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Legislative Brief

COBRA Regulations: Handy Reference Guide

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that employers provide former employees and dependents who lose group health benefits with an opportunity to continue group health insurance coverage. Since COBRA was originally enacted in 1985, the Internal Revenue Service (IRS), the agency responsible for defining required COBRA coverage, has released three sets of proposed regulations and two sets of final regulations. The IRS released its most recent regulations in January 2001 that finalized the 1999 proposed regulations and made some changes to the final regulations released in 1999.[1] This [b_officialname] Legislative Brief is intended to provide you with a *consolidated* look at the guidance provided in the final IRS regulations released in 1999 and 2001.

Small Employer Exception[2]

- Group health plans maintained by an employer that had fewer than 20 employees on at least 50% of its typical business days in the previous calendar year are not subject to COBRA. *(1999 final regulations)*[3]
- Only common law employees are taken into account for purposes of the small employer plan exception. Self-employed individuals, independent contractors, and directors are not counted. *(1999 final regulations)*[4]
- Both part-time and full-time employees must be counted, whether they are eligible for health insurance or not. *(1999 final regulations)*
- Part-time employees must be counted on a pro-rata basis. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee works for the employer divided by the number of hours that an employee must work in order to be considered full time. This method of calculation is intended to produce the same result regardless of how the hours are scheduled. *(1999 proposed regulations; 2001 final regulations)*
- Employers may count part-time employees either on an individual basis or on an aggregate basis because both methods produce the same results. Therefore, an employer can determine the number of part-time employees for COBRA purposes by looking at each employee's hours for the year or by adding up all hours worked by part-time employees and dividing it by the number of hours required for one worker to be considered working full time. *(2001 final regulations)*

Payment of Premium

- Where the COBRA premium remitted is short by an amount that is not significant, the plan must either a) treat the payment as satisfying the plan's payment obligation, or b) notify the qualified beneficiary of the deficiency and allow a "reasonable period" (which is generally 30 days) for the deficiency to be paid. *(1999 final regulations)*
- An amount is considered insignificant if it is not more than the lesser of $50 or 10% of the required premium amount. *(2001 final regulations)*
- Payment is made on the date it is sent. *(1999 final regulations)*
- A third party may pay COBRA premiums on behalf of a qualified beneficiary. *(1999 final regulations)*

[1] The 1999 final regulations apply to qualifying events occurring in plan years beginning on or after January 1, 2000. Generally, the 2001 final regulations apply to qualifying events occurring on or after January 1, 2002.
[2] The 2001 final regulations adopted the 1999 proposed regulations without change, but clarified the ability to use individual or aggregate calculations.
[3] The 1987 regulations used the term "working days."
[4] The 1987 regulations required the inclusion of self-employed individuals, independent contractors, and directors.

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Core vs. Non-Core Benefits

- Qualified beneficiaries must be given the same rights to elect coverage as similarly situated active employees. *(1999 final regulations)*
- All health care benefits provided by an employer are treated as one plan unless it is clear from the documents governing the arrangement that the benefits are being provided under separate plans and that the arrangements are operated pursuant to such documents.[5] (*2001 final regulations*)
- The determination of whether benefits are provided under one plan or separate plans impacts a qualified beneficiary's right to separately elect medical, dental, or vision benefits.

  Example: Employer Y offers two health plans: one provides major medical and one provides dental. An employee covered under both plans at the time of a qualifying event has a right to elect a) medical, b) dental, or c) both.

