

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

By

**Karen Pollitz
Stephanie Lewis
Mila Kofman
Eliza Bangit
Kevin Lucia**

**GEORGETOWN UNIVERSITY
HEALTH POLICY INSTITUTE**

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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 WYOMING

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

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CHAPTER 1

A SUMMARY OF YOUR PROTECTIONS

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

HOW AM I PROTECTED?

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

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status. This is called **nondiscrimination**. (See page 6.)*
- *All group health plans in Wyoming 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 group health plan will begin to pay for care for that condition. Generally, if you join a new group health plan, your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage. (See page 8.)*
- *Your health insurance cannot be canceled because you get sick. Most health insurance is **guaranteed renewable**. (See pages 14, 20 and 23.)*
- *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 14.)*

- *If you lose your group health insurance and meet other qualifications, you will be **federally eligible**.* If so, you can buy an individual health plan from the **Wyoming Health Insurance Pool (WHIP)**. You will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for a WHIP policy. (See page 20.)
- *If you have had difficulty obtaining affordable individual health insurance because of your health condition, you may also be eligible for WHIP coverage.* In this case you may face a new pre-existing condition exclusion period. (See page 21.)
- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age of your employees 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 23.)
- *Wyoming limits how much premiums can vary due to a small group's health status and industry.* Even within these limits, however, premiums can be significantly higher if someone in your small group has a serious health condition or if the group is considered a high-risk industry. In addition, premiums can vary based on age and other characteristics of those in your group. (See page 23.)
- *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 Wyoming **Medicaid** program offers free or subsidized health coverage for pregnant women, families with children, elderly, and disabled individuals with very low incomes. (See page 25.)
- *If your children are 18 years old or younger, do not have health insurance, and meet other qualifications, you may be able to buy insurance for them through Wyoming Kid Care (CHIP) program.* (See page 27.)
- *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 incomes tax credit to help pay for new health coverage.* This credit is called the **Health Coverage Tax Credit (HCTC)**, and it is equal to 65% of the cost of qualified health coverage. (See Page 29.)
- *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 29.)

WHAT ARE THE LIMITS ON MY PROTECTIONS?

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

- *If you change jobs, you usually cannot take your old health benefits with you. Except when you exercise your federal COBRA or state continuation rights, you are not entitled to take your actual group health coverage with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did. (See page 6.)*
- *If you change jobs, your new employer may not offer you health benefits. If your employer does offer health benefits then the decision on whether to offer you health insurance cannot be based on factors related to your health status. (See page 6.)*
- *If you get a new job with health benefits, your coverage may not start right away. Employers and health maintenance organizations (**HMOs**) can require **waiting periods** before your health benefits begin. (See page 7.)*
- *If you have a break in coverage, you may have to satisfy a new pre-existing condition exclusion period when you join a new group health plan. (See pages 7.)*
- *Even if your coverage is continuous, there may be a pre-existing condition exclusion period for some benefits if you join a group health plan that covers benefits your old plan did not. For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition. (See page 8.)*
- *If you work for certain non-federal public employers in Wyoming, not all of the group health plan protections may apply to you. (See page 11.)*
- *In Wyoming, your access to individual health insurance may depend on your health status. Private insurers are not prohibited from turning you down, charging more, or limiting coverage because of pre-existing conditions. (See page 12.)*
- *In most cases the law does not limit what you can be charged for individual health plans. You can be charged substantially higher premiums because of your health status, age, gender, and other characteristics. (See page 14.)*

- *If you are federally eligible, the Wyoming Health Insurance Pool is your only guaranteed access to individual health insurance, though you may be able to buy individual health insurance from other insurance companies. (See page 20.)*
- *If you join the Wyoming Health Insurance Pool and are not federally eligible, you may face a pre-existing condition exclusion period. (See page 22.)*

CHAPTER 2

YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

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

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

- *You have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees. Or, your employer may offer an HMO plan that you cannot join because you live outside of the plan's service area.
- *You cannot be turned away or charged more because of your health status.* Health status means your medical condition or history, **genetic information**, evidence of insurability (including conditions arising out of acts of violence), or disability. This protection is called nondiscrimination. Employers have the right to refuse or restrict coverage for other reasons (such as part time employment), as long as these are unrelated to health status and applied consistently.

