

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

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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 NEW HAMPSHIRE

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

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# CHAPTER 1

## A SUMMARY OF YOUR PROTECTIONS

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

### HOW AM I PROTECTED?

In New Hampshire, 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 New Hampshire 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 coverage is **guaranteed renewable** (see pages 15 and 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**. For example, it can help when you are between jobs, or when you retire early and are not yet eligible for Medicare. There are limits on what you can be charged for this coverage (see page 15).*

- *If you lose your coverage under a fully insured group health plan and meet other qualifications, you are guaranteed the right to buy **conversion coverage**. You will not face a new pre-existing condition exclusion period (see page 20).*
- *If you lose your group health plan and meet other qualifications, you will be **HIPAA eligible**. If so, you can buy health insurance from the **New Hampshire Health Plan**. You will not face a new pre-existing condition exclusion period if you are HIPAA eligible. There are limits on what you can be charged for this health insurance (see page 21).*
- *If you are not HIPAA eligible and have had difficulty obtaining affordable individual health insurance because of your health condition, you may also be eligible for health insurance from the **New Hampshire Health Plan**. If you are eligible because of health reasons and you have had no previous health coverage, you may face a new pre-existing condition exclusion period. There are limits on what you can be charged for this insurance (see page 21).*
- *If you are a small employer buying a fully insured **small 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 fully insured health plans for small employers must be sold on a **guaranteed issue** basis (see page 24).*
- *If you are a small employer buying a fully insured group health plan, there are limits on what you can be charged due to the health status and some other factors of those in your group (see page 24).*
- *If you are self-employed, you may qualify to buy a fully insured small group health plan as a business group of one (see page 25).*
- *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 New Hampshire **Medicaid** program offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes (see Chapter 5).*
- *If your children are 19 years old or younger and do not have health insurance and meet other qualifications, you may be able to buy health insurance for them through the New Hampshire **Healthy Kids Program**, which offers subsidized health insurance for certain uninsured children (see page 29).*
- *If you believe you may be at risk for cancer but are uninsured or underinsured, you may be eligible for screening and treatment. The **Let No Woman Be Overlooked** Breast and Cervical Cancer program provides free cancer screening for qualified*

residents. Some women diagnosed with breast or cervical cancer through this program may be eligible for medical care through Medicaid (see page 29).

- *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 coverage is called the **Health Coverage Tax Credit**, and is equal to 65% of the cost of qualified coverage, including COBRA, state continuation coverage and health insurance offered through the New Hampshire Health Plan (see page 30).*
- *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 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 group health plan 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 include the same doctors that your old health plan did (see page 10).*
- *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 their decision is based on factors unrelated to your health status (see page 6).*
- *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 7).*
- *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. If you had some prior health coverage, you may not have to satisfy the entire pre-existing condition exclusion period (see page 8).*
- *Even if your coverage is **continuous**, there may be a pre-existing condition exclusion period for some benefits if you join a fully insured large group health plan or a **self-insured** group health plan that covers benefits your old group 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 certain non-federal public employers in New Hampshire, not all of the group health plan protections may apply to you (see page 11).*
- *In New Hampshire, your access to individual health insurance may depend on your health status. Private **insurers** and HMOs are not prohibited from turning you down or charging you more because of your health condition (see page 13).*
- *If you are HIPAA eligible, the New Hampshire Health Plan is your only guaranteed access to individual health insurance. However, you may be able to buy an individual health insurance policy from a private insurer (see Chapter 3).*
- *If you move away from New Hampshire, you may not be able to buy individual health insurance in another state unless you are HIPAA eligible.*

## CHAPTER 2

# YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

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

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

- *You have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees such as part-time, non-permanent, or seasonal 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. Large 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. Small employers, on the other hand, must offer coverage to all of their eligible employees.

#### 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.

- *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 during this time. If your group plan offers family coverage, your dependents can elect coverage as well. Enrollment during a special enrollment period is *not* considered **late enrollment**.

