NYS Continuation Assistance Demonstration Program for Entertainment Industry Employees

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Introduction

This is a pilot program which was created to assist eligible entertainment industry employees in maintaining health insurance during episodic employment.

For applications received on or after August 1, 2010 the program will reinstitute the 12 month lifetime maximum on premium assistance. Applicants who are accepted into this program shall receive assistance equal to fifty percent of their COBRA/continuation premiums for a lifetime total of up to 12 months. Applicants cannot receive more than 12 months of premium assistance in total.

Coordination of the Federal COBRA Premium Assistance and the NYS Continuation Assistance

In February of this year, President Obama signed the American Recovery and Reinvestment Act (ARRA), which authorized the payment of a subsidy for certain individuals who need to continue their group health insurance after termination of employment. The ARRA provides for a payment of a subsidy equal to 65% of the COBRA premium for assistance eligible individuals for fifteen months. The statute defines an assistance eligible individual as one who:

1. Has been involuntarily terminated at any time between 9/1/08 and 5/31/10; and
2. Elects COBRA timely.

Individuals employed in the entertainment industry may be eligible for both the ARRA COBRA subsidy and the NYS Continuation Assistance program, which provides for the payment of a subsidy equal to 50% of the COBRA premium for eligible employees of the entertainment industry.

Individuals who are eligible for both subsidies may choose to access both subsidies at the same time, or they may choose to defer the New York State subsidy until they have accessed the full fifteen months of the Federal subsidy. We recommend that individuals evaluate their personal circumstances when making this choice. The Continuation Assistance Program is able to accommodate both scenarios as follows:

1. If an eligible individual would like to access both subsidies at the same time, we will pay the 35% premium that remains after the 65% Federal subsidy has been applied for up to 12 months or until the individual goes off of COBRA, whichever comes first.
2. If an eligible individual accesses the Federal subsidy for the full fifteen month period, and then applies for and is accepted into the NYS program, we will pay the 50% subsidy for up to 12 months, or until they go off of COBRA, whichever comes first.

Eligibility Requirements

To participate in this program, you must meet all of the following requirements:

1. you must be a New York State resident;
2. you must be eligible for, or already covered by, COBRA/continuation coverage through a collectively bargained plan covering entertainment industry employees;
3. you must not already be receiving continuation assistance through a Department of Health program;

4. you must not be eligible for Medicare;
5. you must not be eligible for employer sponsored coverage; and
6. you must meet the household income limitation, as set forth below:

Amounts effective January 1, 2009, updated annually. Pregnant women count as 2 people.

Family Size	Monthly Household Income
1	Up to $2,257
2	Up to $3,036
3	Up to $3,815
4	Up to $4,594
5	Up to $5,373
6	Up to $6,153
Extra Person	Add $780

Once you are accepted into the program, you will not lose your eligibility if your income increases above the household income limitation during the time you are receiving assistance through this program.

However, you will lose your eligibility for the premium subsidy if any of the following were to occur:

1. your continuation coverage/COBRA ends;
2. you move out of New York State;
3. you become eligible for Medicare; or
4. you become eligible for employer insurance.

Please also note that, as part of your application, you will be required to sign an acknowledgment that if you become eligible for employer insurance, you will lose your eligibility for the premium subsidy as of that date and the state may seek to recover any monies paid by the state on your behalf for the period you were eligible for employer insurance.

Due to the limited funding available for this program, applications will be accepted on a first come, first serve basis. If the Insurance Department does not have enough funding available to ensure 12 months of assistance for an applicant, we will be required under the law to deny your application.

To find answers to Frequently Asked Questions about the NYS Continuation Assistance Program for Entertainment Industry Employees, please select this link.

How Do I Apply for the NYS Continuation Assistance Demonstration Program?

If you meet the eligibility criteria outlined above and would like to apply to receive premium subsidies through this program, please download the **standard application form for the NYS Continuation Assistance Program**, complete the application and send it, with the appropriate documentation, to the address identified below:

NYS Continuation Assistance Program
New York State Insurance Department
P.O. Box 7184
Albany, New York 12224-0184

Note: This application form is in PDF Format and requires the free **Adobe Acrobat Reader**.

If you cannot download this form, please call the Albany Health Bureau of the NYS Department of Insurance at (518) 473-6107.

Important Note

Please be aware that this legislation does not permit the Insurance Department to apply premium subsidies retroactively.

What this means is that if you are eligible for premium subsidies through this program in January, but you do not apply for subsidies through this program until April, the Insurance Department cannot reimburse you for premiums in January, February or March. To that effect, if you are interested in receiving this subsidy, you may want to apply to the Insurance Department as soon as you become aware that you are eligible for continuation coverage or when you begin receiving continuation coverage.

If you have questions on the application process or the program in general, please call the Albany Health Bureau of the NYS Department of Insurance at (518) 473-6107.

