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

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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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As an Indiana 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 an Indiana resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group health plans and individual health insurance. Chapter 4 highlights your protections as a small employer. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from Indiana, your protections may change. Since this guide is a summary, it may not answer all of your questions. For places to contact for more information, see page 34. For information about how to find consumer guides for other states on the Internet, see page 34. A list of helpful terms and their definitions begins on page 35. These terms are in **boldface type** the first time they appear.

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CHAPTER 1
A SUMMARY OF YOUR PROTECTIONS

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

HOW AM I PROTECTED?

In Indiana, 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 Chapter 2)

- *All group health plans in Indiana must limit exclusion of pre-existing conditions*. There are rules about what counts as a pre-existing condition and how long you must wait before a new 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 Chapter 2)

- *Your health insurance cannot be canceled because you get sick.* Most health insurance is **guaranteed renewable**. (see Chapter 3 for Individual Coverage, and Chapter 4 for Small Group Coverage)

- *If your son or daughter is in college and covered as a dependent under your group, but cannot maintain student status due to illness, he or she may still be able to remain covered as your dependent for up to one year.* (see Chapter 2)

- *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. 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 Chapter 3)

- *If you lost your group health plan because of involuntary termination of employment that occurred between September 1, 2008 and December 31, 2009, you may be eligible for a federal tax credit that can help you pay for your COBRA premiums for up to nine months.* (see Chapter 3)

- *If you lose your group health plan and meet other qualifications, you will be **HIPAA eligible***. If so, you can buy an individual health insurance policy from the **Indiana Comprehensive Health Insurance Association (ICHIA)**. You will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for an ICHIA policy. (see Chapter 3)

- *If you have had difficulty obtaining affordable individual health insurance because of your health condition, you may also be able to buy insurance from ICHIA.* In this case you may face a new pre-existing condition exclusion period. There are limits on what you can be charged for an ICHIA policy. (see Chapter 3)

- *If you lose your fully insured **small group health plan** and meet other qualifications, you may be eligible to buy a **conversion 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 Chapter 3)

- *You may not be turned down, charged more or face a pre-existing exclusion period by an individual insurer because of your genetic information.* (see Chapter 3)

- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group*. All health plans for small employers must be sold on a **guaranteed issue** basis. (see Chapter 4)

- *As a small employer, you may not be turned down or charged more because of the genetic information of a member of your group.* In addition, insurance companies are not allowed to even ask about genetic tests or family history of people in your group when you apply for coverage. (see Chapter 4)

- *If you are a small employer buying a group health plan, there are limits on what you can be charged due to the health status, age, gender, or occupation of those in your group.* (see Chapter 4)

- *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 Indiana 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 child is 19 years old or younger and meets other qualifications, you may be able to enroll him or her in **Hoosier Healthwise** program.* Hoosier Healthwise offers free or reduced price health coverage for children who do not qualify for Medicaid. (see Chapter 5)

- *If you believe you may be at risk for cancer but are uninsured or underinsured, you may be eligible for screening and treatment.* The **Indiana Breast and Cervical Cancer Program** provides free cancer screening for qualified residents. Some women diagnosed with breast or cervical cancer through this program may be eligible for medical care through Medicaid. (see Chapter 5)

- *If you are uninsured and have a low or modest household income, you may be eligible for subsidized health insurance through the **Healthy Indiana Plan (HIP)**.* (see Chapter 5)

- *If you 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 you pay for new health coverage.* This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 80% of the cost of qualified coverage, including COBRA and other types of health insurance coverage. (see Chapter 5)

- *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 Chapter 5)

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, you are not entitled to take your actual group health plan with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did. (see Chapter 2)

- *Employers are not required to provide health benefits for their employees, so if you change jobs, you may find that your new employer does not offer you health*

coverage. Employers are required only to make sure that any health benefits they do offer do not discriminate based on health status. (see Chapter 2)

- *If you get a new job with health benefits, your coverage may not start right away*. Employers can require **waiting periods** before your health benefits begin. (see Chapter 2)

- *If you have a break in coverage of 63 days or more, you may have to satisfy a new pre-existing condition period when you join a new group health plan.* (see Chapter 2)

- *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 up to one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition. (see Chapter 2)

- *If you work for a non-federal public employer in Indiana, such as a state or municipal government, not all of the group health plan protections may apply to you.* (see Chapter 2)

