

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

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**January 2006**

## **ACKNOWLEDGMENTS AND DISCLAIMER**

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

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

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

January 2007

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# A CONSUMER'S GUIDE TO GETTING AND KEEPING HEALTH INSURANCE IN IOWA

As a resident of Iowa, 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 resident of Iowa. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group 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 Iowa, your protections may change. Since this guide is a summary, it may not answer all of your questions. For places to contact for more information, see page 33. For information about how to find consumer guides for other states on the Internet, see page 34. A list of helpful terms and their definitions begins on page 35. These terms are in boldface type the first time they appear.

## Contents

1. A summary of your protections .....	2
How am I protected? .....	2
What are the limits on my protections? .....	4
2. Your protections under group health plans.....	6
When does a group health plan have to let me in?.....	6
Can a group health plan limit my coverage for pre-existing conditions?.....	8
Limits to protections for certain government workers.....	10
As you are leaving group coverage.....	11
3. Your protections when buying individual health insurance.....	12
Individual health insurance sold by private insurers.....	12
COBRA and state continuation coverage.....	14
Conversion .....	19
Iowa Comprehensive Health Association (HIP-IOWA) .....	20
4. Your protections as a small employer or a self employed person.....	23
Do insurance companies have to sell me health insurance?.....	23
Can I be charged more because of my group's health status?.....	23
What if I am self-employed? .....	24
A word about association plans .....	24
5. Financial assistance.....	25
Medicaid .....	25
<i>hawk-i</i> : Healthy and Well Kids in iowa.....	28
Iowa Breast & Cervical Cancer Early Detection Program (Care for Yourself) ..	28
Other programs.....	29
The Federal Health Coverage Tax Credit (HCTC).....	29
For more information... ..	33
Helpful terms .....	35

# 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 insurance**), so your protections may vary if you leave Iowa. 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 Iowa resident.

### HOW AM I PROTECTED?

In Iowa, 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 5).
- *All group health plans in Iowa 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 7).
- *Your health insurance cannot be canceled because you get sick.* All health insurance is **guaranteed renewable** (see pages 13 and 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** 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 13).

- *If you are **HIPAA eligible** or have been denied individual insurance because of your health status, you can buy coverage from the **Iowa Comprehensive Health Association (HIP-IOWA)**. There are limits on what you can be charged for an HIP-IOWA policy. However, depending on how you become eligible, you may face a new pre-existing condition exclusion period (see page 18).*
- *If you are a current **Basic and Standard** policy holder, you have the option to purchase coverage from HIP-IOWA or maintain your current coverage (see page 19).*
- *If you lose your group health plan, you may also be able to buy a **conversion** policy. You will not face a new pre-existing condition exclusion period (see page 17).*
- *If you are a small employer buying a **small group health plan**, you cannot be turned down because of the health status, age, or any other factor that might predict the use of health services of those in your group. All health plans for small employers must be sold on a **guaranteed issue** basis. Premiums can vary, within limits, based on the health status of your group (see page 22).*
- *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 Iowa **Medicaid** program offers free health coverage for certain families, children, pregnant women, elderly, and disabled individuals (see Chapter 5).*
- *If you believe that you may be at risk for breast or cervical cancer, you may be eligible for free screening and treatment. The **Care for Yourself** program, the Iowa Breast and Cervical Cancer Early Detection Program, provides qualified women with free breast and cervical cancer screenings. Women diagnosed with breast or cervical cancer through this program may be eligible for treatment through Medicaid (see page 28).*
- *If your child is 19 years or younger, does not have health insurance, and meets other qualifications, you may be able to receive low cost or free health insurance for them through the **Healthy and Well Kids in Iowa (hawk-I)** (see page 28).*
- *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**, and is equal to 65% of the cost of qualified coverage, including COBRA and coverage offered through HIP-IOWA (see page 29).*

