

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

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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 OKLAHOMA

As an Oklahoma 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 Oklahoma 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. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from Oklahoma, 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 Oklahoma. 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 Oklahoma resident.

HOW AM I PROTECTED?

In Oklahoma, 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 Oklahoma must limit exclusion of pre-existing conditions. There are rules about what counts as a pre-existing condition and how long you must wait before a new group health plan will begin to pay for care for that condition. Generally, if you join a new group health plan, your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage (see page 8).*
- *Your health insurance cannot be canceled because you get sick. Most health insurance is **guaranteed renewable** (see pages 14 and 24).*
- *If you leave your job, you may be able to remain in your old group health plan for a certain length of time. This is called **COBRA** continuation coverage. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage (see page 14).*

- *If your fully insured group health insurance is terminated, you will be able to remain covered for 30 days, or possibly longer, depending on your health status. This is due to an Oklahoma **extension of coverage** law. This law does not apply to **health maintenance organizations (HMOs)** (see page 18).*
- *If you lose your group health insurance and meet other qualifications, you will be **HIPAA eligible**. If so, you can buy an individual health insurance policy from the **Oklahoma Health Insurance High Risk Pool** (High Risk Pool). You will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for a High Risk Pool policy (see page 20).*
- *If you have had difficulty obtaining affordable individual health insurance because of your health condition, you may also be eligible for High Risk Pool coverage. In this case you may face a new pre-existing condition exclusion period. There are limits on what you can be charged for a High Risk Pool policy (see page 20).*
- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group. All health plans for small employers must be sold on a **guaranteed issue basis** (see page 24).*
- *If you are a small employer buying a group health plan, then your premiums can vary due to health status, industry and other characteristics. There are limits on what you can be charged based on these factors (see page 24).*
- *If you work for a small employer, are self-employed, are at or below 200% FPL, and meet other eligibility requirements you may be able to buy subsidized health insurance through the **Insure Oklahoma/O-EPIC** program (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 Oklahoma **Medicaid** program (SoonerCare) offers free or subsidized health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes (see page 27).*
- *If you believe you may be at risk for breast or cervical cancer but are uninsured or underinsured, you may be eligible for screening and treatment. The **Take Charge** program provides free cancer screening for qualified residents. In addition, women diagnosed with cancer through this program may be eligible for medical care through the Oklahoma Medicaid program (see page 28).*

- *If you have a low or modest household income, and meet other eligibility requirements, you may be eligible for subsidized health insurance through the Insure Oklahoma/O-EPIC Individual plan (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 credit is called the **Health Coverage Tax Credit (HCTC)**, and is equal to 65% of the cost of qualified coverage, including COBRA and health insurance purchased through the High Risk Pool (see page 31).*
- *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 31).*

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, Oklahoma extension of coverage, or state continuation rights, you are not entitled to take your actual group health coverage with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did.*
- *Employers are not required to provide health benefits for their employees, so if you change jobs, your new employer may not offer you health benefits. If your employer offers health benefits then the decision on whether to offer your health insurance cannot be based on factors related 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 require **waiting periods** before your health benefits begin. HMO's can require **affiliation periods** (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 (see page 8).*

- *Even if your coverage is **continuous coverage**, there may be a pre-existing condition exclusion period for some benefits if you join a group health plan that covers benefits your old plan did not.* For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition (see page 10).
- *If you work for certain non-federal public employers in Oklahoma, not all of the group health plan protections may apply to you (see page 10).*
- *In Oklahoma, 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 (see page 12).
- *Even if you are HIPAA eligible, you can be turned down for individual health insurance policies.* The High Risk Pool is your only guaranteed access to individual health insurance, though you may be able to buy individual health insurance from other insurance companies (see page 20).
- *Once you obtain individual coverage, your ability to switch plans may be limited as well.* While you have protections when you move from an individual policy to a group plan, Oklahoma law does not protect you from the imposition of an **elimination rider** when you move from one individual plan to another, even if you had prior **continuous coverage**. Furthermore, you are not assured the right to buy another individual policy (see page 13).
- *If you buy health insurance through the High Risk Pool and are not HIPAA eligible, you will face a pre-existing condition exclusion period (see page 22).*

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. 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?

