

COMPLIANCE OVERVIEW

Provided by Power Kunkle Benefits Consulting

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows individuals to continue their group health plan coverage in certain situations. Specifically, COBRA requires group health plans to offer continuation coverage to covered employees and dependents when coverage would otherwise be lost due to certain specific events.

These events include the death of a covered employee, termination or a reduction in the hours of a covered employee's employment, divorce of a covered employee and spouse, and a child's loss of dependent status under the plan.

COBRA sets rules for how and when continuation coverage must be offered and provided, how employees and their families may elect continuation coverage and when continuation coverage may be terminated.

Employers may require individuals to pay for COBRA coverage. Group health coverage for COBRA participants is usually more expensive than coverage for active employees, since many employers pay a part of the premium for active employees.

LINKS AND RESOURCES

- The Department of Labor's (DOL) COBRA continuation coverage [Web page](#).
- [An Employer's Guide to Group Health Continuation Coverage Under COBRA](#) – DOL resource
- The DOL's model COBRA forms – [Model General Notice](#) and [Model Election Notice](#)

HIGHLIGHTS

COBRA BASICS

- COBRA allows certain employees, spouses and dependents to temporarily continue their health coverage at group rates.
- COBRA coverage must be the same as the coverage that is available to similarly situated active employees who are not receiving COBRA benefits.

COMPLIANCE TIPS

Avoid common compliance mistakes by:

- Determining if COBRA applies to your health plan;
- Knowing which events trigger the requirement to offer COBRA coverage;
- Providing the required COBRA notices on a timely basis; and
- Establishing payment procedures for COBRA premiums.

This Compliance Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.



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WHEN DOES COBRA APPLY?

Most private-sector employers that maintain group health plans for their employees must comply with COBRA’s continuation coverage requirements. This includes, for example, corporations, partnerships and tax-exempt organizations. However, COBRA does not apply to group health plans maintained by **small employers**. A “small employer” means an employer that had **fewer than 20 employees** on typical business days during the preceding calendar year.

COBRA also applies to plans sponsored by state and local governments. It does not apply, however, to plans sponsored by the federal Government or by churches and certain church-related organizations.

Impact of State Continuation Coverage – Many states have laws similar to COBRA that apply to fully insured group health plans, including plans maintained by churches and employers with fewer than 20 employees. These are sometimes called **mini-COBRA laws**. Even if a plan is not subject to COBRA, it may still be required to provide continuation coverage under state insurance laws.

Once an employer determines that it is subject to COBRA, it must look at its plans. An employer-sponsored welfare benefit plan is subject to COBRA if it provides medical care. “Medical care” broadly includes medical, dental, vision and drug coverage. The following table indicates whether welfare benefits commonly offered by employers are subject to COBRA:

Type of Benefit	Subject to COBRA?	
	Yes	No
Group medical plans	✓	
Dental and vision plans	✓	
Health FSAs and HRAs	✓	
HSAs		✓
Disease-specific policies (providing medical care)	✓	
Group life insurance		✓
Disability plans (long-term or short-term)		✓
AD&D coverage		✓

WHO IS ENTITLED TO COBRA COVERAGE?

A group health plan is required to offer COBRA continuation coverage only to **qualified beneficiaries** and only after a **qualifying event** has occurred.

Qualified Beneficiaries

A qualified beneficiary is an individual who was covered by a group health plan on the day before a qualifying event occurred and who is an employee, an employee's spouse or former spouse, or an employee's dependent child. In addition, any child born to or placed for adoption with a covered employee during a period of continuation coverage is automatically considered a qualified beneficiary.

Qualifying Events

An employer must offer COBRA coverage only when group health plan coverage ends (or would end) due to a qualifying event. Not all losses of health coverage are caused by qualifying events. For example, a cancellation of health plan coverage—whether at the employee's request or because of the employee's failure to pay premiums—is not, by itself, a qualifying event that triggers the requirement to offer COBRA coverage.

The period of COBRA coverage offered to qualifying beneficiaries is known as the “maximum coverage period.” The length of the maximum coverage period depends on the type of qualifying event that has occurred. There are situations where the maximum coverage period can be extended (due to disability or a second qualifying event) or terminated early (for example, when COBRA premiums are not paid).

