



The Vita Viewpoint Important Information for Decision Makers

Summary of Salient Changes to COBRA Regs

Changing Coverage / Adding Dependents

Qualified Beneficiaries: A covered employee who had retired on or before the day of bankruptcy of the employer, is also a qualified beneficiary (the definition of qualified beneficiary specifies newborns, adopted children, surviving spouse or dependent child of the covered employee).

Pre-Existing Coverage: The *Geissal vs. Moore Medical Clinic* decision prevents group health plans from terminating COBRA continuation coverage on the basis of other coverage that a qualified beneficiary had prior to electing COBRA continuation coverage. This decision eliminated the “substantial reduction” line of reasoning from lower courts.

Open Enrollment Rights: Open enrollment rights must be extended to qualified beneficiaries in any situation where they are extended to similarly situated employees. A similarly situated employee is defined as the group of covered employees, spouses of covered employees, or dependent children of covered employees receiving coverage under a group health plan.

Change in Family Status: Qualified beneficiaries have the same rights as active employees to add new family members. The regulations define which dependent additions are considered qualified beneficiaries with full COBRA rights and which are merely covered under COBRA.

Changes to Coverage: Qualified beneficiaries need only be offered the coverage in effect immediately before the qualifying event, regardless if the coverage ceases to be of value. If a qualified beneficiary moves out of state and was enrolled in an HMO plan, the employer **must** allow a change of coverage if they maintain an existing plan for similarly situated non-COBRA beneficiaries. Open enrollment rights must be extended to qualified beneficiaries in the same manner they are extended to similarly situated active employees. Employers must also comply with the special HIPAA open enrollment rights.

Region-Specific Plans: Employers must provide coverage for a qualified beneficiary who moves out of the service area of the current plan if the employer maintains a plan that provides out of area coverage for active employees.

Coverage Subject to COBRA

Core and Non-Core Coverage: Employers are no longer required to offer medical coverage (core coverage) alone if they have “bundled” health plans. “Bundled” health plans are plans that offer medical, dental and vision coverage as one plan, subject to an individual contribution.

Coverage Subject to COBRA (Continued)

Health Care Flexible Spending Accounts: Employers are not required to offer Health Care Spending Accounts *after* the plan year ends if: the benefits provided are excepted benefits under HIPAA, *or* if the amount paid into the plan will be greater than the amount which could be paid out (in most cases this would be true because the continuation of FSA benefits under COBRA does not provide a tax savings and is subject to a 2% administration fee). If the maximum benefit available is less than the amount required as payment, COBRA continuation coverage for the FSA need not be offered at all.

Group Health Plan: Considered exceptions that Medical Spending Accounts (MSAs) and Long Term Care (LTC) insurance are not group health plans.

Coverage Termination Provisions

Terminating COBRA Coverage “For Cause”: If a plan terminates the coverage of an active employee for submitting a fraudulent claim, then COBRA coverage may be terminated for the same reason. It is important that employers act consistently between active employees and COBRA qualified beneficiaries.

Medicare Part A and B Entitlement: COBRA coverage may be terminated if a qualified beneficiary becomes entitled to (and actually covered under) Medicare part A or B subsequent to their election of COBRA. COBRA coverage may not be terminated if the qualified beneficiary is entitled to (and actually covered under) Medicare part A or B prior to their election of COBRA.

Premium Provisions

Premium Payment: Any individual can pay COBRA premiums on behalf of a qualified beneficiary. Additionally, weekly payments may also be accepted toward paying monthly premiums in full.

Premium Increases: COBRA requires that premiums cannot increase during the 12-month determination period. New regulations clarify that premiums may only increase during the 12-month determination under three circumstances: 1) Upon a disability extension; 2) A plan requires payment that is less than the maximum amount of the premium; 3) A qualified beneficiary changes to more expensive coverage (premiums must be reduced if the qualified beneficiary changes to less expensive coverage).

Initial Premium: The option of having qualified beneficiaries' first payment for COBRA coverage apply prospectively does not have to be given. For example, if Jane Doe terminates on January 31, 1999 and elects COBRA on March 31, 1999, the initial premium payment should be for the month of February and not the month of April.

