Hard Times and Health Insurance: Staying Covered When You Lose Your Job

A Guide for New Yorkers

United Hospital Fund

Hard Times and Health Insurance: Staying Covered When You Lose Your Job is a United Hospital Fund publication written by Peter Newell and Mark Scherzer, Esq.

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State officials now estimate that over 180,000 New Yorkers could lose their jobs in the current economic downturn. More than 500,000 were receiving unemployment insurance benefits in January 2009. If, in these hard times, you lose your job or your work hours are reduced, the consequences can go beyond just loss of income. Your valuable employee benefits, including the health insurance you have through your job, could be lost as well.

Both federal and New York State laws provide you with ways to postpone or avoid losing your health benefits, or to take advantage of other coverage options. In this booklet, we explain those protections and provide practical suggestions on how to exercise them. We also review the significant new federal assistance and protections provided in the recently enacted American Recovery and Reinvestment Act, the federal stimulus legislation.

Regardless of the option you choose, following these simple rules will help you preserve and exercise important rights and protections:

1. Make sure your employer or health plan administrator has up-to-date records of your family's current mailing address, and take a few moments to find and review the documents related to your employer-sponsored health coverage;

2. Make sure that you put requests in writing and keep copies of all correspondence with your employer or health plan. Save copies of e-mails and keep a log of any oral communications as well; and

3. Pay careful attention to the many deadlines that apply to all of these coverage options. Missing a deadline by even one day can mean the loss of coverage or subsidies, or significant out-of-pocket costs for pre-existing conditions (see "The 62-Day Limit," page 2).

Portability and Pre-Existing Condition Limitations: Don't Forget the 62-Day Limit!

Families looking to replace employer-based coverage face many decisions and many deadlines. One of the most important deadlines to keep in mind is "the 62-day limit"—particularly if you or a family member is under care for a medical condition.

Federal and New York laws prevent health plans from rejecting applicants based on their pre-existing medical conditions, but allow the exclusion of benefits related to a pre-existing condition for up to one year. When calculating this one-year waiting period, health plans must "credit" past periods of continuous coverage, and any periods between your employment date and the beginning date of your coverage, toward the 12-month maximum exclusion. Lapses in coverage of up to 62 days do not count as an interruption in coverage. When coverage ends for any reason, health plans are required to provide you with a "certificate of creditable coverage," which makes it easier to demonstrate past coverage when enrolling in a new plan.

Thus, consumers with one year of continuous prior coverage should never face benefit exclusions related to a pre-existing condition. When a lapse in coverage of *more* than 62 days occurs, however, health plans are permitted to "start the clock over again" and impose a new waiting period for any condition for which treatment or consultation was received in the six months before the coverage began. "Treatment" could include routine care like taking a prescription drug for blood pressure or asthma.

These rules place a premium on maintaining continuous coverage. While all care unrelated to the pre-existing condition is covered, significant out-of-pocket costs for the condition can undermine the financial protection insurance policies are supposed to provide. You and your family should keep this important deadline in mind at all times when considering your health coverage options.

Generally, coverage options fall into four categories: 1) enrolling family members in employer-based coverage that had previously been declined; 2) continuing employer-based coverage after leaving a job, through federal "COBRA" or New York State "continuation" laws; 3) exercising the option under state law to "convert" group coverage to an individual policy (known as "conversion"); or 4) shopping for policies available for individuals and families, some of which require applicants to meet income or other eligibility standards.

Switching to Other Coverage

Special enrollment periods for spouse's coverage
If you lose your group coverage, are married, and your spouse's employer offers coverage, your spouse and you and your children (if your spouse's plan offers coverage to dependents) are eligible to sign up for coverage in your spouse's plan. This "special enrollment period"—required by a federal law called the Health Insurance Portability and Accountability Act (HIPAA)—applies to both "fully insured" plans, in which the employer buys a health insurance policy to cover workers, and to "self-insured" or "self-funded" plans, in which the employer assumes the financial risk of employees' claims.

To take advantage of the special enrollment period, your spouse's group health plan must be notified within 30 days of the loss of the other coverage. Although most employers typically restrict changes in enrollment to a single, annual "open enrollment" period in the fall, this special enrollment period can occur at any time of the year, even if your spouse previously declined the coverage.

HIPAA provides for the special enrollment period not only when other coverage has been lost, but also when marriage, birth, or adoption creates a new dependent. As with loss of coverage, you must give the plan notice within 30 days of the birth, marriage, or adoption in order to get the special enrollment period.

Special enrollment periods for domestic partner's coverage

If you are not married but have a domestic partner, your domestic partner may have access to employer-based coverage. If your domestic partner had coverage through you, he or she would benefit from the HIPAA special enrollment period. Your partner would just have to give notice to his or her employer, within 30 days of the loss of your coverage, to be able to enroll in his or her own employer's plan.

HIPAA has no rules, however, requiring an open enrollment period for the dependents of domestic partners who lose their coverage. In other words, if you and your partner were both covered on your plan, and that coverage is being lost, your partner's employer must give him or her a special enrollment period but is not required to give you one as well. But if your partner's employer offers coverage to domestic partners, it may also have voluntarily decided to permit such a special enrollment period as long as you meet the employer group's conditions for domestic partner coverage.

Extending Your Employer-Sponsored Coverage: COBRA and State Continuation

If you have lost your group coverage because you quit, were laid off, or your hours were reduced below the minimum required for coverage, or a life event such as death or divorce caused you to lose your entitlement to coverage as a dependent, you can extend or "continue" your group coverage by paying the sponsoring employer or union for it. There are two separate but very similar sets of rules governing extensions of coverage: federal rules included in the Consolidated Omnibus Budget Reconciliation Act of 1986, or COBRA, and New York State rules on continuation.

