# A CONSUMER'S GUIDE
# TO
# GETTING AND KEEPING HEALTH INSURANCE
# IN
# NEW JERSEY

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

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# A CONSUMER'S GUIDE TO GETTING AND KEEPING HEALTH INSURANCE IN NEW JERSEY

As a New Jersey 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 New Jersey resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group 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 New Jersey, 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 39. For information about how to find consumer guides for other states on the Internet, see page 40. A list of helpful terms and their definitions begins on page 41. These terms are in **boldface type** the first time they appear.

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# CHAPTER 1
# A SUMMARY OF YOUR PROTECTIONS

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

## HOW AM I PROTECTED?

In New Jersey, your health insurance options do not depend on your **health status**.

- *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 8).

- *All health plans in New Jersey must limit exclusion of pre-existing conditions.* There are rules about what counts as a pre-existing condition and how long you must wait before a new health plan will begin to pay for care for that condition. Generally, if you enroll in a new plan, the time that you were covered under your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a break in coverage that exceeds 31, 63 or 90 days, depending on type of plan you are joining (see pages 12 and 20).

- *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. Your insurance company also can refuse to renew your individual health insurance policy if that company decides to stop selling all individual health insurance in New Jersey. Depending on the type of plan you have, there may be other reasons why your insurance company can refuse to renew your coverage (see pages 22 and 28).

- *If you leave your job, you may be able to remain in your old group health plan for a certain length of time.* This is called **COBRA** continuation coverage or **state continuation coverage**. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage (see page 22).

- *If you have coverage through an employer's fully insured group health plan and you lose eligibility to that coverage because of divorce, you can buy a* ***conversion policy***. This is an individual policy you buy from the company that insured your employer's group plan (see page 27).

- *If you are a small employer buying a group health plan, you cannot be charged more due to the health status or claims experience of people in your group.* However, your premiums will vary within limits based on age, gender, and family size of those in your group and will vary based on where you are located. This is called **modified community rating** (see page 28).

- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group.* This is called **guaranteed issue** (see page 28).

- *You cannot be turned down for an individual health insurance policy because of your health status, age, or any other factor that might predict your use of health services.* All individual health insurance policies must be sold on a guaranteed issue basis (see page 17).

- *In general, if you are buying an individual health insurance policy, you cannot be charged more for your health insurance due to health status, age, gender, or occupation.* Also, your premiums do not vary based on where you live. This is called **community rating** (see page 21). However, policies called "Basic and Essential" plans can charge you more based on age, gender, and where you live.

- *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 New Jersey **Medicaid** program offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low-incomes. In addition, some women who are diagnosed with breast or cervical cancer may be eligible for medical care through Medicaid (see Chapter 5).

- *Your child may be eligible for free or inexpensive health insurance through the **NJ FamilyCare** Program if they are 18 years old or younger, uninsured and your family income is modest or low* (see page 34).

- *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 state continuation coverage (see page 35).

- *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 35).

## WHAT ARE THE LIMITS ON MY PROTECTIONS?

As important as they are, the federal and state health insurance reforms are limited. Therefore, you also should understand how the laws do not protect you.

- *If you change jobs, you usually cannot take your old health benefits with you.* Except when you exercise your federal COBRA or state continuation rights, you are not entitled to take your actual group health plan with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did (see page 8).

- *If you change jobs, your new employer may not offer you health benefits*. Employers are required only to make sure that their decision is based on factors unrelated to your health status (see page 8).

- *If you get a new job with health benefits, your coverage may not start right away*. Employers can require **waiting periods** before your health benefits begin. **HMOs** can require **affiliation periods** in the large group market (see page 8).

- *If you have a break in coverage of 63 days or more before your large group coverage begins, or a break more than 90 days before your **small group** coverage begins, you may have to satisfy a new pre-existing condition exclusion period when you join a new health plan* (see page 13).

- *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 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 page 14).

- *If you work for a non-federal public employer in New Jersey, not all of the group health plan protections may apply to you* (see page 15).

- *If you buy a Basic and Essential plan from an individual insurer, it may not cover all of your medical needs.* Unlike, other all other individual health insurance policies sold in New Jersey, the Basic and Essential plan is not required to cover all of the services that some consumers have come to expect in an individual policy. In addition, if you buy a Basic and Essential plan, your premiums can vary based on your age, gender and where you live (see page 20).

- *Unless you are HIPAA eligible, if you have a break in coverage of more than 31 days before your new individual health insurance policy becomes effective, you may have to satisfy a new pre-existing condition exclusion period* (see page 20).

