A. The Short Course Is for You

If you thought (until recently) that COBRA referred only to exotic snakes, this short course is for you. We meet you at every EBIA seminar. You are the company's accountant or recently promoted employee assigned by the boss to "figure out this COBRA stuff." You are the new hire in HR. You are the staff person for the insurance brokerage that has decided to administer COBRA for its clients.

And now you are the newly minted COBRA administrator. This short course is just for you. No legal citations and no court cases. Just a simple guide to where you're going.

Word of Warning. This short course is general and simple. COBRA is detailed and complex, with many exceptions and special rules. At times, COBRA is vague, even contradictory. Getting COBRA wrong can have serious legal consequences. This short course orients you. When administering COBRA, do not rely on this short course alone. You must read the rest of this manual to understand the details.

B. What You'll Learn in the Short Course

The short course teaches you -

- the basic rules of COBRA;
- COBRA's peculiar vocabulary;
- the roles of the employer and the plan administrator in COBRA compliance, including action items, deadlines, and required paperwork; and
- the duties of the qualified beneficiary.

C. COBRA in a Nutshell

At the risk of oversimplification, here is the basic COBRA requirement broken into its component parts:

- A qualified beneficiary who
- loses group health plan coverage
- due to a qualifying event
- may elect to continue group health plan coverage
- for a limited time
- on a self-pay basis.

The 80/20 Rule. The basic COBRA rules cover probably 80% of the cases that a plan administrator will ever see-but dealing with the other 20% of cases requires knowledge of the exceptions and special rules. (And as is so often the case with exceptions, about 80% of this manual is devoted to the 20% of cases that are governed by the exceptions.)

What we commonly call "COBRA coverage" technically is "group health plan continuation coverage." Under COBRA, an individual who might otherwise lose coverage under a group health plan can pay to continue that coverage for a limited time.

Caution About Insurers. Except for the group health plans that insurers provide to their own employees, COBRA does not apply directly to insurers. However, the policies issued by both group insurers and stop-loss insurers generally require them to cover COBRA continuation claims. It is possible for employers to get into

disputes with insurers about whether COBRA is required in particular circumstances. Careful COBRA administrators will formulate COBRA policies and procedures after consulting with insurers, to make sure that insurance coverage will be available when the plan must provide COBRA coverage. When questions arise about whether COBRA is required in particular circumstances, COBRA administrators will likely wish to seek input from insurers; however, the potential COBRA liability (and the final decision regarding COBRA compliance) rests with the administrator and plan sponsor.

D. COBRA's Legal Framework

COBRA is a federal law whose provisions appear in three places: the Employee Retirement Income Security Act (ERISA); the Internal Revenue Code (Code); and the Public Health Service Act (PHSA). Generally, the provisions of COBRA read the same in all three statutes. The COBRA provisions of ERISA and the Code apply to the group health plans of private-sector employers, while the COBRA provisions of the PHSA apply to the group health plans of state and local governments.

Both the IRS and DOL have issued COBRA regulations. Generally, the IRS COBRA regulations relate to COBRA's rules regarding COBRA coverage, answering such questions as-what is COBRA coverage; who may elect COBRA; and how long will COBRA coverage last? The DOL's regulations relate to the notices and disclosures that employers, plan administrators, and qualified beneficiaries must provide under COBRA.

E. What Employers Are Subject to COBRA?

Almost all group health plans of private and public employers must comply with COBRA. Certain small employer plans (discussed in the following paragraph), certain church plans, and federal government plans are not subject to COBRA.

A small employer is exempt from complying with COBRA for qualifying events (discussed below) occurring in the current calendar year. An employer is a small employer if there were fewer than 20 employees employed on a typical business day during the previous calendar year. Employees of related companies are grouped together for purposes of this rule, and all employees must be counted, not just those covered by the employer's group health plan. Complex rules govern how to count part-time employees.

Note Regarding State Laws. Many states have health continuation coverage laws. Generally, these laws apply to insurers and may impose on insurers and their insurance products requirements that are different from or additional to the COBRA requirements that we discuss in this manual. In the infrequent instances when these state laws apply to employers or their health plans (not just to insurers), such laws generally are preempted by federal law. Nevertheless, employers need to be aware of state-law requirements that may affect them or their health plans, in addition to the obligations imposed by COBRA.

F. What Plans Are Subject to COBRA?

1. Group Health Plans

COBRA applies to group health plans. Generally, a group health plan is a plan that satisfies two criteria:

- it provides medical care; and
- it is maintained by an employer.

a. What Does Medical Care Include?

"Medical care" has a broad definition, including the diagnosis, cure, mitigation, treatment, or prevention of disease and any other undertaking affecting any structure or function of the body. Generally speaking, it includes medical, dental, vision, and drug treatments and coverage.

Example: Plan That Provides Both Health and Life Insurance. An employer covers all of its employees under a medical plan and group term life insurance. When an employee quits, the employee has a right under COBRA to elect to continue coverage under only the medical plan. The employee has no right under COBRA to continue group term life insurance because group term life insurance is not medical care. (Note, however, that some state laws give terminating employees the right to continue group term life insurance.)

Certain plans that provide for long-term care services are not group health plans and therefore are not subject to COBRA -even when they provide for benefits that include medical care.

b. What Is a Plan Maintained by an Employer?

Plans subject to COBRA include much more than medical insurance arrangements maintained by employers-for example:

- plans for which an HMO provides the medical services;
- group insurance plans in which employees pay the premiums;
- treatment programs and clinics maintained by employers (except for first-aid care provided free of charge to employees during working hours);
- self-insured medical reimbursement plans;
- employee assistance programs;
- health flexible spending arrangements (health FSAs) (whether offered as part of or outside of a cafeteria plan);
- health reimbursement arrangements (HRAs);
- discount programs; and
- wellness programs.

Caution: Some Voluntary Plans Are Subject to COBRA. Some employers offer their employees voluntary employee-pay-all medical insurance programs, in which the employers have minimal involvement (such as allowing the insurer to contact employees during working hours, collecting employee premiums and remitting them to the insurer, and similar activities). These arrangements can be subject to COBRA, and employers should get advice before encouraging or allowing them; otherwise, employers can be left with COBRA obligations and no corresponding insurance coverage.

2. Health Savings Accounts

Health savings accounts (HSAs) are tax-favored IRA-type trust accounts that "eligible individuals" covered by

certain high-deductible health plans (HDHPs) can establish to pay for certain medical expenses. HSAs are not subject to the COBRA requirements of the Code, even if they are employer maintained. Congress did not explicitly amend the COBRA provisions of ERISA or the PHSA to provide a similar exemption from COBRA for HSAs, but this inconsistency appears to be a legislative drafting glitch.

3. Limited Obligations for Certain Health Flexible Spending Arrangements

A health flexible spending arrangement (health FSA) is an arrangement whereby an employer agrees to reimburse an employee for out-of-pocket medical expenses up to a specified dollar limit. Employees typically pay for their health FSA coverage with pre-tax salary reductions under a cafeteria plan. Health FSAs are group health plans subject to COBRA, but they raise many difficulties in interpreting and complying with COBRA because health FSAs are not typical health insurance arrangements. Employers can design health FSAs to meet certain requirements that will allow them to offer COBRA coverage only to individuals who have "underspent" their health FSA accounts, on a limited basis and for a limited period of time.

Limited COBRA Obligation Generally Inapplicable to HRAs. The special limited COBRA obligation for certain health FSAs is not available for most HRAs. Employers that sponsor HRAs generally must offer COBRA to all qualified beneficiaries (not just those who have underspent their accounts) for the entire COBRA maximum coverage period (discussed below). COBRA compliance presents special difficulties for HRA sponsors (e.g., determining the COBRA premium).

G. What Triggers the Obligation to Offer COBRA Coverage?

Assume that an employee, Jane, terminates employment. At the end of the month, Jane's medical plan coverage will cease. In COBRA jargon, Jane has experienced a "qualifying event." That is, she has lost (or will lose) coverage due to one of the events specified in COBRA-namely, termination of employment. Her employer must offer her the opportunity to elect COBRA. In this manual, we say that termination of employment is a "triggering event." Generally, when a triggering event causes a loss of plan coverage, there is a qualifying event.