Discrimination due to health status is not permitted

The Acme Company offers two different health plans. Full time employees are offered a high option plan that covers prescription drugs; part time employees are offered a low option plan that does not. This is permitted under the law. By contrast, in a cost-cutting move, Acme restricts its high option plan to those employees who can pass a physical examination. This is not permitted under the law.

- *You must be given a special opportunity to sign up for your group health plan if certain changes happen to your family.* In addition to any regular **enrollment period** your employer or group health plan offers, you must be offered a special, 30-day opportunity to enroll in your group health plan after certain events. You can elect coverage at this time. If your group plan offers family coverage, your dependents can elect coverage as well. Enrollment during a **special enrollment period** is *not* considered **late enrollment**.

Certain changes can trigger a special enrollment opportunity

- The birth, adoption, or placement for adoption of a child
 - Marriage
 - Loss of other coverage (for example, that you or your dependents had through yourself or another family member and lost because of death, divorce, legal separation, termination, retirement, or reduction in hours worked)
-
- *Under Wyoming law, newborns, adopted children, and children placed for adoption are automatically covered under the parents' fully insured health plan for the first 31 days, if the plan covers dependents. The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.*
 - *Under Wyoming law, your disabled child can remain covered as a dependent under your health plan into adulthood. This applies if your dependent was already disabled and covered under the health plan before he or she reached the limiting age for dependent coverage. You will be required to submit proof of your child's continued incapacity and dependency within 31 days following the date that your child reaches the limiting age and annually thereafter. Subsequently, if you change health plans, you might not be able to cover your disabled son or daughter as a dependent under the new health plan.*
 - *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage. This waiting period is called an HMO **affiliation period**, and you will not have health insurance coverage during this time. This waiting period, however, must be applied consistently and cannot vary due to your health status.*
 - *If you have to take leave from your job due to illness, the birth or adoption of a child, or to care for a seriously ill family member, you may be able to keep your group health coverage for a limited time. A federal law known as the **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job-protected leave in these circumstances.*

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

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

If you decide not to return to work at the end of the leave period, your employer may require you to pay back the employer's share of the health insurance premium. However, if you don't return to work because of factors outside your control (such as a need to continue caring for a sick family member, or because your spouse is transferred to a job in a distant city), you will not have to pay back the premium.

For more information about your rights under the FMLA, contact the **U.S. Department of Labor**.

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

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

- *A group health plan can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined the plan. This period is called the **look back period**.*
- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns, newly adopted children, children placed for adoption, or genetic information.*
- *Coverage for pre-existing conditions can be excluded under group health plans only for a limited time. The maximum period is 12 months. However, if you enroll late in a group health plan (after you were hired and not during a regular or special enrollment period) you may have a pre-existing condition exclusion period of up to 18 months. Note that Wyoming requires fully insured small group plans to accept late enrollees after no more than an 18 month waiting period, an 18 month pre-existing condition period, or a combination of the two not to exceed 18 months.*
- *When you join a new group health plan, the law protects you from a new pre-existing condition exclusion period, provided you maintain continuous **creditable coverage**. Most health insurance is creditable coverage.*

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

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

In most cases, you should get a **certificate of creditable coverage** when you leave a health plan. You also can request certificates at other times. If you cannot get one, you can submit other proof, such as old health plan ID cards or statements from your doctor showing bills paid by your health insurance plan.

- *The definition of **continuous coverage** depends on the type of employer health plan you are joining.* If you are joining a self-insured group health plan, coverage counts as continuous if it is not interrupted by a break of 63 or more days in a row. If you are joining a fully insured group health plan or a state or local government plan, coverage counts as continuous if it is not interrupted by a break of more than 90 days in a row.