- *If you move away from New Jersey, you may not be able to buy individual health insurance in another state unless you are HIPAA eligible.*

# 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-funded group health plan**. The plan's benefits information must indicate whether the plan is self-funded.

## 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.

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

- *When you begin a new job with health coverage through an HMO, the HMO may require a waiting period before coverage begins*. This waiting period is called an HMO affiliation period, and you will not have health insurance coverage during this time. An affiliation period cannot exceed 2 months (3 months for late enrollees), and you cannot be charged a premium during it. In New Jersey, affiliation periods are not permitted in the individual or small group markets.

- *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 New Jersey law, newborns and adopted newborns 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 baby within the 31 days in order to continue coverage beyond the 31 days.

- *If a fully insured group health plan covers dependents, then it must extend coverage to domestic partners of covered enrollees.* Under New Jersey law, domestic partners of covered enrollees are considered eligible dependents for the purposes of fully insured group health plan.

- *Under New Jersey 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*. Your adult child must be incapable of self-sustaining employment by reason of the disability and remain dependent on you for support. Proof of incapacity must be furnished to the plan within 31 days of the child reaching the age at which dependent coverage would normally end. The plan can require you to continue furnishing proof of disability and dependency in the future.

- *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.

- *In New Jersey, fully insured group plans must extend dependent coverage to eligible children up to the age of 30.*

    - *You must have a qualifying event.* You must have reached, or about to reach, the age, defined under the terms of the coverage, which you would otherwise lose eligibility for coverage under a fully insurance group health plan that is regulated by the State of New Jersey. This age may vary plan to plan. In addition, your sponsoring parent must still be enrolled in a fully insured group health plan that is regulated by the State of New Jersey.

    - *You must meet other requirements.* You must be under the age of 30 and single with no children of your own. You cannot be covered under any other health benefit plan or be eligible for Medicare. You have to be either a resident of New Jersey or, if you live out of state, a full time student.

- *You must elect this extension of coverage.* If you are eligible and you want to avoid a break in coverage, you must elect in writing within 30 days prior to the qualifying event.

  You can also elect later but then, for fully insured large group plans, you must wait until the plan's open enrollment period. Fully insured small group plans must give you the right to elect annually, during the 30 days following the anniversary date that you aged off the plan.

  Finally, if you cannot elect at the time of your qualifying event because you do not meet all of the eligibility requirements (e.g. you're a resident of another state), but subsequently meet the eligibility requirements (e.g. you move back to New Jersey), you can elect within 30 days of meeting the requirements for eligibility.

- *You do not have to maintain continuous enrollment to maintain eligibility for this extension of coverage.* You are permitted to re-enroll as many times as you want during the time between your qualifying event and the age of 30, however you may have to wait, unless you are re-establishing eligibility (e.g. you move back to New Jersey), until the annual opportunity to enroll. However, if you have a lapse in coverage, you may face a pre-existing condition exclusion period.

- *Employers are not required to contribute to your premium.* In most cases, you will be required to pay the entire cost of the premium.

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

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

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

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

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

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

When you first enroll in a group health plan, the employer or insurance company may ask you questions to determine whether 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 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.

- *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 or newly adopted children, children placed for adoption, or genetic information*.

- *Under group health plans, coverage for pre-existing conditions can be excluded only for a limited time*. The maximum period varies for different kinds of group plans. Also, if you enroll late in your group health plan (after you were hired and not during a regular or special enrollment period), you may have a longer pre-existing condition exclusion period up to 18 months. Ask your prospective employer if you are not sure what limit applies to you.

**The maximum pre-existing condition exclusion period varies**

| Type/ Health Plan | Number of Employees | Maximum Exclusion Period |
|---|---|---|
| Fully Insured | 2-5 | 6 months (all enrollees) |
| Fully Insured | 6-50 | 0 months (regular and special enrollees)<br>6 months (late enrollees) |
| Fully Insured | 51+ | 12 months (all enrollees) |
| Self-funded | any size | 12 months (regular and special enrollees)<br>18 months (late enrollees) |

- *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 are considered creditable coverage.

**What is creditable coverage?**

Most health insurance counts as creditable coverage, including:

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

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

- *Coverage counts as continuous if it is not interrupted by a significant break. In the large group market, coverage counts as continuous if it is not interrupted by a break of 63 or more days in a row.* In the small group market, coverage cannot be interrupted by 90 days.

