

**A CONSUMER'S GUIDE
TO
GETTING AND KEEPING HEALTH INSURANCE
IN
THE DISTRICT OF COLUMBIA**
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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 THE DISTRICT OF COLUMBIA

As a D.C. 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 D.C. resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group and individual health plans. Chapter 4 highlights your protections as a small employer or self-employed person. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from D.C., 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 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 printed in **boldface type** the first time they appear.

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CHAPTER 1

A SUMMARY OF YOUR PROTECTIONS

Numerous state and federal laws make it easier for people with **pre-existing conditions** to get or keep **health insurance**, or to change from one **health plan** to another. A federal law, known as the **Health Insurance Portability and Accountability Act (HIPAA)** sets national standards for all health plans. In addition, states can pass different reforms for the health insurance plans they regulate (**fully insured group health plans** and **individual health insurance policies**), so your protections may vary if you leave D.C.. 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 D.C. resident.

HOW AM I PROTECTED?

In D.C., as in many other states, your health insurance options are somewhat dependent on your **health status**. Even if you are sick, however, the laws protect you in the following ways.

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status. This is called **nondiscrimination** (see page 6).*
- *All group health plans in D.C. 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 group plan your old coverage will be credited toward the pre-existing condition exclusion period, provided you did not have a long break in coverage (see page 8).*
- *Your health insurance cannot be canceled because you get sick. All health insurance is **guaranteed renewable** (see pages 15 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** 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 15).*
- *If you lose your fully insured group HMO plan and meet other qualifications, you may be able to buy a **conversion policy**. This is an individual policy*

from the company that insured your former group policy. You will not face a new pre-existing condition exclusion period. However, there are few limits on what you can be charged for a conversion policy and the benefits may be less generous than your previous group coverage (see page 20).

- *If you lose your group health insurance and meet other qualifications, you will be **HIPAA eligible**.* If so, you can buy an individual health policy from any individual insurer operating in D.C. You will not face a new pre-existing condition exclusion period. Insurers must offer you a choice of at least two policies, including one with comprehensive benefits (see pages 12).
- *Currently, CareFirst Blue Cross Blue Shield sells an individual health insurance policy to all D.C. residents, regardless of health.* You will not be turned down for this policy because you are sick. This is called **guaranteed issue**. The rates for this policy will vary based only on your age, not your health status. Plus, CareFirst does impose any preexisting exclusion periods on enrollees of this policy, so you will not have to wait to receive treatment of your preexisting conditions. (see page 12).
- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any other factor that might predict the use of health services of those in your group.* All health plans for small employers must be sold on a guaranteed issue basis (see page 22).
- *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.* D.C.'s **Medicaid** program offers free health coverage for pregnant women, families with children, and elderly and disabled individuals with very low incomes (see page 24).
- *If your children are 19 years old or younger, do not have health insurance and meet other qualifications, you may be able to get coverage for yourself and your children through the **DC Healthy Families Program**.* Healthy Families provides comprehensive coverage to enrollees and lasts for a 12 month period (see page 26).
- *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 **Project WISH: Women Into Staying Healthy Program** provides qualified women with free breast and cervical cancer screening. Some women diagnosed with breast or cervical through this program may be eligible for treatment through D.C. Medicaid Program (see pages 27).

- *If you are a resident of D.C. and do not have health insurance, you may be eligible for healthcare coverage through the **DC HealthCare Alliance**. You must meet certain eligibility requirements to participate in this program (see page 28).*
- *If you have lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program**, you may be eligible for a federal income tax credit to help 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 and a policy offered through CareFirst Blue Cross Blue Shield (see page 28).*
- *If you are a retiree aged 55-65 and receiving benefits from **Pension Benefit Guarantee Corporation (PBGC)**, then you may be eligible for the HCTC (see page 28).*

