

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

By

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

**GEORGETOWN UNIVERSITY
HEALTH POLICY INSTITUTE**

January 2006

ACKNOWLEDGMENTS AND DISCLAIMER

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

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

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

January 2006

© Copyright 2006 Georgetown University, Health Policy Institute.

All rights reserved. No portion of this guide may be reprinted, reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without permission from the authors. Permission can be obtained by writing to: Georgetown University Health Policy Institute, 3300 Whitehaven Street, NW Suite 5000 Washington, DC. 20057.

A CONSUMER’S GUIDE TO GETTING AND KEEPING HEALTH INSURANCE IN OHIO

As an Ohio 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 an Ohio resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group and individual health insurance. Chapter 4 highlights your protections as a small employer or self-employed person. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from Ohio, 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 31. For information about how to find consumer guides for other states on the Internet, see page 32. A list of helpful terms and their definitions begins on page 33. These terms are printed in **boldface type** the first time they appear.

CONTENTS	
1. A summary of your protections	2
How am I protected?.....	2
What are the limits on my protections?	4
2. Your protections under group health plans.....	6
When does a group health plan have to let me in?.....	6
Can a group health plan limit my coverage for pre-existing conditions?....	8
Limits to protections for certain government workers.....	10
As you are leaving group coverage	11
3. Your protections when buying individual health insurance.....	12
Individual health insurance sold by private insurers.....	12
Guaranteed Issue Basic and Standard Plans	14
COBRA continuation coverage.....	17
Conversion Coverage	22
4. Your protections as a small employer or a self-employed person	24
Do insurance companies have to sell me health insurance?.....	24
Can I be charged more because of my group’s health status?.....	24
What if I am self employed?	25
A word about association plans	25
5. Financial assistance.....	26
Medicaid.....	26
Breast and Cervical Cancer Prevention Project (BCCP).....	29
Ohio’s Best Rx Program	29
Other assistance programs.....	29
The Federal Health Coverage Tax Credit (HCTC).....	29
For more information.....	33
Helpful Terms.....	35

CHAPTER 1

A SUMMARY OF YOUR PROTECTIONS

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

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

HOW AM I PROTECTED?

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

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status. This is called **nondiscrimination** (see page 5).*
- *All health plans in Ohio 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 health plan will begin to pay for care for that condition. Generally, if you join a new 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 pages 7).*
- *Your health insurance cannot be canceled because you get sick. All health insurance is **guaranteed renewable** (see pages 13, 16 and 22).*
- *If you leave your job, you may be able to remain in your old group health plan for a certain length of time. This is called **COBRA** continuation coverage or **state continuation coverage**. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage (see page 16).*
- *If you lose your group health plan and meet other qualifications, you can buy **conversion coverage**. This is an individual health policy from the company that insured your employer group. You cannot be denied coverage because of your*

health status, and you will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for conversion coverage (see page 21).

- *All individual market health insurers in Ohio must have an annual **open** enrollment period, during which you can buy certain kinds of individual health insurance regardless of your health status. This is called **guaranteed issue**. You must meet certain requirements to be eligible to buy a basic or standard plan during an open enrollment period (see page 13).*
- *If you are **HIPAA eligible**, you can buy certain kinds of individual health insurance any time during the year. You do not have to wait for an open enrollment period. If you are HIPAA eligible, you have additional protections when you buy either a basic or standard plan or a conversion policy (see pages 13 and 21).*
- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any other factor that might predict the use of health services of those in your group. All health plans for small employers must be sold on a guaranteed issue basis (see page 23).*
- *If you are a small employer buying a group health plan, there are limits on how much your premiums can vary due to the health status, age, gender, or other characteristics of those in your group. Even within these limits, however, premiums can be significantly higher if someone in your group has a serious health condition (see page 23).*
- *If you have low or modest household income, you may be eligible for free or subsidized health coverage for yourself or members of your family. The Ohio Medicaid program offers free health coverage for pregnant women, families with children, and elderly and disabled individuals with very low incomes (see Chapter 5).*
- *If your children are 18 years old or younger, do not have health insurance and meet other qualifications, you may be able to buy insurance for them through the **Healthy Start** or **Healthy Families** program (see page 26).*
- *If you believe that you may be at risk for cancer, you may be eligible for free screening and treatment. The **Breast and Cervical Cancer Prevention Project** provides free breast and cervical cancer screenings for qualified residents of Ohio. Women diagnosed with breast or cervical cancer through this program may be eligible for medical care through Medicaid (see page 30).*
- *If you lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program**, you may be eligible for a federal income tax credit to help you pay for new health coverage. This credit is called the **Health Coverage Tax Credit (HCTC)**, and is equal to 65% of the cost of qualified*

coverage, including COBRA, state continuation coverage and policies offer through numerous private insurers (see page 29).

