Neighborhood Health
Partnership

A United Healthcare Company

Dear Employer:

Subject: ARRA 2009 – Application of the Group Coverage Continuation Premium Reduction to Subscribers who are Subject to Florida Continuation rather than COBRA.

As you may already know, under the American Recovery and Reinvestment Act of 2009 (ARRA), workers who lose their health coverage as a result of an involuntary termination and who are eligible for state continuation coverage may be eligible to receive a 65 percent Federal subsidy toward their and their dependents' state continuation premiums.

You should understand that the normal procedure for enrolling your former employees in the state continuation plan will continue as normal. (See attached reminder of standard process) This new procedure is ONLY for determining who of those who have elected coverage are eligible for the subsidy.

Below are some facts that outline what Neighborhood Health Partnership's responsibility is, and what your responsibility is, with regard to notifying this eligibility population of their rights to the subsidy and administering continuation coverage. We have included a copy of the notification and attachments they will be receiving.

Per ARRA, an employer may (but is not required to) allow an assistance-eligible individual (AEI) to elect a lower priced health plan, if such a plan is currently available to plan participants.

Should you have additional questions regarding these activities, please contact Premium Services at 305-715-2400 or 1-800-354-0222.

Sincerely,

Premium Services

How to initiate a Mini-COBRA policy.

The former member should submit a letter of intent containing the following elements to Neighborhood Health Partnership within 63 days of the coverage termination date or qualifying event date (whichever is later):

- Member’s Name
- Social Security Number
- Group Policy Number
- Date of Qualifying Event
- The Member’s Return Mailing Address
- Contact Phone Number

Send this letter of intent requesting Mini-COBRA coverage to the following address:

Neighborhood Health Partnership
ATTN: Premium Services
P.O. Box 025680
Miami, Florida 33102-5680
Fax: 1-800-743-5087

Within 14 days of receipt Neighborhood Health Partnership will respond to the letter of intent. A Florida Election and Premium Notice Form detailing the rates and length of coverage are returned to the member by certified mail. This information will also include the information for the next steps the member should take.

The Neighborhood Health Partnership ARRA Guide for Florida Employer Groups Where the Carrier is Required to Send Subsidy Election Notification

The American Recovery and Reinvestment Act of 2009 (ARRA) contains provisions that may allow individuals who are eligible for State Continuation coverage and who lost their coverage as a result of an involuntary termination, to receive a 65 percent Federal subsidy toward their and their dependents' State Continuation premiums for up to 15 months.

In addition to the federal ARRA legislation, some states have amended their own Continuation laws to include additional requirements, provisions and required actions by both Employers and Carriers.

This guide is for Employers in States that require Neighborhood Health Partnership to notify former employees of their rights under the ARRA.

Neighborhood Health Partnership is responsible for providing coverage at the subsidized rate and collecting the subsidized funds from the Federal Government.

Compliance with the ARRA and applicable State Continuation laws will require coordination between employers and Neighborhood Health Partnership.

Included in this guide are:

- Description of the ARRA compliance process
    - Participant Notification
    - Participant Notification & Carrier Notification of Involuntarily Terminated Members
    - Participant Enrollment & Carrier Notification of Participants claiming the subsidy
    - Administration of Pre-Existing Condition Clause
    - Billing
    - Reporting
    - Discontinuation of Subsidy
- Summary of Roles, Responsibilities and Required Actions
    - Employer
    - Neighborhood Health Partnership

Description of Process

The following narrative outlines the general process for compliance with the ARRA and applicable State Continuation laws.

Participant Notification

The established process for state continuation election has not changed. The only addition is that those employees who were involuntary terminated on or after September 1, 2008 through February 28, 2010 have the opportunity to receive a subsidy offered under ARRA.

The employer should utilize their standard means of enrollment to add any new State Continuation participants to their plan (i.e. via Employer eServices, faxed or mailed enrollment form, etc).

Participant Notification & Carrier Notification of Involuntarily Terminated Members

Neighborhood Health Partnership will be responsible for notifying former employees who were involuntarily terminated on or after September 1, 2008 through February 28, 2010 and who elect state continuation of their right for the subsidy.

Neighborhood Health Partnership will act in accordance with the ARRA and provide notice of the subsidy and the "Request for Treatment as an Assistance Eligible Individual" form to the employer's former employees so they may apply for the subsidy.

Please note that this requirement applies to members who terminated back to 9/1/08 and are still continuing coverage as well as future terminations through 02/28/2010.

The ARRA dictates that the subsidized coverage begins on the earliest possible start date allowed by the plan's insuring rules, on or after 2/17/2009. The employer should take this into account when determining a participant's continuation of coverage effective date.

The employer must determine whether or not each former employee who experienced a qualifying event during the time specified was involuntarily terminated.

Please refer to IRS Notice 2009-27 for guidance and information on the definition of involuntary termination.
http://www.dol.gov/ebsa/cobra.html

Once this determination has been made, the employer must complete the enclosed Involuntarily Terminated Member Identification Form and submit it to one of the following:

Neighborhood Health Partnership
P.O. Box 025680
Miami, FL 33102-5680
Attention: Premium Services
Fax: 1-800-743-5087

Neighborhood Health Partnership will receive, document and track all participants identified by the employer as having been involuntarily terminated.

Note: Neighborhood Health Partnership will only offer subsidized premiums to participants for which we have received a completed Involuntarily Terminated Member Identification Form.