The following chart outlines the steps to take in analyzing whether a COBRA election should be offered. These steps are discussed in more detail in the following paragraphs.

This chart assumes that the plan administrator is timely notified of the qualifying event. Below, we discuss what happens if a qualified beneficiary or covered employee does not provide a timely qualifying event notice.

1. The Seven Triggering Events

COBRA has a list of seven specific triggering events. They are-

- termination of a covered employee's employment (other than for gross misconduct);
- a reduction of a covered employee's hours of employment;
- the death of a covered employee;
- a divorce or legal separation from the covered employee;
- ceasing to be a dependent child under the terms of the plan;
- the covered employee's becoming entitled to Medicare; and

- employer bankruptcy (this relates only to retiree plans).

2. The Gross Misconduct Exception

The triggering event of termination of employment does not include termination for gross misconduct. When a covered employee is terminated for gross misconduct, there is no qualifying event for the covered employee or for the spouse or dependent children. COBRA contains no definition of gross misconduct, and no consistent standard has been articulated by the courts or regulators. Except for the most flagrant conduct that is clearly a substantial and willful disregard of the employer's interests, plan administrators cannot be sure which employee conduct would fall into the category of gross misconduct.

Recommendation Regarding the Gross Misconduct Exception. The law in this area is uncertain and fact-specific. Plan administrators should seek legal advice before they deny COBRA coverage for employee misconduct.

3. What Is a Loss of Plan Coverage?

A loss of group health plan coverage means "to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event." Obviously, if one loses group health plan coverage entirely, there has been a loss of coverage. But the rule is broader than that. It applies when the triggering event causes a change in the "terms and conditions" under which an individual is covered. A loss of coverage includes-

- an increase in required premiums;
- a reduction of benefits; and
- any other change in the terms or conditions of coverage.

Example: Reduction of Benefits. XYZ Co. provides an employer-paid medical plan with two types of coverage. Coverage A is a generous package of benefits for employees who are scheduled to work at least 80 hours per month. Coverage B is a less generous benefits package for all other employees. Tom is scheduled to work 100

hours per month and has Coverage A. His employer then reduces Tom's hours of employment to 60 hours per month, which means that Tom will no longer have Coverage A benefits. Tom has experienced a loss of coverage. He must be given the opportunity to elect COBRA coverage under Coverage A, even though he is entitled to Coverage B medical benefits.

4. Triggering Event Must Cause Loss of Coverage

Carefully examine the plan documents to determine if a triggering event causes a qualified beneficiary to lose coverage. Not all events listed in COBRA cause a loss of coverage in all cases.

Triggering Event Plus Loss of Coverage Is a Qualifying Event. If no loss of plan coverage occurs as a result of a triggering event, there is no qualifying event. Likewise, if a loss of plan coverage occurs for a reason not listed as a triggering event, there is no qualifying event. If there is no qualifying event, there is generally no obligation to offer COBRA.

Example: Plan Termination. An employer terminates a medical plan that it had been providing for its employees. All of the employees have lost coverage. This is not a qualifying event, however, because the loss of coverage is due to the employer's termination of the plan. Plan termination is not a listed COBRA triggering event.

Reduction or Elimination of Coverage in Anticipation of Qualifying Event. What if Fran, an employee of X Co., cancels her husband Bill's medical insurance coverage because she plans to file for divorce? What if Cheapco cancels all medical coverage for its employees one month before laying off half of them? In these and similar cases, the IRS COBRA regulations make an exception to the requirement that the triggering event must cause a loss of coverage. We won't go into detail here, but watch out for these situations. For example, X Co. may have to offer COBRA to Bill due to his divorce from Fran, even though the divorce did not cause a loss of coverage (because Fran had canceled his coverage earlier).

5. Leaves of Absence

A leave of absence is a reduction of hours and is therefore a triggering event that may cause a loss of coverage. If an employee who takes a leave of absence does not return to work, did a qualifying event take place at the beginning of the leave or when the employee failed to return to work? These are matters that employers must determine as part of their leave policies. Special rules apply to leaves taken under the Family and Medical Leave Act (FMLA), so that a qualifying event occurs when an employee fails to return to work or gives notice that he or she does not intend to return to work.

6. Mergers and Acquisitions

Certainly there are times when a business reorganization or the acquisition of a business entity will create a triggering event (most likely termination of employment) that causes a loss of coverage for covered employees and their families. This is just the tip of the iceberg, however, when it comes to thinking about how COBRA may affect mergers and acquisitions. The IRS COBRA regulations deal (in a complex fashion) with the various COBRA consequences of mergers and acquisitions involving corporations. COBRA is an important (and potentially costly) issue in merger and acquisition negotiations, and expert legal advice should be obtained every step of the way.

7. Severance Agreements and Severance Pay

A severance agreement may provide for immediate or delayed termination of an employee's employment. It may also provide for a reduction of an employee's hours of employment followed by termination (for example, when an employee remains an employee for a period of time but is either permitted or required to not return to work). If either the termination or reduction of hours causes, or will cause, an employee or his or her spouse or dependent children to lose group health plan coverage within the COBRA maximum coverage period (we discuss the maximum coverage period below), then a COBRA qualifying event has occurred.

Often, the parties to a severance agreement don't even think about the COBRA consequences. Severance agreements should specifically address COBRA and how it will be handled; otherwise, unintended COBRA consequences and liabilities for the employer and the plan can arise.

H. Who Must Be Offered COBRA?

1. Qualified Beneficiaries

Every qualified beneficiary who will lose group health plan coverage as the result of a qualifying event must be offered the opportunity to elect COBRA within the election period. To be a qualified beneficiary, a person generally must satisfy two conditions:

- the person must be a covered employee, the spouse of a covered employee, or the dependent child of a covered employee; and
- the person must be covered by a group health plan immediately before the qualifying event (the triggering event).

A covered employee can be a qualified beneficiary only with respect to the qualifying events of termination of employment or reduction of hours of employment.

Qualified beneficiaries who do not elect COBRA when they are entitled to do so are no longer qualified beneficiaries when the COBRA election period (discussed below) expires.

Example: Coverage Immediately Before Qualifying Event. Arthur, an employee of ABC Co., is covered under ABC's medical plan. June, his wife, is covered only under her employer's medical plan. Crawford, their son, is covered under ABC's medical plan. Arthur's employment at ABC terminates and, as a result, Arthur and Crawford will cease to be covered by the ABC medical plan at the end of the month. Arthur and Crawford are qualified beneficiaries. June is not.

2. Covered Employees May Be Non-Employees

COBRA's definition of "covered employee" is expansive and includes retirees, independent contractors, self-employed persons, and partners of a partnership, as well as employees, if those individuals are provided coverage under a group health plan because they are performing or have performed services for the employer.

3. Children as Qualified Beneficiaries

In general, the covered dependent children of a covered employee are qualified beneficiaries.

a. Newborn or Adopted Children

Under a special rule, a child born to or adopted by a covered employee during a period of COBRA coverage is a qualified beneficiary entitled to COBRA coverage, even though such a child was not covered immediately before the qualifying event. Below, we discuss the length of COBRA coverage for adopted and newborn children.

Example: Newborn or Adopted Children Can Be Qualified Beneficiaries. What if Frank terminates employment with XYZ Co., elects COBRA under the XYZ Co. medical plan for himself and his wife, and then has a new baby girl, Frankie, six months later? This new member of Frank's family is a qualified beneficiary entitled to COBRA coverage.

b. Qualified Medical Child Support Orders

There is one circumstance in which a child can be a qualified beneficiary regardless of whether he or she is a dependent of the covered employee: when the child is receiving benefits pursuant to a qualified medical child support order (QMCSO). A QMCSO may require the group health plan of the noncustodial parent to provide coverage to the employee's child, even though the child may not be a "dependent" under the plan's definition.

4. Qualified Beneficiaries With Other Coverage or Medicare Entitlement

A qualified beneficiary who has other group health plan coverage or who is entitled to Medicare at the time of a COBRA election is entitled to elect COBRA and may choose to have dual coverage for the entire COBRA coverage period.

