

COBRA FINAL REGULATIONS
DEPARTMENT OF THE TREASURY
26 CFR Parts 54 and 602

Effective Date

Final regulations: The final regulations apply with respect to qualifying events occurring in plan years beginning on or after January 1, 2000.

Proposed regulations: Compliance with the new proposed regulations will constitute good faith compliance until the new proposed regulations are finalized.

Plans That Must Comply

Plan exemptions: The final regulations provide that a plan is not a group health plan if substantially all the coverage provided under the plan is for qualified long-term care services. The final regulations also provide that amounts contributed by an employer to a medical savings account are not considered part of a group health plan for purposes of COBRA (although a high-deductible health plan will not fail to be a group health plan simply because it covers a holder of a medical savings account).

Group health plan: A group health plan is a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer or employee organization or to the families of such individuals. These individuals include employees, former employees, the employer, and others associated or formerly associated with the employer or employee organization in a business relationship.

Health care: Under the final regulations a plan generally is considered to provide health care whether it does so directly or through insurance, reimbursement, or other means and whether it does so through an on-site facility or a cafeteria or other flexible benefit arrangement. Under the final regulations, in the case of a cafeteria plan or other flexible benefit arrangement, the COBRA continuation coverage requirements apply only to the health care benefits under the cafeteria plan or other flexible benefit arrangement that an employee has actually chosen to receive.

Health FSA's: Health FSAs satisfy the definition of group health plan in section 5000(b)(1) and, accordingly, are generally subject to the COBRA continuation coverage requirements. However, COBRA is intended to ensure that a qualified beneficiary has guaranteed access to coverage under a group health plan and that the cost of that coverage is no greater than 102 percent of the applicable premium. The IRS and Treasury believe that the purposes of COBRA are not furthered by requiring an employer to offer COBRA for a plan year if the amount that the employer could require to be paid for the COBRA coverage for the plan year would exceed the maximum benefit that the qualified beneficiary could receive under the FSA for that plan year and if the qualified beneficiary could not avoid a break in coverage, for purposes of the HIPAA portability provisions, by electing COBRA coverage under the FSA. Accordingly, the new proposed regulations contain a rule limiting the application of the COBRA continuation coverage requirements in the case of health FSAs. Under this rule, if the health FSA satisfies two conditions, the health FSA need not make COBRA continuation coverage available to a qualified beneficiary for any plan year after the plan year in which the qualifying event occurs. The first condition that the health FSA must satisfy for this exception to apply is that the health FSA is not subject to the HIPAA portability provisions in sections 9801 through 9833 because the benefits provided under the health FSA are excepted benefits. (See sections 9831 and 9832.) The second condition is that, in the plan year in which the qualifying event of a qualified beneficiary occurs, the maximum amount that the health FSA could require to be paid for a full plan year of COBRA continuation coverage equals or exceeds the maximum benefit available under the health FSA for the year. It is contemplated that this second condition will be satisfied in most cases. Moreover, if a third condition is satisfied, the health FSA need not make COBRA continuation coverage available with respect to a qualified beneficiary at all. This third condition is satisfied if, as of the date of the qualifying event, the maximum benefit available to the qualified beneficiary under the health FSA for the remainder of the plan year is not more than the maximum amount that the plan could require as payment for the remainder of that year to maintain coverage under the health FSA.

Small employer exemption: The final regulations, generally following the 1987 proposed regulations, set forth rules for determining whether a group health plan is a small-employer plan. In general, a group health plan other than a multiemployer plan is a small-employer plan if it is maintained for a calendar year by an employer that normally employed fewer than 20 employees during the preceding calendar year, and a group health plan

that is a multiemployer plan is a small-employer plan if each of the employers contributing to the plan for a calendar year normally employed fewer than 20 employees during the preceding calendar year. Whether the plan is a multiemployer plan or not, the term employer includes all members of a controlled group. An example in the final regulations clarifies that the controlled group includes foreign members, and thus a U.S. subsidiary with fewer than 20 employees is subject to COBRA if the controlled group has 20 or more employees worldwide. The final regulations set forth additional rules for the application of the small-employer plan exception to multiemployer plans, and the new proposed regulations contain the same definition of multiemployer plan that is in section 414(f).

Under the final regulations, an employer is considered to have normally employed fewer than 20 employees during a particular calendar year if it had fewer than 20 employees on at least 50 percent of its typical business days during that year.

