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

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This guide is intended to help consumers understand their protections under federal and state law. The authors have made every attempt to assure that the information presented in this guide is accurate as of the date of publication. However, the guide is a summary, and should not be used as a substitute for legal, accounting, or other expert professional advice. Readers should consult insurance regulators or other competent professionals for guidance in making health insurance decisions. The authors, Georgetown University, and the Health Policy Institute specifically disclaim any personal liability, loss or risk incurred as a consequence of the use and application, either directly or indirectly, of any information presented herein.

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As a Texas 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 Texas 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 Texas, 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 laws for the health plans they regulate (**fully insured group health plans** and **individual health insurance**), so your protections may vary if you leave Texas. 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 Texas resident.

HOW AM I PROTECTED?

In Texas, 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 Texas 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 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)

- *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)

- *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 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 you 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 **Texas Health Insurance Pool**. You will not face a new pre-existing condition exclusion period. (see Chapter 3)

- *If you are not HIPAA eligible and have had difficulty obtaining affordable individual health insurance because of your health condition, you may also be eligible for Texas Health Insurance Pool coverage.* If you qualify for this coverage because of health reasons and you have had no previous health coverage, you may face a new pre-existing condition exclusion period. There are limits on what you can be charged for a Pool policy. (see Chapter 3)

- *If you are a small employer buying a fully insured **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*. All health insurance policies for small employers must be sold on a **guaranteed issue** basis. However, the insurance carrier can turn you down if your small business does not meet the participation or contribution requirements. (see Chapter 4)

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

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

- *If you have low or modest household income, you may be eligible for free or subsidized health coverage for yourself or members of your family.* The Texas **Medicaid** program offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes. In addition, some women diagnosed with breast or cervical cancer may be eligible for medical care through Medicaid. Another program, the **Texas Children's Health Insurance Program (CHIP)** offers subsidized health coverage for certain uninsured children. (see Chapter 5)

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

- *If you lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program**, you may be eligible for a federal income tax credit to help you pay for new health coverage.* This credit is called the **Health Coverage Tax Credit (HCTC)**, and is equal to 80% of the cost of qualified coverage, including COBRA and a policy offered through the Texas Health Insurance Risk Pool. (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 group health plan 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 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 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 impose **waiting periods** before your health benefits begin. **HMO's** can impose 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 group health plan that covers benefits your old group 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 certain non-federal public employers in Texas, not all of the group health plan protections may apply to you.* (see Chapter 2)

- *If you are HIPAA eligible, your only guaranteed access to individual health insurance is through the Texas Health Insurance Pool.* (see Chapter 3)

- *In Texas, 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)

- *The law does not limit what you can be charged for individual health insurance*. You can be charged substantially higher premiums because of your health status, age, gender, and other characteristics. (see Chapter 3)

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

- *If you are a small employer, you may be charged more for health insurance if someone in your group is sick.* While there are limits on what you can be charged based on health status, generally premiums can be significantly higher if someone in your group has a serious health condition. Also, the insurance carrier can turn you down if your small business does not meet the participation or contribution requirements. (see Chapter 4)

CHAPTER 2
YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

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

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

- *In general, you have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees. Or, your employer may offer an **HMO** plan that you cannot join because you live outside 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. Large employers may refuse or restrict coverage for other reasons (such as part-time employment), as long as these are unrelated to health status and applied consistently.

Discrimination due to health status is not permitted

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

- *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. You will not have health insurance coverage during this time.

- *When you begin a new job with health insurance through an HMO, the HMO may require an affiliation period before coverage begins.* During this **affiliation period,**

you will not have health insurance overage. The HMO cannot impose any pre-existing condition exclusions if it imposes an affiliation period. An HMO affiliation period cannot exceed 2 months (3 months for late enrollees), and you cannot be charged a premium during this time.