Following the lead of many other states, New York enacted continuation rules in 1985, providing six months of additional coverage. The federal government enacted better rules the following year, providing 18, 29, or 36 months of coverage, depending on the circumstances that made you eligible for the extension. In 1992, when New York enacted other major insurance reforms, it improved its continuation rules to match the federal COBRA time limits for coverage.

When does COBRA apply and when does state continuation apply?

COBRA applies to people who work for a private employer (other than a church or a church-sponsored organization) that provides either self-funded or fully insured health coverage, and which typically employed 20 or more employees in the previous year. It also applies to people covered through a plan that includes multiple employer groups, as long as there is at least one employer of the required size. COBRA applies, as well, to state or local government employees, and to people who have coverage through employee organizations (unions). Rules similar to COBRA's apply to federal employees.

New York State continuation applies to people who are covered through insurance policies regulated by the state, and who work for employers with fewer than 20 employees or for churches and church-sponsored organizations, including schools and health care facilities. Due to some conflicting provisions in state law, individuals employed for less than three months may, in rare instances, encounter some resistance to their exercising continuation rights, because of ambiguities in the statute, but should pursue these rights anyway. In essence, state continuation "wraps around" federal COBRA rules, providing the right to extend coverage for certain groups not protected by the federal law. Because the rules of COBRA and New York State continuation are otherwise so similar, we will refer to them both as "COBRA" and discuss them together, but alert you to any differences between the two (look for the tinted "Alert" boxes).

Who qualifies for COBRA?

An employee who has been covered under a health plan for any amount of time qualifies for COBRA if he or she quits, is fired or laid off, or has his or her working hours reduced below the minimum required for coverage. A plan's disqualification of an employee from coverage when the employee becomes eligible for Medicare also triggers COBRA eligibility.

ALERT

COBRA is unavailable to people fired for "gross misconduct." State continuation is available regardless of the reason for a firing. If you are working for an employer who provides a group insurance policy regulated by New York State, you will be entitled to continuation even if you were fired for allegedly gross misconduct.

For dependents, COBRA is available for people whose spouses lose their jobs or hours, or for spouses who get divorced from a covered employee or whose covered-employee spouse dies. Dependent children become eligible for COBRA when the employee through whom they are covered loses his or her coverage, or dies, or when they become too old to be covered as dependents.

ALERT

COBRA does not authorize continuation rights for domestic partners. Although employers are not required to provide coverage for domestic partners, New York law provides continuation rights for domestic partners who are covered as dependents, as long as the dependent relationship continues.

Lay-off, reduction in hours, loss of coverage because an employee becomes eligible for Medicare, death, divorce, legal separation, and a minor's aging out of a parent's group coverage (usually at age 19 for children not attending college, or age 23 for children who do attend college) are all considered "qualifying events." Each person's right to COBRA is individual. All members of a family who were covered together can take COBRA, or just one or two may do so. Thus, some people find that—rather than enrolling everybody in COBRA—it is less expensive to enroll their children in a public program such as Child Health Plus, which can be purchased on a sliding scale depending on income (see page 25), while enrolling the adults in the family in COBRA.

How long can I keep COBRA?

If the reason for the loss of coverage was loss of employment or reduction in hours, COBRA lasts for up to 18 months from the date coverage was lost. If the reason for loss of coverage is loss of dependent status because of divorce, death of the covered employee, or aging out of coverage for dependent children, then coverage can continue for up to 36 months. If a second qualifying event (divorce, or death of the covered employee, for example), that would have entitled the member to 36 months of COBRA occurs during the initial 18-month continuation period, the dependent can add a second 18 months to the initial 18-month period, but the employee cannot.

COBRA provides extra coverage for people who are totally disabled at the time of their qualifying event or who become disabled within 60 days after it. If the Social Security Administration determines that a person became disabled within that period, and the person provides a copy of the Social Security notice to the employer within 60 days of the notice being issued, COBRA can be extended an additional 11 months beyond the initial 18-month period, for a total of 29 months.

Maximum Duration of COBRA Coverage

Eligibility Category	Duration of Coverage
Employee/Family	18 Months
Disabled Employee or Dependent	29 Months
Dependent Child Aging Off Policy	36 Months
Divorced Spouse/Dependents	36 Months
Deceased Employee's Spouse/Dependents	36 Months

What other factors can cause COBRA to end?

COBRA ends when a person who has elected continuation first becomes covered under a new group health plan that does not exclude coverage for his or her pre-existing conditions, or first becomes eligible for coverage under Medicare. If a person was already covered by a second plan or by Medicare before the qualifying event, however, then that other coverage is not a bar to COBRA, and continuation rights can still be exercised.

COBRA can also end if the employer group drops coverage for the whole group, or if the enrollee engages in activities that would justify dropping a regular group member (for example, failing to pay premiums, moving out of the geographic area covered by the health plan, or committing claims fraud).

What if my employer goes bankrupt?
Whether COBRA will be available to you in the event your employer goes bankrupt depends on the circumstances of the bankruptcy and whether your employer seeks special bankruptcy protection under federal laws.

If the employer group simply dissolves and its business is wound up in bankruptcy dissolution or otherwise, the health insurance coverage will, in most cases, cease to exist. There is no policy under which you could continue to get coverage, so your COBRA rights will have no effect. If your employer purchased a group insurance policy in the state of New York, however, then you will have conversion rights (described in the following section). If your employer was self-insured, you will not have any rights, other than as an unsecured creditor with claims for past medical expenses that should have been covered by the plan.

