

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

By

**Karen Pollitz
Jennifer Libster
Eliza Bangit
Kevin Lucia
Mila Kofman**

**GEORGETOWN UNIVERSITY
HEALTH POLICY INSTITUTE**

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

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

As a Missouri resident, you have rights under federal and state law that will protect you when you seek to buy, keep, or switch your health insurance, even if you have a serious health condition.

This guide describes your protections as a Missouri 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 Missouri, your protections may change. Since this guide is a summary, it may not answer all of your questions. For places to contact for more information, see page 33. For information about how to find consumer guides for other states on the Internet, see page 33. A list of helpful terms and their definitions begins on page 34. These terms are in **boldface type** the first time they appear.

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CHAPTER 1

A SUMMARY OF YOUR PROTECTIONS

Numerous state and federal laws make it easier for people with **pre-existing conditions** to get or keep **health insurance**, or to change from one **health plan** to another. A federal law, known as the **Health Insurance Portability and Accountability Act (HIPAA)** sets national standards for all health plans. In addition, states can pass different reforms for the health insurance plans they regulate (**fully insured group health plans** and **individual health insurance policies**), so your protections may vary if you leave Missouri. Neither federal nor state laws protect your access to health insurance in all circumstances. So please read this guide carefully.

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

HOW AM I PROTECTED?

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

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status. This is called **nondiscrimination** (see page 6).*
- *All group health plans in Missouri 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 24).*
- *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 insurance policies for small employers must be sold on a **guaranteed issue** basis. However, the insurance carrier can turn*

you down if your small business does not meet the participation or contribution requirements (see page 24).

- *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 15).*
- *If you lose your group health plan and meet other qualifications, you will be **HIPAA eligible**. If so, you are guaranteed the right to buy an individual health insurance policy from any insurance company that sells such plans in Missouri. Insurance companies must offer you a choice of at least 2 plans (see page 12).*
- *If you lose your group health plan and meet other qualifications, you may be able to buy a **conversion policy**. You will not face a new pre-existing condition for benefits covered under your prior plan. There are no limits on what you can be charged for a conversion policy and the benefits may not be as generous as your prior group coverage (see page 20).*
- *You can buy insurance from the **Missouri Health Insurance Pool (MHIP)** 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. There are limits on what you can be charged for an MHIP policy (see page 21).*
- *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 Missouri **Medicaid** program offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes. MC+ for Kids (part of the Medicaid program in Missouri) offers free or subsidized health coverage for some uninsured children. In addition, some women diagnosed with breast or cervical cancer may be eligible for medical care through Medicaid (see Chapter 5).*
- *If you have 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 pay for new health coverage. This credit is called the **Health Coverage Tax Credit (HCTC)**, and is equal to 65% of the cost of qualified health coverage, including COBRA (see page 30).*

- *If you are a retiree aged 55-65 and receiving benefits from **Pension Benefit Guarantee Corporation (PBGC)**, then you may be eligible for the HCTC (see page 30).*

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 plan 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 11).*
- *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 6).*
- *If you get a new job with health benefits, your coverage may not start right away. Employers can require **waiting periods** before your health benefits begin (see page 6).*
- *If you have a break in coverage of 63 days or more, you may have to satisfy a new pre-existing condition exclusion period when you join a new group health plan (see page 9).*
- *Even if your coverage is **continuous**, there may be a pre-existing condition exclusion period for some benefits if you join a group health plan that covers benefits your old plan did not. For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition (see page 10).*
- *If you work for a non-federal public employer in Missouri, not all of the group health plan protections may apply to you (see page 10).*

- *In Missouri, 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 due to your health (see page 12).*
- *If you are HIPAA eligible, there is no limit on what insurance companies can charge you for an individual health insurance policy (see page 14).*
- *If you move away from Missouri, you may not be able to buy individual health insurance in another state unless you are HIPAA eligible.*
- *If you are a small employer with a group consisting of 3-25 employees, you might be charged more for health insurance if someone in your group is sick. While there are limits on what you can be charged based on health status, generally 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 24).*

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 the plan's service area.
- *You cannot be turned away or charged more because of your health status.* Health status means your medical condition or history, **genetic information**, or disability. This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (such as part-time employment), as long as these are unrelated to health status and applied consistently.