Health Flexible Spending Arrangements (Health FSA)

- Health FSAs are subject to COBRA, with some exceptions. (*1999 proposed regulations; 2001 final regulations)*
- An employer is not required to offer COBRA where the maximum amount that the employer could require to be paid for a full year of COBRA coverage equals or exceeds the maximum benefit that the qualified beneficiary could receive under the Health FSA for that year. (*1999 proposed regulations; 2001 final regulations)*
- Where a Health FSA is not subject to HIPAA,[6] COBRA does not require that a qualified beneficiary be entitled to extend their Health FSA where the account has been overspent as of the date of the qualifying event. (*1999 proposed regulations; 2001 final regulations*)
- Where a Health FSA is not subject to HIPAA, COBRA requires that a qualified beneficiary be entitled to extend their Health FSA **through the end of the current plan year** where the account was under spent as of the date of the qualifying event. (*1999 proposed regulations; 2001 final regulations*)
- A careful review of the regulations is warranted in situations where an employer contributes funds to a Health FSA on behalf of an employee and where no other health plan is sponsored by the employer.

Qualified Beneficiaries Moving Outside the Service Area

- Employers must make alternative coverage available to qualified beneficiaries moving outside the service area of a region-specific benefit package. (*1999 final regulations*)
- Where a qualified beneficiary moves outside the service area, an employer must offer coverage under any of its existing plans. (*1999 final regulations*)
- Alternative coverage must be made available not later than the date of the qualified beneficiary's relocation, or, if later, the first day of the month following the month in which the qualified beneficiary requests the alternative coverage. (*2001 final regulations*)
- An employer is not required to incur extraordinary expenses to extend coverage to qualified beneficiaries in areas in which the employer does not have active employees. *(2001 final regulations*)

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[5] The 1987 regulations required an employer to unbundle the non-core and core benefits if the cost of electing non-core benefits was greater than 5%. The 1999 proposed rules suggested that the employer first look at that the instruments governing the employer's arrangement to determine whether benefits were offered under separate plans.

[6] A Health FSA is exempt from HIPAA if: 1) a) the maximum Health FSA benefit is not more than the greater of two times the annual salary reduction election, or b) the annual salary reduction election plus $500; 2) the employee has other employer group health coverage available; and 3) the other coverage is not solely excepted benefits.

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Loss of Coverage Includes an Increase in Premium

- An increase in employee premium or contribution toward the cost of health insurance coverage as a result of a qualifying event is considered a loss of coverage for purposes of COBRA. (*1999 final regulations*)
- The IRS and Treasury Department defined a loss of coverage to include an increase in premium in order to provide the qualified beneficiary with a 60-day election period and 45-day grace period to make the first premium payment. (*2001 final regulations*)

Termination of Coverage in Anticipation of a Qualifying Event

- If coverage is reduced or eliminated in anticipation of an event, the elimination or reduction is disregarded in determining whether the event causes a loss of coverage. (*1999 final regulations*)
- For employer bankruptcy, a loss of coverage includes substantial elimination of coverage that occurs within 12 months before or after the date on which the bankruptcy proceeding begins. (*1999 final regulations*)
- Where an employee eliminates a spouse's coverage in anticipation of divorce, an employer must make COBRA continuation coverage available, effective upon the date of the divorce or legal separation. The employer is not required to provide coverage for any period before the date of the divorce or legal separation. (*1999 final regulations*)
- The qualified beneficiary is entitled to the coverage that the qualified beneficiary had before the qualifying event or to the benefits currently offered to similarly situated non-COBRA beneficiaries. (*2001 final regulations*)

Administering Claims during the Election Period

- The employer must make COBRA continuation coverage available for the entire election period if the qualified beneficiary elects coverage prior to the end of the election period. (*1999 final regulations*)
- In the case of an indemnity or reimbursement arrangement, the employer can provide coverage during the election period, or if the plan allows retroactive reinstatement, the employer can terminate the coverage of the qualified beneficiary and reinstate him or her when the election is made. Claims incurred during the election period do not have to be paid before the election — and if applicable, payment for the coverage — is made. (*1999 final regulations*)
- If a health care provider contacts the employer or group health plan to confirm coverage of a qualified beneficiary during the election period, the plan must give a complete response. The response should include the status of the election, whether payment has been made, and other relevant information related to the qualified beneficiary's right to coverage. (*1999 final regulations*)

