

†Health Benefits Under the Consolidation Omnibus Budget Reconciliation Act (COBRA)

U.S. Department of Labor

Pension and Welfare Benefits Administration
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Below is the complete text of a Department of Labor booklet on COBRA coverage, which is designed to provide employees with general information about their COBRA rights.

Introduction

Health insurance programs allow workers and their families to take care of essential medical needs. These programs can be one of the most important benefits provided by an employer.

There was a time when group health coverage may have been terminated when a worker lost his job or changed employment. That changed in 1986 with the passage of health benefit provisions in the Consolidated Omnibus Budget Reconciliation Act (COBRA). Now, terminated employees or those who lose coverage because of reduced work hours may be able to buy group coverage for themselves and their families for limited periods of time.

If you are entitled to COBRA benefits, your health plan must give you a notice stating your right to choose to continue benefits provided by the plan. You have 60 days to accept coverage or lose all rights to benefits. Once COBRA coverage is chosen, **you may be required to pay for the coverage.**

This booklet is designed to:

- ❖ Provide a general explanation of COBRA requirements.
- ❖ Outline the rules that apply to health plans for employees in the private sector.
- ❖ Spotlight **your** rights to benefits under this law.

What Is the Continuation Health Law?

Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act (COBRA)¹ health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.

COBRA contains provisions giving certain former employees, retirees, spouses and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available in specific instances. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves. It is ordinarily less expensive, though, than individual health coverage.

The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. It applies to plans in the private sector and those sponsored by state and local governments.² The law does not, however, apply to plans sponsored by the federal government and certain church-related organizations.

Group health plans sponsored by private sector employers generally are welfare benefit plans governed by ERISA and subject to its requirements for reporting and disclosure, fiduciary standards and enforcement. ERISA neither establishes minimum standards or benefit eligibility for welfare plans nor mandates the type or level of benefits offered to plan participants. It does, however, require that these plans have rules outlining how workers become entitled to benefits.

Under COBRA, a group health plan ordinarily is defined as a plan that provides medical benefits for the employer's own employees and their dependents through insurance or another mechanism such as a

¹The original health continuation provisions were contained in Title X of COBRA, which was signed into law (Public Law 99-272) on April 7, 1986.

²Provisions of COBRA covering state and local government plans are administered by the U.S. Public Health Service within the Department of Health and Human Services.

†Indicates revised material.

trust, health maintenance organization, self-funded pay-as-you-go basis, reimbursement or combination of these. Medical benefits provided under the terms of the plan and available to COBRA beneficiaries may include:

- ❖ Inpatient and outpatient hospital care
- ❖ Physical care
- ❖ Surgery and other major medical benefits
- ❖ Prescription drugs
- ❖ Any other medical benefits, such as dental and vision care

Life insurance, however, is not covered under COBRA.

Who Is Entitled to Benefits?

There are three elements to qualifying for COBRA benefits. COBRA establishes specific criteria for plans, beneficiaries and qualifying events.

Plan Coverage

Group health plans for employers with 20 or more employees on more than 50 percent of its typical days in the previous calendar year are subject to COBRA. Both full- and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of an employee,

with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered fulltime.

Beneficiary Coverage

A qualified beneficiary generally is an individual covered by a group health plan on the day before a qualifying event who is either an employee, the employee's spouse or an employee's dependent child. In certain cases, a retired employee, the retired employee's spouse and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary. Agents, independent contractors and directors who participate in the group health plan may also be qualified beneficiaries.

Qualifying Events

"Qualifying events" are certain types of events that would cause an individual to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and the amount of time that a plan must offer the health coverage to them under COBRA. A plan, at its discretion, may provide longer periods of continuation coverage. [See Fig 1840.]

