

COBRA Training 2008

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BENEFITS OF TRAINING

TAMRA Benefits

TAMRA, (Technical and Miscellaneous Revenue Act of 1988) lists the criteria for IRS examiners to use during audit to judge an Employer's COBRA compliance failures. The IRS can waive COBRA penalties. Employers who follow the TAMRA criteria and who correct violations within 30 days are in a better position to avoid COBRA's enormous penalties. If, however, an employer does not meet the criteria, then failures are considered "Reasonable Cause" failures and the IRS has no authority to waive penalties.

Requirement #1: The first TAMRA requirement is that individuals responsible for COBRA compliance **must be trained**. Training should include all aspects of COBRA, including, but not limited to: notification procedures, notification language, Qualifying Events, Qualified beneficiaries, COBRA's time frames, consistency in applying COBRA provisions, premium rate calculations and COBRA Terminating Events. Attending an annual seminar is important. You should keep documentation of training.

Requirement #2: The second criteria is the requirement for **written instructions**.

Requirement #3: The program has been **designed by competent professionals** and has been **updated**. All employer materials and procedures should be reviewed by the employer's ERISA attorney.

Requirement #4: The program **monitored by independent auditors**. At a minimum, at least two separate individuals should review all COBRA compliance actions for accuracy, timeliness and completeness. We recommend that employers outsource COBRA compliance administration to a competent administrator who will indemnify the employer for its own failures.

Avoid Penalties

Generally, a plan administrator that provides a late election notice to a QB is subject to a penalty of up to \$110 per day. In addition, if a group health plan fails to comply with COBRA, the employer is subject to an excise tax of up to \$110 per day up to the lesser of 10% of health plan costs or \$500,000. In addition a QB who sues the employer may sue for medical expenses, health coverage and attorney's fees.

Avoid Civil Liability

Avoid missing Qualified Beneficiaries and Qualified Events
Avoid offering COBRA when individuals are not qualified.

Reduce Adverse Selection

You may be held personally liable for COBRA Failures

EMPLOYERS SUBJECT TO COBRA

Do you have 20 or more employees?

Employers are subject to federal COBRA if they have 20 or more employees on more than 50% of their typical business days during the preceding calendar year. Each part-time employee counts as a fraction, with the numerator of the fraction equal to the number of hours worked by that employee. The denominator is equal to the number of hours that must be worked to be considered a full-time employee. The fractions are then added up to determine the total number of "full-time equivalent" employees. You may make this determination on an aggregate basis to simplify the calculation.

All common law employees count, including foreign employees, regardless of their eligibility for the group health plan. Therefore, self-employed individuals, independent contractors and directors are not counted. In at least one court case (*Cruz-Jiminez v Mueblerias Delgado, Inc* March 2002) children of and nephews of owners were considered common law employees and not eligible for the "self-employed" exception. These individuals must also be offered COBRA continuation if the employer is subject to COBRA. Church and Federal Government plans are exempt.

Is your group part of a larger group?

If two or more companies share common ownership, the companies may have to be grouped together for purposes of determining whether or not they are subject to COBRA. For detailed information you may refer to section 607(4) of ERISA. Common ownership rules are complex, so if there is a chance these rules apply, you should seek legal assistance.

Is your group part of a multi-employer plan?

In the case of a multi-employer plan, it is the Plan that is subject to COBRA and not the employer. Examples of multi-employer plans include: a) a plan that is contributed to by more than one employer and b) a plan maintained pursuant to collective bargaining agreements between one or more employee organizations and more than one employer. The Department of labor puts forth other criteria for multi-employer plans.

A multiple employer plan is NOT a MEWA or an association plan. These are called multiple employer plans and should not be confused with multi-employer plans. In a multiple employer plan, the Employer and NOT the Plan is subject to COBRA compliance.

If your company participates in a merger or acquisition, who is responsible for COBRA?

In the case of a merger or acquisition, the rules are complex and we encourage you to contact your legal counsel to discuss the planning issues. Here are the general principles:

- In general, COBRA responsibility belongs to the seller.
- However, if the seller does not maintain any group health plan after the sale, the responsibility for COBRA then belongs to the buyer.
- The parties to the sale alternatively may assign responsibility by contract.
- If the sale is a sale of the stock of a company, employees who maintain employment by the buyer need not be offered COBRA.
- In the event of a sale of assets, employees who terminate employment with the seller and who no longer receive health insurance from the seller experience a Qualified Event and must be offered COBRA. This is so even if these employees are employed by the buyer and have the same coverage.

PLANS SUBJECT TO COBRA

What Coverages are subject to COBRA?

Medical

Dental

Vision

EAP- EAPs are subject to COBRA if they provide a service. For example, if the [EAP provides 3 or 6 counseling visits](#), then it provides services and is subject to COBRA.

Medical FSAs [Exceptions](#) from COBRA - a health FSA must meet [two conditions](#): 1) it [must not be subject to portability provisions under HIPAA](#), and 2) the [maximum amount](#) that the health FSA can charge for a year of COBRA coverage equals or exceeds the maximum benefit available under the health FSA for the year. If the health FSA satisfies the two conditions, it does not have to make COBRA coverage available at all. If a health FSA must make COBRA coverage available, all the general COBRA coverage rules apply including the rule that each QB has separate election rights to amounts available under the health FSA.

[Credit/Debit cards](#): Recently, FSA plans have adopted the use of Credit/Debit cards in large numbers. If you have such a card as part of your FSA plan, you should be sure that use and access to the card is terminated immediately once a qualifying event occurs. If not, the

qualified beneficiary or other family members may continue using the card even if COBRA coverage is not elected.

Simultaneous use of cards: For example, assume an employee experiences a divorce qualifying event. In this case the employee could continue to use card after the Qualifying Event without a problem. However, the divorced spouse might continue to use the card without ever electing or paying for the COBRA coverage. Plan administrators may need to [issue separate cards to Qualified Beneficiaries and implement separate limits](#) for each participant.

HRAs

HRAs must comply with COBRA's requirements. Self-insured HRAs are problematic. COBRA premiums for HRAs must be determined for a 12-month period in advance and it must be based on the cost to the plan of providing coverage to similarly situated beneficiaries who have not experienced a COBRA qualifying event. When HRAs are self-funded, the premium must be actuarially determined or calculated using a "past-cost" method. Although the account balance available in the HRA may differ for each participant based upon their length of time on the plan and claims incurred, employers cannot charge different COBRA premiums according to the remaining benefit available. The premium must be the same for all qualified beneficiaries. In addition, when certain qualifying events occur, such as a divorce, an employer could be stuck with having to contribute more than twice the expected amount because of IRS interpretations of HRA rules.

Individual Policies:

Individual policies are problematic. If there are employer contributions or if the employer provides funds to the employee that could be used, for example, [in a cafeteria plan setting](#) to pay for the benefit, then the arrangement would become a plan [under ERISA](#). This in turn could require the employer to file an [annual 5500](#), could subject the arrangement to COBRA, and could require compliance with a number of HIPAA requirements. Use of a Section 125 plan governing pretax payroll deduction for individual insurance purchases can lead to the policies becoming subject to ERISA, HIPAA and COBRA. *Individual Policies are almost NEVER COBRA compliant, subjecting the employer to serious risk.*

What Coverages are not subject to COBRA?

Life Insurance

LTD

STD

Long Term Care

Cancer Insurance

Specific Disease

EAPs EAPs that are referral only, namely a clearing house of names and telephone numbers of local resources, are not subject to COBRA.

HSA's **The IRS specifies** that HSAs are not subject to COBRA. However, The Department of Labor (DOL) controls regarding the COBRA requirements imposed under ERISA or the Public Health Service Act.

For a Plan, including an HSA to be subject to ERISA, it must be "established or maintained by the employer". If it is, then ERISA's COBRA rules might be applicable. Existing DOL regulations for "employee pay-all" plans indicate that group and group-type health insurance [plans are not subject to ERISA if:](#)

- 1) no contributions are made by an employer, or see paragraph below
- 2) employee participation is completely voluntary
- 3) the employer's sole involvement, without endorsing the program, is to permit the insurer to publicize the program and to collect premiums through payroll deduction and remit them to the insurer; and
- 4) the employer receives no compensation, other than reasonable compensation for administrative services rendered in connection with the program.

