEN DO INDIVIDUAL HEALTH INSURERS HAVE TO SELL ME INSURANCE?

- *In general, private insurers can refuse to sell you individual health insurance because of your health status, your occupation, or other reasons. There are some important exceptions to this, however.*

- *Private insurers in Utah must accept individuals who are not eligible for certain types of private or public insurance. Private insurers are not required to offer you an policy if you have or are able to get health insurance through your job, an association that you belong to, COBRA continuation coverage, state continuation coverage, conversion coverage, Medicare, Medicaid, or HIPUtah.*

- *Under Utah law, newborns, adopted children and children placed for adoption are automatically covered under the parents' individual health plan for the first 30 days, if the plan covers dependents. The insurer may require that the parent enroll the child and pay a premium within 30 days of birth or placement in order to continue coverage beyond the first 30 days. For newborns placed for adoption, this coverage is backdated to the date of birth, if the child is placed for adoption within 30 days of birth.*

- *Under Utah law, adult dependent children who are physically handicapped or mentally retarded must be allowed to remain on their parents' individual health insurance policy beyond the age at which the plan usually terminates dependent coverage. The adult child must be incapable of self-sustaining employment. The health plan may require that you show it proof of your child's incapacity within 30 days of your child's reaching the limiting age, and no more frequently than once every 2 years after that.*

WHAT WILL MY INDIVIDUAL HEALTH PLAN COVER?

- *Utah requires health insurers in the individual market to offer standardized policies in addition to the other policies they sell. **Indemnity**, preferred provider organization (**PPO**), and **HMO** versions of the standardized policies are available. If you buy standardized policies, you will be able to pick a low, medium, or high deductible level. Standardized policies cover hospitalization and doctor services, but do not cover routine pregnancy care. They provide some coverage for mental health and chemical dependency after a 12-month probationary period. Standardized policies make it easier for you to compare the prices that different companies charge. Non-standardized policies can also be offered to you, and you will have to read and compare them carefully.*
- *Utah also requires all health insurance products to cover certain benefits – such as minimum maternity stay lengths and breast reconstruction following mastectomy. (Check with the Utah Department of Insurance for more information about mandated benefits.)*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *There are different ways insurers are allowed, at the time you purchase an individual health insurance policy, to exclude coverage for your pre-existing conditions.*
- *The insurer can impose an **elimination rider** for some conditions. An elimination rider is an amendment to your health insurance contract that permanently excludes coverage for a health condition, body part, or body system. The Utah Department of Insurance maintains a list of conditions that insurers can exclude from your policy. Contact the Department if you have questions about an elimination rider.*

An individual health insurer may also impose a pre-existing condition exclusion period. Pre-existing condition exclusion periods cannot exceed 12 months.

When determining if a condition is pre-existing, an individual health insurer is allowed to look back 6 months to see if you actually received medical advice, diagnosis, or treatment for a condition. This is called the **objective standard**.

- *When you buy a new individual health policy, the law protects you from a new pre-existing condition exclusion period, provided you maintain continuous **creditable coverage**. For individual health insurance, prior coverage is creditable if it was from a private or public health plan that provided similar benefits. Coverage counts as continuous if it is not interrupted by a break of 63 or more days in a row. Individual*

insurers do not have to give you credit for specific conditions that were excluded from any prior individual coverage because of an elimination rider.

- *An individual health insurer can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice. Pregnancy can be counted as a pre-existing condition in individual policies. Insurers are allowed to look back 6 months to see if you had any conditions that fit this definition.*
- *If you are HIPAA eligible and you buy individual health insurance because HIPUtah enrollment is closed, you cannot receive a pre-existing condition exclusion on your policy.*

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

- *If you are buying an individual health insurance policy, there are limits on what you can be charged because of health status, age, or other characteristics. Individual health insurance premiums are based, in part, on average premiums in the small group market. In addition, there are limits on how much your premium can be increased, because of your health status.*
- *When you renew your individual health insurance policy, your premiums can increase substantially as you age or if your health declines. Contact the Utah Insurance Department with questions about your individual health insurance premiums.*

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELLED?

