

## Benefits Assistance Resource Center

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# Understanding Health Coverage Options

## Introduction

For many Social Security beneficiaries accessing employer sponsored benefits is a work incentive that is mostly untapped. Many individuals consider employment as a way to improve their quality of life through increased income. Accessing employer sponsored benefits such as health coverage, short term or long term disability income coverage and life insurance can allow individuals to support their needs as well as those of a spouse and/or dependants. Many employers offer benefits to an individual who has worked for a specified period of time and hours. This paper will focus on accessing employer sponsored health coverage when entering or re-entering the workforce.

Terms and concepts covered in this paper that should be understood when accessing employer sponsored health coverage:

- ◆ Active Work Requirements
- ◆ Service Wait
- ◆ Initial Enrollment Period
- ◆ Open Enrollment Period
- ◆ Special Enrollment Period
- ◆ Pre-Existing Condition(s)
- ◆ Deductibles, Co-payments Co-insurance and Out of Pocket Maximum
- ◆ Types of Health Coverage
- ◆ Pre-Existing Condition(s) Exclusionary Period
- ◆ Reducing a Pre-Existing Condition(s) Exclusionary Period
- ◆ Using Medicaid and Medicare with Employer Sponsored Health Coverage

## Active Work Requirements

Employers usually require an employee to work a minimum number of hours per week to be eligible for employee benefits. This *active work requirement* ranges from 20 to 40 hours per week depending on the employer and health coverage provider.

Introduction .....	1
Active Work Requirements ..	1
Service Wait .....	2
Initial Enrollment Period .....	2
Open Enrollment Period .....	2
Special Enrollment Period ..	3
Pre-Existing Condition .....	3
Deductibles, Co-Payments, and Out of Pocket Maximums .....	3
Types of Health Coverage ...	5
Health Maintenance Organization .....	5
Indemnity Plans .....	6
Preferred Provider Organization Plans .....	7
Point of Service Plans ..	8
Self-Insured Trusts/ Self-Funded Plans .....	9
Pre-Existing Condition .....	10
Pre-Existing Condi- tion(s) Exclusionary Period .....	10
Reducing Pre-Existing Condition Exclu- sionary Periods .....	11
Using Medicaid and Medicare with Employer-Sponsored Health Coverage .....	12
Order of Payers .....	12
High Risk Pools .....	14
Conclusion .....	14
Frequently Asked Questions .....	15
Resources .....	16



Virginia Commonwealth  
University, Rehabilitation  
Research & Training Center  
on Workplace Supports

### Active Work Requirements Example:

Louise accepts a position that provides health coverage that has an *active work requirement* of 30 hours a week. Since the position Louise accepted is 40 hours a week she will meet the *active work requirement* and will be able to enroll in health coverage.

### Service Wait

When an individual accepts employment that offers health coverage they will be required to wait to receive services between one to six months. This period is known as the *service wait*. The *service wait* may be different for each benefit the employer offers.

### Service Wait Example:

Now that Louise has satisfied the *active work requirement* she will have to wait three months before she can use her coverage.

### Initial Enrollment Period

The first time an employer offers health coverage is called the *initial enrollment period*. To be eligible for the *initial enrollment period*, the individual must first meet both the *active work requirement* and *service wait*. Although an individual can enroll in health coverage at a later date, there is only one *initial enrollment period*. Other enrollment periods are called "Open Enrollment Period" or "Open Season".

To avoid being denied coverage through a medical review, known as "proof of good health", individuals should enroll during the *initial enrollment period*. However, if an individual has existing coverage during the *initial enrollment period*, they can avoid a medical review with special enrollment rights offered during a *special enrollment period*. Enrollment after the *initial enrollment period* will automatically trigger an 18-month, *pre-existing conditions exclusionary period*.

### Initial Enrollment Period Example:

The first time Louise's new employer offers health coverage after the *service wait* is her *initial enrollment period*. If Louise declines coverage during the *initial enrollment period*, she will need to wait until the employer offers coverage again - usually referred to as the *open enrollment period*.

### Open Enrollment Period

After the *initial enrollment period* expires, the employer will offer coverage again on a regularly scheduled basis, called an *open enrollment period*. During *open*

*enrollment*, an individual can accept or change health plans. The federal government commonly refers to this as “Open Season”.