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 rights or state continuation rights, you are not entitled to take your actual group health coverage with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did (see page 6).*
- *If you change jobs, your new employer may not offer you health benefits. Employers are required only to make sure that any health benefits they do offer do not discriminate based on health status (see page 6).*
- *If you get a new job with health benefits, your coverage may not start right away. Employers can impose **waiting periods** before your health benefits begin. **HMOs** can require **affiliation periods** (see page 7).*
- *If you have a break in coverage of 63 days or more, you may have to satisfy a new pre-existing condition exclusion period when you join a new group health plan (see page 8).*
- *Even if you have **continuous coverage**, there may be a pre-existing condition exclusion period for some benefits if you join a group health plan that covers certain benefits your old plan did not. For example, say you move from a group plan that does not cover prescription drugs to one that does. You may*

have to wait up to one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition (see page 10).

- *If you work for certain non-federal public employers in D.C., not all of the group health plan protections may apply to you (see page 11).*
- *If you are not HIPAA eligible, individual health insurers in D.C., other than CareFirst Blue Cross Blue Shield, are free to turn you down because of your health status and other factors. In addition, CareFirst Blue Cross Blue Shield can turn you down if you apply for a non-guaranteed issue policy (see page 12).*
- *Even if you are HIPAA eligible, you can be turned down for some individual health insurance policies. The law permits individual insurers to limit your choices to two plans, which are supposed to be comparable to others they sell in the individual market in D.C. (see page 12).*
- *In general, there are no limits to what insurers can charge you for individual health insurance. You can be charged substantially higher premiums because of your health status, age, gender, and other characteristics (see pages 15 and 20).*
- *If you move away from D.C., you may not be able to buy individual health insurance in another state unless you are HIPAA eligible. (see healthinsuranceinfo.net).*
- *If you are a small employer buying a group health insurance policy, you can be charged more, generally without limits, based on the health status, age, gender, and other factors of those in your group. In turn, premiums can be significantly higher if someone in your group has a serious illness (see page 22).*

CHAPTER 2 YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

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

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

- *In general, you have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees. Or, your employer may offer a health maintenance organization (HMO) plan that you cannot join because you live outside of the plan's service area.

- *You cannot be turned away or charged more because of your health status.* Health status means your medical condition or history, **genetic information**, or disability. This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (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 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 health plan offers family coverage, your dependents can elect coverage at this time. Enrollment during a **special enrollment period** is not considered **late enrollment**.

Certain changes can trigger a special enrollment opportunity

- The birth, adoption, or placement for adoption of a child
 - Marriage
 - Loss of other coverage (for example, that you or your dependents have through yourself or another family member and have lost because of death, divorce, legal separation, termination, retirement, or reduction in hours worked)
-
- *Under D.C. law, newborns, adopted children, and children placed for adoption are automatically covered under the parents' fully insured health plan for the first 31 days, if the plan covers dependents. The insurer may require that the parent enroll the child (and pay the premium) within 31 days in order to continue coverage beyond the 31 days*
 - *If you have a disabled child, that child may remain covered under your fully insured group HMO plan after he or she reaches the age at which dependent coverage is usually terminated. To qualify, your son or daughter must be unable to work by reason of physical or mental impairment and must be chiefly dependent on the policyholder for support and maintenance. Proof of dependency 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. This waiting period, however, must be applied consistently and cannot vary due to your health status. You will not have health insurance coverage during this time.*
 - *When you begin a new job with health insurance through an HMO, the HMO may require a waiting period before coverage begins. During this affiliation period, you will not have health insurance coverage. The HMO also cannot impose any pre-existing condition exclusions if it imposes an affiliation period. An HMO affiliation period cannot exceed 2 months (3 months for late enrollees), and you cannot be charged a premium during this time.*
 - *If you have to take leave from your job due to illness, the birth or adoption of a child, or to care for a seriously ill family member, you may be able to keep your group health coverage for a limited time. A federal law known as a **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job-protected leave in these circumstances.*

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

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

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

- *Your right to maintain your health insurance during family or medical leave, may be greater under a D.C. law that is similar to federal FMLA. D.C. FMLA covers some workers who are not covered by the federal FMLA. Under D.C. FMLA, you can take up to 16 weeks of D.C. family leave during a 12-month period (24 month period to care for a family member). In addition, you can take up to 16 weeks for medical leave during a 24-month period. The D.C. law applies to employees who work for employers with 20 or more employees.*

Where D.C. and federal law differ, employers are required to give you the benefit of the more generous law.

