Group Health Plan Guide to COBRA

Introduction

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to temporarily continue health benefits provided by their group health plan (known as "COBRA continuation coverage") under certain circumstances such as job loss, reduction in hours worked, death, divorce, and other life events. Almost all employer group health plans are subject to COBRA requirements, which are found in the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code, and the Public Health Service Act (PHSA). ERISA and the Internal Revenue Code apply to private-sector employers, while the PHSA applies to the group health plans of state and local governments. Most states also have COBRA-type laws that apply to fully insured plans and fill in gaps where federal COBRA might not apply (e.g., small employers under 20 employees). This guide is intended to be a high-level overview of the federal requirements.

Who Is Required to Offer COBRA?

All private-sector employers that had 20 or more employees on more than 50 percent of their typical business days in the previous calendar year and currently offer a group health plan must offer COBRA continuation coverage. Learn which employees to count in the Department of Labor FAQ.

COBRA does not apply to plans offered by the federal government or plans sponsored by religious organizations such as churches and affiliates meeting the ERISA exemption.

What Plan Types Are Subject to COBRA?

COBRA applies to plans that provide medical care and that are maintained by an employer. "Medical care" is broadly defined as "the diagnosis, cure, mitigation, treatment, or prevention of disease and any other undertaking affecting any structure or function of the body." Plans that provide medical care can include:

- Major medical insurance
- Prescription drug plans
- Dental and vision care

- Health reimbursement arrangements
- Health flexible spending accounts
- Discount programs for medical care
- Wellness programs
- Employee assistance programs
- Self-insured medical reimbursement programs
- Onsite health clinics

Plan types not subject to COBRA include:

- Health savings accounts
- Long-term care insurance
- Life insurance
- Disability insurance

What Type of Coverage Must Be Offered under COBRA?

An offer of COBRA continuation coverage can only be made to qualified beneficiaries after a qualifying event and must be the same as the active coverage. Qualified beneficiaries have independent COBRA rights, meaning that in family coverage, for example, each qualified beneficiary can make their own COBRA election. A COBRA enrollee must be provided the same benefits, choices, and services that a similarly situated participant or beneficiary currently receives, including the right to add dependents under HIPAA special enrollment rights for certain family status changes such as birth or marriage. The enrolled beneficiary also has the same rights to choose among available options during open enrollment. Changes to the active group health plan will apply to COBRA participants.

Who Should Be Offered COBRA?

COBRA must be offered to qualified beneficiaries, who are the covered employee, spouse, or dependent child who suffered loss of coverage due to a qualifying event, including:

- Termination of the covered employee's employment for anything other than gross misconduct
- Reduction in hours of employment
- The covered employee becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee
- Loss of dependent child status

Length of COBRA Coverage

COBRA requires that continuation coverage extend from the date of the qualifying event for a maximum of 18 or 36 months, depending on the type of qualifying event. A plan, however, may provide longer periods of coverage beyond the maximum period required by law.

Qualifying Event	Qualified Beneficiary	Coverage Period
Termination of employment or reduction in hours	Employee, spouse, dependent child	18 months Additional 11 months for disability Additional 18 months for second event
Employee entitled to Medicare	Spouse and dependent child	36 months
Divorce or separation from employee	Spouse and dependent child	36 months
Death of employee	Spouse and dependent child	36 months
No longer "dependent child"	Dependent child	36 months

Required COBRA Notices

COBRA requires that group health plans provide specific notices that outline COBRA rights, how it is offered, how to elect coverage, and under what circumstances it can be terminated.

General/Initial Notice

Provided within 90 days of the employee first enrolling in the medical plan. The notice must be included in the Summary Plan Description (SPD). Visit the Department of Labor website for a model General Notice.

Qualifying Event Notice

The employer must notify the COBRA Administrator within 30 days of a qualified beneficiary losing coverage due to:

- Termination or reduction in hours
- Death of the employee
- Medicare entitlement of the employee
- Employer's bankruptcy

The qualified beneficiary or employee must notify the COBRA Administrator within 60 days of the qualified beneficiary losing coverage due to

- Divorce or legal separation
- Child ceasing to be a dependent under the terms of the plan

Election Notice

An Election Notice describes how to elect COBRA and must be provided to each qualified beneficiary within 14 days after the COBRA Administrator receives notice that a qualifying event has occurred (if the employer is the COBRA Administrator, this deadline is extended to 44 days for termination or reduction in hours, death of the employee, Medicare entitlement, or bankruptcy).

Notice of Unavailability

Provided if COBRA coverage is denied and must explain why the individual is not entitled to coverage or an extension within 14 days of the request.

Termination Notice

Provided as soon as possible if COBRA coverage is terminated early, stating the timeframe, reason, and rights under the plan or law to elect alternative coverage. Early termination may occur when:

- Premiums are not paid in full on a timely basis.
- The employer ceases to maintain any group health plan.
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage.
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage.
- A qualified beneficiary engages in fraud or other conduct that would justify terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage.

Electing COBRA

- A qualified beneficiary has 60 days to elect COBRA after receiving the election notice or losing coverage, whichever is later.
- Qualified beneficiaries within a family may make their own election for the same qualifying event. A minor's election will be made by the parent or legal guardian.
- A waiver of COBRA can be revoked, and coverage elected if done within the election period.

Mergers and Acquisitions Considerations

Business reorganizations such as mergers and acquisitions often trigger COBRA liability issues and questions regarding whether the buyer or seller is required to offer COBRA after the transaction and to whom. These rules are complicated, and it is important to ensure that COBRA administration responsibilities are identified prior to closing and are included in the purchase agreement.

In the absence of a contractual agreement, IRS regulations generally assign COBRA liability to the seller, but this is dependent on many factors including whether the seller maintains a group health plan after the sale and whether the transaction is an equity or asset purchase. For example, if the selling group does not maintain any group health plan after the sale, then the buyer must provide COBRA if the buying group maintains a group health plan, and the buyer is a successor employer.

COBRA Premium Payment

An employer can require the qualified beneficiary to pay all, part, or none of the continuation coverage premium.

The applicable premium can be up to 100 percent of the cost to the plan of providing continuation coverage, but employers may also charge an additional two percent administrative fee. The premium for each benefit

option and coverage level in a fully insured plan is the cost of the coverage. Calculating premiums for self-insured and account-based plans is more complicated.

A qualified beneficiary has 45 days after electing COBRA to make the initial premium payment. Subsequently, a qualified beneficiary has a 30-day grace period for premium payments, and coverage may be cancelled for nonpayment.

If a payment is received with an insignificant shortfall, the plan administrator should notify the qualified beneficiary and offer a reasonable period to pay the balance (30 days is considered reasonable).

COBRA Alternatives

Qualified beneficiaries are not required to elect COBRA and may find that there are more affordable or more generous alternatives for medical coverage.

- Other Group Health Plan – Losing coverage qualifies an employee for a special enrollment in a spouse's plan within 30 days of losing coverage.
- Health Insurance Marketplace (Exchange) – Losing coverage qualifies an employee to elect coverage under the local Marketplace within 60 days before or after the loss of coverage.
- Medicare – If the employee is entitled to Medicare but not already enrolled, they have an eight-month special enrollment period after employment or group health coverage ends. If the employee is entitled to Medicare after electing COBRA coverage, COBRA coverage can be terminated early.

Additional Resources

An Employer's Guide to Group Health Continuation Coverage under COBRA

FAQs about COBRA Continuation Health Coverage

FAQs about COBRA Model Notices

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