- *If you are a retiree aged 55-65 and receiving benefits from **Pension Benefit Guaranty Corporation (PBGC)**, then you may 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 5).*
- *Employers are not required to provide health benefits for their employees, so if you change jobs, you may find that your new employer does not offer you health coverage. Employers are only required to make sure that any health benefits they do offer do not discriminate based on health status (see page 5).*
- *If you get a new job with health benefits, your coverage may not start right away. Employers can impose **waiting periods** before your health benefits begin (see page 5).*
- *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 or purchase health insurance through HIP-IOWA (see pages 7 and 21).*
- *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 certain benefits your old plan did not. For example, say you move from a group plan that does not cover prescription drugs to a self-insured 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 9).*
- *If you work for a non-federal public employer in Iowa, such as a state or municipal government, not all of the group health plan protections may apply to you (see page 9).*

- *In Iowa, your access to individual health insurance may depend on your health status.* Individual health insurers can turn you down if you have a serious health condition. They can also charge you higher premiums because your health, age, gender, occupation and other factors (see page 11).

## CHAPTER 2

# YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

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

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

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

### Discrimination due to health status is not permitted

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

- *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage.* This waiting period, however, must be applied consistently and cannot vary due to your health status. Unlike employers, insurers cannot require waiting periods.
- *When you begin a new job with health insurance through an HMO, the HMO may require a waiting period before coverage begins.* This waiting period is called an **HMO affiliation period**, and you will not have health insurance coverage during this time. An affiliation period cannot exceed 2 months (3 months for late enrollees), and you cannot be charged a premium during it.

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

#### **Certain changes can trigger a special enrollment opportunity**

- The birth, adoption, or placement for adoption of a child
  - Marriage
  - Loss of other health insurance (for example, you or your dependents have through yourself or another family member because of death, divorce, legal separation, termination, retirement, or reduction in hours worked)
- *Under Iowa 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 and pay the premium within the 31 days in order to continue coverage beyond the 31 days.
  - *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 impose pre-existing condition exclusions on conditions for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan. This period is also called the look back period.*
- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns, newly adopted children, children placed for adoption, or genetic information.*
- *Under group health plans, coverage for pre-existing conditions can be excluded for no longer than 12 months. However, if you enroll late in your group plan (after you were hired and not during a regular or special enrollment period), you may have a longer 18-month pre-existing condition exclusion period. You will receive credit toward your pre-existing condition period for any previous continuous coverage.*
- *Group health plans that impose pre-existing condition exclusion periods must give you credit for any previous continuous **creditable coverage** that you've had. Most types of private and government-sponsored health insurance are considered creditable coverage.*

### **What is creditable coverage?**

Most health insurance counts as creditable coverage, including:

Children's Health Insurance Program	Medicare
Federal Employees Health Benefits (FEHBP)	Military health coverage (CHAMPUS, TRICARE)
Foreign National Coverage	State high-risk pools
Group health plan (including COBRA)	Student Health Insurance
Indian Health Service	VA Coverage
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.

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

### **What is continuous coverage?**

Group health plans consider coverage as continuous as long as you have not had 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, *45 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 health plan that covers care for diabetes but excludes pre-existing conditions for 12 months. Charter must cover Art's diabetes care immediately, because his 18 months of prior continuous coverage are credited against the 12-month exclusion.

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

In determining continuous coverage, employer-imposed waiting periods and HMO affiliation periods do not count as a break in coverage. If your new plan imposes a pre-existing condition exclusion period, you can credit time under your prior

continuous coverage toward it. If your employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period.

- *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 self-insured plan does cover prescription drugs. However, because her prior policy did not, the new plan refuses to cover her blood pressure medicine for a year.

**Question:** Is this permitted?

**Answer:** Yes. 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 required for other conditions that were not pre-existing.

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

**LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS**

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

In the past, a large number of public employers in Iowa have decided that certain health insurance protections will not apply to their employees. The Center for Medicare and Medicaid Services (CMS) used to post a list of employers which had elected to exempt, however it has removed this information from its web site.

If you are not sure about your protections under your public employee health plan, you should contact your employer. In addition, you can contact CMS directly at (800) 267-2323 ext. 61565 or at (410) 786-1565 to see if your employer has elected to be exempt from certain protection.

