

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

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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 ALASKA

As resident of Alaska, 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 an Alaska resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group health plans and individual health insurance. 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 Alaska, your protections may change. Since this guide is a summary, it may not answer all of your questions. For places to contact for more information, see page 30. For information about how to find consumer guides for other states on the Internet, see page 30. A list of helpful terms and their definitions begins on page 31. These terms are in boldface type the first time they appear.

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CHAPTER 1

A SUMMARY OF YOUR PROTECTIONS

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

HOW AM I PROTECTED?

In Alaska, 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 7.)*
- *All group health plans in Alaska 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 and 22.)*
- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group. All health plans for small employers must be sold on a **guaranteed issue** basis. While there are limits on what you can be charged based on health status, premiums can be significantly higher if someone in your group has a serious health condition. Also, the insurance carrier can turn you down if your small business does not meet the participation or contribution requirements. (See page 22.)*

- *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**. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage. (See page 15.)*
- *If you lose your group health insurance and meet other qualifications, you will be **HIPAA eligible**. If so, you can buy an individual health insurance policy from the **Alaska Comprehensive Health Insurance Association (ACHIA)**. You will not have a pre-existing condition exclusion period. There are limits on what you can be charged for an ACHIA policy. (See page 19.)*
- *You may also be able to buy insurance from ACHIA if you have had difficulty obtaining affordable health insurance from private companies because of your health condition. In this case you may face a new pre-existing condition exclusion period. (See page 19.)*
- *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 Alaska **Medicaid** program offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes. **Denali KidCare** (part of Alaska's Medicaid program) offers free or subsidized health coverage for some uninsured children and pregnant women. (See Chapter 5.)*
- *If you believe you may be at risk for cancer but are uninsured or underinsured, you may be eligible for screening and treatment. The **Breast and Cervical Cancer Health Check Program** provides free cancer screening for qualified residents. Some women diagnosed with breast or cervical cancer through this program may be eligible for medical care through Medicaid. (See page 26.)*
- *If you lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program**, you may be eligible for a federal income tax credit to help you pay for new health coverage. This credit is called the **Health Coverage Tax Credit (HCTC)**, and is equal to 65% of the cost of qualified coverage, including COBRA and health insurance offered through the Alaska Comprehensive Health Insurance Association (ACHIA). (See page 27.)*
- *If you are a retiree aged 55-65 and are receiving benefits from **Pension Benefit Guaranty Corporation (PBGC)**, then you may be eligible for the HCTC. (See page 27.)*

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 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 7.)*
- *Employers are not required to provide health benefits for their employees, so if you change jobs, you may find that your new employer does not offer you health coverage. Employers are required only to make sure that any health benefits they do offer do not discriminate based on health status. (See page 7.)*
- *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 10.)*
- *If you are joining a new group health plan that is self-funded, you may have to satisfy a new pre-existing condition period if you have a break in coverage of 2 or more months. However, if you are joining a new group health plan that is fully funded, you may have to satisfy a new pre-existing condition period if you have a break in coverage of 3 or more months. (See page 8.)*
- *Even if you have **continuous coverage**, there may be a pre-existing condition exclusion period for some benefits if you join a **group health plan** that covers benefits your old plan did not. For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition. (See page 10.)*
- *If you work for a non-federal public employer in Alaska, such as such as a state or municipal government, not all of the group health plan protections may apply to you. (See page 11.)*
- *In Alaska, your access to individual health insurance depends on your health status. Private insurers are not prohibited from turning you down, charging more, or limiting coverage because of pre-existing conditions. If you are HIPAA eligible, ACHIA 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 13.)*

- *In most cases, the law does not limit what you can be charged for individual health insurance. You can be charged substantially higher premiums because of your health status, age, gender, and other characteristics. (See page 14.)*
- *If you move away from Alaska, 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 an HMO plan that you cannot join because you live outside of the plan's service area.
- *You cannot be turned away or charged more because of your health status.* Health status means your medical condition or history, **genetic information**, or disability. This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (such as part-time or seasonal employment), as long as these are unrelated to health status and applied consistently.

