Frequently Asked Questions (FAQs)

What is the purpose of Health Insurance Risk Pools?

Health Insurance Risk Pools serve two primary roles:

1. They provide a means for guaranteed access to insurance, which enables individuals to protect themselves from catastrophic medical bills.
2. They are increasingly recognized for the role they play in keeping the individual insurance markets viable for insurance companies to continue to compete in.

What is the purpose of Inclusive Health?

1. To provide access to quality non-group health care coverage to individuals whose health and/or medical history qualifies them as “high risk” and at a price that is lower than that charged to high-risk individuals by commercial health insurers.
2. To provide insurance under North Carolina State law and the Federal Health Insurance Portability and Accountability Act (HIPAA) for eligible individuals and their dependents.
3. To provide qualified coverage to individuals who are eligible for the tax credit for health insurance costs under the Trade Adjustment Assistance Reform Act and their dependents.

Who is eligible for coverage through Inclusive Health?

To be eligible for Inclusive Health coverage, you must meet all of the following criteria:

- You are a legal resident of the United States.
- You are a resident of the State of North Carolina.

- You do *not* have access to group coverage as an employee or as a dependent of an employee.
- You do *not* qualify for a government program such as Medicare or Medicaid.

In addition, you must meet *one* of the following criteria:

- You have been rejected or refused by an insurer for similar coverage for medical reasons.
- You have been offered coverage by an insurer but with conditional rider limiting coverage.
- You have been refused coverage except at a higher premium rate than Inclusive Health.
- You have similar coverage, but at a single rate higher than Inclusive Health.
- You have a diagnosed medical condition, outlined by Inclusive Health, which allows automatic enrollment into Inclusive Health.
- You are a federally-qualified, HIPAA-eligible individual, including those who currently have this coverage through an insurer. (See description of HIPAA eligible individual)
- You are a resident eligible for the Federal Health Coverage Tax Credit (trade-displaced workers, PBGC recipients). (See below description of HCTC)
- You are an eligible individual with other non-group coverage in place; you can move to Inclusive Health at any time

What is the legal residency requirement in the United States?

You must provide a photocopy of your Social Security card, birth certificate, passport, naturalization/citizenship certificate, unexpired Visa, unexpired I-94 card or green card. If your green card is pending, you will need to supply a photocopy of your Employment Authorization Document (EAD) and Advance Parole (temporary travel document).

What is the residency requirement in North Carolina?

You must be a resident of North Carolina for at least 30 days before applying for Pool coverage. The 30-day residency requirement does not apply to HIPAA Eligibles and HCTC Eligibles; instead, residency need only be in effect as of the date of application to the pool.

What are the Medical Conditions that will automatically qualify an individual for Inclusive Health Coverage?

Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus

Alzheimer's Disease

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)

Aneurysm

Angina Pectoris

Angioplasty

Ankylosing Spondylitis

Cancer (except skin) treated or diagnosed in past 5 years

Cardiomyopathy

Cerebral Palsy

Chronic Obstructive Pulmonary Disease

Chronic Renal Failure

Cirrhosis of the Liver

Congestive Heart Failure

Coronary Insufficiency

Coronary Occlusion

Crohn's Disease

Cystic Fibrosis

Emphysema

Hemochromatosis

Hemophilia

Hepatitis C

Hodgkin's Disease

Huntington's Chorea

Hydrocephalus

Leukemia

Lupus Erythematosus Disseminate

Major Organ Transplant

Multiple or Disseminated Sclerosis

Muscular Dystrophy

Myasthenia Gravis

Myocardial Infarction

Paget's Disease

Paraplegia or Quadriplegia

Parkinson's Disease

Polyarteritis (periarteritis nodosa)

Psoriatic Arthritis

Raynaud's Disease

Rheumatoid Arthritis

Schizophrenia

Stroke (CVA)

Suicide Attempt

Tetralogy of Fallot

Ulcerative Colitis

Who is NOT eligible for Inclusive Health coverage?

