

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

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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 WASHINGTON

As a Washington 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 Washington resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group and individual health insurance plans. Chapter 4 highlights your protections as a small employer or self-employed person. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from Washington, 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 37. For information about how to find consumer guides for other states on the Internet, see page 37. A list of helpful terms and their definitions begins on page 39. These terms are printed 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 insurance plans they regulate (**fully insured group health plans** and **individual health insurance policies**), so your protections may vary if you leave Washington. 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 Washington resident.

### HOW AM I PROTECTED?

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

- *Coverage under your group health plan (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status. This is called **nondiscrimination**. (See page 6.)*
- *All health plans in Washington must limit exclusion of pre-existing conditions. There are rules about what counts as a pre-existing condition and how long you must wait before a new health plan will begin to pay for care for that condition. Generally, if you join a new plan your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage. (See pages 8 and 15.)*
- *Your health insurance cannot be canceled because you get sick. All health insurance is **guaranteed renewable**. (See page 16.)*
- *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 17.)*

- *If you lose your group health insurance and meet other qualifications, you can buy a **conversion policy**. This is an individual health insurance policy from the company that insured your employer group. You cannot be denied coverage because of your health status, and you will not face a new pre-existing condition exclusion period. There are rules about what conversion policies must cover and limits on what you can be charged. (See page 21.)*
- *Insurance companies in this individual market in Washington must follow a standardized health screen to determine who can and cannot be turned down for an individual health insurance policy based on health status. You can review these guidelines at any time to find out whether you are healthy enough to buy individual health insurance. (See page 13.)*
- *If you are turned down for individual health insurance you may qualify for health insurance from the **Washington State Health Insurance Pool (WSHIP)**. (See page 23.)*
- *If you are HIPAA eligible, you are guaranteed the right to buy an individual health insurance policy from a private insurance company or from WSHIP. (See page 13.)*
- *If you are buying an individual health insurance policy, you cannot be charged more for your health insurance due to your health status. (See page 16.)*
- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any other 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 26.)*
- *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. (See page 26.)*
- *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 Washington **Medicaid** program offers free health coverage for pregnant women, families with children, elderly and disabled individuals with moderate to low incomes. The **Washington State Basic Health Program** offers subsidized health coverage to individuals and families. **Basic Health Plus** offers no cost coverage for children under age 19 when eligible families sign up. Finally, the Washington State Health Insurance Pool (WSHIP) offers premium subsidies to enrollees age 50 and older who have low to modest incomes. (See Chapter 5.)*

- *If you have lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program** then you may be eligible for a federal income tax credit to help pay for new health coverage. This credit is called the **Health Coverage Tax Credit (HCTC)**, and it is equal to 65% of the cost of qualified health coverage, including COBRA. (See page 34.)*
- *If you are a retiree aged 55-65 and receiving pension benefits from **Pension Benefit Guarantee Corporation (PBGC)**, then you may also be eligible for the HCTC (See page 34.)*

## 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 6.)*
- *If you change jobs, your new employer may not offer you health benefits. Employers are required only to make sure that any health benefits they do offer do not discriminate based on health status. (See page 6.)*
- *If you get a new job with health benefits, your coverage may not start right away. Employers can require **waiting periods** before your health benefits begin. (See page 6.)*
- *Even if you maintain continuous coverage, a new group health plan may apply a universal waiting period for coverage of certain benefits unrelated to pre-existing conditions. (See page 6.)*
- *If you have a break in coverage of 63 days or more you may have to satisfy a new pre-existing condition exclusion period when you join a new health plan. (See pages 8 and 15.)*

- *Even if your coverage is continuous, there may be a pre-existing condition exclusion period for some benefits if you join a self-insured group health plan that covers certain benefits your old plan did not. For example, say you move from a group plan that does not cover prescription drugs to a self-insured plan 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 11.)*
- *If you work for the City of Richland, not all of the group health plan protections may apply to you. (See page 11.)*
- *If you are not healthy, insurers are free to turn you down for individual health insurance. Your only option will be the Washington State Health Insurance Pool (SHIP). (See pages 13 and 23.)*
- *If you are HIPAA eligible, you can be turned down for some individual health insurance policies. The law permits individual insurers to limit your choices to two plans. (See page 13.)*
- *If you move away from Washington, you may not be able to buy individual health insurance in another state unless you are HIPAA eligible.*

## CHAPTER 2

# YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

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

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

- *You have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees. Or, your employer may offer a **health maintenance organization (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 managers who can pass a physical examination. This is not permitted under the law.

- *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage.* These waiting periods, however, must be applied consistently and cannot vary due to your health status.
- *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 health 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 have through yourself or another family member because of death, divorce, legal separation, termination, retirement, or reduction in hours worked)
- 
- *Under Washington law, newborns, adopted children and children placed for adoption are automatically covered under the parent's fully insured health plan for the first 60 days from the moment of birth, if the plan covers dependents. The insurer may require that the parent notify the insurer of the birth and make payments within 60 days from the date of birth or placement for adoption in order to continue coverage beyond the 60 days.*
  - *Under Washington law, your disabled children may remain covered as a dependent under your group health insurance plan after reaching the age at which dependent coverage would normally be terminated, if certain requirements are met. This applies if your dependent was already disabled and covered under the health plan before he or she reached the limiting age for dependent coverage. You will be required to submit proof of your child's continued incapacity and dependency within 31 days following the date that your child reaches the limiting age and you may be required to submit proof of continued disability every 2 years thereafter. Subsequently, if you change health plans, you might not be able to cover your disabled son or daughter as a dependent under the new health plan.*
  - *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 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 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 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.