**What is continuous coverage?**

You can get continuous coverage under one plan or under several plans as long as you don't have a lapse of 63 or more consecutive days.

Take Art, who has diabetes. Ajax Company covered him under its group health plan for 9 months, but he lost his job and health coverage. Then, 45 days later, Art found a new job at Beta Corporation and had health coverage for 9 more months. Art changed jobs again. His new company, Charter, has a health plan that covers care for diabetes but excludes **pre-existing conditions** for 12 months. Charter must cover Art's diabetes care immediately, because his 18 months of prior continuous coverage are credited against the 12-month exclusion.

Now consider a slightly different situation. Assume Art was uninsured for 95 days between his jobs at Ajax and Beta. In this case, Charter will credit coverage only under Beta's plan toward the 12-month **pre-existing condition** exclusion period. Charter's plan will begin paying for Art's diabetes care in 3 months (1 year minus 9 months). Art does not get credit for his coverage at Ajax since he had a break of more than 63 consecutive days.

- *In determining continuous coverage, employer-imposed waiting periods and HMO affiliation periods do not count as breaks in coverage.* If your new plan imposes a pre-existing condition exclusion period, you can credit time under your prior continuous coverage toward it. If your employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period. HMOs that require an affiliation period cannot exclude coverage for pre-existing conditions.

- *Your protections may differ if you move to a group health plan that offers more benefits than your old health plan did.* Group health 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-funded health plan does cover prescription drugs. However, because her prior policy did not, the new plan refuses to cover her blood pressure medicine for a year.

**Question:** Is this permitted?

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

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

## LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

Federal law permits state, county, and local governments to exempt their employees in self-funded 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 New Jersey have decided that certain health insurance protections will not apply to their employees. The Center for Medicare and Medicaid Services (CMS) used to post a list of employers which had elected to exempt, however it has removed this information from its web site.

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

**AS YOU ARE LEAVING GROUP COVERAGE…**

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

- *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 state continuation coverage (see page 35).

- *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 35).

# CHAPTER 3
# YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group health plans, you may want to buy an individual health insurance policy from a private health insurance company. New Jersey has enacted extensive insurance reforms to guarantee residents access to this kind of insurance. There are some alternatives to individual health insurance – such as COBRA, state continuation coverage or **conversion**. 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 New Jersey, your ability to buy an individual health insurance policy does not depend on your health status.* In general, individual health insurance companies in New Jersey are not allowed to turn down residents of New Jersey because of health status, age, gender, or other factors.

- *You must meet certain residency standards.* You must be a resident of New Jersey for 6 months or newly arrived with the intent to stay six month to buy individual health insurance on a guaranteed basis.

- *In general, you are only eligible to buy an individual health insurance policy year round provided you are not eligible for, or covered by, other coverage.* However, there are some exceptions:

  If you are eligible for, or covered by, Medicaid, you are eligible to buy individual health insurance at any time of the year.

  If you are eligible for, or covered by, job-based coverage that is different than individual health insurance policies offered in New Jersey, you are eligible to buy individual health insurance during open enrollment in November of each year. Contact the NJ DOBI for questions about how to compare your current job-based coverage with individual health insurance policies.

If you currently have an individual health insurance policy, you are eligible to buy a different individual health insurance policy. Depending on the type of policy you have and the policy you want to buy, you may have to wait until open enrollment in November of each year. Contact the NJ DOBI for questions about how to compare your current coverage with other policies.

If you have, or are eligible for COBRA coverage, state continuation coverage or extended dependent coverage under your parent's fully insured plan because you are under the age of 30, then you are eligible to buy an individual health insurance policy at any time of the year.

If you are eligible or have other coverage, call the New Jersey Individual Health Benefits Program with questions about your ability to buy individual coverage in such situations.

- *If you are HIPAA eligible, you are guaranteed the right to buy individual health insurance from any individual market insurer.* You can purchase an individual policy at any time of the year. You do not have to be a resident of New Jersey for any specific length of time.

**To be HIPAA eligible, you must meet certain criteria**

If you are HIPAA eligible you are guaranteed the right to buy an individual health insurance policy and are exempted from pre-existing condition exclusion periods. To be HIPAA eligible, you must meet all of the following:

- You must have had 18 months of continuous creditable coverage, at least the last day of which was under a group health plan.
- You also must have used up any COBRA or state continuation coverage for which you were eligible.
- You must not be eligible for Medicare, Medicaid or a group health plan.
- You must not have health insurance.
- 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 an individual plan, because the last day of your continuous health coverage must have been in a group plan. You can become HIPAA eligible again by maintaining continuous coverage and rejoining a group plan.