- *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 29).*

WHAT ARE THE LIMITS ON MY PROTECTIONS?

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

- *If you change jobs, you usually cannot take your old health benefits with you. Except when you exercise your federal COBRA or state continuation rights, you are not entitled to take your actual group health 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 5).*
- *If you change jobs, your new employer may not offer you health benefits. Employers are required only to make sure that their decision is based on factors unrelated to your health status (see page 5).*
- *If you get a new job with health benefits, your coverage may not start right away. Employers and **health maintenance organizations (HMOs)**, which are also called **health insuring corporations (HICs)** can require **waiting periods** before your health benefits begin (see page 6).*
- *If you work for one of a number of local governments or school districts in Ohio, not all of the group health plan protections may apply to you (see page 9).*
- *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 fully insured group health plan (see pages 8).*
- *Even if your coverage is continuous, there may be a pre-existing condition exclusion period for some benefits if you join a **self-insured group health plan** that covers certain benefits your old plan did not. For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to one year before your new self-insured health plan will pay for drugs prescribed to treat a pre-existing condition (see page 9).*

- *Except in the case of basic and **standard health plans**, your access to individual health insurance may depend on your health status. Private insurers are not prohibited from turning you down, charging more or limiting coverage because of pre-existing conditions. If you are HIPAA eligible or purchasing health insurance during an open enrollment period, you are only guaranteed access to basic or standard health insurance plans (see page 13).*
- *If you move away from Ohio, you may not be able to buy individual health insurance in another state unless you are HIPAA eligible (see page 14).*

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 a health maintenance organization (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.* 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 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 employees who can pass a physical examination. This is *not permitted* under the law.

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

Certain changes can trigger a special enrollment opportunity

- The birth, adoption, or placement for adoption of a child
 - Marriage
 - Loss of other coverage (for example, that you or your dependents have through yourself or another family member because of death, divorce, legal separation, termination, retirement, or reduction in hours worked)
-
- *Under Ohio law, newborns, adopted children and children placed for adoption are automatically covered under the parent's fully insured health plan for the first 31 days, if the plan covers dependents. The insurer may require that the parent enroll the dependent within the 31 days in order to continue coverage beyond the 31 days.*
 - *In Ohio, disabled dependents are permitted to remain insured under their parent's fully insured group health plan after they reach the age at which dependent coverage is usually terminated. The adult dependent must be unmarried, incapable of self-sustaining employment by reason of mental retardation or physical handicap and must rely on the policyholder for support. In addition, proof of dependency and disability must be provided to the insurer within 31 days of the dependent reaching the limiting age and periodically after that.*
 - *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. Small employers offering fully insured health plans may not impose waiting periods longer than 90 days.*
 - *When you begin a new job with health insurance through an HMO or HIC, the HMO/HIC may require an **affiliation period** before coverage begins. You will not have health insurance coverage during this time. An affiliation period cannot exceed 60 days (90 days if you are a late enrollee), and you cannot be charged a premium during it.*
 - *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 a **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job protected leave in these circumstances. 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.*

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 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 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 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.

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

If you are applying to enroll late in a fully insured group health plan, insurance companies are permitted to wait up to 12 months or until the next open enrollment period before they enroll you in the group health plan, and then may impose an 18-month pre-existing condition exclusion period. You must be accepted.

- *When you join a new group health plan, the law protects you from a new pre-existing condition exclusion period, provided you maintain continuous **creditable coverage**. Most health insurance coverage is 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 of prior coverage, such as old health plan ID cards or statements from your doctor showing bills paid by your health insurance plan.

If you are joining a group health 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 exclusion periods.

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 63 or more consecutive days.

Take Art, who has diabetes. Ajax Company covered him under its group health plan for 9 months, but he lost his job and health coverage. Then, *45 days later*, Art found a new job at Beta Corporation and had health coverage for 9 more months. Art changed jobs again. His new company, Charter, has a health plan that covers care for diabetes but excludes pre-existing conditions for 12 months. Charter must cover Art's diabetes care immediately, because his 18 months of prior continuous coverage are credited against the 12-month exclusion.

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

- *In determining continuous coverage, employer-imposed waiting periods and HMO/HIC affiliation periods do not count as breaks in coverage.* If your new plan imposes a pre-existing condition exclusion period, you can credit time under your prior continuous coverage toward it. If your employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period. HMOs/HICs that require an affiliation period cannot exclude coverage for pre-existing conditions.
- *Your protections may differ if you move to a self-insured group health plan that offers more benefits than your old health plan did.* Self-insured 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. Fully insured group health plans in Ohio cannot do this.

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

Question: Is this permitted?