For more detailed information on D.C.'s FMLA, contact the Office of Human Rights at (202) 727-4559.

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

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

- *Group plans can as apply a pre-existing condition exclusion period only 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. This period is also called the look back period.*

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- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns or newly adopted children, children placed for adoption, or genetic information.*
- *Group health plans can exclude coverage for pre-existing conditions for a limited time. The maximum period is 12 months. However, if you enroll late in a group health plans (after you are hired and not during a regular or special enrollment period), you may have a longer pre-existing condition exclusion period of up to 18 months.*
- *Group plans that impose pre-existing condition exclusion periods must give you credit for any previous continuous **creditable coverage** that you've had. Most types of private and government sponsored health coverage are considered creditable coverage. Coverage counts as continuation if it has not been interrupted by a break of 63 or more days in a row.*

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

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

In most cases, you should get a **certificate of creditable coverage** when you leave a health plan. You also can request certificates at other times. If you cannot get one, you can submit other proof, such as old health plan ID cards or statements from your doctor showing bills paid by your health 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 towards it. If your employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period. HMOs that require an affiliation period cannot exclude coverage for pre-existing conditions.

What is continuous coverage?

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

Take Art, who has diabetes. Ajax Company covered him under its group health plan for 9 months, but he lost his job and health coverage. Then, 45 days later, Art found a new job at Beta Corporation and had health coverage for 9 more months. Art changed jobs again. His new company, Charter, offers 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 he has more than 12 months of prior continuous coverage credited against the 12-month exclusion.

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

- *Your protections may differ if you move to group health plan that offers more benefits than your old health plan did.* Plans may look back to determine whether your previous health plan covered certain benefits. If you did not have continuous coverage for a certain benefit, your new self-insured plan may impose a pre-existing condition exclusion period for that benefit for up to six months.

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 health 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, some public employers in D.C. 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 coverage. See Chapter 3 for more information.
- *If you have lost your group health insurance and are receiving benefits from the Trade Adjustment Assistance (TAA) program, you may be eligible for a federal income tax credit to help you pay for new health coverage.* This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 65% of the cost of qualified health coverage (see page 28).
- *If you are a retiree aged 55-65 and receiving benefits from the Pension Benefit Guaranty Corporation (PBGC), you may also be eligible for the HCTC (see page 28).*

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 plan from a private insurer. However, in D.C. – as in most other states – you have limited guaranteed access to individual health insurance in the private market. There are some alternatives to private individual health insurance coverage, such as COBRA coverage or conversion policies. This chapter summarizes your protections under different kinds of health plan coverage.

INDIVIDUAL HEALTH POLICIES SOLD BY PRIVATE INSURERS

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

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

- *In general, companies that sell individual health insurance in D.C., are free to turn you down because of your health status and other factors. When applying for individual health insurance, you may be asked questions about health conditions you have now or have 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.*
- *Currently, CareFirst BlueCross BlueShield (CareFirst) offers one individual health insurance policy to any D.C. resident regardless of health status. This policy is called the Blue Preferred Open Enrollment policy. CareFirst does impose any preexisting exclusion periods on enrollees of this policy, so you will not have to wait to receive treatment of your preexisting conditions. Premiums for this policy will vary based on age, but not health status. For all other policies sold, CareFirst will ask questions about your health status and may turn you down based on your health conditions or health history.*
- *If you are HIPAA eligible, private insurance companies that sell individual health insurance must offer you the choice of at least two policies. Companies that do not designate two policies must offer you a choice of all their individual insurance policies. Policies sold to HIPAA eligible individuals cannot impose pre-existing condition exclusion periods. However, there is no limit on what you can be charged for this coverage.*

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible in D.C. you are guaranteed the right to buy individual health insurance policies and are exempted from pre-existing condition exclusion periods. 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 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.

