Catastrophic Disability Medical Insurance

Preliminary Report

LEOFF Plan 2 Retirement Board

October 21, 2009

Issue Description

- Members who suffer catastrophic duty-related disabilities may may not be able to afford retiree medical insurance.

Background

- Limited employer sponsored retiree coverage
- Coverage through other programs
- Confusing State/Federal regulations, critical timelines, and providers
- Cost

COBRA

- Continuation of employer health care for 18 months
- Pay 102% of total insurance premium

Extended COBRA

- Continuation coverage extended additional 11 months
- Must meet Social Security disability standard
- Pay 150% of total insurance premium for the additional 11 months

Medicare

- Eligibility
- Disabled – Social Security Standard
- 29 month waiting period

Medicare

- Medicare has
  - Part A – Hospital insurance
  - Part B – Medical insurance
  - Part C – Medicare Advantage
  - Part D – Prescription drug coverage

Medicare

- Medicare Part A premium $443.00 per month; Most people receive at no cost
- Medicare Part B premium; Most people pay $96.40 per month

Option 1

- Reimburse catastrophic disability retirees medical insurance premiums for COBRA and extended COBRA

Option 2

- Reimburse catastrophic disability retirees medical insurance premiums for COBRA, extended COBRA, and Medicare Parts A & B.

Catastrophic Disability Medical Insurance

Questions?

LAW ENFORCEMENT OFFICERS' AND FIRE FIGHTERS' PLAN 2 RETIREMENT BOARD

Catastrophic Disability Retirement Medical Insurance

Preliminary Report

October 21, 2009

1. Issue

Members who suffer catastrophic duty-related disabilities may not be able to afford retiree medical insurance.

2. Staff

Tim Valencia, Senior Research and Policy Manager
(360) 586-2326
tim.valencia@leoff.wa.gov

3. Members Impacted

This issue could affect all members and retirees who are catastrophically disabled in the line of duty.

4. Current Situation

A catastrophic disability benefit is established for a member who is totally disabled in the line of duty. LEOFF Plan 2 may pay a benefit up to 70% of the member's final average salary. Combined benefits from LEOFF Plan 2, Social Security disability, and Workers' Compensation cannot exceed 100% of the member's final average salary. Any amount that exceeds 100% will be offset from the LEOFF Plan 2 benefit.

LEOFF Plan 2 does not provide access to or pay for any health care insurance for any disability retirees. A catastrophic disability retiree should have access to health care insurance through their employer, federal programs, or on the open market.

5. Background Information and Policy Issues

The purpose of a disability retirement benefit is to replace a portion of income for a retiree who cannot work because of a job-related injury or illness, which is expected to be permanent or to last indefinitely. The cost of living for people with disabilities is generally higher than for most due to higher medical costs, paying for disability aids and home adaptations, the cost of transport, help with care and higher costs on day to day living. Extensive medical bills are among the top reasons for personal bankruptcies, accounting for nearly half of all cases filed in the United States.

LEOFF Plan 2 members who are catastrophically disabled may lose employer sponsored health care insurance. According to the 2005 Employer Survey conducted by the Board, only 46.8% of LEOFF 2 members have access to employer sponsored *retiree* medical insurance.

Those without employer-sponsored health care access must rely upon coverage that may be available through Workers' Compensation, COBRA, and Social Security/Medicare. Beyond that, an individual may seek to purchase an individual health care policy or qualify for the State high risk pool.

The varying programs require disabled members, or those assisting them, to navigate a confusing minefield of State/Federal regulations, critical timelines, and providers. Important protections can be lost if appropriate and timely actions are not taken. Additionally, the cost for a catastrophically disabled member to continue medical insurance may be prohibitive.

This report identifies and explains some of the areas of complexity that catastrophically disabled members face in seeking medical insurance and discusses the costs a person may face under the various forms of coverage.

Catastrophic Disability

Legislation enacted in 2006 created the Catastrophic Duty Disability Benefit. This legislation created a disability allowance equal to 70 percent of final average salary, which receives favorable tax treatment and is not actuarially reduced for early retirement, for a LEOFF Plan 2 member who is catastrophically disabled in the course of employment.

The standard for catastrophic disability mirrors the standard used by the Social Security Act, which also governs Medicare. A catastrophic disability is defined as a member's inability to perform any substantial gainful activity due to a physical or mental condition that may be expected to result in death or last for at least 12 months. Substantial gainful activity is defined as average earnings of more than $980 per month (2009), adjusted annually.

