

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

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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 FLORIDA

As a Florida 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 Florida 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 Florida, your protections may change. Since this guide is a summary, it may not answer all of your questions. For places to contact for more information, see page 35. For information about how to find consumer guides for other states on the Internet, see page 35. A list of helpful terms and their definitions begins on page 37. These terms are in **boldface type** the first time they appear.

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CHAPTER 1

A SUMMARY OF YOUR PROTECTIONS

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

HOW AM I PROTECTED?

In Florida, 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 Florida 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 group health plan will begin to pay for care for that condition. Generally, if you join a new group health 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).*
- *Your health insurance cannot be canceled because you get sick. Most 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 continuation coverage** or **state continuation coverage**. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage (see page 15).*

- *If you lose coverage under a **fully insured group health plan** in Florida, you may be able to buy a **conversion policy**. This is an individual policy from the company that insured your former policy. You will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for a conversion policy (see page 20).*
- *If you lose your group health plan and meet other qualifications, you will be **HIPAA eligible**. If so, and you do not qualify for a conversion policy, you are guaranteed the right to buy an individual health insurance policy from any insurance company that sells such plans in Florida. Insurers that sell individual health insurance must offer you a choice of at least two policies. You will not face a new pre-existing condition exclusion period (see page 12).*
- *You may be eligible to buy a guaranteed-issue policy if your individual health insurer or HMO terminated your coverage due to insolvency, dropped all individual coverage in Florida, or if you moved out of your individual health insurer's service area (see page 13).*
- *If you are a small employer buying a group health insurance policy, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group. All health plans for small employers must be sold on a **guaranteed issue** basis (see page 22).*
- *If you are a small employer buying a group health plan policy, you can be charged more, within limits, based on the health status of those in your group. Even with these limits, however, premiums can be significantly higher if someone in your group has a serious health condition (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. The Florida **Medicaid** program offers free health coverage for pregnant women, families with children, elderly, and disabled individuals with very low incomes (see Chapter 5).*
- *If your children are 18 years old or younger, do not have health insurance and meet other qualifications, they may be eligible to buy health insurance through the Florida **KidCare Program** (see page 27).*
- *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 **Mary Brogan Breast and Cervical Cancer Program** provides qualified women with free breast and cervical cancer screening. In addition, women diagnosed with cancer may be eligible for treatment through the Florida Medicaid Program (see page 28).*

- *If you have lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program** then you may be eligible for a federal income tax credit to help pay for new health coverage. This credit is called the **Health Coverage Tax Credit (HCTC)**, and it is equal to 65% of the cost of qualified health coverage, including COBRA, state continuation coverage, and a specific policy offered through Blue Cross and Blue Shield of Florida (see page 29).*
- *If you are a retiree aged 55-65 and receiving pension benefits from **Pension Benefit Guarantee Corporation (PBGC)**, then you may also be eligible for the HCTC (see page 29).*

WHAT ARE THE LIMITS ON MY PROTECTIONS?

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

- *If you change jobs, you usually cannot take your old health benefits with you. Except when you exercise your federal COBRA or state continuation rights, you are not entitled to take your actual group health 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 require **waiting periods** before your health benefits begin. Health maintenance organizations (**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 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 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 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 Florida, not all of the group health plan protections may apply to you (see page 10).*

- *In Florida, if you are not HIPAA eligible, your access to individual health insurance may depend on your health status.* Private insurers are not prohibited from turning you down, charging more, or limiting coverage because of pre-existing conditions (see page 12).
- *Even if you are HIPAA eligible, you can be turned down for some individual health policies.* The law permits insurers to limit your choices to two policies, which are supposed to be comparable to others they sell in the individual market in Florida (see page 12).
- *The law does not limit what you can be charged for individual health policies except when you are buying a conversion policy.* You can be charged substantially higher premiums because of your health status, age, gender, and other characteristics (see page 15).
- *If you are a small employer buying a group health plan policy, you can be charged more, within limits, due to the health status of those in your group.* In addition, you can be charged higher premiums, within limits, because of the age, gender, family size, tobacco use of those in your group, and where your business is located (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 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 (for example, if you work less than 30 hours per week or only on a temporary basis), as long as these are unrelated to health status and applied consistently.

