CONSUMER'S GUIDE
TO
GETTING AND KEEPING HEALTH INSURANCE
IN
COLORADO

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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 COLORADO

As a Colorado 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 Colorado 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 Colorado, 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 36. These terms are in **boldface type** the first time they appear.

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CHAPTER 1
A SUMMARY OF YOUR PROTECTIONS

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

HOW AM I PROTECTED?

In Colorado, 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 Colorado 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 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 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 or state continuation coverage 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 state high-risk pool, **CoverColorado**. You will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for a CoverColorado 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 CoverColorado.* In this case you may face a new pre-existing condition exclusion period. There are limits on what you can be charged for a CoverColorado policy. (see Chapter 3)

- *If you lose your fully insured 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. (see Chapter 3)

- *When you apply for an individual health insurance policy, insurance companies may not turn you down, charge you more or impose a pre-existing condition exclusion period because of your **genetic information**.* In addition, insurance companies are not allowed to even ask about your genetic tests or family history when you apply for coverage. (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 fully insured health plans for small employers must be sold on a **guaranteed issue** basis. (see Chapter 4)

- *If you are a small employer buying a small group plan, you cannot be charged higher premiums based on the health status and claims history of those in your group.* However, premiums will vary based the age, geographic area, industry of your group and other factors. This is called **modified community rating.** (see Chapter 4)

- *As a small employer, you cannot 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 self-employed or an employer with a sole employee, you may qualify to buy a* ***small group health plan policy*** *as a* ***business group of one****.* (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 Colorado **Medicaid** program offers free health coverage and other assistance for qualifying families, children, pregnant women, elderly and disabled individuals. (see Chapter 5)

- *If your child is 18 years old or younger, does not have health insurance and meets other qualifications, you may be able to enroll them in the* ***Child Health Plan Plus (CHP+)*** *program.* CHP + offers free or reduced price health coverage for children who do not qualify for Medicaid. (see Chapter 5)

- *If you believe that you may be at risk for cancer, you may be eligible for free screening and treatment.* **The Women's Wellness Connection (WWC)** provides qualified women with free breast and cervical cancer screening. In addition, women diagnosed with cancer through this program may be eligible for medical care through the Colorado Medicaid program. (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, state continuation coverage, and CoverColorado. (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 or state continuation rights, you are not entitled to take your actual group health plan with you when you leave a job.

Your new health plan may not cover all of the benefits or the same doctors that your old plan did. (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 only required 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. **HMOs** can require **affiliation periods.** (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 exclusion period when you join a new group health plan.* (see Chapter 2)

- *Even if your coverage is **continuous**, there may be a pre-existing condition exclusion period for some benefits if you join a **self-insured 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 Colorado, such as a county or municipal government, not all of the group health plan protections may apply to you.* (see Chapter 2)

- *In Colorado, your access to individual health insurance depends on your health status.* Private insurers are not prohibited from turning you down, charging more, or limiting coverage due to your health. (see Chapter 3)

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

- *If you move away from Colorado, 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?

- *In general, 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 30-day 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 a group plan

- *Under Colorado law, newborns, adopted children and children placed for adoption are automatically covered under the parents' fully insured health plan for the first 31 days, if the plan covers dependents.* The insurer may require that the parent enroll the child and pay the premium within the 31 days in order to continue coverage beyond the 31 days.

- *Under Colorado law, your unmarried, disabled child may remain covered under your fully insured group plan into adulthood, if the plan covers dependents.* In order to qualify, your child must be medical certified as disabled and dependent on you.

- *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. A new federal law allows dependent children who take a medically 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. For more information about this important protection, contact the U.S. Department of Labor at (866) 444-EBSA (3272).

  In addition, in Colorado, fully insured group health plans that cover dependents, must cover your unmarried child up to the age of 25, provided they continue to have the same legal residence as you or remain financially dependent upon you.

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. Unlike employers, insurers cannot require waiting periods. If your new job has health insurance through an HMO, the HMO may also require a waiting period called an HMO affiliation period, and you will not have health insurance coverage during this time. An affiliation period cannot exceed 2 months (3 months for late enrollees), and you cannot be charged a premium during this period.