- *Under D.C. law, newborns, adopted children, and children placed for adoption are automatically covered under the parents' individual health insurance policy for the first 31 days, if the policy covers dependents.* The insurer may require that the parent enroll the child (and pay the premium) within 31 days in order to continue coverage beyond the 31 days
- *If you have a disabled child, that child may remain covered under your fully insured group HMO plan after he or she reaches the age at which dependent coverage is usually terminated.* To qualify, your son or daughter must be unable to work by reason of physical or mental impairment and must be chiefly dependent on the policyholder for support and maintenance.. Proof of dependency must be furnished within 31 days of reaching the time limit and may be required periodically thereafter.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy.* D.C. does not require health insurers in the individual market to sell standardized policies. Insurers can design different policies and you will have to read and compare them carefully. For example, most individual market policies may provide only limited coverage for prescription drugs. However, D.C. does require all insurers to cover certain benefits – such as mammograms, prostate cancer screening, and diabetes

treatment. Check with D.C. Department of Insurance, Securities and Banking for more information about mandated benefits.

- *If you are HIPAA eligible, individual insurers must offer you a choice of at least two state-approved policies, whose benefits must be similar to others they typically sell. At least one of those policies must offer comprehensive benefits. If two policies are not designated, you must be offered a choice of all of their individual insurance policies.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *No pre-existing condition exclusion periods or elimination riders can be imposed on your HIPAA guaranteed issue policy.*
- *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 periods. In D.C., there are no limits on how long an individual market insurer can apply a pre-existing condition exclusion period.*

The definition of pre-existing condition is different under individual health insurance than under group health plans. Individual health insurance can count as pre-existing any condition that was present before the first day of coverage, whether or not medical advice, diagnosis, care, or treatment was recommended or received before that first day. Unlike group health plans, individual health insurers are not limited in how far back they can look for evidence of a pre-existing condition. In D.C., pregnancy can count as a pre-existing condition, but not genetic information.

- *Individual health insurers do not have to give you credit for your prior coverage.*
- *If you make a claim during the first three years of coverage, the insurer can look back 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, that the condition was pre-existing at the time of application, it can refuse to pay for expenses for that condition.*

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

- *If you have an expensive health condition, your individual health insurance premiums may be very high. The law does not prohibit D.C. health insurers from charging you more because of your health status, age and other factors.*
- *When you renew your individual health insurance policy, your premiums can increase based on certain factors, such as your age.*

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELED?

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

COBRA AND STATE CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

If you are leaving your job and you had group health coverage, you may be able to stay in your group health plan for an extended time through COBRA. The information presented below was taken from publications prepared by the U.S. Department of Labor. You should contact this agency 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 who is eligible for COBRA continuation can make their own decision.* If your dependents were covered under your employer plan, they may independently elect COBRA coverage as well.
- *You must be notified of your COBRA rights when you join the group health plan, and again if you qualify for COBRA coverage.* The notice rules are somewhat complicated and you should contact the U.S. Department of Labor for more information.

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

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

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 lost your group health insurance and are receiving benefits from the Trade Adjustment Assistance (TAA) program, you may be eligible for a federal income tax credit to help you pay for new health coverage. The credit is called the Health Coverage Tax Credit (HCTC), and it is equal to 65% of the cost of qualified health coverage, including COBRA and a policy offered through CareFirst Blue Cross Blue Shield (see page 28).*
- *If you are a retiree aged 55-65 and receiving pension benefits from PBGC, and receiving benefits from the Trade Adjustment Assistance (TAA) Program, then you may be eligible for a federal income tax credit to help pay for new health coverage. This credit is called the Health Coverage Tax Credit (HCTC) (see page 28).*

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 a disability determination letter from the Social Security Administration, and you must notify your group health plan within 60 days of receiving this disability determination.*

HOW LONG CAN COBRA COVERAGE LAST?

