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

By

Karen Pollitz
Jennifer Libster
Mila Kofman
Eliza Bangit
Kevin Lucia

GEORGETOWN UNIVERSITY
HEALTH POLICY INSTITUTE

January 2006

ACKNOWLEDGMENTS AND DISCLAIMER

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

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

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

January 2006

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

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

This guide describes your protections as a New York resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group health plans and individual health policies. Chapter 4 highlights your protections as a small employer. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from New York, your protections may change. Since this guide is a summary, it may not answer all of your questions. For more information, see page 32. For information about how to find consumer guides for other states on the Internet, see page 32. A list of helpful terms and their definitions begins on page 33. These terms are in boldface type the first time they appear.

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CHAPTER 1
A SUMMARY OF YOUR PROTECTIONS

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

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

HOW AM I PROTECTED?

In New York, your health insurance options do not depend on your **health status**.

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status.* This is called **nondiscrimination** (see page 5).

- *All health plans in New York must limit exclusion of pre-existing conditions.* There are rules about what counts as a pre-existing condition and how long you must wait before a new health plan will begin to pay for care for that condition. Generally, if you join a new plan your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage (see pages 7 and 13).

- *Your individual or group health plan cannot be canceled because you get sick.* Most health insurance is **guaranteed renewable**. Note, however, that the precise definition of guaranteed renewable may vary based on what type of insurance you have (see pages 14 and 21).

- *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 14).

- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group.* All health plans for small employers must be sold on a guaranteed issue basis (see page 21).

- *If you are a small employer buying a group health plan, you cannot be charged more due to the health status, age, gender, or occupation of those in your group*. This is called **community rating** (see page 21).

- *You cannot be turned down for an individual health insurance policy because of your health status, age, or any other factor that might predict your use of health services*. This is called **guaranteed issue** (see page 21).

- *If you are buying an individual health insurance policy, you cannot be charged more for your health insurance due to health status, age, gender, or occupation*. This is called community rating (see page 13).

- *If you have low or modest household income, you may be eligible for free or subsidized health coverage for yourself or members of your family.* The New York **Medicaid** program offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low-incomes. The **Child Health Plus** Program offers free or subsidized health coverage for uninsured children. In addition, the **Family Health Plus** Program offers free health coverage for eligible uninsured families and individuals (see Chapter 5).

- *If you have low or modest household income and your employer does not provide health insurance, you may be eligible for subsidized health coverage for yourself or members of your family.* The **Healthy New York** program offers low-cost health insurance to uninsured working individuals, small employers and sole-proprietors (see page 27).

- *If you have lost you 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 (see page 28).

- *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 29).

WHAT ARE THE LIMITS ON MY PROTECTIONS?

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

- *If you change jobs, you usually cannot take your old health benefits with you.* Except when you exercise your federal COBRA or state continuation rights, you are not entitled to take your actual group health plan with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did.

- *If you change jobs, your new employer may not offer you health benefits.* If your employer does offer health benefits then the decision on whether to offer you health insurance cannot be based on factors related to your health.

- *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. **HMOs** can require **affiliation periods** (see page 8).

- *If you have a break in coverage of 63 days or more, you may have to satisfy a new pre-existing condition exclusion period when you join a new health plan* (see pages 7 and 13).

- *Even if your coverage is* ***continuous****, there may be a pre-existing condition exclusion period for some benefits if you join a group health plan that covers benefits your old plan did not.* For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition (see page 9).

- *If you work for a non-federal public employer in New York, not all of the group health plan protections may apply to you* (see page 10).

- *If you move away from New York, you may not be able to buy individual health insurance in another state unless you are* ***HIPAA eligible*** (see page 12).

CHAPTER 2
YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

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

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

- *You have to be eligible for the group health plan*. For example, your employer may not give health benefits to all employees. Or, your employer may offer an HMO plan that you cannot join because you live outside of the plan's service area.
- *You cannot be turned away or charged more because of your health status.* **Health status** means your medical condition or history, **genetic information**, evidence of insurability (including conditions arising out of acts of violence), or disability. This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (such as part time employment), as long as these are unrelated to health status and applied consistently.

Discrimination due to health status is not permitted

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

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

Certain changes can trigger a special enrollment opportunity

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

- *Under New York law, newborns and adopted newborns are automatically covered under the parents' fully insured health plan for the first 30 days, if the plan covers dependents.* The insurer may require that the parent enroll the baby within the 30 days in order to continue coverage beyond the 30 days. If an adopted newborn's birth parents have health insurance, your insurance is not required to cover the baby's initial hospital stay following birth.