If an individual denies coverage during the *initial enrollment period* they will need to undergo a medical review to qualify for coverage. However, an individual can be exempted from a medical review if they qualify for special enrollment rights. If an individual fails to enroll in a plan during the *initial enrollment period* and does not qualify for special enrollment rights, then they are subject to a medical review and can be denied coverage.

#### **Open Enrollment Period Example:**

If Louise elects coverage during the *initial enrollment period* she can use this opportunity to make changes in her coverage. If she denies coverage during the *initial enrollment period* she will be subject to a medical review in order to qualify for coverage during the *open enrollment period*.

#### **Special Enrollment Period**

Individuals with existing health coverage have the option of enrolling in an employers’ plan during a *special enrollment period* without a medical review.

#### **Special Enrollment Period Example:**

If Louise takes a new job with existing group coverage, she does not need to enroll in her new employers’ health plan during the *initial enrollment period*. Instead, Louise can enjoy the benefit of using her current coverage until it expires, after which she can enroll in her employers’ plan without a medical review.

#### **Pre-Existing Condition**

An individual is considered to have a *pre-existing condition* if any medical treatment was received within the past six-months prior to enrollment in that employer’s health plan. Treatment includes being prescribed medications and physician consultations.

#### **Pre-Existing Condition Example:**

Louise has been treated for Type II Diabetes for the past two years. To manage her illness she has been taking several medications. Although she had not seen a doctor for the past 9 months taking these medications is considered treatment and she therefore is considered to have a *pre-existing condition*.

### Example Combining Active Work Requirements, Service Wait, Initial Enrollment Period, Open Enrollment Period, and Pre-Existing Conditions:

Louise accepts a position with an annual salary of \$20,000. One of the benefits offered by her new employer is health coverage through a Preferred Provider Organization (PPO). To manage her Diabetes she takes several medications that cost over \$250 per month. The new employer coverage requires Louise to contribute towards the monthly premium payment and a percentage of the cost of the coverage. Louise was concerned about these additional expenses and chose to decline coverage during the *initial enrollment period* and wait until *open enrollment*. Louise was able to stock up on her medication and did not see a reason to continue her existing coverage under COBRA. This was another reason why she chose to wait until the *open enrollment period* to access the employer's health plan. The human resources representative did not inform Louise about *pre-existing condition(s) exclusionary period* because Louise did not disclose that she had Type II Diabetes.

Louise is now running low on medication and will need to see her doctor in the next two months so she begins to consider enrolling in her employer's health coverage during the upcoming *open enrollment period*. She is surprised to discover that "proof of good health" is a requirement of the employer's health plan and was denied coverage. She did not realize that the insurance provider had every right to deny coverage due to her *pre-existing condition* - Diabetes. Had she enrolled during the *initial enrollment period* she would have been covered. Louise was also unaware that the COBRA coverage she had given up could have reduced or eliminated the *pre-existing condition(s) exclusionary period* if she had enrolled during the *initial enrollment period*. As a result, Louise begins looking for another job, not because she dislikes the one she has, but because she needs to find a new employer who offers health coverage.

### Deductibles, Co-Payments, Co-insurance and Out of Pocket Maximums

A *deductible* is the amount of money an individual is responsible for paying prior to the health plan's contribution to coverage. The percentage of a bill that the individual pays is called a *co-payment*. The percentage of a medical bill that the health plan pays for is *co-insurance*. *Out of pocket maximum* is the maximum amount an individual pays for health care services in a calendar year before the insurer begins to pay for services at 100%.

### Deductibles, Co-payment, Co-insurance, and Out-of-Pocket Maximum Example:

Alex has hardly been sick in his life and never spent time in the hospital. Last December Alex broke his leg skiing and was rushed to the local hospital. The break was so bad that surgery was required. Afterwards he endured several months of physical therapy. The bill for the hospital stay, surgery and physical therapy amounted to \$60,000.

Because Alex had rarely been ill, he hadn't yet used his health coverage and therefore had not paid the required *deductible*.

