

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

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Supported by a grant from

THE ROBERT WOOD JOHNSON FOUNDATION

February 2002

ACKNOWLEDGMENTS AND DISCLAIMER

The authors wish to express appreciation to the Robert Wood Johnson Foundation for its support of this project.

The authors also wish to express appreciation to Nicole Tapay, Lauren Polite, Jalena Specht, Elizabeth Hadley, and Robert Imes for their work developing the first edition of these guides.

Finally, the authors wish to express appreciation to the staff of the Florida Department of Insurance for their review of this document. Their help was invaluable in our research and understanding of Florida state and federal 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 Institute for Health Care Research and Policy 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.

February 2002

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

As a Florida 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 Florida 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 or self-employed person. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from Florida, 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 29. For information about how to find consumer guides for other states on the Internet, see page 29. A list of helpful terms and their definitions begins on page 30. 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 plans**), so your protections may vary if you leave Florida. Florida has expanded protections for certain kinds of health insurance beyond what federal law requires. 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 Florida resident.

HOW AM I PROTECTED?

In Florida, 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 5.)*
- *All group health plans in Florida must limit exclusion of pre-existing conditions. There are rules about what counts as a pre-existing condition and how long you must wait before a new health plan will begin to pay for care for that condition. Generally, if you join a new 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 pages 8 and 15.)*
- *Your health insurance cannot be canceled because you get sick. Most health insurance is **guaranteed renewable**. (See pages 16 and 21.)*

- *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 16.)*
- *If you have had at least 3 months of coverage under a fully insured group health plan and then lose it, you are guaranteed the right to buy an individual health plan from the company that provided your group coverage. This is called a **conversion policy**. There are rules about what conversion policies must cover and limits on the premium you can be charged. You will not face a new pre-existing condition exclusion period under a conversion policy. (See page 20.)*
- *If you are federally eligible, but do not qualify for a conversion policy, you are guaranteed the right to buy an individual health plan from any insurance company that sells such plans in Florida. Insurance companies must offer you a choice of at least two plans. (See page 13.)*
- *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 22.)*
- *If you are a small employer buying a group health plan, you can be charged more, within limits, due to the health status of those in your group. In addition, you can be charged higher premiums, within limits, because of the age, gender, family size, tobacco use of those in your group and where your business is located. (See page 22.)*
- *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 Florida **Medicaid** program offers free health coverage for pregnant women, families with children, elderly, and disabled individuals with very low incomes. The Florida KidCare Program provides health coverage to low-income children under the age of 19 who are not eligible for Medicaid and who have limited or no health insurance. (See page 25.)*

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 coverage 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.*
- *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.*
- *If you get a new job with health benefits, your coverage may not start right away. Employers and health maintenance organizations (**HMOs**) can require **waiting periods** before your health benefits begin. (See pages 7.)*
- *If you have a break in coverage of 2 to 3 months or more, you may have to satisfy a new pre-existing condition exclusion period when you join a new plan. (See pages 8 and 15.)*
- *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 six months or one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition. (See page 11.)*
- *If you work for certain non-federal public employers in Florida, not all of the group health plan protections may apply to you. (See page 11.)*
- *If you are not **federally eligible**, individual health plans in Florida are free to turn you down because of your health status and other factors. (See page 13.)*

- *Even if you are federally eligible, you can be turned down for some individual health plans. The law permits insurance companies to limit your choices to two plans, which are supposed to be comparable to others they sell in the individual market in Florida. (See page 13.)*
- *Except when you are federally eligible, individual health plans can permanently exclude coverage for your pre-existing condition through a rider, which is an amendment to your insurance contract.*
- *The law does not limit what you can be charged for individual health plans except when you are buying a conversion policy. You can be charged substantially higher premiums because of your health status, age, gender, and other characteristics. (See page 15.)*

CHAPTER 2

YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

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

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

- *You have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees. 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. However, if you work for a small employer in Florida, insurance companies must offer coverage to all eligible employees.

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 coverage (for example, that you or your dependents had through yourself or another family member and lost because of death, divorce, legal separation, termination, retirement, or reduction in hours worked)
-
- *Under Florida law, newborns, newly adopted children and children placed for adoption are automatically covered under the parents' fully insured health plan for the first 31 days if the plan covers dependents. The insurer may require that the parent enroll the baby within the 31 days in order to continue coverage beyond the 31 days.*
 - *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.*
 - *When you begin a new job with health insurance through an HMO, the HMO may require an **affiliation period** before coverage begins. During this affiliation period, you will not have health insurance coverage. An HMO affiliation period cannot exceed 2 months (3 months for late enrollees), and you cannot be charged a premium during it.*
 - *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 a **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 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.

