HEALTH BENEFITS UNDER COBRA

THE CONSOLIDATED OMNIBUS RECONCILLIATION ACT

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

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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 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
- Physician 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.

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

<2>Provisions 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.

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Who is Entitled to Benefits?

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

Plan Coverage

Group health plans for employers with 20 or more employees on more than 50 percent of the working days in the previous calendar year are subject to COBRA. The term "employees" includes all full-time and part-time employees, as well as self-employed individuals. For this purpose, the term employees also includes agents, independent contractors and directors, but only if they are eligible to participate in a group health plan.

Beneficiary Coverage

A qualified beneficiary generally is any individual covered by a group health plan on the day before a qualifying event. A qualified beneficiary may be an employee, the employee's spouse and dependent children, and in certain cases, a retired employee, the retired employee's spouse and dependent children.

Qualifying Events

"Qualifying events" are certain types of events that would cause, except for COBRA continuation coverage, an individual to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and the required 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.

The types of 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 types of qualifying events for **spouses** are:

- 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 types of qualifying events for **dependent children** are the same as for the spouse with one addition:

- Loss of "dependent child" status under the plan rules

Periods of Coverage[3]

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

<3>The 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.

<4>In the case of individuals who qualify for Social Security disability benefits, special rules apply to extend coverage an additional 11 months.

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Your Rights: Notice and Election Procedures

COBRA outlines procedures for employees and family members to elect continuation coverage and for employers and plans to notify beneficiaries. The qualifying events contained in the law create rights and obligations for employers, plan administrators and qualified beneficiaries.

Qualified beneficiaries have the right to elect to continue coverage that is identical to the coverage provided under the plan. Employers and plan administrators have an obligation to determine the specific rights of beneficiaries with respect to election, notification and type of coverage options.

Notice Procedures

General Notices

An initial general notice must be furnished to covered employees, their spouses and newly hired employees informing them of their rights under COBRA and describing provisions of the law.

COBRA information also is required to be contained in the summary plan description (SPD) which 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 booklet 90 days after a person becomes a participant or a beneficiary begins receiving benefits or within 120 days after the plan is subject to the reporting and disclosure provisions of the law.

Specific Notices

Specific notice requirements are triggered for employers, qualified beneficiaries and plan administrators when a qualifying event occurs. Employers must notify plan administrators within 30 days after an employee's death, termination, reduced hours of employment or entitlement to Medicare. Multiemployer plans may provide for a longer period of time.

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

Disabled beneficiaries must notify plan administrators of Social Security disability determinations. A notice must be provided within 60 days of a disability determination and prior to expiration of the 18-month period of COBRA

coverage. These beneficiaries also must notify the plan administrator within 30 days of a final determination that they are no longer disabled.

Plan administrators, upon notification of a qualifying event, must automatically provide a notice to employees and family members of their right to elect COBRA coverage. The notice must be provided in person or by first class mail within 14 days of receiving information that a qualifying event has occurred.

There are two special exceptions to the notice requirements for multiemployer 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.

Election

The election period is the time frame during which each qualified beneficiary may choose whether to continue health care coverage under an employer's group health plan. Qualified beneficiaries have a 60-day period to elect whether to continue coverage. This period is measured from the later of the coverage loss date or the date the notice to elect COBRA coverage is sent. COBRA coverage is retroactive if elected and paid for by the qualified beneficiary.

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

A waiver of coverage may be revoked by or on behalf of a qualified beneficiary before the end of the election period. A beneficiary may then reinstate coverage. Then, the plan need only provide continuation coverage beginning on the date the waiver is revoked.

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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. John may elect and pay for a maximum of 18 months of coverage by the employer's group health plan at the group rate. (See Paying for "COBRA Coverage")

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 purchase health coverage with the plan of his former wife's employer. 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 1987 and 1988. Mary H., a secretary with six years of service, leaves in June 1988 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 1987 and is not subject to COBRA requirements.

