Catastrophic Disability Retirement Medical Insurance Initial Consideration

LEOFF Plan 2 Retirement Board

October 22, 2008

Overview

- Issue Description
- Health Care Access
- Workers' Compensation
- COBRA
- Individual Health Care Policy

Issue Description

- Members who suffer catastrophic duty-related disabilities may not have access to health care insurance

Health Care Access

- Over 53% of members do not have access to employer sponsored retiree health care insurance

- Coverage through other programs
  - Workers' Compensation
  - COBRA
  - Individual Policy
  - State High Risk Pool

Workers' Compensation

- Medical related to injury covered
- Coverage continues until stabilization or no further recovery expected
- Coverage ends on start date of pension

COBRA

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

- If eligible for Social Security disability, coverage extends out to 29 months
- Pay 150% of total insurance premium for the additional 11 months

Individual Health Care Policy

- Standard Health Questionnaire
  - Exemptions
  - Guaranteed issuance
- Pre-Existing Conditions
- HIPPA/Creditable Coverage

Catastrophic Disability Health Care Insurance

QUESTIONS?

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

Catastrophic Disability Retirement Medical Insurance

Initial Consideration

October 22, 2008

1. Issue

Members who suffer catastrophic duty-related disabilities may not have access to health care insurance.

2. Staff

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3. Members Impacted

For purposes of Senate Bill 5615 in 2005 the Office of the State Actuary estimated that approximately 11 members would have duty-related total disabilities during the first year the benefit is available.

4. Current Situation

A catastrophic disability benefit is established for a member who is totally disabled in the line of duty. The 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. The LEOFF Plan 2 benefit cannot be offset below the member's accrued retirement benefit. LEOFF Plan 2 may pay a benefit up to 70% of final average salary. A member receiving a catastrophic disability benefit will be required to submit necessary financial documents reporting any earnings from employment, payments from Social Security disability and payments from Workers' Compensation.

LEOFF Plan 2 does not provide access to or pay for any health care insurance for any disability retirees. A disability retiree may have access to health care insurance through their employer, union or associations, or the open market. LEOFF Plan 2 does pay for PEBB benefits for survivors of members that were killed in the course of employment.

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 the top reason for personal bankruptcies, accounting for about 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 retirement health care. Those without employer-sponsored health care access must rely upon coverage that may be available through Workers' Compensation and COBRA. After 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. This report identifies and explains some of the areas of complexity that catastrophically disabled members face in seeking health care insurance.

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.

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 $940 per month (2008), adjusted annually based on Federal Social Security standards.

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 given 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 (Consolidated Omnibus Budget Reconciliation Act) is usually the next alternative for continuing health care coverage.

COBRA is a federal law that allows individuals working in companies of 20 or more employees to continue their health insurance benefits for up to 18 months after their employment terminates for any reason, excluding gross misconduct. During the time that an individual is covered by COBRA, they are responsible for paying 102 percent of the total health insurance premium, including any portion of the premium that may have been paid by the employer. If an individual has a Social Security-approved disability (Appendix A) that started within 60 days of when COBRA benefits were elected, the individual is then eligible to use OBRA (see below) to continue health insurance benefits for an additional 11 months, for a total of 29 months.

OBRA

OBRA is a federal law that allows individuals to extend their COBRA coverage for an additional 11 months. Only individuals who elected to use COBRA because of a Social Security approved disability are eligible for OBRA. During the time that an individual is covered by OBRA, they are responsible for paying 150 percent of the total health insurance premium, including any portion of the premium that may have been paid by the employer. If still disabled once OBRA coverage expires, the individual will be eligible for Medicare, which provides health coverage for people who have been disabled for 29 months and are approved for Social Security.

Individual Health Care Coverage

After COBRA coverage is exhausted, an individual may need to shop for individual health care coverage. 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 your 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)[1].

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.

[1] RCW 48.43.018(1)(c)

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.

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. Supporting Information

Appendix A: Social Security Disability and Medicare

Appendix B: Washington State Health Insurance Pool

Appendix C: HIPPA – Title 1

Appendix D: Insurance Commissioner Publications

Appendix A:

Social Security

The Social Security Administration (SSA) oversees two programs that pay disability income benefits to individuals who are legal United States residents, Social Security Disability Insurance (SSDI) and SSI.

Social Security Disability Insurance (SSDI) provides a benefit based on an individual's FICA contributions. This program requires that an individual pay into Social Security for at least 20 of the last 40 quarters (five of the last 10 years) for individuals age 31 or older. SSDI requires a full and unpaid five-month waiting period. Eligibility begins in the sixth month, and payment is received at the beginning of the seventh month to cover the previous month. This program has no asset limits and is solely based on contributions to FICA and medical eligibility.

Supplemental Security Income (SSI) provides a minimum monthly income for those without other resources. To receive SSI an individual must apply for other disability benefits if eligible, such as SSDI. Assets must add up to $2,000 or less. However, assets may include an individual's home as long as they live in it, and may include a car as long as it is valued at or below $4,500. The value of the car can be above $4,500 if it is used to get to and from medical appointments. An individual should apply for SSI as soon as possible after becoming disabled so as to establish an "onset date" and to start an application. Social Security's Definition of Disability is defined as a physical or emotional impairment which is severe enough to keep a person from doing work for a continuous period of not less than 12 months or which can be expected to result in death.

Medicare

Medicare provides health coverage for people who qualify for Social Security. Most people become eligible when they reach the age of 65, or if they have been disabled for 29 months. Medicare covers hospitalization, skilled nursing, home health and hospice care, but requires certain deductibles, premiums and co-payments. If receiving outpatient care, Medicare will cover 80 percent of allowable outpatient medical services after a $100 deductible. The individual is responsible for 20 percent of the charge, regardless of the cost. Medicare does not cover outpatient prescription drugs unless they are administered in a doctor's office or an outpatient clinic. Because of this, many patients choose to enroll in Medicare HMOs or to buy relatively inexpensive private health insurance supplements to reduce their out-of-pocket costs.

Appendix B:

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:

HIPAA Title I: Health Care Access, Portability, and Renewability[2]

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.

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,

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

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)

Appendix D:

Insurance Commissioner Publications

Health Insurance: Frequently Asked Questions
http://www.insurance.wa.gov/publications/health/health_insurance_faq.pdf

Shopping for individual health care coverage
http://www.insurance.wa.gov/publications/health/individual_health_care_coverage.pdf

A consumers guide to health care coverage
http://www.insurance.wa.gov/publications/health/consumers_guide_health_care.pdf

Losing your employer-sponsored health insurance
http://www.insurance.wa.gov/publications/shiba_helpline/Losing_employer_insurance.pdf

Your rights under COBRA
http://www.insurance.wa.gov/publications/health/cobra.pdf