- *Under New York law, disabled adult children can remain on their parent's fully insured group health plan after reaching the age at which dependent coverage is usually terminated, if they meet certain requirements.* Conditions that would make your child eligible for this extension include: mental illness, developmental disability, mental retardation, or physical handicap. Your adult child must be incapable of self-sustaining employment by reason of the disability. Proof of incapacity must be furnished to the plan within 31 days of the child reaching the age at which dependent coverage would normally end.

- *In New York, special protections apply if you have an adult child who is a full time student and who is covered under your fully insured group health plan policy.* If your child becomes ill and must take a leave of absence from school, the policy must allow your child to continue on your policy for up to one year. The rate the insurer charges you must be the same as if your adult child were still in school full time. The plan is allowed to require that you provide it with certification from a physician to document the adult child's illness.

- *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage.* This waiting period, however, must be applied consistently and cannot vary due to your health status.

- *When you begin a new job with health insurance through an HMO, the HMO may require an **affiliation period** before coverage begins*. During this affiliation period, you will not have health insurance coverage. An HMO affiliation period cannot exceed 2 months, and you cannot be charged a premium during it.

- *If you have to take leave from your job due to illness, the birth or adoption of a child, or to care for a seriously ill family member, you may be able to keep your group health plan for a limited time*. A federal law known as the **Family and Medical**

Leave Act (FMLA) guarantees you up to 12 weeks of job-protected leave in these circumstances.

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

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

If you decide not to return to work at the end of the leave period, your employer may require you to pay back the employer's share of the health insurance premium. However, if you don't return to work because of factors outside your control (such as a need to continue caring for a sick family member, or because your spouse is transferred to a job in a distant city), you will not have to repay the premium.

For more information about your rights under the FMLA, contact the **U.S. Department of Labor**.

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

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

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

- *Under group health plans, coverage for pre-existing conditions can generally be excluded for no longer than 12 months.* However, if you enroll late in a self-insured group health plan (after you are hired and not during a regular or special enrollment period), you may have an 18-month pre-existing condition exclusion period. Late enrollees in fully insured health plans can only be subject to a 12-month pre-existing condition exclusion period.

- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns or newly adopted children, children placed for adoption, or genetic information.*

- *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.

- *When you join a new group health plan, the law protects you from a new pre-existing condition exclusion period, provided you maintain continuous* ***creditable coverage****.* Coverage counts as continuous if it is not interrupted by a break of 63 or more days in a row.

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

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

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

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

What is continuous coverage?

You can get continuous coverage under one plan, or several plans, as long as you don't have a lapse of 63 or more days.

Art, who is diabetic, worked for the Ajax Company and was covered under its group health plan for 9 months. He lost his job and was without coverage for 45 days. Fortunately, on the 46th 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 care for diabetes but requires a pre-existing condition exclusion period. In New York, fully insured group health plans count as continuous all creditable coverage that is not interrupted by a lapse of 63 consecutive days or more. Therefore, because Art's lapse in coverage was less than 63 days, he will get credit for his coverage at Ajax. Beta's plan will begin paying for Art's diabetes care after 3 months (12-month exclusion period minus 9 months of creditable coverage).

Now consider a slightly different situation. Assume Art lacked coverage for 63 days between his jobs at Ajax and Beta. In this case, Art will not get credit for his prior coverage at Ajax because it was followed by a break of 63 days or more. Beta's plan will begin paying for Art's diabetes care at the end of the full 12-month exclusion period.

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

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

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

Question: Is this permitted?

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

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

Federal law permits state, county, and local governments to exempt their employees in self-insured group health plans from some of the protections discussed previously in this chapter. Public employers must make this choice annually. When they do so, they are required to notify the federal government and specify which health insurance protections will not apply to their employees' group health plan.

In the past, a large number of public employers in New York have decided that certain health insurance protections will not apply to their employees. The Center for Medicare and Medicaid Services (CMS) used to post a list of employers which had elected to exempt, however it has removed this information from its web site.

If you are not sure about your protections under your public employee health plan, you should contact your employer. In addition, you can contact CMS directly at (800) 267-2323 ext. 91565 or at (410) 786-1565 to see if your employer has elected to be exempt from certain protection.