<u>Qualifying event(s)</u>	<u>Eligible person(s)</u>	<u>Coverage</u>
Termination 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.*
- *In D.C., you are not guaranteed the right to buy individual health insurance of your choice, unless you have used up the COBRA continuation coverage available to you.*

WHAT ABOUT D.C. CONTINUATION COVERAGE?

D.C. permits certain individuals to continue coverage under their fully insured group health plan, even after they lose eligibility as a member of that group.

- *If your employer offers fully insured health benefits, you and your dependents may also be eligible for up to 3 months of state continuation coverage, a D.C. law that is similar to COBRA. This includes health care benefits for covered members of a small group with fewer than 20 employees.*
- *To qualify for state continuation coverage, you must have been covered under a fully insured group health plan, were not terminated for gross misconduct, and not eligible for COBRA. Also you must apply within 45 days of losing your coverage.*

CONVERSION

WHEN DO I HAVE TO BE OFFERED A CONVERSION POLICY?

- *In D.C., if you have fully insured group HMO coverage through your employer and you leave that job, you can buy a conversion policy. This is an individual policy you get from the HMO that insured your employer's group plan. To qualify for a conversion policy, you must apply in writing within 31 days of termination of your former group coverage.*
- *You also may qualify for a conversion policy if your employer drops the fully insured group HMO coverage.*

WHAT WILL A CONVERSION POLICY COVER?

- *At a minimum, conversion policies are only required to provide basic health care services, so benefits may be less generous than what you received under your former group coverage.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *You will not have a new pre-existing condition exclusion period for your conversion policy. The conversion policy can only exclude coverage for pre-existing conditions that were excluded under the prior group health plan.*

WHAT CAN I BE CHARGED FOR A CONVERSION POLICY?

- *Premiums for conversion coverage may be higher than your prior group coverage. Premiums for conversion are determined by the insurer issuing the policy and can vary based on your age, health status, gender, and other factors.*

CAN MY CONVERSION POLICY BE CANCELED?

- *Your conversion 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 A SELF-EMPLOYED PERSON

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. D.C. has enacted some reforms that expand some of these protections. Generally, small employers are those that employ 2-50 employees. Please note, however, that the definitions of small employer and employee are somewhat different under federal and state law. Check with D.C. Department of Insurance, Securities and Banking to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down.* This is called guaranteed issue. If you employ at least 2 but not more than 50 employees, health insurance companies must sell you any **small group health insurance policy** they sell to other small employers if the employer group meets the participation requirements. They can also require you to contribute a minimum percentage of your workers' premiums. They can also require you to pay a minimum share 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, or if they are discontinuing that health plan or if they are withdrawing from the small employer market. In the case of discontinuance, they must give you a chance to buy other plans they sell to groups of your size.

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

- *In general, you can be charged higher premiums because someone in your group is seriously ill.* The law does not prohibit D.C. health insurers from charging you more because of the health status of your group or other factors.

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are not eligible to buy a group health plan on your own (though you may be able to join another group health plan through a family member). Therefore, the laws that protect employers' access to group health plans do not apply to you. Your access to health insurance is protected by the laws that apply to individuals (see Chapter 3).*
- *If you are self-employed and buy your own health insurance, you 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 and self-employed people 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 D.C. Department of Insurance about your protections in association health plans.*

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of D.C. who cannot afford to buy health insurance. Medicaid offers free or subsidized 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 DC 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 however, questions concerning immigration status and eligibility should be directed to the DC Department of Health.

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

In D.C. you may be eligible for Medicaid if you are a child, 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 D.C. Medical Assistance Administration for more information.

