

DEPARTMENT OF THE TREASURY

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Continuation Coverage Requirements Applicable to Group Health Plans

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Sec. 54.4980B-1 COBRA in general.

The COBRA continuation coverage requirements are described in general in the following questions-and-answers:

Q-1: What are the health care continuation coverage requirements contained in section 4980B of the Internal Revenue Code and in ERISA?

- (a) Section 4980B provides generally that a group health plan must offer each qualified beneficiary who would otherwise lose coverage under the plan as a result of a qualifying event an opportunity to elect, within the election period, continuation coverage under the plan. The continuation coverage requirements were added to section 162 by the Consolidated Budget Reconciliation Act of 1985 (COBRA), Public Law 99-272 (100 Stat. 222), and moved to section 4980B by the Technical and Miscellaneous Revenue Act of 1988, Public Law 100-647 (102 Stat. 3342). Continuation coverage required under section 4980B is referred to in Secs. 54.4980B-1 through 54.4980B-10 as COBRA continuation coverage.
- (b) COBRA also added parallel continuation coverage requirements to Part 6 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. 1161-1168), which is administered by the U.S. Department of Labor. If a plan does not comply with the COBRA continuation coverage requirements, the Internal Revenue Code imposes an excise tax on the employer maintaining the plan (or on the plan itself), whereas ERISA gives certain parties--including qualified beneficiaries who are participants or beneficiaries within the meaning of Title I of ERISA, as well as the Department of Labor--the right to file a lawsuit to redress the noncompliance. The rules in Secs. 54.4980B-1 through 54.4980B-8 apply for purposes of section 4980B and generally also for purposes of the COBRA continuation coverage requirements in Title I of ERISA. However, certain provisions of the COBRA continuation coverage requirements (such as the definitions of group health plan, employee, and employer) are not identical in the Internal Revenue Code and Title I of ERISA. In those cases in which the statutory language is not identical, the rules in Secs. 54.4980B-1 through 54.4980B-10 nonetheless apply to the COBRA continuation coverage requirements of Title I of ERISA, except to the extent those rules are inconsistent with the statutory language of Title I of ERISA.
- (c) A group health plan that is subject to section 4980B (or the parallel provisions under ERISA) is referred to as being subject to COBRA. (See Q&A-4 of Sec. 54.4980B-2). A qualified beneficiary can be required to pay for COBRA continuation coverage. The term qualified beneficiary is defined in Q&A-1 of Sec. 54.4980B-3. The term qualifying event is defined in Q&A-1 of Sec. 54.4980B-4. COBRA continuation coverage is described in Sec. 54.4980B-5. The election procedures are described in Sec. 54.4980B-6. Duration of COBRA continuation coverage is addressed in Sec. 54.4980B-7, and payment for COBRA continuation coverage is addressed in Sec. 54.4980B-8. Section 54.4980B-9 contains special rules for how COBRA applies in connection with business reorganizations and employer withdrawals from a multiemployer plan, and Sec. 54.4980B-10 addresses how COBRA applies for individuals who take leave under the Family and Medical Leave Act of 1993. Unless the context indicates otherwise, any reference in Secs. 54.4980B-1 through 54.4980B-10 to COBRA refers to section 4980B (as amended) and to the parallel provisions of ERISA.

Q-2: What standard applies for topics not addressed in Secs. 54.4980B-1 through 54.4980B-10?

A-2: For purposes of section 4980B, for topics relating to the COBRA continuation coverage requirements of section 4980B that are not addressed in Secs. 54.4980B-1 through 54.4980B-10 (such as methods for calculating the applicable premium), plans and employers must operate in good faith compliance with a reasonable interpretation of the statutory requirements in section 4980B.

Sec. 54.4980B-2 Plans that must comply.

The following questions-and-answers apply in determining which plans must comply with the COBRA continuation coverage requirements:

Q-1: For purposes of section 4980B, what is a group health plan?

- (a) For purposes of section 4980B, 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 their families. Individuals who have an employment-related connection to the employer or employee organization consist of employees, former employees, the employer, and others associated or formerly associated with the employer or employee organization in a business relationship (including members of a union who are not currently employees). Health care is provided under a plan whether provided directly or through insurance, reimbursement, or

otherwise, and whether or not provided through an on-site facility (except as set forth in paragraph (d) of this Q&A-1), or through a cafeteria plan (as defined in section 125) or other flexible benefit arrangement. (See paragraphs (b) through (e) in Q&A-8 of this section for rules regarding the application of the COBRA continuation coverage requirements to certain health flexible spending arrangements.) For purposes of this Q&A-1, insurance includes not only group insurance policies but also one or more individual insurance policies in any arrangement that involves the provision of health care to two or more employees. A plan maintained by an employer or employee organization is any plan of, or contributed to (directly or indirectly) by, an employer or employee organization. Thus, a group health plan is maintained by an employer or employee organization even if the employer or employee organization does not contribute to it if coverage under the plan would not be available at the same cost to an individual but for the individual's employment-related connection to the employer or employee organization. These rules are further explained in paragraphs (b) through (d) of this Q&A-1. An exception for qualified long-term care services is set forth in paragraph (e) of this Q&A-1, and for medical savings accounts in paragraph (f) of this Q&A-1. See Q&A-6 of this section for rules to determine the number of group health plans that an employer or employee organization maintains.

- (b) For purposes of Secs. 54.4980B-1 through 54.4980B-10, health care has the same meaning as medical care under section 213(d). Thus, health care generally includes the diagnosis, cure, mitigation, treatment, or prevention of disease, and any other undertaking for the purpose of affecting any structure or function of the body. Health care also includes transportation primarily for and essential to health care as described in the preceding sentence. However, health care does not include anything that is merely beneficial to the general health of an individual, such as a vacation. Thus, if an employer or employee organization maintains a program that furthers general good health, but the program does not relate to the relief or alleviation of health or medical problems and is generally accessible to and used by employees without regard to their physical condition or state of health, that program is not considered a program that provides health care and so is not a group health plan. For example, if an employer maintains a spa, swimming pool, gymnasium, or other exercise/fitness program or facility that is normally accessible to and used by employees for reasons other than relief of health or medical problems, such a facility does not constitute a program that provides health care and thus is not a group health plan. In contrast, if an employer maintains a drug or alcohol treatment program or a health clinic, or any other facility or program that is intended to relieve or alleviate a physical condition or health problem, the facility or program is considered to be the provision of health care and so is considered a group health plan.
- (c) Whether a benefit provided to employees constitutes health care is not affected by whether the benefit is excludable from income under section 132 (relating to certain fringe benefits). For example, if a department store provides its employees discounted prices on all merchandise, including health care items such as drugs or eyeglasses, the mere fact that the discounted prices also apply to health care items will not cause the program to be a plan providing health care, so long as the discount program would normally be accessible to and used by employees without regard to health needs or physical condition. If, however, the employer maintaining the discount program is a health clinic, so that the program is used exclusively by employees with health or medical needs, the program is considered to be a plan providing health care and so is considered to be a group health plan.
- (d) The provision of health care at a facility that is located on the premises of an employer or employee organization does not constitute a group health plan if--
 - (1) The health care consists primarily of first aid that is provided during the employer's working hours for treatment of a health condition, illness, or injury that occurs during those working hours;
 - (2) The health care is available only to current employees; and
 - (3) Employees are not charged for the use of the facility.
- (e) A plan does not constitute a group health plan subject to COBRA if substantially all of the coverage provided under the plan is for qualified long-term care services (as defined in section 7702B(c)). For this purpose, a plan is permitted to use any reasonable method in determining whether substantially all of the coverage provided under the plan is for qualified long-term care services.
- (f) Under section 106(b)(5), amounts contributed by an employer to a medical savings account (as defined in section 220(d)) are not considered part of a group health plan subject to COBRA. Thus, a plan is not required to make COBRA continuation coverage available with respect to amounts contributed by an employer to a medical savings account. A high deductible health plan does not fail to be a group health plan subject to COBRA merely because it covers a medical savings account holder.

Q-2: For purposes of section 4980B, what is the employer?

- (a) For purposes of section 4980B, employer refers to--
 - (1) A person for whom services are performed;
 - (2) Any other person that is a member of a group described in section 414(b), (c), (m), or (o) that includes a person described in paragraph (a)(1) of this Q&A-2; and
 - (3) Any successor of a person described in paragraph (a)(1) or (2) of this Q&A-2.
- (b) An employer is a successor employer if it results from a consolidation, merger, or similar restructuring of the employer or if it is a mere continuation of the employer. See paragraph (c) in Q&A-8 of Sec. 54.4980B-9 for rules describing the circumstances in which a purchaser of substantial assets is a successor employer to the employer selling the assets.

Q-3: What is a multiemployer plan?

A-3: For purposes of Secs. 54.4980B-1 through 54.4980B-10, a multiemployer plan is a plan to which more than one employer is required to contribute, that is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and that satisfies such other

requirements as the Secretary of Labor may prescribe by regulation. Whenever reference is made in Secs. 54.4980B-1 through 54.4980B-10 to a plan of or maintained by an employer or employee organization, the reference includes a multiemployer plan.

Q-4: What group health plans are subject to COBRA?

- (a) All group health plans are subject to COBRA except group health plans described in paragraph (b) of this Q&A-4. Group health plans described in paragraph (b) of this Q&A-4 are referred to in Secs. 54.4980B-1 through 54.4980B-10 as excepted from COBRA.
- (b) The following group health plans are excepted from COBRA--
 - (1) Small-employer plans (see Q&A-5 of this section);
 - (2) Church plans (within the meaning of section 414(e)); and
 - (3) Governmental plans (within the meaning of section 414(d)).
- (c) The COBRA continuation coverage requirements generally do not apply to group health plans that are excepted from COBRA. However, a small-employer plan otherwise excepted from COBRA is nonetheless subject to COBRA with respect to qualified beneficiaries who experience a qualifying event during a period when the plan is not a small-employer plan (see paragraph (g) of Q&A-5 of this section).
- (d) Although governmental plans are not subject to the COBRA continuation coverage requirements, group health plans maintained by state or local governments are generally subject to parallel continuation coverage requirements that were added by section 10003 of COBRA to the Public Health Service Act (42 U.S.C. 300bb-1 through 300bb-8), which is administered by the U.S. Department of Health and Human Services. Federal employees and their family members covered under the Federal Employees Health Benefit Program are covered by generally similar, but not parallel, temporary continuation of coverage provisions enacted by the Federal Employees Health Benefits Amendments Act of 1988. See 5 U.S.C. 8905a.

Q-5: What is a small-employer plan?

- (a) Except in the case of a multiemployer plan, a small-employer plan is a group health plan maintained by an employer (within the meaning of Q&A-2 of this section) that normally employed fewer than 20 employees (within the meaning of paragraph (c) of this Q&A-5) during the preceding calendar year. In the case of a multiemployer plan, a small-employer plan is a group health plan under which each of the employers contributing to the plan for a calendar year normally employed fewer than 20 employees during the preceding calendar year. See Q&A-6 of this section for rules to determine the number of plans that an employer or employee organization maintains. The rules of this paragraph (a) are illustrated in the following example:
 - Example. (i)** Corporation S employs 12 employees, all of whom work and reside in the United States. S maintains a group health plan for its employees and their families. S is a wholly-owned subsidiary of P. In the previous calendar year, the controlled group of corporations including P and S employed more than 19 employees, although the only employees in the United States of the controlled group that includes P and S are the 12 employees of S.
 - Example. (ii)** Under Sec. 1.414(b)-1 of this chapter, foreign corporations are not excluded from membership in a controlled group of corporations. Consequently, the group health plan maintained by S is not a small-employer plan during the current calendar year because the controlled group including S normally employed at least 20 employees in the preceding calendar year.
- (b) An employer is considered to have normally employed fewer than 20 employees during a particular calendar year if, and only if, it had fewer than 20 employees on at least 50 percent of its typical business days during that year.
- (c) All full-time and part-time common law employees of an employer are taken into account in determining whether an employer had fewer than 20 employees; however, an individual who is not a common law employee of the employer is not taken into account. Thus, the following individuals are not counted as employees for purposes of this Q&A-5 even though they are referred to as employees for all other purposes of Secs. 54.4980B-1 through 54.4980B-10--
 - (1) Self-employed individuals (within the meaning of section 401(c)(1));
 - (2) Independent contractors (and their employees and independent contractors); and
 - (3) Directors (in the case of a corporation).
- (d) In determining the number of the employees of an employer, each full-time employee is counted as one employee and each part-time employee is counted as a fraction of an employee, determined in accordance with paragraph (e) of this Q&A-5.
- (e) An employer may determine the number of its employees on a daily basis or a pay period basis. The basis used by the employer must be used with respect to all employees of the employer and must be used for the entire year for which the number of employees is being determined. If an employer determines the number of its employees on a daily basis, it must determine the actual number of full-time employees on each typical business day and the actual number of part-time employees and the hours worked by each of those part-time employees on each typical business day. Each full-time employee counts as one employee on each typical business day and each part-time employee counts as a fraction, with the numerator of the fraction equal to the number of hours worked by that employee and the denominator equal to the number of hours that must be worked on a typical business day in order to be considered a full-time employee. If an employer determines the number of its employees on a pay period basis, it must determine the actual number of full-time employees employed during that pay period and the actual number of part-time employees employed and the hours worked by each of those part-time employees during the pay period. For each day of that pay period, each full-time employee counts as one employee and each part-time employee counts as a fraction, with the numerator of the fraction equal to the number of hours worked by that employee during that pay period and the denominator equal to the number of

hours that must be worked during that pay period in order to be considered a full-time employee. The determination of the number of hours required to be considered a full-time employee is based upon the employer's employment practices, except that in no event may the hours required to be considered a full-time employee exceed eight hours for any day or 40 hours for any week.

- (f) In the case of a multiemployer plan, the determination of whether the plan is a small-employer plan on any particular date depends on which employers are contributing to the plan on that date and on the workforce of those employers during the preceding calendar year. If a plan that is otherwise subject to COBRA ceases to be a small-employer plan because of the addition during a calendar year of an employer that did not normally employ fewer than 20 employees on a typical business day during the preceding calendar year, the plan ceases to be excepted from COBRA immediately upon the addition of the new employer. In contrast, if the plan ceases to be a small-employer plan by reason of an increase during a calendar year in the workforce of an employer contributing to the plan, the plan ceases to be excepted from COBRA on the January 1 immediately following the calendar year in which the employer's workforce increased.
- (g) A small-employer plan is generally excepted from COBRA. If, however, a plan that has been subject to COBRA (that is, was not a small-employer plan) becomes a small-employer plan, the plan remains subject to COBRA for qualifying events that occurred during the period when the plan was subject to COBRA. The rules of this paragraph (g) are illustrated by the following examples:

Example 1. An employer maintains a group health plan. The employer employed 20 employees on more than 50 percent of its working days during 2001, and consequently the plan is not excepted from COBRA during 2002. Employee E resigns and does not work for the employer after January 31, 2002. Under the terms of the plan, E is no longer eligible for coverage upon the effective date of the resignation, that is, February 1, 2002. The employer does not hire a replacement for E. E timely elects and pays for COBRA continuation coverage. The employer employs 19 employees for the remainder of 2002, and consequently the plan is not subject to COBRA in 2003. The plan must nevertheless continue to make COBRA continuation coverage available to E during 2003 until the obligation to make COBRA continuation coverage available ceases under the rules of Sec. 54.4980B-7. The obligation could continue until August 1, 2003, the date that is 18 months after the date of E's qualifying event, or longer if E is eligible for a disability extension.