We look forward to additional guidance from the DOL.

The DOL has said that employer contributions to HSAs [will not create an ERISA plan if the employer does not:](#)

- 1) limit eligible employees' ability to move their funds to another HSA beyond restrictions imposed by the tax code;
- 2) impose conditions on using HSA funds beyond those allowed by the code;
- 3) make or influence investment decisions regarding HSA funds
- 4) represent that the HSAs are an employee welfare benefit plan established or maintained by the employer; or
- 5) receive any payment or compensation in connection with an HSA.



WHO IS A QUALIFIED BENEFICIARY (QB)

Which employees are "Covered Employees" under COBRA?

A covered employee is [any individual](#) who is [currently](#) or was [previously provided coverage](#) under a group health plan subject to COBRA as a result of the performance of services for one or more persons maintaining the plan. Covered persons therefore [include independent contractors](#), self-employed individuals, partners, directors and retirees, if covered by the plan, even though they may not be "common law employees".

Must an individual be covered by a plan the day before a Qualified Event (QE), to be offered COBRA?

Under COBRA, a "Qualified Beneficiary" (QB) is an individual who is covered under the employer's group health plan [the day before a COBRA Qualifying Event](#) (QE) takes place. A QB can be the employee, the covered spouse of the employee (not a domestic partner) or a covered dependent child of the employee.

Do you offer coverage to newborn or adopted children by the employees already electing COBRA?

A child born to or placed for adoption with a Qualified Beneficiary is also a QB. A newborn or adopted child is entitled to special enrollment within 30 days following birth or adoption and coverage must be retroactive to the date of birth. [Conceivably, a child Qualified Beneficiary could have a child](#) during the COBRA continuation period and that child (grandchild of the employee) would be entitled to enroll in the plan. [If the child Qualified Beneficiary also marries](#) during the COBRA continuation period, the child QB may also enroll their [new spouse](#) in the plan.

Do you offer coverage to a child covered under the terms of a QMCSO or NMSN?

("Qualified Medical Child Support Order" or "National Medical Support Notice")

A child covered under a QMCSO or NMSN is a Qualified Beneficiary with the right to elect continuation coverage under COBRA. Care should be taken to be sure COBRA election forms are sent to the correct party. For example, the death of a covered non-custodial parent-employee is a COBRA qualifying event that triggers a 36-month extension of group coverage for the enrolled child. Notices should be sent to each child subject to the order, and to the custodial parent at the child's last known address.

A [parent may not avoid QMCSO](#) or NMSN responsibilities by waiving their own coverage. If the employee is eligible to participate in the plan, the child named in the order must be provided coverage. If as a condition, the plan requires that the employee be a plan participant, then the plan must enroll both. If the order specifies other coverage, such as dental or vision, the employee may be required to enroll for these coverages as well.

State laws require health plans to:

- 1) Enroll a child under a parent's insurance even if the child is born out of wedlock, does not reside with the insured parent, does not reside in the insurer's service area, or is not claimed as a dependent on the parent's federal tax return.
- 2) Enroll a child pursuant to an order regardless of the plan's open enrollment restrictions
- 3) Comply with court or administrative orders that require a parent to provide health coverage for a child
- 4) Permit a custodial parent to file claims on behalf of a child under the non-custodial parent's health insurance and to make benefit payments to the custodial parent.

If you offer Domestic Partner coverage on your health plan, do you offer COBRA continuation to Domestic Partners?

A Domestic Partner is NOT a Qualified Beneficiary under Federal COBRA. However, some insurance carriers will permit extending COBRA benefits to Domestic Partners. In this case, the employer decides whether or not to offer the benefit and there may be an extra premium charged by the carrier for this option.

Although Domestic Partners do not qualify as Qualified Beneficiaries as domestic partners, they may qualify if they otherwise meet the definition of a tax code dependent. In any event, at open enrollment QBs must be given the same rights as similarly situated active employees and that would include the right to add the Domestic Partner at open enrollment.

Do you consider U.S. citizens working abroad as QBs when they incur a qualifying event?

These individuals are Qualified Beneficiaries.

Do you consider Resident aliens who receive U.S. Income as QBs when they incur a qualifying event?

These individuals are Qualified Beneficiaries. However, non-resident aliens who receive no U.S. income are not qualified beneficiaries.

RIGHTS OF QUALIFIED BENEFICIARIES

GENERAL RULE 1: Each Qualified Beneficiary (QB) must be offered the group health insurance benefits the individual was receiving immediately before the Qualifying Event. Coverage with any changes at all is not acceptable. QB's must also be given all the same rights as similarly situated active employees.

GENERAL RULE 2: All health care benefits provided by one business are treated as one plan unless it is clear that the benefits provided are provided as separate plans and governed by separate plan documents. Accordingly, if active employees do not have the opportunity to select plan options and must take the entire plan, the only option that must be made available to QBs is the entire plan. However, if active employees have choices, then QBs must be offered each plan independently.

GENERAL RULE 3: Each QB has independent election rights and therefore each family member may elect different types of or combinations of coverage.

GENERAL RULE 4: QBs have some additional rights that similarly situated active employees do not have. – see below

Are QB's given the same rights as similarly situated employees (i.e., make changes for family status changes, changes at open enrollment, etc.)?

QBs have the same rights as active employees to add new family members at [Open Enrollment](#) and also are entitled to [HIPAA's Special Enrollment rights](#). **Offer all QBs and potential QBs all Open Enrollment options at open enrollment and when changing carriers.**

Each QB who has elected COBRA coverage also has the right during open enrollment to [switch to another plan](#) in the same way that active employees do.

Do you allow each qualified beneficiary independent election rights?

Active employees make decisions with respect to the plan for themselves, their spouse and dependents. However, each qualified beneficiary may independently elect coverage and each QB has the same rights as a similarly situated active employee.

QBs also have rights during open enrollment that similarly situated active employees do not. Each QB member of the family could choose coverage for themselves or for other family members under a separate plan, even though the family members of actively employed individuals could not choose coverage under a separate plan.

But note that eligible spouses and children of the covered employee who did not elect COBRA coverage during the original election period do not have the status and rights of qualified beneficiaries when they later enroll at open enrollment. This means that they

- 1) may not independently elect coverage for themselves,
- 2) they cannot continue coverage when the employee ceases to be covered,

3) if a second COBRA qualifying event occurs, they will not become entitled to an extension of federal COBRA coverage.

Are your COBRA rates at 102% or less?

You are allowed to charge up to an additional 2% of the "applicable premium" to cover your administrative expenses. "Applicable premium" means the cost to the plan for similarly situated plan participants who have not had a QE.

If a QB is continuing coverage under the 11-month disability extension, the employer may charge the disabled QB up to 150% of the "applicable premium" from the 19th to the 29th month. Non-disabled family members may be charged up to 150% of the applicable premium as well, but only if the disabled individual is electing coverage. If the disabled QB is not covered, then the 102% limit applies.

For self-funded plans, IRC Code 4980B reads, "Self-Funded Plans must use an actuarially determined rate that reflects cost of the benefit across all participants; not based on the cost to the Plan for COBRA continues only. Alternatively, self-funded plans may develop COBRA rates on the basis of past cost, adjusted by the percentage change in the implicit price deflator of the gross national product.

How often can you raise the cost in a pre-determined period?

Premiums may not be raised more than once in a pre-determined 12-month period. This is called a determination period. Exceptions exist for : 1) disability extension, 2) changes by the QB to a more expensive coverage or addition of a new benefit, 3) when a QB adds a family member, and 4) when the plan charged less than the maximum permissible premium.

The determination period is any 12 -month period the plan chooses that is consistent from year to year. It is based on the plan, not the date the QB elected COBRA.

Problems – Exceptions specifically do NOT include a second mid-year premium increase on account of an increase in age in an age-banded plan. Exceptions also specifically do NOT include when an insured group health plan changes insurers mid-year.

Can you charge a single dependent who elects COBRA the dependent or family rate?