The second difference relates to the term employee. Under the 1987 proposed regulations, self-employed individuals and independent contractors are counted as employees for purposes of the small-employer plan exception if they are covered under a plan of the employer. Commenters argued that only common law employees should be counted for this purpose. Unlike the definition of covered employee and the definition of group health plan, the reference to employees for purposes of the small-employer plan exception have not been amended to include individuals who are not common law employees. Consequently, under the final regulations, only common law employees are taken into account for purposes of the small-employer plan exception; self-employed individuals, independent contractors, and directors are not counted.

In determining whether a plan is eligible for the small-employer plan exception, part-time employees, as well as full-time employees, must be taken into account. Under the new proposed regulations, instead of each part-time employee counting as a full employee, each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee works for the employer divided by the number of hours that an employee must work in order to be considered a full-time employee. The number of hours that must be worked to be considered a full-time employee is determined in a manner consistent with the employer's general employment practices, although for this purpose not more than eight hours a day or 40 hours a week may be used.

In determining whether a multiemployer plan satisfies the requirements for the small-employer plan exception, the 1987 proposed regulations provide a special rule permitting the multiemployer plan to be considered a small-employer plan for a year if any contributing employer that grew to be too large to qualify for the exception during the preceding year ceases to contribute to the plan by February 1 of the current year. Questions have been raised about the need for and the authority for this special rule. Based on these concerns, the final regulations eliminate this special rule for multiemployer plans.

Number of group health plans: Under these rules, the employer or employee organization is generally permitted to establish the separate identity and number of group health plans under which it provides health care benefits to employees. Thus, if an employer or employee organization provides a variety of health care benefits to employees, it generally may aggregate the benefits into a single group health plan or disaggregate benefits into separate group health plans. The status of health care benefits as part of a single group health plan or as separate plans is determined by reference to the instruments governing those arrangements. If it is not clear from the instruments governing an arrangement or arrangements to provide health care benefits whether the benefits are provided under one plan or more than one plan, or if there are no instruments governing the arrangement or arrangements, all such health care benefits provided by a single entity (determined without regard to the controlled group) constitute a single group health plan.

Under the new proposed regulations, a multiemployer plan and a plan other than a multiemployer plan are always separate plans. In addition, any treatment of health care benefits as constituting separate group health plans will be disregarded if a principal purpose of the treatment is to evade any requirement of law.

Plan years: Under the final regulations, the plan year is the year designated as such in the plan documents. If the plan documents do not designate a plan year (or if there are no plan documents), the plan year is the deductible/limit year used by the plan. If the plan does not impose deductibles or limits on an annual basis, the plan year is the policy year. If the plan does not impose deductibles or limits on an annual basis and the plan is not insured (or the insurance policy is not renewed annually), the plan year is the taxable year of the employer. In any other case, the plan year is the calendar year.

Excise taxes for COBRA failures: In the case of a multiemployer plan, the excise tax is imposed on the plan; in the case of any other plan, the excise tax is imposed on the employer maintaining the plan. In certain circumstances, the excise tax can be imposed on other persons involved with the provision of benefits under the plan, such as an insurer providing benefits under the plan or a third party administrator administering claims under the plan.

Individual liability: The U.S. DOL has advised the IRS and Treasury that to the extent a plan fiduciary subjects a plan to liability for the COBRA excise tax on account of her or his imprudent actions, the plan fiduciary may be held personally liable under Title I of ERISA for the amount of the tax.

Qualified Beneficiaries

Bankruptcy: For a qualifying event that is the bankruptcy of the employer, any covered employee who retired on or before the date of any substantial elimination of group health plan coverage is a qualified beneficiary; the spouse, surviving spouse, or dependent child of the retired covered employee is also a qualified beneficiary if the spouse, surviving spouse, or dependent child was a beneficiary under the plan on the day before the bankruptcy qualifying event.

Covered employee: A covered employee can be a qualified beneficiary only in connection with a qualifying event that is the termination (or reduction of hours) of the covered employee's employment or the employer's bankruptcy.

Nonresident alien: The final regulations provide that a covered employee is not a qualified beneficiary if her or his status as a covered employee is attributable to certain periods in which she or he was a nonresident alien (in which case the covered employee's spouse and dependent children are also not qualified beneficiaries).

New born qualified beneficiaries: Although a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is a qualified beneficiary, a child born to or placed for adoption with a qualified beneficiary other than the covered employee after a qualifying event, or a person who becomes the spouse of a qualified beneficiary (regardless of whether the qualified beneficiary is the covered employee) after a qualifying event is not a qualified beneficiary.