- *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.*

- *Group health plans can only exclude coverage for pre-existing conditions for a limited time.* The maximum exclusion period depends on the type of group health plan you are joining. If you are joining a fully-insured group health plan in Colorado, the maximum exclusion period is 6 months. If you are joining a self-insured group health plan, the maximum exclusion period is 12 months.

  If you enroll late in a self-insured group plan (after you were hired and not during a regular or special enrollment period), you may have a pre-existing condition exclusion period of 18 months. Or, if you are a late enrollee in a fully insured group health plan, the health plan might exclude you altogether for up to one year.

  Ask your prospective employer if you are not sure what limit applies to you.

- *Group health plans that impose pre-existing condition exclusion periods must give you credit for any previous continuous **creditable coverage** that you've had.* Most types of private and government-sponsored health insurance are considered 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 of prior coverage, 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 significant break.* Fully insured group health plans in Colorado count coverage as continuous if it is not interrupted by a break of 90 or more days in a row. Self-insured group health plans consider coverage continuous if it is not interrupted by a break of 63 or more days in a row.

What is continuous coverage?

You can get continuous coverage under one plan or under several plans as long as you don't have a significant lapse.

Take Art, who has diabetes. Ajax Company covered him under its group health plan for 3 months, but he lost his job and health coverage. Then, *75 days later*, Art found a new job at Beta Corporation and had health coverage for 3 more months. Art changed jobs again to work for Charter Company, and immediately joined the health plan. Charter has a fully insured group health plan that covers care for diabetes but excludes pre-existing conditions for 6 months. Charter must cover Art's diabetes care *immediately*. This is because Art's prior coverage under the Ajax and Beta plans was not interrupted by a break (of 90 days). He must be given credit for 6 months of prior, continuous coverage toward the Charter plan's 6-month exclusion.

Now consider a slightly different situation. Assume Charter has a self-insured group health plan. In this case, Charter will give Art credit only for his Beta's plan coverage. Art does not get credit for his coverage at Ajax since he had a break of *more than 63 consecutive days.* Charter's plan will begin paying for Art's diabetes care in 3 months (6 months minus 3 months).

- *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.

- *Your protections may differ if you move to a self-insured 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 health plan may impose a pre-existing condition exclusion period for that category. Plans that use this method of crediting prior coverage must use it for everyone and must disclose this to you when you enroll. Under Colorado insurance law, fully insured group plans are not permitted to use this alternative method of crediting prior coverage.

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

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

Question: Is this permitted?

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

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

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

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

In the past, a large number of public employers in Colorado 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 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, state continuation coverage, conversion coverage, and CoverColorado coverage.

- *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.* This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 80% of the cost of qualified health coverage, including COBRA, state continuation coverage, and CoverColorado. (see Chapter 5)

- *If you are a retiree aged 55-65 and receiving benefits from Pension Benefit Guaranty Corporation (PBGC), you may also 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 insurer. However, in Colorado – as in most other states – you have limited guaranteed access to individual health insurance sold by insurers. There are some alternatives to individual health insurance in the private market – such as COBRA coverage and CoverColorado 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 Colorado, your ability to buy an individual health insurance policy depends on your health status.

- *In general, insurers that sell individual health insurance in Colorado are free to turn you down because of your health status and other factors*. When applying for individual health insurance, you may be asked questions about health conditions you have now or had in the past. Depending on your health status, insurers might refuse to sell you coverage or they may offer to sell you a policy that has special limitations on what it covers. If you are turned down or offered a policy with reductions or restrictions, you may be eligible for CoverColorado coverage.

  However, under no circumstance can you be turned down, charged more or face a pre-existing exclusion period 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, CoverColorado is your only guaranteed source of individual health insurance.*

- *In Colorado, newborns, adopted children, and children placed for adoption are automatically covered under the parents' individual health insurance, if the plan covers dependents.* Generally, the automatic period of coverage lasts for the first 31 days following the birth or adoptions, however the length may vary policy to policy. The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.

- *Under Colorado law, your unmarried, disabled child may remain covered under your fully insured group plan into adulthood, if the plan covers dependents.* In order to qualify, your child must be medical certified as disabled and dependent of the parent.

- *If you are self-employed, you may qualify to buy a small group health plan as a business group of one.* (see Chapter 4)

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Individual health insurers can impose **elimination riders**.* This is an amendment to your health insurance policy that that may permanently exclude a specific, named health condition you may have or have had in the past. In Colorado, elimination riders may only exclude specific health conditions (such as asthma) from coverage, not the body parts or systems they affect (such as your respiratory system).