AS YOU ARE LEAVING GROUP COVERAGE…

- *If you are leaving your job or otherwise losing access to your group health plan, you may be able to remain covered under the group health plan for a limited time.* In addition, you may have special protections when buying certain kinds of individual health insurance. See Chapter 3 for more information about COBRA continuation coverage, state continuation coverage, conversion, and individual health insurance for "HIPAA eligible individuals."

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group health plan, you may want to buy an individual health insurance policy from a private health insurer. New York has enacted extensive insurance reforms to guarantee residents access to this kind of insurance. There are some alternatives to individual health insurance – such as COBRA, state continuation coverage and conversion coverage. This chapter summarizes your protections under different kinds of health insurance coverage.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

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

In New York, your ability to buy individual health insurance does not depend on your health status.

- *Insurers that sell individual health insurance in New York are not permitted to turn you down because of your health status or other factors.*

- *In New York, insurers that sell individual health insurance offer family coverage to persons who are interested in purchasing it.* Some HMOs may also offer husband-wife policies and parent-child(ren) policies.

- *Under New York law, newborns, adopted children, and children placed for adoption must be covered under your health insurance policy for the first 30 days following birth and adoption, if the policy covers dependents.* The insurer may require that the parent enroll the child within 31 days in order to continue coverage beyond 31 days.

- *Under New York law, disabled adult children can remain on their parent's individual health insurance policy after reaching the age at which dependent coverage is usually terminated, if they meet certain requirements.* Conditions that would make your child eligible for this extension include: mental illness, developmental disability, mental retardation, or physical handicap. Your adult child must be incapable of self-sustaining employment by reason of the disability. Proof of incapacity must be furnished to the insurer within 31 days of the child reaching the age at which dependent coverage would normally end.

- *In New York, special protections apply if you have an adult child who is a full time student and who is covered under your individual health insurance policy.* If your child becomes ill and must take a leave of absence from school, then the policy must

allow your child to continue on your policy for up to one year. The rate the insurer charges you must be the same as if your adult child were still in school full time. The insurer is allowed to require that you provide it with certification from a physician to document the adult child's illness.

- *If you are HIPAA eligible, you are guaranteed the same right to purchase individual health insurance as other individuals.* However, private insurers cannot impose any pre-existing condition exclusion periods on the policy you purchase.

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible you are guaranteed the right to buy an individual health insurance policy and are exempted from pre-existing condition exclusion periods. In New York, where state law is more protective, you do not need to meet all of the requirements of HIPAA eligibility to have this protection. However, if you move out of New York, this information may be important to you.

To be HIPAA eligible, you must meet all of the following:

- You must have had 18 months of continuous creditable coverage*, at least the last day of which was under a group health plan*.
- You also must have used up any COBRA or state continuation coverage for which you were eligible.
- You must not be eligible for Medicare, Medicaid or a group health plan.
- You must not have health insurance. (Note, however, if you know your group coverage is about to end, you can apply for coverage for which you *will* be HIPAA eligible.)
- You must apply for health insurance for which you are HIPAA eligible within 63 days of losing your prior coverage.

HIPAA eligibility ends when you enroll in an individual policy, because the last day of your continuous health coverage must have been in a group plan. You can become HIPAA eligible again by maintaining continuous coverage and rejoining a group health plan.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *HMOs are required to offer a standardized policy to all consumers.* You may select either the HMO or the **point-of-service (POS)** versions of the policy. Both versions offer comprehensive coverage, including hospital and physician care, maternity care, preventive checkups and immunizations, and prescription drugs.

The HMO policy option requires you to seek care only from doctors and hospitals that contract with the HMO. For a hospital stay and some other services, you will have to pay a deductible up to $500 before the policy begins to pay. Most other services require a copayment, although some services do not require a copayment at all.

The POS policy option lets you decide whether to get care from providers in or out of the HMO network. When you get care in-network, your out-of-pocket costs will be smaller – the same as they are under the HMO option. If you go out of network, your out-of-pocket costs will be higher. The policy will only pay 80% of covered charges once you have paid a $1,000 deductible. You will have to pay the other 20%, plus any extra amount billed by the provider.

- *The New York Insurance Department issues a free guide called the New York Consumer Guide to Health Insurers which lists plan options and the companies selling them.* Please visit at: http://www.ins.state.ny.us/hginfo.htm.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you buy an individual health insurance policy, there are limits on pre-existing condition exclusion periods that can be imposed.* Pre-existing condition exclusion periods cannot exceed 12 months. Individual health insurers can look back 6 months to see if you actually received care or treatment for a condition.

