



BENEFIT *Advisor*

In This Issue

In this fourth issue of the McGrawWentworth Benefit Advisor for 2009, we discuss health care alternatives when employees lose coverage through their employer plans. With a number of reductions in the workforce happening across the country, finding affordable health care alternatives is a challenge.

Individuals will have many alternatives to consider in addition to COBRA. Employers may want to help educate individuals about their options.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGrawWentworth website at www.mcgrawwentworth.com.

“Health Care Alternatives”

Workforce reductions have become common in Michigan and across the country. The weakening economy is forcing many employers to make very difficult decisions.

Losing a job can devastate employees, families and communities. Along with the loss of income, employees are forced to make tough choices on health plan coverage. Most employees will have the option to elect COBRA. Because of new federal assistance, COBRA has become much more affordable than before. On the other hand, if the employee is not eligible for COBRA assistance or the assistance runs out, health care coverage becomes an expensive luxury.

This *Benefit Advisor* discusses the following health care alternatives:

- COBRA – Assistance from Federal Government
- Children’s Health Insurance Program
- Medicaid
- Medicare
- Individual Health Plan Options
- Conversion Plans

Employers are obligated to inform employees about continuation rights under COBRA. New regulations will also require specific notices regarding the Children’s Health Insurance Program. In these hard times, individuals need to understand all their health care coverage options.

When employer health care coverage is either not available or not affordable, employees may not know where to turn.



This *Advisor* provides critical information to help you create a health care information resource so that

employees that have lost group health plan coverage are aware of their options. This information will also help employees investigate health coverage alternatives when COBRA does not apply; for example when health benefits are discontinued for the entire company or the company eliminates coverage for an entire class of employees.

COBRA – Assistance from Federal Government

COBRA rules apply to most employers other than small group and certain church health plans. This federal law requires employers to allow qualified beneficiaries to continue their coverage under the group health plan if they lose coverage because of a qualifying event. The employee must pay the full cost of coverage, including, at the employer's discretion, an additional 2% administrative fee.

COBRA enables most laid-off employees to continue their health care coverage. However, COBRA can be very expensive. To help employees pay for their COBRA coverage, Congress recently passed the American Recovery and Reinvestment Act of 2009 (ARRA). This act allows the government to subsidize 65% of the COBRA premium for assistance-eligible individuals (AEIs). It allows employers to tax a 65% tax credit for AEIs that pay 35% of the COBRA premium. McGraw Wentworth has published a number of *Special Alerts* on the COBRA subsidy in the last two months. Please see our website for more details on the COBRA assistance.

Not all COBRA-eligible participants will qualify for ARRA assistance either because there was no qualifying event or because the participant may not be considered a qualified beneficiary. In addition, ARRA currently allows only nine months of premium assistance. If employees are not eligible for federal assistance, COBRA may not be affordable. If COBRA is not affordable, the following health care options should be considered.



Children's Health Insurance Program

Each state offers a needs-based comprehensive health program that covers children and in some cases pregnant women. One of the key Obama administration mandates is to achieve universal health care coverage for children either through employers' plans or through the state Children's Health Insurance Program (CHIP).

The President recently signed the Children's Health Insurance Program and Reauthorization Act of 2009. This act made a number of changes to the CHIP program. One of the key changes is expanded eligibility based on the annual Federal Poverty Limit (FPL). The 2009 FPL is \$22,000 for a family of four. Before April 1, 2009, children living at home in families making less than 200% of the FPL or less than \$44,000 a year would be eligible for coverage. Effective April 1, the income limit will increase to 300% of the FPL, so that families earning up to \$66,000 a year will now qualify.

The Michigan CHIP program is called MiChild. MiChild costs just \$10 a month and offers comprehensive medical coverage for eligible children including:

- Regular checkups
- Shots
- Emergency care
- Some dental care
- Pharmacy benefits
- Hospital care
- Prenatal care and delivery

- Mental health and substance abuse services
- Some vision care

More information on the MiChild program can be found at http://www.michigan.gov/mdch/0,1607,7-132-2943_4845_4931---,00.html.

If your employee has a child living in another state, your employee can Google that state's CHIP program for information.