- *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

- *In Texas, if you work for a small employer and receive health coverage through your employer's fully insured plan, the plan must also offer coverage for your spouse and dependents.* A fully insured large employer plan is not required to provide spousal and dependent coverage, but if it does, it must offer to cover each eligible spouse and dependent.

- *Under Texas law, newborns and adopted children are automatically covered under the parents' fully insured group 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 day period.

- *Under Texas law, your grandchild may be covered under your fully insured group health plan.* In order for your grandchild to qualify for coverage, your plan must

cover dependents and your grandchild must be under 25 years old, unmarried, and dependent on you.

- *Under Texas law, disabled adult children can remain on their parent's fully insured group health plan after reaching the age at which dependent coverage is usually terminated, if they meet certain requirements.* To qualify, your adult son or daughter must be incapable of self-sustaining employment because of mental retardation or physical disability and must be chiefly dependent on the policyholder for support and maintenance. Proof of incapacity and must be furnished to the insurer with 31 days of reaching the limiting age and may be required subsequently in the future.

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

  In addition, in Texas, fully insured group health plans must cover as a dependent your unmarried child up to the age of 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.

  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 and state law allow 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.

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

- *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 for 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 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 on 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.

- *HMOs may not exclude coverage for pre-existing conditions.* Instead, HMOs may impose an affiliation period before the health coverage begins.

- *Other group health plans 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, 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 a group health plan (after you were hired and not during a regular or special enrollment period), the rules are different depending on the type of plan you join.

If you seek to enroll late in a self-insured group health plan, your pre-existing condition exclusion cannot exceed 18 months.

If you seek to enroll late in a fully insured group health plan in Texas, the plan must either admit you immediately or admit you at the next open enrollment period. Fully insured group health plans must have at least one 31-day open enrollment period each year. If the plan admits you immediately, you may have a pre-existing condition exclusion period for up to 18 months. If the plan requires you to wait until the next open enrollment period, you may have a pre-existing condition exclusion period of up to 12 months.

- *Group plans that impose pre-existing condition exclusion periods must give you credit for any previous continuous* ***creditable coverage*** *that you've had.* Most types of private and government-sponsored health insurance are considered creditable coverage.

- *Coverage counts as continuous if it is not interrupted by a break of 63 or more days in a row.*

  In addition, in Texas, if you had a break in health coverage of more than 63 days in a row, and then enroll in a fully insured group health plan, that plan must give you credit for previous creditable coverage you had in effect at any time during the 12-month period preceding enrollment.

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.

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.

What is continuous coverage?

Self-insured and fully insured group health plans credit continuous coverage differently

Take Art, who has diabetes. He had had health insurance every day of his life, since birth, until recently, when he was laid off for 3 months. Fortunately, Art then found a new job with health coverage at Ajax Company. Ajax has a self-insured group health plan that covers diabetes but excludes pre-existing conditions for 12 months. Because Art had a lapse in health coverage longer than 63 days in a row, Ajax's plan is not required to give him credit for his prior health coverage. Ajax's group health plan will pay for Art's diabetes care in 12 months.

Now consider a slightly different situation. Assume Ajax has a fully insured group health plan. In Texas, even if you have a break in health coverage longer than 63 days, fully insured group health plans must give you credit for any creditable coverage you had in force during the 12-month period preceding enrollment. Therefore, Ajax will give Art credit for 9 months of prior creditable coverage (12 months minus the 3-month lapse in health coverage). Art's pre-existing condition exclusion period will only be 3 months, at the end of which Ajax will begin paying for Art's diabetes care.

- *Your protections may differ if you move to a self-insured group health plan that offers more benefits than your old one did*. Self-insured group health 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 self-insured 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. Fully insured group plans in Texas cannot use this method of crediting 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 Texas 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 YOU'RE GROUP HEALTH PLAN…

- *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 continuation coverage, state continuation coverage, conversion coverage, and the Texas Health Insurance Risk Pool.