Fully insured and self insured group plans count continuous coverage differently?

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

Take Art, who has diabetes. Ajax Company covered him under its group health plan for 9 months, but he lost his job and health coverage. Then, *70 days later*, Art found a new job at Beta Corporation and had health coverage for 9 more months. Art changed jobs again. His new company, Charter, has a fully insured health plan that covers care for diabetes but excludes pre-existing conditions for 12 months. Charter must cover Art's diabetes care immediately, because he has not had a lapse in coverage longer than 90 days in a row. His 18 months of prior continuous coverage are credited against the 12-month exclusion.

Now consider a slightly different situation. Charter's group health plan is self-insured. Self-insured plans must count as continuous all credible coverage that is not interrupted by a break of 63 days or more consecutive days. In this case, Art will not get credit for his prior coverage at Ajax because it was followed by a break greater than 63 days. However, his coverage under Beta's plan is credible. Charter will begin paying for Art's diabetes care in three months (12 months-9 months).

- *In determining continuous coverage, employer-imposed waiting periods and HMO affiliation periods do not count as a break in coverage.* If your new plan imposes a pre-existing condition exclusion period, you can credit time under your prior coverage toward it. If your employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period. HMOs that require an affiliation period cannot exclude coverage for pre-existing conditions.
- *Your protections may differ if you move to a group health plan that offers more benefits than your old one did.* Plans can look back to determine whether your previous health plan covered prescription drugs, mental health, substance abuse, dental care, or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new group health plan may impose a pre-existing condition exclusion period for that category. Plans that use this method of crediting prior coverage must use it for everyone and must disclose this to you when you enroll.

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

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

Question: Is this permitted?

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

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

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

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

According to the latest list available from the federal government, the cities of Casper and Laramie have decided that certain health insurance protections will *not* apply to their employees. However, other non-federal public employers in Wyoming may have made this choice after this guide was written. If you are not sure about your protections under your public employee health plan, you should contact your employer.

AS YOU ARE LEAVING GROUP COVERAGE...

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

CHAPTER 3

YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

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

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

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

In Wyoming, your ability to buy an individual health insurance policy may depend on your health status.

- *In general, companies that sell individual health insurance in Wyoming are free to turn you down because of your health status and other factors. When applying for an individual health insurance policy, you may be asked questions about health conditions you have now or have had in the past. Depending on your health status, insurers might refuse to sell you coverage or offer to sell you a policy that has special limitations on what it covers. If you are turned down or offered a policy with reductions or restrictions, you may be eligible for the High Risk Pool.*

- *Under Wyoming law, newborns, adopted children, and children placed for adoption are automatically covered under the parents' individual health insurance policy for the first 31 days, if the plan covers dependents. The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.*

- *Under Wyoming law, your disabled child can remain covered as a dependent under your individual health insurance policy into adulthood. This applies if your dependent was already disabled and covered under the health plan before he or she reached the limiting age for dependent coverage. You will be required to submit proof of your child's continued incapacity and dependency within 31 days following the date that your child reaches the limiting age and annually thereafter. Subsequently, if you change health plans, you might not be able to cover your disabled son or daughter as a dependent under the new health plan.*

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy. Wyoming does not require health insurers in the individual market to sell standardized individual health insurance policies. Health plans can design different policies and you will have to read and compare them carefully. However, Wyoming does require all health plans to cover certain benefits, such as diabetes care. Check with the Wyoming Department of Insurance for more information about mandated benefits.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *There are different ways that an individual health insurance plan can exclude a pre-existing condition.*

The plan can impose an **elimination rider**, which is an amendment to your health insurance contract that permanently excludes coverage for a health condition, body part, or body system. Or a plan can apply a temporary exclusion period on any pre-existing condition.

Individual plans can count as **preexisting conditions** only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within 6 months before individual coverage begins. The maximum exclusion period that can be imposed is 12 months.