The Children's Health Insurance Program and Reauthorization Act of 2009 made substantial changes to these federally funded, state-run health programs. In addition, the new act also requires employers to notify employees of these programs. For more details on these requirements, please read our *Special Alert* at http://www.mcgrawwentworth.com/Special_Alert/2009/Special_Alert_Issue_3.pdf.

Medicaid

Medicaid is a federally funded, state-run health care program available to any state resident that meets the financial needs requirements. Financial need usually depends on income and assets and varies from state to state.

The Medicaid needs-based assessment is more restrictive than the CHIP program assessment.

The federal government stipulates:

- Each state must cover the groups of people listed below although the financial eligibility levels for these different groups do not have to be the same.
 - Older people, people with disabilities and people who are blind
 - Children and pregnant women
 - State residents that meet the financial requirements and apply for coverage
- All states have programs to cover the cost of nursing home care for people with limited incomes and assets who need this level of care.
- All states have programs to provide home- and community-based care to people with limited incomes and assets who need long-term care services.
- All states must cover home health care for those with limited incomes and assets who need it.

Medicaid provides comprehensive coverage for the following services:

- Doctor visits
- Hospital care
- Well check-ups and immunizations
- X-ray and lab services
- Nursing home care
- Hospice care
- Chiropractic services
- Additional services including mental health, substance abuse, hearing aids, vision, speech and physical therapy, and so on

Coverage for some services depends on age or medical necessity. In addition, states often contract with health plans to deliver Medicaid benefits. Once you become eligible for Medicaid, you will be told your plan options or the plan you will be enrolled in. Medicaid health plans can dictate the doctors, hospitals and pharmacies they will cover. The Medicaid plan may make some exceptions in situations where someone is seriously ill and in treatment.



Medicare

Medicare is a federally funded and federally administered program that provides health care benefits to older Americans and the disabled.

You become Medicare eligible in three ways:

- **When you turn age 65** (coverage is effective the first day of the month in which you turn 65).
- **If you become disabled.** To qualify for disability benefits, you must have been disabled and unable to work for at least five months. After that you can begin receiving social security disability income. You become eligible for Medicare twenty-four months after your social security income starts. In reality, a disabled person becomes Medicare eligible twenty-nine months after the date of disability – the total includes the original five-month waiting period for disability

income and twenty-four months of income benefits.

- **If you have certain medical conditions.** For example, people with End Stage Renal Disease are Medicare eligible, but the effective date of coverage depends on their treatment. The details regarding End Stage Renal Disease qualification can be found at http://www.cms.hhs.gov/employerservices/04_endstagerenaldisease.asp.

People with ALS (Amyotrophic Lateral Sclerosis or Lou Gehrig's disease) automatically become eligible for Medicare the month their disability income benefits begin.

Once you become eligible, you have a limited time to enroll in certain parts of Medicare. If you do not enroll in some parts of Medicare on time, you may incur late enrollment penalties.

The Medicare program has three parts:

- **Medicare Part A:** Covers inpatient hospital services. The payroll taxes you paid throughout your working years pay for Part A. However, services are not covered totally; there is significant cost-sharing in Part A.

- **Medicare Part B:** Covers outpatient physician services, x-ray and lab services and so on. Medicare Part B is a voluntary benefit program requiring a monthly premium and that premium increases every year. Once you meet the calendar year deductible, Part B covers 80% of most services.
- **Medicare Part D:** Covers outpatient prescription drugs. Medicare Part D is also a voluntary benefit program requiring a monthly premium. Insurance carriers and administrators across the country provide Part D benefits. In most areas, you can choose from a number of Part D plan options.

The government also allows private health insurance carriers to replace Medicare coverage. Medicare Advantage plans replace Medicare Parts A and B, and sometimes D. Private health insurance carriers offer these plans at competitive prices.

For more information on Medicare, please see our *Benefit Advisor* at http://www.mcgrawhrentworth.com/Benefit_Advisor/2008/BA_Issue_9.pdf.

Individual Health Plan Options

People can always apply for health coverage through an individual insurance carrier. These carriers must comply with any Health Insurance Portability and Accountability Act (HIPAA) rules the state requires. The goal of the HIPAA provisions is to make sure people have at least one health plan option in their state.