### **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. See Chapter 3 for more information about COBRA coverage, conversion coverage, and ICHA coverage for “HIPAA eligible individuals.”*
- *If you lost your group health plan and are receiving benefits from the Trade Adjustment Assistance (TAA) Program, you may be eligible for a federal income tax credit to help you pay for new health coverage. This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 65% of the cost of qualified health coverage, including COBRA and coverage offered through HIP-IOWA, the Iowa Comprehensive Health Association (see page 29).*
- *If you are a retiree aged 55-65 and receiving benefits from Pension Benefit Guaranty Corporation (PBGC), you may also be eligible for the HCTC (see page 29).*

## CHAPTER 3

# YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group health plan, you may want to buy an individual health insurance policy from a private health insurance company. There are some alternatives to individual health insurance in the private market such as continuation coverage, conversion policies or Iowa Comprehensive Health Association (HIP-IOWA) coverage. This chapter summarizes your protections under different kinds of health insurance coverage.

### INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

#### ***WHEN DO INDIVIDUAL HEALTH INSURERS HAVE TO SELL ME A POLICY?***

In Iowa, your ability to buy individual health insurance depends on your health status. There are certain circumstances, however when you must be allowed to buy individual coverage.

- *In general, insurers that sell individual health insurance in Iowa are free to turn you down because of your health status and other factors.* When applying for individual health insurance, 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 offer to sell you a policy with special limitations on what it covers. If this happens, you can buy health insurance from Iowa's Comprehensive Insurance Association (HIP-IOWA).
- *In Iowa, newborns, adopted children, and children placed for adoption are automatically covered under the parents' individual health plan for the first 31 days, if the plan provides coverage for dependents.* The insurer may require that the parent enroll the child and pay the premium within the 31 days in order to continue coverage beyond the 31 days.
- *If you have a disabled child, that child may remain covered under your individual health insurance policy after he or she reaches the age at which dependent coverage is usually terminated.* To qualify, your adult son or daughter must be incapable of self-support because of mental retardation or physical disability and must be chiefly dependent on the policyholder for support. Proof of incapacity must be furnished to the insurer within 31 days of reaching the limiting age and may be required subsequently in the future.

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

- *It depends on what you buy.* Iowa does not require health insurers in the individual market to sell standardized policies, except in certain situations (see below). Health plans can design different policies and you will have to read and compare them carefully. Often, individual health policies provide less comprehensive coverage than group health plans, especially for certain services such as maternity care, mental health care, or prescription drugs. However, Iowa does require all health plans to cover certain benefits – such as cancer screening and diabetic supplies and services. Check with the Iowa Division of Insurance for more information about mandated benefits.

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

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

The insurer 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 an insurer can impose a pre-existing condition exclusion period up to 24 months on any pre-existing condition.

In Iowa, a pre-existing condition is any condition which existed within the five years prior to obtaining an individual health insurance policy- whether or not it was diagnosed- for which the insurer believes most people would have sought care. This is called the **prudent person standard**.

In addition, any time you make a claim within the first two years after the effective date of the policy, your individual health insurer has the right to look back to see if the condition was pre-existing. If the insurer finds evidence your condition was pre-existing, it can refuse to pay the claim.

- *Unlike group health plans in Iowa, individual health insurers do not have to give credit for your prior coverage.*
- *Pregnancy can be considered a pre-existing condition by individual health insurers.*
- *Genetic information collected as a result of a health condition that has already been diagnosed can be used by insurers to determine whether a pre-existing condition exists.*

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

- *There are limits on how much individual health insurers can increase your premiums based on your health status. Even within these limits, your premiums can be significantly higher if you have a serious health condition. In addition, your premiums may be higher based on your age, gender, occupation and other factors.*

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

- *Your coverage cannot be canceled because you get sick. This is called guaranteed renewability. You have this protection provided that you pay the premiums, 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 short-term (or temporary) health insurance policies. Short-term policies are *not* renewable. They will only cover you for a limited time, such as 6 months. If you want to renew coverage under a short-term policy, you will have to reapply and there is no guarantee that coverage will be re-issued at all or at the same price. In addition, pre-existing conditions are never covered by short-term (or temporary) health insurance policies.*

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

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

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

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 opportunity to elect COBRA begins on 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.
- When COBRA is elected during this special, second 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 be faced with a new pre-existing condition exclusion period under COBRA.* However, if you were in the middle of a pre-existing condition exclusion period when your qualifying event occurred, you will have to finish it.