Example 2. The facts are the same as in Example 1. The employer continues to employ 19 employees throughout 2003 and 2004 and consequently the plan continues to be excepted from COBRA during 2004 and 2005. Spouse S is covered under the plan because S is married to one of the employer's employees. On April 1, 2002, S is divorced from that employee and ceases to be eligible for coverage under the plan. The plan is subject to COBRA during 2002 because X normally employed 20 employees during 2001. S timely notifies the plan administrator of the divorce and timely elects and pays for COBRA continuation coverage. Even though the plan is generally excepted from COBRA during 2003, 2004, and 2005, it must nevertheless continue to make COBRA continuation coverage available to S during those years until the obligation to make COBRA continuation coverage available ceases under the rules of Sec. 54.4980B-7. The obligation could continue until April 1, 2005, the date that is 36 months after the date of S's qualifying event.

Example 3. The facts are the same as in Example 2. C is a dependent child of one of the employer's employees and is covered under the plan. A dependent child is no longer eligible for coverage under the plan upon the attainment of age 23. C attains age 23 on November 16, 2005. The plan is excepted from COBRA with respect to C during 2005 because the employer normally employed fewer than 20 employees during 2004. Consequently, the plan is not obligated to make COBRA continuation coverage available to C (and would not be obligated to make COBRA continuation coverage available to C even if the plan later became subject to COBRA again).

Q-6: How is the number of group health plans that an employer or employee organization maintains determined?

- (a) The rules of this Q&A-6 apply in determining the number of group health plans that an employer or employee organization maintains. All references elsewhere in Secs. 54.4980B-1 through 54.4980B-10 to a group health plan are references to a group health plan as determined under Q&A-1 of this section and this Q&A-6. Except as provided in paragraph (b) or (c) of this Q&A-6, all health care benefits, other than benefits for qualified long-term care services (as defined in section 7702B(c)), provided by a corporation, partnership, or other entity or trade or business, or by an employee organization, constitute one group health plan, unless--
- (1) It is clear from the instruments governing an arrangement or arrangements to provide health care benefits that the benefits are being provided under separate plans; and
- (2) The arrangement or arrangements are operated pursuant to such instruments as separate plans.
- (b) A multiemployer plan and a nonmultiemployer plan are always separate plans.
- (c) If a principal purpose of establishing separate plans is to evade any requirement of law, then the separate plans will be considered a single plan to the extent necessary to prevent the evasion.
- (d) The significance of treating an arrangement as two or more separate group health plans is illustrated by the following examples:

Example 1. (i) Employer X maintains a single group health plan, which provides major medical and prescription drug benefits. Employer Y maintains two group health plans; one provides major medical benefits and the other provides prescription drug benefits.

(ii) X's plan could comply with the COBRA continuation coverage requirements by giving a qualified beneficiary experiencing a qualifying event with respect to X's plan the choice of either electing both major medical and prescription drug benefits or not receiving any COBRA continuation coverage under X's plan. By contrast, for Y's plans to comply with the COBRA continuation coverage requirements, a qualified beneficiary experiencing a

qualifying event with respect to each of Y's plans must be given the choice of electing COBRA continuation coverage under either the major medical plan or the prescription drug plan or both.

Example 2. If a joint board of trustees administers one multiemployer plan, that plan will fail to qualify for the small-employer plan exception if any one of the employers whose employees are covered under the plan normally employed 20 or more employees during the preceding calendar year. However, if the joint board of trustees maintains two or more multiemployer plans, then the exception would be available with respect to each of those plans in which each of the employers whose employees are covered under the plan normally employed fewer than 20 employees during the preceding calendar year.

Q-7: What is the plan year?

- (a) The plan year is the year that is designated as the plan year in the plan documents.
- (b) If the plan documents do not designate a plan year (or if there are no plan documents), then the plan year is determined in accordance with this paragraph (b).
 - (1) The plan year is the deductible/limit year used under the plan.
 - (2) If the plan does not impose deductibles or limits on an annual basis, then the plan year is the policy year.
 - (3) If the plan does not impose deductibles or limits on an annual basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year.
 - (4) In any other case, the plan year is the calendar year.

Q-8: How do the COBRA continuation coverage requirements apply to cafeteria plans and other flexible benefit arrangements?

- (a)(1) The provision of health care benefits does not fail to be a group health plan merely because those benefits are offered under a cafeteria plan (as defined in section 125) or under any other arrangement under which an employee is offered a choice between health care benefits and other taxable or nontaxable benefits. However, the COBRA continuation coverage requirements apply only to the type and level of coverage under the cafeteria plan or other flexible benefit arrangement that a qualified beneficiary is actually receiving on the day before the qualifying event. See paragraphs (b) through (e) of this Q&A-8 for rules limiting the obligations of certain health flexible spending arrangements.
- (2) The rules of this paragraph (a) are illustrated by the following example:

Example: (i) Under the terms of a cafeteria plan, employees can choose among life insurance coverage, membership in a health maintenance organization (HMO), coverage for medical expenses under an indemnity arrangement, and cash compensation. Of these available choices, the HMO and the indemnity arrangement are the arrangements providing health care. The instruments governing the HMO and indemnity arrangements indicate that they are separate group health plans. These group health plans are subject to COBRA. The employer does not provide any group health plan outside of the cafeteria plan. B and C are unmarried employees. B has chosen the life insurance coverage, and C has chosen the indemnity arrangement.

(ii) B does not have to be offered COBRA continuation coverage upon terminating employment, nor is a subsequent open enrollment period for active employees required to be made available to B. However, if C terminates employment and the termination constitutes a qualifying event, C must be offered an opportunity to elect COBRA continuation coverage under the indemnity arrangement. If C makes such an election and an open enrollment period for active employees occurs while C is still receiving the COBRA continuation coverage, C must be offered the opportunity to switch from the indemnity arrangement to the HMO (but not to the life insurance coverage because that does not constitute coverage provided under a group health plan).

- (b) If a health flexible spending arrangement (health FSA), within the meaning of section 106(c)(2), satisfies the two conditions in paragraph (c) of this Q&A-8 for a plan year, the obligation of the health FSA to make COBRA continuation coverage available to a qualified beneficiary who experiences a qualifying event in that plan year is limited in accordance with paragraphs (d) and (e) of this Q&A-8, as illustrated by an example in paragraph (f) of this Q&A-8. To the extent that a health FSA is obligated to make COBRA continuation coverage available to a qualified beneficiary, the health FSA must comply with all the applicable rules of Secs. 54.4980B-1 through 54.4980B-10, including the rules of Q&A-3 in Sec. 54.4980B-5 (relating to limits).
- (c) The conditions of this paragraph (c) are satisfied if--
 - (1) Benefits provided under the health FSA are excepted benefits within the meaning of sections 9831 and 9832; and
 - (2) The maximum amount that the health FSA can require to be paid for a year of COBRA continuation coverage under Q&A-1 of Sec. 54.4980B-8 equals or exceeds the maximum benefit available under the health FSA for the year.
- (d) If the conditions in paragraph (c) of this Q&A-8 are satisfied for a plan year, then the health FSA is not obligated to make COBRA continuation coverage available for any subsequent plan year to any qualified beneficiary who experiences a qualifying event during that plan year.
- (e) If the conditions in paragraph (c) of this Q&A-8 are satisfied for a plan year, the health FSA is not obligated to make COBRA continuation coverage available for that plan year to any qualified beneficiary who experiences a qualifying event during that plan year unless, as of the date of the qualifying event, the qualified beneficiary can become entitled to receive during the remainder of the plan year a benefit that exceeds the maximum amount that the health FSA is permitted to require to be paid for COBRA continuation coverage for the remainder of the plan year. In determining the amount of the benefit that a qualified beneficiary can become entitled to receive during the remainder of the plan year, the health FSA may deduct from the maximum benefit available to that

qualified beneficiary for the year (based on the election made under the health FSA for that qualified beneficiary before the date of the qualifying event) any reimbursable claims submitted to the health FSA for that plan year before the date of the qualifying event.

(f) The rules of paragraphs (b), (c), (d), and (e) of this Q&A-8 are illustrated by the following example:

Example. (i) An employer maintains a group health plan providing major medical benefits and a group health plan that is a health FSA, and the plan year for each plan is the calendar year. Both the plan providing major medical benefits and the health FSA are subject to COBRA. Under the health FSA, during an open season before the beginning of each calendar year, employees can elect to reduce their compensation during the upcoming year by up to \$1200 per year and have that same amount contributed to a health flexible spending account. The employer contributes an additional amount to the account equal to the employee's salary reduction election for the year. Thus, the maximum amount available to an employee under the health FSA for a year is two times the amount of the employee's salary reduction election for the year. This amount may be paid to the employee during the year as reimbursement for health expenses not covered by the employer's major medical plan (such as deductibles, copayments, prescription drugs, or eyeglasses). The employer determined, in accordance with section 4980B(f)(4), that a reasonable estimate of the cost of providing coverage for similarly situated nonCOBRA beneficiaries for 2002 under this health FSA is equal to two times their salary reduction election for 2002 and, thus, that two times the salary reduction election is the applicable premium for 2002.

(ii) Because the employer provides major medical benefits under another group health plan, and because the maximum benefit that any employee can receive under the health FSA is not greater than two times the employee's salary reduction election for the plan year, benefits under this health FSA are excepted benefits within the meaning of sections 9831 and 9832. Thus, the first condition of paragraph (c) of this Q&A-8 is satisfied for the year. The maximum amount that a plan can require to be paid for coverage (outside of coverage required to be made available due to a disability extension) under Q&A-1 of Sec. 54.4980B-8 is 102 percent of the applicable premium. Thus, the maximum amount that the health FSA can require to be paid for coverage for the 2002 plan year is 2.04 times the employee's salary reduction election for the plan year. Because the maximum benefit available under the health FSA is 2.0 times the employee's salary reduction election for the year, the maximum benefit available under the health FSA for the year is less than the maximum amount that the health FSA can require to be paid for coverage for the year. Thus, the second condition in paragraph (c) of this Q&A-8 is also satisfied for the 2002 plan year. Because both conditions in paragraph (c) of this Q&A-8 are satisfied for 2002, with respect to any qualifying event occurring in 2002, the health FSA is not obligated to make COBRA continuation coverage available for any year after 2002.

(iii) Whether the health FSA is obligated to make COBRA continuation coverage available in 2002 to a qualified beneficiary with respect to a qualifying event that occurs in 2002 depends upon the maximum benefit that would be available to the qualified beneficiary under COBRA continuation coverage for that plan year. Case 1: Employee B has elected to reduce B's salary by \$1200 for 2002. Thus, the maximum benefit that B can become entitled to receive under the health FSA during the entire year is \$2400. B experiences a qualifying event that is the termination of B's employment on May 31, 2002. As of that date, B had submitted \$300 of reimbursable expenses under the health FSA. Thus, the maximum benefit that B could become entitled to receive for the remainder of 2002 is \$2100. The maximum amount that the health FSA can require to be paid for COBRA continuation coverage for the remainder of 2002 is 102 percent times 1/12 of the applicable premium for 2002 times the number of months remaining in 2002 after the date of the qualifying event. In B's case, the maximum amount that the health FSA can require to be paid for COBRA continuation coverage for 2002 is 2.04 times \$1200, or \$2448. One-twelfth of \$2448 is \$204. Because seven months remain in the plan year, the maximum amount that the health FSA can require to be paid for B's coverage for the remainder of the year is seven times \$204, or \$1428. Because \$1428 is less than the maximum benefit that B could become entitled to receive for the remainder of the year (\$2100), the health FSA is required to make COBRA continuation coverage available to B for the remainder of 2002 (but not for any subsequent year).

(iv) Case 2: The facts are the same as in Case 1 except that B had submitted \$1000 of reimbursable expenses as of the date of the qualifying event. In that case, the maximum benefit available to B for the remainder of the year would be \$1400 instead of \$2100. Because the maximum amount that the health FSA can require to be

paid for B's coverage is \$1428, and because the \$1400 maximum benefit for the remainder of the year does not exceed \$1428, the health FSA is not obligated to make COBRA continuation coverage available to B in 2002 (or any later year). (Of course, the administrator of the health FSA is permitted to make COBRA continuation coverage available to every qualified beneficiary in the year that the qualified beneficiary's qualifying event occurs in order to avoid having to determine the maximum benefit available for each qualified beneficiary for the remainder of the plan year.)

Q-9: What is the effect of a group health plan's failure to comply with the requirements of section 4980B(f)?

Under section 4980B(a), if a group health plan subject to COBRA fails to comply with section 4980B(f), an excise tax is imposed. Moreover, non-tax remedies may be available if the plan fails to comply with the parallel requirements in ERISA, which are administered by the Department of Labor.

Q-10: Who is liable for the excise tax if a group health plan fails to comply with the requirements of section 4980B(f)?

- (a) In general, the excise tax is imposed on the employer maintaining the plan, except that in the case of a multiemployer plan (see Q&A-3 of this section for a definition of multiemployer plan) the excise tax is imposed on the plan.
- (b) In certain circumstances, the excise tax is also imposed on a person involved with the provision of benefits under the plan (other than in the capacity of an employee), such as an insurer providing benefits under the plan or a third party administrator administering claims under the plan. In general, such a person will be liable for the excise tax if the person assumes, under a legally enforceable written agreement, the responsibility for performing the act to which the failure to comply with the COBRA continuation coverage requirements relates. Such a person will be liable for the excise tax notwithstanding the absence of a written agreement assuming responsibility for complying with COBRA if the person provides coverage under the plan to a similarly situated nonCOBRA beneficiary (see Q&A-3 of Sec. 54.4980B-3 for a definition of similarly situated nonCOBRA beneficiaries) and the employer or plan administrator submits a written request to the person to provide to a qualified beneficiary the same coverage that the person provides to the similarly situated nonCOBRA beneficiary. If the person providing coverage under the plan to a similarly situated nonCOBRA beneficiary is the plan administrator and the qualifying event is a divorce or legal separation or a dependent child's ceasing to be covered under the generally applicable requirements of the plan, the plan administrator will also be liable for the excise tax if the qualified beneficiary submits a written request for coverage.

Sec. 54.4980B-3 Qualified beneficiaries.

The determination of who is a qualified beneficiary, an employee, or a covered employee, and of who are the similarly situated nonCOBRA beneficiaries is addressed in the following questions-and-answers:

Q-1: Who is a qualified beneficiary?

