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

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June 2009

ACKNOWLEDGMENTS AND DISCLAIMER

The authors wish to express appreciation to Elizabeth Hadley, Robert Imes, Stephanie Lewis, Mila Kofman, Lauren Polite, Jalena Specht, and Nicole Tapay for their work developing earlier editions of these guides.

The authors also wish to express appreciation to the staff of the Kentucky Department of Insurance for their review of this document. Their help was invaluable in our research and understanding of applicable law and policy. Without them, this guide would not have been possible. However, any mistakes that may appear are our own.

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 a Kentucky resident, you have rights under federal law 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 Kentucky 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 Kentucky, 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 33. For information about how to find consumer guides for other states on the Internet, see page 33. A list of helpful terms and their definitions begins on page 34. These terms are printed in **boldface type** the first time they appear.

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Last Reviewed June 2009

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 Kentucky. 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 Kentucky resident.

HOW AM I PROTECTED?

In Kentucky, 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 health plans in Kentucky 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 health plan will begin to pay for care for that condition. Generally, if you join a new 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 for Group Coverage, and Chapter 3 for Individual Coverage)

- *Your health insurance cannot be canceled because you get sick.* Most health coverage 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 period of time.* This is called **COBRA** or **state continuation coverage**. It can help when you are between jobs, or when you retire early and are not yet eligible for Medicare. 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 insurance coverage 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, **Kentucky Access**. You will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for a Kentucky Access policy. (see Chapter 3)

- *If you have had difficulty obtaining affordable individual health insurance because of your health condition or if you have one of 35 high cost medical conditions, you may also be eligible for a Kentucky Access policy.* In this case you may face a new pre-existing condition exclusion period. There are limits on what you can be charged for a Kentucky Access policy. (see Chapter 3)

- *If you lose your group coverage under a 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 cannot 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. (Chapter 3)

- *If you are a small employer buying a **small 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.* This is called **guaranteed issue**. (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 have low or modest household income, you may be eligible for free or subsidized health coverage for yourself or members of your family.* The Kentucky **Medicaid** program offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes. (see Chapter 5)

- *If your children are 18 years old or younger, do not have health insurance, and meet other qualifications, you may be able to buy insurance for them through the* ***Kentucky Children's Health Insurance Program (KCHIP)***. (see Chapter 5)

- *If you believe that you may be at risk for cancer, you may be eligible for free screening and treatment.* The Kentucky Women's Cancer Screening Program 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 Kentucky Medicaid program. (see Chapter 5)

- *If you lost your health insurance and are receiving benefits from the* ***Trade Adjustment Assistance (TAA) Program*** *then you may be eligible for a federal income tax credit to help pay for new health coverage*. This credit is called the **Health Coverage Tax Credit (HCTC)**, and it is equal to 80% of the cost of qualified health coverage, including COBRA and state continuation coverage. (see Chapter 5)

- *If you are a retiree aged 55-65 and receiving pension benefits from* ***Pension Benefit Guarantee Corporation (PBGC),*** *then you may also be eligible for the HCTC.* (see 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 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 include the same doctors that your old health 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. **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 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 group health plan that covers certain benefits your old plan did not.* For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to one year before your new plan will pay for drugs prescribed to treat a pre-existing condition. (see Chapter 2)

- *If you work for certain non-federal public employers in Kentucky, not all of the group health plan protections may apply to you*. (see Chapter 2)

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

- *If you are HIPAA eligible, Kentucky Access is your only guaranteed access to individual health insurance coverage.* 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 purchase individual health insurance, there are some limits on how much your premiums can vary due to your health status, age, and other factors.* (see Chapter 3)

- *If you enroll in Kentucky Access and are not HIPAA eligible, you will face a pre-existing condition exclusion period.* (see Chapter 3)

- *If you move away from Kentucky, 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 of the plan's service area.

- *You cannot be turned away or charged more because of your health status.* Health status means your medical condition or history, genetic information, or disability. This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (such as part time employment) as long as these are unrelated to health status and applied consistently.

Discrimination due to health status is not permitted

The Acme Company 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 managers 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 or other health insurance coverage.* 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 health plan offers family coverage, your dependents can elect coverage as well. Enrollment during a special enrollment period is not considered **late enrollment**.