The following chart outlines the seven qualifying events under COBRA and the corresponding maximum coverage periods:

Qualifying Event	Maximum Coverage Period
Termination of employment	18 months
Reduction of hours	18 months
Divorce or legal separation	36 months
Covered employee's death	36 months
Child's loss of dependent status under plan's terms	36 months
Entitlement to Medicare	36 months
Employer bankruptcy (for retirees and their dependents)	36 months

HOW LONG DOES COBRA COVERAGE LAST?

COBRA requires that continuation coverage extends from the date of the qualifying event for a limited period of time of 18 or 36 months, as described in the chart above. A group health plan may terminate continuation coverage earlier than the end of the maximum period for any of the following reasons:

- ✓ Premiums are not paid in full on a timely basis;

- ✓ The employer ceases to maintain any group health plan;
- ✓ A qualified beneficiary begins coverage under another group health plan after electing continuation coverage;
- ✓ A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage; or
- ✓ A qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice.

There are two situations that can extend the 18-month maximum period of continuation coverage:

Type of Extension	Length	Requirements	Who Qualifies
Disability	11-month extension (for a total of 29 months of continuation coverage)	The Social Security Administration (SSA) determines that the qualified beneficiary is disabled before the 60th day of continuation coverage and the disability continues during the rest of the initial 18-month period of continuation coverage.	The qualified beneficiary with the disability and all of the qualified beneficiaries in the family
Second qualifying event	18-month extension (for a total of 36 months of continuation coverage)	A second qualifying event occurs that is the death of the covered employee, the divorce or legal separation of the covered employee and spouse, Medicare entitlement (in certain circumstances) or loss of dependent child status under the plan. The second event can be a second qualifying event only if it would have caused the qualified beneficiary to lose coverage under the plan in the absence of the first qualifying event.	Qualified beneficiaries who are covered spouses and children

WHAT BENEFITS MUST BE OFFERED?

Qualified beneficiaries must be offered coverage that is identical to that available to similarly situated beneficiaries who are not receiving COBRA coverage under the plan. Generally, this will be the same coverage that the qualified beneficiary had immediately before qualifying for continuation coverage. A change in the benefits under the plan for the active employees will also apply to qualified beneficiaries.

Qualified beneficiaries must be allowed to make the same choices given to non-COBRA beneficiaries under the plan, such as during periods of open enrollment by the plan.

WHO PAYS FOR COBRA COVERAGE?

Group health plans can require qualified beneficiaries to pay for COBRA continuation coverage, although plan sponsors can choose to provide continuation coverage at reduced or no cost. The maximum amount charged to qualified beneficiaries cannot exceed **102 percent** of the cost to the plan for similarly situated individuals covered under the plan who have not incurred a qualifying event. For qualified beneficiaries receiving the 11-month disability extension, the premium for those additional months may be increased to **150 percent** of the plan's total cost of coverage.

COBRA premiums may be increased if the costs to the plan increase, but they generally must be fixed in advance of each 12-month premium cycle. The plan must allow qualified beneficiaries to pay premiums on a monthly basis if they ask to do so, and the plan may allow them to make payments at other intervals (weekly or quarterly).

Also, qualified beneficiaries cannot be required to pay premiums at the time they make COBRA elections. Plans must provide at least 45 days after the election for making an initial premium payment. If a qualified beneficiary fails to make any payment before the end of the initial 45-day period, the plan can terminate the qualified beneficiary's COBRA rights. The plan sponsor may establish due dates for premiums for subsequent periods of coverage, but it must provide a minimum 30-day grace period for each payment.

WHAT NOTICES MUST BE PROVIDED?

The following COBRA notices are required to be provided in certain situations:

COBRA Notice	Description
General (or initial) notice	General description of COBRA rights under the plan. Must be provided within the first 90 days of coverage.
Election notice	Describes right to COBRA coverage and how to make an election. Must be provided to qualified beneficiaries after a qualifying event.
Notice of unavailability of COBRA coverage	Must be provided after a group health plan denies a request for COBRA coverage (or a request for an extension). It informs the individual that he or she is not eligible for COBRA coverage (or for an extension).
Notice of early termination of COBRA coverage	When a group health plan decides to terminate continuation coverage early, the plan must give the qualified beneficiary a notice of early termination.