Determination of Qualified Participants

Neighborhood Health Partnership will track and monitor participant response to the previously distributed Request for Treatment as an Assistance Eligible Individual form.

In accordance with the ARRA and applicable state continuation laws, Neighborhood Health Partnership will only consider participants that respond to the Request for Treatment as an Assistance Eligible Individual form and apply for the subsidy within 60 days as being potentially eligible to receive the subsidy.

Neighborhood Health Partnership will provide the subsidy to participants who meet the following criteria:

- Respond to Request for Treatment as an Assistance Eligible Individual form within 60 days;
- Elect to participate in subsidy via the Request for Treatment as an Assistance Eligible Individual form;
- Were identified by the employer as having been involuntarily terminated.

Administration of Pre-Existing Condition Clause (if applicable)

The ARRA requires that carriers ignore any gaps in coverage associated with the special election of subsidized State Continuation coverage with respect to determining the HIPAA 63-day gap in coverage rule (which would allow the imposition of a pre-existing condition exclusion). Neighborhood Health Partnership has established an internal process to ensure that all claims are processed in accordance with the ARRA's requirements.

Billing

After Neighborhood Health Partnership has determined which members will receive the subsidy as outlined above, we will begin billing for that participant at the subsidized rate.

If Neighborhood Health Partnership bills the employer, the monthly invoice will reflect the full premium amount for that participant followed by a 65% credit. The employer should collect only 35% of the total premium due from the participant.

If Neighborhood Health Partnership direct bills the employer's former employees, the participant's monthly invoice will reflect the full premium amount, followed by a 65% credit.

Reporting

Neighborhood Health Partnership will report all members billed at the subsidized rate to the IRS for purposes of recovering the subsidized funds.

Discontinuation of Subsidy

The ARRA allows for a participant to claim the subsidized rate for up to 15 months.

Neighborhood Health Partnership will track and monitor participants through their 15 months of subsidy eligibility (state continuation durations may differ from the maximum subsidy assistance timeframes allowed by ARRA). Prior to the expiration of a participant's subsidized rate, Neighborhood Health Partnership will send a Subsidy Expiration notice to the participant alerting them that they no longer qualify for the reduced rate.

After 15 months of being billed at the subsidized rate, Neighborhood Health Partnership will discontinue providing the 65% credit and will resume billing the full amount.

Additional Items

The AARA dictates that an employer may allow eligible individuals to elect a lower cost health plan, provided that same plan already exists, and is available to the active membership.

Should you have additional questions regarding this stipulation, please contact Premium Services at 305-715-2400 or 1-800-354-0222.

Summary of Roles, Responsibilities and Required Actions

Employer:

- Enrollment of participants into State Continuation plans through standard means
- Determination of appropriate coverage effective dates
- Determination of whether or not a participant was involuntarily terminated
- Upon receipt of notification from participant, provide notification to Neighborhood Health Partnership that a participant no longer qualifies for the subsidy.
- Submission of a completed Involuntarily Terminated Member Identification Form to Neighborhood Health Partnership for each participant claiming the subsidy
- Collection of 35% premium (only if the employer collects premium from the State Continuation participants)

Neighborhood Health Partnership:

- Notification to eligible individuals about the subsidy offered under the ARRA.
- Document and track all involuntarily terminated participants identified by the employer
- Determine which members will be receiving the subsidy based on meeting response requirements outlined in the ARRA and attestation of involuntary termination from the employer
- Administer Pre-Existing condition clauses in accordance with the ARRA
- Bill the subsidized rate for qualified participants identified by the employer
- Report subsidized individual to the IRS
- Recover subsidized funds from the federal government
- Track and monitor participants through their 15 months of subsidy eligibility
- Send Subsidy expiration notifications to participants who are about to no longer qualify for the subsidy
- Discontinue billing at the subsidized rate after participants no longer qualify

Involuntarily Terminated Member Identification Form

Please Submit Completed Form to:
Neighborhood Health Partnership, Inc

P.O. BOX 025680

Miami, FL 33102-5680

Fax: 1-800-743-5087

Employer Group Information			
Please complete the following information for the Employer	**Policy Name:**		
	Policy Number:	**Employer Tax Identification Number:**	
	Contact Name:	**Contact Phone:**	
	Employer Billing Address:		

Employee Information	
Please provide the following information for each employee who had a qualifying event on or after September 1st, 2008, including indication as to whether the employee was involuntarily terminated.	
Employee or Participant Full Name:	**Relationship: (i.e. spouse, child)** **Subscriber Identification Number: (blank if not known)**
Employee or Participant Street Address:	**City:**
State:	**Zip:**
Employee or Participant SSN#:	**Telephone Number(s):**
Date of Qualifying Event (M/D/Y):	**Date of Termination (M/D/Y):**
****Was the Employee Involuntarily Terminated?**	
Is the Employee or Participant Currently Enrolled in Employer's Group Coverage through a State Continuation Law?	
Date Employee was Notified of Termination Rights:	**(blank if not known)**
Start Date of Continuation (if already on continuation):	**(blank if not known)**
End Date of Continuation (if already on continuation):	**(blank if not known)**
Employer Contact Signature:	**Date:**
*****For guidelines on definitions of "Involuntarily Terminated" employees, please refer to guidance released from United States Department of Labor (http://www.dol.gov/ebsa/cobra.html)***	