Medicare eligibility: The final regulations eliminate the rule in the 1987 proposed regulations that an individual is not a qualified beneficiary if, on the day before the qualifying event, the individual was entitled to Medicare benefits.

Cease to be a qualified beneficiary: An individual ceases to be a qualified beneficiary if she or he does not elect COBRA continuation coverage by the end of the election period. The final regulations clarify that an individual who elects COBRA continuation coverage ceases to be a qualified beneficiary once the plan's obligation to provide COBRA continuation coverage has ended.

Covered employee: A covered employee generally includes any individual who is or has been provided coverage under a group health plan because of her or his present or past performance of services for the employer maintaining the group health plan (or by reason of membership in the employee organization maintaining the plan). Thus, retirees and former employees covered by a group health plan are covered employees if the coverage is provided in whole or in part because of the previous employment. Thus, common law employees, self-employed individuals, independent contractors, and corporate directors can be covered employees. Generally, mere eligibility for coverage--as opposed to actual coverage--does not make an individual a covered employee. However, if an individual who otherwise would be a covered employee is denied coverage under a group health plan in violation of applicable law (including HIPAA), the individual is considered a covered employee.

Qualifying Events

Bankruptcy: The addition of employer bankruptcy as a qualifying event reflects the amendments made to COBRA by OBRA 1986.

Reasons for termination not relevant: The reasons for which an employee has a termination of employment or a reduction of hours of employment generally are not relevant in determining whether the termination or reduction of hours is a qualifying event. Thus, a voluntary termination, a strike, a lockout, a layoff, or an involuntary discharge each may constitute a qualifying event. However, if an employee is discharged for gross misconduct, the termination of employment does not constitute a qualifying event.

Reduction of hours: The final regulations clarify that a reduction of hours of a covered employee's employment includes any decrease in the number of hours that a covered employee works or is required to work that does not constitute a termination of employment. A covered employee's loss of coverage by reason of

a failure to work the minimum number of hours required for coverage constitutes a reduction of hours of employment.

Loss of coverage: The final regulations clarify that a loss of coverage includes an increase in an employee premium or contribution resulting from one of the events described above. The loss of coverage need not be concurrent with the event; it is enough that the loss of coverage occur at any time before the end of the maximum coverage period. For employer bankruptcies, the term to lose coverage also includes a substantial elimination of coverage that occurs within 12 months before or after the date on which the bankruptcy proceeding begins.

"In anticipation of": Reductions or elimination's in coverage in anticipation of an event are disregarded in determining whether the event results in a loss of coverage. This rule also applies in cases where a covered employee discontinues the coverage of a spouse in anticipation of a divorce or legal separation. In such a case, upon receiving notice of the divorce or legal separation, a plan is required to make COBRA continuation coverage available, effective on the date of the divorce or legal separation (but not for any period before the date of the divorce or legal separation).

New born timelines: In the case of a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the qualifying event that gives rise to that period of COBRA continuation coverage is the qualifying event applicable to that child. Thus, if a second qualifying event has occurred before such a child is born (for example, if the covered employee dies), the second qualifying event also applies to the newborn child.

COBRA Continuation Coverage

Same coverage: The final regulations have been revised to incorporate the statutory standard that a qualified beneficiary is entitled to the coverage made available to similarly situated beneficiaries with respect to whom a qualifying event has not occurred.

Plan changes or elimination's: The 1987 proposed regulations address in a separate question-and-answer the type of coverage that must be made available to qualified beneficiaries if a change is made in the coverage provided to similarly situated non COBRA beneficiaries. The final regulations include this rule. In doing so, the final regulations delete several specific requirements in the 1987 proposed regulations. For example, if coverage for the similarly situated non COBRA beneficiaries is changed or eliminated, the 1987 proposed regulations require that qualified beneficiaries be permitted to elect coverage under any remaining plan made available to the similarly situated active employees. Many commenters objected that in the case of a mere change in benefits, the requirement to give qualified beneficiaries an election among other plans would give them greater rights than those active employees might have. The final regulations follow the suggestion of the commenters in providing that the general principle--that qualified beneficiaries have the same rights as similarly situated non COBRA beneficiaries--applies in this situation. The same principle also applies in determining whether credit for deductibles must be carried over from a discontinued plan to a new plan. Nevertheless, if an employer or employee organization providing more than one plan to a group of similarly situated non COBRA beneficiaries eliminates benefits under one plan without giving the similarly situated non COBRA beneficiaries the right to enroll in another plan, that option would still have to be made available to qualified beneficiaries if the employer continued to maintain a group health plan because of the employer's obligation to continue to make COBRA continuation coverage available.