Duration of COBRA Coverage

- Where a qualified beneficiary is no longer disabled, COBRA may be terminated in the month that is more than 30 days after a final determination that a qualified beneficiary is no longer disabled. Termination of coverage applies for all qualified beneficiaries whose coverage is provided pursuant to the disability extension. However, coverage may not be terminated prior to the original 18-month continuation period. (*1999 proposed regulation; 2001 final* regulations)
- Where a qualified beneficiary is born or adopted during a COBRA period and applies for the disability extension under COBRA, the 60-day period is measured from the date of the child's birth or adoption. (*1999 final regulations*)

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- COBRA may be terminated where a qualified beneficiary, after the date of election, **first becomes covered** under another group health plan that does not contain a pre-existing condition limitation or where the pre-existing condition limitation is satisfied pursuant to HIPAA. (*1999 final regulations*)
  - ✓ Mere eligibility for another group health plan does not terminate a qualified beneficiary's right to COBRA continuation coverage through his or her prior employer.
  - ✓ Coverage which was in force prior to the date of election does not serve to terminate a qualified beneficiary's right to COBRA.
- COBRA may be terminated where a qualified beneficiary after the date of election **first becomes entitled** to Medicare (Part A or B). (*1999 final regulations*)
  - ✓ Because the statute uses the term entitled, this is often an area where questions arise. The term "entitled" has been interpreted to mean covered.
  - ✓ Coverage under either Part A or B is sufficient to terminate a qualified beneficiary's right to COBRA.
  - ✓ If a qualified beneficiary is covered under Medicare prior to making his or her COBRA election, the qualified beneficiary continues to have COBRA rights.

FMLA & COBRA

- A qualifying event occurs when an employee who is covered under a group health plan immediately prior to FMLA leave (or who becomes covered under a group health plan during FMLA) does not return to work with the employer at the end of the FMLA leave and would, but for COBRA, lose coverage. (*1999 proposed regulations*; *2001 final regulations*)
- The qualifying event is deemed to occur on the last day of the employee's FMLA leave. The maximum coverage period begins on that day. (*1999 proposed regulations*; *2001 final regulations*)

Multiple Employer Plan Withdrawal

- An employer's cessation of contributions to a multi-employer plan is not a qualifying event for purposes of COBRA. (*1999 proposed regulations; 2001 final regulations*)
- A multi-employer plan must make COBRA coverage available to a qualified beneficiary who was receiving plan benefits on the day before contributions ceased, and is or whose qualifying event occurred in connection with a covered employee whose last employment before the qualifying event was with the multi-employer plan. (*1999 proposed regulations; 2001 final regulations*)
- Where a non-contributing employer has another existing plan or establishes another group health plan covering a significant portion of its employees previously covered under the multi-employer plan, the plan established by the employer must make COBRA coverage available to existing qualified beneficiaries. (*1999 proposed regulations; 2001 final regulations*)

Business Reorganizations

- Parties to a transaction involving a sale of company assets or stock are free to allocate responsibility for COBRA continuation coverage by contract. However, where the party that is contractually obligated to provide COBRA defaults, the party otherwise obligated by law to provide COBRA remains liable. *(1999 proposed regulations; 2001 final regulations)*
- For both sales of stock and sales of substantial assets, if the seller continues to maintain a group health plan after the sale, the seller retains the COBRA obligations. *(1999 proposed regulations; 2001 final regulations)*

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- Where the seller no longer provides any group health plan to any employee, the responsibility for providing COBRA falls on the buyer that is a successor employer. *(1999 proposed regulations; 2001 final regulations)*
- Whether an employee has experienced a qualifying event as a result of a business reorganization is determined in part by the type of transaction that takes place (stock vs. asset). The regulations contain numerous examples which demonstrate when a qualifying event has occurred during a business reorganization. In general, the employee must have a termination of employment *and* a loss of coverage.

Please contact your [B_officialname] representative with any questions.

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