- (a)(1) Except as set forth in paragraphs (c) through (f) of this Q&A-1, a qualified beneficiary is--
- (i) Any individual who, on the day before a qualifying event, is covered under a group health plan by virtue of being on that day either a covered employee, the spouse of a covered employee, or a dependent child of the covered employee; or
 - (ii) Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage.
- (2) In the case of a qualifying event that is the bankruptcy of the employer, a covered employee who had retired on or before the date of substantial elimination of group health plan coverage is also a qualified beneficiary, as is any spouse, surviving spouse, or dependent child of such a covered employee if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse, or dependent child is a beneficiary under the plan.
- (3) In general, an individual (other than a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage) who is not covered under a plan on the day before the qualifying event cannot be a qualified beneficiary with respect to that qualifying event, and the reason for the individual's lack of actual coverage (such as the individual's having declined participation in the plan or failed to satisfy the plan's conditions for participation) is not relevant for this purpose. However, if the individual is denied or not offered coverage under a plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law (such as the Americans with Disabilities Act, 42 U.S.C. 12101-12213, the special enrollment rules of section 9801, or the requirements of section 9802 prohibiting discrimination in eligibility to enroll in a group health plan based on health status), then, for purposes of Secs. 54.4980B-1 through 54.4980B-10, the individual will be considered to have had the coverage that was wrongfully denied or not offered.
- (4) Paragraph (b) of this Q&A-1 describes how certain family members are not qualified beneficiaries even if they become covered under the plan; paragraphs (c), (d), and (e) of this Q&A-1 place limits on the general rules of this paragraph (a) concerning who is a qualified beneficiary; paragraph (f) of this Q&A-1 provides when an individual who has been a qualified beneficiary ceases to be a qualified beneficiary; paragraph (g) of this Q&A-1 defines placed for adoption; and paragraph (h) of this Q&A-1 contains examples.
- (b) In contrast to a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, an individual who marries any qualified beneficiary on or after the date of the qualifying event and a newborn or adopted child (other than one born to or placed for adoption with a covered employee) are not qualified beneficiaries by virtue of the marriage, birth, or placement for adoption or by virtue of the individual's status as the spouse or the child's status as a dependent of the qualified beneficiary. These new family members do not themselves become qualified beneficiaries even if they become covered under the plan. (For situations in which a plan is required to make coverage available to new family members of a qualified beneficiary who is receiving COBRA continuation coverage, see Q&A-5 of Sec. 54.4980B-5, paragraph (c) in Q&A-4 of Sec. 54.4980B-5, and section 9801(f)(2).)
- (c) An individual is not a qualified beneficiary if, on the day before the qualifying event referred to in paragraph (a) of this Q&A-1, the individual is covered under the group health plan by reason of another individual's election of COBRA continuation coverage and is not already a qualified beneficiary by reason of a prior qualifying event.
- (d) 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 that is the bankruptcy of the employer.
- (e) An individual is not a qualified beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income (within the meaning of section 911(d)(2)) that constituted income from sources within the United States (within the meaning of section 861(a)(3)). If, pursuant to the preceding sentence, an individual is not a qualified beneficiary, then a spouse or dependent child of the individual is not considered a qualified beneficiary by virtue of the relationship to the individual.
- (f) A qualified beneficiary who does not elect COBRA continuation coverage in connection with a qualifying event ceases to be a qualified beneficiary at the end of the election period (see Q&A-1 of Sec. 54.4980B-6). Thus, for example, if such a

former qualified beneficiary is later added to a covered employee's coverage (e.g., during an open enrollment period) and then another qualifying event occurs with respect to the covered employee, the former qualified beneficiary does not become a qualified beneficiary by reason of the second qualifying event. If a covered employee who is a qualified beneficiary does not elect COBRA continuation coverage during the election period, then any child born to or placed for adoption with the covered employee on or after the date of the qualifying event is not a qualified beneficiary. Once a plan's obligation to make COBRA continuation coverage available to an individual who has been a qualified beneficiary ceases under the rules of Sec. 54.4980B-7, the individual ceases to be a qualified beneficiary.

- (g) For purposes of Secs. 54.4980B-1 through 54.4980B-10, placement for adoption or being placed for adoption means the assumption and retention by the covered employee of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement for adoption with the covered employee terminates upon the termination of the legal obligation for total or partial support. A child who is immediately adopted by the covered employee without a preceding placement for adoption is considered to be placed for adoption on the date of the adoption.
- (h) The rules of this Q&A-1 are illustrated by the following examples:
- Example 1.** (i) B is a single employee who voluntarily terminates employment and elects COBRA continuation coverage under a group health plan. To comply with the requirements of section 9801(f), the plan permits a covered employee who marries to have her or his spouse covered under the plan. One month after electing COBRA continuation coverage, B marries and chooses to have B's spouse covered under the plan.
(ii) B's spouse is not a qualified beneficiary. Thus, if B dies during the period of COBRA continuation coverage, the plan does not have to offer B's surviving spouse an opportunity to elect COBRA continuation coverage.
- Example 2.** (i) C is a married employee who terminates employment. C elects COBRA continuation coverage for C but not C's spouse, and C's spouse declines to elect such coverage. C's spouse thus ceases to be a qualified beneficiary. At the next open enrollment period, C adds the spouse as a beneficiary under the plan.
(ii) The addition of the spouse during the open enrollment period does not make the spouse a qualified beneficiary. The plan thus will not have to offer the spouse an opportunity to elect COBRA continuation coverage upon a later divorce from or death of C.
- Example 3.** (i) Under the terms of a group health plan, a covered employee's child, upon attaining age 19, ceases to be a dependent eligible for coverage.
(ii) At that time, the child must be offered an opportunity to elect COBRA continuation coverage. If the child elects COBRA continuation coverage, the child marries during the period of the COBRA continuation coverage, and the child's spouse becomes covered under the group health plan, the child's spouse is not a qualified beneficiary.
- Example 4.** (i) D is a single employee who, upon retirement, is given the opportunity to elect COBRA continuation coverage but declines it in favor of an alternative offer of 12 months of employer-paid retiree health benefits. At the end of the election period, D ceases to be a qualified beneficiary and will not have to be given another opportunity to elect COBRA continuation coverage (at the end of those 12 months or at any other time). D marries E during the period of retiree health coverage and, under the terms of that coverage, E becomes covered under the plan.
(ii) If a divorce from or death of D will result in E's losing coverage, E will be a qualified beneficiary because E's coverage under the plan on the day before the qualifying event (that is, the divorce or death) will have been by reason of D's acceptance of 12 months of employer-paid coverage after the prior qualifying event (D's retirement) rather than by reason of an election of COBRA continuation coverage.
- Example 5.** (i) The facts are the same as in Example 4, except that, under the terms of the plan, the divorce or death does not cause E to lose coverage so that E continues to be covered for the balance of the original 12-month period.
(ii) E does not have to be allowed to elect COBRA continuation coverage because the loss of coverage at the end of the 12-month period is not caused by the divorce or death, and thus the divorce or death does not constitute a qualifying event. See Q&A-1 of Sec. 54.4980B-4.

Q-2: Who is an employee and who is a covered employee?

- (a)(1) For purposes of Secs. 54.4980B-1 through 54.4980B-8 (except for purposes of Q&A-5 in Sec. 54.4980B-2, relating to the exception from COBRA for plans maintained by an employer with fewer than 20 employees), an employee is any individual who is eligible to be covered under a group health plan by virtue of the performance of services for the employer maintaining the plan or by virtue of membership in the employee organization maintaining the plan. Thus, for purposes of Secs. 54.4980B-1 through 54.4980B-10 (except for purposes of Q&A-5 in Sec. 54.4980B-2), the following individuals are employees if their relationship to the employer maintaining the plan makes them eligible to be covered under the plan--
- (i) Self-employed individuals (within the meaning of section 401(c)(1));
 - (ii) Independent contractors (and their employees and independent contractors); and
 - (iii) Directors (in the case of a corporation).
- (2) Similarly, whenever reference is made in Secs. 54.4980B-1 through 54.4980B-8 (except in Q&A-5 of Sec. 54.4980B-2) to an employment relationship (such as by referring to the termination of employment of an employee or to an employee's being employed by an employer), the reference includes the relationship of those individuals who are employees within the meaning of this paragraph (a). See paragraph (c) in Q&A-5 of Sec. 54.4980B-2 for a narrower meaning of employee solely for purposes of Q&A-5 of Sec. 54.4980B-2.
- (b) For purposes of Secs. 54.4980B-1 through 54.4980B-10, a covered employee is any individual who is (or was) provided coverage under a group health plan (other than a plan that is excepted from COBRA on the date of the qualifying event; see Q&A-4 of Sec. 54.4980B-2) by virtue of being or having been an employee. For example, a retiree or former employee who is covered by a group health plan is a covered employee if the coverage results in whole or in part from her or his previous employment. An employee (or former employee) who is merely eligible for coverage under a group

health plan is generally not a covered employee if the employee (or former employee) is not actually covered under the plan. In general, the reason for the employee's (or former employee's) lack of actual coverage (such as having declined participation in the plan or having failed to satisfy the plan's conditions for participation) is not relevant for this purpose. However, if the employee (or former employee) is denied or not offered coverage under circumstances in which the denial or failure to offer constitutes a violation of applicable law (such as the Americans with Disabilities Act, 42 U.S.C. 12101 through 12213, the special enrollment rules of section 9801, or the requirements of section 9802 prohibiting discrimination in eligibility to enroll in a group health plan based on health status), then, for purposes of Secs. 54.4980B-1 through 54.4980B-10, the employee (or former employee) will be considered to have had the coverage that was wrongfully denied or not offered.

Q-3: Who are the similarly situated non-COBRA beneficiaries?

For purposes of Secs. 54.4980B-1 through 54.4980B-10, similarly situated non-COBRA beneficiaries means the group of covered employees, spouses of covered employees, or dependent children of covered employees receiving coverage under a group health plan maintained by the employer or employee organization who are receiving that coverage for a reason other than the rights provided under the COBRA continuation coverage requirements and who, based on all of the facts and circumstances, are most similarly situated to the situation of the qualified beneficiary immediately before the qualifying event.

Sec. 54.4980B-4 Qualifying events.

The determination of what constitutes a qualifying event is addressed in the following questions and answers:

Q-1: What is a qualifying event?

- (a) A qualifying event is an event that satisfies paragraphs (b), (c), and (d) of this Q&A-1. Paragraph (e) of this Q&A-1 further explains a reduction of hours of employment, paragraph (f) of this Q&A-1 describes the treatment of children born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, and paragraph (g) of this Q&A-1 contains examples. *See Q&A-1 through Q&A-3 of Sec. 54.4980B-10 for special rules in the case of leave taken under the Family and Medical Leave Act of 1993 (29 U.S.C. 2601-2619).*
- (b) An event satisfies this paragraph (b) if the event is any of the following--
- (1) The death of a covered employee;
 - (2) The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of a covered employee's employment;
 - (3) The divorce or legal separation of a covered employee from the employee's spouse;
 - (4) A covered employee's becoming entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395-1395ggg);
 - (5) A dependent child's ceasing to be a dependent child of a covered employee under the generally applicable requirements of the plan; or
 - (6) A proceeding in bankruptcy under Title 11 of the United States Code with respect to an employer from whose employment a covered employee retired at any time.
- (c) An event satisfies this paragraph (c) if, under the terms of the group health plan, the event causes the covered employee, or the spouse or a dependent child of the covered employee, to lose coverage under the plan. For this purpose, to lose coverage means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event. Any increase in the premium or contribution that must be paid by a covered employee (or the spouse or dependent child of a covered employee) for coverage under a group health plan that results from the occurrence of one of the events listed in paragraph (b) of this Q&A-4 is a loss of coverage. In the case of an event that is the bankruptcy of the employer, lose coverage also means any substantial elimination of coverage under the plan, occurring within 12 months before or after the date the bankruptcy proceeding commences, for a covered employee who had retired on or before the date of the substantial elimination of group health plan coverage or for any spouse, surviving spouse, or dependent child of such a covered employee if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse, or dependent child is a beneficiary under the plan. For purposes of this paragraph (c), a loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the maximum coverage period (see Q&A-1 and Q&A-6 of Sec. 54.4980B-7). However, if neither the covered employee nor the spouse or a dependent child of the covered employee loses coverage before the end of what would be the maximum coverage period, the event does not satisfy this paragraph (c). If coverage is reduced or eliminated in anticipation of an event (for example, an employer's eliminating an employee's coverage in anticipation of the termination of the employee's employment, or an employee's eliminating the coverage of the employee's spouse in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.
- (d) An event satisfies this paragraph (d) if it occurs while the plan is subject to COBRA. Thus, an event will not satisfy this paragraph (d) if it occurs while the plan is excepted from COBRA (see Q&A-4 of Sec. 54.4980B-2). Even if the plan later becomes subject to COBRA, it is not required to make COBRA continuation coverage available to anyone whose coverage ends as a result of an event during a year in which the plan is excepted from COBRA. For example, if a group health plan is excepted from COBRA as a small-employer plan during the year 2001 (see Q&A-5 of Sec. 54.4980B-2) and an employee terminates employment on December 31, 2001, the termination is not a qualifying event and the plan is not required to permit the employee to elect COBRA continuation coverage. This is the case even if the plan ceases to be a small-employer plan as of January 1, 2002. Also, the same result will follow even if the employee is given three

months of coverage beyond December 31 (that is, through March of 2002), because there will be no qualifying event as of the termination of coverage in March. However, if the employee's spouse is initially provided with the three-month coverage through March 2002, but the spouse divorces the employee before the end of the three months and loses coverage as a result of the divorce, the divorce will constitute a qualifying event during 2002 and so entitle the spouse to elect COBRA continuation coverage. See Q&A-7 of Sec. 54.4980B-7 regarding the maximum coverage period in such a case.

- (e) A reduction of hours of a covered employee's employment occurs whenever there is a decrease in the hours that a covered employee is required to work or actually works, but only if the decrease is not accompanied by an immediate termination of employment. This is true regardless of whether the covered employee continues to perform services following the reduction of hours of employment. *For example, an absence from work due to disability, a temporary layoff, or any other reason (other than due to leave that is FMLA leave; see Sec. 54.4980B-10) is a reduction of hours of a covered employee's employment if there is not an immediate termination of employment.* If a group health plan measures eligibility for the coverage of employees by the number of hours worked in a given time period, such as the preceding month or quarter, and an employee covered under the plan fails to work the minimum number of hours during that time period, the failure to work the minimum number of required hours is a reduction of hours of that covered employee's employment.
- (f) The qualifying event of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is the qualifying event giving rise to the period of COBRA continuation coverage during which the child is born or placed for adoption. If a second qualifying event has occurred before the child is born or placed for adoption (such as the death of the covered employee), then the second qualifying event also applies to the newborn or adopted child. See Q&A-6 of Sec. 54.4980B-7.
- (g) The rules of this Q&A-1 are illustrated by the following examples, in each of which the group health plan is subject to COBRA:

Example 1. (i) An employee who is covered by a group health plan terminates employment (other than by reason of the employee's gross misconduct) and, beginning with the day after the last day of employment, is given 3 months of employer-paid coverage under the same terms and conditions as before that date. At the end of the three months, the coverage terminates.

(ii) The loss of coverage at the end of the three months results from the termination of employment and, thus, the termination of employment is a qualifying event.

Example 2. (i) An employee who is covered by a group health plan retires (which is a termination of employment other than by reason of the employee's gross misconduct) and, upon retirement, is required to pay an increased amount for the same group health coverage that the employee had before retirement.

(ii) The increase in the premium or contribution required for coverage is a loss of coverage under paragraph (c) of this Q&A-1 and, thus, the retirement is a qualifying event.

Example 3. (i) An employee and the employee's spouse are covered under an employer's group health plan. The employee retires and is given identical coverage for life. However, the plan provides that the spousal coverage will not be continued beyond six months unless a higher premium for the spouse is paid to the plan.

(ii) The requirement for the spouse to pay a higher premium at the end of the six months is a loss of coverage under paragraph (c) of this Q&A-1. Thus, the retirement is a qualifying event and the spouse must be given an opportunity to elect COBRA continuation coverage.

Example 4. (i) F is a covered employee who is married to G, and both are covered under a group health plan maintained by F's employer. F and G are divorced. Under the terms of the plan, the divorce causes G to lose coverage. The divorce is a qualifying event, and G elects COBRA continuation coverage, remarries during the period of COBRA continuation coverage, and G's new spouse becomes covered under the plan. (See Q&A-5 in Sec. 54.4980B-5, paragraph (c) in Q&A-4 of Sec. 54.4980B-5, section 9801(f)(2).) G dies. Under the terms of the plan, the death causes G's new spouse to lose coverage under the plan.

(ii) G's death is not a qualifying event because G is not a covered employee.

Example 5. (i) An employer maintains a group health plan for both active employees and retired employees (and their families). The coverage for active employees and retired employees is identical, and the employer does not require retirees to pay more for coverage than active employees. The plan does not make COBRA continuation coverage available when an employee retires (and is not required to because the retired employee has not lost coverage under the plan). The employer amends the plan to eliminate coverage for retired employees effective January 1, 2002. On that date, several retired employees (and their spouses and dependent children) have been covered under the plan since their retirement for less than the maximum coverage period that would apply to them in connection with their retirement.