5. People Who Are Not Qualified Beneficiaries Can Obtain COBRA Coverage

A qualified beneficiary who has elected COBRA can add family members to the plan's coverage during open enrollment periods on the same basis as active employees covered by the plan. In addition, qualified beneficiaries who have elected COBRA have the same right to enroll family members under the special enrollment rules of the Health Insurance Portability and Accountability Act (HIPAA) as do employees or plan participants. (The open enrollment and special enrollment rights of qualified beneficiaries are discussed in more detail below.)

However, the addition during open enrollment or special enrollment of people who are not qualified beneficiaries does not make them qualified beneficiaries.

Example: Adding Spouse at Open Enrollment. When John's employment terminates, he elects COBRA. His wife, Julie, does not. John later adds Julie as a covered spouse during open enrollment. Julie is not a qualified beneficiary. If John dies, Julie's coverage may be terminated because she has no COBRA rights independent of John's.

6. Domestic Partners and Their Children

An unmarried domestic partner will not be a qualified beneficiary and will not have independent COBRA election rights even if covered under the plan on the day before a qualifying event. Under COBRA, only covered employees, spouses, and dependent children may be qualified beneficiaries. Note that a qualified beneficiary would be entitled to enroll his or her domestic partner for coverage at open enrollment if active employees are entitled to do so. In addition, we believe that a domestic partner's child who is covered under a plan as a dependent child will be a qualified beneficiary if covered under the plan on the day before a qualifying event.

I. What Type of COBRA Coverage Must Be Offered?

1. Coverage Offered Must Be Same as Before Qualifying Event

COBRA coverage must be identical to the coverage provided to similarly situated beneficiaries under the plan (or plans) under which a qualified beneficiary was covered before the qualifying event. This ordinarily will be the same coverage that the qualified beneficiary had before the qualifying event, and it must be offered even if it ceases to be of value to the qualified beneficiary. Special rules apply to determine how particular aspects of plan coverage, such as amounts accumulated toward deductibles, plan limits, and conversion options, will be handled once COBRA coverage begins.

Caution: Later Change in COBRA Coverage Is Possible Due to Open Enrollment or HIPAA Special Enrollment Rights. Although qualified beneficiaries generally are entitled to continue only the coverage that they had in place immediately before the qualifying event, a qualified beneficiary can have broad rights to change COBRA coverage later, as discussed below.

2. Qualified Beneficiaries May Change Coverage at Open Enrollment

If a plan has an open enrollment period for active employees, this must be made available to COBRA qualified beneficiaries as well. A qualified beneficiary may do the following things during open enrollment, if non-COBRA beneficiaries are allowed to do so:

- change benefit options or packages within the plan under which he or she was covered prior to the

qualifying event;

- add coverage for dependents; and
- switch to other group health plans of the sponsoring employer.

Consequently, open enrollment materials furnished to active employees under a plan must also be furnished to COBRA qualified beneficiaries.

3. Qualified Beneficiaries May Add Family Members Under HIPAA Special Enrollment Rules

Under HIPAA, employees who are eligible to participate in a group health plan have the right to specially enroll certain family members upon the loss of other group health plan coverage or upon acquiring a new spouse or a new dependent. Once a qualified beneficiary is receiving COBRA coverage, the qualified beneficiary has the same right to enroll family members under the HIPAA rules as if the qualified beneficiary were an employee or a participant in the plan. These rights are available only to qualified beneficiaries who timely elected COBRA and who are receiving COBRA coverage.

4. Employer Modifications to Plan

If group health plan coverage for active employees changes, then the COBRA coverage for similarly situated qualified beneficiaries also changes. For example, when an employer changes insurance companies or insurance contracts, or changes from one type of coverage to another (e.g., from an insurance arrangement to an HMO) for active employees, this change applies to COBRA qualified beneficiaries as well.

J. Length of COBRA Coverage

Let's assume that a qualified beneficiary timely elects COBRA, which we will get to in a moment. How long does COBRA coverage last? When does it start?

COBRA coverage generally starts on the date of the qualifying event (that is, on the date of the triggering event). And generally, COBRA coverage can last for the "maximum coverage period." The maximum coverage period varies according to the type of triggering event, as the following illustration shows.

1. Maximum Coverage Period

Example: Maximum COBRA Coverage Period for Employment Termination. Gary and his wife, Jane, are covered under the medical plan of Gary's employer. Gary's employment terminates on September 18, 2019. Subject to certain exceptions, if Gary or Jane elects COBRA, the maximum coverage period will be 18 months, measured from September 18, 2019. In other words, COBRA coverage could last through March 17, 2021.

Word of Explanation. If you've been involved in COBRA administration, you may be thinking, "At our company, Gary's and Jane's plan coverage would end on September 30, and the 18-month maximum coverage period would begin on October 1." Without bogging you down with details better left for comprehensive discussion later in this manual, let us say this: We've given you COBRA's general rule (the maximum coverage period starts with the triggering event). The way your company calculates the maximum is common, but it may be slightly more generous than what COBRA requires. It's okay to follow your practice, so long as your insurer approves.

Children born to or adopted by a covered employee during a period of COBRA coverage are entitled to the maximum coverage period for the qualifying event that triggered the COBRA coverage.

Example: Maximum Coverage Period for a Newborn. Murdy is an employee covered under Group Health Plan A. When her employment terminates, she elects COBRA under Plan A. Her maximum coverage period is 18 months, under the basic rule. On the last day of the tenth month of her COBRA coverage, Murdy gives birth. Her child is a qualified beneficiary. If Murdy enrolls her child in the plan, the child's maximum coverage period will be the remaining eight months of Murdy's maximum coverage period.

2. Extension of Maximum Coverage Period

The maximum coverage period for a loss of coverage due to a termination of employment (or reduction of hours) is 18 months. This maximum coverage period, however, can be extended.

a. Multiple Qualifying Events

If, after a qualifying event that is a termination of employment or reduction of hours, one of the following events (called second qualifying events) occurs during the initial 18-month coverage period:

- the covered employee dies;
- the covered employee divorces or legally separates; or
- the covered employee's child ceases to be a dependent;

then the maximum coverage period for the spouse or dependent child who is a qualified beneficiary is extended to 36 months, measured from the same date on which the 18-month period started. A diagram of the multiple qualifying event rule follows:

This extension rule applies only if the second qualifying event would have caused a loss of coverage for the qualified beneficiary under the terms of the plan if it had occurred first. The extension is available for qualified beneficiaries who elect COBRA and who are still receiving COBRA coverage at the time of the second qualifying event, whether or not the covered employee elects COBRA.

Extension of Disability Extension. As discussed below, an extended 29-month maximum coverage period is available in certain circumstances when a qualified beneficiary is disabled. This 29-month period is extended to 36 months for second qualifying events occurring within the 29-month period, under the rules for multiple qualifying events (discussed above).

The multiple qualifying event rule also may apply if the covered employee becomes entitled to Medicare during the original 18-month (or 29-month) maximum coverage period. An extension due to Medicare entitlement is infrequently required, however, because Medicare entitlement rarely causes a loss of plan coverage. (The Medicare Secondary Payer rules generally (but not always) prevent plans from terminating coverage due to Medicare entitlement.)

A plan generally may require qualified beneficiaries to notify the plan administrator within 60 days after a second qualifying event and to follow procedures established by the plan administrator for this purpose, as conditions to providing an extension of the maximum coverage period under the multiple qualifying event rule. However, see our warning boxes below: Plans must establish and disclose "reasonable procedures" before their notice procedures or deadlines may be enforced against qualified beneficiaries.

b. Disability Extension

If all of the following conditions are met, then the maximum coverage period for all qualified beneficiaries (including disabled and nondisabled qualified beneficiaries) who became eligible for COBRA as a result of the same qualifying event is extended to 29 months, measured from the same date on which the original maximum coverage period started:

- a qualified beneficiary is disabled (as determined by the Social Security Administration (SSA)) on any day

during the first 60 days of COBRA coverage;

- the qualifying event was the covered employee's termination of employment or reduction of hours;
- the qualified beneficiary notifies the plan administrator of his or her disability within 60 days after the latest of (1) the date of the Social Security Administration's determination of disability; (2) the date of the qualifying event; (3) the date on which the qualified beneficiary would lose coverage under the plan; and (4) the date on which the qualified beneficiary is informed of the obligation to provide notice of his or her disability to the plan administrator; and
- the qualified beneficiary notifies the plan administrator before the end of the original 18-month maximum coverage period.

A diagram of the disability extension follows:

Extension of Disability Extension. This 29-month period is extended to 36 months for multiple qualifying events occurring within the 29-month period, under the rules for multiple qualifying events, which are discussed above.

A plan generally may require qualified beneficiaries to notify the plan administrator of a qualified beneficiary's disability within the timeframes spelled out above and to follow procedures established by the plan administrator for this purpose, as conditions to providing a disability extension of the maximum coverage period. However, see our warning boxes below: Plans must establish and disclose "reasonable procedures" before their notice procedures, or deadlines may be enforced against qualified beneficiaries.

c. Covered Employee's Entitlement to Medicare Pre-Termination or Pre-Reduction of Hours

If the covered employee becomes entitled to Medicare in the 18 months before the triggering event (termination of employment or reduction of hours), then the maximum coverage period for the spouse and dependent children ends 36 months after the covered employee became entitled to Medicare.

Here's an example that illustrates how the rule works to give spouses and dependent children an extended period of COBRA coverage when the employee becomes entitled to Medicare and then either terminates employment or reduces hours during the subsequent 18 months.

d. Employer Bankruptcy (Retiree Plans Only)

In bankruptcy proceedings involving an employer with retiree health coverage, covered retirees and their related qualified beneficiaries who lose coverage under certain circumstances may have maximum coverage periods far exceeding the usual 18 to 36 months (up to the qualified beneficiary's lifetime).

3. Early Termination of COBRA Coverage

A plan can terminate a qualified beneficiary's COBRA coverage early, before the maximum coverage period (including any extension) expires, if any of the following events occurs (and if the plan is written to provide for termination in these circumstances):

- the required premium for the qualified beneficiary's coverage is not paid on time (taking into account any grace periods and other special rules);
- the qualified beneficiary becomes entitled to Medicare after electing COBRA;
- the qualified beneficiary becomes covered by another group health plan after electing COBRA;
- the employer ceases to maintain any group health plan for any employee (for these purposes, the employer is defined to include affiliated entities in the employer's "control group"-if any of these related entities continues to maintain a group health plan, COBRA coverage cannot be terminated);
- if the maximum coverage period has been extended under the disability extension, the qualified beneficiary who had been disabled is determined not to be disabled (COBRA coverage may be terminated for all qualified beneficiaries enjoying extended COBRA coverage under the disability extension); or
- for cause (i.e., if the plan could terminate an active employee's coverage for cause, such as for filing a false benefit claim, then the plan may terminate COBRA coverage for the same reason).

Warning: Termination Notice Requirement. The DOL's COBRA regulations require plan administrators to provide a notice of termination of COBRA coverage to any qualified beneficiary whose COBRA coverage terminates before

the expiration of the maximum coverage period.

4. Coverage During COBRA Election and Premium Payment Periods

A group health plan need not provide COBRA coverage to a qualified beneficiary until a timely election is made and required premiums are timely paid. However, once COBRA is timely elected and payment is timely made, COBRA generally must be provided from the date that coverage would otherwise have been lost.

K. The COBRA Election Process

1. COBRA Election Timeline

The timeline below illustrates a typical sequence of events leading up to a COBRA election.

The qualifying event illustrated above is a loss of coverage due to termination of the covered employee's employment. As you'll learn, the sequence of events can be different. The loss of plan coverage, for example, might occur after the employer notifies the plan administrator or even after the plan administrator provides the COBRA election notice to the qualified beneficiary. The timing can also vary, as illustrated later in our discussion of COBRA and adverse selection.

2. Qualifying Event Notice

The COBRA election process begins with a notice to the plan administrator that a qualifying event has occurred. The notice comes either (a) from the employer; or (b) from the qualified beneficiary or covered employee.

a. Employer's Notice Obligation

The employer must notify the plan administrator when a qualified beneficiary loses or will lose coverage due to-

- termination, or reduction of hours, of a covered employee's employment;
- death of the covered employee;
- the covered employee's becoming entitled to Medicare; or

- the employer's bankruptcy.

The employer generally must notify the plan administrator within 30 days after the triggering event. Often, the employer is also the plan administrator. In such cases, the real question is how much time the employer/plan administrator has in which to notify the qualified beneficiary of his or her COBRA election rights. We discuss the plan administrator's election notice deadline in more detail below.

b. Qualified Beneficiary/Covered Employee Notice Obligation

A qualified beneficiary or covered employee must notify the plan administrator when a qualified beneficiary loses or will lose coverage due to-

- divorce or legal separation; or
- a child's ceasing to be a dependent under the terms of the plan.

The qualified beneficiary or covered employee generally must notify the plan administrator within 60 days after the triggering event and generally must follow procedures established by the plan administrator for this purpose (such as, for example, using a required form of notice or providing the notice to a particular person at a specific address). If this notice deadline has been properly disclosed (see the box below), a qualified beneficiary who does not provide a timely notice of qualifying event will not be entitled to elect COBRA.

Warning:Disclosure of "Reasonable Procedures" and Notice Deadlines Is Essential. The DOL's COBRA regulations require plans to establish "reasonable procedures" for qualified beneficiaries and covered employees to use in providing notices to the plan. These procedures must be disclosed in the plan's summary plan description (SPD). If a plan fails to establish and disclose "reasonable procedures," covered employees and qualified beneficiaries can provide informal notices (including oral notices) to the plan, directed to parties other than those ordinarily handling COBRA notices, and the plan will be bound by these notices. Qualified beneficiaries and covered employees also can give notices after the normal 60-day deadline if a plan's notice procedures and deadlines have not been disclosed to them in its SPD or initial COBRA notice.

To avoid serious consequences, each plan administrator should have adopted "reasonable procedures" and disclosed them (and the plan's notice requirements and deadlines) both in the plan's SPD and in the plan's initial COBRA notice.

3. Notice of Unavailability of COBRA Coverage

If the plan administrator receives a notice of qualifying event, a notice of second qualifying event, or a notice of disability and determines that the individual described in the notice is not entitled to COBRA coverage (or to an extension of the maximum COBRA coverage period), then the administrator must provide the individual with an explanation as to why he or she is not entitled to COBRA coverage (or to extended COBRA coverage). The administrator generally must furnish this notice of unavailability within 14 days after the plan administrator has been furnished with notice of a qualifying event, a second qualifying event, or a disability.

4. COBRA Election Notice

The plan administrator must notify each qualified beneficiary who will lose coverage under the plan as the result of a qualifying event of his or her rights under COBRA (unless the notice of unavailability described above is provided).

Providing the election notice is the most critical step in COBRA administration. That is because the qualified beneficiary's election period (discussed below) will not end until at least 60 days after the plan administrator provides the election notice. If the plan administrator fails to properly provide the COBRA election notice, the qualified beneficiary will have an open-ended right to elect COBRA.

The plan administrator must provide the election notice generally within 14 days after receiving a qualifying event notice. The election notice deadline is different, however, when the employer and plan administrator are the same entity: The DOL COBRA regulations provide that the employer has 44 days in which to furnish an election notice to qualified beneficiaries after a qualifying event that is a termination or reduction of hours, death of the covered employee, the covered employee's becoming entitled to Medicare, or the employer's bankruptcy.

When the Employer Is Also Plan Administrator. Before issuance of the DOL COBRA regulations, some courts adopted the 44-day election notice period, but others held that the notice period is 14 days. No matter what the deadline may be for sending the election notice, it is to a plan's advantage to provide the election notice

promptly, to reduce the risk of adverse selection (discussed below).

The following diagram illustrates the sequence from the qualifying event to the qualifying event notice to the COBRA election notice:

5. *COBRA Election*

COBRA coverage is not automatic. A qualified beneficiary must affirmatively elect-within the election period-to continue his or her group health plan coverage. Generally, a qualified beneficiary elects COBRA by returning a written election to the plan administrator.

Each plan must set a COBRA election period that begins no later than the date that plan coverage is lost and lasts at least until 60 days after-

- the date that group health plan coverage is lost; or
- if later, the date that the plan administrator provides the COBRA election notice.