To receive coverage for the hospital stay and surgery Alex was responsible for :

- ◆ \$500 of his medical bills (*deductible*).
- ◆ 20% of the remaining medical expenses up to the *out of pocket maximum* of \$2,000.
- ◆ The insurance provider then covers 80% of the remainder of the *bills (co-insurance)* to the out of pocket maximum (*co-insurance*)
- ◆ 100% after the *deductible* and *out of pocket maximum* have been met the total expenses Alex will have during any calendar year will be \$2,500 (*co-payment*).

\$500	+	\$2,000	=	\$2,500
Deductible	+	Out of Pocket Maximum	=	Total Cost to Alex

## Types of Health Coverage

Many individuals with disabilities use Medicaid or Medicare. Medicaid is administered by each state and can vary in the type of services offered to recipients. Medicare, on the other hand, is a federal program that provides hospital and medical services to Social Security beneficiaries.

Employers may choose to provide a variety of private health plans. Each type provides coverage in different ways with advantages and disadvantages. An issue to consider is the cost associated with the coverage. Although some coverage will enable an individual to have greater access to medical providers, the individual must be able to afford the cost associated with this choice.

Individual policies are available based on medical review, known as “proof of good health”. Usually, individual policies are available for individuals who have not had any medical treatment for a potentially disabling medical condition during the past 10 years or more. This includes prescription drugs and physician consultations.

## Health Maintenance Organization (HMO)

HMO plans contract with a specific list or panel of medical providers that individuals are required to use. As a member of an HMO, individuals are assigned a primary care physician who is responsible for coordinating their care. If an individual requires a specialist, a referral from the primary care physician is mandatory. As long as an individual sees a doctor within the HMO network, only a small *co-payment* is charged per visit (generally ranging from \$5 to \$25). Most other costs are covered by the plan.

There are no *deductibles* or claim forms when care is received within the plan. If an individual wants to see a medical provider outside of the HMO network for a second opinion or other medical care, a written authorization from the HMO is required. Without authorization, the HMO will not cover the cost of the visit. The authorization process may take up to one week.

If an individual's request to receive a particular treatment or to see a specialist outside of the plan is denied an appeal can be filed.

### HMO Example:

Allen has been living with HIV/AIDS for 20 years. During that time, he has seen the same physician. He is about to accept a new position offering a different HMO that does not include his current physician. Allen is now left with the task of finding a new physician if he enrolls in his employer's health plan. Fortunately, Allen's current physician refers him to a new physician that is in his employer's HMO. Allen is made aware that if he needs a second opinion from his previous doctor it would require written authorization from the new HMO.

### Indemnity Plans

Indemnity plans allow individuals to choose any doctor or hospital. These plans typically have a *deductible* that must be paid before the plan pays for any medical expenses.

Once the *deductible* has been met, the health plan will pay a percentage of the medical expenses, usually between 70% to 80%, known as *co-insurance*.

As indemnity plans vary greatly, individuals must satisfy the requirements of the plan as it relates to them. Once the annual *out of pocket maximum* has been met, the plan will pay 100% of covered expenses for the remainder of the year. If, for example, the *out of pocket maximum* is \$3,000 annually, the insurance plan will pay 100% of an individual's claim for that year after the *out of pocket maximum* has been met.

### Indemnity Plan Example:

Jean manages a branch of a large banking institution on the west coast. Her husband, Roy, has a part-time position with a big box retailer. The retailer however, does not offer benefits to part-time employees. Roy has been trying to negotiate full-time employment so that he can access his employer's benefits package, but has been unsuccessful. Roy is currently covered by Jean's policy so the lack of his own health coverage is not critical. However, one afternoon Roy experiences chest pains and shortness of breath and is rushed to the emergency room. Preliminary tests show he needs immediate quadruple by-pass surgery to prevent a massive heart attack. He and Jean do not hesitate to agree to the surgery. There is a long period of convalescence and the extra income Roy was bringing in is gone. In addition, he requires a great deal of rehabilitative treatment. He and Jean proceed with the physician's treatment plan unconcerned until they begin to receive medical bills. They realize they have a huge patient liability to pay before the insurance company will cover the cost of medical treatment.

The patient liability is as follows:

- ◆ \$1,000 annual *deductible* for their family. Only \$250 of the *deductible* had been paid prior to Roy's surgery. That leaves \$750 to be paid.
- ◆ A 30% *co-payment* required for all hospitalization and surgical procedures.
- ◆ A 25% *co-payment* required for all outpatient treatment and office visits.