### Certain changes can trigger a special enrollment opportunity

- The birth, adoption, or placement for adoption of a child
  - Marriage
  - Loss of other coverage (for example, that you or your dependents had through yourself or another family member and lost because of death, divorce, legal separation, termination, retirement, or reduction in hours worked)
- 
- *In New Hampshire, newborns, adopted children, and dependent grandchildren are automatically covered under the parents' fully insured group health plan for the first 31 days, if the plan covers dependents. The health plan may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.*
  - *In New Hampshire, adult dependents who are physically disabled or mentally retarded are able to stay on their parents' fully insured group health plan after they have reached the age at which the health plan usually cancels dependent coverage. In order to be eligible, the adult dependent must be incapable of self-support and must be dependent on the policyholder for support. Proof of incapacity must be provided to the health plan within 31 days of reaching the limiting age.*
  - *New Hampshire requires fully insured group health plans to accept late enrollees, although you might have to wait until the next annual open enrollment period.*
  - *When you begin a new job, your employer may impose 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. However, 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 time.*
  - *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 for 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 premium. However, if you don't return to work because of factors outside your control (such as a need to continue caring for a sick family member, or because your spouse is transferred to a job in a distant city), you will not have to repay the premium.

For more information on 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 a specific period immediately before you joined that plan or before the start of the waiting period. This period is also called the look back period. The amount of time a group health plan can look back varies depending on the type of plan you join. If you are joining a fully-insured group plan, the maximum look back period is 3 months. If you are joining a self-insured group plan, the maximum look back period is 6 months.*
- *Group health plans can only exclude coverage for pre-existing conditions for a limited time. The maximum exclusion period depends on the type of group health plan you are joining. If you are joining a fully insured group health plan in New Hampshire, the maximum exclusion period is 9 months. If you are joining a self-insured group health plan, the maximum exclusion period is 12 months. If you enroll late in your group health plan (after you are hired and not during a regular or special enrollment period), your pre-existing condition exclusion period cannot exceed 18 months.*
- *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 that impose pre-existing condition exclusion periods must give you credit for any previous continuous **creditable coverage** that you have 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.

- *Health coverage counts as continuous if it is not interrupted by a significant break of 63 days or more in a row. The new coverage must be in place on the 63<sup>rd</sup> day in order to avoid any pre-existing condition exclusion periods.*

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

You can get continuous coverage under one plan, or several plans, as long as you don't have a lapse of 63 or more 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 *self-insured* health plan that covers care for diabetes but excludes pre-existing conditions for 12 months. Charter must cover Art's diabetes care immediately because 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 – 9 months). Art does not get credit for his coverage at Ajax since he had a break in coverage of 63 or more consecutive days. However, if Charter offered a *fully insured* group health plan, Art's diabetes care coverage would begin immediately because fully insured group health plans in New Hampshire must disregard a lapse in coverage due to unemployment.

- *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, the plan must 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. In addition, if you were unemployed and uninsured prior to enrolling in a fully insured group health plan in New Hampshire, but had coverage before you were unemployed, the gap in coverage you experienced during your period of unemployment shall not count as a break in coverage.
- *Your protections may differ if you move to a fully insured large group health plan or a self-insured group health plan that offers more benefits than your old one did.* These plans can look back to determine whether your previous health plan covered prescription drugs, mental health, substance abuse, dental care, or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new self-insured group health plan may impose a pre-existing condition exclusion period for that category. Group plans that use this method of crediting prior coverage must use it for everyone and must disclose this to you when you enroll. Fully insured small group health plans in New Hampshire do not use this method of crediting coverage.

**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 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 New Hampshire 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 continuation coverage, state continuation coverage, conversion policy, and high-risk pool coverage for “HIPAA eligible individuals” and others.*
- *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 coverage is called the Health Coverage Tax Credit, and is equal to 65% of the cost of qualified coverage, including COBRA, state continuation coverage and health insurance offered through the New Hampshire Health Plan (see page 30).*
- *If you are a retiree aged 55-65 and receiving benefits from Pension Benefit Guaranty Corporation (PBGC), you may 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 health coverage, you may want to buy an individual health insurance policy from a private insurer. However, in New Hampshire – as in most other states – you have limited guaranteed access to individual health insurance in the private market. There are some alternatives to private individual health insurance coverage – such as COBRA coverage, state continuation coverage, and New Hampshire Health Insurance Plan coverage. This chapter summarizes your protections under different kinds of health plan coverage.