Core v. noncore benefits: The 1987 proposed regulations include detailed rules requiring that qualified beneficiaries generally be offered the option of electing only core coverage or both core and noncore coverage. After careful consideration, the IRS and Treasury have decided not to include in either the final or the new proposed regulations any such requirement to offer for core coverage separately.

Deductibles and plan limits: The 1987 proposed regulations establish standards for determining the deductibles and limits that apply to COBRA continuation coverage in a period in which an individual or a group of family members has coverage that is not COBRA continuation coverage and then elects COBRA continuation coverage. The 1987 proposed regulations would require that each resulting family unit be credited with all the expenses incurred by the entire family before the qualifying event. The final regulations revise this rule. Under the final regulations, in computing deductibles and limits for the family unit receiving COBRA coverage, the plan is required to take into account only those expenses incurred before the qualifying event by family members who are part of the resulting family unit after the qualifying event.

Moving outside HMO coverage area: The 1987 proposed regulations provide that qualified beneficiaries moving outside the area served by a region-specific plan must be given the right to obtain other coverage from the employer maintaining the region-specific plan. The rule conditions the right to other coverage on the employer having employees in the area to which the qualified beneficiary is moving. The final regulations eliminate the condition that an employer have employees in the area to which the qualified beneficiary is moving and instead require that coverage be made available to the qualified beneficiary if the employer or employee organization would be able to provide coverage to the qualified beneficiary under one of its existing plans.

Open enrollment rights: The 1987 proposed regulations require, in the case of a plan providing open enrollment rights, that open enrollment rights be extended to qualified beneficiaries if an employer maintains two or more plans. The final regulations eliminate the condition that an employer or employee organization maintain two or more plans for a qualified beneficiary to have open enrollment rights. Thus, open enrollment rights must be extended to qualified beneficiaries in any case in which they are extended to similarly situated active employees.

Adding new family members: The 1987 proposed regulations require that qualified beneficiaries be given the same right to add new family members that similarly situated active employees have. COBRA continuation coverage is more than just a continuation of the coverage a qualified beneficiary had before the qualifying event; it includes the same procedural rights to expand or change coverage that similarly situated active employees have. Accordingly, the final regulations provide guidance on the application of the HIPAA special enrollment rights to qualified beneficiaries and retain the rule in the 1987 proposed regulations regarding the right of qualified beneficiaries to add new family members (even though not eligible for the HIPAA special enrollment rights) to the same extent that active employees are permitted to add new family members.

Electing COBRA Continuation Coverage

The final regulations set forth rules regarding elections of COBRA continuation coverage by qualified beneficiaries. For purposes of determining whether a qualified beneficiary's election of COBRA continuation coverage is timely, the election is deemed to be made on the date it is sent to the employer or plan administrator. The final regulations clarify that a qualified beneficiary need not herself or himself elect COBRA continuation coverage; that election can be made on behalf of the qualified beneficiary by a third party (including a third party that is not a qualified beneficiary).

Divorce/legal separation: A covered employee or qualified beneficiary is required to notify the plan administrator of a qualifying event that is a divorce or legal separation of the covered employee or a dependent child's ceasing to be a dependent child under the plan terms. The 1987 proposed regulations prescribe that the notification should be given to the employer or other plan administrator. The final regulations simply require that the notice be provided to the plan administrator. The notice must be provided within 60 days after the date of the qualifying event or the date on which the qualified beneficiary would lose coverage because of the qualifying event, whichever is later. If the notice is not provided, the group health plan is not required to make COBRA continuation coverage available to the qualified beneficiary. A single notice sent by or on behalf of the covered employee or any one of the qualified beneficiaries satisfies the notice requirement .

Coverage during election period: The group health plan must make COBRA continuation coverage available for the entire election period if the qualified beneficiary elects coverage prior to the end of the period. An employer or employee organization maintaining a group health plan using an indemnity or reimbursement arrangement can satisfy this requirement by continuing the qualified beneficiary's coverage during the election period or by discontinuing the coverage until the qualified beneficiary elects COBRA and then retroactively reinstating the qualified beneficiary's coverage. Under the final regulations the date of the qualifying event is not delayed merely because a plan provides coverage during the election period. Claims incurred by the qualified beneficiary during the election period do not have to be paid until COBRA continuation coverage is elected and any payment required for coverage is made.