- *In Indiana, your access to individual health insurance may depend on your health status*. Private insurers are not prohibited from turning you down, or charging more because of your health status. (see Chapter 3)

- *If you are HIPAA eligible, ICHIA is your only guaranteed access to individual health insurance.* However, if you are healthy, you may be able to buy individual health insurance policy from a private insurer. (see Chapter 3)

- *If you move away from Indiana, you may not be able to buy individual health insurance in another state unless you are HIPAA eligible.* (see Chapter 3)

CHAPTER 2
YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

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

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

- *You have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees such as part time, non-permanent, or seasonal employees. Or, your employer may offer an HMO plan that you cannot join because you live outside 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 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 opportunity to enroll in your group health plan after certain events. Depending on the event, these special enrollment periods can last either 30 or 60 days. 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
- Involuntary 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)

Certain changes can trigger a 60-day special enrollment opportunity

- Loss of eligibility under Medicaid or SCHIP
- Eligibility for a state Medicaid or SCHIP premium assistance subsidy applicable to premiums for a group plan

- *Under Indiana 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 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 to the insurer within 120 days of reaching the limiting age and may be required subsequently in the future.

- *If your group health plan covers dependents, you may be able to keep your son or daughter covered under the plan after the age of majority.* Most group health plans will allow your son or daughter to remain covered under your family plan past the age of 19 if they are a full time student.

  If your son or daughter is in college and covered as a dependent under your group, but cannot maintain student status due to illness, he or she may still be able to remain covered as your dependent for up to one year. Federal law allows dependent children who take a medical necessary leave of absence due to a serious illness or injury to remain covered as dependents under their parents' group plan for up to one year or until the coverage would otherwise end, whichever comes first. This law will apply to plan years beginning on or after October 9, 2009.

  In addition, in Indiana fully insured group health plans (and individual health insurance policies if they provide coverage for dependents) must cover as a dependent your unmarried child up to age 24. This law does not apply to self-

insured group health plans. Check with your employer to find out the kind of group health plan you have.

Read you plan documents carefully to determine when your child will "age off" your group health plan.

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

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

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

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

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

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

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

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

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

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

- *Under group health plans, coverage for pre-existing conditions can be excluded only for a limited time.* The maximum exclusion period depends on the type of group health plan you are joining (see box below).

  If you enroll late (after you were hired and not during a regular or special enrollment period), you may have a longer pre-existing condition exclusion period. (Note that fully insured small group health plans in Indiana are required to accept late enrollees.) Ask your prospective employer if you are not sure what limit applies to you.

The maximum pre-existing condition exclusion period varies

Type of group health plan	Maximum exclusion period
Self-insured group health plan, any size	12 months (regular enrollees)
Self-insured group health plan, any size	18 months (late enrollees)
Fully insured group plan, 2-50 eligible workers	9 months (regular enrollees)
Fully insured group plan, 2-50 eligible workers	15 months (late enrollees)
Fully insured group plan, 51+ eligible workers	12 months (regular enrollees)
Fully insured group plan, 51+ eligible workers	18 months (late enrollees)

- *If you join a new group health plan, the law protects you from a new pre-existing condition exclusion period, provided you maintain* ***continuous creditable coverage***.

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

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

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

- *Coverage counts as continuous if it is not interrupted by a break of 63 or more days in a row.* In determining continuous coverage, employer-imposed waiting 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.

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 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, 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 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 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 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 plan may impose a pre-existing condition exclusion period for that category. Plans that use this method of crediting prior coverage must use it for everyone and must disclose this to you when you enroll.

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

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

Question: Is this permitted?

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

- *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 Indiana have decided that certain health insurance protections will not apply to their employees. The Center for Medicare and Medicaid Services (CMS) used to post a list of employers which had elected to exempt, however it has removed this information from its web site.

If you are not sure about your protections under your public employee health plan, you should contact your employer. In addition, you can contact CMS directly at (800) 267-2323 ext. 61565 or at (410) 786-1565 to see if your employer has elected to be exempt from certain protection.

AS YOU ARE LEAVING GROUP COVERAGE…

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

- *If you 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 you pay for new health coverage.* This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 80% of the cost of qualified coverage, including COBRA and other types of health insurance coverage. (see Chapter 5)

- *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 Chapter 5)

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group health plan, you may want to buy an individual health insurance policy from a private health insurance company. However, in Indiana – as in most other states – you have limited guaranteed access to individual health insurance. There are some alternatives to individual health insurance coverage in the private market – such as COBRA coverage and ICHIA coverage. 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 Indiana, your ability to buy individual health insurance may depend on your health status.

