

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

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August 2009

ACKNOWLEDGMENTS AND DISCLAIMER

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

The authors also wish to express appreciation to the staff of the Oregon Insurance Division 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.

August 2009

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

As an Oregon 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 Oregon resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group and individual health plans. 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 Oregon, 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 35. For information about how to find consumer guides for other states on the Internet, see page 35. A list of helpful terms and their definitions begins on page 36. 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 policies**), so your protections may vary if you leave Oregon. Oregon has expanded protections for certain kinds of health insurance beyond what federal law requires. 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 Oregon resident.

HOW AM I PROTECTED?

In Oregon, 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, than other members of the group, because of your health status. This is called **nondiscrimination**. (see Chapter 2)*
- *All health plans in Oregon 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 Chapter 2 for Group Coverage, Chapter 3 for Individual Coverage)*
- *When you apply for an individual health insurance policy, insurance companies cannot turn you down, charge you more or impose a pre-existing condition exclusion period because of your genetic information. In addition, insurance companies are not allowed to even ask about your genetic tests or family history when you apply for coverage. (see Chapter 3)*

- *Your health insurance cannot be canceled because you get sick. Most health insurance is **guaranteed renewable**. (see Chapter 3 for Individual Coverage, Chapter 4 for Small Group Coverage)*
- *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 Chapter 3)*
- *If you lost your group health plan because of involuntary termination of employment that occurred between September 1, 2008 and December 31, 2009, you may be eligible for a federal tax credit that can help you pay for your COBRA or state continuation coverage premiums for up to nine months. (see Chapter 3)*
- *If you have had at least 6 months of coverage under a group health plan and then lose it, you are guaranteed the right to buy individual coverage, also known as a **portability policy**, for yourself and your family. (see Chapter 3)*
- *Portability policy premiums cannot vary because of your health status, though they can vary, within limits, due to age, family composition and the benefits offered. This is called **modified community rating**. (see Chapter 3)*
- *If you have been denied individual coverage because of your health status, you also can buy individual coverage from the **Oregon Medical Insurance Pool (OMIP)**. In this case you will pay a premium surcharge and may have a pre-existing condition exclusion period. (see Chapter 3)*
- *Individual health insurance policies cannot charge higher premiums due to your health status. Premiums for these policies can vary due to age, family size, and the type of plan you seek. The amount of premium variation based upon age permitted for these policies is greater than for portability policies. (see Chapter 3)*
- *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. This is called **guaranteed issue**. (see Chapter 4)*

- *If you are a small employer buying a group health plan, you cannot be charged more due to the health status of those in your group. You can, however, be charged higher premiums, within limits, because of the age of those in your group, family composition and geographic area. This is called modified community rating. (see Chapter 4)*
- *As a small employer, you cannot be turned down or charged more because of the genetic information of a member of your group. In addition, insurance companies are not allowed to even ask about genetic tests of family history of people in your group when you apply for coverage. (see Chapter 4)*
- *If you have low or modest household income, you may be eligible for free or subsidized health insurance coverage for yourself or members of your family. The Oregon **Medicaid** program offers free health coverage for pregnant women, families with children, medically needy, and elderly and disabled individuals. (see Chapter 5)*
- *If your children are 18 years old or younger, have limited or no health insurance, are not eligible for Medicare and meet other qualifications they may be able to buy insurance through the **Oregon Children's Health Insurance Program (OR CHIP)**. (see Chapter 5)*
- *If you have low or modest household income, you may be eligible for the **Family Health Insurance Assistance Program (FHIAP)**, which subsidizes health insurance premiums for qualified Oregonians. (see Chapter 5)*
- *If you believe you may be at risk for cancer but are uninsured or underinsured, you may be eligible for screening and treatment. The **Oregon Breast and Cervical Cancer Medical Program (BCCP)** provides free cancer screening for qualified residents. Some women diagnosed with breast or cervical cancer through this program may be eligible for medical care through Medicaid. (see Chapter 5)*
- *If you have lost your health insurance and are 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 credit is called the **Health Care Tax Credit (HCTC)**, and it is equal to 80% of the cost of qualified health coverage, including COBRA. (see Chapter 5)*
- *If you are a retiree aged 55-65 and receiving pension benefits from **Pension Benefit Guarantee Corporation (PBGC)**, then you may also be eligible for the HCTC. (see Chapter 5)*

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 group health coverage with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did. (see Chapter 2)*
- *Employers are not required to provide health benefits for their employees, so if you change jobs, you may find that your new employer does not offer you health benefits. Employers are required only to make sure that any health benefits they do offer do not discriminate based on health status. (see Chapter 2)*
- *If you get a new job with health benefits, your coverage may not start right away. Employers can impose **waiting periods** before your health benefits begin. **HMOs** can impose **affiliation periods**. (see Chapter 2)*
- *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 health plan. (see Chapter 2 for Group Coverage, Chapter 3 for Individual Coverage)*
- *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 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 six months or one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition. (see Chapter 2)*
- *If you work for certain non-federal public employers in Oregon, not all of the group health plan protections may apply to you. (see Chapter 2)*
- *Individual health insurers in Oregon are free to turn you down because of your health status and other factors, unless you are buying a portability policy. If you obtain an individual health insurance policy, your ability to switch plans may be limited as well. (see Chapter 3)*

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?