Discrimination due to health status is not permitted

The Acme Company has 200 employees and offers two different health plans. Full time employees are offered a high option plan that covers prescription drugs; part time employees are offered a low option plan that does not. This is *permitted* under the law. By contrast, in a cost-cutting move, Acme restricts its high option plan to those employees who can pass a physical examination. This is *not permitted* under the law.

- *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage.* This waiting period, however, must be applied consistently and cannot vary due to your health status. Unlike employers, insurers cannot require waiting periods.
- *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 Alaska 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. Similarly, if the plan covers dependents, new spouses can be covered beginning on the 1st day of the 1st month after the date the health plan receives the enrollment request. The insurer may require that the enrollment request be received within 31 days of the date of marriage in order for coverage to be effective.
 - *If you have to take leave from your job due to illness, the birth or adoption of a child, or to care for a seriously ill family member, you may be able to keep your group health coverage for a limited time.* A federal law known as the **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job-protected leave in these circumstances.

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

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

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

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

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

When you first enroll in a group health plan, the employer or insurance company may ask if you have any pre-existing conditions. Or, if you make a claim during the first year of coverage, the plan may **look back** to see whether it was for such a condition. If so, it may try to exclude coverage for services related to that condition for a certain length of time. However,

federal and state laws protect you by placing limits on these pre-existing condition exclusion periods under group health plans. In some cases, your protections will vary depending on the type of group health plan you belong to.

- *A group health plan can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan. This period is called the look back period.*
- *Under group health plans, coverage for pre-existing conditions can be excluded for no longer than 12 months when you join a plan as a regular or special enrollee. However, if you enroll late in a self-insured group health plan (after you are hired and not during a regular or special enrollment period), you may have an 18-month pre-existing condition exclusion period. Late enrollees in fully insured health plans may face one of three possibilities: (1) immediate enrollment in the plan with an 18-month exclusion period; (2) denial of plan coverage for 18 months, after which the plan must admit you without any pre-existing condition exclusion period; or (3) some combination of denial of coverage and a pre-existing condition exclusion period, which together does not exceed 18 months. A fully insured group health plan must treat all its late enrollees the same, whatever method it chooses to use.*
- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns, newly adopted children, children placed for adoption, or genetic information.*
- *Group plans that impose pre-existing condition exclusion periods must give you credit for any previous continuous **creditable coverage** that you've had. Most types of private and government-sponsored health insurance are considered creditable coverage.*

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

Federal Employees Health Benefits (FEHBP)	Medicare
Group health insurance (including COBRA)	Military health coverage (CHAMPUS, TRICARE)
Indian Health Service	State health insurance
Individual health insurance	high risk pools
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 of prior coverage, 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 varies depending on the type of group health plan you are joining.* For self-insured group health plans, coverage counts as continuous if it is not interrupted by a break of 63 or more days in a row. For fully insured group health plans, coverage counts as continuous if it is not interrupted by a break of 90 or more days in a row.

Fully insured and self-insured group health plans count continuous coverage differently.

Art, who is diabetic, 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 immediately joined Beta's *fully insured* group health plan, which covers diabetes but excludes pre-existing conditions for a year. In Alaska, fully insured group health plans count as continuous all creditable coverage that is not interrupted by a lapse of 90 or more consecutive days. Because his lapse in coverage was less than 90 days, Art will get credit for his coverage at Ajax. Beta's plan will begin paying for Art's diabetes care right away.

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. 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. Beta's plan will begin paying for Art's diabetes care in one year.

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

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

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

Question: Is this permitted?

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

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

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

Federal law permits state, county, and local governments to exempt their employees in self-insured 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 City of Fairbanks has decided that certain health insurance protections will *not* apply to its employees. If you have group health coverage through this employer, you should contact it for more information. Other non-federal public employers in Alaska 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 insurance coverage. See Chapter 3 for more information about COBRA and ACHIA coverage for "HIPAA eligible individuals."