Discrimination due to health status is not permitted

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

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

Certain changes can trigger a special enrollment opportunity

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

- *Under Florida law, newborns, newly adopted children and children placed for adoption are automatically covered under the parent's fully insured health plan for the first 31 days if the plan covers dependents.* The insurer may require that the parent enroll the baby within the 31 days in order to continue coverage beyond the 31 days.
- *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.* 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. And HMO affiliation period cannot exceed 2 months (3 months for late enrollee), 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.

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

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

- *A group health plan can 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.*
- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns or newly adopted children, children placed for adoption, or **genetic information**.*
- *Group health plans can exclude coverage for pre-existing conditions only for a limited time. The maximum period is 12 months. 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. You will receive credit toward your pre-existing condition exclusion period for any previous continuous coverage.*
- *Group health plans that impose pre-existing condition exclusion periods must give you credit for any previous continuous **creditable coverage**. Most types of private and government sponsored health coverage are considered creditable coverage.*

Coverage counts as continuous if it is not interrupted by a break of 63 days or more 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 plan (including COBRA)	Student health insurance
Indian Health Service	VA coverage
Individual health insurance	
Medicaid	

In most cases, you should get a **certificate of creditable coverage** when you leave a health plan. You also can request certificates at other times. If you cannot get one, you can submit other proof 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 group health plan that offers more benefits than your old one did.* Plans can look back to determine whether your previous health plan covered prescription drugs, mental health, substance abuse, dental care, or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new group health plan may impose a pre-existing condition exclusion period for that category.

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

Sue needs prescription medication to control her blood pressure. She had 2 years of continuous coverage under her employer's group health plan, which did not cover prescription drugs. Sue changes jobs, and her new employer's fully insured plan does cover prescription drugs. However, because her prior plan 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 covering 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 Florida 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. See Chapter 3 for more information about COBRA continuation coverage, state continuation coverage, conversion coverage, and individual health policy coverage for "HIPAA eligible individuals."
- *If you have lost your group health plan 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, and a specific policy offered through Blue Cross and Blue Shield of Florida (see page 29).

- *If you are a retiree aged 55-65 and receiving pension benefits from the Pension Benefit Guaranty Corporation (PBGC), you may also be eligible for the HCTC (see page 29).*

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 policy from a private insurer. However, in Florida – as in most other states – you have limited guaranteed access to individual health insurance. Whether you can buy an individual health policy may depend on your health status, the kind of coverage you want to buy, and other circumstances. There are alternatives to individual health insurance coverage — such as COBRA coverage and conversion policies. 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 Florida, your ability to buy individual health insurance may depend on your health status. There are certain circumstances, however, when you must be allowed to buy individual health insurance.

- *In general, insurers that sell individual health insurance in Florida are free to turn you down because of your health status and other factors. When applying for an individual 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. However, you cannot be denied a policy based on a history of breast cancer if you completed treatment more than two years ago. Insurers can turn you down based on a history of other types of cancer.*
- *If you have had at least 3 months of coverage under a fully insured group health plan and then lose it, you are guaranteed the right to buy a conversion policy. Insurers must offer you a choice of at least two policies. You will not have a new pre-existing condition exclusion period (see page 20).*
- *If you are HIPAA eligible but do not qualify for a conversion policy, you are guaranteed the right to buy an individual health policy from any insurance company that sells such policies in Florida. Insurers must offer you a choice of at least two policies.*

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible you are guaranteed the right to buy individual health insurance in every state and are exempted from pre-existing condition exclusion periods. In Florida, if your most recent coverage was under a fully insured group plan, you can buy a conversion policy. If not, you can buy individual coverage from any insurer in the state that offers individual policies.

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

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

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

- *Certain other people who lose other health insurance, may be eligible to buy a guaranteed-issue individual health insurance policy.* If your individual health insurer or HMO terminated your coverage due to insolvency, dropped all individual coverage in Florida, or if you moved out of your individual health insurer's service area, other insurers must offer you individual coverage regardless of your health status.
- *Under Florida law, newborns, newly adopted children and children placed for adoption are automatically covered under the parents' individual health insurance policy for the first 31 days if the plan covers dependents.* The insurer may require that the parent enroll the baby within the 31 days in order to continue coverage beyond the 31 days.