- *A group health plan can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan. This period is also called the **look back** period. (If you are enrolling in an individual health plan or if you are self-employed, the definition of pre-existing condition is different.)*
- *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 is 12 months. You will receive credit toward your pre-existing condition exclusion period for any previous continuous coverage.*
- *If you enroll late in your group health plan (after you are hired and not during a regular or special enrollment period), you may have a longer pre-existing condition exclusion period. If you are a late enrollee, you may have an 18-month pre-existing condition exclusion period. Florida requires fully insured group health plans to accept late enrollees.*
- *If you join a new group health plan, the law protects you from a new pre-existing condition exclusion period, provided you maintain continuous **creditable coverage**.*

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

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

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 insurance plan.

If you are joining a group health plan, coverage counts as continuous if it is not interrupted by a break of *63 or more days* in a row.

What is continuous coverage?

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

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

Now consider a slightly different situation. Assume Art was uninsured for *90 days* between his jobs at Ajax and Beta. In this case, charter will credit coverage only under Beta's plan toward the 12-month pre-existing condition exclusion period. Charter's plan will begin paying for Art's diabetes care in 3 months (1 year minus 9 months). Art does not get credit for his coverage at Ajax since he had a break of *more than 63 consecutive days*.

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

- *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.
- *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 fully 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 covering prescription drugs she needs for other conditions that were not pre-existing.

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

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

According to the latest list available from the federal government, seven public employers have decided that certain health insurance protections will *not* apply to their employees. If you have group health coverage through these employers, you should contact them for more information. Other non-federal public employers in Florida may have made this choice after this guide was written. If you are not sure about your protections under your public employee health plan, you should contact your employer.

Florida public employers that elected to exempt their covered employees from certain health insurance protections

City of Clermont
City of Lakeland
City of Port St. Lucie
County of Lee
Florida League of Cities
Orlando Utilities Commission

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 individual health plan coverage for “federally eligible individuals.”*

CHAPTER 3

YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group insurance, you may want to buy an individual health plan from a private health insurance company. However, in Florida – as in most other states – you have limited guaranteed access to individual health insurance. Whether you can buy an individual health plan may depend on your health status, the kind of coverage you want to buy, and other circumstances. There are alternatives to individual health insurance coverage — such as COBRA coverage and conversion policies. This chapter summarizes your protections under different kinds of coverage.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

WHEN DO INDIVIDUAL HEALTH INSURERS HAVE TO SELL ME COVERAGE?

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

- *In general, companies that sell individual health insurance in Florida are free to turn you down because of your health status and other factors. When applying for individual coverage, you may be asked questions about health conditions you have now or had in the past. Depending on your health status, insurers might refuse to sell you coverage or offer to sell you a policy that has special limitations on what it covers.*
- *If you have had at least 3 months of coverage under a fully insured group health plan and then lose it, you are guaranteed the right to buy a conversion policy. You will not have a new pre-existing condition exclusion period.*
- *If you are federally eligible but do not qualify for a conversion policy, you are guaranteed the right to buy an individual health plan from any insurance company that sells such plans in Florida. Insurance companies must offer you a choice of at least two plans.*

To be federally eligible, you must meet certain criteria

If you are federally eligible you are guaranteed the right to buy individual health coverage in every state and are exempted from pre-existing condition exclusion periods. In Florida, if your most recent coverage was under a fully insured group plan, you can buy a conversion policy. If not, you can buy individual coverage from any insurer in the state that offers individual policies.

To be federally 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 federally eligible.)
- You must apply for health insurance for which you are federally eligible within 63 days of losing your prior coverage.

Federal 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 federally eligible again by maintaining continuous coverage and rejoining a group health plan.

WHAT WILL MY INDIVIDUAL HEALTH PLAN COVER?