Low income persons eligible for Medicaid in D.C.*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Child up to 19	300% (monthly income of about \$4,400 for a family of 3)
Working Parent	207%
Non-Working Parent	200%
Pregnant woman	300%
Medically Needy	
Individual	53%
Couple	41%

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

To get an idea of how your income compares to the federal poverty level, use the federal poverty guideline issued by the U.S. Department of Health and Human Services for the year 2008:

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

For larger families add \$3,600 for each additional person

So, for example, using this guideline, 300% of the federal poverty level for a family of 3 would be an annual income of \$52,800 or a monthly income of \$4,400.

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 **Temporary Assistance for Needy Families (TANF)** should also know that when you get a job and your TANF benefits end, you generally can stay on Medicaid for a 12-month transitional period.*

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

- *Poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits 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 their health insurance is limited or does not cover these services.
- *Retired or disabled people who have low incomes and are enrolled in Medicare may also qualify for help from Medicaid.* Even though your income may be too high to qualify for Medicaid coverage, there may be other ways Medicaid can help you.

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

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

- *There may be other ways Medicaid can help.* To find out if you or other members of your family qualify for Medicaid, contact the D.C. Medical Assistance Administration at (202) 442-5988.

DC HEALTHY FAMILIES PROGRAM

DC Healthy Families is a free health insurance program for low-income families living in DC. It is part of a part of a national initiative, the Children's Health Insurance Program (CHIP), to ensure that all children have health insurance.

- *If you are a resident of D.C. and have children under the age of 19, you and your children may be eligible for free health insurance through DC Healthy Families.* In addition, D.C. Healthy Families covers guardians, pregnant women, and adolescents that live alone.
- *To be eligible, a family must have a household income at or below 200% of the federal poverty level (FPL).* In 2008, for a family of 3, this works out to an annual income of up to \$35,200 or a monthly income of up to \$2,950.

- *If your family income is too high for family coverage, then your child may be eligible independently for DC Healthy Families.* For your child to be independently eligible for coverage through DC Healthy Families, your family income must be less than 300% of FPL. In 2008, for a family of 3, this worked out to an annual income of \$52,000 or a monthly income of \$4,400.
- *Enrollment in Healthy Families lasts for 12-month period.* Eligibility for the program is assessed once per year. At least 60 days before your eligibility runs out, you will receive a letter asking you to update changes in your residency, income, and family size.
- *If eligible, DC Healthy Families should cover most of your medical needs.* This includes coverage for doctor's visits, hospital care, specialty and diagnostic care, dental, and prescription medication. Once enrolled, you will not have to wait before getting care related to a pre-existing condition.
- *For more information, contact D.C. Healthy Families at (888) 557-1116 or visit them online at*
http://www.dchealth.dc.gov/doh/cwp/view,a,1371,q,575879,dohNav_GID,1807.asp or <http://providers-dchealthyfamilies.com/index.htm#>.

<p>BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT PROGRAM (BCCPTP): PROJECT WISH</p>
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- *The Breast and Cervical Cancer Prevention Program (Project WISH: Women Into Staying Healthy) provides qualified women with breast and cervical cancer screening at no cost.* Women who are screened through this program and diagnosed with breast and/or cervical cancer may be eligible for treatment through Medicaid.
- *In order to be eligible for breast or cervical cancer screenings through Project WISH, you must be 40 years or older.* In addition, you must meet income eligibility standards and be uninsured or underinsured.

For more information, please call the D.C. Department of Health at (202) 442-5900 or visit them online at
http://dchealth.dc.gov/DOH/cwp/view,a,1373,q,582368,dohNav_GID,1801,dohNav,%7C33183%7C33184%7C,.asp.

DC HEALTHCARE ALLIANCE

The DC HealthCare Alliance is a public program that provides free healthcare to certain individuals and families.