- *Your policy cannot be canceled because you get sick. This is called **guaranteed renewability**. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of managed care plans, continue to live in the plan service area.*
- *Some insurance companies sell temporary health insurance policies. Temporary policies are not guaranteed renewable. They will only cover you for a limited time, such as six months. If you want to renew coverage under a temporary policy after it expires you will have to reapply and there is no guarantee that coverage will be re-issued at all or at the same price.*

COBRA 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 30.)*

- *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 30.)*

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?		
<u>Qualifying event(s)</u>	<u>Eligible person(s)</u>	<u>Coverage</u>
Termination	Employee	18 months *
Reduced hours	Spouse Dependent child	
Employee enrolls in Medicare	Spouse	36 months
Divorce or legal separation	Dependent child	
Death of covered employee		
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.

STATE CONTINUATION COVERAGE

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

CONVERSION COVERAGE

When you leave group coverage, you may also be able to buy a conversion policy. This is an individual health plan from the insurance company that covered your former group.

WHEN DO I HAVE TO BE OFFERED CONVERSION COVERAGE?

- *If you were covered under a fully insured group health plan for 6 months, you may be able to buy a conversion policy. You can buy a conversion policy if you lost your group coverage because you left your job or because the group coverage was terminated. However, before being eligible for a conversion policy, you must exhaust any COBRA or state continuation coverage that was available to you.*

WHAT WILL A CONVERSION POLICY COVER?

- *Conversion policies are required to offer coverage in accordance with the standardized health plans that are offered to people seeking coverage in the regular individual health insurance market. (See above.)*

WHAT ABOUT COVERAGE FOR MY PREEXISTING CONDITION?

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

WHAT CAN I BE CHARGED FOR A CONVERSION POLICY?

- *If you are buying a conversion policy, there are limits on what you can be charged because of health status, age, or other characters. These rates are based, in part, on*

average premiums in the small group market and may include some consideration of your health status. Your premiums will probably be more expensive than if you buy an individual health insurance policy.

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.

UTAH COMPREHENSIVE HEALTH INSURANCE POOL (HIPUtah)

Utah has a high risk pool, administered by Regence BlueCross BlueShield, to provide coverage for people who are unable to buy private health insurance because of their health status.

WHEN CAN I GET COVERAGE FROM HIPUtah?

- *If you are HIPAA eligible, you can apply for health insurance from HIPUtah.* If HIPUtah reaches its enrollment cap and is not accepting new members, you will be guaranteed access to an individual policy through a private individual health insurer.

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible you are guaranteed the right to buy some kind of individual coverage in every state and are exempted from pre-existing condition exclusion periods. In Utah, HIPAA eligible individuals can buy coverage from HIP. To be HIPAA eligible, you must meet all of the following:

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

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.

- *If you are not HIPAA eligible, you can buy coverage from HIPUtah if you have lived in Utah for at least 12 months.* In addition, you must show proof of uninsurability. You are considered uninsurable if you meet HIPUtah's eligibility criteria.

If HIPUtah decides that you do not meet the criteria for being uninsurable, you will be able to apply for coverage from a private insurer, including the insurer who turned you down. The insurer will be required to accept you as long as you reapply within 30 days and meet certain other requirements.

You can also apply for HIPUtah coverage directly if you think you are uninsurable, without having to apply for private health insurance first. If HIPUtah decides that you do not meet the criteria for being uninsurable, you will be able to apply for private health insurance. Insurers will be required to accept you as long as you apply within 45 days and meet certain other requirements.

- *HIPUtah may sometimes be closed to new enrollees due to a lack of funds.* If this happens, you will be able to buy an individual policy from a private insurer, unless all the insurers in the state have already taken their share of uninsurable persons. In that case, you may have to wait up to 6 months for coverage.

If you have questions about the eligibility rules for HIPUtah, contact the Utah Department of Insurance.

- *HIPUtah only offers individual coverage, so each member of your family needs to qualify on his or her own for a HIPUtah policy.*

WHAT WILL HIPUtah COVER?