- *In New Jersey, if you are under the age of 30 and a dependent of a person covered under a fully insured group plan that offers coverage to dependents, then, instead of buying individual health insurance, you may be able to get coverage through your parent's plan* (see page 10).

- *Under New Jersey law, newborns, adopted children and children placed for adoption are automatically covered under the parent's individual health insurance policy for the first 31 days, if the plan covers dependents*. For single or husband and wife plans, the insurer will require that the parent enroll the dependent within 31 days in order to continue coverage beyond the 31 days.

- *If you have a disabled child, that child may remain covered under your individual health insurance policy after he or she reaches the age which dependent coverage is otherwise terminated. To qualify,* your adult son or daughter must be incapable of self-sustaining employment by reason of the disability and remain dependent on you for support. Proof of incapacity must be furnished to the plan within 31 days of the child reaching the limiting age and may be required subsequently in the future.

- *In New Jersey, special protections apply if you have an adult child who is a full time student and who is covered under your individual health insurance policy*. Children who are full time students may remain covered under your policy until their 23rd birthday.

- *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.

  In addition, if you have an individual health insurance policy and later become eligible for Medicare or coverage under a group plan, you can keep your individual policy along with either Medicare or your coverage under the group policy.

## *WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?*

- *New Jersey requires individual insurers to offer comprehensive standardized policies*. Depending on the insurer that you call, you may select from either four standard indemnity policies, an HMO policy or a preferred provider organization (PPO) policy. Each standardized policy includes comprehensive coverage, including hospital and physician care, maternity care, preventive checkups and immunizations, and prescription drugs

- *New Jersey requires that all individual insurers offer the Basic and Essential Plan, a standardized policy that is not comprehensive.* The Basic and Essential Plan does not cover benefits that consumers may have come to expect in individual health insurance policies, such as chemotherapy, outpatient prescriptions drugs and maternity care. It is important that you read the policy description carefully before deciding to purchase the Basic and Essential Plan.

- *You can compare you benefit options.* The New Jersey Insurance Department issues a free guide called the New Jersey Individual Coverage Program: Buyer's Guide, which lists plan options. The Department's web site, http://www.nj.gov/dobi/reform.htm, lists companies selling individual policies along with premium rates.

## *WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?*

- *If you are HIPAA eligible, you will not face a pre-existing exclusion period when you enroll in an individual health insurance plan.*

- *If you are not HIPAA eligible, you may have a 12 month pre-existing condition exclusion period when you first buy an individual market policy.* Individual insurers can count as pre-existing any condition for which you received – or, in your insurance company's judgment, for which most people would have sought – medical advice, care or treatment in the 6 months before individual coverage begins. This is called the **prudent person rule**.

  You will get credit toward your pre-existing condition exclusion period for any prior creditable coverage you have, provided no more than 31 days lapse between your old and new coverage.

  In New Jersey, individual health insurers consider pregnancy to be a pre-existing condition, but complications of pregnancy must be covered. Genetic information cannot be considered a pre-existing condition.

- *Insurers can exclude coverage for a pre-existing condition when you first buy the policy, or any time during the first 12 months after your policy takes effect.* If you make a claim during the first year of coverage, the insurer can look back 12 months 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 pre-existing, it can refuse to pay for expenses for that condition for up to 12 months.

- *In New Jersey, individual health insurance policies are not allowed to impose **elimination riders (or waivers)**, which permanently exclude coverage for a health condition, body part, or body system.*

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

- *It depends on what you buy.* Except for the Basic and Essential Plan, individual insurers cannot vary premiums for individual health insurance policies due to your age, gender, health status, occupation, or geographic location. This is called community rating.

  Premiums for the Basic and Essential Plan can vary, within limits, based on your age, gender and where you live. However, they cannot vary based on your health status. This is called **modified community rating.**

- *Premiums vary depending on your family size and the type of plan you select.* Check http://www.nj.gov/dobi/reform.htm for the most current premium rates or call (800) 838-0935 for a copy of premium comparison information.

## *CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELED?*

- *If you have an individual health insurance policy, 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, individual health insurance policies may not be renewed if the policy is completely removed by the State of New Jersey or if the individual health insurer that is selling the policy completely withdraws from the individual market.