Fig. 1840
Periods of Coverage³

Qualifying Events	Beneficiary	Coverage
Termination	Employee	18 months ⁴
Reduced hours	Spouse Dependent child	
Employee entitled to Medicare	Spouse	36 months
Divorce or legal separation	Dependent child	
Death of covered employee		
Loss of "dependent child" status	Dependent child	36 months

³The Omnibus Budget Reconciliation Act of 1986 contained amendments to the Internal Revenue Code and ERISA affecting retirees and family members who receive post-retirement health coverage from employers involved in bankruptcy proceedings begun on or after July 1, 1986. This booklet does not address that group.

⁴In the case of individuals who are disabled within the meaning of the "Social Security Act," special rules may apply to extend coverage an additional 11 months to that individual and other individuals who are qualified beneficiaries with respect to the same qualifying event. (See page 13 of this publication for more information.)

The qualifying events for **employees** are:

- ❖ Voluntary or involuntary termination of employment for reasons other than “gross misconduct”
- ❖ Reduction in the number of hours of employment

The qualifying events for **spouses** are:

- ❖ Voluntary or involuntary termination of the covered employee’s employment for any reason other than “gross misconduct”
- ❖ Reduction in the hours worked by the covered employee
- ❖ Covered employee’s becoming entitled to Medicare
- ❖ Divorce or legal separation of the covered employee
- ❖ Death of the covered employee

The qualifying events for **dependent children** are the same as for the spouse with one addition:

- ❖ Loss of “dependent child” status under the plan rules

Your Rights: Notice and Election Procedures

COBRA outlines how employees and family members may elect continuation coverage. It also requires employers and plans to notify qualified beneficiaries.

Notice Procedures

General COBRA rights must be described in the summary plan description (SPD) that all participants receive. ERISA requires employers to furnish modified and updated SPDs containing certain plan information and summaries of material changes in plan requirements. Plan administrators must automatically furnish the SPD 90 days after a person becomes a participant or a beneficiary begins receiving benefits or within 120 days after the plan is first subject to the reporting and disclosure provisions of ERISA.

Initial Notices

Generally, an initial notice describing COBRA rights must be furnished to covered employees and their spouses at the time coverage under the plan commences.

Other Notices

These notice requirements are triggered for employers, qualified beneficiaries and plan administrators when a qualifying event occurs. Employers must notify plan administrators of a qualifying event within 30 days after an employee’s death, termination, reduced hours of employment or entitlement to Medicare.

A qualified beneficiary must notify the plan administrator of a qualifying event within 60 days after divorce or legal separation or a child’s ceasing to be covered as a dependent under plan rules.

Plan administrators, upon receiving notice of a qualifying event, must provide an election notice to the qualified beneficiaries of their right to elect COBRA coverage. The notice must be provided in person or by first class mail within 14 days after the plan administrator receives notice that a qualifying event has occurred.

There are two special exceptions to the notice requirements for multi-employer plans. First, the time frame for providing notices may be extended beyond the 14- and 30-day requirements if allowed by plan rules. Second, employers are relieved of the obligation to notify plan administrators when employees terminate or reduce their work hours. Plan administrators are responsible for determining whether these qualifying events have occurred.

Qualified beneficiaries who wish to take advantage of the 11-month disability extension must notify plan administrators of the disabled qualified beneficiary’s Social Security disability determinations. A notice must be provided within 60 days of a disability determination and prior to expiration of the initial 18-month period of COBRA coverage. These beneficiaries also must notify the plan if the qualified beneficiary is determined by Social Security to be no longer disabled.

Election

Qualified beneficiaries must be given an election period during which each qualified beneficiary may choose whether to elect COBRA coverage. Qualified beneficiaries must be given at least 60 days for the election. This period is measured from the later of the coverage loss date or the date the COBRA election notice is provided. COBRA coverage is retroactive if elected and paid for by the qualified beneficiary.

Each qualified beneficiary may independently elect COBRA coverage. A covered employee or the covered employee's spouse, however, may elect COBRA coverage on behalf of all other qualified beneficiaries. A parent or legal guardian may elect on behalf of a minor child.