There has been uncertainty regarding whether the election period is measured from the date that the COBRA election notice is sent by the plan administrator or from the date that it is actually received by the qualified beneficiary. This has made a difference in some cases when a qualified beneficiary's election was sent at the end of the election period. This uncertainty has been reduced by the DOL, which stated in the preamble to its COBRA regulations that COBRA election notices sent by first-class, certified, or express mail are treated as "furnished" on the date that they are mailed. Plan administrators nevertheless may wish to get legal advice in deciding how they will handle any remaining uncertainty regarding measurement of the election period, and they should obtain the concurrence of any insurance companies that are involved.

In contrast, the IRS COBRA regulations clearly provide that a COBRA election is effective when sent by the qualified beneficiary, not when received by the plan administrator. Plan administrators need to institute recordkeeping procedures to establish and prove when the election period begins and ends and when elections

are sent by qualified beneficiaries.

Each qualified beneficiary has an independent right to elect COBRA. This means, for example, that if group health plan coverage for a covered employee's spouse and child terminates due to the covered employee's termination of employment, the spouse and child each have a right to elect COBRA, even if the covered employee does not.

L. COBRA Premium

A plan may-but is not required to-charge a premium for COBRA coverage. In most cases, the qualified beneficiary pays the premium for COBRA coverage, but employers and plans must accept premium payments on behalf of the qualified beneficiary, regardless of who (for example, a hospital or an employer) makes the payment.

The COBRA premium for a month's coverage cannot be more than 102% of the "applicable premium." There is an exception for COBRA coverage during the disability extension: Generally, the COBRA premium during the disability extension period is limited to 150% of the applicable premium if the disabled qualified beneficiary is included in the COBRA coverage group.

1. Determining the "Applicable Premium"

The applicable premium is based on the "cost to the plan" for providing coverage under the plan. In general, for insured plans, the applicable premium for a qualified beneficiary's coverage is the monthly insurance premium paid to the insurer. Self-insured plans must engage in a more complex calculation of the applicable premium, based on reasonable actuarial estimates of future costs or on past costs adjusted for changes in a cost-of-living index. The applicable premium for health FSAs generally is the annual benefit amount elected by the participant (divided by 12 to determine the monthly amount).

For HRAs, which are similar to health FSAs in many respects, the applicable premium calculation is more complicated. Unused portions of the annual benefit amount may be carried over to later years. Consequently, the cost to the plan is difficult to calculate because participants will not feel constrained to use the annual benefit amount all in one year, as they do under the "use-or-lose" rule for health FSAs.

When an employer maintains more than one plan (or more than one benefit option within a plan), a separate applicable premium is calculated for each plan (or benefit option). In addition, the applicable premium for a single plan may be different for different coverage levels (i.e., single employee rates, employee-plus-spouse rates,

family rates, and so on).

All plans must determine the applicable premium (or premiums) in advance for a 12-month period called the "determination period." The determination period can be any 12-month period selected by the plan, but it must be applied consistently from year to year and must be the same for all qualified beneficiaries covered under the same benefit option.

2. Changing the COBRA Premium

The applicable premium may not be changed during the 12-month determination period, although it may be changed (if determined and fixed in advance) for the next determination period. There are, however, three circumstances in which a plan may increase a COBRA premium during a determination period:

- to implement the increase permitted during the disability extension (from 102% to 150% of the applicable premium);
- to increase the COBRA premium up to the permitted level, if the plan is requiring payment of less than the maximum permissible amount (less than 102% or 150% of the applicable premium); and
- to charge for new coverage, if a qualified beneficiary's coverage changes (because of, for example, a new election during open enrollment or a second qualifying event that changes the family coverage unit) to more expensive coverage for which a higher applicable premium was fixed before the determination period.

Caution: Mid-Year Premium Changes Can Create Difficulty. Insurance premium increases occurring in the middle of a determination period cannot be passed on to qualified beneficiaries. Employers with insured plans should use every effort to contract for premium increases effective only as of the beginning of the determination period.

The premium charged for COBRA coverage must be reduced if a qualified beneficiary's coverage changes to a type for which a lower applicable premium has been fixed.

3. COBRA Premiums: Payment Deadlines and Other Rules

COBRA prescribes both-

- the earliest date on which a plan may require payment of the initial COBRA premium after a COBRA election; and
- the earliest date on which a plan may require payment of subsequent COBRA premiums.

A plan may not require payment of the initial premium earlier than 45 days after the qualified beneficiary elects COBRA. After that, premiums generally are due on the first day of each month, subject to a grace period. The grace period must be at least 30 days, and it must be longer than 30 days if (a) the plan by its terms allows covered employees or qualified beneficiaries a longer period in which to pay; or (b) the arrangement with the plan's insurer, HMO, or other similar entity that provides plan benefits allows the employer a longer period in which to pay for coverage for similarly situated non-COBRA beneficiaries.

COBRA requires plans to allow monthly premium payments (plans cannot require qualified beneficiaries to pay their premiums on a quarterly or less frequent basis). COBRA does not require a plan to send out monthly bills, although some plans do. Plans must notify qualified beneficiaries of changes in premiums.

A plan is not required to notify qualified beneficiaries of overdue payments, and it may terminate COBRA coverage for nonpayment or insufficient payment of premiums after the expiration of any applicable payment or grace period. But the DOL's COBRA regulations require plan administrators to provide a notice of termination to any qualified beneficiary whose COBRA coverage is terminated early for nonpayment of premiums (or for any other reason, if COBRA coverage is terminated before the expiration of the maximum coverage period).

Insignificant Shortfalls. A special rule applies when a COBRA premium payment is not significantly less than the required amount. A plan may not terminate COBRA coverage for such an "insignificant shortfall" unless it first notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period (generally 30 days) for payment of the deficiency to be made. A premium payment shortfall is insignificant if it is less than or equal to the lesser of (a) $50; or (b) 10% of the COBRA premium required by the plan.

Premium payments are deemed to be made when sent; plan administrators should maintain records relating to late payments (including postmarked envelopes) to support termination of COBRA coverage.

M. Election and Payment Periods May Increase Adverse Selection

COBRA coverage is expensive for group health plans because the average claims cost for COBRA qualified beneficiaries is higher than the average claims cost for active employees and their dependents. Because a group health plan can charge only 102% of the cost to the plan-determined using the claims cost for active employees, their dependents, and qualified beneficiaries-the COBRA premium never truly reflects the cost of coverage for qualified beneficiaries.

One reason why the claims costs for qualified beneficiaries are higher than for active employees and their dependents is that the structure of the notice, election, and payment periods gives qualified beneficiaries a very long time after a qualifying event occurs before they must pay for coverage. That's apparent from the following chart.

In this illustration, the period from termination of employment until initial premium payment is 149 days. If the qualifying event were a loss of coverage due to a divorce or a child's ceasing to be a dependent, the period could be at least 30 days longer (because the covered employee or qualified beneficiary has at least 60 days from the date of the qualifying event in which to notify the plan administrator).

While most of these periods are outside of the plan administrator's control, the plan administrator can provide election notices promptly in order to reduce the potential for adverse selection illustrated above.

N. Checklist: COBRA Notices and Other Plan Communications

1. Overview

The following paragraphs contain a list of the various notices and other written communications that COBRA requires of employers and/or plan administrators. We also discuss certain optional items that may be used in COBRA administration. To maintain simplicity, we have not fully explained all of these items in this short course (although we do so later in this manual). But the checklist may help you relate your own COBRA administration procedures to the information we've given you in the short course.

2. Two Most Important COBRA Notices: Initial Notice & Election Notice

The initial notice and the election notice are the two most important COBRA notices.

The initial notice communicates to plan participants their COBRA rights and obligations generally. The initial notice must be furnished by the plan administrator to the covered employee and spouse when plan coverage first begins. The DOL's COBRA regulations provide that this requirement is generally met if the initial notice is delivered within 90 days after coverage begins.

Example: Spouse Becomes Covered at a Different Time. Frank is unmarried when he starts work at ABC Co. and becomes covered by the company's group health plan. Five years later, he and Lily get married, and she becomes automatically covered under the terms of the plan. When should the plan provide the initial COBRA notice?
The plan should give Frank an initial COBRA notice within 90 days after he starts work at the company, and it should give Lily an initial COBRA notice five years later, within 90 days after she first becomes covered under the plan.