HMO coverage during election window: For a group health plan providing health services--including a health maintenance organization or a walk-in clinic--a qualified beneficiary who has not elected and paid for COBRA continuation coverage can be required to choose either to elect and to pay for coverage or to pay a reasonable and customary charge for plan services (but only if the qualified beneficiary will be reimbursed for that charge within 30 days after she or he elects COBRA continuation coverage and makes any payment for coverage). Alternatively, the plan can treat the qualified beneficiary's use of the plan's health services as a constructive election of COBRA continuation coverage and, if it so notifies the qualified beneficiary prior to the use of services, can require payment for COBRA continuation coverage.

Verification of benefits: The final regulations require that the plan make a complete response to any inquiry from a health care provider regarding the qualified beneficiary's right to coverage under the plan during the election period. Thus, if the qualified beneficiary has not yet elected COBRA continuation coverage but remains covered under the plan during the election period (subject to retroactive cancellation if no election is made), the plan must so inform the health care provider. Conversely, if the qualified beneficiary is not covered during the election period prior to her or his election, the plan must inform the health care provider that the qualified beneficiary does not have current coverage but will have retroactive coverage if COBRA continuation coverage is elected.

Waiver of COBRA: A qualified beneficiary who waives COBRA continuation coverage during the election period can revoke the waiver before the end of the election period, but the group health plan is not then required to provide coverage as of any date prior to the revocation.

Withholding money: The employer maintaining the group health plan is not permitted to withhold money, benefits, or anything else to which the qualified beneficiary is entitled under any law or agreement in order to induce a qualified beneficiary to make payment for COBRA continuation coverage or to surrender any rights under COBRA.

Independent elections: A group health plan must offer each qualified beneficiary the opportunity to make an independent election to receive COBRA continuation coverage and, during an open enrollment period, to choose among any options available to similarly situated active employees. This requirement also applies to any child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage. If a covered employee or the spouse of a covered employee elects COBRA continuation coverage and the election does not specify whether the election is for self-only coverage, the election is deemed to include an election of COBRA continuation coverage on behalf of other qualified beneficiaries .

Duration of COBRA Continuation Coverage

Termination during disability extension: First, the new proposed regulations clarify that a determination that a qualified beneficiary is no longer disabled allows termination of COBRA continuation coverage for all qualified beneficiaries who were entitled to the disability extension. Second, the new proposed regulations clarify that such a determination does not allow termination of the COBRA continuation coverage of a qualified beneficiary before the end of the maximum coverage period that would apply without regard to the disability extension.

Coverage at time of COBRA event: Section 4980B(f)(2)(B)(iv) provides that a qualified beneficiary's right to COBRA continuation coverage may be terminated when the qualified beneficiary "first becomes," after the date of the COBRA election, covered under another group health plan (subject to certain additional conditions) or entitled to Medicare benefits. The final regulations add two new questions-and-answers that provide guidance on this provision.

The final regulations provide that an employer may cut off the right to COBRA continuation coverage based upon other group health plan coverage or entitlement to Medicare benefits only if the qualified beneficiary first becomes covered under the other group health plan coverage or entitled to the Medicare benefits after the date of the COBRA election.

Coverage by another health plan after the event: The statutory rule allowing a plan to discontinue COBRA continuation coverage on account of coverage under another group health plan was amended by OBRA 1989 to prohibit the discontinuance if the qualified beneficiary's other coverage was subject to a preexisting condition exclusion. This amendment was further modified by HIPAA to allow discontinuance of COBRA continuation coverage if the preexisting condition exclusion does not apply or is satisfied by reason of the limitations on preexisting condition exclusions in section 9801. The final regulations reflect this amendment and clarify that coverage under another group health plan includes coverage under a governmental plan.

Termination for Medicare entitlement: The final regulations clarify that entitlement to Medicare benefits means being enrolled in Medicare and does not mean merely being eligible to enroll in Medicare. The final regulations also clarify that being entitled to either Part A or B is sufficient for the plan to discontinue COBRA continuation coverage (assuming that the entitlement to Medicare benefits first arises after COBRA continuation coverage has been elected).

Termination for cause: The final regulations provide that, for example, if a plan terminates the coverage of similarly situated active employees for the submission of a fraudulent claim, then the COBRA continuation coverage of a qualified beneficiary can also be terminated for the submission of a fraudulent claim.