You are not eligible for coverage under Inclusive Health if:

1. You have or obtain medical care benefits substantially similar to, or more comprehensive than, the benefit plan offered by Inclusive Health, or you would be eligible to have coverage if you elected to obtain it, except that:
    a. You may maintain other coverage for the period of time you are satisfying a pre-existing condition waiting period under Inclusive Health; and

b. You may maintain Inclusive Health coverage for the period of time you are satisfying a pre-existing condition waiting period under another health insurance policy to replace the Inclusive Health policy.

2. You are determined to be eligible for enrollment in Medicaid, or Medicare, unless Inclusive Health offers Medicare supplemental insurance coverage.

3. You have previously terminated Inclusive Health coverage unless 12 months have lapsed since the termination, except that this shall not apply if you are a federally-defined eligible individual or eligible to receive benefits under the Trade Adjustment Assistance Program.

4. You are an inmate or resident of a public institution, unless you are a federally-defined eligible individual.

5. Your premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or a dependent of a government agency or health care provider. This does not apply if you are receiving benefits under the Trade Adjustment Assistance Program or receiving premium subsidies made available by the State based on individual income levels, or

6. You have other insurance coverage in place on the date that Inclusive Health takes effect.

Coverage under Inclusive Health shall end:

1. On the date you are no longer a resident of North Carolina.

2. On the date you request coverage to end.

3. Upon the death of the covered individual.

4. On the date that state law requires cancellation of the Inclusive Health policy.

5. At the option of the Pool, 30 days after Inclusive Health makes an inquiry concerning your eligibility or residence to which you do not reply.

6. Failure to make premium payments, after a 31-day grace period.

7. If the individual has preformed an act or practice that constitutes fraud or made an intentional misrepresentation or material fact under the terms of the coverage.

What qualifies me as a HIPAA Federally-Defined Eligible Individual?

You are considered HIPAA-eligible if:

- You have a total of 18 months of creditable coverage.
- You have avoided a significant break in health coverage of 63 or more full days in a row. A significant break in coverage results in the individual losing credit for the coverage before the break.
- You do not have any medical coverage, other than that which will soon be exhausted;
- If COBRA, state continuation coverage, or Federal Temporary Continuation Coverage was offered, you must have accepted and exhausted it. Although an individual may apply for HIPAA coverage before the termination of COBRA, COBRA must be exhausted and then the new coverage will start.
- You must not be eligible for any other employment related group health coverage, Medicare or Medicaid.
- Your last coverage must have been through an employer or union plan (COBRA, State and Federal continuation coverage also meet this requirement) or a church plan (as defined under section 3(33) of the Employee Retirement Income Security Act of 1974.
- You must not have lost your last coverage through fraud or non payment of premiums.
- Generally, you must not have accepted, after losing employer group coverage, a conversion policy or policy of limited duration because they are both forms of individual coverage and will terminate your HIPAA portability rights*.

* Please note, a person accepting a conversion policy may still be eligible for Inclusive Health coverage. For more information, please call (866) 665-2117.

What is the Federal Health Coverage Tax Credit (HCTC)?

The three groups of potentially eligible individuals for the HCTC are:

PBGC Pension Benefit Recipients: you are at least 55 years old and receive a pension benefit payment from the Pension Benefit Guaranty Corporation (PBGC). You also qualify if you are at least 55 years old and currently receive PBGC benefits as a survivor, beneficiary or an alternate payee.

TAA Recipients: you receive either an income supplement from your state called a Trade Readjustment Allowance (TRA) or unemployment insurance. You also either attend Trade Adjustment Assistance (TAA)-approved training or have a waiver saying you don't need training.

ATAA Recipients: you are at least 50 years of age and receive benefits under the Alternative Trade Adjustment Assistance (ATAA) program.

