

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

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December 2004

ACKNOWLEDGMENTS AND DISCLAIMER

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

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

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

December 2004

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A CONSUMER’S GUIDE TO GETTING AND KEEPING HEALTH INSURANCE IN VERMONT

As a Vermont 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 Vermont 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 Vermont, 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 29. For information about how to find consumer guides for other states on the Internet, see page 29. A list of helpful terms and their definitions begins on page 30. 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 Vermont. Vermont has enacted comprehensive reforms to expand your access to health insurance and to guarantee fair pricing of policies. Neither federal nor state laws protect your access to health insurance in all circumstances. So please read this guide carefully.

The following information summarizes how federal and state laws do – or do not – protect you as a Vermont resident.

HOW AM I PROTECTED?

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

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status. This is called **nondiscrimination**. (See page 5.)*
- *All health plans in Vermont must limit exclusion of pre-existing conditions. There are rules about what counts as a pre-existing condition and how long you must wait before a new health plan will begin to pay for care for that condition. Generally, if you join a new plan your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage. (See pages 7 and 14.)*
- *If you leave your job, you may be able to remain in your old group health plan for a certain length of time. This is called **COBRA** continuation coverage or **state continuation coverage**. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage. (See page 15.)*
- *You cannot be turned down for an individual health insurance because of your health status, age, or any other factor that might predict your use of health services. This is called **guaranteed issue**. (See page 12.)*

- *If you are buying an individual health policy, you cannot be charged more for your health insurance due to your health status. This is called **community rating**. (See page 14.)*
- *Your individual or group health insurance cannot be canceled because you get sick. Most health insurance is **guaranteed renewable**. (See pages 14 and 21.)*
- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group. All health plans for small employers must be sold on a guaranteed issue basis. (See page 21.)*
- *If you are a small employer buying a group health plan, you cannot be charged more due to the health status of those in your group. This is called community rating. (See page 21.)*
- *If you are self-employed with no other workers, you are eligible to buy health insurance under the same rules that are applicable to other small employers.*
- *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 Vermont **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 but are uninsured or underinsured, you may be eligible for free screening and treatment. The Ladies First 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 25.)*
- *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 **Dr. Dinosaur**. (See Chapter 5.)*
- *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 insurance offered through two individual health insurers (See page 26.).*

- *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 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.

- *If you change jobs, you usually cannot take your old health benefits with you. Except when you exercise your federal COBRA or state continuation rights, you are not entitled to take your actual group health coverage with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did. (See page 5.)*
- *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 get a new job with health benefits, your coverage may not start right away. Employers can require **waiting periods** before your health benefits begin. (See page 6.)*
- *If you have a break in coverage of 63 days you may have to satisfy a new pre-existing condition exclusion period when you join a new health plan. (See pages 7 and 14.)*
- *Even if your coverage is **continuous**, there may be a pre-existing condition exclusion period for some benefits if you join a 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 8.)*
- *If you work for a non federal government employee in Vermont, not all of the group health plan protections may apply to you. (See page 10.)*
- *If you move away from Vermont, you may not be able to buy individual health insurance in another state unless you are **HIPAA eligible**. (See page 13.)*

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 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)

- *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.*
- *Under Vermont law, if an employer permits its employees' civil partners to enroll in its health plan, then insurance companies must make coverage available to them.*
- *Under Vermont law, newborns and adopted children are automatically covered under the parents' fully insured health plan for the first 31 days, if the plan covers dependents. The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.*
- *Under Vermont law, adult children who have certain medical conditions or disabilities can remain on their parent's fully insured group health plan after reaching the age at which dependent coverage is usually terminated. Your adult child must remain dependent on you for support and be unmarried. The plan can require you to provide proof of the adult child's medical condition or disability and financial dependency no more than once each year.*
- *If you have to take leave from your job due to illness, the birth or adoption of a child, or to care for a seriously ill family member, you may be able to keep your group health coverage for a limited time. A federal law known as the **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job-protected leave in these circumstances.*

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

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

If you decide not to return to work at the end of the leave period, your employer may require you to pay back the employer's share of the health insurance premium. However, if you do not 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 the FMLA, contact the **U.S. Department of Labor**.