Answer: Yes. However, the plan must pay for covered doctor visits, hospital care, and other services for Sue's high blood pressure. It also must pay for covered prescription drugs 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 Ohio 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. 91565 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. See Chapter 3 for more information about COBRA continuation coverage, state continuation coverage, conversion policies and individual health insurance for “HIPAA eligible individuals.”*
- *If you lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program**, you may be eligible for a federal income tax credit to help you pay for new health coverage. This credit is called the **Health Coverage Tax Credit (HCTC)**, and is equal to 65% of the cost of qualified coverage, including COBRA, state continuation coverage and policies offer through numerous private insurers (see page 29).*
- *If you are a retiree aged 55-65 and receiving benefits from **Pension Benefit Guarantin (PBGC)**, then you may be eligible for the HCTC (see page 29).*

CHAPTER 3

YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

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

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

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

In Ohio, your ability to buy individual health insurance may depend on your health status. There are certain circumstances, however, when you must be allowed to buy individual health insurance.

- *In general, insurers that sell individual health insurance in Ohio are free to turn you down because of your health status and other factors. When applying for individual health insurance, you may be asked questions about health conditions you have now or had in the past. Depending on your health status, insurers might refuse to sell you coverage or offer to sell you a policy that has special limitations on what it covers.*

However, there are certain times of year that you cannot be turned down because of your health status, age, or any other factor that might predict your use of health services. This is called **guaranteed issue**. During open-enrollment periods, insurers must sell you either a basic or standard plan.

In addition, if you are HIPAA eligible, you are guaranteed the right to purchase either a basic or standard plan.

There are special rules that apply to these plans (see below).

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

- *In Ohio, if your individual health insurance policy covers dependents, disabled dependents may be permitted to remain insured after they reach the age at which dependent coverage is usually terminated. The adult dependent must be unmarried, incapable of self-sustaining employment by reason of mental retardation or physical handicap and must rely on the policyholder for support. In addition, proof of dependency and disability must be provided to the insurer within 31 days of the dependent reaching the limiting age and periodically after that.*

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy. Individual health insurers can design policies and you will have to read and compare them carefully. However, Ohio does require all health plans to cover certain benefits – such as treatment for diabetes and post-delivery hospital stays. Check with the Ohio department of Insurance for more information about mandated benefits.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you buy an individual health insurance policy then there are different ways that insurers can exclude a pre-existing condition.*

The insurer can impose an **elimination rider**, which is an amendment to your health insurance contract that permanently excludes coverage for a health condition, body part, or body system. Or a plan can impose a 12 month pre-existing condition period on any pre-existing condition.

Insurers can count as pre-existing any condition for which you received – or, in your insurer’s judgment, for which you should have sought – medical care, treatment, diagnosis or advice in the 6-month period prior to enrollment. This is called the **prudent person rule**.

If an insurer imposes a pre-existing exclusion period, it must give you credit toward the pre-existing condition exclusion period for any prior creditable coverage you had, provided no more than 30 days lapse between your old and new coverage.

- *Generally insurers cannot consider genetic information as pre-existing condition. However, it is important to note the definition of “genetic information” is defined more narrowly than employer sponsored group plans.*
- *Pregnancy can be considered a pre-existing condition under individual policies. Also, except in guaranteed issue policies, insurers can exclude coverage for maternity benefits – whether or not you are pregnant when you buy the policy – for up to the first 270 days you are enrolled.*
- *HICs/HMOs are not allowed to have pre-existing condition exclusion periods for basic health care services.*

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

- *In Ohio, premiums must relate to the benefits offered.* However, generally there are no limits on how much insurers can vary premiums for non-guaranteed issue policies due to age, gender, health status, family size, and certain other factors.

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELED?

- *If you have an individual health insurance policy, 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, premiums can also increase within limits as you age.
- *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.

GUARANTEED ISSUE BASIC AND STANDARD PLANS

WHEN DO INDIVIDUAL HEALTH INSURERS HAVE TO SELL ME A BASIC OR STANDARD PLAN?

- *If you are HIPAA eligible and meet other requirements, you can buy either a basic or standard plan at any time during the year.* You are always guaranteed the right to buy one of these policies from the insurer that covered you before you lost your group policy. You do not have to wait for an annual open enrollment period. In addition, all other individual insurers must offer you the option to buy either the basic or standard plan except those insurers that have met their annual enrollment cap.

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible in Ohio you are guaranteed the right to buy a conversion policy or another individual health insurance policy. You are exempted from pre-existing condition exclusion periods. In addition, there are rules about what the plan must cover and what can be charged. 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 may be able to buy either a basic or standard plan during open enrollment.* To buy either a basic or standard plan during an open enrollment period, you must not be eligible for any other group health plan, COBRA or state continuation coverage, or Medicare.
- *Different types of individual insurers have different open enrollment periods.* **Indemnity health plans** must have an open enrollment period beginning in January of each year. Managed care plans must have a 30-day open enrollment period each year as well, although the time of year may vary.