- *In general, you have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees. Or, your employer may offer an HMO plan that you cannot join because you live outside of the plan's service area.
- *You cannot be turned away or charged more because of your health status.* Health status means your medical condition or history, **genetic information** or disability. This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (for example, if you work less than 30 hours per week or only on a temporary basis), as long as these are unrelated to health status and applied consistently.

Discrimination due to health status is not permitted

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

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

Certain changes can trigger a special enrollment opportunity

- The birth, adoption, or placement for adoption of a child
- Marriage
- Loss of other coverage (for example, that you or your dependents had through yourself or another family member and lost because of death, divorce, legal separation, termination, retirement, or reduction in hours worked)

- *Under Oklahoma law, newborns, adopted children, and children placed for adoption are automatically covered under the parents' fully insured health plan for the first 31 days, if the plan covers dependents. The insurer may require that the parent enroll the child within the first 31 days and pay the premium in order to continue coverage beyond the first 31 days.*
- *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. You will not have health insurance coverage during this time.*
- *When you begin a new job with health insurance through an HMO, the HMO may require a waiting period before coverage begins. During this affiliation period, you will not have health insurance coverage. The HMO also cannot impose any pre-existing condition exclusions if it imposes an affiliation period. An HMO 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 coverage for a limited time. A federal law known as the **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job-protected leave in these circumstances.*

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

If you qualify for leave under the 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 the FMLA, contact the **U.S. Department of Labor**.

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

When you first enroll in a group health plan, the employer or insurance company may ask if you have any pre-existing conditions. Or, if you make a claim during the first year of coverage, the plan may look back to see whether it was for such a condition. If so, it may try to exclude coverage for services related to that condition for a certain length of time. However, federal and state laws protect you by placing limits on these pre-existing condition exclusion periods under group health plans. In some cases, your protections will vary depending on the type of group health plan you belong to.

- *A group health plan can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined the plan. This period is also called the **look back** period.*
- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns, newly adopted children, children placed for adoption, or **genetic information**.*
- *Group health plans can exclude coverage for pre-existing conditions 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. Late enrollees in fully-insured small employer group health plans (groups of 2-50) may be excluded from coverage for up to 18 months or subject to an 18 month pre-existing condition exclusion period, or some other combination of exclusion from coverage and a pre-existing condition exclusion period that does not exceed 18 months. .*
- *Group health plans that impose pre-existing condition exclusion periods must give you credit for any previous continuous **creditable coverage** that you've had. Most types of private and government-sponsored health insurance are considered creditable coverage.*

Coverage counts as continuous if it has not been interrupted by a break of 63 or more days in a row.

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 insurance (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 plan.

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

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*.

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

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

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

Question: Is this permitted?

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

- *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, few public employers in Oklahoma 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 that 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 (877) 267-2323 ext. 61565 or at (410) 786-1565 to see if your employer has elected to be exempt from certain protection.

AS YOU ARE LEAVING GROUP COVERAGE...

- *If you are leaving your job or otherwise losing access to your group health coverage, you may be able to remain covered under the group health plan for a limited time. In addition, you may have special protections when buying certain kinds of individual health coverage. See Chapter 3 for more information about COBRA and state continuation coverage, Oklahoma extension of coverage protection, conversion coverage, and coverage for “HIPAA eligible individuals.”*
- *If you lost your group 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 health coverage, including COBRA and health insurance purchased through the Health Insurance High Risk Pool (see page 31).*
- *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 31).*

CHAPTER 3

YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

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

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

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

In Oklahoma, your ability to buy individual health insurance depends on your health status.

