

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

By

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

**GEORGETOWN UNIVERSITY
HEALTH POLICY INSTITUTE**

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

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

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

This guide describes your protections as a Washington resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group and individual health insurance 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 Washington, 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 45. For information about how to find consumer guides for other states on the Internet, see page 45. A list of helpful terms and their definitions begins on page 46. These terms are printed in **boldface type** the first time they appear.

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CHAPTER 1

A SUMMARY OF YOUR PROTECTIONS

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

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

HOW AM I PROTECTED?

In Washington, 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 health plans in Washington must limit exclusion of pre-existing conditions. There are rules about when a **pre-existing condition exclusion** period can be applied and how long you must wait before a new health plan will begin to pay for care for that condition. Generally, if you join a new plan your old coverage will be credited toward the pre-existing condition exclusion period, provided you did not have a long break in coverage (see pages 9 and 19).*
- *Your health insurance cannot be canceled because you get sick. All health insurance is **guaranteed renewable** (see page 20).*
- *If you leave your job, you may be able to remain in your old group health plan for a certain length of time. This is called **COBRA** continuation coverage or **state continuation coverage**. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage (see page 20).*

- *If you lose your group health insurance and meet other qualifications, you can buy a **conversion policy**. This is an individual health insurance policy from the company that insured your employer's group plan. You cannot be denied coverage because of your health status, and you will not face a new pre-existing condition exclusion period. There are rules about what conversion policies must cover and limits on what you can be charged (see page 25).*
- *If you meet certain qualifications, you can buy individual health insurance without regard to health status. This is called **guaranteed issue** (see page 15).*
- *If you are turned down for individual health insurance you may qualify for coverage from the **Washington State Health Insurance Pool (WSHIP)** (see page 27).*
- *If you lose your group health plan and meet other qualifications, you will be **HIPAA eligible**. If so, you will have the chance to purchase individual coverage, either from a private insurer or from WSHIP, that will not impose a pre-existing condition exclusion period (see page 17).*
- *If you are buying an individual health insurance policy, you cannot be charged more for your health insurance due to your health status. Premiums may vary based on age. This is called **modified community rating** (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 other factor that might predict the use of health services of those in your group. All health plans for small employers must be sold on a **guaranteed issue** basis. In addition, you cannot be charged more due to the health status of those in your group (see page 31).*
- *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 Washington **Medicaid** program offers free health coverage for pregnant women, families with children, elderly and disabled individuals with moderate to low incomes (see page 34).*
- *If your child is 18 years old or younger, not eligible for Medicaid and not covered by other creditable insurance, he or she may be eligible to enroll in the **Children's Health Insurance Program (SCHIP)** (see page 37).*

- *If you believe you may be at risk for breast or cervical cancer, you may be eligible for free screening and treatment.* The Washington Breast and Cervical Health Program provides qualified women with free breast and cervical screening. In addition, women diagnosed with cancer may be eligible for treatment through Medicaid (see page 38).
- *If you have low or moderate household income and meet other qualifications, you may be eligible for subsidized health coverage through the **Basic Health Program (BHP)**.* If eligible, you will have access to comprehensive health insurance with low cost sharing at a below market monthly premium (see page 39).
- *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 Coverage Tax Credit (HCTC)**, and it is equal to 65% of the cost of qualified health coverage, including COBRA (see page 41).
- *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 page 41).

WHAT ARE THE LIMITS ON MY PROTECTIONS?

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

- *If you change jobs, you usually cannot take your old health benefits with you.* Except when you exercise your federal COBRA or state continuation rights, you are not entitled to take your actual group health 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 page 10).
- *If you change jobs, your new employer may 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 page 11).
- *If you get a new job with health benefits, your coverage may not start right away.* Employers can require **waiting periods** before your health benefits begin (see page 11).

- *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 pages 9 and 19).*
- *Even if you have **continuous coverage**, a new group health plan may apply a universal waiting period for coverage of certain benefits unrelated to pre-existing conditions (see page 11).*
- *Even if your coverage is continuous, there may be a pre-existing condition exclusion period for some benefits if you join a **self-insured group health plan** that covers certain benefits your old plan did not. For example, say you move from a group plan that does not cover prescription drugs to a self-insured group health plan 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 11).*
- *If you work for certain non-federal public employers in Washington, not all of the group health plan protections may apply to you (see page 13).*
- *Your ability to buy individual health insurance in Washington may depend on your health status.. Insurance companies in the individual market in Washington can turn you down if you are sick. Insurers must use a standardized health screen to determine who can and cannot be turned down for an individual health insurance policy based on health status. You can review these guidelines at any time to find out whether you are healthy enough to buy individual health insurance (see page 15).*
- *If you have been uninsured for more than 63 days before the date of application for individual health insurance, you may face a 9-month pre-existing condition exclusion period (see page 19).*
- *If you are self-employed with no other workers, you are not eligible to buy a group health insurance policy on your own. Therefore the laws that protect employer's 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 move away from Washington, you may not be able to buy individual health insurance in another state unless you are HIPAA eligible (see healthinsuranceinfo.net).*

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 a **health maintenance organization (HMO)** plan that you cannot join because you live outside of the plan's service area.
- *You cannot be turned away or charged more because of your health status.* 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 managers who can pass a physical examination. This is *not permitted* under the law.

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

Certain changes can trigger a special enrollment opportunity

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

- *Under Washington law, newborns, adopted children and children placed for adoption are automatically covered under the parent's fully insured health plan, if the plan covers dependents. The automatic coverage only lasts for the first 60 days following the birth or adoption. The insurer may require that the parent notify the insurer of the birth within 60 days and pay higher premiums in order to continue coverage beyond the 60 days.*
- *Under Washington law, your disabled children can remain covered under your fully insured group health insurance plan after he or she reaches the age at which dependent coverage usually terminates. To qualify, your adult son or daughter must be incapable of self-support because of developmental disability or physical handicap and must be chiefly dependent on the policyholder for support and maintenance. Proof of incapacity must be furnished within 31 days of reaching the time limit and may be required periodically thereafter.*
- *When you begin a new job, your employer may require a waiting period before you can sign up for the group health plan. 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.*
- *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 a **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 do not 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**.

- *Under Washington law, your protections to keeping your health insurance during family and medical leave may be more protective than under federal FMLA.*

Under the Washington Family Care Act, if you work for an employer who provides a paid leave benefit (sick time, vacation, holiday PTO, and some short-term disability plans), you can use that paid leave to care for sick family members, including spouses, children, parents, parent in-laws and grandparents, with a serious health condition. During this time, you may be able to keep your group health insurance.