Certain changes can trigger a special enrollment opportunity

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

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 Kentucky law, newborns are automatically covered under your fully insured group health plan for the first 31 days following birth. Adopted children and children placed for adoption are automatically covered if the plan covers dependents.* The insurer may require that the parent enroll the child within the 31 days and pay higher premiums in order to continue coverage beyond the 31 days.

- *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 Kentucky fully insured group health plans that provide coverage for dependents must cover as a dependent your unmarried child up to age 25. 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, insurance companies 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 coverage for a limited time.* A federal law known as the **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job-protected leave in these circumstances. If you qualify for leave under the FMLA, your employer must continue your health benefits. You will have to continue paying your share of the premium.

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

  If you qualify for leave under the 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 premium. However, if you don't return to work because of factors outside your control (such as a need to continue caring for a sick family member, or because your spouse is transferred to a job in a distant city), you will not have to repay the premium.

  For more information about your rights under 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 during the 6-month period immediately before you joined that plan.* This period is called a **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 period allowed for exclusion is 12 months. However, if you enroll late in your 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 up to 18 months.

- *Group health plans that impose pre-existing condition exclusion periods must give you credit for any previous continuous **creditable coverage** that you have 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 break of 63 or more days in a row.*

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 coverage toward it. If your employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period. HMOs that require an affiliation period cannot exclude coverage for pre-existing conditions.

What is continuous coverage?

You can get continuous coverage under one plan, or under several plans as long as you don't have a lapse 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.* Self-insured plans can look back to determine whether your previous health plan covered prescription drugs, mental health, substance abuse, dental care, or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new self-insured group health plan may impose a pre-existing condition exclusion period for that category. Group health plans regulated by Kentucky are prohibited from doing this.

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 a year.

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 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 number of public employers in Kentucky 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. See Chapter 3 for more information about COBRA, state continuation coverage, conversion policy, and Kentucky Access.

- *If you have lost your group health insurance and are receiving benefits from the Trade Adjustment Assistance (TAA) program, you may be eligible for a federal income tax credit to help you pay for new health coverage.* This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 80% of the cost of qualified health coverage. (see Chapter 5)

- *If you are a retiree aged 55-65 and receiving pension benefits from the Pension Benefit Guaranty Corporation (PBGC), you may also be eligible for the HCTC.* (see 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 or you may be eligible for coverage under a program offered by the state, Kentucky Access. However, in Kentucky – as in most other states – you have limited guaranteed access to individual health insurance in the private market. There are some alternatives to private individual health insurance, such as COBRA coverage or conversion policy. 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 COVERAGE?

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

- *In general, companies that sell individual health insurance in Kentucky 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 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 Kentucky Access coverage.

  However, under no circumstance can 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, Kentucky Access is your only guaranteed source of individual health insurance.*

- *In Kentucky, newborns are automatically covered under the parents' individual health insurance for the first 31 days.* The insurer may require that the parent enroll the baby and pay the premium within the 31 days in order to continue coverage beyond the 31 days.

- *In Kentucky, mentally retarded and physically disabled dependents are permitted to remain insured under their parents' individual health insurance after they reach the age at which dependent coverage is usually terminated, if certain conditions are met.* The adult dependent must be incapable of self-support and must rely on the policyholder for support. In addition, proof of dependency and disability must be provided to the insurer within 31 days of the dependent reaching the limiting age.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE COVER?

- *It depends on what you buy.* Kentucky does not require health insurers in the individual market to sell standardized policies. Insurers can design different policies and you will have to read and compare them carefully. However, Kentucky does require all policies to cover certain benefits – for example, diabetes care and mammography screening. Check with the Kentucky Department of Insurance for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Individual health insurers cannot impose **elimination riders.*** An elimination rider is an amendment to your health insurance policy that permanently excludes coverage for a health condition, a body part, or a body system. Elimination riders are not allowed.

- *Individual health insurers can count as pre-existing any condition for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice during the six-month period immediately before purchasing coverage.* In Kentucky, an individual market insurer can apply a pre-existing condition exclusion period for up to 12 months. Pregnancy can be considered a pre-existing condition. However, genetic information cannot be used as a basis for a pre-existing condition.

- *If you make a claim during the first three 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.