The election notice gives qualified beneficiaries information regarding their rights and obligations with reference to a specific qualifying event. When a qualifying event occurs (and after notice of the event is provided to the plan administrator), the plan administrator must furnish an election notice to each qualified beneficiary (including the covered employee, covered spouse, and any covered dependent child) who loses plan coverage in connection with the qualifying event.

Initial Notices and Election Notices Should Be in Compliance With DOL's COBRA Regulations. The DOL maintains model forms of the initial notice and election notice on its website-plans may, but are not required to, use these models to achieve compliance with the regulations.

Many disputes arise as to whether qualified beneficiaries have been given the initial COBRA notice or the COBRA election notice (or whether the contents of these notices were adequate). Appropriate and timely notices (and complete and accurate records regarding their contents and delivery) facilitate smooth COBRA administration, help reduce overall COBRA benefits cost (by reducing the period for adverse selection), discourage litigation, and, if litigation does occur, put the plan in the strongest possible position to defend its actions.

3. Other Mandatory Notices and Communications

a. Notice of Unavailability of COBRA Coverage

Under the DOL's COBRA regulations, if the plan administrator receives a notice of qualifying event, a notice of second qualifying event, or a notice of disability and determines that the individual described in the notice is not entitled to COBRA coverage (or to an extension of the maximum COBRA coverage period), then the administrator must provide to the individual a notice of unavailability of COBRA coverage.

Unavailability Notice Is a DOL Requirement. The notice of unavailability is a requirement imposed by the DOL in its COBRA regulations; this notice requirement does not appear in the COBRA statute itself.

b. Notice of Termination of COBRA Coverage

Under the DOL's COBRA regulations, when COBRA coverage terminates before the end of the maximum coverage period, the plan administrator must provide a written notice of termination to each affected qualified beneficiary.

Termination Notice Is a DOL Requirement. The notice of termination is a requirement imposed by the DOL in its COBRA regulations; this notice requirement does not appear in the COBRA statute itself.

c. Qualifying Event Notice to Plan Administrator

The employer generally must give notice to the plan administrator within 30 days after the occurrence of any of the following triggering events (if they lead to a loss of coverage under the plan): a covered employee's termination of employment, a covered employee's reduction of hours, the death of a covered employee, a covered employee's becoming entitled to Medicare, or employer bankruptcy.

d. Notice of COBRA Premiums Short by Insignificant Amount

A COBRA premium payment that is insufficient by only a small amount may have to be accepted as full payment by a plan. Payment of such an insufficient amount must be treated as satisfying the COBRA payment requirement *unless* the plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made.

e. Open Enrollment Materials

During any open enrollment period made available for similarly situated active employees under the plan, qualified beneficiaries may modify the COBRA coverage that they initially elected and may enroll additional dependents. Open enrollment materials therefore must be furnished to COBRA qualified beneficiaries.

f. Individual Conversion Policy Notices

Plans that include an option for conversion to individual coverage after group coverage ends must make this

option available to qualified beneficiaries during the 180-day period ending on the date that their maximum coverage period expires. A notice of conversion option during the 180-day period is not specifically required by COBRA. (But note that the DOL's COBRA regulations require disclosure in a notice of termination of COBRA coverage of any conversion options available to qualified beneficiaries.) We think that a notice to COBRA beneficiaries of their conversion option during the last 180 days of the COBRA maximum coverage period is the best way to comply with COBRA's requirement to make the conversion option available.

g. Summary Plan Descriptions

ERISA requires group health plans maintained by nongovernmental, nonchurch employers to distribute a summary plan description (SPD) to plan participants, COBRA qualified beneficiaries, and certain others. COBRA information must be included in an ERISA group health plan's SPD.

SPD Requirements in DOL's COBRA Regulations. The DOL's COBRA regulations require plans to establish "reasonable procedures" for covered employees and qualified beneficiaries to use in providing notices to the plan. Under the regulations, plans must disclose these procedures in their SPDs. A plan that fails to establish and disclose reasonable procedures will be bound by informal notices, including oral notices, directed to parties other than those ordinarily handling COBRA notices.

h. Summary of Material Modifications

A summary of material modifications (SMM) must be distributed by group health plans that are required to distribute SPDs whenever there is a material change in the plan (for example, premium increases and plan amendments).

i. Disclosures to Health Care Providers

A plan must disclose information to inquiring health care providers (for example, physicians, hospitals, or pharmacies) regarding a qualified beneficiary's right to coverage under the plan during-

- the COBRA election period;
- the 45-day initial COBRA premium payment period; and
- the 30-day grace period for COBRA premium payments.

j. Notice of Change in COBRA Premium

The COBRA premium for a qualified beneficiary may change because, for example, he or she elects different coverage during open enrollment, the plan elects to charge the increased premium permitted during a disability extension period, or the insurance company providing coverage increases or decreases premiums. As we have discussed, premium increases may be charged to a qualified beneficiary only at certain times. The plan administrator must notify qualified beneficiaries of COBRA premium increases in advance.

4. Optional Items

Sophisticated COBRA administration often involves the use of notices that COBRA itself does not require. These notices may serve one or more purposes: (a) to provide good "customer service"; (b) to streamline administration by making inquiries unnecessary; and (c) to "get out front" on issues that could easily lead to misunderstandings or lawsuits.

You and your professional advisors may conclude that one or more of the following notices and communications should be used in administering your plan.

a. Coupon Books or Monthly Statements (Not Bills)

Plans are not required to send billing statements for COBRA premiums.

Some plans notify a qualified beneficiary of COBRA premium obligations only once, as part of the election notice and election form. Others issue coupon books that contain a coupon for each month of the maximum coverage period. Others send monthly premium statements. (These statements should indicate that they are merely reminders, not bills, and that payment is due on the due date, subject to the grace period, whether or not a monthly statement is provided.) Coupon books or monthly statements (with remittance slips) can serve two useful functions: (1) to remind the qualified beneficiary of the due date and of the date that the 30-day grace period expires; and (2) to obtain representations from the qualified beneficiary that he or she remains entitled to

COBRA coverage (that is, for example, a representation that the qualified beneficiary has not become entitled to Medicare or become covered by another group health plan).

b. Confirmation of COBRA Election

The plan administrator could send a letter to the qualified beneficiary confirming the details of the qualified beneficiary's election (including types of coverage elected, duration of coverage, premiums, and payment due dates). The confirmation could also remind the qualified beneficiary to notify the plan administrator of events that either extend or prematurely terminate COBRA coverage.

c. Notice of Extension of COBRA Coverage

A qualified beneficiary's maximum coverage period can be extended under the multiple qualifying event rule or the disability extension rule. In our view, COBRA does not require that a qualified beneficiary be given notice of such an extension (although one court recently held that such a notice requirement applies when a second qualifying event causes an extension of the maximum coverage period). Even if not required, an extension notice would serve to eliminate confusion and, if applicable, to inform the qualified beneficiary that the amount of the COBRA premium has changed (if a second qualifying event also causes a change in the qualified beneficiary's family unit or the plan charges an increased premium as permitted during a disability extension).

d. Notice of Denial of COBRA Coverage Due to Gross Misconduct

The triggering event of termination of employment does not include termination because of gross misconduct; a plan is not required to provide COBRA coverage to such a terminated employee, the spouse, or the dependent children. A plan is not required to give notice that it is denying COBRA coverage because of a termination for gross misconduct. However, many plans elect to do so in order to avoid confusion and limit potential liability.

e. Termination Notice at Expiration of Maximum Coverage Period

A termination notice (notice by the plan administrator to the qualified beneficiary advising of the termination of the qualified beneficiary's COBRA coverage) is not required if a qualified beneficiary's COBRA coverage ends at the expiration of the maximum coverage period. But a notice is required by the DOL's COBRA regulations if

COBRA coverage is terminated before the end of the maximum coverage period. A notice of conversion rights may need to be given as well, and sometimes these are provided together with a general termination notice.

f. Late Premium Payment Reminder Letters

A plan administrator could send a late premium payment reminder letter to a qualified beneficiary whose premium has not been paid by the due date. Such a letter would advise that coverage will be canceled if payment is not received within the grace period. The letter is not required by COBRA but may serve to avoid unnecessary litigation.