- *Individual insurers can also impose pre-existing condition exclusion periods.* In Colorado, an individual market insurer can apply a pre-existing condition exclusion period for up to 12 months.

  The definition of pre-existing condition is different under individual health insurance than under group health plans. Individual health insurers can count as pre-existing any condition for which you received medical advice, care, treatment, or diagnosis in the 12 months prior to purchasing coverage. This is called the **objective standard**.

  Pregnancy may be considered a pre-existing condition in an individual health insurance policy. However, genetic information cannot be used as a basis for a pre-existing condition.

- *If you make a claim during the first two years of coverage, the 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.

- *Like fully insured group health plans, individual health insurers in Colorado must give you credit for prior continuous coverage.* Coverage counts as continuous if it is not interrupted by a break of 90 or more days in a row. However, prior coverage will not be credited against elimination riders.

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

- *Generally, in Colorado, there are no limits on how much you can be charged for an individual health insurance policy.* Individual premiums can vary due to health status, age, gender, family size, 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 you bought.* This means that your rates will depend on the health of the entire pool of people with the same policy, not just on 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 Colorado Division 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 AND STATE CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

If you are leaving your job and you had group coverage, you may be able to stay in your group plan for an extended time through COBRA 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 his or her own decision.* If your dependents were covered under your employer plan, they may elect COBRA coverage even if you do not.

- *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 have a new pre-existing condition exclusion period under COBRA.* However, if you were in the middle of a pre-existing condition exclusion period when your qualifying event occurred, you will have to finish it.

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

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

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

- *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 the 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 are eligible for the Health Coverage Tax Credit (HCTC), the federal government will pay 80% of your COBRA premium.* (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, 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 within 60 days of that qualifying event. You must obtain this disability determination from the Social Security Administration, and you must notify your group health plan of this disability determination.

How long can COBRA coverage last?

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

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

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

- *COBRA coverage also ends if your old employer stops offering a health benefit plan to its other employees.*

- *COBRA coverage might end if you are in a managed care plan that is available only to people living in a limited geographic area and you move out of that area.* However, if you are eligible for COBRA and are moving out of your current health plan's service area, your employer must provide you with the opportunity to switch to a different plan, but only if the employer already offers other plans to its employees. Examples of the other plans your employer may offer you are a managed care plan whose service area includes the area you are moving to, or another plan that does not have a limited service area.

WHAT ABOUT STATE CONTINUATION COVERAGE?

- *Colorado continuation coverage is similar to COBRA.* If you were covered under any fully insured group health plan that is otherwise not required to offer Federal COBRA (generally those with less than 20 employees) for 6 months or more and you lose coverage, you may be able to continue coverage under your former plan for up to 18 months.

- *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 state continuation coverage premiums for up to nine months.* This tax credit is part of The American Recovery and Reinvestment Act of 2009 (ARRA), and covers 65% of the your state continuation premium. For more information call the Employee Benefits Security Administration at the United State Department of Labor at (866) 444-3272 or visit them online at *http://www.dol.gov/ebsa/cobra.html*. In addition, see "Health Information About State Continuation Coverage And ARRA" available the website of the Department of Health And Human Services at http://www.cms.hhs.gov/COBRAContinuationofCov/.

- *Check with your former employer or the Colorado Division of Insurance if you think state continuation coverage applies to you.*

CONVERSION COVERAGE

WHEN AM I ELIGIBLE FOR A CONVERSION POLICY?

- *In Colorado, if you have coverage through an employer's fully insured group health plan and you lose that coverage, you are eligible to buy a conversion policy.* A conversion policy is an individual policy you buy from the company that insured your employer's group plan.

- *To qualify for a conversion policy, you must have had at least 3 months of continuous coverage through an employer's fully insured group health plan.* In addition, you must not be covered under or eligible for coverage under Medicare or another group health plan. Finally, you must elect the conversion policy in writing and make payment within 31 days of termination of your prior group coverage.

- *You do not need to be HIPAA eligible to buy a conversion policy.* However, if you do elect a conversion policy, you will lose your HIPAA eligibility status.

WHAT DOES A CONVERSION POLICY COVER?