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

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage. The first premium must be paid within 45 days of electing COBRA coverage.*
- *If you elect the 11-month disability extension, the premium will increase to 150% of the total cost of coverage. See below for more information about the disability extension.*
- *If you lost your group health plan and are receiving benefits from the Trade Adjustment Assistance (TAA) Program, you may be eligible for a federal income tax credit to help you pay for COBRA coverage. This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 65% of the cost of qualified coverage, including COBRA (see page 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 (see box).*

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 form 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 IOWA CONTINUATION COVERAGE?

- *If your employer offers fully insured health benefits and has fewer than 20 workers and you have been covered under your group plan for at least 3 months, you may also be eligible for up to 9 months of continuation coverage under an Iowa law that*

*is similar to COBRA.* You must elect continuation coverage within 10 days after notification of your right to continue coverage. In addition, you must pay premiums for continuation coverage within 31 days of the date that your group coverage would otherwise end. Ask your former employer or the Iowa Division of Insurance about state continuation coverage if you think it applies to you.

## **CONVERSION**

### ***WHEN DO I HAVE TO BE OFFERED A CONVERSION POLICY?***

- *In Iowa, if you have coverage through an employer's fully insured group health plan and you lose eligibility for that coverage, you may be eligible to buy a **conversion policy**.* This is an individual policy you get from the company that insured your employer's group plan.

To qualify, though, you must have been covered under the employer's plan for the entire 3 months immediately prior to termination. You do not need to be HIPAA eligible to buy a conversion policy, however you must have used up any COBRA or state continuation coverage that was offered to you. In addition, you cannot be eligible for any other insurance plan that covers similar benefits as the conversion policy.

You must apply within 10 days after notification of your right to elect a conversion policy. In addition, you must pay premiums for the conversion policy within 31 days of the date that your group coverage ended.

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

- *You must be offered the choice of at least three basic conversion policies covering hospital stays and surgery.* Each of the three basic options offers the same hospital room and board services, but with different levels of coverage (i.e. 100%, 75%, and 50% of covered services).

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

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

### ***WHAT CAN I BE CHARGED FOR MY CONVERSION POLICY?***

- *Conversion coverage will be more costly than your former plan. Conversion premiums are not subject to the same limits applied to other individual health insurance. Contact the Iowa Division of Insurance if you have questions about your conversion policy premium.*

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

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

## **IOWA COMPREHENSIVE HEALTH ASSOCIATION (HIP-IOWA)**

Iowa maintains a high-risk pool, called the Iowa Comprehensive Health Association (HIP-IOWA). HIP-IOWA provides health coverage for residents who are HIPAA eligible, for residents eligible for HCTC, and for residents with expensive health conditions who are unable to buy individual health insurance.

### ***WHEN AM I ELIGIBLE FOR HIP-IOWA?***

- *You can buy health insurance coverage from HIP-IOWA if you are an Iowa resident for at least 6 months and can demonstrate proof of uninsurability. You are considered uninsurable in Iowa if you have written evidence that you have been:*
  - *denied coverage because of your health status within the last 9 months;*
  - *offered health insurance that restricts or excludes coverage for your pre-existing condition within the last 9 months;*
  - *offered health insurance with premiums exceeding the HIP-IOWA rate within the last nine months; or*
  - *diagnosed with one of a list of serious health conditions (such as cancer or AIDS).*

In addition, you must not be eligible for health insurance through a group plan or Medicare or Medicaid.