If the employer does not dissolve, but uses the bankruptcy laws to restructure its business, then the law does provide some protections. Certainly, if a health plan continues to exist in a company that is undergoing reorganization, the COBRA rights of former employees continue as well.

Further, the bankruptcy laws give special protections to retiree health plans of companies in Chapter XI, requiring that such companies continue their retiree health plans as a condition of approval of their reorganization plan. If a company in reorganization discontinued its retiree health plan up to a year prior to the filing of the Chapter XI petition or in the context of the bankruptcy, then the filing of the petition is considered a COBRA-qualifying event, giving those who were covered under the retiree plan the right to elect COBRA coverage on the company's regular health plan. In that case, the COBRA right continues for life.

What benefits are covered under COBRA policies?
Your coverage while on COBRA is the same as that of the members who continue in the group. If your employer changes insurers or the benefits on the health plan, your coverage will change along with that of the other group members.

How much does COBRA cost?
During the 18- or 36-month continuation periods, the employer can charge the full cost of the premium, plus a 2% surcharge. The full cost includes the share the employee previously paid plus the share the employer previously paid, which can mean a considerable increase in premium over what the employee paid when actively employed. Generally, out-of-pocket costs incurred toward deductibles and coinsurance while covered as an employee are carried over to the COBRA coverage. Though expensive, most COBRA coverage is still cheaper than the premiums for comprehensive coverage sold to individuals.

Disabled persons who extend their COBRA coverage for the extra 11 months, on top of the initial 18 months, can be charged the full cost plus a 50% surcharge during the additional 11 months.

ALERT

New York laws do not permit the additional 50% surcharge for disabled persons covered by plans with 50 or fewer employees, so disabled individuals electing state continuation from groups of this size can only be charged the 102%-of-premium rate that regular COBRA beneficiaries must pay.

How do I elect COBRA?
Employees, employers, and plan administrators all have responsibilities regarding the election of COBRA. The rules for each party—and your rights and obligations as a plan member—should be written in a Summary Plan Description (SPD), given to you within 90 days of becoming covered by the plan. If you do not have it, you should request the SPD from your employer. If you request the SPD or other plan documents in writing and the employer fails to respond within 30 days, the employer may be penalized up to $110 per day.

If you have a qualifying event that you would know about and your employer would not, such as divorce, legal separation, or your child attaining an age that disqualifies him or her from coverage, you must give your employer notice of that event.

Employers are allowed some flexibility in the rules for electing COBRA, but must meet certain minimum requirements. The employer has to allow you at least 60 days to give notice of any qualifying event of which you have knowledge. If your employment is terminated or your hours reduced, you become eligible for Medicare, or you (as the covered employee) die, or if the employer declares bankruptcy, the employer must notify the plan within 30 days.

Within 14 days of receiving notice of either kind of qualifying event (whether in your personal life or employment), the plan must give you notice of your right to elect COBRA. The notice should give you all the information you need to decide whether to elect COBRA, including the cost of the coverage, and explain how to enroll. The notice must give you at least 60 days from the date of the notice, or 60 days from the end of your coverage, whichever is later, to file your election. You will have at least 45 days from the time you file the election to pay the premiums. The premiums and the coverage will be retroactive to the date of your qualifying event.

How do I pay for COBRA coverage?

Your plan must allow you to pay premiums monthly if you wish, but may also permit other payment options (such as weekly or quarterly premiums). There is no requirement that you be sent periodic premium notices, however. The plan must provide a 30-day grace period after the payment due date, but if the premium is not received within those 30 days then the coverage can be cancelled without any right to reinstatement. Some employers use COBRA service companies to collect premiums, and they can be particularly unforgiving about late payments.

ALERT

State continuation law requires individuals to send their first monthly payment at the same time they elect coverage, and does not provide a 30-day grace period for late premiums.

Update: New Federal Assistance for COBRA Enrollees

If you lost your job involuntarily after September 1, 2008, and were eligible but did not elect to enroll in COBRA, or you did enroll but allowed coverage to lapse or worry about affording the premiums, or if you become eligible for COBRA because of an involuntary loss of employment this year, the American Recovery and Reinvestment Act (ARRA)—the federal stimulus bill enacted in February 2009—may provide premium subsidies and a special COBRA election period for you. Many details won't be known until several federal agencies issue regulations and provide additional guidance, but following are questions and answers on the major components of the new federal rules.

How does the ARRA affect COBRA and state continuation?

The ARRA provides significant premium assistance for some individuals and families who are eligible for COBRA and state continuation due to a job loss. The law also gives certain workers the ability to enroll or re-enroll in COBRA when they had previously declined it or allowed it to lapse, and to switch to a lower-price plan if the employer group offers one to active employees.

Who is eligible for a COBRA premium reduction?

The premium reduction is available for workers and dependents who are eligible for COBRA and meet two tests. First, COBRA eligibility must be triggered by *involuntary termination from employment*. Second, the involuntary termination and accompanying COBRA eligibility *must occur during a "window" beginning September 1, 2008, and ending December 31, 2009*. While the ARRA does not technically base eligibility for premium reductions on household income, the law establishes income thresholds and provides for "recapture" of premium subsidies for higher-income recipients.

Who is ineligible for the premium reduction?
Individuals who were involuntarily terminated from employment outside the ARRA window, or who became COBRA-eligible due to qualifying events unrelated to involuntary termination from employment are not eligible. The latter category includes workers, spouses, and dependents who became eligible and enrolled in COBRA due to death, divorce, aging off of employer-based coverage, voluntary or involuntary reductions in hours, or voluntary termination of employment.