- *In general, companies that sell individual health insurance in Oklahoma are free to turn you down because of your health status and other factors. When applying for individual coverage, 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.*
- *If you have trouble buying private health insurance due to your health status, you may be eligible for the Oklahoma Health Insurance High Risk Pool (see page 20).*
- *Under Oklahoma law, newborns and adopted children are automatically covered under the parents' individual health insurance policy for the first 31 days, if the plan covers dependents. The insurer may require that the parent enroll the child and pay the required premium within 31 days in order to continue coverage beyond the 31 days.*
- *If you have a disabled child, that child may remain covered under your individual health insurance policy after he or she reaches the age at which dependent coverage is usually terminated. To qualify, your adult son or daughter must be incapable of self-support because of mental retardation or physical disability and must be chiefly dependent on the policy holder for support. Proof of incapacity must be furnished within 31 days of reaching the time limit.*

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy.* Oklahoma does not require health insurers in the individual market to sell standardized policies. Health plans can design different policies and you will have to read and compare them carefully. However, Oklahoma does require all health plans to cover certain benefits – for example, mammograms and diabetes treatment. Check with the Oklahoma Insurance Department for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Individual health insurers can impose elimination riders.* This is an amendment to your health insurance policy that permanently excludes coverage for a health condition or even an entire body part or system.
- *Oklahoma insurers can also impose a pre-existing condition exclusion period.* There are few limits on pre-existing condition exclusion periods in individual health insurance in Oklahoma. This means that individual health insurers can decide how long to exclude your pre-existing condition.

Also, an individual health insurer may impose a pre-existing condition exclusion period. There are no legal limits on how long a pre-existing condition exclusion can last. The duration of a pre-existing condition exclusion period is determined by the individual health insurer.

In addition, there is no standard definition of pre-existing condition for the individual market under Oklahoma insurance law. Often, the definition is a condition for which you received care, or – in the insurer’s judgment – for which you should have sought care. This is called the **prudent person rule**. Further, individual health insurers are not required to credit prior health coverage toward pre-existing condition exclusion periods. In Oklahoma, pregnancy can count as a pre-existing condition, but not genetic information.

- *If you make a claim during the first two years of coverage, the insurer can look back to see if the claim is for a condition that would have been considered a pre-existing condition.* If the insurer determines that the condition is a pre-existing condition, it can refuse to pay for expenses for that condition.

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

- *If you have an expensive health condition, your individual health insurance premiums may be very high. The law does not prohibit individual health insurers from charging you more because of your health status.*
- *When you renew your individual coverage, your premiums can increase as your age increases.*

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELED?

- *Your coverage cannot be canceled because you get sick. This is called guaranteed renewability. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of **managed care plans**, continue to live in the plan service area.*
- *Some insurance companies sell short-term health insurance policies. Temporary policies are *not* guaranteed renewable. They will only cover you for a limited time, such as 6 months. If you want to renew coverage under a temporary policy after it expires, you will have to reapply and there is no guarantee that coverage will be re-issued at all or at the same price.*

COBRA AND STATE CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

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

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

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

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

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

COBRA QUALIFYING EVENTS

For employees

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

For spouses

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

For dependent children

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

- *Each person who is eligible for COBRA continuation can make his or her own decision.* If your dependents were covered under your employer plan, they may independently elect COBRA coverage as well.
- *You must be notified of your COBRA rights when you join the group health plan, and again if you qualify for COBRA coverage.* The notice rules are somewhat complicated and you should contact the U.S. Department of Labor for more information.

In general, if the event that qualifies you for COBRA coverage involves the death, termination, reduction in hours worked, or Medicare eligibility of a covered worker, the employer has 30 days to notify the group health plan of this event. However, if the qualifying event involves divorce or legal separation or loss of dependent status, you have 60 days to notify the group health plan. Once it has been notified of the qualifying event, the group health plan has 14 days to send you a notice about how to elect COBRA coverage. Each member of your family eligible for COBRA coverage then has 60 days to make this election.

Once you elect COBRA, coverage will begin retroactive to the qualifying event. You will have to pay premiums dating back to this period.