- *You can also buy coverage from HIP-Iowa if you are HIPAA eligible. The 6-month residency requirement does not apply when you are HIPAA eligible.*

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

If you are HIPAA eligible, you are guaranteed the right to buy some kind of individual health insurance without any pre-existing condition exclusion periods. In Iowa, you are only guaranteed the right to buy individual coverage through HIP-IOWA. 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.
- You must apply for health insurance for which you are federally eligible within 63 days of losing your prior coverage.

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

- *If you are a current Basic and Standard policy holder, you have the option to purchase coverage from HIP-IOWA or maintain your current coverage.*
- *You can also buy coverage from HIP-IOWA if you have been certified as eligible for federal premium assistance under HCTC.*

**WHAT WILL HIP-IOWA HEALTH INSURANCE COVERAGE COVER?**

- *HIP-IOWA coverage includes hospital and physician care, diagnostic tests and x-rays, prescription drugs, home health care, and other services. HIP-IOWA does not cover routine maternity care. However, you have the option of adding coverage for maternity benefits for an additional premium.*
- *HIP-IOWA offers you the choice of three cost sharing arrangements. The annual deductible options are \$1,000, \$1,500 and \$2,500.*
- *Following the payment of your deductible, for most services, you will be charged 20% coinsurance for care. After you pay a maximum amount for covered services (also called out-of-pocket limit), HIP-IOWA will pay 100% of the cost of your*

covered care for the rest of the year. HIP-IOWA has a lifetime limit of \$3 million.

- *HIP-IOWA also offers a Medicare supplement plan.*

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

- *If you are HIPAA eligible, HIP-IOWA cannot impose a pre-existing condition exclusion period.*
- *If you are not HIPAA eligible, HIP-IOWA will exclude coverage for your pre-existing condition for 180 days. When you enroll, HIP-IOWA will look back 180 days prior to the effective date of your benefit plan to see if you had a condition for which you actually received medical advice, diagnosis, care or treatment.*

HIP-IOWA will not credit your prior coverage against this pre-existing condition exclusion period unless your prior coverage was terminated involuntarily and you apply for HIP-IOWA coverage within 63 days of losing your prior coverage.

#### **WHAT CAN I BE CHARGED FOR MY HIP-IOWA HEALTH INSURANCE COVERAGE?**

- *HIP-IOWA premiums vary depending on your age and the deductible you choose.*

For example, as of January 1, 2005, the monthly premium for a 24-year-old single, non-smoking male range between \$185 to \$233, depending on the deductible. By contrast, the monthly premium for a 64-year-old non-smoking single male range from \$648 to \$816, depending on the deductible.

- *Contact the HIP-IOWA plan administrator at (877) 793-6880 for more information about HIP-IOWA premiums and eligibility.*

#### **HOW LONG DOES HIP-IOWA COVERAGE LAST?**

- *HIP-IOWA coverage is renewable as long as you pay your premium, continue to reside in Iowa, and meet other eligibility requirements.*

## CHAPTER 4

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

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. Iowa 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 Iowa 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 people, but not more than 50 eligible employees, health insurance companies must sell you any small group health plan they sell to other small employers. However, 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 health plan or if they are withdrawing from the small employer market. 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?

- *As a small employer, you can be charged higher premiums, within limits, based on your group's health status, claims experience or duration of coverage.* Premiums also can vary based on the age, gender, geographic location, size and other characteristics of your group. If you have questions about your small group health plan premiums, contact the Iowa 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 plan do not apply to you. The laws that apply to individuals protect your access to health insurance. (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 Iowa Division of Insurance about your protections in association health plans.*

## CHAPTER 5

# FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Iowa who cannot afford to buy health insurance. Medicaid, hawk-i, and Care for Yourself (the Iowa Breast and Cervical Cancer Early Detection Program) 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 Health Coverage Tax Credit (HCTC) Program provides tax credits to early retirees and some workers who lose their jobs or whose work hours and wages are reduced as a result of increased imports. This chapter provides summary information about these programs and contact information for further assistance.