Am I eligible for a premium reduction if I am covered under New York State continuation rather than COBRA?
Yes, in most instances. The ARRA specifically authorizes assistance to individuals covered under state continuation laws "comparable" to COBRA, as long as those individuals meet the criteria for premium assistance.

How does the income threshold in the ARRA work?
The law establishes a threshold for single-filer taxpayers with modified adjusted gross income (MAGI) of $125,000 or less, or $250,000 in the case of a joint return. The IRS is authorized to recapture the premium assistance received by any "high-income individuals" who have income over those thresholds by adding the total amount of subsidy the individual received during the tax year to the income tax liability of the taxpayer for that tax year. A portion of the premium reduction will be recaptured starting at the $125,000/$250,000 threshold, and the complete premium reduction will be recaptured from taxpayers with MAGI of $145,000/$290,000 and above.

Since the nine-month premium reduction may straddle two tax years, some taxpayers may face an additional liability in the 2009 tax year, for example, but may not be subject to recapture of the subsidy in the 2010 tax year, because of a decline in income. Taxpayers who are certain they are not eligible for the subsidy can file a waiver with their former employer permanently declining premium assistance, but you may want to consider the risk that your income could drop and consult with a tax advisor before making this irrevocable election.

How much of a subsidy does the premium reduction provide, and how does it work?
You are responsible for paying 35% of the COBRA premium. Third parties such as relatives, charities, or government agencies are permitted to make the payments on your behalf. The federal government will make up the difference by reducing the payroll taxes owed by the employer group, plan administrator, or insurer that initially covers the remaining 65% of the premium.

How long does the premium reduction last?
Premium assistance ends on the earliest of three dates: 1) nine months after the date the individual began paying the reduced premium; 2) the date the individual's COBRA or continuation coverage ends; or 3) the date the individual becomes eligible for a new group health plan through an employer, or eligible for Medicare.

How does the "eligibility for group coverage" standard work?
Individuals who become eligible for a group health plan while on COBRA (including coverage through a spouse) and who are enrolled in the premium reduction program are required to notify the plan administrator. Group coverage is broadly defined as an arrangement in which medical treatment is provided by an employer, a group of employers, or a union. Eligibility for coverage under a group health reimbursement arrangement, a health flexible spending arrangement, or treatment at an on-site facility maintained by the employer that consists primarily of first-aid services, wellness or similar care, does not count.

For those individuals receiving premium reductions who become eligible for a group health plan, the premium reduction continues through any waiting period in place for new employees and up until the date the new employee is eligible to be covered under that plan. Individuals on COBRA who are receiving a premium reduction but who fail (without reasonable cause) to notify their old employer of eligibility for new group coverage can be assessed penalties of 110% of the amount of the subsidy provided.

Here are some examples of how these cut-off dates for premium assistance work:

Example 1. Jack Doe loses his job on April 1, 2009, and elects COBRA coverage and premium assistance effective that date for himself and his family. The family's subsidy will end on December 31, 2009, even though their COBRA coverage runs through September 1, 2010.

Example 2. Jill Doe was laid off on September 1, 2008, and elected COBRA coverage for herself effective that date. She enrolls in the premium reduction program on April 1, 2009. Her premium assistance would end on December 31, 2009, two months before the end of her COBRA coverage.

Example 3. Jane Doe's hours are cut back to part-time in June 2009, and she loses eligibility for coverage at work and enrolls in COBRA. She is not eligible for premium assistance because her COBRA qualifying event was not the loss of employment. She then quits her job altogether in September 2009. She is still not eligible for premium assistance because her loss of employment was not involuntary.

Example 4. Josh Doe is laid off and enrolls in COBRA coverage and the premium assistance program effective July 1, 2009. He finds a new full-time job with health benefits on September 1, 2009, and, after the employer's 60-day waiting period for new employees is up, becomes eligible for group coverage on November 1, 2009. Even though the new coverage is not as good as the COBRA coverage and requires higher out-of-pocket costs, Josh's COBRA premium assistance ends on November 1, 2009. He can decline the new employer coverage and continue his old COBRA coverage for the balance of the 18-month COBRA period, but must do so at his own expense, without premium assistance.

How do I enroll in the premium reduction program?

The ARRA sets out enrollment rules for two categories of eligible individuals, based on their status on the date the new law was adopted. If you become eligible for COBRA and premium reductions *after* the enactment of the ARRA, your plan administrator must include details on the premium reduction program along with the notices required for COBRA. You can enroll in the premium reduction program by following your plan's instructions on electing COBRA coverage and paying 35% of the premium for the first month's coverage. If you do pay the full premium for the first month, 65% of that must be credited against future premiums or reimbursed to you.

If you were *already* receiving COBRA when the ARRA took effect, plan administrators must notify you of the availability of the premium reduction. If you meet the ARRA standards you'll have 60 days from the date of notification to apply for the premium reduction. If your employer group offers more than one health plan to active workers, you will also be notified of your right to switch to a lower-premium plan, if one is available and the employer group opts to make this offer.

What if I was eligible for COBRA, but turned it down or cancelled it because I couldn't afford it?

Premium assistance rules grant those who lost jobs during the ARRA window, but either did not elect COBRA or allowed elected coverage to lapse, an extended enrollment period to sign up for both COBRA and a premium reduction, as long as they otherwise meet the eligibility requirements. Plan administrators are required to notify individuals eligible for the extension of this new right within 60 days of the enactment of the ARRA, and these individuals have 60 days, from the date they receive notice from their employers, to elect COBRA and a premium reduction. The ARRA's COBRA election extension provisions also require health plans to disregard any lapse in insurance for individuals who did not elect COBRA—from the date they became COBRA-eligible to the date of the enactment of the ARRA—when calculating any pre-existing waiting periods for individuals who subsequently elect coverage.