- *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 (such as part time employment), as long as these are unrelated to health status and applied consistently. However, if you work for a small employer in Oregon, insurance companies must offer coverage to all eligible employees.

Discrimination due to health status is not permitted

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

- *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 an **affiliation period** before coverage begins. During this affiliation period, you will not have health insurance coverage. The HMO 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 it.*
- You must be given a special opportunity to sign up for your group health plan if certain changes happen to your family. In addition to any regular **enrollment period** your employer or group health plan offers, you must be offered a special opportunity to enroll in your group health plan after certain events. Depending on the event, these **special enrollment periods** can last either 30 or 60 days. 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 30-day special enrollment opportunity

- The birth, adoption, or placement for adoption of a child
- Marriage
- Involuntary 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)

Certain changes can trigger a 60-day special enrollment opportunity

- Loss of eligibility under Medicaid or SCHIP
- Eligibility for a state Medicaid or SCHIP premium assistance subsidy applicable to premiums a group plan

- *Under Oregon law, newborns and adopted children are automatically covered under the parents' fully insured health plan for the first 31 days, if your plan provides dependent coverage. The insurer may require that the parent notify the plan and pay a premium within the first 31 days in order to continue coverage beyond the first 31 days.*
- *If your group health plan covers dependents, you may be able to keep your son or daughter covered under the plan after the age of majority. Most group health plans will allow your son or daughter to remain covered under your family plan past the age of 19 if they are a full time student.*

If your son or daughter is in college and covered as a dependent under your group, but cannot maintain student status due to illness, he or she may still be able to remain

covered as your dependent for up to one year. A new federal law allows dependent children who take a medically necessary leave of absence due to a serious illness or injury to remain covered as dependents under their parents' group plan for up to one year or until the coverage would otherwise end, whichever comes first. This law will apply to plan years beginning on or after October 9, 2009.

Read your plan documents carefully to determine when your child will "age off" your group health plan.

- *If you have to take leave from your job due to illness, the birth or adoption of a child, or to care for a seriously ill family member, you may be able to keep your group health coverage for a limited time.* A federal law known as the **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job-protected leave in these circumstances.

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

If you qualify for leave under FMLA, your employer must continue your health benefits. You will have to continue paying your share of the premium.

If you decide not to return to work at the end of the leave period, your employer may require you to pay back the employer's share of the health insurance premium. However, if you don't return to work because of factors outside 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**.

- *If you work for a company with fewer than 50 employees, you may have similar family leave protections under the Oregon Family Leave Act.* For more information about this law contact the Oregon Bureau of Labor and Industries at (971) 673-0761.

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 six months 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.

- *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.*
- *Group health plans can exclude coverage for pre-existing conditions only for a limited time. The maximum period is 6 months if you are in a fully insured group health plan and 12 months if you are in a self-insured group health plan. If a waiting period and a pre-existing condition exclusion period are imposed, the combined waiting period cannot exceed 12 months. You will receive credit toward your pre-existing condition exclusion period for any previous continuous coverage.*
- *If you enroll late in your group health plan (after you are hired and not during a regular or special enrollment period), you may have a longer pre-existing condition exclusion period. If you are a late enrollee in a fully insured group health plan, you may have a pre-existing condition exclusion period or you may be excluded from all coverage for up to 12 months. If you are a late enrollee in a self-insured group health plan, you may have an 18-month pre-existing condition exclusion period.*
- *Group health plans that impose pre-existing condition exclusion periods must give credit for any previous **continuous creditable coverage** that you've had. Most types of private and government-sponsored health coverage are considered to be creditable coverage.*

What is creditable coverage?

Most health coverage counts as creditable coverage, including, but not limited to:

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

In most cases, you should get a certificate of creditable coverage when you leave a health plan. You also can request certificates at other times. If you cannot get one, you can submit other proof, such as old health plan ID cards or statements from your doctor showing bills paid by your health plan.

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

In determining continuous coverage, employer-imposed waiting periods and HMO affiliation periods do not count as a break in coverage. If your new plan imposes a pre-existing condition exclusion period, you can credit time under your prior continuous coverage toward it. If your employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period. 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 3 more months. Art changed jobs again. His new company, Charter, has a fully insured health plan that covers care for diabetes but excludes pre-existing conditions for 6 months. Charter must cover Art's diabetes care immediately, because his 12 months of prior continuous coverage are credited against the 6-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 6-month pre-existing condition exclusion period. Charter's plan will begin paying for Art's diabetes care in 3 months (6 months minus 3 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. In Oregon, fully insured health plans cannot impose pre-existing condition exclusions in this manner.