- *Vermont also has a law that requires some employers to continue your health benefits while you take a leave of absence because you are taking family or medical leave. This law covers some workers who are not covered by the FMLA. You are eligible for “family leave”, to assist with the care of a ‘seriously ill’ member of your family, if you have work for an employer with 15 or more employees for an average of 30 or more hours a week for one year. You are eligible for “parental leave”, during a pregnancy and following the birth of an a child or within a year following the initial adoption of a child 16 years of age or younger, if you have work for an employer with 10 or more employees for an average of 30 or more hours a week for one year. You can take up to 12 weeks of Vermont “family” or “parental” leave during a 12-month period.*

Where Vermont and federal law differ, employers are required to give you the benefit of the more generous law.

For more detailed information on Vermont’s family and medical leave law, contact the Vermont Attorney General’s office at (888) 745-9195.

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

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

- *A group health plan can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan. This period is also called the look back period.*
- *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 self-insured group health plan or a fully insured **large 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. In no situation, however, can a*

fully insured **small group health plan** impose a pre-existing condition exclusion period for more than 12 months.

- *Group health plans that impose pre-existing condition exclusion periods must give you credit for any previous continuous **creditable coverage** that you've had.* Most types of private and government-sponsored health insurance are considered 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	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 insurance plan.

- *The rules for what counts as **continuous coverage** is different depending on the type of plan you join.*

If you are joining a fully insured large group plan or a self-insured plan, coverage counts as continuous if it is not interrupted by a break of *63 or more days* in a row. If you are joining a fully insured small group plan, coverage counts as continuous if it is not interrupted by a break of *90 days or more*.

Different plans count creditable coverage differently

Art, who is diabetic, worked for the Ajax Company and was covered under its group health plan for 8 months. He lost his job and has been without coverage for 70 days.

Art has two job offers – one from Beta Corporation and one from Omega, Inc. – and he can start at either place tomorrow.

Beta Corporation has a self-insured health plan. If Art takes the job at Beta, he will not get credit for his prior coverage because the break in coverage has been more than 63 days. A pre-existing condition exclusion period of up to 12 months can be imposed on his coverage.

Omega, Inc., has a fully insured small group health plan. If Art takes the job at Omega, he will get credit for his prior coverage because the break in coverage was less than 90 days. Therefore, Art will have a pre-existing condition exclusion of 4 months (12 months minus 8 months of prior continuous coverage).

- *A special rule applies to fully insured small group plans.* If a person joining one of these plans has nine or more months of prior continuous coverage, no pre-existing condition exclusion period can be imposed.
- *In determining continuous coverage, employer-imposed waiting periods do not count as a break in coverage.* If your new plan imposes a pre-existing condition exclusion period, you can credit time under your prior continuous coverage toward it. If your employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period.
- *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.*
- *Your protections may differ if you move to a group health plan that offers more benefits than your old one did.* Plans can look back to determine whether your previous health plan covered prescription drugs, mental health, substance abuse, dental care, or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new group health plan may impose a pre-existing condition exclusion period for that category. Plans that use this method of crediting prior coverage must use it for everyone and must disclose this to you when you enroll.

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

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

Question: Is this permitted?

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

- *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 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, there are no state, county, or local governments in Vermont that have decided to exempt themselves from any of the noted protections. However, a non-federal public employers may have made this choice after this guide was written. If you are not sure about your protections under your public employee health plan, you should contact your employer.

AS YOU ARE LEAVING GROUP COVERAGE...

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

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- *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 insurance offered through two individual health insurers (See page 26).*
- *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 26).*

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 plan from a private health insurance company. Vermont has enacted extensive insurance reforms to guarantee residents access to this kind of insurance. There are some alternatives to individual health insurance, such as COBRA and VIPER coverage. This chapter summarizes your protections under different kinds of health plan coverage.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

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

In Vermont, your ability to buy individual health coverage does not depend on your health status.