(ii) The elimination of retiree coverage under these circumstances is a deferred loss of coverage for those retirees (and their spouses and dependent children) under paragraph (c) of this Q&A-1 and, thus, the retirement is a qualifying event. The plan must make COBRA continuation coverage available to them for the balance of the maximum coverage period that applies to them in connection with the retirement.

Q-2: Are the facts surrounding a termination of employment (such as whether it was voluntary or involuntary) relevant in determining whether the termination of employment is a qualifying event?

Apart from facts constituting gross misconduct, the facts surrounding the termination or reduction of hours are irrelevant in determining whether a qualifying event has occurred. Thus, it does not matter whether the employee voluntarily terminated or was discharged. For example, a strike or a lockout is a termination or reduction of hours that constitutes a qualifying event if the strike or lockout results in a loss of coverage as described in paragraph (c) of Q&A-1 of this section. Similarly, a layoff that results in such a loss of coverage is a qualifying event.

Sec. 54.4980B-5 COBRA continuation coverage.

The following questions-and-answers address the requirements for coverage to constitute COBRA continuation coverage:

Q-1: What is COBRA continuation coverage?

- (a) *If a qualifying event occurs, each qualified beneficiary (other than a qualified beneficiary for whom the qualifying event will not result in any immediate or deferred loss of coverage) must be offered an opportunity to elect to receive the group health plan coverage that is provided to similarly situated nonCOBRA beneficiaries (ordinarily, the same coverage that the qualified beneficiary had on the day before the qualifying event). See Q&A-3 of Sec. 54.4980B-3 for the definition of similarly situated nonCOBRA beneficiaries. This coverage is COBRA continuation coverage. If coverage is modified for similarly situated nonCOBRA beneficiaries, then the coverage made available to qualified beneficiaries is modified in the same way. If the continuation coverage offered differs in any way from the coverage made available to similarly situated nonCOBRA beneficiaries, the coverage offered does not constitute COBRA continuation coverage and the group health plan is not in compliance with COBRA unless other coverage that does constitute COBRA continuation coverage is also offered. Any elimination or reduction of coverage in anticipation of an event described in paragraph (b) of Q&A-1 of Sec. 54.4980B-4 is disregarded for purposes of this Q&A-1 and for purposes of any other reference in Secs. 54.4980B-1 through 54.4980B-10 to coverage in effect immediately before (or on the day before) a qualifying event. COBRA continuation coverage must not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.*
- (b) In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the child is generally entitled to elect immediately to have the same coverage that dependent children of active employees receive under the benefit packages under which the covered employee has coverage at the time of the birth or placement for adoption. Such a child would be entitled to elect coverage different from that elected by the covered employee during the next available open enrollment period under the plan. See Q&A-4 of this section.

Q-2: What deductibles apply if COBRA continuation coverage is elected?

- (a) Qualified beneficiaries electing COBRA continuation coverage generally are subject to the same deductibles as similarly situated nonCOBRA beneficiaries. If a qualified beneficiary's COBRA continuation coverage begins before the end of a period prescribed for accumulating amounts toward deductibles, the qualified beneficiary must retain credit for expenses incurred toward those deductibles before the beginning of COBRA continuation coverage as though the qualifying event had not occurred. The specific application of this rule depends on the type of deductible, as set forth in paragraphs (b) through (d) of this Q&A-2. Special rules are set forth in paragraph (e) of this Q&A-2, and examples appear in paragraph (f) of this Q&A-2.
- (b) If a deductible is computed separately for each individual receiving coverage under the plan, each individual's remaining deductible amount (if any) on the date COBRA continuation coverage begins is equal to that individual's remaining deductible amount immediately before that date.
- (c) If a deductible is computed on a family basis, the remaining deductible for the family on the date that COBRA continuation coverage begins depends on the members of the family electing COBRA continuation coverage. In computing the family deductible that remains on the date COBRA continuation coverage begins, only the expenses of those family members receiving COBRA continuation coverage need be taken into account. If the qualifying event results in there being more than one family unit (for example, because of a divorce), the family deductible may be computed separately for each resulting family unit based on the members in each unit. These rules apply regardless of whether the plan provides that the family deductible is an alternative to individual deductibles or an additional requirement.
- (d) Deductibles that are not described in paragraph (b) or (c) of this Q&A-2 must be treated in a manner consistent with the principles set forth in those paragraphs.
- (e) If a deductible is computed on the basis of a covered employee's compensation instead of being a fixed dollar amount and the employee remains employed during the period of COBRA continuation coverage, the plan is permitted to choose whether to apply the deductible by treating the employee's compensation as continuing without change for the duration of the COBRA continuation coverage at the level that was used to compute the deductible in effect immediately before the COBRA continuation coverage began, or to apply the deductible by taking the employee's actual compensation into account. In applying a deductible that is computed on the basis of the covered employee's compensation instead of being a fixed dollar amount, for periods of COBRA continuation coverage in which the employee is not employed by the employer, the plan is required to compute the deductible by treating the employee's compensation as continuing without change for the duration of the COBRA continuation coverage either at the level that was used to compute the deductible in effect immediately before the COBRA continuation coverage began or at the level that was used to compute the deductible in effect immediately before the employee's employment was terminated.
- (f) The rules of this Q&A-2 are illustrated by the following examples; in each example, deductibles under the plan are determined on a calendar year basis:
- Example 1.** (i) A group health plan applies a separate \$100 annual deductible to each individual it covers. The plan provides that the spouse and dependent children of a covered employee will lose coverage on the last day of the month after the month of the covered employee's death. A covered employee dies on June 11, 2001. The spouse and the two dependent children elect COBRA continuation coverage, which will begin on August 1, 2001. As of July 31, 2001, the spouse has incurred \$80 of covered expenses, the older child has incurred no covered expenses, and the younger one has incurred \$120 of covered expenses (and therefore has already satisfied the deductible).

(ii) At the beginning of COBRA continuation coverage on August 1, the spouse has a remaining deductible of \$20, the older child still has the full \$100 deductible, and the younger one has no further deductible.

Example 2. (i) A group health plan applies a separate \$200 annual deductible to each individual it covers, except that each family member is treated as having satisfied the individual deductible once the family has incurred \$500 of covered expenses during the year. The plan provides that upon the divorce of a covered employee, coverage will end immediately for the employee's spouse and any children who do not remain in the employee's custody. A covered employee with four dependent children is divorced, the spouse obtains custody of the two oldest children, and the spouse and those children all elect COBRA continuation coverage to begin immediately. The family had accumulated \$420 of covered expenses before the divorce, as follows: \$70 by each parent, \$200 by the oldest child, \$80 by the youngest child, and none by the other two children.

(ii) The resulting family consisting of the spouse and the two oldest children accumulated a total of \$270 of covered expenses, and thus the remaining deductible for that family could be as high as \$230 (because the plan would not have to count the incurred expenses of the covered employee and the youngest child). The remaining deductible for the resulting family consisting of the covered employee and the two youngest children is not subject to the rules of this Q&A-2 because their coverage is not COBRA continuation coverage.

Example 3. Each year a group health plan pays 70 percent of the cost of an individual's psychotherapy after that individual's first three visits during the year. A qualified beneficiary whose election of COBRA continuation coverage takes effect beginning August 1, 2001 and who has already made two visits as of that date need only pay for one more visit before the plan must begin to pay 70 percent of the cost of the remaining visits during 2001.

Example 4. (i) A group health plan has a \$250 annual deductible per covered individual. The plan provides that if the deductible is not satisfied in a particular year, expenses incurred during October through December of that year are credited toward satisfaction of the deductible in the next year. A qualified beneficiary who has incurred covered expenses of \$150 from January through September of 2001 and \$40 during October elects COBRA continuation coverage beginning November 1, 2001.

(ii) The remaining deductible amount for this qualified beneficiary is \$60 at the beginning of the COBRA continuation coverage. If this individual incurs covered expenses of \$50 in November and December of 2001 combined (so that the \$250 deductible for 2001 is not satisfied), the \$90 incurred from October through December of 2001 are credited toward satisfaction of the deductible amount for 2002.

Q-3: How do a plan's limits apply to COBRA continuation coverage?

(a) Limits are treated in the same way as deductibles (see Q&A-2 of this section). This rule applies both to limits on plan benefits (such as a maximum number of hospital days or dollar amount of reimbursable expenses) and limits on out-of-pocket expenses (such as a limit on copayments, a limit on deductibles plus copayments, or a catastrophic limit). This rule applies equally to annual and lifetime limits and applies equally to limits on specific benefits and limits on benefits in the aggregate under the plan.

(b) The rule of this Q&A-3 is illustrated by the following examples; in each example limits are determined on a calendar year basis:

Example 1. (i) A group health plan pays for a maximum of 150 days of hospital confinement per individual per year. A covered employee who has had 20 days of hospital confinement as of May 1, 2001 terminates employment and elects COBRA continuation coverage as of that date.

(ii) During the remainder of the year 2001 the plan need only pay for a maximum of 130 days of hospital confinement for this individual.

Example 2. (i) A group health plan reimburses a maximum of \$20,000 of covered expenses per family per year, and the same \$20,000 limit applies to unmarried covered employees. A covered employee and spouse who have no children divorce on May 1, 2001, and the spouse elects COBRA continuation coverage as of that date. In 2001, the employee had incurred \$5,000 of expenses and the spouse had incurred \$8,000 before May 1.

(ii) The plan can limit its reimbursement of the amount of expenses incurred by the spouse on and after May 1 for the remainder of the year to \$12,000 ($\$20,000 - \$8,000 = \$12,000$). The remaining limit for the employee is not subject to the rules of this Q&A-3 because the employee's coverage is not COBRA continuation coverage.

Example 3. (i) A group health plan pays for 80 percent of covered expenses after satisfaction of a \$100-per-individual deductible, and the plan pays for 100 percent of covered expenses after a family has incurred out-of-pocket costs of \$2,000. The plan provides that upon the divorce of a covered employee, coverage will end immediately for the employee's spouse and any children who do not remain in the employee's custody. An employee and spouse with three dependent children divorce on June 1, 2001, and one of the children remains with the employee. The spouse elects COBRA continuation coverage as of that date for the spouse and the other two children. During January through May of 2001, the spouse incurred \$600 of covered expenses and each of the two children in the spouse's custody after the divorce incurred covered expenses of \$1,100. This resulted in total out-of-pocket costs for these three individuals of \$800 ($\300 total for the three deductibles, plus $\$500$ for 20 percent of the other $\$2,500$ in incurred expenses [$\$600 + \$1,100 + \$1,100 = \$2,800$; $\$2,800 - \$300 = \$2,500$]).

(ii) For the remainder of 2001, the resulting family consisting of the spouse and two children has an out-of-pocket limit of \$1,200 ($\$2,000 - \$800 = \$1,200$). The remaining out-of-pocket limit for the resulting family consisting of the employee and one child is not subject to the rules of this Q&A-3 because their coverage is not COBRA continuation coverage.

Q-4: Can a qualified beneficiary who elects COBRA continuation coverage ever change from the coverage received by that individual immediately before the qualifying event?

- (a) In general, a qualified beneficiary need only be given an opportunity to continue the coverage that she or he was receiving immediately before the qualifying event. This is true regardless of whether the coverage received by the qualified beneficiary before the qualifying event ceases to be of value to the qualified beneficiary, such as in the case of a qualified beneficiary covered under a region-specific health maintenance organization (HMO) who leaves the HMO's service region. The only situations in which a qualified beneficiary must be allowed to change from the coverage received immediately before the qualifying event are as set forth in paragraphs (b) and (c) of this Q&A-4 and in Q&A-1 of this section (regarding changes to or elimination of the coverage provided to similarly situated nonCOBRA beneficiaries).
- (b) If a qualified beneficiary participates in a region-specific benefit package (such as an HMO or an on-site clinic) that will not service her or his health needs in the area to which she or he is relocating (regardless of the reason for the relocation), the qualified beneficiary must be given, within a reasonable period after requesting other coverage, an opportunity to elect alternative coverage that the employer or employee organization makes available to active employees. If the employer or employee organization makes group health plan coverage available to similarly situated nonCOBRA beneficiaries that can be extended in the area to which the qualified beneficiary is relocating, then that coverage is the alternative coverage that must be made available to the relocating qualified beneficiary. If the employer or employee organization does not make group health plan coverage available to similarly situated nonCOBRA beneficiaries that can be extended in the area to which the qualified beneficiary is relocating but makes coverage available to other employees that can be extended in that area, then the coverage made available to those other employees must be made available to the relocating qualified beneficiary. The effective date of the alternative coverage must be not later than the date of the qualified beneficiary's relocation, or, if later, the first day of the month following the month in which the qualified beneficiary requests the alternative coverage. However, the employer or employee organization is not required to make any other coverage available to the relocating qualified beneficiary if the only coverage the employer or employee organization makes available to active employees is not available in the area to which the qualified beneficiary relocates (because all such coverage is region-specific and does not service individuals in that area).
- (c) If an employer or employee organization makes an open enrollment period available to similarly situated active employees with respect to whom a qualifying event has not occurred, the same open enrollment period rights must be made available to each qualified beneficiary receiving COBRA continuation coverage. An open enrollment period means a period during which an employee covered under a plan can choose to be covered under another group health plan or under another benefit package within the same plan, or to add or eliminate coverage of family members.
- (d) The rules of this Q&A-4 are illustrated by the following examples:

Example 1. (i) E is an employee who works for an employer that maintains several group health plans. Under the terms of the plans, if an employee chooses to cover any family members under a plan, all family members must be covered by the same plan and that plan must be the same as the plan covering the employee. Immediately before E's termination of employment (for reasons other than gross misconduct), E is covered along with E's spouse and children by a plan. The coverage under that plan will end as a result of the termination of employment.

(ii) Upon E's termination of employment, each of the four family members is a qualified beneficiary. Even though the employer maintains various other plans and options, it is not necessary for the qualified beneficiaries to be allowed to switch to a new plan when E terminates employment.

(iii) COBRA continuation coverage is elected for each of the four family members. Three months after E's termination of employment there is an open enrollment period during which similarly situated active employees are offered an opportunity to choose to be covered under a new plan or to add or eliminate family coverage.

(iv) During the open enrollment period, each of the four qualified beneficiaries must be offered the opportunity to switch to another plan (as though each qualified beneficiary were an individual employee). For example, each member of E's family could choose coverage under a separate plan, even though the family members of employed individuals could not choose coverage under separate plans. Of course, if each family member chooses COBRA continuation coverage under a separate plan, the plan can require payment for each family member that is based on the applicable premium for individual coverage under that separate plan. See Q&A-1 of Sec. 54.4980B-8.

Example 2. (i) The facts are the same as in Example 1, except that E's family members are not covered under E's group health plan when E terminates employment.

(ii) Although the family members do not have to be given an opportunity to elect COBRA continuation coverage, E must be allowed to add them to E's COBRA continuation coverage during the open enrollment period. This is true even though the family members are not, and cannot become, qualified beneficiaries (see Q&A-1 of Sec. 54.4980B-3).

Q-5: Aside from open enrollment periods, can a qualified beneficiary who has elected COBRA continuation coverage choose to cover individuals (such as newborn children, adopted children, or new spouses) who join the qualified beneficiary's family on or after the date of the qualifying event?

- (a) Yes. Under section 9801, employees eligible to participate in a group health plan (whether or not participating), as well as former employees participating in a plan (referred to in those rules as participants), are entitled to special enrollment rights for certain family members upon the loss of other group health plan coverage or upon the acquisition by the employee or participant of a new spouse or of a new dependent through birth, adoption, or placement for adoption, if certain requirements are satisfied. Employees not participating in the plan also can obtain rights for self-enrollment under those rules. Once a qualified beneficiary is receiving COBRA continuation coverage (that is, has timely elected and made timely payment for COBRA continuation coverage), the qualified beneficiary has the same right to enroll family members under those special enrollment rules as if the qualified beneficiary were an employee or participant within the meaning of those rules. However, neither a qualified beneficiary who is not receiving COBRA continuation coverage nor a former qualified beneficiary has any special enrollment rights under those rules.