- *Individual health plans that apply a pre-existing exclusion period have to give credit for your prior coverage as long as your coverage has been continuous with no more than a 90-day lapse.*
- *In Wyoming, pregnancy and genetic information can be considered a pre-existing condition in all individual health insurance policies.*

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

- *Generally, in Wyoming, there are no limits on how much individual premiums can vary due to age, gender, health status, family size, and other factors.*

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELLED?

- *Your coverage cannot be cancelled because you get sick. This is called guaranteed renewability. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of **managed care plans**, continue to live in the plan service area. However, guaranteed renewability does not protect you from having your premiums go up at renewal.*
- *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 6 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-at the same price or at all.*

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 coverage. The information presented below was taken from publications prepared by the U.S. Department of Labor. You should contact them for more information about your rights under COBRA.

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

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

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

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

COBRA QUALIFYING EVENTS

For employees

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

For spouses

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

For dependent children

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

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

- *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 (e.g. layoff) that caused the loss of group health plan coverage.)*
- *When COBRA is elected during this special second election period, coverage starts on the first date of the special election period. Any time that has elapsed between the original qualifying event and the first date of the special election period is not counted as a lapse in coverage in determining continuous coverage history.*

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

WHAT WILL COBRA COVER?

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

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage. The first premium must be paid within 45 days of electing COBRA coverage.*
- *If you elect the 11-month disability extension, the premium will increase to 150% of the total cost of coverage. See below for more information about the disability extension.*
- *Certain dislocated workers who receive benefits under the Trade Adjustment Assistance (TAA) Program may be eligible for a federal income tax credit to help pay for COBRA or other qualified coverage. The tax credit will cover 65% of your premium. (See page 29.)*
- *If you are a retiree aged 55-65 and receiving pension benefits from PBGC, then you may be eligible for a federal income tax credit to help pay for new health coverage. This credit is called the Health Coverage Tax Credit (HCTC). (See page 29.)*

HOW LONG DOES COBRA COVERAGE LAST?

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

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 within 60 days of that qualifying event. You must obtain this disability determination from the Social Security Administration, and you must notify your group health plan of this disability determination.

HOW LONG CAN COBRA COVERAGE LAST?

<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 WYOMING CONTINUATION COVERAGE?

- *If your employer offers a fully insured group health plan and has fewer than 20 employees, you may also be eligible for up to 12 month continuation coverage under a Wyoming law that is similar to COBRA. However, an eligible person must apply in writing and pay within a 31-day period following termination of the group policy. Ask your former employer or the Wyoming Department of Insurance about state continuation coverage if you think that it applies to you.*

CONVERSION COVERAGE

WHEN DO I HAVE TO BE OFFERED CONVERSION COVERAGE?

- *In Wyoming, if you have coverage through an employer's fully insured group health plan or state or local governmental plan, and you become ineligible for that coverage, you are eligible to buy conversion coverage. This is an individual health insurance policy you get from the company that insured your previous group plan.*
- *Conversion rights are also available to a surviving spouse and child upon the death of an insured or when they cease to be a qualified family member under a group policy.*
- *To qualify, for a conversion policy, you must apply within 31 days of the termination of the group plan. Also, you must first use up any COBRA or state continuation coverage.*
- *You do not need to be federally eligible to buy a conversion policy. However, if you do elect a conversion policy, you will lose your federal eligibility status.*

WHAT DOES A CONVERSION POLICY COVER?

- *The insurance company that provided your group plan must offer you a choice of three basic conversion policies and one major medical conversion policy. All conversion policies must cover hospital stays and surgery, however the major medical conversion policy must also cover physician and other non-hospital expenses.*
- *Each of the three basic conversion options offers the same hospital and room and board services, but with different levels of payable coverage (i.e. 100%, 75% and 50%).*

WHAT ABOUT T COVERAGE FOR MY PRE-EXISTING CONDITION?

- *A conversion policy may not impose a new pre-existing condition exclusion period. However, if you were in a pre-existing exclusion period under your old group health plan when it ended, you may have to finish it.*

HOW MUCH CAN I BE CHARGED FOR CONVERSION COVERAGE?