- *In general, companies that sell individual health insurance in Indiana are free to turn you down because of your health status and other factors.* When applying for individual coverage, 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 they might offer to sell you a policy that has special limitations on what it covers. If you have trouble buying and individual policy, you may be able to get coverage from ICHIA.

  However, under no circumstance may you be turned down, charged more or face a pre-existing exclusion period by an individual insurers because of your genetic information. Genetic information includes the results of a genetic test and your family history of health conditions.

- *If you are HIPAA eligible, Indiana Comprehensive Health Insurance Association (ICHIA) is your only guaranteed source of individual health insurance.*

- *In Indiana, 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 provides coverage for dependents.* The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.

- *If you have a disabled child, that child may remain covered under your 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 furnished to the insurer within 31 days of reaching the limiting age and may be required subsequently in the future.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy*. Indiana does not require health insurers in the individual market to sell standardized policies. Health insurers can design different policies and you will have to read and compare them carefully. Sometimes, individual health insurance policies provide less comprehensive coverage than group health plans, especially for certain services such as maternity care, mental health care, or prescription drugs. However, Indiana does require all individual health insurers to cover certain benefits – such as cancer screening and diabetic supplies and services. Check with the Indiana Department of Insurance for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *There are limits on the pre-existing condition exclusion periods that individual health insurers can impose*. If they agree to sell you a policy, insurers cannot exclude coverage for your pre-existing condition for longer than 12 months. Health insurers in Indiana may not impose **elimination riders,** which are amendments to your health insurance contract that permanently exclude coverage for a health condition, body part, or body system. However, insurers in Indiana are permitted to impose waivers, which exclude coverage on your pre-existing conditions for up to 10 years. Insurers are permitted to impose up to 2 waivers per individual.

- *There are rules about what counts as a pre-existing condition in individual health insurance in Indiana.* A pre-existing condition is anything for which you received medical advice, care, treatment, or diagnosis in the 12 months prior to purchasing coverage. In addition, insurers can count as pre-existing any condition for which the insurer believes most people would have sought care. This is called the **prudent person rule**.

  Pregnancy can be a pre-existing condition in individual health insurance policies, but genetic information cannot. Individual health insurers cannot impose pre-existing condition exclusion periods on newborns, newly adopted children, or children placed for adoption.

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

- *You will get credit toward your pre-existing condition exclusion period for any prior coverage you had under a small group health plan.* You must not have had a lapse of more than 30 days between your old and new coverage. However, individual health insurers are not required to credit your prior coverage in large group health plans, self-insured group health plans, or other individual health insurance. Also, individual health insurers can refuse to cover you altogether if you have a pre-existing condition.

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

- *Indiana law does not limit what insurers can charge you for health coverage*. You can be charged more because of your health status, age, and other factors. However, premiums cannot vary based on your genetic information.

- *When your policy is renewed, the premium increases will be based on the claim experience of the pool of people who bought the same policy that you bought*. This means that your rates will depend on the health of the entire pool of people with the policy, not your health alone. However, regardless of the claim that you have made, your premiums can increase on other factors, such as your age, or the length of time you have held the policy.

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELED?

- *Your coverage cannot be canceled because you get sick.* This is called guaranteed renewability. Generally, 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.

  However, if you make a claim during the first two years of coverage under your policy, the insurer might re-investigate information you provided during the application process to determine whether you made a misstatement. If so, the insurer might try to take back your policy and void coverage altogether.

  If you become involved in one of these "post-claims" investigations, be sure to call the Indiana Department of Insurance to learn more about your rights.

- *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 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 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.

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

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

COBRA QUALIFYING EVENTS

For employees

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

For spouses

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

For dependent children

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

- *Each person who is eligible for COBRA continuation can make 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 80% of their premiums.
- *For some laid off workers, TAA benefits begin after their 60-day period to elect COBRA continuation coverage has expired*. In this circumstance, TAA-eligible people have a second 60-day period, starting on the date of their TAA eligibility, to elect COBRA. (However, in no case can COBRA be elected more than 6-months following the original qualifying event (i.e. layoff) that caused the loss of group health plan coverage.)
- When COBRA is elected during this special, second election period, coverage starts on the first date of the special election period. Any time that has elapsed between the original qualifying event and the first date of the special election period is not counted as a lapse in coverage in determining continuous coverage history.