- *If you have a disabled 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 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 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.* Florida does not require health insurers in the individual market to sell standardized policies. Insurers can design different policies and you will have to read and compare them carefully. However, Florida does require all health insurers to cover certain benefits – such as childhood immunizations, mammograms, and diabetes treatment. Check with the Florida Department of Financial Services for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are HIPAA eligible and purchasing a guaranteed issue individual health insurance policy, no pre-existing condition exclusion periods can be applied.*
- *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 health policies cannot impose an elimination rider for breast cancer unless you have been treated for it within the past two years. Elimination riders cannot be applied to HIPAA eligible individuals. In addition, insurers cannot impose riders based on a diagnosis of breast cancer if you completed treatment more than two years ago.
- *Florida insurers can also impose a pre-existing condition exclusion period.* Pre-existing condition exclusion periods cannot exceed 2 years.

The definition of pre-existing is different under individual health insurance than under group health plans. Individual health insurance can count as pre-existing conditions only those for which you received, or – in your insurer’s judgment, for which you should have sought – a diagnosis or medical advice or treatment in the 2-year period prior to obtaining the individual health policy. This is called the **prudent person rule**. Individual health policies can apply pre-existing condition exclusion periods for pregnancy, but not for genetic information.

If a 2-year 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 62 days or more between your old and new coverage.

- *If you make a claim during the first 2 years of coverage, the insurer can look back 2 years 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 prudent person 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 does not prohibit Florida health insurers from charging you more because of your health status, age, gender, and other case characteristics.*

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.*
- *Your health insurance policy may be canceled if the insurer discontinues your health policy or withdraws from the individual market. Upon meeting other requirements, you may be eligible to buy an individual policy in the individual market (see above).*
- *Some insurance companies sell temporary health insurance policies. Temporary policies are not guaranteed renewable. They will only cover you for a limited time, such as six months. If you want to renew coverage under a temporary policy after it expires you will have to reapply and there is no guarantee that coverage will be re-issued at all or at the same price.*

COBRA CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

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

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

First, you must work for an employer with 20 or more employees. 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.*

- *To qualify as HIPAA eligible, you must choose and use up any COBRA or state continuation coverage available to you.*
- *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 may not be faced with a new pre-existing condition exclusion period under COBRA. However, if you were in the middle of a pre-existing condition exclusion period when your qualifying event occurred, you will have to finish it.*

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage. The first premium must be paid within 45 days of electing COBRA coverage.*
- *If you elect the 11-month disability extension, the premium will increase to 150% of the total cost of coverage.*
- *If you have lost your group health plan 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, and a specific policy offered through Blue Cross and Blue Shield of Florida (see page 29).*
- *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 29).*

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

LENGTH OF COBRA COVERAGE

<u>Qualifying Event(s)</u>	<u>Eligible Person(s)</u>	<u>Coverage</u>
Termination Reduced hours	Employee Spouse Dependent Child	18 months*
Employee enrolled in Medicare Divorce or legal separation Death of covered employee	Spouse Dependent Child	36 months
Loss of dependent child status	Dependent Child	36 months

*Special rules may extend coverage an additional 11 months for certain disabled individuals and their eligible family members

- *Usually, COBRA continuation coverage ends when you join a new health plan. However, if your new plan has a waiting period or a pre-existing condition exclusion period, you can keep whatever COBRA continuation coverage you have left during that period. For specifics, ask your former employer or contact the U.S. Department of Labor.*
- *COBRA coverage also ends if your employer stops offering health benefits to other employees.*
- *COBRA coverage might end if you are in a managed care plan that is available only to people living in a limited geographic area and you move out of that area. However, if you are eligible for COBRA and are moving out of your current health plan's service area, your employer must provide you with the opportunity to switch to a different plan, but only if the employer already offers other plans to its employees. 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.*

WHAT ABOUT FLORIDA CONTINUATION COVERAGE?

- *If your employer offers fully insured health benefits, you may be eligible for up to 18 months of continuation coverage (29 months in the case of disability) under a Florida law that is similar to COBRA. You must give written notice to your insurer within 30 days of losing eligibility for the group plan to continue coverage under Florida law. Ask your former employer or the Florida Department of Financial Services about state continuation coverage if you think it applies to you.*

CONVERSION

If you lose coverage under a fully insured group health plan in Florida and meet other requirements, you are guaranteed the right to buy a conversion policy. This is an individual health policy sold by the insurance company that covered your former group.

WHEN AM I ELIGIBLE FOR A CONVERSION POLICY?