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

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

Question: Is this permitted?

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

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

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

Federal law permits state, county, and local governments to exempt their employees in self-insured 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' health insurance plan.

In the past, some public employers in Oregon 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 (877) 267-2323 ext. 6156 or at (410) 786-1565 to see if your employer has selected to be exempt from certain protections.

AS YOU ARE LEAVING GROUP COVERAGE...

- *If you are leaving your job or otherwise losing access to your group health coverage, you may be able to remain covered under the group health plan for a limited time. In addition, you may have special protections when buying certain kinds of individual health insurance coverage. See Chapter 3 for more information about COBRA continuation coverage, individual insurance, and coverage for “HIPAA eligible individuals.”*
- *If you have 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 it is equal to 80% of the cost of qualified health coverage, including COBRA. (see Chapter 5)*
- *If you are a retiree aged 55-65 and receiving pension benefits from the Pension Benefit Guaranty Corporation (PBGC), you may also be eligible for the HCTC. (see Chapter 5)*

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 Oregon – as in most other states – you have limited guaranteed access to individual health insurance. When you are eligible to buy a “portability” policy,” you will have more protections than others buying individual policies. There also are some alternatives to individual health insurance coverage – such as COBRA coverage, state continuation coverage and the Oregon Medical Insurance Pool (OMIP). 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 Oregon, 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 Oregon are free to turn you down because of your health status and other factors. When applying for an individual health insurance policy, 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 health insurance or offer to sell you a policy that has special limitations on what it covers.*

However, under no circumstances can you be turned down, charged more or face a pre-existing condition exclusion period because of your genetic information. Genetic information includes the results of a genetic test and your family history of health conditions.

- *If you have had prior coverage, you may be eligible to buy a portability policy. Your protections under portability policies are described later on in this chapter.*
- *In addition, if you are turned down by an individual health insurer, you may be able to buy health insurance from the Oregon Medical Insurance Pool (OMIP). OMIP coverage is described later on in this chapter.*

- *In Oregon, newborns and adopted children are automatically covered under the parents' individual health insurance policy for the first 31 days, if the policy covers dependents. The insurer may require that the parent enroll the baby within the 31 days in order to continue coverage beyond the 31 days.*

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy. Oregon does not require health insurers in the individual market to sell standardized policies. Insurers can design different policies and you will have to read and compare them carefully. However, Oregon does require all individual health insurers to cover certain benefits – such as mammograms. Check with the Oregon Division of Insurance for more information about mandated benefits.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you can buy an individual health insurance policy, there are limits on pre-existing condition exclusion periods that can be imposed. In general, if you have been uninsured for more than 63 days before your individual health insurance policy becomes effective, you may face a 6-month pre-existing condition exclusion period.*

Alternatively, an insurer may choose to impose a 90-day waiting period before coverage becomes effective. You will not have to pay a premium during the waiting period. Policies that require a 90-day waiting period cannot impose a pre-existing condition exclusion.

- *Individual health insurance can count as pre-existing conditions only those for which you actually received (or recommended to receive) a diagnosis, medical advice, or treatment in the 6 months prior to obtaining the individual health insurance policy. Individual health insurance policies can count pregnancy as a pre-existing condition, but not genetic information.*
- *Individual health insurers that impose pre-existing condition exclusion periods must give credit for any previous continuous creditable coverage. Most types of private and government sponsored health coverage are considered to be creditable coverage. Coverage counts as continuous if it has not been interrupted by a break of 63 or more days in a row.*
- *After you purchase your individual health insurance policy, insurer can still exclude coverage for a pre-existing condition, even if it was not specifically excluded in the terms of the policy. If you make a claim during the first two years of coverage, the insurer can look back 6 months from the time of your application to see if the claim*

is for a condition that would have been considered a pre-existing condition. If the insurer determines, using the objective standard, that the condition is a pre-existing condition, it can refuse to pay for expenses for that condition.

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

- *In Oregon, your individual health insurance policy premiums can vary to reflect your age, benefit plans, family composition and geographic area, but not your health status or your genetic information. This is called modified community rating.*
- *When you renew your individual coverage, your premiums will increase based on your age.*

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELED?