In general, most individual health insurance carriers require medical underwriting. The medical underwriting process generally includes medical and health history questions as well as a home visit by a nurse to do biometric screenings. Carriers can agree to cover the person, decline coverage because of a pre-existing medical condition, charge a higher rate because of medical status or exclude coverage for certain medical conditions.

HIPAA requires states to have at least one option available for people with pre-existing medical conditions who may not be able to get coverage through an individual carrier.

States have the following three choices:

- **Carrier of Last Resort:** One carrier in the state agrees to cover state residents without requiring medical underwriting. Michigan chose this approach and Blue Cross Blue Shield is the carrier of last resort. This means when you apply for Blue Cross Blue Shield of Michigan coverage, you do not have to answer medical questions. To qualify for Blue Cross Blue Shield of Michigan coverage, you need to have been a Michigan resident for at least six months during the year.
- **High Risk Pool:** Most states have adopted this approach to comply with HIPAA. A high risk pool is a state-funded, usually carrier-run, program that covers a state resident declined previously because of a medical condition. Premium

taxes, assessed on all insurance carriers admitted to do business in the state, fund these high risk pools. In addition, individuals must pay for the coverage.

- **No Medical Underwriting:** If a state does not use the first or second approach described above, carriers in that state cannot medically underwrite residents who apply for coverage.



Former employees need to understand how the individual medical insurance market works, especially

when they have a pre-existing condition. You may want to refer former employees interested in individual health coverage to your state's Department of Insurance for information.

Individual health insurance coverage is generally considered creditable coverage under HIPAA portability rules. Individuals should verify with the carrier that the individual coverage will qualify as creditable coverage.

If the coverage is considered creditable, and an individual becomes covered by a group health plan in the future, time spent covered under the individual plan, providing there is not a break in creditable coverage, would count toward the new group health plan's pre-existing condition limitation.

The individual health insurance market can be confusing and the plans and rates are different from group health plans. However, with the current turmoil in employment opportunities throughout the country, individual health insurance coverage may be the least expensive way to get catastrophic health plan coverage.

Conversion Plans

Many, but not all, group health plans offer conversion plans. A conversion plan is an individual health policy that requires no medical underwriting. Typically, a person has thirty or sixty days after the group health plan coverage ends to get a conversion policy. Coverage can end when employment ends or when the COBRA continuation period ends. The conversion option may also appeal to employees that are no longer eligible for benefits. For example, if your organization decides to stop covering your part-time employees, they would not be eligible for COBRA. These employees may want to consider a conversion health plan.

Most states require health insurance carriers to offer conversion policies under fully insured health plans. If your group health plan is fully-insured, it probably includes conversion rights. If your plan is self-funded, it probably does not include conversion rights. Self-funded plans generally require the employer to pay a substantial fee in order to offer conversion coverage. Therefore, most self-funded employers do not include conversion rights in their



group health plans. One exception to these general guidelines is Blue Cross Blue Shield of Michigan. Blue Cross Blue Shield of Michigan typically offers conversion rights to fully insured and self-funded clients.

Conversion plans are not right for everyone. In general, the premiums are fairly expensive. The purpose of conversion is to provide a health plan option for anyone that has a pre-existing condition and would not otherwise be able to secure coverage. In Michigan, the conversion rates for Blue Cross Blue Shield are not as high as in other states because it is the carrier of last resort.

Concluding Thoughts

Employers are struggling to survive in these difficult economic times. Most employers have had to reduce their workforce to continue to survive. Reducing the workforce is not an easy decision. Employees that are let go lose not only their income, but also their health insurance coverage.

The government has stepped in to help unemployed workers pay for COBRA continuation coverage in specific situations. However, some former employees will not qualify for government assistance and others will need coverage beyond the nine-month government assistance period. These employees need to know that coverage is available through many sources other than just expensive, employer-provided COBRA.

In your role as an employer, you need to make sure your employees receive all the required COBRA notifications. You cannot discourage former employees from electing COBRA. Because COBRA will be too expensive for some employees, however, you may want to explain all the health insurance options available to them. If you can offer ideas to help your employees find affordable coverage, you may make a big difference in a difficult time.

If you have any questions about health coverage options, please contact your McGraw Wentworth Account Director. **MW**

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