Even with the quality insurance product Jean's employer provides, catastrophic situations like this can easily amount to tens of thousands of dollars that the patient is obligated to pay. Fortunately Jean's policy has an *out of pocket maximum* that caps or limits the patient's financial responsibility to \$3,000 per year after they meet the \$1,000 annual deductible totaling \$4,000. So, although the ultimate cost of Roy's by-pass surgery was well above \$250,000, he and Jean were only responsible for \$3,750.

## Preferred Provider Organization (PPO) Plans

PPO plans contract with a specific list of medical providers. Members have the option of using physicians who are not in the PPO network at a higher cost. When individuals see a doctor who is in the network, the PPO will pay between 80% to 100% of the medical bills once the annual *deductible* is met. When medical care is received outside of the network, the plan requires that individuals pay a higher *deductible* and/or *co-payment*.

Although many plans require individuals to pay a *co-payment*, once the annual *out-of-pocket maximum* is met, the plan pays 100% of covered expenses for the remainder of the year. If, for example, the *out-of-pocket maximum* is \$2,000 annually, the insurance plan will pay 100% of an individual's claims after the *out-of-pocket maximum* has been met.

### PPO Example:

Melanie and Jeff recently had a baby named Jerrod. They chose the finest maternity hospital in the city and Melanie's pre-natal care has been provided by the best doctor they could find. They were expecting the cost of her pre-natal care, her stay in the hospital and birth to be covered once the *deductible* and *co-payments* were met up to the *out of pocket maximum*.

Their PPO providers was as follows:

- ◆ *Deductible* \$500
- ◆ *Co-payment* 20%
- ◆ *Out of pocket maximum* of \$2,000

Their total annual cost within PPO is \$2,500

Melanie and Jeff believed the total would be \$2,500, but they were surprised to find out that their bills totaled \$3,800.

What they discovered was that although all the providers they chose accepted their coverage, they were all outside of the Preferred Provider Organization (PPO). They did not consider that this choice would increase their *deductible* to \$800, *co-payments* to 30% and the *out of pocket maximum* to \$3,000. Although Melanie and Jeff had not anticipated these extra expenses they understood the increased access to additional providers would be a more expensive option and were satisfied with their decision.

Their coverage with non PPO providers was as follows:

- ◆ *Deductible* \$800
- ◆ *Co-payment* 20%
- ◆ *Out of pocket maximum* of \$3,000

Their total annual cost within PPO is \$3,800

## Point of Service (POS) Plans

A POS plan is the most versatile type of plan and provides two to three tiers (points) of coverage. As members of a POS plan, individuals can move between these different tiers of coverage each time care is received.

**Tier 1:** Tier 1 functions the same way as managed care. If an individual chooses to receive care through a primary care physician, they will be responsible for only a small *co-payment* and no annual *deductible*. The primary care physician can refer the individual to other specialists within the network.

### Tier 1 Example:

Joan and Steven's child, Emily, has caught a cold. Steven is a stay-at-home Dad who telecommutes to work while taking care of the children. Steven feels that if Emily stays home from school her cold will heal on its own. After three days, however, Emily develops a persistent cough and fever. Fearing that Emily might have bronchitis or pneumonia, Steven takes her to the doctor and is told she has an infection that can be treated with antibiotics.

Steven leaves with Emily and a prescription and in a few days Emily is her old self. The *co-payment* for the doctor's visit was \$15.00. The *co-payment* for the antibiotic was \$10.00

**Tier 2:** Tier 2 functions similarly to a Preferred Provider Organization (PPO). Individuals can self-refer to any provider within the network. The insurance will pay a certain percentage of the medical fee while the member covers the remaining fees. Individuals are responsible for an annual *deductible* and *co-payments*. If, for example, the *out of pocket maximum* is \$2,000, the insurance plan will pay 100% of an individual's claim once this amount has been paid.

### Tier 2 Example:

Joan has had breast cancer and is in remission. It is very important for her to see specialists without having to be referred by her primary care provider. She can choose to do this through the Tier 2 part of her POS plan as long as her specialists are included in the list of approved providers. When using this option Joan is responsible for a \$500 annual *deductible* and a 20% *co-payment* for all office visits. If she sees a specialist once ever three months, her average *co-payment* for each visit would be around \$25.