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

WHAT WILL COBRA COVER?

- *Your covered health benefits under COBRA will be the same as those you had before you qualified for COBRA.* For example, if you had coverage for medical, hospitalization, dental, vision, and prescription drug benefits before COBRA, you can continue coverage for all of these benefits under COBRA. If these benefits were covered under more than one plan (for example, a separate health insurance and dental insurance plan) you can choose to continue coverage under any or all of the plans. Life insurance is not covered by COBRA.

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Because your group coverage is continuing, you will not 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 plan because of involuntary termination of employment that occurred between September 1, 2008 and December 31, 2009, you may be eligible for a federal tax credit that can help you pay for your COBRA premiums for up to nine months.* This tax credit was created as part of The American Recovery and Reinvestment Act of 2009 (ARRA) and covers 65% of your COBRA premium. For more information, call the Employee Benefits Security Administration at the United State Department of Labor at (866) 444-3272 or visit the COBRA/AARA information center at http://www.dol.gov/ebsa/cobra.html. Information about the COBRA tax credit is also available from the IRS at http://www.irs.gov/newsroom/article/0,,id=204505,00.html and Department of Health And Human Services at http://www.cms.hhs.gov/COBRAContinuationofCov/.

- *If you 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.* The credit is called the Health Coverage Tax Credit (HCTC), and it is equal to 80% of the cost of qualified health coverage, including COBRA. (see Chapter 5)

- *If your 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 Chapter 5)

- *Call the Department of Labor at (866) 444-3272 to find out if other temporary COBRA subsidies are available to you.*

HOW LONG DOES COBRA COVERAGE LAST?

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

In addition, special rules for disabled individuals may extend the maximum period of coverage to 29 months. To qualify for the disability extension, you must have been disabled at the time of your COBRA qualifying event (such as termination of employment or reduction in hours) or within 60 days of that qualifying event. You must obtain this disability determination from the Social Security Administration, and you must notify your group health plan of this disability determination.

LENGTH OF COBRA COVERAGE

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

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

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

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

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

CONVERSION

WHEN DO INSURERS HAVE TO SELL ME A CONVERSION POLICY?

- *In Indiana, if you have coverage through a small employer's fully insured group health plan and you leave that job, you are eligible to buy a conversion policy.* This is an individual policy you get from the company that insured your employer's group plan.

- *To qualify for a conversion policy, you must have had at least 90 days of continuous coverage through an employer's small group health plan.* In addition, you must not be eligible for a group health plan, and you must request the conversion policy within 30 days of becoming eligible for it.

- *You do not have to elect COBRA continuation coverage before you are allowed to buy a conversion policy.* If you do elect COBRA continuation coverage, however, you will have the right to buy a conversion policy when COBRA coverage ends.

- *You do not need to be HIPAA eligible to buy a conversion policy.*

WHAT DOES A CONVERSION POLICY COVER?

- *The benefits under a conversion policy may not be the same as those under your former employer group health plan.* The conversion policy's benefits may be less generous than those you used to have. However, at a minimum, conversion policies must cover inpatient hospital and physician care, outpatient hospital and physician care, diagnostic laboratory services, diagnostic and therapeutic radiological services, and emergency care.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

WHAT CAN I BE CHARGED FOR A CONVERSION POLICY?

- *Premiums for a conversion policy are limited to one and one half times (150%) the rate an eligible employee would have been charged under the small employer's health plan.* If you have questions about conversion policy premiums, contact the Indiana Department of Insurance.

CAN A 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.

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION (ICHIA)

Indiana has a high risk pool program, called the Indiana Comprehensive Health Insurance Association (ICHIA) that offers insurance for people with health conditions who are unable to buy private health insurance coverage and for people who are HIPAA eligible. ICHIA is also considered a qualified health plan for individuals eligible for the health coverage tax credit (HCTC). (see Chapter 5)

WHEN CAN I GET COVERAGE FROM ICHIA?

- *If you are HIPAA eligible, you can purchase an individual health insurance policy from ICHIA.*

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible in Indiana, you are guaranteed the right to buy an individual insurance policy plan from ICHIA 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 ICHIA coverage within 63 days of losing your prior coverage.