If a qualified beneficiary waives COBRA coverage during the election period, he or she may revoke the waiver of coverage before the end of the election period. A beneficiary may then elect COBRA coverage. Then, the plan need only provide continuation coverage beginning on the date the waiver is revoked.

How COBRA Coverage Works

Example 1:

John Q. participates in the group health plan maintained by the ABC Co. John is fired for a reason other than gross misconduct and his health coverage is terminated. If his employer properly notifies the plan administrator, John may elect a maximum of 18 months of COBRA coverage under the employer's group health plan. He may be required to pay a premium of up to 102 percent of the lost to the plan for the coverage. (See *Paying for COBRA Coverage* on page 15.)

Example 2:

Day laborer David P. has health coverage through his wife's plan sponsored by the XYZ Co. David loses his health coverage when he and his wife become divorced. David may elect COBRA coverage under the plan of his former wife's employer if he or his former wife notifies the plan administrator of the divorce not more than 60 days after it becomes final. Since in this case divorce is the qualifying event under COBRA, David is entitled to a maximum of 36 months of COBRA coverage.

Example 3:

RST, Inc. is a small business which maintained an insured group health plan for its 10 employees in 1997 and 1998. Mary H., a secretary with six years of service, leaves in June 1998 to take a position with a competing firm which has no health plan. She is not entitled to COBRA coverage with the plan of RST, Inc. since the firm had fewer than 20 employees in 1997 and is not subject to COBRA requirements.

Covered Benefits

Qualified beneficiaries must be offered coverage identical to that available to similarly situated beneficiaries who are not receiving COBRA coverage under the plan (generally, the same coverage that the qualified beneficiary had immediately before qualifying for continuation coverage).

For example, a beneficiary may have had medical, hospitalization, dental, vision and prescription benefits under single or multiple plans maintained by the employer. Assuming a qualified beneficiary had been covered by three separate health plans of his former employer on the day preceding the qualifying event, that individual generally will have the right to elect to continue coverage in any of the three health plans.

A change in the benefits under the plan for active employees will also apply to qualified beneficiaries. Qualified beneficiaries must be allowed to make the same choices given to non-COBRA beneficiaries under the plan, such as during periods of open enrollment by the plan.

Duration of Coverage

COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA beneficiaries generally are eligible to pay for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Coverage **begins** on the date that coverage would otherwise have been lost by reason of a qualifying event and will end at the end of the maximum period. It may end earlier if:

- ❖ Premiums are not paid on a timely basis
- ❖ The employer ceases to maintain any group health plan
- ❖ After the COBRA election, coverage is obtained with another employer group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.
- ❖ After the COBRA election, a beneficiary becomes entitled to Medicare benefits. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

Special rules for disabled individuals and certain family members may extend the maximum periods of coverage. If a qualified beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled within the first 60 days of COBRA coverage, then that qualified beneficiary and all of the qualified beneficiaries in his or her family may be able to extend COBRA continuation coverage for up to an additional 11 months. However, qualified beneficiaries should be aware that they may lose all rights to the additional 11 months of coverage if notice of the determination is not provided within 60 days of the date of the determination and before the expiration of the 18-month COBRA continuation period. The qualified beneficiary who is disabled or any qualified beneficiaries in his or her family may notify the plan administrator of the determination.

Although COBRA specifies certain periods of time that continued health coverage must be offered to qualified beneficiaries, COBRA does not prohibit plans from offering continuation health coverage that goes beyond the COBRA periods.

Some plans allow participants and beneficiaries to convert group health coverage to an individual policy.

If this option is available from the plan, you have the right to exercise the option under COBRA when you reach the end of your COBRA continuation coverage. The option must be given to enroll in a conversion health plan within 180 days before COBRA coverage ends. The premium for a conversion policy may be more expensive than the premium of a group plan, and the conversion policy may provide a lower level of coverage. The conversion option, however, is not available if the beneficiary ends COBRA coverage before reaching the end of the maximum period of COBRA coverage.