End of COBRA coverage period: The statute has been amended to add the disability extension, to permit plans to extend the notice period if the maximum coverage period is also extended (referred to as the optional extension of the required periods), and to add a special rule in the case of Medicare entitlement preceding a qualifying event that is the termination or reduction of hours of employment. The new proposed regulations reflect these statutory changes. The maximum coverage period for a qualifying event that is the bankruptcy of the employer has also been added to the new proposed regulations.

Disability extension: The 1998 proposed regulations set forth the requirements for a disability extension to apply to a qualified beneficiary. Those requirements have been incorporated into the final regulations, with one clarification. One of the conditions for a disability extension to apply is that the qualified beneficiary be disabled during the first 60 days of COBRA continuation coverage. In the case of a qualified beneficiary who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the final regulations clarify that the 60-day period is measured from the date of the child's birth or placement for adoption.

Second events: The 1987 proposed regulations set forth standards for expanding the maximum coverage period in the case of multiple qualifying events. Since 1987, the statutory rules for multiple qualifying events have been affected by the addition of the disability extension and the optional extension of required periods. The final regulations reflect the statutory changes. In addition, the final regulations clarify that a termination of employment following a qualifying event that is a reduction of hours of employment does not expand the maximum coverage period.

Alternative coverage: The 1987 proposed regulations address situations in which, following a qualifying event, an employer provides alternative coverage, rather than COBRA continuation coverage, to a former employee and her or his spouse and dependent children. The 1987 proposed regulations provide that if the alternative coverage does not satisfy the requirements for COBRA continuation coverage, each qualified beneficiary must be given the opportunity to elect COBRA continuation coverage instead of the alternative coverage. If, however, the alternative coverage would satisfy the requirements for COBRA continuation coverage, the 1987 proposed regulations provide that, at the time of the original qualifying event, the employee, spouse, and dependent children need not be provided with the opportunity to elect COBRA continuation coverage. The final regulations generally retain these rules but also clarify that if the employer increases the employee share of premiums upon the occurrence of a qualifying event, the qualified beneficiaries must be offered the opportunity to elect COBRA continuation coverage.

The 1987 proposed regulations further provide that, if the alternative coverage does not satisfy the requirements for COBRA continuation coverage and if, after the original qualifying event, a qualifying event occurs that would cause a spouse or dependent child to lose the alternative coverage, the spouse or child must be offered COBRA continuation coverage. However, if the alternative coverage satisfies the requirements for COBRA continuation coverage, and if another qualifying event that causes the spouse or dependent child to lose the alternative coverage occurs more than 18 months after the original qualifying event, the 1987 proposed regulations provide that the spouse or dependent child need not be offered COBRA continuation coverage. The final regulations modify the 1987 proposed regulations and provide that if an event such as the death of or divorce from the covered employee would end the right of a spouse or dependent child to receive the alternative coverage (whether during or after the first 18 months of COBRA continuation coverage), then that event is a qualifying event, regardless of whether the alternative coverage would satisfy the requirements for COBRA continuation coverage.

Uniformed Services Act: The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) gives certain members of the military reserves the right to up to 18 months of continuation coverage when they are called to active duty. Many people have asked if the USERRA and COBRA periods of continuation coverage run concurrently or consecutively. The final regulations clarify that USERRA coverage is alternative coverage. Thus, the periods run concurrently.

Individual conversion: The 1987 proposed regulations include the statutory rule requiring that a conversion option otherwise made available under the plan be made available within 180 days before the end of the maximum coverage period. The final regulations adopt this rule without change.

Paying for COBRA Continuation Coverage

COBRA premium payments from 3rd parties: The 1987 proposed regulations identify the qualified beneficiary as the person that can be required to pay the applicable premium. In order to make clear that any person may make the required payment on behalf of a qualified beneficiary, the final regulations modify the rule in the 1987 proposed regulations to refer to the payment requirement without identifying the person who makes the payment.

150 % COBRA premium payment: The 1998 proposed regulations address the amount that a plan can require to be paid for COBRA continuation coverage during the disability extension. This amount is 150 percent of the applicable premium instead of the limit of 102 percent of the applicable premium that applies for coverage outside the disability extension. The 1998 proposed regulations specifically reserve the issue of the amount a plan could require to be paid in a case where only nondisabled family members of the disabled individual receive COBRA continuation coverage during the disability extension. Commenters suggested that the 150 percent rate could be required if the disabled individual was part of the coverage group but that the limit could be the 102 percent rate if only nondisabled qualified beneficiaries were in the coverage group. The final regulations adopt this suggestion.

