

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

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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 CONNECTICUT

As a Connecticut 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 Connecticut resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group health plans and individual health insurance. Chapter 4 highlights your protections as a small employer or self-employed person. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from Connecticut, 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 34. For information about how to find consumer guides for other states on the Internet, see page 35. A list of helpful terms and their definitions begins on page 36. These terms are in **boldface type** the first time they appear.

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CHAPTER 1

A SUMMARY OF YOUR PROTECTIONS

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

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

HOW AM I PROTECTED?

In Connecticut, 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 Connecticut 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 8 and 14).*
- *Your coverage cannot be canceled because you get sick. This is called **guaranteed renewability** (see pages 15 and 22).*

- *If you leave your job, you may be able to remain in your old group health plan for a certain length of time. This is called **COBRA** or **state continuation coverage**. For example, it can help when you are between jobs or when you retire early and are not yet eligible for Medicare. There are limits to what you can be charged for this coverage (see page 15).*
- *If you lose your group health plan and meet other qualifications, you will be **HIPAA eligible**. If so, you can buy individual health insurance from the **Connecticut Health Reinsurance Association (HRA)**. You will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for a HRA policy (see page 22)*
- *If are not HIPAA eligible and you lose coverage under a fully insured group health plan in Connecticut, you may be able to buy an individual health insurance policy from **HRA** or a **conversion** policy from your prior group insurer. You will not face a new pre-existing condition exclusion period. There are limits to what you can be charged for a HRA policy but not for a conversion policy (see pages 20 and 24).*
- *You can also buy insurance from HRA if you are a Connecticut resident over the age of 19 and under the age of 65. In this case you may face a new pre-existing condition exclusion period (see page 23).*
- *If you are a small employer buying a group health insurance policy for 1-50 employees, 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 be sold on a **guaranteed issue basis** (see page 25).*
- *If you are a small employer buying a group health insurance policy, you cannot be charged more due to the health status of those in your group. You can, however, be charged higher premiums, within limits, because of the age, gender, industry and location of those in your group and group size. This is called **adjusted community rating** (see page 25).*
- *If you have low or modest household income, you may be eligible for free or subsidized health insurance coverage for yourself or members of your family. The Connecticut **Medicaid** program offers free health or subsidized coverage for pregnant women, families with children, medically needy, and elderly and disabled individuals with very low incomes (see Chapter 5).*

- *If you have low or modest household income, but are not eligible for Medicaid, your children may be eligible for free or low cost health insurance through the **Healthcare for Uninsured Kids (HUSKY)** program (see page 29).*
- *If you believe that you have or are at risk for breast or cervical cancer, you may be eligible for free screening and treatment. **The Breast and Cervical Early Detection Program** provides qualified women with free breast and cervical cancer screening. In addition, women who have been diagnosed with breast or cervical cancer may be eligible for health care coverage through Medicaid (see page 30).*
- *If you have lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program** then you may be eligible for a federal income tax credit to help pay for new health coverage. This credit is called the **Health Care Tax Credit (HCTC)**, and it is equal to 65% of the cost of qualified coverage, including COBRA, state continuation coverage, and coverage through the Connecticut Health Reinsurance Association (HRA) (see page 31).*
- *If you are a retiree aged 55-65 and are receiving pension benefits from **Pension Benefit Guarantee Corporation (PBGC)**, then you may also be eligible for the HCTC (see page 31).*

WHAT ARE THE LIMITS ON MY PROTECTIONS?

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

- *If you change jobs, you usually cannot take your old health benefits with you. Except when you exercise your federal COBRA or state continuation rights, you are not entitled to take your group health coverage with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did (see page 6).*
- *If you change jobs, your new employer may not offer you health benefits. Employers are required only to make sure that their decision is based on factors unrelated to your health status (see page 6).*
- *If you get a new job with health benefits, your coverage may not start right away. Employers can require **waiting periods** before your health benefits begin. **HMOs** can require **affiliation periods** (see page 7).*

- *If you have a break in coverage of 63 days or more, you may have to satisfy a new pre-existing condition exclusion period when you join a new group health plan (see page 9).*
- *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 six months or one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition (see page 10).*
- *If you work for certain non-federal public employers in Connecticut, not all of the group health plan protections may apply to you (see page 11).*
- *In Connecticut, your access to individual health insurance may depend on your **health status**. Individual insurers in Connecticut are not prohibited from turning you down or limiting your coverage because of your pre-existing conditions (see page 14).*
- *If you have an expensive health condition, your individual health insurance premiums may be very high. The law doesn't prohibit Connecticut health insurers from charging you more because of your health status, age, gender, family size, where you live, and the type of policy that you buy (see page 15).*
- *If you are **HIPAA eligible**, or if you are a Connecticut resident over age 19 and under the age of 65, the **Connecticut Health Reinsurance Association (HRA)** is your only guaranteed access to an individual health insurance policy (see page 22).*
- *If you purchase HRA coverage and are not HIPAA eligible, you will face a pre-existing condition exclusion period (see page 23).*