What will happen when I apply?

Upon receipt of your application for acceptance into the NYS Continuation Assistance Program, the Insurance Department will review your application for completeness and eligibility. If you are determined to be eligible for this program, you will be notified in writing. Your union fund will also be notified so that they can seek direct payment from the New York State Insurance Department. Continuation assistance in the amount of a fifty percent premium subsidy will be paid directly to your union fund, on your behalf, for the period you are enrolled in COBRA continuation coverage and continue to meet the criteria of this program.

How will subsidy payments be paid?

Once your union's request for payment is accepted and processed by the Insurance Department, continuation assistance in the amount of a fifty percent premium subsidy will be paid directly to your union fund, on your behalf, for the period you are enrolled in COBRA continuation coverage and continue to meet the criteria of this program. Your continued responsibility for the remaining 50% premium amount will be paid directly to your union by you. Therefore, any questions and/or concerns regarding your payment amount and/or due date should be directed to your union.

What is COBRA/continuation coverage?

In general, most employers or unions who provide group health plans must offer each individual covered under a group health plan, who would otherwise lose coverage under the plan because of a ***"qualifying event"***, an opportunity to elect continuation of the coverage, otherwise known as COBRA benefits or self-pay benefits.

The member's union will have the responsibility of notifying the member of their right to elect continuation of coverage. If the member chooses to elect continuation of coverage, he or she must request their continuation of coverage in writing within 60 days following the later of: (1) the date of termination; or (2) the date he or she is given notice of the right of continuation by either his or her employer, union or the plan.

If the member is electing continuation of coverage, he or she must pay up to 102% of the premium at the group rate for the benefits being continued under the group contract. The maximum continuation coverage is 18 months after the qualifying event. However, the COBRA Subsidy Program will pay half the premium payment for a period of 12 months per COBRA period. Therefore, if the member elects continuation of coverage for the full period of 18 months, he or she can only qualify for 12 months of premium assistance for that COBRA period.

If you have questions as to what COBRA/continuation coverage is, you can find answers to **Frequently Asked Questions about COBRA coverage by selecting this link**.

Updated 05/27/2009

NYS Continuation Assistance Program
Application for Entertainment Industry Employees

Application Instructions

SECTION 1 Applicant Information

In this section we ask how for your contact information. **The program is only available to New York State residents.**

SECTION 2 Entertainment Industry Information

To qualify for this program you must be currently receiving or eligible for COBRA continuation coverage through an entertainment industry union fund. Please provide your entertainment industry union fund information in Section 3.

SECTION 3 COBRA Continuation Coverage

Please answer the questions in Section 3 about your COBRA continuation coverage, including the first month that you are seeking assistance for. **We cannot provide retroactive premium assistance. You may apply for assistance in the current month if your application is received by the 15th of the month, otherwise premium assistance will begin next month.**

Please attach documentation of your COBRA continuation coverage eligibility.

SECTION 4 Household Income

Family Size	Monthly Household Income
1	Up to $2,257
2	Up to $3,036
3	Up to $3,815
4	Up to $4,594
5	Up to $5,373
Extra person	Add $780

Amounts effective January 1, 2009, updated annually.

Pregnant women count as 2 people.

In order to qualify for the NYS Continuation Assistance Program, your household income must fall within the limits established for the program. Please list your current **gross** monthly income and the current **gross** monthly income of your spouse (if residing in your household) in the space provided in Section 4. Do not count income for any other household member.

You may count your domestic partner as a spouse for this program if he/she is covered as a dependent under your policy.
Important -- Please use your income from the **previous full calendar month only**. All income must be counted, not just entertainment related income.

Please include wages, salary, self-employment income, interest and dividends, social security income, retirement income, alimony, unemployment benefits, workers compensation, royalties and residual payments. Please **do not** include gifts, public assistance, supplemental security income (SSI), foster care payments or child support payments you receive.

The NYS Continuation Assistance Program income limitations vary by household size. Refer to the chart to determine if you meet the household income requirements.

Please attach documentation of your gross household income for the previous full calendar month.

SECTION 5 Certification

Please carefully review and complete the certification in Section 5.

SUBMITTING YOUR APPLICATION

Important – Please review your application and ensure that each section has been fully completed.

Submit your application to the following address:

NYS Continuation Assistance Program
New York State Insurance Department
P.O. Box 7184
Albany, NY 12224-0184

QUESTIONS? Please call (518) 486-7815 or e-mail us at cobraprogram@ins.state.ny.us.

For more information about this program, please visit:
www.ins.state.ny.us/cobra/cobra_entertainment.htm

Confidentiality Statement: All of the information you provide on this application will remain confidential. The information will only be provided to the state agencies that oversee the program and process payments.