The total disability benefit is reduced to the extent that in combination with certain workers' compensation payments and Social Security disability benefits, the disabled member would not receive more than 100 percent of final average salary.

Workers' Compensation Benefits

If a worker is injured on the job and files a workers' compensation claim which is approved, Labor and Industries (L&I) or the Self Insured employer will cover medical bills directly related to the injury. This coverage may continue until a doctor certifies that the injury has stabilized and reached a point where further recovery is not expected. If the member qualifies, they will be awarded a Workers' Compensation disability pension.

Coverage for medical treatment ends on the date that a workers' compensation pension goes into effect. An exception is made in some cases where continued treatment is needed to protect an injured worker's life. If this kind of discretionary coverage is approved, a statement of the coverage limits will be included on the notice of the pension award. There is also no provision in the law for providing medical coverage for dependents through workers' compensation.

If objective medical evidence shows the condition caused by the injury or disease has worsened and requires additional health care attention, the claim may be reopened. If applying for medical coverage only, the request can be made at any time. In most cases, a decision will be made within 90 days.

COBRA Benefits

At the point which medical coverage under Workers' Compensation ends and employer sponsored health insurance coverage ends, COBRA is usually the next step for continuing medical insurance.

COBRA stands for the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, a bill that was passed in 1986, and it amends the Employee Retirement Income Security Act (ERISA), the IRS Code and the Public Health Service Act. COBRA requires that a group health plan must offer every qualified person the opportunity to continue the same coverage they had while an employee or a dependent, after they cease to be one. In most instances, it gives an employee that has been terminated or has voluntarily resigned, the opportunity to continue their existing level of medical coverage.

The actual scope of individuals that are covered is quite broad because COBRA also applies to dependents of employees as well, which can included spouses, children, etc.; but the cost will usually be much higher. The reason for this difference in price is because employers will no longer be paying part of the premium, that financial burden falls entirely on the insured.

Qualification

If an employee experiences a "qualifying event" such as voluntary resignation, the employer's COBRA Administrator will mail a package detailing COBRA rights, how to enroll, and payment information. Usually most former employees are qualified to receive COBRA but here is a clearer list:

1. An employee and his or her dependents that would otherwise lose coverage because of a reduction in scheduled work hours or termination for a reason other than gross misconduct.
2. A spouse and/or children who would lose coverage because of divorce or legal separation.
3. A surviving spouse and/or children who would lose coverage because of death.
4. A spouse and/or children who would lose coverage because of an employee's entitled to Medicare.
5. An employee's child who would lose coverage because they no longer meet the definition of being a dependent.

The list is pretty comprehensive and covers most situations. Unless dismissed because of gross misconduct, an employee and their dependents are likely qualified for COBRA.

Coverage Period
How long a person may continue coverage under their former employer's medical coverage is called a continuation period and this period will differ based on the qualifying event and the specific scenario. The continuation period starts with the qualifying event and not the date COBRA is elected.

If coverage is lost because of termination, retirement, layoff, strike, or reduction in hours, the maximum continuation period is **18 months**. If disabled before or within the first 60 days of COBRA coverage, then the period increases to **29 months** (**Disability Extension**, see next section).

If dependents lose coverage because of divorce, separation, death, loss of dependent status, or because of Medicare entitlement, the maximum continuation period is 36 months. The continuation period may also end for an individual, before the original period of 18, 29, or 36 months if:

1. The qualified person becomes covered by Medicare.
2. The qualified person becomes covered by another group health plan that doesn't contain a pre-existing condition limitation or exclusion, or where the pre-existing condition limitation doesn't apply because there has been enough previous creditable coverage to satisfy the new plan's limitation time period. In non-legal speak, the qualified person, who would otherwise be excluded, isn't.
3. Premium isn't paid.
4. The employers group health plan is terminated, but the continuation period can be completed under a different plan.

Disability Extension[1]
Special rules for disabled individuals and certain family members may entitle them to an 11-month extension of Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

[1] http://www.cms.hhs.gov/COBRAContinuationofCov/06_ExtendedPeriodsofCoverage.asp#TopOfPage; viewed 10/5/09

continuation coverage (from 18 to 29 months). Specifically, if a qualified beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled within the first 60 days of COBRA coverage, then that qualified beneficiary and all of the qualified beneficiaries in his or her family may be able to extend COBRA continuation coverage for up to an additional 11 months[2].