- *Group health plans can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan. This period is also called the **look back** period.*
- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns, or newly adopted children, children placed for adoption, or genetic information.*
- *Group health plans are not prohibited from applying a universal waiting period for specific benefits. Universal waiting periods are most often used for expensive conditions like pregnancy or organ transplantation. If they are used, however, they must apply to everyone and cannot be related to pre-existing conditions. Check with your employer to see if your health plan has this type of universal waiting period.*
- *Coverage for pre-existing conditions can be excluded under group health plans only for a limited time. The maximum period varies for different kinds of group plans. Also, if you enroll late in your group plans (after you were hired and not during a regular or special enrollment period), you may have a longer pre-existing condition exclusion period. Ask your prospective employer if you are not sure what limits apply to you.*

**The maximum pre-existing condition exclusion period varies**

<u>Type of Group Health Plan</u>	<u>Maximum Exclusion Period</u>
Fully insured	9 months (all enrollees)
Self-insured	12 months (regular and special enrollees) 18 months (late enrollees)

- *If you work for a fully insured small employer, a pre-existing condition exclusion may not apply if you have had similar health coverage for at least 9 months. If you have group health coverage but it is not through a small employer, you will not have a pre-existing condition exclusion if your prior coverage was similar and was continuous for at least 3 months. If you had less than 9 months (if you are in a small group plan) or less than 3 months of continuous coverage (if you are in a large group plan), then you will be given credit for the time you had coverage.*
- *Group health plans that impose pre-existing condition exclusions periods must give you credit for any previous continuous creditable coverage that you have had. Most types of private and state sponsored health coverage 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)
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.

For self-insured plans, coverage counts as **continuous** if it is not interrupted by a period of 63 days or more in a row. For a fully-insured plan, the break in coverage can be no longer than 90 days. Employer-imposed waiting periods and HMO **affiliation periods** do not count as a break in coverage. If your new plan imposes a pre-existing exclusion period, you can credit time under your prior continuous coverage towards it. If your employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period.

**The allowable lapses in coverage varies**

The maximum lapse in coverage you can have and still be counted as having continuous coverage depends on the type of health plan you are joining. Under either type of plan, you must have applied for coverage by the last day of the permitted lapse period.

<u>Type of Group Health Plan</u>	<u>Lapse in Coverage Allowed</u>
Self-insured plan	63 days
Fully Insured plan	90 days

**What is continuous coverage?**

The rules defining continuous coverage depend on the type of employer-sponsored group health plan you are joining.

Art, who has diabetes, worked for Ajax Company and was covered under its group health plan for 18 months. He lost his job and was without coverage for 75 days. Fortunately, on the 76th day after leaving Ajax, Art found a new job at Beta Corporation. He enrolled immediately in Beta's fully insured group health plan, which covers diabetes but imposes pre-existing condition exclusion periods. In Washington, fully insured group health plans count as continuous all creditable coverage that is not interrupted by a lapse of more than 3 consecutive months. Therefore, because Art's lapse in coverage was less than 3 months, Beta's fully insured plan will credit his coverage at Ajax against any exclusion period. Beta's plan will begin paying for Art's diabetes care immediately.

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

- *No pre-existing condition exclusion period can be applied without appropriate notice.* Your group health plan must inform you, in writing, if it intends to impose such a period. Also, if needed, it must help you get a certificate of creditable coverage from your old health plan.
- *Your protections may differ if you join a self-insured group health plan that offers more benefits than your old one did.* Self-insured plans can look back to determine whether your previous health plan covered prescription drugs, mental health, substance abuse, dental care or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new self-insured group health plan may impose a pre-existing condition exclusion period for that category. In Washington, fully insured group health plans are not permitted to do this.

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

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

**Question:** Is this permitted?

**Answer:** Yes, by self-insured group health plans, but not by fully insured health plans in Washington. However, the self-insured 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 required for other conditions that were not pre-existing.

**LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS**

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

According to the latest list available from the federal government, the City of Richland has decided that certain protections will not apply to its employees.

## 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 policies, and individual health insurance coverage for “HIPAA eligible individuals.”
- *If you have lost your group health insurance and are receiving benefits from the Trade Adjustment Assistance (TAA) Program, you may be eligible for a federal income tax credit to help you pay for new health coverage.* This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 65% of the cost of qualified health coverage, including COBRA. (See Chapter 5.)
- *If you are a retiree aged 55-65 and receiving pension benefits from the Pension Benefit Guaranty Corporation (PBGC), you may also be eligible for the HCTC.* (See Chapter 5.)

## **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 insurance policy from a private health insurance company. However, in Washington – as in most other states – you have limited guaranteed access to private individual health insurance. There are some alternatives to private individual health insurance coverage – such as COBRA 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 COVERAGE?***

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

- *Generally, insurers that sell individual coverage in Washington can turn you down if you have health problems or a history of health problems.* In most cases, you will be required to complete a standard health questionnaire (a health screen) to determine your eligibility for an individual health insurance policy. Your health conditions will be assigned points depending on how costly they are. If you accumulate more than 288 points, you can be turned down. If you accumulate less than 288 points on the health screen, the insurer cannot turn you down.
- *If you are not eligible for an individual health insurance policy because of your health, the insurer must give you a written notice telling you that you are eligible for health coverage provided by the Washington State Health Insurance Pool (WSHIP).* (See page 25.) The insurer must also provide you with an application for WSHIP. If the insurer does not provide or postmark the notice within 15 business days, then the insurer must sell to you an individual health insurance policy.
- *There are some situations when you do not have to take a health questionnaire and must be offered an individual health insurance policy*

You do not have to take a health questionnaire and be offered an individual policy if you are relocating from one area of the state to another or you are changing plans to stay with a family doctor who was removed from the network of your previous plan.

You do not have to take a health questionnaire and must be offered an individual policy if you are HIPAA eligible. If you are a HIPAA eligible individual, you qualify to buy an insurance policy from an insurance company selling individual health insurance. Insurers must offer you a choice of all the individual health insurance policies they sell, unless they elect to make a choice of only two policies available to HIPAA eligible individuals.