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

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 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 have lost your group health plan and are receiving benefits from the Trade Adjustment Assistance (TAA) program, you may be eligible for a federal income tax credit to help you pay for new health coverage. This credit is called the Health Coverage Tax Credit (HCTC), and it is equal to 65% of the cost of qualified health coverage, including COBRA (see page 31).*
- *If you are a retiree aged 55-65 and receiving pension benefits from PBGC, and receiving benefits from the Trade Adjustment Assistance (TAA) Program, then you may be eligible for a federal income tax credit to help pay for new health coverage. This is called the Health Coverage Tax Credit (HCTC) (see page 31).*

HOW LONG DOES COBRA COVERAGE LAST?

- *COBRA coverage usually 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

* Special rules may extend coverage an additional 11 months for certain disabled individuals and their eligible family members.

- *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.*

OKLAHOMA EXTENSION OF COVERAGE

In Oklahoma, if your coverage under a fully insured group health plan is terminated, you and your covered dependents can have coverage extended for a period of time. For example, if you lost your job, or if your employer has ceased to provide fully insured health benefits to all employees, you can qualify for this temporary coverage extension.

- *In general, you can remain insured for 30 days after termination.* You will not be charged a premium for coverage during this 30-day extension period.. However, if you make a claim during this period, the insurance company may deduct the premium from the amount it pays for that claim. If you join another health plan before the end of the 30-day period, your extended coverage will end immediately.
- *Under certain circumstances you may be able to extend your coverage for a longer period of time.* If you are pregnant, totally disabled, or if you are undergoing treatment for a serious health condition that began before your group coverage was terminated, you may be able to extend coverage for 3 or 6 months. To qualify for this longer extension of coverage, you must have been covered under your fully insured group health plan for at least 6 months. During this longer extension of coverage, you will have to pay the same premium that was charged for your fully insured group health plan before it was terminated.

If you qualify for this longer extended coverage, you can keep it even if you join a new health plan. This can help you if your new plan imposes a pre-existing condition period.

- *If your group coverage was through an HMO, you may have some extension of coverage protections.* These rules are different from those that apply to non-HMO plans.

HMOs are required to continue covering your health care if you became pregnant prior to the end of your coverage. This coverage ends following delivery and discharge from the hospital.

HMOs are also required to continue coverage if you were admitted to an in-patient facility prior to the end of your coverage. This coverage ends when you are discharged from the in-patient facility, or when your benefits expire, whichever is earlier.

CONVERSION AND STATE CONTINUATION COVERAGE

Oklahoma law provides individuals with some rights to purchase a conversion or state continuation policy when certain events occur. A conversion policy is an individual policy sold by the insurer that provided your prior coverage. Conversion policies may be more expensive than your prior coverage and may not contain the same benefits. A continuation policy provides you with the ability to buy into the group policy that covered you before.

- *If you lose coverage through a fully insured HMO plan you may be able to obtain a conversion policy from the HMO.* To be eligible for a conversion policy, you must have lost coverage involuntarily (for example, due to unemployment, divorce, or widowhood). You will not be able to get a conversion policy if you have or are

eligible for other comparable coverage. In addition, you usually will not be offered a conversion policy if the group contract under which you were covered was.. If you are eligible, you must exercise your conversion rights within 31 days.

- *Non-HMO fully insured group health plans are not required to offer conversion coverage. However, if the plan chooses to offer a conversion option to the covered person, then it must also offer a conversion policy to the covered person's spouse at divorce, the death of the covered person, or when the covered person becomes unemployed.*
- *People who lose dependent coverage may also be eligible for conversion policies from HMOs. If your family members lost coverage through your fully insured HMO individual health insurance policy for reasons other than nonpayment of premiums or the expiration of the term the policy was issued for, the insurer must offer them a conversion policy or a continuation policy. The insurer is not required to offer them coverage if they are eligible for other coverage.*

OKLAHOMA HEALTH INSURANCE HIGH RISK POOL (HIGH RISK POOL)

Oklahoma maintains a high-risk pool, called the Oklahoma Health Insurance High Risk Pool, to provide insurance for residents of Oklahoma with health conditions who are unable to buy private health insurance and for people who are HIPAA eligible and TAA eligible.

WHEN CAN I BUY HEALTH INSURANCE FROM THE HIGH RISK POOL?