- *Like group health plans, individual health insurers in Kentucky must give you credit for prior continuous coverage.* Coverage counts as continuous if it is not interrupted by a break of 63 days or more.

WHAT CAN I BE CHARGED FOR INDIVIDUAL HEALTH INSURANCE?

- *All individual health insurance in Kentucky must limit how much premiums vary due to health status, age, and other factors.* Even within these limits, however, if you have a serious health condition, your premiums may be significantly higher than the rates charged for other individuals. In addition, when you renew your individual coverage, your premiums can increase substantially as you age.

  If you have questions about your premiums, contact the Kentucky Department of Insurance.

CAN MY INDIVIDUAL HEALTH INSURANCE 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, guaranteed renewability does not protect you from having your premiums go up at renewal, and premiums can also increase within limits as you age or your health declines.

  Further, if you make a claim during the first three 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 Illinois Department of Insurance to learn more about your rights.

- *Some individual insurers sell temporary health insurance policies.* Temporary policies are not guaranteed renewable. They will only cover you for a limited time, such as six months. If you want to renew coverage under a short-term 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 or state continuation coverage. The information presented below was taken from publications prepared by the U.S. Department of Labor. You should contact them for more information about your rights under COBRA.

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

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

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

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

COBRA QUALIFYING EVENTS

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

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

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

- *Each person who is eligible for COBRA continuation can make his or her own decision.* If your dependents were covered under your employer plan, they may independently elect COBRA coverage as well.

- *You must be notified of your COBRA rights when you join the group health plan, and again if you qualify for COBRA coverage.* The notice rules are somewhat complicated and you should contact the U.S. Department of Labor for more information.

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

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

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 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.*

- *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.* This credit is called the Health Coverage Tax Credit (HCTC), and it is equal to 80% of the cost of qualified health coverage, including COBRA and state continuation coverage. (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, dependents are sometimes eligible for up to 36 months of COBRA continuation coverage, depending on their qualifying event.

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

LENGTH OF COBRA COVERAGE

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

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

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

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

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

WHAT ABOUT KENTUCKY CONTINUATION COVERAGE?

- *Kentucky has a law that provides continuation coverage to people who are not eligible for COBRA because their employer has fewer than 20 employees.*

- *If you had coverage through an employer's fully insured group health plan for at least three months and you lose your job, you may be eligible for state continuation coverage.*

  All persons seeking state continuation coverage must not have or be eligible for other health coverage, including Medicare, group health insurance, or substantially similar individual insurance.

- *Spouses and dependents are also eligible for state continuation coverage in cases of divorce from the insured or the death of the insured.*

- *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 was enacted in The American Recovery and Reinvestment Act of 2009 (ARRA) and covers 65% of your state continuation coverage 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. Also see "Health Information About State Continuation Coverage And ARRA" on the website

of the Department of Health And Human Services at http://www.cms.hhs.gov/COBRAContinuationofCov/.

- *State continuation coverage can last up to 18 months, but coverage can end sooner if you fail to pay your premiums or if your old employer's group policy is terminated and not replaced.*

CONVERSION POLICIES

WHEN AM I ELIGIBLE FOR A CONVERSION POLICY?

- *In Kentucky, 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 get 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 apply and pay your first premium within 31 days after receiving notice of your conversion rights.

- *Conversion rights are also available to a surviving spouse and children upon the death of the insured, to a child when the child reaches that age at which dependent coverage is terminated, and to a former spouse and children at divorce.*

- *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?

- *Conversion policy benefits must meet certain minimum benefit requirements, which may not be the same as those under your former plan.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *A conversion policy cannot impose a new pre-existing condition exclusion period.* However, if you were in the middle of an exclusion period under your former group health plan coverage, you may have to finish it.

HOW MUCH CAN I BE CHARGED FOR A CONVERSION POLICY?

- *Conversion policy premiums may be much more expensive than your former group plan premiums.* Kentucky does place limits on how much you can be charged, but your age and health status will be taken into account in figuring your premiums.

CAN MY CONVERSION POLICY BE CANCELED?

- *Conversion policies, like other individual health insurance policies, are guaranteed renewable.* Your coverage cannot be canceled 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 plan, continue to live in the plan service area. Also, if you become eligible for Medicare or other insurance with similar benefits, you will no longer be eligible for a conversion policy.