Example 4:

Jane W., a stock broker, left a brokerage firm in May 1990 to take a position with a chemical company. She was five months pregnant at the time. The health plan of the chemical company has a pre-existing condition clause for maternity benefits. Even though Jane signs up for the new employer's plan, she has the right to elect and receive coverage under the old plan for COBRA purposes because the new plan limits benefits for pre-existing conditions.

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Covered Benefits

Qualified beneficiaries must be offered coverage identical to those received 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 has the right to elect to continue coverage in any of the three health plans.

Non-core benefits are vision and dental services, except where they are mandated by law in which case they become core benefits. Core benefits include all other benefits received by a beneficiary immediately before qualifying for COBRA coverage.

If a plan provides both core and non-core benefits, individuals may generally elect either the entire package or just core benefits. Individuals do not have to be given the option to elect just the non-core benefits unless those were the only benefits carried under that particular plan before a qualifying event.

A change in the benefits under the plan for active employees may apply to qualified beneficiaries. Beneficiaries also may change coverage during periods of open enrollment by the plan.

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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 can **end** when:

- The last day of maximum coverage is reached
- Premiums are not paid on a timely basis
- The employer ceases to maintain any group health plan
- 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
- A beneficiary is entitled to Medicare benefits

Special rules for disabled individuals 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 at the time of a termination of employment or reduction in hours of employment and the qualified beneficiary properly notifies the plan administrator of the disability determination, the 18-month period is expanded to 29 months.

Although COBRA specifies certain maximum required 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 beneficiaries to convert group health coverage to an individual policy. If this option is available from the plan under COBRA, it must be offered to you. In this case, the option must be given for the beneficiary to enroll in a conversion health plan within 180 days before COBRA coverage ends. The premium is generally not at a group rate. The conversion option, however, is not available if the beneficiary ends COBRA coverage before reaching the maximum period of entitlement.

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Paying for COBRA Coverage

Beneficiaries may be required to pay the entire premium for coverage. The premium cannot exceed 102 percent of

the cost to the plan for similarly situated individuals who have not incurred a qualifying event. Premiums reflect the **total** cost of group health coverage, including both the portion paid by employees and any portion paid by the employer before the qualifying event, plus two percent for administrative costs.

For disabled beneficiaries receiving an additional 11 months of coverage after the initial 18 months, the premium for those additional months may be increased to 150% of the plan's total cost of coverage.

Premiums due 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.

The initial premium payment 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.

The due date may not be prior to the first day of the period of coverage. For example, the due date for the month of January could not be prior to January 1 and coverage for January could not be cancelled if payment is made by January 31.

Premiums for the rest of the COBRA period must be made within 30 days after the due date for each such premium or such longer period as provided by the plan. The plan, however, 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 deductibles, catastrophic and other benefit limits.

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Claims Procedures

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

You should submit a written claim for benefits to whomever is designated to operate the health plan (employer, plan administrator, etc.). If the claim is denied, notice of denial must be in writing and furnished 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 have 60 days to appeal a denial and must receive a decision on the appeal within 60 days after that unless the plan:

- provides for a special hearing, or
- the decision must be made by a group which meets only on a periodic basis.

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.

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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 ceases, 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.

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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. See PWBA Field Office Directory or:

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

The Internal Revenue Service, which is in the Department of the Treasury, is responsible for publishing regulations on COBRA provisions relating to eligibility and premiums. Both Labor and Treasury share jurisdiction for enforcement.

The U.S. Public Health Service, located in 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 concerning public sector employees is available from the:

- U.S. Public Health Service
- Office of the Assistant Secretary for Health
- Grants Policy Branch (COBRA)
- 5600 Fishers Lane
- (Room 17A-45)
- Rockville, Maryland 20857

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.

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Conclusion

Rising medical costs have transformed health benefits from a privilege to a 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 plan 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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