- *If you are HIPAA eligible, you can buy health insurance from High Risk Pool.*

To be HIPAA eligible, you must meet certain criteria

No matter where you live in the U.S., if you are HIPAA eligible you are guaranteed the right to buy individual health insurance of some kind with no pre-existing condition exclusion period. In Oklahoma, you are only guaranteed the right to buy coverage 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 federally 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 federally eligible again by maintaining continuous coverage and rejoining a group health plan.

- *You can also buy health insurance from the High Risk Pool if you have lived in Oklahoma for at least 12 months and can demonstrate proof of eligibility.* There are several different ways to show eligibility:
 - You have been turned down for coverage by two insurance companies because of a health condition;
 - You have been quoted a premium rate for an individual policy that is substantially more than the High Risk Pool rate;
 - You have been offered individual health insurance, but it contains an elimination rider on a condition you have;
 - You have been diagnosed with serious condition, such as cancer, AIDS, or diabetes, that would limit your ability to purchase health insurance; or,

You only need to show that you are eligible in one of these ways in order to health insurance from the High Risk Pool.

- *You can also buy health insurance from the High Risk Pool if you have been certified as eligible for federal premium assistance under the HCTC.* HCTC eligible individuals are not required to exhaust COBRA continuation coverage and cannot have other health insurance coverage.

- *The High Risk Pool will sell you a family policy, even if only one person in your family qualifies for coverage.*

WHAT WILL THE HIGH RISK POOL COVER?

- *Health insurance from the High Risk Pool includes hospital and physician care, prescription drugs, maternity care, and other services. There are separate limits on coverage for alcohol and drug abuse treatment. Total coverage is subject to a lifetime maximum of \$500,000.*
- *The High Risk Pool offers 6 plan options. Benefits are the same under all options, but the annual deductible varies. Your deductible choices are \$500, \$1,000, \$1,500, \$2,000, \$5,000, and \$7,500.*
- *All High Risk Pool coverage is through a **managed care plan**. After you have satisfied your annual deductible, the High Risk Pool will pay 80% of covered charges when you get care from a doctor or other provider in the High Risk Pool's network. If you get care from an out-of-network provider, the High Risk Pool will only pay 60% of covered charges. The maximum annual out-of-pocket expense is \$10,000.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are HIPAA eligible, you will not receive a pre-existing condition exclusion when you enroll in the High Risk Pool.*
- *If you are not HIPAA eligible, you may have a 12-month pre-existing condition exclusion period when you first enroll in the High Risk Pool. When you enroll, the High Risk Pool will look back 6 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.*
- *The High Risk Pool will waive the pre-existing condition period if you had continuous coverage under another health plan. The High Risk Pool counts policies that provide hospital, medical or surgical expense benefits as creditable coverage. Your break in coverage must be less than 63 days in order for your pre-existing condition to be waived.*

WHAT CAN I BE CHARGED FOR HIGH RISK POOL COVERAGE?

- *High Risk Pool premiums are limited to about 150% of the amount that a healthy person would pay if he or she bought a similar plan sold by a private insurer. Premiums will vary based on your age, gender, family size, and the deductible you choose.*

For example, the monthly premium for a 24-year old single man ranges from \$128 to \$354, depending on the deductible he chooses. By contrast, the monthly premium for a 64-year old single man ranges from \$632 to \$1,657, depending on the deductible he chooses.

- *If you are eligible for the Health Coverage Tax Credit (HCTC) and enrolled in the High Risk Pool, the federal government will pay 65% of your premium each month.*

HOW LONG DOES HIGH RISK POOL COVERAGE LAST?

- *High Risk Pool policies are renewable as long as you pay your premiums, continue to reside in Oklahoma, and meet other eligibility requirements. If your High Risk Pool policy is terminated or you cancel it, you will have to wait 12 months before you can reapply for Pool coverage, unless you are HIPAA eligible or HCTC eligible.*

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. Oklahoma has enacted reforms to expand some of these protections. Generally, small employers are those that employ 2-50 employees. Please note, however, that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Oklahoma Insurance Department to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down.* This is called guaranteed issue. If you employ at least 2 but not more than 50 people, health insurance companies must sell you any **small group health insurance policy** they sell to other small employers. However, they can require that a minimum percentage of your eligible employees sign up for coverage. They can also require you to pay a minimum share of your workers' premiums. If you are buying a **large group health plan** for 51 or more employees, your group can be turned down.
- *Your insurance cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud, or if they are discontinuing that 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?