- *In New York, pregnancy can be considered a pre-existing condition in individual health policies, but insurers can only exclude it from coverage for 10 months.* Genetic information cannot be considered a pre-existing condition.

- *In New York, individual health insurers are not allowed to impose* ***elimination riders****, which permanently exclude coverage for a health condition, body part, or body system.*

- *You will get credit for prior continuous coverage that was not interrupted by a break of 63 or more days in a row.* No pre-existing condition exclusion periods can be imposed on you if you are HIPAA eligible.

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

- *Premiums for individual health policies in New York cannot vary due to your age, gender, health status, or occupation.* This is called community rating. Premiums may vary depending on your family size, where you live in the state, and the type of policy you select. Check with the company for the most current premium rates.

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 you pay the premiums, do not defraud the company, and in the case of **managed care plan**, continue to live in the policy service area. However, guaranteed renewability does not protect you from having your premiums go up at renewal.

COBRA AND STATE CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

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

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

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

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

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

COBRA QUALIFYING EVENTS

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

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

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

- *Each person who is eligible for COBRA continuation can make his or her own decision.* If your dependents were covered under your employer plan, they may independently elect COBRA coverage as well.

- *You must be notified of your COBRA rights when you join the group health plan, and again if you qualify for COBRA coverage.* The notice rules are somewhat complicated and you should contact the U.S. Department of Labor for more information.

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

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

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

- *In New York, you can buy individual health insurance regardless of whether you used up your COBRA coverage.* Compare the options to see which is best for you.

If you are planning to move to another state, you may need to be HIPAA eligible to buy individual coverage. In this case, you may want to consider COBRA.

You will have to pay premiums dating back to this period.

SPECIAL SECOND CHANCE TO ELECT COBRA FOR TRADE-DISLOCATED WORKERS

- *A second COBRA election period may be available for TAA eligible people who did not elect COBRA when it was first offered*. The second election period can be exercised 60 days from the 1st day of TAA eligibility, but in no case later than 6 months following loss of coverage. Coverage elected during this second election begins retroactive to the beginning of the special election period – not back to qualifying event.
- *Certain people who lost their job-based health coverage because of the impact of imports on their employers have a limited second chance to elect COBRA*. People who are receiving benefits from the Trade Adjustment Assistance (TAA) Program are eligible for a federal income tax credit (the Health Coverage Tax Credit, or HCTC) that will pay 65% of their premiums.
- *For some laid off workers, TAA benefits begin after their 60-day period to elect COBRA continuation coverage has expired*. In this circumstance, TAA-eligible people have a second 60-day period, starting on the date of their TAA eligibility, to elect COBRA. (However, in no case can COBRA be elected more than 6-months following the original qualifying event (i.e. layoff) that caused the loss of group health plan coverage.)
- *When COBRA is elected during this special, second election period, coverage starts on the first date of the special election period*. Any time that has elapsed between the original qualifying event and the first date of the special election period is not counted as a lapse in coverage in determining continuous coverage history.

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

WHAT WILL COBRA COVER?

- *Your covered health benefits under COBRA will be the same as those you had before you qualified for COBRA.* For example, if you had coverage for medical, hospitalization, dental, vision, and prescription drug benefits before COBRA, you can continue coverage for all of these benefits under COBRA. If these benefits were covered under more than one plan (for example, a separate health insurance and

dental insurance plan) you can choose to continue coverage under any or all of the plans. Life insurance is not covered by COBRA.

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage.* The first premium must be paid within 45 days of electing COBRA coverage.

- *If you elect the 11-month disability extension, the premium will increase to 150% of the total cost of coverage.* See below for more information about the disability extension.

- *Certain dislocated workers who receive benefits under the Trade Adjustment Assistance (TAA) Program may be eligible for a federal income tax credit to help pay for COBRA or other qualifies coverage.* The tax credit will cover 65% of your premium (see page 31).

- *If you are a retiree aged 55-65 and receiving pension benefits from PBGC, 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) (see page 31).

HOW LONG DOES COBRA COVERAGE LAST?

- *COBRA coverage generally lasts up to 18 months and cannot be renewed.* However, certain disabled people can opt for coverage up to 29 months, and dependents are sometimes eligible for up to 36 months of COBRA continuation coverage, depending on their qualifying event (see box).