CHAPTER 2

YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

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

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

- *In general, you have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees. Or, your employer may offer an HMO plan that you cannot join because you live outside of the plan's service area.
- *You cannot be turned away or charged more because of your health status.* Health status means your medical condition or history, **genetic information** or disability. This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (such as part time employment), as long as these are unrelated to health status and applied consistently. However, if you work for a small employer in Connecticut, insurance companies must offer coverage to all eligible employees.

Discrimination due to health status is not permitted

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

- *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 loss because of death, divorce, legal separation, termination, retirement, or reduction in hours worked)
- *Under Connecticut law, newborns and adopted children are automatically covered under the parents' fully insured health plan, if your plan provides dependent coverage.* The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.
 - *If you have a disabled child, that child may remain covered under your fully insured group health plan after he or she reaches the age at which dependent coverage is usually terminated.* To qualify, your adult son or daughter must be incapable of self-support because of mental retardation or physical disability and must be chiefly dependent on the policyholder for support. 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 health coverage.* These waiting periods, however, must be applied consistently and cannot vary due to your health status. You will not have health insurance coverage during this time.
 - *When you begin a new job with health insurance through an HMO, the HMO may require an **affiliation period** before coverage begins.* During this affiliation period, you will not have health insurance coverage. The HMO also cannot impose any pre-existing condition exclusions if it imposes an affiliation period. An HMO affiliation period cannot exceed 2 months (3 months for late enrollees), and you cannot be charged a premium during this time.

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

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

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

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

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

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

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

- *A group health plan can as apply a pre-existing condition exclusion period only to those conditions 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. The plan cannot count as diagnosis, treatment or medical advice routine follow-up care to determine if breast cancer has reoccurred in a person who is breast cancer free unless evidence of breast cancer is found as a result of the follow-up. This period is also called the look back period.*

- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns or newly adopted children, children placed for adoption, or **genetic information**.*
- *Group health plans can only exclude covering for pre-existing conditions for a limited time. The maximum period is 12 months if you are in a group health plan. However, if you enroll late in a group health plan (after you were hired and not during a regular or special enrollment period) you may have a pre-existing condition exclusion period of up to 18 months.*
- *Group plans that imposed pre-existing condition exclusion periods must give you credit for any previous continuous **creditable coverage** that you've had. Most types of private and government sponsored health coverage is considered creditable coverage.*
- *Determining if coverage is continuous, depends on the type of plan you are joining. For fully-insured group health plans, coverage counts as continuous if it is not interrupted by a break of 120 or more days in a row. This is true unless you have involuntarily lost your job, in which case the prior coverage counts as continuous if it is not interrupted by a break of 150 or more days in a row. For self-insured group health plans, 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	Medicare
Federal Employees Health Benefits (FEHBP)	Military health coverage
Foreign National Coverage	(CHAMPUS, TRICARE)
Group health plan (including COBRA)	State high-risk pools
Indian Health Service	Student health insurance
Individual health insurance	VA coverage
Medicaid	

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

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

What is continuous coverage?

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

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

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

- *Your protections may differ if you move to a self-insured group health plan that offers more benefits than your old one did.* Self-insured plans can look back to determine whether your previous health plan covered prescription drugs, mental health, substance abuse, dental care, or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new group health plan may impose a pre-existing condition exclusion period for that category.

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

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

Question: Is this permitted?

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

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

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

Federal law permits state, county, and local governments to exempt their employees in self-insured 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 Connecticut have decided that certain health insurance protections will not apply to their employees. The Center for Medicare and Medicaid Services (CMS) used to post a list of employers which had elected to exempt, however it has removed this information from its web site.

If you are not sure about your protections under your public employee health plan, you should contact your employer. In addition, you can contact CMS directly at (877) 267-2323 ext. 61565 or at (410) 786-1565 to see if your employer has elected to be exempt from certain protection.

AS YOU ARE LEAVING GROUP COVERAGE...