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you have a pre-existing condition, Florida insurers can exclude coverage for your condition for 2 years, or permanently. If a 2-year exclusion period is applied, you can get credit for any prior continuous creditable coverage you have had. However, no pre-existing condition exclusion periods can be applied if you are federally eligible.*

The definition of pre-existing condition is different under individual health plans than under group health plans. Individual health plans can count as pre-existing any condition for which you received, or – in your insurer’s judgment, for which you should have sought – a diagnosis or medical advice or treatment in the 2-year period prior to joining the individual health plan. This is called the **prudent person rule**. Individual health plans can apply pre-existing condition exclusion periods for pregnancy, but not for genetic information.

- *Individual health plans can also impose elimination riders. This is an amendment to your health insurance policy that permanently excludes coverage for a health condition or even an entire body part or system. Individual health plans cannot impose an elimination rider for breast cancer unless you have this condition currently or have been in treatment for it within the past two years.*

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 Florida health insurers from charging you more because of your health status, age, gender, and other case characteristics.*

In addition, when you renew your individual coverage, your premiums can increase substantially as you age.

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELLED?

- *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.
- *Some insurance companies sell temporary health insurance policies.* Temporary policies are not guaranteed renewable. They will only cover you for a limited time, such as 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 2-19 employees, you may qualify for state continuation coverage. (See below.)

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

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

COBRA QUALIFYING EVENTS

For employees

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

For spouses

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

For dependent children

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

- *Each person who is eligible for COBRA continuation can make their own decision.* If your dependents were covered under your employer plan, they may independently elect COBRA coverage as well.
- *To qualify as federally eligible, you must choose and use up any COBRA or state 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 begin retroactive to the qualifying event. You will have to pay premiums dating back to this period.

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

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage.* The first premium must be paid within 45 days of electing COBRA coverage.
- *If you elect the 11-month disability extension, the premium will increase to 150% of the total cost of coverage.* See next page for more information about the disability extension.

HOW LONG DOES COBRA COVERAGE LAST?

- *COBRA coverage generally lasts up to 18 months and cannot be renewed.* However, dependents are sometimes eligible for up to 36 months of COBRA continuation coverage, depending on their qualifying event. In addition, special rules for disabled individuals may extend the maximum period of coverage to 29 months. To qualify for the disability extension, you must have been disabled at the time of your COBRA qualifying event (such as termination of employment or reduction in hours) or be determined to have become disabled within 60 days of that qualifying event. You must obtain this disability determination from the Social Security Administration, and you must notify your group health plan within 60 days of this disability determination.

LENGTH OF COBRA COVERAGE		
Qualifying Event	Eligible Person	Coverage
Termination Reduced hours	Employee Spouse Dependent Child	18 months*
Employee enrolled in Medicare Divorce or legal separation Death of covered employee	Spouse Dependent Child	36 months
Loss of dependent child status	Dependent Child	36 months

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

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

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

WHAT ABOUT FLORIDA CONTINUATION COVERAGE?

- *If your employer offers health benefits and has fewer than 20 workers, you may also be eligible for up to 18 months of continuation coverage under a Florida law that is similar to COBRA. You must give written notice to your insurer within 30 days of losing eligibility for the group plan to continue coverage under Florida law. Ask your former employer or the Florida Department of Insurance about state continuation coverage if you think it applies to you.*

CONVERSION POLICIES

If you lose coverage under a fully insured group health plan in Florida and meet other requirements, you are guaranteed the right to buy a conversion policy. This is an individual health plan sold by the insurance company that covered your former group.

WHEN AM I ELIGIBLE FOR CONVERSION COVERAGE?

- *You must have been covered under your fully insured group health plan at least 3 months before coverage ended. In addition, you must use up any available COBRA or state continuation coverage before you can buy a conversion policy.*
- *Your coverage cannot have been terminated because you failed to pay your premium. However, if your group coverage was cancelled because your employer failed to pay the premium, you can buy a conversion policy.*
- *You must apply for a conversion policy within 63 days of losing coverage.*

- *If your terminated coverage is replaced by similar group coverage within 31 days, you cannot buy a conversion policy.*

WHAT DOES A CONVERSION POLICY COVER?

- *You must be offered standardized conversion policies that meet state requirements for minimum coverage. In addition, if your group health plan covered maternity or dental benefits, these benefits must be covered under your conversion policy. Insurers can offer non-standard conversion policies as well. Ask the Florida Department of Insurance if you have questions about coverage under a conversion policy.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *You will not have a new pre-existing condition exclusion period for your conversion policy. The conversion policy can only exclude coverage for pre-existing conditions that were excluded under the prior group policy.*

HOW MUCH CAN I BE CHARGED FOR CONVERSION COVERAGE?