- *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 and a policy offered through the Texas Health Insurance Risk Pool. (see Chapter 5)

- *If you are a retiree aged 55-65 and receiving benefits from Pension Benefit Guaranty Corporation (PBGC), then you may be eligible for the HCTC.* (see Chapter 5)

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group health plan, you may want to buy an individual policy from a private health insurer. However, in Texas – 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, state continuation coverage, and Texas Health Insurance Risk Pool 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 Texas, your ability to buy an individual health insurance policy from a private insurance company depends on your health status.

- *In general, companies that sell individual health insurance in Texas are free to turn you down because of your health status and other fac*tors. 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 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 coverage from the Texas Health Insurance Pool.

  However, under no circumstance may you be turned down, charged more, or face a pre-existing condition exclusion period by an individual insurer 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, you will be able to buy coverage from the Texas Health Insurance Pool.

- *In Texas, newborns, adopted children, and children placed for adoption are automatically covered under the parents' individual health insurance for the first 31 days, if the plan covers dependents*. The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.

- *Under Texas law, your grandchild may be covered under your individual health insurance policy.* In order for your grandchild to qualify for coverage, your policy must cover dependents and your grandchild must be under 25 years old, unmarried, and dependent on you.

- *Under Texas law, disabled adult children can remain covered under your individual health insurance policy after reaching the age at which dependent coverage is usually terminated, if they meet certain requirements.* To qualify, your adult son or daughter must be incapable of self-sustaining employment because of mental retardation or physical disability and must be chiefly dependent on the policyholder for support and maintenance. Proof of incapacity and must be furnished to the insurer with 31 days of reaching the limiting age and may be required subsequently in the future.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy.* Texas 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. Health plans are required to provide you with written descriptions of their products so that you can compare the differences.

- *Make sure that the policy that you purchase covers all your needs.* By law, all insurers in Texas must offer at least one plan that includes coverage for many required state mandated benefits, such as childhood immunizations and mammograms. However, Texas does permit insurers that sell individual health insurance to offer one or more **Consumer Choice Benefits Plans**, which are lower-cost plans that do not include all of mandated benefits normally covered in other insurance plans (for example, chemical dependency treatment or diabetes supplies and equipment).

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 permanently excludes coverage for a health condition nor even an entire body part or system.

- *However, if you buy an individual health insurance policy from an HMO, you will not face a pre-existing exclusion period.* HMOs in Texas cannot impose pre-existing exclusion periods.

- *If you are buying a non-HMO individual health insurance policy in Texas, there are different ways insurers are allowed, at the time you purchase the policy, to exclude coverage for your pre-existing conditions.*

  An individual health insurer may also impose a pre-existing condition exclusion period. Pre-existing condition exclusion periods cannot exceed 24 months. However, if the individual health insurer does not ask you questions about your health or medical treatment history when you apply for health coverage and it does not exclude a condition by name on your policy, it can only exclude pre-existing conditions for 12 months.

  When determining if a condition is pre-existing, an individual health insurer is allowed to look back 5 years to see if you actually received care for a condition. In addition, the insurer can look for evidence of symptoms for which most people, in the insurer's opinion, would have sought care. This is called the **prudent person standard.** Individual health insurance policies can count pregnancy as a pre-existing condition, but not genetic information.

- *After you purchase your individual health insurance policy, insurers can still exclude coverage for a pre-existing condition, even if it wasn't specifically excluded by the terms of your individual health insurance policy.* If you make a claim during the first 2 years of coverage, your individual health insurer can look back 5 years from the time of your application to see if the claim is for a condition that would have been considered a pre-existing condition. If the insurer determines, using the prudent person standard, that the condition is a pre-existing condition, it can refuse to pay for related expenses.

- *Individual health insurers have to give you credit for your prior continuous coverage if your most recent coverage was under a group, government, individual, or church plan.* The same types of coverage that are creditable in fully insured group health plans are also considered creditable in individual health insurance. Coverage is considered continuous if the gap between health plans is less than 63 days. If you have 18 months of continuous creditable coverage, you will not face a pre-existing condition exclusion period.