Discrimination due to health status is not permitted

The Acme Company has 200 employees and offers two different health plans. Full time employees are offered a high option plan that covers prescription drugs; part time employees are offered a low option plan that does not. This is *permitted* under the law. By contrast, in a cost-cutting move, Acme restricts its high option plan to those 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.* These waiting periods, however, must be applied consistently and cannot vary due to your health status. Unlike employers, insurers cannot require waiting periods. If your new job has health insurance through an HMO, the HMO may also require a waiting period 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 this period.

- *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 health insurance (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 Missouri law, newborns and adopted children are automatically covered under the parents' fully insured health plan for the first 31 days, if the plan covers dependents.* The insurer may require that the parent enroll the child (and pay the premium) within the 31 days in order to continue coverage beyond the 31 day period.
 - *Under Missouri law, your disabled child may remain covered under your fully insured group plan into adulthood.* This applies if your child was already disabled and covered under the plan before he or she reached the limiting age for dependent coverage. You will be required to submit proof of your child's continued incapacity and dependency within 31 days following the date your child reaches the limiting age and periodically thereafter.
 - *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 plan 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.

- *Group health plans can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan. This period is also called the look back period.*
- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns, newly adopted children, children placed for adoption, or genetic information.*
- *Group health plans can only exclude coverage for pre-existing conditions for a limited time. The maximum period allowed for exclusion is 12 months. However, if you enroll late in a group health plan (after you were hired and not during a regular or special enrollment period), you may have a pre-existing condition exclusion period of up to 18 months.*
- *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:

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.* The new coverage must be in place on the 63rd day in order to avoid any pre-existing condition exclusions. 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.

What is continuous coverage?

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

Take Art, who has diabetes. Ajax Company coverage him under its group health plan for 9 months, but he lost 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 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*.

- *Your protections may differ if you move to a group health plan that offers more benefits than your old one did.* Plans can look back to determine whether your previous health plan covered prescription drugs, mental health, substance abuse, dental care, or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new group health plan may impose a pre-existing condition exclusion period for that category. Plans that use this method of crediting prior coverage must use it for everyone and must disclose this to you when you enroll.

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

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

Question: Is this permitted?

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

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

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

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

In the past, a large number of public employers in Missouri 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 plan, 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 policies. See Chapter 3 for more information about COBRA, state continuation coverage, conversion coverage, and MHIP coverage.*
- *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 (see page 30).*
- *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 30).*

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 insurer. However, in Missouri – as in most other states – you have limited guaranteed access to individual health insurance sold by insurers. There are some alternatives to individual health insurance in the private market – such as COBRA coverage and MHIP 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 A POLICY?

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

- *In general, insurers that sell individual health insurance in Missouri 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 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 MHIP coverage (see page 20).

- *However, if you are HIPAA eligible, private insurers cannot turn you down.* All companies that sell individual insurance must offer you coverage. Insurers can offer you all of their individual health policies, their two most popular individual health insurance policies, or two policies specially designed for HIPAA eligible individuals – a “high” and a “low” option, whose benefits must be similar to those sold to everyone else. Companies that do not designate two policies must offer you a choice of all their individual insurance policies.

To be HIPAA eligible, you must meet certain criteria

No matter where you live in the U.S., if you are HIPAA eligible you are guaranteed the right to buy individual health coverage of some kind with no 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 HIPAA eligible.)
- You must apply for health insurance for which you are HIPAA eligible within 63 days of losing your prior coverage.

Your HIPAA eligible status ends as soon as you enroll in an individual health insurance policy, 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.