- *If you are a D.C. resident without health insurance, then you may be eligible for free health coverage through DC HealthCare Alliance. Your family income may not exceed 200% of federal poverty level. In 2008, for a family of 3, this works out to an annual income of up to \$35,200 or a monthly income of up to \$2,950.*
- *Every 12 months you will be required to prove that you are still eligible for the Alliance program. You can only receive health coverage within the program for 12 months at a time. You will need to be recertified by the program within 90 days of the end of each 12 month period.*
- *If eligible, DC HealthCare Alliance will cover most of your medical needs. This includes coverage for doctor's visits, hospital care, specialty and diagnostic care, dental, and prescription medication.*
- *You must receive care from a DC HealthCare Alliance provider. All services provided by DC HealthCare Alliance providers are free of charge. If you chose to receive care and/or services from a non-Alliance provider, you are responsible for payment for all services.*

For more information contact the DC HealthCare Alliance at 1-866-842-2810 or 202-842-2810 or visit them online at <http://www.chartered-health.com/dcha/1Alliance.htm> or <http://providers-dchealthyfamilies.com/index.htm#>.

OTHER STATE PROGRAMS

There may be other financial assistance programs available. Please call the DC Department of Health at (202) 442-5999 for more information.

THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)

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

WHEN AM I ELIGIBLE FOR THE HCTC?

- *To be eligible for the tax credit, you must be receiving Trade Adjustment Assistance (TAA) benefits or retirement benefits from the PBGC. If you are receiving PBGC benefits, you also must be at least 55 years old. In addition, you must not be enrolled in Medicare, Medicaid, or in other employer-sponsored coverage for which the employer contributes at least half of the premium.*
- *HCTC may apply to your family, too. If you are eligible, you can use the credit to help purchase qualified health coverage for your qualified family members. Qualified family members are your spouse and dependents that you can claim on your federal tax return. Family members are not eligible if they are enrolled in another group health plan where the employer pays at least 50% of the cost of coverage, or in Medicaid, SCHIP, FEHBP, Tricare/CHAMPUS.*
- *Eligibility for HCTC is not based on income. In addition, the HCTC is refundable. This means you can claim the credit even if you do not earn enough income to owe federal income tax.*

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

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

WHAT HEALTH COVERAGE IS ELIGIBLE FOR THE TAX CREDIT?

- *The HCTC can only be used to help pay for “qualified” health coverage. COBRA continuation coverage is considered qualified health coverage. (See Chapter 3 for more information about COBRA.) In addition, D.C. has designated a policy offered by CareFirst Blue Cross Blue Shield as a state qualified health plan.*

HOW DO I CLAIM THE HCTC?

- *You can claim the HCTC on your tax return and be reimbursed for 65% of the premium you paid for qualified coverage while you were eligible for the*

HCTC. Currently, this is the only way to claim the HCTC if your qualified health plan is provided through a spouse's employer.

- *Alternatively, you can choose to have your credit sent directly to your qualified health plan each month. To do this, you must register with the HCTC customer service center by calling 1-866-628-HCTC (1-866-628-4282), Monday through Friday between the hours of 7 am and 7 pm, Central time. TDD/TYY callers, please call 1-866-626-HCTC (1-866-626-4282).*

WHERE CAN I GET MORE INFORMATION?

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

FOR MORE INFORMATION

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

For questions about:	Contact:
Individual health insurance Fully insured group health insurance State continuation coverage	<i>D.C. Department of Insurance, Securities and Banking</i> (202) 727-8000 http://disr.washingtondc.gov/disr/site/default.asp
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor</i> <i>Employee Benefits Administrator</i> <i>Employee & Employer Assistance Hotline and Publications</i> (866) 444-EBSA (3272) http://www.dol.gov/ebsa
Medicaid	<i>DC Department of Health</i> (202) 442-5988 http://dchealth.dc.gov/doh/cwp/view,a,3,q,573226,dohNav_GID,1807.asp
DC Healthy Families Program	<i>DC Department of Health</i> (888) 557-1116 http://providers-dchealthyfamilies.com/index.htm# or http://www.dchealth.dc.gov/doh/cwp/view,a,1371,q,575879,dohNav_GID,1807.asp
Project WISH: The Breast and Cervical cancer Prevention Program	<i>DC Department of Health</i> (202) 442-5900 http://dchealth.dc.gov/DOH/cwp/view,a,1373,q,582368,dohNav_GID,1801,dohNav,3318333184,.asp
DC Alliance Healthcare Program	<i>DC Department of Health</i> (202) 842-2810 http://www.chartered-health.com/dcha/1Alliance.htm or http://providers-dchealthyfamilies.com/index.htm#
The Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service (IRS)</i> 1-866-628-HCTC (1-866-628-4282) http://www.irs.gov/individuals/index.html (Click on HCTC) or call HCTC customer service center
Finally, if you would like to obtain a consumer guide for a different state, visit the web at http://www.healthinsuranceinfo.net	

