Topic Six: Health Insurance 101 and Long Term Care

1. **What is COBRA continuation health coverage?**
   The Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions amend the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to require group health plans to provide a temporary continuation of group health coverage that otherwise might be terminated.

2. **What does COBRA do?**
   COBRA requires continuation coverage to be offered to covered employees, their spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain specific events. COBRA continuation coverage is often more expensive than the amount that active employees are required to pay for group health coverage, since the employer usually pays part of the cost of employees' coverage and all of that cost can be charged to individuals receiving continuation coverage.

3. **What group health plans are subject to COBRA?**
   The law generally applies to all group health plans maintained by private-sector employers with 20 or more employees, or by state or local governments. The law does not apply to plans sponsored by the Federal Government or by churches and certain church-related organizations. In addition, many states, including Mississippi, have laws similar to COBRA, including those that apply to health insurers of employers with less than 20 employees (sometimes called mini-COBRA). Federal COBRA coverage usually lasts 18 months. In Mississippi, mini-COBRA lasts only 12 months.

4. **Who is entitled to continuation coverage under COBRA?**
   In order to be entitled to elect COBRA continuation coverage, your group health plan must be **covered** by COBRA; a qualifying event must occur; and you must be a **qualified beneficiary** for that event.

   Qualifying Events - Qualifying events are events that cause an individual to lose his or her group health coverage. The type of qualifying event determines who the qualified beneficiaries are for that event and the period of time that a plan must offer continuation coverage. COBRA establishes only the minimum requirements for continuation coverage. A plan may always choose to provide longer periods of continuation coverage.
   The following are qualifying events for covered employees if they cause the covered employee to lose coverage:
   - Termination of the employee's employment for any reason other than gross misconduct; or
   - Reduction in the number of hours of employment.

   The following are qualifying events for the spouse and dependent child of a covered employee if they cause the spouse or dependent child to lose coverage:
   - Termination of the covered employee's employment for any reason other than gross misconduct;
   - Reduction in the hours worked by the covered employee;
   - Covered employee becomes entitled to Medicare;
   - Divorce or legal separation of the spouse from the covered employee; or
   - Death of the covered employee.

In addition to the above, the following is a qualifying event for a dependent child of a covered employee if it causes the child to lose coverage:

- Loss of dependent child status under the plan rules. Under the Affordable Care Act, plans that offer coverage to children on their parent' plan must make the coverage available until the adult child reaches the age of 26.

Qualified Beneficiaries - A qualified beneficiary is an individual covered by a group health plan on the day before a qualifying event occurred that caused him or her to lose coverage. A qualified beneficiary must be a covered employee, the employee's spouse or former spouse, or the employee's dependent child. In certain cases involving the bankruptcy of the employer sponsoring the plan, a retired employee, the retired employee's spouse or former spouse, and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during a period of continuation coverage is automatically considered a qualified beneficiary.

5. How do I become eligible for COBRA continuation coverage?

To be eligible for COBRA coverage, you must have been enrolled in your employer's health plan when you worked and the health plan must continue to be in effect for active employees. COBRA continuation coverage is available upon the occurrence of a qualifying event that would, except for the COBRA continuation coverage, cause an individual to lose his or her health care coverage.

6. How long do I have to elect COBRA coverage?

If you are entitled to elect COBRA coverage, you must be given an election period of at least 60 days (starting on the later of the date you are furnished the election notice or the date you would lose coverage) to choose whether or not to elect continuation coverage. Each of the qualified beneficiaries for a qualifying event may independently elect COBRA coverage. This means that if both you and your spouse are entitled to elect continuation coverage, you each may decide separately whether to do so. The covered employee or spouse must be allowed to elect on behalf of any dependent children or on behalf of all of the qualified beneficiaries. A parent or legal guardian may elect on behalf of a minor child.

7. Under COBRA, what benefits must be covered?

If you elect continuation coverage, the coverage you are given must be identical to the coverage currently available under the plan to similarly situated active employees and their families (generally, this is the same coverage that you had immediately before the qualifying event). You will also be entitled, while receiving continuation coverage, to the same benefits, choices, and services that a similarly situated participant or beneficiary is currently receiving under the plan, such as the right during open enrollment season to choose among available coverage options. You will also be subject to the same rules and limits that would apply to a similarly situated participant or beneficiary, such as copayment requirements, deductibles, and coverage limits. The plan's rules for filing benefit claims and appealing any claims denials also apply. Any change made to the plan's terms that apply to similarly situated active employees and their families will also apply to qualified beneficiaries receiving COBRA continuation coverage. If a child is born to or adopted by a covered employee during a period of continuation coverage, the child is automatically considered to be a qualified beneficiary receiving continuation coverage. You should consult your plan for the rules that apply for adding your child to continuation coverage under those circumstances.