- *There is no limit on what your insurer can charge for conversion coverage. These policies often are more expensive than your prior group coverage.*

CAN MY POLICY BE CANCELLED?

- *Conversion policies, like other individual health insurance policies, are guaranteed renewable. Your coverage cannot be cancelled if you get sick.*

WYOMING HEALTH INSURANCE POOL (WHIP)

Wyoming maintains a high risk pool, called the Wyoming Health Insurance Pool or WHIP, to provide insurance for residents of Wyoming with health conditions who are unable to by private health insurance and for people who are federally eligible.

WHEN CAN I GET COVERAGE FROM WHIP?

- *You must be a resident of Wyoming.*
- *You can buy coverage from WHIP if you are “uninsurable”. You are considered “uninsurable” if:*
 - *You have been turned down for an individual health insurance policy by at least one insurance company because of a health condition; or*
 - *You are offered an individual health insurance policy with reductions or exclusions more restrictive than WHIP coverage; or*
 - *You have been offered individual health insurance policy, including coverage under a conversion policy that is more expensive than WHIP coverage.*

You only need to show that you are “uninsurable” in one of these ways in order to get WHIP coverage.

- *If you are federally eligible, you can buy health insurance from WHIP. You will not have a pre-existing condition exclusion period.*

To be federally eligible, you must meet certain criteria

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

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

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

- *WHIP does not offer family coverage.* Each member of your family who wants to enroll in WHIP will have to qualify on his or her own.
- *If you are on Medicare disability and cannot obtain a Medigap policy, or if you obtain one but only at rates exceeding the WHIP rates, then you can purchase a Coordination of Benefits (COB) plan through WHIP.*

WHAT WILL WHIP COVER?

- *WHIP offers 2 plan options.* Both plans offer similar benefits (hospital, physician, catastrophic pregnancy, etc.) but with different levels of co-payments and deductibles. Depending on the plan option, WHIP will pay between 70% and 100% of the covered charges after you have satisfied any deductible. After you have paid the maximum amount for covered services (also called the out-of-pocket limit), WHIP will pay 100% of covered charges.

- *WHIP offers two cost sharing options. Option 1 limits your out-of-pocket costs for covered services to \$4,000 annually and has a maximum lifetime limit of \$350,000 per person. Option 2 limits your out-of-pocket costs for covered services to \$2,000 annually and has a lifetime limit of \$600,000. Option two also provides greater coverage for outpatient rehabilitation and preventative care.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are federally eligible, you will not have a pre-existing condition exclusion when you enroll in WHIP.*
- *If you are not federally eligible, you may have a 12-month pre-existing condition exclusion period when you first enroll in WHIP. When you enroll, WHIP will look back 6 months to see if you had a condition for which you actually received a diagnosis, medical advice, or treatment- or for which most people would have sought a diagnosis, medical advice, or treatment. Pregnancy can be considered a pre-existing condition.*
- *WHIP will credit your prior creditable coverage against the pre-existing condition exclusion period, provided that there was not a break in coverage greater than 90 days in a row.*

WHAT CAN I BE CHARGED FOR WHIP COVERAGE?

- *WHIP premiums are set to be about twice as much as healthy people would pay for similar coverage sold by a private insurer. WHIP premiums will vary based on your age, gender, and the cost sharing option that you choose.*

For example, the monthly premium for a 24-year-old single man ranges from \$262 to \$323, depending on the option he chooses. By contrast, the monthly premium for a 64-year-old single man ranges from \$780 to \$970, depending on the benefits option he chooses.

- *Premiums are updated each year in July.*

HOW LONG DOES WHIP COVERAGE LAST?