  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 within 60 days of that qualifying event. You must obtain this disability determination from the Social Security Administration, and you must notify your group health plan of this disability determination.

HOW LONG CAN COBRA COVERAGE LAST?

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

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

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

- *COBRA coverage also ends if your employer stops offering health benefits to other employees.*

- *COBRA coverage might end if you are in a managed care plan that is available only to people living in a limited geographic area and you move out of that area.* However, if you are eligible for COBRA and are moving out of your current health plan's service area, your employer must provide you with the opportunity to switch to a different plan, but only if the employer already offers other plans to its employees. 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 NEW YORK CONTINUATION COVERAGE?

- *If your employer offers health benefits, you may also be eligible for up to 18 to 36 months of continuation coverage under a New York law that is similar to COBRA.*

To qualify, you must apply for state continuation coverage within 60 days of losing your old coverage. Ask your former employer or the New York Insurance Department about state continuation coverage if you think it applies to you.

- *In New York, you can buy individual health insurance regardless of whether you used up your state continuation coverage.* Compare the options to see which is best for you. If you are planning to move to another state, you may need to be HIPAA eligible to buy individual coverage. In this case, you may want to consider continuation coverage.

CONVERSION

WHEN AM I ELIGIBLE FOR CONVERSION COVERAGE?

- *If you were covered under a fully insured group health plan and leave it, you may be able to buy a conversion policy.* This is an individual health policy from the insurance company that covered your former group. You can buy a conversion policy if you lost your group coverage because you left your job or because the group coverage was terminated. However, you must have been covered under your fully insured group health plan for at least 3 months, and you must apply for a conversion policy within 45 days after your group coverage was terminated.

- *You can buy a conversion policy either instead of or after you use up your COBRA or state continuation coverage.* You cannot buy a conversion policy if you have comparable coverage under another group or individual health policy.

WHAT WILL MY CONVERSION POLICY COVER?

- *Conversion policies are required to meet minimum standards set out in state regulations.* Even so, the benefits may be less generous than what you received under your former group coverage.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Your conversion policy cannot impose a new pre-existing condition exclusion period.* However, you might have to satisfy the unexpired portion of any pre-existing condition exclusion period from your former health plan.

WHAT CAN I BE CHARGED FOR MY CONVERSION POLICY?

- *Premiums for conversion health plans can vary depending on your class of risk, age, and the amount of coverage you purchase.* Contact the New York Department of Insurance if you have questions about conversion policy premiums.

HOW LONG DOES MY CONVERSION POLICY LAST?

- *Your policy cannot be canceled because you get sick.* This is called guaranteed renewability. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of managed care plans, continue to live in the plan service area.

CHAPTER 4
YOUR PROTECTIONS AS A SMALL EMPLOYER OR SELF-EMPLOYED PERSON

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. New York has enacted comprehensive reforms to expand small employer's access to health insurance and to limit premium variation due to health status. Generally, small employers are those that employ 2-50 employees. Check with the New York Insurance Department to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down.* This is called guaranteed issue. If you employ at least 2 but not more than 50 people, health insurance companies must sell you any **small group health plan** they sell to other small employers. HMOs cannot require that a minimum percentage of your eligible employees participate in your group health plan, but other insurers are allowed to set such requirements. If you are buying a **large group health plan** for 51 or more employees, your group can be turned down.

- *Small businesses with low-wage workers may be eligible to buy health insurance at reduced cost through a program called Healthy New York.* See Chapter 5 for more information about this program.

- *Your insurance cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions. However, they can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud.

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

- *Premiums for all health plans sold to small employers in New York are community rated.* That means your premium cannot vary due to the health status, claims experience, age, gender, or occupation of people in your group. Premiums may vary due to family size and geographic location.

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you may be eligible to buy a group health plan on your own (or you may be able to join another group health plan through a family member).* If you cannot find a carrier that sells group coverage to sole proprietors, you can buy an individual health insurance policy and be 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 an increasing percentage of the cost of your premium from your federal income tax.*

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of New York who cannot afford to buy health insurance. Medicaid, Child Health Plus, Family Health Plus, and Healthy New York offer subsidized health insurance coverage, direct medical services or other help at little or no cost to you.

In addition, the federal government, under 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 New York 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. Single individuals and childless couples may also be eligible if their income is below the cash assistance standard of need for their county of residence. Other legal residents who are not U.S. citizens may be eligible for Medicaid if they have emergency needs. Enrolling in Medicaid or Child Health Plus will not affect an immigrant family's ability to get a green card or become a citizen.

