

CONTINUATION AND CONVERSION POLICIES

What are they?

Continuation and conversion policies are for certain people who lose their group health insurance coverage. People who lose coverage may be entitled to continue their group health insurance coverage for a certain length of time (“continuation” policy). After this time has run out, they may be able to convert their group plan into an individual non-group policy (“conversion” policy). Both state and federal laws govern continuation and conversion policies; however, federal laws are limited to employers with 20 or more employees.

Who are they for?

Some people who lose their group health insurance are entitled to continuation and conversion coverage. Typically, these are individuals who had group employment-based health insurance coverage. The most common examples of people who qualify for continuation and conversion coverage are those who:

- ◆ Have had their hours reduced so they no longer qualify for health insurance coverage
- ◆ Have been fired from or have quit a job
- ◆ Lose employer-based health insurance due to divorce, legal separation, or the death of the covered employee
- ◆ Are children who have aged out of dependent coverage

How to obtain coverage

You are entitled to written notice of continuation and conversion options. Different rules apply as to when the notice must be given and to whom, depending on whether the situation is governed by federal or state law. You also must be given a set amount of time to choose this type of coverage. Most employers do not pay for continuation coverage. If you elect to take the coverage, you probably will have to pay the premiums yourself.

INTRODUCTION

North Carolina enacted continuation and conversion laws in 1981. The federal government enacted similar laws in 1986. The federal laws are commonly called COBRA (for the Consolidated Omnibus Budget Reconciliation Act, in which these provisions are found).

Federal COBRA laws govern most situations. COBRA gives beneficiaries greater rights than state law to continuation policies and some rights to conversion policies, but it applies only to those who had group health insurance coverage from an employer with 20 or more employees. An employee who had health insurance coverage from a smaller firm would be covered under the North Carolina continuation and conversion laws.

COBRA requires certain employers to offer employees and former employees and their spouses and dependents the opportunity to continue their group health insurance coverage if they lose coverage because of what is called a “qualifying event.” After the time for being covered by a continuation policy has run out, COBRA requires certain insurers to give you the right to convert your group health insurance into an individual (non-group) policy. However, federal law does not give much guidance on conversion policies. State law provides the terms of coverage for conversion policies. Thus, with certain limited exceptions, conversion policies will be discussed in the state section, not in the COBRA section.

FEDERAL CONTINUATION POLICIES (COBRA)

Introduction

COBRA does not apply to all employers. It is limited to employers who employed 20 or more employees on a typical business day during the preceding calendar year and who were already providing a group health plan to their employees. COBRA does not apply to plans provided by the federal government or by church-related organizations. Also, COBRA does not require employers to begin providing coverage if they weren't already doing so. If an employer ends its group health plan for all of its employees, it is not required to provide continuation or conversion insurance options to any employee, former employee, or qualified beneficiary.

Benefits

Continuation insurance must be identical to the plan it provides to current employees. When the employer modifies the plan for current employees, coverage must be similarly modified for those receiving continuation benefits. So, for instance, if your employer's health insurance for employees is a major medical plan, the continuation insurance offered to you cannot be just a catastrophic plan. And, if your former employer adds benefits for current employees, the same benefits must be added to continuation plans.

Eligibility

Employees, former employees, the spouse or surviving spouse of an employee, and dependent children who were previously covered under an employer's health plan may qualify to have their group health insurance continue. (In other words, if your family members are not covered under your employment-based plan, you can't purchase insurance for them under your continuation insurance.) These individuals

may qualify for continuation policies if one of the following things (called “qualifying events”):

- ◆ The covered employee dies
- ◆ The covered employee loses health insurance because he or she was fired, quit the job, or no longer qualifies because of reduced hours
- ◆ The covered employee is legally separated or divorced from his or her spouse
- ◆ The covered employee becomes entitled to Medicare benefits
- ◆ A dependent child ceases to be a dependent

In general, COBRA permits you to have continuation coverage for up to 18 months (longer in some special cases). If you have not become covered by a new group plan at the end of the maximum time, COBRA requires that you be offered conversion insurance. Information about your right to purchase a conversion policy should be in your original policy.