To be eligible for the HCTC, you must meet some general requirements. You meet these general requirements if the following statements are true for every month that you want to claim the tax credit:

- You are not entitled to Medicare benefits.
- You are not entitled to health coverage through the military health system (CHAMPUS/TRICARE). This does not include health coverage received as a Veterans Affairs (VA) benefit.
- You are not in prison.
- You cannot be claimed as a dependent on someone else's federal tax return.

Types of Qualified Health Plans

The following types of health insurance are qualified for the HCTC:

1. COBRA: this is federal legislation that lets you extend your job-based health coverage if you lose your job or run into other qualifying events that cause you to lose your health insurance.

   If you pay more than 50% of the cost for COBRA, you can receive the HCTC.

   If you pay 50% or less of the cost for COBRA, you cannot receive the HCTC.

   To get the HCTC with COBRA, you will have to provide a signed copy of the COBRA Election Letter or other proof showing you have this kind of health insurance. If your COBRA health insurance is about to end, you may be able to use another type of qualified health insurance. Read below to learn more.

2. State-qualified health plan: these are plans that a state's Department of Insurance approves as meeting the requirements of the Trade Act of 2002 for the HCTC.

   You must buy a state-qualified health plan directly from an insurance company or other organization designated by your state. A state-qualified health plan can be a private health insurance plan offered by a company or a public health insurance plan offered by a state. This type of plan is not available through an employer.

   There may be multiple health plan options available to you in your state. You should review and compare these options to decide on the best choice for you and your family.

3. Spousal coverage: this is health insurance that you get through your spouse’s employer.

If your spouse pays more than 50% of the cost for spousal coverage, you can receive the HCTC.

If your spouse pays 50% or less of the cost for spousal coverage, you cannot receive the HCTC.

Any portion of the cost for spousal coverage that is paid before taxes are taken out is considered to have been paid by the spouse's employer. Therefore, that portion figures into the percentage of the cost for which the company pays.

You can only receive the monthly HCTC if your spouse's health insurance is COBRA. If your spouse's health insurance is not COBRA, you can only receive the yearly HCTC on your federal tax return.

4. Non-group/individual health plan: this is health insurance sold by a private health insurance company, broker or agent to one individual or one family at a time. This is not group health insurance.

   Your first day of non-group/individual coverage must have started at least 30 days before your last day with the company that made you eligible for PBGC pension payments or trade adjustment benefits. Because of this 30-day requirement, non-group/individual coverage is rare for the HCTC.
   To learn more about the HCTC program check online at
   http://www.irs.gov/individuals/article/0,,id=109915,00.html
   or call 1-800-829-1040.

What is Creditable Coverage?

Creditable coverage is health coverage under any of the following:

> Most health coverage is HIPAA creditable coverage. Creditable coverage includes prior coverage under an employer group health plan (including a governmental, church plan or a group health plan in a foreign country), health insurance coverage (either group or individual), Medicare, Medicaid, a military-sponsored health care program for members or certain former members of the uniformed services, and for their dependents, a program of the Indian Health Service, a State high risk pool, the Federal Employees Health Benefits Program, a public health plan (including any plan established or maintained by a State, the US Government, a foreign country or any political subdivision of a State, the US Government or a foreign country), a health benefit plan provided for Peace Corps members and Title XXI of the Social Security Act (State Children's Health Insurance Program).

What is a Certificate of Creditable Coverage?

Group health plans and health insurance issuers in both group and individual markets are required to furnish certificates of creditable coverage as documentation of health coverage. You may need to request this from your last insurance company and any other entities that can establish the length of coverage needed to satisfy pre-existing condition exclusions.

If your prior carrier has not provided you with a certificate, other examples of proof of prior coverage can include:

- Explanation of benefits or other correspondence from a plan or issuer indicating coverage.
- Pay stubs showing a payroll deduction for health coverage.
- Health insurance identification card.

Is there a lifetime maximum under Inclusive Health coverage?

Yes. There is a lifetime maximum of $1,000,000 (One million dollars).

Are there pre-existing conditions?