- *WHIP policies are renewable as long as you pay your premiums, continue to reside in Wyoming, and meet other eligibility requirements.*

CHAPTER 4

YOUR PROTECTIONS AS A SMALL EMPLOYER OR SELF-EMPLOYED PERSON

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. Wyoming has enacted reforms to expand some of these protections. Generally, small employers are those that employ 2-50 employees. Please note, however, that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Wyoming Department of Insurance to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down.* This is called guaranteed issue. If you employ at least 2 but not more than 50 people, health insurance companies must sell you any **small group health plan** that your group qualifies for and that they sell to other small employers. However, they can require that a minimum percentage of your eligible employees sign up for coverage. They can also require you to pay a minimum share of your workers' premiums. If you are buying a **large group health plan** for 51 or more employees, your group can be turned down.

- *Your insurance cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud, or if they are discontinuing that insurance product. In the latter case, they must give you a chance to buy other plans they sell to groups of your size.

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

- *Wyoming limits how much premiums can vary due to a small group's health status and industrial grouping.* Even within these limits, however, premiums can be significantly higher if someone in your small group has a serious health condition or if the group is involved with a high-risk industry. In addition, premiums can vary based on age and other characteristics of those in your group.

- *Wyoming also limits how much small group plan premiums can increase at renewal because of claims experience.*
- *For groups with more than 50 employees, Wyoming does not limit premium variations when coverage is first issued or renewed.*

Check with the Wyoming Department of Insurance if you have any questions about your group plan premiums.

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are not eligible to buy a group health plan on your own (though you may be able to join another group health plan through a family member). Therefore, the laws that protect employers' access to group health plans do not apply to you. Your access to health insurance is protected by the laws that apply to individuals. (See Chapter 3.)*
- *If you are self-employed and buy your own health insurance, you are eligible to deduct the entire cost of your premium from your federal income tax.*

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5 FINANCIAL ASSISTANCE

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

MEDICAID

Medicaid is a program that provides health coverage to some low-income Wyoming residents. Medicaid covers families with children and pregnant women, the elderly, and people with disabilities, if state and federal guidelines are met. Legal residents who are not U.S. citizens may be eligible for Medicaid emergency services however, questions concerning immigration status and eligibility should be directed to the Wyoming Department of Family Services.

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

In Wyoming you may be eligible for Medicaid if you are an individual, 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, so you should contact the Wyoming Department of Family Services for more information.

Low income persons eligible for Medicaid in Wyoming*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Infant	133% (monthly income of about \$1,691 for family of 3)
Child 1-5	133%
Child 6-18	100%
Parent	62%
Pregnant woman	133%

* Eligibility information was compiled from secondary sources, including Center for Budget and Policy Priorities, the Henry J. Kaiser Family Foundation, Families USA, and the Robert Wood Johnson Foundation Covering Kids Program, and may have changed since this guide was published. Contact your state Medicaid program for the most up to date information and for other eligibility requirements that may apply.

To get an idea of how your income compares to the federal poverty level, use the federal poverty guideline issued by the U.S. Department of Health and Human Services for the year 2003:

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

For larger families add \$3,080 for each additional person

So, for example, using this guideline, 133% of the federal poverty level for a family of 3 would be an annual income of \$20,296, or a monthly income of \$1,691.

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

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

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

- *Poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits are automatically eligible for Medicaid.*

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

- *Retired or disabled people who have low incomes and are enrolled in Medicare may also qualify for help from Medicaid. Even though your income may be too high to qualify for Medicaid insurance coverage, there may be other ways Medicaid can help you.*

If your household income is below the poverty level, Medicaid will pay your Medicare monthly premium and your Medicare deductibles and coinsurance. This is called the Qualified Medicare Beneficiary (QMB) program.

If your household income is above 100% but below 120% of the poverty level, Medicaid will pay for your monthly Medicare premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

Contact the Wyoming Department of Family Services for more information about other eligibility requirements.

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

WYOMING KID CARE (CHIP) PROGRAM

The Wyoming Kid Care (CHIP) Program is a state-designated program that provides health insurance to low-income children under the age of 19 who are not eligible for Medicaid and who have no health insurance.