### **INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS & HMOS**

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

In New Hampshire, your ability to buy individual health insurance depends on your health status. There are certain circumstances, however, when you must be allowed to buy an individual health insurance policy.

- *In general, insurers that sell individual health insurance in New Hampshire 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 a policy or offer to sell you a policy that has special limitations on what it covers.*
- *If you are HIPAA eligible, you are not guaranteed the right to buy individual health insurance from private insurers. However, you are guaranteed health insurance coverage from the New Hampshire Health Insurance Plan (see page 21).*
- *In New Hampshire, newborns, adopted children, and dependent grandchildren are automatically covered under the parents' individual health insurance for the first 31 days, if the policy otherwise provides coverage for dependents. The health insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.*
- *In New Hampshire, adult dependents with physical disabilities or mental retardation are able to stay on their parents' individual health insurance policy after they have reached the age at which the policy usually cancels dependent coverage. In order to be eligible, the adult dependent must be incapable of self-support and must be*

dependent on the policyholder for support. The health insurer may require that you show it proof of incapacity again in the future within 31 days of the expiration of dependent coverage.

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

- *It depends on what you buy.* New Hampshire does not require health insurers and HMOs in the individual market to sell standardized health plans. Health insurers and HMOs can design different plans and you will have to read and compare them carefully. Health insurers are required to provide you with written descriptions of their products so that you can compare the differences. New Hampshire does require all individual health policies to cover certain benefits – such as coverage for diabetes services and supplies and autologous bone marrow transplants. Check with the New Hampshire Department of Insurance for more information about mandated benefits.

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

- *There are different ways insurers are allowed, at the time you purchase an individual health insurance policy, to exclude coverage for your pre-existing conditions.*

The insurer can impose an **elimination rider** for some conditions. An elimination rider is an amendment to your health insurance contract that permanently excludes coverage for a health condition, body part, or body system.

Also, an insurer may impose a pre-existing condition exclusion period. Pre-existing condition exclusion periods cannot exceed 9 months. In addition, any pre-existing condition exclusion period that is applied to your individual health insurance policy must be reduced by any continuous creditable coverage. The same types of coverage that are available in group health plans are also considered creditable for individual health insurance. Coverage counts as continuous if it is not interrupted by a break of 63 or more days in a row.

When determining if a condition is pre-existing, an individual health insurer is allowed to look back 3 months to see if you actually received medical advice, diagnosis, or treatment for a condition. This is called the objective standard.

- *Pregnancy can be counted as a pre-existing condition by individual insurers.* However, genetic information cannot be used as a basis for a pre-existing condition.

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

- *There are limits on how you can be charged for individual health insurance because of your health status, age, and tobacco use.* Even within these limits, your premiums can be very high if you have a serious health condition.

In addition, when you renew your individual health insurance policy, your premiums can increase substantially as you age or if your health declines.

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

- *Your individual health insurance 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 HMO plans, continue to live in the plan service area. Your health insurance policy may also be canceled if the insurer or HMO discontinues your health insurance policy or withdraws from the individual market.
- *Some insurers sell short-term health plans.* Short-term policies are *not* guaranteed renewable. They will only cover you for a limited time, such as 12 months or less. If you want to renew coverage under a short-term health policy after it expires, you will have to reapply and there is no guarantee that the health insurer will be-reissued at the same price or at all.

## **COBRA AND STATE CONTINUATION COVERAGE**

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

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

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

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

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

Finally, you must have a qualifying event that would cause you to lose your group health 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 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 choose and use up any COBRA or state continuation coverage available to you.*

### **WHAT WILL COBRA COVER?**

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

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

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

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

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

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage. The first premium must be paid within 45 days of electing COBRA coverage.*
- *If you elect the 11-month disability extension, the premium will increase to 150% of the total cost of coverage. See below for more information about the disability extension.*
- *If you are eligible for the Health Coverage Tax Credit (HCTC), the federal government will pay 65% of your COBRA premium (see page 30).*

### ***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.*

## LENGTH OF COBRA COVERAGE

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

## STATE CONTINUATION COVERAGE

- *If your employer offers a fully insured group health plan, you may also be eligible for state continuation coverage under a New Hampshire law that is similar to COBRA. You must have been employed for at least six months prior to losing your coverage. You will not have a new pre-existing condition exclusion period as long as you maintain continuous coverage. Ask your former employer or the New*

Hampshire Department of Insurance about state continuation coverage if you think it applies to you.