However, qualified beneficiaries may lose all rights to the additional 11 months of coverage if notice of the determination is not provided to the plan administrator within 60 days of the date of the determination (when the determination is issued during the initial 18-month period of COBRA coverage) and before the expiration of the 18-month period. The qualified beneficiary who is disabled or any qualified beneficiaries in his or her family may notify the plan administrator of the determination.

Cost – COBRA and Disability Extention

Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since the employer usually pays a part of the premium for active employees while COBRA participants pay the entire premium themselves. COBRA coverage may be less expensive, though, than individual health coverage.

Premiums for COBRA continuation coverage cannot exceed **102 percent** of the cost to the plan for similarly situated individuals who have not experienced a COBRA qualifying event. The cost to the plan is both the portion paid by employees and any portion paid by the employer before the qualifying event. The COBRA premium can equal 100 percent of that combined amount plus a 2 percent administrative fee.

For example, if the cost of providing health benefits coverage for a similarly situated employee who has not experienced a COBRA qualifying event is $400 per month, $100 of which is paid by the employee and $300 of which is paid by the employer, the plan may charge the individual a COBRA premium of up to $408 per month (102 percent times $400). The employer is not responsible for any portion of the individual's COBRA premium, but may, if it wishes, pay a portion, or all, of the qualified beneficiary's premium.

For qualified beneficiaries receiving the 11-month disability extension of coverage, the premium for those additional months may be increased from 102 percent to **150 percent** of the plan's total cost of coverage as long as the disabled qualified beneficiary participates in the additional coverage.

Using the example above, if the cost of providing health benefits coverage for a similarly situated employee who has not experienced a COBRA qualifying event is $400 per month, $100 of which is paid by the employee and $300 of which is paid by the employer, the plan may charge an individual, under extended COBRA, a premium of up to $600 per month (150

[2] An individual who has been determined under Title II or Title XVI of the Social Security Act to have been disabled before the first day of COBRA continuation coverage, and who has not been determined to be no longer disabled at any time between the date of that disability determination and the first day of COBRA continuation coverage, is considered to be disabled within the first 60 days of COBRA continuation coverage.

percent times $400). Again, the employer is not responsible for any portion of the individual's COBRA premium, but may, if it wishes, pay a portion, or all, of the qualified beneficiary's premium.

COBRA premiums may be increased if the costs to the plan increase for similarly situated non-COBRA beneficiaries, but, for COBRA purposes, such premiums generally must be fixed in advance of each 12-month premium cycle. The plan must allow payment of premiums on a monthly basis but may give the option to make payments at other intervals (for example, weekly or quarterly).

Required Notices

An employee or qualified beneficiary must notify the plan administrator of a qualifying event within 60 days after divorce (or legal separation if that results in loss of plan coverage) or a child's ceasing to be covered as a dependent under the plan's rules. Also, a qualified beneficiary must notify the plan administrator within 60 days of those events when they occur during the initial 18 or 29-month period of coverage in order to qualify for an extension of the coverage period to 36 months.

If a second qualifying event is the death of the covered employee or the covered employee becoming entitled to Medicare benefits, a group health plan may require qualified beneficiaries to notify the plan administrator within 60 days of those events, as well. Ordinarily, the employer is responsible for notifying the plan administrator of an event that is the death of a covered employee or the covered employee becoming entitled to Medicare benefits. However, if the covered employee's employment has been terminated, the employer may not be in a position to be aware of those events. If the plan does not require qualified beneficiaries to notify the plan within 60 days of a second qualifying event, that is the death of the covered employee or the covered employee becoming entitled to Medicare benefits, a qualified beneficiary should provide that notice by the later of the last day of the 18-month period or the date that is 60 days after the date of the second event.

Qualified beneficiaries who wish to take advantage of the 11-month disability extension generally must notify plan administrators of the disabled qualified beneficiary's disability determination under the Social Security Act on a date that is both within 60 days after the date of the disability determination and prior to the expiration of the initial 18-month period of COBRA coverage.

The plan cannot require an individual who receives a disability determination under the Social Security Act before experiencing a COBRA qualifying event (that is the covered employee's termination, or reduction of hours, of employment) to notify the plan of the determination within 60 days of the determination because that requirement expressly applies to a "qualified beneficiary." An individual whose disability determination is issued before the COBRA qualifying event is not a "qualified beneficiary" at the time the disability determination is issued.