- (b) In addition to the special enrollment rights described in paragraph (a) of this Q&A-5, if the plan covering the qualified beneficiary provides that new family members of active employees can become covered (either automatically or upon an appropriate election) before the next open enrollment period, then the same right must be extended to the new family members of a qualified beneficiary.
- (c) If the addition of a new family member will result in a higher applicable premium (for example, if the qualified beneficiary was previously receiving COBRA continuation coverage as an individual, or if the applicable premium for family coverage depends on family size), the plan can require the payment of a correspondingly higher amount for the COBRA continuation coverage. See Q&A-1 of Sec. 54.4980B-8.
- (d) The right to add new family members under this Q&A-5 is in addition to the rights that newborn and adopted children of covered employees may have as qualified beneficiaries; see Q&A-1 in Sec. 54.4980B-3.

Sec. 54.4980B-6 Electing COBRA continuation coverage.

The following questions-and-answers address the manner in which COBRA continuation coverage is elected:

Q-1: What is the election period and how long must it last?

- (a) A group health plan can condition the availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the qualified beneficiary would lose coverage on account of the qualifying event. (See paragraph (c) of Q&A-1 of Sec. 54.4980B-4 for the meaning of lose coverage.) The election period must not end before the date that is 60 days after the later of--
 - (1) The date the qualified beneficiary would lose coverage on account of the qualifying event; or
 - (2) The date notice is provided to the qualified beneficiary of her or his right to elect COBRA continuation coverage.
- (b) An election is considered to be made on the date it is sent to the plan administrator.
- (c) The rules of this Q&A-1 are illustrated by the following example:

Example. (i) *An unmarried employee without children who is receiving employer-paid coverage under a group health plan voluntarily terminates employment on June 1, 2001. The employee is not disabled at the time of the termination of employment nor at any time thereafter, and the plan does not provide for the extension of the required periods (as is permitted under paragraph (b) of Q&A-4 of Sec. 54.4980B-7).*

(ii) *Case 1: If the plan provides that the employer-paid coverage ends immediately upon the termination of employment, the election period must begin not later than June 1, 2001, and must not end earlier than July 31, 2001. If notice of the right to elect COBRA continuation coverage is not provided to the employee until June 15, 2001, the election period must not end earlier than August 14, 2001.*

(iii) *Case 2: If the plan provides that the employer-paid coverage does not end until 6 months after the termination of employment, the employee does not lose coverage until December 1, 2001. The election period can therefore begin as late as December 1, 2001, and must not end before January 30, 2002.*

(iv) *Case 3: If employer-paid coverage for 6 months after the termination of employment is offered only to those qualified beneficiaries who waive COBRA continuation coverage, the employee loses coverage on June 1, 2001, so the election period is the same as in Case 1. The difference between Case 2 and Case 3 is that in Case 2 the employee can receive 6 months of employer-paid coverage and then elect to pay for up to an additional 12 months of COBRA continuation coverage, while in Case 3 the employee must choose between 6 months of employer-paid coverage and paying for up to 18 months of COBRA continuation coverage. In all three cases, COBRA continuation coverage need not be provided for more than 18 months after the termination of employment (see Q&A-4 of Sec. 54.4980B-7), and in certain circumstances might be provided for a shorter period (see Q&A-1 of Sec. 54.4980B-7).*

Q-2: Is a covered employee or qualified beneficiary responsible for informing the plan administrator of the occurrence of a qualifying event?

- (a) In general, the employer or plan administrator must determine when a qualifying event has occurred. However, each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of a qualifying event that is either a dependent child's ceasing to be a dependent child under the generally applicable requirements of the plan or a divorce or legal separation of a covered employee. The group health plan is not required to offer the qualified beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the plan administrator within 60 days after the later of--
 - (1) The date of the qualifying event; or
 - (2) The date the qualified beneficiary would lose coverage on account of the qualifying event.
- (b) For purposes of this Q&A-2, if more than one qualified beneficiary would lose coverage on account of a divorce or legal separation of a covered employee, a timely notice of the divorce or legal separation that is provided by the covered employee or any one of those qualified beneficiaries will be sufficient to preserve the election rights of all of the qualified beneficiaries.

Q-3: During the election period and before the qualified beneficiary has made an election, must coverage be provided?

- (a) In general, each qualified beneficiary has until 60 days after the later of the date the qualifying event would cause her or him to lose coverage or the date notice is provided to the qualified beneficiary of her or his right to elect COBRA continuation coverage to decide whether to elect COBRA continuation coverage. If the election is made during that

period, coverage must be provided from the date that coverage would otherwise have been lost (but see Q&A-4 of this section). This can be accomplished as described in paragraph (b) or (c) of this Q&A-3.

- (b) *In the case of an indemnity or reimbursement arrangement, the employer or employee organization can provide for plan coverage during the election period or, if the plan allows retroactive reinstatement, the employer or employee organization can terminate the coverage of the qualified beneficiary and reinstate her or him when the election (and, if applicable, payment for the coverage) is made.* Claims incurred by a qualified beneficiary during the election period do not have to be paid before the election (and, if applicable, payment for the coverage) is made. If a provider of health care (such as a physician, hospital, or pharmacy) contacts the plan to confirm coverage of a qualified beneficiary during the election period, the plan must give a complete response to the health care provider about the qualified beneficiary's COBRA continuation coverage rights during the election period. For example, if the plan provides coverage during the election period but cancels coverage retroactively if COBRA continuation coverage is not elected, then the plan must inform a provider that a qualified beneficiary for whom coverage has not been elected is covered but that the coverage is subject to retroactive termination. Similarly, if the plan cancels coverage but then retroactively reinstates it once COBRA continuation coverage is elected, then the plan must inform the provider that the qualified beneficiary currently does not have coverage but will have coverage retroactively to the date coverage was lost if COBRA continuation coverage is elected. (See paragraph (c) of Q&A-5 in Sec. 54.4980B-8 for similar rules that a plan must follow in confirming coverage during a period when the plan has not received payment but that is still within the grace period for a qualified beneficiary for whom COBRA continuation coverage has been elected.)
- (c)(1) In the case of a group health plan that provides health services (such as a health organization or a walk-in clinic), the plan can require with respect to a qualified beneficiary who has not elected and paid for COBRA continuation coverage that the qualified beneficiary choose between--
- (i) Electing and paying for the coverage; or
 - (ii) Paying the reasonable and customary charge for the plan's services, but only if a qualified beneficiary who chooses to pay for the services will be reimbursed for that payment within 30 days after the election of COBRA continuation coverage (and, if applicable, the payment of any balance due for the coverage).
- (2) In the alternative, the plan can provide continued coverage and treat the qualified beneficiary's use of the facility as a constructive election. In such a case, the qualified beneficiary is obligated to pay any applicable charge for the coverage, but only if the qualified beneficiary is informed that use of the facility will be a constructive election before using the facility.

Q-4: Is a waiver before the end of the election period effective to end a qualified beneficiary's election rights?

If, during the election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver of COBRA continuation coverage is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the employer, employee organization, or plan administrator, as applicable.

Q-5: Can an employer or employee organization withhold money or other benefits owed to a qualified beneficiary until the qualified beneficiary either waives COBRA continuation coverage, elects and pays for such coverage, or allows the election period to expire?

No. An employer, and an employee organization, must not withhold anything to which a qualified beneficiary is otherwise entitled (by operation of law or other agreement) in order to compel payment for COBRA continuation coverage or to coerce the qualified beneficiary to give up rights to COBRA continuation coverage (including the right to use the full election period to decide whether to elect such coverage). Such a withholding constitutes a failure to comply with the COBRA continuation coverage requirements. Furthermore, any purported waiver obtained by means of such a withholding is invalid.

Q-6: Can each qualified beneficiary make an independent election under COBRA?

Yes. Each qualified beneficiary (including a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage. If the plan allows similarly situated active employees with respect to whom a qualifying event has not occurred to choose among several options during an open enrollment period (for example, to switch to another group health plan or to another benefit package under the same group health plan), then each qualified beneficiary must also be offered an independent election to choose during an open enrollment period among the options made available to similarly situated active employees with respect to whom a qualifying event has not occurred. If a qualified beneficiary who is either 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 all other qualified beneficiaries with respect to that qualifying event. An election on behalf of a minor child can be made by the child's parent or legal guardian. An election on behalf of a qualified beneficiary who is incapacitated or dies can be made by the legal representative of the qualified beneficiary or the qualified beneficiary's estate, as determined under applicable state law, or by the spouse of the qualified beneficiary. (See also Q&A-5 of Sec. 54.4980B-7 relating to the independent right of each qualified beneficiary with respect to the same qualifying event to receive COBRA continuation coverage during the disability extension.) The rules of this Q&A-6 are illustrated by the following examples; in each example each group health plan is subject to COBRA:

Example 1. (i) Employee H and H's spouse are covered under a group health plan immediately before H's termination of employment (for reasons other than gross misconduct). Coverage under the plan will end as a result of the termination of employment.

(ii) Upon H's termination of employment, both H and H's spouse are qualified beneficiaries and each must be allowed to elect COBRA continuation coverage. Thus, H might elect COBRA continuation coverage while the spouse declines to elect such coverage, or H might elect COBRA continuation coverage for both of them. In contrast, H cannot decline COBRA continuation coverage on behalf of H's spouse. Thus, if H does not elect COBRA continuation coverage on behalf of the spouse, the spouse must still be allowed to elect COBRA continuation coverage.

Example 2. (i) An employer maintains a group health plan under which all employees receive employer-paid coverage. Employees can arrange to cover their families by paying an additional amount. The employer also maintains a cafeteria plan, under which one of the options is to pay part or all of the employee share of the cost for family coverage under the group health plan. Thus, an employee might pay for family coverage under the group health plan partly with before-tax dollars and partly with after-tax dollars.

(ii) If an employee's family is receiving coverage under the group health plan when a qualifying event occurs, each of the qualified beneficiaries must be offered an opportunity to elect COBRA continuation coverage, regardless of how that qualified beneficiary's coverage was paid for before the qualifying event.

Sec. 54.4980B-7 Duration of COBRA continuation coverage.

The following questions-and-answers address the duration of COBRA continuation coverage:

Q-1: How long must COBRA continuation coverage be made available to a qualified beneficiary?

- (a) Except for an interruption of coverage in connection with a waiver, as described in Q&A-4 of Sec. 54.4980B-6, COBRA continuation coverage that has been elected for a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates --
- (1) The last day of the maximum coverage period (see Q&A-4 of this section);
 - (2) The first day for which timely payment is not made to the plan with respect to the qualified beneficiary (see Q&A-5 in Sec. 54.4980B-8);
 - (3) The date upon which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee;
 - (4) The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan, as described in Q&A-2 of this section;
 - (5) The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits, as described in Q&A-3 of this section; and
 - (6) In the case of a qualified beneficiary entitled to a disability extension (see Q&A-5 of this section), the later of :
 - (i) Either 29 months after the date of the qualifying event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act (42 U.S.C. 401-433 or 1381-1385) that the disabled qualified beneficiary whose disability resulted in the qualified beneficiary's being entitled to the disability extension is no longer disabled, whichever is earlier; or
 - (ii) The end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.
- (b) However, a group health plan can terminate for cause the coverage of a qualified beneficiary receiving COBRA continuation coverage on the same basis that the plan terminates for cause the coverage of similarly situated nonCOBRA beneficiaries. For example, if a group health plan terminates the coverage of active employees for the submission of a fraudulent claim, then the coverage of a qualified beneficiary can also be terminated for the submission of a fraudulent claim. Notwithstanding the preceding two sentences, the coverage of a qualified beneficiary can be terminated for failure to make timely payment to the plan only if payment is not timely under the rules of Q&A-5 in Sec. 54.4980B-8.
- (c) In the case of an individual who is not a qualified beneficiary and who is receiving coverage under a group health plan solely because of the individual's relationship to a qualified beneficiary, if the plan's obligation to make COBRA continuation coverage available to the qualified beneficiary ceases under this section, the plan is not obligated to make coverage available to the individual who is not a qualified beneficiary.

Q-2: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to coverage under another group health plan?

- (a) If a qualified beneficiary first becomes covered under another group health plan (including for this purpose any group health plan of a governmental employer or employee organization) after the date on which COBRA continuation coverage is elected for the qualified beneficiary and the other coverage satisfies the requirements of paragraphs (b), (c), and (d) of this Q&A-2, then the plan may terminate the qualified beneficiary's COBRA continuation coverage upon the date on which the qualified beneficiary first becomes covered under the other group health plan (even if the other coverage is less valuable to the qualified beneficiary). By contrast, if a qualified beneficiary first becomes covered under another group health plan on or before the date on which COBRA continuation coverage is elected, then the other coverage cannot be a basis for terminating the qualified beneficiary's COBRA continuation coverage.
- (b) The requirement of this paragraph (b) is satisfied if the qualified beneficiary is actually covered, rather than merely eligible to be covered, under the other group health plan.

- (c) The requirement of this paragraph (c) is satisfied if the other group health plan is a plan that is not maintained by the employer or employee organization that maintains the plan under which COBRA continuation coverage must otherwise be made available.
- (d) The requirement of this paragraph (d) is satisfied if the other group health plan does not contain any exclusion or limitation with respect to any preexisting condition of the qualified beneficiary (other than such an exclusion or limitation that does not apply to, or is satisfied by, the qualified beneficiary by reason of the provisions in section 9801 (relating to limitations on preexisting condition exclusion periods in group health plans)).
- (e) The rules of this Q&A-2 are illustrated by the following examples:
 - Example 1.** (i) Employer X maintains a group health plan subject to COBRA. C is an employee covered under the plan. C is also covered under a group health plan maintained by Employer Y, the employer of C's spouse. C terminates employment (for reasons other than gross misconduct), and the termination of employment causes C to lose coverage under X's plan (and, thus, is a qualifying event). C elects to receive COBRA continuation coverage under X's plan. (ii) Under these facts, X's plan cannot terminate C's COBRA continuation coverage on the basis of C's coverage under Y's plan.
 - Example 2.** (i) Employer W maintains a group health plan subject to COBRA. D is an employee covered under the plan. D terminates employment (for reasons other than gross misconduct), and the termination of employment causes D to lose coverage under W's plan (and, thus, is a qualifying event). D elects to receive COBRA continuation coverage under W's plan. Later D becomes employed by Employer V and is covered under V's group health plan. D's coverage under V's plan is not subject to any exclusion or limitation with respect to any preexisting condition of D. (ii) Under these facts, W can terminate D's COBRA continuation coverage on the date D becomes covered under V's plan.
 - Example 3.** (i) The facts are the same as in Example 2, except that D becomes employed by V and becomes covered under V's group health plan before D elects COBRA continuation coverage under W's plan. (ii) Because the termination of employment is a qualifying event, D must be offered COBRA continuation coverage under W's plan, and W is not permitted to terminate D's COBRA continuation coverage on account of D's coverage under V's plan because D first became covered under V's plan before COBRA continuation coverage was elected for D.

Q-3: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to the qualified beneficiary's entitlement to Medicare benefits?

- (a) If a qualified beneficiary first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395-1395ggg) after the date on which COBRA continuation coverage is elected for the qualified beneficiary, then the plan may terminate the qualified beneficiary's COBRA continuation coverage upon the date on which the qualified beneficiary becomes so entitled. By contrast, if a qualified beneficiary first becomes entitled to Medicare benefits on or before the date that COBRA continuation coverage is elected, then the qualified beneficiary's entitlement to Medicare benefits cannot be a basis for terminating the qualified beneficiary's COBRA continuation coverage.
- (b) A qualified beneficiary becomes entitled to Medicare benefits upon the effective date of enrollment in either part A or B, whichever occurs earlier. Thus, merely being eligible to enroll in Medicare does not constitute being entitled to Medicare benefits.