### MEDICAID

Medicaid is a program that provides health coverage to some low-income Iowa residents. Medicaid covers families with children and pregnant women, medically needy individuals, the elderly, and persons with disabilities, if state and federal guidelines are met. Legal residents who are not U.S. citizens may be eligible for Medicaid. However, non-citizens who do not have immigration documents cannot enroll in Medicaid. Questions concerning immigration status and eligibility should be directed to the Iowa Department of Human Services.

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

Medicaid-eligible individuals include infants, children, pregnant women, and parents whose family income meets the Medicaid income standards.

If you are in one of these categories of persons but your income is above Medicaid eligibility limits, you may qualify for Medicaid if your income minus your medical expenses meets “eligibility needy” thresholds.

Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account, so you should contact your local department of social services for more information.

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

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Infant	200% (monthly income of \$2,767 for a family of 3)
Child Age 1-19	133%
Working Parent	79%
Non-Working Parent	32%
Pregnant women	200%
Medically Needy	
Individual	67%
Couple	50%

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

To get an idea of how your income compares to the federal poverty level, use the federal poverty guideline issued by the U.S. Department of Health and Human Services for the year 2006:

<u>Size of Family Unit</u>	<u>Poverty Guideline (annual income)</u>
1	\$ 9,800
2	\$13,200
3	\$16,600

For larger families add \$3,400 for each additional person

So, for example, using this guideline, 200% of the federal poverty level for a family of 3 would be an annual income of \$34,200, or a monthly income of \$2,767.

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 **Temporary Assistance for Needy Families (TANF)** can get Medicaid.*

Parents should know that when you get a job and your TANF benefits end, you generally can stay on Medicaid for a 12-month transitional period.

Parents should know that when your family's TANF benefits end, your children may also qualify for transitional Medicaid coverage for 12 months. Or, they may qualify

for Medicaid themselves if your family's income meets the Medicaid income standards.

- *People who are aged, blind or disabled may be eligible for Medicaid under the **Supplemental Security Income (SSI)**-related programs.* Eligibility is determined by following the general policies of the Supplemental Security Income (SSI) program.

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.

- *Persons who are disabled but employed and have higher income levels may be eligible for Medicaid benefits under the **Medicaid for Employed People with Disabilities (MEPD)** program.* To qualify for MEPD, you must be employed, disabled and under the age of 65 with a family income of less than or equal to 250% of the poverty level. MEPD enrollees with income levels over 150% of the federal poverty level must pay a premium based on income level.
- *People who have high medical expenses may also qualify for Medicaid.* You may qualify as medically needy if you are a child, a parent of a dependent child, pregnant, elderly, or disabled and have high medical expenses that when subtracted from your income, would make you eligible for Medicaid coverage. For example, people who have to pay a lot for prescription drugs, nursing home care, or other long term care services sometimes qualify as medically needy if they don't have health insurance that covers these services.
- *Retired or disabled people who have low incomes and are enrolled in Medicare may also qualify for help from Medicaid.* Even though your income may be too high to qualify for Medicaid insurance coverage, there may be other ways Medicaid can help you.

If your household income is 100% of the poverty level or below, Medicaid will pay your monthly premium for Medicare Part A and B, 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 Part B premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

If your household income is 120% or below 135%, Medicaid will cover the costs of your Medicare Part B premiums. This is called the Expanded Specified Low-Income Medicare Beneficiary Program.

- *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 Iowa Department of Human Services at (800) 972-2017 or visit [http://www.dhs.state.ia.us/dhs2005/dhs\\_homepage/index.html](http://www.dhs.state.ia.us/dhs2005/dhs_homepage/index.html).

### ***hawk-i*: HEALTHY AND WELL KIDS IN IOWA**

*hawk-i* is a state-designed program that provides health insurance coverage to low income children under the age of 19 who are not eligible for Medicaid and who have limited or no health insurance.