- *You can choose from 3 plan options under HIPUtah. Covered benefits are the same under all three plans, but the annual deductible varies. You have a choice of an annual deductible of \$500, \$1,000 or \$2500. After a deductible, HIP pays 80% of covered services by participating providers and 60% of covered services provided by non-participating providers. The maximum out-of-pocket liability per plan year is \$1,000 in coinsurance plus the annual deductible. After this maximum is reached, HIPUtah will pay 100% of covered services by participating providers and 95% of covered services provided by non-participating providers.*

Covered benefits include hospital and physician care, prescription drugs, home health, and other services. There is an annual limit of \$250,000 and a lifetime limit of \$1 million per person on covered benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are HIPAA eligible, you will not receive a pre-existing condition exclusion when you enroll in HIPUtah.*
- *If you are not HIPAA eligible, you may have a 6-month pre-existing condition exclusion period when you first enroll in HIPUtah. When you enroll, HIPUtah will look back 6 months to see if you had a condition for which you actually received – or for which most people would have sought – a diagnosis, medical advice, or treatment. This is called the **prudent person rule**. Pregnancy can be considered a pre-existing condition and can be excluded for 10 months following the start of your HIPUtah coverage.*
- *HIPUtah will credit prior continuous coverage toward your pre-existing condition exclusion if you apply for HIPUtah coverage within 63 days of losing your prior coverage.*

WHAT CAN I BE CHARGED FOR HIPUtah COVERAGE?

- *Premiums will vary based on your age and the plan you choose. For example, the monthly premium for a 24-year-old male ranges from \$201 to \$300, depending on*

the coverage option selected. By contrast, the monthly premium for a 64-year-old male ranges from \$425 to \$636.

HOW LONG DOES HIPUtah COVERAGE LAST?

- *HIPUtah policies are renewable as long as you pay your premiums, continue to reside in Utah, and meet other eligibility requirements. If HIPUtah decides not to renew your policy because your condition is no longer uninsurable, it will provide you with a certificate that will enable you to obtain a private health insurance policy.*

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. Utah 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 Utah Insurance Department to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down. This is called **guaranteed issue**. If you employ at least 2 but not more than 50 people, health insurance companies must sell you any small group health plan they sell to other small employers. However, they can require that a minimum percentage of your eligible employees sign up for coverage. They can also require you to pay a minimum share of your workers' premiums. If you are buying a **large group health plan** for 51 or more employees, your group can be turned down.*
- *Your insurance cannot be canceled because someone in your group becomes sick. This is called **guaranteed renewability** and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud, or if they are discontinuing that insurance product. In the latter case, they must give you a chance to buy other plans they sell to groups of your size.*

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

- *Within limits, you can be charged higher premiums based on the health, risk, and demographic characteristics of your group. For small employers, Utah limits the difference in premiums and the annual increase that can be charged. For groups with more than 50 employees, Utah does not limit premium variation or increases. If you have questions about your group health insurance premiums, contact the Utah Department of Insurance.*

WHAT PLAN CHOICES DO I HAVE?

- *Utah requires health insurers in the small group market to offer standardized policies in addition to other policies they sell. Indemnity, preferred provider organization (PPO), and HMO versions of the standardized plans are available. If you buy a standardized plan, you will be able to pick a low, medium, or high deductible level. Standardized plans cover hospitalization, provider services, and pregnancy care, as well as some limited mental health and chemical dependency benefits after a 12-month probationary period. Standardized plans make it easier for you to compare the prices that different companies charge. Non-standardized plans can also be offered to you, and you will have to read and compare them carefully.*

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are not eligible to buy a group health plan on your own (though you may be able to join another group health plan through a family member). Therefore, the laws that protect employers' access to group health plans do not apply to you. Your access to health insurance is protected by the laws that apply to individuals. (See Chapter 3.)*
- *If you are 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 Utah Department of Insurance about your protections in association health plans.*

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Utah who cannot afford to buy health insurance. **Medicaid** and the Utah Children's Health Insurance 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

Medicaid is a program that provides health coverage to some low-income Utah residents. Medicaid covers families with children and pregnant women, medically needy individuals, 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 may be eligible for Medicaid to cover emergency services only.

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

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

Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account, so you should contact the Utah Department of Health or your local Medicaid Eligibility Office for more information.