Under the Washington Family Leave Act, you may be permitted to take leave for pregnancy or childbirth for up to 12 weeks in addition to the time otherwise permitted under federal FMLA for other reasons besides pregnancy or childbirth. During this time, you may be able to keep your group health insurance.

Finally, under Washington Human Rights Commission law, if you are pregnant and work for a business with 8 or more employees, you may be able to take leave for as much time needed before or after childbirth as long as your medical provider determines that you to work. During this time, you may be able to keep your group health insurance.

To learn more about your rights under The Washington State Family Leave Act and Washington State Human Rights Commission law, and how these laws coordinate with federal FMLA, contact the Employment Standards Office of the Washington State Department of Labor and Industries at 1-866-219-7321 or visit them online at <http://www.lni.wa.gov/>.

In addition, if your questions are related to pregnancy or childbirth related leave, also contact the Washington State Human Rights Commission at 1-800-233-3247 or online at <http://www.hum.wa.gov/>.

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

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

- *Generally, group health plans can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan. This period is also called the look back period.*

However, a special rule applies to fully-insured large group plans. These types of group health plans can only look back 3 months from the time that you joined the plan to determine whether a pre-existing condition existed.

- *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 are not prohibited from applying a universal waiting period for specific benefits. Universal waiting periods are most often used for expensive conditions like pregnancy or organ transplantation. If they are used, however, they must apply to everyone and cannot be related to pre-existing conditions. Check with your employer to see if your group health plan has this type of universal waiting period.*
- *Group health plans can exclude coverage for pre-existing conditions only for a limited time. The maximum period varies for different kinds of group health plans (see chart below). Also, if you enroll late in a self-insured group health plan (after you were hired and not during a regular or special enrollment period), you may have a longer pre-existing condition exclusion period. Ask your prospective employer if you are not sure what limits apply to you.*

The maximum pre-existing condition exclusion period varies

Type of Group Health Plan	Maximum Exclusion Period
Fully insured small group plan	9 months (all enrollees)
Fully insured large group plan	3 months (all enrollees)
Self-insured group plan	12 months (regular and special enrollees) 18 months (late enrollees)

- *Group health plans that impose pre-existing condition exclusions periods must give you credit for any previous continuous **creditable coverage** that you have had. Most types insurance considered creditable coverage.*

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

Children's Health Insurance Program	Medicare
Federal Employees Health Benefits (FEHBP)	Military health coverage (CHAMPUS, TRICARE)
Foreign National Coverage	State high-risk pools
Group health 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 insurance plan.

- *For self-insured plans, coverage counts as continuous if it is not interrupted by a break of 63 days or more in a row. However, for fully-insured group health plans, the break in coverage can be no longer than 90 days 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 towards 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?

The rules defining continuous coverage depend on the type of employer-sponsored group health plan you are joining.

Art, who has diabetes, worked for Ajax Company and was covered under its group health plan for 18 months. He lost his job and was without coverage for 75 days. Fortunately, on the 76th day after leaving Ajax, Art found a new job at Beta Corporation. He enrolled immediately in Beta's fully insured group health plan, which covers diabetes but imposes pre-existing condition exclusion periods. In Washington, fully insured group health plans count as continuous all creditable coverage that is not interrupted by a lapse of more than 90 consecutive days. Therefore, because Art's lapse in coverage was less than 90 consecutive days, Beta's fully insured plan will credit his coverage at Ajax against any exclusion period. Beta's plan will begin paying for Art's diabetes care immediately.

Now consider a slightly different situation. Assume Beta Corporation's group health plan is self-insured. Self-insured plans must count as continuous all creditable coverage that is not interrupted by a break of 63 or more consecutive days. Therefore, in this case, Art's prior coverage at Ajax will not be credited toward any exclusion period because it was followed by a break greater than 63 days. Beta's plan will begin paying for Art's diabetes care at the end of his pre-existing condition exclusion period.

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

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

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

Question: Is this permitted?

Answer: Yes. However, the plan must pay for covered doctor visits, hospital care, and other services for Sue's high blood pressure. It also must pay for covered prescription drugs required 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

WHAT WILL MY GROUP HEALTH PLAN COVER?

- *It depends on what your employer offers.* Employers are free to design whatever health benefit they choose to offer their employees.

However, you cannot be offered less comprehensive benefits because of your health status. Health status means your medical condition or history, genetic information, or disability. This protection is called nondiscrimination.

- *If you are covered under a fully-insured group plan, it must cover certain required benefits.* Policies sold by Washington insurers must cover at least those benefits that are required by plans offered through Washington Basic Health (see Chapter 5). In addition, Washington requires all fully-insured group health plans to cover certain mandated benefits, for example, diabetes treatment and mammograms. Insurers may sell policies that cover additional benefits beyond those required by law. In addition, insurers have flexibility to vary cost sharing (deductibles, co-pays, etc.) under the policies they design.

For more information about which benefits must be covered in your fully-insurance group plan, check with the Washington State Office of the Insurance Commissioner at (800) 562-6900.

WHAT CAN I BE CHARGED FOR MY GROUP HEALTH INSURANCE?

- *You cannot be charged more because of your health status.* Health status means your medical condition or history, genetic information, or disability. This protection is called nondiscrimination. However, your premiums may vary on other factors not related to your health status.

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 Washington 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 plan, you may be able to remain covered under the group health plan for a limited time. In addition, you may have special protections when buying certain kinds of individual health insurance. See Chapter 3 for more information about COBRA continuation coverage, conversion, individual health insurance and the Washington State Health Insurance Pool.*
- *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 is equal to 65% of the cost of qualified health coverage, including COBRA (see page 41).*
- *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 page 41).*

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 policy from a private health insurance company. However, in Washington – as in most other states – you have limited guaranteed access to private individual health insurance. Whether you can buy an individual health insurance policy may depend on your health status, the kind of coverage you want to buy, and other circumstances. There are some alternatives to private individual health insurance coverage – such as COBRA coverage and Washington State Health Insurance Pool coverage. This chapter summarizes your protections under different kinds of health plan coverage.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

WHEN DO INSURERS HAVE TO SELL ME AN INDIVIDUAL HEALTH INSURANCE POLICY?

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

- *Generally, in Washington, insurers that sell individual health insurance can turn you down because of your health status.* In most cases, you will be required to complete the Standard Health Questionnaire (SHQ). The questionnaire is used by insurers to determine your eligibility for an individual health insurance policy.

The SHQ includes more than 200 questions about your current and recent past health conditions. Your health conditions will be assigned points depending on how costly they are. If you accumulate more than 325 points on the SHQ, insurers can turn you down for individual health insurance. If you accumulate less than 325 points, the insurer cannot turn you down and must offer you all of the individual market policies that it currently sells in the individual market.