You are not entitled to a conversion policy, however, if:

- ◆ The employer ceases to provide any group health plan to any employee
- ◆ You fail to pay a required premium
- ◆ You become covered by another plan or by Medicare
- ◆ You are covered by a self-funded plan

Limitations and exclusions

Continuation plans are not allowed to require medical underwriting. That is, the coverage cannot be limited because of a person’s health history or the potential need for health services. Anyone who received benefits prior to a “qualifying event” cannot be denied coverage because he or she falls into a particular risk group, or fails to meet certain health requirements. In addition, conditions that were covered before the qualifying event took place must continue to be covered.

Continuation plans are not permitted to impose new pre-existing condition exclusions. They may, however, contain the same provisions as those in the plan available to the company’s current employees. Thus, with continuation coverage, you may be required to serve out any waiting period that you have not yet satisfied under your employer-based coverage. For example, if you have already met ten months of a twelve-month waiting period while employed, you might be subject to a two-month waiting period under the continuation policy.

Notice

An employee and spouse must receive written notice of their rights to continuation coverage when their coverage under a group plan begins (i.e., when the employee first is covered by the employer’s health insurance plan). Notice about rights to continuation coverage must be given again after a qualifying event.

The employer has the responsibility of notifying the insurance company if an employee dies, is fired, has his or her hours reduced, or becomes eligible for Medicare. If one of these events occurs, notice must be given to the insurance company, HMO, or plan administrator within 30 days of the qualifying event.

The employee or qualified beneficiary is responsible for notifying the health plan if the qualifying event is divorce or separation, or if a dependent “ages out” of coverage. In these instances, notice must be given to the health plan within 60 days of the event.

After the insurance company, HMO or plan administrator receives notice of the qualifying event, it has 14 days to notify you of your right to continuation insurance.

Federal COBRA law states that when an employer is obligated to provide conversion insurance, they must provide notice of this option in the 180-day period before continuation coverage expires. The COBRA conversion option is not available if you discontinue your continuation coverage before your eligibility expires (usually 18 months), or if the plan is self-funded.

Enrollment

You must be given at least 60 days after receiving notice of eligibility to elect continuation coverage (though an insurance company may give you more than 60 days). The coverage is then retroactive to the date of the qualifying event. Thus, once you elect continuation coverage, you are covered for all health services that were rendered during the 60-day “election period.” Each qualified beneficiary may make an independent election. So, for instance, you might elect continuation coverage after losing your job, and your spouse (who was covered by your insurance but could get coverage through his or her job) might choose not to take the coverage.

Length of coverage

People who elect coverage are ordinarily entitled to continue their group health insurance for at least 18 months. Coverage begins as soon as the group plan’s coverage expires, and not when continuation coverage is elected or when the first premium is paid. Once continuation coverage is elected, the coverage is retroactive to the date that employer-based group health coverage ended.

The normal 18-month period can be extended under certain circumstances. For example, the period of coverage is 36 months when the qualifying event is:

- ◆ Divorce or legal separation (which would otherwise result in the employee’s spouse losing coverage)
- ◆ Death of the employee
- ◆ A dependent child reaching the age of maturity
- ◆ The employee becoming entitled to Medicare

The period of coverage can be extended for 11 months (up to 29 months) for some qualified beneficiaries who are disabled at the time of the qualifying event (or within 60 days thereafter). To be eligible for the additional 11 months coverage, the individual must provide information of a Social Security disability determination within 60 days of the date of the determination and before the expiration of the initial 18-month period.