In addition, where you are HIPAA eligible, you can also buy individual coverage from WSHIP, if you prefer. (See page 23) To be HIPAA eligible, you must meet certain criteria.

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

If you are HIPAA eligible you are guaranteed the right to buy an individual health insurance policy and are exempted from pre-existing condition exclusion periods. In Washington, if your most recent coverage was under a fully insured employer group plan, you can buy a conversion policy. If, not you can buy individual coverage from any insurer in the state that offers individual policies.

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 (90 days if applying for group insurance coverage) of losing your prior coverage.

- *Under Washington law, newborns, adopted children and children placed for adoption are automatically covered under the parent's individual health insurance policy for the first 60 days, if the plan covers dependents. The insurer may require that the parent enroll the dependent within 60 days in order to continue coverage beyond the 60 days.*

- *Under Washington law, your disabled children may remain covered as a dependent under your individual health insurance policy after reaching the age at which dependent coverage would normally be terminated.* This protection applies if your dependent was already disabled and covered under the health plan before he or she reached the limiting age for dependent coverage. You will be required to submit proof of your child's continued incapacity and dependency within 31 days following the date that your child reaches the limiting age and you may be required to submit proof of continued disability every 2 years thereafter. Subsequently, if you change health plans, you might not be able to cover your disabled son or daughter as a dependent under the new health plan.
- *Even if you qualify to buy an individual health insurance policy, the insurer can refuse to enroll you due to the insurer's limits on capacity to serve existing enrollees.* The Commissioner of Insurance must determine that the insurer's clinical, financial, or administrative capacity will be impaired. Contact the Office of the Insurance Commissioner for more information at (800) 397-4422.

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

- *It depends on what you buy.* Washington does not require health insurers in the individual market to sell standardized policies. Health insurers can design different policies and you will have to read and compare them carefully. However, Washington requires all health plans to cover certain benefits, such as certain types of mental health benefits.

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

- *Individual health insurance policies must limit pre-existing condition exclusion periods.* Plans can impose pre-existing condition exclusion periods for up to 9 months. Individual health insurance policies count as pre-existing any condition for which you received – or, in your insurer's judgment, for which you should have sought – medical care, treatment, diagnosis or advice in the 6-month period prior to enrollment. This is called the **prudent person rule**. Pregnancy can be a pre-existing condition in an individual health insurance policy.
- *In some circumstances, you can credit prior coverage against the new individual health insurance policy pre-existing exclusion period.* You will get credit toward your pre-existing condition exclusion period only if your prior benefits are equal to or greater than the current plan, you are moving out of the prior plan's service area, or your doctor moves to another plan. You will not be given credit for prior coverage if your prior plan was a catastrophic plan. To receive credit, your coverage

must be continuous with no more than a 63-day lapse between your old and new coverage.

- *You will not have a pre-existing condition exclusion if you are HIPAA eligible.*
- *In general, if you have been uninsured for more than 63 days before your individual health insurance coverage becomes effective, you may face a 9-month pre-existing condition exclusion period.*

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

- *Individual health insurance policy premiums in Washington cannot vary due to your health status. Premiums will vary, though, depending on your age, family size, where you live and the type of plan you seek. This is called adjusted community rating. A thumbnail comparison of rates in the individual insurance market is available online at:  
[http://www.insurance.wa.gov/publications/health/Navigating\\_Individual\\_Health\\_Care.pdf](http://www.insurance.wa.gov/publications/health/Navigating_Individual_Health_Care.pdf).  
Check with the insurance company to get the most current premium rates and to see if they offer discounts.*

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

- *If you have an individual health insurance policy, your coverage cannot be canceled because you get sick. This is called guaranteed renewability. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of managed care plans, continue to live in the plan service area. However, premiums can increase within limits as you age.*
- *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 CONTINUATION COVERAGE

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

- *If you are leaving your job and you had group coverage, you may be able to stay in your group plan for an extended time through COBRA and/or state continuation coverage. The information presented below was taken from publications prepared by the U.S. Department of Labor. You should contact them for more information about your rights under COBRA.*
- *To qualify for COBRA continuation coverage, you must meet 3 criteria:*

First, you must work for an employer with 20 or more employees.

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 use up any COBRA 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 be faced with 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.*
- *If you have lost your group health insurance and are receiving benefits from the Trade Adjustment Assistance (TAA) program, you may be eligible for a federal income tax credit to help you pay for new health coverage. This credit is called the Health Coverage Tax Credit (HCTC), and it is equal to 65% of the cost of qualified health coverage, including COBRA. (See chapter 5).*

- *If you are a retiree aged 55-65 and receiving pension benefits from Pension Benefit Guaranty Corporation (PBGC), and receiving benefits from the Trade Adjustment Assistance (TAA) Program, then you may be eligible for the federal Health Care Tax Credit to help pay for new health coverage. (See chapter 5).*

**HOW LONG DOES COBRA COVERAGE LAST?**

- *COBRA coverage generally lasts up to 18 months and cannot be renewed. However, dependents are sometimes eligible for up to 36 months of COBRA continuation coverage, depending on the qualifying event. In addition, special rules for disabled individuals may extend the maximum period of coverage to 29 months. To qualify for the disability extension, you must have been disabled at the time of your COBRA qualifying event (such as termination of employment or reduction in hours) or be determined to have become disabled within 60 days of the qualifying event. You must obtain this disability determination from the Social Security Administration, and you must notify your group health plan within 60 days of receiving this disability determination letter, and before your original 18 months expires.*

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

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

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

### **WHAT ABOUT WASHINGTON CONTINUATION COVERAGE?**

- *If your employer offers health benefits and has fewer than 20 workers, you may also be eligible for continuation coverage if your plan elected this option, under a Washington law that is somewhat similar to COBRA. Washington requires insurers to offer continuation coverage to group health plans; your eligibility depends on whether your plan elected to offer such coverage and the terms of that offer. Ask your former employer or the Washington State Office of the Insurance Commissioner about state continuation coverage if you think it applies to you.*