- *A child whose family has a household income below 200% of the federal poverty level is eligible for hawk-i.* For a family of 3, this works out to an annual income of about \$34,200 or a monthly income of about \$2,767.
- *hawk-i provides comprehensive coverage to enrollees.* Services include doctor visits, hospital care, prescriptions, mental health services, preventative well-child exams, immunizations, and vision services, as well as other services.
- *hawk-i is low cost or free, depending on your family income.* Some families pay no monthly premiums, while others may have to pay a maximum of \$20 dollars a month.
- *For more information on hawk-i, contact customer service at (800) 257-8563 or visit <http://www.hawk-i.org>.*

### **IOWA BREAST & CERVICAL CANCER EARLY DETECTION PROGRAM (CARE FOR YOURSELF)**

- *Care for Yourself, the Iowa Breast and Cervical Cancer Early Detection Program, provides qualified woman breast and cervical cancer screenings at no cost.* Women screened through this program and diagnosed with breast or cervical cancer may be eligible for free treatment, throughout the duration of treatment, through Medicaid. In addition, Medicaid will cover all of your medical needs including treatment for non-cancer related medical services.

- *In order to be eligible for screening through the Care for Yourself program, you must be between the ages of 40 and 64. However, if you are under the age of 40 and experiencing breast symptoms, you may qualify for screening as well. You also may not have other health insurance and your income must be under 250% of the federal poverty level.*
- *For more information or to enroll, call the Care for Yourself program at (515) 281-5616 or visit <http://www.idph.state.ia.us/careforyourself/default.asp>.*

## **OTHER PROGRAMS**

There may be other financial assistance programs available. Please call the Iowa Department of Human Services at (800) 972-2017 or visit [http://www.dhs.state.ia.us/dhs2005/dhs\\_homepage/index.html](http://www.dhs.state.ia.us/dhs2005/dhs_homepage/index.html).

## **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 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: HIP-IOWA offers coverage for HCTC eligible individuals. For more information about the state qualified plan please visit the HIP-IOWA web site at <http://www.hipiowa.com/>.

- 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 see the DOL website at*

<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.

<b>For questions about:</b>	<b>Contact:</b>
Individual health Insurance Fully insured group health plan	<i>Iowa Division of Insurance</i> (877) 955-1212 <a href="http://www.iid.state.ia.us/">http://www.iid.state.ia.us/</a>
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor Employee Benefits Administrator Employee &amp; Employer Assistance Hotline and Publications</i> (866) 444-EBSA (3272) <a href="http://www.dol.gov/ebsa">http://www.dol.gov/ebsa</a>
HIP-IOWA	<i>Iowa Comprehensive Health Association Coverage</i> (877)-793-6880 <a href="http://www.hipiowa.com/">http://www.hipiowa.com/.</a>
Medicaid	<i>Iowa Department of Human Services</i> (800) 972-2017 <a href="http://www.dhs.state.ia.us/dhs2005/dhs_homepage/index.html">http://www.dhs.state.ia.us/dhs2005/dhs_homepage/index.html</a>
hawk-i	<i>Iowa Department of Human Services</i> (800) 257-8563 <a href="http://www.hawk-i.org">http://www.hawk-i.org</a>
Care For Yourself (Iowa Breast and Cervical Cancer Early Detection Program)	<i>Iowa Department of Public Health</i> (515) 281-5616 <a href="http://www.idph.state.ia.us/careforyourself/default.asp">http://www.idph.state.ia.us/careforyourself/default.asp</a> .

Other Programs	<i>Iowa Department of Human Services</i> (800) 972-2017 <a href="http://www.dhs.state.ia.us/dhs2005/dhs_homepage/index.html">http://www.dhs.state.ia.us/dhs2005/dhs_homepage/index.html</a> .
Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service</i> (866) 628-HCTC <a href="http://www.irs.gov/individuals/index.html">http://www.irs.gov/individuals/index.html</a>

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 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 worker's old firm 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 pre-existing conditions. Premiums cannot be charged during HMO affiliation periods. Iowa law allows for the use of HMO affiliation periods in small group health plans. See also HMO, Small Group Health Plans.

***Care for Yourself.*** Program which provides free screening for breast and cervical cancer to eligible Iowa residents. Eligible women diagnosed with breast or cervical cancer may be eligible for free coverage through Medicaid for treatment of their condition.