- *The benefits under a conversion policy will probably not be the same as those under your former plan.* The conversion policy's benefits may be less generous than those you used to have.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

HOW MUCH CAN I BE CHARGED FOR A CONVERSION POLICY?

- *Conversion policies may cost much more than your previous group health plan.* There is no limit on what you can be charged for a conversion policy. You may be charged higher rates based on your health, age, gender, and other factors. Contact the Colorado Department of Insurance if you have questions about conversion policy premiums.

CAN MY CONVERSION POLICY BE CANCELED?

- *Conversion policies, like other individual health insurance policies, are guaranteed renewable.* Your coverage cannot be covered because you get sick. 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's service area.

COVERCOLORADO

Colorado has a high-risk pool program, called CoverColorado that offers insurance for people with health conditions who are unable to buy private health insurance coverage and for people who are HIPAA eligible. CoverColorado 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 COVERCOLORADO?

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

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible in Colorado, you are guaranteed the right to buy an individual health insurance from CoverColorado 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*. (Note that in Colorado, coverage under student health insurance is considered group coverage.)
- 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 CoverColorado within 90 days of losing your prior coverage. (In other states, 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 CoverColorado or an individual plan, because the last day of your continuous health coverage must have been in a group plan. You can become HIPAA eligible again by maintaining continuous coverage and rejoining a group health plan.

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

- *If you are not HIPAA eligible, you can buy coverage from CoverColorado if you are "uninsurable."* You are considered uninsurable if you: 1) have been turned down for coverage within the past 6 months because of previous medical conditions; 2) have had your health insurance involuntarily terminated within the past 60 days for reasons other than non-payment of a premium; 3) are unable to find private health insurance coverage that is less expensive than CoverColorado health insurance; 4) are uninsured and have a diagnosis of one of several medical conditions including cancer, diabetes, or HIV/AIDS or transferring from a high risk pool in another state.

  In addition, to buy coverage from CoverColorado you must be have been a Colorado resident for at least 6 months and not be eligible for Medicare, Medicaid, or any other health insurance coverage. The residency requirement is waived for those transferring from another state's high risk insurance pool and for HIPAA eligible individuals.

- *CoverColorado does not offer family coverage.* Each individual member of the family must qualify for coverage independently.

WHAT WILL COVERCOLORADO COVER?

- *CoverColorado coverage includes hospital and physician care, diagnostic tests and x-rays, prescription drugs, and limited mental health care services.*

- *CoverColorado offers you a choice of eight plans, each with a different deductible.* All CoverColorado plans have a preferred provider (PPO) network of doctors and hospitals in your area. Generally for most services, depending on the plan, you will be charged between 20% and 30% coinsurance for care from a network provider and 50% coinsurance for care from an out-of-network provider. All plans have a lifetime cap of $1,000,000 on covered benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are HIPAA eligible or eligible for the Health Coverage Tax Credit (HCTC), you will not have a pre-existing condition exclusion when you enroll in CoverColorado.* Elimination riders are not permitted on CoverColorado plans.

- *If you are not HIPAA eligible, you may have a pre-existing condition exclusions period.* If you have not been insured in the 90 days prior to applying for CoverColorado, expenses related to any pre-existing medical condition will not be covered for the first six months that you are enrolled. In CoverColorado, a pre-existing condition is one for which you actually received a diagnosis, medical advice, or treatment in the 6 months prior to enrollment. CoverColorado can impose a pre-existing condition exclusions on pregnancy.

  CoverColorado will credit prior continuous coverage toward your pre-existing condition exclusion if you apply for CoverColorado coverage within 90 days of losing your prior coverage.

WHAT CAN I BE CHARGED FOR COVERCOLORADO COVERAGE?

- *Premiums will vary based on the plan you choose.* In addition, CoverColorado charges enrollees different rates based on their age, gender, smoking status, and the geographic area they live in. CoverColorado can charge rates up to 50% higher than premiums charged to healthy people for similar coverage by private health insurers.

For example, the monthly premium for a 24-year-old, non-smoking male in Denver ranges from $71.66 to $180.49, depending on which deductible is selected. By contrast, the monthly premium for a 64-year-old, non-smoking male in Denver ranges from $375.87 to $946.84, depending on the deductible selected.