COBRA premium rate increases/decreases: The 1987 proposed regulations provide that the amount required to be paid for a qualified beneficiary's COBRA continuation coverage must be fixed in advance for each 12-month determination period. The final regulations permit a plan to increase the amount it requires to be paid for COBRA continuation coverage during a determination period to take into account the permitted increases during the disability extension, to explicitly permit a plan that is requiring payment of less than the maximum permissible amount to increase the amount required to be paid during the 12-month determination period, and to permit an increase if a qualified beneficiary changes to more expensive coverage.

Weekly COBRA premium payments: The 1987 proposed regulations set forth the statutory requirement that qualified beneficiaries be allowed to pay for COBRA coverage in monthly installments. The final regulations add weekly payment as an example to make clear that shorter than monthly installments are also permitted.

Retroactive premium payment: The 1987 proposed regulations provide that the first payment for COBRA continuation coverage does not apply prospectively only. In order to make clear that a plan is not precluded from allowing a qualified beneficiary to apply the first payment prospectively only, the final regulations provide that qualified beneficiaries need not be given the option of having the first payment for COBRA continuation coverage apply prospectively only.

45 Day premium payment period: The 1987 proposed regulations address the issue of timely payment for COBRA continuation coverage, including an interpretation of the statutory grace periods of 45 days for the initial payment and 30 days for all other payments. Commenters pointed out that the application of the statutory grace period rules could produce an anomalous result in some situations, such as allowing a plan to require payment for the third month of COBRA continuation coverage earlier than the plan could require payment for the first two months. OBRA 1989 amended the 45-day grace period rule to prevent this, and the final regulations conform to the OBRA 1989 change. The final regulations also clarify that payment is considered made on the date it is sent.

Verification of benefits during 30-day grace period: The final regulations add a requirement relating to the response that a plan must give when a health care provider contacts the plan to confirm coverage of a QB with respect to whom the required payment has not been made for the current period (but for whom any applicable grace period has not expired). The plan is required to inform the health care provider of all of the details of the qualified beneficiary's right to coverage during the applicable grace periods.

Insufficient premium payments: Many individuals have inquired about a plan's right to discontinue their COBRA continuation coverage because the amount of the payment made was short by an amount that is not significant. The final regulations establish a mechanism for the treatment of payments that are short by an insignificant amount. Either the plan must treat the payment as satisfying the plan's payment requirement or it must notify the qualified beneficiary of the amount of the deficiency and grant the qualified beneficiary a reasonable period of time for the deficiency to be paid. The final regulations provide that, as a safe harbor, a period of 30 days is deemed to be a reasonable period for this purpose.

Business Reorganizations

The new proposed regulations make clear that the parties to a transaction are free to allocate the responsibility for providing COBRA continuation coverage by contract, even if the contract imposes responsibility on a different party than would the new proposed regulations. So long as the party to whom the contract allocates responsibility performs its obligations, the other party will have no responsibility for providing COBRA continuation coverage. If, however, the party allocated responsibility under the contract defaults on its obligation, and if, under the new proposed regulations, the other party would have the obligation to provide COBRA continuation coverage in the absence of a contractual provision, then the other party would retain that obligation. Moreover, the party with the underlying responsibility under the regulations can insist on appropriate security and, of course, could pursue contractual remedies against the defaulting party.

The new proposed regulations provide, for both sales of stock and sales of substantial assets, such as a division or plant or substantially all the assets of a trade or business, that the seller retains the obligation to make COBRA continuation coverage available to existing qualified beneficiaries. In addition, in situations in which the seller ceases to provide any group health plan to any employee in connection with the sale whether such a cessation is in connection with the sale is determined on the basis of the facts and circumstances of each case and thus is not responsible for providing COBRA continuation coverage, the new proposed regulations provide that the buyer is responsible for providing COBRA continuation coverage to existing qualified beneficiaries. This secondary liability for the buyer applies in all stock sales and in all sales of substantial assets in which the buyer continues the business operations associated with the assets without interruption or substantial change.