- *If you lost your health insurance and are receiving benefits from the Trade Adjustment Assistance (TAA) Program, you may be eligible for a federal income tax credit to help you pay for new health coverage. This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 65% of the cost of qualified coverage, including COBRA and health insurance offered through the Alaska Comprehensive Health Insurance Association (ACHIA). (See page 27.)*
- *If you are a retiree aged 55-65 and are receiving benefits from Pension Benefit Guaranty Corporation (PBGC), then you may be eligible for the HCTC. (See page 27.)*

CHAPTER 3

YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group insurance, you may want to buy an individual health plan from a private health insurance company. However, in Alaska – as in most other states – you have limited guaranteed access to individual health insurance. There are some alternatives to individual health insurance coverage in the private market – such as COBRA coverage and ACHIA coverage. This chapter summarizes your protections under different kinds of health plan coverage.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

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

In Alaska, your ability to buy an individual health insurance policy from a private insurance company depends on your health status.

- *In general, companies that sell individual health insurance in Alaska 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 had in the past. Depending on your health status, insurers might refuse to sell you coverage or they 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 ACHIA coverage. (See page 19.)
- *Under Alaska 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 policy 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. Similarly, if the policy covers dependents, new spouses can be covered beginning on the 1st day of the 1st month after the date the health plan receives the enrollment request. The insurer may require that the enrollment request be received within 31 days of the date of marriage in order for coverage to be effective.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

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

screening. Check with the Alaska Division of Insurance for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *In Alaska there are different ways an individual health insurer can exclude a pre-existing condition.* The insurer can impose an **elimination rider**. An elimination rider is an amendment to your health insurance contract that temporarily or permanently excludes coverage for a health condition, body part, or body system.

Also, an individual health insurer may impose a pre-existing condition exclusion period. There is no standard definition of pre-existing condition for the individual market under Alaska law; however, typically, a health plan will define a pre-existing condition exclusion to include both conditions that you actually received care for, as well as conditions or symptoms for which the insurer believes most people in your situation would have sought care. This is called the prudent person rule. Further, individual health insurers are not required to credit prior health coverage toward pre-existing condition exclusion periods.

In Alaska, pregnancy can be considered a pre-existing condition by individual health insurers. In addition, genetic information cannot be considered a pre-existing condition in the absence of a diagnosis.

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

- *If you have an expensive health condition, your individual health insurance premiums may be very high.* The law does not prohibit Alaska health insurers from charging you more because of your health status.

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELLED?

- *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, guaranteed renewability does not protect you from having your premiums go up at renewal, and premiums can also increase within limits as you age or your health declines.
- *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-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 coverage. The information presented below was taken from publications prepared by the U.S. Department of Labor. You should contact them for more information about your rights under COBRA.

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

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

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

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

COBRA QUALIFYING EVENTS

For employees

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

For spouses

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

For dependent children

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

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

- *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 the 60-day period to elect COBRA continuation coverage has expired. In this circumstance, TAA-eligible people have a second 60-day period, starting on the date of their TAA eligibility, to elect COBRA. (However, in no case can COBRA be elected more than 6-months following the original qualifying event (i.e. layoff) that caused the loss of group health plan coverage.)*
 - *When COBRA is elected during this special, second election period, coverage starts on the first date of the special election period. Any time that has elapsed between the original qualifying event and the first date of the special election period is not counted as a lapse in coverage in determining continuous coverage history.*
- *To qualify as HIPAA eligible, you must choose and use up any COBRA or state continuation coverage available to you.*

WHAT WILL COBRA COVER?

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

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage.* The first premium must be paid within 45 days of electing COBRA coverage.
- *If you elect the 11-month disability extension, the premium will increase to 150% of the total cost of coverage.* See below for more information about the disability extension.
- *If you are eligible for the HCTC, the federal government will pay 65% of your COBRA premium.* (See page 27.)

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 of hours). You must obtain a disability determination letter from the Social Security

Administration, and you must notify your group health plan within 60 days of receiving this disability determination letter, and before your original 18 months expires.

LENGTH OF COBRA COVERAGE		
<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 a health benefit plan to its 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.*

ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION (ACHIA)

Alaska has a high risk pool program, called the Alaska Comprehensive Health Insurance Association (ACHIA), that offers insurance for people with health conditions who are unable to buy private health insurance coverage and for people who are HIPAA eligible.

WHEN CAN I GET A POLICY FROM ACHIA?