g. Letter to Dependent Child Regarding Loss of Dependent Status

A child's ceasing to be a covered dependent under a group health plan is a COBRA qualifying event. Even though the qualified beneficiary has the obligation to notify the plan administrator of this occurrence, some plan administrators affirmatively seek out information on over-age dependent children.

h. Spouses or Dependent Children Dropped From Coverage

When an employee drops a spouse or dependent child from coverage, two different kinds of communications may take place:

- The employee typically is required to complete an enrollment change form. Some forms ask for the reason why an employee is dropping a spouse or dependent. To avoid the appearance of intruding into the employee's private business, the form might ask only whether the reason is a divorce (or legal separation, assuming that it causes a loss of coverage under the plan) or a child's ceasing to be a dependent under the plan. If the employee responds either that a divorce (or legal separation) has occurred or that a child has ceased to be a dependent under the plan, this would satisfy the obligation to notify the plan administrator of a qualifying event, triggering the plan administrator's obligation to provide an election notice.
- Some plans may elect to notify a spouse or dependent child who is dropped from coverage by an employee, although merely dropping their coverage is not a COBRA qualifying event (there also needs to

be a triggering event, like divorce). The purpose of such a notice would be to avoid later disputes (for example, regarding whether the cancellation of coverage was in anticipation of a qualifying event and therefore gave rise to COBRA rights).

i. Letter to Qualified Beneficiaries Attaining Age 65

COBRA coverage may terminate early if, after the date of the COBRA election, a qualified beneficiary becomes entitled to Medicare. A plan administrator may wish to send a letter to a qualified beneficiary who, while receiving COBRA coverage, attains age 65. The letter would remind the beneficiary that COBRA coverage stops at Medicare entitlement, and it would require certification, as a condition of continuing COBRA, that the beneficiary has not yet become entitled to Medicare. And if COBRA coverage is terminated early because of Medicare entitlement, then the plan administrator must provide the notice of termination of COBRA coverage.

5. COBRA Administration Procedures

Although COBRA does not require written COBRA administration procedures, we recommend that plan administrators use written procedures to guide them in COBRA administration. These procedures should outline (a) the circumstances under which COBRA coverage must be offered by the plan; (b) the mechanics of notices and elections; (c) the "reasonable procedures" for notices from covered employees and qualified beneficiaries as required by the DOL's COBRA regulations; and (d) other practical guidance. They may enhance administrative efficiency, help protect against compliance mistakes, help to reduce IRS excise taxes imposed in connection with unintentional COBRA violations, and support a plan's defense in a COBRA lawsuit.

6. Word of Caution About COBRA Administration Software

Because COBRA requires employers and plan administrators to track various notice, election, and payment periods, as well as other data for tens, hundreds, or thousands of qualified beneficiaries, employers and third-party administrators increasingly rely on computers to perform their tasks. Many COBRA-related tasks (such as tracking deadlines and organizing mass mailings) are well-suited for computerization. But employers and plan administrators must not forget that COBRA has many "gray areas" that don't lend themselves easily to computerization, requiring informed judgment in individual cases.

O. Consequences of Failure to Comply With COBRA

Failure to comply with COBRA can lead to significant financial consequences. Different consequences flow from different compliance failures, and, of course, the amount of possible damages awarded in any particular case will depend on the circumstances of the qualified beneficiary (or beneficiaries). But all of the following consequences can arise from a COBRA compliance failure:

- excise tax penalties may be assessed by the IRS (up to $200 per day) for each day on which a plan fails to comply with COBRA (excise taxes must be self-reported on IRS Form 8928);
- statutory penalties of $110 per day may be recovered (by qualified beneficiaries) for the plan administrator's failure to provide certain notices as required by COBRA;
- qualified beneficiaries may sue to recover COBRA coverage (such suits carry the potential for large damages, which, in the case of an insured plan, may not be covered by the plan's insurance);
- failure to provide adequate initial and election notices can create exposure to "other relief," which might include damages for such things as a deterioration of a qualified beneficiary's medical condition due (indirectly) to failure to provide an adequate COBRA notice; and
- in lawsuits under ERISA for COBRA coverage, the court is permitted to award attorneys' fees to the prevailing party.

P. Review of COBRA Action Items and Deadlines

The flowchart below summarizes what you've just learned and highlights key actions that administrators must take once a qualifying event has occurred. The qualifying event of termination of employment is used for illustrative purposes.

Q. COBRA in the Life of an Employee

As a final review, let's take a guided tour through COBRA using the employment history of Sally at Zipco.

Sally starts work at Zipco when she is 21 years old, fresh out of college, unmarried, with no children. This is her first full-time job, and she has only recently moved out of her parents' home and into her own apartment. Sally has COBRA coverage when she starts work at Zipco. She is a cautious person, and she elected, in June of 2008 when she graduated from college, to pay for COBRA coverage through her father's employer. (Prior to health care reform, her graduation was a qualifying event because she lost coverage under her father's employer's group health plan upon ceasing to be a full-time student.)

Zipco is located in Illinois and has subsidiaries in several states. Its employees number in the hundreds, and Zipco clearly is not eligible for the small employer exception to COBRA. Zipco has a group health plan with three options for its employees: insured medical coverage, an HMO, and combined dental and vision insurance coverage. Zipco's subsidiaries each have different group health plans for their employees. Zipco is the plan administrator for its own plan and the plans of its subsidiaries. Let's see what Zipco does during the span of Sally's employment with the company (and afterwards) to comply with COBRA.

1. Sally Starts Work

Sally starts work on June 1, 2009. She elects the Zipco insured medical option and insured dental/vision option and immediately becomes covered under both, with no waiting period and no preexisting condition exclusions. Her COBRA coverage under her dad's plan terminates because she has become covered under a new group health plan.

Plan administrator action: On July 1, 2009, Zipco mails (by first-class mail, addressed to Sally at her new apartment) a copy of the company's initial COBRA notice, which outlines Sally's rights and obligations under COBRA with respect to Zipco's group health plan.

Two years later, in the April open enrollment period, Sally switches from the Zipco insured medical option to the Zipco HMO option. No qualifying event = no COBRA obligations for Zipco. (There is no obligation to provide an initial notice because the insured medical option and the HMO option are benefit options of the same Zipco "plan," and Sally has already received an initial notice for this plan.)

2. Sally Takes a Leave of Absence

Sally is having a very successful career at Zipco, and Zipco wants her to have additional training in graduate school. On September 1, 2011, Sally begins a one-year leave of absence to study for her master's degree. Zipco's plan provides that the start of a leave of absence causes a loss of plan coverage (i.e., the maximum COBRA coverage period runs from the leave of absence start date). Sally's maximum COBRA coverage period ends on February 28, 2013. She and Zipco have previously agreed that Zipco will pay for her COBRA coverage for one year, through August 31, 2012.

Plan administrator action: Zipco sends Sally a COBRA election notice (by first-class mail, to her apartment address) on September 10, 2011.

Sally promptly elects COBRA both for the HMO option and the insured dental/vision option. As agreed, Zipco pays the premium for her COBRA coverage for one year.

While Sally is in school, she moves to a different apartment. Her supervisor at Zipco, who has become a friend, knows that she has moved.

Plan administrator action: Sally's supervisor reminds her to notify the Zipco HR department of her new address. Sally does so, and Zipco changes all of its internal records to note her new address.

3. Sally Returns to Work

Sally comes back to work on September 1, 2012, with her master's degree and a promotion. She enrolls for coverage under the Zipco plan's HMO option and dental/vision option (the same coverage she had under COBRA).

Plan administrator action: Zipco advises the HMO and the dental/vision insurer that Sally is no longer on COBRA and that she is once again covered as an active employee. On October 1, 2012, Zipco mails (by first-class mail, addressed to Sally at her new apartment) a copy of the company's initial COBRA notice, which outlines Sally's

rights and obligations under COBRA with respect to Zipco's group health plan. Although providing another initial notice at this stage technically may not be required, cautious plan administrators may elect to do so.

4. Sally Gets Married

On October 24, 2013, Sally marries Sam, whom she met in graduate school. Sam is self-employed as a consultant. Sally and Sam go on a three-week honeymoon, and they move into Sam's house when they get back from their trip.