## **CONVERSION**

### **WHEN AM I ELIGIBLE FOR A CONVERSION POLICY?**

- *In Washington, if you have coverage through an employer's fully insured group health plan and you leave that job, you can buy conversion coverage. This is an individual health insurance policy you get from the company that insured your employer's group plan. To qualify, you must not be eligible for Medicare, not be covered by another group plan, and termination may not be for misconduct. You must apply for conversion coverage and pay your premium for the first calendar quarter of coverage within 31 days of termination of your former group (or continuation) coverage.*

You can also buy a conversion policy if you lost your group health coverage due to death or divorce of the covered employee, or if you no longer qualify as a dependent child of the covered employee.

### ***WHAT DOES A CONVERSION POLICY COVER?***

- *Covered benefits under a conversion policy might not be the same as under your former group health plan. Benefits covered under the conversion plan available to you will vary depending on your situation.*
- *You will have the choice of at least 3 benefit plan options; a comprehensive medical plan, a basic medical plan and a major medical plan. All three plans provide coverage for hospital stays, inpatient and out patient medical care and surgical costs. The amount of your deductible will vary depending on the plan you select. For more information on your plan options contact your health insurance provider.*

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

- *Your conversion policy cannot impose a new pre-existing condition exclusion period. However, if you were in the middle of an exclusion period under your former group health plan coverage, you may have to finish it.*

### ***HOW MUCH CAN I BE CHARGED FOR A CONVERSION POLICY?***

- *There are no limits on how much you will be charged for a conversion policy. Your premium will be based on your age, health and the type of plan you choose.*
- *Depending on your health status, you may have a choice between buying a conversion policy or a private individual health insurance policy. Check out both options to see which is best for you.*

### ***CAN MY CONVERSION POLICY BE CANCELED?***

- *Conversion policies, like other individual health insurance policies, are guaranteed renewable.*

## **WASHINGTON STATE HEALTH INSURANCE POOL**

### ***WHEN AM I ELIGIBLE FOR WSHIP?***

- *If you are denied coverage for an individual health plan because of your health, you can enroll in WSHIP. You must enroll within 90 days of receiving the denial notice from an insurer.*

- *If you are HIPAA eligible, you can also buy coverage through WSHIP. HIPAA eligible individuals also qualify to purchase an individual health insurance policy from an individual insurer. The premium for an individual policy from an individual insurer may be lower than through WSHIP. The benefits and premiums under WSHIP and private insurance policies may be different. Compare to see which coverage is better for you.*
- *You are also eligible for WSHIP if you live in a county where comprehensive health insurance is not available. If the only policy available is a **catastrophic policy**, you are eligible to buy health insurance from WSHIP.*
- *You are also eligible for health insurance from WSHIP if you qualify for Medicare and have been denied a Medicare supplemental policy for medical reasons or are offered a Medicare supplemental policy with restrictions, pre-existing condition exclusions, or higher-than-standard.*
- *Coverage for your spouse and/or dependant children (under 19 and unmarried) is available if you are eligible for, and enrolled in, health insurance through WSHIP. Coverage can also be extended to dependent children over the age of 19 who are disabled.*
- *You may not be eligible for health insurance coverage from WSHIP for a variety of reasons (these exceptions do not apply to HIPAA eligible individuals):*
  - You are not eligible for health insurance coverage from WSHIP if WSHIP has paid \$1 million in benefits on your behalf. Benefits include spending on: hospital and professional services, prescription drugs, maternity care, and limited mental health and chemical dependency.
  - You are also not eligible if you terminated your prior coverage in the pool unless it has been one year or longer since you were covered by WSHIP or you have had other continuous coverage and that coverage involuntarily terminated for any reason except non-payment of premiums.
  - If you are covered by a public program, you are not eligible for coverage through WSHIP.

## ***WHAT WILL WSHIP COVER?***

- *As of January 2004, WSHIP offered a choice of 3 plans — a standard plan, a preferred provider (network) plan and a Medicare plan. Under the standard plan, you can go to any provider and the plan covers a fixed percentage of the medical charges (plan pays 80% for most benefits, you pay 20%). The preferred provider plan pays a higher percentage when you receive services from a provider participating in the plan's network. You have a choice of annual deductibles. The annual deductibles are \$500, \$1,000, or \$1,500 for the standard plan and \$500 or \$1000 for the network plan. Both plans cover hospital services, mental health, and prescription drugs. For a full description of covered benefits, contact WSHIP directly. There is a third plan for individuals who are eligible for Medicare. That plan pays the Medicare deductible and co-payments and covers some additional benefits including prescription drugs.*

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

- *There may be a pre-existing condition exclusion period that applies to you. WSHIP can impose pre-existing condition exclusion periods for up to 6 months. WSHIP counts as pre-existing any condition for which you received – or, in WSHIP's judgment, for which you should have sought – medical care, treatment, diagnosis or advice in the 6-month period prior to enrollment. This is called **the prudent person rule**.*

You will get credit toward your pre-existing condition exclusion period only if your prior benefits are equal to or greater than the current plan, you are moving out of the prior plan's service area or your doctor moves to another plan. You will not be given credit for prior coverage if your prior plan was a catastrophic plan. To receive credit, your coverage must be continuous with no more than a 63-day lapse between your old and new coverage.