- *Florida limits the premiums that can be charged for conversion policies. The premium for your conversion policy cannot be more than 200 percent of the typical rate in the individual market. Contact the Florida Department of Insurance if you have questions about conversion policy premiums.*

CAN MY CONVERSION COVERAGE BE CANCELLED?

- *Your coverage cannot be canceled because you get sick. This is called guaranteed renewability. You have this protection provided that you do not lose your prior coverage because of failure to pay the premiums and your discontinued group coverage was not replaced by similar group coverage within 31 days after discontinuation.*

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. Florida has enacted reforms to expand some of these protections. Some of these reforms apply to groups of different sizes. Generally, small employers are those that employ 1-50 employees. Self-employed persons count as small employers in Florida, but have somewhat different protections. Please note that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Florida Department of Insurance to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down.* This is called guaranteed issue. If you employ no more than 50 people, health insurance companies must sell you any **small group health plan** they sell to other small employers. However, they can require that a minimum percentage of your workers participate in your group health plan. They can also require you to contribute a minimum percentage of your workers' premiums. If you are buying a **large group health plan** for 51 or more employees, your group can be turned down.
- *Your insurance cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud.

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

- *As a small employer, you can be charged higher premiums because someone in your group is seriously ill.* You also can be charged somewhat more due to the age, gender, family size and tobacco use of those in your group and where your business is located. This applies to all small groups of up to 50 employees.

WHAT PLAN CHOICES DO I HAVE?

- *Insurance companies must offer small employers standardized health plans. In Florida, insurers must offer small employers 2 plans whose benefits are defined in law: a standard plan and a basic plan. Standardization helps you compare differences in cost and coverage. Carriers can also offer non-standardized plans.*

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are considered to be a group of one. Insurers are required to accept your application for the standard plan or basic plan in August of each year to make coverage effective on October 1, of that year. They can refuse to sell you other plans, however. Further, the rules for pre-existing condition exclusion periods are somewhat different.*

For groups of one, pregnancy can be counted as a pre-existing condition.

If you are a group of one and you have had no prior coverage, the group health plan can exclude coverage for your pre-existing condition for up to 2 years. The plan can count as pre-existing any condition for which you received, or – in your insurer’s judgment, for which you should have sought – a diagnosis, treatment or medical advice in the 2 years prior to enrolling in the plan. This is called the prudent person rule. If you had prior coverage, you will receive credit toward your pre-existing condition exclusion period for any time you satisfied under your prior coverage provided there was no break in coverage greater than 63 days.

- *In order to show that you qualify as a self-employed person or a business group of one, insurance companies are allowed to require that you provide them with your tax forms.*
- *If you are self-employed and buy your own health insurance, you are eligible to deduct an increasing percentage of the cost of your premium from your federal income tax. This deduction is 70% for 2002, and 100% in 2003 and thereafter.*

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Florida who cannot afford to buy health insurance. Medicaid and the Florida KidCare Program offer free or subsidized health insurance coverage, direct medical services or other help. 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 Florida residents. Medicaid covers families with children and pregnant women, the elderly, and people with disabilities, if state and federal guidelines are met. Legal residents who are not U.S. citizens may be eligible for Medicaid. With the exception of financial assistance for certain emergency medical conditions, non-citizens who do not have immigration documents cannot enroll in Medicaid.

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

In Florida, 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 Florida Department of Children and Families for more information.

- *Parents who receive benefits under TANF (also known Work and Gain Economic Self-Sufficiency, or WAGES) should know that when you get a job and your TANF benefits end, you generally can stay on Medicaid for a 12-month transitional period.*

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

Low income persons eligible for Medicaid in Florida*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Infant	200% (monthly income of about \$2,438 for family of 3)
Child 1-5	133%
Child 6-18	100%
Parent	68%
Pregnant woman	185%

* Eligibility information was compiled from secondary sources, including Center for Budget and Policy Priorities, the Henry J. Kaiser Family Foundation, Families USA, and the Robert Wood Johnson Foundation Covering Kids Program, 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 2001:

<u>Size of Family Unit</u>	<u>Poverty Guideline</u> (annual income)
1	\$ 8,590
2	\$11,610
3	\$14,630

For larger families add \$3,020 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 \$29,260, or a monthly income of \$2,438.