  If your gap in health coverage was 63 days or more and your most recent coverage was under a group, government, individual, or church plan, you must be given credit for any creditable coverage in effect at any time during the 18 months preceding your application for coverage. This means that although you will have a pre-existing condition exclusion period, it will be shorter than it would otherwise be.

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

- *Generally, in Texas, there are no limits on how much individual premiums can vary due to age, gender, health status, family size, and other factors.* However premiums cannot vary based on your genetic information.

- *When you renew your individual coverage, your premiums will increase based on your age and other factors.* However, premium increases must be applied to all persons in your class and not on an individual basis. A class may be grouped by age, sex, or by each individual health insurance product.

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELED?

- *Your coverage cannot be canceled because you get sick.* This is called guaranteed renewability. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of **managed care plans**, continue to live in the plan service area. 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.

- *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 Texas Department of Insurance to learn more about your rights.

- *Some insurance companies sell temporary health insurance policies.* Temporary policies are *not* guaranteed renewable. They will only cover you for a limited time, such as 6 months. If you want to renew coverage under a temporary policy after it expires, you will have to reapply and there is no guarantee that the health plan will be-reissued at all or at the same price.

COBRA AND STATE CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

If you are leaving your job and you had group health plan, you may be able to stay in your group health plan for an extended time through COBRA and/or state continuation coverage. The information presented below was taken from publications prepared by the U.S. Department

of Labor. You should contact it for more information about your rights under COBRA.

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

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

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

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

COBRA QUALIFYING EVENTS

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

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

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

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

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

  In general, if the event that qualifies you for COBRA coverage involves the death, termination, reduction in hours worked, or Medicare eligibility of a covered worker,

the employer has 30 days to notify the group health plan of this event. However, if the qualifying event involves divorce or legal separation or loss of dependent status, you have 60 days to notify the group health plan. Once it has been notified of the qualifying event, the group health plan has 14 days to send you a notice about how to elect COBRA coverage. Each member of your family eligible for COBRA coverage then has 60 days to make this election.

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

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

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.

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 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 COBRA coverage.* This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 80% of the cost of qualified coverage, including COBRA. (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 a federal income tax credit to help pay for new health coverage.* This is called the Health Coverage Tax Credit (HCTC). (see Chapter 5)

- *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) 444-3272or 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/.

- *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.

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 employer stops offering health benefits to other employees.*

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

WHAT ABOUT STATE CONTINUATION COVERAGE

- *If your employer offers fully-insured health benefits, you may be eligible for up to 9 months of continuation coverage under a Texas law that is similar to COBRA.* To qualify, you must apply for state continuation coverage within 60 days of losing your old coverage. Ask your former employer or the Texas Department of Insurance about state continuation coverage if you think it applies to you.

- *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 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/.

TEXAS HEALTH INSURANCE POOL

Texas has a risk pool program, called the Texas Health Insurance Pool, to provide insurance for residents of Texas who are unable to buy private health insurance due to their health conditions, and for people who are HIPAA eligible.

WHEN CAN I BUY COVERAGE FROM THE TEXAS HEALTH INSURANCE POOL?

- *If you are HIPAA eligible, you can buy health insurance from the Texas Health Insurance Pool.*

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 health insurance of some kind with no pre-existing condition exclusion periods. In Texas, you are guaranteed the right to buy coverage only from the Texas Health Insurance Pool. To be HIPAA eligible, you must meet all of the following:

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

HIPAA eligibility ends when you enroll in the Pool 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, there are many different ways to qualify for coverage through the Texas Health Insurance Pool.* You are eligible if:
    - You are eligible for the Health Coverage Tax Credit (HCTC). (see Chapter 5)
    - You were turned down for coverage by an insurer or HMO because of your health;
    - You received a certificate from an agent saying that the agent would be unable to find coverage for you because of your health;
    - You were offered coverage by an insurer, but the health plan contained an elimination rider that would have reduced the benefits you would receive from the health plan;
    - You were offered coverage by an insurer or HMO, but it would have been more expensive than buying coverage from the Pool; or

- You have been diagnosed with a serious health condition, for example, cancer, epilepsy, or AIDS.