For information about the Standard Health Questionnaire, including a copy of the questionnaire, how you are scored and how to appeal your score, visit <https://www.wship.org>.

- *If an insurer denies you health insurance based on your health status, it must provide the denial in writing promptly and notify you about other coverage options.* The insurer must give you written notice that you are eligible for health coverage provided by the Washington State Health Insurance Pool (WSHIP). (See page 25.) The insurer must also provide you with an application for WSHIP. If the insurer does not provide or postmark the notice within 15 business days, then the insurer must sell to you individual health insurance.
- *Some residents cannot be turned down for individual health insurance based on health status.* This is called guaranteed issue. There are some situations when you do not have to take the SHQ and must be offered an individual health insurance policy on a guaranteed issue basis:
 - You changed residences from one part of Washington state to another part where you current health plan is not offered.
 - You used up any COBRA that was available to you.
 - Your former employer, who provided you with health coverage, has gone out of business while you were on COBRA
 - You were covered under a group plan that is exempt from COBRA and you had at least 24 months of continuous group coverage.
 - Your doctor or health care provider stopped being part of the provider network on your current individual health insurance plan. (In order for this exception to apply, your doctor must be on the new plan that you are applying for and you must have received some service from that provider during the 12 months before they left your current plan.)
 - You have been disenrolled in the Washington Basic Health Plan (BHP) after being continuously covered by the program for at least 24 months.

You must submit your application for individual health insurance within 90 days of the noted qualifying events. In most cases, you can submit your application in anticipation of the event.

- *Overall, most HIPAA eligible individuals do not have to take the SHQ.* However, if you are HIPAA eligible and your prior employer-sponsored group coverage was exempt from COBRA (e.g. your employer had less than 20 employees) and you do not have 24 months of continuous group coverage, then you must take the SHQ. If, as a result, you are not offered an individual health insurance policy, you are eligible for coverage through WSHIP.

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 coverage of some kind with no pre-existing condition exclusion periods. In Washington, you are guaranteed the same right to purchase individual health insurance as all other individuals in Washington, although most HIPAA eligible individuals are not required to take the standardized health screening. (see above) To be HIPAA eligible, you must meet all of the following:

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 (90 days if applying for group insurance coverage) of losing your prior coverage.
- *Under Washington law, newborns, adopted children and children placed for adoption are automatically covered under the parent's individual health insurance policy for the first 60 days, if the plan covers dependents.* The insurer may require that the parent enroll the dependent within 60 days in order to continue coverage beyond the 60 days. Children added to their parent's policy within this time frame cannot be required to complete the SHQ.

- *Under Washington law, your disabled child can remain covered under your individual health insurance policy after he or she reaches the age at which dependent coverage usually terminates.* To qualify, your adult son or daughter must be incapable of self-support because of developmental disability or physical handicap and must be chiefly dependent on the policyholder for support and maintenance. Proof of incapacity must be furnished within 31 days of reaching the time limit and may be required periodically thereafter
- *Even if you qualify to buy an individual health insurance policy, the insurer can refuse to enroll you due to limits on the insurer's capacity to serve existing enrollees.* The Commissioner of Insurance must determine that the insurer's clinical, financial, or administrative capacity will be impaired. Contact the Washington State Office of the Insurance Commissioner for more information at (800) 562-6900.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy.* Washington does not require health insurers in the individual market to sell standardized policies. However, insurers in the individual market must categorize the policies they offer as either comprehensive or catastrophic. **All comprehensive individual health insurance policies** must cover, at a minimum, the same benefits that are required by plans offered through Washington Basic Health. (see Chapter 5) Even with these requirements, insurers can cap coverage for benefits under comprehensive policies. For example, some insurers offer individual policies with a cap of \$2,000 on covered pharmaceutical benefits per year.

Insurers can also sell **catastrophic policies** in the individual market. Typically, these policies have limited benefits and extremely high cost sharing. In addition, unlike comprehensive individual policies, catastrophic policies are not required to include coverage for any specific benefits.

Washington requires all individual policies, whether comprehensive or catastrophic, to cover certain mandated benefits, for example, diabetes treatment and mammograms. Overall, when buying individual health insurance, you will have to read and compare all your options carefully.

- *For more information about which benefits must be covered in your individual health insurance policy, check with the Washington State Office of the Insurance Commissioner at (800) 562-6900*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Individual health insurers cannot impose **elimination riders**. These are amendments to an insurance policy that permanently exclude coverage for a health condition, body part, or body system.*

However, individual health insurers can impose a pre-existing condition exclusion period. Pre-existing condition exclusion periods cannot exceed 9 months.

The definition of pre-existing condition is different under individual health insurance than under group health plan. Individual health insurers count as pre-existing any condition for which you received – or, in your insurer’s judgment, for which you should have sought – medical care, treatment, diagnosis or advice in the 6-month period prior to enrollment. This is called the **prudent person rule**. In individual policies pregnancy can count as a pre-existing condition, but not genetic information.

- *If you make a claim during the first year 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 at the time the policy became effective. If the insurer determines that the condition is a pre-existing condition, it can refuse to pay for expenses for that condition.*
- *In some circumstances, you will get credit for prior continuous coverage against the imposition of a pre-existing condition exclusion period. You will get credit only if your prior coverage was under a comprehensive individual health insurance policy or a group plan, You will not be given credit for prior coverage if your prior plan was a catastrophic plan. Generally, to receive credit, your coverage must be continuous with no more than a 63-day lapse between your old coverage and your new policy. However, if you are buying a new individual health insurance policy because you are moving out of your prior plan’s service area or you are following your medical provider to a new plan, then you cannot have a break longer than 90 days.*
- *Individual policies cannot impose a pre-existing condition exclusion if you are HIPAA eligible.*

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

- *In Washington, premiums for an individual health insurance policy cannot vary due to your health status.* Premiums will vary, though, depending on your age, family size, where you live and the type of plan you seek. This is called adjusted community rating. Check directly with individual health insurer to get the most current premium rates and to see if they offer **wellness activity discounts** or **tenure discounts**.
- *When you renew your individual coverage, your premiums can increase as you age.*

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 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 CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

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

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

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share) plus a 2% administrative fee) for COBRA continuation coverage. The first premium must be paid within 45 days of electing COBRA coverage.*
- *If you elect the 11-month disability extension, the premium will increase to 150% of the total cost of coverage.*
- *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 65% of the cost of qualified health coverage, including COBRA (see page 42).*
- *If you are a retiree aged 55-65 and receiving pension benefits from Pension Benefit Guaranty Corporation (PBGC), and receiving benefits from the Trade Adjustment Assistance (TAA) Program, then you may be eligible for the federal Health Care Tax Credit to help pay for new health coverage (see page 42).*

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 the 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 the 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 receiving this disability determination letter and before your original 18 months expires.