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

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

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

- *People who have high medical expenses may also qualify for Medicaid.* You may qualify as medically needy if you have high medical expenses that, when subtracted from your income, would make you eligible for Medicaid coverage. For example, people who have to pay a lot for prescription drugs, nursing home care, or other long term care services sometimes qualify as medically needy if they don't have health insurance that covers these services.
- *Retired or disabled people who have low incomes and are enrolled in Medicare may also qualify for help from Medicaid.* Even though your income may be too high to qualify for Medicaid insurance coverage, there may be other ways Medicaid can help you.

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

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

Contact the Department of Children and Families 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 Florida Agency for Health Care Administration, or to apply contact the Department of Children and Families Office for the district office in the city or county in which you reside.

FLORIDA KIDCARE PROGRAM

Florida KidCare is a state-designed program that provides health coverage to low-income children under the age of 19 who are not eligible for Medicaid and who have limited or no health insurance.

- *A child whose family has a household income below 200% of the federal poverty level is eligible for Florida KidCare. For a family of 3, this works out to an annual income of \$29,260 or a monthly income of about \$2,438.* Premiums are on a sliding scale.

- *Eligibility is guaranteed for one year for children under age 5 and six months for children age 6 and older as long as monthly premiums are paid.*
- *No child is denied eligibility based on disability.*

FOR MORE INFORMATION...

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

For questions about:	Contact:
Individual health insurance Fully insured group health insurance	Florida Department of Insurance (800) 342-2762 http://www.doi.state.fl.us
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	U.S. Department of Labor, Atlanta Regional Office (404) 562-2156, or contact U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C. (202) 219-4377 For Department of Labor publications: (800) 998-7542 http://www.dol.gov/dol/pwba
Medicaid	Florida Agency for Health Care Administration (888) 419-3456 http://www.fdhc.state.fl.us Florida Department of Children and Families (800) 342-0825 http://www.state.fl.us/cf
Florida KidCare Program	Florida KidCare Program (800) 540-5437 http://www.floridakidcare.org

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.

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

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

Continuous Coverage. If you are joining a self-insured group health plan or if you want to be federally 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, Federally Eligible, Fully Insured Group Health Plan, Individual Health Plan, Self-Insured Group Health Plan.

Conversion. Your right, when leaving a fully insured group health plan in Florida, to convert your policy to an individual health plan. You must have been covered under the group health plan for at least 3 months and use up any COBRA or state continuation coverage before you can buy a conversion policy. There are rules about what conversion policies must cover and what premiums can be charged. See also Fully Insured Group Health Plan.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; an individual health plan; 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; or a state health insurance high risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Plan.

Elimination Rider. A feature permitted in individual health plans that permanently excludes coverage for a pre-existing condition.

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

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

Federally Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be federally 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 Florida and in other states. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

Florida KidCare. Florida KidCare is a state-designed program that provides health coverage to low-income children under the age of 19 who are not eligible for Medicaid and who have limited or no health insurance.

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by Florida. 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 1 employee. See also Fully Insured Group Health Plan, Self-Insured Group Health Plan.

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All health plans sold to Florida small employers with 2 to 50 employees are guaranteed issue. If you are self-employed, basic and standard small group health plans are guaranteed issue. If you are federally eligible, insurance companies must offer you a conversion policy for at least two individual health plans that are guaranteed issue. 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.

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 12-month 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.

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

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

Kassebaum-Kennedy. See HIPAA.

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 Floridians. All other states have Medicaid programs, too, though eligibility levels and covered benefits will vary.

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

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. 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 (Individual Health Plans). Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 2-year period immediately preceding enrollment in a health plan, or for which an ordinarily prudent person would have sought medical advice, care or treatment. Under individual health plans, pregnancy can be counted as a pre-existing condition. Genetic information 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. See also Genetic Information, Prudent Person Rule.

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

Prudent Person Rule. In individual health plans 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 in the 2 years prior to enrolling in an individual health plan. See Pre-existing condition (Individual Health Plan).

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 Florida.

Small Group Health Plans. Plans with no more than 50 employees, including the self-employed.

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 Florida, if you are in a fully insured group health plan sponsored by an employer with 2 to 19 employees and meet other requirements, you also have rights to continue your health coverage when your job ends.

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

Temporary Assistance for Needy Families (TANF). A program 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.

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.