- You only need to show that you are eligible in one of these ways in order to get Pool coverage. The Texas Health Insurance Pool requires that you not be eligible for other, similar employer-based coverage before you can get coverage from the Pool.

- *Your eligibility for Texas Health Insurance Pool coverage will be delayed under certain circumstances.* If prior to applying you had been covered under a small group health plan, you lost that coverage, you were then eligible for state continuation coverage, and you did not elect that state continuation coverage, then you are not eligible to apply for the Texas Health Insurance Pool until your state continuation coverage would have run out. Usually, this is nine months from the date you lost your small group coverage. This delay in eligibility for the pool does not apply to people who had been eligible for COBRA coverage.

- *The Pool offers family coverage, so if one person in your family qualifies, your family can get Pool coverage*. Each person in your family will be assessed a separate premium.

WHAT WILL THE TEXAS HEALTH INSURANCE POOL COVER?

- *Coverage includes hospital and physician care, maternity services, prescription drugs, treatment for serious mental health illness, and other services.* Five plan options are available with varying deductibles and coinsurance maximums, including one HSA qualified plan. All plans are preferred provider organization (PPO) plans. This means that when you receive care from a health care provider within the network, the plan will pay more than if you get care from a provider outside the network.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are HIPAA eligible or eligible for the HCTC, your health coverage will not be subject to a pre-existing condition exclusion when you enroll in the Texas Health Insurance Pool.*

- *If you are not HIPAA or HCTC eligible, you may have a 12-month pre-existing condition exclusion period when you first enroll in the Texas Health Insurance Pool.* When you enroll, the Pool will look back 6 months to see if you had a condition for which you actually received a diagnosis, medical advice, or treatment. Pregnancy

can be considered a pre-existing condition. Elimination riders are not permitted on the Pool plans.

Generally, if your break in coverage is less than 63 days and you had 12 months of prior coverage, no pre-existing condition exclusion will be imposed when you join the Pool. Even if your break in coverage is 63 days or more, the Pool will give you credit for any coverage that was in effect in the 12 months prior to the effective date of your coverage. The Pool considers creditable coverage to include most types of prior individual or group health plan that you may have had.

However, if before you applied to the Pool you were covered under a group health plan, and you were eligible for COBRA when you left that plan, and you didn't elect COBRA, then when you join the Pool you will have a six-month pre-existing condition exclusion no matter how much prior coverage you had.

WHAT CAN I BE CHARGED FOR TEXAS HEALTH INSURANCE POOL COVERAGE?

- *Premiums will vary based on the health plan you choose, your age and gender, the geographic area where you live, and whether you smoke.* Pool rates are limited to twice the amount that a healthy person who bought a similar plan sold by a private insurer would pay.

  For example, a 24-year-old man who was a non-smoker would pay $156 to $449 in monthly premiums, depending on which deductible option he chose and what part of the state he lived in. On the other hand, a 64-year-old man who was a non-smoker would pay $481 to $1,380 in monthly premiums, depending on the deductible option he chose and where he lived. Please note that rates may have changed since this guide was written, so contact the Texas Health Insurance Pool administrator for the most current information.

HOW LONG DOES TEXAS HEALTH INSURANCE POOL COVERAGE LAST?

- *Coverage under the Texas Health Insurance Pool is renewable as long as you pay your premiums, continue to reside in Texas, and meet other eligibility requirements.* If you cancel your Pool coverage, you will not be able to reapply for coverage under the Pool for 12 months, unless you are HIPAA eligible or you can show a good faith reason for canceling.