HOW LONG CAN COBRA COVERAGE LAST?		
<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.

WHAT ABOUT WASHINGTON CONTINUATION COVERAGE?

- *If your employer offers a fully-insured group plan and has fewer than 20 workers, you may also be eligible for continuation coverage.* Washington requires insurers to offer continuation coverage as an option to employers. Availability of state continuation coverage for you depends on whether your employer elected such coverage and the terms of that coverage under the rules of your group health plan. Ask your former employer or the Washington State Office of the Insurance Commissioner about state continuation coverage if you think it applies to you.

CONVERSION

WHEN AM I ELIGIBLE FOR A CONVERSION POLICY?

- *In Washington, if you are losing eligibility for a fully insured group health plan, you may be able to buy a conversion policy.* This is an individual health insurance policy you get from the company that insured your employer's group health plan
- *You must meet certain qualifications to be eligible for conversion.* To qualify, you must be losing eligibility for coverage under the fully insured group plan for any reason other than misconduct. Even in the case of misconduct, an employee's spouse and dependents are still eligible to convert. You may also be eligible for conversion coverage if you had elected continuation coverage (for example, through COBRA) and it has run out. In addition, you must not be eligible for Medicare or another group plan.
- *Eligibility for a conversion policy is time sensitive.* You must apply for conversion and pay your premium for the first calendar quarter of coverage within 31 days of termination of your prior group health plan or continuation coverage.

WHAT DOES A CONVERSION POLICY COVER?

- *Covered benefits under a conversion policy might not be the same as under your former group health plan. The benefits available to you under a conversion policy will depend on which type of conversion policy you buy.*
- *You will have the choice of at least 3 benefit plan options; a comprehensive medical plan, a basic medical plan and a major medical plan. All three plans provide coverage for hospital stays, inpatient and out patient medical care and surgical costs but the lifetime maximum varies from \$75,000 to \$500,000, depending on the plan. In addition, the amount of your deductible will vary depending on the plan you select.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

HOW MUCH CAN I BE CHARGED FOR A CONVERSION POLICY?

- *Premiums for conversion coverage are determined by the insurer issuing the policy. The cost is typically much higher than premiums you paid for your group health plan.*
- *Depending on your health status, you may have a choice between buying a conversion policy or a private individual health insurance policy. Check out both options to see which is best for you.*

CAN MY CONVERSION POLICY BE CANCELED?

- *Your coverage cannot be cancelled 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.*

WASHINGTON STATE HEALTH INSURANCE POOL (WSHIP)

WHEN CAN I GET HEALTH INSURANCE FROM THE WSHIP?

- *If you are denied coverage for individual health insurance because of your health, you can enroll in WSHIP. You must enroll within 90 days of receiving the denial notice from an insurer.*
- *You are also eligible for WSHIP if you live in a county where comprehensive health insurance is not available. If the only policy available to you is a **catastrophic policy**, you are eligible to buy health insurance from WSHIP.*
- *You may also be eligible for WSHIP if you qualify for Medicare. To qualify, you must have been denied a Medicare supplemental policy for medical reasons, or offered a Medicare supplemental policy with restrictions, pre-existing condition exclusions, or higher-than-standard premiums.*
- *WSHIP also offers family coverage. Coverage for your spouse and/or dependent children (under 19 and unmarried) is available if you are eligible for and enrolled in WSHIP. Coverage can also be extended to dependent children over the age of 19 who are disabled.*
- *A variety of circumstances would make you ineligible for WSHIP.*
 - *You are not eligible for health insurance coverage from WSHIP if WSHIP has paid \$2 million in benefits on your behalf. Benefits include spending on: hospital and professional services, prescription drugs, maternity care, and limited mental health and chemical dependency.*
 - *You are not eligible if you terminated your prior coverage in the pool within the last 12 months, unless you can show that you had other continuous coverage from the date that WSHIP terminated and which has been involuntarily terminated for any reason except non-payment of premiums.*
 - *You are not eligible for WSHIP if you are covered by another public program offering similar health benefits.*
 - *You are not eligible if you are an inmate of a public institution.*

WHAT WILL WSHIP COVER?

- *As of January 2008 WSHIP offers a choice of 5 non-Medicare options. These include a standard plan, a preferred provider plan, a HSA preferred provider plan and two “limited” preferred provider plans.*
- *Benefits vary depending on the type of plan you buy. Benefits are generally comprehensive and similar for the standard plan, the preferred provider plan and the HSA preferred provider plan. However, the two “limited” preferred provider plans have more limited covered benefits, including very minimal prescription drug coverage (capped at \$2,000 or \$3,000 per year, depending on the plan). In addition, these plans have more limitations on rehabilitative services, skilled nursing care, medical supplies and equipment and spinal manipulation, among others. The limited preferred provider plan B doesn’t cover maternity benefits. All plans have a lifetime maximum of \$2 million.*
- *Cost-sharing varies depending on the type of plan you buy. The annual deductible options under the standard plan are \$500, \$1,000, or \$1,500. Under the preferred provider plans, you can choose an annual deductible of \$500, \$1,000, \$2,500 or \$5,000. Under the two “limited” plans, only a \$1,500 deductible option is offered. Finally the HSA-qualified Preferred Provider Plan has a \$3,000 deductible.*

The amount of cost sharing you will face after you have met the deductible also varies. With the standard plan, you can go to any provider and the plan covers 80 percent of allowed charges for most benefits. The preferred provider plans pay 80 percent of covered charges when you receive services from a provider participating in the plan’s network, but only 60 percent of covered charges for out-of-network care. Depending on the plan option you select, prescription drugs are subject to co-pays or co-insurance.

All plan options have an annual out-of-pocket maximum on cost sharing. These maximums vary by plan option and range from \$1,000 to \$10,000 for in-network care. Prescription drugs have separate annual-out-of-pocket maximums. Non-network medical care may be subject to higher maximums. Once you have reached the out-of-pocket maximum, the plan will pay 100% of allowed charges for covered services for the remainder of the year.