- *A premium discount is available to some lower income enrollees.* To be eligible, your income must be less than $50,000 and you must meet an asset test. If you qualify, depending on your income, your CoverColorado premium will be reduced up to 30 percent. Contact CoverColorado for more information.

- *If you are eligible for HCTC, you can enroll in MHIP and the federal government will pay 80% of your premium each month.* You should call the HCTC customer contact center toll free at (866) 628-4282 Monday through Friday, 7 am to 7 pm central time. The customer contact center can provide you registration material and help you fill them out so you can take advantage of the tax credit. (see Chapter 5)

HOW LONG DOES COVERCOLORADO COVERAGE LAST?

- *CoverColorado policies are renewable as long as you pay your premiums, continue to reside in Colorado, and meet other eligibility requirements.* If you fail to pay the premium or you voluntarily leave the CoverColorado program, you will not be eligible to re-apply until 12 months after the termination date.

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. Colorado 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 Colorado Division 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 people, health insurance companies must sell you any small group health plan policy they sell to other small employers if your group meets the participation requirements. An eligible employee is one who works 24 hours or more a week on a regular basis, including household employees.

  However, insurers 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 are buying a **large group health plan policy** for 51 or more employees, your group can be turned down.

- *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 health plan or if they are withdrawing from the small employer market. In the case of discontinuance, they must give you a chance to buy other plans they sell to groups of your size.

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

- *If you are a small employer buying a small group plan, you cannot be charged higher premiums based on the health status and the claim history of those in your group.* However, premiums will vary based the age, geographic area, industry of your group and other factors. This is called **modified community rating.** However, insurers cannot charge higher premiums based on the genetic information of those in your group.

- For large groups with more than 50 eligible employees, Colorado does not limit premium variation or increases, except that large groups also cannot be charged more based on genetic information.

- *If you have questions about your group health plan premiums, contact the Colorado Division of Insurance.*

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you may be eligible to buy small group health plan coverage as a self-employed business group of one.* To qualify, you must work in your business at least 24 hours per week on a regular basis. In addition, your business must have generated taxable income or you must have derived a substantial part of your income from the business. Substantial income is defined as an amount sufficient to pay your health insurance premium.

- *If you qualify as a self- employed business group of one, small group health insurers must offer you the choice of a **standard** or **basic health plan** on a guaranteed issue basis during open enrollment periods.* You cannot be turned down because of your health status. You may be able to buy other, non-standardized policies insurers sell to other small employers, as well; however, insurers can turn you down for these non-standardized policies because of your health status.

- *You are only eligible to buy coverage as a self-employed business group of one during annual open enrollment periods.* Your annual open enrollment period is the 31-day period following your birthday. Self-employed business groups of one are also entitled to coverage within 31 days of the following events: exhaustion of COBRA or state continuation coverage; the date you first meet the definition of a business group of one; or involuntary termination of other health insurance coverage. At all other times, 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 Colorado Division of Insurance about your protections in association health plans.

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Colorado who cannot afford to buy health insurance. Medicaid, the Child Health Plan Plus Program, and Women's Wellness Connect free or subsidized health insurance coverage, direct medical services and other help at little or no cost to you.

In addition, the federal government, under Trade Adjustment Assistance (TAA) Program, provides tax credits to some workers who lose their jobs or whose work hours and wages are reduced as a result of increased imports. This chapter provides summary information about these programs and contact information for further assistance.

MEDICAID

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

  Medicaid-eligible individuals in Colorado include infants, children, pregnant women, and parents if 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 Colorado Department Of Health Care Policy - for more information.

Low income persons eligible for Medicaid in Colorado*

Category	Income eligibility (as percent of federal poverty level)
Child 0-5	133%
Child 6-19	100%
Non-working Parents	60%
Working Parents	66%
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	U.S. 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 Colorado Works (also known as Temporary Assistance for Needy Families, or TANF) are also eligible for Medicaid.*

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

- *Foster children and adopted foster children placed in your home by a local County Social/Human Services Office are also eligible for Medicaid.*

- *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.

- *Some people who need long-term care may also receive help through Medicaid.* This includes people who are elderly, blind, or disabled, who have traumatic brain injury, or who have HIV/AIDS. If you think you might be eligible, contact your local County Department of Social/Human 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, 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 your County Department of Social/Human Services for more information about other eligibility requirements.