When Sally and Sam get back from their honeymoon (on November 18), Sally notifies the Zipco HR department of her new address. She also enrolls Sam in the Zipco plan, opting for HMO and dental/vision coverage, using her special enrollment rights under HIPAA. Sam's coverage will start December 1.

Plan administrator action: Zipco changes all of its internal records to note Sally's marriage to Sam and to record their new address. On January 1, 2014, Zipco mails (by first-class mail, addressed to Sam at his house (now the couple's house)) a copy of the company's initial COBRA notice, which outlines Sam's rights and obligations under COBRA with respect to Zipco's group health plan.

5. Sally Gets Promoted and Relocates

On January 1, 2015, Sally is promoted to a senior management position with Abco, a wholly owned subsidiary of Zipco, located in Oregon. Although she and Sam are excited about the move to Oregon and the promotion, they don't like the medical insurance plan that Abco has for its employees, and Abco doesn't have a dental/vision option. Sally and Sam's coverage under the Zipco plan terminates on the day that Sally goes to work for Abco. We think that there is no qualifying event and that no COBRA obligations arise on the part of Zipco, although this is a gray area. Sally is still working for the same employer, as "employer" is defined by COBRA (the "employer" is the combined group consisting of Zipco and Abco).

Sally and Sam find private dental/vision coverage through the Chamber of Commerce after they move to Oregon. They enroll in the Abco medical insurance plan.

Plan administrator action: Zipco changes all of its internal records to note Sally's and Sam's new address in Oregon. On February 1, 2015, Zipco (as plan administrator for Abco) mails (by first-class mail, addressed to Sally

and Sam at their new home in Oregon) a copy of the Abco initial COBRA notice, which outlines Sally's and Sam's rights and obligations under COBRA with respect to the Abco plan.

6. Sally Has a Baby

On July 4, 2016, Sally and Sam have a new baby, Susie. Sally enrolls Susie in the Abco medical insurance plan, effective July 4, using her special rights under HIPAA.

Plan administrator action: Zipco changes all of its internal records to note Sally's new dependent and her date of birth.

7. Sally Takes FMLA Leave

Sally takes a three-month leave of absence under the Family and Medical Leave Act (FMLA), beginning July 4, 2016. Under the FMLA, Sally's medical coverage must continue as it would for an active employee unless and until she either (a) gives notice that she will not return to work; or (b) does not return to work at the end of her leave of absence. So there is no qualifying event and Abco has no COBRA obligations at the beginning of Sally's leave.

Sally returns to work, as scheduled, three months later. Her medical insurance coverage continues uninterrupted.

8. Sally and Sam Divorce

Alas, the pressures of child-rearing are too much for Sally and Sam, and they begin to argue incessantly. Sam moves out on May 1, 2018, and Sally and Sam are divorced on November 1, 2018. The date of divorce is the date that Sam's coverage would terminate under the Abco medical plan. Sam has no idea where his copy of Abco's initial COBRA notice is, but he calls Abco to ask what he should do to keep his medical coverage in place. Abco sends him a copy of the initial notice, which describes notice procedures that Sam must follow when providing a notice of second qualifying event to the plan. He sends the required notice, following the plan's procedures, on November 25, 2018 (well within the 60-day period for sending such a notice).

Plan administrator action: Zipco mails a COBRA election notice (by first-class mail, addressed to Sam at his new

address) on December 2, 2018.

In December, Sam timely elects COBRA under the Abco medical insurance plan, and he pays the premium for November and December. His maximum coverage period is 36 months from the date of the divorce; Sam can still be covered by the Abco medical plan until October 31, 2021, if he continues to pay for coverage on time and if no event causing early termination of COBRA coverage occurs.

9. Sam Remarries

On May 1, 2020, Sam marries Della, and he adopts Della's 12-year-old son Robert. He enrolls Della and Robert for coverage under the Abco plan, using his special enrollment right under HIPAA-he is entitled to enroll Della and Robert for the remainder of his COBRA maximum coverage period. Della and Robert are not qualified beneficiaries and are not entitled to any COBRA notices or other COBRA rights.

10. Abco Changes Its Group Health Plan

Effective January 1, 2021, Abco changes from an insurance arrangement to an HMO for its group health plan participants. This is not a qualifying event, and it gives rise to no COBRA rights for Sally and Susie. Sam's, Della's, and Robert's coverage can be changed to the HMO plan for the remainder of Sam's maximum coverage period because this change was made for similarly situated active employees.

Plan administrator action: On February 1, 2021, Zipco (as plan administrator for Abco) mails (by first-class mail, addressed to Sally and Susie) an initial COBRA notice outlining Sally's and Susie's rights and obligations under COBRA with respect to the new HMO plan (although such a replacement initial notice technically may not be required).

11. Sally Quits

On March 1, 2021, after a successful career with Abco and Zipco, Sally gives notice that she will be leaving Abco on March 31, 2021, and will be beginning work with an unrelated company (XYCo.) in Oregon.

March 31 is Sally's last day at Abco. She starts work at XYCo. on May 1, and she becomes covered under XYCo.'s

group health plan on that day, with no waiting period. Termination of employment from Abco is a qualifying event for Sally, but Sally's termination has no effect on the COBRA coverage already in place for Sam and his new family. Sam's maximum coverage period remains the same.

Plan administrator action: Zipco (as plan administrator for Abco) mails a COBRA election notice (by first-class mail, addressed to Sally and Susie) on April 10, 2021.

On May 10, 2021, Sally sends her COBRA election form to Zipco, electing COBRA with the Abco HMO plan for herself and Susie. She is entitled to do this even though she has new coverage under the XYCo. plan because the new coverage was in place before she made her COBRA election. (If her XYCo. coverage did not start until after she elected COBRA coverage, then her COBRA coverage could be terminated early.) Sally and Susie's maximum coverage period is 18 months from the date that Sally's employment with Abco ended (i.e., until September 30, 2022).

12. Sam Fails to Pay His COBRA Premium on Time

Sam fails to send his COBRA premium payment for May 2021 (which was due on May 1) and has not sent it by May 31, 2021 (the last day of the 30-day grace period provided by the plan for late premium payments). Zipco does not make it a practice to send late premium payment reminders to qualified beneficiaries (and COBRA does not require such reminders). Sam's Abco COBRA coverage (and the coverage of Della and Robert) terminates, effective April 30, 2021.

Plan administrator action: On June 1, 2021, Zipco sends a notice addressed to Sam and Della that, due to nonpayment of the COBRA premium, the COBRA coverage of Sam, Della, and Robert terminated, effective April 30, 2021. Note that there is no need to send a HIPAA certificate of creditable coverage to Sam, Della, and Robert because such certificates are no longer required as of December 31, 2014.

13. Sally Dies

On August 1, 2022 (during her 18-month COBRA period), Sally dies in a car accident. Her daughter Susie, who is only six years old, goes to live with Sam, Della, and Robert. On September 1, 2022, Sam writes to Zipco, notifying Zipco of Sally's death, giving Susie's new address, asking for any notices and communications to be sent to him, and asking to have Susie's COBRA coverage extended.

Plan administrator action: Zipco changes all of its internal records to note Susie's new address and guardian. It notifies the Abco HMO of the extended coverage period to which Susie is now entitled. Zipco sends a letter to Sam, confirming that Susie's maximum COBRA coverage period has been extended to 36 months and notifying him of a change in Susie's COBRA premium to reflect a change in her family group. It is our view that COBRA does not require plan administrators to send a notice when the maximum coverage period has been extended, but many employers elect to do so.

Susie's COBRA coverage period under the Abco HMO plan is extended to 36 months, and she may continue receiving COBRA coverage for that long (through March 31, 2024) if her COBRA premiums are paid on time and if no other event causing early termination occurs.

Note that XYCo. must also offer 36 months of COBRA coverage to Susie, by sending a COBRA election notice to Susie's remaining parent and guardian, Sam. Under the XYCo. plan, Sally's death would be a qualifying event for her dependent child, Susie, with a maximum coverage period of 36 months. Susie's maximum coverage period under the XYCo. plan would end on August 1, 2025.

R. Conclusion

Congratulations! You did it! You survived the short and speedy tour of the ins and outs of COBRA. Relax, take a break. When you're ready, we encourage you to explore the rest of this comprehensive COBRA manual.