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

***Continuous Coverage.*** 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. See also Creditable Coverage.

**Conversion.** Your right, when leaving a fully insured group health plan, to convert your policy to an individual health insurance policy. In Iowa, conversion coverage also extends to surviving or divorced spouses, dependent children and children who lose their dependent status under their parent's plan rules. You must use up any COBRA or state continuation coverage before you can buy a conversion policy. See also, COBRA, State Continuation Coverage.

**Creditable Coverage.** Health insurance coverage under any of the following: a group health plan; an individual health plan; Medicare; Medicaid; State Children's Health Insurance Program, CHAMPUS and TRICARE (health coverage for military personnel, retirees, and dependents); the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country), or a state health insurance risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Plan.

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

**Elimination Rider.** A feature permitted in individual health insurance policies that permanently exclude coverage for a health condition, body part, or body system.

**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 plan purchased by an employer from an insurance company. Fully insured health plans are regulated by the state of Iowa. See also Self-Insured Group Health Plans.

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

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

***hawk-i (Healthy and Well Kids in Iowa).*** A state designed program that provides health insurance coverage to low income children under the age of 19 who do not qualify for Medicaid and who have no health insurance.

***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 was passed in 1996 to help people buy and keep health insurance, even when they have serious health conditions, the law sets basic requirements that health plans must meet. Since states can and have modified and expanded upon these provisions, consumers' protections vary from state to state.

**HIPAA Eligible.** Status you attain once you have had 18 months of continuous creditable health coverage. To be HIPAA-eligible, you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. When you are buying an individual health insurance policy, HIPAA eligibility gives you greater protections than you would otherwise have in Iowa and in other states. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

**HMO.** Health maintenance organization. A kind of health insurance plan. HMOs usually require you to get care from doctors who work for or contract with the HMO. They generally do not require deductibles, but often do charge a small fee, called a copayment, for services like doctor visits or prescriptions. HMOs in Iowa can require affiliation periods. See also Affiliation Period.

**Individual Health Insurance.** 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 insurance policies are regulated by the state of Iowa.

**Iowa Comprehensive Health Association (HIP-IOWA).** The state-run program for people with high health risks (called a high-risk pool). ICHA also sells coverage to those who are HIPAA eligible. See also HIPAA Eligible.

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

**Late Enrollment.** Enrollment in a health plan at a time other than the regular or a special enrollment period. Iowa requires fully insured group plans to cover you if you are a late enrollee. However, you may be subject to a longer pre-existing condition exclusion period. See also Special Enrollment Period.

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

**Managed Care.** A kind of health insurance plan. Like an HMO, managed care plans can limit coverage to health care provided by doctors and hospitals that work for or contract with them - also called "network providers." Often managed care plans will require you to get permission (a "referral") from your family doctor before you get care from a specialist in their network. Some managed care plans will reduce coverage for your care if you go to a non-network provider or if you get specialist 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.

**Medicaid for Employed People with Disabilities (MEPD).** Medicaid coverage group implemented to allow persons with disabilities to work and to continue to have access to medical assistance.

**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, and 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. (HIP-IOWA, Group Plans)** Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a 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 Plans)** Pre-existing conditions are any conditions for which you received medical advice, care or diagnosis in the last five years. In addition, plans can count as pre-existing any condition for which the plan believes most people would have sought care. Pregnancy can 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 covered within 30 days and adopted children cannot be subject to pre-existing condition exclusions.

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

***Prudent Person Standard.*** In individual health insurance only, a rule that permits insurers to exclude as pre-existing any condition for which - in the insurer's judgement – most people would have sought care or treatment.

***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 Iowa.

***Small Group Health Plans.*** Plans with at least 2 but not more than 50 eligible 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. In Iowa, if you are in a fully insured group health plan sponsored by an employer with 2 to 19 employees, you have the right to continue your health coverage for up to 9 months when your job ends. Under state continuation coverage, you will be required to pay the full premium (including the share you employer used to pay on your behalf). See also COBRA.

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

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

***Trade Adjustment Assistance 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 6 benefits and reemployment services to assist unemployed workers in preparing for and

obtaining suitable new 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.