- *Your policy 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 a managed care plan's service area. However, your health policy may be canceled if the insurer does not continue to offer the coverage for all policyholders.*
- *However, if you make a claim during the first two years of coverage under your policy, the insurer might re-investigate information you provided during the application process to determine whether you made a misstatement. If so, the insurer might try to take back your policy and void coverage altogether. If you become involved in one of these “post-claims” investigations, be sure to call the Oregon Insurance Division to learn more about your rights.*
- *Some insurance companies sell temporary health insurance policies. Temporary policies are not guaranteed renewable. They will only cover you for a limited time, such as six months. If you want to renew coverage under a temporary policy after it expires you will have to reapply and there is no guarantee that coverage will be re-issued at all or at the same price.*

COBRA AND STATE CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

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

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

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

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 their 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 80% 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 lost your group health plan because of involuntary termination of employment that occurred between September 1, 2008 and December 31, 2009, you may be eligible for a federal tax credit that can help you pay for your COBRA premiums for up to nine months.* This tax credit was created as part of The American Recovery and Reinvestment Act of 2009 (ARRA) and covers 65% of your COBRA premium. For more information call the Employee Benefits Security Administration at the United State Department of Labor at (866) 444-3272 or visit the COBRA/AARA information center at <http://www.dol.gov/ebsa/cobra.html>. Information about the COBRA tax credit is also available from the IRS at <http://www.irs.gov/newsroom/article/0,,id=204505,00.html> and Department of Health And Human Services at <http://www.cms.hhs.gov/COBRAContinuationofCov/>.

- *If you have 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 Care Tax Credit (HCTC), and it is equal to 80% of the cost of qualified health coverage, including COBRA. (see Chapter 5)*
- *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 credit is called the Health Care Tax Credit (HCTC). (see Chapter 5)*
- *Call the Department of Labor at (866) 444-3272 to find out if other temporary COBRA subsidies are available to you.*

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 of hours) or be determined to have become disabled within 60 days of that qualifying event. You must obtain a disability determination letter from the Social Security Administration, and you must notify your group health plan within 60 days of receiving this disability determination.*

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

* 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.*

WHAT ABOUT OREGON CONTINUATION COVERAGE?

- *If your employer has 20 or more workers and provides group coverage under a fully insured group health plan, you may also be eligible for continuation coverage under an Oregon law that is similar to COBRA. State continuation coverage lasts for up to 9 months. To qualify for it, you must have been covered under your former group plan for at least 3 months and you must request continuation coverage within 10 days of termination of employment or notice of continuation right. Ask your former employer or the Oregon Insurance Division about state continuation coverage if you think it applies to you.*
- *If you lost your group health plan because of involuntary termination of employment that occurred between September 1, 2008 and December 31, 2009, you may be eligible for a federal tax credit that can help you pay for your state continuation coverage premiums for up to nine months. This tax credit was enacted in The American Recovery and Reinvestment Act of 2009 (ARRA) and covers 65% of your state continuation coverage premium. For more information call the Employee Benefits Security Administration at the United State Department of Labor at (866) 444-3272 or visit them online at <http://www.dol.gov/ebsa/cobra.html>. Also see "Health Information About State Continuation Coverage And ARRA" on the website of the Department of Health And Human Services at <http://www.cms.hhs.gov/COBRAContinuationofCov/>.*
- *Call the Department of Labor at (866) 444-3272 to find out if other temporary COBRA subsidies are available to you.*

ONE FINAL WORD ABOUT COBRA AND STATE CONTINUATION

- *In Oregon, in some cases, you will have a choice between COBRA and a portability policy. Compare the options to see what is best for you. Remember, though, that in some other states – and even sometimes in Oregon – you must use up your COBRA coverage before you are guaranteed the right to buy an individual health insurance policy.*

PORTABILITY POLICIES

WHEN DO INSURERS HAVE TO SELL ME A PORTABILITY POLICY?

- *If you have had at least 6 months of coverage under a fully insured group health plan in Oregon and then lose it, you are guaranteed the right to a portability policy for yourself and your family. You must apply within 63 days of losing your group coverage.*
- *If your prior coverage was in a self-insured group plan, you can obtain a portability policy from Oregon Medical Insurance Pool (OMIP). See below for more information on OMIP.*
- *Portability policies must offer family coverage to eligible enrollees and their dependents who lost group coverage.*

WHAT WILL MY PORTABILITY POLICY COVER?

- *You must be offered the type of plan that is most similar to your prior group plan – an **indemnity** plan or an **HMO**. These are standardized plans with comprehensive benefits.*
- *You must also be offered at least two levels of coverage: a high cost option (known as the prevailing plan) and a low cost option. The low cost option will require higher deductibles and cost sharing than the prevailing plan option. Each of these plans covers hospitalization, doctor visits, prescription drugs and maternity care. The prevailing indemnity plan has a \$750 annual deductible for individuals. Most services are subject to 20% coinsurance; when you have paid \$15,000 in cost sharing the plan will pay 100% for covered services for the rest of the year. The prevailing HMO plan does not have a deductible, and has a \$1,500 annual out-of-pocket maximum for individuals.*

The low-cost indemnity option has a \$1,500 annual deductible for individuals. Most services are subject to 30% coinsurance; when you have paid \$20,000 in cost sharing

the plan will pay 100% for covered services for the rest of the year.. The low-cost HMO plan does not have a deductible, and has a \$3,000 annual out-of-pocket maximum for individuals.

All indemnity plans have a lifetime limit of \$2 million on covered benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Portability policies cannot impose pre-existing condition exclusion periods.*

WHAT CAN I BE CHARGED FOR A PORTABILITY POLICY?