- *A child whose family has a household income up to 185% of the federal poverty level (FPL) is eligible for the Wyoming Kid Care (CHIP) Program.* For a family of three, this works out to an annual income of up to \$28,236 or a gross monthly income of \$2,353.

Financial eligibility criteria limits are adjusted annually to reflect increases in cost of living.

- *The Wyoming Kid Care (CHIP) Program does not impose a pre-existing condition exclusion period.* If a family meets the eligibility guidelines, a child's pre-existing medical condition does not exclude him from coverage.
- *The Wyoming Kid Care (CHIP) Program provides comprehensive coverage to enrollees including doctor's visits, hospital care, prescriptions, mental health, dental, vision and hearing services.*

CARING PROGRAM FOR CHILDREN

The Caring Program for Children is a program designed by Blue Cross Blue Shield of Wyoming to provide basic health and dental care to children of low income families that are not eligible for Medicaid or The Wyoming Kid Care (CHIP) program.

- *To be eligible for the Caring Program a child must meet the following eligibility requirements:*

- *Unmarried Wyoming resident whose family income does not exceed 180% of the Federal Poverty Level.*
- *Not covered by Medicaid, Wyoming Kid Care (CHIP) program, or have any public or private health insurance coverage.*
- *Resident of the State of Wyoming and a U.S. Citizen.*
- *Full time student through grade 12, unless not of school age.*
- *Between the age of 0-19.*

- *The Caring Program only covers primary and preventative medical and dental services. This program does not cover chronic conditions.*

- *For more information about enrolling a child in the Caring Program, call toll-free at (888) 556-8074 statewide, or call 634-1393 in Cheyenne.*

WOMEN'S BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (WOMEN'S HEALTH SOURCE)

- *The Women's Breast and Cervical Cancer Early Detection program is a program which provides breast and cervical cancer screening and diagnostic services to low income, uninsured women who are at risk for developing breast or cervical cancer.*
- *Women who are screened and/or diagnosed with breast or cervical cancer through the Women's Breast and Cervical Cancer Early Detection program and need treatment for breast or cervical are eligible for Medicaid.*
- *In order to be eligible for the Women's Breast and Cervical Early Detection Program you must meet certain income requirements for the program, meet certain age/risk categories, be a Wyoming resident, be uninsured or underinsured, be in need of medical treatment, and not be eligible or pending eligibility for other Medicaid coverage.*
- *To request an application or for additional questions, you may contact Woman's Breast and Cervical Early Detection Program directly at 1-800-246-1296.*

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 PREMIUM WILL THE TAX CREDIT COVER?

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

WHAT HEALTH COVERAGE IS ELIGIBLE FOR THE TAX CREDIT?

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

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

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

State-qualified health plans. Currently, Wyoming has not designated a state qualified health plan.

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

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

FOR MORE INFORMATION...

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

For questions about:	Contact:
Individual Health Insurance Fully Insured Group Health Insurance	<i>Wyoming Department of Insurance</i> (800) 438-5768 http://insurance.state.wy.us
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor, Kansa City Regional Office</i> (866) 275-7922, or contact <i>U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C.</i> (202) 219-8776 <i>For Department of Labor publications:</i> (866) 444-EBSA (3272) http://www.dol.gov/ebsa/
Health Insurance High Risk Pool (WHIP)	<i>Blue Cross and Blue Shield of Wyoming</i> (WHIP administrator) (307) 634-1393 (800) 442-2376 http://insurance.state.wy.us/consumer.html
Medicaid	<i>Wyoming Department of Family Services</i> (800) 251-1269 http://dfsweb.state.wy.us
Wyoming Kid Care (CHIP) Program	<i>Wyoming Kid Care (CHIP) Program</i> (877) 543-7669 http://kidcare.state.wy.us/
Caring Program for Children	<i>Blue Cross Blue Shield</i> (888) 556-8074 634-1393 (Cheyenne) http://www.bcbswy.com/wyoming/caringProg.html
Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service (IRS)</i> (866) 628-HCTC (4282) http://www.irs.gov/individuals/ (Click on HCTC)

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

HELPFUL TERMS

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.