ALERT

Because of the quick adoption of state legislation in March, employees and dependents covered under New York State continuation law will also be entitled to the ARRA's extended enrollment period and pre-existing condition protections. Workers eligible for the subsidy and the extended enrollment period should receive notice of the availability of these benefits before April 17, 2009.

Is there other financial assistance available for COBRA premiums?

A federal program provides eligible workers with tax credits of up to 65% of the premium for COBRA or for new coverage

that meets federal standards. Known as the **Health Coverage Tax Credit** (HCTC), the tax benefits are generally available under complicated eligibility rules to workers or groups of workers who have lost their jobs due to the impact of global trade patterns, or whose pension benefits have been taken over by the federal Pension Benefit Guaranty Corporation. The ARRA extended the program, increased premium subsidies to 80%, and expanded eligibility.

The tax benefit is refundable, meaning that it applies without regard to a taxpayer's liability, and can be obtained as a refund through a normal annual tax filing or as an advance credit that is remitted directly to an insurer for coverage (see http://www.irs.gov/individuals/article/0,,id=187948,00.html for more information).

New York State has a fund for **entertainment industry** workers who meet income standards ($2,257 per month for an individual, $4,594 for a family of four), and who are eligible for COBRA through their union. The program pays up to 50% of COBRA premiums for up to 12 months (see http://www.ins.state.ny.us/cobra/cobra_entertainment.htm for more information). Assistance with that program can also be found at the Health Insurance Resource Center run by the Actors Fund (http://www.actorsfund.org).

The New York State Health Department administers a program providing assistance toward COBRA premiums for HIV-positive New York residents who meet income, resource, and other requirements. Information on the **ADAP Plus Insurance Continuation** (APIC) program is available at http://www.health.state.ny.us/diseases/aids/about/hlthcare.htm.

Some support organizations for people with specific diseases may help with COBRA payments in emergencies.

What happens when continuation coverage ends?
If you come to the end of your 18- or 36-month continuation period and you have not become eligible for new employer group coverage, a "conversion policy" from the insurer who issued the initial group plan may be an option (see "Conversion Policies," page 17). Other public and private coverage options are discussed beginning on page 22.

If your continuation coverage ends because you've become covered by Medicare, you may only buy special plans to supplement Medicare (known as Medigap or Medicare Supplement plans), Medicare drug plans (Part D), or Medicare Advantage plans (see http://www.medicare.gov/ for more information). If your continuation coverage ends because you become eligible for a new group plan, additional individual coverage is unavailable, except for catastrophic health coverage with very high deductibles, which may be available through your employer or through fraternal societies.

What should I do if I believe I am eligible for COBRA or a COBRA premium reduction but do not receive a notice?
Write to your employer and the insurer asking for your COBRA coverage. If you request continuation coverage and the plan does not think you are eligible for it, it must notify you in writing within 14 days about why it thinks you are ineligible. The notice should explain how to appeal that determination. If you lose the appeal, you may have the right to sue and may want to consult an attorney. The U.S. Department of Labor has now been charged with setting up an expedited appeals system for individuals denied premium assistance under the ARRA.

You can also contact the U.S. Department of Labor for assistance if your employer group is covered by the federal COBRA law, or the New York State Insurance Department if your employer group is subject to New York State continuation requirements. See the "Resources" section beginning on page 27 for more information on filing these kinds of complaints and for other resources that might be helpful.

Conversion Policies Under New York Law

New York's insurance law requires health plans to offer individuals who lose eligibility for employer-sponsored benefits "conversion rights," or the ability to "convert" their group policies to individual policies. Originally enacted nearly 100 years ago for group life insurance coverage, conversion was more recently expanded to include health insurance.

Conversion, which predates COBRA, was once an extremely valuable benefit for consumers because it allowed them to purchase individual policies, regardless of the state of their health, when they lost job-based coverage. COBRA, New York's own insurance reforms (which guarantee issuance of comprehensive, individual policies to all residents without regard to their health), and the limited benefits permitted under some conversion policies make conversion rights relatively less valuable now.

Still, exercising conversion rights—either in place of COBRA or continuation or when those expire—may be a reasonable option for some consumers losing job-based coverage.

Who qualifies for conversion coverage?
Employees who have been covered for at least three months under a fully insured health plan provided by an employer (and their dependents) are eligible for conversion if their eligibility for the employer-sponsored plan is terminated for any reason—including layoffs, death of the employee, or divorce—as long as they are not eligible for other job-based coverage. If the reason for your loss of coverage is divorce from or the death of the covered employee, or you are a dependent minor aging out of the group, the three-month requirement does not apply to you; new dependents can be added to conversion policies at any time. Employees covered under self-insured plans do not have conversion rights.

You will not be eligible for conversion if you are eligible for Medicare or other group coverage, or if you have other individual coverage that is comprehensive enough that you would be considered "overinsured" by having both the conversion policy and the individual policy at the same time. Health plans file overinsurance rules with the State Insurance Department and have broad discretion in applying the rules.

How long does conversion coverage last?
Unlike COBRA or continuation coverage, conversion policies are not time-limited. Lifetime benefit maximums for some types of policies, however, mean that conversion policies may be helpful for only a short period of time for people with serious medical conditions. As is the case with COBRA coverage, termination of conversion coverage can be triggered by actions such as engaging in fraud or failing to pay premiums.