HELPFUL TERMS

Affiliation Period. The time an HMO may require you to wait after you enroll and before your coverage begins. HMOs that require an affiliation period cannot exclude coverage of preexisting 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.

Continuous Coverage. Health insurance coverage that is not interrupted by a break of 63 or more consecutive days. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. See also Creditable Coverage.

Conversion policy. Your right, when leaving a fully insured group HMO in D.C., to convert your policy to an individual health plan. You will not face a new pre-existing condition exclusion period. See also Fully Insured Group Health Plan, Individual Health Plan.

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

DC Healthcare Alliance. DC program offers health coverage to low income families. To be eligible, family income may not exceed 200% of federal poverty level.

DC Healthy Families Program. DC program offers health coverage to low income children, pregnant women, and other eligible individuals. To be eligible for family coverage, family income may not exceed 200% of the federal poverty level. For a child to be independently eligible for coverage through DC Healthy Families, their family income must be less than 300% of FPL.

Elimination Rider. A feature permitted in an individual health insurance policy that permanently excludes coverage for a health condition, body part, or body system.

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

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

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by D.C.. 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. Group and individual health plans cannot consider preexisting (and therefore exclude coverage for) a condition about which you have genetic information, unless that health condition has been diagnosed by a health professional. See also Group Health Plan, Individual Health Plan.

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

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All health plans sold to small employers in D.C. are guaranteed issue. If you are HIPAA eligible, insurance companies must offer you at least two individual health plans that are guaranteed issue. Plans that are guaranteed issue can turn you away for other reasons.

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

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

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

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

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

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

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

Large Group Health Insurance Policy. One with more than 50 eligible 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 preexisting condition exclusion period. See also Special Enrollment Period.

Look Back. The maximum length of time, immediately prior to enrolling in a health plan, which can be examined for evidence of preexisting conditions. See also Preexisting Condition.

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

Medicaid. A program providing comprehensive health insurance coverage and other assistance to certain low-income residents of D.C.. All other states have Medicaid programs, 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, based on 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 30 days cannot be subject to pre-existing condition exclusions.

Pre-existing Condition (Individual Health Insurance Policy). Any condition that was present before the first day of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. In D.C., under individual health insurance policies, pregnancy can 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. See also Prudent Person Rule.

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

Project WISH. Also called the Breast and Cervical Cancer Prevention Program, provides free screening for breast and cervical cancer to eligible DC residents. Women screened through the program and diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid for treatment of their condition.

Prudent Person Rule. In individual health plans only, a rule that permits insurers to exclude as preexisting any condition for which – in the insurer’s judgment – most people would have sought care or treatment prior to enrolling in an individual health plan.

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 D.C..

Small Group Health Insurance Policy. Plans for groups with 2 to 50 eligible 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 31 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 some states, if you are in a fully insured group health plan with fewer than 20 employees, you also have rights to continue your health coverage when your job ends. However, the District does not have such a law.

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

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

Trade Adjustment Assistance (TAA) Program. A program authorized by the Trade Adjustment Assistance Reform Act of 2002. This program provides aid to workers who lose their job or whose hours of work and wages are reduced as a result of increased imports. The TAA Program offers six benefits and reemployment services to assist unemployed workers prepare for and obtain new suitable employment. In addition, TAA offers a significant tax credit that covers 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 preexisting condition exclusion period begins on the first day of the waiting period. See also Preexisting Condition Exclusion Period.