8. **How long does COBRA coverage last?**
   COBRA requires that continuation coverage extend from the date of the qualifying event for a limited period of 18 or 36 months. The length of time depends on the type of qualifying event that gave rise to the COBRA rights. A plan, however, may provide longer periods of coverage beyond the maximum period required by law. When the qualifying event is the covered employee's termination of employment or reduction in hours of employment, qualified beneficiaries are entitled to 18 months of continuation coverage. When the qualifying event is the end of employment or reduction of the employee's hours, and the employee became entitled to Medicare less than 18 months before the qualifying event, COBRA coverage for the employee's spouse and dependents can last until 36 months after the date the employee becomes entitled to Medicare. For example, if a covered employee becomes entitled to Medicare 8 months before the date his/her employment ends (termination of employment is the COBRA qualifying event), coverage for his/her spouse and children would last 28 months (36 months minus 8 months). For more information on how entitlement to Medicare impacts the length of COBRA coverage, contact the Department of Labor's Employee Benefits Security Administration at **askebsa.dol.gov** or by calling 1-866-444-3272. For other qualifying events, qualified beneficiaries must be provided 36 months of continuation coverage.

9. **Can continuation coverage be terminated early for any reason?**
   A group health plan may terminate coverage earlier than the end of the maximum period for any of the following reasons:
   - Premiums are not paid in full on a timely basis;
   - The employer ceases to maintain any group health plan;
   - A qualified beneficiary begins coverage under another group health plan after electing continuation coverage;
   - A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage; or
   - A qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

   If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage. If you decide to terminate your COBRA coverage early, you generally won't be able to get a Marketplace plan outside of the open enrollment period.

10. **Where can I find more information about COBRA?**
    If you have questions concerning COBRA, you may contact the Mississippi Insurance Department at 1-800-562-2957.

Long Term Care

1. **What is long-term care?**
   Long-term care involves a variety of services designed to meet a person's health or personal care needs during a short or long period of time. These services help people live as independently and safely as possible when they can no longer perform many everyday activities on their own.

2. **What types of services does long-term care provide?**
   Long-term services can include:
   - home-based services -- home health care, homemaker services, friendly visitor/companion services, and emergency response systems
   - community-based services -- adult day service programs, senior centers, transportation services, meals programs, and respite care
   - facility-based care -- adult foster care, board and care homes, assisted living facilities, nursing homes, and continuing care retirement communities

3. **Why do people need long-term care?**
   People often need long-term care when they have a serious, ongoing health condition or disability. The need for long-term care can arise suddenly, such as after a heart attack or stroke. Most often, however, it usually develops gradually, as people get older and frailer or as an illness or disability gets worse.

4. **What is the most common type of long-term care?**
   The most common type of long-term care is personal care -- help with everyday activities, also called "activities of daily living." These activities include bathing, dressing, grooming, using the toilet, eating, and moving around -- for example, getting out of bed and into a chair

5. **How long does long-term care last?**
   Long-term care can last a short time or a long time. Short-term care lasts several weeks or a few months while someone is recovering from a sudden illness or injury. For example, a person may get short-term rehabilitation therapy at a nursing facility after hip surgery, then go home.
   Long-term care can also be ongoing, as with someone who is severely disabled from a stroke or who has Alzheimer's disease. Many people can remain at home if they have help from family and friends or paid services. But some people move permanently to a nursing home or other type of facility if their needs can no longer be met at home.

6. **How common is the need for long-term care among older people?**
   About 70 percent of people over age 65 need some type of long-term care during their lifetime. More than 40 percent need care in a nursing home for some period of time.

7. **How can you tell if you will need long-term care?**
   It is difficult to predict how much or what type of long-term care you might need. Several things increase your risk of needing long-term care.
   - Age -- The risk generally increases as you get older.
   - Gender -- Women are at higher risk than men, primarily because they often live longer.
   - Marital status -- Single people are more likely than married people to need care from a paid provider.

- Lifestyle -- Poor diet and exercise habits can increase your risk.
- Health and family history -- These factors also affect risk.

8. **Who provides long-term care in the home?**
   It depends on a person's exact needs. Most home-based care is personal care, such as help with bathing, dressing, and taking medications. Unpaid family members, partners, friends, and neighbors provide most of this type of care. Other types of home-based care, such as skilled nursing care after surgery, are provided by paid professionals, including nurses, home health care aides, therapists, and homemakers.

9. **What kinds of options are available to pay for long-term care?**
   Most people don't have enough money to pay for all long-term care costs on their own, especially ongoing or expensive services like a nursing home. Often, they rely on a combination of resources to pay for care. These may include:
   - personal funds
   - government health insurance programs, such as Medicare and Medicaid
   - private health insurance plans
   - private financing options, such as long-term care insurance, life insurance policies, and reverse mortgages.

10. **Doesn't Medicare cover most long-term care costs?**
    No. Contrary to what many people think, Medicare does not cover most long-term care costs. It does pay for some part-time services for people who are homebound and for short-term skilled nursing care, but it does not cover ongoing personal care at home, like help with bathing. It may cover part of the first 100 days in a nursing home.

11. **If you're perfectly healthy. Why should you think about long-term care?**
    Maybe you will never need long-term care. But an unexpected accident, illness, or injury can change your needs, sometimes suddenly. The best time to think about long-term care is before you need it. Planning for the possibility of long-term care gives you time to learn about services in your community and what they cost. It also allows you to make important decisions while you are still able.

12. **What has the Mississippi Insurance Department seen in connection to LTC Rates?**
    - Over the past several years, MID has received requests for LTC rate increases that range from 5% to 43%.
    - Over the past year, MID has noticed an average rate increase of approximately 24.4%.
    - Our office has what we call a "desk-rule" to review these requests and, if not actuarially justified, we request the companies reduce the amount of their request.

"The information described was supported by Funding Opportunity Number PR-PRP-18-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies."