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

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July 2010

ACKNOWLEDGMENTS AND DISCLAIMER

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

The authors also wish to express appreciation to the staff of the Maryland Insurance Administration and the United States Department of Labor. 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.

July 2010

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

As a Maryland 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 Maryland resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group and individual health plans. Chapter 4 highlights your protections as a small employer. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from Maryland, 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 36. For information about how to find consumer guides for other states on the Internet, see page 36. A list of helpful terms and their definitions begins on page 37. These terms are in boldface type the first time they appear.

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Revisited July 2010

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 plans**), so your protections may vary if you leave Maryland. 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 Maryland resident.

HOW AM I PROTECTED?

In Maryland, as in many other states, your health insurance options are somewhat dependent on your **health status**. Even if you are sick, however the laws protect you in the following ways.

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status.* This is called **nondiscrimination** (see page 6). (Effective October 1, 2009, if you are a new employee joining an existing group health plan, you may be subject to a pre-existing condition exclusion period of up to 12 months, based on a medical history **look back** of 6 months).

- *All group health plans in Maryland must limit exclusion of pre-existing conditions.* There are rules about what counts as a pre-existing condition and how long you must wait before a new group health plan will begin to pay for care for that condition. Generally, if you join a new group health plan, your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage (see page 8).

- *Your health insurance cannot be canceled because you get sick.* Most health coverage is **guaranteed renewable** (see page 15 and 25).

- *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**. For example, 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 page 19).

- *If you lose your group health insurance and meet other qualifications, you will be **HIPAA eligible**.* If so, you can buy an individual health insurance policy from the **Maryland Health Insurance Plan** (MHIP). You will not face a new pre-existing condition exclusion period if you are HIPAA eligible. (see page 15).

- *If you are not HIPAA eligible but have had difficulty obtaining an affordable individual health insurance policy because of your health condition, you may also be eligible under MHIP*. You may be subject to a 2 month pre-existing condition exclusion period. (see page 15).

- *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*. All fully insured health plans for small employers must be sold on a **guaranteed issue** basis. However, the insurance carrier can turn down the small employer if the small employer does not meet the participation requirements (see page 26).

- *If you are a small employer buying a group health plan, you cannot be charged more due to the health status of those in your group.* You can, however, be charged higher premiums, within limits, based on where your business is located and the age and family composition of people in your group. This is called **modified community rating** (see page 27). (Effective July 1, 2010, small employers buying a group health plan for the first time may be subject to an increase or decrease in premium based on health status not to exceed 10% in the first year, 5% in the second year, 2% in the third year, and the modified community rate thereafter).

- *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 Maryland **Medicaid** program (called **HealthChoice** for some people who enroll in it) offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes. Maryland's **Children Health Program** is a part of the Medicaid program that provides health insurance to some low-income children and pregnant women (see page 29).

- *If you are a small employer with between 2 and 9 employees who earn low to moderate wages, you may be eligible for a premium subsidy toward your group health plan.* (Chapter 4 provides more detail on this premium subsidy program known as the Health Insurance Partnership).

- *If you are a small employer offering health insurance to your employees and paying at least 50% of the premium, you may be eligible to receive a tax credit beginning in 2010.* The Small Business Health Care Tax Credit is one of the federal health reform initiatives under the Patient Protection and Affordable Care Act signed into law by President Obama on March 23, 2010. This small business tax credit can be as much as 35% of the premium between 2010 and 2013, increasing to up to 50% of the premium beginning in 2014. The following link will lead you to more information on the Small Business Health Care Tax Credit: http://www.irs.gov/newsroom/article/0,,id=223666,00.html. You may want to consult with your broker or a knowledgeable Certified Public Accountant to ensure that your business qualifies for this tax credit.

- *If you believe that you have or are at risk for breast or cervical cancer, you may be eligible for free screening and treatment.* **The Maryland Breast and Cervical Cancer Screening Program** provides qualified women with free breast and cervical cancer screenings. In addition, women diagnosed with cancer may be eligible for treatment (see page 32).

- *If you have lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program** then you may be eligible for a federal income tax credit to help pay for new health coverage*. This credit is called the **Health Coverage Tax Credit** (HCTC), and it is equal to 65% of the cost of qualified health coverage, including COBRA and coverage under the Maryland Health Insurance Plan (MHIP) (see page 33).

- *If you are a retiree aged 55-65 and receiving pension benefits from **Pension Benefit Guarantee Corporation** (PBGC), then you may also be eligible for the HCTC* (see page 33).

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 coverage with you.* Except when you exercise your federal COBRA or state continuation rights, you are not entitled to take your actual group health coverage with you when you leave a job. Your new health plan may not cover all of the benefits or include the same doctors that your old health plan did (see page 6).

- *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 their decision is based on factors unrelated to your health status (see page 6).

- *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 (see page 7).

- *If you have a break in coverage of 63 days or more, you may have to satisfy a new pre-existing condition exclusion period when you join a non-**HMO**, fully insured large group plan or a self-insured group plan* (see page 8).

- *Even if your coverage is continuous, there may be a pre-existing condition exclusion period for some benefits if you join a fully insured large group health plan or a self-insured 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 one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition (see page 8).

- *If you work for certain non-federal public employers in Maryland, not all of the group health plan protections may apply to you* (see page 11).

- *Individual health insurers in Maryland are free to turn you down because of your health status and other factors*. Even if you are HIPAA eligible, you can be turned down for individual health insurance. Your only option for guaranteed coverage is from the Maryland Health Insurance Plan (MHIP) (see page 13).

- *In most cases 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 page 15).

- *Except when you are joining an HMO, all individual health insurers in Maryland can impose elimination riders and pre-existing condition exclusion periods, and do not have to give you credit for prior coverage* (see page 14).

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. Also, if you enroll in a fully insured plan, your protections will vary based on whether your plan is an HMO or non-HMO plan.

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

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

Certain changes can trigger a special enrollment opportunity

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

- *Under Maryland law, newborns, adopted children, and children placed for adoption must be covered under your fully insured group health plan for the first 31 days following birth, adoption, or placement, 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 Maryland law, children who have been placed under your guardianship (other than a temporary guardianship of 12 months or less) must be covered under your fully insured group health plan for the first 31 days following placement, 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 Maryland law, dependent grandchildren may also be eligible for coverage under your fully insured group health plan.* If your grandchild was placed in your custody by court-order and your plan covers dependents, then your grandchild is eligible for coverage.

- *Under Maryland law, your disabled child can remain covered as a dependent under your health plan into adulthood.* This applies if your dependent was already disabled and covered under the health plan before he or she reached the limiting age for dependent coverage. In addition, your disabled dependent must be unmarried. You will have to document that you provide support for your disabled dependent. Subsequently, if you change health plans, you might not be able to cover your disabled son or daughter as a dependent under the new 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 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.

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.

- *Generally, group plans in Maryland, including fully insured large group plans and self-insured group health plans, are permitted to impose pre-existing condition exclusion periods for new enrollees.*

- *Pre-existing condition exclusion periods can only be imposed on conditions for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan.* This period is also called the look back period.

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

- *Group health plans can only exclude coverage for pre-existing conditions for a limited time.* The maximum exclusion period is 12 months. However, if you enroll late in one of these types of group health plans (after you are hired and not during a regular or special enrollment period), you may have a longer pre-existing condition exclusion period, up to 18 months.

- *Currently, HMOs and fully insured small group plans cannot impose pre-existing condition exclusion periods.* However, if you enroll late in a small group health plan (after you are hired and not during a regular or special enrollment period), the plan can impose a pre-existing condition exclusion period of up to 12 months. (Beginning October 1, 2009 small group plans (except for HMOs) will be allowed to impose a pre-existing condition exclusion period of up to 12 months based on a 6-month look back period. This change makes the small employer market consistent with existing HIPAA laws).

- *Group health plans that impose pre-existing condition exclusion periods must give you credit for any previous continuous* ***creditable coverage*** *that you've had.* Most types of private and government sponsored health coverage is considered creditable coverage. Coverage counts as continuous if it is not interrupted by a break of 63 days in a row.

What is creditable coverage?

Most health coverage counts as creditable coverage, including, but not limited to:

Federal Employees Health Benefits (FEHBP)
Group health insurance (including COBRA)
Indian Health Service
Individual health insurance
Medicaid
Medicare
Military health coverage (TRICARE)
State health insurance high risk pools

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

Coverage counts as continuous if it is not interrupted by a break of 63 days in a row. Employer-imposed waiting periods do not count as a break in coverage. If your new plan imposes a pre-existing exclusion period, you can credit time under your prior continuous coverage towards it. If your employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period.

What is continuous coverage?

You are considered to have continuous coverage under one plan, or several plans, as long as you don't have a lapse of 63 or more 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, offers 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 he has more than 12 months of prior continuous coverage 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 – 9 months). Art does not get credit for his coverage at Ajax since he had a break in coverage of 63 or more consecutive days.

- *Your protections may differ if you move to a group health plan that offers more benefits than your old one did.* Plans can look back to determine whether your previous health plan covered prescription drugs, mental health, substance abuse, dental care, or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new group health plan may impose a pre-existing condition exclusion period for that category.

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

Sue needs prescription medication to control her blood pressure. She had 2 years of continuous coverage under her employer's group health plan, which did not cover prescription drugs. Sue changes jobs, and her new employer's 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, some public employers in Maryland 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. 91565 or at (410) 786-1565 to see if your employer has elected to be exempt from certain protection.

AS YOU ARE LEAVING GROUP COVERAGE…

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

- *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 65% of the cost of qualified health coverage, including COBRA and coverage under the Maryland Health Insurance Plan (MHIP) (see page 33).

- *If you are a retiree aged 55-65 and receiving pension benefits from the Pension Benefit Guaranty Corporation (PBGC), you may also be eligible for the HCTC* (see page 33).

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored health coverage, you may want to buy an individual health policy from a private insurer. However, in Maryland – 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 coverage – such as COBRA coverage, state continuation coverage, and Maryland Health Insurance Plan coverage. This chapter summarizes your protections under different kinds of health plan coverage.

INDIVIDUAL HEALTH COVERAGE SOLD BY PRIVATE INSURERS & HMOS

WHEN DO HEALTH INSURERS HAVE TO SELL ME INDIVIDUAL COVERAGE?

In Maryland, your ability to buy an individual health insurance policy may depend on your health status.

- *Insurers that sell individual health insurance in Maryland are free to turn you down because of your health status and other factors.* When applying for an individual health insurance policy, you may be asked questions about health conditions you have now or had in the past. Depending on your health status, insurers might refuse to sell you a policy or offer to sell you a policy that has special limitations on what it covers. If this happens, you can buy health insurance from the Maryland Health Insurance Plan (MHIP).

- *Under Maryland law, newborns, adopted children, and children placed for adoption must be covered under your individual health insurance policy for the first 31 days following birth, adoption, or placement, 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 Maryland law, children who have been placed under your guardianship (other than a temporary guardianship of less than 12 months) must be covered under your individual health insurance policy for the first 31 days following placement, if the policy 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 Maryland law, dependent grandchildren may also be eligible for coverage under an individual health policy*. If your grandchild was placed in your custody by

court-order and your plan covers dependents, then your grandchild is eligible for coverage.

- *Under Maryland law, your disabled child can remain covered as a dependent under your health plan into adulthood.* This applies if your dependent was already disabled and covered under the health insurance policy before he or she reached the limiting age for dependent coverage. In addition, your disabled dependent must be unmarried. You will have to document that you provide support for your disabled dependent. If you subsequently change health insurance policies, you might not be able to cover your adult disabled dependent son or daughter as a dependent under the new health insurance policy.

WHAT WILL MY INDIVIDUAL HEALTH POLICY COVER?

- *It depends on what you buy.* Maryland does not require individual health insurers to sell standardized policies. Insurers can design different policies and you will have to read and compare them carefully. However, Maryland does require all individual health insurance policies to cover certain benefits – such as mammograms and prostate cancer screening. Check with the Maryland Insurance Administration for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you buy an individual health insurance policy from an HMO, you will not face a pre-existing exclusion period.* HMO's cannot impose pre-existing exclusion periods.

- *If you buy a non-HMO individual health insurance policy, there might be an* ***elimination rider*** *on any medical condition that you currently have or had in the past.* An elimination rider is an amendment to your health plan contract that temporarily or permanently excludes coverage for a health condition, body part, or body system.

  In addition, if you make a claim during the first 24 months of the policy, the insurer can refuse that claim and others related to the condition if it determines the condition was present within 7 years of the time of application. (This will change to 5 years, effective October 1, 2009 for individual health plans). Pre-existing conditions include those that were not previously diagnosed, but caused symptoms for which the plan determines a prudent person would have sought care. This is the **prudent person standard**.

  Pregnancy can be considered a pre-existing condition in individual health insurance policies, but genetic information cannot.

Finally, if a pre-existing condition does apply on your individual health insurance policy, you cannot reduce it by crediting prior continuous coverage.

WHAT CAN I BE CHARGED FOR INDIVIDUAL HEALTH COVERAGE?

- *If you have an expensive health condition, your individual health insurance premiums may be very high.* The law does not prohibit individual health insurers in Maryland from charging you more because of your health status.

- *In addition, when you renew your individual health insurance policy, your premiums can increase substantially as you age.*

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELLED?

- *Your health 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 HMOs, continue to live in the plan service area. Your health coverage may also be cancelled if the insurer or HMO discontinues your health policy or withdraws from the individual market.

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

MARYLAND HEALTH INSURANCE PLAN (MHIP)

Maryland has a risk pool program called the Maryland Health Insurance Plan (MHIP). MHIP offers health coverage for persons who are HIPAA eligible, for people eligible for HCTC, and for people with expensive health conditions who are unable to buy individual coverage.

WHEN CAN I GET COVERAGE FROM MHIP?

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

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible in Maryland you are eligible for coverage under the Maryland Health Insurance Plan (MHIP), Maryland's high risk 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 individual coverage, because the last day of your continuous health coverage must have been in a group plan. You can become HIPAA eligible again by maintaining continuous coverage and rejoining a group health plan.

- *If you are eligible for the HCTC, then you can buy health insurance from the MHIP* (see page 33).

- *If you are "medically eligible" you can buy coverage from MHIP.* You are considered medically eligible if you were turned down for coverage within the last 6 months by an insurer or HMO because of your health. In addition, if you were offered insurance that excludes or limits coverage for your pre-existing health condition, or if you were offered coverage that is more expensive than MHIP because of the health of the insured, you are considered uninsurable. You are also medically eligible if you have one of the serious medical conditions (such as AIDS or cancer) listed by MHIP. The list of qualifying health conditions can be found at www.marylandhealthinsuranceplan.net.

  Medically eligible individuals must have been a Maryland resident for at least 6 months to enroll in MHIP.

- *You can also buy coverage from MHIP if you have moved to Maryland from another state's high risk pool.*

- *The high risk pool offers both individual and family policies, so dependents are also eligible for coverage under the high risk pool.*

- *To be eligible for MHIP, you must not be eligible for employer-sponsored group health coverage, Medicaid or Medicare.*

WHAT DOES MHIP COVER?

- *You can choose from 4 plan options under MHIP – an HMO plan, 2 PPO options, and a high deductible plan. Covered benefits are the same under all plans, but the cost sharing varies.*

- *Covered benefits include hospital and physician care, prescription drugs, maternity care, mental health, and other services.* There is a lifetime maximum of $2.5 million per person on covered benefits.

- *Under the HMO plan, non-emergency care is covered only when provided by a hospital, doctor, or other provider in the MHIP network.* There is no annual deductible under the HMO plan. You will pay a co-pay (usually $25 to $35) for each covered service and prescription.