- *Oklahoma law limits how much small employers can be charged for health insurance.* Within limits, premiums for small group health insurance policies can vary based on health status, 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 variations. If you have questions about your group health insurance premiums, contact the Oklahoma Insurance Department.

- *For small employers, Oklahoma places some limits on annual premium increases that can be charged.*

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.*

INSURE OKLAHOMA /OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE (O-EPIC)

- *O-EPIC helps small employers pay for health insurance for workers with incomes up to 200% of the federal poverty level. O-EPIC also offers subsidies to eligible employees and their spouses.*

For your small business to be eligible for subsidies, you must have no more than 50 full-time employees. In addition, you must offer a qualified health plan (or plan to), and contribute at least at 25% of the premium. If you have dropped insurance coverage, your business must wait 6 months before being eligible to participate in O-EPIC.

- *Participating employers are required to offer health insurance coverage that meets minimum standards. The plan offered must provide coverage for hospital services, physician services, lab and x-ray, office visits, and prescription drugs. In addition, the plan's out of pocket maximum cannot exceed \$3,000 per person per year, prescription drug deductibles may not exceed \$500 per person per year, and office visit co-payments cannot exceed \$50 per visit. O-EPIC provides a list of qualified plans on its website.*
- *If your small business is eligible for subsidies, you may receive up to \$1,000 per year per eligible employee to help offset the cost of health insurance. Eligible employees are Oklahoma residents, 19-64 years old who are at or below 200% FPL. Participating employees must contribute the lesser of 15% of premiums or 3% of their gross income.*

- *Individuals may also be eligible for subsidized coverage under O-EPIC (see Chapter 5).*
- To learn more about O-EPIC, call the Oklahoma Division of Medical Assistance at (888) 365-3742 or visit them on the web at <http://www.insureoklahoma.org>.

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5 FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Oklahoma who cannot afford to buy health insurance. Medicaid, SoonerCare, Oklahoma Cares and other programs offer free or subsidized health insurance coverage, direct medical services or other help at little or no cost to you. In addition, the federal 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 these programs and contact information for further assistance.

MEDICAID

Medicaid, also called SoonerCare in Oklahoma, is a program that provides health coverage to some low-income Oklahoma residents. Medicaid covers families with children and pregnant women, 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, however questions concerning immigration status and eligibility should be directed to the Oklahoma Health Care Authority.

- *For certain categories of people, eligibility for Medicaid is based on the amount of your household income.* In Oklahoma you may be eligible for Medicaid if you are an infant, a child, pregnant, the parent of a dependent child, elderly, or disabled 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 Oklahoma Department of Human Services for more information.

Low income persons eligible for Medicaid in Oklahoma*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Infant	185% (monthly income of about \$2,713 for family of 3)
Child 1-18	185%
Parents	34%
Pregnant woman	185%
Medically Needy	
Individual	36%
Couple	34%

* 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 2008:

<u>Size of Family Unit</u>	<u>Poverty Guideline (annual income)</u>
1	\$10,400
2	\$14,000
3	\$17,600

For larger families add \$3,600 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 \$32,560, or a monthly income of \$2,713.

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

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

In addition, your children may qualify for Medicaid if your family's income meets certain income standards.

- *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 at least for a limited time.

- *Being on TANF or SSI, is not the only way to qualify for Medicaid.* For certain categories of people, eligibility for Medicaid is based on the amount of your household income.
- *Retired or disabled people who have low incomes and are enrolled in Medicare may also qualify for help from Medicaid.* Even though your income may be too high to qualify for Medicaid insurance coverage, there may be other ways Medicaid can help you.

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

If your household income is above 100% but below 120% of the poverty level, Medicaid will pay for your monthly Medicare premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

- *There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify for Medicaid, contact the Oklahoma Health Care Authority through the SoonerCare Helpline at 1-800-987-7767.