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. Texas 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 Texas Department of Insurance to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down.* This is called guaranteed issue. If you employ at least 2 but not more than 50 employees, health insurance companies must sell you any small group health plan they sell to other small employers. However, they can require that a minimum percentage of your eligible workers participate in your group health plan. 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 employees, your group can be turned down.

- *Your insurance cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud, or if they are discontinuing that health plan or if they are withdrawing from the small employer market. In the case of discontinuance, they must give you a chance to buy other plans they sell to groups of your size.

- *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.

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

- *Under Texas law, small employers can be charged more, within limits, based on the health status, claims history, and demographics of the group.* Even within these limits, premiums can be significantly higher if someone in your group has a serious health condition. If you have 51 or more eligible employees, there are no limits on premium variations or increases. If you have questions about your group health plan premiums, contact the Texas Department of Insurance.

WHAT PLAN CHOICES DO I HAVE?

- *By law, all insurers in Texas must offer at least one plan that includes coverage for required state mandated benefits, such as childhood immunizations and mammograms.* In addition, insurers must also offer one or more Consumer Choice Benefits Plans, which are lower-cost plans that do not include all of mandated benefits normally covered in other insurance plans (for example, chemical dependency treatment or diabetes supplies and equipment). For more information about *mandated benefits* and *Consumer Choice Benefit Plans* in Texas, please contact the Texas Department of Insurance at (800) 578-4677 or (512) 463-6169.

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are not eligible to buy a small employer 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 coverage is protected by the laws that apply to individuals. (see Chapter 3)

- *If you are self-employed and buy your own health coverage, you may be eligible to deduct 100% of the cost of your premium from your federal income tax.*

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Texas who cannot afford to buy health insurance. Medicaid, the Children's Health Insurance Program (CHIP), and the **Texas Breast and Cervical Cancer Control Program** 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 early retirees and some workers who lose their jobs or whose work hours and wages are reduced as a result of increased imports. This chapter provides summary information about these programs and contact information for further assistance.

MEDICAID

Medicaid is a program that provides health coverage to some low-income Texas 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.

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

  In Texas you may be eligible for Medicaid if you are an infant, a child, pregnant, or a parent of a dependent child and your family income meets the Medicaid income standards.

  Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account, so you should contact the Texas Department of Human Services for more information.

Low income persons eligible for Medicaid in Texas

Category	Income eligibility (as percent of federal poverty level)
Infant	185%
Child 1-5	133%
Child 6-19	100%
Non-Working Parent	13%
Working Parent	27%
Pregnant woman	185%

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

To get an idea of how your income compares to the federal poverty level,* use the federal poverty guideline issued by the U.S. Department of Health and Human Services for the year 2009:

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

For larger families, add $3,740 for each additional person

So, for example, using this guideline, 200% of the federal poverty level for a family of 3 would be an annual income of $36,620, or a monthly income of $3,052.

* Contact your local department of social services for the most up to date information and for other eligibility requirements that may apply.

- *Families who get cash benefits from **TANF** (also known as Temporary Assistance for Needy Families) can get Medicaid. In addition, your children may qualify for Medicaid if your family's income meets certain income standards.*

- *Very poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits can also qualify for Medicaid.* You do not need to submit a separate application 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 if you are elderly or you are still considered disabled and you continue to have medical need.

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

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

  If your household income 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.

  Contact your local Department of Human Services for more information about other eligibility requirements.

- *There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify for Medicaid, contact the Texas Department of Human Services. To obtain the locations and telephone numbers of sites near you call (800) 252-8263.

TEXAS CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

CHIP is part of the federal Children's Health Insurance Program (CHIP) and provides heath insurance for uninsured children of low-income families who do not have access to affordable health insurance.

- *If a child aged 19 or younger does not have health insurance, CHIP provides payment of medical expenses at little or no cost.* The price a family pays depends on your family income.

- *CHIP enrolls children from families whose family income is up to 200% of the federal poverty level (FPL).* For example, for a family of three making less than $3,052 per month, the child (or children) would be eligible for coverage.