General Notice

Group health plans must give plan participants a general notice describing COBRA rights under the plan. The general notice must be provided within the **first 90 days of coverage**. Group health plans can satisfy this requirement by including the general notice in the plan's summary plan description (SPD) and by delivering the SPD within this time limit.

The DOL has developed a [Model General Notice](#), which is also available in [Spanish](#). Employers are not required to use the DOL's Model Notice. However, use of the Model Notice, appropriately completed, will be considered by the DOL to be good faith compliance with COBRA's content requirements for the general notice.

Election Notice

After receiving a notice of a qualifying event, the plan must provide the qualified beneficiaries with an election notice, which describes their rights to continuation coverage and how to make an election. The election notice must be provided to the qualified beneficiaries within **14 days** after the plan administrator receives the notice of a qualifying event from the employer or a qualified beneficiary.

The employer is required to notify the plan administrator of most qualifying events. However, qualified beneficiaries are responsible for notifying the plan administrator of a divorce (or legal separation) or a dependent child's loss of dependent status under the plan.

In many cases, the employer is also the plan administrator. For qualifying events where the employer is required to provide notice to the plan administrator (termination or reduction in hours, death of the employee, or employee becoming entitled to Medicare) and the employer is also the plan administrator, the election notice must be provided to the qualified beneficiary within **44 days** of the later of:

- ✓ The date of the qualifying event; or
- ✓ The date on which the qualifying beneficiary loses coverage due to the qualifying event.

The DOL has developed a [Model Election Notice](#), which is also available in [Spanish](#). The model notice includes information about other coverage options that may be available through the Health Insurance Marketplace (or Exchanges) as potentially more affordable alternatives to COBRA coverage. Plan administrators are not required to use the model notice, but properly using it is considered good faith compliance with COBRA's notice content requirements.

Notice of Unavailability of COBRA Coverage

Group health plans may sometimes deny a request for continuation coverage (or for an extension of continuation coverage) when the plan determines the requester is not entitled to receive it. When a group health plan makes the decision to deny a request for continuation coverage (or a request for an extension), the plan must give the individual a notice of unavailability of continuation coverage. The notice must be provided within **14 days** after the request is received, and the notice must explain the reason for denying the request.

Notice of Early Termination of COBRA Coverage

Continuation coverage must generally be made available for a maximum period (for example, 18 or 36 months). The group health plan may terminate continuation coverage early, however, for any of a number of specific reasons. When a group health plan decides to terminate continuation coverage early for any of these reasons, the plan must give the qualified beneficiary a notice of early termination. The notice must be given as soon as practicable after the decision is made, and it must describe the date that coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage.

WHAT ARE THE RULES FOR ELECTING COBRA?

COBRA requires group health plans to give qualified beneficiaries an election period during which they can decide whether to elect continuation coverage. COBRA also gives qualified beneficiaries specific election rights.

At a minimum, each qualified beneficiary must be given **at least 60 days** to choose whether to elect COBRA coverage. This 60-day period is measured from the later of: (1) the date the election notice is provided; or (2) the date on which the qualified beneficiary would otherwise lose coverage under the group health plan due to the qualifying event.

Each qualified beneficiary must be given an independent right to elect continuation coverage. This means that when several individuals (such as an employee, his or her spouse and their dependent children) become qualified beneficiaries due to the same qualifying event, each individual can make a different choice. The plan must allow the covered employee or the covered employee's spouse, however, to elect continuation coverage on behalf of all of the other qualified beneficiaries for the same qualifying event. A parent or legal guardian of a qualified beneficiary must also be allowed to elect on behalf of a minor child.

If a qualified beneficiary waives continuation coverage during the election period, he or she must be permitted to later revoke the waiver of coverage and elect continuation coverage, as long as the revocation is done before the end of the election period. If a waiver is later revoked, however, the plan is permitted to make continuation coverage begin on the date the waiver was revoked.