- *Companies that sell individual health insurance in Vermont are not permitted to turn you down because of your health status and other factors.* However, they are not required to sell you insurance if you are able to get group insurance through your employer or the employer of a family member.
- *In Vermont, insurers that sell individual health insurance must offer family coverage to persons who are interested in purchasing it for a spouse or a dependent.* In Vermont, partners in a civil union are entitled to the same individual health insurance benefits and protections as married couples.
- *In Vermont, newborns and newly adopted children are automatically covered under the parents' individual health insurance policy for the first 31 days.* The insurer may require that the parent enroll the baby within the 31 days in order to continue coverage beyond the 31 days.
- *Under Vermont law, adult children who have certain medical conditions or disabilities can remain on their parent's individual health insurance policy after reaching the age at which dependent coverage is usually terminated.* Your adult child must remain dependent on you for support and be unmarried. The insurer can require you to provide proof of the adult child's medical condition or disability and financial dependency no more than once each year.

- *If you are HIPAA eligible, you are guaranteed the same right to purchase individual health insurance as other individuals.* However, private insurers cannot impose any pre-existing condition exclusion periods on the policy you purchase.

To be HIPAA eligible, you must meet certain criteria

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

To be HIPAA eligible, you must meet all of the following:

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

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.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy.* Insurers are free to design different policies, so you will have to compare the differences carefully to decide which policy is best for you. All comprehensive health insurance policies cover hospitalization, physician services, home care, maternity care, diabetes education, and mammograms. Also, treatment for mental health and substance abuse must be covered in the same way that other illnesses are covered, with no special limits on the number of visits and covered days or on cost sharing.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you buy an individual health policy, there are limits on pre-existing condition exclusion periods that can be imposed. Pre-existing condition exclusion periods cannot exceed 12 months. Individual health insurers can look back 6 months to see if you actually received care or treatment for a condition. Genetic information cannot be considered a pre-existing condition. Pregnancy can be considered a pre-existing condition.*
- *In Vermont, individual health insurers are not allowed to impose **elimination riders**, which permanently exclude coverage for a health condition, body part, or body system.*
- *You will get credit for prior continuous coverage that was not interrupted by a break of 63 or more days in a row. If you have at least nine months of prior continuous coverage, no pre-existing condition exclusion period can be imposed on your coverage. No pre-existing condition exclusion periods can be imposed on you if you are HIPAA eligible.*

WHAT CAN I BE CHARGED FOR INDIVIDUAL HEALTH INSURANCE POLICY?

- *Premiums for individual health policies in Vermont cannot vary due to your health status. Insurers may not use medical underwriting or medical screening to set rates. Insurers may deviate from the community rating to a limited extent due to the age and gender of an individual.*

Rates will also vary due to benefits purchased and family size. Single person, two-person (a married couple or an adult with a child), and family coverage (three or more people) must be offered.
- *Rates are set for twelve months at a time. At renewal, premiums cannot be increased by more than 20%, unless the Division of Health Care Administration approves a larger increase in order to safeguard the solvency of the insurer.*

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELED?

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

COBRA AND STATE CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

If you are leaving your job and you had group 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 26.)*

- *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 26.)*

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.

WHAT ABOUT STATE CONTINUATION COVERAGE?

- *If your employer offers health benefits and has fewer than 20 workers, you may also be eligible for up to 6 months of continuation coverage under a Vermont law that is similar to COBRA. In order to be eligible, you must have had at least 3 months of coverage under the fully insured group plan, be losing your group membership because of job termination or the death of the covered employee, and meet other requirements. Ask your former employer or the Vermont Division of Health Care Administration about state continuation coverage if you think it applies to you.*

CONVERSION

WHEN AM I ELIGIBLE FOR A CONVERSION POLICY?

- *In Vermont, if you have coverage through an employer's fully insured group health plan and you lose that coverage you may be eligible to buy a conversion policy. A conversion policy is an individual policy you buy from the company that insured your employer's group plan.*
- *To qualify for conversion coverage, you must exhaust any available COBRA or state continuation coverage. In addition, when you apply you cannot be eligible for Medicare, any other group coverage or have individual health insurance.*

WHAT WILL A CONVERSION POLICY COVER?