If the plan does not specify an alternative 60-day period with respect to a disability determination issued before the qualifying event, the qualified beneficiary is required to notify the plan of the disability determination only within the initial 18-month period of continuation coverage. Qualified beneficiaries also must notify the plan administrator within 30 days after the date of any final determination that a qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act (SSA).

Medicare

A member whose employer does not participate in social security is still eligible for Medicare under age 65 if they pay into Medicare, meet the definition of disability according to Social Security requirements, and are subject to the same exams, reviews and waiting periods as individuals that paid Social Security taxes. A disabled member who has not paid into either Medicare or Social Security may still be eligible[3] to access Medicare Benefits but, if allowed, it would likely be at a higher cost than a person who has paid into Medicare.

There is a 29 month waiting period for Medicare benefits for a disabled member. According to the SSA Program Operations Manual System[4] the employee must serve the equivalent of the 5 month disability cash benefit waiting period and a 24-month D-HI [Hospital Insurance for the Disabled] waiting period. This aligns with the 29 month period that a disabled member would be on COBRA continuation.

Scope of Medicare Benefits

The original Medicare program has two parts: Part A (Hospital Insurance), and Part B (Medical Insurance). Only a few special cases exist where prescription drugs are covered by original Medicare, but as of January 2006, Medicare Part D provides more comprehensive drug coverage. Medicare Advantage plans, also known as Medicare Part C, are another way for beneficiaries to receive their Part A, B and D benefits. All Medicare benefits are subject to medical necessity.

Part A: Hospital Insurance

Part A covers inpatient hospital stays (at least overnight), including semiprivate room, food, tests, and doctor's fees.

Part A covers brief stays for convalescence in a skilled nursing facility if certain criteria are met:

1. A preceding hospital stay must be at least three days, three midnights, not counting the discharge date.
2. The nursing home stay must be for something diagnosed during the hospital stay or for the main cause of hospital stay.

[3] Members continuously employed since prior to April 1986 who have not subsequently fallen under mandatory coverage requirements will not have paid into Medicare. An inquiry has been made to SSA to determine if a disabled member can purchase Medicare benefits.

[4] SSA Program Operations Manual System Section HI 00801.440 (B)(2).

3. If the patient is not receiving rehabilitation but has some other ailment that requires skilled nursing supervision then the nursing home stay would be covered.
4. The care being rendered by the nursing home must be skilled. Medicare part A does not pay for custodial, non-skilled, or long-term care activities, including activities of daily living (ADL) such as personal hygiene, cooking, cleaning, etc.

The maximum length of stay that Medicare Part A will cover in a skilled nursing facility per ailment is 100 days. Many insurance companies have a provision for skilled nursing care in the policies they sell. If a beneficiary uses some portion of their Part A benefit and then goes at least 60 days without receiving facility-based skilled services, the 100-day clock is reset and the person qualifies for a new 100-day benefit period.

The premiums, deductibles, and coinsurance costs for Medicare Part A are outlined in Appendix A, although most people do not pay a monthly Part A premium because they meet the premium free requirements.

Part B: Medical Insurance
Part B medical insurance helps pay for some services and products not covered by Part A, generally on an outpatient basis. Part B is optional and may be deferred if the beneficiary or their spouse is still actively working. There is a lifetime penalty (10% per year) imposed for not enrolling in Part B unless actively working.

Part B coverage includes physician and nursing services, x-rays, laboratory and diagnostic tests, influenza and pneumonia vaccinations, blood transfusions, renal dialysis, outpatient hospital procedures, limited ambulance transportation, immunosuppressive drugs for organ transplant recipients, chemotherapy, hormonal treatments such as Lupron, and other outpatient medical treatments administered in a doctor's office. Medication administration is covered under Part B only if it is administered by the physician during an office visit.

Part B also helps with durable medical equipment (DME), including canes, walkers, wheelchairs, and mobility scooters for those with mobility impairments. Prosthetic devices such as artificial limbs and breast prosthesis following mastectomy, as well as one pair of eyeglasses following cataract surgery, and oxygen for home use are also covered.

The premiums, deductibles, and coinsurance costs for Medicare Part B are outlined in Appendix A.