- *In general, if you have been uninsured for more than 63 days before your coverage through WSHIP becomes effective, you may face a 6-month pre-existing condition exclusion period. If you are HIPAA eligible, you will not have a pre-existing condition exclusion applied to you.*

### ***WHAT CAN I BE CHARGED FOR WSHIP COVERAGE?***

- *Premiums depend on the WSHIP plan you select, your age, your income, and your prior coverage.* For example, for people who are not HIPAA eligible, the network plan option with a \$500 deductible, the monthly premium is \$315.77 for a 24-year-old but \$1,023.81 for a 64-year-old. Somewhat lower premiums are available for HIPAA eligible individuals. Premium subsidies are available for enrollees aged 50 or older with incomes lower than 301 percent of the federal poverty level.

### ***CAN WSHIP COVERAGE BE CANCELLED?***

- *Your coverage cannot be canceled because you get sick or have high medical claims.* This is called guaranteed renewability. You have this protection provided that you pay the premiums and do not defraud the WSHIP.

## **CHAPTER 4**

# **YOUR PROTECTIONS AS A SMALL EMPLOYER OR A SELF EMPLOYED PERSON**

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. Washington has enacted some reforms that 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 Washington State Office of the Insurance Commissioner to be sure that you know which protections apply to your group.

### **DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?**

- *With few exceptions, employers of any size cannot be turned down.* This is called guaranteed issue. However, if you employ at least 2 but not more than 50 employees, health insurance companies can require your group to meet participation requirements in order to buy small group coverage. If your group has 3 or fewer employees, insurance companies can require that up to 100% of your eligible workers participate in your group health plan. If your group has between 4 and 50 eligible employees, insurers can require that up to 75% of the eligible workers participate in your group health plan.
  
- *Your insurance cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans of all sizes. However, insurers can require you to continue meeting minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums, or if you commit fraud, or if they are discontinuing that health plan or withdrawing from the small employer market.

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

- *Premiums for all health plans sold to small employers in Washington are based on adjusted community rating.* That means your premium cannot vary due to the health status of people in your group. Premiums will vary with age, family size and where your business is located but cannot vary more than 375%. Your business may be eligible for a wellness activity discount of up to 20%.

## WHAT PLAN CHOICES DO I HAVE?

- *Insurance companies must offer small employers every small group health plan they sell, including a health plan with benefits similar to those in the Washington Basic Health Plan. Standardizing one benefit plan helps you compare differences in cost between insurance companies.*
- *You may also enroll your employees in a **managed care plan** through the Washington Basic Health Plan. Your company must be licensed to do business in the state of Washington. The Washington Basic Health Plan requires you to contribute a minimum of \$52 for the monthly premium of full time employees and \$32 for part time employees. Enrollment is limited to those employees who are Washington State residents not institutionalized at time of enrollment, not on or eligible for Medicare, and whose income does not exceed 200% of the federal poverty level.*
- *Tips for small employers buying health insurance are available on the Washington State Office of the Insurance Commissioner website at <http://www.insurance.wa.gov>.*

## WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are eligible to buy either a group health plan on your own for you and your family, or an individual health insurance policy. You may want to compare your coverage options to see which is best for you. You may also apply as an individual through the Basic Health plan if you meet the eligibility requirements.*
- *If you are self-employed and buy your own health insurance, you are eligible to deduct the cost of your premium from your federal income tax.*

## A WORD ABOUT ASSOCIATION AND STUDENT HEALTH PLANS

- *Some small employers and self-employed people, and other individuals buy health coverage through professional or trade associations. Some student health plans are also considered association plans. The laws applying to association health coverage and student health coverage can be different than those for other health plans. Check with the Washington State Office of the Insurance Commissioner about your protections in association and student health plans.*

## CHAPTER 5

# FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Washington who cannot afford to buy health insurance. Medicaid, CHIP, and Basic Health Plan offer free or subsidized health insurance coverage, direct medical services or other help. In addition, the federal Trade Adjustment Assistance (TAA) Program provides tax credits to some workers who lose their jobs or whose work hours and wages are reduced as a result of increased imports. This chapter provides summary information about these programs and contact information for further assistance.

### MEDICAID

Medicaid is a program that provides health coverage to some low-income Washington 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 cannot enroll in Medicaid but may be eligible for other state funded programs. Questions concerning immigration status and eligibility should be directed to the Washington Department of Social and Health Services.

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

In Washington you may be eligible for Medicaid if you are a child, a parent of a child, or pregnant, 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. For more information you should contact the Washington Department of Social and Health Services at (800) 737-0617 or online at: <http://www1.dshs.wa.gov/>

### Low income persons eligible for Medicaid in Washington\*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Child up to 19	200% (monthly income of about \$2,612 for a family of 3)
Parent	100%
Pregnant woman	185%

\* Eligibility information was compiled from *State Health Facts Online* (Henry 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. Web site: <http://fortress.wa.gov/dshs/maa/>

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)(100%)</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 and children under the age of 19 participating in TANF (also known as Washington Work First cash assistance program) are automatically covered.*

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.

Parents should know that when your family's TANF benefits end, your children may also qualify for transitional Medicaid coverage for 12 months. Or, your children may qualify for Medicaid themselves if your family's income meets the Medicaid income standards.

Families on TANF, children and pregnant women are required, in most counties, to be enrolled in Healthy Options, Washington State's managed care plan.

- *Pregnant women, once eligible, are eligible throughout pregnancy regardless of changes in income or how many people live in the home. Coverage is available for 60 days after pregnancy ends. Newborns are covered for one year.*
- *Very poor elderly, blind or disabled people who get Supplemental Security Income (SSI) benefits automatically qualify for Medicaid.*

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

Washington State has a program called Health Care for Workers with Disabilities. This program has an income limit of 220% of the poverty level with certain income deductions and premiums assessed to the individual to participate in the cost of care.

- *People who have high medical expenses may also qualify for Medicaid. You may qualify as medically needy if you 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 may qualify as medically needy if their health insurance is limited or does not cover 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 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 135% of the poverty level, Medicaid will pay for your monthly Medicare premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

If you are disabled and working, DSHS will pay your Medicare Part A premium if your income is not greater than 200% of the poverty level.