Contact the Oklahoma Health Care Authority for more information.

TAKE CHARGE: BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM

- *The Take Charge program provides qualified woman with breast and cervical cancer screening at no cost.* Women who are screened through the program and diagnosed with breast and/or cervical cancer may be eligible for treatment through Medicaid.
- *In order to be eligible for screening through the Take Charge Program, you must be an Oklahoma resident, aged 19 to 64.* In addition, you must meet income eligibility standards, and be uninsured or underinsured.
- *If you have an abnormal screening and meet other eligibility standards, you may be eligible for diagnosis and treatment through the Oklahoma Cares program.*
- *For more information, please contact the Take Charge program at (888) 669-5934 or visit www.health.state.ok.us/program/cds/breastcervical.html.*

INSURE OKLAHOMA/OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE (O-EPIC) – INDIVIDUAL PLAN

O-EPIC is a program that makes low-cost health insurance available to small employers, self-employed and individuals (See Chapter 4 for information for small employers).

WHEN CAN I GET INSURANCE THROUGH O-EPIC?

- *To qualify, you must meet eligibility requirements.* Key requirements include: You must be between 19 and 64 years old, an Oklahoma resident, and uninsured. You must not be enrolled in Medicaid or Medicare. You must earn less than 200% of the federal poverty level and meet citizenship requirements

- In addition, you must be “categorically eligible.” This means you must either be 1) self-employed and uninsured; 2) working for a small employer that does not provide a qualified health plan; 3) working for a small employer that offers a qualified health plan that you are not eligible for; 4) unemployed and eligible to receive unemployment benefits from the Oklahoma Employment Security Commission; or 5) an adult with a disability who is working for any size employer and has a **ticket to work**.

WHAT WILL O-EPIC COVER?

- *O-EPIC provides basic coverage to eligible individuals.* Coverage includes physician services, hospitalization, prescription drugs, X-rays, maternity care, and durable medical equipment. No coverage is provided for dental, vision or hearing services. All individuals are subject to a \$1 million lifetime benefit limit. Some services are subject to co-payments

Individuals will also be responsible for co-payments, typically ranging from \$5 to \$50.

WHAT ABOUT PRE-EXISTING CONDITIONS?

- *O-EPIC does not impose pre-existing condition exclusion periods.*

WHAT CAN I BE CHARGED FOR O-EPIC COVERAGE?

- *Monthly premiums vary based on income.* You may be responsible for premiums up to \$51.39 per month for an individual or \$68.91 per month for an individual and a spouse.
- *For more information about Insure Oklahoma 1-888-365-3742 or visit them on the web at <http://www.insureoklahoma.org>.*

OTHER STATE PROGRAMS

There may be other financial assistance programs available. Please call the Oklahoma Health Care Authority at (800) 987-7767 or visit them at <http://www.okhca.org/>.

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 not be enrolled in Medicare, Medicaid, or in other employer-sponsored coverage for which the employer contributes at least half of the premium.*
- *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 PREMIUM 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. COBRA continuation coverage is considered qualified health coverage. (See Chapter 3 for more information about COBRA.) In addition, Oklahoma has designated the Oklahoma Health Insurance High Risk Pool. (See Chapter 3.)*

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).*

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 insurance	Oklahoma Insurance Department (800) 522-0071 (in-state) (405) 521-2828 http://www.oid.state.ok.us
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	U.S Labor Department of Labor Employee Benefits Administrator Employee & Employer Assistance Hotline and Publications (800) 828-4777 (608) 221-4551 http://www.dol.gov/ebsa
Oklahoma Health Insurance High Risk Pool	Epoch Group (plan administrator) (800) 255-6065 (ext. 4767) http://www.okhrp.com/
Insure Oklahoma/ Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC)	Insure Oklahoma (800) 365-3742 http://www.insureoklahoma.org/
Medicaid (SoonerCare)	Oklahoma Health Care Authority (800) 987-7767 http://www.okhca.org/
Take Charge: Breast and Cervical Cancer Early Detection Program	Oklahoma Department of Health (888) 669-5934 (405) 271-4072 http://www.health.state.ok.us/program/cds/breastcervical.html
Federal Health Coverage Tax Credit (HCTC)	Internal Revenue Service (IRS) (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 in Oklahoma do not impose affiliation periods, but HMOs in many other states do impose them. HMOs that require an affiliation period cannot exclude coverage of pre-existing conditions. Premiums cannot be charged during HMO affiliation periods. 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 worker may receive 50% of the wage differential (up to \$10,000) during their 2 year eligibility period. To be eligible for the ATAA program, workers may not earn more than \$50,000 per year in their new employment. Also, the firm where the workers worked must meet certain eligibility criteria.