What benefits do conversion policies cover?
Two types of conversion policies are offered, individual (or "direct pay") HMO policies and "statutory conversion" policies. The type of conversion policy you are offered depends on the type of insurance company providing coverage to the group. HMOs will offer one of two kinds of direct pay HMO policies for conversion rights. For-profit insurers licensed under Article 42 of the Insurance Law, which typically provide indemnity or PPO-type coverage (explained below), must offer statutory conversion policies. Non-profit insurers offering HMO coverage through Article 43 of the New York State Insurance Law may offer both kinds of conversion policies.

The two direct pay HMO policies offered as conversion coverage are the same as those HMOs must offer to all individuals in the state; one allows enrollees to obtain care outside of the managed care network for additional cost. Both types of policies offer comprehensive benefits without lifetime maximums and with low out-of-pocket charges (see "Other Coverage Options," page 22, for more information on these plans).

Statutory conversion policies are less common but still offered to some consumers losing group coverage, particularly in cases where the employer group provides indemnity or PPO coverage. (Indemnity plans generally reimburse consumers for medical expenses they have incurred according to a fixed schedule, and do not require the use of network providers. PPO coverage typically allows consumers to see network providers at no or little cost, or be reimbursed according to a schedule for out-of-network care.) The core requirements for statutory conversion benefits have not been updated in decades. Health insurers must meet minimum standards, which provide a menu of four options.

Basic Plans I, II, and III provide varying levels of indemnity coverage for hospital and surgical services, ranging from $130 a day toward 21 days of hospital inpatient costs, and $2,600 in surgical benefits, to $330 per day toward 70 days of hospital inpatient costs, and $3,500 in surgical benefits.

A fourth option, major medical coverage, may be offered as stand-alone coverage or to supplement any of the basic plans by adding coverage for additional days and services and

Minimum Statutory Conversion Policy Benefits

Benefits	Basic Plan I	Basic Plan II	Basic Plan III	Major Medical
Hospital Room and Board	$130 per day up to 21 days	$230 per day up to 30 days	$330 per day up to 70 days	N/A
Hospital Misc. Expenses	$1,300 max. per cause	$2,300 max. per cause	$3,300 max. per cause	N/A
Surgical Expenses	$1,400 max. per cause	$2,400 max. per cause	$3,500 max. per cause	N/A
Combined Benefits	N/A	N/A	N/A	$1,000 annual deductible 80% coinsurance $200,000 max. lifetime or per cause

increasing reimbursement amounts. Health plans are required to offer this major medical option to individuals whose group plan had a major medical level of benefits, and may limit the offering to these group plans. The policies usually carry a lifetime benefit cap of $200,000. Health plans are authorized to offer benefits that exceed the required minimums, including riders covering private duty nursing, stays in skilled nursing facilities, and other services. Some options may cover prescription drug benefits only if the drugs are administered in a hospital setting.

How much do conversion policies cost?

Statutory conversion policy premiums vary according to the health plan and benefits selected. Individual rates for an Empire BlueCross BlueShield conversion policy reviewed earlier this year, for example, ranged from $51 a month for Basic Plan I to $117 monthly for Basic Plan III; major medical coverage could be obtained for an additional $50 in monthly premiums. Individual rates for statutory conversion coverage offered by UnitedHealthcare of New York ranged from $51.50 per month for a Basic I policy to $276 per month for a policy combining basic and major medical benefits.

Rates for individual direct pay HMO coverage are much higher, and vary depending on the region and health plan. The State Insurance Department posts updated rates monthly, for each county, at http://www.ins.state.ny.us/ihmoindx.htm.

How do I exercise conversion rights?

Conversion is a state mandate on health insurers. New York laws require insurers to give employees notice of conversion rights when their employer-based coverage ends, unless the group health insurance contract requires the employer group to provide the notice to workers. Employees are entitled to receive written notice of their conversion privilege from the employer group or the health plan within 15 days after the termination of group coverage. Employees have 45 days after the date of termination to elect conversion coverage and send in the initial premium. If written notice is provided between 16 and 90 days after the termination of group coverage, employees have an additional 45 days to respond, with coverage retroactive to the date of termination.

In a glaring loophole in the law, however, consumers lose the ability to opt for conversion after 90 days, whether or not proper notice has been given by the health plan or the employer. Further, a federal appeals court has determined that employees have no remedy in court if they are not provided with notice when coverage ends, as long as they got information about conversion in their plan materials.

For consumers who don't receive timely notification of conversion rights, the best way to preserve or exercise this option is to look up the conversion information provided in the policy or "certificate" you received from your employer, and request conversion coverage directly from the insurer within 90 days of the date the group coverage ends. Since

health plans are allowed to "outsource" their conversion obligation to other insurers, the insurer providing conversion coverage may be different from the insurer who provided coverage for you through the group health plan.

Is it worth it to buy a statutory conversion policy if I am offered one?
Statutory conversion policies have very limited benefits. Benefits available through a COBRA policy or a direct pay HMO policy will usually offer more financial protection against the medical expenses a family would face in the event of serious illness. Statutory conversion coverage should only be considered if other options are simply unaffordable or unavailable. Even with the limited benefits, however, maintaining coverage under a statutory conversion policy also provides "insurance" against having to pay out of pocket for pre-existing conditions in the future, by averting a 63-day lapse in coverage (see "The 62-Day Limit," page 2).