- *For a full description of covered benefits, contact WSHIP directly at 1-800-877-5187 or visit them on the web for a summary description of each plan at <https://www.wship.org>*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *WSHIP can impose a pre-existing condition exclusion period. Pre-existing condition exclusion periods cannot exceed 6 months.*

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

- *In some circumstances, you will get credit for prior continuous coverage against the imposition of a pre-existing condition exclusion period. You will get credit only if you had prior benefits under a previous group plan or individual health insurance policy. You will not be given credit for prior coverage if your prior plan was a catastrophic plan. To receive credit, your coverage must be continuous with no more than a 63-day lapse between your old coverage and new WSHIP plan.*
- *You will not face a pre-existing condition exclusion if you are HIPAA eligible.*

WHAT CAN I BE CHARGED FOR WSHIP COVERAGE?

- *Premiums depend on the plan you select and your age. For example, if you select standard plan option with a \$500 deductible, the monthly premium is \$343.00 for a 24-year-old but \$1, 533.69 for a 64-year-old. Generally the preferred provider plans are less expensive compared to the standard plan but the cost sharing requirements are greater and the benefits may be more limited.*
- *You may be eligible for a premium discount depending on the WSHIP plan you select, your income and your history of health insurance coverage. Premium discounts and low-income rates are available for the standard plan only. Enrollees with incomes up to 300 percentage of the federal poverty level are eligible for modest premium discounts of approximately 15-25 percent. In addition, regardless of income, modest premium discounts (ranging from 5 to 20 percent) are available for new enrollees who had at least 18 months of prior continuous coverage before joining WSHIP, and for any WSHIP enrollee who has been covered under the program for at least 36 months.*

For a full description of premiums and premium discounts, contact WSHIP directly at 1-800-877-5187 or visit them on the web for at <https://www.wship.org>.

HOW LONG DOES WSHIP COVERAGE LAST?

- *Your coverage cannot be canceled because you get sick or have high medical claims. This is called guaranteed renewability. You have this protection provided that you pay the premiums and do not defraud the WSHIP.*

CHAPTER 4

YOUR PROTECTIONS AS A SMALL EMPLOYER OR A SELF EMPLOYED PERSON

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. Washington has enacted some reforms that expand some of these protections. Generally, small employers are those that employ 2-50 employees. Please note, however, that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Washington State Office of the Insurance Commissioner 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 employees, health insurance companies must sell you any **small group health plan** policy they sell to other small employers if the employer group meets the participation requirements. A plan can require that a minimum percentage of your workers participate in your group health plan. They can also require you to contribute a minimum percentage of your workers' premiums. In Washington, if your group has 3 or fewer employees, insurance companies can require that up to 100% of your eligible workers participate in your group health plan. If your group has between 4 and 50 eligible employees, insurers can require that up to 75% of the eligible workers participate in your group health plan. If you are buying a **large group health plan** policy 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 require you to continue meeting 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 withdrawing from the small employer market. In the latter case, they must give you a chance to buy other plans they sell to groups of your size.

WHAT PLAN CHOICES DO I HAVE?

- *In Washington, small group health insurance policies must cover certain benefits. Washington does not require health insurers to offer standardized policies to small employers. However all small employer policies must cover, at a minimum, the same benefits that are required by policies offered through Washington Basic Health (see Chapter 5). In addition, Washington requires all small group health insurance policies to cover certain mandated benefits, for example, diabetes treatment and mammograms. Beyond these requirements, small group health insurance policies may vary significantly. Insurers may sell policies that cover additional benefits beyond those required by law. In addition, insurers have flexibility to vary cost sharing (deductibles, co-pays, etc.) under the policies they design. It is important to review your choices carefully before buying a policy for your employees.*
- *For more information about which benefits must be covered under small group health insurance policies, check with the Washington State Office of the Insurance Commissioner at (800) 562-6900.*

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

- *In Washington, insurers cannot vary premiums for your small employer group policy on the health status of your group. However, premiums can vary, within limits, based on age, family size and where your business is located. This is called adjusted community rating. In addition, your business may be eligible for a wellness activity discount of up to 20% off the cost of the entire premium.*

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are not eligible to buy a group health insurance policy on your own (though you may be able to join a 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 the cost of your premium from your federal income tax.*

A WORD ABOUT ASSOCIATION AND STUDENT HEALTH PLANS

- *Some small employers and self-employed people, and other individuals buy health coverage through professional or trade associations. Some student health plans are also considered association plans. The laws applying to association health coverage and student health coverage can be different than those for other health plans. Check with the Washington State Office of the Insurance Commissioner about your protections in association and student health plans.*

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Washington who cannot afford to buy health insurance. Medicaid, Children's Health Insurance Plan and Basic Health Plan offer 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 Washington 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 after they have been in the U.S. for five years. Questions concerning immigration status and eligibility should be directed to the Washington Department of Social and Health Services.

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

In Washington you may be eligible for Medicaid if you are a child, a parent of a child, or pregnant, 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. For more information, you should contact the Washington State Department of Social and Health Services at (800) 563-3022 or visit them online at: <http://www1.dshs.wa.gov/>.

Low income persons eligible for Medicaid in Washington*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Child up to 19	200% (In 2007, monthly income of about \$2,862 for a family of 3)
Parent	100%
Pregnant woman	185%
Parents	
Working	79%
Non-working	39%

* Eligibility information was compiled from *State Health Facts Online* (Henry 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 2007:

<u>Size of Family Unit</u>	<u>Poverty Guideline (annual income) (100%)</u>
1	\$10,210
2	\$13,690
3	\$17,170

For larger families add \$3,480 for each additional person

So, for example, using this guideline, 200% of the federal poverty level for a family of 3 would be an annual income of \$34,340 or a monthly income of \$2,862.

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

- *Families participating in **Temporary Assistance for Needy Families (TANF)** (also known as Washington Work First cash assistance program) are automatically covered.*

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.

Families on TANF, children and pregnant women are required, in most counties, to be enrolled in Healthy Options, one of the Washington State DSHS Medicaid managed care plans.

- *Pregnant women, once eligible, are eligible throughout pregnancy regardless of changes in income or how many people live in the home.* Coverage is available for 60 days after pregnancy ends. Newborns are covered for one year.
- *Very poor elderly, blind or disabled people who get **Supplemental Security Income (SSI)** benefits automatically qualify for Medicaid.*

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

Washington State has a program called Health Care for Workers with Disabilities. This program has an income limit of 220% of the poverty level with certain income deductions and premiums assessed to the individual to participate in the cost of care.

- *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 may qualify as medically needy if their health insurance is limited or does not cover these services.
- *Retired or disabled people who have low incomes and are enrolled in Medicare may also qualify for help from Medicaid.* Even though your income may be too high to qualify for Medicaid 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 135% of the poverty level, Medicaid will pay for your monthly Medicare premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

If you are disabled and working, DSHS will pay your Medicare Part A premium if your income is not greater than 200% of the poverty level.