- *If you are leaving your job or otherwise losing access to your group health coverage, you may be able to remain covered under the group health plan for a limited time. In addition, you may have special protections when buying certain kinds of individual health insurance coverage. See Chapter 3 for more information about COBRA and state continuation coverage, conversion, and the Connecticut Health Reinsurance Association.*
- *If you have lost your group health coverage 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, state continuation coverage, and coverage through the Connecticut Health Reinsurance Association (HRA) (see page 31).*
- *If you are a retiree aged 55-65 and are receiving pension benefits from the Pension Benefit Guaranty Corporation, you may also be eligible for the HCTC (see page 31).*

CHAPTER 3

YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group insurance, you may want to buy an individual health insurance policy from a private health insurance company. However, in Connecticut – as in most other states – you have limited guaranteed access to individual health insurance in the private market. There also are some alternatives to individual health insurance coverage – such as COBRA coverage, conversion, and coverage through the Connecticut Health Reinsurance Association (HRA). This chapter summarizes your protections under different kinds of health plan coverage.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

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

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

- *In general, insurers that sell individual health insurance policies in Connecticut are free to turn you down because of your health status and other factors. When applying for an individual health insurance policy, you may be asked questions about health conditions you have now or had in the past. Depending on your health status, insurers might refuse to sell you coverage or offer to sell you a policy that has special limitations on what it covers.*
- *You may be eligible to buy an individual policy through the Connecticut Health Reinsurance Association (HRA), the state's high risk pool, if you are a resident and over the age of 19 and under the age of 65 (see page 22).*
- *In Connecticut, newborns and adopted children are automatically covered under the parents' fully insured health plan for the first 31 days, if the plan covers dependents. The insurer may require the parent to enroll the child within the 31 days in order to continue coverage beyond the 31 days.*

- *If you have a disable child, that child may remain covered under your individual health insurance policy after he or she reaches the age at which dependent coverage is usually terminated. To qualify, your son or daughter must be incapable of self-support because of mental retardation or physical disability and must be chiefly dependent on the policy holder for support. Proof of incapacity must be furnished within 31 days of reaching the time limit and may be required periodically thereafter.*

WHAT WILL MY INDIVIDUAL HEALTH POLICY COVER?

- *It depends on what you buy. Connecticut does not require individual health insurers in the individual market to sell standardized policies. Insurers can design different policies and you will have to read and compare them carefully. However, Connecticut does require all health plans to cover certain benefits — such as prostate cancer screening and diabetes testing and treatment. Check with the Connecticut Department of Insurance for more information about mandated benefits.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Individual health insurers can impose **elimination riders**. This is an amendment to your health insurance policy that permanently excludes coverage for a health condition or even an entire body part or system.*
- *Individual insurers can also impose **pre-existing condition exclusion period**. Pre-existing condition exclusion periods cannot exceed 12 months. A pre-existing condition exclusion period are only those conditions for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 12 months immediately before you joined the plan. This is called the objective standard. In Connecticut, pregnancy and genetic information cannot be considered a pre-existing condition in individual health insurance policies.*

If a 12-month exclusion period is applied, you can get credit for any prior continuous creditable coverage you have had as long as you have not had a gap of 120 days or more between your old and new coverage.

- *If you make a claim during the first two years of coverage, the insurer can look back 12 months from the time of your application to see if the claim is for a condition that would have been considered a pre-existing condition. If the insurer determines, using the objective standard, that the condition is a pre-existing condition, it can refuse to pay for expenses for that condition.*

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

- *If you have an expensive health condition, your individual health insurance premiums may be very high. The law doesn't prohibit Connecticut health insurers from charging you more because of your health status and other factors, such as your age and gender.*

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELED?

- *Your coverage cannot be canceled if you get sick. This is called **guaranteed renewability**. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of managed care plans, continue to live in a managed care plan's service area. However, your health coverage may be canceled if the insurer discontinues your health policy or withdraws from the individual market.*
- *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 apply for a new contract. 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 and/or state continuation coverage. The information presented below was taken from publications prepared by the U.S. Department of Labor. You should contact the department for more information about your rights under COBRA.

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

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

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

Finally, you must have a qualifying event that would cause you to lose your group health 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 eligible for COBRA continuation can make his/her own decision.* If your dependents were covered under your employer plan, they may independently elect COBRA coverage as well.
- *You must be notified of your COBRA rights when you join the group health plan, and again if you qualify for COBRA coverage.* The notice rules are somewhat complicated and you should contact the U.S. Department of Labor for more information.