Part C: Medicare Advantage plans
With the passage of the Balanced Budget Act of 1997, Medicare beneficiaries were given the option to receive their Medicare benefits through private health insurance plans, instead of through the original Medicare plan (Parts A and B). These programs were known as "Medicare+Choice" or "Part C" plans. Pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, "Medicare+Choice" plans were made more attractive to Medicare beneficiaries by the addition of prescription drug coverage and became known as "Medicare Advantage" (MA) plans.

Traditional or 'fee-for-service' Medicare has a standard benefit package that covers medically necessary care members can receive from nearly any hospital or doctor in the country. For people who choose to enroll in a Medicare Advantage health plan, Medicare pays the private health plan a capitated rate, or a set amount, every month for each member. Members typically also pay a monthly premium in addition to the Medicare Part B premium to cover items not covered by traditional Medicare (Parts A & B), such as prescription drugs, dental care, vision care and gym or health club memberships. In exchange for these extra benefits, enrollees may be limited on the providers they can receive services from without paying extra. Typically, the plans have a 'network' of providers that patients can use. Going outside that network may require permission or extra fees.

Medicare Advantage plans are required to offer coverage that meets or exceeds the standards set by the original Medicare program, but they do not have to cover every benefit in the same way. If a plan chooses to pay less than Medicare for some benefits, like skilled nursing facility care, the savings may be passed along to consumers by offering lower copayments for doctor visits. Medicare Advantage plans use a portion of the payments they receive from the government for each enrollee to offer supplemental benefits. Some plans limit their members' annual out-of-pocket spending on medical care, providing insurance against catastrophic costs over $5,000, for example. Many plans offer dental coverage, vision coverage and other services not covered by Medicare Parts A or B, which makes them a good value for the health care dollar, if you want to use the provider included in the plan's network or 'panel' of providers.

Medicare Advantage members receive additional coverage and medical benefits not enjoyed by traditional Medicare members, and savings generated by Medicare Advantage plans may be passed on to beneficiaries to lower their overall health care costs. Other important distinctions between Medicare Advantage and traditional Medicare are that Medicare Advantage health plans encourage preventive care and wellness and closely coordinate patient care. Medicare Advantage Plans that also include Part D prescription drug benefits are known as a Medicare Advantage Prescription Drug plan or a MA-PD.

Each year many individuals disenroll from MA plans. A recent study noted that about 20 percent of enrollees report that their most important reason for leaving was due to problems getting care. There is some evidence that disabled beneficiaries are more likely to experience multiple problems in managed care. Some studies have reported that the older, poorer, and sicker persons have been less satisfied with the care they have received in MA plans.

Part D: Prescription Drug plans

Medicare Part D went into effect on January 1, 2006. Anyone with Part A or B is eligible for Part D. It was made possible by the passage of the Medicare Prescription Drug, Improvement, and Modernization Act. In order to receive this benefit, a person with Medicare must enroll in a stand-alone Prescription Drug Plan (PDP) or Medicare Advantage plan with prescription drug coverage (MA-PD). These plans are approved and regulated by the Medicare program, but are actually designed and administered by private health

insurance companies. Unlike Original Medicare (Part A and B), Part D coverage is not standardized. Plans choose which drugs (or even classes of drugs) they wish to cover, at what level (or tier) they wish to cover it, and are free to choose not to cover some drugs at all. The exception to this is drugs that Medicare specifically excludes from coverage, including but not limited to benzodiazepines, cough suppressant and barbiturates.

Medicare supplement (Medigap) policies
Some people elect to purchase a type of supplemental coverage, called a Medigap plan, to help fill in the holes in Original Medicare (Part A and B). These Medigap insurance policies are standardized by CMS, but are sold and administered by private companies. Some Medigap policies sold before 2006 may include coverage for prescription drugs. Medigap policies sold after the introduction of Medicare Part D on January 1, 2006 are prohibited from covering drugs. Medicare regulations prohibit a Medicare beneficiary from having both a Medicare Advantage Plan and a Medigap Policy. Medigap Policies may only be purchased by beneficiaries that are receiving benefits from Original Medicare (Part A & Part B).

Individual Health Care Coverage

After COBRA coverage is exhausted and even after beginning Medicare coverage, an individual may desire additional coverage and need to shop for an individual medical insurance policy. As pointed out, there may be gaps in Medicare which may be covered by individual medical insurance.