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

- *If you are eligible for the HCTC, you can purchase an individual health insurance policy from ICHIA.*

- *If you are not HIPAA eligible, you can buy coverage from ICHIA if you are* "uninsurable." You are considered uninsurable if you: 1) have been turned down for coverage that is similar to ICHIA coverage; or 2) are unable to find private health insurance coverage that is cheaper than ICHIA health insurance.

  In addition, to buy coverage from ICHIA you must be an Indiana resident for at least 12 months and not be eligible for Medicaid or any other health insurance coverage.

- *ICHIA offers family coverage.* However, ICHIA does not offer family rates. Each enrolled family member will have to pay the monthly rate based on his or her age and gender.

WHAT WILL ICHIA COVER?

- *ICHIA coverage includes hospital and physician care, diagnostic tests and x-rays, prescription drugs, and other services*.

- *ICHIA offers you a choice of four cost-sharing arrangements.* The annual deductible options are $500, $1,000, $1,500, or $2,500.

  All four ICHIA plans have a Preferred Provider Network (PPN) of doctors and hospitals in your area. Generally for most services, you will be charged 20% coinsurance for care from a PPN provider and 40% coinsurance for care from a non-PPN provider. After you have paid a maximum amount for covered services (also called the out-of-pocket limit) ICHIA will pay 100% of the eligible expenses for the remainder of the calendar year. ICHIA's out-of-pocket limits range from $1,500 to $5,000. Plans offered through ICHIA do not impose a lifetime benefit maximum on covered benefits.

  Separate coverage limits apply to mental health and substance abuse benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are HIPAA eligible, you will not have a pre-existing condition exclusion when you enroll in ICHIA.* Elimination riders are not permitted on ICHIA plans.

- *If you are not HIPAA eligible, ICHIA will exclude coverage for your pre-existing condition for 3 months.* ICHIA will look back 3 months before you enrolled to see if you had a condition for which you actually received a diagnosis, medical advice, or treatment. ICHIA can impose pre-existing condition exclusions on pregnancy.

  ICHIA will credit prior continuous coverage toward your pre-existing condition exclusion if you apply for ICHIA coverage within 6 months of losing your prior coverage.

WHAT CAN I BE CHARGED FOR ICHIA COVERAGE?

- *ICHIA charges enrollees different rates based on their age, gender and the geographic area they live in.* Under Indiana law, ICHIA rates are not allowed to be more than 150% of the amount that a healthy person would pay if he or she bought a similar plan sold by a private insurer.

- *In addition, premiums vary based on the plan you choose*. For example, the monthly premium for a 24-year-old male ranges from $234 to $285, depending on which plan option is selected and where you live. By contrast, the monthly premium for a 64-year-old male ranges from $807 to $984, depending on which plan option is selected and where you live.

  Contact ICHIA for the most current information about premium and coverage options.

HOW LONG DOES ICHIA COVERAGE LAST?

- *ICHIA policies are renewable as long as you pay your premiums, continue to reside in Indiana, and meet other eligibility requirements.*

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

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

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down. This is called guaranteed issue*. If you employ at least 2 people, but not more than 50 eligible employees, health insurance companies must sell you any small group health plan they sell to other small employers. However, they can require that a minimum percentage of your eligible employees sign up for coverage. They can also require you to pay a minimum share of your workers' premiums. If you wish to buy a **large group health plan** (one that covers more than 50 eligible employees), insurers are allowed to refuse to sell you a policy.

- *Under no circumstances may you be turned down or charged more because of the genetic information of someone in your group.* In addition, insurance companies may not even ask about genetic test results or family history of people in your group when you apply for coverage.

- *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 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?

- *Within limits, you can be charged higher premiums based on the health, risk, and demographic characteristics of your group*. For small employers, Indiana limits the difference in premiums and the annual increase that can be charged. For groups with more than 50 employees, Indiana does not limit premium variation or increases. Insurers in Indiana cannot charge higher premiums based on the genetic information of those in your group. If you have questions about your group health plan premiums, contact the Indiana Department of Insurance.

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 are eligible to deduct 100% of the cost of your premium from your federal income tax.*

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Indiana who cannot afford to buy health insurance. Medicaid, the Breast and Cervical Cancer Program and other programs offer frees or subsidized health insurance coverage, direct medical services and other help. This chapter provides summary information about these programs and contact information for further assistance.