- *You must enroll in Medicaid through your County Social Services Office.* You can check the Blue Pages (Government) in the phone book or call the State Customer Service Line at:

  Metro Denver: (303) 866-3513
  Outside Metro Area: (800) 211-3943
  TTD: (303) 866-3305

  Or check the Internet at http://www.cdhs.state.co.us/servicebycounty.htm for an online list of these offices.

- *There may be other ways that Colorado Medicaid can help.* To find out if you or other members of your family qualify for Colorado Medicaid, contact the Colorado Department Of Health Care Policy at (800) 221-3943 or (303) 866-2993 or visit online at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197364086675

CHILD HEALTH PLAN PLUS (CHP+)

- *The Child Health Plan Plus Program (CHP+) offers free or low-cost health insurance for low-income children who are not eligible for Medicaid.* Children ages 18 and under with household family incomes below 200% of the federal poverty level are eligible to enroll if, during the past 3 months, they have not been covered by an employer health plan in which the employer paid at least 50% of the premium.

- *CHP+ covers hospital and physician care, prescription drugs, mental health care, and other services.* Depending on where you live, services are provided either by an HMO or by a fee-for-service network.

- *Most families will not have to pay an annual enrollment fee or co-payments for each doctor visit.* Generally, for those who do have to pay fees, it costs $25 to enroll one child for a year and $35 to enroll two or more children for a year. Co-payments are generally $1-$5 per visit for routine medical care.

- *When you sign your child up for CHP+, he or she will be enrolled for one year, even if your income changes.*

- *For more information, contact the CHP+ Program at (800) 359-1991 or visit online at http://www.cchp.org/.*

WOMENS'S WELLNESS CONNECTION (WWC)

- *The Women's Wellness Connection (WWC), part of the National Breast and Cervical Cancer Early Detection Program, provides qualified women with free breast and cervical cancer screenings.* If your screened through this program and diagnosed with breast or cervical cancer, you may be eligible for free health coverage through Medicaid which extends throughout the duration of treatment.

- *In order to be eligible for screening through the program, you must be a Colorado resident and meet age, income and insurance requirments.* You must have no or limited health coverage, be ineligible for Medicaid or Medicare, and have an income at or below 250% of the federal poverty level. Also, you must not have had a mammogram or Pap test in the last 12 months or for women who have lost insurance, had an abnormal test, and need follow-up.

- *For information, contact Women's Wellness Connection, at (303) 692-2581 or (866) 9355 or visit http://www.cdphe.state.co.us/pp/cwcci/index.html or http://www.womenswellnessconnection.org/.*

OTHER STATE PROGRAMS

There may be other financial assistance programs available. Please contact the Colorado Department Of Health Care Policy at (800) 221-3943 or (303) 866-2993 or visit online at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197364086675.

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, Colorado has designated state continuation and CoverColorado as qualified health coverage. (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 Colorado continuation coverage	*Colorado Division of Insurance* 1560 Broadway, Suite 850 Denver, CO 80202 (800) 930-3745, or (303) 894-7490 http://www.dora.state.co.us/insurance
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	*U.S. Department of Labor* *Employee Benefits Security Administration* *Employee & Employer Assistance Hotline and Publications* (866) 444-EBSA (3272) http://www.dol.gov/ebsa/
CoverColorado	*CoverColorado* (888) 461-3811 or (800) 259-2656 TDD http://www.covercolorado.org
Medicaid	*Colorado Department of Health Care Policy and Financing* (800) 221-3943 or (303) 866-2993 (Denver Metro Area) http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197364086675
Child Health Plus (CHP+)	*Colorado Department of Health Care Policy and Financing* (800) 359-1991 (800) 221-3943 or (303) 866-2993 (Denver Metro Area) http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197364086675
Womens's Wellness Connection (WWC)	*Colorado Department of Public Health and Environment* (303) 692-2480 http://www.cdphe.state.co.us/pp/cwcci/cwccihom.asp.
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.**

HELPFUL TERMS

Affiliation Period. The times that an HMO may require you to wait after you enroll and before your group coverage begins. HMOs that require an affiliation period cannot exclude group coverage of pre-existing conditions. 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.

