

Seizure Disorders Facts and Issues (SDFI)

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Maintaining Employer-Provided Group Health Insurance After Coverage Terminates

Major strides have been made through two federal laws to help individuals obtain and maintain employer-provided group health insurance coverage as well as to limit the effect of “pre-existing condition” clauses that affect so many people with epilepsy. Under the Comprehensive Omnibus Benefits Reform Act of 1986 (COBRA), individuals who are no longer eligible for group health coverage due to job loss or another “qualifying event,” such as a reduction in work hours, can purchase continued health insurance coverage for up to 18 months (this may be extended in limited circumstances). And spouses and dependents of a covered employee who were receiving benefits under the employee’s plan but become ineligible (for instance, if a dependent child reaches the age of majority or is no longer a student) may also continue coverage under specified circumstances. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the amount of time insurers can deny coverage for pre-existing conditions, including epilepsy, to twelve months -- and in some cases can insure that there is no waiting period whatsoever for new coverage -- provided the policy includes coverage for the condition.

Accordingly, COBRA and HIPAA can work together to maintain group insurance coverage while finding or starting a new job and to limit the effect of pre-existing condition exclusion periods that may apply to new insurance coverage. The benefits and qualifying requirements of each program are discussed below. **Importantly, as discussed below, the economic stimulus bill that was signed into law by the President in 2009 expanded eligibility for COBRA and provides a significant reduction in the premium required for continued coverage to certain qualified individuals.**

COBRA

If an individual has group health insurance through his or her employer, the individual, his or her spouse and dependents can continue that coverage for eighteen months if a “qualifying event” (causing the employee to lose insurance coverage) takes place. This right to obtain continued coverage under COBRA only applies with regard to group health plans for private employers which have had twenty or more employees in the previous calendar year, and to state and local government employees. The most common qualifying events are the employee’s termination (including the employee voluntarily quitting), or a cut in the employee’s hours which results in the employee no longer satisfying applicable minimum work hour requirements for insurance coverage. However, COBRA coverage is not an option if the employee is terminated for “gross misconduct.”

Moreover, if a dependent child of an employee receiving group coverage loses coverage because he or she is no longer a dependent (for instance, he or she is no longer a minor or a full-time student), the individual may obtain up to 36 months of COBRA coverage. This frequently can be an important means of ensuring continued health coverage for youth with epilepsy, who may not be able to obtain health insurance coverage otherwise -- either because they are not employed or based on their pre-existing condition. (See the discussion below regarding how COBRA and HIPAA limit the ability of a new employer health plan to exclude health insurance coverage for pre-existing conditions.) Similarly, a spouse of an employee with health coverage may obtain up to 36 months of COBRA coverage following specified qualifying events (death of the employee or a legal separation or divorce).

The employer must notify the health plan within 30 days of a qualifying event (an employee’s termination, reduction in hours, or death). Within 14 days afterwards, the health plan must notify the employee (or beneficiary) of his or her right to continue coverage. The employee or beneficiary must respond within 60 days if they wish to continue on the group health insurance plan, and then has 45 days after electing coverage to pay the initial premium.

The individual who chooses continued coverage will have to pay both the employee and employer portions of the premium plus a 2% service charge. The individual's continuing premium cost may not exceed 102% of the premium cost for the full employee rate. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees, while COBRA participants generally pay the entire premium themselves. It is ordinarily considerably less expensive, though, than individual health insurance coverage.

This coverage may continue for 18 months, as long as the premiums are paid. If the individual should join a new employer's group health plan, the COBRA coverage is not automatically terminated. The individual has the option of either continuing the COBRA coverage for the full 18 months or terminating it. Continuing COBRA coverage when joining a new plan may be helpful if plan participants are subject to exclusions or waiting period requirements under the policy. However, the individual may need to carry the premiums of both policies during this time.

If an individual was determined to be disabled under the Social Security Act within the first 60 days of COBRA coverage, the individual may choose to buy an additional 11 months of COBRA coverage, extending the COBRA coverage to 29 months. If the individual chooses this option, any beneficiaries also receiving the COBRA coverage will be eligible for this extended period. Plans can charge 150 percent of the premium cost for the extended period of coverage.

When the COBRA coverage ends, an offer will be made for an option to convert to an individual health plan if this option is generally available to active employees under the plan. Assuming the employee wishes to convert, he or she will want to determine if the conversion plan is affordable (it is likely to be more expensive than group coverage) and extensive enough, or if an individual needs to seek coverage elsewhere.