Generally, individual health insurers are required to advertise their open enrollment periods in newspapers at least 2 weeks prior to, and then throughout, their open enrollment periods.

- *Even during open enrollment periods, individual health insurers are required to enroll only a limited number of people.* Once a plan reaches its state-approved enrollment cap, it can refuse to sell you individual health insurance for that year. Also, plans are not required to enroll you if you are confined to a health care facility because of a chronic illness. A health insurer is also not required to hold open enrollment if the insurer is not financially sound.

WHAT WILL MY BASIC OR STANDARD PLAN COVER?

- *Basic and standard health plans must meet specific minimum standards as required under Ohio state insurance law. However, even with these standards, plans might vary slightly depending on the insurer and you will have to read and compare them carefully.*
- *A state board defines benefits that must be offered under basic and standard health plans and may change these definitions periodically. These descriptions that follow were current as of December 2004.*

The **standard health plan** covers hospital and physician services, limited prescription drug benefits, and other health services. Certain benefits, such as mental health care, maternity care, preventive services, and organ transplants, are subject to special limits. Coverage for all services is limited to a lifetime maximum of \$1 million. An annual deductible of \$750 applies. Other cost sharing for covered services will vary depending on the type of plan you choose. For example, some plans pay 80% for covered services and you pay 20%. Others pay 60% and you pay 40%. Benefits and cost sharing may be somewhat different in standard health plans offered by HMOs or HICs.

The **basic health plan** covers hospital and physician services, limited prescription drug benefits, and other health services. Routine maternity care is not covered. The basic health plan pays 50% of the cost of covered services after an annual deductible of \$1,000. All coverage is limited to \$50,000 per calendar year. In addition, special limits apply to coverage for certain services, such as mental health care, preventive services, and organ transplants. Benefits and cost sharing may be somewhat different in basic health plans offered by HMOs or HICs.

WHAT CAN I BE CHARGED FOR A BASIC OR STANDARD PLAN?

- *Insurers are limited on how much they can charge you for either a basic or standard plan. If you are HIPAA eligible, there is a limit on what you can be charged. This limit works out to be about twice the rate charged to other people who do not come in through open enrollment.*

If you are not HIPAA eligible, there also are limits on what you can be charged for basic and standard health plans during open enrollment. Contact the Ohio Department of Insurance if you have questions about basic or standard plan premiums.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Insurers are limited on how long they apply a pre-existing condition exclusion period under a basic or standard plan.*

If you are HIPAA eligible and buy either a basic or standard plan, insurers cannot impose a pre-existing condition exclusion period.

If you are not HIPAA eligible and buy either a basic or standard plan during open enrollment, you may have a pre-existing condition exclusion period. Individual health insurers can exclude coverage for pre-existing conditions for up to one year. You must be given credit for any prior creditable coverage you had, provided no more than 30 days lapse between your old and new coverage. Individual plans also can require a one-year waiting period before they will cover organ transplants. However, newborn infants cannot be subjected to this waiting period for transplant coverage or any other benefit offered by the plan. HICs/HMOs are not allowed to apply pre-existing conditions to basic services such as maternity care.

CAN MY BASIC OR STANDARD PLAN BE CANCELED?

- *If you buy either a basic or standard health insurance plan, 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.*

COBRA CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

If you are leaving your job and you had group coverage, you may be able to stay in your group plan for an extended time through COBRA or state continuation coverage. The information presented below was taken from publications prepared by the U.S. Department of Labor. You should contact the department 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 their own decision. If your dependents were covered under your employer plan, they may independently elect COBRA coverage as well.*
- *To qualify as HIPAA eligible, you must choose and use up any COBRA or state continuation coverage available to you.*
- *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.*

WHAT WILL COBRA COVER?

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

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage. The first premium must be paid within 45 days of electing COBRA coverage.*
- *If you elect the 11-month disability extension, the premium will increase to 150% of the total cost of coverage. See below for more information about the disability extension.*
- *If you lost your health insurance and are receiving benefits from the Trade Adjustment Assistance (TAA) Program, you may be eligible for a federal income tax credit to help you pay for new health coverage. This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 65% of the cost of qualified coverage, including COBRA and coverage offered through the South Carolina Health Insurance Pool (SCHIP) (see page 31).*
- *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 31).*

HOW LONG DOES COBRA COVERAGE LAST?

- *COBRA coverage generally lasts up to 18 months and cannot be renewed. However, dependents are sometimes eligible for up to 36 months of COBRA continuation coverage, depending on their qualifying event. In addition, special rules for disabled individuals may extend the maximum period of coverage to 29 months. To qualify for the disability extension, you must have been disabled at the time of your COBRA qualifying event (such as termination of employment or reduction in hours) or be determined to have become disabled within 60 days of that qualifying event. You must obtain this disability determination from the Social Security Administration, and you must notify your group health plan within 60 days of this disability determination.*

LENGTH OF COBRA COVERAGE

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

* Certain disabled persons and their eligible family members can extend coverage an additional 11 months, for a total of up to 29 months.