## **CONVERSION**

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

- *In New Hampshire, if you have coverage through an employer's fully insured group health plan and you leave that job, you can buy conversion coverage. You must have been covered under your employer's group health plan for at least 60 days and have applied within 31 days of losing your coverage. Surviving spouses, former dependent spouses and children who are no longer eligible for dependent coverage can also buy conversion coverage.*

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

- *Covered benefits under conversion coverage may be identical to your employer's group coverage at your option. However, benefits covered under conversion coverage cannot be greater than that available under your former employer's group health plan.*

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

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

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

- *Premiums for conversion coverage can vary depending on your health status, age, the amount of coverage you purchase and other characteristics. Contact the New Hampshire Department of Insurance if you have questions about conversion plan premiums.*

### ***HOW LONG DOES A CONVERSION POLICY LAST?***

- *Conversion coverage, like other individual health insurance, is guaranteed renewable.*

## NEW HAMPSHIRE HEALTH PLAN

New Hampshire has a risk pool program that went into effect on July 1, 2002 called the New Hampshire Health Plan. The high risk pool offers health coverage for persons who are HIPAA eligible and for people with expensive health conditions who are unable to buy individual coverage.

### ***WHEN CAN I GET COVERAGE FROM THE NEW HAMPSHIRE HEALTH PLAN?***

- *If you are HIPAA eligible, you can buy health insurance from the New Hampshire Health Plan.*

#### **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 an individual health insurance policy of some kind with no pre-existing condition exclusion periods. In New Hampshire, you are guaranteed the right to buy coverage only from the high risk pool. 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.

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 not HIPAA eligible, you can buy health insurance from the New Hampshire Health Plan if you were turned down for coverage by an insurer or HMO because of your health or were offered an insurance policy by an insurer or HMO, but it would have been more expensive than buying health insurance from the New Hampshire Health Plan.*

In addition, if you have a pre-qualifying medical condition, you do not have to first apply to a private carrier before applying for coverage. This list maybe amended from time to time by the New Hampshire Health Plan board. You should check the webpage for an updated list of pre-qualifying conditions.

- *The New Hampshire Health Plan offers coverage to those that are eligible and their dependents and spouse. However, each person must purchase his own individual policy.*

#### **WHAT WILL THE NEW HAMPSHIRE HEALTH PLAN COVER?**

- *Health insurance from the New Hampshire Health Plan includes hospital and physician care, maternity services, prescription drugs, treatment for serious mental health illness, and other services. Four plan options are available with varying deductibles and coinsurance maximums. The high risk pool offers both indemnity and managed care plan options. In the indemnity plan you can receive care from any provider. The high risk pool pays a percentage of the expenses for covered services. In the managed care plan a higher percentage of the cost of care will be covered when you see a provider within the network instead of a provider outside the network.*

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

- *If you are HIPAA eligible, your coverage will not be subject to a pre-existing condition exclusion when you enroll in the New Hampshire Health Plan.*
- *If you are not HIPAA eligible, you may have a 9 month pre-existing condition exclusion period when you first enroll in the New Hampshire Health Plan. When you enroll, the New Hampshire Health Plan will look back 3 months to see if you had a condition for which you actually received a diagnosis, medical advice, or treatment. Pregnancy can be considered a pre-existing condition. Elimination riders are not permitted.*

If your break in coverage is less than 63 days, the New Hampshire Health Plan will give you credit for any coverage that was in effect prior to the effective date of your high risk pool coverage. The New Hampshire Health Plan considers creditable coverage to include most types of prior individual health insurance or group health plan that you may have had.

### ***WHAT CAN I BE CHARGED FOR NEW HAMPSHIRE HEALTH PLAN COVERAGE?***

- *Premiums will vary based on the health plan you choose, your age and whether you smoke. High risk pool rates are limited to 150% of the amount that a healthy person who bought a similar policy sold by a private insurer would pay.*

For example, a 24-year-old man who was a non-smoker would pay \$148 to \$242 in monthly premiums, depending on which plan option he chose. On the other hand, a 64-year-old man who was a non-smoker would pay \$582 to \$950 in monthly premiums, depending on the plan option he chose. Please note that high risk pool rates may have changed since this guide was written, so contact the pool administrator for the most current information.