In addition, the federal Health Coverage Tax Credit (HCTC) Program provides tax credits to early retirees and 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 Indiana residents. Hoosier Healthwise is the Medicaid managed care program that covers families with children and pregnant women if state and federal guidelines are met. The elderly, and people with disabilities can also enroll in Medicaid if state and federal guidelines are met. Legal residents who are not U.S. citizens may be eligible for Medicaid. Non-citizens who do not have immigration documents cannot enroll in Medicaid, but may be covered if treated for an emergency condition.

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

  In Indiana you may be eligible for Hoosier Healthwise if you are a child, a pregnant woman, or a parent of a child and your family income meets the Medicaid income standards.

  Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account, so you should contact the Indiana Family and Social Services Administration for more information.

Low income persons eligible for Medicaid in Indiana*

Category	Income eligibility (as percent of federal poverty level)
Child 0-1	200%
Child 1-19	150%
Non-working parents	20%
Working parents	26%
Pregnant woman	200%

* 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 2009:

Size of Family Unit	Poverty Guideline (annual income)
1	$ 10,830
2	$ 14,570
3	$ 18,310

For larger families add $3,740 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 $36,620, or a monthly income of $3,052.

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

- *Families who get cash benefits from **TANF (Temporary Assistance for Needy Families)** are probably also eligible for Hoosier Healthwise.*

  Parents should know that when you get a job, you may qualify for transitional coverage under Hoosier Healthwise for a 12-month period.

- *Poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits are 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 under a different eligibility category that may require payment of a premium.

- *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, Medicaid may be able to help you with your Medicare expenses.

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

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

  Contact the Indiana Family and Social Services Administration 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 Indiana Family and Social Services Administration.

HOOSIER HEALTHWISE

- *Hoosier Healthwise is a health care program available to children up to age 19, pregnant women, and low-income families with children.* If you are in one of these categories of people and your income is below 150% of the federal poverty level (FPL) you may qualify for Package A and not be charged a premium. If you are a child and live in a family with an income between 150% and 200% of the FPL, you may qualify for Package C and you will have to pay a small premium for coverage, ranging from $22 to $50.

- *Hoosier Healthwise provides comprehensive coverage to enrollees.* This includes doctor visits, preventive well-child visits, prescription drugs, dental and vision care, labs and x-ray services, mental health, hospitalization, as well as other services.

- *Children with private health insurance can enroll in Hoosier Healthwise depending on family size and household income.* Call Hoosier Healthwise for more detail on eligibility or visit online at http://www.in.gov/fssa/ompp/2544.htm.

BREAST AND CERVICAL CANCER PROGRAM

- *The Indiana Breast and Cervical Cancer Program provides qualified woman with free screenings for breast and cervical cancer.* Women screened through this program and diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid which extends throughout the duration of treatment.

- *To be eligible for screening, you must be at least 40 and no more than 64 years of age (if 65 and older, you must not be enrolled in Medicare Part B to be eligible for screening), have no or limited health insurance, and a family income at or below 200% of the federal poverty level (FPL).*

- *For more information, please call Indiana Breast and Cervical Cancer Program at (800) 433-0746 or visit or visit http://www.in.gov/isdh/19851.htm.*

HEALTHY INDIANA PLAN (HIP)

The Healthy Indiana Plan (HIP) is a program offered by the state of Indiana that makes low-cost health insurance available to low income Indiana residents.

WHEN CAN I GET HIP COVERAGE?

- *If you are between 19 and 64 years old, do not have access to employer sponsored coverage, have been uninsured for at least 6 months, and earn up to 200% FPL, you may be able to buy health insurance through HPI.* Individuals who meet all the eligibility requirements but are above 200% FPL, may be able to buy HIP coverage at full cost.

  As of July 2009, there is a waiting list for HIP coverage for childless adults.

- *Individuals with COBRA, accident only policies and disease specific policies are not subject to the 6 month uninsured requirement.* In addition, if you are only eligible for employer sponsored coverage as a dependent on your spouse's coverage, you are not considered to have access to employer sponsored coverage and may be eligible for HIP.

WHAT WILL HIP COVER?

- *HPI provides comprehensive coverage to eligible individuals.* Coverage includes physician services, hospital, prescription drugs, X-rays, and mental health services. Vision, dental and pregnancy are not covered benefits. All individuals are subject to a $300,000 annual cap and a $1 million lifetime cap. Currently, Anthem and MDWise with AmeriChoice are participating in HIP.