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

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

  Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account, so you should contact you local department of social services for more information.

Low-income persons eligible for Medicaid in New York*

Category	Income eligibility (as percent of federal poverty level)
Infant	200% (monthly income of about $2,612 for family of 3)
Child 1-5	133%
Child 6-18	100%
Parent	150%
Pregnant woman	200%

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

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

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

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

- *Continuous Medicaid coverage for children (up to the age of 19) is provided for 12 months following eligibility determination regardless of any changes in income or circumstances.*

- *Very poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits can also qualify for Medicaid.*

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

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

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

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

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

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

- *People who have high medical expenses may also qualify for Medicaid.* You may qualify as medically needy if you have high medical expenses that, when subtracted from your income, would make you eligible for Medicaid coverage. For example, people who have to pay a lot for prescription drugs, nursing home care, or other long term care services sometimes qualify as medically needy if they don't have health insurance that covers these services.

- *Retired or disabled people who have low-incomes and are enrolled in Medicare may also qualify for help from Medicaid.* Even though your income may be too high to qualify for Medicaid insurance coverage, there may be other ways Medicaid can help you.

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

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

  Contact your local department of social services for more information about other eligibility requirements.

- *There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify for Medicaid, contact the department of social services.

To obtain the locations and telephone number of an office near you, call the New York State Department of Health at (518) 486-9057, or visit the internet at www.health.state.ny.us/nysdoh/medicaid/main.htm.

CHILD HEALTH PLUS

Child Health Plus is a state-designed program that provides health coverage to low-income children under the age of 19 who are not eligible for Medicaid and who have limited or no health insurance. Child Health Plus is a managed care program which puts emphasis on preventive and primary care.

- *The Child Health Plus Program provides health insurance coverage for children under the age of 19, who are residents of New York State, and whose parents have low or moderate incomes.*

- *No child is denied eligibility based on disability.*

- *Eligibility is guaranteed for one year unless the child moves from the state, enrolls in Medicaid, or is found to have other insurance coverage.*

- *The Child Health Plus Program provides comprehensive coverage to enrollees including doctor's visits, hospital care, prescriptions, some mental health, dental vision and hearing services.*

- *Coverage is free to families with gross household income below 160% of the federal poverty level, and is available to families with higher income for a small premium.*

- *For more information on Child Health Plus, contact the New York Department of Health at (800) 698-4543.*

FAMILY HEALTH PLUS

New York Family Health Plus (FHP) is a state-designated program that provides health insurance to uninsured adults between 19 and 64 who are not eligible for Medicaid.

- *Family Health Plus is available to single adults, couples without children, and low-income parents.*

- *An individual who has an income up to 100% of the federal poverty level (FPL), or $9,800 annually, is eligible for Family Health Plus.* A family with children, which has an income up to 150% of the federal poverty level, is eligible for New York

Family Health Plus. For a family of three, this works out to an annual income of up to $24,900 or a gross monthly income of $2,075.

- *Additional eligibility requirements include residency of New York state and United States citizenship, with some exceptions for certain immigration categories.*

- *Family Health Plus program provides comprehensive coverage to enrollees including doctor's visits, hospital care, prescription drugs, vision and speech, diabetic supplies and treatment, and mental health services.*

- *Family Health Plus is free to individuals and families who qualify for eligibility.* There is no application cost and once enrolled there are no co-payments of deductibles.

- *For more information on Family Health Plus, please contact the New York Department of Health at 1-877-9FHPLUS (934-7587).*

HEALTHY NEW YORK

Healthy New York is a state sponsored plan designed to provide health insurance to uninsured workers and their families. The program offers streamlined health insurance coverage to individuals and small employers by offering standardized health insurance benefit packages that are offered by all HMOs.

- *Healthy New York offers benefits to small employers, sole proprietors, and uninsured working individuals*. Eligibility for Healthy New York varies depending on the applicant.

- *Small employers may be eligible if they employ 50 or fewer employees, at least 30% earn $32,000 a year or less, has not offered health insurance during the past 12 months, at least 50% of employee participate in the plan (at least one participant must earn $34,000 a year or less), and the business must be located in New York state*. Additionally, the employer and the employee must equally share the cost of the premiums

- *Individuals and sole proprietors may be eligible if they work for an employer that does not provides health insurance, they earn no more than 250% of the federal poverty level*. For a family of 3, this works out to an annual income of $41,500 or a gross monthly income of $3,458. Additionally, the individual must have been uninsured for the last 12 months or have lost coverage due to a qualifying event, including loss of employment, death of a family member, change of residence, change of employer, divorce, or loss of eligibility of health coverage.