### ***HOW LONG DOES NEW HAMPSHIRE HEALTH PLAN COVERAGE LAST?***

- *Health insurance from the New Hampshire Health Plan is renewable as long as you pay your premiums, continue to reside in New Hampshire, 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. New Hampshire has enacted reforms to expand some of these protections. Generally, small employers are those that employ 1-50 employees. Please note, however, that the definitions of small employer and employee are somewhat different under federal and state law. Check with the New Hampshire 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 1 but not more than 50 employees, health insurers and HMOs must sell you any small group health plan they sell to other small employers.

However, they can require that up to 75% of your eligible employees sign up for coverage if it is the only source of coverage being offered or 37.5% of your eligible employees sign up for coverage if other plan options are being offered as well. If you are buying a **large group health plan** for 51 or more employees, your group can be turned down.

- *Your group health plan 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 and HMOs can impose other conditions, however. They can require you to meet minimum participation 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 cannot be charged more, within limits, because someone in your group is seriously ill.* Premiums can vary, based on the age of your employees, the location of your business, the type of business, and the size of your group.

- *If you have questions about your group health plan premiums, contact the New Hampshire Department of Insurance.*

#### **WHAT IF I AM SELF-EMPLOYED?**

- *If you are self-employed with no other workers, you are eligible to buy a small employer group health plan on your own (though you may be able to join another group health plan through a family member). However, insurers only have to offer guaranteed issue coverage to self employed during two open enrollment periods in March and September.*
- *If you are self-employed and buy your own health coverage, 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 coverage through professional or trade associations. The laws applying to association health coverage can be different than those for other health plans. Check with the New Hampshire Department of Insurance about your protections in association health plans.*

## CHAPTER 5

# FINANCIAL ASSISTANCE

Help is available to certain low-income residents of New Hampshire who cannot afford to buy health insurance. Medicaid, the Healthy Kids, and the Let No Woman be Overlooked programs offer free or subsidized health insurance coverage, direct medical services or other help. This chapter provides summary information about these programs and contact information for further assistance.

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 New Hampshire residents. Medicaid coverage for children is called Healthy Kids. Medicaid also covers medically needy individuals, the elderly, and people with disabilities, if state and federal guidelines are met. Legal residents who are not U.S. citizens may be eligible for Medicaid.

- *Eligibility for Medicaid is based on the amount of your household income and your family or disability status.*

In New Hampshire you may be eligible for Medicaid if you are an infant, a child, a parent of a child, or a pregnant woman, 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 New Hampshire Department of Health and Human Services for more information.

## Low income persons eligible for Medicaid in New Hampshire

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Infant	300% (monthly income of about \$3918 for family of 3)
Child 1-5	185%
Child 6-19	185%
Non-working Parent	47%
Working Parent	58%
Pregnant woman	185%
Medically Needy	
-Individual	76%
-Couple	70%

\* 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, 185% of the federal poverty level for a family of 3 would be an annual income of \$30,170, or a monthly income of \$2,559.

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 the Family Assistance Program and the New Hampshire Employment Program) automatically receive Medicaid. Or you and your children may qualify for Medicaid if your family's income meets certain income standards.*

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

- *Poor elderly, disabled or blind people who get **Supplemental Security Income (SSI)** benefits or meet certain age and/or disability-related criteria in addition to income and resource criteria can also qualify 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 are a child, 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 do not have health insurance that covers these services.
- *Elderly 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.

Contact your local Department of Health and Human Services for more information about other eligibility requirements.

- *There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify for Medicaid, contact the New Hampshire Department of Health and Human Services Division of Family Assistance. To obtain the locations and telephone numbers of sites near you call (800) 852-3345, ext. 4238.

## HEALTHY KIDS

The New Hampshire Healthy Kids Program is a Medicaid expansion program that provides health coverage to low-income children under the age of 19 who are not eligible for Medicaid and who have no health insurance and pregnant women ineligible for Medicaid.