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

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

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

SPECIAL SECOND CHANCE TO ELECT COBRA FOR TRADE-DISLOCATED WORKERS

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

WHAT WILL COBRA COVER?

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

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

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage. The first premium must be paid within 45 days of electing COBRA coverage.*
- *If you elect the 11-month disability extension, the premium will increase to 150% of the total cost of coverage. See below for more information about the disability extension.*
- *If you have lost your group health coverage 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 state continuation coverage or coverage through the Connecticut Health Reinsurance Association (HRA) (see page 31).*
- *If you are a retiree aged 55-65 and are receiving pension benefits from PBGC, and are receiving benefits from the Trade Adjustment Assistance (TAA) Program, then you may be eligible for a federal income tax credit to help pay for new health coverage. This credit is called the Health Care Tax Credit (HCTC) (see page 31).*

HOW LONG DOES COBRA COVERAGE LAST?

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

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

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

- *COBRA coverage might end if you are in a managed care plan that is available only to people living in a limited geographic area and you move out of that area. However, if you are eligible for COBRA and are moving out of your current health plan's service area, your employer must provide you with the opportunity to switch to a different plan, but only if the employer already offers other plans to its employees. Some examples of the other plans your employer may offer you are a managed care plan whose service area includes the area you are moving to, or another plan that does not have a limited service area.*
- *In Connecticut, you can buy coverage through the Connecticut Health Reinsurance Association regardless of whether you used up your COBRA continuation coverage. Compare the options to see which is best for you. However, if you are planning to move to another state, you may need to be HIPAA eligible to buy individual coverage. If so, you may want to consider COBRA.*

WHAT ABOUT CONNECTICUT CONTINUATION COVERAGE?

- *If your employer offers fully insured health benefits, including employer groups of less than 20, you may be eligible for continuation coverage under a Connecticut law that is similar to COBRA. If you are eligible, you must apply in writing and pay within a 60 days period following the termination of your group policy. Ask your former employer or the Connecticut Department of Insurance about state continuation coverage if you think it applies to you.*

CONVERSION POLICIES

WHEN AM I ELIGIBLE FOR A CONVERSION POLICY?

- *In Connecticut, if you were covered under a fully insured group health plan and you leave that plan, you may be able to buy a conversion policy. This is an individual health policy sold through the Connecticut Health Reinsurance Association (HRA). In addition, your former group insurer may offer a non-HRA conversion policy besides the one offered through the HRA.*
- *To qualify for a conversion policy, you must have lost group health insurance that you had been covered under for at least 12 months. In addition, you must not be covered under another comparable group health plan or individual health insurance policy.*

- *You must elect conversion within 120 days, in the case of voluntary termination of employment, or 150 days, in the case of involuntary termination of employment.*
- *You do not have to elect COBRA continuation coverage or state continuation coverage before you are allowed to buy a conversion policy. However, if you decide to purchase a conversion policy, you will no longer be considered HIPAA eligible.*

WHAT WILL MY CONVERSION POLICY COVER?

- *HRA offers a choice of three plans comparable to plans offered to small employers: HMO coverage, PPO coverage (in-network and out-of-network options) and a Special Health Care Plan. The benefits covered are generally the same under each plan, but the Special Health Care Plan does not cover outpatient prescription drugs. Plans also differ with respect to deductibles and other coinsurance requirements. All eligible family members must be covered.*
- *Non-HRA conversion policies must meet certain minimum benefit requirements, which may not be the same as those under your former plan. In addition, these conversion policies may not include important state mandated benefits that are otherwise required in HRA conversion policies.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

HOW MUCH CAN I BE CHARGED FOR A CONVERSION POLICY?

- *There are limits on what you can be charged for HRA conversion policy. Generally, the premium rates are 25% to 50% higher than the average rate of certain employer group premiums in Connecticut. For a male below the age of 30, for example, the HRA HMO plan monthly premium would be \$311.97. For a 60 year old male, on the other hand, the rate would be \$1,355.01. There might be different rates for the Special Health Care Plan depending on your income. Contact the Connecticut Health Reinsurance Association for more information about premiums.*

- *There is no limit on what your insurer can charge for a non-HRA conversion policy. Premiums are determined based on the age and classification of risk of each person applying for a converted policy. These policies are often more expensive than your prior group coverage.*

CAN A CONVERSION POLICY BE CANCELED?