Low income persons eligible for Medicaid in Utah*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Infant	133% (monthly income of about \$1,568 for family of 3)
Child 1-5	133%
Child 6-18	100%
Working Parent	46%
Non-working Parent	53%
Pregnant woman	133%
Medically Needy	
Individual	53%
Couple	48%

* Eligibility information was compiled from *State Health Facts Online*, the Kaiser Family Foundation, and may have changed since this guide was published. Contact your state Medicaid program for the most up to date information and for other eligibility requirements that may apply.

To get an idea of how your income compares to the federal poverty level, use the federal poverty guideline issued by the U.S. Department of Health and Human Services for the year 2004:

<u>Size of Family Unit</u>	<u>Poverty Guideline (annual income)</u>
1	\$ 9,310
2	\$12,490
3	\$15,670

For larger families add \$3,180 for each additional person

So, for example, using this guideline, 133% of the federal poverty level for a family of 3 would be an annual income of \$20,841, or a monthly income of \$1,737.

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

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

In addition, your children may qualify for transitional Medicaid coverage for 12 months. Or, you may qualify for Medicaid yourself if your family's income meets the Medicaid income standards.

- *Very poor 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, Medicaid will pay your Medicare monthly premium and your Medicare deductibles and coinsurance.* This is called the Qualified Medicare Beneficiary (QMB) program.

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

If your household income is below 135% of the poverty level, the Qualifying Individuals Program will pay your monthly Medicare Part B premium. This program also pays a small portion of your monthly Medicare Part B premium if your household income is between 135% and 175% of the poverty level.

Contact your Department of Health for more information about other eligibility requirements.

- *There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify or apply for Medicaid, contact the Utah Department of Health or your local Medicaid Eligibility office.

CHILDREN'S HEALTH INSURANCE PLAN (CHIP)

Utah's Children's Health Insurance Program is a state-designed program that provides

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

- *Your child must meet certain qualifications.* Your child must be under the age of 19, be a US citizen or a legal resident and be uninsured. In addition, your household income can be no greater than 200% of the federal poverty level. For a family of 3, this works out to an annual income of about \$31,340, or a monthly income of about \$2,612.
- *If eligible, your child will have comprehensive coverage to enrollees.* Comprehensive coverage includes doctor visits, hospital care, prescriptions, mental health services, preventive well-child exams, immunizations, and vision services.
- *You may have to contribute to help pay for your child CHIP coverage.* Depending on your income, you may have to pay a small monthly premium. In addition, you will have to pay a small co-payment for each service that your child needs.
- *For more information, please contact the Utah's Child's Health Insurance Plan at (888) 222-2542 or 1-877-KIDS-NOW or <http://health.utah.gov/chip/>*

UTAH CANCER CONTROL PROGRAM

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

- *The Utah Cancer Control 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 Utah Cancer Control Program, you must meet age and income guidelines.* You must have an income at or below 250% of the federal poverty level (FPL), be between the ages of 50 and 64. Even if you have health insurance, you may still qualify for some free services.
- *For more information, please contact the Utah Cancer Control Program at 1-800-717-1811 or 1-801-538-6712 or <http://www.utahcancer.org/>*

OTHER STATE PROGRAMS

There may be other financial assistance programs available. Please contact the Utah Department of Health at 1-801-538-6101 or <http://health.utah.gov/>

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.*
 - *State qualified plans: In Utah, state qualified plans include state continuation coverage and a policy offered through the State of Utah Department of Workforce Services.*
 - *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 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	<i>Utah Department of Insurance</i> (800) 439-3805 (Utah only) (801) 538-3800 http:// www.insurance.state.ut.us
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor, San Francisco Office</i> (415) 975-4588, or contact: <i>U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C.</i> (202) 219-4377 <i>For Department of Labor publications:</i> (800) 998-7542 http://www.dol.gov/dol/pwba
Utah Comprehensive Health Insurance Pool (HIPUtah)	<i>Regence Blue Cross Blue Shield (plan administrator)</i> (801) 333-5573 or (800) 662-3398 http://www.ut.regence.com/needCoverage/hipUtah/
Medicaid	<i>Department of Health</i> (801) 538-6155 (Salt Lake City area) (800) 662-9651 (toll-free Utah and surrounding states) http://www.health.utah.gov/medicaid/
CHIP	<i>Utah Department of Health</i> <i>CHIP</i> (888) 222-2542 (877) KIDS-NOW http://health.utah.gov/chip/
Utah Cancer Control Program	<i>Utah Department of Health</i> 1-800-717-1811 or (801) 538-6712 http://www.utahcancer.org/

Other Programs	<i>Department of Health</i> (801) 538-6101 http://health.utah.gov/html/utah_medicaid.html
Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service</i> (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.