Paying for COBRA Coverage

Beneficiaries may be required to pay for COBRA coverage. The premium cannot exceed 102 percent of the cost to the plan for similarly situated individuals who have not incurred a qualifying event, including both the portion paid by employees and any portion paid by the employer before the qualifying event, plus 2 percent for administrative costs.

For qualified beneficiaries receiving an additional 11-month disability extension of coverage, the premium for those additional months may be increased to 150 percent of the plan's total cost of coverage.

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

The initial premium must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the loss of coverage due to the qualifying event. Premiums for successive periods of coverage are due on the date stated in the plan with a minimum 30-day grace period for payments. Payment is considered to be made on the date it is sent to the plan.

If premiums are not paid by the first day of the period of coverage, the plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

If the amount of the payment made to the plan is made in error but is not significantly less than the amount due, the plan is required to notify you of the deficiency and grant a reasonable period (for this purpose, 30 days is considered reasonable) to pay the difference. The plan is not obligated to send monthly premium notices. COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to copayments and deductibles, and are subject to catastrophic and other benefit limits.

Claims Procedures

Health plan rules must explain how to obtain benefits and must include written procedures for processing claims. Claims procedures must be described in the SPD booklet.

You should submit a claim for benefits in accordance with the plan's rule for filing claims. If the claim is denied, you must be given notice of the denial in writing generally within 90 days after the claim is filed. The notice should state the reasons for the denial, any additional information needed to support the claim and procedures for appealing the denial.

You will have at least 60 days to appeal a denial and you must receive a decision on the appeal generally within 60 days after that.

Contact the plan administrator for more information on filing a claim for benefits. Complete plan rules are available from employers or benefits offices. There can be charges up to 25 cents a page for copies of plan rules.

Coordination With Other Benefits

The Family and Medical Leave Act (FMLA), effective August 5, 1993, requires an employer to maintain coverage under any "group health plan" for an employee on FMLA leave under the same conditions coverage would have been provided if the employee had continued working. Coverage provided under the **FMLA is not COBRA coverage**, and FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an employer's obligation to maintain health benefits under FMLA cases, such as when an employee notifies an employer of his or her intent not to return to work.

Further information on FMLA is available from the nearest office of the Wage and Hour Division,

listed in most telephone directories under U.S. Government, Department of Labor, Employment Standards Administration.

Role of the Federal Government

Continuation coverage laws are administered by several agencies. The Departments of Labor and Treasury have jurisdiction over private-sector health plans. The United States Public Health Service administers the continuation coverage law as it affects public-sector health plans.

The Labor Department's interpretative and regulatory responsibility is limited to the disclosure and notification requirements. If you need further information on your election or notification rights with a private-sector plan, write to the nearest office of the Pension and Welfare Benefits Administration. [*Editor's Note:* This agency is now known as the Employee Benefits Security Administration (EBSA).] Consult the "U.S. Government, U.S. Department of Labor" listing in your telephone directory for the office nearest you or call toll free 1-800-998-7542 and request a list of PWBA Regional Offices. Or write to:

**U.S. Department of Labor
Pension and Welfare Benefits Administration
Division of Technical Assistance and Inquiries
200 Constitution Ave., N.W. (Room N-5619)
Washington, D.C. 20210**

The Internal Revenue Service, which is in the Department of the Treasury, has issued regulations on COBRA provisions relating to eligibility, coverage and premiums in 26 CFR Part 54, "Continuation Coverage Requirements Applicable to Group Health Plans." Both the Departments of Labor and Treasury share jurisdiction for enforcement of these provisions.