- *There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify for Medicaid, contact your local Community Services Office or Adult and Aging Office. You can also apply for Medicaid there.

Contact your county DSHS office for more information about other eligibility requirements. To obtain the locations and telephone numbers of sites near contact the Washington State Department of Social and Health Services at (800) 563-3022 or visit them online at: <http://www1.dshs.wa.gov/>

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

The State Children's Health Insurance Program (SCHIP) is a state program that provides health insurance to low-income families with children under the age of 19 who are not eligible for Medicaid and are uninsured.

- *To be eligible for SCHIP, your child must meet certain qualifications.* Your household income must be at or below 250% of the federal poverty level (FPL). For a family of 3, this works out to an annual income of about \$42,920 or about \$3,577 per month. In addition, your child cannot be eligible for Medicaid or have other "creditable health coverage". Creditable health coverage means coverage under a group health plan or other health insurance that provides access to physician, hospital, radiology and laboratory services.
- *If your child drops employer sponsored group health plan to enroll in SCHIP s/he may have wait 4 months before becoming eligible for coverage.* Generally, if one drops employer sponsored health care there is a 4-month waiting period to be eligible for SCHIP. However, there are *many* exceptions to this rule. For example, if your child has a condition that, without treatment, would be life threatening or cause serious or loss of function, s/he may be eligible to apply for SCHIP immediately. Before you drop any health insurance for SCHIP, it is important to check in advance to see if and when your child will be eligible for SCHIP.

- *SCHIP does not impose a pre-existing condition exclusion period and your child cannot be excluded because of his or her health.* SCHIP coverage begins the first day of the month in which the application was submitted. So, if you apply on March 21 and your child is found eligible, s/he will be covered as of March 1. Continued eligibility for SCHIP will be reassessed every 6 months.
- *SCHIP covered benefits are comprehensive.* The program's benefits are the same as those provided by the Medicaid program for children. SCHIP provides doctor visits, hospital care, prescriptions, mental health services, preventative well-child exams, immunizations, dental and eye exams, among other services.
- *You will have to pay a small monthly premium.* As of January 1, 2008 the monthly premium costs of SCHIP is \$15 per child per month, with a \$45 family maximum per month.
- *If your income goes down and you cannot pay premiums, your children may be eligible for Medicaid, which requires no premiums.* For more information on Medicaid eligibility call the Washington State Department of Social and Health Services at (800) 562-3022 or visit them online at <http://www1.dshs.wa.gov>
- *For more information on the Children's Health Insurance Program, call (877) KIDS-NOW or (877) 543-7669) or visit them online at <http://fortress.wa.gov/dshs/maa/chip/>.*

WASHINGTON BREAST AND CERVICAL HEALTH PROGRAM (BCHP)

- *The Breast and Cervical Health Program (BCHP) provides qualified women with breast and cervical cancer screening at no cost.*
- *In order to be eligible for screening through the BCHP, you must certain eligibility criteria.* Generally, you must be between the ages of 40 and 64, uninsured or underinsured and your income must be at or below 250% of the federal poverty level. However, in some situations, eligibility for this program may be expanded beyond these general requirements. If you have been diagnosed or you think that you might be at risk for breast or cervical cancer, it is best to call to the BCHP to determine your eligibility for screening or treatment.

- *Women who are screened or diagnosed with breast or cervical cancer through the BCHP may be eligible for treatment through Medicaid. Even women diagnosed outside the program are encouraged to contact the BCHP for assistance in securing treatment.*
- *For more information about the Washington Breast and Cervical Health Program (BCHP) call the Washington State Department of Health website at (888) 438-2247 or visit them online at www.doh.wa.gov/wbchp/default.htm.*

WASHINGTON BASIC HEALTH (WBH)

Washington has a program to help make health insurance affordable to working people and others who lack health coverage. The Washington Basic Health (WBH) offers individuals and families coverage through a subsidized program, depending on family income. Coverage is made available through private insurers.

- *To get the Washington Basic Health (WBH), you must meet certain eligibility criteria. To be eligible for coverage you: 1) cannot be on or eligible for Medicare; 2) cannot be institutionalized at the time of enrollment; 3) must be a Washington State resident; and 4) must have a gross family income less than 200% of the Federal Poverty Level (\$34,340 or a monthly income of \$2,862 for a family of 3).*

Currently, the WBH is enrolling new members. However, enrollment will be available only as long as there is state funding. Depending on future state funding, you may have to wait before can join the Washington Basic Health Plan

- *WBH can impose a pre-existing condition exclusion period. Pre-existing condition exclusion periods cannot exceed 9 months.*

WBH can count as pre-existing any condition for which you received or was recommended to received – or, in WBH’s judgment, for which you should have sought –medical diagnosis, care or treatment (including medication) or consultation in the 6-month period prior to enrollment.

No pre-existing condition exclusion period will be imposed on the maternity benefit, prescription drugs or oxygen.

- *In some circumstances, you will get credit for prior continuous coverage against the imposition of a pre-existing condition exclusion period* You will get credit toward your pre-existing condition exclusion period for prior coverage that was “similar” to the Basic Health coverage you have, provided that no more than 3 months lapsed between your old coverage and your WBH. “Similar coverage” includes Basic Health, Medicaid programs, Indian Health Services and most private health insurance plans, among other types of coverage.
- Coverage under the WBH is generally comprehensive. Covered benefits include physician services, inpatient and outpatient hospital services, prescription drugs, primary and preventive health care, emergency services, ambulance services, radiology and laboratory, skilled nursing, hospice, and home health care (health plan’s discretion), out of area emergency care, chemical dependency, mental health, chiropractic/physical therapy and organ transplants. You must be enrolled in WBH for 12 consecutive months before you will be covered for organ transplant procedures (except for newborns or for a condition that is not preexisting).

Maternity benefits for eligible subsidized members are provided through the Maternity Benefits Program through DSHS; these include full prenatal care, delivery, post-partum care, care for pregnancy complications, and termination of pregnancy.