Children's Health Insurance Plan. Utah's Children's Health Insurance Program is a state-designed program that provides health coverage to low-income children under the age of 19 who are not eligible for Medicaid and who have limited or no health insurance.

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. Under federal rules, health insurance coverage that is not interrupted by a break of 63 or more consecutive days. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. Federal rules apply when you join group health plans. Under Utah rules, coverage is continuous when you join an individual health plan if not interrupted by a break of 63 or more consecutive days. If you are buying HIPUtah coverage and you are not HIPAA eligible, you must apply within 31 days of losing prior coverage, unless your prior coverage was another state's high risk pool, in which case you have 63 days. See also Creditable Coverage, HIPAA eligible, Fully Insured Group Health Plan, HIPUtah, Individual Health Plan, Self-Insured Group Health Plan.

Creditable Coverage (Group Health Insurance). 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. See also Continuous Coverage, Group Health Plan, Individual Health Plan.

Creditable Coverage (HIPUtah). Health insurance coverage that was involuntarily terminated and that had a similar pre-existing condition exclusion. See also Continuous Coverage, HIPUtah.

Creditable Coverage (Individual Health Plan). Coverage under a public or private health plan. See also Continuous Coverage, Individual Health Plan.

Elimination Rider. A feature permitted in individual health plans that permanently excludes coverage for a pre-existing condition.

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 Utah. 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 group health plan cannot consider pre-existing (and therefore exclude coverage for) a condition about which you have genetic information, unless that health condition has been diagnosed by a health professional.

Group Health Plan. Health insurance (usually sponsored by an employer, union or professional association) that covers at least 2 employees. See also Fully Insured Group Health Plan, Self-Insured Group Health Plan.

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All health plans sold to small employers with 2 to 50 employees in Utah 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 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. No matter where you live in the U.S., if you are HIPAA eligible you must be offered at least some type of individual health plan with no pre-existing condition periods. In Utah, federal eligibility gives you greater protections that you would otherwise have when you are guaranteed issue a policy from HIPUtah or private insurers. See also HIPUtah, COBRA, Continuous Coverage, Creditable Coverage (Group Health Insurance).

HIPUtah. Utah Comprehensive Health Insurance Pool, the state-run insurance program for HIPAA eligible persons and for people with high health risks (called a high risk pool).

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. At time of this guide's writing, no HMOs are operating in Utah. See also Affiliation Period.

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

Individual Health Plan. Policies for people not connected to an employer group. This term also refers to coverage purchased by self-employed persons who have no other employees. Individual health plans are regulated by Utah.

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

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

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

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

PPO. Preferred provider organization. A kind of health insurance plan that has a limited network of physicians and hospitals, like an HMO. Unlike an HMO, a PPO will pay for health care you get outside of its network, although the amount it pays will be less than if you had gone to a network provider. Similarly, a PPO might let you visit a specialist without a referral, but in that case you would have to pay more than if you had gotten a referral. See also HMO.

Pre-existing Condition (Group Health Insurance). 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 (HIPUtah). Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan, or for which an ordinarily prudent person would have sought medical advice, care or treatment. Pregnancy can be counted as a pre-existing condition by HIP. See also Prudent Person Rule.

Pre-existing Condition (Individual Health Insurance). 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 policy. In Utah, under individual health insurance policies, pregnancy can be counted as a pre-existing condition.

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(HIPUtah). In HIPUtah coverage only, a rule that permits HIP to exclude as pre-existing any condition for which – in HIPUtah’s judgment – most people would have sought care or treatment prior to enrolling in the health 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 Utah.

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

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

State Continuation Coverage. A program similar to COBRA for small employers with fewer than 20 employees. See also COBRA.

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

Temporary Assistance for Needy Families (TANF). A program (also known as Utah Works) 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.

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

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.