Contact your county DSHS office for more information about other eligibility requirements or contact the DSHS state office at (800) 737-0617.

- *There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify for Medicaid, contact your local Community Services Office or Adult and Aging Office. You can also apply for Medicaid there.

To obtain the locations and telephone numbers of sites near you call the Department of Social and Health Services. Web Site: <http://www1.dshs.wa.gov>

## **CHILDREN'S HEALTH INSURANCE PROGRAM**

The Children's Health Insurance Program (CHIP) is a federal/state program that covers children under the age 19 whose family's income is too high for Medicaid but below 250% of the federal poverty level.

- *To be eligible for CHIP, your child cannot be eligible for Medicaid or have other creditable medical insurance (covers physician, hospital, radiology and laboratory services).*
- *There is no pre-existing condition exclusion period and your child cannot be excluded because of his or her health.*
- *If eligible, your child will have access to comprehensive coverage.* CHIP provides doctor visits, hospital care, prescriptions, mental health services, preventative well-child exams, immunizations, dental and eye exams.
- *You will have to pay a small monthly premium.* As of July 1, 2004 the monthly premium costs of CHIP are now \$15 per child per month, with a \$45 family maximum per month.

If your income goes down and you cannot pay premiums, your children may be eligible for Medicaid, which has no premiums. For more information call the Department of Social and Health Services at (800) 562-3022 to find out.

- *For more information call (877) KIDS-NOW (877) 543-7669) for more information about the CHIP program.*

## WASHINGTON BREAST AND CERVICAL HEALTH PROGRAM (BCHP)

- *If you're a low-income, uninsured or underinsured woman who is at risk of developing breast or cervical cancer, you may be eligible for free breast and cervical screenings through the Breast and Cervical Health Program (BCHP). In addition, BCHP provides medical coverage for women who have been diagnosed with breast or cervical cancer or a related pre-cancerous condition.*
- *To be eligible, you must be identified as needing treatment through the Department of Health's (DOH) Breast and Cervical Health Program or by the Breast and Cervical Early Detection program funded by the Centers for Disease Control (CDC). Income and eligibility guidelines are determined by the Department of Health screening program.*
- *If you are diagnosed with breast and/or cervical cancer through the screening program and are uninsured, you may be eligible for free health coverage through the Medicaid program. If eligible, Medicaid will cover all your medical costs.*
- *In order to be eligible for treatment through Medicaid, you must be between the ages of 40-64, have been screened by the BCHP or the CDC-funded program, require treatment for breast or cervical cancer, have a household income at or below 200% of the poverty level and you cannot have other health insurance.*
- *For more information see the Washington State Department of Health website at [www.doh.wa.gov/wbchp/default.htm](http://www.doh.wa.gov/wbchp/default.htm) or call the DOH consumer hotline at: (800) 525-0127 or (888) 438-2247.*

## WASHINGTON BASIC HEALTH PLAN

Washington has a program to help make health insurance affordable to working people and others who lack health coverage. The Washington Basic Health Plan offers individuals and their families a managed care plan through a subsidized program, depending on family income.

- *To get coverage, you must meet certain eligibility criteria. To be eligible for coverage under the you: 1) cannot be on or eligible for Medicare; 2) cannot be institutionalized at the time of enrollment; 3) must be a Washington State resident; and 4) must have a gross family income less than 200% of the Federal Poverty Level (\$31,340 for a family of 3).*

However, since subsidies are only available as long as there is state funding, you may have to wait before can enroll in the Subsidized Program. Financial assistance in the Program is determined on a sliding scale basis with families with lower income receiving more financial assistance.

- *If eligible, you may face a pre-existing condition exclusion period.* The Washington Basic Health Plan limits pre-existing condition exclusion periods to 9 months for all benefits. No pre-existing condition exclusion period will be imposed on the maternity benefit and prescription drugs. You will get credit toward your pre-existing condition exclusion period for prior coverage that was similar to the Basic Health Plan coverage you have, provided that no more than 3 months lapse between your old and new coverage.
- Coverage under the Washington Basic Health Plan is comprehensive. Covered benefits include physician services, inpatient and outpatient hospital services, prescription drugs, primary and preventive health care, emergency services, ambulance services, radiology and laboratory, skilled nursing, hospice, and home health care (health plan's discretion), out of area emergency care, chemical dependency, mental health, chiropractic/physical therapy and organ transplants. You must be enrolled in Basic Health for 12 consecutive months before you will be covered for organ transplant procedures except under certain conditions.

Maternity benefits for eligible subsidized members are provided through the Maternity Benefits Program through DSHS; these include full prenatal care, delivery, post-partum care, care for pregnancy complications, and termination of pregnancy.

- *If eligible, you will have to pay a small monthly premium.* Basic Health charges monthly premiums based on age, family size, income and health plan selection. The minimum monthly premium is \$17. The office visit co-payment is \$15 and the emergency room co-payment is \$100. A \$150 annual deductible and 20% coinsurance have also been added to the plan. There is also a \$1,500 annual out-of-pocket maximum.
- *For more information contact the Basic Health Program at (800) 826-2444.*

## WSHIP

The Washington State Health Insurance Pool (WSHIP) offers premium subsidies to enrollees age 50 and older who have low and modest incomes.

See Chapter 3 for more info about WSHIP.

## THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)

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

### ***WHEN AM I ELIGIBLE FOR THE HCTC?***

- *To be eligible for the tax credit, you must be receiving Trade Adjustment Assistance (TAA) benefits or retirement benefits from the PBGC. If you are receiving PBGC benefits, you also must be at least 55 years old.*
- *In addition, you must meet other requirements. Specifically, you are not eligible for the HCTC if any of the following apply to you:*
  - *You have a health plan maintained by an employer or former employer that pays at least 50% of the cost of your coverage. Any share of your premium that is paid by you or your spouse on a pre-tax basis is considered to have been paid by your employer and must be included as such when determining the percentage of employer coverage.*
  - *You are enrolled in Medicare (Part A or B).*
  - *You are enrolled in the Federal Employees Health Benefits Program (FEHBP), Medicaid, or State Children's Health Insurance Program (SCHIP).*
  - *You are entitled to health coverage through the U.S. military health system (Tricare/CHAMPUS).*
  - *You can be claimed as a dependent on someone else's federal tax return.*
  - *You received a lump sum payment of your entire PBGC benefit before August 6, 2002.*
  - *As of the first day of the current month in which you are otherwise eligible, you are imprisoned under a federal, state or local authority.*

- *HCTC may apply to your family, too.* If you are eligible, you can use the credit to help purchase qualified health coverage for your qualified family members. Qualified family members are your spouse and dependents that you can claim on your federal tax return. Family members are not eligible if they are enrolled in another group health plan where the employer pays at least 50% of the cost of coverage, or in Medicaid, SCHIP, FEHBP, Tricare/CHAMPUS.
- *Eligibility for HCTC is not based on income.* In addition, the HCTC is refundable. This means you can claim the credit even if you do not earn enough income to owe federal income tax.

### ***HOW MUCH OF MY HEALTH COVERAGE COST WILL THE TAX CREDIT COVER?***

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

### ***WHAT HEALTH COVERAGE IS ELIGIBLE FOR THE TAX CREDIT?***

- *The HCTC can only be used to help pay for “qualified” health coverage.* Qualified health coverage includes:
  - *COBRA continuation coverage, as long as your employer or former employer contributes less than 50% of the total health plan premium.*
  - *Individual 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](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.

<b>For questions about:</b>	<b>Contact:</b>
Individual health insurance policies Fully insured group health plans	<i>Washington State Office of the Insurance Commissioner</i> OIC (360) 753-3613 OIC Consumer hotline (800) 562-6900 <i>Assistance with access and coverage</i> (800) 397- 4422 <i>Basic Health Plan Information</i> (800) 826-2444 <a href="http://www.insurance.wa.gov/">http://www.insurance.wa.gov/</a>
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor</i> (206) 398-8039 (Seattle District Office, for Washington) or (206) 553-4244 (COBRA, Pension and Welfare Benefits Administration), or (314) 539-2706 (St. Louis District Office)  <i>U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C.</i> (202) 219-8776  <i>For Department of Labor publications:</i> (866) 444-EBSA (3272) <a href="http://www.dol.gov/dol/ebsa">http://www.dol.gov/dol/ebsa</a>
Washington State Health Insurance Pool (WSHIP)	<i>Washington State Health Insurance Pool</i> (800) 877-5187 <a href="https://www.wship.org/Default.asp">https://www.wship.org/Default.asp</a>
Medicaid	<i>Washington Department of Social and Health Services</i> (800) 737-0617 <a href="http://www1.dshs.wa.gov/">http://www1.dshs.wa.gov/</a>
CHIP	<i>Department of Social and Health Services</i> (800) 562-3022 (877) KIDS-NOW (877) 543-7669 <a href="http://fortress.wa.gov/dshs/maa/CHIP/">http://fortress.wa.gov/dshs/maa/CHIP/</a>
Washington Breast and Cervical Health Program (BCHP)	<i>Washington State Department of Health</i> (800) 525-0127 (888)438-2247 <a href="http://www.doh.wa.gob/wbchp/default.htm">http://www.doh.wa.gob/wbchp/default.htm</a>

<b>For questions about:</b>	<b>Contact:</b>
Washington Basic Health Plan	<i>Washington State Health Care Authority</i> (800) 826-2444 <a href="http://www.basicealth.hca.wa.gov/">http://www.basicealth.hca.wa.gov/</a>
The Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service (IRS)</i> 1-866-628-HCTC (1-866-628-4282) <a href="http://www.irs.gov/individuals/index.html">http://www.irs.gov/individuals/index.html</a> (Click on HCTC) or call HCTC customer service center

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

## HELPFUL TERMS

***Adjusted Community Rating.*** A requirement that Washington health insurance companies establish a rate for each individual and small group policy that does not vary due to the health status of those who buy that health insurance. For individual health insurance policies, premiums may only vary based on age, family size, where you live or what plan you seek. Individuals can earn wellness activity discounts and tenure discounts. For small employer group health plans, premiums can only vary based on age, family size, where your business is located, and what plan you seek. Discounts may be earned for wellness activities. See also Wellness Activity Discounts, Tenure Discounts.

***Affiliation Period.*** The time an HMO may require you to wait after you enroll and before your coverage begins. HMOs that require affiliation periods cannot exclude coverage of pre-existing conditions. Premiums cannot be charged during HMO affiliation periods. Washington law does not allow for the use of HMO affiliation periods. See also HMO.

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

***Basic Health.*** A health coverage program administered by the Health Care Authority, available to Washington residents who meet income guidelines, are not eligible for Medicare, and are not institutionalized at the time of enrollment.

***Basic Health Plus.*** A Medicaid Program administered by the Department of Social and Health Services and the Health Care Authority for children from low income families. There are no premiums or co payments.

***Catastrophic policy.*** In Washington, a health insurance policy covering an individual which requires a calendar year deductible of \$1,500 or more in addition to \$3,000 or more in annual out-of-pocket costs is a catastrophic policy. A health insurance policy covering a family is a catastrophic policy if it requires a calendar year deductible of \$3,000 or more in addition to \$5,000 or more in annual out-of-pocket costs.

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

Children's Health Insurance Program (CHIP). The Children's Health Insurance Program is a state run program for low-income children under the age of 19 who are uninsured or underinsured and who are not eligible for Medicaid.