- *Although not permitted for sale in New Jersey, temporary health insurance policies are routinely sold in other states.* Temporary policies are not guaranteed renewable. They will only cover you for a limited period of time, such as six months. If you want to renew coverage under a temporary policy after it expires, you will have to reapply and there is no guarantee that coverage will be re-issued at all or at the same price.

## COBRA CONTINUATION COVERAGE

### *WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?*

If you are leaving your job and you had group coverage, you may be able to stay in your group plan for an extended time through COBRA or state continuation coverage. The information presented below was taken from publications prepared by the U.S. Department of Labor. You should contact them for more information about your rights under COBRA.

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

  First, you must work for an employer with 20 or more employees. If you work for an employer with less than 20 employees, you may qualify for state continuation coverage (see page 27).

  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.

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

- *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 be re-instated 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 is reinstated 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.

***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 cannot be continued under COBRA.

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

***WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?***

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

***WHAT CAN I BE CHARGED FOR COBRA COVERAGE?***

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage*.

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

- *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 state continuation coverage (see page 35).

- *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 35).

***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 determined to have been disabled within 60 days of the time of your COBRA qualifying event (such as termination of employment or reduction in hours). You must obtain this disability determination 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<br>Reduced hours | Employee<br>Spouse<br>Dependent child | 18 months * |
| Employee enrolls in Medicare<br>Divorce or legal separation<br>Death of covered employee | Spouse<br>Dependent child | 36 months |
| Loss of "dependent child" status | Dependent child | 36 months |

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

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

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

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

- *In New Jersey, you can buy an individual health insurance policy regardless of whether you used up your COBRA continuation coverage*. Compare the options to see which is best for you. However, if you are planning to move to another state, you may need to be HIPAA eligible to buy individual coverage. If so, you may want to consider COBRA.

### *WHAT ABOUT STATE CONTINUATION COVERAGE?*

- *If your employer offers fully insured health benefits and has fewer than 20 employees and you have been covered under that group plan, you may also be eligible continuation coverage under a New Jersey law that is similar to COBRA.* Unlike COBRA, you must elect in writing within 30 days after the qualifying event. In addition, you will have to make a premium payment (employer and employee share, plus a 2% administrative fee) within a certain period of time after electing coverage. Ask your former employer or contact the New Jersey Insurance Department about state continuation coverage if you think it applies to you. In addition, information about state continuation coverage is available on the New Jersey's Small Employer Health Coverage Program at http://www.nj.gov/dobi/sehpage.htm.

### *WHAT ABOUT OTHER WAYS TO EXTEND COVERAGE UNDER GROUP PLANS?*

- *In New Jersey, fully insured group plans must extend dependent coverage to eligible children up to the age of 30.* If you are under the age of 30 and a dependent of a person covered under a fully insured group plan that offers coverage to dependents, then you may be able to get coverage through that plan (see page 10).

- In New Jersey, if you are losing fully insured group coverage, except large group HMO coverage, because you are totally disabled, then you, and your qualified dependents, may be eligible to extend your coverage until you are no longer disabled. To qualify you have been covered under the group plan for 3 months prior to the date that you would otherwise coverage under the plan. Ask your former employer or contact the New Jersey Insurance Department about continuation coverage for the totally disabled, if you think it applies to you.

## CONVERSION

### *WHEN AM I ELIGIBLE FOR A CONVERSION POLICY?*

*In New Jersey, if you are losing fully insured group health plan because of divorce, you may have the right to purchase a conversion policy.* This is an individual policy you buy from the company that insured your employer's group plan. For more information about conversion policies, contact the New Jersey Department of Banking and Insurance at (609) 633-1882 ext. 50302 or visit them on the web at http://www.nj.gov/dobi/sehpage.htm

# 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. New Jersey has enacted comprehensive reforms to expand small employers' access to health insurance and to limit premium variation due to health status. Generally, small employers are those that employ 2-50 employees. Please note, however, that the definition of small employer and employee is somewhat different under federal and state law. Check with the New Jersey Department of Banking and 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 people eligible for health benefits, health insurance companies must sell you any small group health plan they sell to small employers. However, they can require that up to 75% of your eligible workers either participate in your group health plan or waive coverage since they have group coverage from another source. They can also require you to contribute at least 10% of the total group premium for your workers. If you are buying a **large group health plan** for 51 or more eligible employees, your group can be turned down.