What should I do if I do not receive an offer of a conversion policy?
Request an offer, in writing, from your employer group and your health plan. If you do not receive the forms to purchase the coverage, you can file a consumer complaint with the state Insurance Department (see "Resources, State Agencies," page 28).

Other Coverage Options

Private Coverage
New York has strong laws guaranteeing state residents the right to purchase comprehensive coverage regardless of their age, sex, occupation, or medical status. Individuals with pre-existing medical conditions cannot be denied coverage, and are entitled to full benefits if they have been covered continuously for one year.

All HMOs in the state must offer two standardized individual HMO policies to state residents. The first option requires that all care be obtained from HMO networks of participating providers. The second, known as a "Point of Service" plan, allows consumers to use out-of-network providers, but for higher premiums and out-of-pocket costs. Both types of policies offer comprehensive coverage with low out-of-pocket costs and full prescription drug benefits. For a fuller description of benefits and a county-by-county list of premium rates for the health plans offering coverage, see www.ins.state.ny.us/ihmoinx.htm.

Empire BlueCross BlueShield (http://www.empireblue.com/home-visitors.html) and GHI (http://www.ghi.com/) sell "hospital only" policies for individuals in some parts of the state at lower rates than for comprehensive coverage. While these types of policies provide year-round benefits for care delivered at hospital facilities, they do not cover doctor visits, many prescription drugs, outpatient diagnostic tests, or primary or preventive care, and may limit coverage to hospitals participating in a network, or vary reimbursement based on a hospital's network status. Excellus Health Plan, in central and western New York (https://www.excellusbcbs.com/wps/portal/xl), also offers limited-benefit coverage to lower-income workers and workers who have lost their jobs; its subsidiary, Univera, offers similar coverage in the Buffalo area (https://www.univerahealthcare.com/wps/portal/uv).

If you work in one of a select number of occupations as an independent contractor, an association policy through the Freelancers Union, www.workingtoday.org, might be another option. If you are the proprietor and sole employee of a small business and a member of the local chamber of commerce, you may be eligible to purchase a small-group policy at a premium no more than 15% higher than small-group rates. For help locating a local chamber, see http://www.canys.org/. The Long Island Association Health Alliance (http://www.liahealthalliance.com/enterprise.htm) and the New York City-based HealthPass (www.healthpass.com) also offer sole-proprietor coverage.

Regardless of income or assets, families can purchase coverage for children under the age of 19 at the full premium charged by health plans under the state's **Child Health Plus** (CHP) program (see page 25 for information on subsidized coverage). Rates vary by health plan and by region, ranging from $105 to $209 per child per month. See http://www.health.state.ny.us/nysdoh/chplus/where_do_i_apply.htm#county for a list of health plans that offer this coverage.

Although individual coverage is customarily provided through a one-year contract, consumers have the right to terminate a policy by notifying the health plan in writing at least 30 days prior to the desired termination date.

Public Coverage

New York State offers a menu of publicly subsidized health care programs for individuals. These programs limit eligibility based on income, and often limit the amount of "resources" or assets (e.g., bank accounts, investments, etc.) a family can hold. Income determinations are based on the income of the entire household, for the month preceding the application for the program. Care is usually provided through Managed Care Organizations (MCOs) that contract with the state to provide the benefits, which are comprehensive and have low cost-sharing. See http://www.health.state.ny.us/health_care/index.htm for information on state health care programs, and http://www.health.state.ny.us/forms/doh-4220all.pdf for applications. Income and resource limits shown are effective April 1, 2009.

For those who recently lost a job, proving that you have either applied for unemployment insurance benefits or are already receiving them will speed the application process. For information on filing an unemployment insurance claim see http://www.labor.state.ny.us/ui/how_to_file_claim.shtm, or call 1.888.209.8124 (for New York State residents) or 1.877-358.5306 (for out-of-state residents) between 8:00 am and 5:00 pm, Monday through Friday.

Low-income families with limited assets may be eligible for **Medicaid**, by far the state's largest health insurance program. Income limits are based on family size and the age of enrollees, and begin at $706 per month for single adults; up to $13,800 in assets are permitted. Higher income limits apply for pregnant women and children, and special allowances are made for individuals with high medical bills or who are receiving SSI (Supplemental Security Income). Medicaid can also provide eligible individuals with assistance with paying their COBRA premiums.

Medicaid is jointly administered by the New York State Department of Health and local governments, with local governments in charge of applications and eligibility determinations. For more information on Medicaid, visit http://www.health.state.ny.us/health_care/medicaid/#. For the location of a local office where you can apply, see http://www.health.state.ny.us/health_care/medicaid/ldss.htm. New York City residents can contact the city's Human Resources Administration at 1.877.472.8411. Services for pregnant women, mothers, and infants are also available through the **Pre-Natal Care Assistance Program** (PCAP); see http://www.health.state.ny.us/nysdoh/perinatal/en/pcap.htm or call 1.800.522.5006.

Family Health Plus (FHP) provides comprehensive managed care coverage for adults between the ages of 19 and 64 with slightly higher incomes than allowed for Medicaid. Income and resource limits range from $903 monthly income/$13,800 in resources, for single adults, to $2,757 monthly income/$26,130 in resources, for a family of four. Enrollees pay no premiums, but may have responsibility for modest co-payments. For information on FHP see http://www.health.state.ny.us/nysdoh/fhplus/. For local help with enrollment see http://www.health.state.ny.us/nysdoh/fhplus/where.htm.