- *Under the PPO plan options, you can receive care in or out of the MHIP network*. After you have satisfied the annual deductible, you will pay coinsurance of 20 percent for care received in-network and 40 percent for care received out-of-network, depending on the plan, up to a varying annual out-of-pocket limit. When you reach this limit, MHIP will pay 100 percent of covered services for the rest of the year. Coinsurance does not apply to prescription drugs; instead, you will pay a co-pay for each prescription. A separate annual deductible also applies to prescription drugs.

- *The PPO plans offer a choice of deductibles*. The $500 PPO plan has an annual deductible of $3,000 per person for most services and a separate $100 annual deductible for prescription drugs. The $1,000 PPO plan has an annual deductible of $3,500 per person for most services and a separate $250 annual deductible for prescription drugs per person, but not to exceed $500 per family. The High Deductible Health Plan (HDHP) has an annual deductible of $2,600 for all services and prescription drugs combined.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are HIPAA eligible, you will not be subject to a pre-existing condition exclusion when you enroll in MHIP.*

- *If you are not HIPAA eligible, you will have a 2-month pre-existing condition exclusion period when you first enroll in MHIP.* When you enroll, MHIP will look back 6 months to see if you had a condition for which you actually received a diagnosis or for which medical advice or treatment was recommended or received. The 2 month exclusion period can be reduced if you were previously covered under another health plan within 63 days of applying to MHIP. In addition, if you were previously uninsured, MHIP offers an option to waive the pre-existing condition exclusion period. If you choose this option, your MHIP premium will be increased for the first six months that you are covered under the program.

HOW MUCH CAN I BE CHARGED FOR MHIP COVERAGE?

- *Premiums vary based on your age and the plan you choose.* For example, if you are 24, the monthly premium is $157 for the $1,000 PPO, $199 for the $500 PPO, $313 for the HMO, and $84 for the HDHP. If you are 64, the monthly premium is $364 for the $1,000 PPO, $459 for the $500 PPO, $724 for the HMO and $195 for the HDHP.

- *Higher premiums are established for family coverage.*

- *Premiums are updated annually in July.* Contact MHIP for the most current information.

- *If you have low or moderate income, y*ou may qualify for reduced premiums and lower deductibles under a plan option called MHIP+. The annual savings can range up to $5,400, depending on your total household income. Please refer to the application for details.

- *If you are eligible for HCTC, you can enroll in MHIP and the federal government will pay 65% of your premium each month.* You should call the HCTC customer contact center toll free at 1-866-628-4282 Monday through Friday, 7 am to 7 pm central time. The customer contact center can provide you registration material and help you fill them out so you can take advantage of the tax credit. (see page 33).

HOW LONG DOES HEALTH POOL COVERAGE LAST?

- *Coverage under MHIP is renewable as long as you pay your premiums, continue to reside in Maryland, and meet other eligibility requirements.*

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 coverage, 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 (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 number of hours worked

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

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

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

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

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

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

SPECIAL SECOND CHANCE TO ELECT COBRA FOR TRADE-DISLOCATED WORKERS

- *A second COBRA election period may be available for TAA eligible people who did not elect COBRA when it was first offered*. The second election period can be exercised 60 days from the 1st day of TAA eligibility, but in no case later than 6 months following loss of coverage. Coverage elected during this second election begins retroactive to the beginning of the special election period – not back to qualifying event.

- *Certain people who lost their job-based health coverage because of the impact of imports on their employers have a limited second chance to elect COBRA*. People who are receiving benefits from the Trade Adjustment Assistance (TAA) Program are eligible for a federal income tax credit (the Health Coverage Tax Credit, or HCTC) that will pay 65% of their premiums.

- *For some laid off workers, TAA benefits begin after their 60-day period to elect COBRA continuation coverage has expired*. In this circumstance, TAA-eligible people have a second 60-day period, starting on the date of their TAA eligibility, to elect COBRA. (However, in no case can COBRA be elected more than 6-months following the original qualifying event (i.e. layoff) that caused the loss of group health plan coverage.)

- When COBRA is elected during this special, second election period, coverage starts on the first date of the special election period. Any time that has elapsed between the original qualifying event and the first date of the special election period is not counted as a lapse in coverage in determining continuous coverage history.

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

WHAT WILL COBRA COVER?

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

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Because your group coverage is continuing, you will not have a new pre-existing condition exclusion period under COBRA.* However, if you were in the middle of a pre-existing condition exclusion period when your qualifying event occurred, you will have to finish it.

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

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

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

- *Certain dislocated workers who receive benefits under the Trade Adjustment Assistance (TAA) Program, and retirees aged 55-65 receiving pension benefits from PBGC may be eligible for a federal income tax credit to help pay for COBRA or other qualified coverage.* The tax credit will cover 65% of your premium (see page 33).

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 of hours) or be determined to have become disabled within 60 days of that qualifying event. You must obtain a disability determination letter from the Social Security Administration, and you must notify your group health plan within 60 days of receiving this disability determination letter, and before your original 18 months expires.

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 MARYLAND STATE CONTINUATION COVERAGE?

- *If your employer offers a fully insured group health plan, you may also be eligible for continuation coverage under Maryland laws that are similar to COBRA.*

- *Continuation coverage is available to you and your dependents if you lost your group coverage due to the termination of employment.* You are eligible if you are a resident of the state and have been employed for at least three months prior to losing

your coverage. In the case of termination, you may remain covered under the plan for up to 18 months. If your family was covered under the plan, they are eligible for continuation coverage, as well. You will not have a new pre-existing condition exclusion period as long as you maintain continuous coverage. Ask your former employer or the Maryland Insurance Administration about state continuation coverage if you think it applies to you.