Q-4: When does the maximum coverage period end?

- (a) Except as otherwise provided in this Q&A-4, the maximum coverage period ends 36 months after the qualifying event. The maximum coverage period for a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is the maximum coverage period for the qualifying event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption. Paragraph (b) of this Q&A-4 describes the starting point from which the end of the maximum coverage period is measured. The date that the maximum coverage period ends is described in paragraph (c) of this Q&A-4 in a case where the qualifying event is a termination of employment or reduction of hours of employment, in paragraph (d) of this Q&A-4 in a case where a covered employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395-1395ggg) before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, and in paragraph (e) of this Q&A-4 in the case of a qualifying event that is the bankruptcy of the employer. See Q&A-8 of Sec. 54.4980B-2 for limitations that apply to certain health flexible spending arrangements. See also Q&A-6 of this section in the case of multiple qualifying events. Nothing in Secs. 54.4980B-1 through 54.4980B-10 prohibits a group health plan from providing coverage that continues beyond the end of the maximum coverage period.
- (b)(1) The end of the maximum coverage period is measured from the date of the qualifying event even if the qualifying event does not result in a loss of coverage under the plan until a later date. If, however, coverage under the plan is lost at a later date and the plan provides for the extension of the required periods, then the maximum coverage period is measured from the date when coverage is lost. A plan provides for the extension of the required periods if it provides both--
 - (i) That the 30-day notice period (during which the employer is required to notify the plan administrator of the occurrence of certain qualifying events such as the death of the covered employee or the termination of employment or reduction of hours of employment of the covered employee) begins on the date of the loss of coverage rather than on the date of the qualifying event; and
 - (ii) That the end of the maximum coverage period is measured from the date of the loss of coverage rather than from the date of the qualifying event.

- (2) In the case of a plan that provides for the extension of the required periods, whenever the rules of Secs. 54.4980B-1 through 54.4980B-10 refer to the measurement of a period from the date of the qualifying event, those rules apply in such a case by measuring the period instead from the date of the loss of coverage.
- (c) In the case of a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the qualifying event if there is no disability extension, and 29 months after the qualifying event if there is a disability extension. See Q&A-5 of this section for rules to determine if there is a disability extension. If there is a disability extension and the disabled qualified beneficiary is later determined to no longer be disabled, then a plan may terminate the COBRA continuation coverage of an affected qualified beneficiary before the end of the disability extension; see paragraph (a)(6) in Q&A-1 of this section.
- (d)(1) If a covered employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395-1395ggg) before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period for qualified beneficiaries other than the covered employee ends on the later of--
- (i) 36 months after the date the covered employee became entitled to Medicare benefits; or
 - (ii) 18 months (or 29 months, if there is a disability extension) after the date of the covered employee's termination of employment or reduction of hours of employment.
- (2) See paragraph (b) of Q&A-3 of this section regarding the determination of when a covered employee becomes entitled to Medicare benefits.
- (e) In the case of a qualifying event that is the bankruptcy of the employer, the maximum coverage period for a qualified beneficiary who is the retired covered employee ends on the date of the retired covered employee's death. The maximum coverage period for a qualified beneficiary who is the spouse, surviving spouse, or dependent child of the retired covered employee ends on the earlier of--
- (1) The date of the qualified beneficiary's death; or
 - (2) The date that is 36 months after the death of the retired covered employee.

Q-5: How does a qualified beneficiary become entitled to a disability extension?

- (a) A qualified beneficiary becomes entitled to a disability extension if the requirements of paragraphs (b), (c), and (d) of this Q&A-5 are satisfied with respect to the qualified beneficiary. If the disability extension applies with respect to a qualifying event, it applies with respect to each qualified beneficiary entitled to COBRA continuation coverage because of that qualifying event. Thus, for example, the 29-month maximum coverage period applies to each qualified beneficiary who is not disabled as well as to the qualified beneficiary who is disabled, and it applies independently with respect to each of the qualified beneficiaries. See Q&A-1 in Sec. 54.4980B-8, which permits a plan to require payment of an increased amount during the disability extension.
- (b) The requirement of this paragraph (b) is satisfied if a qualifying event occurs that is a termination, or reduction of hours, of a covered employee's employment.
- (c) The requirement of this paragraph (c) is satisfied if an individual (whether or not the covered employee) who is a qualified beneficiary in connection with the qualifying event described in paragraph (b) of this Q&A-5 is determined under Title II or XVI of the Social Security Act (42 U.S.C. 401-433 or 1381-1385) to have been disabled at any time during the first 60 days of COBRA continuation coverage. *For this purpose, the period of the first 60 days of COBRA continuation coverage is measured from the date of the qualifying event described in paragraph (b) of this Q&A-5 (except that if a loss of coverage would occur at a later date in the absence of an election for COBRA continuation coverage and if the plan provides for the extension of the required periods (as described in paragraph (b) of Q&A-4 of this section) then the period of the first 60 days of COBRA continuation coverage is measured from the date on which the coverage would be lost).* However, in the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the period of the first 60 days of COBRA continuation coverage is measured from the date of birth or placement for adoption. For purposes of this paragraph (c), an individual is determined to be disabled within the first 60 days of COBRA continuation coverage if the individual has been determined under Title II or XVI of the Social Security Act to have been disabled before the first day of COBRA continuation coverage and has not been determined to be no longer disabled at any time between the date of that disability determination and the first day of COBRA continuation coverage.
- (d) The requirement of this paragraph (d) is satisfied if any of the qualified beneficiaries affected by the qualifying event described in paragraph (b) of this Q&A-5 provides notice to the plan administrator of the disability determination on a date that is both within 60 days after the date the determination is issued and before the end of the original 18-month maximum coverage period that applies to the qualifying event.

Q-6: Under what circumstances can the maximum coverage period be expanded?

- (a) The maximum coverage period can be expanded if the requirements of Q&A-5 of this section (relating to the disability extension) or paragraph (b) of this Q&A-6 are satisfied.
- (b) *The requirements of this paragraph (b) are satisfied if a qualifying event that gives rise to an 18-month maximum coverage period (or a 29-month maximum coverage period in the case of a disability extension) is followed, within that 18-month period (or within that 29-month period, in the case of a disability extension), by a second qualifying event (for example, a death or a divorce) that gives rise to a 36-month maximum coverage period. (Thus, a termination of employment following a qualifying event that is a reduction of hours of employment cannot be a second qualifying event that expands the maximum coverage period; the bankruptcy of an employer also cannot be a second qualifying event that expands the maximum coverage period.) In such a case, the original 18-month period (or 29-month period, in the*

case of a disability extension) is expanded to 36 months, but only for those individuals who were qualified beneficiaries under the group health plan in connection with the first qualifying event and who are still qualified beneficiaries at the time of the second qualifying event. No qualifying event (other than a qualifying event that is the bankruptcy of the employer) can give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event (or more than 36 months after the date of the loss of coverage, in the case of a plan that provides for the extension of the required periods; see paragraph (b) in Q&A-4 of this section). For example, if an employee covered by a group health plan that is subject to COBRA terminates employment (for reasons other than gross misconduct) on December 31, 2000, the termination is a qualifying event giving rise to a maximum coverage period that extends for 18 months to June 30, 2002. If the employee dies after the employee and the employee's spouse and dependent children have elected COBRA continuation coverage and on or before June 30, 2002, the spouse and dependent children (except anyone among them whose COBRA continuation coverage had already ended for some other reason) will be able to receive COBRA continuation coverage through December 31, 2003. See Q&A-8(b) of Sec. 54.4980B-2 for a special rule that applies to certain health flexible spending arrangements.

Q-7: If health coverage is provided to a qualified beneficiary after a qualifying event without regard to COBRA continuation coverage (for example, as a result of state or local law, the Uniformed Services Employment and Reemployment Rights Act of 1994 (38 U.S.C. 4315), industry practice, a collective bargaining agreement, severance agreement, or plan procedure), will such alternative coverage extend the maximum coverage period?

- (a) No. The end of the maximum coverage period is measured solely as described in Q&A-4 and Q&A-6 of this section, which is generally from the date of the qualifying event.
- (b) If the alternative coverage does not satisfy all the requirements for COBRA continuation coverage, or if the amount that the group health plan requires to be paid for the alternative coverage is greater than the amount required to be paid by similarly situated nonCOBRA beneficiaries for the coverage that the qualified beneficiary can elect to receive as COBRA continuation coverage, the plan covering the qualified beneficiary immediately before the qualifying event must offer the qualified beneficiary receiving the alternative coverage the opportunity to elect COBRA continuation coverage. See Q&A-1 of Sec. 54.4980B-6.
- (c) If an individual rejects COBRA continuation coverage in favor of alternative coverage, then, at the expiration of the alternative coverage period, the individual need not be offered a COBRA election. However, if the individual receiving alternative coverage is a covered employee and the spouse or a dependent child of the individual would lose that alternative coverage as a result of a qualifying event (such as the death of the covered employee), the spouse or dependent child must be given an opportunity to elect to continue that alternative coverage, with a maximum coverage period of 36 months measured from the date of that qualifying event.

Q-8: Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a qualified beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the maximum coverage period, the group health plan must, during the 180-day period that ends on that expiration date, provide the qualified beneficiary the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated nonCOBRA beneficiaries under the group health plan. If such a conversion option is not otherwise generally available, it need not be made available to qualified beneficiaries.

Sec. 54.4980B-8 Paying for COBRA continuation coverage.

The following questions-and-answers address paying for COBRA continuation coverage:

Q-1: Can a group health plan require payment for COBRA continuation coverage?

- (a) Yes. For any period of COBRA continuation coverage, a group health plan can require the payment of an amount that does not exceed 102 percent of the applicable premium for that period. (See paragraph (b) of this Q&A-1 for a rule permitting a plan to require payment of an increased amount due to the disability extension.) The applicable premium is defined in section 4980B(f)(4). A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the plan with respect to that qualified beneficiary (see Q&A-1 of Sec. 54.4980B-7). For the meaning of timely payment, see Q&A-5 of this section.
- (b) A group health plan is permitted to require the payment of an amount that does not exceed 150 percent of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary (for example, whether single or family coverage) if the coverage would not be required to be made available in the absence of a disability extension. (See Q&A-5 of Sec. 54.4980B-7 for rules to determine whether a qualified beneficiary is entitled to a disability extension.) A plan is not permitted to require the payment of an amount that exceeds 102 percent of the applicable premium for any period of COBRA continuation coverage to which a qualified beneficiary is entitled without regard to the disability extension. Thus, if a qualified beneficiary entitled to a disability extension experiences a second qualifying event within the original 18-month maximum coverage period, then the plan is not permitted to require the payment of an amount that exceeds 102 percent of the applicable premium for any period of COBRA continuation

coverage. By contrast, if a qualified beneficiary entitled to a disability extension experiences a second qualifying event after the end of the original 18-month maximum coverage period, then the plan may require the payment of an amount that is up to 150 percent of the applicable premium for the remainder of the period of COBRA continuation coverage (that is, from the beginning of the 19th month through the end of the 36th month) as long as the disabled qualified beneficiary is included in that coverage. The rules of this paragraph (b) are illustrated by the following examples; in each example the group health plan is subject to COBRA:

Example 1. (i) An employer maintains a group health plan. The plan determines the cost of covering individuals under the plan by reference to two categories, individual coverage and family coverage, and the applicable premium is determined for those two categories. An employee and members of the employee's family are covered under the plan. The employee experiences a qualifying event that is the termination of the employee's employment. The employee's family qualifies for the disability extension because of the disability of the employee's spouse. (Timely notice of the disability is provided to the plan administrator.) Timely payment of the amount required by the plan for COBRA continuation coverage for the family (which does not exceed 102 percent of the cost of family coverage under the plan) was made to the plan with respect to the employee's family for the first 18 months of COBRA continuation coverage, and the disabled spouse and the rest of the family continue to receive COBRA continuation coverage through the 29th month.

(ii) Under these facts, the plan may require payment of up to 150 percent of the applicable premium for family coverage in order for the family to receive COBRA continuation coverage from the 19th month through the 29th month. If the plan determined the cost of coverage by reference to three categories (such as employee, employee-plus-one-dependent, employee-plus-two-or-more-dependents) or more than three categories, instead of two categories, the plan could still require, from the 19th month through the 29th month of COBRA continuation coverage, the payment of 150 percent of the cost of coverage for the category of coverage that included the disabled spouse.

Example 2. (i) The facts are the same as in Example 1, except that only the covered employee elects and pays for the first 18 months of COBRA continuation coverage.

(ii) Even though the employee's disabled spouse does not elect or pay for COBRA continuation coverage, the employee satisfies the requirements for the disability extension to apply with respect to the employee's qualifying event. Under these facts, the plan may not require the payment of more than 102 percent of the applicable premium for individual coverage for the entire period of the employee's COBRA continuation coverage, including the period from the 19th month through the 29th month. If COBRA continuation coverage had been elected and paid for with respect to other nondisabled members of the employee's family, then the plan could not require the payment of more than 102 percent of the applicable premium for family coverage (or for any other appropriate category of coverage that might apply to that group of qualified beneficiaries under the plan, such as employee-plus-one-dependent or employee-plus-two-or-more-dependents) for those family members to continue their coverage from the 19th month through the 29th month.

- (c) *A group health plan does not fail to comply with section 9802(b) (which generally prohibits an individual from being charged, on the basis of health status, a higher premium than that charged for similarly situated individuals enrolled in the plan) with respect to a qualified beneficiary entitled to the disability extension merely because the plan requires payment of an amount permitted under paragraph (b) of this Q&A-1.*

Q-2: When is the applicable premium determined and when can a group health plan increase the amount it requires to be paid for COBRA continuation coverage?

- (a) The applicable premium for each determination period must be computed and fixed by a group health plan before the determination period begins. A determination period is any 12-month period selected by the plan, but it must be applied consistently from year to year. The determination period is a single period for any benefit package. Thus, each qualified beneficiary does not have a separate determination period beginning on the date (or anniversaries of the date) that COBRA continuation coverage begins for that qualified .
- (b) During a determination period, a plan can increase the amount it requires to be paid for a qualified beneficiary's COBRA continuation coverage only in the following three cases:
- (1) The plan has previously charged less than the maximum amount permitted under Q&A-1 of this section and the increased amount required to be paid does not exceed the maximum amount permitted under Q&A-1 of this section;
 - (2) The increase occurs during the disability extension and the increased amount required to be paid does not exceed the maximum amount permitted under paragraph (b) of Q&A-1 of this section; or
 - (3) A qualified beneficiary changes the coverage being received (see paragraph (c) of this Q&A-2 for rules on how the amount the plan requires to be paid may or must change when a qualified beneficiary changes the coverage being received).
- (c) If a plan allows similarly situated active employees who have not experienced a qualifying event to change the coverage they are receiving, then the plan must also allow each qualified beneficiary to change the coverage being received on the same terms as the similarly situated active employees. (See Q&A-4 in Sec. 54.4980B-5.) If a qualified beneficiary changes coverage from one benefit package (or a group of benefit packages) to another benefit package (or another group of benefit packages), or adds or eliminates coverage for family members, then the following rules apply. If the change in coverage is to a benefit package, group of benefit packages, or coverage unit (such as family coverage, self-plus-one-dependent, or self-plus-two-or-more-dependents) for which the applicable premium is higher, then the plan may increase the amount that it requires to be paid for COBRA continuation coverage to an amount that does not exceed the amount permitted under Q&A-1 of this section as applied to the new coverage. If the change in coverage is to a benefit package, group of benefit packages, or coverage unit (such as individual or self-plus-one-dependent) for which the applicable premium is lower, then the plan cannot require the payment of an amount that exceeds the amount permitted under Q&A-1 of this section as applied to the new coverage.