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

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

Continuous Coverage. Under federal rules, health insurance coverage that is not interrupted by a break of 63 or more consecutive days. Employer waiting periods 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 in self-insured group health plans. See also Creditable Coverage, HIPAA Eligible.

Conversion. An individual health insurance policy that is sold by the plan that provided your prior coverage.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; an individual health plan; Medicare; Medicaid; State Children's Health Insurance Program, CHAMPUS and TRICARE (health coverage for military personnel, retirees, and dependents);

the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country), or a state health insurance risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Insurance.

Elimination Rider. A feature permitted in 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, Special Enrollment Period.

Extension of Coverage. In Oklahoma, your right to temporarily extend coverage under a fully insured group health plan after coverage is terminated. Generally, you can extend coverage up to 30 days, unless you join a new health plan before then. However, if you are pregnant, disabled, or undergoing treatment for a serious illness before your coverage terminated, you may be able to extend coverage for up to 3 to 6 months. Different extension of coverage protections apply if you were enrolled in an HMO.

Family and Medical Leave Act (FMLA). A federal law that guarantees up to 12 weeks of job protected leave for certain employees when they need to take time off due to serious illness, to have or adopt a child, or to care for another family member. When you qualify for leave under FMLA, you can continue coverage under your group health plan.

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

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

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

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

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

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

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

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

Health Insurance High Risk Pool. The state-run insurance program for federally eligible persons and for people with high health risks (called a high risk pool).

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

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

HMO. Health maintenance organization. A kind of health insurance plan. HMOs usually limit coverage to care from doctors who work for or contract with the HMO. They generally do not require deductibles, but often do charge a small fee, called a copayment, for services like doctor visits or prescriptions. If you are covered under an HMO, the HMO might require an affiliation period before coverage begins. 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 service. 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 self-employed persons who have no other employees. Individual health insurance policies are regulated by Oklahoma.

Insure Oklahoma/O-EPIC. Insure Oklahoma/O-EPIC is a state-run program that provides low-cost health insurance to small employers, self-employed, and individuals.

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

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

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

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

Medicaid. Called SoonerCare in Oklahoma. A program providing comprehensive health insurance coverage and other assistance to certain low-income Oklahoma 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 (Group Health Insurance and High Risk Pool). Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan. Pregnancy cannot be counted as a pre-existing condition if you are joining a group plan or if you are federally eligible. 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.

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. A definition that individual health insurance policies can use which permits them to exclude as pre-existing any condition for which – in the insurer's judgment – most people would have sought care or treatment prior to enrolling in an individual health insurance policy.

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 Oklahoma.

Small Group Health Plans. 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.

State Continuation Coverage. A state program similar to COBRA, which allows people to remain in their former group coverage 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.

Take Charge: Breast and Cervical Cancer Prevention Program. Program which provides free screening for breast and cervical cancer to eligible Oklahoma residents. Women screened and yield abnormal results may be eligible for free health coverage through Medicaid for treatment of their condition.

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

Ticket To Work. A program created under the Ticket to Work and Work Incentives Improvement Act. As part of this program, a ticket to work helps certain SSA disability beneficiaries go back to work by helping some beneficiaries obtain vocational rehabilitation, training, job referrals and other employment support services free of charge. Participation in this program is voluntary. You can get information about the Ticket to Work Program by visiting their web page at www.yourtickettowork.com

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

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