- *The benefits under a conversion policy will probably not be the same as those under your former plan. The conversion policy's benefits may be less generous than those you used to have or those that you may get with an individual health insurance policy.*

WHAT ABOUT MY PRE-EXISTING CONDITION?

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

HOW MUCH CAN I BE CHARGED FOR A CONVERSION POLICY?

- *Generally there are no limits on what insurers can charged you for a conversion policy.* Conversion policies may cost much more than your previous group health plan. You may be charged higher rates based on your health, age, gender, and other factors.
- *For some beneficiaries, there may be a limit on what you can be charged for a conversion policy.* If you loose your group coverage because of a death of either a spouse or parent (and you are an orphan), then insurers can only charge you up to 102% of the rates that you were charged for your group health insurance.

CAN MY CONVERISON POLICY BE CANCELED?

- *Conversion policies, like other individual health insurance policies, are guaranteed renewable.* Your coverage cannot be canceled because you get sick. 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's service area.

CHAPTER 4

YOUR PROTECTIONS AS A SMALL EMPLOYER OR SELF-EMPLOYED PERSON

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. Vermont has enacted comprehensive reforms to expand small employer's access to health insurance and to limit premium variation due to health status. Generally, small employers are those that employ 1-50 employees. Check with the Vermont Division of Health Care Administration to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down.* This is called guaranteed issue. If you employ at least 1 but not more than 50 people, health insurance companies must sell you any **small group health plan** they sell to other small employers. However, health insurers can usually require that up to 75% of your eligible workers participate in your group health plan. If you are buying a **large group health plan** for 51 or more employees, your group can be turned down.
- *Your insurance cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud.

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

- *Premiums for all health plans sold to small employers in Vermont are community rated.* Insurers may not use medical underwriting or medical screening when they set rates. Insurers may not deviate from the community rate to any extent due to age, gender, health status or any other factor of the people in the group.
- *Rates are guaranteed for six months at a time.* At renewal, all small groups buying the same insurance product may face a percentage increase that is uniformly applied to everyone.

WHAT PLAN OPTIONS DO I HAVE?

- *In Vermont, carriers must offer a standardized plan, called the common health plan, to small employers. Two versions of the common health plan are available. Both versions have the same benefits, but the deductibles and out-of-pocket limits are different. The common health plan covers physician services, hospitalization, maternity, mental health, and prescription drugs. Insurance companies are permitted to offer you other plans as well, so you will need to compare the different plans carefully.*

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, your protections are similar to those for other Vermont small employers. All small group plans must be offered to you on a guaranteed issue basis with community rated premiums. However, an insurance company may require proof that you are a Vermont resident before selling you group health insurance.*
- *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 Vermont Division of Health Care Administration about your protections in association health plans.*

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Vermont who cannot afford to buy health insurance. Medicaid and various other programs offer free or subsidized health insurance coverage, direct medical services or other help.

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 Vermont residents. Medicaid covers families with children, pregnant women, and adults who are aged (aged 65 or older), blind, or disabled, if state and federal guidelines are met. Dr. Dynasaur is part of the Medicaid program and provides coverage for some children and pregnant women. 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.

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

In Vermont you may be eligible for Medicaid if you are an infant, a child, a pregnant woman, or a parent of a 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 Vermont Health Access Member Services Unit for more information.

Low income persons eligible for Medicaid in Vermont*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Child 0-18	300% (monthly income of about \$3,917 for family of 3)
Pregnant woman	200%
Working Parent	185%
Non-Parent	192%
Medically Needy	
Individual	102%
Couple	76%

* 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, 200% of the federal poverty level for a family of 3 would be an annual income of \$31,340, or a monthly income of \$2,612.

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

- *Families who get cash benefits from **TANF** (also called **ANFC** or **Reach Up**) may also be eligible for Medicaid, but eligibility is not directly linked to TANF.*

Parents 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.

- *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.*

- *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.

- *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.
- *There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify for Medicaid, contact the Vermont Health Access Member Services Unit at 1- 800-250-8427 or <http://www.dsw.state.vt.us>.

LADIES FIRST

Ladies First is a program that provides free screenings for breast and cervical cancer, cardiovascular disease risk factors and diabetes to eligible Vermont female residents. Eligible women diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid for treatment of their condition.