- *There are several ways to qualify for ACHIA coverage. If you are HIPAA eligible, you will be able to purchase ACHIA coverage.*

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible in Alaska, you are guaranteed the right to buy an individual health plan from ACHIA and are exempted from pre-existing condition exclusion periods. 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 federally eligible.)
- In Alaska, you must apply within 90 days to receive ACHIA coverage without a pre-existing condition exclusion period. (In most other states, however, you must apply for health insurance for which you are HIPAA eligible within 63 days of losing your prior coverage.)

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

- *If you are eligible for the federal health coverage tax credit (HCTC), you can buy health insurance from the Alaska Comprehensive Health Insurance Association (ACHIA).*
- *If you have difficulty obtaining affordable private health insurance because of your health status, you may be able to get coverage from ACHIA. You are eligible to purchase ACHIA coverage if you have lived in Alaska for at least 12 months, are not eligible for a small employer health plan, do not have other health insurance coverage including coverage from a government health plan (such as the Indian*

Health Service, Veteran's Administration benefits, or Medicaid), and meet one of the following criteria:

You have been turned down for coverage by one insurance company;

You have been diagnosed with one of a list of health conditions such as cancer, diabetes, heart disease, or AIDS; or

You were offered coverage by an insurance company, but the policy contained a restrictive rider that would have substantially reduced the benefits of the insurance policy.

- *ACHIA does not offer family coverage.* Each member of your family who wants ACHIA coverage needs to qualify on his or her own.

WHAT WILL ACHIA COVER?

- *ACHIA coverage includes hospital and physician care, diagnostic tests and x-rays, prescription drugs, and other services.* For most services, the plan will pay for 80% of covered charges after you have satisfied your annual deductible. After you have paid a maximum amount for covered services, ACHIA will pay 100% of your covered charges. Separate coverage limits apply to mental health and substance abuse benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are HIPAA or HTCT eligible, you will not receive a pre-existing condition exclusion when you enroll in ACHIA.* Elimination riders are not permitted on ACHIA plans.
- *If you are not HIPAA eligible, you may have a 6-month pre-existing condition exclusion period when you first enroll in ACHIA.* When you enroll, ACHIA will look back 3 months to see if you had a condition for which you actually received – or for which most people would have sought – a diagnosis, medical advice, or treatment. This is called the prudent person rule. Pregnancy and genetic information can be considered pre-existing conditions. Elimination riders are not permitted on ACHIA plans.
- *ACHIA will credit prior continuous coverage toward your pre-existing condition exclusion if you apply for ACHIA coverage within 31 days of losing your prior coverage.* ACHIA will consider your prior coverage creditable if it was involuntarily terminated and contained a similar pre-existing condition exclusion.

WHAT CAN I BE CHARGED FOR ACHIA COVERAGE?

- *Premiums will vary based on the plan you choose.* In addition, ACHIA charges enrollees different rates based on their age and the geographic area they live in. Under Alaska law, ACHIA rates are not allowed to be more than 200% of the amount that a healthy person would pay if he or she bought a similar plan sold by a private insurer. In practice, however, ACHIA rates have generally been about 150% to 175% of the rates that healthy people pay.

For example, the monthly premium for a 24-year-old person ranges from \$162 to \$417, depending on which deductible option is selected. By contrast, the monthly premium for a 64-year-old person ranges from \$583 to \$1,506, depending on which deductible option is selected.

Contact ACHIA at (888) 290-0616 or visit <http://www.achia.com/> for the most current information about premium and coverage options.

HOW LONG DOES ACHIA COVERAGE LAST?

- *ACHIA policies are renewable as long as you pay your premiums, continue to reside in Alaska, 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. Alaska 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 Alaska Division of Insurance to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down. This is called **guaranteed issue**. If you employ at least 2 but not more than 50 people, health insurance companies must sell you any **small group health plan** they sell to other small employers. However, they can require that a minimum percentage of your eligible employees sign up for coverage. They can also require you to pay a minimum share of your workers' premiums. If you wish to buy a **large group health plan** (one that covers more than 50 employees), your group can be turned down.*
- *If you are a small employer in Alaska, insurance companies initially must offer coverage to all of your eligible employees. Alaska law defines "eligible employee" as any employee whose normal work week is 30 hours or more. Even if you decide not to offer health benefits to all "eligible employees," insurers must initially offer you a small group health plan that would cover all of your eligible employees. If you choose not to offer health benefits to all of your eligible employees, remember that you may not condition eligibility for health benefits on the health status of your employees or their dependents to decide who receives coverage, but you may use other factors such as part-time employment*
- *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 case of discontinuance, they must give you a chance to buy other plans they sell to groups of your size.*