- *A child up to age 19 whose family has a household income below 185% of the federal poverty level is eligible for Healthy Kids Gold program. For a family of 3, this works out to an annual income of about \$30,710, or a monthly income of about \$2,559. Uninsured infants under age 1 whose family income is no more than 300% of the federal poverty level are eligible for the Gold program as well. There are no premiums for this program.*
- *Uninsured children up to age 19 with income higher than 185% but not more than 400% of the federal poverty level can get coverage under the Healthy Kids Silver program. Under this program there is a monthly premium based on family size and household income.*
- *Eligibility is guaranteed for six months unless the child moves from the state, enrolls in Medicaid, reaches age 19, or is found to have other health coverage. Eligibility can also be canceled if it is obtained due to fraud or false or misleading statements or for nonpayment of premiums.*
- *For more information, call (877) 464-2447 ext. 343.*

## LET NO WOMAN BE OVERLOOKED: THE BREAST AND CERVICAL CANCER SCREENING PROGRAM

Let No Woman Be Overlooked is a program that provides free screening for breast and cervical cancer to eligible New Hampshire residents.

- *The Let No Woman Be Overlooked program provides qualified women with full healthcare benefits through Medicaid 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 that 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 program, you must meet age, income, and insurance guidelines. You must have no or limited health insurance coverage and have an income at or below 250% of the federal poverty level. Eligible*

women aged 18 and older are eligible for annual Pap tests while women aged 40 and older are eligible for mammograms every 1-2 years.

- *For more information, please contact the New Hampshire Division of Chronic Disease Prevention and Control at (800) 852-3345 ext. 4931 or <http://www.dhhs.nh.gov/DHHS/CDPC/LIBRARY/Fact+Sheet/bccp-screening.htm>.*

## **OTHER ASSISTANCE PROGRAMS**

There may be other financial assistance programs available. Please contact the New Hampshire Department of Health and Human Services at (800) 852-3345 ext. 5254.

## **THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)**

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

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

- *To be eligible for the tax credit, you must be receiving Trade Adjustment Assistance (TAA) benefits or retirement benefits from the PBGC. If you are receiving PBGC benefits, you also must be at least 55 years old.*
- *In addition, you must meet other requirements. Specifically, you are not eligible for the HCTC if any of the following apply to you:*
  - You have a health plan maintained by an employer or former employer that pays at least 50% of the cost of your coverage. Any share of your premium that is paid by you or your spouse on a pre-tax basis is considered to have been paid by your employer and must be included as such when determining the percentage of employer coverage.
  - You are enrolled in Medicare (Part A or B).
  - You are enrolled in the Federal Employees Health Benefits Program (FEHBP), Medicaid, or State Children's Health Insurance Program (SCHIP).

- You are entitled to health coverage through the U.S. military health system (Tricare/CHAMPUS).
- You can be claimed as a dependent on someone else's federal tax return.
- You received a lump sum payment of your entire PBGC benefit before August 6, 2002.
- As of the first day of the current month in which you are otherwise eligible, you are imprisoned under a federal, state or local authority.
- *HCTC may apply to your family, too.* If you are eligible, you can use the credit to help purchase qualified health coverage for your qualified family members. Qualified family members are your spouse and dependents that you can claim on your federal tax return. Family members are not eligible if they are enrolled in another group health plan where the employer pays at least 50% of the cost of coverage, or in Medicaid, SCHIP, FEHBP, Tricare/CHAMPUS.
- *Eligibility for HCTC is not based on income.* In addition, the HCTC is refundable. This means you can claim the credit even if you do not earn enough income to owe federal income tax.

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

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

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

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

- State-qualified health plans. At this time, New Hampshire has designated state-based continuation coverage and health insurance offered through the New Hampshire Health Plan as a state qualified health plan.