- *CHIP provides comprehensive coverage to enrollees.* This includes doctor and nurse care, immunization and preventative care, health clinic care, laboratory tests and x-rays, prescription drugs, medical equipment and medical transportation, dental care, eye care, hospital care, mental health services, and preventative well-child visits, as well as other services.

- *Children entering CHIP after leaving private health insurance will have a 90-day waiting period before becoming eligible for benefits.* However, this waiting period may be waived in some situations, including if the child has lost coverage because his or her parent lost their job or exhausted COBRA.

- *For more information, contact the Texas Health and Human Services Commission at (800) 252-8263 or visit http://www.hhsc.state.tx.us/chip/index.html.*

TEXAS BREAST AND CERVICAL CANCER CONTROL PROGRAM

- *The Texas Breast and Cervical Cancer Control Program provides a qualified woman with full healthcare benefits through Medicaid at no cost or for a nominal co-payment.* Women screened through this program and diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid which extends throughout the duration of cancer treatment. Women screened outside this program and diagnosed with cancer may also be eligible for free health coverage through Medicaid. In addition, Medicaid will cover all of your medical needs including treatment of non-cancer related services.

- *In order to be eligible for screening through the Texas Breast and Cervical Cancer Control Program, you must have an income at or below 200% of the federal poverty level (FPL) and you must be a Texas resident.* In addition, you must have no or limited health coverage and be ineligible for Medicaid and Medicare. For breast cancer screening, women aged 50-64 have priority while women aged 18-64 who have not received a Pap smear within the previous 5 years have priority for cervical cancer screening.

- *For more information, please contact the Texas Department of State Health Services at (512) 458-7796 or visit http://www.dshs.state.tx.us/bcccs/default.shtm.*

OTHER STATE PROGRAMS

There may be other financial assistance programs available. Please call the Texas Department of Health and Human Services at (877) 787-8999.

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 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, Texas has designated the Texas Health Insurance Risk Pool and a plan sold by Blue Cross and Blue Shield of Texas as state qualified plans. (see Chapter 3)

HOW DO I CLAIM THE HCTC?

- *You can claim the HCTC on your tax return and be reimbursed for 80% of the premium you paid for qualified coverage while you were eligible for the HCTC.* Currently, this is the only way to claim the HCTC if your qualified health plan is provided through a spouse's employer.

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

WHERE CAN I GET MORE INFORMATION?

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

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

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

FOR MORE INFORMATION…

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

For questions about:	Contact:
Individual health insurance State continuation coverage Fully insured group health plan	*Texas Department of Insurance* (800) 252-3439 (in-state only) (512) 463-6464 http://www.tdi.state.tx.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
Texas Health Insurance Pool	*Blue Cross/Blue Shield of Texas (plan administrator)* (888) 398-3927 (800) 735-2986 (TDD) http://www.txhealthpool.com
Medicaid	*Texas Department of Human Services* (800) 448-3927 http://www.dhs.state.tx.us
Children's Health Insurance Program (CHIP)	*Texas Department of Health* (800) 252-8263 http://www.texcarepartnership.com
Texas Breast and Cervical Cancer Control Program	*Texas Department of State Health Services* (512) 458-7796 http://www.dshs.state.tx.us/bcccs/default.shtm
Federal Health Coverage Tax Credit (HCTC)	*Internal Revenue Service* 1-866-628-HCTC http://www.irs.gov/individuals/index.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 July 2009

HELPFUL TERMS

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

Certificate of Creditable Coverage. A document provided by your health plan that lets you prove you had coverage under that health 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.

Children's Health Insurance Program (CHIP). CHIP is a program that provides health coverage to some children from low income families.

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 health plan's 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 plus a 2% administrative charge). COBRA continuation coverage generally lasts 18 months, or 36 months for dependents in certain circumstances.

Consumer Choice Benefit Plan. Lower-cost plan that does not include all of mandated benefits normally covered in other insurance plans (for example, chemical dependency treatment or osteoporosis screening). Small employers carriers must offer one or more of these plans to small employers, while others carriers may offer these plans to consumers.