- *In Missouri, newborns, adopted children, and children placed for adoption are automatically covered under the parents' individual health insurance policy for the first 31 days, if the plan provides coverage for dependents.* The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.
- *Under Missouri law, your disabled child may remain covered under your fully insured group plan into adulthood.* This applies if your child was already disabled and covered under the plan before he or she reached the limiting age for dependent coverage. You will be required to submit proof of your child's continued incapacity and dependency within 31 days following the date your child reaches the limiting age and periodically thereafter.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy.* Missouri 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, Missouri

does require all health plans to cover certain benefits – for example, mammograms and diabetes care. Check with the Missouri Department of Insurance for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITIONS?

- *If you are HIPAA eligible, no pre-existing condition exclusion periods can be imposed when buying an individual policy.*
- *However, if you are not HIPAA eligible, there are different ways individual health insurers 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 lasting up to 24 months. If you make a claim during the first 24 months of coverage, your individual health insurer has the right to look back to see if the condition was pre-existing. If it determines your condition existed prior to the effective date of the policy, it can refuse to pay the claim.

- *Pregnancy may be considered a pre-existing condition in an individual health insurance policy. However, genetic information cannot be used as a basis for a pre-existing condition.*
- *Unlike group health plans, individual health insurers do not have to give you credit for prior coverage.*

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

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

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE 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, 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 six months. If you want to renew coverage under a temporary policy after it expires, you will have to reapply and there is no guarantee that coverage will be re-issued at all or at the same price.*

COBRA 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 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 plan.

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

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

WHAT WILL COBRA COVER?

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

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

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

HOW LONG DOES COBRA COVERAGE LAST?

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

HOW LONG CAN COBRA COVERAGE LAST?

Qualifying event(s)	Eligible person(s)	Coverage
Termination Reduced hours	Employee Spouse Dependent child	18 months *
Employee enrolls in Medicare Divorce or legal separation Death of covered employee	Spouse	36 months Dependent child
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.*

WHAT ABOUT STATE CONTINUATION COVERAGE?

Missouri law provides for continuation coverage in certain circumstances. If any of the following situations is similar to yours, ask your former employer or the Missouri Department of Insurance to see if you are eligible for state continuation coverage.

- *Persons who were covered under a group health plan for at least 3 months and whose employer had fewer than 20 employees can qualify for 9 months of continuation coverage.*
- *Surviving spouses over the age of 55 who have used up their federal COBRA continuation and whose coverage was through a fully insured group plan may be able to continue coverage until they reach age 65 or otherwise lose eligibility.*
- *In certain circumstances, persons who have fully insured group plans and become disabled may also be able to extend their benefits for a limited time.*

CONVERSION

WHEN AM I ELIGIBLE FOR A CONVERSION POLICY?

- *In Missouri, if you have coverage through an employer's fully insured group health plan for at least 3 months and you lose that coverage, and you are not eligible for other group coverage, you are eligible to buy a conversion policy. A conversion policy is an individual insurance policy that you buy from the company that insured your employer's group plan.*
- *To qualify for a conversion policy, you first must have used up any COBRA or state continuation coverage.*
- *You do not need to be HIPAA eligible to buy a conversion policy. However, if you do elect a conversion policy, you will lose your HIPAA eligibility status.*

WHAT DOES A CONVERSION POLICY COVER?

- *The benefits under a conversion policy will probably not be the same as those under your former plan. The conversion policy's benefits may be less generous than those you used to have.*

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 any unfinished portion of any pre-existing condition exclusion period from your former health plan.*

HOW MUCH CAN I BE CHARGED FOR A CONVERSION POLICY?

- *Conversion policies may cost much more than your previous group health plan. There is no limit on what you can be charged for a conversion policy. You may be charged higher rates based on your health, age, gender, and other factors. Contact the Missouri Department of Insurance if you have questions about conversion policy premiums.*

CAN MY CONVERSION POLICY BE CANCELED?

- *Conversion policies, like other individual health insurance policies, are guaranteed renewable. Your coverage cannot be canceled because you get sick. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of managed care plans, continue to live in the plan's service area.*

MISSOURI HEALTH INSURANCE PROGRAM (MHIP)

Missouri has a high risk pool program, called the Missouri Health Insurance Program (MHIP), which offers insurance for people with health conditions who are unable to buy private health insurance. Individuals leaving group coverage who have exhausted their state continuation coverage or COBRA are also eligible for MHIP.