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

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

- *Premiums for all health plans sold to small employers in New Jersey are based on modified community rating*. That means your premium cannot vary due to the health status or claims experience of people in your group. However, within limits,

premiums will vary based on the age, gender and family size of those in your group and because of the location of your business. The New Jersey Small Employer Health Benefits Program issues buyer's guides describing standard small group health plans and an annual premiums comparison survey. The Department's web site, http://www.nj.gov/dobi/sehpage.htm, lists companies selling small group policies along with sample premium rates as applicable to a specimen group.

## WHAT PLAN CHOICES DO I HAVE?

- *Insurance companies must offer small employers standardized health plans*. New Jersey requires that five standardized health plans (options A through E) plus a sixth HMO option be offered to all small employers. The standardized plans help you compare differences in cost and coverage. Carriers may offer riders to the standard plans. Carriers also can offer non-standard plans. These policies are subject to the same requirements as standard health plans.

- *You can compare you benefit options.* The New Jersey Insurance Department issues a free guide called the New Jersey Small Employer Health Benefits Plan Buyer's. The Department's web site, http://www.nj.gov/dobi/sehpage.htm, lists companies selling small group policies along with sample premium rates as applicable to a specimen group.

## WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are not eligible to buy a group health plan on your own (though you may be able to join another group health plan through a family member).* Therefore, the laws that protect employers' access to group health plan do not apply to you. Your access to health insurance is protected by the laws that apply to individuals.

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

## A WORD ABOUT ASSOCIATION PLANS

- *Although not permitted for sale in New Jersey, in other states, some small employers, self-employed people, and other individuals buy coverage sold though professional or trade associations*. In those states, the laws applying to association health coverage can be different than those for other health plans sold. If you are moving to a state that permits the sale of association health coverage, check with the Insurance Department of that state about your protections in this type of coverage.

# CHAPTER 5
# FINANCIAL ASSISTANCE

Help is available to certain low-income residents of New Jersey who cannot afford to buy health insurance. Medicaid and NJ FamilyCare offers free or subsidized health insurance coverage to qualified low income individuals.

In addition, the federal government, under Trade Adjustment Assistance (TAA) Program provides tax credits to some workers who lose their jobs or whose work hours and wages are reduced as a result of increased imports.

This chapter provides summary information about these programs and contact information for further assistance.

## MEDICAID

Medicaid is a program that provides health coverage to some low-income New Jersey 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. Other legal residents who are not U.S. citizens may be eligible for Medicaid if they have emergency needs. Non-citizens who do not have immigration documents cannot enroll in Medicaid but may be eligible for other state funded programs, such as NJ Family Care, if lawfully admitted.

- *In New Jersey you may be eligible for Medicaid if you are an infant, a child, a pregnant woman, or a parent of a child, and your family income meets the Medicaid income standards.*

- *Income eligibility levels for these categories are described below.* Your assets and some expenses also may be taken into account, so you should contact you local department of social services for more information.

**Low-income persons eligible for Medicaid in New Jersey***

| Category | Income eligibility (as percent of federal poverty level) |
|---|---|
| Infant | 200% (monthly income of about $2,767 for a family of 3) |
| Child 1-5 | 133% |
| Child 6-19 | 133% |
| Non-working Parent | 100% |
| Working Parent | 100% |
| Pregnant woman | 200% |
| Medical Needy | |
| Individual | 51% |
| Couple | 45% |

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

To get an idea of how your income compares to the federal poverty level, use the federal poverty guideline issued by the U.S. Department of Health and Human Services for the year 2006:

| Size of Family Unit | Poverty Guideline (annual income) |
|---|---|
| 1 | $ 9,800 |
| 2 | $13,200 |
| 3 | $16,600 |

For larger families add $3,400 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 $34,200, or a monthly income of $2,767.

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 **Temporary Assistance for Needy families (TANF)**, which is also known as Work First New Jersey or WFNJ, can get Medicaid.*

  Parents should know that when you get a job and your TANF benefits end, you generally can stay on Medicaid for up to a 24-month transitional period.

Parents should know that when your family's TANF benefits end, your children may also qualify for transitional Medicaid coverage for up to 24 months. Or, they may qualify for Medicaid themselves if your family's income meets the Medicaid income standards.

- *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 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 between 100% and 135% of the federal poverty level, Medicaid will pay for your monthly Medicare premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

- *There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify for Medicaid, contact the department of social services.