Inclusive Health coverage shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage for any condition for which medical advice, care or treatment was recommended or received for conditions during the 12-month period immediately preceding the effective date of coverage. If an individual enrolls in Inclusive Health during the first six months (until June 30, 2009), the pre-existing condition waiting period is six months.

Pre-existing limitations conditions do not apply to:

- A child, covered within 31 days of the child's birth, placement for adoption or placement as a foster child.
- A Federally Defined Eligible (HIPAA) Individual.
- A Trade Adjustment Assistance eligible individual.

What happens if I do not pay my premium?

Pool coverage will terminate after a 31-day grace period, retroactive to the end of the month for which the last premium was paid.

Is my doctor a network provider?

The best way is to search for your physician at (hyperlink to provider network) or to directly ask your physician if they are part of the Inclusive Health MedCost network.

Is group coverage available?

No, all policies are issued on an individual basis.

Is family/dependent coverage available?

No, all premiums are based on an individual rate. Each family member who qualifies and enrolls will be charged the rate applicable to them.

- Except for dependents of an individual who is eligible for the Federal Health Coverage Tax Credit, each family member must independently qualify for coverage under the eligibility rules. A separate application is required for each family member. However, dependents who can obtain health insurance in the commercial market or through an employer may find it less expensive than paying the Inclusive Health rate.
- Dependents who qualify for coverage may be enrolled, under separate policies and will be charged an individual rate based on their age, gender and whether you are a smoker or not.

Can my employer pay my premium?

No, employers cannot pay premium since this is not a group or an employer sponsored plan.

Can I re-apply for coverage after termination?

If you fail to pay the premium, or you voluntarily leave Inclusive Health, you will not be eligible to re-apply until 12 months after termination date, unless you are HIPAA or TAA eligible.

Will enrollment in Inclusive Health disqualify me from eligibility for other health insurance coverage in the future?

No. Inclusive Health enrollment will not disqualify you from eligibility for other health insurance coverage in the future.

Inclusive Health is considered prior creditable coverage and in the event you leave, the program will provide a Certificate of Creditable Coverage showing your effective and termination dates. This will prove continuous coverage to a new insurance carrier and should prevent the carrier from imposing a pre-existing limitation on your new policy.

How do I find out about Risk Pools in other states?

Contact the National Association of State Comprehensive Health Insurance Pools at www.NASCHIP.org.

What is a Health Savings Account ?

An HSA works like an IRA, except that money is used to pay health care costs. Participants enroll in a high-deductible insurance plan. Then, a tax-deductible savings account is opened to cover current and future medical expenses not covered by the high deductible health plan. Up to $2,900 may be deposited, and along with the earnings, are not taxable. The funds can then be withdrawn to cover qualified medical expenses tax-free. Unused balances roll over from year to year.

(Note: The annual limit on HSA deposits are set by federal law and may change from year to year. Please consult the IRS or your tax advisor to learn more about future HSA annual deposit limit modifications.)

How do I contact the Inclusive Health Customer Service?

The Inclusive Health Customer Service Department is available Monday through Friday, from 8:00 a.m. to 5:00 p.m. Eastern Standard Time.

Our toll free number is (866) 665-2117.

Am I eligible for Inclusive Health coverage if I also have Medicare or Medicaid?

If you are eligible for Medicare or Medicaid, you cannot purchase Inclusive Health coverage. If you have Inclusive Health, it will terminate when you become eligible for Medicaid or Medicare.

What are some things to consider when choosing an Inclusive Health benefit plan?

- How much premium can you afford to pay? See the Premium Rate Calculator at www.inclusivehealth.org/applicants to see how much the plans cost.
- What are your prescription drug needs?
- How much deductible would you prefer to pay each year?
- How much annual out-of-pocket expense can you afford in the event you reach the maximum out-of-pocket amount?

When is coverage effective after I send in my application?

If your application is received and processed by the 15th of the month, the effective date of the application can be as early as the first day of the month following its approval by Inclusive Health. You'll receive a confirmation letter from Inclusive Health if you are approved for coverage that will specify your effective date.