- *WBH members face cost sharing for most covered services.* The office visit co-payment is \$15 and the emergency room co-payment is \$100. For services with a coinsurance (most), once a \$150 annual deductible has been met, the health plan pays 80% and you pay 20% until you have reached an out-of-pocket maximum of \$1500. Co-payment for office visits do not count against the out-of-pocket maximum.
- *WBH members must pay a monthly premium.* Basic Health premiums are based on age, family size, income and plan option. The minimum premium is \$17 per month but can rise significantly if you are older with more income. For example, if you are 60 years old with household income of \$1,700/month and you live in Clark County, you would be required to pay just below \$280/month for a WBH plan administered by Kaiser Permanente. However, if you were 24 years of age living in the same area and making \$850 per month, you would pay \$45.90 for the same policy.
- *For more information contact the Washington Basic Health at (800) 826-2444 or visit them on the web at <http://basic.health.hca.wa.gov/>.*

WSHIP

The Washington State Health Insurance Pool (WSHIP) offers modest premium discounts to enrollees who have low and modest incomes. These discounts can reduce your premium by 15 to 25 percent, and they apply only to the most expensive WSHIP plan option.

See Chapter 3 for more info about WSHIP.

THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)

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

WHEN AM I ELIGIBLE FOR THE HCTC?

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

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

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

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

WHAT HEALTH COVERAGE IS ELIGIBLE FOR THE TAX CREDIT?

- *The HCTC can only be used to help pay for "qualified" health coverage.* Qualified health coverage includes:
 - COBRA continuation coverage, as long as your employer or former employer contributes less than 50% of the total health plan premium. (See Chapter 3 for COBRA).
 - State-qualified health plans. In Washington, the Washington State Basic Health (WBH) is the state qualified health plan. For more information contact the Washington Basic Health Program at (800) 826-2444 or visit them on the web at <http://basic.health.hca.wa.gov/>

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

HOW DO I CLAIM THE HCTC?

- *You can claim the HCTC on your tax return and be reimbursed for 65% of the premium you paid for qualified coverage while you were eligible for the HCTC. Currently, this is the only way to claim the HCTC if your qualified health plan is provided through a spouse's employer.*
- *Alternatively, you can choose to have your credit sent directly to your qualified health plan each month. To do this, you must register with the HCTC customer service center by calling 1-866-628-HCTC (1-866-628-4282), Monday through Friday between the hours of 7 am and 7 pm, Central time. TDD/TYY callers, please call 1-866-626-HCTC (1-866-626-4282).*
- *You will have to fill out a registration form verifying your eligibility for the HCTC and your enrollment in qualified coverage. You will also fill out a payment invoice. Each month, you will send the HCTC program your 35% share of the premium for qualified coverage. The HCTC program will combine this payment with the tax credit covering the other 65% of the premium and forward the entire payment to your qualified health plan.*
- *You must register in advance to have the HCTC paid directly to your health plan each month. Usually, the direct payments won't begin until at least a month after you register with the HCTC program. Call the HCTC customer service center for more information*

WHERE CAN I GET MORE INFORMATION?

- *For more information about the HCTC, contact the HCTC customer service center at 1-866-628-HCTC, or see the IRS website at <http://www.irs.gov/individuals/index.html> (click on HCTC)*

- *For more information about TAA benefits contact, <http://www.doleta.gov/tradeact/>.*
- 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 policies Fully insured group health plans	<i>Washington State Office of the Insurance Commissioner</i> OIC Consumer hotline (800) 562-6900 http://www.insurance.wa.gov/
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor, Employee Benefits Administrator Employee & Employer Assistance Hotline and Publications:</i> (866) 444-EBSA (3272) http://www.dol.gov/ebsa/
Washington State Health Insurance Pool (WSHIP)	<i>Washington State Health Insurance Pool</i> (800) 877-5187 https://www.wship.org/
Medicaid	<i>Washington State Department of Social and Health Services</i> (800) 800-562-3022 http://www1.dshs.wa.gov/
State Children's Health Insurance Plan (SCHIP)	<i>Washington State Department of Social and Health Services</i> (877) KIDS-NOW (877) 543-7669 http://fortress.wa.gov/dshs/maa/CHIP/
Washington Breast and Cervical Health Program (BCHP)	<i>Washington State Department of Health</i> (888) 438-2247 http://www.doh.wa.gov/wbchp/
Washington Basic Health (WBH)	<i>Washington State Health Care Authority</i> (800) 826-2444 http://www.basichealth.hca.wa.gov/
The Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service (IRS)</i> (866)-628-HCTC (4282) http://www.irs.gov/individuals/ (Click on HCTC)

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

HELPFUL TERMS

Adjusted Community Rating. A requirement that Washington health insurance companies establish a rate for each individual and small group policy that does not vary due to the health status of those who buy that health insurance. For individual health insurance policies, premiums may only vary based on age, family size, where you live or what plan you seek. Individuals can earn wellness activity discounts and **tenure discounts**. For small employer group health plans, premiums can only vary based on age, family size, where your business is located, and what plan you seek. Discounts may be earned for wellness activities. See also Wellness Activity Discounts, Tenure Discounts.

Affiliation Period. The time an HMO may require you to wait after you enroll and before your coverage begins. HMOs that require affiliation periods cannot exclude coverage of pre-existing conditions. Premiums cannot be charged during HMO affiliation periods. Washington law does not allow for the use of 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.

Basic Health (WBH). The system created and administered by the state of Washington to enable low income individuals, families to purchase basic health care services through participating managed health care plans. WBHPP is administered by the Health Care Authority, available to Washington residents who meet income guidelines, are not eligible for Medicare, and are not institutionalized at the time of enrollment. Premiums are based on age and income.

Basic Health Plus (BHP). A Medicaid Program administered by the Department of Social and Health Services and the Health Care Authority for children from low income families. There are no premiums or co payments.

Catastrophic Policy. In Washington, a health insurance policy covering an individual which requires a calendar year deductible of \$1,750 or more in addition to \$3,000 or more in annual out-of-pocket costs is a catastrophic policy. In the case of a health insurance policy covering a family a catastrophic policy is one that requires a calendar year deductible of \$3,000 or more in addition to \$6,000 or more in annual out-of-pocket costs. Finally, a catastrophic policy is also one that provides benefits for hospital inpatient and outpatient services, professional and prescription drugs in conjunction with such hospital inpatient and outpatient services and excludes or substantially limits outpatient physician services and those services usually provided in an office setting.

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

COBRA. Stands for the Consolidated Omnibus Budget Reconciliation Act, a federal law in effect since 1986. COBRA permits you and your dependents to continue in your employer's group health plan after your job ends. If your employer has 20 or more employees, you may be eligible for COBRA continuation coverage when you retire, quit, are fired, or work reduced hours. Continuation coverage also extends to surviving, divorced or separated spouses; dependent children; and children who lose their dependent status under their parent's plan rules. You may choose to continue in the group health plan for a limited time and pay the full premium (including the share your employer used to pay on your behalf) plus a 2% administrative fee. COBRA continuation coverage generally lasts 18 months, or 36 months for dependents in certain circumstances. See also State Continuation Coverage.