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

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

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

Continuous Coverage (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 Plans, state and local governmental plans and the Wyoming Health Insurance Pool). Under Wyoming rules, health insurance coverage that is not interrupted by a break of more than 90 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. Wyoming rules apply to you if you are joining a fully insured group health plan, a state or local governmental plan or buying a private

individual health plan or one through the Wyoming Health Insurance Pool. See also Creditable Coverage, Federally Eligible, Wyoming Health Insurance Pool.

Conversion. Your right, when leaving a group health plan in Wyoming, to convert your policy to an individual health plan. You must use up any COBRA or state continuation coverage before you can buy a conversion policy. Conversion policies must offer 4 coverage options. Since there are no limits on how much insurance companies can charge for conversion policies, they can be significantly more expensive than your group health plan. See also Group Health Plan.

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

Elimination Rider. A feature permitted in individual health plans that allow plans to permanently exclude coverage for a health condition, body part, or body system.

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

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

Federally Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be federally eligible, you also must have used up any COBRA or state continuation coverage available to you, you must not be eligible for Medicare, Medicaid, or a group health plan, and you must not have other health insurance. In Wyoming, you are guaranteed the right to buy coverage through the Wyoming Health Insurance Pool if you are federally eligible, but you must apply within 90 days of losing your prior creditable coverage. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured group health plans are regulated by the state of Wyoming. 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 preexisting (and

therefore exclude coverage for) a condition about which you have genetic information, unless that health condition has been diagnosed by a health professional.

Group Health Plan. Health insurance (usually sponsored by an employer, union or professional association) that covers at least 2 employees.

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All small group health plans sold to small employers in Wyoming are guaranteed issue. Plans that are guaranteed issue can turn you away for other reasons.

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

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

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

Health 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 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.

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

Individual Health Plan. Policies for people not connected to an employer group. This term also refers to coverage purchased by the self-employed for themselves (or their family members) but for no other employees. Individual health plans are regulated by the state of Wyoming.

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

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

Look Back Period. The maximum length of time, immediately prior to enrolling in a health plan that can be examined for evidence of preexisting conditions. See also Preexisting 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, and therefore may limit enrollment to those people who live within a particular coverage area. Managed care plans may 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. See also HMO.

Medicaid. A program providing comprehensive health insurance coverage and other assistance to certain low-income Medicaid 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 benefit pension plans. The agency receives no

funds from general tax revenues. Operations are financed largely by insurance premiums paid by companies that sponsor pension plans and by PBGC's investment returns.

Preexisting Condition. Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan. Pregnancy cannot be counted as a preexisting condition in a group health plan but can in an individual health plan. Genetic information about your likelihood of developing a disease or condition, without a diagnosis of that disease or condition, cannot be considered a preexisting condition in a group health plan, but can in an individual health plan. Newborns, newly adopted children, and children placed for adoption covered within 31 days of birth cannot be subject to preexisting condition exclusion periods in individual or group health plans. See also Preexisting Condition Exclusion Period.

Preexisting Condition Exclusion Period. The time during which a health plan will not pay for covered care relating to a preexisting condition. See also Preexisting Condition.

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

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

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

State Continuation Coverage. A program similar to COBRA, but for small employers. In Wyoming, if you are in a fully insured group health plan or a state or local governmental plan with 2 to 19 employees, you also have rights to continue your health coverage for up to 12 months when your job ends. See also COBRA.

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

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

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

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

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

Waiting Period. The time you may be required to work for an employer before you are eligible for health benefits. Not all employers require waiting periods. Waiting periods do not count as gaps in health insurance for purposes of determining whether coverage is continuous. Waiting periods reduce preexisting condition exclusion periods.

Wyoming Health Insurance Pool (WHIP). The state-run program for people with high health risks (called a high risk pool). The Wyoming Health Insurance Pool sells coverage to those who are federally eligible and to others with serious health conditions who cannot buy affordable coverage from private health insurance companies.