For all other medical treatment Joan opts for Tier 1 services using her family primary care provider who is in the network. This way she feels she has the most options available to her.

**Tier 3:** Tier 3 functions comparably to an indemnity plan. Individuals can self-refer to a provider of their choice outside of the network. The insurer pays a



lower percentage of the medical bill than paid in Tier 2. Individuals will be responsible for a higher annual *deductible* and *co-payment* than that of Tier 2. Although many plans require individuals to pay a *co-insurance*, sometimes referred to as a *co-payment*, individuals are required to pay this percentage only until the annual *out of pocket maximum* has been met. If, for example, the *out of pocket maximum* is \$3000, the insurance plan will pay 100% of an individual's claim for that year once this amount has been paid.

### **Tier 3 Example:**


In September Joan's oncologist falls ill and discontinues her practice. All of her patients, including Joan, have been referred to a doctor who is not a part of the preferred provider list of Tier 2. Joan's faith in the previous doctor's recommendation encourages her to use the Tier 3 coverage in her plan to see the new oncologist in spite of the potential increase in annual costs. Joan learns that to use Tier 3 the annual *deductible* is \$600, the *co-payments* are 30% and there is an *out of pocket maximum* is \$3,000. She is relieved to know that the total annual cost to use Tier 3 is \$3,600. With her family's ability to choose amongst the three tiers for services applicable to each individual's medical needs, the system is ideal.

## **Self-Insured Trusts/Self-Funded Plans**

These are plans in which a large company or union covers an individuals' medical expenses with funds set aside to pay claims. Since this type of coverage is less regulated, there is a great deal of variation among the policies. If individuals are members of a self-insured trust, they should thoroughly review the benefits to determine what is covered. For most self-insured plans, benefits for *pre-existing conditions* are limited severely during the first year of coverage unless, the individual has had prior creditable coverage.

### **Self-Insured Trusts/Self-Funded Plans Example:**

Samantha's company is bought by a major corporation. Samantha has been a loyal employee of the company for nearly 30 years. In the last 10 she began to develop symptoms of Multiple Sclerosis (MS). Because of treatments and medication, she has been able to maintain her position with the company and a comfortable lifestyle. When the company changed hands, Samantha was offered the opportunity to access the new companies' HMO similar to the one she was on or a Self-Insured Trust. Samantha chose the Self-Insured Trust because it offered more choice to providers that she had previously had access to in her previous HMO. However, this coverage would now require *deductibles* and *co-payments* up to the *out of pocket maximum*. She did not have to concern herself about any *pre-existing condition(s)* *exclusionary period* because she had prior creditable coverage.



## Pre-Existing Condition

An individual or family member is considered to have a *pre-existing condition* if any medical treatment was received within the past six-months. This includes prescription medication and physician consultations.

### Pre-Existing Condition Example:

Leon has been suffering from chronic heartburn for nearly six months. During a physical exam he mentions this to his doctor who prescribes a medication that, if taken on a daily basis, will eliminate acid reflux.

It is now early summer. Leon is changing jobs and has taken a 3 month sabbatical before starting a new position early the following autumn. Leon spends the summer overseas and reports to work in mid-September. The new job is going well and Leon is beyond his probationary period and is now a permanent employee. When he begins to use his new Preferred Provider Organization (PPO) he discovers due to his original diagnosis and treatment of acid reflux within the past six months he is considered to have a *pre-existing condition* and his medications is therefore not covered.

### Pre-Existing Condition(s) Exclusionary Period

When an individual has a *pre-existing condition* they will have a specified time period when coverage for that condition is either not provided or, in some cases, limited. That time period can be for up to 12 months. A *pre-existing condition(s) exclusionary period* varies by the type of health coverage and the state.

### Pre-Existing Condition(s) Exclusionary Example:

Although Leon discovered he has a *pre-existing condition* that will not be covered, he learns that this will be temporary. It is explained to him that group health coverage can designate certain periods of time that a *pre-existing condition* does not have to be covered and after that time the condition has to be covered. Leon is comforted to find out that any and all other medical conditions have to be covered because he enrolled during the *initial enrollment period*. This gives him the security to know that if anything else were to happen he would be covered. He learns that the maximum *pre-existing condition(s) exclusionary period* nationally is 12 months and is pleased to find out that in his state, a *pre-existing condition(s) exclusionary period* for PPO is six months.