- *You cannot be charged more because of your health status, but premiums can vary due to age, family size and the plan option you select. This is called modified community rating.*

CAN MY PORTABILITY POLICY BE CANCELED?

- *Your policy 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 policy service area.*

OREGON MEDICAL INSURANCE POOL (OMIP)

Oregon maintains a high-risk pool, called the Oregon Medical Insurance Pool (OMIP), to provide insurance for residents of Oregon who are unable to buy private health insurance due to their health conditions, and for people who are HIPAA eligible and TAA eligible. There are several ways you can qualify to buy an individual health insurance policy from OMIP. OMIP offers single party coverage (an adult or child), two party coverage (one adult and one dependent spouse or child), or family coverage. There are limits on what you can be charged by OMIP. Rates are based on choice of plan, age, family size and geography. There are also limits on pre-existing condition exclusion periods that can be imposed.

WHEN CAN I BUY HEALTH INSURANCE FROM OMIP?

- *If you had coverage in Oregon under a self-insured group health plan for at least 6 months and apply within 63 days of losing it, you can obtain a portability policy from OMIP. You will first be required to use up any COBRA coverage available to you.*

- *If you have been covered under a fully insured group health plan issued in another state, apply for coverage within 63 days of losing it, you can buy a portability policy from OMIP.*
- *If you are HIPAA eligible but not eligible to buy a portability policy from a private insurance company, you can buy coverage from OMIP.*

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible you are guaranteed the right to buy some type of individual coverage in every state and you will have no from pre-existing condition exclusion periods. In Oregon you can buy a portability plan from a private insurer or from OMIP.

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.

Federal 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 and not eligible to buy a portability policy, you can buy health insurance from OMIP if you meet other requirements. There are several ways to become eligible:*
 - You have been turned down for coverage by one insurance company because of a health condition;
 - You have been offered coverage by an insurance company that contained a waiver that would substantially reduce your coverage due to an existing health condition;

- You have been diagnosed with a serious condition, such as cancer, AIDS or diabetes, that would limit your ability to purchase health insurance.
- *You can also buy health insurance from OMIP if you have been certified as eligible for federal premium assistance under the HCTC. (see Chapter 5)*

WHAT WILL OMIP COVER?

- *Health insurance from OMIP includes hospital and physician care, prescription drugs, mental health and other services. Total coverage is limited to a lifetime maximum of \$2,000,000.*
- *OMIP offers 4 plan options. Benefits are the same under all options, but the annual deductible and cost sharing varies. If you are medically eligible, your deductible choices are \$500, \$750, \$1,000 or \$1,500. If you are eligible for a portability policy, your deductible choices are \$750 or \$1,500.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *OMIP will exclude coverage for your pre-existing condition for 6 months. OMIP will look back 6 months before you enroll to see if you had a condition for which you actually received a diagnosis or treatment. You will get credit for prior coverage if it was involuntarily terminated and you apply for coverage within 63 days of termination. However, if you sign up for coverage under a portability policy through OMIP, you will not have a pre-existing condition exclusion period.*

HOW MUCH CAN I BE CHARGED FOR OMIP COVERAGE?

- *If you qualify for a portability policy through OMIP you will be charged the standard OMIP premium. This is similar to rates normally charged by private insurers for someone your age.*
- *If you do not qualify for a portability policy, you will pay a “high risk” premium that is 25% higher than the standard OMIP rate.*
- *Premiums vary depending on your plan choice and age. For example, a 24-year old man would pay \$207 per month for a portability policy with a \$750 deductible under OMIP, while a 64-year old man would pay \$508 per month for the same policy. For a non-portability plan with a \$750 deductible, the 24-year old man would pay \$271 per month, while the 64-year old man would pay \$608 per month. The high risk rate is 25% higher than the portability rate. Contact OMIP for more information about plan options and premiums.*

- *Contact OMIP for the most current information about premiums and coverage options.*

CAN MY OMIP COVERAGE BE CANCELED?

- *OMIP coverage is renewable as long as you pay your premiums, condition to reside in Oregon, 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 for 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. Oregon has enacted reforms to expand some of these protections. Some of these reforms apply to groups of different sizes. Generally, small employers are those that employ 2-50 employees. Please note that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Oregon Insurance Division to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down.* This is called guaranteed issue. If you employ at least 2 but not more than 50 people, health insurance companies must sell you any **small group health plan** they sell to other small employers if the employer group meets the participation requirements. They can also require you to contribute a minimum percentage 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 group health coverage cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud or if they are discontinuing that health plan or if they are withdrawing from the small employer market. In the case of discontinuance, they must give you a chance to buy other plans they sell to groups of your size.
- *Under no circumstances may you be turned down or charged more because of the genetic information of someone in your group.* In addition, insurance companies may not even ask about genetic test results or family history of people in your group when you apply.