Common concerns under the circumstance of catastrophic disability are the ability to obtain health care coverage in light of certain pre-existing conditions. Both Federal and State laws ensure that individuals, such as catastrophically disabled members, will have reasonable access to health care coverage. The process usually starts with the Standard Health Questionnaire.

Standard Health Questionnaire
Most people buying individual health insurance in Washington state need to complete a standardized health screen questionnaire. This questionnaire identifies eligibility for the Washington State Health Insurance Pool (WSHIP) (Appendix B). If an individual fails the questionnaire, they automatically qualify for WSHIP. Premiums for WSHIP coverage are higher than commercial health plans. However, WSHIP offers some high deductible plan options with lower premiums.

There are several exemptions where the standard health questionnaire does not have to be completed. An individual is *not* required to fill out the health screen questionnaire when applying for individual insurance if they:

- Will exhaust COBRA coverage or will lose it because the former employer closed its business.
- Have 24 months of continuous coverage through a small employer.
- Have moved out of the individual's existing plan's service area within Washington state.

- Are staying with a primary care doctor who left the individual's existing plan.
- Are losing coverage with the state Basic Health Plan and have 24 months of continuous coverage under the plan.
- Have received a notice about the discontinuation of a conversion plan. This is a limited benefit policy an individual may have a right to convert to after their group insurance ends.
- Are adding a newborn or newly adopted or soon-to-be adopted child to the health plan.

In the case where an individual exhausts COBRA coverage and is seeking an individual health benefit plan, the provider ***must*** accept the application for coverage (guaranteed issuance)[5].

Pre-existing Conditions
A "preexisting condition exclusion" is a limitation or exclusion of health benefits based on the fact that a physical or mental condition was present before the first day of coverage. However, the Health Insurance Portability and Accountability Act (HIPAA) (Appendix C) limits the extent to which a plan or issuer can apply a pre-existing condition exclusion.

A pre-existing condition exclusion is limited to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period ending on the enrollment date in a plan or policy.

During the pre-existing condition exclusion period, the plan or issuer may opt not to cover or pay for treatment of a medical condition based on the fact that the condition was present prior to an individual's enrollment date under the new plan or policy. (The plan or insurer must, however, pay for any *unrelated* covered services or conditions that arise once coverage has begun.) The enrollment date is the first day of coverage, or if there is a waiting period before coverage takes effect, the first day of the waiting period.

The HIPAA limitation is usually referred to as "Creditable Coverage" and is discussed in more detail in the next section.

Creditable Coverage
The concept of creditable coverage is that an individual is given credit for previous health coverage against the application of a pre-existing condition exclusion period when moving from one group health plan to another, from a group health plan to an individual policy, or from an individual policy to a group health plan.

An individual will receive credit for previous coverage that occurred *without a break of 63 days or more*. However, any coverage occurring prior to a break in coverage of 63 days or more would not have to be credited against a pre-existing condition exclusion period.

[5] RCW 48.43.018(1)(c)

For example, if an individual had nine months of coverage under a prior plan, an insurance company with a 9 month pre-existing condition exclusion would waive your waiting period. If the individual had four months prior coverage, they would have to wait five months for the new insurance to cover a pre-existing condition.

Most health coverage is creditable coverage, including prior coverage under:

- a group health plan (including a governmental or church plan)
- health insurance coverage (either group or individual)
- Medicare
- Medicaid
- military-sponsored health care program such as CHAMPUS
- a program of the Indian Health Service
- a State high risk pool
- the Federal Employees Health Benefit Program
- a public health plan established or maintained by a State or local government and
- a health benefit plan provided for Peace Corps members.

6. Policy Options

Policy Option 1: Reimburse catastrophic disability retirees medical insurance premiums for COBRA and extended COBRA.

Under this option, LEOFF Plan 2 would provide reimbursement for payment of any medical insurance premiums for COBRA and extended COBRA. The retiree would be responsible for any other medical insurance premiums and costs. This option would include all six (6) Catastrophic Disability retirees that have been approved and any future Catastrophic Disability Retirees.

Policy Option 2: Reimburse catastrophic disability retirees medical insurance premiums for COBRA, extended COBRA, and Medicare Parts A & B.

Under this option, LEOFF Plan 2 would provide reimbursement for payment of any medical insurance premiums for COBRA, extended COBRA, Medicare Part A and Medicare Part B only. The retiree would be responsible for any other medical insurance premiums and costs. This option would include all six (6) Catastrophic Disability retirees that have been approved and any future Catastrophic Disability Retirees.