Q-3: Must a plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. A group health plan must allow payment for COBRA continuation coverage to be made in monthly installments. A group health plan is permitted to also allow the alternative of payment for COBRA continuation coverage being made at other intervals (for example, weekly, quarterly, or semiannually).

Q-4: Is a plan required to allow a qualified beneficiary to choose to have the first payment for COBRA continuation coverage applied prospectively only?

No. A plan is permitted to apply the first payment for COBRA continuation coverage to the period of coverage beginning immediately after the date on which coverage under the plan would have been lost on account of the qualifying event. Of course, if the group health plan allows a qualified beneficiary to waive COBRA continuation coverage for any period before electing to receive COBRA continuation coverage, the first payment is not applied to the period of the waiver.

Q-5: What is timely payment for COBRA continuation coverage?

- (a) Except as provided in this paragraph (a) or in paragraph (b) or (d) of this Q&A-5, timely payment for a period of COBRA continuation coverage under a group health plan means payment that is made to the plan by the date that is 30 days after the first day of that period. Payment that is made to the plan by a later date is also considered timely payment if either--
- (1) Under the terms of the plan, covered employees or qualified beneficiaries are allowed until that later date to pay for their coverage for the period; or
 - (2) Under the terms of an arrangement between the employer or employee organization and an insurance company, health maintenance organization, or other entity that provides plan benefits on the employer's or employee organization's behalf, the employer or employee organization is allowed until that later date to pay for coverage of similarly situated nonCOBRA beneficiaries for the period.
- (b) Notwithstanding paragraph (a) of this Q&A-5, a plan cannot require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that qualified beneficiary.
- (c) If, after COBRA continuation coverage has been elected for a qualified beneficiary, a provider of health care (such as a physician, hospital, or pharmacy) contacts the plan to confirm coverage of a qualified beneficiary for a period for which the plan has not yet received payment, the plan must give a complete response to the health care provider about the qualified beneficiary's COBRA continuation coverage rights, if any, described in paragraphs (a), (b), and (d) of this Q&A-5. For example, if the plan provides coverage during the 30- and 45-day grace periods described in paragraphs (a) and (b) of this Q&A-5 but cancels coverage retroactively if payment is not made by the end of the applicable grace period, then the plan must inform a provider with respect to a qualified beneficiary for whom payment has not been received that the qualified beneficiary is covered but that the coverage is subject to retroactive termination if timely payment is not made. Similarly, if the plan cancels coverage if it has not received payment by the first day of a period of coverage but retroactively reinstates coverage if payment is made by the end of the grace period for that period of coverage, then the plan must inform the provider that the qualified beneficiary currently does not have coverage but will have coverage retroactively to the first date of the period if timely payment is made. (See paragraph (b) of Q&A-3 in Sec. 54.4980B-6 for similar rules that the plan must follow in coverage during the election period.)
- (d) If timely payment is made to the plan in an amount that is not significantly less than the amount the plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the plan's requirement for the amount that must be paid, 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. For this purpose, as a safe harbor, 30 days after the date the notice is provided is deemed to be a reasonable period of time. *An amount is not significantly less than the amount the plan requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:*
- (1) Fifty dollars (or such other amount as the Commissioner may provide in a revenue ruling, notice, or other guidance published in the Internal Revenue Bulletin (see Sec. 601.601(d)(2)(ii) of this chapter)); or
 - (2) 10 percent of the amount the plan requires to be paid.
- (e) Payment is considered made on the date on which it is sent to the plan.

Sec. 54.4980B-9 Business reorganizations and employer withdrawals from multiemployer plans.

The following questions-and-answers address who has the obligation to make COBRA continuation coverage available to affected qualified beneficiaries in the context of business reorganizations and employer withdrawals from multiemployer plans:

Q-1: For purposes of this section, what are a business reorganization, a stock sale, and an asset sale?

For purposes of this section:

- (a) A business reorganization is a stock sale or an asset sale.
- (b) A stock sale is a transfer of stock in a corporation that causes the corporation to become a different employer or a member of a different employer. (See Q&A-2 of Sec. 54.4980B-2, which defines employer to include all members of a controlled group of corporations.) Thus, for example, a sale or distribution of stock in a corporation

that causes the corporation to cease to be a member of one controlled group of corporations, whether or not it becomes a member of another controlled group of corporations, is a stock sale.

- (c) An asset sale is a transfer of substantial assets, such as a plant or division or substantially all the assets of a trade or business.
- (d) The rules of Sec. 1.414(b)-1 of this chapter apply in determining what constitutes a controlled group of corporations, and the rules of Secs. 1.414(c)-1 through 1.414(c)-5 of this chapter apply in determining what constitutes a group of trades or businesses under common control.

Q-2: In the case of a stock sale, what are the selling group, the acquired organization, and the buying group?

In the case of a stock sale--

- (a) The selling group is the controlled group of corporations, or the group of trades or businesses under common control, of which a corporation ceases to be a member as a result of the stock sale;
- (b) The acquired organization is the corporation that ceases to be a member of the selling group as a result of the stock sale; and
- (c) The buying group is the controlled group of corporations, or the group of trades or businesses under common control, of which the acquired organization becomes a member as a result of the stock sale. If the acquired organization does not become a member of such a group, the buying group is the acquired organization.

Q-3: In the case of an asset sale, what are the selling group and the buying group?

In the case of an asset sale--

- (a) The selling group is the controlled group of corporations or the group of trades or businesses under common control that includes the corporation or other trade or business that is selling the assets; and
- (b) The buying group is the controlled group of corporations or the group of trades or businesses under common control that includes the corporation or other trade or business that is buying the assets.

Q-4: Who is an M&A qualified beneficiary?

- (a) Asset sales: In the case of an asset sale, an individual is an M&A qualified beneficiary if the individual is a qualified beneficiary whose qualifying event occurred prior to or in connection with the sale and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was associated with the assets being sold.
- (b) Stock sales: In the case of a stock sale, an individual is an M&A qualified beneficiary if the individual is a qualified beneficiary whose qualifying event occurred prior to or in connection with the sale and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the acquired organization.
- (c) In the case of a qualified beneficiary who has experienced more than one qualifying event with respect to her or his current right to COBRA continuation coverage, the qualifying event referred to in paragraphs (a) and (b) of this Q&A-4 is the first qualifying event.

Q-5: In the case of a stock sale, is the sale a qualifying event with respect to a covered employee who is employed by the acquired organization before the sale and who continues to be employed by the acquired organization after the sale, or with respect to the spouse or dependent children of such a covered employee?

No. A covered employee who continues to be employed by the acquired organization after the sale does not experience a termination of employment as a result of the sale. Accordingly, the sale is not a qualifying event with respect to the covered employee, or with respect to the covered employee's spouse or dependent children, regardless of whether they are provided with group health coverage after the sale, and neither the covered employee, nor the covered employee's spouse or dependent children, become qualified beneficiaries as a result of the sale.

Q-6: In the case of an asset sale, is the sale a qualifying event with respect to a covered employee whose employment immediately before the sale was associated with the purchased assets, or with respect to the spouse or dependent children of such a covered employee who are covered under a group health plan of the selling group immediately before the sale?

(a) Yes, unless--

- (1) The buying group is a successor employer under paragraph (c) of Q&A-8 of this section or Q&A-2 of Sec. 54.4980B-2, and the covered employee is employed by the buying group immediately after the sale; or
- (2) The covered employee (or the spouse or any dependent child of the covered employee) does not lose coverage (within the meaning of paragraph (c) in Q&A-1 of Sec. 54.4980B-4) under a group health plan of the selling group after the sale.

- (b) Unless the conditions in paragraph (a)(1) or (2) of this Q&A-6 are satisfied, such a covered employee experiences a termination of employment with the selling group as a result of the asset sale, regardless of whether the covered employee is employed by the buying group or whether the covered employee's employment is associated with the purchased assets after the sale. Accordingly, the covered employee, and the spouse and dependent children of the covered employee who lose coverage under a plan of the selling group in connection with the sale, are M&A qualified beneficiaries in connection with the sale.

Q-7: In a business reorganization, are the buying group and the selling group permitted to allocate by contract the responsibility to make COBRA continuation coverage available to M&A qualified beneficiaries?

Yes. Nothing in this section prohibits a selling group and a buying group from allocating to one or the other of the parties in a purchase agreement the responsibility to provide the coverage required under Secs. 54.4980B-1 through

54.4980B-10. However, if and to the extent that the party assigned this responsibility under the terms of the contract fails to perform, the party who has the obligation under Q&A-8 of this section to make COBRA continuation coverage available to M&A qualified beneficiaries continues to have that obligation.

Q-8: Which group health plan has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries in a business reorganization?

- (a) In the case of a business reorganization (whether a stock sale or an asset sale), so long as the selling group maintains a group health plan after the sale, a group health plan maintained by the selling group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that sale. This Q&A-8 prescribes rules for cases in which the selling group ceases to provide any group health plan to any employee in connection with the sale. Paragraph (b) of this Q&A-8 contains these rules for stock sales, and paragraph (c) of this Q&A-8 contains these rules for asset sales. Neither a stock sale nor an asset sale has any effect on the COBRA continuation coverage requirements applicable to any group health plan for any period before the sale.
- (b)(1) In the case of a stock sale, if the selling group ceases to provide any group health plan to any employee in connection with the sale, a group health plan maintained by the buying group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that stock sale. A group health plan of the buying group has this obligation beginning on the later of the following two dates and continuing as long as the buying group continues to maintain a group health plan (but subject to the rules in Sec. 54.4980B-7, relating to the duration of COBRA continuation coverage)--
- (i) The date the selling group ceases to provide any group health plan to any employee; or
 - (ii) The date of the stock sale.
- (2) The determination of whether the selling group's cessation of providing any group health plan to any employee is in connection with the stock sale is based on all of the relevant facts and circumstances. A group health plan of the buying group does not, as a result of the stock sale, have an obligation to make COBRA continuation coverage available to those qualified beneficiaries of the selling group who are not M&A qualified beneficiaries with respect to that sale.
- (c)(1) In the case of an asset sale, if the selling group ceases to provide any group health plan to any employee in connection with the sale and if the buying group continues the business operations associated with the assets purchased from the selling group without interruption or substantial change, then the buying group is a successor employer to the selling group in connection with that asset sale. A buying group does not fail to be a successor employer in connection with an asset sale merely because the asset sale takes place in connection with a proceeding in bankruptcy under Title 11 of the United States Code. If the buying group is a successor employer, a group health plan maintained by the buying group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that asset sale. A group health plan of the buying group has this obligation beginning on the later of the following two dates and continuing as long as the buying group continues to maintain a group health plan (but subject to the rules in Sec. 54.4980B-7, relating to the duration of COBRA continuation coverage)--
- (i) The date the selling group ceases to provide any group health plan to any employee; or
 - (ii) The date of the asset sale.
- (2) The determination of whether the selling group's cessation of providing any group health plan to any employee is in connection with the asset sale is based on all of the relevant facts and circumstances. A group health plan of the buying group does not, as a result of the asset sale, have an obligation to make COBRA continuation coverage available to those qualified beneficiaries of the selling group who are not M&A qualified beneficiaries with respect to that sale.
- (d) The rules of Q&A-1 through Q&A-7 of this section and this Q&A-8 are illustrated by the following examples; in each example, each group health plan is subject to COBRA:

Stock Sale Examples

Example 1. (i) Selling Group S consists of three corporations, A, B, and C. Buying Group P consists of two corporations, D and E. P enters into a contract to purchase all the stock of C from S effective July 1, 2002. Before the sale of C, S maintains a single group health plan for the employees of A, B, and C (and their families). P maintains a single group health plan for the employees of D and E (and their families). Effective July 1, 2002, the employees of C (and their families) become covered under P's plan. On June 30, 2002, there are 48 qualified beneficiaries receiving COBRA continuation coverage under S's plan, 15 of whom are M&A qualified beneficiaries with respect to the sale of C. (The other 33 qualified beneficiaries had qualifying events in connection with a covered employee whose last employment before the qualifying event was with either A or B.) (ii) Under these facts, S's plan continues to have the obligation to make COBRA continuation coverage available to the 15 M&A qualified beneficiaries under S's plan after the sale of C to P. The employees who continue in employment with C do not experience a qualifying event by virtue of P's acquisition of C. If they experience a qualifying event after the sale, then the group health plan of P has the obligation to make COBRA continuation coverage available to them.

Example 2. (i) Selling Group S consists of three corporations, A, B, and C. Each of A, B, and C maintains a group health plan for its employees (and their families). Buying Group P consists of two corporations, D and E. P enters into a contract to purchase all of the stock of C from S effective July 1, 2002. As of June 30, 2002, there are 14 qualified beneficiaries receiving COBRA continuation coverage under C's plan. C continues to employ all of its employees and continues to maintain its group health plan after being acquired by P on July 1, 2002.

(ii) Under these facts, C is an acquired organization and the 14 qualified beneficiaries under C's plan are M&A qualified beneficiaries. A group health plan of S (that is, either the plan maintained by A or the plan maintained by B) has the obligation to make COBRA continuation coverage available to the 14 M&A qualified beneficiaries. S and P could negotiate to have C's plan continue to make COBRA continuation coverage available to the 14 M&A qualified beneficiaries. In such a case, neither A's plan nor B's plan would make COBRA continuation coverage available to the 14 M&A qualified beneficiaries unless C's plan failed to fulfill its contractual responsibility to make COBRA continuation coverage available to the M&A qualified beneficiaries. C's employees (and their spouses and dependent children) do not experience a qualifying event in connection with P's acquisition of C, and consequently no plan maintained by either P or S has any obligation to make COBRA continuation coverage available to C's employees (or their spouses or dependent children) in connection with the transfer of stock in C from S to P.

Example 3. (i) The facts are the same as in Example 2, except that C ceases to employ two employees on June 30, 2002, and those two employees never become covered under P's plan.

(ii) Under these facts, the two employees experience a qualifying event on June 30, 2002 because their termination of employment causes a loss of group health coverage. A group health plan of S (that is, either the plan maintained by A or the plan maintained by B) has the obligation to make COBRA continuation coverage available to the two employees (and to any spouse or dependent child of the two employees who loses coverage under C's plan in connection with the termination of employment of the two employees) because they are M&A qualified beneficiaries with respect to the sale of C.

Example 4. (i) Selling Group S consists of three corporations, A, B, and C. Buying Group P consists of two corporations, D and E. P enters into a contract to purchase all of the stock of C from S effective July 1, 2002. Before the sale of C, S maintains a single group health plan for the employees of A, B, and C (and their families). P maintains a single group health plan for the employees of D and E (and their families). Effective July 1, 2002, the employees of C (and their families) become covered under P's plan. On June 30, 2002, there are 25 qualified beneficiaries receiving COBRA continuation coverage under S's plan, 20 of whom are M&A qualified beneficiaries with respect to the sale of C. (The other five qualified beneficiaries had qualifying events in connection with a covered employee whose last employment before the qualifying event was with either A or B.) S terminates its group health plan effective June 30, 2002 and begins to liquidate the assets of A and B and to lay off the employees of A and B.

(ii) Under these facts, S ceases to provide a group health plan to any employee in connection with the sale of C to P. Thus, beginning July 1, 2002 P's plan has the obligation to make COBRA continuation coverage available to the 20 M&A qualified beneficiaries, but P is not obligated to make COBRA continuation coverage available to the other 5 qualified beneficiaries with respect to S's plan as of June 30, 2002 or to any of the employees of A or B whose employment is terminated by S (or to any of those employees' spouses or dependent children).