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

- *Depending on the number of workers you employ, there are limits on what you can be charged for health coverage. If you are a small employer, you cannot be charged higher premiums because someone in your group is seriously ill. You can, however, be charged somewhat more due to the age, gender and family size of those in your group and where your business is located. This is called modified community rating.*

WHAT PLAN CHOICES DO I HAVE?

- *Insurance companies must offer small employers a uniform basic health plan. Standardization helps you compare differences in cost and coverage. Carriers can also offer non-standardized plans.*
- *The Oregon Insurance Division publishes a free brochure describing small employer basic and standard health plans. The brochure also lists the names and numbers of insurance companies selling these plans to small employers and describes the premiums charged. For more information please see the Oregon Department of Consumer and Business Services: Insurance Division at http://www.oregoninsurance.org/docs/serff/gp_health_smgphealth.html.*

WHAT IF I AM SELF-EMPLOYED?

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

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Oregon who cannot afford to buy health insurance. The Oregon Health Plan (OHP), consisting of Medicaid, the Oregon Children's Health Insurance Program and the Family Health Insurance Assistance Program offers free or subsidized health insurance coverage, direct medical services or other help. In addition, the federal 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 is a program that provides health coverage to some low-income Oregon residents. Medicaid covers families with children and pregnant women, medically needy individuals, the elderly, and people with disabilities, if state and federal guidelines are met. Legal residents who are not U.S. citizens may be eligible for Medicaid. Non-citizens who do not have immigration documents cannot enroll in Medicaid.

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

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

Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account, so you should contact the Office of Medical Assistance program of the Oregon Department of Human Services for more information.

Low income persons eligible for Medicaid in Oregon*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Child to age 5	133% (monthly income of about \$2,029 for family of 3)
Child 6-18	100%
Parent	100%
Pregnant woman	185%
Medically Needy	
Individual	58%
Couple	54%

* Eligibility information was compiled from *State Health Facts Online* (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 2009:

<u>Size of Family Unit</u>	<u>Poverty Guideline (annual income)</u>
1	\$ 10,830
2	\$ 14,570
3	\$ 18,310

For larger families, add \$3,740 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 \$33,874, or a monthly income of \$2,823.

* Contact your local department of social services for the most up to date information and for other eligibility requirements that may apply.

- ***Families who get cash benefits from TANF (also known as Temporary Assistance for Needy Families) can get Medicaid.***

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

Parents should know that when your family's TANF benefits end, your children may also qualify for transitional Medicaid coverage for 12 months. Or, your children may qualify for Medicaid themselves if your family's income meets the Medicaid income standards.

- *Very 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.

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

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

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

- *There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify for Medicaid, contact the Office of Medical Assistance Programs at (800) 359-9517.

OREGON CHILDREN'S HEALTH INSURANCE PROGRAM (OR CHIP)

The Oregon Children's Health Insurance Program (OR CHIP) is a state-designed program that provides health coverage to low-income children under the age of 19 who are not eligible for Medicaid and who are uninsured or underinsured.

- *A child whose family has a household income below 185% of the federal poverty level is eligible for OR CHIP.* For a family of 3, this works out to an annual income of about \$33,874, or a monthly income of about \$2,823.

- *Eligibility is guaranteed for one year unless the child moves from the state, enrolls in Medicaid, is found to have other insurance coverage, or becomes financially ineligible.*
- *For more information contact the Office of Medical Assistance Programs at (800) 359-9517.*

FAMILY HEALTH INSURANCE ASSISTANCE PROGRAM (FHIAP)

The Family Health Insurance Assistance Program (FHIAP) subsidizes health insurance premiums for qualified Oregonians.

- *To be eligible for FHIAP, you must be an Oregon resident and your family income must be within the FHIAP guidelines. There are also rules about how many assets (such as cash savings) you can have. Finally, you cannot be eligible for or enrolled in Medicare.*
- *In addition, you must have been uninsured at least 6 months before applying for the subsidy. However, this rule does not apply if you have been on Medicaid within the last six months.*
- *The size of your subsidy will depend on your income. If you qualify, FHIAP will pay 50%, 70%, 90% or 95% of your health insurance premium. You may be eligible for additional subsidies if you have dependent children or if you are pregnant.*
- *You can use FHIAP assistance to buy private individual health insurance on your own, or group coverage under your employer plan. If your employer offers health benefits, however, you must use your FHIAP assistance to enroll in that group health plan. The exception is when your employer does not contribute anything to the group plan premium; in this case you can use the FHIAP to help pay for an individual health insurance policy.*
- *If you have dependent children, you must buy coverage for them, as well. FHIAP emphasizes coverage for children, so you may not use the subsidy for only yourself if your children are uninsured.*
- *FHIAP is not always open for new enrollees. People are helped on a first-come-first-served basis until the program is full. When you sign up, you may be on a waiting list. Contact the Oregon Insurance Pool Governing Board to add your name to the waiting list.*

- *For more information about FHIAP, contact the Oregon Insurance Pool Governing Board at (800) 542-3104 or visit their website at <http://www.oregon.gov/OPHP/FHIAP/>.*

OREGON BREAST AND CERVICAL CANCER PROGRAM

The Oregon Breast and Cervical Cancer Program (BCCP) provides free screening services for breast and cervical cancer for eligible Oregon residents. Eligible women diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid for treatment of their condition.