7. Supporting Information

Appendix A: Medicare Part A & Part B Costs
Appendix B: Washington State Health Insurance Pool
Appendix C: HIPPA – Title 1

Appendix A: Medicare Part A & Part B Costs

Medicare Premiums for 2009:

Part A: Hospital Insurance
Most people do not pay a monthly Part A premium because they or a spouse has 40 or more quarters of Medicare-covered employment.

- The Part A premium is $244.00 per month for people having 30-39 quarters of Medicare-covered employment.
- The Part A premium is $443.00 per month for people who are not otherwise eligible for premium-free hospital insurance and have less than 30 quarters of Medicare-covered employment.

Part B: Medical Insurance

- $96.40 per month

Medicare Deductible and Coinsurance Amounts for 2009:

Part A: Hospital Insurance
For each benefit period Medicare pays all covered costs except the Medicare Part A deductible (2009 = $1,068) during the first 60 days and coinsurance amounts for hospital stays that last beyond 60 days and no more than 150 days.

Cost for each benefit period:

- A total of $1,068 for a hospital stay of 1-60 days.
- $267 per day for days 61-90 of a hospital stay.
- $534 per day for days 91-150 of a hospital stay (Lifetime Reserve Days).
- All costs for each day beyond 150 days

Skilled Nursing Facility Coinsurance

- $133.50 per day for days 21 through 100 each benefit period.

Part B: Medical Insurance
Covers Medicare eligible physician services, outpatient hospital services, certain home health services, durable medical equipment.

- $135.00 per year deductible
- 20% of the Medicare-approved amount for services after meeting the $135.00 deductible.)

Medicare Part A Costs by Covered Services and Items[6]

Blood	If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 pints of blood you get in a calendar year or have the blood donated. In most cases, the hospital gets blood from a blood bank at no charge, and you won't have to pay for it or replace it.
Home Health Care	You pay: $0 for home health care services 20% of the Medicare-approved amount for durable medical equipment
Hospice Care	You pay: • $0 for hospice care • A copayment of up to $5 per prescription for outpatient prescription drugs for pain and symptom management • 5% of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver, so the usual caregiver can rest) • Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home).
Hospital Stay	You pay: $1,068 deductible and no coinsurance for days 1–60 each benefit period $267 per day for days 61–90 each benefit period $534 per "lifetime reserve day" after day 90 each benefit period (up to 60 days over your lifetime) All costs for each day after the lifetime reserve days Inpatient mental health care in a psychiatric hospital limited to 190 days in a lifetime
Skilled Nursing Facility Stay	You pay: $0 for the first 20 days each benefit period $133.50 per day for days 21–100 each benefit period All costs for each day after day 100 in a benefit period

[6] http://www.medicare.gov/publications/pubs/pdf/10050.pdf

Medicare Part B Costs by Covered Services and Items

Part B Deductible	You pay the first $135 yearly for Part B-covered services or items.
Blood	If the provider has to buy blood for you, you must either pay the provider costs for the first 3 pints of blood you get in a calendar year or have the blood donated. In most cases, the provider gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. You pay 20% of the Medicare-approved amount for additional pints of blood you get as an outpatient, and the Part B deductible applies.
Clinical Laboratory Services	You pay $0 for Medicare-approved services.
Home Health Services	You pay $0 for Medicare-approved services. You pay 20% of the Medicare-approved amount for durable medical equipment.
Medical and Other Services	You pay 20% of the Medicare-approved amount for most doctor services (including most doctor services while you are a hospital inpatient), outpatient therapy, most preventive services, and durable medical equipment.
Mental Health Services	You pay 50% for most outpatient mental health care.
Other Covered Services	You pay copayment or coinsurance amounts.
Outpatient Hospital Services	You pay a coinsurance or copayment amount that varies by service for each individual outpatient hospital service. No copayment for a single service can be more than the amount of the Part A hospital deductible ($1,068 in 2009).

Appendix B: Washington State Health Insurance Pool

Washington State Health Insurance Pool (WSHIP)

The Washington State Health Insurance Pool (WSHIP) was created by the Washington State Legislature to provide access to health insurance coverage to all residents of the state who are denied individual health insurance. To be eligible for WSHIP, an individual must be a resident of Washington state; must have been rejected for coverage by an insurance carrier based upon the results of the Standard Health Questionnaire, or live in a Washington state county where individual health benefit plans are not offered; and must not be eligible for Medicare coverage.