- *Some individuals may be eligible for benefits through the HIP Enhanced Services Plan.* The state may determine that HIP enrollees with certain health conditions are eligible for the HIP Enhanced Services Plan, which provides benefits through the Indiana Comprehensive Health Insurance Association (ICHIA).

WHAT ABOUT PRE-EXISTING CONDITIONS?

- *There are no pre-existing condition exclusion periods when you buy health insurance through HIP.*

WHAT CAN I BE CHARGED FOR HIP COVERAGE?

- *You may be required to contribute up to 5% of your household income towards the premiums, depending on your household size and income.* The state will contribute the remaining premiums. In addition, individuals may be responsible for co-payments for emergency room visits.

- For more information about HIP, the *Family and Social Services Administration, Healthy Indiana Plan at (877) 438-4479 or visit them on the web at* http://www.in.gov/fssa/hip/.

OTHER PROGRAMS

- *There may be other financial assistance programs available.* Please contact Indiana Family and Social Services Administration at (800) 889-9949 or visit them on the web at http://www.IN.gov/fssa/.

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 80% 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 COST WILL THE TAX CREDIT COVER?

- *The HCTC is equal to 80% 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, Indiana has designated plans sold through Anthem Blue Cross Blue Shield and coverage offered through the Indiana Comprehensive Health Insurance Association as qualified health plans. (see Chapter 3)

HOW DO I CLAIM THE HCTC?

- *You can claim the HCTC on your tax return and be reimbursed for 80% 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 (866) 628-HCTC (866-628-4282), Monday through Friday between the hours of 7 am and 7 pm, Central time. TDD/TYY callers, please call (866) 626-HCTC (866-626-4282).

WHERE CAN I GET MORE INFORMATION?

- *For more information about the HCTC, contact the HCTC customer service center at (866) 628-HCTC, or see the IRS website at* http://www.irs.gov/individuals/article/0,,id=187948,00.html.

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

- *For more information about PBGC, call (202) 326-4000 or visit online at http://www.pbgc.gov.*

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 Conversion	*Indiana Department of Insurance* (800) 622-4461 (Indiana only) (317) 232-2385 http://www.state.in.us/idoi/index.htm
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	*U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C.* (202) 219-8776 *For Department of Labor Employee Benefits Security Administration: Employee & Employer Assistance Hotline and Publications:* (866) 444-EBSA (3272) http://dol.gov/ebsa
Indiana Comprehensive Health Insurance Association (ICHIA)	*ICHIA* P.O. Box 33730 Indianapolis, IN 46203-0730 (800) 552-7921 or (317) 614-2133 http://www.onlinehealthplan.com/ (click "Guest")
Medicaid (including Hoosier Healthwise)	*Indiana Family and Social Services Administration* (800) 889-9949 http://www.IN.gov/fssa/
Healthy Indiana Plan (HIP)	*Indiana Family and Social Services Administration* (877) 438-4479 http://www.in.gov/fssa/hip/
Indiana Breast and Cervical Cancer Program	*Indiana Department of Health* (800) 433-0746 or visit http://www.in.gov/isdh/19851.htm
Other Programs	*Indiana Family and Social Services Administration* (317) 233-4454 http://www.in.gov/fssa/
Federal Health Coverage Tax Credit (HCTC)	*Internal Revenue Service* (866) 628-HCTC http://www.irs.gov/individuals/article/0,,id=187948,00.html

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

Last Reviewed June 2009

HELPFUL TERMS

Alternative Trade Adjustment Assistance (ATAA). ATAA is a benefit for workers at least 50 years old who have obtained different, full-time employment within 26 weeks of the termination of adversely-affected employment. These worker 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.

Breast and Cervical Cancer Program. Program which provides free screening for breast and cervical cancer to eligible Indiana residents. Eligible women diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid for treatment of their condition.

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. In general, health insurance coverage that is not interrupted by a break of 63 or more consecutive days. Employer waiting periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. If you are buying ICHIA coverage and you are not HIPAA eligible, you must apply within 6 months of losing prior coverage. See also ICHIA.

Conversion Policy. A policy that must be offered to you if you lose coverage under a fully insured group health plan in Indiana that you had been enrolled in for at least three months. You must not be eligible for a group health plan, and you must request the conversion policy within 30 days of becoming eligible for it. See also Fully Insured Group Health Plan.