Leon's heartburn returns in the next couple of months and the medication he has been taking now seems to be losing its effect. The doctor orders a CT scan and discovers a small tumor in Leon's esophagus. The doctor is not certain if it is cancerous, but recommends immediate surgery to biopsy and remove the tumor. After the surgery is over Leon is relieved to learn that the tumor was benign. He was also pleased to know that his employer's PPO covered the operation because it occurred after the *pre-existing condition(s) exclusionary period*.

## Reducing Pre-Existing Condition Exclusionary Periods

The Health Insurance Portability and Accountability Act (HIPAA) can reduce or eliminate *pre-existing condition(s) exclusionary periods*. HIPAA is federal law that contains health coverage protections for individuals with disabilities and pre-existing condition(s) who work or change jobs, as well as other important provisions on health care accountability and reporting. Title I of HIPAA passed in 1996. This federal law has been in effect since July 1, 1997. The provisions of this law that are being discussed in this paper relate to using previous health coverage, or creditable coverage, to *reduce pre-existing condition(s) exclusionary periods*.

HIPAA creates access to employer-sponsored and other group health coverage for employees and family members who have a *pre-existing condition*. The federal law defines a *pre-existing condition* as one that individuals received medical treatment for within the past six months. This includes prescription medications and physician consultations. Group coverage can exclude treatment for *pre-existing conditions* for certain periods of time, referred to as *pre-existing condition(s) exclusionary periods*.

HIPAA states that no group health coverage (such as employer sponsored or association affiliated) may have more than a 12-month period when *pre-existing conditions* are not covered. When enrolling in group coverage, any previous creditable health coverage (public, individual or group) can be used to reduce the length of any *pre-existing condition(s) exclusionary period* if the gap between old and new coverage is 63 days or less.

Review of the essentials of this provision:

- ◆ The length of the reduction of any *pre-existing condition(s) exclusionary period* for new health coverage is based on prior months of credit from previous enrollment in health coverage.
- ◆ Medicaid and Medicare are included as types of previous creditable health coverage.
- ◆ The months of credit are counted in full months. For example, 6 months of prior coverage will reduce an exclusionary period by 6 months.
- ◆ The gap between old and new coverage must be less than 63 days.
- ◆ HIPAA only applies to group coverage, not individual policies. However, prior coverage by an individual policy can count as creditable coverage only when changing to group coverage.

### HIPPA Example:

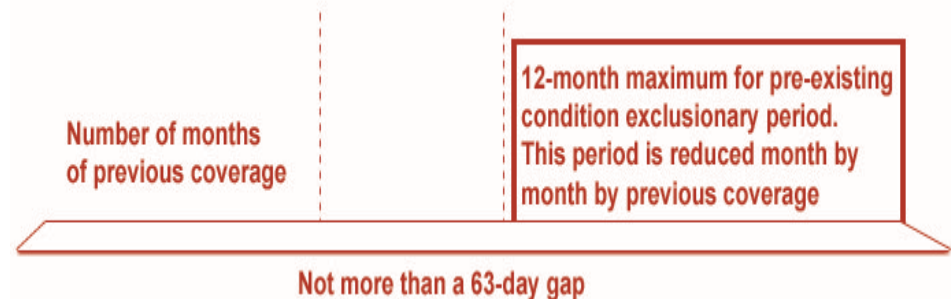
Although Elizabeth has been sought by head hunters for positions that would pay her considerably more money, she has turned down every offer due to a bout of depression that has been manageable for several years now. She in no way wants to jeopardize her health coverage by being denied treatment for a *pre-existing condition* should her depression worsen and not respond to treatment.

(continued)

According to her benefits planner she spoke with, however, there is a provision in the HIPPA law that waives *pre-existing conditions* as long as she elects new group coverage within 63 days of prior coverage. Armed with this new information she is now able to take a new position. Taking this job will increase her salary, change her career prospects, and provide her with superior health coverage. With this new coverage she will be able to continue to see her psychiatrist without an interruption in treatment.