- *You can remain enrolled as long as you pay your premium and continue to meet eligibility requirements.*

CONNECTICUT HEALTH REINSURANCE ASSOCIATION (HRA)

Connecticut maintains a high risk pool, called the Connecticut Health Reinsurance Association or HRA. HRA provides insurance coverage for all residents of Connecticut who meet certain requirements.

WHEN CAN I GET COVERAGE FROM HRA?

- *If you are a resident of Connecticut and over the age of 19 and under the age of 65 you can buy a policy) from HRA. HRA does offer dependent coverage to spouses and children, up to the age of 19, or up to the age of 23 if a full time student.*
- *If you are HIPAA eligible, you are eligible for coverage from HRA.*

If you move out of Connecticut, this information may be important to you.

To be HIPAA eligible, you must meet certain criteria:

- 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.
- You must apply for health insurance for which you are HIPAA eligible within 63 days of losing your prior coverage.

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

- *If you are not HIPAA eligible but losing group coverage, you may be eligible for a group conversion policy from HRA (see page 20).*
- *If you are eligible for the Federal Health Coverage Tax Credit, then you are eligible for coverage from HRA (see page 31).*

WHAT WILL HRA COVER?

- *All eligible individuals are eligible for a PPO policy.*

The individual PPO and the portability PPO policies both have an annual deductible of \$1,500 for an individual in-network and \$3,000 for a family in-network. After the deductible is met, HRA pays 80% of the claims until your out-of-pocket limit for the policy is met. The out-of-pocket is \$7,500 for an individual in-network and \$15,000 for a family in-network. HRA pays 100% for most covered services once the annual deductible has been met.

- *Individuals who are HIPAA eligible, TAA eligible or eligible for a HRA-conversion policy can also choose an HMO policy.* These policies do not have an annual deductible. Most services are subject to a \$25 co-pay. In-patient hospital services are subject to a \$250 per day co-pay. There is a \$5,000 individual out-of-pocket limit and a \$10,000 family out-of-pocket limit.
- *The Special Health Care Plan is available for people who meet certain financial requirements.* If you are eligible for this policy, you will be responsible for a deductible and may be responsible for some out-of-pocket expenses.
- *HRA plans are comprehensive.* These plans all covers hospital and physician care, well-child care, maternity care, and other services. Out-patient prescription drugs are covered the PPO and HMO policies, but not under the Special Health Care Plan. All covered benefits are subject to a lifetime maximum of \$1,000,000.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION

- *If you are eligible for a HRA plan because you are HIPAA eligible, TAA eligible or eligible for a HRA-conversion policy, you will not be subject to a pre-existing condition exclusion when you enroll in a HRA plan.*

Otherwise, all other eligible individuals will have a 12-month pre-existing condition exclusion period when you first enroll in HRA. When you enroll, HRA will look back to see if you had a condition during the 6 months immediately before the date of enrollment. Pregnancy can be considered a pre-existing condition, but not genetic information.

WHAT CAN I BE CHARGE FOR HRA COVERAGE?

- *Premiums will vary based on the plan you choose.* In addition, HRA charges enrollees different rates based on their age and gender. The premium rates are 25% to 50% higher than the average rate of certain group premiums in Connecticut.

The monthly HRA premium for a 24-year old man ranges from \$250 to \$322, depending on which plan option is selected; and the monthly premium for a 64-year old many ranges from \$1087 and \$1402, depending on which plan is selected.

Reduced premiums are available to low-income persons who choose the Special Health Care Plan (see Chapter 5).

HOW LONG DOES HRA COVERAGE LAST?

- *HRA plans are renewable as long as you pay your premiums, continue to be a resident of Connecticut, and meet other eligibility requirements.*

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. Connecticut has enacted reforms to expand some of these protections. Some of these reforms apply to groups of different sizes. Generally, small employers are those that employ 1-50 employees. Please note that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Connecticut Department of Insurance to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down.* This is called guaranteed issue. If you employ not more than 50 people, health insurance companies must sell you any **small group health insurance policy** they sell to other small employers. However, they can require that a minimum percentage of your workers participate in your group health plan. They can also require you to contribute a minimum percentage of your workers' premiums. If you are buying a **large group health insurance 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 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?

- *If you are a small group as defined under Connecticut law, you cannot be charged higher premiums because someone in your group is seriously ill.* You can, however, be charged somewhat more due to the age, gender and family size of those in your group, the type and size of your business and where your business is located. This is called adjusted community rating.

- *For groups with more than 50 employees, Connecticut does not limit premium variations when coverage is first issued or renewed.*

WHAT PLAN CHOICES DO I HAVE?