NYS Continuation Assistance Program

Application for Entertainment Industry Employees

SECTION 1 Applicant Information

□ Mr. □ Mrs. □ Miss □ Ms. Legal Name: First _____ MI ____ Last _____			
Stage Name (if applicable):			
Telephone No.: Day ( )	Evening ( )		
Home Address (Residence): Please note - you must be a New York State resident. Street			
City	State	Zip	County
Mailing Address (if different than home address): Street			
City	State	Zip	County

SECTION 2 Entertainment Industry Information

1. Are you currently eligible for, or receiving, COBRA continuation insurance from an entertainment industry union? (Note: if this does not apply to you, you are not eligible for this program.)

   □ Yes, I am currently eligible for, or receiving, COBRA continuation insurance from an entertainment industry union fund.

   Please provide the following information about your union fund membership:

   Fund Name: _____

   Fund Address: _____

   _____

   _____

2. Have you applied for this COBRA assistance program before? □ Yes □ No

3. Please provide a brief description of your most recent entertainment job:

   _____

   _____

   _____

   _____

SECTION 3 COBRA Continuation Coverage Information

1. Please provide the date you became or will become eligible for COBRA continuation coverage:

   _____

2. Please provide the date when your eligibility for COBRA continuation coverage ends:

   _____

3. Please indicate the first month for which you are seeking COBRA assistance: _____

   IMPORTANT! Premium assistance cannot be provided for prior months. You may apply for assistance in the current month if your application is received on or before the 15th of the current month. Otherwise, premium assistance will begin in the following month.

4. Please provide the full amount of your COBRA continuation insurance premium: $_____

   This premium is due every: □ Month □ Quarter □ Other (please explain) _____

   _____

5. Please attach a copy of the notification letter provided by your union fund stating your COBRA continuation coverage eligibility. This letter must include the dates for which you are eligible for COBRA continuation coverage. **Do not send a certificate of creditable coverage.**

   Notification letter attached? □ Yes □ No

6. Please provide the number of people (including yourself) who will be covered by the COBRA continuation policy: _____.

SECTION 4 Household Income

1. Please list the **monthly gross income** for both you and your spouse (if not separated or divorced) for the **previous full calendar month only.** (For example, if you are applying in February, please provide gross income for January.) You may count your domestic partner as a spouse for this program if he/she is covered under your policy. Please include all income received in the **previous full calendar month**, regardless of when the income was earned. (For example: if a paycheck is dated 11/1 but the pay period is 10/24-10/31, this would count toward November income.) **You must include exact income, not an estimate**.

   Please include wages, salary, interest and dividends, self-employment income, social security income, retirement income, alimony, unemployment benefits, workers compensation, royalties and residual fees. Please **do not** include gifts, public assistance, supplemental security income (SSI), foster care payments or child support received.

   All income is to be counted, including any non-entertainment related income.

   Applicant's Monthly Gross Income **$**_____

   Spouse's Monthly Gross Income **$**_____

   Total **$**_____

2. **IMPORTANT!** You must attach documentation of your household income for the previous full calendar month. The following are examples of acceptable documentation:

   - ❑ Pay Stubs
   - ❑ Copies of paychecks
   - ❑ Letter from employer
   - ❑ Printout of unemployment payments
   - ❑ Self-employment documents (i.e. bank statements, business records, invoices, etc.)
   - ❑ Other (please explain)
     _____
     _____
     _____

   If you have indicated no income in question 1 above **or** your documentation only represents a partial month, please explain.

   _____
   _____
   _____
   _____
   _____

3. The household income limits vary, depending upon your family size (see instructions). Please provide the number of people in your family (pregnant woman count as two people when determining family size): _____.

   For the purposes of this program "family" means yourself, your spouse (if residing in your household) and any dependents eligible for coverage under your policy. Count your domestic partner if he/she is covered under your insurance. Please note that the number of people in your family does not need to be the same as the number of people being covered under your COBRA insurance. (In other words, count your spouse, even if you are seeking coverage only for yourself.)

SECTION 5 Certification (Important – please read carefully)

By signing this certification of eligibility, I certify under penalty of perjury that all statements contained in this certification are true. I further certify that I am ineligible for Medicare and I am not currently receiving continuation assistance through a COBRA subsidy program pursuant to the NYS Public Health Law.

I acknowledge that I will lose eligibility for this premium assistance if I should become eligible for Medicare or should move outside the state of New York, and will notify the NYS Insurance Department accordingly. I hereby acknowledge that if I am awarded continuance assistance and later become eligible for health insurance coverage through another union or an employer, I will no longer be eligible to receive continuation assistance through this program and the NYS Insurance Department may seek to recover any assistance provided to me after the date I became eligible for such health insurance coverage.

I understand that any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Date_____ Signature_____

Send this application to:

The NYS Continuation Assistance Program
New York State Insurance Department
P.O. Box 7184
Albany, NY 12224-0184