IRS Revenue Ruling 96-8 Appendix J--provides: A spouse or dependent electing COBRA individually should be charged the single premium--not dependent or family rate. If QB's from the same family elect different types of coverage, they may be charged the applicable premium based on their status/classification. If an election of COBRA does not specify the particular coverage or who is electing coverage, the election is deemed to include all offered coverage on behalf of all QBs.

Do you allow QB's to make monthly payments?

Final 1999 Regulations clarify that QBs must be allowed to make monthly COBRA premium payments. Employers may allow other options such as weekly, quarterly or semi-annual payments, but must offer monthly payments.

Do you allow EXACTLY a 30-day grace period?

"You must allow a 30-day grace period". This grace period begins on the first day of the coverage period, not when the employer's premium is due. Payment must be considered made on the date mailed. (Save the envelope with postmarks)

Making an exception and allowing more than 30 days may allow COBRA beneficiaries to challenge in court later terminations for late payment. Creating the exception may end up providing an extended due date for all COBRA premiums for the affected qualified beneficiary. *Washicheck v. The Ultimate Ltd.* 11/10/2005



In addition, just because a plan accepts a late COBRA premium, payment **does not mean that the QB has coverage**. A state appeals court in Arkansas noted that a group health insurer did not have to provide COBRA coverage when an employer accepted a late premium payment. *Bowling v. HMO Partners, Inc.*, 2005

If active employees have longer than a 30 day period to pay premiums the same period must be extended to COBRA participants.

Do you have formal procedures for handling NSF checks (giving the employee an opportunity to pay in case of a bank error)? COBRA has no specific requirement that the plan administrator must provide notice of a bounced check. However, under **ERISA's rules governing fiduciary conduct**, circumstances might exist under which a fiduciary (acting in the best interest of participants and beneficiaries – **for instance**, if the plan administrator had **reason to know** of the QB's need for coverage and there was a **significant time left** in the premium payment grace period) must inform a QB of a bounced check.

Do you have a formal procedure for handling insufficient payments? (giving the employee an opportunity to remit the shortage?)

IRS Final Regulations in 1999 provide that if a COBRA payment is short by an "insignificant amount", a plan must either a) consider the payment as payment in full or b) notify the QB of the deficiency amount and provide a reasonable additional period (30 days) to pay the shortfall.

What is "insignificant" is defined in Final Regulations issued in January 2001. "Insignificant" means the shortfall is not greater than the **lesser of 1) \$50 or 2) 10%** of the amount to be paid. The IRS may modify the \$50 amount through future guidance. See "Notice of Insignificant Premium Underpayment" in the Notices section below.

Do you offer alternative coverage to QBs moving outside of the region-specific service area no later than the date of relocation or the first day of the month following the QB's request for alternative coverage?

1999 final regulations require that if a QB leaves an HMO's service area, the employer must allow the QB to switch to another existing plan as described above when the employer makes group health coverage available to similarly situated nonqualified beneficiaries or to other employees that can extend to the area where the QB is relocating.

The employer is not required to "create" a new plan for a QB who moves out of the plan's coverage area. Employers should still offer COBRA even though it appears that the coverage would be of no value to the QB. Emergency services or the ability to return to the service area to receive benefits are still available and valuable.

QUALIFYING EVENTS (QE)

General Rule 1: There must be a qualifying loss of coverage. That means all 3 conditions must be satisfied

Condition 1: Coverage must be in effect on the day before the QE AND

Condition 2: There must be a loss of coverage ("loss" is defined many ways) AND

Condition 3: Loss must be caused by a listed event (QE) under COBRA

All three conditions must be met. Simply a loss of coverage is not, alone, necessarily a COBRA qualifying event.

COBRA law includes only specific events. Therefore, any other circumstances that result in a loss of coverage are not qualifying events. This could be for example, a change in eligibility terms of your insurance policy or if an employee changes jobs from a covered class of employees to a non-covered class of employees. Similarly, if an employee requests that dependent coverage be dropped at open enrollment, there is a loss of coverage, but no QE because choosing to drop coverage is not a covered event triggering COBRA rights.

The COBRA law is complex in many areas including this one. It's best to discuss this with your ERISA attorney.

REMEMBER, if you offer COBRA in a situation that is not a Qualifying Event, your insurance carrier may refuse to pay claims. Just because a premium is paid and accepted by the insurer, it does not mean your insurer must pay COBRA claims of participants who are not eligible for COBRA. The employer may then become liable for payment of the claims.



Is retirement a loss of coverage when a retiree health plan is offered?

Generally, employers are allowed to offer any alternatives to COBRA coverage that they wish. Often, alternative coverage situations arise under retiree health plans. If alternative coverage is identical to COBRA coverage (including COBRA's procedural protections such as the 60 day election period and initial 45 day grace period), it may be credited toward satisfying COBRA's requirements with periods of coverage running concurrently.

If the alternative coverage does not satisfy ALL of COBRA's requirements, the Plan must also offer the QB COBRA coverage. This rule applies even if the only difference between coverage for active employees and alternative coverage employees is the premium contribution amount. Alternative coverage situations also arise for other reasons such as: requirements of State law, industry practice, severance agreements or collective bargaining agreements. In such cases the rules are the same.

If an event, such as the death of a covered employee or divorce from the covered employee, would end the right of a spouse or dependent child to receive the alternative coverage, then that event is a QE and COBRA must be offered for 36 months from that event, regardless of whether the event occurs within the initial 18-month period or whether alternative coverage is as good as COBRA.

Any increase in premium or contribution that must be paid for coverage as the result of a qualifying event is considered a loss of coverage triggering COBRA eligibility. The IRS's position is that an affected person would not be entitled to the procedural protections of COBRA, such as the 60-day election period, and the 45 days following election to pay the first premium. In some cases these procedural protections in COBRA might be more valuable than an alternative coverage option. However, as long as the procedural rights are protected, the plan can offer the identical coverage retiree plan as the only COBRA option.

Is a change in hours, a loss of coverage? (example: changing from full-time to part-time with an attending increase in contribution)

A reduction of hours occurs whenever there is a decrease in the hours that a covered employee is required to work or actually works.

Under COBRA, a "qualifying event" must also occur that causes a qualified beneficiary to "lose" group health coverage. Final regulations define a "loss" to include any change in the terms of coverage, even a change in the participant's contribution amount, if the increase is tied to a Qualifying Event..

For example, single full time employees pay \$50 per month for coverage. An employee changes from full-time to part-time and now must pay \$100 per month for the same coverage. This change in terms is a qualifying event.

Since COBRA premiums would cost much more, why would this be important? The regulators want employees who would drop coverage due to the increased cost to be able to take advantage of COBRA's anti-selection opportunity (i.e. to be able to elect

retroactively in the event of a claim arising during the COBRA election period). The same situation arises in the event of an employee dropping a spouse or child from coverage due to increased cost precipitated by a qualifying event.

When do you disregard coverage that is lost "in anticipation" of a qualifying event in determining whether the event is a qualifying event?

Generally, [coverage must be in effect on the day before a qualifying event](#). However, if an employee drops a spouse from coverage in anticipation of a divorce or legal separation, the later divorce or legal separation is still a qualifying event even though coverage was not in effect on the day before the qualifying event. Whether a reduction or termination of coverage is in anticipation of a qualifying event is [a question to be resolved based on all the relevant facts](#). The Plan is required to make COBRA coverage available as of the date of the QE, such as the date of divorce or legal separation, but not for any prior period. Therefore, under these circumstances, coverage would not be retroactive. The span of time between the loss of coverage and the QE does not matter.

It is possible that an employee may drop a spouse from coverage for reasons unrelated to a divorce and then coincidentally a divorce may occur. An IRS revenue ruling (2002-88) provides that [if a spouse otherwise would have lost plan coverage before the divorce for unrelated reasons, then the divorce is not a qualifying event](#).

A Plan Administrator, therefore, should implement procedures to [identify the reasons](#) why an employee is dropping a spouse from coverage, such as by requiring that the employee fill out a [change form](#) specifying the reason for dropping the spouse from coverage. COBRA Administrators do not provide this service. You should perform this internally.