- *In Florida, if you have 3 months of coverage through an employer's fully insured group health plan and you leave that plan, you may be eligible to buy a conversion policy. This is an individual policy you get from the company that insured your employer's group plan.*
- *You must exhaust any available COBRA or state continuation coverage before you can buy a conversion policy.*
- *Your coverage cannot have been terminated because you failed to pay your premium. However, if your group coverage was canceled because your employer failed to pay the premium, you can buy a conversion policy.*
- *If your terminated coverage is replaced by similar group coverage within 31 days, you cannot buy a conversion policy.*
- *You must apply for a conversion policy within 63 days of losing coverage.*
- *Conversion rights are also available to dependents covered under the employer's group plan.*

WHAT DOES A CONVERSION POLICY COVER?

- *You must be offered two standardized conversion policies that meet state requirements for minimum coverage. In addition, if your group health plan covered maternity, dental, or mental health and substance abuse benefits, these benefits must be covered under your conversion policy. Insurers can offer non-standard conversion policies as well. Ask the Florida Department of Financial Services if you have questions about coverage under a conversion policy.*

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.*

HOW MUCH CAN I BE CHARGED FOR MY CONVERSION POLICY?

- *Florida limits the premiums that can be charged for conversion policies. The premium for your conversion policy cannot be more than 200% of the typical rate for an individual policy. These policies may cost more than your prior group coverage. Contact the Florida Department of Financial Services if you have questions about conversion policy premiums.*

CAN MY CONVERSION POLICY BE CANCELED?

- *Your coverage cannot be canceled because you get sick. This is called guaranteed renewability. You have this protection provided that you do not lose your prior coverage because of failure to pay the premiums and your discontinued group coverage was not replaced by similar group coverage within 31 days after discontinuation.*

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. Florida 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. Self-employed persons count as small employers in Florida, but have somewhat different protections. Please note that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Florida Department of Financial Services 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 no more than 50 people, health insurance companies must sell you any **small group health plan 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 plan policy** for 51 or more employees, your group can be turned down.
- *Your insurance cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They 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, if you commit fraud, or if they are discontinuing that insurance product. In the latter case, 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?

- *Florida limits how much premiums can vary due to a small group's health status.* Even within these limits, however, premiums can be significantly higher if someone in your small group has a serious health condition. In addition, premiums can vary based on age, gender, family size and tobacco use of those in your group and where your business is located.

- *Florida also limits how much small group plan premiums can increase at renewal because of claims experience. Even so, premiums may increase significantly if someone in your group had expensive claims.*
- *For groups with more than 50 employees, Florida does not limit premium variations when coverage is first issued or renewed.*

WHAT PLAN CHOICES DO I HAVE?

- *Insurance companies must offer small employers standardized health plans. In Florida, insurers must offer a basic health benefit plan and a standard health benefit plan. Standardization helps you compare differences in cost and coverage. Carriers can also offer non-standardized plans.*

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are considered to be a group of one. Insurers are required to accept your application for the standard health plan or basic health plan in August of each year to make coverage effective on October 1, of that year. They can refuse to sell you other plans, however. Further, the rules for pre-existing condition exclusion periods are somewhat different.*

For groups of one, pregnancy can be counted as a pre-existing condition.

If you are a group of one and you have had no prior coverage, the group health plan can exclude coverage for your pre-existing condition for up to 2 years. The plan can count as pre-existing any condition for which you received, or – in your insurer’s judgment, for which you should have sought – a diagnosis, treatment or medical advice in the 2 years prior to enrolling in the plan. This is called the prudent person standard. If you had prior coverage, you will receive credit toward your pre-existing condition exclusion period for any time you satisfied under your prior coverage provided there was no break in coverage greater than 63 days.

- *In order to show that you qualify as a self-employed person or a business group of one, insurance companies are allowed to require that you provide them with your tax forms.*
- *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 are different than those for other health plans. Check with the Florida Department of Financial Services about your protections in association health plans.*

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Florida who cannot afford to buy health insurance. Medicaid and the Florida KidCare Program offer 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 Florida 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, questions concerning immigration status and eligibility should be directed to the Florida Department of Children and Families more information.

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

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

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 Florida Department of Children and Families for more information.