HIPAA reduces and may eliminate *pre-existing condition(s) exclusionary periods* for all group health coverage such as Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Point of Service (POS), Indemnity Plans, and Self-Insured Trusts.

**Figure 1: HIPAA**



## Using Medicaid and Medicare with Employer-Sponsored Health Coverage

Private employer-sponsored coverage can be used in conjunction with Medicaid and Medicare. Adding private health coverage can expand access to providers and extend benefits to family members. Unfortunately, most individuals believe that use or eligibility of private health coverage will make them ineligible for Medicaid or Medicare. As a result, many deny themselves access to employer sponsored health coverage. It is important to inform current and new providers of multiple types of health coverage to insure proper billing and to avoid patient liability.

### Order of Payers

When an individual is eligible for Medicaid and private health coverage simultaneously the private coverage becomes primary (pays first) and Medicaid becomes secondary.

When an individual is eligible for Medicare and private health coverage simultaneously the private coverage becomes primary (pays first) and Medicare becomes secondary. However, Medicare only pays the difference between the employer coverage and the cost of the covered expense up to what Medicare would usually pay for the covered expense.

If employment ceases and the individual uses COBRA or retiree coverage with Medicare, then Medicare is the primary payer.

If an individual is eligible for Medicaid, Medicare and private health coverage then the order is as follows: private insurer, Medicare, and finally Medicaid.

Social Security Disability Insurance beneficiaries have eight months after employer coverage stops, regardless of COBRA, to enroll in Medicare Part B without a penalty.

**Note:** Employers with fewer than 20 employees are not required to provide primary health coverage to individuals older than 65. If the employer chooses to provide coverage to this group, then Medicare is the primary payment source.

### Example of Using Medicare with Employer-Sponsored Health Coverage

Gus has been working for the same small company for 40 years. He enjoys his work, likes his employer and at age 70 has no intention of retiring. In addition to his employer's health insurance, he has Medicare. Gus had an emergency appendectomy two weeks shy of his 71st birthday. He was admitted to the hospital and the surgery was performed. Instead of billing his primary insurer, Medicare paid for the majority of the surgery and hospital stay. Since Gus received coverage from a small employer (under 100 employees) Medicare covered the surgery as the primary payer with the private coverage becoming secondary.

### Example of Using Medicaid with Employer-Sponsored Health Coverage

Michael was a Supplemental Security Income recipient who is now working making \$10,000 annually and is enrolled in his employer sponsored health coverage with *deductible* and *co-payments*. He is also still eligible for 1619 (b) (see 1619(b) briefing paper) continuation of his Medicaid.

Michael has been receiving bills for lab work and consultations that he believed had been paid for so he calls the lab and asks to speak to the billing department and asks why he's being billed. The lab representative answers that he is being billed *for co-payments* that his primary insurer requires. He says he understands — though he doesn't — and calls his primary care physician's office and asks to speak the billing department there. Again he questions the bill. After a moment the billing representative agrees with him and assures him that the lab and the physician's office will be reminded that not only does he have private insurance but also Medicaid that will take care of any *co-payments* that may be billed to him.

He is relieved until the following month when he receives a bill from the same lab. He angrily tears into the envelope and yanks out the bill. His concerns are immediately alleviated when he sees the figure at the bottom of the bill next to the words BALANCE DUE: \$0.

Some things to consider when combining Medicaid and/or Medicare with Employer Sponsored Health Coverage:

- ◆ Enrolling in employer sponsored coverage at the right time to avoid a medical review is critical.
- ◆ Determining whether the employers' plan will cover current physician(s) and specialists.
- ◆ Informing new health insurance carrier of Medicare eligibility to establish payment order and avoid patient liability.
- ◆ Taking into account special provisions for continued Medicaid and Medicare coverage while working (see Medicare paper and 1619(b) provisions).

## High Risk Pools

Often times an individual does not qualify for Medicaid or Medicare nor has access to employer sponsored coverage. This leaves the individual with relying on purchasing an individual health insurance policy. Individual policies can deny coverage based on *pre-existing condition(s)* leaving many people uninsured. As a result, many states offer coverage through "high-risk pools." Coverage offered through high-risk pools vary greatly from state to state. Waiting lists, time limits and annual and lifetime caps are common. Although there may be restrictions, high-risk pools can be attractive for individuals who are self-employed and lack access to any other type of health coverage.