A HIPAA certificate of coverage must be provided any time a spouse is dropped from group health coverage. A Plan Administrator could add language to the HIPAA certificate indicating that if the loss of coverage was in anticipation of a divorce or legal separation, the spouse may have rights under COBRA to continue coverage. Such documents, of course, should be reviewed by your ERISA attorney.

Qualifying Events requiring 18 months of COBRA coverage:

1) voluntary or involuntary termination of employment

2) reduction in hours of employment

This includes a strike.

This includes a layoff

Generally, this includes a leave of absence

3) filing of a bankruptcy proceeding (for retirees and certain dependents only).

COBRA is not required if termination is for gross misconduct. However, if you fail to offer COBRA for this reason, you may wind up in court as "Gross Misconduct" is not

defined in COBRA Regulations. When in doubt, seek the advice of a qualified ERISA attorney.

Leave Issues and COBRA

Make sure your company leave policy is consistent with your health insurers leave provision in your insurance contract. For example, [your leave policy may provide](#) that employees are kept on your health insurance plan [for 6 months](#) following the inception of leave. Your [insurance contract](#) may, in conflict, provide that employees may only be kept on the plan during leave for [90 days](#). In this case you must resolve this difference by explaining that COBRA begins following the 90 day period. Otherwise a COBRA violation could occur. Some insurers might not permit the back-dating of COBRA if you miss the actual Qualifying Event date.

The Family and Medical Leave Act of 1993 (FMLA) applies to employers with 50 or more employees during at least 20 workweeks in the current or preceding calendar year within a 75 mile radius.

FMLA leave is NOT a qualifying event for COBRA purposes. COBRA regulations state that FMLA leave results in [a qualifying event if](#) an employee [1\) was covered](#) under an employer's health plan the day before taking the FMLA leave, [AND 2\) does not return](#) to employment at the end of FMLA leave, [AND 3\) would lose coverage](#) in the absence of COBRA.

If the employer's health plan voluntarily extends coverage beyond those COBRA qualifying event dates, COBRA does not begin until the group health coverage is actually lost. Combined FMLA/non-FMLA leaves create the need for clear policies.

Employees who have worked for the employer at least 12 months, for at least 1,250 hours during the 12 months prior to the FMLA leave and who work at a location where at least 50 employees are employed within 75 miles of the location are eligible. The employer must maintain insurance coverage during the leave under the same conditions as before the leave, including the rate of contributions towards premiums.

Employers who are subject to both federal and state laws must comply with the provision that provides the greater benefit to their employees. However, final IRS regulations make it clear that a state greater period of coverage does NOT affect the determination of when a COBRA qualifying event has occurred. (IRS Final Regs Jan 10, 2001).

California's workers' compensation law prevents employers from discriminating against employees based on their work-related injuries. However, according to a federal district court, this nondiscrimination provision cannot prohibit the termination of group health coverage (and the offering of COBRA) when employees go out on a workers compensation leave of absence, particularly where the health plan provisions apply regardless of the reason for the leave. The case is *Scotti v. The Los Robles Regional Center*, 117 F. Sup. 2d 982 (C.D., Calif, Oct 2, 2000). Be sure to consult with your own legal counsel on this one.

USERRA Leave (The United Services Employment and Re-employment Rights Act of 1994) With respect to USERRA leave, final regulations clarify that USERRA leave beyond 31 days is a qualifying event. If USERRA leave is less than 31 days, the employer must continue to pay its share of the health premium. Upon return from military service, the individual must be returned to the health plan without waiting periods, limitations, or other exclusions, even if the individual returns after 24 months.

If the individual has incurred a service-related disability during the leave, the plan can exclude coverage for such disability only. If an individual covered by USERRA Rules elects COBRA and then later becomes covered under TRICARE, the U.S. Department of Defense health care program, TRICARE is NOT considered "other employer provided coverage" and will not terminate an individual's right to continue COBRA coverage. TRICARE coverage would be secondary to the COBRA coverage, and COBRA coverage would be primary. More information is available at [Http://www.dol.gov/asp/programs/handbook/userra.htm](http://www.dol.gov/asp/programs/handbook/userra.htm).

Qualifying Events requiring 24 months of COBRA coverage:

USERRA Leave (The United Services Employment and Re-employment Rights Act of 1994).

The Veterans' Benefits Improvements Act of 2004, requires employers to provide an annual notice of USERRA rights. This notice requirement can be met through a general posting at the work-place location where the employer provides general notices to employees.

The new law also extends the 18-month coverage right to up to 24 months.

Qualifying Events requiring 29 months of COBRA coverage:

Disability approved by Social Security. To Qualify

- (a) QB's must have experienced an 18-month qualifying event;
- (b) Social Security must have determined that the individual was disabled either before the COBRA Qualifying Event or within the first 60 days of COBRA continuation coverage;
- (c) The Plan Administrator must have been provided with a copy of the Social Security Administration's Determination of Disability (within 60 days after the determination is issued and before the end of the initial 18 months of COBRA).

Plans may not decline to provide the disability extension for failure to provide a timely disability notice unless the affected QBs were adequately notified, in advance, of the notice obligations and time frames. The employer's General (Initial) COBRA notice must list the reporting responsibility in the event of disability. All QB's (family members) with respect to the same qualifying event are entitled to the extension.

The Plan can charge 150% of the applicable premium [during this 11-month extension period](#), while the disabled individual is covered. However, [if only non-disabled QBs are covered](#), only the 102% of premium amount may be charged.

The [disabled QB does not have to elect COBRA](#) for the other QB's to get extensions to 29 months. If a second QE occurs during this 11 month extension period, QBs must be offered the maximum coverage period of up to 36 months total. If a Qualified Beneficiary is deemed by Social Security to no longer be disabled, all QBs in the 11-month extension period otherwise entitled to the disability extension may be terminated on the first of the month 30 days after the date of the final determination that the QB is no longer disabled.

Qualifying Events requiring 36 months of COBRA coverage:

(a) Employee's Death (QBs are the covered spouse and dependent children)

(b) Employee's entitlement to Medicare

1) [Retirees](#): For groups with 20 or more employees, terminating an [active employee's](#) group health coverage due to entitlement to Medicare would be a [violation of the Medicare Secondary Payer Rules](#). However, a retiree who experiences a loss of coverage due to first becoming entitled to Medicare after retirement (Part A Only as Part B or a supplement is irrelevant) is an example of when Medicare entitlement would be a QE. The spouse and dependent children are the only qualified beneficiaries.

2) [COBRA QBs](#): When an employee enrolls on COBRA and then [first becomes entitled to Medicare](#) after eligibility for COBRA, COBRA ends. If the employee is enrolled on Medicare prior to their eligibility for COBRA, the employee may not be terminated from COBRA on account of becoming eligible for Medicare.

However, this may be a "Multiple-Qualifying Event" (see below). The IRS in Revenue Ruling 2004-22 stated that the second qualifying event must cause a loss of coverage if it was the first qualifying event. In other words, had the first qualifying event (i.e. termination or reduction in hours) not occurred, and had the second event occurred first, would the second event have resulted in a loss of coverage? If not, the second event would not, constitute a multiple qualifying event. Medicare entitlement generally does not result in a loss of coverage under the group health plan for an active employee when it occurs before the termination of employment.

3) [Active Employees](#): In the case of an active employee who becomes entitled to Medicare and then later terminates employment or loses coverage due to a reduction of hours the following rules apply: [If a termination or reduction of hours occurs less than 18 months after the employee's Medicare entitlement, Dependent QBs must be offered 36 months](#) of COBRA from the date of Medicare entitlement or 18 months from the termination or reduction of hours, whichever is longer. And Employee QBs receive 18 months from the termination or reduction of hours.

(c) Divorce or legal separation from the covered employee (QBs are the covered spouse and dependent children)

(d) Loss of dependent status under the plan (QBs are the dependent children)

Multiple Qualifying Events:

When a 36-month event occurs during an 18-month, 24-month or 29-month COBRA continuation period, the QB may extend coverage for a total of 36 months from the original qualifying event date. If a QB qualifies for the 11 month HIPAA disability extension, and if another qualifying event occurs at any time during the first 29 months of disability extension, the multiple qualifying event rule still applies. When this occurs during the 11-month extension period, the 150% premium can be charged through the end of the 36-month period only if the qualifying event occurs during the period of extended COBRA coverage created by the disability provision.