***Creditable Coverage* (ICHIA).** Health insurance coverage that was involuntarily terminated and that had a similar pre-existing condition exclusion. See also Continuous Coverage, ICHIA.

***Creditable Coverage* (Group Health Plan).** Health insurance coverage under any of the following: a group health plan; individual health insurance; 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 risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Insurance.

Elimination Rider. An amendment permitted in individual health insurance policies that permanently excludes your coverage for a health condition, body part, or body system. Elimination riders are not permitted in Indiana.

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 plan purchased by an employer from an insurance company. Fully insured health plans are regulated by Indiana. See also Self-Insured Group Health Plans.

Genetic Information. Genetic test results indicating your or a member of your family's risk of developing a health condition. Genetic information includes the existence or history of a disease or disorder in a family member. Genetic services, including genetic counseling and education received by you or a family member, is also considered part of your genetic information.

Group Health Plan. Health plan (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 with 2 to 50 employees in Indiana 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 tax credit, you must be 1) receiving Trade Readjustment Allowance (TRA) benefits or 2) will receive TRA benefits once your unemployment benefits are exhausted or 3) receiving benefits under the Alternative Trade Adjustment Assistance (ATAA) program or 4) aged 55 or older and receiving benefits from the Pension Benefit Guaranty Corporation (PBGC).

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

Health Plan Year. That calendar period during which your health plan coverage is in effect. Many group health plan years begin on January 1, while others begin in a different month.

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

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 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. Under federal law, to be HIPAA eligible you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. No matter where you live in the U.S., if you are HIPAA eligible you must be offered at least some type of individual health insurance with no pre-existing condition periods. In Indiana, you must be offered coverage through ICHIA. See also ICHIA, COBRA, Continuous Coverage, Creditable Coverage.

Hoosier Healthwise. Indiana's Medicaid program that provides managed care coverage for some low-income children, families, and pregnant women who have limited or no health insurance.

ICHIA. Indiana Comprehensive Health Insurance Association, the state-run insurance program for HIPAA eligible persons and for people with high health risks (called a high risk pool).

Individual Health Insurance Policy. Policies for people not connected to an employer group. This term also refers to coverage purchased by self-employed persons who have no other employees. Individual health insurance policies are regulated by Indiana.

Large Group Health Plan. A health plan covering employees and their dependents in which the employer employs more than 50 employees.

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

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

Managed Care Plan. A kind of health insurance plan. Like an HMO, managed care plans can limit coverage to health care provided by doctors or hospitals who work for or contract with them -- also called "network" providers, and therefore may limit enrollment to those people who live within a particular coverage area. Managed care plans may require you to get permission (a "referral") from your family doctor before you get care from a specialist in their network. Some managed care plans will cover your care at a lower rate if you go to a non-network provider or if you get specialty care without a referral. See also HMO.

Medicaid. A program providing comprehensive health insurance coverage and other assistance to certain low-income Indiana residents. The Medicaid program offered to pregnant women, children, and families with children is called Hoosier Healthwise. 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 and 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 Plan).** 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 **(ICHIA).** Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 3-month period immediately preceding enrollment in a health plan Pregnancy can be counted as a pre-existing condition by ICHIA. See also Prudent Person Rule.

Pre-existing Condition **(Individual Health Insurance).** Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12 month period preceding enrollment in a health plan, or for which an ordinarily prudent person would have sought medical advice, care or treatment. In Indiana, under individual health insurance policies, pregnancy can be counted as a pre-existing condition. Genetic information can not trigger a pre-existing condition exclusion in individual health insurance policies. See also Prudent Person Rule.

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

Prudent Person Rule. In individual health insurance 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 prior to enrolling in an individual health insurance 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 Indiana.

Small Group Health Plan. A health plan covering employees and their dependents in which the employer employ at least 2 employers but not more than 50 employees.

Special Enrollment Period. A time, triggered by certain specific events, during which you and your dependents must be permitted to sign up for coverage under a group health plan. Employers and group health insurers must make such a period available to employees and their dependents when their family status changes or when their health insurance status changes. Special enrollment periods must last at least 30 or 60 days, depending on the qualifying event. 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 for small employers with fewer than 20 employees. Indiana does not require state continuation coverage, but some other states do. See also COBRA.

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

Temporary Assistance for Needy Families (TANF). A program 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 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 80% 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.