COBRA coverage may also be terminated early if after electing COBRA the individual joins another health plan (including Medicare) that covers all existing conditions. If the new plan does not cover a certain condition that COBRA is currently covering, or if you are still subject to a twelve-month pre-existing condition clause, you can maintain the double coverage.

COBRA Extension and Subsidy under 2009 Economic Stimulus Bill

The American Recovery and Reinvestment Act of 2009 expanded eligibility for COBRA and provides a premium reduction to certain qualified individuals. Individuals who were involuntarily terminated by their employer on or after September 1, 2008 through December 31, 2009 who are eligible for COBRA and elect COBRA may be eligible to pay a reduced premium amount that is only 35 percent of the premium costs for the COBRA coverage.

The premium reduction for an individual ends upon eligibility for other group coverage (or Medicare), after nine months from the beginning of the reduction, or when the maximum period of COBRA coverage ends, whichever occurs first. The premium reduction provisions relate only to premiums for coverage periods beginning after the law was enacted -- February 17, 2009.

If you were terminated between September 1, 2008 and December 31, 2009 and were covered by your employer's plan on your last day of employment, your plan administrator should provide you a notice of your eligibility to elect COBRA and to receive a premium reduction. Individuals involuntarily terminated during this period have the right to elect COBRA coverage even if they did not elect coverage when it was first offered; they may also do so if they did elect COBRA, but are no longer enrolled (for example, because they were unable to continue paying the premium). This election period begins February 17, 2009 and ends 60 days after the plan provides the required notice. You may want to contact your employer directly to ask about getting the premium reduction, and how to reconcile any amounts you might have overpaid after February 17, 2009.

If you have specific questions about your situation and how these new rules apply to you, you may wish to speak to a benefits advisor in the Department of Labor's Employee Benefits Security Administration, by calling 1.866.444.3272. You should also check the Employee Benefits Security Administration's dedicated Web page at www.dol.gov/COBRA.

HIPAA

Individuals with various health conditions are often reluctant to leave jobs because they are afraid pre-existing condition clauses will limit coverage of any such conditions under a new insurance plan. This is of particular concern to people with epilepsy who can not physically or financially afford any lapse in health insurance coverage. HIPAA limits the amount of time an insurer can refuse to cover pre-existing conditions to 12 months. HIPAA also ensures that in some cases there is no waiting period for new coverage. However, an insurer is still not required to cover every condition and disability. In some cases, they can still deny coverage altogether for certain conditions as long as the decision is based on sound actuarial data. But so long as epilepsy, or any other condition, is covered under a new plan, the pre-existing condition waiting period can be no longer than 12 months. State laws may offer more generous protections than HIPAA. You may want to contact your state insurance commissioner's office to ask about the law where you live. A good place to start is the Web site of the National Association of Insurance Commissioners at www.naic.org.

A “pre-existing condition” is considered to be any condition for which medical advice, diagnosis, care or treatment was recommended or received within the previous six-month period. The maximum amount of time a plan can refuse coverage for any such condition is 12 months. If an individual starts a new job and is subject to a waiting period before being eligible to join the health plan, the waiting period and twelve-month period for the pre-existing conditions must coincide.

The twelve-month period for pre-existing conditions may be reduced if the individual provides the new insurance plan with proof of their prior health coverage. When leaving a health plan, the plan must provide you with a Certificate of Coverage which details the dates you were covered under the plan. This continuous coverage can be credited toward the pre-existing condition period, provided there was not a “significant break” in coverage between jobs – which is defined as 63 or more days. Therefore, if you had at least 12 months of “creditable coverage” (which can be from a group health plan, HMO, individual health insurance policy, Medicare, or Medicaid) and then left your job and you started a new job within 63 days thereafter, the pre-existing condition period would not apply. Your condition would be covered immediately (provided that the plan

regularly covers that condition). COBRA coverage can also be credited towards continuous coverage.

HIPAA can also help provide access to individual insurance when group coverage is not an option -- without the imposition of a pre-existing condition exclusion. HIPAA guarantees access to an individual plan if: the individual had group coverage for at least 18 months, did not have a significant break in coverage (63 or more days in a row), did not have their group coverage terminated because of fraud or nonpayment of premiums, is ineligible for COBRA or has exhausted COBRA benefits, and is not eligible for coverage under another group health plan.

For more information regarding HIPAA and COBRA and other health programs, visit the Department of Labor's Web site at <http://www.dol.gov/dol/topic/health-plans/cobra.htm>, or the Centers for Medicare and Medicaid Services Web site, www.cms.hhs.gov/HealthInsReformforConsume/02_WhatHIPAADoesandDoesNotDo.asp

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