WSHIP provides comprehensive coverage, including a prescription drug benefit. WSHIP bases premiums on age and type of plan selected. WSHIP provides some discount rates to people age 50-64 with low income, people continuously insured with their previous plan, and people who have been in WSHIP for more than three years.

WSHIP bases premiums on age and type of plan selected. Premiums for WSHIP coverage are higher than commercial health plans. However, WSHIP offers some high deductible plan options with lower premiums. There are two WSHIP options available for people who are not on Medicare:

- ✓ **The Standard Plan (Plan 1)**, which is fee-for-service, allows individuals to go to the doctor of their choice.
- ✓ **The Network Plan (Plan 3)** uses providers from the First Choice network.

WSHIP also has a separate plan that is only available for people on Medicare (the Basic Plan.) This plan has different eligibility criteria. WSHIP provides some discount rates to people with low income, people continuously insured with their previous plan, and people who have been in WSHIP for more than three years.

Appendix C: HIPPA – Title 1

HIPAA Title I: Health Care Access, Portability, and Renewability[7]

Title I of HIPAA regulates the availability and breadth of group health plans and certain individual health insurance policies. It amended the Employee Retirement Income Security Act, the Public Health Service Act, and the Internal Revenue Code.

Title I also limits restrictions that a group health plan can place on benefits for preexisting conditions. Group health plans may refuse to provide benefits relating to preexisting conditions for a period of 12 months after enrollment in the plan or 18 months in the case of late enrollment.[a] However, individuals may reduce this exclusion period if they had group health plan coverage or health insurance prior to enrolling in the plan. Title I allows individuals to reduce the exclusion period by the amount of time that they had "creditable coverage" prior to enrolling in the plan and after any "significant breaks" in coverage.[b] "Creditable coverage" is defined quite broadly and includes nearly all group and individual health plans, Medicare, and Medicaid.[c] A "significant break" in coverage is defined as any 63 day period without any creditable coverage.[d]

Some health care plans are exempted from Title I requirements, such as long-term health plans and limited-scope plans such as dental or vision plans that are offered separately from the general health plan. However, if such benefits are part of the general health plan, then HIPAA still applies to such benefits. For example, if the new plan offers dental benefits, then it must count creditable continuous coverage under the old health plan towards any of its exclusion periods for dental benefits.

However, an alternate method of calculating creditable continuous coverage is available to the health plan under Title I. That is, 5 categories of health coverage can be considered separately, including dental and vision coverage. Anything not under those 5 categories must use the general calculation (e.g., the beneficiary may be counted with 18 months of general coverage, but only 6 months of dental coverage, because the beneficiary did not have a general health plan that covered dental until 6 months prior to the application date). Unfortunately, since limited-coverage plans are exempt from HIPAA requirements, the odd case exists in which the applicant to a general group health plan cannot obtain certificates of creditable continuous coverage for independent limited-scope plans such as dental to apply towards exclusion periods of the new plan that does include those coverages.

Hidden exclusion periods are not valid under Title I (e.g., "The accident, to be covered, must have occurred while the beneficiary was covered under this exact same health insurance contract." Such clauses must not be acted upon by the health plan and also must be re-written so that they comply with HIPAA.

[7] http://en.wikipedia.org/wiki/HIPAA, 10/7/08

To illustrate, suppose someone enrolls in a group health plan on January 1, 2006. This person had previously been insured from January 1, 2004 until February 1, 2005 and from August 1, 2005 until December 31, 2005. To determine how much coverage can be credited against the exclusion period in the new plan, start at the enrollment date and count backwards until you reach a significant break in coverage. So, the five months of coverage between August 1, 2005 and December 31, 2005 clearly counts against the exclusion period. But the period without insurance between February 1, 2005 and August 1, 2005 is greater than 63 days. Thus, this is a significant break in coverage, and any coverage prior to it cannot be deducted from the exclusion period. So, this person could deduct five months from his or her exclusion period, reducing the exclusion period to seven months. Hence, Title I requires that any preexisting condition begin to be covered on August 1, 2006.

a) 29 U.S.C. § 1181(a)(2)
b) 29 U.S.C. § 1181(a)(3)
c) 29 U.S.C. § 1181(c)(1)
d) 29 U.S.C. § 1181(c)(2)(A)