WHEN CAN I GET COVERAGE FROM MHIP?

- *If you have had difficulty obtaining affordable private health insurance because of your health status, you may be able to purchase MHIP coverage. You are eligible to purchase MHIP coverage if you are a Missouri resident and you are not eligible for Medicare, Medicaid, or a private health plan (unless it would cost you more than 300% of the standard rate). You must also meet one of the following conditions:*
 - *You have been turned down for coverage by an insurance company within the past 6 months because of a current or pre-existing medical condition;*
 - *You were involuntarily terminated from your prior coverage and have been unable to find or were turned down for new private coverage;*
 - *You were accepted for coverage by an insurance company, but your premiums would have been in excess of 300% of the standard rate;*

- You were offered coverage by an insurance company, but the policy contained an elimination rider that would have substantially reduced the benefits of the insurance policy; or
- You were previously covered under an employer's group health plan and exhausted any available state continuation coverage or COBRA and have attained the maximum coverage period. You must apply for MHIP within 60 days of the end of your state continuation coverage or COBRA.
- *MHIP does not offer family coverage, so each member of your family who wants MHIP coverage needs to qualify on his or her own.*

WHAT WILL MHIP COVER?

- *MHIP coverage includes hospital and physician care, home health care, maternity care, prescription drugs, and other services. Limited drug and alcohol abuse services are included. For most services, the plan will pay for 80% of covered charges after you have satisfied your annual deductible if you receive care in-network. After you have paid a maximum amount of coinsurance charges for covered in-network services, MHIP will pay 100% of your covered charges for the rest of the calendar year. Less generous payment rules apply to care received from non-network providers inside the plan's service area, and care received outside the plan's service area is only covered if it is received during the course of an emergency. Separate coverage limits also apply to mental health and substance abuse benefits.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *You may have a 12-month pre-existing condition exclusion period when you first enroll in MHIP. When you enroll, MHIP will look back 6 months to see if you had a condition for which you actually received a diagnosis, medical advice, or treatment, or a condition that you knew about. In most cases, pregnancy can be considered a pre-existing condition. Elimination riders are not permitted on MHIP plans.*

MHIP will credit prior continuous coverage toward your pre-existing condition exclusion if you apply for MHIP coverage within 60 days of involuntarily losing your prior coverage. MHIP will consider your prior coverage creditable if it was involuntarily terminated and contained a similar pre-existing condition exclusion.

MHIP will also waive your pre-existing condition exclusion period if your previous health insurance coverage premium was in excess of 300% of the standard insurance

rate and you enroll in the MHIP plan immediately following the termination of your prior coverage.

- *The MHIP pre-existing exclusion does not apply to the prescription drug benefit. Your prescription drug benefit is effective immediately upon your MHIP coverage effective date.*

WHAT CAN I BE CHARGED FOR MHIP COVERAGE?

- *Premiums will vary based on the plan you choose. MHIP offers deductible options of \$500, \$1000, \$2500, and \$5000. In addition, MHIP charges enrollees different rates based on their age, sex, and the deductible level they choose. Under Missouri law, MHIP rates are not allowed to be more than twice of the amount that a healthy person would pay if he or she bought a similar plan sold by one of the state's five largest insurers.*

For example, for 2006, the monthly premium for a 24-year-old man ranges from \$142 to \$303, depending on which deductible option is selected. By contrast, the monthly premium for a 64-year-old man ranges from \$623 to \$1267, depending on which deductible option is selected.

Contact MHIP for the most current information about premium and coverage options.

HOW LONG DOES MHIP COVERAGE LAST?

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

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

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

- *For small employee groups of 3 to 25, Missouri limits how much premiums can vary based on the health status of group members.* Even within these limits, premiums can be significantly higher if someone in your small group has a serious health condition. In addition, premiums can vary based on age, industry, and other characteristics of those in your group.