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

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

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are not eligible to buy a group health plan on your own (though you may be able to join another group health plan through a family member).* Therefore, the laws that protect employers' access to group health plans do not apply to you. Your access to health insurance is protected by the laws that apply to individuals. (See Chapter 3.)
- *If you are self-employed and buy your own health insurance, you are eligible to deduct 100% of the cost of your premium from your federal income tax.*

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5 FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Alaska who cannot afford to buy health insurance. Medicaid (including Denali KidCare), the **Breast and Cervical Cancer Health Check** and other programs offer free or subsidized health insurance coverage, direct medical services or other help at little or no cost to you. 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 (including Denali KidCare) is a program that provides health coverage to some low-income Alaska residents. Medicaid covers families with children, pregnant women, the elderly, and people with disabilities, if state and federal guidelines are met. Legal residents who are not U.S. citizens may be eligible for Medicaid. Non-citizens who do not have immigration documents cannot enroll in Medicaid, but may be covered if treated for an emergency condition. Denali KidCare is part of Alaska's Medicaid program. It provides coverage for some children and pregnant women who meet income guidelines.

- *For certain categories of people, eligibility for Medicaid is based on the amount of your household income.* In Alaska you may be eligible for Medicaid if you are a child, a pregnant woman, or a parent of a child and your family income meets the Medicaid income standards. Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account, so you should contact the Division of Public Assistance for more information.

Low income persons eligible for Medicaid in Alaska*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Child 0-19	175% (monthly income of about \$2,285 for family of 3)
Non-Working Parent	75%
Working Parent	81%
Pregnant woman	175%

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

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

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

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

So, for example, using this guideline, 175% of the federal poverty level for a family of 3 would be an annual income of \$27,423 or a monthly income of about \$2,285.

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

- *Families who get cash benefits from TANF (also known as ATAP or Alaska Temporary Assistance Program) may also be eligible for Medicaid, but eligibility is not directly linked to TANF.*

Parents should know that when you get a job and your Family Medicaid benefits end, you may qualify for transitional Medicaid for a 12-month period.

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

Disabled individuals should know that if your income earned from a job increases so that you no longer qualify for SSI or Adult Public Assistance state supplement, you may be able to continue your Medicaid coverage under a different eligibility category that may require payment of a premium.

- *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, Medicaid may be able to help you with your Medicare expenses.

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

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

Contact the Division of Public Assistance 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 Division of Public Assistance

To obtain the locations and telephone number of sites near you call (800) 211-7470 (state-wide) or 562-3671 (Anchorage area).

For more information about Denali KidCare, call (888) 318-8890 (state-wide) or 269-6529 (Anchorage area).

BREAST AND CERVICAL CANCER HEALTH CHECK (BCHC)

The Alaska Breast and Cervical Health Check (BCHC) program provides breast and cervical cancer screening to eligible women of Alaska.

- *The Alaska Breast and Cervical Health Check (BCHC) program provides qualified woman with free screenings for breast and cervical cancer.* Women screened through this program and diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid which extends throughout the duration of treatment
- *Eligibility for this program is based on several factors.* To be eligible for breast exams, pelvic exams, and Pap tests, you must be between the ages of 18 and 64. To receive mammogram services, you must be between 50 and 64 years of age. Additionally, your income must be at or below 312% of the Federal Poverty Level (FPL) and you must be uninsured or underinsured.
- *For more information, please contact the Alaska Department of Health and Social Services at (800) 410-6266 or visit their website at <http://health.hss.state.ak.us/dhcs/bchc/about/default.htm>.*

OTHER PROGRAMS

There may be other financial assistance programs available. Please contact the Alaska Department of Health and Social Services at (907) 465-5824 or <http://health.hss.state.ak.us/dhcs/programs.htm>

THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)

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

WHEN AM I ELIGIBLE FOR THE HCTC?

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

another group health plan where the employer pays at least 50% of the cost of coverage, or in Medicaid, SCHIP, FEHBP, Tricare/CHAMPUS.