Asset Sale Examples

Example 5. (i) Selling Group S provides group health plan coverage to employees at each of its operating divisions. S sells the assets of one of its divisions to Buying Group P. Under the terms of the group health plan covering the employees at the division being sold, their coverage will end on the date of the sale. P hires all but one of those employees, gives them the same positions that they had with S before the sale, and provides them with coverage under a group health plan. Immediately before the sale, there are two qualified beneficiaries receiving COBRA continuation coverage under a group health plan of S whose qualifying events occurred in connection with a covered employee whose last employment prior to the qualifying event was associated with the assets sold to P.

(ii) These two qualified beneficiaries are M&A qualified beneficiaries with respect to the asset sale to P. Under these facts, a group health plan of S retains the obligation to make COBRA continuation coverage available to these two M&A qualified beneficiaries. In addition, the one employee P does not hire as well as all of the employees P hires (and the spouses and dependent children of these employees) who were covered under a group health plan of S on the day before the sale are M&A qualified beneficiaries with respect to the sale. A group health plan of S also has the obligation to make COBRA continuation coverage available to these M&A qualified beneficiaries.

Example 6. (i) Selling Group S provides group health plan coverage to employees at each of its operating divisions. S sells substantially all of the assets of all of its divisions to Buying Group P, and S ceases to provide any group health plan to any employee on the date of the sale. P hires all but one of S's employees on the date of the asset sale by S, gives those employees the same positions that they had with S before the sale, and continues the business operations of those divisions without substantial change or interruption. P provides these employees with coverage under a group health plan. Immediately before the sale, there are 10 qualified beneficiaries receiving COBRA continuation coverage under a group health plan of S whose qualifying events occurred in connection with a covered employee whose last employment prior to the qualifying event was associated with the assets sold to P.

(ii) These 10 qualified beneficiaries are M&A qualified beneficiaries with respect to the asset sale to P. Under these facts, P is a successor employer described in paragraph (c) of this Q&A-8. Thus, a group health plan of P has the obligation to make COBRA continuation coverage available to these 10 M&A qualified beneficiaries.

(iii) The one employee that P does not hire and the family members of that employee are also M&A qualified beneficiaries with respect to the sale. A group health plan of P also has the obligation to make COBRA continuation coverage available to these M&A qualified beneficiaries.

(iv) The employees who continue in employment in connection with the asset sale (and their family members) and who were covered under a group health plan of S on the day before the sale are not M&A qualified beneficiaries because P is a successor employer to S in connection with the asset sale. Thus, no group health plan of P has

any obligation to make COBRA continuation coverage available to these continuing employees with respect to the qualifying event that resulted from their losing coverage under S's plan in connection with the asset sale.

Example 7. (i) Selling Group S provides group health plan coverage to employees at each of its two operating divisions. S sells the assets of one of its divisions to Buying Group P1. Under the terms of the group health plan covering the employees at the division being sold, their coverage will end on the date of the sale. P1 hires all but one of those employees, gives them the same positions that they had with S before the sale, and provides them with coverage under a group health plan.

(ii) Under these facts, a group health plan of S has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the sale to P1. (If an M&A qualified beneficiary first became covered under P1's plan after electing COBRA continuation coverage under S's plan, then S's plan could terminate the COBRA continuation coverage once the M&A qualified beneficiary became covered under P1's plan, provided that the remaining conditions of Q&A-2 of Sec. 54.4980B-7 were satisfied.)

(iii) Several months after the sale to P1, S sells the assets of its remaining division to Buying Group P2, and S ceases to provide any group health plan to any employee on the date of that sale. Thus, under Q&A-1 of Sec. 54.4980B-7, S ceases to have an obligation to make COBRA continuation coverage available to any qualified beneficiary on the date of the sale to P2. P1 and P2 are unrelated organizations.

(iv) Even if it was foreseeable that S would sell its remaining division to an unrelated third party after the sale to P1, under these facts the cessation of S to provide any group health plan to any employee on the date of the sale to P2 is not in connection with the asset sale to P1. Thus, even after the date S ceases to provide any group health plan to any employee, no group health plan of P1 has any obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to P1 by S. If P2 is a successor employer under the rules of paragraph (c) of this Q&A-8 and maintains one or more group health plans after the sale, then a group health plan of P2 would have an obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to P2 by S (but in such a case employees of S before the sale who continued working for P2 after the sale would not be M&A qualified beneficiaries). However, even in such a case, no group health plan of P2 would have an obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to P1 by S. Thus, under these facts, after S has ceased to provide any group health plan to any employee, no plan has an obligation to make COBRA

continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to P1.

Example 8. (i) Selling Group S provides group health plan coverage to employees at each of its operating divisions. S sells substantially all of the assets of all of its divisions to Buying Group P. P hires most of S's employees on the date of the purchase of S's assets, retains those employees in the same positions that they had with S before the purchase, and continues the business operations of those divisions without substantial change or interruption. P provides these employees with coverage under a group health plan. S continues to employ a few employees for the principal purpose of winding up the affairs of S in preparation for liquidation. S continues to provide coverage under a group health plan to these few remaining employees for several weeks after the date of the sale and then ceases to provide any group health plan to any employee.

(ii) Under these facts, the cessation by S to provide any group health plan to any employee is in connection with the asset sale to P. Because of this, and because P continued the business operations associated with those assets without substantial change or interruption, P is a successor employer to S with respect to the asset sale. Thus, a group health plan of P has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the sale beginning on the date that S ceases to provide any group health plan to any employee. (A group health plan of S retains this obligation for the several weeks after the date of the sale until S ceases to provide any group health plan to any employee.)

Q-9: Can the cessation of contributions by an employer to a multiemployer group health plan be a qualifying event?

The cessation of contributions by an employer to a multiemployer group health plan is not itself a qualifying event, even though the cessation of contributions may cause current employees (and their spouses and dependent children) to lose coverage under the multiemployer plan. An event coinciding with the employer's cessation of contributions (such as a reduction of hours of employment in the case of striking employees) will constitute a qualifying event if it otherwise satisfies the requirements of Q&A-1 of Sec. 54.4980B-4.

Q-10: If an employer stops contributing to a multiemployer group health plan, does the multiemployer plan have the obligation to make COBRA continuation coverage available to a qualified beneficiary who was receiving coverage under the multiemployer plan on the day before the cessation of contributions and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the employer that has stopped contributing to the multiemployer plan?

(a) In general, yes. (See Q&A-3 of Sec. 54.4980B-2 for a definition of multiemployer plan.) If, however, the employer that stops contributing to the multiemployer plan makes group health plan coverage available to (or starts contributing to another multiemployer plan that is a group health plan with respect to) a class of the employer's employees formerly covered under the multiemployer plan, the plan maintained by the employer (or the other multiemployer plan), from that date forward, has the obligation to make COBRA continuation coverage

available to any qualified beneficiary who was receiving coverage under the multiemployer plan on the day before the cessation of contributions and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the employer.

(b) The rules of Q&A-9 of this section and this Q&A-10 are illustrated by the following examples; in each example, each group health plan is subject to COBRA:

Example 1. (i) Employer Z employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan M. As required by the collective bargaining agreement, Z has been making contributions to M. Z experiences financial difficulties and stops making contributions to M but continues to employ all of the employees covered by the collective bargaining agreement. Z's cessation of contributions to M causes those employees (and their spouses and dependent children) to lose coverage under M. Z does not make group health plan coverage available to any of the employees covered by the collective bargaining agreement.

(ii) After Z stops contributing to M, M continues to have the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to M and whose coverage under M on the day before the qualifying event was due to an employment affiliation with Z. The loss of coverage under M for those employees of Z who continue in (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 2. (i) The facts are the same as in Example 1 except that B, one of the employees covered under M before Z stops contributing to M, is transferred into management. Z maintains a group health plan for managers and B becomes eligible for coverage under the plan on the day of B's transfer.

(ii) Under these facts, Z does not make group health plan coverage available to a class of employees formerly covered under M after B becomes eligible under Z's group health plan for managers. Accordingly, M continues to have the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to M and whose coverage under M on the day before the qualifying event was due to an employment affiliation with Z.

Example 3. (i) Employer Y employs two classes of employees skilled and unskilled laborers covered by a collective bargaining agreement and participating in multiemployer group health plan M. As required by the collective bargaining agreement, Y has been making contributions to M. Y stops making contributions to M but continues to employ all the employees covered by the collective bargaining agreement. Y's cessation of contributions to M causes those employees (and their spouses and dependent children) to lose coverage under M. Y makes group health plan coverage available to the skilled laborers immediately after their coverage ceases under M, but Y does not make group health plan coverage available to any of the unskilled laborers.

(ii) Under these facts, because Y makes group health plan coverage available to a class of employees previously covered under M immediately after both classes of employees lose coverage under M, Y alone has the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to M and whose coverage under M on the day before the qualifying event was due to an employment affiliation with Y, regardless of whether the employment affiliation was as a skilled or unskilled laborer. However, the loss of coverage under M for those employees of Y who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 4. (i) Employer X employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan M. As required by the collective bargaining agreement, X has been making contributions to M. X experiences financial difficulties and is forced into bankruptcy by its creditors. X continues to employ all of the employees covered by the collective bargaining agreement. X also continues to make contributions to M until the current collective bargaining agreement expires, on June 30, 2001, and then X stops making contributions to M. X's employees (and their spouses and dependent children) lose coverage under M effective July 1, 2001. X does not enter into another collective bargaining agreement covering the class of employees covered by the expired collective bargaining agreement. Effective September 1, 2001, X establishes a group health plan covering the class of employees formerly covered by the collective bargaining agreement. The group health plan also covers their spouses and dependent children.

(ii) Under these facts, M has the obligation to make COBRA continuation coverage available from July 1, 2001 until August 31, 2001, and the group health plan established by X has the obligation to make COBRA continuation coverage available from September 1, 2001 until the obligation ends (see Q&A-1 of Sec. 54.4980B-7) to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to M and whose coverage under M on the day before the qualifying event was due to an employment affiliation with X. The loss of coverage under M for those employees of X who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 5. (i) Employer W employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan M. As required by the collective bargaining agreement, W has been making contributions to M. The employees covered by the collective bargaining agreement vote to decertify their current employee representative effective January 1, 2002 and vote to certify a new employee representative effective the same date. As a consequence, on January 1, 2002 they cease to be covered under M and commence to be covered under multiemployer group health plan N.

(ii) Effective January 1, 2002, N has the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to M and whose coverage under M on the day before the qualifying event was due to an

employment affiliation with W. The loss of coverage under M for those employees of W who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Sec. 54.4980B-10 Interaction of FMLA and COBRA.

The following questions-and-answers address how the taking of leave under the Family and Medical Leave Act of 1993 (FMLA) (29 U.S.C. 2601-2619) affects the COBRA continuation coverage requirements:

Q-1: In what circumstances does a qualifying event occur if an employee does not return from leave taken under FMLA?

- (a) The taking of leave under FMLA does not constitute a qualifying event. A qualifying event under Q&A-1 of Sec. 54.4980B-4 occurs, however, if--
- (1) An employee (or the spouse or a dependent child of the employee) is covered on the day before the first day of FMLA leave (or becomes covered during the FMLA leave) under a group health plan of the employee's employer;
 - (2) The employee does not return to employment with the employer at the end of the FMLA leave; and
 - (3) The employee (or the spouse or a dependent child of the employee) would, in the absence of COBRA continuation coverage, lose coverage under the group health plan before the end of the maximum coverage period.
- (b) However, the satisfaction of the three conditions in paragraph
- (a) of this Q&A-1 does not constitute a qualifying event if the employer eliminates, on or before the last day of the employee's FMLA leave, coverage under a group health plan for the class of employees (while continuing to employ that class of employees) to which the employee would have belonged if the employee had not taken FMLA leave.

Q-2: If a qualifying event described in Q&A-1 of this section occurs, when does it occur, and how is the maximum coverage period measured?

A qualifying event described in Q&A-1 of this section occurs on the last day of FMLA leave. (The determination of when FMLA leave ends is not made under the rules of this section. See the FMLA regulations, 29 CFR Part 825 (Secs. 825.100-825.800).) The maximum coverage period (see Q&A-4 of Sec. 54.4980B-7) is measured from the date of the qualifying event (that is, the last day of FMLA leave). If, however, coverage under the group health plan is lost at a later date and the plan provides for the extension of the required periods (see paragraph (b) of Q&A-4 of Sec. 54.4980B-7), then the maximum coverage period is measured from the date when coverage is lost. The rules of this Q&A-2 are illustrated by the following examples:

Example 1. (i) Employee B is covered under the group health plan of Employer X on January 31, 2001. B takes FMLA leave beginning February 1, 2001. B's last day of FMLA leave is 12 weeks later, on April 25, 2001, and B does not return to work with X at the end of the FMLA leave. If B does not elect COBRA continuation coverage, B

will not be covered under the group health plan of X as of April 26, 2001.

(ii) B experiences a qualifying event on April 25, 2001, and the maximum coverage period is measured from that date. (This is the case even if, for part or all of the FMLA leave, B fails to pay the employee portion of premiums for coverage under the group health plan of X and is not covered under X's plan. See Q&A-3 of this section.)

Example 2. (i) Employee C and C's spouse are covered under the group health plan of Employer Y on August 15, 2001. C takes FMLA leave beginning August 16, 2001. C informs Y less than 12 weeks later, on September 28, 2001, that C will not be returning to work. Under the FMLA regulations, 29 CFR Part 825 (Secs. 825.100-825.800), C's last day of FMLA leave is September 28, 2001. C does not return to work with Y at the end of the FMLA leave. If C and C's spouse do not elect COBRA continuation coverage, they will not be covered under the group health plan of Y as of September 29, 2001.

(ii) C and C's spouse experience a qualifying event on September 28, 2001, and the maximum coverage period (generally 18 months) is measured from that date. (This is the case even if, for part or all of the FMLA leave, C fails to pay the employee portion of premiums for coverage under the group health plan of Y and C or C's spouse is not covered under Y's plan. See Q&A-3 of this section.)

Q-3: If an employee fails to pay the employee portion of premiums for coverage under a group health plan during FMLA leave or declines coverage under a group health plan during FMLA leave, does this affect the determination of whether or when the employee has experienced a qualifying event?

No. Any lapse of coverage under a group health plan during FMLA leave is irrelevant in determining whether a set of circumstances constitutes a qualifying event under Q&A-1 of this section or when such a qualifying event occurs under Q&A-2 of this section.

Q-4: Is the application of the rules in Q&A-1 through Q&A-3 of this section affected by a requirement of state or local law to provide a period of coverage longer than that required under FMLA?

No. Any state or local law that requires coverage under a group health plan to be maintained during a leave of absence for a period longer than that required under FMLA (for example, for 16 weeks of leave rather than for the 12 weeks required under FMLA) is disregarded for purposes of determining when a qualifying event occurs under Q&A-1 through Q&A-3 of this section.

Q-5: May COBRA continuation coverage be conditioned upon reimbursement of the premiums paid by the employer for coverage under a group health plan during FMLA leave?

No. The U.S. Department of Labor has published rules describing the circumstances in which an employer may recover premiums it pays to maintain coverage, including family coverage, under a group health plan during FMLA leave from an employee who fails to return from leave. See 29 CFR 825.213. Even if recovery of premiums is permitted under 29 CFR 825.213, the right to COBRA continuation coverage cannot be conditioned upon the employee's reimbursement of the employer for premiums the employer paid to maintain coverage under a group health plan during FMLA leave.

Approved: December 18, 2000.

Robert E. Wenzel,

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Jonathan Talisman,

Acting Assistant Secretary of the Treasury.

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