KENTUCKY ACCESS

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

WHEN CAN I GET COVERAGE FROM KENTUCKY ACCESS?

- *If you are HIPAA eligible, you can buy health insurance from Kentucky Access.*

To be HIPAA eligible, you must meet certain criteria

No matter where you live in the U.S., if you are HIPAA eligible you are guaranteed the right to buy individual coverage of some kind with no pre-existing condition exclusion periods. In Kentucky, you are guaranteed the right to buy coverage only from Kentucky Access. 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 for which you were eligible.
- You must not be eligible for Medicare, Medicaid, or a group health plan.
- You must not have health insurance. (Note, however, if you know your group coverage is about to end, you can apply for coverage for which you *will* be HIPAA eligible.)
- You must apply for health insurance for which you are HIPAA eligible within 63 days of losing your prior coverage.

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

- *If you are not HIPAA eligible, you can buy coverage from Kentucky Access if you are a Kentucky resident for at least 12 months and can demonstrate eligibility in one of the following ways:*

    - You have been turned down for individual health insurance by an insurer;
    - You have been offered individual health insurance that is substantially similar to those offered by Kentucky Access, but it would cost more than Kentucky Access coverage;
    - You have been diagnosed with a serious health condition such as multiple sclerosis, some cancers, or AIDS (contact Kentucky Access for a complete listing of qualifying conditions); or
    - You are a GAP-qualified individual.

    You are not eligible for Kentucky Access coverage if you already have or are eligible for any other health insurance, including individual health insurance, group health plan, Medicaid, or Medicare. Note that you may still be eligible even if you are offered an individual health insurance policy so long as the policy is substantially similar to those offered through Kentucky Access and the rates are higher than what you would pay in Kentucky Access.

- *If one person in your family qualifies for Kentucky Access coverage, the other members of your family are eligible for Kentucky Access coverage as long as they are Kentucky residents.*

WHAT DOES KENTUCKY ACCESS COVER?

- *Kentucky Access offers three plan options – one fee-for-service (FFS) plan and two preferred provider organization (PPO) plans.* Various deductible options are available for some of these plans. The plans cover hospitalization, surgical expenses, doctor visits, preventive care, maternity services, and home health care. Enhanced benefits for prescription drugs and mental health/substance abuse coverage can be added to your package for an additional premium. Plan options are subject to change. Please contact Kentucky Access for more information.

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 Kentucky Access.* Elimination riders are not permitted on Kentucky Access plans.

- *If you are not HIPAA eligible, you will have a 12-month pre-existing condition exclusion period when you first enroll in Kentucky Access.* When you enroll, Kentucky Access will look back 6 months see if you had a condition for which you actually received medical advice, diagnosis, care or treatment. Kentucky Access will give you credit for prior continuous coverage if your break in coverage is not 63 days or more.

HOW MUCH CAN I BE CHARGED FOR KENTUCKY ACCESS COVERAGE?

- *Premiums will vary based on the plan you choose.* In addition, Kentucky Access charges enrollees different rates based on their age and gender. For example, a 24-year-old man could pay between $188 and $320 per month, depending on the plan and deductible option he chooses, and a 64-year-old man could pay between $753 and $1,278. An additional monthly premium is required if adding pharmacy benefits and/or mental health/substance abuse coverage. These figures are current as of the writing of this guide. Check with Kentucky Access for the most up-to-date information on premium rates and plan options.

HOW LONG DOES COVERAGE LAST?

- *Kentucky Access policies are renewable as long as you pay your premiums, continue to reside in Kentucky, 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. Kentucky has enacted reforms to expand some of these protections. Some of these reforms apply to groups of different sizes. Generally, small employers are those that employ 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 Kentucky Department of Insurance to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME INSURANCE?

- *With few exceptions, small employers cannot be turned down.* This is called guaranteed issue. If you employ at least 2 but not more than 50 people eligible for health benefits, health insurance companies must sell you any **small group health** plan they sell to 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 are buying a **large group health plan** for 51 or more eligible employees, your group can be turned down.

- *Under no circumstances can 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 group health coverage cannot be canceled if someone in your group becomes seriously ill.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums, if you commit fraud, if they are discontinuing that product, or if they are withdrawing from the small employer market. In 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?