- To obtain the locations and telephone number of an office near you, call the New Jersey Division of Medical Assistance and Health Services at 800-356-1561 or visit them on the web at http://www.state.nj.us/humanservices/dmahs/index.html

## NJ FAMILYCARE

- *In New Jersey, if your children are 18 years old and younger, are uninsured and meet certain eligibility requirements, they may be eligible for health insurance through NJ Family Care.*

- *To be eligible, your child must be a resident of New Jersey, cannot have any other health insurance coverage, including Medicaid, and must meet certain family income guidelines*. Children living in families with incomes up to 350% of the federal poverty level are eligible for NJ FamilyCare. For example, a child that lives in a family of four that has an annual income up to $70,000 would qualify.

- *If eligible for NJ FamilyCare, your child will be covered for most medical services.* NJ FamilyCare covers doctor visits, prescriptions, lab tests, x-rays, lab tests, eyeglasses and dental care (for most eligible kids).

- *Premiums for health insurance through FamilyCare is based on family income.* Significant premium assistance is available for lower income families.

- *To apply, you must complete an application.* For additional information, call 800-701-0710 or visit on line at www.njfamilycare.org.

## NEW JERSEY CANCER EDUCATION AND EARLY DETECTION SCREENING PROGRAM

- ***The New Jersey Cancer Education and Early Detection Screening Program (NJCEED)*** *provides qualified men and women with comprehensive screening services for breast, cervical, prostate, and colorectal cancer.*

- *In order to be eligible for screening through the NJCEED, you must be between the ages of 17 and 65, a New Jersey resident, have no insurance or limited insurance and have an income under 250% of the federal poverty level.*

- *If you're a woman screened through NJCEED and diagnosed with breast or cervical cancer, you may be eligible for treatment through Medicaid.* If eligible, you will continue to be eligible for treatment through the duration of your cancer treatment. In addition, Medicaid will cover all of your medical needs including treatment for non-cancer related medical services.

- *For more information, please call the New Jersey Cancer Education and Early Detection Screening Program at 1-800-328-3838 or visit them on the web at* http://www.state.nj.us/health/cancer/njceed/index.shtml

## OTHER PROGRAMS

- *There may be other financial assistance programs available.* Please call both the New Jersey Department of Human Services at (800-356-1561) and the New Jersey Department of Health and Senior Services at (800-367-6543).

## 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 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 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/CHAMPUS).

- 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, 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 65% 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.* Qualified health coverage includes:

- *COBRA continuation coverage and, 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.*

- *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.)

- *State qualified plans:* At this time, New Jersey has designated state-based continuation coverage and Aetna New Jersey HCTC Discretionary Plan as the state qualified health plan.

***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 see the DOL website at 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<br>Small employer health insurance<br>State continuation coverage<br>Conversion coverage<br>Fully insured group health plan | *New Jersey Department of Banking and Insurance*<br>(609) 633-1882 ext. 50302<br>http://njdobi.org/<br><br>*To request an Individual health insurance Buyer's Guide call (800) 838-0953 or a Small Employer Health Benefits Buyer's Guide call*<br>(800) 263-5912 |
| Self-funded/Self-funded group health plans<br>COBRA continuation coverage<br>Family and Medical Leave Act | *U.S. Department of Labor,*<br>*Employee Benefits Security Administration*<br>*Employee & Employer Assistance Hotline and Publications*<br>(866) 444-EBSA (3272)<br>http://www.dol.gov/ebsa/ |
| Medicaid | *New Jersey Department of Human Services*<br>*Division of Medical Assistance and Health Services*<br>(800) 356-1561 or (609) 588-2600<br>http://www.state.nj.us |
| NJ Family Care | *New Jersey Department of Human Services*<br>(800) 701-0710<br>http://www.njfamilycare.org/ |

| | |
|---|---|
| New Jersey Cancer Education and Early Detection Screening Program | *New Jersey Department of Health and Senior Services*<br>(800) 328-3838<br>www.state.nj.us/health/fhs/canceredu/breast.htm |
| Other Programs | *New Jersey Department of Human Services*<br>(800) 356-1561<br>http://www.state.nj.us/humanservices/index.html<br><br>and<br><br>*New Jersey Department of Health and Senior Services* at (800) 367-6543<br>http://www.state.nj.us/health/ |
| The Federal Health Coverage Tax Credit (HCTC) | *Internal Revenue Service (IRS)*<br>(866) 628-HCTC (1-866-628-4282)<br>http://www.irs.gov/individuals/index.html<br>(Click on HCTC)<br>or call HCTC customer service center |

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

# HELPFUL TERMS

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

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

***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.

***Community Rating.*** A rule that prohibits health plan premiums in New Jersey from varying based on your age, gender, health status, or occupation. Individual health policy premiums, except in regards to the Basic and Essential Plan, are subject to community rating.