- *Usually, COBRA continuation coverage ends when you join a new health plan. However, if your new plan has a waiting period or a pre-existing condition exclusion period, you can keep whatever COBRA continuation coverage you have left during that period. For specifics, ask your former employer or contact the U.S. Department of Labor.*
- *COBRA coverage also ends if your employer stops offering 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. Some 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 OHIO CONTINUATION COVERAGE?

Ohio permits certain individuals to continue coverage under their fully insured group health plan, even after they lose eligibility as a member of that group.

- *If your employer offers fully insured health benefits, you may also be eligible for up to 6 months of continuation coverage under an Ohio law that is similar to COBRA. If your employer has fewer than 20 workers, state continuation coverage is the only continuation coverage available to you.*

- *To qualify for state continuation coverage, you must have been covered under your fully insured group health plan for at least three months, be eligible for unemployment, not be eligible for Medicare, and not enrolled in or eligible for other group health plans or COBRA. Also you must apply within 31 days of losing your coverage, if you have not received notice, or within 10 days of losing your coverage if you received notice of continuation rights prior to loss of coverage, or 10 days from the day you were notified about continuation coverage, whichever is later. Continuation coverage is not required to include dental, vision care, prescription drugs, or any other benefits under the group plan above hospital, surgical or major medical benefits. Ask your former employer or the Ohio Department of Insurance about state continuation coverage if you think it applies to you.*
- *In Ohio, you are not guaranteed the right to buy individual health insurance unless you have used up the COBRA or state continuation coverage available to you.*

CONVERSION COVERAGE

WHEN AM I ELIGIBLE FOR CONVERSION COVERAGE?

- *In Ohio, if you have coverage through an employer's fully insured group health plan and you leave that job, you can buy conversion coverage. This is an individual policy you get from the company that insured your employer's group plan. To qualify, you must have been continuously covered under the group plan for at least one year. If you are covered by a HIC/HMO, the one year coverage requirement does not apply. In addition, you first must use up any COBRA or state continuation coverage. Finally, you must apply for conversion coverage and pay your premium for the first calendar quarter of coverage within 30 days of termination of your former group (or continuation) coverage.*
- *You can also buy a conversion policy if you lost your group health plan due to death or divorce of the covered employee, or if you no longer qualify as a dependent child of the covered employee.*

WHAT DOES CONVERSION COVERAGE COVER?

- *Covered benefits under conversion coverage may not be the same as under your former group health plan. Benefits covered under the conversion plan available to you will vary depending on your situation.*

If you are HIPAA eligible, you must be offered a choice of a basic or standard plan (see page 13). Insurers can offer you other conversion plans as well.

If you are not HIPAA eligible, the insurer can decide which conversion type of conversion coverage to offer, which may or may not include a basic or standard plan (see page 13). Either way, conversion plan benefits might be very different from those covered under your former 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 CONVERSION COVERAGE?

- *If you are HIPAA eligible, premiums for standard and basic conversion plans are limited to twice the rate insurers charge other individuals or groups buying that plan.*
- *Generally if you are not HIPAA eligible, there are few limitations on how much you are charged for conversion coverage. However, if you are offered a basic or standard conversion plan, there are limits to how much insurers can charge you (see page 15).*
- *Depending on your health status, you may have a choice between buying conversion coverage or a private individual insurance policy. Check out both options to see which is best for you.*

CAN MY POLICY BE CANCELED?

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

CHAPTER 4

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

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. Ohio has enacted some reforms that 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 Ohio 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 eligible for health benefits, health insurance companies must sell you any **small group health plan** they sell to small employers. However, they can require that a minimum percentage of your employees sign up for coverage. They can also require you to pay a minimum share of your workers' premiums. If you are buying a **large group health plan** for 51 or more employees, your group can be turned down.
- *Your insurance cannot be canceled because someone in your group becomes seriously ill.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud, or if they are discontinuing that insurance product. In the latter case, they must give you a chance to buy other plans they sell to groups of your size.

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

- *Within limits, premiums for small group health plans can vary based on the health status, age, gender, industry, and other characteristics of those in your group.* Even within these limits, however, premiums can be significantly higher if someone in your group has a serious health condition. If you have 51 or more eligible employees, there are no limits on premium variation. Check with the Ohio Department of Insurance if you have questions about your group health plan premiums.

WHAT IF I AM SELF EMPLOYED?

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

A WORD ABOUT ASSOCIATION PLANS

- *Some small employers and self-employed people 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 Ohio Department of Insurance about your protections in association health plans.*

CHAPTER 5 FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Ohio who cannot afford to buy health insurance. Medicaid, Healthy Start, Healthy Families, the Breast and Cervical Cancer Project, Ohio's Best Rx Program, along with other 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 government, under the Trade Adjustment Assistance (TAA) Program, provides tax credits to some workers who lose their jobs or whose work hours and wages are reduced as a result of increased imports. This chapter provides summary information about this program and contact information for further assistance.