- *Healthy New York offers two standard benefits packages, one with limited prescription drug coverage and one without*. The benefit plan covers doctor's visits, hospital care, maternity, adult preventative care, diabetic supplies and equipment, x-rays and lab services, and emergency care. Enrollees are required to obtain services from within the network and are responsible for co-payments.

- *The cost of coverage varies depending on where you live and the type of coverage you elect*. To find out more about costs, please visit the Healthy New York web site at: http://www.ins.state.ny.us/website2/hny/english/hny.htm .

- To request an application or for additional information, you may contact Healthy New York at 1-866-HEALTHY NY (866-432-5849).

CANCER SERVICES PROGRAM PARTNERSHIP

- *The Cancer Services Program Partnership is a program which provides breast and cervical cancer screening and diagnosis services to low income, uninsured or underinsured women who are at risk for developing breast or cervical cancer.*

- *To be eligible you must earn less than 250% of the federal poverty level, and who are uninsured or whose insurance does not cover cervical and breast cancer screening and diagnosis.*

- *If you're a woman screened through the Cancer Services Program and diagnosed with breast or cervical cancer, you may be eligible for treatment though the duration of your cancer treatment.* In addition, Medicaid will cover all of your medical needs, including treatment for non-cancer related clinical needs.

- *For more information please visit the New York State Department of Health web site at: http://www.health.state.ny.us/nysdoh/cancer/center/partnerships.htm.*

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 employer-sponsored coverage and must be included as such to determine 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 PREMIUM WILL THE TAX CREDIT COVER?

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

WHAT HEALTH COVERAGE IS ELIGIBLE FOR THE TAX CREDIT?

- *The HCTC can only be used to help pay for "qualified" health coverage.* Qualified health coverage includes:
- *COBRA continuation coverage, as long as your employer or former employer contributes less than 50% of the total health plan premium.*
- *Individual heath insurance in which you were enrolled for at least the last 30 days before you were separated from the job that makes you eligible for TAA benefits or for payments from the PBGC.*
- *State qualified plans: currently, New York State has designated several plans as qualified health plans.* All HMOs offer two standardized plans that are qualified health plans, one being a standard HMO option and the other being a POS plan. Additionally, HCTC Healthy New York has been designated as a qualified plan. HCTC Healthy New York is available to all individuals who are eligible for HCTC. Healthy New York plans are also designated plans.
- *Your spouse'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/ (click on HCTC).*

- *For more information about TAA benefits contact, http://www.doleta.gov/tradeact/*

- *For more information about PBGC, contact, http://www.pbgc.gov or call 1-202-326-4000 with general inquiries.*

FOR MORE INFORMATION…

As a summary, this guide will not answer every question for every person in every circumstance. In addition, it is not a substitute for legal advice. If you have more questions, contact the agencies listed below or consult an attorney.

For questions about:	Contact:
Individual health insurance Fully insured group health plan	*New York Insurance Department* (800) 342-3736 (212) 480-6400 (New York City) (516) 221-8064 (Long Island) (518) 474-6600 (Albany) (716) 847-7619 (Buffalo) http://www.ins.state.ny.us
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	*U.S. Department of Labor* *Employee Benefits Administrator* *Employee & Employer Assistance Hotline and Publications* (866) 444-EBSA (3272) http://www.dol.gov/ebsa
Medicaid	*New York Department of Health* (518) 486-9057 http://www.health.state.ny.us
Child Health Plus	*New York Department of Health* (800) 698-4543 http://www.health.state.ny.us
Family Health Plus	*New York Department of Health* 1-877-9FHPLUS (934-7587). http://www.health.state.ny.us
Healthy New York	1-866-HEALTHY NY (866-432-5849) http://www.ins.state.ny.us/website2/hny/english/hny.htm
The Federal Health Coverage Tax Credit (HTCT)	*Internal Revenue Service (IRS)* (866) 638-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

Last Reviewed January 2006

HELPFUL TERMS

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.