Coverage can be discontinued at any time, if:

- ◆ The employer stops providing group health coverage to all employees.
- ◆ A premium payment is not made on time. (Note: payments are considered timely if they are made within 30 days of their due date, although employers may allow a longer grace period).
- ◆ The qualified beneficiary becomes covered under another group health plan (as long as he or she is not subject to a pre-existing condition exclusion).
- ◆ The qualified beneficiary becomes covered by Medicare. In that event, the person who is covered by Medicare will be ineligible for continuation coverage, but his or her dependents and/or spouse may continue to receive continuation coverage.

Premiums

Employers can, and usually do, require the former employee or qualified beneficiary to pay a premium for continuation coverage. However, the premium cannot exceed 102% of the cost of insurance for a similarly situated beneficiary who is still receiving the employer-sponsored health insurance coverage. So, for instance, if your employer-based coverage costs \$200 a month, your continuation coverage may cost you up to \$204. If a former employee is provided with extended disability coverage, then the premium can be increased to 150% of the cost of insurance after the initial 18 months of coverage.

Other provisions

Under COBRA, you cannot be required to make your first continuation premium payment until 45 days after you elect continuation coverage. (State law, by contrast, requires your first payment before employer-based coverage ends.)

Even if you become covered under a new group health plan, continuation coverage cannot be discontinued if the new group coverage is substantially less comprehensive than your old policy.

STATE CONTINUATION AND CONVERSION POLICIES

Introduction

North Carolina's continuation and conversion privileges apply to all former employees who were continuously covered under an employer's insurance policy for three months prior to termination of coverage. As long as that requirement is met, continuation coverage is available, regardless of the circumstances involving loss of employment. The state's continuation coverage also applies to employers with fewer than 20 employees. The state's continuation and conversion privileges do not apply to self-funded (ERISA) plans. In addition to employees who lose employment-based group health insurance plans, members who lose coverage under other group plans (for example, association plans), can also qualify for continuation coverage. As noted previously, state law provides most of the guidance for conversion policies.

State Continuation Policies

Benefits

North Carolina continuation laws do not require the continuation plan to be identical to the plan offered other employees or members covered under the group plan. For example, continuation plans are not required to include dental, vision care, or prescription drug benefits, even if current employees receive coverage for these services. In general, the state continuation laws require only that group continuation plans include hospital, surgical, or major medical plans.

Eligibility

In addition to the COBRA eligibility requirements listed above, state law requires that, in order to be eligible for continuation coverage, an employee or member must have been continuously insured under the group health plan for three consecutive months before losing coverage.

Limitations and exclusions

Insurers are not permitted to impose new exclusions or waiting periods under the state's continuation law.

Notice and enrollment

Notification of the continuation privilege must be included in each certificate of coverage. In addition, employers must give employees notice of the option to continue coverage on insurance identification cards, or orally or in writing as part of the employment exit process (for example, in an exit interview).

Length of coverage

State continuation policies must be provided for 18 months from the date the employee or member's insurance ended. However, the policy may be discontinued earlier, if:

- ◆ The employee or member stops paying premiums
- ◆ The employee or member becomes eligible to be covered for similar group health insurance benefits
- ◆ The employer stops providing coverage to all employees. Note: in these instances, the employee or member has the right to convert the policy to an individual policy (see conversion section, below).

If an employer changes group health insurance policies, the employee is entitled to continue his or her conversion policy under the successor group policy for the remainder of the continuation policy period.

Premiums

North Carolina laws require you to make your first premium payment for continuation coverage before your employer-based insurance expires. North Carolina law also allows insurance companies to require payment at the beginning of the month that service is provided (that is, you may have to pay your January premium by January 1, not by February 1). Premiums for continuation coverage cannot be more than the 102% of the premiums charged to others under the insurance plan, but the employee is responsible for the total cost of the premiums.

State Conversion Policies

Benefits

Generally, conversion policies will not be as comprehensive as the coverage offered through the original employer plan. Insurers have the option to offer conversion coverage through individual or group policies.