***Continuous Coverage.*** If you are joining a self-funded 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 and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. See also Creditable Coverage, HIPAA eligible, Fully Insured Group Health Plan, Individual health insurance, Self-funded Group Health Plan.

***Conversion Policy.*** Your right, when losing coverage under fully insured group health plans due to divorce in New Jersey, to convert your policy into an individual health insurance policy. You will not face a new pre-existing condition exclusion period. Your conversion policy will be similar to individual health insurance policies offered to individuals.

***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.

***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 (or waiver).*** An amendment permitted in individual health insurance policies in some states that permanently excludes your coverage for a health condition, body part, or body system. Elimination riders are not permitted in New Jersey.

***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 insurance company. Fully insured health plans are regulated by New Jersey. See also Self-funded 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.*** A health plan (usually sponsored by an employer, union or professional association) that covers at least 2 employees. See also Fully Insured Group Health Plan, Self-funded 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 individuals and small employers with 2 to 50 employees in New Jersey are guaranteed issue. Plans that are guaranteed issue can only turn you away for other reasons permitted under by law.

***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. The precise definition of guaranteed renewable may vary based on what type of insurance you have. 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 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 Plan Year.*** That calendar period during which your health plan coverage is in effect. Many group health plan years begin on January 1, while others begin in a different month.

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

***HIPAA.*** The Health Insurance Portability and Accountability Act, sometimes known as Kassebaum-Kennedy, after the two senators who spearheaded the bill. 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. No matter where you live in the U.S., if you are HIPAA eligible you must be offered at least some type of individual health insurance with no pre-existing condition periods. In New Jersey, you do not need to meet all the requirements of HIPAA eligibility to have this protection. 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 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, Point-of-Service (POS).

***Indemnity Health Plan.*** A kind of health plan that reimburses you or your health care provider on the basis of services rendered. Indemnity plans generally do not restrict you to a limited network of providers for covered care. However, indemnity plans often impose other restrictions on covered services. For example, plans can require prior authorization of hospital care or other expensive services.

***Individual Health Insurance.*** Policies for people not connected to an employer group. Individual health insurance is regulated by New Jersey. All residents without access to employer-sponsored or government-sponsored health insurance can buy coverage for themselves and their families from a variety of private insurance companies. All individual policies offer standardized benefits and are community rated. See also Community Rating.

***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.

***Medicaid.*** A program providing comprehensive health insurance coverage and other assistance to certain low-income people living in New Jersey. All other states have Medicaid programs, too, though eligibility levels and covered benefits will vary.

***Modified Community Rating.*** A rule that prohibits insurers from varying premiums based on health status, while allowing premiums to vary based on other factors, such as age, gender and geographic location.

***New Jersey Cancer Education and Early Detection Screening Program (NJCEED*).** A program provding qualified men and women with comprehensive screening services for breast, cervical, prostate, and colorectal cancer. In addition, a woman screened through NJCEED and diagnosed with breast or cervical cancer may be eligible for treatment through Medicaid.

***NJ Family Care.*** A program that provides insurance for children under the age of 19 who are uninsured and are not eligible for Medicaid.

***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.

***Point-of-Service (POS).*** A type of managed care plan that lets you decide whether to get care from providers in or out of the HMO network. When you get care in-network, your out-of-pocket costs will be less than if you get care outside of the network. See also HMO.

***Pre-existing Condition.*** Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan. For group coverage, pregnancy cannot be counted as a pre-existing condition. Genetic information about your likelihood of developing a disease or condition, without a diagnosis of that disease or condition, cannot be considered a pre-existing condition. Newborns, newly adopted children, and children placed for adoption covered within 30 days cannot be subject to pre-existing condition exclusions.

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

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

***Self-funded 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-funded. Self-funded plans are regulated by the U.S. Department of Labor, not by New Jersey.

***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 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 New Jersey, if you are in a fully insured group health plan sponsored by an employer with 2 to 19 employees and meet other requirements, you and your dependents also have rights to continue your health coverage for up to 18 or 36 months (depending on your circumstance) when you are no longer eligible for your employer's health plan. See also COBRA.

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

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

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

***U.S. Department of Labor.*** A department of the federal government that regulates employer provided health benefit plans. You may need to contact the Department of Labor if you are in a self-funded 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.