- *You can be charged higher premiums, within limits, based on the health, risk, and demographic characteristics of your group.* For small employers, Kentucky limits the difference in premiums and the annual increase that can be charged. For groups with 51 or more eligible employees, Kentucky does not apply these same limits on premium variation or increases. If you have questions about your group health insurance premiums, contact the Kentucky 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 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 Kentucky Department of Insurance about your protections in association health plans.

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Kentucky who cannot afford to buy health insurance. Medicaid, the Kentucky Women's Cancer Screening Program, and the Kentucky Children's Health Insurance Program (KCHIP) offer free or subsidized health insurance coverage, direct medical services or other help at little or no cost to you.

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

MEDICAID

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

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

  In Kentucky you may be eligible for Medicaid if you are an infant, a child, pregnant, 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.

Low income persons eligible for Medicaid in Kentucky*

Category	Income eligibility (as percent of federal poverty level)
Infant 0-1	185%
Child 1-19	150%
Non-Working parents	36%
Working parents	62%
Pregnant woman	185%
Medically needy	
Individual	30%
Couple	28%

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

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

- *Parents who receive benefits under **TANF (also known as Kentucky Transitional Assistance Program, or K-TAP)** should know that when you get a job and your TANF benefits end, you generally can stay on Medicaid for a 12-month transitional period.*

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

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

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

- *People who have high medical expenses may also qualify for Medicaid under the "spend down" option.* You may qualify as medically needy if you have high medical expenses that, when subtracted from your income, would make you eligible for Medicaid coverage. For example, people who have to pay a lot for prescription drugs, nursing home care, or other long term care services sometimes qualify as medically needy if they don't have health insurance that covers these services.

- *People who are age 65 or over and who have low incomes and are enrolled in Medicare may also qualify for help from Medicaid*. Even though your income may be too high to qualify for Medicaid insurance coverage, there may be other ways Medicaid can help you.

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

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

- *There may be other ways that Medicaid can help.* You can apply for Medicaid at the local Department of Community Based Services office.

KENTUCKY CHILDREN'S HEALTH INSURANCE PROGRAM (KCHIP)

Kentucky Children's Health Insurance Program is a state-designed program that provides health coverage to low-income Kentucky children under the age of 19 who are not eligible for Medicaid and who have no health insurance.

- *A child whose family has a household income at or below 200% of the federal poverty level is eligible for KCHIP.* For a family of three, this works out to an annual income of about $36,620, or a monthly income of about $3,052.

- *A child whose family has a household income at or above 150% of the federal poverty level is required to pay a premium*. So a family of three whose annual household income is above $27,465, or a monthly income above $2,289, will have to pay a $20 monthly premium.

- *Some of the benefits include hospital care, physician services, emergency services, prescription drugs, well child services, mental health services, vision, hearing, and dental care, lab and x-ray services, and physical, speech, and occupational therapy.*

- *You can pick up an application for the Children's Health Insurance Program at the local Health Department office or the local Department of Community Based Services office.* You can also request that an application be sent to you by mail by calling (877) 524-4718.

BREAST AND CERVICAL CANCER TREATMENT PROGRAM

- *Low-income Kentucky residents who have been screened through a local health department and diagnosed with breast and/or cervical cancer are eligible to receive treatment through Medicaid.*

- *In order to be eligible for cancer treatment coverage, you must have been screened and diagnosed with breast or cervical cancer by the Kentucky Women's Cancer Screening Program through a local health department, you are 40-64 years of age with no comprehensive health insurance coverage or Medicare, must meet satisfactory immigration status, is a Kentucky resident, and your income is at or below 250% of federal poverty level.* For a family of 3, this is an annual income of no more than $45,775.