According to recent IRS Revenue Ruling 2004-22, the second event is a multiple qualifying event only if it would have caused the qualified beneficiary to lose coverage under the plan had the first qualifying event not occurred. (The DOL's new model COBRA notices have been updated for this rule).

GENERAL NOTICE (formerly the Initial Notice)

The DOL now refers to the "Initial Notice" as the "General Notice". New Final COBRA regulations were issued May 25, 2004 and new notice requirements are effective immediately. The new regulations now require that specific information be in the notice. The number of required elements has increased. The DOL also offered a new "model notice" which is offered on our web site. The DOL has stated that older model notices will be considered out of compliance after November 25, 2004.

In preparing the new General Notices, plan administrators should modify the model notice appropriately as the model notice has choices of optional language and specific locations where plan-specific information must be entered. We urge administrators to review the model notice with legal counsel prior to use. The standard universally applicable language in the notice is "loose" in areas and could result in inadvertent expansion of COBRA coverage beyond the minimum required.

The final rules include a new model General Notice. This model notice is updated from that provided in the 2003 proposed rules.

The notice is designed for single-employer "standard" group health plans and is not suitable for medical FSA plans.

State laws may affect your General Notice requirements as well. For example, in California, AB 1401 provides a Cal-COBRA extension for up to 18 months following the end of Federal COBRA. AB 2208 mandates "equal" coverage for domestic partners. You may wish to add Cal-COBRA information to your General Notice informing individuals of this right. If your plan will offer COBRA or COBRA-like benefits to domestic partners, you will need to add language pertinent to domestic partner issues.

Another California requirement (AB 356, 2005) is additional language warning employees of the dangers of applying for individually underwritten insurance during their COBRA election period. The language is:

“Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.”

Foreign Language Requirements

There are no foreign language requirements for COBRA notices in either COBRA or ERISA. However, plan administrators are subject to Department of Labor (DOL) regulations with regard to summary plan descriptions (SPDs), which must contain a description of COBRA rights and obligations. The DOL requires that foreign language assistance SPDs be provided in order to adequately inform participants of rights and obligations for:

- 1) Plans that cover fewer than **100** participants at the beginning of the plan year in which **25 percent or more** of all plan participants are literate only in the same non-English language;
or
- 2) Plans that cover 100 or more participants at the beginning of the plan year in which the **lesser of 500 or more participants or 10% or more of all plan participants** are literate only in the same non-English language.

The SPD must contain a notice in the common non-English language that assistance is available. The assistance may be provided in the form of personal counseling. State laws may contain additional requirements.

90-day delivery. Send an Initial notice within 90 days of initial coverage

The COBRA law requires employers and plan administrators to notify employees and beneficiaries of their COBRA rights. The purpose of the initial notice is to meet this requirement by explaining to employees, spouses and dependents their obligations and their rights to COBRA coverage.

The Initial Notice must be mailed by first class mail to all covered employees and their spouses (not dependent children) when the plan first becomes subject to Federal COBRA.

New enrollees under the plan must be mailed the notice within 90 days of the beginning date on which the covered employee or spouse first becomes covered under the plan. In cases where a Qualifying Event occurs within the 90-day General Notice period, the plan administrator may satisfy their General Notice obligation by providing the Qualifying Event notice alone within the period otherwise required to furnish a Qualifying Event notice.

Final regulations confirm the importance of the employer sending an Initial Notice of COBRA Rights when an employee and spouse first become covered under the employer's health plan. **COBRA may not be denied without adequate notification.**

"if a QB has not been adequately informed of the obligation to provide a notice of a Qualifying Event, for example a divorce or legal separation or a dependent child ceasing to be covered under the plan, the QB's failure to provide timely notice will not affect the Plan's obligation to make continuation coverage available."

Plans may satisfy the initial notice requirement by including the required information in the summary plan description (SPD) of the plan and providing the SPD at a time that complies with the timing requirements for the general notice. The SPD must meet all the requirements of both COBRA and of the SPD content regulation. However, spouses and dependents must still receive an initial COBRA Notice and therefore spouses and dependents still need to receive a separate initial notice.

Delivery - Are your notices mailed by first class mail to all eligible members to the last known complete address?

At the time of notification, if the last known address of the covered employee, his or her spouse, and dependent children (if any) are the same, a single first-class mailing addressed to the "covered employee and spouse and dependent children (if any)", will be in good faith compliance with the notice requirements.

In the event that employees and qualified beneficiaries/dependents [live at separate addresses](#), separate notices must be sent to their respective addresses. Hand delivery is not recommended.

COBRA notices must be sent to the QB's last known mailing address to be in good faith compliance. If not, the plan administrator may be subject to notice penalties if the QB claims that the notice was never received. It is therefore critical that address changes that might be reported to another department are communicated to the plan administrator. Even omitting the street designation "North" from an otherwise correct address raised enough questions about an employer's compliance for a federal district court in MN. to deny the employer's summary judgment motion to dismiss a COBRA claim. *Amin v. Flagstone Hospitality Management* 11/14/2005.

Record Retention - Do you retain proof/record of mailing

Proof of mailing should be retained. Documentation alternatives are either: (a) a log, or (b) Certificate of Mailing. The employer must demonstrate that the Notice was sent, not received.

We recommend "Proof of mailing" receipts, [not "Certified Mail"](#). Often, people do not pick up their "Certified Mail". In this case you will be notified that your QB did NOT receive their notice. Courts will establish what your standard of care is in this event.

Addition of Covered Individuals - Are initial notices sent to employees and dependents who are later added to the plan?

(I.e... Open Enrollment, Marriage, Birth or Adoption)

General Notices must be sent to additional dependents whenever a new dependent is added to the plan at a time later than the employee's entry. This is often missed.

QUALIFYING EVENT NOTICE (and election form)

Updating of Notice - Have your Qualified Event notices and election forms been [updated](#) for final Regs issued May 26, 2004 and State COBRA Changes? USERRA Changes?

New final regulations, issued effective May 26, 2004 address notice and notification requirements. The DOL released an updated model Qualifying Event Notice and Election form for use primarily by single-employer plans. These forms are not suitable for multiple-employer plans, plans sponsored by unions for their members or to be used when bankruptcy is the qualifying event. This model notice is available on our web site. Employers should understand that although the model notices meet the requirements of federal COBRA, it is advisable to have additional provisions and language in their notices in addition to the provisions in the model notices. We recommend that employers have their ERISA attorney review their documents. The issues are the same as with the General Notice.

The Department of Labor will no longer consider use of the model general notice in ERISA Technical Release 86-2 (June 26, 1986) to be good faith compliance with the requirements of COBRA. All COBRA notices should be updated promptly.

State laws may affect your General Notice requirements as well. For example, in California, AB 1401 provides a Cal-COBRA extension for up to 18 months following the end of Federal COBRA. AB 2208 mandates "equal" coverage for domestic partners. You may wish to [add Cal-COBRA information](#) to your General Notice informing individuals of this right. If your plan will offer COBRA or COBRA-like benefits to domestic partners, you will need to add language pertinent to [domestic partner issues](#).

Another California requirement ([AB 356, 2005](#)) is additional language warning employees of the dangers of applying for individually underwritten insurance during their COBRA election period. The language is:

"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

The Employer Is Responsible For Which Qualifying Events?

Termination of employment
Reduction in hours of employment
An employee's Medicare entitlement
Death of an employee, or
Chapter 11 bankruptcy (limited to retirees)

To the extent such events cause a loss of coverage under the plan.

Timeline for Qualifying Event Notice

The employer has up to 30 days to notify the Plan Administrator that a QE has occurred.

The Plan Administrator has 14 days to send the QE Notice and Election Form

The QB has 60 days to elect COBRA

The QB has 45 days to make the first premium payment

The 30-Day Employer Notice Period

COBRA allows the employer 30 days to notify the Plan Administrator that a QE has occurred. The Plan Administrator usually is the employer or a Provider the employer has contracted with. In either case, the Plan Administrator should be clearly and consistently identified in the SPD and in all other materials describing COBRA.