Basic Health Plan. A standardized health plan that group health plan carriers in Colorado must offer to individuals who are eligible for a conversion policy or who qualify as a self-employed business group of one. The basic health plan covers a comprehensive list of services, including hospital and physician care, maternity care, prescription drugs, and mental health services, but imposes higher cost sharing than the standard health plan. See also Business Group of One, Conversion Policy, Standard Health Plan.

Business Group of One. A self-employed individual with no other workers, or one who does not sponsor a group health plan for his workers. During annual open enrollment periods, self-employed business groups of one can qualify to purchase a basic or standard health small group health plan on a guaranteed issue basis. See also Basic Health Plan, Guaranteed Issue, Small Group Health Plan, Standard Health Plan.

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

Child Health Plan Plus (CHP+). A program that offers free or reduced cost health insurance to low-income, uninsured children in Colorado who do not qualify for Medicaid. See also Medicaid.

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 (CoverColorado). Health insurance coverage that is not interrupted by a significant lapse. If you are buying CoverColorado coverage as a HIPAA eligible individual, you must apply within 63 days of losing your prior group coverage. If you are not joining as a HIPAA eligible individual, you must apply within 6 months of losing prior coverage. See also CoverColorado, HIPAA Eligible.

Continuous Coverage (Fully Insured Group Health Plans). Health insurance coverage that is not interrupted by a break of 90 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. See also Fully Insured Group Health Plan.

Continuous Coverage (Self-Insured Group Health Plans). 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. See also Self-Insured Group Health Plan.

Conversion Policy. A policy that must be offered to you if you lose coverage under a fully insured group health plan in Colorado that you had been enrolled in for at least three months. People eligible for a conversion policy must be offered a basic and standard health plan. See also Basic Health Plan, Fully Insured Group Health Plan, Standard Health Plan.

CoverColorado. A state-run insurance program (sometimes called a high-risk pool) for HIPAA eligible persons and for people with high health risks. See also HIPAA Eligible.

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 Policy.

Elimination Rider. An amendment permitted in individual health insurance policies that permanently excludes your coverage for a specified health condition. See also Individual Health Insurance.

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

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 Colorado. See also Self-Insured Group Health Plan.

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. Self-employed people can also qualify as a self-employed business group of one during annual open enrollment periods. See also Business Group of One, 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 Colorado are guaranteed issue. Basic and standard health plans must be sold on a guaranteed issue basis to qualified self-employed business groups of one. Plans that are guaranteed issue can turn you away for other reasons. See also Basic Health Plan, Business Group of One, Small Group Health Plan, Standard Health Plan.

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 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. 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 an individual health insurance policy, HIPAA eligibility gives you greater protections than you would otherwise have in Colorado 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.

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

Large Group Health Plan Policy. 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. Often managed care plans will require you to get permission (a 'referral') from you family doctor before you receive care from a specialist in their network. Some managed care plans will cover your care at a lower rate if you go to a non-network provider or if you get specialist care without a referral.

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

Modified Community Rating. A rule that prohibits health plan from varying premiums based on your health status.

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 Statute.

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 (CoverColorado). Any condition 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 can be counted as a pre-existing condition by CoverColorado.

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 31 days cannot be subject to pre-existing condition exclusions.

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. In Colorado, under individual health insurance policies, pregnancy can be counted as a pre-existing condition. Genetic information cannot trigger a pre-existing condition exclusion in individual health insurance policies.

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

Self-Insured Group Health Plans. Plans set up by an employer who sets 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 Colorado.

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. In addition, during open enrollment periods, self-employed individuals with no other employees can qualify to purchase small group health plan coverage as a self-employed business group of one. See also Business Group of One.

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.

Standard Health Plan. A standardized health plan that group health plan carriers in Colorado must offer to individuals who are eligible for a conversion policy or who qualify as a self-employed business group of one. The standard health plan covers a comprehensive list of services, including hospital and physician care, maternity care, prescription drugs, and mental health services, but imposes lower cost sharing than the basic health plan. See also Basic Health Plan, Business Group of One, Conversion Policy.

State Continuation Coverage. A program similar to COBRA for small employers in Colorado with fewer than 20 employees. 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, or Colorado Works). 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.

Women's Wellness Connection. Program which provides free screening for breast and cervical cancer to eligible Colorado residents. Eligible women diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid for treatment of their condition.