- *Some of the benefits include hospital and physician services, emergency care, vision, and dental care, prescription drugs, and laboratory services.*

- *You can pick up an application at your local health department or for more information, call the Kentucky Women's Cancer Screening Program at (502) 564-2154 or visit online at http://chfs.ky.gov/dph/info/wpmh/cancerscreening.htm.*

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 PREMIUM 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, Kentucky has designated a plan through Anthem Blue Cross Shield and state-based continuation coverage as state 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 State continuation coverage Conversion coverage Fully insured group health insurance	*Kentucky Department of Insurance* (502) 564-3630 (800) 595-6053 (toll-free) (800) 462-2081 (TDD) http://www.doi.state.ky.us/
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
State High-Risk Pool	*Kentucky Access* (866) 405-6145 https://www.kentuckyaccess.com/index.cfm
Kentucky Children's Health Insurance Program (KCHIP)	*To apply, visit your local Health Department or Department of Community Based Services and pick up an application.* You may also request that an application be mailed to you by calling: (877) 524-4718 (toll free) (877) 524-4719 (TDD) (800) 662-5397 (Spanish) Or visit the KCHIP website at: http://kidshealth.ky.gov/en/kchip/
Kentucky Medical Assistance Program (MEDICAID)	*To apply, visit your local Department for Community Based Services Office.* If you have questions about member services call: (800) 635-2570 (800) 775-0296 (TDD) Or visit the website at: http://www.chfs.ky.gov/dms/
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

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

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

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

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

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

Conversion. Your right, when leaving a fully insured group health plan in Kentucky, to convert your policy to individual health insurance. There are rules about the type of coverage that must be offered and the premiums that can be charged by conversion policies in Kentucky. See also Fully Insured Group Health Plan.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; individual health insurance; Medicare; Medicaid; CHAMPUS (health coverage for military personnel, retirees, and dependents); Federal Employees Health Benefits Program (FEHBP); Indian Health Service; Peace Corps; or a state health insurance high risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Insurance.

Elimination Rider. A feature permitted in individual health insurance that excludes coverage for a specific health condition, body part, or body system. Unlike pre-existing condition exclusion periods, which can be no longer than 12 months, elimination riders can last indefinitely. Individual health insurers can look back 3 years for evidence of a health problem. You can apply to have an elimination rider modified or removed, but the health plan is not obligated to do so.

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.

Fee-For-Service (FFS) Plan. A health plan that allows the enrollee to choose which doctors and hospitals to use without requiring or providing incentives for the enrollee to use a network of doctors and hospitals. FFS plans are more costly than managed care plans such as HMOs and PPOs.

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured group health plans are regulated by Kentucky. 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 insurance (usually sponsored by an employer, union or professional association) that covers at least 2 employees.

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. By federal law, all health plans sold to small employers are guaranteed issue. Plans that are guaranteed issue can turn you away for other reasons.

Guaranteed Renewability. A feature in most health plans that means your coverage cannot be canceled because you get sick. HIPAA requires health insurance to be guaranteed renewable. Your coverage can be canceled for other reasons unrelated to your health status. Disease-specific health plans (such as those covering only cancer) are not required to be guaranteed renewable in Kentucky.

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

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

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

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

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

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

Individual Health Insurance Policy. Policies for people not connected to an employer group. This term also refers to coverage purchased by the self-employed for themselves (or their family members) but for no other employees. Individual health insurance are regulated by Kentucky.

Kentucky Access. The state-run program for HIPAA eligible persons and people with high health risks (called a high risk pool). Kentucky Access sells individual coverage to those who are HIPAA eligible and to people with serious health conditions who cannot buy coverage from private health insurance companies.

KCHIP. Kentucky Children's Health Insurance Program, a state-designed program that provides health coverage to low-income Kentucky children under the age of 19 who are not eligible for Medicaid and who have limited or no health insurance.

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

Late Enrollment. Enrollment in a health plan at a time other than the regular or a special enrollment period. Late enrollees can 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 Elimination Rider, Pre-existing Condition.

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

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

Pre-existing Condition. 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. Group health plans cannot count pregnancy 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 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.

Preferred Provider Organization (PPO) Plan. A PPO is a type of managed care plan that will cover more of your medical expenses when you use a health care provider such as a doctor or a hospital that is part of the PPO network. When you use a provider outside the network, the health plan will cover less of the costs.

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 Kentucky.

Small Group Health Plans. Plans with at least 2 but not more than 50 eligible employees.

Special Enrollment Period. A time, triggered by certain specific events, during which you and your dependents must be permitted to sign up for coverage under a group health plan. Employers and group health insurers must make such a period available to employees and their dependents when their family status changes or when their health insurance status changes. Special enrollment periods must last at least 30 to 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 people who used to receive health benefits from a small employer 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. See also Medicaid.

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

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