The 14-Day Plan Administrator Delivery Period

The Plan Administrator must send the election notice within 14 days of notification. When [the employer is also the plan administrator](#), the employer has the full [44 days](#) to send the notice. [If the employer uses a Third Party Administrator \(TPA\)](#) the 44-day period controls unless the TPA has agreed to be the ERISA Plan Administrator.

Employers who are accustomed to using the entire 44-day period who later contract with a [COBRA Administrator who becomes the Plan Administrator](#) have only 30 days now to notify the plan administrator and should take steps to change their processes to meet this requirement.

[With a little planning](#), managers can reduce the notification period by using their own records. For instance [dependents' birth dates](#) are often part of employees' records. Periodic review can therefore alert managers to the moment when dependents are no longer qualified and can cut up to 60 days off the COBRA election period. Cutting the time line down can save the Plan considerable money. If the employer gets its notification out immediately as opposed to waiting possibly 60 days for the dependent to notify the employer of the QE, this will [reduce the window of free coverage up to 60 days](#).

In a survey conducted by Charles D. Spencer & Associates, Inc reported in the Employee Benefit Plan Review, September 1993 p. 14, average continuation of coverage claim costs were [148% of active employee claim costs](#). The survey had 204 respondents (108 employers with more than 500 employees, 60 employers with less than 500 employees and 36 Third Party Administrators). The higher cost is attributed to [anti-selection](#) and emphasizes the need to keep election periods to the minimum required period of time.

The 60-Day QB Election Period

Once notified, the Qualified Beneficiary (QB) must have at least a 60 day period to elect COBRA, with the election period ending the later of:

- 1) 60 days following the date coverage ends on account of the QE, or
- 2) 60 days following the date of the notice.

The date coverage ends is the first date of no coverage. If the election period ends on a Saturday, Sunday or Holiday, the election period must be extended to the next business day. COBRA elections are deemed made on the date sent. (Keep the envelopes and postmarks)

Each QB has independent election rights. In some plans, the date of loss of coverage can be different for employees and dependents. And it is possible to have different election period ending dates for each coverage type (i.e. some plans may end on the last day of the month and others may end on the date of termination).

Incapacitation of the QB can extend the election period by the period of incapacitation.

The 45-Day Initial Payment Period

Once the Qualified Beneficiary (QB) elects COBRA, they have 45 days from the election date to make the first premium payment. Generally, the employer may require that all retroactive premiums be due and paid by the end of the 45 day period (current to within 30 days).

However, if the QB wishes to have only one month of COBRA coverage without the opportunity to continue coverage beyond the first month, the employer must permit payment of only the first month of COBRA continuation coverage.

During the initial election period and initial 45-day grace period, the QB can pay 1 month at a time and coverage must be furnished for the month(s) paid. The employer should outline a procedure with respect to the premium due date and premium collection, inform QBs of the procedure and apply it consistently. Premiums are deemed made on the date postmarked.

The Reinstatement Method: If the employer reinstates COBRA coverage for a QB before premiums are received, the employer is at risk if the QB does not pay the premium within the grace period. Remember, the notice hopefully went out within 14 days of termination, the QB had 60 days to elect and add to that the 45 day grace period and 4-5 months premium may be due. However, many insurers may only permit retroactive terminations up to 30 days. This may leave the employer exposed to 3 months premiums per QB. To protect employers, the 1999 Final Regulations state that in the case of plans that allow retroactive reinstatement of coverage, coverage can be terminated at the time of the qualifying event and reinstated when the election (and, if applicable, premium payment) is made.

The Employee/QB Is Responsible For Which Qualifying Events?

The Employee or other Qualified Beneficiaries (QB) are required to provide notice to the plan administrator of the following Qualifying events:

- * Divorce or legal separation
- * Dependent child ceasing to be a dependent
- * When a Social Security Administration determination of disability occurs
- * A subsequent qualifying event that occurs during the initial COBRA period (18 months to 29 months)

Employers must establish "reasonable" procedures for providing notice to the plan administrator in these situations. Procedures are reasonable if:

- * The notice procedures identify the person or entity to whom the notice must be provided
- * The procedures specify the means by which the notice must be provided
- * The procedures specify the information that the plan deems necessary to show such an event has occurred
- * The procedures are described in the SPD and in the general notice

The plan must allow a QB at least 60 days from the later of the date of delivery of the General Notice, the date of the Qualifying Event, the date coverage ends, or the date of disability determination (in the event of disability) to provide this notice to the plan administrator.

Following the notice by the QB, the time lines discussed apply.

NOTE: if reasonable procedures are not established, any written or oral communication that identifies the specific event and is made to any person who usually handles the employer's benefit matters may be deemed sufficient notice.

Disclosure Duty to Health Care Providers:

During election periods, any grace period for premiums and especially if using the retroactive reinstatement method, the plan must truthfully, accurately and completely inform any health care provider who inquires about the coverage status of a QB. This should include the date active coverage ends, the date the COBRA election period ends, whether or not the COBRA election has been made, whether or not the premium has been paid, the date the premium is due and the fact that coverage will be retroactive if election and payment is made timely. This is all very important since new rules provide that a third party has the ability to elect COBRA for a QB. Anyone can make the premium payment. Premium payment is an election of COBRA.

For example, if a hospital calls to ask if a person has insurance coverage, the employer cannot simply say there is no coverage. The employer must give the health care provider a complete response by confirming that the QB is in their COBRA election period, whether an election has been made, when the election period ends, the status of premium payment such as when the grace period for premium payment ends and the

fact that coverage will be reinstated retroactively if timely election and timely payment is made. Since much of this information may be given by phone, employers should document the telephone call along with what information was given, when and to whom.

Trade Assistance Act (TAA)

The Trade Adjustment Act of 2002 expands COBRA benefits to workers who lose their jobs or have a reduction in hours as a direct result of competition from foreign trade or production being moved to other countries. It provides: 1) for a second COBRA election period of 60 days to TAA-certified former employees and 2) a tax credit for up to 65% of the premiums paid for COBRA medical coverage and other qualified plans. The special second election period begins on the first day the month during which the individual becomes TAA eligible and the election must also be made within six months of the initial loss of coverage. COBRA coverage then begins on the first day of the second election period (no provision for making coverage retroactive to the initial date of loss of coverage. However, the gap in coverage from the initial loss of coverage date to the start of the second election period is not counted as lapse in coverage for the purposes of HIPAA's 63-day lapse in coverage rule. The IRS has indicated that the second COBRA election period does not extend the original COBRA benefit period.

If you believe the Trade Adjustment Act applies to you, go to http://wdsc.doleta.gov/trade_act/ on the web for more information or consult with your ERISA attorney

Procedures for Qualifying Event Notice and Election

Keep proof of mailing. The Department of Labor, states that employers should always mail COBRA notices by 1st class mail and that handing a former employee a COBRA notice in an exit interview will not satisfy proper notification criteria. To help avoid lawsuits, employers should maintain consistency when sending COBRA notifications by using first class mail, preferably with a Certificate of Mailing.

Documentation alternatives are either: (a) [a consistently maintained Log](#), or (b) certificate of mailing. Although proof of mailing is not required, "Certificate of Mailing" proves you mailed the envelope, and it goes by first class mail (which can be forwarded by the Post Office). Certificate of Mailing is cheap insurance to prove you mailed your notices timely. Notification is deemed made on the date it is mailed, according to proposed regulations.?

Do not use "certified mail", which requires a signature at the receiving end. Many Qualified Beneficiaries (QBs) may not go the post office timely to pick up their certified mail. You will be informed that they did not receive their notice resulting in the requirement that you repeat the mailing over and over again. Also, problems may arise if a neighbor, grandparent or other person signs for it and the QB does not receive it. Further, administrators may be setting themselves up to possibly have to produce the returned receipt if sued over notice violations.