- *Continuation coverage is available to you if you lost your group coverage due to the death of your spouse or parent*. Coverage is available to you, if you were covered under the plan for at least three months prior to their death. You may remain covered under the plan for up to 18 months.

- *In the case of divorce, you can buy continuation coverage if you were covered under your spouse's group plan for at least 30 days prior to your divorce.* Continuation coverage is available until you remarry or become eligible for new group coverage or Medicare, whichever comes first. If your former spouse quits his or her job, your coverage will end when your spouse's coverage terminates. In this case, if your spouse is covered under another plan, you can get coverage under their new group plan.

CONVERSION

WHEN AM I ELIGIBLE FOR CONVERSION COVERAGE?

- *If you were covered under a fully insured group health plan and you leave that plan, you may be able to buy a conversion policy.* This is an individual health policy from the insurance company that covered your former group. You can buy a conversion policy if you lost your group coverage because you left your job or because the group coverage was terminated. In addition, in the case of divorce or death, your dependents may purchase a conversion policy.

- *You can buy a conversion policy either instead of or after you use up your COBRA or state continuation coverage.* You cannot buy conversion coverage if you have comparable coverage under another group or individual health plan.

- *If you decide to purchase a conversion policy, you will no longer be considered HIPAA eligible.*

WHAT WILL THE CONVERSION POLICY COVER?

- *Conversion policies are required to meet minimum standards set out in state regulations.* Even so, the benefits may be less generous than what you received under your former group coverage.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Your conversion policy cannot impose a new pre-existing condition exclusion period.* However, you might have to satisfy the unexpired portion of any pre-existing condition exclusion period from your former health plan.

WHAT CAN I BE CHARGED FOR A CONVERSION POLICY?

- *Premiums for conversion health plans can vary depending on your health status, age, the amount of coverage you purchase and other characteristics.* Contact the Maryland Insurance Administration if you have questions about conversion policy premiums.

CAN MY CONVERSION POLICY BE CANCELLED?

- *Your coverage cannot be cancelled 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.

CHAPTER 4
YOUR PROTECTIONS AS A SMALL EMPLOYER

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. Maryland 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 Maryland Insurance Administration 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 if the employer group meets the participation requirements. An insurance carrier can require that a minimum percentage of your workers participate in your group health plan as long as this percentage is not greater than 75%. If you are buying a large group health plan for 51 or more employees, your group can be turned down.

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

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

- *As a small employer, under current Maryland law, you cannot be charged higher premiums because someone in your group is seriously ill.* You can, however, be charged somewhat more due to the age and family size of those in your group and where your business is located. This is called modified community rating. These rules apply to all small group health plans. If you have any questions about your premiums, contact the Maryland Insurance Administration. (Effective July 1, 2010, small employers buying a group health plan for the first time may be subject to an increase or decrease in premium based on health status not to exceed 10% in the first year, 5% in the second year, 2% in the third year, and the modified community rate thereafter).

WHAT PLAN CHOICES DO I HAVE?

- *In Maryland, insurers can only offer the standard plan to employers with 2 to 50 eligible employees.* This is a policy that has the benefits required by Maryland Insurance Administration regulations. Benefits covered under the standard plan are generally comprehensive, although prescription drug coverage is limited and substantial cost sharing (deductibles and coinsurance) applies. Detailed information about what is covered under Maryland's Comprehensive Standard Health Benefit Plan for small businesses can be found at http://mhcc.maryland.gov/smallgroup/cshbp_brochure.htm.

  Insurers can offer separate packages of additional benefits (called "benefit riders") that you can buy along with the standard plan to increase covered benefits or reduce cost sharing. Some, but not all, of these benefit riders are guaranteed issue to small employers. Once a benefit rider has been sold, however, it must be guaranteed renewable. Standardization helps you compare differences in cost and coverage.

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 employer's access to group health insurance do not apply to you. Other laws apply to an individual's access to health insurance (see Chapter 3).

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

A WORD ABOUT ASSOCIATION PLANS

- *Association plans are not an option for employers in Maryland. Insurers can only offer the standard plan as required by the Maryland Insurance Administration to employers with 2 – 50 employees.*
- However, self-employed people, and other individuals may buy health insurance through professional or trade associations. The laws applying to association health coverage can be different from other health plans. Check with the Maryland Insurance Administration about your protections in association plans.

A WORD ABOUT THE HEALTH INSURANCE PARTNERSHIP

- *The Health Insurance Partnership is a premium subsidy program that has been available since October 2008 as a means to reduce the number of uninsured in Maryland.* It is available to small businesses that employ between 2 and 9 full-time employees at the time of initial application, as long as the business has not offered a group health plan during the previous 12 months. If the business meets wage and salary requirements established by the Commission, it could be eligible to receive a subsidy of up to 50% of the premium. The business can continue receiving a premium subsidy until the group size grows to 19 employees or until the average annual wage of all full-time employees reaches $50,000. Other eligibility requirements include establishing a Section 125 premium conversion plan and including a wellness benefit as part of the group health plan. The Health Insurance Partnership is administered by the Maryland Health Care Commission. Detailed information on the Health Insurance Partnership can be found at http://mhcc.maryland.gov/partnership.