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

Elimination Rider. An amendment permitted in individual health insurance policies issued by an insurer that permanently excludes health coverage for a health condition, body part, or body system.

Enrollment Period. The period during which all employees and their dependents can sign up for coverage under an employer group health plan. Besides permitting workers to elect health coverage 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. Texas requires all fully insured group health plans to hold an annual open enrollment period. See also Fully Insured 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. A health plan purchased by an employer from an insurer or HMO. Fully insured group health plans are regulated by Texas. 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. See also Fully Insured Group Health Plan, Self-Insured Group Health Plan.

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All health plans sold to small employers with 2 to 50 employees in Texas are guaranteed issue.

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 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 coverage, 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, consumers' protections vary from state to state.

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

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

Individual Health Policy. Policies for people not connected to an employer group. This term also refers to coverage purchased by self-employed persons who have no other employees. In general, individual health insurance is regulated by the state of Texas, but certain protections related to HIPAA eligible individuals and other issues are enforced by the federal government.

Insurer. Another term for insurance company. This term does not include HMOs.

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

Late Enrollment. Enrollment in a health plan at a time other than the regular or a special enrollment period. Texas requires fully insured group plans to cover you if you are a late enrollee, although you may have to wait for the next open 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 Pre-existing Condition.

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

Medicaid. A program providing comprehensive health insurance coverage and other assistance to certain low-income Texas 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, because of your health status. Group health plans can restrict your coverage based on other factors (such as part time employment) that are unrelated to health status. See also Group Health Plan, Health Status.

Pension Benefit Guaranty Corporation (PBGC). PBGC is a federal government corporation established by Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) to encourage the continuation and maintenance of defined benefit pension plans, provide timely and uninterrupted payment of pension benefits to participants and beneficiaries in plans covered by PBGC. It currently guarantees payment of basic pension benefits earned by American workers and retirees participating in private-sector defined benefit pension plans. The agency receives no funds from general tax revenues. Operations are financed largely by insurance premiums paid by companies that sponsor pension plans and by PBGC's investment returns.

Pre-existing Condition (Group health 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 (Texas Health Insurance Risk Pool). 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 the Texas Health Insurance Pool.

Pre-existing Condition (Individual Health Insurance). Any symptoms for which medical advice, diagnosis, care or treatment was ever recommended or received, or for which an ordinarily prudent person would have sought medical advice, care or treatment within a 5-year period preceding enrollment. In Texas, under individual health policies, pregnancy can be counted as a pre-existing condition. See also Prudent Person Rule.

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

Prudent Person Rule. In individual health insurance only, a rule that permits insurers to exclude as pre-existing any condition for which – in the insurer's judgment – most people would have sought care or treatment.

Self-Insured Group Health Plans. Plans set up by employers who set aside funds to pay their employees' health claims. Because employers often hire insurers or HMOs 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 Texas.

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

Special Enrollment Period. A time, triggered by certain specific events, during which you and your dependents must be permitted to sign up for coverage under a group health plan. Employers and group health insurers must make such a period available to employees and their dependents when their family status changes or when their health insurance status changes. Special enrollment periods must last at least 30 or 60 days, depending on the qualifying event. Enrollment in a health plan during a special enrollment period is not considered late enrollment. See also Late Enrollment.

State Continuation Coverage. A program required to be offered by insurers and HMOs for former employees of small employers as well as some other groups of people. Continuation coverage allows people to keep their group health plan for a limited time. See also COBRA.

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

Temporary Assistance for Needy Families (TANF). A program (also known as Texas Works and Choices) 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.

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

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.

Texas Health Insurance Pool. Also called the "Pool," the state-run program that provides health coverage for HIPAA eligible persons and for people with high health risks.

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 coverage. Not all employers require waiting periods. Waiting periods do not count as gaps in health coverage 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.