- *The BCCP provides qualified Oregon residents with free screenings for breast and cervical cancer. Women screened through this program and diagnosed with breast or cervical cancer may be eligible for free coverage through Medicaid.*
- *In order to be eligible for screening through the BCCP, you must meet age and income guidelines and insurance requirements. You must be between the age of 40 and 64 for most services; however, men and women under the age of 40 may be eligible for some breast cancer screening services. In addition, you must be uninsured or underinsured and have an income at or below 250% of the federal poverty level.*
- *For more information, please call the Oregon Department of Human Services at (800) 422-6012 or the Oregon Health Services Breast and Cervical Cancer Program at (877) 225-7070 or visit their website <http://www.oregon.gov/DHS/ph/bcc/index.shtml>.*

THE FEDERAL HEALTH CARE 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 80% 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 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 COST WILL THE TAX CREDIT COVER?

- *The HCTC is equal to 80% 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, Oregon has designated OMIP as a state qualified health plan. (see Chapter 3)

HOW DO I CLAIM THE HCTC?

- *You can claim the HCTC on your tax return and be reimbursed for 80% 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 (866) 628-HCTC (866-628-4282), Monday through Friday between the hours of 7 am and 7 pm, Central time. TDD/TYY callers, please call (866) 626-HCTC (866-626-4282).

WHERE CAN I GET MORE INFORMATION?

- *For more information about the HCTC, contact the HCTC customer service center at (866) 628-HCTC, or see the IRS website at <http://www.irs.gov/individuals/article/0,,id=187948,00.html>.*
- *For more information about TAA benefits, visit <http://www.doleta.gov/tradeact>.*
- *For more information about PBGC, call (202) 326-4000 or visit online at <http://www.pbgc.gov>.*

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	<i>Oregon Insurance Division</i> (503) 947-7980 http://www.cbs.state.or.us/external/ins
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C.</i> (202) 219-8776 <i>For Department of Labor Employee Benefits Security Administration: Employee & Employer Assistance Hotline and Publications:</i> (866) 444-EBSA (3272) http://dol.gov/ebsa
Oregon Medical Insurance Program (OMIP)	<i>Oregon Blue Cross Blue Shield (plan administrator)</i> (800) 542-3104 (in-state only) (800) 848-7280 http://www.cbs.state.or.us/external/omip
Medicaid	<i>Oregon Department of Human Services, Office of Medical Assistance Programs</i> (503) 945-5772 (800) 232-3020 (in-state only) (800) 375-2863 (TTY) http://www.oregon.gov/DHS/healthplan/
Oregon Breast and Cervical Cancer Program	<i>Oregon Department of Human Services</i> (800) 422-6012 (877) 225-7070 http://www.oregon.gov/DHS/ph/bcc/index.shtml
Oregon Child Health Insurance Program (OR CHIP)	<i>Office of Medical Assistance Programs</i> (800) 359-9517 http://www.oregon.gov/DHS/healthplan/app_benefits/main.shtml
Family Health Insurance Assistance Program (FHIAP)	<i>Oregon Insurance Pool Governing Board</i> (800) 542-3104 (Oregon only) (503) 373-1692 <i>To add your name to the FHIAP reservation list, call</i> (800) 542-3104 http://www.oregon.gov/OPHP/FHIAP/
The Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service (IRS)</i> (866) 628-HCTC (1-866-628-4282) http://www.irs.gov/individuals/article/0,,id=187948,00.html

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

HELPFUL TERMS

Affiliation Period. The 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. See also HMO.

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

Certificate of Creditable Coverage. A document provided by your health plan that lets you prove you had coverage under that 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. See also State Continuation Coverage.

Continuous Coverage. Health insurance coverage is continuous if it 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 group health plans and, if you are HIPAA eligible, when you buy an individual health insurance policy. See also Creditable Coverage, HIPAA Eligible, Fully Insured Group Health Plan, Individual Health Insurance Policy, Self-Insured Group Health Plan.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; an individual health insurance policy; Medicare; Medicaid; CHAMPUS (health coverage for military personnel, retirees, and dependents); the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; or a state health insurance high risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Insurance Policy.

Elimination Rider. A feature permitted in individual health insurance policies that excludes coverage for a pre-existing condition. Unlike pre-existing condition exclusion periods, which can be no longer than 12 months, elimination riders can last indefinitely. Elimination riders cannot be imposed if you are HIPAA eligible.