- *Eligibility for HCTC is not based on income.* In addition, the HCTC is refundable. This means you can claim the credit even if you do not earn enough income to owe federal income tax.

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

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

WHAT HEALTH COVERAGE IS ELIGIBLE FOR THE TAX CREDIT?

- *The HCTC can only be used to help pay for “qualified” health coverage.* Qualified health coverage includes:
 - COBRA continuation coverage, as long as your employer or former employer contributes less than 50% of the total health plan premium.
 - State qualified plans: In Alaska, the Alaska Comprehensive Health Insurance Association offers “qualified health coverage.”
 - Individual health insurance in which you were enrolled for at least the last 30 days before you were separated from the job that makes you eligible for TAA benefits or for payments from the PBGC.
 - Your husband’s or wife’s insurance from work, as long as the employer contributes less than 50% of the total health plan premium. (At this time, you can only claim the credit with this type of coverage when you file your federal tax return and not in advance.)

HOW DO I CLAIM THE HCTC?

- *You can claim the HCTC on your tax return and be reimbursed for 65% of the premium you paid for qualified coverage while you were eligible for the HCTC.* Currently, this is the only way to claim the HCTC if your qualified health plan is provided through a spouse’s employer.
- *Alternatively, you can choose to have your credit sent directly to your qualified health plan each month.* To do this, you must register with the HCTC customer service center by calling 1-866-628-HCTC (1-866-628-4282), Monday through Friday between the hours of 7 am and 7 pm, Central time. TDD/TYY callers, please call 1-866-626-HCTC (1-866-626-4282).

- *You will have to fill out a registration form verifying your eligibility for the HCTC and your enrollment in qualified coverage. You will also fill out a payment invoice. Each month, you will send the HCTC program your 35% share of the premium for qualified coverage. The HCTC program will combine this payment with the tax credit covering the other 65% of the premium and forward the entire payment to your qualified health plan.*
- *You must register in advance to have the HCTC paid directly to your health plan each month. Usually, the direct payments won't begin until at least a month after you register with the HCTC program. Call the HCTC customer service center for more information*

WHERE CAN I GET MORE INFORMATION?

- *For more information about the HCTC, contact the HCTC customer service center at 1-866-628-HCTC, or see the IRS website at <http://www.irs.gov/individuals/index.html> (click on HCTC)*
- *For more information about TAA benefits contact, http://www.doleta.gov/tradeact/2002act_summary.asp.*
- *For more information about PBGC, contact, <http://www.pbgc.gov> or call 1-202-326-4000 with general inquiries.*

FOR MORE INFORMATION...

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

For questions about:	Contact:
Individual health insurance Fully insured group health insurance	<i>Alaska Division of Insurance</i> (800) 467-8725 (Alaska only) (907) 465-2515 http://www.dced.state.ak.us/insurance
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor, Seattle Regional Office</i> (206) 553-4244, or contact <i>U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C.</i> (202) 219-8776 <i>For Department of Labor publications:</i> (800) 998-7542 http://www.dol.gov/dol/pwba
Alaska Comprehensive Health Insurance Association (ACHIA)	<i>Aetna U.S. Health Care (plan administrator)</i> (888) 290-0616 (907) 787-2209 http://www.achia.com
Medicaid (including Denali KidCare) Chronic and Acute Medical Assistance (CAMA)	<i>Alaska Division of Public Assistance</i> (800) 211-7470 (state-wide) 562-3671 (Anchorage area) http://www.hss.state.ak.us For information on Denali KidCare (888) 318-8890 (state-wide) 269-6529 (Anchorage)
Breast & Cervical Cancer Health Check (BCHC)	<i>Alaska Department of Health and Social Services</i> (800) 410-6266 http://health.hss.state.ak.us/dhcs/bchc/about/default.htm
Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service</i> (866) 628-HCTC http://www.irs.gov/individuals/index.html

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

HELPFUL TERMS

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

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

CAMA. Stands for Chronic and Acute Medical Assistance. CAMA is a program that helps needy Alaska residents with little or no insurance get urgent medical care.