A particular type of asset sale raises issues for which the new proposed regulations do not provide any special rules. (Thus, the general rules in the new proposed regulations for business reorganizations would apply to this type of transaction.) This type of asset sale is one in which, after purchasing a business as a going concern, the buyer continues to employ the employees of that business and continues to provide those employees exactly the same health coverage that they had before the sale (either by providing coverage through the same insurance contract or by establishing a plan that mirrors the one that provided benefits before the sale). The application of the rules in the new proposed regulations to this type of asset sale would require the seller to make COBRA continuation coverage available to the employees continuing in employment with the buyer (and to other family members who are qualified beneficiaries). Ordinarily, the continuing employees (or their family members) would be very unlikely to elect COBRA continuation coverage from the seller when they can receive the same coverage (usually at much lower cost) as active employees of the buyer.

Consideration is being given to whether, under appropriate circumstances, such an asset sale would be considered not to result in a loss of coverage for those employees who continue in employment with the buyer after the sale. A countervailing concern, however, relates to those qualified beneficiaries who might have a reason to elect COBRA continuation coverage from the seller. An example of such a qualified beneficiary would be an employee who continues in employment with the buyer, whose family is likely to have medical expenses that exceed the cost of COBRA coverage, and who has significant questions about the solvency of the buyer or other concerns about how long the buyer might continue to provide the same health coverage.

Under one possible approach, a loss of coverage would be considered not to have occurred so long as the purchasing employer in an asset sale continued to maintain the same group health plan coverage that the seller maintained before the sale without charging the employees any greater percentage of the total cost of coverage than the seller had charged before the sale. For this purpose, the coverage would be considered unchanged if there was no obligation to provide a summary of material modifications within 60 days after the change due to a material reduction in covered services or benefits under the rules that apply under Title I of ERISA. If these conditions were satisfied for the maximum coverage period that would otherwise apply to the seller's termination of employment of the continuing employees (generally 18 months from the date of the sale), then those terminations of employment would never be considered qualifying events. If the conditions were not satisfied for the full maximum coverage period, then on the date when they ceased to be satisfied the seller would be obligated to make COBRA continuation coverage available for the balance of the maximum coverage period.

Comments are invited on the utility of such a rule, either in situations in which the seller retains an ownership interest in the buyer after the sale (for example, a sale of assets from a 100-percent owned subsidiary to a 75-percent owned subsidiary) or, more generally, in situations in which the seller and the buyer are unrelated. Suggestions are also solicited for other rules that would protect qualified beneficiaries while providing relief to employers in these

situations.

Employer Withdrawals From Multiemployer Plans

The new proposed regulations provide that the multiemployer plan generally continues to have the obligation to make COBRA continuation coverage available to qualified beneficiaries associated with that employer. (There generally would not be any obligation to make COBRA continuation coverage available to continuing employees in this situation because a cessation of contributions is not a qualifying event.) However, once the employer provides group health coverage to a significant number of employees who were formerly covered under the multiemployer plan, or starts contributing to another multiemployer plan on their behalf, the employer's plan (or the new multiemployer plan) would have the obligation to make COBRA continuation coverage available to the existing qualified beneficiaries. This rule is contrary to the holding in *In re Appletree Markets, Inc.*, 19 F.3d 969 (5th Cir. 1994), which held that the multiemployer plan continued to have the COBRA obligations with respect to existing qualified beneficiaries after the withdrawing employer established a plan for the same class of employees previously covered under the multiemployer plan.

Interaction of FMLA and COBRA

Under the new proposed regulations, the taking of FMLA leave by a covered employee is not itself a qualifying event. Instead, a qualifying event occurs when an employee who is covered under a group health plan immediately prior to FMLA leave (or who becomes covered under a group health plan during FMLA leave) does not return to work with the employer at the end of FMLA leave and would, but for COBRA continuation coverage, lose coverage under the group health plan. The qualifying event is deemed to occur on the last day of the employee's FMLA leave, and the maximum coverage period generally begins on that day. In the case of such a qualifying event, the employer cannot condition the employee's rights to COBRA continuation coverage on the employee's reimbursement of any premiums paid by the employer to maintain the employee's group health plan coverage during the period of FMLA leave.

Any lapse of coverage under the group health plan during the period of FMLA leave and any state or local law requiring that group health plan coverage be provided for a period longer than that required by the FMLA are disregarded in determining whether the employee has a qualifying event on the last day of that leave.

However, the employee's loss of coverage at the end of FMLA leave will not constitute a qualifying event if, prior to the employee's return from FMLA leave, the employer has eliminated group health plan coverage for the class of employees to which the employee would have belonged if she or he had not taken FMLA leave.