A WORD ABOUT THE SMALL BUSINESS HEALTH CARE TAX CREDIT

- *If you are a small employer offering health insurance to your employees and paying at least 50% of the premium, you may be eligible to receive a tax credit beginning in 2010.* The Small Business Health Care Tax Credit is one of the federal health reform initiatives under the Patient Protection and Affordable Care Act signed into law by President Obama on March 23, 2010. This small business tax credit can be as much as 35% of the premium between 2010 and 2013, increasing to up to 50% of the premium beginning in 2014. The following link will lead you to more information on the Small Business Health Care Tax Credit:

http://www.irs.gov/newsroom/article/0,,id=223666,00.html. You may want to consult with your broker or a knowledgeable Certified Public Accountant to ensure that your business qualifies for this tax credit.

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Maryland who cannot afford to buy health insurance. Medicaid and some other state programs offer free or subsidized health insurance coverage, direct medical services or other help. In addition, the federal government, under the Trade Adjustment Assistance (TAA) Program provides tax credits to some workers who lose their jobs or whose work hours and wages are reduced as a result of increased imports. This chapter provides summary information about these programs and contact information for further assistance.

MEDICAID

Medicaid is a program that provides health coverage to some low-income Maryland 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. Most Medicaid enrollees receive their care through the Maryland mandatory managed care program, the HealthChoice Program.

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

  In Maryland 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, so you should contact the Department of Social Services for more information.

Low income persons eligible for Medicaid in Maryland

Category	Income eligibility (as percent of federal poverty level)
Child 0-1	<185%
Child 1-5	<133%
Child 6-18	<100%
Parent	116%
Pregnant woman	250%

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

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

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

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

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

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

- *Families who get cash benefits from TANF (also known as FIP or Family Investment Program) can get Medicaid.*

  Parents 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.

  Parents should know that when your family's TANF benefits end, your children may also qualify for transitional Medicaid coverage for 12 months. Or, your children may qualify for Medicaid themselves if your family's income meets the Medicaid income standards.

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

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

- *People who have high medical expenses may also qualify for Medicaid.* You may qualify as medically needy if you 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 135% of the poverty level, Medicaid will pay for your monthly Medicare premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

  Contact the Department of Social 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 Maryland Department of Social Services.

MARYLAND'S CHILDREN HEALTH PLAN (MCHP) AND MCHP PREMIUM PROGRAM

- *The Maryland Children's Health Program (MCHP) is a federal/state program that gives full health benefits for children up to age 19, and pregnant women of any age who meet the income guidelines.*

  To be eligible, a child's family income must be at or below 300% of the federal poverty level and the applicant cannot be eligible for Medicaid. Pregnant women qualify if their family income does not exceed 250% of the federal poverty level.

  MCHP participants receive care through the Maryland Managed Care Program, HealthChoice. Participants do not pay for this coverage.

- *The MCHP Premium Program is low cost health insurance coverage for uninsured children under the age of 19 whose family income is above 200% but at or below 300% of the federal poverty level.*

  It provides access to health insurance for eligible children through their parent's or guardian's employer sponsored insurance or through the Maryland Managed Care Program, HealthChoice.

  Participants must pay a small monthly premium.

- *For more information, call the MCHP Hotline at (800) 456-8900.*

MARYLAND BREAST AND CERVICAL CANCER SCREENING PROGRAM

- *If you believe you may be at risk for breast or cervical cancer, you may be eligible for free screening and/or treatment through one of two programs administered through the Maryland Breast and Cervical Cancer Screening Program.*

- *The Maryland Breast and Cervical Cancer Screening Program provides qualified women with breast and cervical cancer screenings at no cost.* Women screened through this program and diagnosed with breast or cervical cancer will be eligible for free treatment through Medicaid.

  In order to be eligible for screening through this program, you must be between the ages 40-64 years of age. In addition, you must be either uninsured or underinsured and your income must not be greater than 250% of poverty. Women over 65 may be eligible if they do not have Medicare Part B and meet this income standard.

- *The Breast and Cervical Cancer Diagnosis and Treatment Program provides eligible residents of any age with free diagnosis and treatment for breast and cervical cancer.* In order to be eligible for this program you must meet certain income criteria and be uninsured or underinsured.

- *A specific application is required for both of these programs.* To find out if you are eligible for either of these programs call the Maryland Cancer Hotlines at 1-800-477-9774.

MARYLAND PRIMARY ADULT CARE PROGRAM

- *The Maryland Primary Adult Care Program provides eligible people with free visits to a primary care provider and assistance buying prescription medication.*

- *In order to be eligible, you must be over 19, meet income requirements, and not be enrolled in Medicare.*

- *To receive benefits, you must complete the Maryland Primary Adult Care Program application form.* To find out if you are eligible and to enroll, call 1-800-226-2142 or go to *http://www.dhmh.state.md.us/mma/pac/index.htm*.

MARYLAND PHARMACY ASSISTANCE PROGRAM

- *The Maryland Pharmacy Assistance Program can help low income people buy prescription medicine*. The income and asset limits are higher than Medicaid.

- *To receive an MPP card you must complete the Maryland Pharmacy Program application form*. Call 1-800-226-2142 for an application.

THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)

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

WHEN AM I ELIGIBLE FOR HCTC?

- *To be eligible for the tax credit, you must be receiving Trade Adjustment Assistance (TAA) benefits or retirement benefits from the PBGC.* If you are receiving PBGC benefits, you also must be at least 55 years old.