MEDICAID

Medicaid is a program that provides health coverage to some low-income Ohio residents. Medicaid covers families with children and pregnant women, the elderly, and people with disabilities, if state and federal guidelines are met. Those who qualify for Medicaid programs must be Ohio residents and U.S. citizens. Additionally, certain legal residents who are not U.S. citizens may be eligible for coverage. Non-citizens who do not have immigration documents cannot enroll in Medicaid programs.

For all categories of Medicaid, eligibility is based on the amount of your household income. For children with family incomes over 150% of the federal poverty level, eligibility is restricted to uninsured children who have not had health insurance for at least 6 months. For those who are applying for coverage because they are elderly or have a disability, eligibility is also based on the amount of assets an individual may have. Assets are things like cash, savings, stocks and bonds, etc.

Low income persons eligible for Medicaid in Ohio*

Category	Income eligibility (as percent of federal poverty level)
Uninsured Children	200%
Children (up to 19)	200%
Pregnant women	150%
Parents	90%

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

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

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

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

So, for example, using this guideline, 200% of the federal poverty level for a family of 3 would be an annual income of \$33,200, or a monthly income of \$2,767.

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

WHAT IS HEALTHY START?

- *The name of the Medicaid program for low income children and pregnant women in Ohio is Healthy Start. Eligibility requirements are as follows:*
- *A child whose family has a household income between 151 – 200% of the federal poverty level (FPL) must be uninsured in order to be eligible for Healthy Start. For a family of 3, this is an annual income of up to \$33,200– or \$2,767 per month.*
- *A child whose family has an income below 150% FPL can be eligible for Healthy Start regardless of insurance status. For a family of 3, this is an annual income of about \$24,900 – or \$2,075 per month.*
- *A pregnant woman whose family income is below 150% FPL is also eligible for Healthy Start. When determining eligibility, a pregnant woman, at minimum, is considered a family of two. In addition, babies born to mothers on Healthy Start are automatically eligible for coverage for one full year.*
- *Healthy Start does not impose a pre-existing condition exclusion period. If a family meets the eligibility guidelines, a child's pre-existing medical condition does not exclude him or her from coverage.*
- *Healthy Start provides comprehensive coverage to enrollees including, but not limited to, doctor visits, hospital care, prescriptions, mental health services and substance abuse, preventive well-child exams, immunizations, dental, and vision services.*

- *To apply, families must complete a short, mail in application. No face-to-face interview is required. Applications can be obtained by contacting 1-800-324-8680/TDD 1-800-292-3572, or by visiting the local county Department of Job and Family Services, or on the internet at www.state.oh.us/odjfs/ohp.*

WHAT IS HEALTHY FAMILIES?

- *The name of the Medicaid program for low income families - both parents and children – is Healthy Families. A family with income less than 100% FPL is eligible. (See page 27 for poverty level for 2006).*
- *Healthy Families provides comprehensive coverage to enrollees including doctor visits, hospital care, prescriptions, mental health services and substance abuse, preventative well-child exams, immunizations, dental, and vision services.*

To apply, families must complete a short, mail in application. No face to face interview is required. Applications can be obtained by contacting 1-800-324-8680/TDD 1-800-292-3572, or by visiting the local county Department of Job and Family Services, or on the internet at www.state.oh.us/odjfs/ohp.

WHO ELSE IS ELIGIBLE FOR MEDICAID COVERAGE?

- *Families and children participating in Ohio Works First (OWF) cash assistance program are automatically covered. Families who leave OWF for employment are eligible for 6 to 12 months during a transitional period, in addition, your children may qualify for Healthy Start if your family's income meets those income standards, even if your income rises above 100%FPL.*
- *Poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits 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.

- *Retired or disabled people who have low incomes and are enrolled in Medicare may also qualify for help from Medicaid through the Ohio Medicare Premium Assistance Program. Even though your income may be too high to qualify for Medicaid 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.

If your household income is above 100% but below 135% of the poverty level, Medicaid will pay for your monthly Medicare premiums only.

Contact your County Job and Family Services office for more information about other eligibility requirements. Call 1-800-324-8680/ TDD 1-800-292-3572 to obtain the location and telephone number of this office.