The Department of Health and Human Services has published Title XXII of the Public Health Service Act entitled "Requirements for Certain Group Health Plans for Certain State and Local Employees." Information about COBRA provisions for public-sector employees is available from the:

**U.S. Department of Health and Human Services
Division of Cost Allocations (COBRA)
Room 1067, Cohen Building
330 Independence Ave., S.W.
Washington, D.C. 20201**

Federal employees are covered by a law similar to COBRA. Those employees should contact the personnel office serving their agency for more information on temporary extensions of health benefits.

Conclusion

Rising medical costs have transformed health benefits from a privilege to household necessity for most Americans. COBRA creates an opportunity for persons to retain this important benefit.

Workers need to be aware of changes in health care laws to preserve their benefit rights. A good starting point is reading your summary plan description (SPD) booklet. Most of the specific rules on COBRA benefits can be found there or with the person who manages your health benefits plan.

Be sure to periodically contact the health plan to find out about any changes in the type or level of benefits offered by the plan.

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**NOTICE OF CHANGES UNDER HIPAA TO
COBRA CONTINUATION COVERAGE
UNDER GROUP HEALTH PLANS**

On Aug. 21, 1996, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law (Pub. Law 104-191). HIPAA section 421 makes changes, described below, to three areas in the continuation coverage rules applicable to group health plans under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as amended [*sic*]. These three areas relate to the disability extension, the definition of qualified beneficiary and the duration of COBRA continuation coverage. These changes are effective beginning Jan. 1, 1997, regardless of when the event occurs that entitles an individual to COBRA continuation coverage.

Section 421(e) of HIPAA requires group health plans that are subject to COBRA to notify, by Nov. 1, 1996, individuals who have elected COBRA continuation coverage of these changes. The Department is issuing this release to apprise employers and plan administrators of the changes in the continuation coverage rules made by HIPAA and to inform them of their obligation under HIPAA to notify qualified beneficiaries of such changes. Such notification must be given to qualified beneficiaries by Nov. 1, 1996. The following is a discussion of the specific changes in the continuation coverage rules made by HIPAA.

Disability Extension. Under current law, if an individual is entitled to COBRA continuation coverage because of a termination of employment or reduction in hours of employment, the plan generally is only required to make COBRA continuation coverage available to that individual for 18 months. However, if the individual entitled to the COBRA continuation

coverage is disabled (as determined under the Social Security Act) and satisfies the applicable notice requirements, the plan must provide COBRA continuation coverage for 29 months, rather than 18 months. Under current law, the individual must be disabled at the time of the termination of employment or reduction in hours of employment. HIPAA makes changes to the current law to provide that, beginning Jan. 1, 1997, the disability extension will also apply if the individual becomes disabled at any time during the first 60 days of COBRA continuation coverage. HIPAA also makes clear that, if the individual entitled to the disability extension has nondisabled family members who are entitled to COBRA continuation coverage, those nondisabled family members are also entitled to the 29-month disability extension.

Definition of Qualified Beneficiary. Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain cases, the covered employee. Under current law, in order to be a qualified beneficiary, an individual must generally be covered under a group health plan on the day before the event that causes a loss of coverage (such as a termination of employment or a divorce from or death of the covered employee). HIPAA changes this requirement so that a child who is born to the covered employee, or who is placed for adoption with the covered employee, during a period of COBRA continuation coverage is also a qualified beneficiary.

Duration of COBRA Continuation Coverage. Under the COBRA rules there are situations in which a group health plan may stop making COBRA continuation coverage available earlier than usually permitted. One of those situations is where the qualified beneficiary obtains coverage under another group health plan. Under current law, if the other group health plan limits or excludes coverage for any pre-existing condition of the qualified beneficiary, the plan providing the COBRA continuation coverage cannot stop making the COBRA continuation coverage available merely because of the coverage under the other group health plan. HIPAA limits the circumstances in which plans can apply exclusions for pre-existing conditions. HIPAA makes a coordinating change to the COBRA rules so that if a group health plan limits or excludes benefits for pre-existing conditions but because of the