- *In addition, you must meet other requirements.* Specifically, you are not eligible for the HCTC if any of the following apply to you:

    - *You have a health plan maintained by an employer or former employer that pays at least 50% of the cost of your coverage*. Any share of your premium that is paid by you or your spouse on a pre-tax basis is considered to have been paid by your employer and must be included as such when determining the percentage of employer coverage.

    - *You are enrolled in Medicare (Part A or B).*

    - *You are enrolled in the Federal Employees Health Benefits Program (FEHBP), Medicaid, or State Children's Health Insurance Program (SCHIP).*

    - *You are entitled to health coverage through the U.S. military health system (Tricare).*

    - *You can be claimed as a dependent on someone else's federal tax return.*

- *You received a lump sum payment of your entire PBGC benefit before August 6, 2002.*

- *As of the first day of the current month in which you are otherwise eligible, you are imprisoned under a federal, state or local authority.*

- *HCTC may apply to your family, too.* If you are eligible, you can use the credit to help purchase qualified health coverage for your qualified family members. Qualified family members are your spouse and dependents that you can claim on your federal tax return. Family members are not eligible if they are enrolled in another group health plan where the employer pays at least 50% of the cost of coverage, or in Medicaid, SCHIP, FEHBP, or Tricare.

- *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 65% of health insurance premiums for qualified health insurance coverage.*

WHAT HEALTH COVERAGE IS ELGIBLE FOR THE TAX CREDIT?

- *The HCTC can only be used to help pay for "qualified" health coverage.* Qualified health coverage includes:

    - *COBRA continuation coverage, as long as your employer or former employer contributes less than 50% of the total health plan premium.*

    - *Individual heath insurance in which you were enrolled for at least the last 30 days before you were separated from the job that makes you eligible for TAA benefits or for payments from the PBGC.*

    - *State-qualified health plans.* In Maryland, MHIP is the state qualified health plan (see page 15).

    - *Your husband's or wife's insurance from work, as long as the employer contributes less than 50% of the total health plan premium. (*At this time, you can only claim the credit with this type of coverage when you file your federal tax return and not in advance.)

HOW DO I CLAIM THE HCTC?

- *You can claim the HCTC on your tax return and be reimbursed for 65% of the premium you paid for qualified coverage while you were eligible for the HCTC.* Currently, this is the only way to claim the HCTC if your qualified health plan is provided through a spouse's employer.

- *Alternatively, you can choose to have your credit sent directly to your qualified health plan each month.* To do this, you must register with the HCTC customer service center by calling 1-866-628-HCTC (1-866-628-4282), Monday through Friday between the hours of 7 am and 7 pm, Central time. TDD/TYY callers, please call 1-866-626-HCTC (1-866-626-4282).

- *You will have to fill out a registration form verifying your eligibility for the HCTC and your enrollment in qualified coverage.* You will also fill out a payment invoice. Each month, you will send the HCTC program your 35% share of the premium for qualified coverage. The HCTC program will combine this payment with the tax credit covering the other 65% of the premium and forward the entire payment to your qualified health plan.

- *You must register in advance to have the HCTC paid directly to your health plan each month.* Usually, the direct payments won't begin until at least a month after you register with the HCTC program. Call the HCTC customer service center for more information.

WHERE CAN I GET MORE INFORMATION?

- *For more information about the HCTC, contact the HCTC customer service center at 1-866-628-HCTC, or see the IRS website at http://www.irs.gov/individuals/index.html (click on HCTC).*

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

- *For more information about PBGC, contact, http://www.pbgc.gov or call 1-202-326-4000 with general inquiries.*

FOR MORE INFORMATION…

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

For questions about:	Contact:
Individual health insurance State continuation coverage Conversion coverage Fully insured group health insurance	*Maryland Insurance Administration* (800) 492-6116 (410) 468-2000 http://www.mdinsurance.state.md.us
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	*U.S. Department of Labor* *Employee Benefits Security Administration* *Employee & Employer Assistance Hotline and Publications* (866) 444-EBSA (3272) http://www.dol.gov/ebsa/
Maryland Health Insurance Plan	*Maryland Health Insurance Plan* (888) 444 - 9016780 -7150 (443) 738 - 0667 http://www.marylandhealthinsuranceplan.net
Medicaid	*Maryland Department of Social Services* (800) 492-5231 (410) 767-5800. http://www.dhmh.state.md.us/mma/
Maryland Children's Health Program (MCHP) and MCHP Premium	*Maryland Department of Health and Mental Hygiene* (800) 456-8900 http://www.dhmh.state.md.us/mma/mchp/
The Maryland Breast and Cervical Cancer Screening Program	*Maryland Family Health Administration* (800) 477-9774 http://www.fha.state.md.us/
Federal Health Coverage Tax Credit (HCTC)	*Internal Revenue Service (IRS)* http://www.irs.gov/ (Search HCTC) or call HCTC customer service center 1-866-628-HCTC (1-866-628-4282)

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

HELPFUL TERMS

Alternative Trade Adjustment Assistance (ATAA). ATAA is a benefit for workers at least 50 years old who have obtained different, full-time employment within 26 weeks of the termination of adversely-affected employment. These workers may receive 50% of the wage differential (up to $10,000) during their 2 year eligibility period. To be eligible for the ATAA program, workers may not earn more than $50,000 per year in their new employment. Also, the firm where the workers worked must meet certain eligibility criteria.