BREAST AND CERVICAL CANCER PREVENTION PROJECT (BCCP)

- *The Breast and Cervical Cancer Prevention Project (BCCP) is a program that provides education, screening, re-screening, diagnostics and case management related to breast and cervical cancer for Ohio's eligible female residents.*
- *In order to be eligible for BCCP, you must meet age, income and insurance guidelines. In order to receive Pap tests and clinical breast exams, you must be 40 years of age or older. In order to be eligible to receive mammograms, you must be 50 years of age or older. Additionally, you must be uninsured or underinsured, and your household income may not exceed 200% of the poverty level.*
- *Women screened through this program and diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid that will extend throughout the duration of treatment.*
- *For more information, please contact the Ohio Department of Health at (614) 644-8700 or <http://jfs.ohio.gov/Ohp/bcps/bccp/index.stm>.*

OTHER ASSISTANCE PROGRAMS

There may be other financial assistance programs available. Please contact the Ohio Department of Health <http://www.odh.state.oh.us/>.

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 or state continuation coverage, as long as your employer or former employer contributes less than 50% of the total health plan premium.*
 - *Individual health insurance in which you were enrolled for at least the last 30 days before you were separated from the job that makes you eligible for TAA benefits or for payments from the PBGC.*
 - *State qualified plans: In Ohio, several private insurers offer, “qualified health coverage”. For more information, see <http://www.irs.gov/individuals/index.html>*
 - *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/>.*
- *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 State continuation coverage	<i>Ohio Department of Insurance</i> (800) 686-1526 (in-state only) (614) 644-2673 http://www.ohioinsurance.gov
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor Employee Benefits Security Administration Employee & Employer Assistance Hotline and Publications</i> (866) 444-EBSA (3272) http://www.dol.gov/ebsa/
Medicaid Healthy Start Healthy Families	<i>Ohio Department of Job and Family Services</i> (614) 466-6282 (800) 292-3572 (TDD) (800) 324-8680 http://www.state.oh.us/odjfs/ohp/0001general.stm
Breast and Cervical Prevention Project	<i>Ohio Department of Health</i> (614) 644-8700 or http://jfs.ohio.gov/Ohp/bcps/bccp/index.stm .
Ohio's Best Rx Program	<i>Ohio Department of Health</i> (614) 466-9783 http://www.ohiobestrx.org/

Other Assistance Programs	<i>Ohio Department of Health</i> (614) 466-3543 http://www.odh.state.oh.us/ .
The Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service (IRS)</i> (866) 628-HCTC http://www.irs.gov/individuals/index.html (Click on HCTC); or call HCTC customer service center

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 require an affiliation period cannot exclude coverage of pre-existing conditions. Premiums cannot be charged during HMO affiliation periods. Ohio law allows for the use of HMO affiliation periods in group health plans. See also HMO, Small Group Health Plan.

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.

Basic Health Plan. A health plan established by the state of Ohio to offer people the choice of buying coverage for a minimum set of specified benefits. The basic health plan imposes a high level of cost sharing, including a \$1000 annual deductible, 50% coinsurance for most covered services, and an annual limit of \$50,000 on all covered benefits. Benefits and cost sharing under the basic health plan vary somewhat, depending on whether you are purchasing coverage from an HIC. The basic health plan must be offered by all individual health insurance companies during their annual open enrollment periods. See HIC, Individual Health Insurance, Open Enrollment Period.

Breast and Cervical Cancer Prevention Project. A program which provides free screening for breast and cervical cancer to eligible Ohio residents. Eligible women diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid for treatment of their condition.

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

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

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. Under Ohio rules, coverage is continuous if not interrupted by a break of more than 30 days in a row. Ohio rules apply when you are buying an individual health insurance policy and you are not HIPAA eligible. See also Creditable Coverage, HIPAA eligible.

Conversion Coverage. Your right, when leaving a fully insured group health plan in Ohio, to convert your policy to an individual health insurance policy. You will not face a new pre-existing condition exclusion period. Unless you are HIPAA eligible, you must be offered a hospital, surgical, or medical expenses policy currently being sold by the insurance company. If you are HIPAA eligible, you must be offered a choice between a standard and basic health plan. Conversion coverage also extends to surviving, divorced or separated spouses; dependent children; and children who lose their dependent status under their parent's plan rules. See also HIPAA eligible.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance in Colorado; 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 high risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Insurance.

Elimination Rider. An amendment to an individual health insurance policies that permanently excludes 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, Open Enrollment Period, 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. A health plan purchased by an employer from an insurance company. Fully insured group health plans are regulated by the state of Ohio. See also Self-Insured Group Health Plans.

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

Genetic Information (Individual Health Insurance). Includes laboratory tests of a person's genes or chromosomes that are linked to physical or mental disorders or impairments, or that indicate the risk of developing a health condition. A health plan cannot consider pre-existing (and therefore exclude coverage for) a condition about which you have genetic information, unless that health condition has been diagnosed by a health professional.

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

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All health plans sold to small employers in Ohio are guaranteed issue. Standard and Basic individual health insurance policies must be sold on a guaranteed issue basis year-round to HIPAA eligible individuals, and to other people during annual open enrollment periods. 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. **Kassebaum-Kennedy** 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.