- *For groups of 2 and groups larger than 25, there are no limits on how much employers can be charged if someone in the group is sick. Also, there are no limits on how much premiums can go up at renewal.*

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 Missouri Department of Insurance about your protections in association health plans.*

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Missouri who cannot afford to buy health insurance. Medicaid, the Children's Health Insurance Program (also called MC+ For Kids), and the **Show Me Healthy Women Program** 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 Missouri residents. Medicaid covers families with children and pregnant women, the elderly, and people with disabilities, if state and federal guidelines are met. Legal residents who are not U.S. citizens may be eligible for Medicaid. Non-citizens who do not have immigration documents cannot enroll in Medicaid. MC+ for Kids is part of Missouri's Medicaid program. It provides coverage for some children from low-income families.

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

In Missouri you may be eligible for Medicaid if you are an infant, a child, a pregnant woman, or a parent of a child and your family income meets the Medicaid income standards.

Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account, so you should contact the Division of Medical Services and Family Support Division more information.

Low income persons eligible for Medicaid in Missouri*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Infant	300%
Child 1-19	300%
Working Parent	42%
Non-Working Parent	22%
Pregnant woman	185%

* 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</u> (annual income)
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, 300% of the federal poverty level for a family of 3 would be an annual income of \$49,800, or a monthly income of \$4,150.

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 **Temporary Assistance for Needy Families**) can get Medicaid.* In addition, your children may qualify for Medicaid if your family's income meets certain income standards.
- *Very poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits can also qualify for Medicaid.* You do not need to submit a separate application for Medicaid.

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

coverage if you are elderly or you are still considered disabled and you continue to have medical need.

- *People who have high medical expenses may also qualify for Medicaid.* You may qualify as medically needy if you have high medical expenses that, when subtracted from your income, would make you eligible for Medicaid coverage. For example, people who have to pay a lot for prescription drugs, nursing home care, or other long term care services sometimes qualify as medically needy if their health insurance is limited or does not cover these services.
- *Retired or disabled people who have low incomes and are enrolled in Medicare may also qualify for help from Medicaid.* Even though your income may be too high to qualify for Medicaid insurance coverage, there may be other ways Medicaid can help you.

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

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

- *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 Medical Services at (573) 751-3324 or the Family Support Division at (573) 751-3221.

MC + FOR KIDS

MC+ for Kids is part of the federal Children's Health Insurance Program and provides health insurance for uninsured children of low-income families who do not have access to affordable health insurance.

- *If a child aged 19 and under does not have health insurance, MC+ provides payment of medical expenses at little or no cost.* The price a family pays depends on your family income.
- *MC+ enrolls children from families whose family income is up to 300% of the Federal Poverty Level.* For example, for a family of three making less than \$4,150 per month, the child (or children) would be eligible for coverage.

- *MC+ provides comprehensive coverage to enrollees. This includes doctor and nurse care, immunization and preventative care, health clinic care, laboratory tests and x-rays, prescription drugs, medical equipment and medical transportation, dental care, eye care, hospital care, mental health services, and preventative well-child visits, as well as other services.*
- *For more information, contact Missouri's Health Insurance Program for Children, under the Family Support Division, at 1-888-275-5908 or visit <http://www.dss.mo.gov/mcplus/index.htm>.*

SHOW ME HEALTHY WOMEN

- *Show Me Healthy Women provides a qualified woman with free breast and cervical cancer screening at no cost or for a nominal co-payment. 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. In addition, Medicaid will cover all of your medical needs including treatment of non-cancer related services.*
- *In order to be eligible for screening through the Show Me Healthy Women Program, you must be at least 35 years of age. In addition, you must have no or limited health coverage, be ineligible for Medicaid and Medicare, and have an income under 200% of the federal poverty level (FPL).*
- *If you are a non-resident or not a U.S. citizen, you may still participate in free breast and cervical cancer screenings in Missouri. However, you may not participate in Missouri's Medicaid treatment program if cancer treatment is required. All states bordering Missouri will accept referrals from the Show Me Healthy Women program into their Medicaid treatment programs.*
- *For more information, please call the Missouri Department of Health and Senior Services, Bureau of Cancer and Chronic Disease Control, Show Me Healthy Women Program, at (573) 522-2845.*

OTHER PROGRAMS

There may be other financial assistance programs available. Please call the Missouri Department of Social Services at (573) 751-4815.

