THE FIVE W's AND ONE H

COBRA

(Consolidate Omnibus Budget Reconciliation Act of 1985)

Who is required to offer COBRA?[1]

- All private sector employers with 20 or more employees on at least ½ of their typical business days during the preceding calendar year and that offer employer-sponsored group health plans.
- Private sector employers offering a group health plan whose employee count fluctuates above 20 employees during a calendar year, become subject to COBRA on the following first day of January.
- Private sector employers offering a group health plan whose employee count goes below 20 employees during a calendar year, will continue to offer COBRA through the end of that calendar year. (Existing COBRA participants coverage does not terminate even after the end of the calendar year.)
- Most state or local governmental employers (e.g., city, county, public schools) must comply with "public sector" COBRA.
- Churches and some church-related organizations can be exempt from COBRA.

1 Several states have their own "Mini-COBRA" laws. These laws may require employers with fewer than 20 employees and offer a fully insured plan to continue coverage under state insurance law. State Mini-COBRA laws vary significantly and may also require employers subject to Federal COBRA to provide coverage beyond the normal 18, 29, or 36 months.

What does COBRA require?

- Group health plans must offer temporary continuation coverage to qualified beneficiaries (i.e., individuals covered under the group health plan the day before a COBRA qualifying event occurs, does not include domestic partners) who experience an event which would cause their group health plan coverage to end (e.g., termination of employment, reduction of hours, divorce).
- Employers (or their COBRA Administrator) must notify qualified beneficiaries of their COBRA rights – there are two primary required notices:
  - General (initial) notice: within 90 days of health plan coverage enrollment.
  - Election notice: within 45 days upon a qualifying event occurring.
- Each qualified beneficiary can independently elect and maintain COBRA for the coverage in effect at the time of the qualifying event. Domestic partners are not qualified beneficiaries, therefore, in general do not have independent COBRA election rights.
- Qualified beneficiaries have the same rights under the plan as similarly situated active employees. (e.g., qualified beneficiaries may change their plan elections at open enrollment).

What events are COBRA Qualifying Events?

The following are COBRA Qualifying Events for a covered employee if it causes the covered employee to lose coverage.

- Termination of the covered employee's employment for any reason other than "gross misconduct".
- Reduction in the covered employees' hours of employment such that they are no longer eligible.
  - If the employer uses the lookback method, and the employee worked enough hours during the prior measurement period, the employer may be required to maintain coverage until the end of the stability period.

In addition to the above, the following are COBRA Qualifying Events for a covered spouse and dependent child if they cause the spouse or dependent to lose coverage.

- Covered employee enrolls on Medicare. This is only a COBRA Qualifying Event if the Medicare enrollment causes the loss of coverage. Due to the Medicare Secondary Payer rules, it is rare that Medicare enrollment would cause a spouse to lose coverage, usually they lose coverage because the employee decided to enroll on Medicare and cancel the employer coverage.
- Divorce or legal separation of the spouse from the covered employee.
- Death of the covered employee.

In addition to the above, the following is a qualifying event for a dependent child.

- Loss of "dependent child" status under the plan rules. Under the ACA, plans offer coverage to dependent children to age 26.

Which plans are subject to COBRA?

All group health plans defined under Treasury Regulation §54.4980 B-2, Q/A-1 that provide "medical care" based on the IRC 213(d) definition. This includes:

- Medical, dental, vision plans, health FSA (Flexible Spending Arrangements) and Health Reimbursement Arrangements (HRAs).

- Some employee assistance programs (EAPs) & wellness programs depending on the plan's benefits or design.
- On-Site medical clinics providing more than first aid.

When may COBRA be terminated?

- The maximum coverage period is 18 or 36 months unless the qualified beneficiary becomes disabled, or a second qualifying event occurs.
  - 18 months: termination, reduction of hours.
  - 36 months (spouse/dependent only): death of employee, Medicare entitlement, divorce or legal separation, dependent child ceasing to be a dependent.
  - 18 months + additional 11 months (29 months total) if a qualified beneficiary is deemed by the Social Security Administration to be disabled by or before the end of the first 60 days of COBRA.
- Coverage may be terminated early, and an early termination notice provided if:
  - Qualified beneficiary fails to make a timely payment (initial payment due 45 days from the election date, prospective monthly premiums must be allowed a minimum 30-day grace period each and every month from the payment due date.)
  - Qualified beneficiary becomes covered by another group health plan or Medicare after electing COBRA.
  - The employer cancels or ceases to maintain any group health plan.

Why worry about COBRA compliance?

- Depending on the type of COBRA violation, an employer may be exposed to:
  - IRS penalties: excise taxes of $100 per day for each impacted qualified beneficiary,
  - ERISA penalties: up to $110 per day and
  - Employee lawsuits which may result in liability for medical expenses, attorney's fees, etc.

How much can group health plans charge for COBRA?

- The COBRA premium must be computed and fixed before the "determination period," which is any consistent, year to year, 12-month period the employer chooses. However, it typically coincides with the beginning of the plan year or policy renewal date.
- The maximum employers are allowed to charge is up to 102 percent of the "applicable premium" defined as "the cost to the plan for such period of coverage for similarly situated beneficiaries to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee)".
  - For an insured plan this is generally the premium charged by the insurer.
  - A self-insured plan, there is no clear regulatory guidance on how this is calculated, other than "in good faith compliance with a reasonable interpretation." Often the COBRA premium for a self-insured plan is based on past cost history or determined with actuarial assistance based on plan specifics (e.g., claims data, administrative costs, stop-loss, average number of participants).
- The premium for the additional 11 months of a disability extension may be increased to 150 percent of the applicable premium.

Though not addressed in this brief overview, there are normally very strict timelines for qualified beneficiaries to elect and pay for COBRA.

Check with your Alera Group consultant for additional details.

Resources:

COBRA Overview Booklet

Medicare, COBRA, and Coordination of Benefits

Mini-COBRA Quick Facts