### High-Risk Pool Example:

John owns a small antique shop. He is the only employee and thus is not eligible for employer group coverage. John has diligently researched the health insurance market for individual policies and has found that he does not qualify for coverage due to a *pre-existing condition*. Through a friend, John finds out that he may qualify for insurance through his states' high-risk pool. Although he has to wait for 30 days to access a policy, he has 4 different choices in health plans. However, under these plans there are limitations including an annual cap of \$50,000 and lifetime cap of \$500,000. Also, John would only be able to use health insurance through the high-risk pool for two years. So, John would need to invest in health coverage in the future.

## Conclusion

Knowledge about the interface between employer-sponsored health insurance and public benefits allows individuals with disabilities to choose to work without worrying about the impact on their benefits. Blending public and private, employer-sponsored benefits enables individuals to maximize benefits coverage. This empowers individuals with disabilities to choose the best combination of benefits with or without work.



## Frequently Asked Questions

### In general, how does private health coverage work?

When Social Security beneficiaries are able to access employer benefits, such as private health coverage, they increase their ability to access more providers and services that may not have been made available previously. In 2006, this will be even more important with the new Medicare drug law in effect. Private health coverage may assist dually eligible beneficiaries in meeting their prescription needs.

### What is a pre-existing condition?

A *pre-existing condition* is any condition that has been treated within the past six months. Treatment includes prescription medication and physician consultations.

### When is the best time to enroll in employer health coverage if you have a pre-existing condition?

When Social Security beneficiaries are able to access employer benefits, such as private health coverage, they increase their ability to access more providers and services that may not have been made available previously. In 2006, this will be even more important with the new Medicare drug law in effect. Private health coverage may assist dually eligible beneficiaries in meeting their prescription needs.

### What do insurers consider prior creditable coverage?

Creditable coverage includes Medicaid, Medicare and private health insurance (group or individual policies). You can use prior health coverage, month for month, to reduce or eliminate a *pre-existing condition exclusionary period* as long as the gap between creditable coverage and new coverage is not greater than 63 days.

### How does private health insurance apply to Benefits Planning Assistance and Outreach (BPAO) and Protection and Advocacy (P&A) activities?

It is important for benefits planners and Protection & Advocacy to understand how employer sponsored or association affiliated group coverage is an untapped incentive for working Social Security beneficiaries. Family members may also benefit from a beneficiaries' health coverage if spousal and/or dependant coverage is offered. In some states premium costs can be paid by Medicaid. Access to private health insurance can increase the incentive for employment by increasing not only income, but benefits as well.

## Resources

Kaiser Family Foundation <http://www.kff.org>

Kaiser Family Foundation (State Health Fact Sheets)  
<http://www.statehealthfacts.org/>

Family USA: <http://www.familiesusa.org/site/PageServer>

High Risk Health Insurance Plans:  
<http://www.healthinsurance.org/riskpoolinfo.html>

Self-employed Country:  
<http://www.selfemployedcountry.org/riskpools/states.html>

Institute for Health Care Research and Policy, Georgetown University:  
<http://www.healthinsuranceinfo.net>

State Insurance Department:  
[http://www.naic.org/state\\_contacts/sid\\_websites.htm](http://www.naic.org/state_contacts/sid_websites.htm)

National Portal (The Authoritive Source for Regulatory Insurance Information):  
<http://www.naic.org/NBP/Basic.jsp>

<p><b>Virginia Commonwealth University's</b></p> <p><b>Benefits Assistance Resource Center</b></p> <p>Give us a call or e-mail us....We are the answer to your Social Security Work Incentives questions!!!</p> <p><b>Virginia Commonwealth University</b> <b>Benefits Assistance Resource Center</b> <b>P.O. Box 842011</b> <b>1314 W. Main St.</b> <b>Richmond, VA 23284-2011</b> <b>(804) 828-1851 VOICE -- (804) 828-2494 TTY -- (804) 828-2193</b> <b>FAX</b> <b><a href="http://www.vcu-barc.org">http://www.vcu-barc.org</a></b></p>	
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