- *Insurance companies must offer small employers, size 1 to 50 people, standardized “Blue Ribbon” health insurance policies. Carriers must also make available to you any non-standardized plans that they offer.*

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are eligible to buy the Basic Small Employer Health Plan. For more information about the Basic Employer Health Plan, contact the Connecticut Insurance Department, Life and Health Division at (800) 297-3800.*
- *Insurance companies are allowed to require proof that you are self-employed or a business group of one.*
- *If you are self-employed and buy your own health insurance, you may be eligible to deduct 100% of the cost of your premium from your federal income tax.*

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Connecticut who cannot afford to buy health insurance. Medicaid, which includes the Healthcare for Uninsured Kids and Youth (HUSKY), and other programs offer free health insurance coverage, direct medical services or other help. In addition, the federal government, under the Trade Adjustment Assistance (TAA) program, provides tax credits to some workers who lose their jobs or whose work hours and wages are reduced as a result of increased imports. This chapter provides summary information about these programs and contact information for further assistance.

MEDICAID

Medicaid is a program that provides health coverage to some low-income Connecticut residents. Medicaid covers families with children and pregnant women, medically needy individuals, the elderly, and people with disabilities, if state and federal guidelines are met. Legal residents who are not U.S. citizens may be eligible for Medicaid. Non-citizens who do not have immigration documents cannot enroll in Medicaid.

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

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

Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account, so you should contact the Medical Assistance Program of the Connecticut Department of Social Services

Low income persons eligible for Medicaid in Connecticut*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Child to age 19	185% (monthly income of about \$2,559 for family of 3)
Pregnant woman	185%
Parents	
working	157%
non-working	150%
Medically needy	
Individual	80%
Couple	76%

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

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

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

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

So, for example, using this guideline, 185% of the federal poverty level for a family of 3 would be an annual income of \$30,710, or a monthly income of \$2,559.

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

- *Parents who receive benefits under TANF (also called Jobs First in Connecticut) should also know that when you get a job and your TANF benefits end, you generally can stay on Medicaid for a 12-month transitional period.*

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

- *Poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits are automatically eligible for Medicaid.*

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

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

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

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

Contact your Medical Assistance Program of the Connecticut 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 Medical Assistance Programs of the Connecticut Department of Social Services.

HEALTHCARE FOR UNINSURED KIDS AND YOUTH (HUSKY)

HUSKY (Healthcare for Uninsured Kids and Youth) is Connecticut's public health insurance program for children and teenagers under 19.

- *Eligibility for the HUSKY program is based only on age, residency and health insurance status, not income.* If you have children under the age of 19 living in Connecticut, they might be eligible for the HUSKY program. Generally, the HUSKY program is intended for children who don't have health insurance but there are many exceptions. Even if your child has health insurance, you should call the HUSKY program to find out if they are eligible for the HUSKY program.
- *Coverage through the HUSKY program is considered comprehensive.* If eligible, your child will be covered for most medical services through a managed care plan
- *There may be some costs associated with HUSKY coverage.* Coverage through the HUSKY program is either free or low cost depending on your family income and family size
- *To find out if more information regarding the HUSKY program, please call (877)-CT-HUSKY (877)284-8759).*

BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM

- *The Breast and Cervical Cancer Program provides free screening and diagnostic services for qualified women.*
- *In order to be eligible for the screening and diagnostic services, you must be 40 or older and have either no health insurance or have a health insurance which doesn't cover diagnostic services.* There are, however, exceptions to the age requirement: mammograms are available for younger women age 35-39 with symptoms and/or specific risk factors for breast cancer. In addition, some women aged 19 or older may qualify for Pap tests.
- *If you are diagnosed with breast and/or cervical cancer through the screening program, you may be eligible for free health coverage through the Medicaid program.* If eligible, Medicaid will cover all your medical costs.
- *For more information, please contact the Connecticut State Department of Public Health – Breast and Cervical Cancer Early Detection program, at (860) 509-7804. For a list of screening locations, please visit http://www.dph.state.ct.us/BCH/HEI/bccedp_program_locations.htm.*

HRA LOW-INCOME PREMIUM SUBSIDY

- *If your income is below 200% of the Federal Poverty Level (\$19,600 for an individual) you may be eligible for reduced premiums and cost sharing. Low-income subsidies are only available for the Special Health Care Plan (see page 22).*
- *Premiums will vary based on based on age and gender. The monthly Special Health Care Plan Low-Income Premium for a 24-year old man is \$149.*

The monthly HRA premium for a 24-year old man ranges from \$250 to \$322, depending on which plan option is selected; and the monthly premium for a 64-year old many ranges from \$1087 and \$1402, depending on which plan is selected.