Partial Premium Payments: When a premium payment is short by an “insignificant amount,” the plan must either treat the payment as satisfying plan requirements or notify the qualified beneficiary of the premium underpayment and provide a reasonable period of time to pay the deficiency (30 days is considered reasonable). An “insignificant amount” is not defined.

Disability Provisions

Disability Extension: The new regulations clarify that a determination that a qualified beneficiary is no longer disabled, allows termination of COBRA continuation for all qualified beneficiaries who were entitled to the disability extension. However, this does not allow for termination prior to the end of the coverage period that qualified beneficiaries were entitled to without the disability extension.

Disability Extension Premiums for the Nondisabled: When only nondisabled family members continue coverage during the 11 month disability extension, they can only be charged 102 percent of the applicable premium. The rate can be 150% of the premium if the disabled individual is part of the coverage group.

Employer Provisions

Small-Employer (<20) Exception: Part-time employees are now counted as a fraction of a full-time employee in calculating whether the employer has 20 employees (Employing 20 or more employees for over half the business days makes an employer subject to federal COBRA regulations). In addition, employers can use pay periods instead of business days for counting purposes. The new regulations modify the term "controlled group" to include foreign members when determining if an employer qualifies for the small-employer exception. Only common law employees are counted.

Determining the Number of Group Health Plans: Employers can generally establish the separate identity and number of its group health plans under which it provides health benefits to employees.

Employer Withdrawals From Multi-Employer Plans: New regulations state that the plan must make COBRA Continuation Coverage available to all qualified beneficiaries losing coverage because of the withdrawal.

Excise Tax Sanctions: Employers can be penalized with an excise tax of \$100 per individual (\$200 per family maximum) per day for non-compliance with the COBRA regulations. Under some circumstances the excise tax may be imposed on an insurer providing benefits under the plan or a third party administrator administering claims under the plan.

Miscellaneous

Multiple Qualifying Events: A termination of employment following a qualifying event of a reduction of hours is not considered a multiple qualifying event that extends the maximum coverage period. Termination of employment and reduction of hours are not considered different types of qualifying events.

Business Reorganizations: The new regulations establish rules for determining COBRA liabilities. Essentially they require that some business entity must retain responsibility for the ongoing COBRA rights of qualified beneficiaries.

Interaction of FMLA and COBRA: The rules in the new regulations are substantially the same as the rules in IRS notice 94-103.

Miscellaneous (Continued)

Elections by Third Party: New regulations illustrate the fact that COBRA continuation coverage can be elected by a third party. For example, if Jane Doe becomes incapacitated during her 60 day election period for any reason and is unable to sign her COBRA election form, John Doe or any other entity, may elect COBRA Continuation Coverage on behalf of Jane Doe.

Deductibles: In calculating limits and deductibles, the plan must only focus on expenses incurred prior to the qualifying event by family members who elect COBRA continuation coverage through health plans which are "bundled". For example, a group health plan applies a separate \$100 annual deductible to each individual it covers. A covered employee dies on September 1, 1999 and coverage for the employee's spouse and children runs until the end of the month. The spouse and children elect COBRA Coverage, which begins October 1, 1999. As of September 15th the spouse has incurred \$50 of covered expenses, child 1 has incurred \$110 of expenses and child 2 has incurred \$0 of expenses. At the beginning of COBRA coverage, October 1, 1999, the spouse has a remaining deductible of \$50, child 1 has the full deductible of \$100 and child 2 has no further deductible.

Provider Inquiries: Stipulates that the plan must inform the provider about the status of COBRA coverage and election, even if the qualified beneficiary has not yet paid for or elected COBRA coverage. Specifically, provider must be informed of qualified beneficiaries right to elect COBRA and the retroactive nature of coverage if elected and paid for in a timely manner.

Plan Year: The rule has changed for determining a plan year so that it is consistent with temporary regulations under HIPAA. Under HIPAA, a Plan Year is the year that is designated as the Plan Year in a group health plan document.

For questions or additional information, please contact Vita Benefits Group at (650) 968-8811.