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

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

Continuous Coverage. Under federal rules, health insurance coverage that is not interrupted by a break of 63 or more consecutive days. Employer waiting periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. Federal rules apply when you join a self-insured group health plan. Under Alaska rules, coverage is continuous if not interrupted by a break of 90 consecutive days. Alaska rules apply when you are joining a fully insured group health plan, or if you are federally eligible and buying coverage from ACHIA. If you are buying ACHIA coverage and you are not federally eligible, you must apply within 31 days of losing prior coverage. See also ACHIA, Creditable Coverage, Federally Eligible, Fully Insured Group Health Plan, Self-Insured Group Health Plan.

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

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

Denali KidCare. Alaska's Denali KidCare program provides insurance for some low income children under the age of 19 and pregnant women who have limited or no health insurance.

Elimination Rider. An amendment permitted in individual health plan contracts that permanently excludes your 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.

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by Alaska. See also Self-Insured Group Health Plans.

Genetic Information. Includes information about family history or genetic test results indicating your risk of developing a health condition. A group health plan cannot consider pre-existing (and therefore exclude coverage for) a condition about which you have genetic information, unless that health condition has been diagnosed by a health professional.

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

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All health plans sold to small employers with 2 to 50 employees in Alaska are guaranteed issue. Plans that are guaranteed issue can turn you away for other reasons.

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

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

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

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

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

HIPAA. The Health Insurance Portability and Accountability Act was passed in 1996 to help people buy and keep health insurance, even when they have serious health conditions, the law sets a national floor for health insurance reforms. Since states can and have modified and expanded upon these provisions, consumers' protections vary from state to state.

HIPAA Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare, 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. When you are buying individual health coverage, federal eligibility confers greater protections on you than you would otherwise have in Alaska and in other states. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

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

Large Group Health Plan. A health plan covering employees and their dependents in which the employer employs more than 50 employees.

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

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

Medicaid. A program providing comprehensive health insurance coverage and other assistance to certain low-income Alaska residents. All other states have Medicaid programs, too, though eligibility levels and covered benefits will vary.

Nondiscrimination. A requirement that group health plans not discriminate against you based on your health status. Your coverage under a group health plan cannot be denied or restricted, nor can you be charged a higher premium, because of your health status. Group health plans can restrict your coverage based on other factors (such as part time employment) that are unrelated to health status. See also Group Health Plan, Health Status.

Pension Benefit Guaranty Corporation (PBGC). PBGC is a federal government corporation established by Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) to encourage the continuation and maintenance of defined benefit pension plans, provide timely and uninterrupted payment of pension benefits to participants and beneficiaries in plans covered by PBGC. It currently guarantees payment of basic pension benefits earned by American workers and retirees participating in private-sector defined benefit pension plans. The agency receives no funds from general tax revenues. Operations are financed largely by insurance premiums paid by companies that sponsor pension plans and by PBGC's investment returns.

Pre-existing Condition (ACHIA). Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 3-month period immediately preceding enrollment in a health plan, or for which an ordinarily prudent person would have sought medical advice, care or treatment. Pregnancy can be counted as a pre-existing condition by ACHIA. Genetic information can also trigger a pre-existing condition exclusion under this plan. See also Prudent Person Rule.

Pre-existing Condition (Group Health Insurance). Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan. Pregnancy cannot be counted as a pre-existing condition. Genetic information about your likelihood of developing a disease or condition, without a diagnosis of that disease or condition, cannot be considered a pre-existing condition. Newborns, newly adopted children, and children placed for adoption covered within 30 days cannot be subject to pre-existing condition exclusions.

Pre-existing Condition (Individual Health Insurance). Any condition for which medical advice, diagnosis, care or treatment was *ever* recommended or received, or for which an ordinarily prudent person would have sought medical advice, care or treatment. In Alaska, under individual health insurance policies, pregnancy can be counted as a pre-existing condition. Genetic information can also trigger a pre-existing condition exclusion in individual health plans. See also Prudent Person Rule.

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

Prudent Person Rule. In individual health plans and ACHIA 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 prior to enrolling in an individual health plan.

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

Small Group Health Plan. A health plan covering employees and their dependents in which the employer employ at least 2 employees but not more than 50 employees.

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

State Continuation Coverage. A program similar to COBRA for small employers with fewer than 20 employees. Alaska does not have a state continuation coverage law, but some other states do. See also COBRA.

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

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

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

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

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