- *For more information about the HRA Low-Income Premium Subsidy, please call the Connecticut Health Reinsurance Association at (800) 842-0004 or visit their web site at <http://www.hract.org/hra/>.*

OTHER PROGRAMS

- *There may be other financial assistance programs available. For more information about medical assistance programs, please call Connecticut Department of Social Services at (800) 842-1508.*

THE FEDERAL HEALTH CARE TAX CREDIT (HCTC)

A federal income tax credit is available to help certain trade dislocated workers and early retirees, and their dependents, buy qualified health insurance coverage. The Health Coverage Tax Credit (HCTC) covers 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 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 health insurance in which you were enrolled for at least the last 30 days before you were separated from the job that makes you eligible for TAA benefits or for payments from the PBGC.
 - State-qualified health plans. In Connecticut, state based continuation coverage and coverage through the Health Reinsurance Association of Connecticut are considered the state qualified health plans.
 - Your husband’s or wife’s insurance from work, as long as the employer contributes less than 50% of the total health plan premium. (At this time, you can only claim the credit with this type of coverage when you file your federal tax return and not in advance.)

HOW DO I CLAIM THE HCTC?

- *You can claim the HCTC on your tax return and be reimbursed for 65% of the premium you paid for qualified coverage while you were eligible for the HCTC. Currently, this is the only way to claim the HCTC if your qualified health plan is provided through a spouse’s employer.*
- *Alternatively, you can choose to have your credit sent directly to your qualified health plan each month. To do this, you must register with the HCTC customer service center by calling 1-866-628-HCTC (1-866-628-4282), Monday through Friday between the hours of 7 am and 7 pm, Central time. TDD/TYY callers, please call 1-866-626-HCTC (1-866-626-4282).*
- *You will have to fill out a registration form verifying your eligibility for the HCTC and your enrollment in qualified coverage. You will also fill out a payment invoice. Each month, you will send the HCTC program your 35% share of the premium for qualified coverage. The HCTC program will combine this payment with the tax credit covering the other 65% of the premium and forward the entire payment to your qualified health plan.*

- *You must register in advance to have the HCTC paid directly to your health plan each month. Usually, the direct payments won't begin until at least a month after you register with the HCTC program. Call the HCTC customer service center for more information*

WHERE CAN I GET MORE INFORMATION?

- *For more information about the HCTC, contact the HCTC customer service center at 1-866-628-HCTC, or see the IRS website at <http://www.irs.gov/individuals/index.html> (click on HCTC).*
- *For more information about TAA benefits contact, <http://www.doleta.gov/tradeact/>.*
- *For more information about PBGC, contact, <http://www.pbgc.gov> or call 1-202-326-4000 with general inquiries.*

FOR MORE INFORMATION...

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

For questions about:	Contact:
Individual health insurance Fully insured group health plan	<i>Connecticut Insurance Department</i> (860) 297-3800 (800) 203-3447 (CT only) (800) 842-0004 (HRA) http://www.state.ct.us/cid
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 Hotlines and Publications</i> (800) 444-EBSA (3272) http://www.dol.gov/ebsa
High Risk Pool	<i>Health Reinsurance Association (HRA)</i> (800) 842-0004 http://www.hract.org/hra/index.htm
Medicaid	<i>Connecticut Department of Social Services</i> (800) 842-1508 (800) 842-4524(TDD/TYY) http://www.dss.state.ct.us

HUSKY (Healthcare for Uninsured Kids and Youth)	<i>State of Connecticut Department of Social Services</i> (877) 284-8759 http://www.huskyhealth.com
Breast and Cervical Cancer Program	<i>Connecticut State Department of Public Health</i> (860) 509-7804 http://www.dph.state.ct.us/BCH/HEI/bccedp_program_locations.htm
The Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service (IRS)</i> (866) 628-HCTC http://www.irs.gov/individuals/index.html (click on HCTC); or call HCTC customer service center

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

HELPFUL TERMS

Adjusted Community Rating (also known as community rating by class in Connecticut). A requirement that Connecticut health insurance companies establish a rate for each small group policy (covering 50 or fewer employees) that does not vary due to the health status of those who buy that health insurance. For small group health plans, premiums can vary above or below the community rate based on age, gender, family size, group size and type of business, as well as where the business is located.