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

Children's Health Program. A state-run health insurance program for low income children and pregnant women. The Children's Health Program is part of Maryland's Medicaid program.

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

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

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

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.

Elimination Rider. An amendment permitted in individual health insurance policies that exclude your coverage for a health condition, body part, or body system. Elimination riders can last indefinitely. Elimination riders cannot be imposed if you are HIPAA eligible and buy a HIPAA policy from MHIP.

Family and Medical Leave Act (FMLA). A federal law that guarantees up to 12 weeks of job-protected leave for certain employees when they need to take time off due to serious illness, to have or adopt a child, or to care for another family member. When you qualify for leave under FMLA, you can continue coverage under your group health plan.

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

Genetic Information. Includes information about family history or genetic test results indicating your risk of developing a health condition. A health plan cannot consider pre-existing (and therefore exclude coverage for) a condition about which you have genetic information, unless that health condition has been diagnosed by a health professional.

Group Health Plan. Health insurance (usually sponsored by an employer, union or professional association) that covers at least 2 eligible 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. The standardized health plan and certain benefit riders sold to Maryland small employers with 2 to 50 employees are guaranteed issue. HIPAA eligible persons are guaranteed issue of MHIP coverage. Plans that are guaranteed issue can turn you away for other reasons.

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

HealthChoice. HealthChoice is part of Maryland's Medicaid program. See also Medicaid.

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

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

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

HIPAA. The Health Insurance Portability and Accountability Act passed in 1996 to help people buy and keep health insurance, even when they have serious health conditions. The law sets a national floor for health insurance reforms. Since states can and have modified and expanded upon these provisions, consumers' protections vary from state to state.

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

HMO. Health maintenance organization. A kind of health insurance plan. HMOs usually limit coverage to care from doctors who work for or contract with the HMO. They generally do not require deductibles, but often do charge a small fee, called a copayment, for services like doctor visits or prescriptions.

Individual Health Plan. Policies for people not connected to an employer group. Individual health plans are regulated by Maryland.

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

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

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

Maryland Health Insurance Plan. A state administered health insurance program for Maryland residents who do not have access to private health insurance.

Medicaid. A program providing comprehensive health insurance coverage and other assistance to certain low-income Maryland residents. All other states have Medicaid programs, too, though eligibility levels and covered benefits will vary. See also Children's Health Program, HealthChoice.

Modified Community Rating. A requirement that Maryland health insurance companies establish a rate for each small group policy that does not vary due to the health status of those who buy that health insurance. For small employers group health plans, premiums can vary based on age, family composition, and geographic location.

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, and provide timely and uninterrupted payment of pension benefits to participants and beneficiaries in plans covered by PBGC. It currently guarantees payment of basic pension benefits earned by American workers and retirees participating in private-sector defined benefit pension plans. The agency receives no funds from general tax revenues. Operations are financed largely by insurance premiums paid by companies that sponsor pension plans and by PBGC's investment returns.

Pre-existing Condition **(Group Health Plans)**. Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan. Currently, fully insured small

group plans and HMOs may not impose pre-existing condition exclusions in Maryland. 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, children placed for adoption, and some children placed for guardianship covered within 31 days cannot be subject to pre-existing condition exclusions.

Pre-existing Condition **(Individual Health Plans)**. Any condition for which medical advice, diagnosis, care, or treatment was recommended or received or for which an ordinarily prudent person would have sought medical advice, care, or treatment, in the case of insurers that are not HMOs. Individual health plans can apply pre-existing condition exclusion periods for pregnancy, but not for genetic information. Newborns, newly adopted children, children placed for adoption, and some children placed for guardianship covered within 31 days cannot be subject to pre-existing condition exclusions. 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 non-HMO individual health plans, 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 relating to a pre-existing condition. See also Pre-existing Condition.

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 Maryland.

Small Group Health Plans. Plans with 2 to 50 employees.

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

State Continuation Coverage. A program similar to COBRA. In Maryland, if you are in a fully insured group health plan sponsored by an employer and meet other requirements, you also have rights to continue your health coverage when your job ends. Spouses and dependent children also have the right to continue health coverage in the case of divorce or death of the covered employee.

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.

Trade Adjustment Assistance (TAA) Program. A program authorized by the Trade Adjustment Assistance Reform Act of 2002. This program provides aid to workers who lose their job or whose hours of work and wages are reduced as a result of increased imports. The TAA Program offers six benefits and reemployment services to assist unemployed workers prepare for and obtain new suitable employment. In addition, TAA offers a significant tax credit that covers 65% of health insurance premiums for certain plans.

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 Readjustment Allowance (TRA). Funding that may be available to eligible workers following their exhaustion of unemployment benefits. Usually, TRA benefits will be paid only if an individual is enrolled in a TAA approved training program. This group includes people who are eligible for a TRA but have not used up their unemployment insurance (UI) benefits.

U.S. Department of Labor. A department of the federal government that regulates employer provided health benefit plans. You may need to contact the Department of Labor if you are in a self-insured group health plan, or if you have questions about COBRA or the Family and Medical Leave Act. See also COBRA, Family and Medical Leave Act.

Waiting Period. The time you may be required to work for an employer before you are eligible for health benefits. Not all employers require waiting periods. Waiting periods do not count as gaps in health insurance for purposes of determining whether coverage is continuous. If your employer requires a waiting period, your pre-existing condition exclusion period begins on the first day of the waiting period. See also Pre-existing Condition Exclusion Period.