Eligibility

Conversion policies are available to individuals who exhaust the 18-month continuation period. Coverage must be provided to both the employee (or member) and his or her eligible dependents who were covered under the group policy on the date that the insurance coverage ended. However, certain individuals are not eligible for conversion policies. These include:

- ◆ Individuals who were not eligible for continuation or who failed to elect continuation coverage
- ◆ Individuals who failed to make timely premium payments
- ◆ Individuals who failed to keep the continuation policy for the entire 18 month period, unless the reason that the individuals failed to continue the insurance coverage was because the employer changed health insurance policies within the continuation period. In these instances, the original group insurer must provide eligible individuals options to convert the policy to individual policies. Alternatively, the individual can continue with the continuation policy under the new group insurer, for any remaining time that he or she was entitled to continuation coverage.

- ◆ Individuals who are or could be covered by Medicare
- ◆ Individuals who are or could be covered by another group health insurance plan
- ◆ Individuals who were terminated from a health maintenance organization (HMO) for cause

If an employer ceases to provide health insurance coverage to all of its employees, the insurer must then make a conversion policy available to covered beneficiaries.

Limitations and exclusions

The insurer must continue to cover all the conditions that were previously covered under the continuation policy. The insurer may not exclude people from conversion coverage based on their health conditions or need for health services.

As with continuation policies, conversion policies may not require individuals to meet certain health tests in order to obtain coverage. Health plans or insurance companies cannot exclude an individual from coverage for a conversion policy based on their medical history or potential need for medical services. Similarly, the plans may not impose new pre-existing condition exclusions.

Notice and enrollment

Notice of the conversion option must be included in each certificate of coverage. Notice need not be given at any other time, unless a new certificate of coverage is issued. For many people, the only notice they will be given of the conversion option is with the original certificate of coverage when they first entered the plan, or on plan anniversary dates if changes were made to the plan and new certificates or booklets were issued.

Written applications for conversion insurance and the payment of the first premium must be made within 31 days of the termination of continuation coverage.

Length of coverage

A converted policy must be renewed annually. The insurer can refuse to renew the policy only if:

- ◆ Having the conversion policy would cause the beneficiary to be overinsured according to the insurer's standards of overinsurance (usually because the beneficiary is or could be covered by another plan)
- ◆ The beneficiary engaged in fraud or material misrepresentation in applying for the benefits
- ◆ The beneficiary becomes eligible for Medicare or other state or federal benefits substantially similar to those under the converted policy

In addition, subscribers to an HMO may lose their HMO-based conversion coverage "for cause." HMO policies should state explicitly what "for cause" means.

Premiums

People who elect conversion policies can be charged non-group rates for their health insurance coverage. Ordinarily, conversion rates are much more expensive than other non-group policies, and insurers have some leeway to increase the amount of premiums charged under a conversion policy. However, all premiums must be “reasonable” and must be determined according to certain specified standards (based on the age and class of risk of the covered individual, and the amount of insurance offered).

Administration

COBRA provisions are federal. The COBRA notification and disclosure provisions are administered by the Pension and Welfare Benefits Administration Office of the U.S. Department of Labor. The Internal Revenue Service oversees the other aspects of the COBRA continuation laws.

State continuation and conversion laws are administered by the N.C. Department of Insurance. Questions about state continuation and conversion requirements can be directed to the Department’s Consumer Services Division.

SOURCES OF LAW

Federal statute(s):	26 U.S.C. § 162(k) (Internal Revenue Code) 42 U.S.C. § 1395c (Medicare Act) 29 U.S.C. §§ 1002, 1161-1168 (Employee Retirement Income Security Act) 42 U.S.C. § 300bb-1 (Public Health Service Act)
State statute(s):	N.C.G.S. §§ 58-53-1 through 58-53-115

FOR MORE INFORMATION

Pension and Welfare Benefits Administration

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Consumer Services Division

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