Affiliation Period. The time an HMO may require you to wait after you enroll and before your coverage begins. HMOs that require an affiliation period cannot exclude coverage of pre-existing conditions. Premiums cannot be charged during HMO affiliation periods. See also HMO.

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.

Child Health Plus. New York's Child Health Plus program provides insurance for children under the age of 19 who are not eligible for Medicaid and who have limited or no health insurance.

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

Community Rating. A rule that prohibits health plan premiums in New York from varying based on your age, gender, health status, or occupation. Small group health plan premiums and individual health insurance premiums are subject to community rating.

Continuous Coverage. If you are joining a self-insured group health plan or if you want to be HIPAA eligible, health insurance coverage is continuous if it is not interrupted by a break of 63 or more consecutive days. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. See also Creditable Coverage, HIPAA Eligible, Fully Insured Group Health Plan, Individual Health Insurance, Self-Insured Group Health Plan.

Conversion. Your right, when leaving a group health plan in New York, to convert your policy to an individual health policy. You must have been insured under your previous coverage for at least 3 months to be eligible for conversion coverage. Conversion policies must offer 3 coverage options. The insurance company may charge you premiums based on your class of risk, age, and amount of insurance provided. See also Group Health Plan.

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

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.

Elimination Rider. An amendment permitted in health plan contracts in some states that permanently excludes your coverage for a health condition, body part, or body system. Elimination riders are not permitted in New York.

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

Fully Insured Group Health Plan. Health plan purchased by an employer from an insurance company. Fully insured health plans are regulated by New York. 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) that covers at least 2 employees. See also Fully Insured Group Health Plan, Self-Insured Group Health Plan.

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All health plans sold to individuals and small employers with 2 to 50 employees in New York are guaranteed issue. Plans that are guaranteed issue can turn you away for other reasons.

Guaranteed Renewability. A feature in health plans that means your coverage cannot be canceled because you get sick. HIPAA requires all health plans to be guaranteed renewable. The precise definition of guaranteed renewable may vary based on what type of insurance you have. 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 Plan Year. That calendar period during which your health plan coverage is in effect. Many group health plan years begin on January 1, while others begin in a different month.

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

Healthy New York. Healthy New York is a state sponsored arrangement that provides insurance to small groups, sole proprietors and uninsured working individuals. The arrangement is intended to provide access to health insurance to working individuals who otherwise would not have access.

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

HIPAA Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. No matter where you live in the U.S., if you are HIPAA eligible you must be offered at least some type of individual health policy with no pre-existing condition periods. In New York, you do not need to meet all the requirements of HIPAA eligibility to have this protection. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

HMO. Health maintenance organization. A kind of health insurance policy. HMOs usually limit coverage to care from doctors who work for or contract with the HMO. They generally do not require deductibles, but often do charge a small fee, called a copayment, for services like doctor visits or prescriptions. HMOs in the individual market in New York must offer a point of service (POS) option, which permits you to get care from providers outside the HMO network. You will pay a greater share of charges when you get care under the POS option. If you are covered under an HMO, the HMO might require an affiliation period before coverage begins. See also Affiliation Period, Point-of-Service (POS).

Individual Health Insurance. Plans for people not connected to an employer group. Individual health policies are regulated by New York.

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

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

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

Managed Care Plan. A kind of health insurance plan. Like an HMO, managed care plans can limit coverage to health care provided by doctors or hospitals who work for or contract with them -- also called "network: providers, and therefore may limit enrollment to those people who live within a particular coverage area. Managed care plans may 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 with a referral. See also HMO.

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

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

Pension Benefit Guaranty Corporation (PBGC). PBGC is a federal government corporation established by Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) to encourage the continuation and maintenance of defined benefit pension plans, provide timely and uninterrupted payment of pension benefits to participants and beneficiaries in plans covered by PBGC. It currently guarantees payment of basic pension benefits earned by American workers and retirees participating in private-sector defined 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.

Point-of-Service (POS). A type of managed care plan that lets you decide whether to get care from providers in or out of the HMO network. When you get care in-network, your out-of-pocket costs will be less than if you get care outside of the network. See also HMO.

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

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

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

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

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

State Continuation Coverage. A program similar to COBRA. In New York, if you are in a fully insured group health plan sponsored by an employer with 2 to 19 employees and meet other requirements, you also have rights to continue your health coverage for up to 18 months when your job ends. In some cases dependents can continue coverage for up to 36 months. See also COBRA.

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

Temporary Assistance for Needy Families (TANF). A program (also known as 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.

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.