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

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

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

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

Continuous Coverage. Health insurance coverage is continuous if it is not interrupted by a break of 63 or more consecutive days. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. Federal rules apply to you in group health plans and, if you are HIPAA eligible, when you buy an individual health insurance policy. See also Creditable Coverage, HIPAA Eligible, Fully Insured Group Health Plan, Individual Health Insurance Policy, Self-Insured Group Health Plan.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; 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. A feature permitted in individual health insurance policies that excludes coverage for a pre-existing condition. Unlike pre-existing condition exclusion periods, which can be no longer than 12 months, elimination riders can last indefinitely. Elimination riders cannot be imposed if you are HIPAA eligible.

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

Fully Insured Group Health Plan. A health plan purchased by an employer from an insurance company. Fully insured health plans are regulated by Connecticut. 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 1 employee, or the self-employed. See also Fully Insured Group Health Plan, Self-Insured Group Health Plan.

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All health plans sold to Connecticut small employers with 1 to 50 employees are guaranteed issue. If you are HIPAA eligible, you must be given access to the HMO Portability Plan by the Connecticut Health Reinsurance Association. Plans that are guaranteed issue can turn you away for other reasons.

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

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

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

Health Reinsurance Association (HRA). A state program for people with high health risks. The Connecticut Health Reinsurance Association sells individual and family coverage to those who are HIPAA eligible and to others between the ages of 19 and 65.

Health Statement. An application form that individual health insurers in Connecticut will request that you complete when you apply for individual health insurance. Small group health plans in Connecticut require completion of a standardized health form for enrollment.

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

Healthcare for Uninsured Kids and Youth. HUSKY is a managed health care program for uninsured children age 18 and younger. Families with higher income can join the program but must pay premiums and/or co-pays. Children covered under HUSKY Part B can also receive supplemental coverage for physical and behavioral health needs under this program. Parents of children covered by HUSKY who meet the income standards are also eligible for HUSKY coverage.

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

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

HMO. Health maintenance organization. A kind of health insurance plan. HMOs usually limit coverage to care from doctors who work for or contract with the HMO. They generally do not require deductibles, but often do charge a small fee, called a copayment, for services like doctor visits or prescriptions. If you are covered under an HMO, the HMO might require an affiliation period before coverage begins. See also Affiliation Period.

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

Individual Health Policy. Policies for people not connected to an employer group. Individual health insurers are regulated by Connecticut.

Kassebaum-Kennedy. See HIPAA.

Large Group Health Plan. One with more than 51 employees.

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

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

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

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

Pension Benefit Guaranty Corporation (PBGC). PBGC is a federal government corporation established by Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) to encourage the continuation and maintenance of defined benefit pension plans, provide timely and uninterrupted payment of pension benefits to participants and beneficiaries in plans covered by PBGC. It currently guarantees payment of basic pension benefits earned by American workers and retirees participating in private-sector defined benefit pension plans. The agency receives no funds from general tax revenues. Operations are financed largely by insurance premiums paid by companies that sponsor pension plans and by PBGC's investment returns.

Pre-existing condition (Group Health Plans). Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan. Pregnancy cannot be counted as a pre-existing condition. Genetic information about your likelihood of developing a disease or condition, without a diagnosis of that disease or condition, cannot be considered a pre-existing condition. Newborns, newly adopted children, and children placed for adoption covered within 31 days cannot be subject to pre-existing condition exclusions.

Pre-existing condition (HRA). 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 HRA, or for which an ordinarily prudent person would have sought medical advice, care or treatment. Unlike group plans or individual health insurance coverage, Pregnancy can be counted as a pre-existing condition by HRA. See Prudent Person Rule.

Pre-existing condition (Individual Health Insurance Policies). Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 12-month period immediately preceding enrollment in a health plan. Pregnancy cannot be counted as a pre-existing condition, though certain complications of pregnancy cannot be excluded as pre-existing conditions. Newborns, newly adopted children and children placed for adoption covered within 31 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 Connecticut.

Small Group Health Insurance Policy. Plans with no more than 50 employees.

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

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.

Trade Adjustment Assistance (TAA) Program. A program authorized by the Trade Adjustment Assistance Reform Act of 2002. This program provides aid to workers who lose their job or whose hours of work and wages are reduced as a result of increased imports. The TAA Program offers six benefits and reemployment services to assist unemployed workers prepare for and obtain new suitable employment. In addition, TAA offers a significant tax credit that covers 65% of health insurance premiums for certain plans

Temporary Assistance for Needy Families (TANF). A program (also known as JOBS FIRST in Connecticut) 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.

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.