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 Missouri, state continuation coverage is the qualified health plan.
 - 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 plan	<i>Missouri Department of Insurance</i> (800) 726-7390 http://insurance.mo.gov/
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor Employee Benefits Administrator Employee & Employer Assistance Hotline and Publications</i> (866) 444-EBSA (3272) http://www.dol.gov/ebsa
Missouri Health Insurance Pool (MHIP)	<i>Missouri Health Insurance Pool (MHIP)</i> (800) 821-2231 or visit them on the web http://www.mhip.org/index.htm
Medicaid Children's Health Insurance Program (MC+ for Kids)	<i>Family Support Division (determines eligibility for Medicaid)</i> (573) 751-3221 Department of Medical Services (888) 275-5908 MC+ for Kids http://www.dss.mo.gov/pr_health.htm
Show Me Health Women Program (Breast and Cervical Cancer Screening)	<i>Missouri Department of Health and Senior Services, Bureau of Cancer and Disease Control</i> (573) 522-2845 http://www.dhss.mo.gov/BreastCervCancer/Eligibility.html
Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service</i> 1-866-628-HCTC http://www.irs.gov/individuals/index.html

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

HELPFUL TERMS

Affiliation Period. The times that an HMO may require you to wait after you enroll and before your group coverage begins. HMOs that require an affiliation period cannot exclude group coverage of pre-existing conditions. See also HMO.

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.

Children's Health Insurance Program. The state Children's Health Insurance Program (also called MC+ For Kids) provides insurance for some low income children under the age of 19 who have limited or no health insurance. MC+ for Kids is part of the state Medicaid program.

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. See also Creditable Coverage, HIPAA Eligible, Group Health Plan.

Conversion Policy. Your right, when leaving a fully insured group health plan in Missouri, to convert your policy to an individual health insurance policy. This right applies if you had at least 3 months of coverage under the group plan and you are not eligible for other coverage.

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

Elimination Rider. An amendment permitted in individual health insurance policies 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 plan purchased by an employer from an insurance company. Fully insured health plans are regulated by Missouri. 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 Missouri are guaranteed issue. Plans that are guaranteed issue can turn you away for other reasons.

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

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

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

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

HIPAA. The Health Insurance Portability and Accountability Act 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 all 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 Missouri 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 limit coverage to care from doctors who work for or contract with the HMO. They generally do not require deductibles, but often do charge a small fee, called a copayment, for services like doctor visits or prescriptions. If you are covered under a HMO, the HMO might require an affiliation period before coverage begins. See Affiliation Period.

Individual Health Insurance Policy. 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. In general, individual health insurers are regulated by the Missouri Department of Insurance, but certain protections related to HIPAA eligible individuals and other issues are enforced by the U.S. Health Care Financing Administration.

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.

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

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

MHIP. Missouri Health Insurance Program, the state-run insurance program for people with high health risks (called a high risk pool).

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, 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 (Group Health Plans). Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a 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 Policies). Any condition for which a diagnosis, care or treatment was recommended or received within the 2 year period prior to coverage. In addition, if you make a claim during the first 2 years of coverage, your plan can look back 12 months, from the date of your application, for any signs or symptoms that would have prompted a prudent person to seek medical care or advice. If it finds such evidence, it can apply a 2 year pre-existing exclusion period for that condition.

Pre-existing Condition (MHIP). Any condition for which medical advice, diagnosis, care or treatment was *ever* recommended or received, or a condition that you knew about. In most cases, pregnancy can also be counted as a pre-existing condition.

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

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

Show Me Healthy Women Program. Program which provides free screening for breast and cervical cancer to eligible Missouri residents. Eligible women diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid for treatment of their condition.

Small Group Health Plan. A health plan covering employees and their dependents in which the employer employ at least 2 employers 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, as well as some other groups of people including surviving spouses over 55 years old and newly disabled workers. 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 Beyond Welfare) 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.