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

Family Health Insurance Assistance Program (FHIAP). The Family Health Insurance Assistance Program (FHIAP) subsidizes health insurance premiums for qualified Oregonians. You can use FHIAP assistance to buy private individual health insurance on your own, or group coverage under your employer plan. If your employer offers health benefits, however, you must use your FHIAP assistance to enroll in that group health plan. The exception is when your employer does not contribute anything to the group plan premium; in this case you can use the FHIAP to buy individual coverage.

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 Oregon. See also Self-Insured Group Health Plans.

Genetic Information. Genetic test results indicating your or a member of your family's risk of developing a health condition. Genetic information includes the existence or history of a disease or disorder in a family member. Genetic services, including genetic counseling and education received by you or a family member, is also considered part of your genetic information.

Group Health Plan. Health insurance (usually sponsored by an employer, union or professional association) that covers at least 1 employee, or the self-employed. 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 Oregon small employers with 2 to 50 employees are guaranteed issue. If you are self-employed or a household employer buying coverage for one full-time employee, basic and standard small group health plans are guaranteed issue. If you are HIPAA eligible, insurance companies must offer you at least two individual health insurance policies that are guaranteed issue. Plans that are guaranteed issue can turn you away for other reasons.

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

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

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

Health Statement. A standardized form that individual health insurance policies in Oregon may request that you complete when you apply for health insurance. Group health plans in Oregon may not require health statements for enrollment.

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

HIPAA. The Health Insurance Portability and Accountability Act was passed in 1996 to help people buy and keep health insurance, even when they have serious health conditions, the law sets basic requirements that all health plans must meet. Since states can and have modified and expanded upon these provisions for state regulated health plans, consumers' protections vary from state to state.

HIPAA Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. When you are buying individual health insurance coverage, federal eligibility gives you greater protections than you would otherwise have in Oregon 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 services. For example, plans can require prior authorization of hospital care or other expensive services.

Individual Health Insurance Policy. Policies for people not connected to an employer group. Individual health insurance policies are regulated by Oregon.

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.

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

Modified Community Rating. A requirement that Oregon health insurance companies establish a rate for each small group policy (covering 25 or fewer employees) that does not vary due to the health status of those who buy that health insurance. For individual and small group health plans, premiums can vary within limits based on age, gender, family size and geographic location. For small group plans and individual portability policies, there are limits on the amount premiums can vary based on age.

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.

Oregon Breast and Cervical Cancer Program. The Oregon Breast and Cervical Cancer Program is a state-run program for low-income women who are uninsured or underinsured. The program provides free screening and diagnostic services, and for some women free treatment through Medicaid.

Oregon Children's Health Insurance Program (OR CHIP). The Oregon Children's Health Insurance Program is a state run program for low-income children under the age of 19 who are uninsured or underinsured and who are not eligible for Medicaid.

Oregon Medical Insurance Pool (OMIP). The Oregon Medical Insurance Pool is the state-run program for people who cannot obtain individual coverage because of a high risk health condition (called a high risk pool). OMIP also provides portability coverage to certain eligible individuals.

Portability Plan. A type of plan that must be offered to individuals coming off at least six months of group coverage, who meet additional requirements. Individuals eligible for portability plan coverage must be offered a prevailing cost and low cost option. Certain individuals are only eligible for portability plans through OMIP. See also OMIP.

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 health plan. Pregnancy cannot be counted as a pre-existing condition. Genetic information about your likelihood of developing a disease or condition, without a diagnosis of that disease or condition, cannot be considered a pre-existing condition. Newborns, newly adopted children, and children placed for adoption covered within 30 days cannot be subject to pre-existing condition exclusions.

Pre-existing condition (Individual Health Plans). Same definition as for group plans . Except, under individual health plans, pregnancy can be counted as a pre-existing condition, though certain complications of pregnancy cannot be excluded as pre-existing conditions. Newborns, newly adopted children and children placed for adoption covered within 30 days cannot be subject to pre-existing condition exclusions.

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

Self-Insured Group Health Plans. Plans set up by employers who set aside funds to pay their employees' health claims. Because employers often hire 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 Oregon.

Small Group Health Plans. Plans with at least 2 but no 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 or 60 days, depending on the qualifying event. Enrollment in a health plan during a special enrollment period is not considered late enrollment. See also Late Enrollment.

State Continuation Coverage. A program similar to COBRA. In Oregon, if you are in a fully insured group health plan sponsored by an employer with 2 to 19 employees and meet other requirements, you also have rights to continue your health coverage for up to 9 months when your job ends.

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

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

Trade Adjustment Assistance (TAA) Program. A program authorized by the Trade Adjustment Assistance Reform Act of 2002. This program provides aid to workers who lose their job or whose hours of work and wages are reduced as a result of increased imports. The TAA Program offers six benefits and reemployment services to assist unemployed workers prepare for and obtain new suitable employment. In addition, TAA offers a significant tax credit that covers 80% of health insurance premiums for certain plans

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

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