Mail to all eligible members: At the time of notification, if the last known address of the covered employee, his or her spouse, and dependent children (if any) are the same, the Department will consider a single first-class mailing [addressed to](#) the covered

employee, his/her spouse, and dependent children (if any), to be in good faith compliance with the election notice requirements of ERISA Section 606(a)(4), provided that a separate election notice for each qualified beneficiary is included in that single mailing or, if a single notice is sent, it clearly identifies the qualified beneficiaries covered by the notice and clearly explains the separate and independent right each has to elect COBRA continuation coverage.

In the event that employees and qualified beneficiaries/dependents live at separate addresses, separate notices must be sent to their respective addresses.

Exit Interviews: Employers must not use the exit interview as the notification of COBRA rights. The Department of Labor states that without exception, employers should always mail COBRA notifications. Handing a notice to an employee in the exit interview does not satisfy proper notification procedure. Use mailing procedures, instead.

Have a system for maintaining current addresses: You might consider mailing a notice once per year asking for current home addresses and the address of any other dependents living at another address. Make sure your other departments, such as your payroll department shares any updated address information with your HR department or whoever is responsible for COBRA administration. Finally, you should keep any returned notices as proof that the notice was mailed to the last known address. .

At a minimum, a COBRA notification system must have a way of keeping the address database up to date for changes. Often, a QB will change addresses in one of the employer's recordkeeping systems (for payroll purposes, for example) and no coordination is done with other relevant data bases. This could lead to a COBRA failure. Having a formal system in place for updating addresses is recommended. If you use a third-party record keeper, create procedures to make sure they are informed of address changes.

Waiving COBRA Coverage

Some employers hope to induce QBs to waive their COBRA rights by including a box to check on their Qualifying Event forms for such purpose.

Employee can elect coverage for dependents, but they may not waive coverage for them. An employee's waiver of dependent election rights is invalid.

If a QB waives COBRA coverage, the waiver can be revoked at any time during the election period, but coverage need not be reinstated retroactively. If you use waivers, indicate the following in writing: 1) The waiver can be revoked and 2) Claims that occur in the waiver period may not be covered.

Some authorities believe that offering a COBRA waiver may be a violation of the Plan Sponsor's ERISA fiduciary duty to operate the Plan exclusively in the interests of the plan participants. This issue is best discussed with your ERISA attorney.

OTHER NOTICES

Open Enrollment Notice

COBRA QBs who elect coverage have rights during open enrollment periods. You must inform them of their rights. The Notice should include information on the options available during the open enrollment period and the monthly premium rates for these options. The employer has 60 days to give notice of a rate change, but cannot charge the increased rate until after the notice has been given. ERISA requires that notification of plan and or benefit modifications should be sent to all participants and COBRA Continuers "within 60 days after the change has been adopted by the plan." You should [include in the group of continuers those individuals who are in their 60-day election period, individuals who have elected but who have not yet paid, and individuals who have elected and paid.](#) Use mailing procedures previously discussed.

Conversion Notice

If your plan allows conversion to individual coverage, a notification within the last 180 days must be sent. Usually non-medical plans, such as dental and vision plans, do not offer conversion policies, but if they do, you must send a conversion notice for these plans, too. The notice must include information on whom to contact to convert and the date coverage ends. Send this notice by first class mail to the Qualified Beneficiary's last known address. In California, AB 1401 provides that all group plans will offer conversion coverage. See the section on AB 1401 below.

ERISA Summary of Material Modifications

ERISA requires COBRA participants to be notified of any material changes in the plan. See "Open Enrollment Notice" above.

Notice of Insignificant Premium Underpayment

An employer must be consistent with all QBs. Therefore if you accept a short payment from one QB as payment in full you [must do the same for all QBs](#). A payment short by the allowed 10% each month can accumulate to nearly 2 premiums in 18 months. The employer may attempt to collect the shortage by notifying the QB and allowing 30 days for them to pay it. However, carriers do not have to honor this additional grace period, leaving the employer responsible for covering the shortage if they cannot collect it. The notice must inform the QB of the amount of the underpayment and the fact that coverage will terminate if the balance of the payment is not received. The QB must be given at least 30 days to pay the short amount. Use mailing procedures previously discussed.

What is "insignificant" is defined in Final Regulations issued in January 2001. "Insignificant" means the shortfall is not greater than the lesser of 1) \$50 or 2) 10% of the amount to be paid. The IRS may modify the \$50 amount through future guidance. See "Rights of Qualified Beneficiaries" above.

CARE/HIPP Notice (California Employers)

You must inform QBs of their right to apply for CARE/HIPP benefits. Mail this notice along with your Qualifying Event Notice. It notifies your QBs that if they qualify, the State of California will pay their COBRA Premium.

Notice of Ineligibility

New final regulations, issued 5/04, require that if the Plan Administrator receives a qualified beneficiary's notice of a qualifying event and determines that a participant is not eligible for continuation coverage, an "Unavailability Notice" is required. Final rules clarify that the "unavailability notice" must be furnished when the plan administrator denies coverage regardless of: (1) the [basis of the denial](#); and 2) [whether the notice involves a first](#) qualifying event, a second qualifying event or a request for a disability extension. The plan administrator must notify the individual of that determination within 14 days of receiving the notice of a qualifying event and include an explanation of why he or she is not eligible for COBRA.

Early Termination Notice

COBRA permits early termination in a number of circumstances, such as:

- * when the employer [ceases to offer group health](#) coverage to its employees
- * when the required premium payment is not timely paid
- * when the [QB becomes covered under another employer sponsored health plan](#) or Medicare
- * when the [QB commits fraud](#) on the plan

In the event of early termination under such circumstances, the Plan Administrator must send a notice of coverage termination. The DOL believes the notice of early termination serves an important administrative function and permits QBs to take appropriate next steps to protect their access to health coverage, either on a group or individual basis.

The notice must be provided as soon as administratively practicable after the termination decision is made and before the regular coverage period is exhausted. It must explain why and when the continuation termination coverage is being terminated, and must describe any rights to other coverage the QBs will have upon termination.

Plans may provide this notice with the HIPAA certificate of creditable coverage. The IRS does not provide model notices.

Termination Due to Other Coverage: The employer may end COBRA early if the QB **first** becomes "entitled" to ("entitled" means actually covered under a plan) another employer's health plan or to Medicare after election of COBRA. However, if the other group health plan limits or excludes coverage for any pre-existing condition, other than an exclusion or limitation which does not apply to or has been satisfied under HIPAA, COBRA must continue to be offered. Care should be exercised here because the employer may not be able to determine whether the other coverage has limitations that will apply to the QBs coverage needs.

HIPAA Portability

HIPAA includes specific protections for employees leaving their jobs or changing jobs by requiring insurers to offer policies to individuals who are not eligible for COBRA, or have already exhausted their COBRA coverage. HIPAA requires all health insurance issuers offering coverage to individuals to accept any "federally eligible individuals" who apply for coverage. A federally eligible individual:

- * has had **18 or more months of continuous creditable coverage**, at least the last day of which was under a group health plan;
- * **has exhausted any COBRA and/or Cal-COBRA** coverage continuation rights;
- * **is not eligible** for Medicare, Medicaid, or a group health plan;
- * does not have other health insurance;
- * **must apply** for health insurance for which he or she is federally eligible **within 63** days of losing prior coverage; and
- * must not have had their most recent health care coverage terminated because of fraud or nonpayment of premiums.

Under HIPAA, a health insurance issuer cannot reject an individual if the individual is federally eligible, agrees to pay the required premiums and lives inside the health plan's service area. An eligible individual does not need to prove insurability, and cannot be excluded from health coverage due to pre-existing conditions. Coverage must be renewed at the individual's option unless he or she does not pay the required premiums, commits fraud or misrepresentation, moves out of the plan's service area, or the health plan withdraws from the individual health plan market.

HIPAA's guaranteed availability requirements do not apply in a state that implements an alternative mechanism which provides federally eligible individuals access to individual health insurance without preexisting condition exclusions. California, implements such alternative mechanisms.

California guarantees federally eligible individuals the right to buy coverage from any insurer selling individual coverage. Insurers may limit an individual's choices to two policies--either the insurer's two most popular policies or two representative policies. An insurer offering two representative policies must provide a selection of a policy with a high benefit package and one with a low benefit package. If a person does not meet the federally eligible individual definition, insurers have the right to turn him or her down due to health status or other factors.