Healthy Start. Healthy start insurance is 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 age 18 and younger who live in families with qualifying incomes and pregnant women.

Healthy Families Healthy Families is Medicaid insurance intended to meet the needs of working families who cannot afford health insurance coverage.

HIC. Health Insuring Corporation. A term in Ohio law for several kinds of health insurance plans. Any insurance company that uses managed health care techniques must be registered as an HIC. HICs may require you to seek covered care from hospitals, doctors and other providers that they contract with, also known as network providers. Or they may require you to pay more for covered services provided outside the HIC network. HICs also often require you to get a referral from your primary care physician in order to see a specialist. All HICs must offer a state-defined package of health care services during a 30-day annual open enrollment period. See also HMO, Open Enrollment Period.

HIPAA. The Health Insurance Portability and Accountability Act, better known as Kassebaum-Kennedy, after the two senators who spearheaded the bill. Passed in 1996 to help people buy and keep health insurance, even when they have serious health conditions, the law sets a national floor for health insurance reforms. Since states can and have modified and expanded upon these provisions, consumers' protections vary from state to state.

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

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

Indemnity Health Plan. A kind of health plan that reimburses you or your health care provider on the basis of services rendered. Indemnity plans generally do not restrict you to a limited network of providers for covered care. However, indemnity plans often impose other restrictions on covered services. For example, plans can require prior authorization of hospital care or other expensive services.

Individual Health Insurance. Policies for people not connected to an employer group. This term also refers to coverage purchased by the self-employed for themselves (or their family members) but for no other employees. Individual health insurance policies are regulated by the state of Ohio. All residents without access to employer-sponsored or government-sponsored health insurance can buy such coverage for themselves and their families from a variety of private carriers during a plan's annual open enrollment period, and may be able to purchase such coverage at other times as well. See Open Enrollment Period.

Kassebaum-Kennedy. See HIPAA.

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

Late Enrollment. Enrollment in a health plan at a time other than a regular or special enrollment period. Ohio requires fully insured group plans to cover you if you are a late enrollee. However, insurance companies are only required to enroll you within 12 months of your request to enroll, and you may be subject to an 18-month pre-existing condition exclusion period upon enrollment. 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. See HIC.

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

Ohio's "Best Rx" Program. A prescription drug discount card program designed to lower the cost of prescription for Ohio's eligible residents.

Open Enrollment Period (Individual Health Insurance). A period each year during which all private individual health insurers must accept individuals who apply for coverage. Individual insurers must offer you the same standard and basic health plans that are offered to small employers. An indemnity health plan open enrollment period begins in January of each year and remains open until the plan has enrolled a specified number of individuals required by law. To date, very few health plans have reached this maximum. An HIC must have an open enrollment period of at least 30 days in length each year, beginning on the anniversary date of receiving its license to operate in Ohio.

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 (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 group 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. See also Genetic Information.

Pre-existing Condition (Individual Health Insurance). Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan, or for which an ordinarily prudent person would have sought medical advice, care or treatment during that period. Under individual health insurance only, pregnancy can be counted as a pre-existing condition and a waiting period of up to 270 days can be imposed for maternity benefits. Newborns and newly adopted children covered within 30 days cannot be subject to pre-existing condition exclusions. Genetic information cannot be counted as a pre-existing condition in individual health insurance. See also Prudent Person Rule. HICs/HMOs may not use pre-existing condition exclusion periods for basic health services.

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

Prudent Person Rule. In individual health insurance only, a rule that permits insurers to exclude as pre-existing any condition for which – in the insurer's judgment – most people would have sought care or treatment in the 6 months prior to enrolling in an individual health insurance policy. See Pre-existing Condition (Individual health insurance).

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 Ohio.

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

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

Standard Health Plan. A health plan established by the state of Ohio that covers a specified set of benefits. Compared to the basic health plan, the standard health plan offers more extensive coverage with lower cost sharing. Standard health plans offered by HICs and HMOs have somewhat different benefits and cost sharing. The standard health plan must be offered by all individual health insurance companies during their annual open enrollment periods. See Basic Health Plan, HIC, HMO, Individual health insurance, Open Enrollment Period.

State Continuation Coverage. A program similar to COBRA. In Ohio, if you are eligible for unemployment insurance and in a fully insured group health plan sponsored by an employer with less than 20 employees, you also have rights to continue your health coverage for up to six months when your job ends. See also COBRA.

Supplemental Security Income (SSI). A program providing cash benefits to certain very low income disabled and elderly individuals. When you qualify for SSI, you generally also qualify for Medicaid. In addition, Medicaid coverage often continues for a limited time if your income increases so that you no longer qualify for SSI. 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. Employers with fully insured group health plans may not have a waiting period that exceeds 90 days. See also Pre-existing Condition Exclusion Period.