Continuous Coverage (Self-Insured Plans). Under federal rules, health insurance coverage that is not interrupted by a break of 63 or more days in a row. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. Federal rules apply to you if you are joining a self-insured group health plan. See also Creditable Coverage, Federally Eligible.

Continuous Coverage (Fully Insured Group and Individual Health Insurance Policies). Under Washington rules, health insurance coverage that is not interrupted by a break of more than 90 days in a row. Employer waiting periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. Washington state rules apply to you if you are joining a fully insured group health plan. When buying individual health insurance, you cannot have a break in coverage of 63 or more days in a row.

Conversion Policy. Your right, when leaving a fully insured group health plan in Washington, to convert your policy to an individual health insurance policy. You will not face a new pre-existing condition exclusion period.

Comprehensive Individual Health Insurance Policy. An individual health insurance policy is suppose to be more comprehensive that a catastrophic policy. All comprehensive individual health insurance policies must cover, at a minimum, the same benefits that are required by plans offered through Washington Basic Health. Even with these requirements, insurers can cap coverage for benefits under comprehensive policies. For example, some insurers offer individual policies with a cap of \$2,000 on covered pharmaceutical benefits per year. Cost sharing requirements cannot reach the limits that define a catastrophic policy. See also Washington Basic Health and Catastrophic Policy

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); Federal Employees Health Benefits; Indian Health Service; Peace Corps; or a state health insurance high risk pool. Used in this definition, health insurance coverage includes any time spent under a pre-existing condition exclusion period. See also Continuous Coverage, Group Health Plan, Individual Health Insurance Policy.

Elimination Rider. A feature permitted in individual health insurance policies that permanently exclude coverage for a health condition, body part, or body system. Elimination riders are not permitted in health insurance plans sold by insurers in Washington.

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

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

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by the state of Washington. 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 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) in the state of Washington that covers at least 1 employee or a self-employed person. 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. 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 policy 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 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, better known as Kassebaum-Kennedy, after the two senators who spearheaded the bill. Passed in 1996 to help people buy and keep health insurance, even when they have serious health conditions, the law sets basic requirements that all health plans must meet. Since states can and have modified and expanded upon these provisions for state regulated health plans (fully insured group and individual 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 federally 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. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

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

Individual Health Insurance. Policies for people not connected to an employer group. Individual health insurance policies are regulated by the state of Washington. Not all residents can buy coverage for themselves and their families. If you are sick, based on the results of a standardized health questionnaire, you may be denied coverage by a private insurance company. All individual policy premiums are based on an adjusted community rate. See also Adjusted Community Rating.

Kassebaum-Kennedy. See HIPAA

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

Late Enrollment. Enrollment in a health plan at a time other than the regular or a special enrollment period. Washington requires fully insured group plans to cover you if you are a late enrollee. However, 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 get 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 specialty care without a referral. The Washington Basic Health Plan offers managed care plans. See also HMO, Washington Basic Health Plan.

Medicaid. A program providing comprehensive health insurance coverage and other assistance to certain low-income Washington 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, due to your health status. Group health plans can restrict your coverage based on other factors (such as part time employment) that are unrelated to health status. See also Group Health Plan, Health Status.

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 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 (Self-insured Group Health Plans). Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a group health plan. Pregnancy cannot be counted as a pre-existing condition. Genetic information about your likelihood of developing a disease or condition, without a diagnosis of that disease or condition, cannot be considered a pre-existing condition. Newborns, newly adopted children, and children placed for adoption covered within 30 days cannot be subject to pre-existing condition exclusions.

Pre-existing Condition (Fully Insured Large Group Plans). Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 3-month period immediately preceding enrollment in a group health plan. Pregnancy cannot be counted as a pre-existing condition. Genetic information about your likelihood of developing a disease or condition, without a diagnosis of that disease or condition, cannot be considered a pre-existing condition. Newborns, newly adopted children, and children placed for adoption covered within 60 days cannot be subject to pre-existing condition exclusions.

Pre-existing Condition (Fully Insured Small Group Plans). Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a group health plan. Pregnancy cannot be counted as a pre-existing condition. Genetic information about your likelihood of developing a disease or condition, without a diagnosis of that disease or condition, cannot be considered a pre-existing condition. Newborns, newly adopted children, and children placed for adoption covered within 60 days cannot be subject to pre-existing condition exclusions.

Pre-existing Condition (Individual Health Insurance). Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan, or for which an ordinarily prudent person would have sought medical advice, care or treatment during that period. Under individual health insurance policies, pregnancy can be counted as a pre-existing condition. Newborns and newly adopted children covered within 60 days cannot be subject to pre-existing condition exclusions. See also Prudent Person Rule.

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

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

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

Small Group Health Plans. Plans with no more than 50 employees and plans for the self employed.

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 Children’s Health Insurance Program (SCHIP). The State 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.

State Continuation Coverage. A program similar to COBRA for some small employers. In Washington, if you are in a fully insured group health plan sponsored by an employer with 2 to 19 employees, you may have rights to continue your health coverage when your job ends, if your employer chose to offer this benefit in its plan. See also COBRA.

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

Temporary Assistance for Needy Families (TANF). A program (also known as the Family Assistance Program or FAP) 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.

Tenure Discount. A discount in the price of your individual health insurance policy premium that may be applied if you have been continuously enrolled in the health plan for 2 or more years. The discount may be as much as 10%.

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 or work and wages are reduced as a result of increased imports. The TAA program offers six benefits and reemployment services to assist unemployed workers prepare for and obtain new suitable employment. In addition, TAA offers a significant tax credit that covers 65% of health insurance premiums for certain plans.

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

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

Washington Basic Health (WBH). The system created and administered by the state of Washington to enable low income individuals, families to purchase basic health care services through participating managed health care plans. WBHPP is administered by the Health Care Authority, available to Washington residents who meet income guidelines, are not eligible for Medicare, and are not institutionalized at the time of enrollment. Premiums are based on age and income.

Washington Basic Health Plus (WBHP). A Medicaid Program administered by the Department of Social and Health Services and the Health Care Authority for children from low income families. There are no premiums or co payments.

Washington State Health Insurance Pool (WSHIP). A state high risk pool for federally eligible individuals and individuals with health problems who do not qualify for private individual health insurance.

Wellness Activity Discount. A discount in the price of your individual or group health plan premium that may be applied if you participate in an explicit program of activity consistent with department of health guidelines, such as smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction and nutrition education, for the purpose of improving enrollee health status and reducing health service costs. The discount may be as much as 20%. See also Tenure Discount, Adjusted Community Rating.