California legislation regulates HIPAA coverage and rates. For health care service plan contracts offered through an HMO or a non-PPO health insurer, federally eligible individuals between the ages of 60 to 64 cannot be charged more than 170% of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area. Carriers are also limited to one rate increase per year.

Similar rate protection extends to individuals covered under conversion coverage mandated by the Knox-Keene Act and other California Codes. Generally, individuals who lose group health care coverage have the right to continue their coverage with the

same insurer under an individual plan after they have exhausted COBRA and Cal-COBRA. Individuals must elect conversion coverage within 63 days of the date their COBRA or Cal-COBRA coverage ended. A health plan may deny an individual application if the individual's coverage under the group contract was less than three months, or if the individual is already covered by or eligible for Medicare. Individual Conversion Coverage offers special protections so that individuals do not need to show evidence of insurability, and cannot be excluded due to a pre-existing condition.

For further information, Georgetown University Health Policy Institute's "A Consumer's Guide to Getting and Keeping Health Insurance," www.healthinsuranceinfo.net provides a summary of consumer rights and protections in all 50 states.

AB 1401 – CAL-COBRA

Continuation: Generally, individuals who began receiving federal COBRA on or after January 1, 2003, who were entitled to less than 36 months of coverage under federal COBRA, and who exhaust that coverage will be eligible to continue that same coverage through Cal-COBRA for up to 36 months from the initial effective date of federal COBRA coverage. Self-insured plans of private-sector employers are not required to comply with Cal-COBRA because of ERISA preemption.

Cal-COBRA applies to Plans that are domiciled in California. If the plan is domiciled in California, Cal-COBRA applies to all covered employees, even those employed outside of California. If the plan is domiciled in another state, Cal-COBRA does not apply, even to employees located in California.

Eligibility: To be eligible for the extension of benefits, enrollees in federal COBRA must satisfy all of the following:

- 1) exhaust federal COBRA coverage on or after January 1, 2003
- 2) have less than 36 months of federal COBRA continuation rights
- 3) live in the carrier's service area
- 4) not be eligible for other group medical coverage or entitled to Medicare
- 5) notify the insurance carrier or health plan administrator within 30 days of when their Federal COBRA terminates.

Premiums: During the extension period, the premium will be 110% of the applicable premium vs. 102% under federal COBRA. During the extension period, the insurance carrier will bill the participant directly.

Administration: Details of how this Cal-COBRA extension will be administered may be a little different for each insurance carrier. Check with your insurance carrier to be sure who is responsible for what. Generally, the employer will be responsible for the following:

- 1) Notify your carrier when a qualified beneficiary is about to exhaust federal COBRA benefits

- 2) When changing plans, notify qualified beneficiaries of their ability to continue coverage under a new group benefit plan for the balance of the period that they would have been covered under the prior group benefit plan
- 3) Notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage

Notices: Generally, ERISA preempts states from requiring that employers provide notices to employees but ERISA does require that employers provide participants with adequate information to explain the plan benefits and participant rights. It would be prudent for employers to at least provide a general statement that California law permits additional continuation coverage periods and provide a contact person at the insurer to get more information. You may want to consult with your ERISA attorney regarding the actual wording.

Tricky:

- 1) dental and vision coverage is NOT eligible for the 36-month extension under Cal-COBRA
- 2) who would want to apply for a Federal COBRA disability extension and pay 150% of the applicable premium when you can pay 110% under Cal-COBRA
- 3) not every carrier is subject to AB 1401. Carriers must be domiciled in California to be subject to the law
- 4) self-funded ERISA plans are not subject to AB 1401 (Government self-funded plans are subject to AB1401)
- 5) many COBRA outsourcing services do not assist with AB 1401.

Outsourcing COBRA Administration

It is a mistake to believe that outsourcing COBRA administration will allow the employer to avoid all responsibility and legal liability for COBRA administration. The employer must be concerned with the following issues:

- 1) The service provider may not be there forever. Any number of changes may cause the employer to want to change or have to change their provider. For example the provider could leave the business, the provider may get bought out by a less desirable company, administration costs may increase and become too high, or your benefits may change so that the current provider cannot practically service you. Without an understanding of COBRA issues, the employer may be unable to deal with such a change.
- 2) A service provider is only as good as the information the employer provides to it. The employer must therefore understand COBRA and its requirements. Plan participants will frequently inform the employer of qualifying events, such as when an employee tells your payroll department to change withholdings or exemptions due to divorce or offers address change information. In addition, the employer must inform the service provider about rate changes, provider changes, benefit changes and new benefits. So the employer cannot get out of the picture entirely.

- 3) You may have multiple plans, each with different administration. If the service provider does not administer them all, the employer is still responsible and the confusion can lead to mistakes.
- 4) Plan documents, Summary Plan Descriptions and COBRA notices must ALL consistently describe the various parties and their responsibilities. This may not be possible with off-the-shelf insurance company provided plan documents and SPDs. If the employer contracts to shift the COBRA liability to a service provider, the contract can be completely undone by SPD language that instructs QBs to deal with the "plan administrator" i.e. the employer (see #90 below). Thus the employer retains the responsibility for all plan documentation and employee communications. Documents should be reviewed by a COBRA knowledgeable attorney.
- 5) You should consider the service provider's ability to administer COBRA the way you wish (i.e. can they or do they end coverage on the date of termination or at the end of the month, as you wish.) Also can they be more liberal than the law if that is what you wish or do you give up the flexibility on this issue.
- 6) The employer always remains responsible for the COBRA administration, whether or not a third party has been hired to provide the administration service. The employer has a FIDUCIARY duty to monitor the quality of the service provider.

Take the recent case of *Scott v Suncoast Beverage Sales, Ltd.*, (11th cir., June 25, 2002)

The employer outsourced its COBRA notice responsibilities to an independent third party firm. In this case, the employee did not receive his COBRA notice from the TPA even though the employer timely notified the TPA of Scott's qualifying event. The 11th circuit court held the employer liable for \$10,800 in notice penalties. The employer's defense of "good faith attempt to comply" was denied on the grounds that "Simply hiring an agent and then instructing the agent to send notice is not sufficient to satisfy the statute".

This case is significant in that it specifically states that a plan administrator remains liable for COBRA outsourcing errors committed by its TPA/service provider. This is consistent with the Department of Labor's position. The employer must take the necessary steps to ensure that the agent will, in all cases, make the necessary notifications.

- 7) Finally, we find that most service providers either do not administer State law requirements related to COBRA, or offer only limited help. Failing state law can create enormous liability just as failing federal COBRA can. That leaves the employer in the position of having to split all the hairs over who is doing what. Ask us for help here. We can help you choose a satisfactory service provider relationship.

When the Department of Labor Audits for COBRA compliance, they will probably ask for the following 6 items:

- 1) Copy of the Policy and Procedures
- 2) Notices (including conversion if it is available)
- 3) Tracking of the notices to employees
- 4) Tracking of premiums
- 5) Staff is properly trained – with documentation
- 6) External audit of the procedures used

What else can you do?

- 1) It is a good idea to obtain errors and omissions insurance specifically for employment practices including COBRA.
- 2) Purchase a service to provide you with updates on legislation and lawsuits.
- 3) Use your ERISA attorney's expertise to review all documents and procedures
- 4) Regularly review your procedures and audit the work.
- 5) Document everything you do, including training and procedure changes.
- 6) Consider purchasing an out-sourcing COBRA solution.
- 7) Alternatively, consider purchasing COBRA administration Software.

This guide is intended only as a partial summary of the IRS Regulations regarding COBRA. Additional information may be obtained from the Department of Labor, the Department of Treasury, the Department of Health and Human Services or your attorney. This checklist is to be used in conjunction with a Group COBRA Compliance Guide offered by a multitude of publishing companies, such as Thompson Publishing, EBIA or Charles Spencer. For specific questions, you must seek an opinion from your own legal advisor.

The information contained in this document is not intended to be legal, accounting or other professional advice. We assume no liability whatsoever in connection with its use, nor are these comments directed to specific situations.

Content may become outdated quickly and other professionals may interpret COBRA administration requirements differently. March 19,2008

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