Low income persons eligible for Medicaid in Florida*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Infant	200% (monthly income of about \$2,862 for family of 3)
Child 1-5	133%
Child 6-18	100%
Pregnant woman	185%
Parents	
Working	60%
Non-Working	23%
Medically Needy	
Individual	25%
Couple	25%

* Eligibility information was compiled *State Health Facts Online*, 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 2007:

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

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

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

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

- *Parents who receive benefits under TANF (also known as Work and Gain Economic Self-Sufficiency, or WAGES) should know that when you get a job and your TANF benefits end, you generally can stay on Medicaid for a 12-month transitional period.*

In addition, your children may qualify for transitional Medicaid coverage for 12 months. Or, you may continue to qualify for Medicaid on the basis of your family's income if it meets the Medicaid income standards.

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

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

- *People who have high medical expenses may also qualify for Medicaid.* You may qualify as medically needy if you are a child, parent of a dependent child, pregnant, elderly, or disabled and 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 do not 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 does not exceed 100% of the poverty level, Medicaid will pay your Medicare monthly premium and your Medicare deductibles and coinsurance. This is called the Qualified Medicare Beneficiary (QMB) program.

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

Contact the Department of Children and Families for more information about other eligibility requirements.

- *There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify for Medicaid, contact the Florida Agency for Health Care Administration, or to apply contact the Department of Children and Families Office for the district office in the city or county in which you reside.

FLORIDA KIDCARE PROGRAM

Florida KidCare is a health insurance program that provides health coverage to low-income families with children under the age of 19 who are not eligible for Medicaid and who are uninsured or underinsured.

- *A child whose family has a household income below 200% of the federal poverty level is eligible for Florida KidCare. For a family of 3, this works out to an annual income of \$33,340 or a monthly income of about \$2,862. Premiums are on a sliding scale.*
- *Kidcare does not impose a pre-existing condition exclusion period. If a family meets the eligibility guidelines, an applicants pre-existing medical condition does not exclude him or her from coverage.*
- *Benefits include doctor visits, hospital and emergency services, surgery, immunizations, prescription coverage, vision, hearing, and behavioral health.*
- *You can get an application for the Florida KidCare Program from county health departments, the Department of Children and Families service center, community health centers, local libraries, many schools, day care centers, and hospitals. You can also call the KidCare Hotline at 1-888-540-5437 or visit their website at <http://www.floridakidcare.org/>.*

MARY BROGAN BREAST AND CERVICAL CANCER PROGRAM

- *The Mary Brogan Breast and Cervical Cancer Program 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 screening through the Florida Breast and Cervical Cancer Early Detection Program, you must be 50 to 64 years of age, do not have insurance that covers the service, have not been screened in the past year, and have an income at or below 200% of the federal poverty level. For a family of three, this is an annual income of no more than \$34,340.*
- *For more information regarding FBCCEDP, please call the Florida Department of Health (Family Healthline) at 1-800-451-2229.*

OTHER STATE PROGRAMS

- *There may be other financial assistance programs available. Please call the Agency for Health Care Administration for more information at 1-888-419-3456 or visit their website at <http://ahca.myflorida.com/>.*

THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)

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

WHEN AM I ELIGIBLE FOR THE HCTC?

- *To be eligible for the tax credit, you must be receiving Trade Adjustment Assistance (TAA) benefits or retirement benefits from the PBGC.* If you are receiving PBGC benefits, you also must be at least 55 years old.
- *In addition, you must meet other requirements.* Specifically, you are not eligible for the HCTC if any of the following apply to you:
 - You have a health plan maintained by an employer or former employer that pays at least 50% of the cost of your coverage. Any share of your premium that is paid by you or your spouse on a pre-tax basis is considered to have been paid by your employer and must be included as such when determining the percentage of employer coverage.
 - You are enrolled in Medicare (Part A or B).
 - You are enrolled in the Federal Employees Health Benefits Program (FEHBP), Medicaid, or State Children's Health Insurance Program (SCHIP).
 - You are entitled to health coverage through the U.S. military health system (Tricare/CHAMPUS).
 - You can be claimed as a dependent on someone else's federal tax return.
 - You received a lump sum payment of your entire PBGC benefit before August 6, 2002.
 - As of the first day of the current month in which you are otherwise eligible, you are imprisoned under a federal, state or local authority.