**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) plus a 2% administrative fee. COBRA continuation coverage generally lasts 18 months, or 36 months for dependents in certain circumstances. See also State Continuation Coverage.

**Continuous Coverage (Self-Insured Plans).** Under federal rules, health insurance coverage that is not interrupted by a break of 63 or more days in a row. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. Federal rules apply to you if you are joining a self-insured group health plan. See also Creditable Coverage, Federally Eligible.

**Continuous Coverage (Fully Insured Group and Individual Health Insurance Policies).** Under Washington rules, health insurance coverage that is not interrupted by a break of more than 3 months in a row. Employer waiting periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. Washington state rules apply to you if you are joining a fully insured group health plan. When buying individual health insurance, you cannot have a break in coverage of 63 or more days in a row.

**Conversion Policy.** Your right, when leaving a fully insured group health plan in Washington, to convert your policy to an individual health insurance policy. You will not face a new pre-existing condition exclusion period.

**Creditable Coverage.** Health insurance coverage under any of the following: a group health plan; an individual health insurance policy; Medicare; Medicaid; CHAMPUS (health coverage for military personnel, retirees, and dependents); Federal Employees Health Benefits; Indian Health Service; Peace Corps; or a state health insurance high risk pool. Used in this definition, health insurance coverage includes any time spent under a pre-existing condition exclusion period. See also Continuous Coverage, Group Health Plan, Individual Health Insurance Policy.

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

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

**Fully Insured Group Health Plan.** Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by the state of Washington. 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) in the state of Washington that covers at least 1 employee or a self-employed person. 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. 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 policy premiums. In general, in order to be eligible for the health coverage tax credit, you must be 1) receiving Trade Readjustment Allowance benefits (TRA), or 2) will receive TRA benefits once your unemployment benefits are exhausted, or 3) receiving benefits under the Alternative Trade Adjustment Assistance (ATAA) program, or 4) aged 55 or older and receiving benefits from the Pension Benefit Guaranty Corporation (PBGC).

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

**Health Plan Year.** That calendar period during which your health plan coverage is in effect. Many group health plan years begin on January 1, while others begin in a different month.

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

**HIPAA.** The Health Insurance Portability and Accountability Act, better known as Kassebaum-Kennedy, after the two senators who spearheaded the bill. Passed in 1996 to help people buy and keep health insurance, even when they have serious health conditions, the law sets basic requirements that all health plans must meet. Since states can and have modified and expanded upon these provisions for state regulated health plans (fully insured group and individual plans), 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 federally eligible, you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare, Medicaid, or a group health plan; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

**HMO.** Health maintenance organization. A kind of health insurance plan. HMOs usually require you to get 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 co-payment, for services like doctor visits or prescriptions. HMOs in Washington cannot require affiliation periods. 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 Insurance Policy.** Policies for people not connected to an employer group. Individual health insurance policies are regulated by the state of Washington. Not all residents can buy coverage for themselves and their families. If you are sick, you may be denied coverage by a private insurance company. All individual policy premiums are based on an adjusted community rate. See also Adjusted Community Rating.

**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. Washington requires fully insured group plans to cover you if you are a late enrollee. However, you may be subject to a longer pre-existing condition exclusion period. See also Special Enrollment Period.

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

**Managed Care Plan.** A kind of health insurance plan. Like an HMO, managed care plans can limit coverage to health care provided by doctors or hospitals who work for or contract with them -- also called "network" providers. Often, managed care plans will require you to get permission (a "referral") from your family doctor before you get care from a specialist in their network. Some managed care plans will cover your care at a lower rate if you go to a non-network provider, or if you get specialty care without a referral. The Washington Basic Health Plan offers managed care plans. See also HMO, Washington Basic Health Plan.

**Medicaid.** A program providing comprehensive health insurance coverage and other assistance to certain low-income Washington 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, due to 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 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 (Self-insured Group Health Plans).*** Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a group 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 (Fully Insured Group).*** 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 group 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 60 days cannot be subject to pre-existing condition exclusions.

***Pre-existing Condition (Individual Health Insurance Policies).*** 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 during that period. Under individual health insurance policies, pregnancy can be counted as a pre-existing condition. Newborns and newly adopted children covered within 60 days cannot be subject to pre-existing condition exclusions. See also Prudent Person Rule.

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

***Prudent Person Rule.*** In individual health insurance policies only, a rule that permits insurers to exclude as pre-existing any condition for which – in the insurer’s judgment – most people would have sought care or treatment in the 6 months prior to enrolling in an individual health insurance policy. See Pre-existing Condition (Individual Health Insurance Policy).

***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 the state of Washington.

***Small Group Health Plans.*** Plans with no more than 50 employees and plans for the self employed.

***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 some small employers. In Washington, if you are in a fully insured group health plan sponsored by an employer with 2 to 19 employees, you may have rights to continue your health coverage when your job ends, if your employer chose to offer this benefit in its plan. 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. See also Medicaid.

***Temporary Assistance for Needy Families (TANF).*** A program (also known as the Family Assistance Program or FAP) 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.

***Tenure Discount.*** A discount in the price of your individual health insurance policy premium that may be applied if you have been continuously enrolled in the health plan for 2 or more years. The discount may be as much as 10%.

***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 or 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.

***Washington Basic Health Plan.*** The system created and administered by the state of Washington to enable low income individuals, families, and employers to purchase basic health care services through participating managed health care plans.

***Washington State Health Insurance Pool (WSHIP).*** A state high risk pool for federally eligible individuals and individuals with health problems who do not qualify for private individual health insurance.

***Wellness Activity Discount.*** A discount in the price of your individual or group health plan premium that may be applied if you participate in an explicit program of activity consistent with department of health guidelines, such as smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction and nutrition education, for the purpose of improving enrollee health status and reducing health service costs. The discount may be as much as 20%. See also Tenure Discount, Adjusted Community Rating.