Children under the age of 19 may be eligible for free or subsidized **Child Health Plus** (CHP) coverage offered by most HMOs and Prepaid Health Service Plans. There is no asset test for CHP, and a family of four with a monthly income of $2,939 or less is eligible for free coverage for kids. Families of four earning between $2,940 and $7,350 per month can get coverage for a monthly fee of $9 to $40 per child, with a maximum of $120 per family. Children in families of four earning over $5,513 per month may be subject to a six-month waiting period for coverage if they were enrolled in an employer-sponsored plan prior to CHP. Exceptions to this rule apply in the event of involuntary loss of coverage, such as job loss. For information, see http://www.health.state.ny.us/nysdoh/chplus/what_is_chp.htm. For a list of local groups that can help you enroll your child see http://www.health.state.ny.us/nysdoh/ chplus/where_do_i_apply.htm#comorg.

The **Healthy NY** (HNY) program has the highest income limit of public programs for adults ($2,257 a month for individuals and $4,594 for a family of four) and no asset test. All HMOs are required to offer HNY policies. Premium rates are significantly lower than for individual HMO policies, due to a state subsidy and scaled-back benefits. Mental health services, substance abuse treatment, chiropractic care, and certain types of rehabilitation are not included in the HNY benefit package. The pharmacy benefit, if one is elected, covers generic drugs only, with a $3,000 annual cap and a $100 deductible. See http://www.healthyny.com for more information.

Non-profit **neighborhood health centers** that receive certain kinds of federal funding must provide primary and preventive care services to uninsured patients, at discounted rates based on family size and income. The Community Health Care Association of New York State (CHCANYS), a statewide trade association of health centers, maintains a website with information about its members and the location of health centers across the state (http://www.chcanys.org/).

Hospitals that accept state funding for treating uninsured patients are required to follow minimum standards. While each hospital is permitted to tailor its financial assistance plan somewhat to meet its individual community's needs, minimum standards require, for example, that hospitals provide discounts to uninsured patients within certain income limits, limit interest payments on unpaid bills, and offer agreements to stretch payments out over time. Hospitals are required to post their financial assistance policies prominently in their facilities, and provide written guides on request. For a good summary of the program and a tool to identify the hospital in your area providing financial assistance to uninsured patients, see http://hospitals.nyhealth.gov/psa.php. New York City's Health and Hospitals Corporation (HHC), which runs the city's public hospitals, has one of the better financial assistance policies. For information, see http://www.nyc.gov/html/hhc/downloads/pdf/hhc-options-10-2008-en.pdf.

Resources: Where Can I Go for Help?

Federal Agencies

Federal COBRA laws are overseen by several agencies. The U.S. Departments of Labor and Treasury have jurisdiction over private-sector group health plans. The Department of Health and Human Services administers the continuation coverage law as it affects public-sector health plans. All three agencies publish regulations and guidance on how the law is implemented.

The **Department of Labor**, the main enforcement agency, provides excellent explanatory materials, which can be found on its website; for problems with or questions about your COBRA rights, you can call or write:
U.S. Department of Labor
Employee Benefits Security Administration
Division of Technical Assistance and Inquiries
200 Constitution Avenue NW, Suite N-5619
Washington, DC 20210
Employee Benefits (toll-free): 1.866.444.3272
http://www.dol.gov/ebsa/pdf/cobraemployee.pdf

The **Internal Revenue Service** has regulatory responsibility for important components of COBRA and the ARRA, particularly with regard to interpreting the laws for employers. For information on COBRA and new rules for the premium assistance program, see:
http://www.irs.gov/ newsroom/article/0,,id=204505,00.html

The **Center for Medicare and Medicaid Services** offers information about COBRA for public-sector employees:
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop C1-22-06
Baltimore, MD 21244-1850
1.877.267.2323 x61565

State Agencies

The New York State Insurance Department has regulatory jurisdiction over matters related to state continuation laws (for employer groups with fewer than 20 workers, church-sponsored organizations, and certain others not eligible for COBRA) and conversion policies. You can call the Department's toll-free Consumer Hotline, file consumer complaints online, or write:
Consumer Services Bureau
New York State Insurance Department
25 Beaver Street
New York, NY 10004-2319
Consumer Hotline (toll-free): 1.800.342.3736
http://www.ins.state.ny.us/

The New York State Attorney General's Health Care Bureau also helps New York consumers with health insurance-related problems:
Consumer Health Line (toll-free): 1.800.428.9071

The New York City Managed Care Consumer Assistance Program supports local groups that help consumers navigate the health care system. The Program's website lists participating agencies and provides consumer guides:
Counseling by phone: 1.212.614.5400
http://www.nycmccap.org/index.html

If you have developed a particular medical condition, a non-profit organization serving the needs of people with your condition might be able to help.

In addition to turning to public agencies, you may wish to consult a private attorney. If you are not given notices when required or not given your COBRA rights, courts can award you penalties of up to $110 per day and may require the offending employer or insurer to pay the medical costs you have incurred from being without coverage.

Would You Like an Update?

Decisions by state and federal regulatory agencies and the adoption of the budget in New York State may affect the options discussed here. If you would like to receive an electronic update, please e-mail us at cobra@uhfnyc.org.

The United Hospital Fund is a health services research and philanthropic organization whose mission is to shape positive change in health care for the people of New York. We advance policies and support programs that promote high-quality, patient-centered health care services that are accessible to all; undertake research and policy analysis to improve the financing and delivery of care in hospitals, clinics, nursing homes, and other care settings; raise funds and give grants to examine emerging issues and stimulate innovative new programs; and work collaboratively with civic, professional, and volunteer leaders to identify and realize opportunities for change. Since 1996, the Fund's Health Insurance Project has been documenting the growing problem of New Yorkers without health insurance, and identifying possible solutions.

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