- *Ladies First provides qualified woman with free screening for breast and cervical cancer, cardiovascular disease risk factors and diabetes.*
- *In order to be eligible for the Ladies First program, you must meet age, income and insurance guidelines.* You must have limited income and be over the age of 18 years old. However, you cannot have Medicaid, VHAP or Medicare Part A.
- *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.*

- *For more information, please contact the Ladies First at 1-800-508-2222 or <http://www.healthyvermonters.info/hs/epi/cdepi/cancer/ladiesfirst/index.html>*

OTHER ASSISTANCE PROGRAMS

There may be other financial assistance programs available. Please contact the Vermont Department of Health at 802-863-7200 or 800-464-4343. or <http://www.healthyvermonters.info/>

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 Vermont, state qualified plans include state continuation coverage and individual insurance offered through two insurers, MVP Health Plan, Inc and Blue Cross Blue Shield of Vermont.*
 - *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 (VIPER) Conversion coverage Fully insured group health insurance	<i>Vermont Division of Health Care Administration</i> (800) 631-7788 (802) 828-2900 http://www.bishca.state.vt.us/ <i>The Vermont Office of Health Care Ombudsman can also help with problems you may have with your health plan.</i> (802) 863-2316 (800) 917-7787
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor, Boston Regional Office</i> (617) 565-9600, 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> (800) 998-7542 http://www.dol.gov/dol/pwba
Vermont Family and Medical Leave	<i>Vermont Attorney General</i> (888) 745-9195
Medicaid (includes Dr. Dynasaur)	<i>Vermont Health Access Member Services Unit</i> (800) 250-8427 http://www.dsw.state.vt.us
Ladies First	<i>Vermont Department of Health</i> (800) 508-2222 http://www.healthyvermonters.info/hs/epi/cde/pi/cancer/ladiesfirst/index.html
Other Programs	<i>Vermont Department of Health</i> (802) 863-7200 or (800) 464-4343 http://www.healthyvermonters.info/
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 that 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. Vermont does not permit HMOs to use affiliation periods, but many other states do allow this. See also HMO.

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

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

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

Community Rating. A requirement that Vermont health insurance companies not vary premiums based on health status, although variations for other reasons are sometimes allowed. Small group health plan and individual health insurance premiums are subject to community rating. See also Individual Health Insurance, Small Group Health Plan.

Continuous Coverage. When joining a self-insured group health plan, a fully insured large group health plan, or purchasing an individual health policy, health insurance coverage that is not interrupted by a break of 63 or more consecutive days. When joining a fully insured small group health plan, coverage counts as continuous if it is not interrupted by a break of 90 or more consecutive days. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. See also Creditable Coverage, HIPAA eligible, Fully Insured Group Health Plan, Individual Health Insurance, Self-Insured Group Health Plan.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; 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 Insurance.

Dr. Dynasaur. Part of Vermont's Medicaid program. Dr. Dynasaur provides health coverage to some low-income children and pregnant women. See also Medicaid.

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.

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

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. Vermont also has a law that gives certain workers the right to take family and medical leave.

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by Vermont. 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 1 employee, or for the self-employed. See also Fully Insured Group Health Plan, Self-Insured Group Health Plan.

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All health plans sold to individuals and small employers in Vermont 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 insurance with no pre-existing condition periods. In Vermont, you do not need to meet all the requirements of federal eligibility to have this protection. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

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

Individual Health Insurance. Health insurance for people not connected to an employer group. Individual health insurance is regulated by Vermont.

Kassebaum-Kennedy. See HIPAA.

Ladies First Program. Program which provides free screening for breast and cervical cancer to eligible Delaware residents. Eligible women diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid for treatment of their condition.

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 Vermont 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. 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 if you are joining a group health plan. 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 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.

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 Vermont.

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. In Vermont, if you have coverage through a fully insured group health plan sponsored by an employer with 2 to 19 employees and meet other requirements, you have the right to continue your health coverage for up to 6 months when your membership in the group ends. See also COBRA.

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

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

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

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

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