- *HCTC may apply to your family, too.* If you are eligible, you can use the credit to help purchase qualified health coverage for your qualified family members. Qualified family members are your spouse and dependents that you can claim on your federal tax return. Family members are not eligible if they are enrolled in another group health plan where the employer pays at least 50% of the cost of coverage, or in Medicaid, SCHIP, FEHBP, Tricare/CHAMPUS.
- *Eligibility for HCTC is not based on income.* In addition, the HCTC is refundable. This means you can claim the credit even if you do not earn enough income to owe federal income tax.

HOW MUCH OF MY 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 and state continuation coverage, as long as your employer or former employer contributes less than 50% of the total health plan premium. (See Chapter 3 for COBRA and state continuation coverage.)
 - State qualified plans: In Florida, a specific policy offered through Blue Cross and Blue Shield of Florida is the state qualified health plan.
 - Individual health insurance in which you were enrolled for at least the last 30 days before you were separated from the job that makes you eligible for TAA benefits or for payments from the PBGC.
 - Your husband’s or wife’s insurance from work, as long as the employer contributes less than 50% of the total health plan premium. (At this time, you can only claim the credit with this type of coverage when you file your federal tax return and not in advance.)
 - State qualified plans: Florida’s continuation coverage and Blue Cross and Blue Shield of Florida have been designated as qualified coverage in this state (see Florida continuation coverage on page 19 for more information).

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>Florida Department of Financial Services</i> (800) 342-2762 http://www.doi.state.fl.us
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) 4440EBSA (3272) http://www.dol.gov/ebsa
Medicaid	<i>Florida Agency for Health Care Administration</i> (888) 419-3456 http://www.fdhc.state.fl.us <i>Florida Department of Children and Families</i> (850) 487-1111 http://www.dcf.state.fl.us/ess/
Florida Breast and Cervical Cancer Early Detection Program	<i>Florida Department of Health (Family Healthline)</i> (800) 451-2229 http://www.doh.state.fl.us/Family/bcc/
Florida KidCare Program	<i>Florida KidCare Program</i> (888) 540-5437 (877) 316-8748 TTY http://www.floridakidcare.org
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

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

Conversion. Your right, when leaving a fully insured group health plan in Florida, to convert your policy to an individual health policy. You must have been covered under the group health plan for at least 3 months and use up any COBRA or state continuation coverage before you can buy a conversion policy. There are rules about what conversion policies must cover and what premiums can be charged. See also Fully 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.

Elimination Rider. A feature permitted in individual health insurance policies that permanently excludes coverage for a pre-existing condition.

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.

Florida KidCare. Florida KidCare is a state-designed program that provides health coverage to low-income children under the age of 19 who are not eligible for Medicaid and who have limited or no health insurance.

Fully Insured Group Health Plan. A health plan by an employer from an insurance company. Fully insured health plans are regulated by Florida. 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. 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 Florida small employers with 2 to 50 employees are guaranteed issue. If you are self-employed, basic and standard small group health plans are guaranteed issue. If you are HIPAA eligible, insurance companies must offer you a conversion policy for at least two individual health policies that are guaranteed issue. Plans that are guaranteed issue can turn you away for other reasons.

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

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

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

Health 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, 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 Florida 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 Policy. Policies for people not connected to an employer group. Individual health policies are regulated by Florida.

Kassebaum-Kennedy. See HIPAA.

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

Late Enrollment. Enrollment in a health plan at a time other than the regular or a special enrollment period. 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 Floridians. 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 30 days cannot be subject to pre-existing condition exclusions.

Pre-existing condition (Individual Health Policies). Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 2-year period immediately preceding enrollment in a health plan, or for which an ordinarily prudent person would have sought medical advice, care or treatment. Under individual health policies, pregnancy can be counted as a pre-existing condition. Genetic information 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. See also Genetic Information, Prudent Person Rule.

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

Prudent Person Rule. In individual health policies only, a rule that permits insurers to exclude as pre-existing any condition for which – in the insurer's judgment – most people would have sought care or treatment in the 2 years prior to obtaining an individual health policy. See Pre-existing condition (Individual Health Policy).

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 Florida.

Small Group Health Plans. Plans with no more than 50 employees, including the self-employed.

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

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

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

Temporary Assistance for Needy Families (TANF). A program 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 pre-existing condition exclusion period begins on the first day of the waiting period. See also Pre-existing Condition Exclusion Period.