### ***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/>.*
- *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 State continuation coverage Fully insured group health plan	<i>New Hampshire Department of Insurance</i> (800) 852-3416 (603) 271-2261 <a href="http://www.state.nh.us/insurance">http://www.state.nh.us/insurance</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>
New Hampshire Health Plan	<i>BMI (plan administrator)</i> (877) 888-NHHP (6447) <a href="http://www.nhhealthplan.org">http://www.nhhealthplan.org</a>
Medicaid Healthy Kids	<i>New Hampshire Department of Health and Human Services Division of Family Assistance</i> (800) 852-3345, ext. 4238 (603) 271-4238 <a href="http://www.dhhs.state.nh.us">http://www.dhhs.state.nh.us</a>
Let No Woman be Overlooked Breast and Cervical Cancer Screening Program	<i>New Hampshire Division of Chronic Disease Prevention and Control</i> (800) 852-3345 ext. 4931 <a href="http://www.dhhs.nh.gov/DHHS/CDPC/LIBRARY/Fact+Sheet/bccp-screening.htm">http://www.dhhs.nh.gov/DHHS/CDPC/LIBRARY/Fact+Sheet/bccp-screening.htm</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

***Affiliation Period.*** The time an HMO may require you to wait after you enroll and before your coverage begins. HMOs that impose an affiliation period cannot exclude coverage of pre-existing conditions. Premiums cannot be charged during HMO affiliation periods. New Hampshire does not permit HMOs to use affiliation periods but other states may do so. See also HMO.

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

***Certificate of Creditable Coverage.*** A document provided by your health plan that lets you prove you had coverage under that health 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 health plan's 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 charge). 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 and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. Federal rules apply to you if you are joining a group health plan and, if you are HIPAA eligible, when you buy an individual health insurance policy. See also Creditable Coverage, HIPAA eligible.

***Conversion Policy.*** A policy that must be offered to you if you lose coverage under a fully insured group health plan in New Hampshire that you had been enrolled in for at least three months and have applied within 31 days of losing your coverage. See also Fully Insured Group Health Plan.

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

***Elimination Rider.*** An amendment permitted in an individual health insurance policy issued by an insurer that permanently excludes health 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 coverage 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. New Hampshire requires all fully insured group health plans to hold an annual open enrollment period. See also Fully Insured 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 insurer or HMO. Fully insured group health plans are regulated by New Hampshire. 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. Group health plans and individual health insurers 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 plan (usually sponsored by an employer, union or professional association) that covers at least 2 employees but includes the self-employed in the fully insured small group health plan market in New Hampshire. 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 1 to 50 employees in New Hampshire are guaranteed issue.

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

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

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

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

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

***Healthy Kids.*** Program intended to meet the needs of working families who cannot afford health insurance coverage for their children, yet earn too much to qualify for Medicaid. Coverage is available for uninsured children aged 19 and younger who live in families with qualifying incomes.

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

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

**HMO.** Health maintenance organization. A type of health 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 an HMO in a state other than New Hampshire, the HMO might require an affiliation period before coverage begins. See also Affiliation Period.

**Individual Health Insurance.** Health insurance for people not connected to an employer group. This term also refers to coverage purchased by self-employed persons who have no other employees. Individual health insurance is regulated by New Hampshire.

**Insurer.** Another term for insurance company. This term does not include HMOs.

**Let No Woman be Overlooked Program.** Program that provides free screening for breast and cervical cancer to eligible New Hampshire residents. Eligible women diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid for treatment of their condition.

**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. New Hampshire requires fully insured group plans to cover you if you are a late enrollee, although you may have to wait for the next open enrollment period. Late enrollees can 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 New Hampshire residents. All other states have Medicaid programs, too, though eligibility levels and covered benefits will vary.

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

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

**Pre-existing Condition.** Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 3-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 31 days 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.

**Self-Insured Group Health Plans.** Plans set up by employers who set aside funds to pay their employees' health claims. Because employers often hire insurers or HMOs 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 New Hampshire.

**Small Group Health Plans.** Plans with between 1 and 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 coverage 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 required to be offered by insurers and HMOs for former employees of small employers as well as some other groups of people. Continuation coverage allows people to keep their group health plan for a limited time. 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 *Family Assistance Program and the New Hampshire Employment Program*) that provides cash benefits to low income families with children. When you qualify for TANF, you generally also qualify for Medicaid. In addition, Medicaid coverage often continues for a limited time or longer if you no longer qualify for TANF. See also Medicaid.

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

***New Hampshire Health Plan.*** The state-run program that provides health coverage for HIPAA eligible persons and for people with high health risks (called a high risk pool).

***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 coverage. Not all employers require waiting periods. Waiting periods do not count as gaps in health coverage 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.